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Comparison of Consumer Protections in Three Health Insurance Markets

MEDICARE ADVANTAGE, QUALIFIED HEALTH PLANS AND MEDICAID MANAGED CARE ORGANIZATIONS

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Executive Summary

Private plans that provide health coverage to people with Medicare or Medicaid, and in the new Marketplaces collectively serve more than 70 million Americans as of January 2015 – and the numbers are on the rise.[1] These plans – Medicare Advantage plans, Qualified Health Plans (QHPs) and Medicaid Managed Care Organizations (MCOs) – operate under rules established by the federal government, many of which are designed to ensure that enrollees have access to coverage and the full scope of benefits and providers to which they are entitled. The rules for plans in each of the three markets differ, even though each market is overseen and regulated, to some degree, by the same federal agency, the Centers for Medicare and Medicaid Services (CMS). In addition, Medicaid MCOs and QHPs may be subject to more stringent consumer protection standards established and enforceable by the state in which they operate. This report examines similarities and differences in federal consumer protection standards for Medicare Advantage plans, QHPs, and Medicaid MCOs. It focuses on rules established at the federal level, though some states have chosen to go above the federal minimums and impose additional requirements for QHPs and Medicaid MCOs.

These three insurance markets were created at different times, for different purposes and for different populations, and to some extent, the different set of rules in which plans operate reflect this diversity. While Medicare is a purely federal program, Medicaid is a joint federal/state program, and the Marketplaces are subject to minimum federal standards but can be administered by either states or the federal government, or the two in partnership. Medicare was designed to serve people ages 65 and older, and younger people with disabilities, without regard to income. Medicaid is a program for individuals with low-incomes and also is a major source of coverage for people with disabilities. The Marketplaces were created to provide insurance to non-elderly people without access to other sources of coverage. The consumer protections now in place for both Medicare Advantage and Medicaid MCOs have evolved over time, and in response to issues that have emerged over many years. The rules for Marketplace plans are relatively new, developed and implemented following enactment of the Affordable Care Act.

Our comparison of the federal consumer protections requirements for Medicare Advantage, QHPs and Medicaid MCOs finds some similarities across the three markets, as well as several notable differences that could have important implications for consumers (See Table ES-1). In some instances, the different set of rules across the three markets can be easily explained; for example, differences in allowable cost-sharing reflect different statutory requirements. However, the rationale for other differences – such as minimum coverage standards for prescription drugs, network adequacy standards, appeal rights when claims are denied, and the circumstances under which an enrollee may change plans mid-year – is less clear.

While beyond the scope of this paper, further work is needed to explore whether the different set of rules for plans that provide coverage to Medicare, Marketplace and Medicaid enrollees are in the best interest of consumers, plans, and the federal government. Many insurers operate in all three markets – so inconsistencies in applicable standards can add to administrative burden. In addition, individuals can and do move between these different sources of coverage, sometimes within the same calendar year, and may also be confused, if their rights and protections shift abruptly following an enrollment change. At the same time, it is important to not dilute existing consumer protections simply for the sake of achieving uniformity, particularly provisions needed to safeguard vulnerable populations. Analysis of the reasons for and impact of some of these differences could inform whether more consistency across programs would be helpful.

Table ES-1. Key Differences in Medicare Advantage, QHPs and Medicaid MCOs

	Medicare Advantage (MA)	QHPs	Medicaid MCOs
Benefits: General approach	Must cover same benefits as traditional Medicare; no flexibility to substitute benefits, but can add additional benefits	Must cover benefits in 10 essential benefit categories with the flexibility to define benefit categories and substitute one benefit for another within categories	All federally required Medicaid benefits and others at state option
Prescription drugs	Must cover substantially all drugs in six protected classes (e.g., cancer medications); must also cover 2 or more drugs in each category; must have Pharmacy & Therapeutics (P&T) Committee for coverage decisions	No protected classes; must cover the greater of the number of drugs in a class covered by the "benchmark plan", or 1 drug in each class; like MA, must have P&T Committee, starting in 2017	Must cover all FDA approved drugs with rebate agreements (if state opts to cover prescription drugs and deliver through MCOs)
Cost-sharing: General approach	Some limits on variations in cost-sharing from traditional Medicare	Discretion to vary cost-sharing within metal categories	Limited cost-sharing at state option; certain populations and services exempt
Out-of-pocket limit	$6,700 for A & B plus a soft cap of $4,700 for Part D in 2015, with 5% coinsurance above cap	$6,600 per individual for all benefits, including prescription drugs, in 2015, rising to $6,850 in 2016	5% of monthly or quarterly income
Balance billing and cost-sharing limits	Out-of-network providers cannot balance bill for services rendered and covered by the plan; Cost-sharing for covered services in HMOs generally limited to in-network amounts	No balance billing restrictions on non-contract providers, including emergency services; Cost-sharing limited to in-network amounts for emergency services provided out-of-network	Balance billing limits similar to MA; Cost-sharing limits similar to MA, with additional protections for individuals with incomes below 100%FPL
Cost-sharing and premium subsidies for low-income enrollees	Subject to an asset test, cost-sharing subsidies available for people with incomes up to 100% FPL for Part A & B benefits and up to 150% FPL for Part D benefits and premiums, and Part B premium subsidies for incomes up to 135%FPL	Not subject to an asset test, cost-sharing reduced for individuals up to 250% FPL; premium subsidies available for people with incomes up to 400% FPL	Not applicable
Enrollment: Enrollment defaults	Default is traditional Medicare	Default is no coverage	Depends on state rules; can mandate MCO enrollment
Rules to switch plans due to provider network changes	Limited allowance to change plans if plan makes "significant" mid-year provider network terminations	No allowance to change plans mid-year if plan terminates providers from networks	Some allowances for mid-year changes in managed long-term services and supports providers
Minimum medical loss ratios (MLRs)	At least 85% of revenues must be spent on healthcare	At least 80% of revenues must be spent on healthcare	No similar federal requirement
Provider network requirements	Must meet time and distance minimums. Plans not required to report claims from out-of-network providers	No time and distance minimums required. Plans required to report claims from out-of-network providers; rule not implemented	Similar to MA
Notices, appeals and grievances: Denial notice content and external appeals	Required to provide standardized notices created by CMS CMS selects the independent review organization (IRO) for external appeals	Notice requirements mirror those for ERISA/self-insured group health plans (less robust) In 8 states, insurer can select IRO for external appeals; parallel to ERISA for self-insured group plans	Notice requirements are detailed External appeals through state fair hearing system with impartial hearing officer
Consumer information and assistance	Medicare.gov (plan finder), 1-800 Medicare and State Health Insurance Assistance Programs (SHIPS). Funded by annual appropriation	Navigator programs and Consumer Assistance Programs (CAP) to help with information, enrollment, subsidy applications, and appeals. Navigators funded by Marketplace operating revenue; CAPs funded by appropriation (last in 2010)	May provide ombudsman and/or enrollment counselor at state option. If MCO enrollment is mandatory, the state must provide beneficiaries with a plan comparison chart

Introduction

Delivering health insurance benefits through private plans, particularly capitated arrangements, can make costs more predictable for state and federal governments and increase care coordination for consumers. However, delivery of insurance benefits through private plans also can add complexity for consumers because each plan and market is unique, and can provide different benefits, require different cost-sharing for services, and often include and exclude different providers. Navigating health coverage delivered through private plans can be especially challenging for consumers with low incomes, low health literacy, cognitive impairments, expensive or chronic health conditions, and those who have a history of being uninsured. Building consumer protections into private health plans can help to ensure enrollees have access to coverage and the full scope of benefits to which they are entitled.

This issue brief examines the similarities and differences in consumer protections in three major sources of insurance coverage delivered through private plans: Medicare Advantage (MA), Qualified Health Plans (QHPs) offered through the Marketplaces, and Medicaid Managed Care Organizations (MCOs). These three insurance markets, to different extents, are overseen by the same agency within the federal government, the Centers for Medicare and Medicaid Services (CMS). Although there are similarities in the consumer protections provided by these various coverage schemes, there are also notable differences, and these differences may raise issues for consumers – particularly those who are enrolled in plans in two or more of the markets either consecutively or concurrently. For example, someone may be covered by a QHP offered through a Marketplace followed by a Medicare Advantage plan when they turn 65. It is likewise possible that individuals with low incomes may be in a QHP, Medicaid MCO, and Medicare Advantage plan within the span of several years due to age, fluctuations in income and/or disability status.

The three insurance markets on which this paper focuses were created for different purposes and for different populations, and their varied structures reflect this diversity. Medicare is a purely federal program, Medicaid is a joint federal/state program, and the Marketplaces are federal, state, or federal-state partnership. Medicare was designed to serve older adults and younger people with disabilities, without regard to income. The Marketplaces were created to provide insurance to people without access to other sources of coverage, and include premium tax credits and subsidies to make coverage more affordable for those with limited incomes. In contrast, Medicaid is a program for individuals with low-incomes and cost-sharing is correspondingly more restricted than in the other two programs. For purposes of this report, Medicaid is included when the comparison to the other two programs is relevant; in other words, when the difference is more than a reflection of the different program target populations or program design intent.

This paper reviews the federal rules that apply for Medicare Advantage plans, QHPs and Medicaid MCOs but assesses neither the degree to which these rules are enforced by state and federal governments, nor whether states apply more stringent requirements than the federal minimum standards for QHPs and Medicaid MCOs. It should be noted that some states have chosen to go above that federal minimum and have imposed additional requirements through their state-based Marketplaces as some states have similarly imposed additional requirements beyond the federal minimum for Medicaid MCOs. Further, a number of consumer protections for QHPs are currently either unimplemented or partially implemented.

Background on Medicare Advantage, Qualified Health Plans and Medicaid Managed Care Organizations

Medicare Advantage (MA) is built on the foundation of Medicare, a federal entitlement health coverage program with federal rules and oversight for people ages 65 and older and younger people with disabilities. The Medicare Advantage program, also known as Medicare Part C, is a voluntary coverage option available to Medicare beneficiaries as an alternative to the traditional fee-for-service Medicare program. Medicare Advantage plans must cover all services that are covered by Medicare Parts A and B, (and, if applicable, the Part D prescription drug benefit). Medicare Advantage plans can, and are often required to, provide benefits in addition to those covered by traditional Medicare.

The Affordable Care Act (ACA) expands access to individual health insurance coverage largely through private, non-employer based, individual health insurance offered through Marketplaces. Under the ACA all private insurance, including Qualified Health Plans (QHPs) offered through the Marketplaces, is subject to minimum federal standards, with flexibility reserved for states to apply stronger standards to plans they regulate. Income-based premium and cost-sharing subsidies are available through the Marketplaces to ensure coverage is affordable for those who have no other source of affordable coverage. Health insurance plans must be certified as QHPs by a Marketplace before they may be sold to consumers on that Marketplace. To be certified, QHPs must provide coverage for certain essential health benefits (EHB), follow established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meet other requirements. QHPs are divided into four different categories based on the percentage of health costs a plan is expected to pay (actuarial value): Bronze, Silver, Gold, and Platinum, all of which must cover EHB.[2]

Medicaid is a major source of coverage for people with low incomes and people with disabilities. Medicaid is jointly financed by the federal government and the states and administered by the states with federal oversight. Federal law requires states participating in Medicaid to cover certain mandatory benefits, and states can choose to cover additional optional benefits. States can choose to provide Medicaid benefits through managed care delivery systems, including managed fee-for-service (FFS) models, such as primary care case management, and capitated models, such as managed care organizations (MCOs), private health plans that contract with the state on a risk basis to deliver Medicaid services.[3] An increasing number of Medicaid beneficiaries – now more than half – receive Medicaid coverage through managed care plans. (*For more information about these three programs, see Appendix A.*)

Comparison of Specific Areas of Consumer Protections

In Medicare, Medicaid, and now, Marketplace QHPs, consumers are guaranteed a base level of access to coverage and financial protection. They are likewise afforded other procedural safeguards. Across the range of consumer protections, including those pertaining to eligibility, enrollment, renewability, benefits, cost-sharing and other categories of consumer protections, there are many similarities between Medicare Advantage plans, QHPs and Medicaid MCOs, as well as some notable differences in such protections, which are highlighted below. While the comparison chart in Appendix C contains a more detailed comparison across a broader range of consumer protections, highlights are summarized below.

Covered Benefits

		Medicare Advantage (MA) plans	QHPs	Medicaid MCOs
Scope of Benefits		MA plans must cover what traditional Medicare covers (set out in statute). Actual scope of benefits provided will vary slightly from plan to plan.	QHPs must cover 10 essential health benefit (EHB) categories; details are determined based on the state benchmark. Generally, benefits are not defined in federal statute or regulation. Plans may substitute actuarially equivalent services within categories; as a result coverage for some services could vary significantly from plan to plan.	State Medicaid programs must cover certain mandatory and any optional benefits that the state elects (set out in statute), and states opt whether to deliver those benefits through MCOs, as specified in the MCO's contract with the state. If the enrollee is entitled to benefits not provided by the MCO, the beneficiary must be provided the service by either FFS Medicaid or another specialized Medicaid managed care plan.
Prescription Drugs	**Drugs required to be covered**	Substantially all drugs in 6 "protected" classes must be covered.	None.	All FDA approved drugs with rebate agreements.*
	Other coverage rules	MA plans must follow Part D rules that require coverage of at least two drugs in each US pharmacopeia category or class. Must establish Pharmacy & Therapeutics (P&T) committees to make drug coverage decisions based on scientific evidence.	QHPs must cover at least one drug per US pharmacopeia category or class OR the same number of drugs in each category and class as the state benchmark, whichever is greater. Starting in 2017, QHPs must establish Pharmacy & Therapeutics (P&T) committees (similar to those required for Part D plans) to make drug coverage decisions based on scientific evidence.	Not applicable.
	Utilization management restrictions	Utilization management allowed, but limited with respect to 6 "protected" classes of drugs.	Utilization management allowed.	Utilization management allowed.

* Note: This statement is true for all states that elect to cover prescription drugs, which all presently do, and if the state opts to provide prescription drugs through managed care.

Source: Authors' analysis, 2015.

Medicare Advantage plans, QHPs and Medicaid MCOs are all required to provide a certain core set of benefits. All three markets require plans to cover a range of similar services, and have similar exclusions from coverage, but state Medicaid programs generally provide greater coverage of long-term services and supports than Medicare Advantage plans or QHPs.[4]
Medicare Advantage plans must provide all services covered under Parts A and B of Medicare except for hospice services (and in certain circumstances, must provide Part D prescription drug coverage). The Medicare Advantage plan benefit package is based on traditional Medicare Parts A, B and D (if applicable) which can have limitations in scope and duration of coverage in certain care settings (for example, Medicare limits coverage in a skilled nursing facility to up to 100 days in a benefit period). Medicare Advantage plans do, however, have some flexibility to loosen, but not tighten, benefit restrictions relative to traditional Medicare's structure (e.g., Medicare Advantage plans can choose to waive coverage limits that apply under traditional Medicare; for example, MA plans can waive the 3-day prior hospital stay requirement for skilled nursing facility coverage, or extend such coverage beyond 100 days per benefit period).

QHPs are required to cover 10 categories of essential health benefits (EHBs) enumerated in statute. Detail defining EHBs is based on a benchmark plan. The default state benchmark package is based on the most popular small group plan, though states can designate other benchmark options. Federal regulation provides limited detail defining benefits within categories, and states may provide more detailed regulation. Otherwise, insurers have flexibility to determine which EHB category applies to specific services covered under the benchmark plan; further, absent state limitations, insurers then have flexibility to substitute actuarially equivalent services within EHB categories. Under federal rules, insurers are not required to report to the Marketplace or to consumers when they adopt such substitutions. As a result, coverage for some services under QHPs could vary significantly plan to plan. Examples of variations in current QHP offerings include limits on the number of home health visits, imaging services, speech therapy and organ transplantation. QHPs are also subject to a 'nondiscrimination' standard; benefit design and cost-sharing design cannot discriminate based on health status and other factors. To date, regulations to define the nondiscrimination standard in further detail have not been issued. For the 2016 plan year, CMS will require QHP insurers to attest that their plan design complies with the nondiscrimination standard. CMS guidance indicates it will monitor complaints data for 2016 QHP plans. Other oversight seems to be evolving; for example, CMS guidance indicates it will "consider" outlier analysis of QHP cost-sharing designs, such as whether drug treatments for given health conditions are assigned to the highest cost-sharing tier. No other compliance standards have been issued to date.

Unlike Medicare Advantage plans and Medicaid MCOs, the actual services in the ten EHB categories that QHPs must cover are not enumerated in statute or regulation. The statute requires the Secretary of Health and Human Services (HHS) to periodically review EHB standards, and HHS has indicated that it will monitor the benchmark/EHB system and may revisit the coverage requirements in 2016.

Federal law requires states participating in Medicaid to cover certain mandatory benefits, and states can choose to cover additional optional benefits. The underlying Medicaid program provides the primary public coverage of long-term services and supports, while only limited coverage for such benefits is provided through Medicare or Marketplace QHPs. States choose whether to deliver long-term care benefits through Medicaid MCOs.

Medicaid has the most comprehensive drug coverage requirements of plans in the three markets, and requires coverage of all FDA approved drugs (provided that the state opts to cover prescription drugs and to deliver that benefit through MCOs, which all currently do). Medicare drug plans are required to cover at least two drugs in each pharmacopeia class while QHPs need only cover one. Medicare plans are also required to provide enrollees with substantially all drugs in six protected classes of drugs while QHPs are not. Plans in all three markets may employ utilization management tools. Medicare Advantage plans that offer drug coverage can develop their own formularies as long as protected classes and non-discrimination requirements are honored. Protected classes include cancer medications, anti-psychotics, anti-convulsants, anti-depressants, immunosuppressants, and anti-retroviral drugs. There are no similarly protected classes of drugs within QHPs but, similar to Medicare Advantage rules, benefit and cost-sharing design cannot be discriminatory. Medicare Advantage plans must also cover at least two drugs in each US pharmacopeia class, whereas QHPs must cover at least one drug per US pharmacopeia class or the same number of drugs in each class as the benchmark, whichever is greater. The protected classes are not relevant for Medicaid since Medicaid must cover all FDA approved prescription drugs for which the manufacturer has a rebate agreement, which in practice means virtually all FDA approved drugs are covered, although states can use utilization management tools, such as preferred drug lists. Starting in 2017, QHPs will be required to establish pharmacy and therapeutics (P&T) committees, similar to those required for Part D plans, to make drug coverage decisions based on scientific evidence. P&T committees will be required to review newly approved drugs and new uses for existing drugs within 90 days of market release and make coverage decisions within 180 days of market release.

Like Medicare Advantage plans, QHPs may use tiering and other utilization management tools. As noted above, benefit and cost-sharing design cannot be applied in a discriminatory manner for QHPs, though regulatory standards have not yet been issued. Recently a complaint to the HHS Office of Civil Rights was filed by patient advocates alleging that the assignment of HIV drugs to higher cost-sharing tiers under certain QHPs violates the nondiscrimination standard.[5] Unlike Medicare Advantage plans, though, QHPs are not required to limit the application of utilization management to any classes of "protected" drugs for which plans must cover all or substantially all drugs in such classes.

For Medicaid, states elect whether to deliver prescription drugs through managed care. Medicaid programs may use utilization management and clinical effectiveness guidelines in drug coverage decisions. States may use a preferred drug list and impose quantity limits although there must be a prior authorization process for exceptions. This is a feature of state Medicaid programs rather than individual Medicaid MCOs just as protected classes in Medicare Advantage plans are a feature of the Medicare program rather than Medicare Advantage.

Cost-Sharing

	Medicare Advantage (MA) plans	QHPs	Medicaid MCOs
Cost-Sharing in Benefit Design	Must be generally actuarially equivalent to benefits covered under traditional Medicare, including equivalence in certain specific service categories, such as inpatient and skilled nursing facility care, which limits a plan's ability to vary deductibles, co-pays and co-insurance.	QHPs must meet actuarial value based on metal level (60%, 70%, 80%, 90%) applied over the entire benefit package. Within and across metal tiers, substantial variation in structure of cost-sharing is observed.	Not applicable; see "out-of-pocket" maximum below.
Out-of-Pocket Maximum	Maximum out-of-pocket limit (MOOP) for medical services (Part A and Part B) is $6,700 for individual enrollees in 2015, with a separate Part D catastrophic coverage maximum of $4,700 out-of-pocket in 2015, after which beneficiaries pay 5% coinsurance, making this a soft rather than "hard cap" with respect to prescription drug costs covered by MA-PDs. Because of the separate caps, total out-of-pocket costs (for A, B and D) could be up to $11,400 beyond which enrollees may still have prescription drug costs.	Maximum out-of-pocket limit of $6,600 for individuals and $13,200 for a family in 2015, including cost-sharing for medical services and prescription drugs. For 2016, the out-of-pocket limit is $6,850 for individuals and $13,700 for a family.	Medicaid has strict limits on out-of-pocket cost-sharing set out in statute. In general, out-of-pocket costs may not exceed 5% of monthly or quarterly income.
Balance Billing	Enrollees are protected from balance billing by non-contract providers and are limited to in-plan cost-sharing amounts for services that are ultimately covered by the plan, including out-of-network emergency services.	Enrollees may pay in-network cost-sharing rates for out-of-network emergency services, but no balance billing protections are required for any out-of-network care in QHPs, including for emergency services.	Comprehensive cost-sharing protections for enrollees, including billing protections that prevent a participating provider from refusing to provide a service due to non-payment of cost-sharing by beneficiaries with incomes at or below 100% FPL.
Low-Income Assistance	Part B premium assistance available through traditional Medicare for individuals with income up to 135% FPL; asset test applies (those at or below 100% FPL are eligible for additional Part A and B cost-sharing assistance). For Part D expenses, individuals with incomes below 150% FPL and limited assets are eligible for Part D premium and cost-sharing assistance.	Enrollees with incomes between 100% and 400% FPL eligible for sliding scale premium tax credits. Enrollees with incomes from 100-250% FPL are also eligible to receive cost-sharing subsides. No asset tests apply.	In states that have expanded Medicaid under the ACA, adults with income up to 138% FPL eligible for Medicaid. No asset test applies.

Source: Authors' analysis, 2015.

Cost-sharing charged by Medicare Advantage plans is bound by actuarial equivalence with traditional Medicare – in other words, Medicare Advantage plans may impose cost-sharing that is different from that under Parts A and B, as long as total Medicare Advantage cost-sharing for Part A and B services does not exceed cost-sharing for those services in traditional Medicare. Medicare Advantage plans must also apply actuarial equivalence to certain service categories; for example, in 2015 Medicare Advantage plans must apply actuarial equivalence to inpatient care, skilled nursing facility, home health, durable medical equipment and Part B drugs. In addition, plans' cost-sharing for some services cannot exceed cost-sharing under Parts A and B: renal dialysis, chemotherapy and skilled nursing facility care.

QHPs must conform to actuarial value (AV) based upon the plan's "metal level" but QHPs generally have significant leeway in how they structure deductibles and other cost-sharing (except in a few states, like California and New York, which require standardized cost-sharing designs). This leads to significant variation in cost-sharing across QHPs. For example, for silver level QHPs in the federal Marketplace in 2015, just over half apply a comprehensive deductible for all services while 45 percent of silver plans have separate medical and drug deductibles. Among plans with separate deductibles, the average medical deductible is about $3,500, though some plans have medical deductibles as low as $0 or as high as $5,000.[6]

Medicare Advantage plans and Medicaid MCOs limit enrollees' financial liability for out-of-network balancing billing, while QHPs are not required to include such protections. QHP cost-sharing protections are generally only applicable for in-network services. While QHPs are required to charge in-network cost-sharing for out-of-network emergency services, no balance billing protections are required for any out-of-network care in QHPs, including for emergency services. This means a provider may collect above and beyond the out-of-network cost-sharing amounts from enrollees if they so choose. By contrast, Medicare Advantage plans and Medicaid MCOs protect enrollees against balance billing by providers for emergency services used outside of the provider network.[7] In general, a Medicare Advantage enrollee is protected from balance billing by non-contract providers and is limited to in-plan cost-sharing amounts for services that are covered by the plan. QHPs do not have comparable protections. Medicaid, including services offered through MCOs, offers comprehensive cost-sharing protections to enrollees, including billing protections that prevent a participating provider from refusing to provide a service due to non-payment of cost-sharing by beneficiaries with incomes at or below 100 percent of the Federal Poverty Level (FPL).

All three types of plans provide for caps on enrollees' in-network out-of-pocket expenses. As noted above, since it is a program designed to serve individuals with low-incomes, Medicaid cost-sharing is more limited than the other two programs. Medicare Advantage plans must establish a maximum out-of-pocket liability amount (MOOP) for all Part A and B services, established annually by CMS. In 2015, the mandatory MOOP is $6,700.[8] There is a separate maximum out-of-pocket or "catastrophic" threshold limit for prescription drugs of $4,700 (for 2015), after which point cost-sharing is the greater of 5 percent or $2.55 for generic or preferred drugs and the greater of 5 percent or $6.35 for all other drugs. The Medicare Advantage MOOP is not indexed to inflation and has not changed in five years, while the cost-sharing threshold under Part D plans is declining annually as the "donut hole" is gradually phased out.

For QHPs, the out-of-pocket limit for 2015 is $6,600 for an individual plan and $13,200 for a family plan. This amount includes prescription drugs. The maximum out-of-pocket limit under QHPs is adjusted each year and

started at $6,350 for individuals and $12,700 for a family plan in 2014. For 2016, the maximum limit is $6,800 for individuals and $13,600 for families.

While both Medicare and QHPs provide low-income subsidies, subsidy eligibility for QHPs has higher income limits and does not impose an asset test. QHPs provide enrollees with incomes between 100 percent and 400 percent FPL ($11,770 – 47,080 in 2015) sliding scale premium tax credits which limit the amount they will pay in premiums to a set percentage of income. QHP enrollees with incomes from 100-250 percent FPL ($11,770 – 29,425 in 2015) are also eligible to receive cost-sharing subsides that lower out-of-pocket caps and deductibles.

In states that have expanded Medicaid under the ACA, adults with income up to 138% FPL ($16,242 per year for an individual in 2015) are eligible for Medicaid. Under federal law, Medicaid premiums and cost-sharing for covered services apply only to certain groups of beneficiaries and are limited in amount. Neither Marketplace financial assistance programs nor Medicaid in poverty-related (MAGI) categories, including newly eligible adults, impose an asset test.

Medicare Advantage enrollees may qualify for the same Medicare low-income programs as traditional Medicare beneficiaries. For people living below 135 percent FPL ($15,889 in 2015) with limited assets, the Medicare Savings Programs pay the Part B premium ($104.90 per month in 2015). For individuals with incomes below 150 percent FPL ($17,655 in 2015) and limited assets, the Part D low income subsidy (LIS) pays the monthly Part D prescription drug premium and lowers co-pays at the pharmacy.

Individuals who attain Medicare eligibility are no longer eligible for either Marketplace subsidies or expansion Medicaid and may face an increase in out-of-pocket costs as their insurance status, and therefore subsidy eligibility, changes. For example, a 64-year old individual with income at 200 percent FPL ($29,425 in 2015) and significant assets can access tax credits and cost-sharing subsidies to help defray the costs of QHP coverage in the Marketplace; however, no premium or cost-sharing assistance is available for the same individual through Medicare once they turn 65. Individuals with Medicaid and some with low incomes receiving Marketplace premium tax credit and cost-sharing subsides may encounter what is referred to as the Medicare "cliff" – meaning that depending upon their income and resources, they may see their out-of-pocket costs increase when they become eligible for Medicare because Medicaid for people over 65 and Medicare have more stringent eligibility requirements for cost-sharing assistance. (*For more information, see Appendix B.*)

ENROLLMENT

		Medicare Advantage (MA) plans	QHPs	Medicaid MCOs
General Enrollment		Open enrollment is October 15 through December 7. Similar to Medicaid, MA has a lock-in period for one year (with some exceptions).	Open enrollment for the 2015 plan year was November 15, 2014 to February 15, 2015. Enrollment periods for the 2016 plan year (and thereafter) will align with the MA enrollment period.	No similar enrollment period; Medicaid enrollment is always open. However, if Medicaid MCO enrollment is mandatory, beneficiaries must have the choice of two plans and have 90 days after enrollment to change plans after which time they generally are "locked-in" to their plan. Enrollees must have the option to change plans after the initial 90 days at least once every 12 months.
Special Enrollment Periods (SEPs)	**Low-income beneficiaries**	Low-income individuals (receiving Medicaid, Medicare Savings Program (MSP) and/or Part D Low Income Subsidy (LIS)) have a monthly SEP to enroll in, change or dis-enroll from MA plans.	No similar requirement.	Not applicable.
	Changes in income	No SEP, unless found newly eligible or ineligible for certain low-income benefits (e.g., Medicaid, MSP, Part D LIS).	SEP only for those already enrolled in QHP who become newly eligible for the advance premium tax credit (APTC) or cost-sharing subsidies (CSR), or for a different level of CSR. Can change plans once per qualifying event.	Not applicable.
	Changes in life circumstances	SEP following a move or loss of certain types of other coverage.	SEP for "life circumstance" changes, such as a change in family status (e.g., marriage, having a child), a move, or other changes that trigger a loss of other minimum essential coverage.	No similar requirement.

	Exceptional circumstances	No similar requirement (except by designation by CMS, e.g., following certain natural disasters).	SEP allowances for exceptional circumstances preventing plan selection or enrollment.	If MCO enrollment is mandatory, may dis-enroll for "good cause" at any time.
	Changes in plan provider networks	Starting in 2015, limited SEP for "significant" network provider terminations.	No similar requirement.	MCO disenrollment allowed if termination of a residential or employment supports provider from enrollee's MLTSS network would result in a disruption in their residence or employment.[9]

Note: MLTSS is Medicaid Managed Long-Term Services and Supports
Source: Authors' analysis, 2015.

The rules for Medicare Advantage plans, QHP, and Medicaid MCO enrollment and disenrollment partly reflect whether enrollment in managed care is mandatory, and whether an alternative source of coverage is available. Medicare Advantage enrollment, as an option for receiving Medicare services guaranteed through federal entitlement, is voluntary for Medicare beneficiaries. Correspondingly, if a person chooses to dis-enroll from a Medicare Advantage plan, or is involuntarily dis-enrolled, the default is traditional Medicare coverage. Since QHPs are not built on the foundation of a federal entitlement, if an individual is dis-enrolled from a QHP there is no default – they are left without coverage unless and until they can exercise enrollment rights and opportunities to gain new coverage. Medicaid also is a federal entitlement for those who meet eligibility requirements. States can choose to deliver Medicaid benefits through managed care and whether to make MCO enrollment voluntary or mandatory, except that CMS must approve the mandatory enrollment of certain populations.

Medicare Advantage and Marketplace rules generally restrict when during the year beneficiaries can enroll and dis-enroll from plans. Both markets provide for special enrollment periods (SEPs) triggered by certain events, while mandatory Medicaid managed care enrollees are allowed to change MCOs at least once per year after their initial enrollment and for "good cause" at any time. Special Enrollment Periods for QHPs emphasize the ability to enroll in coverage when someone loses other coverage, whereas Medicare Advantage SEPs work to allow individuals in to Medicare Advantage plans, out of Medicare Advantage and into traditional Medicare, or into another Medicare Advantage plan. As expected, differences in SEP rights between Medicare Advantage plans and QHPs partly reflect the fact that the "default" from a Medicare Advantage plan is traditional Medicare whereas there is no default for QHP enrollees. CMS sought to protect QHP plan sponsors against adverse risk selection and structured QHP SEPs accordingly. QHP SEPs are more broad than Medicare Advantage SEPs for life-changing events (e.g., marriage, since single v. family enrollment is a factor in QHP eligibility and enrollment, unlike Medicare Advantage) and exceptional circumstances preventing timely plan selection (e.g., serious medical condition and natural disaster; *for more information about SEPs, see Appendix D*).

One notable difference in SEPs between Medicare Advantage plans and QHPs concerns individuals enrolled in certain low-income programs. Medicare Advantage plans allow an ongoing

SEP right to change plans on a monthly basis for individuals enrolled in low-income programs: Medicaid, a Medicare Savings Program and/or the Part D low-income subsidy (LIS). For Medicaid MCO enrollees, who by definition have low incomes, if states require MCO enrollment, there is an on-going SEP for the first 90 days after which time individuals are generally locked-in to their plan (for no more than 12 months). In the Marketplaces, in order to access an SEP based on a change in advance premium tax credit (APTC) or cost-sharing subsidy (CSR) eligibility, an individual must *already* be enrolled in a QHP. This SEP is for switching QHPs rather than enrolling in coverage for the first time.

Another notable difference in SEPs relates to changes in a managed care plan's provider network. Starting in 2015, Medicare Advantage enrollees have a limited right to change plans based upon CMS' finding of "significant" network provider terminations by their Medicare Advantage plans, but there is no corresponding requirement for QHPs (also see network adequacy section below). According to 2013 guidance, enrollees in Medicaid managed long-term services and supports waivers may dis-enroll from their MCO when the termination of a provider from their MLTSS network would result in disruption in their residential or employment support services.

Efficiency Standards

Medical Loss Ratio (MLR)

	Medicare Advantage (MA) plans	QHPs	Medicaid MCOs
Medical Loss Ratio (MLR) Requirements	Plans must maintain at least 85/15 ratio.	Plans must maintain at least 80/20 ratio.	No federal requirement.

Source: Authors' analysis, 2015.

Medical loss ratio (MLR) refers to rules that limit the percentage of plan revenue that can be spent on administrative costs (claims administration, profit, etc.). Medicare Advantage plans must maintain an MLR of at least 85 percent/15 percent. Sanctions for failure to meet this standard can include rebates owed by the plan going back to the Medicare program, a prohibition on enrolling new members, and ultimately, termination of the plan's contract with Medicare. Individual QHPs must maintain an MLR of at least 80 percent/20 percent with any rebates going back to the individual. There is no federal MLR requirement in Medicaid, although states are permitted to include such a requirement in an MCO contract.

Provider Network Requirements: Adequacy, Enforcement, and Information

		Medicare Advantage (MA) plans	QHPs	Medicaid MCOs
General Requirements		Federal law establishes MA network adequacy requirements which broadly require "adequate" provider networks that take into account: (1) number of providers per population size; and (2) time/distance travel requirements so enrollees are not "unduly burdened."	Federal law requires QHPs to have "adequate" provider networks. To date, more specific federal standards, including time/distance standards, have not been required. States may apply additional requirements.	Federal law establishes general network adequacy criteria that all MCOs maintain a network of providers that is "sufficient" to provide adequate access to Medicaid services. MCOs must take into account factors like (1) projected enrollment, (2) geographic location and (3) timely access to care for enrollees.
Consumer Information	**Enrollment information**	MA plans must disclose provider network when beneficiary enrolls or renews enrollment. Plans must make provider directories available upon request and ensure that websites contain current directories at all times. Medicare.gov is not required to link to provider directories.	Links to QHP provider directories must be posted on the Marketplace website. Directories must be updated at least monthly.	State or MCO must provide enrollees with names, locations, and phone numbers of providers.
	Termination of providers	MA plans are required to make a "good-faith effort" to notify enrollees of provider terminations. MA plans can change their provider networks at any time during the year as long as they continue to meet network adequacy standards and	QHPs are not required to inform enrollees of provider terminations. QHPs can change their provider networks at any time during the year as long as they continue to meet network adequacy standards and keep their provider	MCOs are required to notify enrollees of provider terminations. MCOs can terminate providers at any time but must maintain continuity of care.

		keep their provider directory up-to-date.	directory up-to-date.	
	Providers speaking non-English languages	No similar requirement.	No similar requirement.	Must identify providers who speak non-English languages.
	Providers accepting new patients	No similar requirement.	Must identify providers that are accepting new patients, effective for 2016.	Must identify providers that are not accepting new patients.
Compliance and Oversight		CMS uses geo-mapping software to evaluate network adequacy for new contracts; MA plans renewing annual contracts are required to attest that their network meets requirements, with no further review by CMS.	Plans are required to attest to meeting network adequacy requirements; starting in 2015, plans must submit provider network prior to certification; additional oversight by CMS is evolving.	State must ensure through contracts that each MCO gives assurances and provides supporting documentation that demonstrates that MCO has the capacity to serve expected enrollment in service area in accordance with state's access to care standards; state must review plan documentation and certify to CMS that plan complies with state's standards.
Reporting Requirements		Not required by statute to report claims from out-of-network providers.	Required by statute to report claims from out-of-network providers; this provision not yet implemented.	No similar requirement.
Out-of-Network Coverage for Emergency Care		Plans must cover out-of-network emergency services at in-network cost-sharing rates or a standard co-pay set by CMS ($65 in 2015), whichever is lower. Balance billing by providers is limited.	QHPs must cover out-of-network emergency services at in-network cost-sharing rates. However, balancing billing by the provider is not limited.	Medicaid MCOs must adequately and timely cover services out-of-network at no more than in-network costs to enrollee, if service cannot be provided in-network, including emergency care.

Source: Authors' analysis, 2015.

In the Medicare Advantage program, federal network adequacy standards and oversight are more developed than those for QHPs, while QHPs and Medicaid MCOs may be subject to more stringent state specific network adequacy requirements. Network adequacy generally refers to a plan's ability to provide timely and adequate care to enrollees through a sufficient "network" of health care providers. Adequate plan provider networks are crucial to ensuring consumers have timely access to needed health care services. For Medicare Advantage plans, CMS has
a mechanism for review of provider networks in all Medicare Advantage plans against minimum time/distance access standards and distribution of specialists. Actual review of such Medicare Advantage networks, however, occurs only when a plan is new to a service area, is expanding its service area, significantly changes its network, or if CMS receives many complaints about the network; in other words, there is no required annual review for plans renewing existing contracts with CMS. In the financial alignment demonstrations for dually eligible individuals, CMS will review the adequacy of plans' networks annually beginning in 2015.

For QHPs, CMS implementation of network adequacy standards is evolving. In the first year, CMS required insurers to submit the "name" of the provider network (not the names of providers in the network) and attest to its adequacy. Since then, CMS has required QHPs to submit network directories, but agency review is ad hoc, focusing mainly on five provider types, and does not involve analysis against time/distance standards. CMS has suggested such review may take place in future years. CMS guidance also indicates the agency will analyze plan network data for the coming year with a focus on certain providers, which may include hospitals and primary care, mental health, oncology and dental providers. The ACA also requires QHPs and other private health plans to submit data to the Secretary on out-of-network claims and out-of-pocket expenses. These data could be used to develop measures of network adequacy; to-date, however, this provision of the ACA has not been implemented. Medicaid MCO network adequacy is left up to the states, within broad federal guidelines and with federal oversight, however plans must implement procedures to ensure that each enrollee has an ongoing source of primary care appropriate to individual needs, as well as identify people with special health care needs and ensure that they have direct access to specialists as appropriate.

Although Medicare Advantage network adequacy standards and oversight are more developed than that for QHPs, including a specified ratio of certain types of providers, Medicare Advantage plans are not bound by the QHP requirement to contract with a threshold number of essential community providers serving predominantly low-income and medically underserved individuals.

Notice, Appeals and Grievances

	Medicare Advantage (MA) plans	QHPs	Medicaid MCOs
Notice of Denial	Notice of non-coverage is a standard document developed by CMS. Must provide timely description of service denied, the action taken/to be taken, reason for action/service denial, information on rights to expedited and standard appeal, and how to seek an appeal. Notice must use approved language in a readable and understandable format (however requirements that notices be provided in languages other than English are limited).	Notice must be timely and include description of service denied, the action taken/to be taken, reason for action/service denial, and information about appeal rights. This mirrors ERISA guidelines. Under federal law, all denial notices must include brief statement that translation assistance by phone is available. Consumers who want written translation must request it for each notice. State law may apply additional notice requirements.	Notice must be timely and written in accessible language and format that explains the action taken/to be taken, the reason(s) for the action/service denial or termination, enrollee's right to file an appeal, enrollee's right to request state fair hearing (if state does not require exhaustion of plan appeal first) and how to exercise expedited and standard appeal processes, including the right to and process for requesting aid pending, and circumstances under which enrollee may be required to repay.
Appeals Process	Adverse decisions may be appealed to five-level Medicare administrative appeals process, which includes an internal plan review, an external review by an independent contracted reviewer, an Administrative Law Judge hearing, a hearing by the Medicare Appeals Council in HHS, and federal district court. There are expedited appeal rights for cases of urgent medical necessity.	Any plan decision is internally appealable. The opportunity to seek external review is reserved only for adverse determinations that involve clinical judgment. There are expedited appeal rights for cases of urgent medical necessity. Generally, for QHPs the appeals process provides for up to one mandatory internal review with other "voluntary" levels of internal review permitted, an external review, and in some states appeal to state court.	Adverse decisions may be appealed to the plan where enrollees have rights to present evidence and allegations of fact and law at plan hearing and to access documents and records considered at the hearing. They also may access the state fair hearing system which terminates in state court. There are expedited appeal rights for cases of urgent medical necessity.
Independent External Review	Required at consumer's request after internal appeal completed. CMS selects the independent review organization.	Required at consumer's request after internal appeal completed. In most states, state regulator selects the independent review organization; in 8 states where weaker state laws preempted, insurers have choice of using two federal external review systems – one run by HHS	Required at consumer's request. States vary as to whether exhaustion of internal plan appeal process is mandatory before accessing state fair hearing.

		where federal government hires review organization, and one established by DOL for all self-funded employer plans where plan hires review organizations.	
Aid Paid Pending	Not required (other than limited continued coverage when appealing discharges from hospital, skilled nursing facilities and home health coverage).	Not required.	Required for service terminations if timely requested by beneficiary.[10]
Grievances	Prescribed grievance process to express dissatisfaction about matters that are not subject to appeals, such as quality of care or failure to respect enrollee rights.	Complaints and grievance process through the Marketplace.	Similar requirement to MA.
Reporting requirements	Federal requirements for reporting complaints and grievances with the plans.	No federal reporting requirements or data collected, though potential for Secretary to collect data under ACA transparency authority, not yet implemented.	Similar requirement to MA.
Assistance with Appeals	No requirements for MA plan assistance with appeals, although State Health Insurance Assistance Programs (SHIPs) often serve this purpose.	Consumer Assistance Programs (CAPs) established in most states with federal funding to assist QHP enrollees (and other state residents) with appeals.	Medicaid MCOs must assist enrollees with appeals and provide interpreters.

Source: Authors' analysis, 2015.

All three markets require appeals processes for plan enrollees when coverage of a service is denied or terminated. However, the protection afforded to the consumer for a service denial varies widely between the three markets, with the Medicaid program offering the strongest protections for beneficiaries as a result of the property interest beneficiaries have in Medicaid benefits and the due process rights conferred on them by the Constitution.

Medicaid MCOs have very detailed notice requirements and Medicare Advantage is required to provide standardized notices created by CMS while QHPs standards mirror those for plans governed by ERISA which are less robust. Medicaid MCOs must provide written notices in accessible language and format. The notice must include detailed information, including an explanation of the adverse action with reasoning, plan appeal and state fair hearing rights, circumstances under which expedited resolution is available and how to request it. The notice must also include detailed information on the right to have services continue pending the outcome of the appeal and the circumstances under which an enrollee may be required to pay for any care received while the appeal is pending. For QHPs, notices must include a description of the service denied, reason for the denial and information about appeal rights. For denials in

states with a Consumer Assistance Program (CAP), the notice must also include contact information for the CAP. Rules concerning when notice must be provided follow the Employee Retirement Income Security Act (ERISA). Medicare Advantage plans are required to issue beneficiaries a standardized notice form for all denied services which includes information on why the service was denied and appeal rights, including expedited appeals and grievances.

Because Medicaid MCOs and Medicare Advantage are built on the foundation of federal entitlement programs, their appeals processes are more federally standardized than those in QHP. The Medicare five-step administrative appeals process is uniform across the country, whereas there is variation in levels/structures of QHP appeals between states. For example, most QHP enrollees will be bound by their states' external review laws; that is, they will be subject to state law regarding when someone other than their plan must review a service denial. State law regarding external appeals and who may serve as an external appeal body varies somewhat, though state appeals laws must meet minimum standards under the ACA or they can be preempted. In particular, ACA minimum standards require that the external reviewer must be independent, not hired by the health plan. In 8 states where the external appeals law was preempted, however, health insurers can choose on a case by case basis to use one of two federal external appeals systems – one run by HHS, where the external reviewer is hired by the federal government, or one established by the Department of Labor (DOL) for all self-funded employer plans, where the plan hires its own external review organizations.[11] Similar to Medicare, Medicaid MCO baseline appeal rights, including plan appeals and state fair hearings, are in federal law, although states are permitted to make some choices within the federal framework (such as the number of days to request a hearing, or whether a beneficiary must exhaust internal plan appeals before requesting a hearing).

When a timely request is made by a beneficiary, Medicaid law requires MCO services to continue pending appeal whereas Medicare Advantage plans and QHPs are not required to do so. Medicare Advantage plans provide limited continued coverage when appealing discharges from hospital, skilled nursing facilities and home health coverage, and QHPs provide limited continued coverage pending the outcome of an internal plan level appeal.

The Medicare Advantage program has a more standardized, centralized complaint tracking system compared to QHPs and Medicaid managed care complaint tracking, which differs across states. There is a federal complaint tracking system in place for Medicare Advantage plans while grievances against QHPs are filed with plans, state departments of insurance or the Marketplace and vary from state to state – there are no federal reporting requirements or data collected. However, it should be noted that the Secretary of Health and Human Services has the authority to require reporting by plans on claims denials and appeals, but this provision of the Affordable Care Act has not yet been implemented. The basic plan grievance process for Medicaid managed care is set out in federal law and like Medicare Advantage plan's requirements about reporting to CMS, MCOs are required to report to the state on grievances received and disposed of.

Consumer Information, Assistance and Marketing

	Medicare Advantage (MA) plans	QHPs	Medicaid MCOs
General Consumer Information	A Plan Finder tool on the medicare.gov website allows users to perform a personalized or generalized search of Part D and MA plans available by zip code. The Plan Finder allows users to compare certain plan features, such as covered drugs, cost-sharing for certain services, estimated out-of-pocket costs and quality ratings. The tool does not, however, include other information, such as contracted provider networks. Medicare also offers a toll-free, 24/7 national hotline to provide information, compare plans and lodge complaints (1-800-MEDICARE).	Marketplaces must make available plan rating tools reflecting differences in quality, claims payment practices, enrollee satisfaction, and other measures (not yet implemented). Other online plan comparison tools are not yet implemented in federal Marketplaces, but some states provide such tools.	If MCO enrollment is mandatory, the state must provide beneficiaries with a plan comparison chart.
Disclosure of Plan Information	MA plans must disclose at the time of enrollment and at least annually thereafter certain information regarding the plan, including: benefits offered under the plan, information about contracted network providers, supplemental benefits, prior authorization rules or other review requirements that could result in nonpayment, and plan grievance and	Standardized description of covered benefits and cost-sharing (SBC) required of all QHPs. SBCs must include illustrations of cost-sharing that applies under standardized care scenarios to help consumers make plan comparisons (not yet fully implemented).	Information on providers taking new patients and those who speak non-English languages.

		appeals procedures.		
Consumer Assistance		Federally funded (State Health Insurance Assistance Programs – SHIPs). Funded by annual appropriation.	All Marketplaces must provide Navigators who assist with enrollment and application for Marketplace financial assistance. Navigators to be funded through marketplace operating revenue. In addition, all states may establish Consumer Assistance Programs (CAPs). CAPs serve all state residents, including QHP enrollees. CAPs provide enrollment assistance and post-enrollment assistance, including help filing external appeals. CAPs funded by federal grants, authorized at such sums necessary but not currently appropriated.	Medicaid programs may provide ombudsman programs at state option (CMS guidance requires independent advocacy or ombudsman services in MLTSS waiver programs).
Marketing	**Oversight**	Federal oversight of plans, state oversight of agents/brokers.	Some federal oversight with most delegated to states.	Oversight up to states.
	Standards for Marketing Materials	Well-developed federal standards.	Loose federal standards; primarily state standards.	Federal standards with discretion to states to develop enhanced standards.
	Approval of Marketing Materials	File and use (materials must be submitted to regulators but can be used after a designated time period if the regulator fails to respond).	File and use.	State approval required before distribution.

Source: Authors' analysis, 2015.

Consumer Information

Medicare Advantage plans, QHPs and Medicaid MCOs are all required to disclose certain information to enrollees; however, Medicare Advantage plans must generally provide a broader range of information. Medicare offers a uniform plan comparison tool that provides certain information about all plans allowing for an easier side-by-side comparison (Plan Finder), including premiums, cost-sharing, supplemental benefits and quality ratings. Notably, the comparison tool does not include all information individuals may want for comparing plans, such as provider networks. While there is no comparable electronic side-by-side comparison tool for QHPs at the federal level, some state Marketplaces offer them and the standardized Summary of Benefits and Coverage (SBC) that each individual QHP is required to publish does offer consumers a uniform vehicle for plan comparison. The SBC is required of all plans (including group health plans). Each SBC must present standardized information about covered benefits and cost-sharing, as well as benefit limits and exclusions. The documents are required by law to be consumer friendly and easy to use. The SBCs also must provide consumers with standardized coverage illustrations so consumers can compare coverage under different plans for like treatment scenarios (such as an uncomplicated pregnancy). Such a standardized comparison document does not exist for Medicare Advantage; if Medicaid MCO enrollment is mandatory, the state must provide beneficiaries with a plan comparison chart.

Consumer Assistance

QHPs have dedicated consumer assistance entities, including those to assist with enrollment and appeals, written into law, although limited funding has kept the programs from fully developing. Under the ACA, statewide Consumer Assistance Programs (CAPs) are established to provide comprehensive assistance to all state residents in answering questions about their health plans, determining eligibility for coverage and subsidies, enrollment, and help filing appeals of denied claims. The CAPs are required to be advocates for consumers. In addition, by law, CAPs must collect and report data to the Secretary on the types of help consumers need and the problems they encounter, and the Secretary and other state and federal regulators are to use data to enhance oversight. Funding for CAPs is subject to an appropriation and Congress has not appropriated new funds since the ACA was enacted. In addition, the ACA requires that Marketplaces provide for other consumer assistance with enrollment and eligibility through Navigator programs. Navigators must be funded on an ongoing basis through Marketplace operational funds. Navigators are not required to help non-Marketplace consumers, nor are they required to help consumers with appeals or other post-enrollment problems and questions. Rather, the ACA requires Navigators to refer consumers to CAPs in these circumstances.

Medicaid programs may provide ombudsman programs at state option. Also at state option are certified application counselors to assist with eligibility and renewals.[12] For states with MLTSS waiver programs, consumer assistance programs may be more robust. For example, recent CMS guidance requires that an independent advocate or ombudsman program be available to assist participants in navigating the MLTSS delivery system. This includes understanding their rights, responsibilities, choices, and opportunities, and helping to resolve any problems that arise between the participant and their MCO. CMS's MLTSS waiver guidance also requires states to provide beneficiaries with enrollment choice counseling that is independent of health plans, service providers, and entities making eligibility determinations.[13]

The State Health Insurance Assistance Program (SHIP) provides a health insurance advisory service to assist Medicare beneficiaries with the receipt of services under Medicare, Medicaid and other health insurance programs. This includes help with enrollment and appeals. The SHIP program exists in all fifty states and is administered at the county level. Often, community non-profits, Offices for the Aging or long-term care ombudsmen serve as SHIPs although staff is primarily volunteer based. CMS is legislatively required to assess SHIP performance, and CMS uses data gathered by the SHIP National Performance Reporting (NPR) system.

Marketing

The Medicare Advantage program has well-developed marketing rules that plans and their contractors must follow. For example, Medicare marketing rules articulate when CMS must approve marketing materials, outline prohibited marketing practices (including marketing through unsolicited contacts), and provide for coordination with state regulators to address inappropriate marketing practices by plans and agents/brokers. While QHP marketing standards and oversight are left largely to individual states, the creation of designated Marketplaces as centralized, regulated forums to shop for and purchase insurance can serve to reduce the potential for marketing abuses sometimes seen in the individual, non-group market. To be offered on a Marketplace website, plans must submit to uniform rules about the content and display of information. Federal Marketplace regulations sets minimum standards for all Marketplaces (and are the sole standard in the Federally Facilitated Marketplace), while state-administered Marketplaces may require additional standards. Plans must also abide by federal non-discrimination rules in their marketing practices. Medicaid MCOs must get state approval of all marketing materials to ensure they do not mislead, confuse or defraud consumers and are accurate, whereas both Medicare Advantage and QHPs in most states are subject to "file and use" rules, meaning materials must be submitted to regulators but can be used after a designated time period if the regulator fails to respond.

Discussion

Medicare Advantage plans, QHPs and Medicaid MCOs provide coverage for an increasing number of people and increasing shares of the insured population in the United States. Over the course of a lifetime, an individual may be covered in one, two, or all three of these insurance markets. Further, many of the same insurance companies or plan sponsors offer products in two or all three of these markets. While many consumer protections between the markets are similar, differences could both cloud consumers' understanding of their rights in the different programs and fragment oversight by government entities and administration by plan sponsors. Transitioning between types of coverage that have significantly different consumer protections raises issues of not only equity, but ease of administration, oversight and consumer understanding of how to use their insurance and exercise their rights. Whether these differences should be maintained warrants further review by policy makers, within the parameters of baseline protections, such as due process, that are constitutionally required for Medicaid.

There may be opportunities to both enhance and streamline oversight of plans across insurance type without sacrificing beneficiary protections since federal oversight can vary significantly across the programs. For example, as plans with oversight from both the federal government and the states, the federal government has set some standards for Medicaid managed care plans but has provided states considerable discretion – and often more discretion than it has provided to the Medicare Advantage plans. With Medicare Advantage plans, the federal government has gained considerable experience over the course of recent decades in regulating

private Medicare plans, and has increased oversight and expanded consumer protections in reaction to plan behavior and market changes.

The Marketplaces are increasingly populated by the same plan sponsors offering private Medicare and Medicaid products. As a consequence, alignment of consumer protections might also ease administration by the plans offering products in two or all three markets. Likewise, closer alignment of consumer protections between these programs could potentially ease the transition of individuals from one program to another and enhance coordination when someone has more than one type of coverage. Additionally, aligned protections could foster better, more consistent understanding of program rules by consumers.

In addition to aforementioned positive aspects, there may be tradeoffs in strengthening consumer protections. For many of the consumer protections discussed, further enhancement and alignment would be low or no-cost. For example, more uniformity around enrollment periods and consumer information could be low-cost to plans, state and federal governments. However some changes, for example surrounding appeals or benefit design, could cost private plans, public programs, and potentially consumers more resources and money.

Alignment could be achieved in multiple ways, with different effects on plans, enrollees, and federal and state governments. One possibility is that an effort to align protections could cause dilution of consumer protections in favor of uniformity. Another possibility is that alignment could be based on the strongest protection in one single program, and other programs brought up to match that higher standard rather than relying on a lower floor, or a "race to the bottom." The CMS financial alignment demonstrations for dual eligible beneficiaries offer an example of this "higher standard" uniformity, in that where there is a discrepancy in a protection between Medicare and Medicaid, the stronger protection is adopted. It should be noted that certain protections, such as due process for Medicaid beneficiaries, cannot be diluted because they arise from constitutionally protected property rights. Ultimately, better coordination across markets with an emphasis on consumer protections will help to improve health care for all participants.

Appendix A: Background on Medicare Advantage, Marketplace Qualified Health Plans and Medicaid Managed Care Organizations

Medicare Advantage (MA)

Medicare currently covers over 50 million individuals, almost a third of whom are enrolled in Medicare Advantage plans. The Medicare Advantage (MA) program, also known as Medicare Part C, is a voluntary coverage option available to Medicare beneficiaries as an alternative to the traditional fee-for-service Medicare program.[14] Medicare Advantage coverage is offered through private insurance companies in the form of health plans, such HMOs and PPOs. An individual must affirmatively choose to enroll in a Medicare Advantage plan, and once enrolled they generally receive all their Medicare services through the plan. If a person chooses to dis-enroll from a Medicare Advantage plan, or is involuntarily dis-enrolled, they are by default enrolled into traditional Medicare coverage.

Medicare Advantage benefits, cost-sharing and other consumer protections are grounded in the federal rules governing traditional Medicare. Medicare Advantage plans must provide enrollees with coverage of all services that are covered by Medicare Parts A and B except hospice, (and, if applicable, the Part D prescription drug benefit). Medicare Advantage plans can, and are often required to, provide benefits in addition to those covered by traditional Medicare, such as vision and dental services or reduced cost-sharing. The scope of benefits covered by Medicare Advantage generally has the same limitations as traditional Medicare (e.g., number of days covered in a skilled nursing facility); however, plans have leeway to loosen such restrictions. Medicare Advantage plans can also charge varying cost-sharing amounts, including deductibles and co-pays and, unlike traditional Medicare, provide caps on beneficiary out-of-pocket expenses. Cost-sharing in Medicare Advantage is limited by actuarial equivalency rules; in others words, in general, Medicare Advantage enrollees will not pay significantly more out-of-pocket than they would under traditional Medicare.

Medicare Advantage plans are regulated by the federal Centers for Medicare and Medicaid Services (CMS), which also administers other parts of the Medicare program. States are largely preempted from regulating Medicare Advantage plans. The Medicare Advantage program, and its predecessor Medicare+Choice, has had decades of experience operating within the Medicare program. Similarly, CMS has an established track-record of regulatory oversight of Medicare Advantage plans which continues to evolve in response to changes in the market and plan behavior.

Marketplace Qualified Health Plans (QHPs)

In an effort to expand access to health insurance coverage, the Affordable Care Act (ACA) created exchanges, or Marketplaces, through which individuals can shop for insurance coverage effective January 2014.[15] States have the option to build and administer a fully state-based Marketplace, enter into a state-federal partnership Marketplace, or default to a federally-facilitated Marketplace (FFM) administered solely by the federal government. This brief focuses on rules governing the federally facilitated Marketplace. As of January 2015, 11.4 million people had enrolled in private insurance through the Marketplaces.[16]

Health insurance plans must be certified as Qualified Health Plans (QHPs) by a Marketplace before they may be sold to consumers. To be certified, QHPs must cover certain essential health benefits (EHB), follow established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meet other requirements. QHPs are divided into 4 different categories based on actuarial value: Bronze, Silver, Gold, and Platinum, all of which must cover essential health benefits (EHBs).

Oversight of QHPs is shared by the federal and state governments. States perform primary enforcement of federally mandated insurance market reforms that govern QHPs. If a state cannot or will not perform such functions, however, CMS may step in. Currently, oversight and enforcement capacity at the federal level is limited – both for group health plans (DOL and Internal Revenue Service (IRS); HHS for public employer plans) – and for QHPs in federally operated Marketplaces. Note that most private coverage continues to be provided outside the Marketplace, through employer-sponsored group health plans, which are subject to federal regulation and for which most state regulation is preempted by ERISA.

Medicaid Managed Care Organizations (MCOs)

As the nation's primary public health insurance program for people with low incomes, as of January 2015 Medicaid covers over 68 million Americans over the course of a calendar year. It is a major source of coverage for people with low incomes and people with disabilities. Medicaid is jointly financed by the federal government and the states and administered by the states with federal oversight.[17] Federal law requires states participating in Medicaid to cover certain mandatory benefits, and states can choose to cover additional optional benefits.[18]

Before passage of the ACA, federal Medicaid matching funds were available only for specified categories of people with low-incomes: children, pregnant women, parents, people with disabilities, and seniors.[19] States that choose to participate in the Medicaid program must cover people in these groups with income up to federal minimum thresholds, and states have the option to expand coverage to individuals at higher incomes.

The ACA expanded Medicaid to nearly all adults under age 65 with income at or below 138 percent FPL or $16,242 per year (2015) for a single person, with no asset test, effective January 1, 2014.[20] However, the 2012 Supreme Court ruling in *NFIB v. Sebelius* effectively made implementation of the Medicaid expansion a state choice.[21] To date, 29 states, including DC, have implemented the ACA's Medicaid expansion.[22]

States can choose to provide Medicaid benefits through managed care, including managed FFS models, such as primary care case management, and private capitated managed care organizations (MCOs) that contract with the state on a risk basis to deliver Medicaid services. This brief focuses on consumer protections specific to enrollees in Medicaid MCOs. States have the option to make Medicaid managed care enrollment voluntary or mandatory for beneficiaries. However, states are required to seek CMS approval to require managed care enrollment for children with special needs, beneficiaries dually eligible for Medicare and Medicaid, and certain Native Americans. As of July 2014, 39 states including DC had comprehensive risk-based contracts with Medicaid MCOs.[23] Among these states, 16 reported that over 75 percent of their Medicaid beneficiaries were enrolled in MCOs, and 34 states indicated that they made specific policy changes to increase their number of MCO enrollees, such as expanding voluntary or mandatory enrollment to additional coverage groups, in FY 2014 or planned to do so in FY 2015.[24] Over half of Medicaid beneficiaries nationally – mostly, children and

parents – are enrolled in comprehensive MCOs; this share is growing as states expand managed care to include higher-need Medicaid populations, such as people with disabilities[25] and dual eligible beneficiaries, as well as newly eligible Medicaid expansion adults.

Appendix B: Low-Income Assistance and the Medicare "Cliff"

There are substantial differences in income and asset thresholds at which low-income assistance is available to Medicare beneficiaries and those seeking QHP coverage in the Marketplaces. For Medicare beneficiaries, including Medicare Advantage enrollees, assistance with Part A and B deductibles, coinsurance and copayments is available only to individuals with incomes up to 100 percent of the Federal Poverty Level (FPL) ($11,770 in 2015) and who meet certain asset tests. Assistance with paying the Part B premium is available to individuals with incomes up to 135 percent of FPL ($15,889 in 2015), with limited assets, and Part D premium and cost-sharing assistance is available, on a sliding scale, for individuals up to 150 percent of FPL ($17,655 in 2015) and limited assets. Assistance with Medicare Advantage premiums is limited to individuals dually eligible for Medicare and Medicaid, and only at state discretion.[26]

By contrast, in Marketplaces, people with incomes between 100 percent and 400 percent FPL who have no other offer of affordable minimum essential coverage, including Medicaid, can access tax credits to defray premium costs for QHPs; there is no asset test for Marketplace tax credits. Additionally, cost-sharing subsidies are available for individuals between 100 percent and 250 percent of FPL. However, for individuals over 200 percent FPL these subsides lower the out-of-pocket cap on expenses (from $6,600 to $5,200 in 2014) but typically make only modest adjustments to other cost-sharing features, such as annual deductibles. The Affordable Care Act made Medicaid available to more people. Now, in states that implement the Medicaid expansion, individuals with incomes up to 138 percent FPL may qualify. There is no asset test under the new financial methodology that applies to the newly eligible population as well as to other poverty-related coverage groups. Medicaid provides comprehensive coverage with very low out-of-pocket costs.

Individuals who attain Medicare eligibility are no longer eligible for Marketplace subsidies, and they may see their eligibility for Medicaid change. Individuals transitioning to Medicare from Medicaid, and to a lesser extent those under 200 percent FPL enrolled in a QHP with subsides may encounter what is referred to as the Medicare "cliff" – meaning that depending upon their income and resources, they may see their out-of-pocket costs increase when they become eligible for Medicare because of more stringent eligibility requirements for cost-sharing assistance imposed by Medicare low-income programs and Medicaid. For example, Medicaid for seniors (over 65) has a federal income eligibility limit of 100 percent FPL and imposes an asset test in most states (unless states cover seniors at higher incomes or without regard to assets through a waiver). Likewise, Medicare has more stringent eligibility requirements for cost-sharing assistance.[27]

Appendix C: Detailed Table Comparing Consumer Protections for Medicare Advantage, Marketplace Qualified Health Plans, and Medicaid Managed Care Organizations

	Medicare Advantage (MA)	Marketplaces (QHPs)	Medicaid MCOs[28]
Eligibility	*MA plans, QHPs and Medicaid managed care plans are <u>similar</u> in that they are all generally prohibited from basing eligibility on health status, may not impose pre-existing condition exclusions or discriminate based on enrollee need for health services. MA plans, however, may generally exclude individuals with ESRD, and MA Special Needs Plans (SNPs) are available only to Medicare-eligible individuals who meet certain requirements.* *Individuals must be eligible for Medicare Part A and B in order to enroll in an MA plan and individuals must be eligible for Medicaid in order to enroll in a Medicaid managed care plan. Similar to eligibility requirements for the purchase of QHPs, this includes: (1) citizenship and residency requirements, and (2) non-incarceration.* *Individuals are eligible to enroll and purchase QHP coverage as a family plan while MA plan coverage and Medicaid managed care is individual-only coverage.*		
	Must have Parts A and B of Medicare. *42 U.S.C. §1395w-21(a)(3)(A); 42 C.F.R. §422.50(a)(1)* - Eligibility for Medicare is based on entitlement to Social Security retirement, Social Security Disability Insurance (SSDI), and Railroad Retirement or disability or individuals with end-stage renal disease (ESRD.) People with amyotrophic lateral sclerosis (ALS) on SSDI may have their 24 month waiting period waived. *42 U.S.C. §1395c*[29] - Individuals who are not otherwise eligible for Medicare, but who are over age 65 and are U.S. citizens or permanent residents for 5 years may purchase coverage by paying a monthly premium for Part A. *42 U.S.C. §1395i-2* Individuals with ESRD are not eligible for MA plans (with exceptions).	Must meet qualified individual status. A qualified individual is: 1. A citizen of the US or lawfully present 2. Not incarcerated 3. Meets residency requirements *See, generally, 42 C.F.R. § 155.305* Guaranteed Issue. *42 U.S.C. 300gg-1; 45 § C.F.R. 147.104* Plans prohibited from basing eligibility on health-status related factors, including medical conditions (both physical and mental), claims experience, receipt of health care, medical history, genetic information, evidence of insurability, disability, and any other health status related factor determined appropriate by HHS. *42 U.S.C.* § *300gg-4 45 C.F.R.* § 147.110 Plans prohibited from imposing pre-	Must meet Medicaid eligibility based on low-income status or disability status at slightly higher incomes; beneficiaries also must meet non-financial eligibility criteria, such as state residency, citizenship, and immigration status; federal law contains mandatory coverage groups with additional groups covered at state option.[30] Plans are prohibited from discriminating on the basis of an enrollee's health status or need for health care services. *42 USC § 1396b(m)(2)(A)(v); 42 C.F.R. § 438.6(d)(3)* Must live in geographic region covered by plan.

	42 U.S.C. §1395w-21(a)(3)(B); 42 C.F.R. §422.50(a)(2); 42 C.F.R. §422.66(d); also see MMCM, Ch. 2, §20.2, et seq. Must live in geographic area covered by plan. *42 U.S.C. 1395w-21(b)(1)* - Incarcerated individuals are considered not to be within a plan's service area *Medicare Managed Care Manual, Ch. 2, §20.3* MA Special Needs Plans (SNPs) – limit enrollment to individuals who meet the definition of special needs individuals (dually-eligible for Medicare and Medicaid (D-SNPs), individuals requiring an institutional level of care (I-SNPs), and individuals with certain severe or disabling chronic conditions as determined by the plan (C-SNPs)). *42 U.S.C. §1395w-28(b)* An individual who is a Qualified Medicare Beneficiary (QMB), a Specified Low-Income Beneficiary (SLMB), a Qualified Disabled and Working Individual (QDWI) or otherwise eligible for Medicaid and entitled to Medicare cost-sharing assistance under a state Medicaid program cannot enroll in a MA Medical Savings Account (MSA) plan. *42 U.S.C. §1395w-21(b)(3)* MA plan coverage may only be purchased as individual coverage or through an employer-based retiree plan (not family coverage); note that in 2014, 19% of all MA enrollees were in employer group health plans. (MedPAC, 2014)	existing conditions exclusions. *42 USC 300gg-3; 45 C.F.R. 147.108* Must live in geographic area covered by plan.	
Enrollment and Disenrollment	*Medicare Advantage and QHPs are <u>similar</u> in that they may generally restrict enrollment into and disenrollment from plans to limited time periods of the calendar year and special enrollment periods triggered by certain events.*		

	Medicaid applications are accepted year-round, so an individual can enroll in a Medicaid managed care plan whenever she is initially determined eligible for Medicaid. An individual may likewise enroll in MA when he or she first becomes eligible for Medicare. *MA enrollment is voluntary. So is enrollment in a QHP, although uninsured individuals may owe a tax penalty for not having minimum essential coverage and premium tax credit subsidies for nongroup coverage are only available for people enrolled in QHPs. States can choose to offer Medicaid managed care and whether to make enrollment voluntary or mandatory, except that CMS must approve the mandatory enrollment of certain populations.* *A crucial <u>difference</u> between MA, QHPs and Medicaid MCOs relates to disenrollment. If an individual dis-enrolls from an MA plan, they are re-enrolled into traditional Medicare coverage as a default. If an individual dis-enrolls from a QHP, there is no default – the person is left without coverage. With CMS permission, states may require beneficiaries to receive their Medicaid services through managed care. Without CMS permission to require managed care enrollment, Medicaid beneficiaries may dis-enroll from managed care and default into fee-for-service Medicaid the way an MA plan beneficiary defaults into traditional fee-for-service Medicare.* *The limited circumstances in which a plan can involuntarily dis-enroll an individual are similar between QHPs and MA plans (e.g., failure to pay premiums, a move outside of the service area), however, unlike QHPs, MA plans have the option to dis-enroll someone based upon "disruptive behavior" (with CMS' approval). Medicaid managed care plans and QHPs generally may not dis-enroll beneficiaries for disruptive behavior; however, Medicaid managed care plans may do so in extreme cases upon CMS approval.* *For similarities and differences in special enrollment period (SEP) rights between MA and QHPs, see Appendix D, below. Note that there are no equivalent SEP rights in Medicaid managed care.*		
	Default Coverage		
	MA enrollment, as an option for receiving Medicare services guaranteed through federal entitlement, is voluntary for Medicare beneficiaries. Correspondingly, if a person chooses to dis-enroll from an MA plan, or is involuntarily dis-enrolled, the default is traditional Medicare coverage. *42 U.S.C. §1395w-21(c)(3)(A)(i), (g)(3)(c)*	Since QHPs are not built on the foundation of a federal entitlement, if an individual is dis-enrolled from a QHP there is no default – they are left without coverage unless and until they can exercise enrollment rights and opportunities to gain new coverage.	States can choose to adopt Medicaid managed care with voluntary or mandatory enrollment for beneficiaries, except that states need CMS waiver approval to require managed care enrollment for children with special needs, beneficiaries dually eligible for Medicare and Medicaid, and Native Americans. *42 U.S.C. § 1396u-2(a)(1)(A), (2); 42 U.S.C. § 1396n(b)(4); 42 C.F.R. § 438.50(a), (d)* States must have a default enrollment process for assigning beneficiaries subject to mandatory enrollment to a plan; process must seek to preserve existing provider-beneficiary relationship and relationships with

			providers that traditionally serve Medicaid beneficiaries if possible, otherwise state must distribute beneficiaries equitably among plans. *§1396u-2(a)(4)(D); § 438.50(f)* State must give beneficiaries who are required to enroll a choice of at least 2 plans except for rural area residents. *§1396u-2(a)(3); § 438.52*
	Enrollment Periods		
	Prescribed enrollment periods. *42 U.S.C. §1395w-21(e); 42 C.F.R. §422.62* - Initial Coverage Election Period (ICEP) – period during which an individual newly eligible for MA may make an initial enrollment request to enroll in an MA plan; begins 3 months immediately before the individual's first entitlement to both Medicare Part A and Part B and ends on the later of: 1. The last day of the month preceding entitlement to both Part A and Part B, or; 2. The last day of the individual's Part B initial enrollment period. - Annual Coordinated Election Period (ACEP) – allows individuals to join, switch, or disenroll from MA and Part D plans - October 15 – December 7 of every year, with election/choice effective the following January 1 - Medicare Advantage Disenrollment Period (MA-DP) – allows MA enrollee to disenroll from MA plan and return to Traditional Medicare, with right to pick up a stand-alone Part D	Enrollment restricted to Open Enrollment and Special Enrollment Periods. *42 U.S.C.§ 300gg-1; 45 § C.F.R. 147.104* 2013 Initial Open Enrollment Period (very first enrollment period and lasted six months). *45 C.F.R. § 155.410* 2014 Annual Open Enrollment Periods Oct. 15- Dec. 7th 2014. Second annual Open Enrollment Period Nov. 15th to Feb. 15th 2015. *45 C.F.R. 155.410* Special Enrollment Periods. *45 C.F.R. § 155.420*; *see Appendix D, below* Proposed rule on automatic re-enrollment. *45 C.F.R. §155.335(a)* Currently, individuals enrolled in QHPs will generally be automatically re-enrolled at the end of the plan year if the individual does not affirmatively act to renew or change coverage. Proposed changes to automatic renewal process are under discussion, in part, because an individual's	Medicaid applications are accepted year-round so beneficiaries can enroll in a plan when initially determined Medicaid-eligible, if state offers or requires managed care. *42 U.S.C. § 1396a(a)(8); 42 C.F.R. § 435.906* Beneficiaries must be able to dis-enroll from plan for cause at any time and without cause during the 90 days following initial enrollment and at least once annually thereafter. *42 U.S.C. § 1396u-2(a)(4)(A); 42 C.F.R. § 438.56(c)* State must inform enrollees of their disenrollment rights annually. *42 C.F.R. § 438.10(f)(1)*

	prescription drug plan - January 1 – February 14 of every year - Special Enrollment Periods (SEPs) (*see 42 C.F.R. §422.62(b); Medicare Managed Care Manual, Ch. 2, §§30.4, et seq.)* *See Appendix D, below; also see "Network Adequacy" section below* -Note that there is generally no passive enrollment into MA plans (as there is of LIS-enrolled individuals into stand-alone PDPs) with the exception of dual eligibles in certain areas where, e.g., a county operates an MA plan and requires mandatory managed care enrollment for Medicaid enrollees.	premium tax credit subsidy amount can vary from year to year and depend on the QHP selected; as a result cost to an individual could vary dramatically due to auto-renewal in some circumstances.	
	Involuntary Disenrollment by Plans		
	Disenrollment by MA plan – a plan may not disenroll an individual except (*see 42 C.F.R. § 422.74*): - Optional disenrollment – an MA plan <u>may</u> disenroll an individual if 1) any monthly basic and supplementary premiums are not paid on a timely basis, subject to a grace period; 2) the individual has engaged in disruptive behavior; or 3) the individual provides fraudulent information on his or her election form or permits abuse of his/her enrollment card. - Required disenrollment – an MA organization <u>must</u> disenroll an individual if 1) the individual no longer resides in the MA plan's service area; 2) the individual is	General exceptions to guaranteed renewability (i.e., disenrollment): *42 U.S.C. 300gg-2(b) & 45 C.F.R. 147.104* 1. Non-payment of premiums 2. Fraud 3. Termination of coverage 4. Move outside service area 5. Discontinuance of all coverage	The plan's contract with the state Medicaid agency must specify the reasons for which a plan may request disenrollment of a beneficiary. *42 C.F.R. § 438.56(b)(1)* Plans generally may not request disenrollment due to an adverse change in enrollee health status or an enrollee's utilization of health care services, diminished mental capacity, or uncooperative or disruptive behavior resulting from the enrollee's special needs. *42 C.F.R. § 438.56(b)(2)* However, plans may request disenrollment when continued enrollment seriously impairs a plan's ability to furnish services to that enrollee or other enrollees. *42 C.F.R. § 438.56(b)(2)*

	no longer eligible under the plan; 3) the individual loses entitlement to Part A or Part B benefits; or 4) an individual enrolled in a SNP no longer meets the eligibility requirements for that SNP.		
Renewability	*MA and QHPs are <u>similar</u> in their renewability. If an MA plan or QHP in which an individual is enrolled continues to be offered, the individual will automatically continue to be enrolled in the same plan in the following plan year. Renewability of Medicaid managed care enrollment varies by state.*		
	Maintenance of enrollment – an individual who has made an election is considered to have continued that election until either: - the individual changes the election, or - the elected MA plan is discontinued or no longer serves the area in which the individual resides. *42 C.F.R. §422.66(e) – see exception for employer plans at (f)*	A health insurance issuer offering health insurance coverage in the individual, small group, or large group market is required to renew or continue in force the coverage at the option of the plan sponsor or the individual, as applicable. *42 USC § 300gg-2; 45 C.F.R. §147.106(a)* Generally, if an enrollee remains eligible for a plan, he will be automatically re-enrolled into the same plan at the end of the plan year. *45 § C.F.R. 155.335(j)* A plan is prohibited from rescinding coverage in the absence of fraud on the part of the enrollee. *42 USC 300gg-12; 45 C.F.R. §147.128* (see appeal rights)	If state opts to require managed care enrollment and a plan does not have capacity to serve all individuals seeking enrollment, priority shall be given to continuing enrollment of beneficiaries already enrolled in the plan. *42 U.S.C. § 1396u-2(a)(4)(C); 42 C.F.R. § 438.52(e)*
Benefits	*<u>Overview</u>* *All three programs have standards for covered services that private plans must include. All three programs require plans to cover major medical services (hospitalization, ambulatory physician services, diagnostic services, prescription drugs, etc.) In addition, state Medicaid programs generally provide much greater coverage of long-term services and supports compared to MA and QHPs.* *All three programs include additional, specific standards for covering Rx drugs. The MCO standards are most comprehensive in the number and type of Rx drugs that must be covered. MA plans are required to cover all FDA approved drugs in certain protected classes and, for other drugs, must cover at least 2 drugs in each USP category or class. No standards for protected*		

	drug classes apply for QHPs and QHPs are required to cover the greater of (i) the same number of drugs (relative to the state benchmark plan) in each USP category or class or (ii) at least 1 drug in each USP category or class. *All three programs permit private plans some flexibility to vary or supplement the required covered benefit design. QHPs have more flexibility under federal rules compared to MA plans (and states may further limit flexibility of private insurers to modify or vary QHP benefits).* *MA plan and Medicaid managed care benefits are generally more uniform across the country, with more variation in benefit design in QHPs. Both MA and Medicaid are required by federal law to cover a basic floor of service and have less flexibility than QHPs in determining what exactly these services are. MA plans, QHPs and Medicaid MCOs cover a range of similar services, and also have similar exclusions from coverage but state Medicaid programs generally provide greater coverage of long-term services and supports than MA or QHPs. All cover certain preventive health services without cost-sharing.* *MA, QHPs and Medicaid managed care plans can offer supplemental benefits – those that are not generally required to be offered by all plans. With respect to prescription drug coverage, MA and Medicaid managed care plans are required to provide broader coverage than QHPs (when states require Medicaid managed care plans to cover prescription drugs).* *Generally, whereas QHPs cannot impose annual or lifetime dollar limits on essential health benefits, MA plans may impose the same coverage limits set in traditional Medicare. MA plans have some discretion to ease such restrictions but are not required to do so. There are no annual or lifetime dollar limits in the Medicaid program, but Medicaid managed care plans may contract with the state to limit their liability, with any costs exceeding a certain amount covered by Medicaid FFS.* *The following sections provide comparisons of Benefit Package Design, Benefits NOT covered by MA plans and QHPs, Prescription Drug Coverage, Supplemental Benefits and Limits on Services.* *<u>Benefit Package Design</u>* *QHP benefit packages include 10 categories of essential health benefits as modified by a state's chosen benchmark plan. Plans are allowed to use actuarially equivalent substitutes for all services within the 10 categories of essential health benefits. Thus, actual benefits offered within a category of essential health benefit by a QHP will vary from state to state and plan to plan.*[31] *MA benefit packages are based on traditional Medicare benefits. Medicaid managed care benefit packages are based on Medicaid standards, which vary based on the state, subject to federal minimum requirements, and which may vary based on an individual's Medicaid eligibility group.* *Some MA plans and Medicaid managed care plans may choose to offer supplemental benefits not offered through traditional Medicare or in the Medicaid state plan benefit package.* *MA, QHP and Medicaid Managed Care benefit packages are similar in that they both work off a basic framework (traditional Medicare for MA, EHB for QHPs, the Medicaid state plan benefits.) However, the <u>actual benefits</u> offered by a particular MA plan or QHP may vary considerably, although variation in benefit design will tend to be more pronounced in QHPs than MA. Likewise, benefits covered in Medicaid managed care plans vary by state, depending on which benefits, including optional federal benefits, a state chooses to include in its plan contracts and the Medicaid enrollees' coverage group.*

	Both MA and QHPs cover: 1. *inpatient hospitalization* 2. *outpatient services including lab services* 3. *emergency services* 4. *rehabilitative and habilitative services* 5. *preventative benefits without cost-sharing* 6. *pregnancy* *Medicaid managed care comprehensive risk contracts must cover inpatient hospital services and any of the following services, or any three or more of the following services:* 1. *Outpatient hospital services* 2. *Rural health clinic services* 3. *Federally qualified health center services* 4. *Other laboratory and x-ray services* 5. *Nursing facility services* 6. *Early periodic screening diagnostic and treatment services* 7. *Family planning services* 8. *Physician services* 9. *Home health services* *The benefits covered by Medicaid managed care plans are specified in their contract with the state Medicaid agency. Any Medicaid state plan benefits not included in the managed care contract are provided by the state through fee-for-service or separate managed care contracts at state option.* *Neither MA plans nor QHPs nor Medicaid managed care plans are required to offer adult dental or vision coverage.*		
	MA plans must provide benefits under Traditional Medicare Parts A and B (except for hospice care). *42 U.S.C. §1395w-22(a)* - Part A covers care in certain settings, often with duration and other limitations (see, generally, *42 U.S.C. §1395d*): - inpatient hospitalization (up to 90 days per benefit period, with 60 lifetime reserve days); - skilled nursing facility (SNF) care (up to 100 days); - home health (60 day episodes of care, no limit on number of episodes); - hospice services (for those	Essential health benefits (EHB): *42 U.S.C. 300gg-6(a)* and *42 USC 18022(a)* 1. Ambulatory patient services 2. Emergency services 3. Hospitalization 4. Maternity and newborn care 5. Mental health and substance use disorder services, including behavioral health treatment 6. Prescription drugs 7. Rehabilitative and habilitative services and devices 8. Laboratory services 9. Preventive and wellness services and chronic disease management	State Medicaid programs must cover certain services (such as inpatient, outpatient, and laboratory services, among others) and may opt to include other services (such as prescription drugs, dental, physical therapy, private duty nursing, personal care, and case management services, among others);[32] the services for which managed care plans are responsible are specified in the plan's contract with the state Medicaid agency. *42 U.S.C. § 1396u-2(b)(1)* Medicaid MCOs must have a comprehensive risk contract with the state Medicaid agency to cover inpatient hospital services and any of

	diagnosed as being terminally ill); - Part B covers a range of services including physician services, outpatient therapy, diagnostic tests (including certain preventive services with no cost-sharing), durable medical equipment, ambulance services, etc. (see, generally, *42 U.S.C. §1395k*) - Service restrictions apply to some Part B benefits (e.g., annual cap on coverage of outpatient therapy). MA plans have some leeway to ease coverage restrictions under Traditional Medicare (e.g., cover longer inpatient hospital stays, waive the 3-day prior inpatient hospitalization requirement for SNF stays)	10. Pediatric services, including oral and vision care States must select a benchmark plan in order to define EHB. All benchmarks must include EHB or be modified to include any missing benefit categories (e.g., pediatric dental). The benchmark must be chosen from 10 existing plans in each state as specified in federal guidance: the three largest small group plans in the state, based on enrollment; the three largest federal employee health plans based on enrollment; the state's largest commercial HMO plan. If a state does not select a plan, it will default to the largest small group plan in the state based on enrollment. *45 C.F.R. 156.110*; *see also 45 C.F.R. 156.*115 Individual plans may determine which covered services belong in each EHB category. Insurers also have flexibility to modify benchmark coverage, substituting actuarially equivalent services within an EHB category and notifying the applicable insurance regulator when they do so. *45 C.F.R. §156.115(b); 45 C.F.R. §156.200* Coverage of preventative health services without cost-sharing. *42 U.S.C. § 300gg-13, 45 C.F.R § 147.130*	the following services, or any three or more of the following services: 1. Outpatient hospital services 2. Rural health clinic services 3. Federally qualified health center services 4. Other laboratory and x-ray services 5. Nursing facility services 6. Early periodic screening diagnostic and treatment services 7. Family planning services 8. Physician services 9. Home health services *42 C.F.R. § 438.2* Plan contracts must assure coverage of emergency services without prior authorization or network restrictions. *42 U.S.C. § 1396u-2(b)(2)*; *42 C.F.R. § 438.114* Public Health Service Act requirements (*42 U.S.C. § § 300gg-25, 300gg-26*) for maternity care and mental health parity apply to Medicaid managed care plans. *42 U.S.C. § 1396u-2(b)(8)*
Benefits (cont'd)	**Benefits NOT Covered**		
	Benefits Not Covered by Traditional Medicare:	Benefits not Covered as EHB:	Adult vision and dental and long-term services and supports other than

	- Traditional Medicare does not cover certain services, including most dental or vision care, hearing aids and non-skilled long-term care; MA plans may offer services not covered by traditional Medicare.	1. Adult vision 2. Adult dental 3. Long-term care	nursing facility care and home health services for beneficiaries who qualify for nursing facility care are optional Medicaid state plan benefits; however, state Medicaid programs may or may not deliver these services through managed care arrangements.
	<u>Prescription Drug Coverage</u> *MA plans and Medicaid managed care plans are generally required to provide broader drug coverage than QHPs. MA plans must cover at least two drugs per category and class whereas QHPs must cover only one. MA plans must cover all or substantially all drugs within certain protected classes; there are no protected classes of drugs within QHPs. In addition, not all MA plans offer Part D prescription drug coverage, whereas prescription drug coverage is a required essential health benefit for QHPs.*		
	Certain drugs in certain settings are covered under Parts A and B of Medicare (which in turn must be covered by MA plans); Part D is a separate, voluntary benefit that provides coverage of prescription drugs. Not all MA plans offer Part D coverage (but most do – 86% of plans in 2015); MA sponsors may not offer an MA plan in an area unless either that plan (or another MA plan offered by the organization in that same service area) includes required prescription drug coverage. *42 U.S.C.§ 1395w-131(a)* MA plans offering Part D prescription drug coverage are known as Medicare Advantage-Prescription Drug plans (MA-PDs) and must follow Part D rules re: drug coverage. MA plans offering Part D prescription drug coverage must also establish pharmacy and therapeutics (P&T) committees that will develop plan drug formularies. Decisions about drug inclusions and exclusions must be based on scientific evidence.	QHPs must cover at least the greater of: 1 drug per US Pharmacopeia category or class; OR the same number of drugs in each category and class as EHB state benchmark plan. Drug products listed must be chemically distinct. *45 C.F.R. § 156.122* Starting in 2017, QHPs must also establish pharmacy and therapeutics (P&T) committees, similar to those under Medicare Part D, that will develop plan drug formularies. Decisions about drug inclusions and exclusions must be based on scientific evidence. Newly approved drugs and new uses of existing drugs must be reviewed within 90 days and coverage decision made within 180 days of market release. *45 C.F.R. § 156.122* Plans may use tiering and other utilization management tools but non-discrimination rules in benefit design rules at *45 § C.F.R. 156.125* apply to prescription drug benefit. QHPs must have procedures in place that allow an enrollee to request and	Prescription drug coverage is optional for state Medicaid programs, although all states currently cover prescription drugs. *42 U.S.C. § 1396d(a)(12); 42 C.F.R. § 440.120* Federal law requires state Medicaid programs that choose to include prescription drugs to cover all FDA-approved drugs whose manufacturers have entered into a rebate agreement. *42 U.S.C. § 1396r-8* Whether Medicaid managed care plans are responsible to deliver and coordinate prescription drug coverage is specified in the plan's contract with the state Medicaid agency. For beneficiaries dually eligible for Medicare and Medicaid, Medicare provides primary drug coverage, supplemented by Medicaid.

	An individual enrolled in an MA plan can also enroll in a stand-alone Part D plan (PDP) only if his/her MA plan does not offer Part D coverage.[33] Overview of Part D coverage rules: (*see, generally, 42 U.S.C. §1395w-102(e)*) - Drugs coverable under Part D are those approved by the FDA, for which a prescription is required and for which payment is required under Medicaid. - Biological products, including insulin and insulin supplies and smoking cessation drugs are covered. - Excluded from coverage are those categories of drugs for which Medicaid payment is optional, over the counter drugs, and drugs for which payment could be made under Part A or B. - Part D plans (including MA-PDs) are not required to pay for all covered drugs; they may establish their own formularies and cost-sharing (tiering) structures as long as their formularies and benefit structures are not found by CMS to discourage enrollment by certain Medicare beneficiaries (anti-discrimination) (*see 42 C.F.R. §§423.120(b), .272(b)*). - Part D plans (including MA-PDs) must include in their plans' formularies all or substantially all drugs in a category or class	gain access to clinically appropriate drugs not "on formulary." *45 C.F.R. §156.122(c)*; *see also 2015 letter to issuers p. 28 &29.* As part of the QHP Application, issuers must provide a URL to their formularies and must also provide information regarding formularies to consumers, pursuant to *45 C.F.R. §147.200(a)(2)(i)(K)* (see consumer information below). *See, generally, 45 C.F.R § 156.122*	

	identified by CMS ("protected classes" - anticonvulsants, antidepressants, antipsychotics, antiretrovirals, and immunosuppressants; see PPACA § 3307); plans are prevented from imposing certain utilization management tools on protected classes.		
Benefits (cont'd)	**Supplemental Benefits**		
	MA Plans can offer supplemental benefits: - As a result of a rebate payment from Medicare due to a plan's bid being below the CMS-established benchmark rate; plans receiving such rebates must return the rebates to enrollees in the form of either lower premiums or supplemental benefits;[34] or - Plans may offer supplemental benefits (things not covered under Part A or B) for which a separate premium may be charged. *42 U.S.C. §1395w-22*; *42 C.F.R. §422.102*	QHPs can offer supplemental benefits ("other covered services") that go above and beyond EHB. See section on premium subsidy and cost-sharing subsidy below. Subsides only apply to EHB, not supplemental benefits.	Medicaid managed care plans can cover services in addition to those offered under the Medicaid state plan, although those costs cannot be included in contract payment rates. *42 C.F.R. § 438.6(e)*
Benefits (cont'd)	*Limits on Services* *QHPs cannot impose annual or lifetime dollar limits on essential health benefits, but can impose limits on the number of covered days or services that may have applied under the benchmark plan. Special parity rules apply to mental health and substance abuse treatment services. MA plans may impose the same coverage limits set in traditional Medicare. For example, MA plans may impose a limit on inpatient hospital days (lifetime hospital reserve days). MA plans have some discretion to ease such restrictions but are not required to do so. Both MA plans and QHPs are prohibited from designing benefit packages that discriminate against consumers with expensive health conditions. While there are no annual or lifetime dollar limits in the Medicaid program, Medicaid managed care plans may contract with the state to limit their liability, with any costs exceeding a certain amount covered by Medicaid FFS.* *Mental Health Benefits: traditional Medicare rules and hence MA plans may impose a lifetime limit on inpatient days at a psychiatric hospital (up to 190 days). Medicaid managed care plans and QHPs must adhere to mental health parity guidelines so that limits on covered mental health services are not more stringent than those on physical health services.*		

	Anti-discrimination provision: MA plans may not deny, limit, or condition the coverage or provision of benefits based on any health status–related factor; similarly, MA plans cannot design plan benefits in such a way that is likely to substantially discourage enrollment by certain individuals. *42 U.S.C. §1395w-22(b)* MA plans offer a specific set of health benefits at a uniform premium and uniform level of cost-sharing to all Medicare beneficiaries residing in the service area of the MA plan. *42 C.F.R. §422.2* MA plans are generally bound by limits set in traditional Medicare (e.g., hospital lifetime reserve days).	Plans are prohibited from designing benefit packages that discriminate against individuals based on age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions. *45 § C.F.R. 156.125* Plans are prohibited from placing lifetime or annual dollar limits on Essential Health Benefits. *42 USC § 300gg-11; 45 C.F.R. § 147.126* Frequency limits (day/visit) on covered benefits are permitted/allowed consistent with benchmark plan standards and non-discrimination provisions at *45 § C.F.R. 156.125.* Mental health and substance abuse services must meet parity requirements. A QHP cannot impose a financial requirement (such as a copayment or coinsurance) or a quantitative treatment limitation (such as a limit on the number of outpatient visits or inpatient days covered) on mental health or substance use disorder benefits that is more restrictive than the financial requirements or quantitative treatment limitations that apply to at least 2/3 of medical/surgical benefits in the same classification. *42 U.S.C. § 300gg-26*; *42 U.S.C. § 1396u-2(b)(8)*	Plan contracts must identify, define, and specify the amount duration and scope of each service that the plan is required to offer; plans may place appropriate limits on a service based on criteria applied under the state plan, such as medical necessity or for utilization control provided that services can reasonably be expected to achieve their purpose. *42 C.F.R. §438.210(a)* Medicaid managed care plans must meet the mental health parity requirements at *42 U.S.C. § 300gg-26*. *42 U.S.C. § 1396u-2(b)(8)*
Premiums	*Both MA plans and QHPs are limited in how much they can vary premiums. MA plans can only vary premiums by county. QHPs can vary premiums by rating area, which must be approved by the state. In addition, QHPs can also vary premiums by age and tobacco use; MA premiums may not vary based on these factors. In general, Medicaid managed care plans impose no premiums in addition to what may be charged by the underlying state Medicaid program (similar to the underlying Part B premium in Medicare). Under federal law, Medicaid premiums are limited to certain populations and amounts.*		
	In general, MA premiums based upon the	In general, QHP plan premiums can	In general, Medicaid managed care

	difference between Medicare payments to the plan and the plan's costs (or bid submitted to Medicare); these amounts vary by county.[35] MA coverage is only available to individuals or through employer-based (retiree) plans – it is not available as family coverage. No rate review, but plan bids submitted to CMS are reviewed for reasonableness. Since federal payments to plans typically exceed plans' estimated costs, most MA plans do not have a premium for the MA benefits, but often charge a premium for the Part D benefits. Enrollees must continue to pay Part B premium regardless of MA premium amount ($104.90 in 2015 for most individuals). - Note MA plans are allowed to offer reduced Part B premiums as an additional benefit to their enrollees.	only vary based on: 1. individual or family coverage 2. Rating area 3. Age (3:1 ratio) 4. Tobacco usage (1.5:1) *42 USC 300gg-6(c); 42 C.F.R. § 147.102* Rate review required for annual premium increases ≥ 10%. *45 C.F.R. § 155.1020*	plans impose no premiums beyond what may be charged by the underlying state Medicaid program. Under federal law, Medicaid premiums are limited to certain populations and amounts.
Cost-Sharing	*Cost-sharing requirements in MA and QHPs are <u>similar</u> in that protections only apply to essential health benefits (EHB) in QHPs and traditional Medicare equivalent services in MA plans. While QHPs can impose substantial deductibles, MA plans are generally more limited in their ability to do so due to rules requiring that MA cost-sharing be more-or-less equivalent to cost-sharing in traditional Medicare. Medicaid cost-sharing in managed care is at state option and is subject to federal exemptions and limits. Any Medicaid managed care cost-sharing must follow strict federal rules.* *QHPs and Medicaid have a "hard" cap on out-of-pocket expenses. Conversely, while MA plans have a maximum out-of-pocket limit for medical services – which is higher than the corresponding QHP cap – prescription drug coverage under Part D has a separate, "soft" cap that requires some additional cost-sharing even after the threshold is met.*		
	Cost-Sharing in Benefit Design		
	MA plans may impose copayments and deductibles that are different from those under Parts A and B, as long as cost-sharing is "actuarially equivalent" to cost-sharing under Traditional Medicare (in other words, total MA cost-sharing for Part A and B services must not exceed cost-	QHPs cost-sharing varies based on Actuarial Value "metal levels": Bronze (60%) Silver (70%) Gold (80%) Platinum (90%)	Medicaid managed care plan contracts with the state must provide that any cost-sharing is in accordance with federal Medicaid rules; Medicaid cost-sharing is imposed at state option, and federal law exempts certain populations and services from cost-

	sharing for those services in Traditional Medicare). *42 U.S.C. §1395w-24(e)* - Note that CMS also applies this requirement separately to certain service categories (see, e.g., Call Letter[36]) - MA plans cannot vary cost-sharing among enrollees in a plan Plans can charge cost-sharing for services for which there is no cost-sharing charged in traditional Medicare Parts A and B (e.g., hospice care) as long as overall cost-sharing remains actuarially equivalent. *42 U.S.C. §1395w-22(a)(1)(B)(v)* Limitation on variation of cost-sharing – following services cannot exceed cost-sharing under Parts A and B: - renal dialysis services - chemotherapy - skilled nursing facility care[37] - such other services Secretary of HHS deems appropriate (no other services designated yet) *U.S.C. §1395w-22(a)(1)(B)(iv)* CMS reviews plan bids to ensure proposed cost-sharing is within permissible limits.	Enhanced silver plans include cost-sharing reductions (CSR) for enrollees with income below 250% FPL. The actuarial value of CSR plans must be 94% (income 100-150% FPL); 87% (income 151-200% FPL); and 73% (income 201-250% FPL) respectively. As long as plans meet AV and out of pocket caps, and follow nondiscrimination standards, law does not specific how combination of cost-sharing (co-pays, co-insurance and deductibles) is structured. Coverage of preventative health services without cost-sharing. *42 U.S.C. 300gg-13* *See, generally, 45 C.F.R. 156.140*	sharing; federal law also limits Medicaid cost-sharing to nominal amounts for people below the federal poverty level and sets federal maximums for people with higher incomes; any Medicaid premiums and cost-sharing is capped at 5% of monthly or quarterly income. *42 C.F.R. § 438.108*
	Limits on Provider Billing		
	Plan enrollees are protected against balance billing (they generally pay only plan-allowed cost-sharing) when they obtain plan-covered services, including from non-contracted providers. *Medicare Managed Care Manual, Ch. 4, § 180, et seq.* MA has a prior-authorization process: if an enrollee wishes to receive a service from an in-network provider, the provider must seek prior authorization from the plan and	Emergency services received out-of-network must be covered at in-network rates. *42 U.S.C § 18022* However, there is no prohibition against provider balance-billing for out-of-network emergency services. *Id.*	Medicaid MCOs must adequately and timely cover services out-of-network at no more than in-network cost to enrollee, if service cannot be provided in-network, including emergency care.

	inform the enrollee if the plan makes an adverse determination, triggering appeal rights; if, however, the provider furnishes the service and without seeking prior authorization from the plan and the service is not covered, the provider cannot bill the enrollee for more than standard in-plan cost-sharing. *42 C.F.R. §422.105(a); Managed Care Manual, Ch. 4, § 170*[38] Emergency services obtained out-of-network are covered by plans with a limit on charges to enrollees (to amount determined by CMS annually ($65 for 2015), or what the plan would charge the enrollee if he or she obtained the services through the MA organization, whichever is less). *42 C.F.R. §422.113(b)*		
	Out-of-Pocket Limits		
	MA plans must establish a maximum out-of-pocket liability amount (MOOP) for all Part A and B services established annually by CMS (not indexed to inflation). *42 C.F.R. §422.100 and .101* - In 2015, the mandatory MOOP is $6,700; plans that use a lower, voluntary MOOP of $3,400 have greater flexibility in establishing cost-sharing amounts. There is a separate Part D catastrophic coverage maximum of $4,700 out-of-pocket in 2015, after which out-of-pocket costs are very low (but not $0); in other words, there is no "hard" cap on spending.	The maximum out-of-pocket cost limit for any individual Marketplace plan can be no more than $6,600 for an individual and $13,200 for a family in 2015. *45 C.F.R § 156.130(a)(2) and 79 Fed. Reg. 13801* For CSR silver plans in 2015, the maximum annual out-of-pocket cost limit is $2,250 (CSR 94% and CSR 87% plans) and $5,200 (CSR 73% plans). For family plans these amounts are doubled. - Only applies to covered, in-network benefits; no limits on cost-sharing for out-of-network care. *45 C.F.R § 156.230* - This includes both medical services and prescription	As noted above, any Medicaid premiums and cost-sharing is capped at 5% of quarterly or monthly income.

		drugs. *Id.* - For plan or policy years beginning after 2014, the annual limitation on out-of-pocket costs is increased by the premium adjustment percentage described under *Affordable Care Act § 1302(c)(4).* In 2016, the maximum OOP limit for individuals will increase to $6,850 for an individual/$13,700 for a family policy. For CSR policies, the maximum annual OOP limit will remain the same for CSR 94% and CSR 87% plans ($2,250 for individual, $4.500 for family) but will increase for CSR 73% plans to $5,450/individual and $10,900 for families. *45 C.F.R § 156.130*	
Network Adequacy	*In general, MA plans have more established network adequacy requirements than QHPs, meaning MA plans must follow more fixed guidelines as far as number, type, and access to providers. While MA plans, QHPs and Medicaid managed care all have federal network adequacy standards, they are complex. According to federal law, QHP networks must include "essential community providers": medical care providers who serve predominantly low-income, or medically underserved patient populations. MA plans do not have such a requirement. For QHPs and Medicaid managed care, much of the detail on network adequacy is left up to the states. Ensuring adequate provider networks is one place <u>some</u> states go above and beyond federal requirements.* *Like MA plans, QHPs may use mechanisms to control utilization like network tiering and referral requirements provided they do not conflict with non-discrimination provisions. However, QHPs may not require a referral to see an OB-GYN or pediatrician. Medicaid managed care plans must provide direct access to specialists for people with special health care needs and direct access to women's health specialists for routine and preventive health care for female enrollees. MA plans, QHPs, and Medicaid managed care plans must ensure access to out-of-network emergency care.* *While MA plans, QHPs, and Medicaid managed care plans can change their provider networks during the year, enrollees in MA plans, (non-MLTSS waiver) Medicaid managed care plans, and QHPs do not have the right to switch plans if their provider is dropped from the plan's network mid-year (although MA enrollees will have a limited right to do so starting in 2015).*		
	General Rules		
	Coordinated care plans (e.g., HMOs) can use mechanisms to control use of services,	No referral necessary for OB-GYN (OB-GYN designated as PCP).	Plans must implement procedures to ensure that each enrollee has an

	such as referrals from a gatekeeper for an enrollee to receive services within the plan. *42 C.F.R. 422.4(a)(1)(ii)* Specialist referral policies set by plans (however plans must provide or arrange for necessary specialist care, and in particular give female enrollees the option of direct access to a women's health specialist within the network for women's routine and preventive health care services; in addition, the plan must arrange for specialty care outside of the plan provider network when network providers are unavailable or inadequate to meet a member's medical needs). *See, e.g., Medicare Managed Care Manual, Ch. 4, §110.1* PPOs have networks of contracting providers but also provide for reimbursement for all covered benefits regardless of whether the benefits are provided within the network of providers (i.e., out-of-network care). *42 C.F.R. 422.4(a)(1)(v)* Private Fee-for-Service (PFFS) plans in non-network areas[39] and MSAs do not need to establish networks. MA plans can change their provider networks any time during the year, as long as they continue to meet network adequacy standards, provide timely notice (at least 30 days advance notice to affected enrollees), and ensure continuity of care for enrollees.[40]	*45 C.F.R. §147.138* No referral necessary for pediatrician. *45 C.F.R §147.138* Access to out-of-network emergency room services: in-network cost-sharing must apply; however balance billing is not limited. *45 C.F.R §147.138*	ongoing source of primary care appropriate to needs and a person or entity formally designated as primarily responsible for coordinating health care services. *42 C.F.R. § 438.210(b)* State must identify people with special health care needs to plans, and plans must assess these enrollees for any ongoing special conditions that require a course of treatment or regular care monitoring; these enrollees must have direct access to specialists as appropriate. *42 C.F.R. § 438.210(c)(1), (4)* Plans must provide female enrollees with direct access to a women's health specialist in network for covered women's routine and preventive health care. *42 C.F.R. § 438.206(b)(2)* Plans must provide a second opinion from qualified professional within network or arrange for enrollee to obtain one out of network at no cost. *42 C.F.R. § 438.206(b)(3)* Plan must adequately and timely cover services out-of-network if network is unable to provide necessary covered service and must ensure that out of network cost to enrollee is no greater than in network. *42 C.F.R.§ 438.206(b)(4), (5)* State must establish uniform provider credentialing policy that each plan must follow. *42 C.F.R. § 438.214(b)* Plan must make good faith effort to

			give written notice of termination of contracted provider within 15 days of receipt or issuance of termination notice to each enrollee who received primary care from or was seen on a regular basis by that provider. *42 C.F.R. § 438.10(f)(5)*
	Rights Triggered by Provider Terminations		
	There is generally not a right for MA enrollees to change plans mid-year due to provider terminations, however CMS has established a limited special enrollment period right starting in 2015 when CMS has determined that a plan has engaged in "substantial mid-year provider network terminations."[41]	No right to change plans.	CMS's 2013 MLTSS waiver guidance requires states to allow beneficiaries to disenroll from their MCO "when the termination of a provider from their MLTSS network would result in a disruption in their residence or employment."
	Access to and Content of Network		
	Coordinated care plans (e.g., HMOs) contract with a network of providers; CMS is to ensure that all applicable requirements are met, including access and availability, service area, and quality. *42 C.F.R. §422.4(a)* Medicare establishes network adequacy criteria,[42] which include: 1. A minimum number of providers and facilities which vary by county type – population size and density parameters (large metro, metro, micro, rural and counties with extreme access considerations (CEAC), and specialty codes (e.g., primary care, cardiology, etc. for providers; acute inpatient hospitals, outpatient dialysis, etc., re: facilities). 2. Maximum travel time and distance to providers/facilities plan enrollees cannot be "unduly burdened" in terms of travel time and distance required to access providers.	Plans in Marketplaces are required to provide consumers with a "sufficient choice of providers." *42 U.S.C § 18031* Plans are required to maintain a network sufficient in numbers and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay; and Are consistent with the network adequacy provisions of section 2702(c) of the Public Health Service Act (PHS), a provision that allows network plans to limit coverage to its eligible enrollees and to limit enrollment to the network's maximum capacity *45 C.F.R § 156.230(a)(2)* Plan networks must include "essential community providers" in accordance with *45 C.F.R § 156.235.* The network must have a sufficient	Plans must maintain and monitor a network of appropriate providers that is sufficient to provide adequate access to all covered services; plans must consider anticipated Medicaid enrollment, expected utilization of services (taking into consideration the characteristics and health care needs of specific Medicaid populations), number and types of providers required to furnish contracted services, number of network providers who are not accepting new Medicaid patients, and the geographic location of providers and enrollees (distance, travel time, means of transportation ordinarily used by Medicaid enrollees and whether location provides physical access to people with disabilities). *42 U.S.C. § 1396u-2(b)(5); 42 C.F.R. § 438.206(b)(1)* Plans and their network providers must meet state standards for timely access to care and services, taking into account the urgency of need for services; ensure that network providers

		number and geographic distribution of essential community providers, where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals" in the area that the plan serves (the plan's "service area"). Essential community providers include, but are not limited to: FQHCs, Ryan White HIV/AIDS providers, DSH hospitals, Title X Family Planning clinics & hemophilia treatment centers. *42 U.S.C 18031, 45 C.F.R. § 156.235*	offer hours of operation that are no less than hours offered to commercial enrollees or comparable to Medicaid fee-for-service if provider serves only Medicaid enrollees; make services available 24/7 when medically necessary; and participate in state efforts to promote culturally competent service delivery. *42 C.F.R. §438.206(c)*
Network Adequacy (cont'd)	**Oversight**		
	CMS does not review plans' submitted data for network adequacy unless the plan is new to a service area, is expanding the service area, or there are significant changes to the network (no annual review). CMS uses geo mapping software program to evaluate adequacy of networks submitted by MA plan applicants (using network adequacy criteria described above). Largely automated process. Not required by statute to report claims from out-of-network providers.	CMS will assess provider networks using a "reasonable access" standard. For Marketplace plans in 2014, HHS relied mostly on network adequacy reviews that states or health insurance plan accreditors conducted. For 2015, HHS intends to more closely review network adequacy compliance among plans in the FFM looking for plans that seem to be outliers based on their inability to provide "reasonable access" before certifying plans as qualified for the Marketplace. *See 2015 letter to issuers p. 17 and 18*[43] Required by statute to report claims from out-of-network providers. *42 U.S.C.A. § 18031(e)(3); 42 U.S.C. § 300gg-15a*	State Medicaid agency must ensure that all covered services are available and accessible to plan enrollees. *42 C.F.R. § 438.206(a)* State Medicaid agency also must ensure through its contracts that each plan gives assurances and provides supporting documentation that demonstrates that plan has capacity to serve expected enrollment in service area in accordance with state's access to care standards; state must review plan documentation and certify to CMS that plan complies with state's standards. *42 C.F.R. § 438.207(a)-(d)* CMS may request plan documentation. *42 C.F.R. § 438.207(e)*
	Information to Consumers		
	Medicare Marketing Guidelines require MA	*See Consumer Information and*	*See Consumer Information and*

	plans to provide new and renewing enrollees with a provider directory (among other things – see "Consumer Information" below). *Medicare Marketing Guidelines, §30.7* Plans must send a Provider Directory at the time of enrollment and at least every three years after that; additionally, plans must make directories available upon beneficiary request and ensure that websites contain current directories at all times. *Medicare Marketing Guidelines, §60.4* No requirement to identify providers who speak non-English languages. No requirement to identify providers that are not accepting new patients.	*Assistance* For 2016, QHPs must publish online (with hard copy available upon request) an up-to-date, accurate, complete, and plan-specific provider directory. Required information includes provider's location and contact information, specialty, medical group, institutional affiliations, and whether provider is accepting new patients. Directory information must be updated at least monthly. Directory must be accessible to general public (not just enrollees) and published in a machine-readable format. There is no requirement to identify providers who speak non-English languages or who are accessible for patients with disabilities. *45 C.F.R. § 156.230*	*Assistance* Must identify providers who speak non-English languages. Must identify providers that are not accepting new patients.
Appeals and Grievances	*MA plans and QHPs are <u>similar</u> in that both provide processes for appeals, initially through the plan and then by an external reviewer(s). In some cases the external reviewer for QHPs and MA is the same contracted entity (i.e., Maximus Federal Services). In Medicaid managed care, beneficiaries have access to both a plan level appeal and a state fair hearing, although unlike in MA and QHPs, states can choose whether to require beneficiaries to complete the plan level appeal first or allow beneficiaries direct access to a state fair hearing.* *Medicaid managed care requires provision of a terminated service to continue pending the outcome of an appeal, whereas MA plans do not (with some limited exceptions like discharge from institutional settings like hospitals). Also, the Medicare 5-step administrative appeals process is uniform across the country. For QHPs (and other private health plans), federal minimum standards apply to appeal rights and limit the number of levels of appeals that can be required (e.g., no more than 1 level of internal appeal can be required before external review is offered), other variation in levels/structures of QHP appeals can also be found across states. State laws that fail to meet minimum federal standards are preempted. A special rule applies to insurers in preempted states, permitting insurers the choice of using two different federally established external review systems.* *Baseline appeal rights, including plan appeals and state fair hearings, are in federal Medicaid law, although states are permitted to make some choices within that framework, such as the number of days to request a hearing.* *In addition, the MA program has a standardized, centralized complaint tracking system compared to QHP and Medicaid managed care complaint tracking, which is left to the states. There is a formalized (federal) grievance process written into regulation for MA plans while grievances against QHPs are filed with state departments of insurance and vary from state to state. The basic plan grievance process for Medicaid managed care is set out in federal law.*		

	Notice of Denial		
	Notice of non-coverage (NONC) is a standard document developed by CMS which includes reason for service denial, information on rights to expedited and standard appeal and how to seek an appeal. MA plans must use a standardized notice of non-coverage developed by CMS.[44] MA notices must "use approved notice language in a readable and understandable form." *42 C.F.R. §422.568(e)(1)* Note that denial notices and appeals correspondence are not among the documents that MA plans are required to translate into other languages[45]; also see Consumer Information and Assistance section below.	Under federal rules (states can apply enhanced standards) QHPs must provide Limited English Proficiency notices that advise enrollees of oral translation assistance by phone. *42 USC § 300gg-19, 45 C.F.R. § 155.205(c).* Written translation must also be provided upon request; however, QHPs are not required to track translation requests by LEP enrollees; enrollees must request written translation of each notice separately. QHPs must provide notice that includes a description of service denied, the reason for why the claim was denied, and information about appeal rights including expedited appeal rights. The notice must also include contact information for any applicable state Consumer Assistance Program (CAP) which can help consumers file an appeal. *45 C.F.R. §147.136(E)*	MCOs must provide written notices in accessible language and format that explain the action taken/to be taken, the reason(s) for the action, enrollee's right to file an appeal, enrollee's right to request state fair hearing (if state does not require exhaustion of plan appeal first), procedures for exercising appeal rights, circumstances under which expedited resolution is available and how to request it, and right to aid pending/how to request/circumstances under which enrollee may be required to repay.
	Appeals Process		
	MA organizations must provide for both an internal grievance process and a formal appeals process with external review. Appeals address concerns and disagreements with organization determinations (whether an item, service, or procedure is covered) and include procedures that deal with the review of adverse organization determinations; such procedures include reconsiderations by the MA organization, and if necessary, an independent review entity, hearings before administrative law judges (ALJs), review by the Medicare Appeals Council (MAC), and	Right to internal review of all adverse benefit determinations and decisions. Under federal rules, right to external review only for medical necessity denials and related determinations involving clinical judgment. The number of appeal levels varies somewhat depending on state (though no more than one level of external review may be required before external review is offered) and may terminate in state court. *45 C.F.R. § 147.136*	Plans must have a grievance process and an appeal process and must provide beneficiaries with access to the Medicaid state fair hearing system. *42 U.S.C. § 1396u-2(b)(4); 42 C.F.R. § 438.402(a).* Appeals are requests for review of denials or limitations on a requested service or a reduction, suspension or termination of a previously authorized service or the failure of a plan to take timely action. *42 C.F.R. § 438.400(b)*

	judicial review. See *42 C.F.R. §§422.561, .566, et seq.* - Expedited appeals are available in certain scenarios - Amounts in controversy apply for access to ALJ and federal court	<u>Minimum internal review standards</u>: Must comply with all ERISA internal claims and appeals procedures applicable to QHP under *29 C.F.R. 2560.503.-1* and additional requirements including clarification of what constitutes an adverse benefit determination. (A) Expedited notification of benefit determinations involving urgent care; (B) Full and Fair review; (C) Avoiding conflicts of interest; (D) Notice. <u>Minimum external review standards</u>: State has flexibility in determining standards for external review subject to federal minimum standards, which are based on the minimum consumer protections in the NAIC Uniform Model Act. *45 C.F.R. § 147.136* (c) State external review systems that do not meet federal minimum standards are preempted. This is currently the case for 8 states. In preempted states, the insurer is allowed to choose, on a case by case basis, to participate in one of two federally-administered external review systems. Under the HHS-administered process, the federal government selects the external reviewer. Under the DOL-administered process (which also applies to all self-insured group health plans), the plan hires the external reviewer.[46] *45 C.F.R. § 147.136* <u>Expedited Appeals:</u> In the case of urgent care claims for notification of the plan's benefit determination (whether adverse or not) as soon as possible, taking into	Enrollees can file a plan level appeal and request a Medicaid state fair hearing. *42 C.F.R. § 438.4029b)(1)(i)* States set the number of days a beneficiary has to request an appeal (within a range of 20 to 90 days) and determine whether beneficiaries must exhaust the plan appeal process before accessing a state fair hearing. *42 C.F.R. § 438.402(b)(2)* Federal law contains the required elements of notices of plan actions and appeal resolutions and the timeframes in which plans must resolve appeals. *42 C.F.R. § §438.404, 438.408* Plans must have an expedited review process for appeals. *42 C.F.R. § 438.410* Plan appeals must provide enrollees with a reasonable opportunity to present evidence and allegations of fact and law and the opportunity to examine the enrollee's case file and any documents and records considered during the appeal. *42 C.F.R. § 438.406(b)(2), (3)* State or plan must provide information to enrollees about appeal rights. *42 C.F.R. § 438.10(g)*

		account the medical exigencies, but not later than 72 hours after receipt of the claim). *45 C.F.R. 147.136(b)*	
	Aid Paid Pending Appeal		
	Not required (other than limited continued coverage when appealing discharges from hospital, skilled nursing facilities and home health coverage).	Required only during first internal level of appeal. *45 C.F.R. 147.136(b)(2)*	Required for service terminations if timely requested by beneficiary. Plans must provide continued benefits pending appeal, as set out in federal rules. *42 C.F.R. § 438.420*
	Grievances		
	Prescribed grievance process to express dissatisfaction about matters that are not subject to appeals, such as quality of care or failure to respect enrollee rights. *See 42 C.F.R. §§422.561, .564*	QHP issuers operating in a Federally-facilitated Exchange must investigate and resolve, as appropriate, cases from the complainant forwarded to the issuer by HHS. Cases received by a QHP issuer operating in a Federally-facilitated Exchange directly from a complainant or the complainant's authorized representative will be handled by the issuer through its internal customer service process. *45 C.F.R. 156.1010(b)*[47]	Grievances are expressions of dissatisfaction about matters that are not subject to appeals, such as quality of care or failure to respect enrollee rights. *42 C.F.R. § 438.400(b)*
	Reporting Requirements		
	Federal requirements for reporting complaints and grievances with the plans. The complaint tracking module (CTM) is a centralized system for collecting plan complaint information for both plan resolution and CMS oversight of plans; CTM information is factored into plan	No federal requirements for reporting complaints and grievances with the plans nor is data collected. However, ACA data reporting requirements, not yet implemented, mandate periodic reporting by QHPs (and other private health plans) on	Federal requirements for reporting complaints and grievances with the plans. Plans must maintain records of grievances and appeals which are reviewed as part of the state quality strategy.

	quality ratings and corrective action plans.	denied claims and claims payment practices. *§1311(e)(3)*	*42 C.F.R. § 438.416*
	Assistance with Appeals		
	No requirements for MA plan assistance with appeals, although State Health Insurance Assistance Programs (SHIPs) often serve this purpose. *Also see Consumer Assistance below.*	Consumer assistance available for help with appeals; CAPs mandated by federal law to assist QHP enrollees with appeals. *45 C.F.R. § 147. 36 (b)(2)(ii)(E)(5)* *Also see Consumer Assistance below.*	Medicaid MCOs must assist enrollees with appeals and provide interpreters Plans must provide reasonable assistance to enrollees in completing forms and taking other procedural steps, including providing interpreter services. *42 C.F.R. § 438.406* *Also see Consumer Assistance below.*
Marketing	*MA plans and QHPs are similar in that oversight of agents/brokers marketing plans is performed at the state level. Similarly, the state Medicaid agency oversees Medicaid managed care plan marketing, within broad federal standards.* *While the MA program has well-developed federal rules that plans and downstream entities must follow, marketing rules and regulation for QHPs are left up to individual states leading to state-based variation in this area. Like other aspects of the Medicaid program, federal law sets some baseline marketing rules and states can include further restrictions in state law or in their contracts with plans.*		
	The activity of MA plans is generally overseen by CMS; while states oversee/regulate licensure of agents and brokers, MA plans are ultimately responsible for the conduct of such agents/brokers and other downstream entities. Medicare marketing rules include: - CMS approval of marketing materials; - Prohibition against certain marketing practices (including marketing through unsolicited contacts and restrictions on marketing/sales events); - Coordination with states to address fraudulent or inappropriate marketing practices. *See, generally, 42 USC 1395w-21(h)-(j), 42 C.F.R.§ §422.4260, et seq., and Medicare Marketing*	QHP issuers must comply with state marketing laws and regulations. Marketing practices and benefit designs that discourage enrollment of individuals with significant health needs cannot be used. *45 C.F.R. § 156.225* Agents and brokers that sell QHPs are regulated by the state department of insurance and must be certified by the Marketplace to sell QHP coverage.	State must approve plan marketing materials. *42 U.S.C. § 1396u-2(d)(2)(A)(i); 42 C.F.R. § 438.104* Marketing materials must be distributed to plan's entire service area. *42 U.S.C. § 1396u-2(d)(2)(B); 42 C.F.R. § 438.104* Plans may not directly or indirectly engage in door-to-door, telephone or other cold call marketing. *42 U.S.C. § 1396u-2(d)(2)(E); 42 C.F.R. § 438.104* Plans must assure state that marketing plans and materials are accurate and do not mislead, confuse or defraud beneficiaries. *42 U.S.C. § 1396u-2(d)(2)(D); 42 C.F.R. § 438.104*

	Guidelines[48] Plan marketing materials are submitted to CMS, and can be used within certain time frames after submission (from 5 to 45 days, depending upon the materials) unless CMS disapproves – "file and use" *42 C.F.R. §§422.2262 - .2266*		
Consumer Information and Assistance	*MA plans, QHPs, and Medicaid managed care plans are required to disclose certain information to enrollees, however MA plans must generally provide a broader range of consumer information. Medicare offers a uniform plan comparison tool that provides certain information (Plan Finder); there is no comparable tool for QHPs at the federal level, although some state marketplaces offer them. Each QHP is, however, required to offer a standardized Summary of Benefits and Coverage (SBC) for consumers to compare across plans.* *Both Medicare and the Marketplaces offer consumer assistance through publicly-funded programs (SHIPs in Medicare and navigators in the Marketplaces as well as State Consumer Assistance Programs which serve all state residents, including QHP enrollees). Under the ACA, comprehensive consumer assistance services are to be provided to all state residents through CAPs. CAPs must provide eligibility and enrollment assistance for all types of private health coverage and help state residents with post-enrollment questions and problems, including helping consumers file appeals of denied claims. In addition, CAPs are required to track and report data on consumer problems to the Secretary, who in turn, must use this information to strengthen oversight. Under the ACA, additional help is provided specifically for people who seek coverage through Marketplaces. Navigators must provide outreach and enrollment assistance to people seeking coverage through QHPs or otherwise applying for Marketplace financial assistance. For post-enrollment problems, Navigators are required to refer consumers to CAPs. However, Navigators are funded on an ongoing basis by Marketplace operating revenue, while CAPs are funded through federal grants, subject to Congressional appropriations. As a result, Marketplaces spent more than $167 million on Navigators in 2014, while federal CAP grants that year totaled $5 million.* *Medicare SHIPs have ongoing federal funding to perform both enrollment and general consumer assistance for all Medicare beneficiaries, including Medicare Advantage enrollees.*		
	Plan Requirements		
	Disclosure Requirements (under statute) -- MA plans must disclose at the time of enrollment and at least annually thereafter certain information regarding the plan, including: - Service area; - Benefits offered under the plan; - Access – the number, mix, and distribution of plan providers, out-of-network coverage (if any) provided by the plan, and any point-of-service option; - Out-of-area coverage provided by the plan;	Plans are required to: Develop and utilization of uniform explanation of coverage documents and standardized definitions. *42 USC 300gg-15* Enrollees must have access to a provider directory. The QHP provides this directory to the Marketplace and is responsible for keeping directory accurate and up-to-date. It must indicate providers who are not accepting new patients.	State must have a mechanism in place to help enrollees and potential enrollees understand the managed care program. *42 C.F.R. § 438.10(b)(2)* Plans must have a mechanism in place to help enrollees and potential enrollees understand the plan's requirements and benefits. *42 C.F.R. § 438.10(b)(3)* State must provide information to potential enrollees when they first

	- Emergency coverage; - Supplemental benefits – including—whether the supplemental benefits are optional, the supplemental benefits covered, and any monthly supplemental beneficiary premium for the supplemental benefits; - Prior authorization rules or other review requirements that could result in nonpayment; - Plan grievance and appeals procedures - Quality improvement program *42 U.S.C. §1395w-22(c)* Additional information must be provided by the plan upon request of an MA eligible individual: - Certain general coverage information and general comparative plan information; - Information on procedures used by the organization to control utilization of services and expenditures; - Information on the number of grievances, redeterminations, and appeals and on the disposition in the aggregate of such matters; - An overall summary description as to the method of compensation of participating physician Medicare Marketing Guidelines also require MA plans to provide to new and renewing enrollees: - An Annual Notice of Change (ANOC)/Evidence of Coverage (EOC); - Provider directory; (see	*45 C.F.R. §156.230(b)* Enrollees must have access to a plan formulary. *45 C.F.R. § 147.200(a)(2)(i)(K)* (available through the Marketplace online with no log-in; offered via hard copy publication by request) Information must be provided in accessible language and manner for LEP and people with disabilities. *42 C.F.R. § 155.205* LEP Guidelines: For individuals who are limited English proficient, information must be provided through oral interpretation; written translations; and taglines in non-English languages indicating the availability of language services. *42 C.F.R. § 155.205(c)* QHPs must make available, upon request, translated marketing materials in any non-English language that is the primary language of at least 10% of the individuals in a plan benefit package service area; note that this is also the language standard that applies for appeals notices.	become eligible or required to enroll in a plan and within a timeframe that allows they to use the information in choosing among plans: - General information about basic features of managed care; - Which populations are excluded from enrollment, required to enroll, or able to voluntarily enroll; - Plans' responsibilities for care coordination; - Information specific to each plan including benefits covered, any cost-sharing, service area, names, locations, phone numbers and non-English languages spoken by providers and identification of providers not accepting new patients – at minimum, this includes primary care physicians, specialists, and hospitals; - Benefits covered under Medicaid state plan but not under managed care plan contract, including how and where to obtain, any cost-sharing and how transportation is provided *42 C.F.R. § 438.10(e)* State or plan must notify enrollees of their right to request and obtain information at least annually. *42 C.F.R. §438.10(e)(2)* State or plan must provide to enrollees the following: - Names, locations, telephone numbers and non-English languages spoken by

	"Network Adequacy" above); - If the plan offers Part D benefits, a comprehensive or abridged formulary and pharmacy directory *Medicare Marketing Guidelines, §30.7* Customer service call center (§80.1) and plan website (§100) requirements. *Medicare Marketing Guidelines* Limited English Proficient (LEP) guidelines: for markets with a significant non-English speaking population, provide materials in the language of these individuals. Specifically, MA organizations must translate marketing materials into any non-English language that is the primary language of at least 5% of the individuals in a plan benefit package service area. *42 C.F.R. §422.2264(e)* Plans must translate: marketing materials, application, summary of benefits, plan rating information, annual notice of change, drug list, pharmacy list, provider directory. Plan call centers must offer interpreter services. *42 C.F.R. §422.111(h)(1)* Plans must include the CMS created Multi-Language Insert with the Summary of Benefits (SB), ANOC/EOC, and the enrollment form informing individuals about free interpreter services. *Medicare Marketing Guidelines, §§30.5, 30.5.1, 50.4*		providers and identify providers not accepting new patients; - Any restrictions on enrollee's free choice among network providers; - Enrollee rights and protections (§ *438.100*) - Grievance and fair hearing procedures; - Amount, duration, scope of available benefits - Procedures for obtaining benefits - Extent to which and how enrollees may obtain benefits including family planning services from out of network providers; - Extent to which and how after-hours and emergency services are provided - Post-stabilization care services rules - Policy on referrals - Cost-sharing if any - How and where to access state plan benefits that are not covered under contract *42 C.F.R. § 438.10(f)* State or plan must give each enrollee 30 day advance written notice of any significant change in the above information. *42 C.F.R. § 438.10(f)(4)*
	Shopping for and Comparing Plans		

	Medicare offers a Plan Finder tool on the medicare.gov website allowing users to perform a personalized or generalized search of Part D and MA plans available by zip code. - Plan Finder does not include information about providers and providers networks, nor does it contain information in languages other than English and Spanish. - Medicare provides certain information on its website in languages other than English.[49]	Healthcare.gov is an internet web-portal for comparison shopping in Spanish and English. *42 C.F.R. 155.205* Summary of Benefit and Coverage (SBC). *45 C.F.R. § 147.200*	If Medicaid managed care enrollment is mandatory, state Medicaid agency must provide enrollees with information on plans in a comparative chart-like format, including plan service area, covered benefits, any cost-sharing, and quality and performance indicators including enrollee satisfaction, to the extent available. *42 U.S.C. § 1396u-2(a)(5)(C); 42 C.F.R. § 438.10(i)*
	Toll Free Call Centers		
	Medicare offers a toll-free, 24/7 national hotline to provide information, compare plans and lodge complaints (1-800-MEDICARE). Spanish-speaking agents available, interpreter services for other languages.	Consumer call center available through state or federal marketplace. *42 C.F.R. § 155.205*	Plans must provide toll-free numbers for enrollees to file grievances or appeals by phone. Other telephone call center provisions may be required by state law or MCO contract.
	In Person Consumer Assistance		
	State Health Insurance Assistance Program (SHIP) - established in Section 4360 of Public Law 101-508, SHIPs provide a health insurance advisory service to assist Medicare beneficiaries with the receipt of services under Medicare, Medicaid and other health insurance programs. CMS is legislatively required to assess SHIP performance, and CMS uses data gathered by the SHIP National Performance Reporting (NPR) system.[50]	Navigator programs must be established to help consumers choose and enroll in a QHP or Medicaid. *42 C.F.R. 155.210* Marketplaces are authorized to perform consumer assistance and outreach (in addition to Navigator program) aka non-Navigator assistance program *45 C.F.R. 155.205* Entities Marketplaces select to be Navigators must include at least one community-based & consumer-focused non-profit and at least one other type of public or private entity. Navigator funding: initially federal grants sometimes supplemented by states; Navigators must be funded on	States, plans, and enrollment brokers must provide all enrollment notices, informational materials, and instructional materials relating to enrollees and potential enrollees in a manner and format that may be easily understood. *42 U.S.C. § 1396u-2(a)(5)(A); 42 C.F.R. § 438.10(b)(1)* State must make written material available in each prevalent non-English language spoken by a significant number or percentage of enrollees or potential enrollees. *42 C.F.R. § 438.10(c)(1), (2)* Plans must make written information available in the prevalent non-English languages in their service area. *42 C.F.R. § 438.10(b)(3)*

		an ongoing basis through Marketplace operating revenue. Consumer Assistance Programs are specifically authorized by the Affordable Care Act to help consumers use their health insurance (educating consumers about their health insurance rights and responsibilities, assisting with health insurance appeals, and helping resolve problems with premium tax credits) but have not been adequately federally funded. CAPs are required to collect, track, and quantify problems experienced by consumers and periodically report data to the Secretary, who is, in turn, required to use data to determine where additional enforcement actions may be necessary and who must share data with other federal and state regulators. *45 C.F.R. § 155.205*	State and plans must make free oral interpretation services in all non-English languages available to enrollees and potential enrollees. *42 C.F.R. § 438.10(c)(4)*; state and plans must notify enrollees and potential enrollees that oral interpretation is available and how to request services. *42 C.F.R. § 438.10(c)(5)* Written material must use easily understood language and format and be available in alternative formats (e.g., visual limitations, limited reading proficiency). *42 C.F.R. § 438.10(d)* Enrollees have rights to be treated with respect and with due consideration for dignity and privacy, receive information on available treatment options and alternatives presented in manner appropriate to enrollee's condition and ability to understand; participate in health care decisions including right to refuse treatment; be free from restraint or seclusion as a means of coercion, discipline, convenience or retaliation; and to freely exercise rights in a way that does not adversely affect how plans, providers, and state treat the enrollee. *42 C.F.R. § 438.100*
Low-Income Assistance	*<u>Similar</u> In both Medicare and with QHPs, premium subsides and cost-sharing subsides are available. In Medicare, it is the state Medicaid program that pays the Part B premium through the Medicare Savings Program and in QHPs, the subsidy is through the federal government (the IRS). Government (Medicaid for Medicare and IRS for QHP) pays the premium directly.* *<u>Different</u> For MA premiums (premiums above and beyond Part B) there is no assistance above 135% FPL whereas with QHPs premium assistance is offered up to 400% FPL The Part D low-income subsidy (LIS) assistance is available for prescription drug costs to individuals up to 150% FPL.*		

	By definition, all Medicaid beneficiaries have low incomes, and limits on premiums and cost-sharing are included in federal law.		
	Medicare Savings Programs: - Qualified Medicare Beneficiary (QMB) – covers premiums, deductible, coinsurance, copayments; income up to 100% federal poverty level (FPL), assets $7,280/individual, $10,930/couple - Specified Low-Income Medicare Beneficiary (SLMB) – covers Part B premium only; income between 100-120% FPL, assets $7,280/individual, $10,930/couple - Qualified Individual (QI) covers Part B premium only; income between 120-135% FPL, assets $7,280/individual, $10,930/couple - Dual eligibles who are enrolled in MA plans and who are QMBs are entitled to have their states pay MA plan copayments and are excused from liability for such payments (states can also pay MA premiums at their discretion)[51]; other dual eligible are entitled to have at least some copayments paid *42 U.S.C. §1396d(p)(3)* Part D Low-Income Subsidy (LIS): - Covers most or all of Part D premium, most cost-sharing - Automatically eligible if have Medicaid or one of above Medicare Savings Programs - Also available for individuals on sliding scale up to 150% FPL, assets up to $13,640 individual/$27,250 couple	Advance Premium Tax Credits are offered; APTC can be paid in advance, directly to insurers, to reduce enrollee's monthly premium, or can be claimed at the end of the year by consumers as a credit at tax filing. The amount of subsidy is based on a sliding scale depending upon income. *26 C.F.R. § 1.36B* Income eligibility for APTC is 100%-400% FPL. In addition, to be eligible an individual cannot be eligible for other subsidized coverage offered by an employer or through a public program, such as Medicare or Medicaid. APTC amount is calculated as percentage of income (for example, people between 300% and 400% FPL will pay no more than 9.5% of income on premiums for 2nd lowest cost silver plan; APTC amount is difference between benchmark plan cost and this required individual contribution amount). *45 C.F.R. § 155.305* Cost-sharing subsidies also available to individuals with incomes 100%-250% FPL. Cost-sharing subsidies delivered differently, through enhanced silver plans (not through plans in other metal tiers). CSR plans have higher actuarial values (and so lower cost-sharing) compared to regular silver plans. For people with income 100-150% FPL, silver plan actuarial value is increased from 70% to 94%. For	Medicaid eligibility is limited to people with low incomes, and federal law incorporates exemptions and limitations on premiums and cost-sharing (see above for more details).

		people with income 151-200% FPL, CSR plans have actuarial value of 87%. For people with income 201-250% FPL, CSR plans have actuarial value of 73%. In addition, the otherwise applicable maximum OOP limit is reduced to $2,250 in CSR plans for individuals with income 100-200% FPL, and to $5,200 for individuals with income 201-250% FPL. People eligible for CSR plans pay the same premium they would otherwise pay for a silver plan of 70% AV. The federal government separately reimburses the health plan for the value of the reduced cost-sharing. Enrollees have the right to appeal the termination or change in cost-sharing reductions or advance premium tax credits. *45 § C.F.R. 155.1220* <u>Eligibility for APTC and CSR</u>: 1. Citizenship/Residency Requirements 2. Not eligible for other "minimum essential coverage" (Minimum essential coverage includes Medicare, Medicaid and an offer of affordable employer sponsored insurance.) *45 C.F.R. § 155.305*	
Medical Loss Ratio (MLR)	*Both MA plans and QHPs are bound by medical loss ratio (MLR) rules that require designated percentages of revenue generated by plans to be spent on the provision of benefits (vs. administration, profit, etc.). Rebates paid by plans for failure to meet the MLR in the MA context are paid back to the Medicare program, whereas QHPs pay rebates directly to plan enrollees (except for group plans). By contrast, federal law does not require an MLR for Medicaid managed care plans, although states can opt to include an MLR in their plan contracts.*		
	Effective 2014, MA plans must maintain an MLR of 85% (meaning 85% of revenue goes towards benefits).	80/20; 85/15 for insurers selling to large groups (50+); rebate to individual (except group plans).	Federal law does not require an MLR for Medicaid managed care plans; states may choose to require an MLR in

	- If a plan fails to meet the MLR, it must remit sums to the Medicare program. - The Secretary of HHS can preclude new enrollment in plans that do not meet the MLR for 3 consecutive years, and must terminate plans that fail to do so for 5 consecutive years. *HCERA §1103*	*45 C.F.R. § 158.210*	their contracts with plans.

Appendix D: Comparison of Special Enrollment Period (SEP) Rights

There are both similarities and differences in special enrollment period (SEP) rights between Medicare Advantage (MA) plans, Marketplace qualified health plans (QHPs) and Medicaid Managed Care Organizations (MCOs).

The time periods within which MA SEPs must be exercised vary, but SEP elections are generally effective the first of the following month after an election is made. For QHPs, effective dates for most SEPs depend upon when an election is made: if an election is made between the first and the fifteenth day of any month, the Marketplace must ensure a coverage effective date of the first day of the following month; and if an election is made between the sixteenth and the last day of any month, the Marketplace must ensure a coverage effective date of the first day of the second following month.

For MA SEP rights, see 42 C.F.R. §422,62(b) and Medicare Managed Care Manual, Ch. 2, §§30.4, et seq; for QHP SEP rights, see 45 C.F.R. §155.420; for Medicaid MCO "for cause" disenrollment rights see 42 C.F.R §438.56.

Qualifying/Triggering Event	Medicare Advantage (MA)	Qualified Health Plan (QHP)	Medicaid MCO
Substantial violation by plan or material provision of contract	Yes	Yes	Yes – when state imposes this right as an intermediate sanction
Permanent move by individual out of plan service area	Yes	Yes	Yes
Enrollment or non-enrollment in a plan is erroneous due to action, inaction or error	Yes – actor must be a federal employee; SEP is tied to rights applicable under Part D	Yes – actor must be an officer, employee, or agent of the Exchange or HHS or its instrumentalities	Yes- If the MCO fails to make a timely disenrollment determination
Newly eligible or ineligible for assistance	Yes – Title XIX benefits (Medicaid or Medicare Savings Programs) or Part D low-income subsidy (LIS)	Yes – advance payments of the premium tax credit or change in the eligibility for cost-sharing reductions [Note: this only applies to individuals already enrolled in a QHP]	Yes
Life changes – marriage, divorce, having a child, pregnancy, change in disability status, gain or lose dependent, change in income, other changes that may affect income and household size	No	Yes	No
Exceptional circumstances preventing plan selection – serious medical condition, natural disaster, planned system outage	No	Yes	Yes
Domestic violence SEP	No	Yes	No

"In line" SEP (re: application)	No	Yes	No
Employer coverage	Yes – an SEP exists for individuals making MA enrollment requests in to or out of employer-sponsored MA plans, for individuals to disenroll from an MA plan to take employer sponsored coverage of any kind, and for individuals disenrolling from employer-sponsored coverage (including COBRA coverage) to elect an MA plan	Yes – if existing coverage through an eligible employer-sponsored plan will no longer be affordable or provide minimum value	Not applicable
Ongoing SEP for low-income	Yes – individual enrolled in Medicaid, Medicare Savings Program and/or Part D low-income subsidy can enroll, disenroll or change plans on a monthly basis (tied to rights applicable under Part D)	Yes – but QHP allows only one-time enrollment into a plan (QHPs only allow monthly plan changes for "an Indian" as defined by Section 4 of the Indian Care Improvement Act)	Not applicable
Open enrollment period for institutionalized individuals	Yes – continuous for eligible individuals – institutionalized individual is defined as an individual who moves into, resides in, or moves out of an institution [Note: not defined as an SEP under Medicare rules, rather as an "open enrollment period"]	No	No
Termination by regulator of contract or plan non-renewal	Yes	No	No
Trial period re: Medicare supplemental insurance policies (Medigap)	Yes	Not applicable	No
5-Star Quality Rating	Yes – if a plan achieves the top overall quality rating score of 5, there is an SEP to enroll in such plan outside of other enrollment periods	No	No- but may dis-enroll for poor quality of care
Lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the enrollee's health care needs.	No	No	Yes
Plan does not cover the service the enrollee seeks because of moral or religious objections.	No	No	Yes
The enrollee needs related services to be performed at the same time;	No	No	Yes

not all related services are available within the network; and the enrollee's primary care provider or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk			

Endnotes

[1] See Kaiser Family Foundation Medicare Health and Prescription Drug Plan Tracker for Medicare Advantage Enrollment, available at http://kff.org/data-collection/medicare-health-and-prescription-drug-plans/ Kaiser Family Foundation State Health Facts for Marketplace Enrollment, available at http://kff.org/other/state-indicator/state-marketplace-statistics-2015/ Kaiser Family Foundation Medicaid Managed Care Tracker for Medicaid Managed Care Enrollment, available at http://kff.org/medicaid/state-indicator/total-medicaid-mc-enrollment/

[2] A fifth category of "Catastrophic" plans is only available to certain consumers. These plans have somewhat higher cost-sharing, and premium subsidies are not available for Catastrophic QHPs.

[3] The statute also permits other capitated models (Prepaid Inpatient Healthcare Plans (PIHPs) and Pre-paid Ambulatory Health Care Plans (PAHPs)), which have less than a comprehensive risk contract than is required for MCOs. PIHPs include inpatient services, while PAHPs do not.

[4] See, e.g., Kaiser Commission on Medicaid and the Uninsured, *Benefits and Cost-Sharing for Working People with Disabilities in Medicaid and the Marketplace* (Oct. 2014), available at http://kff.org/medicaid/issue-brief/benefits-and-cost-sharing-for-working-people-with-disabilities-in-medicaid-and-the-marketplace/.

[5] "NHeLP and The AIDS Institute Complaint to HHS Re HIV/AIDS Discrimination by Florida Insurers," National Health Law Program and The AIDS Institute, May 29, 2014, available at http://www.healthlaw.org/publications/browse-all-publications/HHS-HIV-Complaint#.VE-BRhZHWkJ. For more information, see *Florida Insurance Commissioner Reaches Agreement with Insurer to Protect People with HIV/AIDS* available at http://www.hivdent.org/__USPublicPolicy__/2014/USPP_FICR112014.html.

[6] See e.g., "Medical and Prescription Drug Deductibles for Plans Offered in Federally Facilitated and Partnership Marketplaces for 2015", Kaiser Family Foundation http://kff.org/health-reform/fact-sheet/medical-and-prescription-drug-deductibles-for-plans-offered-in-federally-facilitated-and-partnership-marketplaces-for-2015/.

[7] For example, for MA enrollee protections concerning balance billing and emergency services, see 42 C.F.R. §422.113(b). See 42 C.F.R. §422.214 concerning what non-contract providers can collect in payment; also see Medicare Managed Care Manual, Ch. 4, §§180 – 190.2, and Ch. 6, §100.

[8] This maximum out-of-pocket amount is for in-network services covered by Medicare Advantage preferred provider plans (PPOs); such plans have higher limits for out-of-network care.

[9] Per CMS guidance, not statute or regulation. CMS, *Guidance to States Using 1115 Demonstrations or 1915(b) Waivers for Managed Long-Term Services and Supports Programs* at 10 (May 2013), available at http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/1115-and-1915b-MLTSS-guidance.pdf. At this time, it has not been fully incorporated in state home and community based services waivers. See, e.g., http://kff.org/medicaid/issue-brief/key-themes-in-capitated-medicaid-managed-long-term-services-and-supports-waivers/.

[10] Current regulations can be read to allow MCOs to provide aid pending appeal only to the end of the current authorization period, rather than during the entire pendency of the appeal, which is problematic for individuals with on-going care needs receiving long-term services and supports.

[11] 45 C.F.R. § 147.136. Also see "Guidance on External Review for Group Health Plans and Health Insurance Issuers Offering Group and Individual Health Coverage, and Guidance for States on State External Review Processes," DOL, June 22, 2011, available at http://www.dol.gov/ebsa/newsroom/tr11-02.html.

[12] 42 C.F.R. § 435.908. Assistance includes "providing information on insurance affordability programs and coverage options, helping individuals complete an application or renewal, working with the individual to provide required documentation, submitting applications and renewals to the agency, interacting with the agency on the status of such applications and renewals, assisting individuals with responding to any requests from the agency, and managing their case between the eligibility determination and regularly scheduled renewals." 42 C.F.R. § 435.908(c)(2). Application assisters may be certified to provide one, some or all of the permitted activities. *Id.*

[13] The Centers for Medicare and Medicaid Services, Guidance to States using 1115 Demonstrations or 1915(b) Waivers for Managed Long-Term Services and Supports Programs (may, 2013), available at http://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/downloads/1115-and-1915b-mltss-guidance.pdf.

[14] See, e.g., "Medicare Advantage Fact Sheet," Kaiser Family Foundation, May 1, 2014, available at http://kff.org/medicare/fact-sheet/medicare-advantage-fact-sheet/.

[15] See, e.g., "Summary of the Affordable Care Act," Kaiser Family Foundation, April 25, 2013, available at http://kff.org/health-reform/fact-sheet/summary-of-the-affordable-care-act/.

[16] See http://aspe.hhs.gov/health/reports/2014/Targets/ib_Targets.pdf.

[17] See, generally, "Medicaid Moving Forward," Kaiser Commission on Medicaid and the Uninsured, June 17, 2014, available at http://kff.org/medicaid/fact-sheet/the-medicaid-program-at-a-glance-update/.

[18] "Medicaid Enrollment and Expenditures by Federal Core Requirements and State Options," Kaiser Commission on Medicaid and the Uninsured, January 1, 2012, available at http://kff.org/medicaid/issue-brief/medicaid-enrollment-and-expenditures-by-federal-core/.

[19] Unless states were granted a waiver by HHS to cover those not otherwise (categorically) eligible.

[20] The ACA expanded Medicaid to 133% FPL. However, in calculating eligibility based on the new Modified Adjusted Gross Income financial methodology, an income disregard of 5% FPL is added, making the expansion effectively up to 138% FPL.

[21] "The Federal Courts' Role in Implementing the Affordable Care Act," Kaiser Family Foundation, September 12, 2014, available at http://kff.org/health-reform/issue-brief/the-federal-courts-role-in-implementing-the-affordable-care-act/.

[22] "Status of State Action on the Medicaid Expansion Decision," Kaiser Commission on Medicaid and the Uninsured, as of Jan. 27, 2015, available at http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/.

[23] "Medicaid in an Era of Health & Delivery System Reform: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2014 and 2015," Kaiser Commission on Medicaid and the Uninsured, October 14, 2014, available at http://kff.org/medicaid/report/medicaid-in-an-era-of-health-delivery-system-reform-results-from-a-50-state-medicaid-budget-survey-for-state-fiscal-years-2014-and-2015/.

[24] Id.

[25] See, generally, "People with Disabilities and Medicaid Managed Care: Key Issues to Consider," Kaiser Commission on Medicaid and the Uninsured, February 1, 2012, available at http://kff.org/medicaid/issue-brief/people-with-disabilities-and-medicaid-managed-care/.

[26] See, e.g., CMS' MMCO - CMCS Informational Bulletin entitled "Billing for Services Provided to Qualified Medicare Beneficiaries (QMBs)," January 6, 2012, available at: www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-01-06-12.pdf.

[27] See, e.g., Leo Cuello, "Health Advocate: Understanding the Medicare Coverage Cliff," National Health Law Program, June 17, 2014, available at http://www.healthlaw.org/publications/browse-all-publications/Health-Advocate-June-2014#.VAukQ2Nl-XQ.

[28] There are different forms of Medicaid managed care from which states can choose, including capitated models and managed fee-for-service models, such as primary care case management. This brief focuses on capitated Medicaid managed care organizations.

[29] Regarding eligibility for Medicare without the 24-month waiting period for people with ALS, see *Benefits Improvement and Protection Act (BIPA)*, Pub. L. No. 106-554 §115, December 21, 2000.

[30] See, generally, "Medicaid Moving Forward," Kaiser Commission on Medicaid and the Uninsured, June 17, 2014, available at http://kff.org/medicaid/fact-sheet/the-medicaid-program-at-a-glance-update/; "The Affordable Care Act's Impact on Medicaid Eligibility, Enrollment, and Benefits for People with Disabilities," Kaiser Commission on Medicaid and the Uninsured, April 8, 2014, available at http://kff.org/health-reform/issue-brief/the-affordable-care-acts-impact-on-medicaid-eligibility-enrollment-and-benefits-for-people-with-disabilities/.

[31] Regarding details on each state's benchmark plan, see "Additional Information on Proposed State Essential Health Benefits Benchmark Plans, CMS: CCIIO, http://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html.

[32] See, generally, "Medicaid Enrollment and Expenditures." The services for which a Medicaid beneficiary is eligible can depend on the benefit package associated with her coverage group.

[33] Regarding MA plan type and access to Part D prescription drug coverage, see 42 C.F.R. §423.30(b): an MA coordinated care plan (HMO, PPO, SNP) enrollee can obtain Part D drug coverage through that plan but not from a stand-alone Part D prescription drug plan (PDP); an enrollee of a PFFS plan that does not provide drug coverage may enroll in a stand-alone PDP; MSA plans may not offer Part D coverage so enrollees of MSAs may also enroll in a stand-alone PDP.

[34] For a discussion of MA payment, see, e.g., "Medicare Advantage Program Payment System," MedPAC, revised October 17, 2014, available at http://www.medpac.gov/documents/payment-basics/medicare-advantage-program-payment-system-14.pdf?sfvrsn=0.

[35] MA premiums are based on plan bids relative to local CMS-established benchmark payment rate. If a plan's bid is above the benchmark rate, plans receive a base payment rate equal to the benchmark rate and enrollees have to pay a basic premium that equals the difference between the bid and the benchmark. If a plan's bid is below the benchmark rate, plans receive a rebate payment from Medicare that must be returned to enrollees in the form of either lower premiums or supplemental benefits. For a discussion of MA payment, see, e.g., "Medicare Advantage Program Payment System," MedPAC.

[36] The 2015 CMS Call Letter states that actuarial equivalence will be applied to the following service categories in 2015: inpatient, skilled nursing facility, home health, durable medical equipment, and Part B drugs. "Note to: All Medicare Advantage Organizations, Prescription Drug Plan Sponsors, and Other Interested Parties," CMS, p. 89, April 7, 2014, available at http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Announcement2015.pdf.

[37] MA cost-sharing for skilled nursing facility (SNF) care: Despite this statutory restriction on charging cost-sharing greater than that allowed in Traditional Medicare, CMS has interpreted this provision to nonetheless allow MA plans to charge cost-sharing for the first

20 days of SNF coverage, even though Traditional Medicare does not charge any cost-sharing for this period. "Note to: All Medicare Advantage Organizations," p. 92.

[38] Also see "Improper Use of Advance Notices of Non-Coverage," CMS Memo, May 5, 2014, available at https://www.unitedhealthcareonline.com/ccmcontent/ProviderII/UHC/en-US/Assets/ProviderStaticFiles/ProviderStaticFilesPdf/Tools%20and%20Resources/Policies%20and%20Protocols/Improper_ABN_Use.pdf.

[39] For purposes of determining whether a PFFS plan must establish a contracted network of providers, a "network area" generally refers to a plan service area in which at least 2 other network-based Medicare Advantage plans are offered. This usually means a coordinated care plan such as an HMO. If a PFFS plan is offered in a non-network area, plan enrollees can see any provider that is willing to accept the plan's terms and conditions. See, e.g., *Medicare Managed Care Manual*, Ch. 16a, CMS, May 27, 2011, available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c16a.pdf.

[40] See, generally, *Medicare Managed Care Manual*, Ch. 4 (Part II), CMS, revised August 23, 2013, available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf. Also see "Medicare Marketing Guidelines," CMS, revised June 26, 2014, available at http://cms.hhs.gov/Medicare/Health-Plans/ManagedCareMarketing/FinalPartCMarketingGuidelines.html; note that §60.4 states: "[MA] Plans must, and Part D Sponsors are expected to, make a good faith effort to provide written notice of termination of a contracted provider/pharmacy at least thirty (30) calendar days before the termination effective date to all members who regularly use the provider/pharmacy's services. This is true whether the termination was for or without cause. When a contract termination involves a primary care professional, all members who are patients of that primary care professional must be notified." This section goes on to note: "In instances where significant changes to the provider/pharmacy network occur, the organization must send a special mailing immediately. In general, plans can define "significant changes" when determining whether a special mailing is necessary. However, CMS may also determine if a mailing is needed and direct plans to conduct such a mailing."

[41] See, e.g., Medicare Managed Care Manual, Ch. 2, §30.4.6 (updated 2014), available at http://www.cms.gov/Medicare/Eligibility-and-Enrollment/MedicareMangCareEligEnrol/Downloads/CY-2015-MA-Enrollment-and-Disenrollment-Guidance.pdf.

[42] See "MA HSD Provider and Facility Specialties and Network Adequacy Criteria Guidance," CMS, available at http://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/CY2014-HSD-Provider-and-Facility-Specialties-Criteria-Guidancev2.pdf.

[43] "2015 Letter to Issuers in the Federally Facilitated Marketplaces," CCIIO, CMS, March 14, 2014, http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-final-issuer-letter-3-14-2014.pdf.

[44] See MA required notices: "MA Denial Notices," CMS, revised June 26, 2014, available at http://www.cms.gov/Medicare/Medicare-General-Information/BNI/MADenialNotices.html; also see "Notices and Forms," CMS, revised October 31, 2013, available at http://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Notices.html.

[45] See, e.g., National Senior Citizens Law Center comments to DHHS Office of Civil Rights, September 30, 2013, available at http://www.nsclc.org/wp-content/uploads/2013/10/LanguageAccessComments.pdf. Note that CMS does provide a Spanish language Integrated Denial Notice for use by MA plans (see http://www.cms.gov/Medicare/Medicare-General-Information/BNI/MADenialNotices.html); also, for MA requirements re: providing Spanish language hospital discharge notices, see Medicare Managed Care Manual, Ch. 13, §150.6.1, available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c13.pdf.

[46] Also see "Guidance on External Review for Group Health Plans and Health Insurance Issuers Offering Group and Individual Health Coverage, and Guidance for States on State External Review Processes," DOL, June 22, 2011, available at http://www.dol.gov/ebsa/newsroom/tr11-02.html.

[47] See Casework Guidance for Issuers in Federally-facilitated Marketplaces, including State Partnership Marketplaces, http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/casework-guidance-03132014.pdf

[48] "Medicare Marketing Guidelines," CMS, revised June 26, 2014, available at http://cms.hhs.gov/Medicare/Health-Plans/ManagedCareMarketing/FinalPartCMarketingGuidelines.html.

[49] See "Information in other languages," Medicare.gov, available at http://medicare.gov/about-us/other-languages/information-in-other-languages.html.

[50] Regarding the SHIP National Performance Reporting (NPR) system, see, e.g., "States," CMS, revised January 8, 2014, available at http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/Privacy/States.html.

[51] Supra at note 26.

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