



October 4, 2010

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

RE: File Code OCHIO-9989-NC

Planning and Establishment of State-Level Exchanges; Request for Comments Regarding Exchange-Related Provisions in Title I of the Patient Protection and Affordable Care Act

Dear Sir or Madam:

Health Care for America Now (HCAN) is a broad coalition of labor, consumer, and provider organizations that led the grassroots effort to pass the Affordable Care Act and works ensure its implementation. We welcome this opportunity to respond to the Request for Comments on behalf of the undersigned organizations regarding the new health insurance Exchanges created by the Affordable Care Act. The Exchanges will provide affordable, high-quality health insurance options to millions of families and employees of small businesses.

In general, the Administration should use the Exchange planning and establishment grants as one way to document state progress in planning for a viable, functional Exchange. Both the federal government and the states have key operational decisions to make in the coming years, including how to avoid adverse selection against the Exchange, how to engage consumer stakeholders in the planning and governance of the Exchanges, and how to ensure that Exchanges are using their leverage to negotiate the best health plan values. HHS should advise states that the core functions of the Exchanges are inherently governmental and should be performed by government workers.

The federal government is charged with establishing an Exchange in states that do not or cannot establish a state Exchange. Strong federal-state collaboration could result in development of a model Exchange. However, if a state is unwilling to cooperate, the federal government should exercise its authority to enforce insurance rules, negotiate with insurers, and protect consumers in the absence of state participation.

Eligibility determination will be critical in ensuring that people understand their public and private insurance options and any health insurance tax credits available to them. Government workers should perform these functions. Successful eligibility and enrollment of millions of currently-uninsured people will require comprehensive outreach and education efforts by the

federal and state governments in collaboration with non-profits, community groups, employers, labor unions, providers, and others.

We look forward to working with you as the planning and establishment of the health insurance Exchanges moves forward.

Sincerely,



Ethan Rome
Executive Director

National Groups

AIDS Action Council
Campaign for Community Change
Direct Care Alliance
Health Care for America Now
Institute for America's Future
Main Street Alliance
National Education Association
National Physicians Alliance
National Rural Social Work Caucus
National Women's Health Network
Northwest Federation of Community Organizations
Raising Women's Voices for the Health Care We Need
USAction

State Groups

Action NC
BluewaveNJ
FACES on Medicaid Coalition (WV)
Georgia Rural Urban Summit
Health Access California
Michigan Citizen Action
Michigan Universal Healthcare Action Network
Montana Organizing Project
National Association of Social Workers, West Virginia Chapter
NJ Citizen Action
North Carolina Fair Share
Ocean State Action
Penn ACTION / HCAN PA
ProgressOhio
United Vision for Idaho
Virginia Organizing
Washington Community Action Network
WV Citizen Action Group

A. STATE EXCHANGE PLANNING AND ESTABLISHMENT GRANTS

The Exchange Planning and Establishment Grants, required under section 1311 of the Affordable Care Act (ACA), can help ensure that states have the resources they need to successfully structure and implement health insurance Exchanges, provide access to affordable, good-quality health coverage, and make effective use of taxpayer dollars.

The grants should be of sufficient size to cover a variety of planning and start-up costs associated with developing and implementing the Exchange, creating conditions to make it run effectively (including through implementation and enforcement of necessary rules outside the Exchange), and coordinating with Medicaid, CHIP and other state insurance options to ensure seamless access to coverage. There are many legitimate uses for grant funds, and there is much work to do. As such, HHS should disapprove grant or grant renewal applications that seek to serve political purposes rather than making substantial progress on Exchange design.

Recommendations for Grant Renewal

HHS should begin providing states with as much detail as possible about the requirements for operating a successful Exchange in compliance with federal standards and, alternatively, additional detail on how a federally-run Exchange would be structured and work in practice if a state elects to not establish its own Exchange. This information will help states make informed decisions about whether, at this time, they plan to set up their own Exchange and seek Establishment and Planning Grant funds or instead rely on a federal Exchange.

In order to receive a second round grant award, a state should be required to submit to the Secretary a letter of intent clearly attesting that the state: 1) plans to establish and operate its own insurance Exchange, and 2) will design and implement an Exchange in a manner fully consistent with federal requirements and regulations. A state that elects not to establish its own Exchange should be ineligible for any additional grant funds unless they are for activities to support a federal Exchange, such as ensuring coordination between the federal Exchange and state insurance regulation or streamlining eligibility procedures and establishing data linkages between the federal Exchange and the state's Medicaid and CHIP programs. As a condition of the grant award, HHS should require a detailed state plan, based on a federal template, that articulates the steps necessary to set up an Exchange in the state and the timeline for completing each element. The same form should be used in subsequent years to track progress in each area.

Additional Grant Awards for States with Innovative Ideas for Exchanges

As noted, section 1311 of the Act makes clear that the grants can be used for a broad array of activities. If sought by a state, HHS should provide additional grant amounts, above the regular grant award level, during a renewal year to promote the development of certain policies that are a matter of flexibility under federal law and regulation and entail additional costs and work by the state but are likely to improve the success of the Exchanges over time. For example, states should receive extra funds to plan a state-sponsored public health insurance option within the Exchange and to evaluate its impact on consumer choice and satisfaction, prices for enrollees, and the effect on tax credit expenditures.

B. IMPLEMENTATION TIMEFRAMES AND CONSIDERATIONS

We believe HHS should establish specific milestones and deadlines in a number of areas. States should be immediately required to assess and report to HHS on what implementing legislation will be necessary to enforce the various insurance market reforms required under the Affordable Care Act and to establish an Exchange. States should also outline an expected timeline for passage of that implementing legislation, particularly in states with biennial legislatures. As soon as practicable, HHS should begin to identify milestones for each year and then refine those targets with more specific benchmarks as the implementation effort proceeds.

The renewal process for the Exchange Planning and Establishment Grants can be a principal tool used to determine whether states have demonstrated progress in meeting the milestones HHS sets including implementing an Exchange and the related insurance market reforms and providing an opportunity for states to give input on appropriate interim goals.

Failure to meet most or all of the annual deadlines and benchmarks should trigger an HHS determination that the state is not making sufficient progress toward establishing an Exchange and, therefore, the federal government will have to establish its own Exchange in the state under section 1321 of the Act. Tying the determination of whether a state is making sufficient progress to these reporting, deadline and benchmark requirements will establish a clear and transparent process for both HHS and the states.

C. STATE EXCHANGE OPERATIONS

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

2011 State Legislative Action and Initial Planning

It is critical that state legislatures enact at least preliminary Exchange enabling legislation no later than 2011 and that states begin to undertake significant planning activities immediately so that there will be sufficient time to ensure that state Exchanges can be readied for operations in 2013 and effectively functioning January 1, 2014. Additionally, states will need time to establish and modify insurance regulations.

Stakeholder Engagement in Exchange Planning

Outlining and demonstrating the existence of an established, widely accepted stakeholder process for creating an Exchange should be an integral requirement of future Exchange-grant funding. This process should include the state agencies with which the Exchanges must work, representatives of legislative committees and legislatively-created bodies responsible for health care, consumers (including representatives of low-income communities, labor representatives and more), employers, providers, persons with relevant expertise and other stakeholders. Health industry stakeholders should have input into decisions regarding technical and workability issues but should be in total a minority of stakeholder bodies.

The stakeholder process should be fully transparent and accountable to the public. It should also include the opportunity for issue-specific working groups to give input into the process. To avoid conflicts of interest, state plans to establish a governing board should not include insurers or health plans that would be subject to regulation and oversight by an Exchange. Transparency of the stakeholder process and of Exchange operations will also be essential to gaining the trust of consumers, employers and insurers.

Consumer stakeholder involvement should be built into the long-term operation of the Exchange through positions on the governing board and in other appropriate leadership and watchdog roles.

Governmental Responsibilities and Contracted Services

States must decide if the Exchange will be operated by an existing state agency, a new state agency, or a non-profit entity established by the state or if the state will participate in a regional exchange or a federally-run Exchange. The Exchanges will have to conduct a number of activities that are essential to their success in delivering affordable, high-quality health insurance coverage.

For example, Exchanges must do the following:

- Establish standards for qualified health plans offered in the Exchange, consistent with Section 1557 of the Act;
- Negotiate with and select plans to participate in the Exchange;
- Certify and decertify plans to be offered in the Exchange and exercise the authority to exclude certain plans if it is in the interests of individuals and employers in the state or if a plan proposes unjustified premium increases;
- Monitor marketing practices, ensure benefits are not having the effect of segmenting risk, ensure an adequate choice of providers, and monitor the handling of consumer complaints;
- Administer risk adjustment mechanisms among participating insurers;
- Establish eligibility criteria, consistent with the ACA;
- Establish and oversee the navigator program;
- Determine whether individuals qualify for the federal premium tax credit and the cost-sharing reductions;
- Establish and administer an appeals process for individuals denied eligibility for the tax credit;
- Screen and enroll eligible people for public programs like Medicaid and the Children's Health Insurance Program (CHIP);
- Determine hardship exemptions for individuals and employers to purchase health insurance;
- Determine penalties for employers who drop or don't provide health care for their employees;
- Establish and administer an appeals process for employers challenging penalties;
- Establish policies and procedures for verification of Social Security numbers, tax credit eligibility and immigration status with federal agencies;
- Handle and transmit confidential information, including federal income tax return data, income and other information included in Medicaid applications, and Social Security Administration data; and
- Resolve inconsistencies with information as reported by the Social Security Administration, Department of the Treasury or Department of Homeland Security.

Because these decisions will determine such things as whether low- and moderate-income individuals and families obtain the premium-tax credits and cost-sharing reductions to which they are eligible and thus whether they can obtain health coverage, there must be strong public accountability for the performance of these functions. Whether they are performed well or poorly will not only affect small businesses, individuals and families, but also taxpayers who would be on the hook if costs are higher than they ought to be. For example, if a state's Exchange does not negotiate with insurers to get the most affordable coverage options, federal costs will rise because the premium tax credit amounts are tied to the cost of the second lowest cost "Silver" level plan offered through the Exchange. We believe that the best way to ensure accountability is through the use of governmental staff to carry out these functions without bias and conflicts of interest and in the best interest of the public.

Moreover, the use of governmental staff to conduct these critical Exchange functions is consistent with the Affordable Care Act and longstanding federal law, because such regulatory, administrative and appeals functions are "inherently governmental."

For example, Section 1313(a)(5) of the Affordable Care Act directs that "the Secretary will provide for the efficient and nondiscriminatory administration of Exchange activities...." This provides a clear basis, and signals strong intent, for the Secretary to ensure that states use governmental staff to perform critical Exchange functions and prohibit states from privatizing inherently governmental functions.

It is also consistent with longstanding federal policy to protect the public interest, in the operation of critical federal activities, from undue commercial or private interests. OMB Circular No. A-76 (revised 2003)¹ sets policy for federal oversight of commercial activities and provides guidance on determination of inherently governmental functions. One of the purposes is "to make agencies accountable to taxpayers for results achieved...." The Guidance states that:

"An inherently governmental activity is an activity that is so intimately related to the public interest as to mandate performance by government personnel. These activities require the exercise of substantial discretion in applying government authority and/or in making decisions for the government. Inherently governmental activities normally fall into two categories: the exercise of sovereign government authority or the establishment of procedures and processes related to the oversight of monetary transactions or entitlements."

Many of the activities carried out by the Exchanges (outlined above) clearly fit this description of inherently governmental work and should be performed by governmental staff accountable to the public. For other activities that are contracted to a vendor, HHS should issue protective regulations and guidance to ensure fair and efficient contracting, the contracting process and activities should be transparent, and the state should provide strict oversight.

Size of the Exchange

¹ Revision to the Office of Management and Budget Circular NO. A-76, "Performance of commercial Activities." Federal Register, Vol 68, No. 103, May 29, 2003, p. 32134.

The law allows states the option to create an individual and a separate small employer (SHOP) Exchange or to combine the two. A thorough study of the existing insurance market in each state needs to be considered when weighing whether to have a combined Exchange, including such factors as whether this would create rate shock for some individuals or employers currently insured. An important consideration in smaller states is whether combining the pools is needed to gain the desired advantages of a single larger pool. Merging the Exchanges would substantially increase the potential enrollment volume and make it more likely (but not guarantee) that the Exchange would have a well-balanced risk pool.

States have flexibility to reduce the small employer size from 100 to 50 employees eligible to participate in the SHOP Exchange (until January 1, 2016). A detailed review of the existing small group insurance market in the state is necessary to determine the impacts of this decision.

An important consideration states must weigh if considering reducing the size of the small group market from 100 to 50 employees is the loss of critical insurance rating protections that are tied to the state's definition of a small group. Limiting the size of small groups would mean that small businesses with 51 to 100 employees could continue to face rates that discriminate based on age, gender and other factors prohibited in the individual and small group markets. Allowing these bad rating practices to continue could be devastating to small groups of 51 to 100 employees with certain demographic characteristics – for example, disproportionately older or female – and may reduce the likelihood of these groups offering coverage at all.

Active Purchaser

An important implementation choice will be whether Exchanges should maximize plan participation by admitting all plans that meet the minimum certification requirements for Qualified Health Plans or use their certification authority to limit Exchange participation to highest-value plans.

The ultimate goal of making affordable health coverage available to individuals and employers can be best achieved by an Exchange acting as an active purchaser and using its authority to only offer plans that enhance value, consumer protection and affordability. Insurers will be adding millions more enrollees through the Exchanges. In return, health plans should be required to achieve a higher level of value for enrollees and for taxpayers that are supplementing the purchase of policies. Active negotiation with insurers will also give them needed leverage to restrain provider payment rates in the face of high provider concentration in many markets. Negotiations should favor plans that promote innovative health-care delivery system reforms that hold promise for slowing the rate of growth in health care costs and should promote a strong foundation of well-coordinated primary and preventive care.

Adverse Selection

The history of insurance pools has taught us that the greatest threat facing Exchanges is adverse selection. A death spiral will ensue if an Exchange becomes essentially a high-risk pool - the Exchange will become unattractive to insurers and coverage will become unaffordable to individuals and employers.

There are several characteristics Exchanges should have to minimize adverse selection:

- State legislation that gives strong and clear direction to Exchange governing boards and managers to create an active and ongoing process to guard against adverse selection.
- Identical regulation of the individual and small group markets inside and outside of the Exchange.
- To extent that any plans are sold outside the Exchange, ensuring that the same plans are available inside and outside the Exchange. For example, states can require insurers outside the Exchange to offer products in the same coverage levels (at least the Silver and Gold levels) as is required for health insurers participating in the Exchange.
- HHS should design a sophisticated standard risk-adjustment system, along with a standard requirement and form for disclosure of data among plans, that states can use to adjust the risk among insurers inside and outside of the Exchange to discourage adverse selection against and within the Exchange. This would work in tandem with the requirement that insurers must use a single risk pool across all their plans inside and outside the Exchange. This should be a federal floor with states permitted to adjust the model to address unique features of state insurance markets and Exchange viability, depending on the degree to which the Exchange is an active purchaser.
- Having a larger Exchange, including as noted, merging the individual and small group markets, generally will reduce the risk of adverse selection

Transparency

HHS should require measures that make the operation of the Exchange as transparent as possible. Such measures should include public meetings, posting evaluations and updates on Exchange performance on the Exchange website, disclosing potential conflicts of interest of members of Exchange governing board or executive staff, and reporting administrative costs for the Exchange. Administrative costs should be itemized in such a way that interested parties can evaluate whether or not expenses improve efficiency (such as more staff time in negotiating with health plans).

Brokers and Distributors

Agents, brokers and distributors are expected to continue to play a role in the newly reformed health care system, but the ACA did not, unfortunately, contemplate specific regulation of these actors. To the extent that agents and brokers play a role in helping small employers and/or individuals consider different insurance plan options, however, their actions could have a disruptive effect and undermine many of the important provisions of the ACA in the absence of clear rules and standards. For example, if agents and brokers steer healthy, young men and/or small employers comprised of such individuals to certain plans outside of the Exchange – and conversely, steer women of childbearing age and/or employers comprised of such individuals to plans inside the Exchange – this could create adverse selection problems and threaten the long-term viability of the Exchanges.

Accordingly, the federal government should require states to provide oversight and regulation of broker and agent activity to ensure that their actions do not undermine the Exchange and other

key provisions and protections of the law. Exchanges should be required to carefully monitor the conduct of insurance agents, brokers and distributors. Regulators should prohibit door-to-door solicitations and bar activities and agent financial incentives and rewards that are designed to steer, discourage or encourage enrollment in particular plans inside or outside of the Exchange based on age, health status, gender or geography, and other factors. If agents, brokers and distributors are permitted to steer individuals to particular Exchange plans to serve their economic interest, they should be required to give prospective customers a large-print notice drafted by HHS, that the customer must sign, which explains that they are not independent, objective navigators, that they receive a fee if the individual signs up for the plan and that there are independent navigators available to help them understand all their options free of charge.

When reviewing the use of brokers, agents or distributors, at the very least states need to ensure the public understands the role of brokers/agents and distributors working for health plans and the availability of independent conflict-free navigators free of charge contemplated by the law. States should also consider whether brokers are able to meet the needs of vulnerable and underserved populations that will be served by the individual Exchange. Likewise, states should separately examine the cost, roles and services for brokers for individuals and small employers. Servicing the needs of individuals and small employers differ.

Marketing costs can be reduced by direct sale of plans from the Exchange to small employers. The experience of other Exchanges and pools (COSE, Pac Advantage, CBIA in Connecticut, the Massachusetts Connector) shows that brokers could play a role marketing the Exchange plans as well as plans outside the Exchange, especially for small employers, though this role should be different considering the availability of the Exchange to perform some functions that brokers now provide.

Whether or not brokers, agents or distributors are utilized, a state Exchange should ensure that navigators and public workers are available free-of-charge to perform these functions for both individuals and small employers.

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

HHS should seek uniformity wherever helpful in Exchange operations and standards by issuing federal guidance and templates that provide states a set of choices, which include federal floors that guarantee certain standards but allow states to establish more protective or innovative policies. Where state systems already exist, consideration should be given to building off what works.

Establishment of uniform federal standards in many areas will facilitate the swift start-up and equitable operation of the Exchange. Rather than each state charting its own course on every design element, a defined federal direction can simplify planning for items that should be uniform nationwide (e.g., determining eligibility for tax credits, determining exemptions to the individual responsibility requirement) and allow states to concentrate planning efforts on areas that are their sole responsibility (e.g., whether to establish one or multiple Exchanges, whether to make the Exchange the sole marketplace for the small group and individual market). Uniformity

in core areas will improve the ability to make meaningful interstate comparisons and to learn and transfer best practices between states. Uniformity of core functions is appropriate to ensure enforcement of key consumer protections in the ACA and to protect against Exchange policies that lead to adverse selection and cause insurance costs (and therefore, taxpayer subsidies) to rise without justification.

HHS should act in a number of areas ripe for uniformity, including:

- Determining eligibility for Exchange participation, individual tax credits and Medicaid/CHIP using a single web portal
- Determining compliance with Section 1557 (non-discrimination) of the ACA
- Developing a standardized format for displaying plan options to consumers
- Developing a standardized format for collecting data from insurers
- Developing a standardized format for reporting plan quality, cost and satisfaction data
- Determining exemptions from the individual responsibility requirement
- Determining how information on individual exemptions and tax credits will be reported to the federal government
- Determining length and timing of open enrollment
- Operating a toll-free telephone hotline that supplements state hotlines to respond to requests for assistance

Uniformity is preferred for the following functions, but HHS guidance, templates and/or minimum standards would be helpful:

- Designing of single web portal for enrollment
- Managing the open enrollment process for individuals and employees in the Exchange
- Publishing information about the Exchange's administrative costs
- Creating a standard risk-adjustment mechanism for insurers operating inside and outside the Exchange
- Grading participating insurers on quality, cost, enrollee satisfaction, etc
- Developing a website that allows consumers to easily compare health plan options
- Providing an electronic calculator to determine the cost of coverage, and potentially other decision support tools for individuals
- Designing an enrollee satisfaction survey
- Developing a process for handling customer complaints, including standards for an appeals process
- Developing a provider complaint process
- Establishing a navigator program for outreach and enrollment support
- Providing consolidated billing and premium payment by employers
- Establishing an electronic interface and facilitate the flow of funds between insurers, employers, and employees, including subsidies and the use of "free choice vouchers"
- Providing plan enrollment information to employers
- Setting marketing rules and standards inside and outside the Exchanges
- Developing state-customizable, focus-group tested outreach materials
- Establishing standards for insurer participation, including certification of Qualified Health Plans

State flexibility may be necessary (within the explicit constraints of ACA) for the following:

- Determining governance principles and legal structure for the Exchange

- Determining whether to create one or multiple Exchanges within a state
- Determining whether to develop joint Exchange with other states
- Determining whether to make the Exchange the sole marketplace for the small group and individual market(s)
- Determining employer size (more than 50 employees) eligibility criteria for participation in the Exchange
- Determining whether to merge the Exchanges for small employers and individuals
- Establishing other mechanisms to reduce risk of adverse selection into the Exchange, e.g., applying the same rules inside and outside the Exchange
- Further standardizing benefits
- Conducting public education and outreach to consumers and small employers
- Administering contracts with insurers, third-party administrators, navigators and other vendors
- Operating a toll-free telephone hotline to respond to requests for assistance and ensure that in-person assistance is available to consumers
- Financing Exchange operations

4. What are the tradeoffs for States to utilize a Federal IT solution for operating their Exchanges, as compared to building their own unique systems to conform to the current State environment? For what kinds of functions would it make more sense for States to build their own systems, or modify existing systems?

The efficacy of an information technology system could make or break the new program. Much of the promise of ACA's expansion of health insurance coverage is built on an assumption of highly-sophisticated healthcare information technology systems at both the state and Federal levels. New protocols, standards and systems will be required to match federal and state data electronically to determine and verify eligibility, accept documents, renew coverage, and allow individuals to manage their benefits online.

The track record of the states in establishing complex information technology systems in the human services area is mixed. For example, Texas and Indiana ran into severe problems when they attempted to transition to more automated systems for Medicaid and Food Stamps. Some states may not have the expertise to contract with and oversee information technology companies effectively. Often contract decisions are determined by overriding political considerations. In addition, the federal government has not addressed the problem of aging computer systems in the Medicaid and Food Stamp programs, and states face severe budget problems that are likely to constrain their ability to purchase the technology systems envisaged in the ACA.

The federal government should provide technical IT assistance to states, including the creation of a federal IT platform that states can tap into, in order to reduce the complexity of the challenges faced by the states. In addition, the problem of outdated Medicaid IT systems, which must be linked to Exchange operations, can be addressed as part of the process of establishing a federal IT platform. Significant federal investment will be needed for state systems' upgrades if we are to succeed in meeting implementation goals.

The federal government's intentions regarding IT solutions should be made clear as soon as possible in order to help states avoid making contractual decisions that eventually could prove

costly. Without guidance from the Department, states may rush into contracts that will not be in compliance with Federal requirements, thus undermining the Exchange operation and leaving states with unnecessary and costly legal obligations.

6. What factors should Exchanges consider in reviewing justifications for premium increases from insurers seeking certification as QHPs? How will states leverage/coordinate the work funded by the rate review grants to inform the decisions about which plans will be certified by QHPs?

State premium rate-review efforts historically have been weak. Too few states require rate approval or have the resources to review the actuarial soundness of health plan submissions. This was a well-documented problem in California this year when an independent actuary found “math errors” that led to vast over-calculation of premiums by Wellpoint’s Anthem Blue Cross subsidiary. The federal premium review grants will improve state capacity to perform these essential tasks. States should use the grants to improve the transparency of rate reviews, including public reporting, more detailed review of service-specific expenses and administrative costs, and cost-containment initiatives. The rate-review process should be used to help states enforce other requirements, including the requirement that insurers establish a single risk pool across all plans inside and outside the Exchange. In addition to the grants, it is critical that states take legislative action to increase their authority to review, approve and recalibrate premium rates.

Given scarce resources and expertise, the premium-review functions within and outside of the Exchange should be combined and should examine the following factors to determine whether premium increases are justified:

- Detailed information about the rate change, including:
 - Average rate increase
 - Aggregate increases by benefit category, including doctors, hospitals, prescription drugs, and other services, by geographic area
 - Rate of change over time
 - Changes in copays and deductibles
 - Changes in benefits
 - Changes in rates paid to providers
 - Number of consumers and employers affected by each rate increase
- Adequacy of premium rates for payment of claims
- Rates are reasonable for the benefits offered, based on actuarial analysis
- Rates are not excessive
- Rates are not discriminatory
- Insurer’s investment income and surplus
- Insurer’s cost containment initiatives
- Insurer’s administrative expenses
- Medical-loss ratio, including consumer rebates issued
- Measures of plan quality and consumer satisfaction
- Prior notice of at least sixty days of rate hikes to consumers and businesses
- Rate hikes and justifications to be posted to the website of the insurer and federal and state regulators

8. What specific planning steps should the Exchanges undertake to ensure that they are accessible and available to individuals from diverse cultural origins and those with low literacy, disabilities, and limited English proficiency?

In addition to online or mail-in applications, phone applications, and in-person services, it is extremely important that states make caseworkers and other staff available to assist individuals with disabilities, limited English proficiency, low-literacy, and diverse cultural origins. Many individuals do not have access to or are unable to navigate electronic systems effectively. Without adequate staff assistance, many applicants will not fully understand their rights and responsibilities. Even individuals without significant cognitive or educational barriers are likely to run into difficulties, especially during a reconciliation process to resolve inconsistencies in data during the verification process and in connection with advance determinations. Similar considerations apply to new obligations facing small businesses. Because these decisions will have important financial consequences for families and businesses, this staff should be a stable and well-trained public staff governed by merit-based personnel systems.

Exchanges should use clear, concise language written at the lowest reasonable education level and take steps to make sure information can be understood by individuals with low literacy, numeracy, and health literacy levels. Exchanges should use consistent terminology and plain language definitions of health care terms, building on the terms being developed by the NAIC consumer information panel. Given widespread consumer confusion over insurance terms, ongoing consumer testing of these terms should be conducted. We also suggest that – where possible – Exchanges use standardized language. Accommodations should also be made to meet the needs of persons with disabilities, including through the use of assistive technologies.

The Exchanges must ensure that information is culturally and linguistically appropriate for recipients with limited English proficiency.² As federally-funded entities, the Exchanges must comply with both Title VI of the Civil Rights Act and section 1557 of the Act. Thus, the Exchanges must follow HHS guidance regarding Title VI Prohibition against national origin discrimination affecting limited English proficient persons (68 FR 47311), and use the four-factor analysis to determine the extent of their obligation to provide LEP services. In conducting this analysis, an Exchange should give weight to the critical role it will play in mediating consumers' interactions with the health insurance market. This must apply to coverage outside the Exchange as well in order to prevent adverse selection against Limited English Proficiency persons.

In addition, as assistance for persons with disabilities, all communications from the Exchange – web-based information, advertisements, information kiosks, printed material and brochures,

² Section 1557 of the ACA extends the provisions of Title VI of the Civil Rights Act of 1964, among other nondiscrimination laws, to “any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under [Title I of the ACA]” – including Exchanges. Section 601 of Title VI holds that no person shall “on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance.” The Supreme Court, in *Lau v. Nichols* (414 U.S. 563, 1974), found that Title VI prohibits conduct that has a disproportionate effect on LEP persons, on the grounds that such conduct constitutes national origin discrimination.

information lines, etc. – must meet the federal Rehabilitation Act’s Section 508 standards for electronic and information technology and the ADA. Information about the Section 508 standards can be located at: <http://www.section508.gov/>. This must apply to coverage outside the Exchange as well in order to prevent adverse selection against persons with disabilities.

The insurance plans that are deemed eligible to sell through the Exchanges should be required to meet these standards in any of their communications with customers as a prerequisite for eligibility and a requirement for operating in the pool.

D. QUALIFIED HEALTH PLANS (QHPS)

1. What are some of the major considerations involved in certifying QHPs under the Exchanges, and how do those considerations differ in the context of individual and SHOP Exchanges, subsidiary Exchanges, regional or interstate Exchanges, or an Exchange operated by the Federal government on behalf of States that do not elect to establish an Exchange?

Under the ACA, Exchanges are responsible for certifying, recertifying, and decertifying health plans, pursuant to the requirements addressed in statute and subsequent HHS regulation.³ At a minimum, the federal certification criteria should set a floor for states, and states should be encouraged to hold plans to even higher standards if they determine it to be in the best interest of consumers.

Certifying, recertifying and decertifying health plans is an activity that requires the exercise of substantial discretion in applying government authority and decision-making. The best way to ensure accountability and transparency is through the use of governmental staff that will carry out these functions without bias and conflicts of interests and in the best interest of the public.

In addition, the ACA does not allow, nor should HHS permit, the relaxation of the certification requirements for other forms of Exchanges, i.e., for the SHOP Exchanges, or for regional or subsidiary Exchanges. And HHS should clarify that an Exchange that operates in more than one state should be able to hold plans to higher standards if determined by the states to be in consumers’ interest, particularly if stronger state laws already exist.

If Exchanges are to deliver the maximum value for consumers and small employers, states must be encouraged to use an active purchaser model as exemplified in Massachusetts. In Massachusetts, the Connector generates premium saving of approximately 6 percent by negotiating for lower bids in Commonwealth Care. Over the three years of the program, premiums have been constrained, growing only 4.7 percent in Commonwealth Care versus 8 percent in other private insurance. The active-purchaser Exchange could give enrolling individuals and small employers the same type of clout that large employers have when they negotiate with an insurance company on behalf of their workers. While circumstances in the marketplace will strongly affect the outcome of such negotiations or selection process, if Exchanges do not actively pursue the best deal possible for consumers, there is little hope that they will fulfill their potential to deliver high value coverage. While insurers may initially have

³ Patient Protection and Affordable Care Act (ACA) § 1331(d)(4).

dominating leverage in negotiations in many areas, over time, this leverage will diminish over time as more plans enter the Exchange market and compete for a large new supply of customers. The Exchanges should be designed to achieve the marketplace we want, not settle for small improvements over the one we have.

Federal regulations should prohibit states from allowing Exchanges to accept all carriers that meet minimum standards without any negotiation or selection process. The premium tax credit amounts to be funded by the federal government will be tied to the cost of the Silver plan offered through the Exchange. Therefore, the federal government has a strong fiscal, as well as policy, interest in ensuring that the Exchanges succeed at containing costs by offering the best value plans possible. Without an active negotiation or selection process, Exchanges will be unable to contain costs and federal costs will grow. Furthermore, if all plans meeting minimum standards are accepted, consumers in many markets will find themselves overwhelmed by a dizzying array of plan options. In such situations, the insurance firms with the most aggressive marketing resources, rather than the highest value plans, will prevail. By way of example, the Commonwealth Connector has recently moved to reduce the number of plans offered in order to eliminate confusion over meaningless differences among plans.

2. What factors should be considered in developing the Section 1311(c) certification criteria? To what extent do states currently have similar requirements or standards for plans in the individual and group markets?

The certification criteria should be driven first and foremost by consumers' need for affordable, adequate and accessible health care coverage. In developing regulations to govern the certification criteria in §1311(c) of the ACA, HHS should look to "best practices" among states for laws and regulations that have benefited consumers.

The statute requires development of certification criteria on a range of issues. We recommend considering the following factors for each area:

- *Essential community providers.* We applaud the language in the statute that requires plans to include in their network, where available, essential community providers that serve medically underserved and low-income populations. Ensuring that consumers in the Exchanges have access to these providers—including women's health centers, HIV/AIDS clinics, public hospitals, and community health centers—will help ensure continuity of care for recently uninsured patients, as well as those who transition off Medicaid because of income fluctuations.
- *Quality Improvement.* Health plans can play a critical role in improving the quality of care – and should be expected to do so. They can benchmark providers against each other to stimulate improvements, reward high quality care, provide data to understand patterns of care and opportunities for improvement, help patients manage their own conditions, reduce readmissions, reduce health care disparities, and encourage adoption and use of health IT. HHS should set out clear metrics for the quality improvement strategies outlined in §1311(g)(1). Plans should be held accountable for their results – with clear goals and benchmarks – so that consumers and employers will know whether plans are hitting the quality improvement and cost containment targets over time.

- *Use of Standard Forms.* We applaud the certification requirement that plans use a standard benefit format to help consumers and small business owners make informed purchasing decisions. Plans should also provide more detailed information on benefits and coverage through an easily-accessed link on the Exchange website. HHS should consider requiring a standard, consumer-friendly “explanation of benefit” (EOB) form (the form typically received by a consumer after a claim has been filed). These forms often cause confusion. Creating a standard, simplified EOB would help consumers better understand their cost-sharing responsibilities. To avoid confusion about enrollment and people unintentionally signing up for a health plan, as they have been misled into doing by unscrupulous brokers of Medicare Advantage and Medicare supplemental insurance plans, we urge HHS develop a standard enrollment form as well.
- *Quality Information for Enrollees.* The information provided to consumers on plan quality measures must be relevant, digestible and actionable for them to make informed purchasing decisions. Providing a laundry list of performance measures is not as valuable for consumers. Most will want some form of composite rating, and there should be a clear and simple explanation of how the measures were determined. HHS should require plans to provide “layers” of information through a web-based interface, so that consumers seeking more detailed information about performance on specific quality and consumer experience measures can access it. And consumers will need to be able to make apples-to-apples comparisons among health plans.

To the extent possible, all certification criteria should be echoed in regulation of the insurance market outside the Exchange. Without identical requirements inside and outside the Exchange, adverse selection is likely. Some particularly important factors suggested below should apply not only for certification of QHPs but for all health plans operating in the state.

- *Marketing standards:* Plans will likely use marketing tools to the extent they are able to encourage the healthiest people to enroll while discouraging those with unhealthy risks. Plans’ behavior in the marketplace, as well as the behavior of their agents and brokers, needs to be continually monitored and the marketing standards may need to be tightened over time.
- *Network adequacy:* Plans should demonstrate that they have a reasonable choice of providers in a reasonable geographic proximity who are taking new patients. In particular, we urge that federal standards prohibit plans from designing networks that will keep out high-cost patients. Regulators should prohibit plans from designing networks that are dominated by physicians and providers in suburban areas while excluding physicians and other providers who are located in lower-income urban areas. Plans should be encouraged to include Medicaid providers to facilitate continuity of care for families transitioning off of Medicaid eligibility or who shift back and forth between Medicaid and Exchange coverage. In addition, we applaud the requirement in the California legislation, AB 1602, which requires carriers to regularly update an electronic directory of contracting providers. This will enable individuals and small businesses to search by health care provider name and see which plans include the provider in their network and to ascertain whether the provider is accepting new patients for a particular health plan.

The ACA also prohibits plans from employing benefit designs that have the effect of discouraging people with significant health needs from enrolling. This is not an uncommon practice among insurers, and HHS ought to set minimum standards for this requirement and encourage states to effectively monitor plans to ensure they are complying. For example, in the Medicare Advantage program, some plans have imposed higher deductibles for hospital stays and increased cost-sharing for certain chemotherapy drugs with the effect of deterring enrollment by people in poorer health. To control this type of practice, plans' benefit designs, and year-to-year changes in benefits, should be carefully reviewed for designs similar to what plans in Medicare Advantage have used in the past. States should also be encouraged to collect and track data on how plan benefit design may be affecting patient mix over time (using data gleaned from premium rate review and risk adjustment programs, for example) in order to detect whether changes in benefit design are provoking adverse selection among plans.

2b. What issues need to be considered in establishing appropriate minimum standards for marketing of QHPs and enforcement of those standards? What are appropriate Federal and State roles in marketing oversight?

As you consider minimum marketing standards, states should be encouraged to set the same standards for plans operating inside and outside the Exchange. Allowing plans operating solely outside the Exchanges to follow less stringent marketing and benefit design standards could set up an unlevel playing field, allowing these plans to use marketing tactics to cherry pick the healthiest risks and discourage sicker individuals. And all plans, whether or not they participate in the Exchange, should be subject to the same market conduct reviews.

In addition, we encourage you to include the following requirements in the marketing standards for plans:

- Health plans should be required to provide standardized information to prospective and new enrollees, including:
 - Information on benefits, limitations, exclusions, restrictions on use of services, and plan ownership;
 - A summary of physicians' financial incentives, written in terms that the average consumer can understand;
 - The stability and composition of the provider and practitioner network, including participating physicians, hospitals and pharmacies. The list should indicate whether the provider or practitioner is accepting new patients covered by the plan, language capacity, hours of operation, and disability accommodation. There should be a "map view" option that shows the location of providers relative to public transportation;
 - Comparative information that is standardized on patients' experience with care in the plan and, to the extent possible, the plan's clinical performance, along with comprehensive information reflecting standardized metrics to compare the performance of participating physicians and other health professionals, hospitals, post-acute care facilities, and home health agencies;
 - Comparative information on out-of-pocket costs for patients with different health conditions;
 - Accreditation information;

- Disenrollment experience;
 - Data on grievances and appeals filed by enrollees; and
 - The plan’s current status with respect to compliance with statutory and regulatory requirements.
- All marketing materials should be approved by the Exchange and/or the state before their use, written at a sixth-grade reading level or lower, and available in languages other than English when the plan serves or will serve substantial numbers of enrollees whose native language is not English.⁴
 - To avoid the possibility of discrimination against population groups based on place of residence, participating plans should be required to serve a complete market area (i.e., they should not be allowed to “gerrymander” their market area).

State regulators should also monitor and regulate the conduct of insurance agents and brokers with uniform standards inside and outside the Exchange. The following activities should be prohibited:

- Door-to-door solicitation
- Offering potential consumers financial or other inducements to enroll
- Discriminatory activities designed to discourage sicker-than-average enrollees and encourage healthier-than-average enrollees.
- Allowing someone to sign a piece of paper that enrolls them in a plan without giving them a standardized, easy-to-read paper that they sign and keep a copy of explaining that by signing they are agreeing to enroll in a particular plan and that plans available through the Exchange will offer a subsidy to people with low and moderate incomes.

3. What factors are needed to facilitate participation of a sufficient mix of QHPs in the Exchange to meet the needs of consumers?

We recognize that many states have little or no competition in their individual and small group markets among health plans, and each state will face unique challenges in trying to attract and retain a sufficient mix of qualified health plans within the Exchange. However, we believe that, over the long term, if states design their Exchanges first and foremost to benefit consumers, so that they are attractive, consumer-friendly marketplaces in which consumers can be assured of adequate, affordable coverage, a sufficient mix of health insurance carriers will follow.

To achieve this, however, it will be critical for states to make the market rules inside and outside the Exchanges the same, so there is a “level playing field” and all plans in the state are required to meet the same certification standards. States that do not do this and allow the market outside the Exchange to operate under substantively different rules will have a difficult time attracting a

⁴ Many, if not all, Exchange-participating plans will be receiving federal financial assistance, including credits, subsidies, or contracts of insurance, and thus will be subject to Section 1557 of the ACA which prohibits discrimination on the bases set forth in Title VI and the Rehabilitation Act, among other statutes. These Acts, in turn, have been interpreted to require the services provided by federal grantees and the federal government meet certain standards in order to be Title VI and Rehabilitation Act compliant. These plans should follow HHS guidance regarding Title VI’s prohibition against national origin discrimination affecting limited English proficient persons (68 FR 47311), and use the four-factor analysis to determine the extent of their obligation to provide LEP services.

healthy mix of insurance carriers to the Exchange. This also raises the risk of adverse selection, which could drive up premium costs for Exchange enrollees.

The requirements for risk adjustment, and the temporary reinsurance and risk corridor programs, as well as the requirement that plans pool risk inside and outside the Exchanges, are critical tools to limit adverse selection and encourage plans to participate in the Exchange. However, these tools will not be sufficient if states do not apply the same rules to plans inside and outside the Exchange. HHS should use grant support and technical assistance to help states enact the laws and rules necessary to mitigate adverse selection between the Exchange and non-Exchange markets.

Standards for participation in an Exchange must advance a legitimate policy goal and not be designed to inappropriately advantage a particular carrier. For example, in a state dominated by one or two carriers, a rule requiring state plans to operate statewide may exclude high-value integrated systems that serve only one region of the state.

Further, to the extent feasible, HHS should promote allowing Medicaid managed care plans, particularly not-for-profit safety-net plans, to participate in the state Exchanges. These plans serve a population of low-income beneficiaries, many of whom have income fluctuations that will cause them to lose eligibility for Medicaid, while gaining eligibility for premium subsidies through the Exchange. To ensure a seamless transition for these individuals and continuity of care for those receiving health care treatment, states should be encouraged, where it is feasible, to allow not-for-profit safety-net Medicaid managed care plans to offer commercial coverage through the Exchange.

6. What factors, bidding requirements, and review/selection practices are likely to facilitate the participation of multiple plans in Exchanges? To what extent should the Exchanges accept all plans that meet minimum standards or select and negotiate with plans?

HHS should prohibit states from requiring Exchanges to accept all eligible carriers without any negotiation or selection process. Allowing Exchanges to negotiate with plans on price is a critical cost containment tool. Section 1311(e)(2) directs Exchanges to actively manage the prices for coverage by directing that premium increases be a factor in determining whether a plan will be certified to offer coverage in the Exchange. This clause provides HHS with the statutory authority to prohibit states from accepting all eligible plans.

F. AN EXCHANGE FOR NON-ELECTING STATES

1. How can the Federal government best work to implement an Exchange in States that do not elect to establish or are unable to establish their own Exchanges?

The federal alternative should be outlined early to allow states to make informed decisions about whether or not to create their own Exchanges, to give the federal government time to contemplate important decisions in Exchange set-up, and to show states examples of best practices.

HHS needs to delineate the roles and responsibilities of the national office versus those of officials at the state or regional level. It must be clear that policy and significant decision-making authority must reside with federal officials, not contractors. Policy-making, regulatory functions, eligibility determinations for subsidies, and senior management authority are inherently governmental activities that should be performed by government personnel who are accountable to the public in the creation of any federal or state-based Exchange. These functions should not be privatized nor otherwise contracted out, unless to personnel in state Medicaid agencies or other personnel in federal, state or local government.

There are a number of activities that will require such cooperation from states if the federal Exchange is to run smoothly. These activities include coordination with the state Medicaid program to ensure smooth eligibility and subsidy determinations, upgrades of obsolete IT systems used by Medicaid departments, and passage of conforming legislation in 2011 and beyond to strengthen the rules governing the outside market to prevent adverse selection.

It may be challenging for HHS to gain cooperation from some states because the law does not explicitly require states to help the federal government implement the federal Exchange. Some states may have insurance rules that have the effect of shifting risk to the Exchange, therefore raising costs for Exchange enrollees. The federal government should ensure regulations afford it all requisite legal authority under the ACA to create and enforce insurance rules in the states in the event that a state will not voluntarily work with the federal government to adopt compatible standards for the outside market or if the state's poor rule enforcement of insurance rules hinders the federal government's ability to operate an effective Exchange. If the federal government has the authority to establish an Exchange, it has the authority to create rules to make that Exchange work. In addition, the federal government should not be bound by laws or rules pertaining to the Exchange that are enacted by non-electing states. If a state has decided not to run an Exchange, its input should still be sought, but it should not have the authority to hinder the federal Exchange through legislation or regulation. That said, states should have the authority to build on the federal Exchange to provide its residents additional consumer protections.

In addition, a clear timeline for federal action should be established and failure to meet benchmarks should trigger federal action. The ACA calls for HHS to create a federally-operated Exchange if (1) a state chooses not to establish an Exchange or (2) if HHS determines on or before January 1, 2013 that the state has failed to take the actions necessary to implement an Exchange. However, January 1, 2013 may be too late to accommodate the local market study and implementation tasks that would need to take place before January 1, 2014. Therefore, HHS should be clear that the failure to reach certain benchmarks, as laid out in the Exchange planning grants, will trigger the initiation of planning for a federal Exchange.

2. Are there considerations for an Exchange operated by the Federal government on behalf of states that do not elect to establish an Exchange that would be different from the state-run Exchanges?

The federal Exchange must maximize its options to control adverse selection. The federal Exchanges will not have full control over the rules in the outside market. There are a number of constraints in ACA that begin to limit adverse selection, including the requirement to pool across markets, availability of subsidies only in the Exchange, coverage of the essential benefits

package, elimination of pre-existing condition exclusions in all new plans, and risk adjustment across markets. However, states will continue to set rules for the outside market that could encourage or discourage adverse selection, including marketing of plans.

Enforcement of the ACA's insurance provisions should be viewed as a shared federal and state responsibility. While traditionally states have enforced insurance laws, if a state refuses to enforce elements of the ACA, the federal government must step in. The ability of patients to fully benefit from the law will depend on rigorous oversight and enforcement. Experience shows that states are very uneven in their enforcement of consumer protections already on the books.

Finally, HHS has to define the role of stakeholders in the governance of the federal Exchanges. For the Exchanges to succeed, various stakeholders need to have a meaningful role in their development and oversight. Whether state or federal, the Exchanges will have steep learning curves, and the experiences may vary considerably among the states for a wide variety of reasons. It is imperative that the leadership of the federal Exchanges has the authority and responsibility to involve stakeholders at the state level.

G. ENROLLMENT AND ELIGIBILITY

1. What are the advantages and issues associated with various options for setting the duration of the open enrollment period for Exchanges for the first year and subsequent years? What factors are important for developing criteria for special enrollment periods?

In the first year, federal guidance should allow for greater flexibility for individuals enrolling in the Exchange so that families have time to learn about the options available to them under the new law and enroll in the plan that best meets their needs. Specifically, guidance should allow for a longer duration open enrollment period prior to January 1, 2014, and ensure that families can enroll at least six months past the January 1, 2014, implementation date in order to take advantage of the publicity and greater public awareness of the availability of Exchange coverage and the coverage requirement.

In subsequent years, guidance should ensure that open enrollment periods are available to families at least once a year during a standardized time period (such as September through early December, which would allow Exchanges to make necessary eligibility determinations and health plans to enroll families for the plan year starting on January 1, 2014, and generally lines up with the open enrollment periods for employer-sponsored insurance). The guidance should also call for the period(s) to last at least 90 days and for insurers to fully advertise the availability of coverage during these open enrollment periods. In addition, the law should follow HIPAA and Medicare guidelines in establishing qualifying events that will trigger special enrollment periods for subscribers and dependents into both subsidized and unsubsidized coverage in the Exchanges, including:

- Changes in family circumstances, such as marital status and change in number of dependents
- Aging out of dependent or child-only coverage
- Birth of child or adoption
- Loss of other public or private coverage

- Employment status change, including termination of employment, change from part-time to full-time status, or vice versa, change in employment status that affects dependent coverage
- Change of residence
- Coverage mandated as a result of a court order

The Secretary should use the authority under Section 1311 of the Act to define “circumstances similar” to the qualifying events enumerated in HIPAA and Medicare Part D. On this basis, a special enrollment period should apply in circumstances where the tax credit eligibility is recalculated and for pregnancy. In addition, an amendment to HIPAA should be sought to allow a special enrollment period for employer-sponsored insurance when a family becomes ineligible for premium tax credits and cost-sharing reductions.

States should be required to encourage individuals seeking coverage through the Exchange to apply, even if open enrollment is closed, if they are likely to be eligible for a special enrollment period or Medicaid/CHIP (which can conduct eligibility determinations and enroll people into coverage at any time). Additionally, those not eligible for special enrollment or Medicaid/CHIP should not be prevented from applying but be clearly notified that they would likely have to update their application information when they can enroll. Exchanges should securely maintain these applications and process them once the person becomes eligible. Families would then be contacted for change of circumstances and, depending on the timeliness of income information provided, for updated income data. These protections will ensure maximum health coverage take-up among populations that have typically moved on and off insurance and run the risk, even in a more streamlined system, of falling through the cracks. Managing this sort of enrollment process will require ongoing coordination among agencies, access to information, and activities that point to the inherently governmental nature of the process.

Small businesses should be allowed to purchase coverage through the Exchange generally at any time (which for currently insured employers would be the end of their current plan year, and for those newly offering coverage, whenever they arrange for such coverage). Employees of the small business would still have open enrollment periods but those periods would depend on when the plan was initially purchased – as it works today in the small group market.

The enrollment design should ensure that individuals never fall into coverage gaps. It should also ensure that the consumer and state Exchange know exactly what plan the individual is enrolled in from the moment they sign up for a plan. And there should be provisions in place for changing plans during the open enrollment period.

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

Eligibility determination results in an approval or denial for a tax credit and should seamlessly coordinate with eligibility determination for existing public programs (e.g., Medicaid or CHIP), whereas enrollment involves deciding on a health plan and making arrangements to participate in a particular plan. A robust eligibility process is essential to ensure that consumers understand their public and private insurance options, the cost implications of tiers of plans, and their eligibility for health insurance tax credits. Eligibility determination is an inherently governmental function.

States must also have the necessary IT infrastructure in place to conduct effective online enrollment, which will be one of the primary ways people will enroll in the Exchange. States should be encouraged to use Establishment and Planning Grants to finance such efforts, and HHS should issue guidelines on the minimum requirements for such IT systems that states must satisfy. Additionally, states will need technical assistance to build effective online enrollment processes, including the development of a federal uniform platform or open source technology that states can adapt.

Online enrollment can be an effective tool, but it is critically important that each system meet a minimum threshold for user-friendly components. This includes ensuring that it is robust enough for high-end users and simple enough for low literacy or limited English proficiency users; that it is available in multiple languages; that it is accessible to individuals with disabilities;⁵ and that enrollment is achieved through a one-step process (i.e., limiting the need to provide follow up documentation or information). In addition, consumers must be informed of how their information will be used and when and to whom it may be disclosed. Consistent with federal and state law, steps should be taken to ensure the privacy and security of consumer data. Data privacy and security policies should be made available to the consumer before and at the time of enrollment.

Online enrollment should rely on solutions that are designed to tailor screening questions based on how individuals answer earlier questions. This “hierarchical” approach would simplify the online enrollment process by directing people to the program for which they are most likely eligible (e.g., Medicaid or premium tax credits) and asking for the information needed for such program (rather than for all of the information needed to determine eligibility for all programs).

Online enrollment is only as effective as the ability of its users to access computers and the Internet, and low-income and underserved communities disproportionately lack access to those. Strategies should be implemented to broaden the availability of such access by placing computer kiosks in central locations, mobile units in rural communities, and training of advisors in community-based organizations, etc. Additionally, online enrollment should be accessible through mobile technology, as low-income people are increasingly using these tools to use the Internet. For people utilizing public computers, it will be important to ensure public confidence and adequate security when providing sensitive personal information.

It is crucial that the Exchanges do not rely on online enrollment alone, but that they create additional avenues for people to apply in person, by mail, by phone, and through existing Medicaid/CHIP enrollment structures.

Employers require additional tools to make the online process a single point of entry, including

⁵ As entities established by the ACA, the Exchanges must operate pursuant to §1557 of ACA, which prohibits discrimination on the bases set forth in Title VI and the Rehabilitation Act, among other statutes. These Acts, in turn, have been interpreted to require that services provided by federal grantees and the federal government meet certain standards in order to be Title VI and Rehabilitation Act compliant. Exchanges should follow HHS guidance regarding Title VI Prohibition against national origin discrimination affecting limited English proficient persons (68 FR 47311), and use the four-factor analysis to determine the extent of their obligation to provide LEP services. In conducting this analysis, an Exchange should give weight to the critical role it will play in mediating consumers’ interactions with the health insurance market. Similarly, Exchanges should follow the accessibility requirements outline for compliance with § 508 of the Rehabilitation Act.

one application, one premium payment (with the Exchange allocating such payments to the appropriate insurers depending on where employees enroll), one source of enrollment changes, qualification and calculation of the small business tax credits, and additional human resources services that are typically provided to small employers (such as COBRA administration, Section 125 services, and flexible spending accounts).

States also should be required to track data measuring consumer satisfaction with online enrollment processes and the success of such systems in enrolling applicants to help inform future improvements to make it easier to enroll online.

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

The full integration of the enrollment and renewal processes for Exchange subsidies and public programs will be critically important because many families will move between Medicaid, CHIP and tax credit eligibility at different periods of their lives.

Many people seeking to enroll in the Exchanges will discover they are eligible for Medicaid instead of tax credits. It is important that Medicaid agencies are utilized to conduct Exchange eligibility and enrollment with a “no wrong door” approach, as the Massachusetts Connector has successfully done. Exchange funds should be used to allow the Medicaid agency to hire the additional staff necessary to provide face-to-face and phone eligibility determinations for this huge new population. Additional strategies for eligibility could include co-location of Medicaid/CHIP staff at Exchanges and deployment of eligibility staff to community and clinic settings.

Implicit in this vision of an integrated eligibility process is an understanding that the eligibility determination process for Exchange plans is inherently public work. Federal requirements that Medicaid eligibility determinations be done by a public agency should apply to the Exchange eligibility process, both to protect the public’s interest and to ensure the creation of a seamless system that works for consumers.

Effective coordination requires a strong information technology infrastructure and interoperable system for eligibility determinations that allows linkages between the Exchanges, Medicaid, and CHIP. The system must ensure real-time eligibility or presumptive determinations, databases that can be used to verify eligibility, information retained for renewal, and single client identifiers for tracking individuals across programs. States need extensive resources and technical assistance to build these systems. Exchange planning and establishment grants should be used for IT upgrades and design.

4. What kinds of data linkages do State Medicaid and CHIP agencies currently have with other Federal and State agencies and data sources? How can the implementation of Exchanges help to streamline these processes for States, and how can these linkages be leveraged to support Exchange operations?

States data linkages and verification systems vary – most have back end verification but still rely on paper documentation, manual processes, and outdated computer systems without interoperability.

7. What considerations should be taken into account in establishing procedures for payment of the cost-sharing reductions to health plans?

Federal officials should, as much as possible, standardize the cost-sharing schedule for individuals eligible for cost-sharing reductions for each of the actuarial value tiers across plans. Without such standardization, families will face a baffling array of cost-sharing levels and rules, making it impossible for them to understand their choices and the out-of-pocket costs they will likely pay. Additionally, federal guidance must ensure that a system is developed to provide clear, understandable information for families to know what the reductions mean for them.

To implement the cost-sharing reductions, HHS and Treasury should provide capitated payments to health plans offering Silver plans to cost-sharing reduction eligible individuals, as suggested by section 1402(c)(3)(B). The plans, in turn, would reduce the cost sharing required to the standardized schedules set by the federal government. This is similar to how the Low Income Subsidy works under Medicare Part D.

H. OUTREACH

1. What kinds of consumer enrollment, outreach, and educational activities are States and other entities likely to conduct relating to Exchanges, insurance market reforms, premium tax credits and cost-sharing reductions, available plan choices, etc., and what Federal resources or technical assistance are likely to be beneficial?

States have had many years of experience conducting consumer enrollment, outreach, and educational activities through Medicaid/CHIP. States should be encouraged to build upon the success to date, with federal action supplementing state outreach. While data are limited on what is the most effective type of outreach activity, state experiences show that a successful model includes one-on-one contact or assistance with individuals and families. States have implemented such measures through grants provided to community-based organizations or payments to application “assistors.” This is a particularly critical avenue for helping harder-to-reach families with limited English proficiency or low literacy. Additionally, outreach should be coordinated with local public agencies to appropriately target activities and assist with any follow up that may be required (and is outside the purview or capacity of the community groups.)

States should be required to ensure that such activities not only involve Exchange coverage, insurance market reforms, premium tax credits and cost-sharing reductions, but also provide information on Medicaid, CHIP and, if a state has elected that option, the basic health plan.

Federal assistance is needed to develop effective and unified messages and standardized language that everyone is now eligible for coverage, provide models of outreach and enrollment programs that have worked, and create federal linkages with effective messengers (e.g. sports

teams and community leaders) that states could utilize.

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

Federal guidance is required to set the parameters within which states must fund and implement the navigator program so consumer assistance reaches all parts of a state. Additionally, the guidance should stress the importance of utilizing a broad range of organizations that have a proven track record working in communities and with families at different income levels, including those now working on Medicaid, CHIP and Medicare enrollment.

Federal guidance should ensure that states undertake enrollment and outreach assistance, such as that as envisioned under the navigator program, prior to 2014. Under the current language of the ACA, the navigator programs are to be funded once the Exchanges are up and running, and federal funds (such as planning grants) may not be used to support them. However, in order to effectively start enrolling individuals in Exchange coverage in 2014, the outreach and enrollment must begin in 2013. Federal authorities should ensure that grant funding (or loans/advances) is available to states for this purpose.

Navigators will play key roles in consumer enrollment, including conducting public education activities to raise awareness of the availability of qualified health plans; distributing fair and impartial information concerning enrollment in health plans and the availability of premium tax credits and cost-sharing reductions; facilitating enrollment in health plans; providing referrals to an appropriate state agency for any enrollee with a grievance, complaint or question regarding health plans, coverage, or a determination under that plan or coverage; and providing information that is culturally and linguistically appropriate to the needs of the population being served.

Navigators should be closely tied to and monitored by the Exchange. This is important so that all navigators receive consistent training and certification and consumers receive uniform information on how to obtain health insurance coverage. Navigators should not be paid based on the number of people they help enroll or the plans they help people enroll in. It is essential that navigators have a firm knowledge of consumer health insurance products. We also urge HHS to establish stringent conflict of interest regulations for insurance agents or brokers who desire to be navigators to ensure that they will be “honest brokers” for consumers, as required by the ACA.

A clear delineation of roles between navigators on the one hand and public agencies and Exchanges on the other is critically important for successful coordination as millions of Americans obtain health coverage. Eligibility determinations for entitlement programs, including Medicaid and SNAP, are statutorily required to be performed by public employees. The ACA requires that Exchanges be administered by States or a quasi-public entity established by a State for this purpose. Receipt of income-based premium tax credits from the Exchange is a new entitlement, and therefore determining eligibility is an inherently governmental function. Navigators should be prohibited from performing any of the eligibility determination functions that are part of the process of making this decision.

Special consideration should be provided for navigators for small businesses. These navigators

should be knowledgeable, trusted and timely educators who know the full spectrum of small businesses. Large employers will also be vital to educating small business owners (and ultimately their employees) on their choices.

Though navigators will serve an important role, a diversity of public and private enrollment assistance is necessary. The non-profit entities contracted with as navigators may be stronger in some communities than others or may have an uneven presence across the state. It's important that a solid corps of public workers is available to perform this function statewide and with diverse communities.

3. What kinds of outreach strategies are likely to be most successful in enrolling individuals who are eligible for tax credits and cost-sharing reductions to purchase coverage through an Exchange, and retaining these individuals? How can these outreach efforts be coordinated with efforts for other public programs?

The most successful strategies will include utilizing community-based groups and application assistants; working through schools, churches, and labor unions; creating trusted messengers; and developing effective media strategies (such as working with ethnic media). Particular efforts should be made to engage medical professionals, offices, hospitals and clinics in outreach. For small businesses, effective strategies will include utilizing trusted messengers, and providing employers with comprehensive information on the availability of coverage and what the ACA means to them (including small business credits, explanation of grandfather plans, and how the Exchanges work). Outreach strategies should also be data-driven. Data can help to identify groups to best target for outreach. Segmenting target audiences allows messages to be tailored to better resonate with those audiences.

Other public programs will be critical “connectors” to the Exchange and Medicaid/CHIP coverage. As much as possible, linkages with other public programs should be automatic. For example, when someone applies for unemployment insurance the system should trigger a review of their eligibility for subsidies or public programs. When a child or adult is enrolled in Free School Lunch or SNAP, there should be automatic or expedited routes to coverage. For example, millions of childless adults who will be newly eligible for Medicaid in 2014 are already enrolled in SNAP and eligibility information for SNAP could thus be used to enroll them in Medicaid once the Medicaid expansion takes effect.

J. CONSUMER EXPERIENCE

1. What kinds of design features can help consumers obtain coverage through the Exchange? What information are consumers likely to find useful from Exchanges in making plan selections?

Consumers need clear, accurate, and easily understood information about their health insurance options. Special care should be given to ensure information is understandable to low-income populations that may have little experience purchasing traditional insurance products and to low literacy populations.

Regulations should make clear that the law requires federal or state Exchanges to ensure that the information is presented in a culturally and linguistically appropriate manner for individuals with limited English proficiency and in a manner accessible to individuals with disabilities. (See discussion in Section C)

To facilitate consumer choice, an Exchange website must present information in a manner that allows consumers to make meaningful comparisons of their health coverage options. Consumers should be able to narrow the list of options to a few select plans to make more detailed, head-to-head comparisons of health plan features, including premiums, cost sharing, benefits and benefit limits, provider networks, formularies and pharmacy benefits, and quality metrics and accreditation status. They should also have the ability to search for a particular doctor or hospital.

Also, the Exchanges should provide consumers with information about how the health insurance system operates in their State. Consumers need information about when, how, and under what circumstances they can switch between plans, along with information on shifting eligibility between Medicaid, CHIP, and private coverage. They should also be informed of relevant state laws, including laws mandating benefit coverage beyond the essential benefits package and laws restricting or banning coverage (e.g., abortion coverage), and consumer protections (e.g., bans on pre-existing condition exclusions, appeals rights, rights and protections regarding out-of-network billing and debt collection practices, etc.). In addition, Exchanges should alert consumers to the existence of and provide contact information for navigators, consumer assistance grant recipients, hospital financial assistance programs, and other similar informational programs.

We encourage HHS and states to conduct extensive consumer testing, test different versions of websites with focus groups, and create consumer feedback mechanisms so the websites can be improved over time. In addition, HHS and state Exchanges should make available tutorial videos that guide consumers through eligibility, plan selection and enrollment.

HHS should clarify the relationship between Healthcare.gov and Exchange websites beginning with the 2013 open enrollment period. Will Exchange websites be built off the Healthcare.gov platform? Or will they be separate with overlapping information? For a myriad reasons, Healthcare.gov should host information for plans in all states.

There must be in-person enrollment options available. Information posted on the Exchange website should be downloadable so the most current and accurate information can be printed and shared with consumers at an enrollment venue. In addition, the Exchanges should prepare and make available standardized written materials with detailed information about coverage options, a list of consumer protections available inside versus outside the Exchange, and directions to in-person, telephone, and online assistance with enrollment. These materials should have the depth necessary for navigators and other Exchange representatives to help consumers choose a plan.

2. What kinds of information are likely to be most useful to consumers as they determine whether to enroll in an Exchange and which plans to select (within or outside of an Exchange)? What are some best practices in conveying information to consumers relating to health insurance, plan comparisons, and eligibility for premium tax credits, or eligibility for other public health insurance programs (e.g., Medicaid)?

When considering health insurance options, consumers need readily accessible and clearly presented information on plans available to them, including premiums, cost sharing, benefits (including non-dollar benefit limits), network, and formulary information. In addition, consumers should be informed of enrollment windows and whether they qualify for subsidies (both premium tax credits and cost-sharing reductions) or public insurance. Information on which consumer protections apply to plans both inside and outside the Exchanges and the requirements qualified health plans must meet will also be important for consumers as they decide on coverage and should be presented in simple language and format, such as in a chart format. Materials for consumers should undergo focus group testing prior to distribution to ensure they are appropriate and useful for consumers. In addition, employers should clarify whether the health insurance offered to employees will satisfy the individual coverage requirement, whether employers will automatically enroll employees into plans offered by the employer, and whether employers will be providing a free choice voucher. By 2014, consumers will need to clearly understand that they must make a choice regarding health insurance coverage in order to meet the individual requirement or face a tax penalty (unless they are exempt).

Before the Exchanges are operational, it is critical consumers have information about subsidies in the Exchange and the new tax implications. This information could be conveyed through commercial and volunteer tax preparers and software, the Internal Revenue Service, employers and others with tax knowledge, and federal and state websites, and should be provided beginning in the tax year 2012 filing season. To prepare consumers for the tax implications of the individual coverage requirement and subsidies, an explanation sheet and sample credit schedule should be provided to every tax filer in advance of filing season, as the IRS has done for the small business tax credit. Over several years, this could include progressively detailed information about health insurance tax benefits and penalties and sample filing scenarios (e.g., if an individual does not have coverage, if a family qualifies for a premium credit or cost-sharing assistance, if a taxpayer faces exclusions like married filing separately status, etc.)

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

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

What types of efforts could be taken to reach individuals from diverse cultural origins and those with low literacy, disabilities, and limited English proficiency?

The Exchanges must operate pursuant to §1557 of ACA, which prohibits discrimination on the bases set forth in Title VI and the Rehabilitation Act, among other statutes. In addition to complying with these legal requirements, Exchanges should take steps to ensure they are

accessible to diverse populations. Information on Exchange websites should be available in multiple languages and be culturally sensitive and linguistically appropriate. The Exchange's toll-free telephone hotline should be clearly displayed on the website and at highly visible places in the community, such as on public transportation. Telephone operators who speak a variety of languages should be available to refer consumers to local resources. An audio component could be integrated into the website in various languages so that consumers could click to listen to information in their native language and understand where to go for additional assistance. Other forms of communication, such as newspapers and radio stations that are popular in racial/ethnic communities, could also serve as useful forms of outreach.

Community health, education and outreach workers with existing relationships in culturally-diverse communities should be incorporated into Exchange outreach efforts. Outreach efforts should consider how to reach people who are homebound or who cannot travel to a state office and a mail campaign should be employed. Outreach efforts involving partnerships with community vendors (such as grocery stores), workplaces (including employers and labor unions), public facilities (such as libraries and public transportation hubs), hospitals, clinics and churches should also be conducted to reach consumers in places they live and frequent. In addition, methods used to contact hard-to-reach populations during the 2010 U.S. Census should also be considered. States and other entities will need sufficient time and funding to train outreach workers and counselors to serve as resources to consumers in the Exchanges and establish effective outreach to culturally-diverse populations.

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

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

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

4. Given that consumer complaints can be an important source of information in identifying compliance issues, what are the pros and cons of various options for collecting and reporting Exchange-related complaints (e.g., collecting complaints at the Federal level versus at the State or Exchange level)?

Consumer complaints and appeals can be an important source of information in identifying compliance issues. Exchanges and navigators should be required to notify all consumers in easy-to-understand language that they have access to both a complaint and appeal process, and how those processes can be triggered. Any deadlines should be reasonable and clearly articulated to consumers. Consumers should have the right to request reconsideration of an initial decision.

Complaints and appeals should be handled by a public agency because this is part of regulating the Exchange and because granting or withholding public benefits is an inherently governmental function. Complaints and appeals could stem from Exchange-related actions and decisions (e.g., denial of a premium tax credit or denial of a hardship exemption from the coverage mandate) or insurance company misbehavior within the Exchange. Both state and federal Exchanges should aggregate the information derived from complaints and appeals so that HHS can collect, analyze and report this information, and regulators and consumers can understand trends and track the resolution of complaints and appeals to ensure that the law is being consistently applied across the country.

State Exchange complaint and appeal data should be provided monthly in a uniform standardized format to federal regulators for national data compilation and analysis. If a state has more than one Exchange, data should be consolidated for state use and forwarded to federal regulators. If a state is part of a regional Exchange, each participating state and federal regulators should receive its data. The federal Exchange also should share its data with federal regulators.