

**America's Health
Insurance Plans**

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October 4, 2010

Office of Consumer Information and Insurance Oversight
Department of Health and Human Services
Hubert H. Humphrey Building, Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Re: Request for Comments Regarding the Exchange-related Provisions of the Patient
Protection and Affordable Care Act (File Code OCIO-9989-NC)

Submitted Via the Federal eRulemaking Portal at www.regulations.gov

Dear Sir or Madam:

I am writing on behalf of America's Health Insurance Plans (AHIP) in response to the Department of Health and Human Services (the Department) Request for Comments, published in the *Federal Register* on August 3, 2010, regarding the Exchange-related provisions of the "Patient Protection and Affordable Care Act" (PPACA).

AHIP is the national association representing approximately 1,300 health insurance plans that provide coverage to more than 200 million Americans. Our members offer a broad range of health insurance products in the commercial marketplace and also participate in Medicare, Medicaid and other public programs.

AHIP has held a longstanding position in support of Exchanges as a vehicle to provide consumers access to innovative plan choices and clear and consistent information about their coverage options. As the Department and states work through the various policy and design issues, our members are ready to serve as a resource to develop solutions that address structural, policy and technical challenges that will need to be navigated to ensure the development of workable structures that fulfill the promise of the legislation.

PPACA outlines a set of federal requirements for the Exchanges, and encourages states to establish detailed policies and procedures. This state-focused model properly recognizes that health care is locally provided. Instead of imposing a highly prescriptive regulatory model, it provides flexibility so states can respond to the unique needs and circumstances of their respective populations. This approach will enable the Exchanges to play a key role in enhancing competition and choice for consumers, without duplicating the other regulatory and monitoring



oversight activities that are already being handled by existing state agencies. Our members are fully committed to working with the states to ensure that the Exchanges serve as a successful channel that, among others, will ensure all Americans gain access to coverage, whether inside or outside of the Exchange.

The following is a summary of the key issues and our recommendations to help guide any forthcoming regulatory activity surrounding the development of Exchanges. An attachment to our letter provides detailed responses to many of the questions that were outlined in the Department's Request for Comments.

1. States are best positioned to implement the Exchanges.

States have the existing regulatory infrastructure and the deep technical experience needed to successfully implement health insurance Exchanges. States also are best suited to design an Exchange infrastructure that delivers high value, high quality care meeting the unique needs of their specific populations. Recognizing that the states are best positioned to establish Exchanges, we believe the Department should encourage all states to take action and help provide them the tools and resources they need to establish their own Exchanges.

***Recommendation:** States that have not already done so should pass enabling legislation establishing a Commission or Committee to evaluate the core issues and options surrounding the development of an Exchange.*

2. An Exchange structure should ensure broad stakeholder representation.

There are different structural options for establishing an Exchange. In all cases, Exchanges should have broad stakeholder representation from health plans, consumer representatives, and employers. There is significant value in seeking input on design issues and involving a wide spectrum of stakeholders in that process.

***Recommendation:** In considering any of these structural options, we suggest that any Exchange include a transparent process for decision-making, financial and budgetary expertise to ensure that the Exchange operation maximizes efficiency and keeps administrative expenses low, is accountable with respect to any funding assessments, taxes and the costs of operating the Exchange, ensures a mission that is closely linked to the functions outlined in the statute, and takes steps to ensure that the regulatory functions performed by other regulatory bodies are not duplicated.*

From the beginning, states should establish rules with respect to transparency so that all meetings and transmittals are made publicly available and in a timely manner so that



stakeholders including consumers may follow the development of the Exchanges and have an opportunity to comment on the process.

3. Preventing the establishment of unnecessary and costly duplicative regulatory structures will ensure a better, high value experience for the consumer.

We believe it would be both unnecessary and costly to establish a separate regulatory framework within the Exchanges. Generally, the Exchanges should focus on ensuring that competition is strong in the market without duplicating the functions of existing regulatory agencies. For example, the function of premium rate review should be handled by existing state regulatory agencies and not duplicated through the Exchanges.

***Recommendation:** Instead of serving as a regulator and attempting to duplicate existing regulatory bodies, the Exchange should leave regulation and enforcement to existing agencies including the state's Department of Insurance. It would be both unnecessary and costly to establish a separate Exchange regulatory framework. Generally, this role should be limited to ensure that competition is strong in the market and to limit the establishment of unnecessary and costly duplicative regulatory frameworks. This model recognizes that states should leverage existing state agencies' expertise, processes and structures to ensure administrative efficiency. This model would serve to complement functions of the existing marketplace and the Exchange while ensuring a better experience for the consumer. In addition there is the potential for duplication of oversight functions between the Federal government and the states. This would also add an unnecessary and costly duplicative regulatory framework and should be avoided.*

4. It will be important to test certain operational frameworks before January 1, 2014 to ensure the best possible consumer experience once the Exchanges are up and running.

We recommend that states and federal regulators take a phased approach to evaluate the many and inter-related operational issues that will be important to ensure a positive and seamless consumer experience.

***Recommendation:** To that end, we recommend that the Department consider encouraging states to run test cases of certain elements prior to implementation on January 1, 2014. This will enable states to evaluate key issues such as the accuracy and timeliness of data transmissions to a secure web portal interface for consumers, the response rate and accuracy of an Exchange hot-line or call center, prompt and efficient financial transactions, seamless eligibility determination, and ongoing eligibility verification between the Exchange and other programs, such as Medicaid and the Children's Health Insurance Program (CHIP). Plans can be a valuable resource to states as they contemplate and work to bridge their understanding of the necessary data and subsequent analysis needed to understand the key characteristics and needs of a population.*



5. Exchanges offer an important channel for individuals and businesses to access choices in the market and should serve to supplement, but not replace, existing markets.

Exchanges should not be built to or expected to serve as the only option for obtaining coverage in the market, but function as another channel for individuals and businesses to encourage high rates of coverage in states and across the nation. Those who have coverage today and who are satisfied with that coverage, should be able to keep that coverage. And in the future, consumers seeking coverage should have options available both through the Exchange and through new and existing products.

By way of example, in Massachusetts most individuals and small businesses finding access to and enrolling in coverage are doing so outside of the Exchange. According to the latest statistics from the Massachusetts Health Connector, 3-5 percent of the total insured population in Massachusetts is enrolled through the Exchange. Out of the 5,473,000 individuals with health coverage in the group and non-group markets, 155,412 are enrolled through Commonwealth Care (subsidized coverage) and 36,649 individuals are enrolled through Commonwealth Choice (non-subsidized coverage).

***Recommendation:** At their core, the Exchanges should be established in the market to serve as an additional opportunity for individuals and businesses to access coverage. Choice and competition should be a principle goal and market rules should ensure this goal is met whether inside or outside of the Exchange. A key principle related to the design of any Exchange should be to ensure that consumers continue to have access to the coverage options they have today, whether inside or outside of the Exchange.*

6. Rate review should be handled by existing state regulatory agencies and not duplicated through the Exchanges.

Review of premiums should continue to be at the state level and build upon the states' traditional role of regulating health insurance premiums. The Health Insurance Premium Review Grants distributed to states by the Department to help them strengthen their oversight capabilities and establish oversight programs recognize the role that states play in this arena.

Several provisions in PPACA focus on the Department's and states' role in oversight of insurance premiums. These include the Medical Loss Ratio (MLR), the provision requiring insurers to provide an explanation of the review of rates to state regulators and the Department, and grant funds for states to help create or further expand upon reporting and review processes. State insurance regulators are uniquely aware of the link between actuarial soundness and



solvency. Thus, we urge that the existing state regulatory agencies be responsible for the review of rates in the Exchange environment.

***Recommendation:** Review of premiums should be tied to principles of actuarial soundness and solvency. Any review of premiums should be considered in the context of new regulations including the MLR requirements and carried out by the existing regulatory agencies.*

7. The Department should work with experts, such as the American Academy of Actuaries and the National Association of Insurance Commissioners (NAIC), to make detailed recommendations on methodologies to establish reinsurance and risk adjustment mechanisms that will serve to address adverse selection both inside and outside of the Exchanges.

We understand the potential for adverse selection in the marketplace and believe several strategies should be pursued to address this issue. Bolstering the personal coverage requirement with mechanisms, such as structured enrollment periods and other strategies to encourage the purchase and maintenance of coverage, will help mitigate the potential for risk selection in the market whether inside or outside of the Exchange. Risk pooling for the individual and small group markets will help encourage market stability. PPACA also includes several structural elements to mitigate risk selection inside and outside of the Exchange, including a temporary reinsurance program, risk corridors, and risk adjusters. It is important for regulators to carefully design these risk mitigation methods to ensure a stable and seamless experience for consumers, whether they are accessing coverage inside or outside of the Exchanges, while also protecting against undue risk selection.

***Recommendation:** On the issue of reinsurance and risk adjustment, we recommend the Department consult with the American Academy of Actuaries and the NAIC to develop best practices for the states with respect to accurate methodologies that recognize the complexity of the information that is required to ensure accuracy and predictability for all of these mechanisms and their inter-relationship to each other. Any development work by the American Academy of Actuaries and the NAIC should be conducted with broad stakeholder input and ensure a public and transparent process.*

8. Operational efficiencies can be enhanced by establishing uniform standards for key data elements.

While the states should have flexibility in designing and implementing their Exchanges, it is critical that national information technology (IT) standards are used for data sharing between the Exchanges and health plans. The federal government should build on its longstanding efforts to standardize the exchange of data between health plans and providers and between health plans



and employers, and utilize the Health Insurance Portability and Accountability Act (HIPAA) electronic transaction standards. This will help keep down administrative costs, enhance the consumer experience, and ensure that certain Exchange system-to-system interactions are as efficient as possible.

***Recommendation:** Utilize common standards for the exchange of information between health plans, the Exchange and other stakeholders building on existing HIPAA standards and financial transaction standards to the extent possible. We also recommend that the federal government encourage states to use uniform definitions for terms (a standardized data dictionary) and utilize a common electronic format (a structured document format) to collect enrollment application information from the consumer. Collecting and utilizing information in standard formats will facilitate the exchange of information to necessary agencies and functional entities and streamline the process for consumers. We urge the federal government to encourage states to adopt these standards as they are developed to help facilitate the operation of Exchanges throughout the states.*

9. Exchanges should offer consistent and objective participation criteria to allow for meaningful choices.

To maximize consumer choice, states should ensure that Exchanges establish consistent and objective criteria for health plan participation based on the requirements in PPACA and existing state legal and regulatory standards. Specifically, any health plan seeking to be certified through an Exchange should be required to meet those certification standards specified in PPACA and the existing requirements of the State Department of Insurance or related agency for being licensed in the state, including meeting market conduct and financial examination requirements. There should be a level playing field holding all health plans to the same standards.

***Recommendation:** If a plan meets the criteria for selection of health plans as stated in Section 1311(c) of PPACA and the existing requirements of the State Department of Insurance or other related agency in order for a health plan to receive a certificate of authority and be licensed and in good standing in that state (including meeting market conduct and financial examinations, compliance with state insurance laws and regulations, and meeting financial and solvency standards), then a plan should be able to participate in any Exchange. In all cases, sufficient time should be allowed to ensure plans can adequately come into compliance and that any criteria should be communicated and disseminated prior to January 1, 2012. Without sufficient notice, plans will not be able to complete testing in time for members to begin to enroll.*

10. Structured enrollment periods are critical elements to help provide access to affordable health coverage in the individual market, given the presence of a very weak enforcement mechanism. At the same time, consideration ought to be given to other strategies that could ensure that all who are eligible participate.



The implementation of the Exchanges coincides with the effective date of other major PPACA provisions, including insurance market reforms, premium subsidies, and the individual coverage requirement. These reforms are deeply interconnected and their long-term success hinges directly on ensuring that as many consumers as possible are obtaining coverage under the reformed health care system.

***Recommendation:** Because the enforcement mechanism for the coverage requirement is weak, it will be extremely important to establish structured enrollment periods for the individual market (both inside and outside of the Exchange) that encourage people to buy coverage during a specific timeframe and not wait until they are sick. The Department has recognized the concerns of adverse selection, and the benefit of assuring a balanced risk pool. A set enrollment period will serve to encourage individuals and families to enroll in coverage, rather than deciding to wait until they experience medical problems to purchase coverage. These strategies will serve to promote the formation of a balanced risk pool that will be vital to the ability of all Americans to obtain affordable coverage on a sustainable basis.*

It also will be important to evaluate other strategies to support the goals of encouraging those who are eligible to enroll. This effort should be accompanied by a multi-faced consumer education effort to bring all Americans into the reformed health care system. Components of this education effort should include making information on coverage options available through web sites, coordinating with agents and brokers, and reaching out to insurance departments and community-based organizations that provide outreach and educational services on insurance options.

11. Successful outreach is critical.

The successful implementation of health reform will require a broad outreach effort to ensure that individuals and businesses that currently do not have coverage are brought into the market. This will serve to enhance competition by mitigating risk selection and ensuring that consumers have access to innovative market choices.

As a fundamental principle, outreach efforts should ensure that clear, meaningful information is available to consumers in a way that allows them to compare benefits from one plan to another and allows them to understand the comprehensive cost of coverage including premiums, deductibles and coinsurance/co-payments. To ensure that consumers have as many resources as possible to access coverage and cost information, individuals and businesses will look to multiple distribution channels including Navigators, websites, state and county agencies, call-lines and brokers and agents. The Exchanges also should build on lessons learned from existing public programs to ensure that consumers have adequate resources they can turn to for assistance with getting enrolled, as well as to ensure consumers stay enrolled continuously following their initial enrollment in plans offered through the Exchanges or outside of the Exchanges.



Recommendation: *HHS and other agencies such as the IRS and the Department of Labor should consider allocating sufficient funding to the states as a means of enhancing outreach efforts separate from investment and planning grants to establish Exchanges. Additional assistance to the states could be utilized in a number of ways, from mailings to direct outreach.*

In all cases, the states and Department should ensure that any education and outreach to consumers take into account the ongoing work related to health literacy to understand the best tools and methods for communicating concepts to individuals and businesses. The health plan community has significant experience in assessing effective health literacy as a means to improve the overall experience and quality of care delivered to consumers and stands ready as a resource in this area.

12. Exchanges should preserve and enhance the ability of employers to offer coverage options to their employees.

The provision of health coverage by employers is a key part of our health care system providing benefits to almost 157 million non-elderly Americans according to the latest data from the Kaiser Family Foundation. It is important that state Exchanges not destabilize this important market, but rather provide additional options for employers to provide coverage. In meeting this goal, states and the Department should carefully consider the following issues.

First, the impact of Exchanges on existing employer markets (both fully-insured and self-funded) should be carefully considered and any design features that serve to destabilize employer sponsored health coverage should be avoided. This analysis should also take into account other PPACA market changes, such as the employer responsibility requirements and the subsidization of coverage provided through the Exchange.

Second, careful consideration should be given to the formation of Exchanges to determine if they provide the best vehicle to extend coverage options to employers.

Third, employers should have access to a wide range of coverage options within an Exchange.

Fourth, the functions of an Exchange should be designed to maximize efficiency and reduce costs for employers.

Recommendation: *The Department must carefully consider the impact of the development of Exchanges on existing employer sponsored health coverage to avoid any design requirements that would serve to destabilize such markets. States, in creating Exchanges, should include an analysis of their existing markets in the planning process to determine where coverage gaps may exist and how coverage can best be provided to employers in a way that enhances choice of coverage without disrupting existing coverage.*



13. Exchanges can provide another channel to facilitate the improvement of quality and affordability of care for consumers.

Section 1311(c) of PPACA lays out specific certification criteria that plans must meet including quality improvement strategies and accreditation standards. There is also a plan rating system that takes into account measures for health plan performance. Plans that are licensed and in good standing with the state and that meet the certification criteria (including quality improvement strategies and accreditation standards) should be approved as qualified health plans.

Some health plans may offer coverage through a variety of delegated contractual relationships such as provider networks and accredited quality and credentialing organizations; such plans may meet the minimum quality criteria for certification through such delegated arrangements so long as applicable accreditation requirements are satisfied.

Health insurance plans strongly agree that qualified health plans should meet core quality standards that are equitable across states to be able to participate in the Exchange and in all cases the standards should be set to facilitate the greatest amount of consumer choice and promote improvement and innovation.

Recommendation: *We believe the following factors should be considered as participation criteria are developed:*

For quality improvement strategies, the following factors should be considered:

- *Whether the health plan is conducting activities that align with the Triple Aim priority areas (improved population health, improved patient experience, and lower per-capita costs) and/or the Institute of Medicine (IOM's) six dimensions of quality care (safe, effective, patient-centered, timely, efficient, equitable).*
- *That the health plan is focusing efforts on addressing: areas that impact a significant number of individuals, high costs, areas of wide variation or high utilization, and/or areas where improvement can be made.*
- *That the health plan is using techniques that positively impact clinician and member behavior.*
- *That the health plan is using the following measures:*
 - *Measures that reflect consumers' health needs and the population being served;*
 - *Measures that are reliable, valid and based on sound scientific evidence;*
 - *Measures that are based on where there has been strong consensus among stakeholders and predictive of overall quality performance;*
 - *Measures that are developed, selected and implemented through a transparent process; and*



- *Measures that assess programs addressing prevention, population health, management of chronic conditions, patient safety and/or care coordination.*

With respect to accreditation standards, those plans that have met a state's existing accreditation standard should be deemed to meet the minimum standards to participate in the Exchange. States that do not have a formal accreditation standard should adopt standards similar to those set by nationally recognized accreditation organizations such as the National Committee for Quality Assurance (NCQA) or the Utilization Review Accreditation Commission (URAC).

Any rating system developed should consider factors that will help ensure consumers receive useful, accurate and up-to-date information about health plan performance. This includes:

- *Measures that reflect processes that plans can influence and impact;*
- *Allowance for appropriate adjustments based on geographic and other appropriate factors;*
- *Reflects plans' performance in meeting certain thresholds as well as making improvements;*
- *Engages health plans in any development of a rating system;*
- *Ensures there is an appropriate transition period for plans with multi-year provider contracts;*
- *Any rating system is regularly evaluated to assess its effectiveness and any unintended consequences; and*
- *To reduce confusion and promote coordination, all requirements and processes included under an Exchange rating system should be equitably applied across the health care sector.*

To ensure that all key stakeholders are aligned in their efforts to achieve quality improvement, physicians, hospitals and other providers should likewise be subject to similar standards.

14. Federal rulemaking and guidance should be transparent and allow stakeholders with the opportunity to provide input.

In cases where the Department will provide guidance to the states on key issues, such as IT standards for Exchange operations, it is important that states, health plans, consumers, employers and other stakeholders clearly understand the Department's goals and objectives in any rulemaking or guidance. Thus, the Department should allow for sufficient time to provide input on any rules well in advance of the date for all states to come into compliance.

The Administrative Procedures Act has served as the framework for federal agencies to promulgate regulations and enumerates the processes and procedures that federal agencies should use when developing and establishing regulatory requirements that bind individuals and entities under an agency's jurisdiction. A key component is that federal rulemaking best occurs



following the issuance of proposed regulations in the *Federal Register* and an adequate opportunity for the public to submit comments and participate in the rulemaking process. We recognize that the statute provides limited exemptions from the public notice-and-comment procedures, and also creates an exception for situations where an agency finds “good cause” for foregoing the proposed regulation process. However, federal agencies can benefit from information offered by the public, particularly when information about proposed policies and requirements can best achieve the agency’s objective or can help identify when proposed requirements may result in unintended consequences. Thus, it will be important for the public to have the opportunity to provide input into any new regulatory requirements pertinent to the Exchanges.

The rules or guidance issued by the Department should also provide stakeholders with sufficient time for implementation. Compliance timelines should take into account the significant operational and administrative challenges faced by states, health plans, employers and other entities in the implementation of the new Exchange frameworks.

***Recommendation:** The Department should issue a Notice of Proposed Rulemaking with a minimum 90 day comment period to allow public and private stakeholders ample opportunity to comment on any rules. In addition, any final rulemaking or guidance should allow sufficient time for implementation in order to ease any administrative or operational challenges with compliance.*

Thank you for considering our comments on these important issues. We stand ready to work with the Administration, the states, and other stakeholders to ensure the development of workable Exchanges that promote innovation, choice, and high quality, affordable coverage options for consumers.

Sincerely,

A handwritten signature in black ink, appearing to read "Jeffrey L. Gabardi". The signature is fluid and cursive, with a large initial "J" and "G".

Jeffrey L. Gabardi
Senior Vice President, State Affairs

Enclosure



Responses to Specific Questions Raised in the Request for Comments

Subsection A. State Exchange Planning and Establishment Grants

We urge HHS to recognize that states will be at various phases of the planning process and that adequate funding is important to provide sufficient resources, particularly given current budget constraints in many states. Many states are likely to consider Federal planning grants to be a critical source of funds in evaluating their policy objectives for Exchange development. In assessing states' compliance with grant requirements, states should be afforded the time needed to ensure a thoughtful and reasoned approach is given when establishing Exchanges including evaluation of the potential interactive effect that each individual design feature has with other design elements and the potential for unintended consequences.

As a matter of precedent, states that have already built Exchanges, including Massachusetts and Utah, spent years developing models to fit their particular markets, and they are still very much a work in progress as they struggle to address costs and other issues. Indeed, crafting a strategy unique to a specific marketplace requires adequate time to assess and ensure that duplicative regulatory frameworks are not created and any inadequacies in the market are addressed.

For instance, when Massachusetts undertook the task of developing the first of its kind Commonwealth Connector, extensive analysis of the state's market showed that any successful Exchange structure needed to provide increased access to subsidized coverage for those already eligible but not enrolled. With this in mind, the Commonwealth Connector included a platform specifically aimed at connecting eligible individuals with available public subsidies, leading to enrollment of more than 170,000 only eighteen months after launch. In Utah, planning and development for the Utah Health Exchange began nearly two years before the Exchange undertook its first limited consideration of the factors of concern that the Exchange was seeking to address. This knowledge led to a platform that was uniquely tailored to the broad concerns facing the Utah marketplace, the need for direct access to coverage for small employer groups, and greater consumer involvement in individual coverage decisions.

In order to ensure that grant requirements support a reasoned approach, we recommend that as a first step, states are encouraged to pass legislation that requires the establishment of a special health insurance Exchange committee to conduct a study that carefully evaluates policy objectives including deficiencies in the current market that an Exchange seeks to address, key design and structural elements necessary to meet those objectives, and states' readiness to build what is required. We recommend that this committee include multi-stakeholder representation across both the public and private sectors, and encourages input from various constituents and stakeholders.

We recommend that the Department consider the establishment of this type of an Exchange committee as a signal that state is proactively evaluating the issues and preparing to establish an Exchange that will be tailored to that state's specific population needs. Layering on additional



federal regulatory guidance at this stage would be premature as states seek to identify their unique solutions to specific problems identified when evaluating their population's needs.

We also recommend that the Department consider encouraging states to establish test programs prior to January 1, 2014 to test certain operational issues in advance of rolling out their Exchanges state-wide. This includes testing the accuracy and timeliness of data transmissions to a secure web portal interface for consumers, the response rate and accuracy of an Exchange hot-line or call center, prompt and efficient financial transactions and links to spending accounts such as Health Savings Accounts, seamless eligibility determination, and ongoing eligibility verification between the Exchange and other programs such as Medicaid and CHIP.

What kinds of governance structures, rules or processes have States established or are likely to establish related to operating Exchanges (e.g., legal structure (such as placement in State agency or nonprofit organization), governance structure, requirements relating to governing board composition etc.)?

As states consider how to develop an Exchange structure that best fits their needs, we suggest the following:

1. Broad stakeholder representation including representation from health plans, consumer representatives, and employers. There is significant value in seeking input on design issues and involving a wide spectrum of stakeholders in that process.
2. Leadership that is independent of oversight by a state insurance commissioner or other insurance regulator.
3. Transparent process for decision-making.
4. Financial and budgetary expertise to ensure that the Exchange operation maximizes efficiency and keeps administrative expenses low.
5. Accountability to state legislators or another appropriate body with respect to any funding assessments and taxes related to Exchanges.
6. Ensuring a mission closely linked to the functions outlined in the statute such that regulatory functions performed by other regulatory bodies are not duplicated in order to ensure a better, high value experience for the consumer.

Instead of serving as a regulator, the Exchange should leave regulation and enforcement to existing agencies including the state's Department of Insurance. It would be both unnecessary and costly to establish a separate Exchange regulatory framework. Generally, this role should be limited to ensure that competition is strong in the market and to limit the establishment of unnecessary and costly parallel regulatory frameworks when states should leverage existing state agencies', expertise, processes and structures in order to ensure administrative efficiency. This model would serve to complement functions of the existing marketplace and the Exchange while ensuring a better experience for the consumer. States must also contemplate the potential for duplication of oversight from the Federal government and the consequences that may have when establishing an effective and efficient Exchange market.



As states consider the governance rules or processes necessary to establish Exchanges, they should consider the role of private companies in performing (or assisting with the performance of) the administrative functions of the Exchange.

In addition states should, from the very beginning, establish rules with respect to transparency so that all meetings and transmittals are made publicly available and in a timely manner so that stakeholders including consumers may follow the development of the Exchanges and have the opportunity to comment on and influence the process. This level of transparency should also apply to any conversations, whether formal or informal, with the federal government on the development of Exchanges.

Subsection B. Implementation Timeframes and Considerations

As states begin working through the many, inter-related issues central to an effective Exchange, they should evaluate the potential effects that each individual design feature has with other design elements. As mentioned in Subsection A, we recommend that the Department: 1) encourage states to establish a Commission or Committee that will focus on key design and operational issues when establishing an Exchange; 2) ensure that the development process includes participation from a wide array of stakeholders including health plans, employers, providers and consumers; and 3) encourage states to test some of the core operational elements of an Exchange prior to rolling it out to a wider audience of consumers.

The health plan community stands ready to be a resource to and engage in partnerships with states to develop solutions that help fulfill the promise of the legislation of better access to care and focusing on value over volume. This includes focusing on the policy, structural, and technical challenges that will need to be navigated to ensure the development of workable structures.

What kinds of guidance or information would be helpful to States, plans, employers, consumers and other groups or sectors as they begin the planning process?

States are the best positioned to implement Exchanges and have the existing regulatory infrastructures and deep technical experience that are needed to successfully implement health insurance Exchanges. States also are best suited to design an Exchange infrastructure that delivers high value, high quality care meeting the unique needs of their specific populations.

When the Department does offer regulatory oversight in key areas, it should conduct a clear and open regulatory process so that all stakeholders may have a common understanding of guidance on an ongoing basis. As all 50 states seek to form Exchanges and given the large amount of flexibility built into PPACA, it will be imperative for the Department to be consistent and clear in any guidance given to one or more states.

As part of this process, any federal rulemaking should closely follow the requirements of the Administrative Procedures Act (APA) and provide stakeholders with opportunity for notice and comment prior to the implementation of regulations. The notice and comment process plays an



essential function in providing federal agencies with the opportunity to interact with members of the public on such key issues as whether the regulations comport with the statute, as well as how practical the proposed regulations would be in real-world situations. Comments can, of course, address a wide variety of issues, such as informing the agency about the relationships and workings in the industry subject to regulation, as well as challenging any errors or omissions in the legal position, data or assumptions used by the agency in its rulemaking.

We also believe it is critical for the Department to undertake and publish an analysis of the economic impact of any Exchange rules subject to the requirements of the Regulatory Flexibility Act, Executive Orders, and other statutory provisions applicable to rulemaking. As noted, the Exchanges are being developed in the context of overall PPACA changes to the insurance market and it is important for all stakeholders to understand the collective effects of those changes. An accurate estimate of the costs and economic impacts associated with implementation provides public and private stakeholders with a better understanding of how the rules will affect the market and the scope of operational and administrative changes that are needed to implement the Exchange framework. As part of this analysis, the Department should share any internal analysis it has done or is undertaking that will serve as the basis of the impact statements published in any Notice of Proposed Rulemaking and Final Rule.

In addition, the Department should carefully consider the timeframes in which it is asking stakeholders to respond to guidance and to regulations. We strongly recommend that when formal regulatory guidance is transmitted, it should include a 90 day notice and comment period. In addition, with respect to memorandums that clarify formal regulatory guidance, the Department should consider the timeframes between when those notices are released and the effective date for compliance. Health plans and other stakeholders will need ample time to create and gain approval of qualified health plans and readjust their operational systems to be ready for open enrollment in late 2013. Accommodating even the smallest of policy changes can be a substantial undertaking. For example, any small modifications to marketing, product, pricing or information technology requirements could cause major disruptions and increase costs.

By way of example, when the Centers for Medicare and Medicaid Services (CMS) implemented the Part D drug benefit program, there were three levels of guidance given to Part D plans: 1) regulatory guidance with the requisite notice and comment period; 2) guidance in the form of memorandums to Part D plans clarifying regulatory guidance; and 3) verbal communication between CMS staff and the Part D plans. In some cases, guidance would require substantial changes to processes such as the development of formularies causing plans to have to re-engineer their formularies, pricing information, and benefit descriptions to come into compliance. In cases where there is verbal communication with plans, to the extent possible, it would be most efficient to first have policies outlined in a formal memo or guidance in order to ensure consistency in application of a specific policy modification.

With respect to what guidance will be most helpful to states and other stakeholders, particularly in the near term, we recommend the Department consider the importance of codifying national electronic data transmission standards in order to ensure that certain Exchange system-to-system interactions are as efficient as possible, which would include a standard application form and enrollment transaction standard.



Our community feels strongly that this is the area where the Department can be most helpful in the near term by way of offering uniform operational and financial transaction standards to states so that they may begin to build a seamless data interface to handle all of the crucial operational elements of the Exchange and the interface with the federal agencies, state agencies, health plans, third party administrators, financial institutions and consumers. Ensuring a seamless and standardized data transmission platform will ease the data and financial transactions that will occur between health plans and the Exchanges to ensure timely, accurate information is conveyed along the way.

Subsection C. State Exchange Operations

As mentioned in Subsection B, while states should have flexibility in designing and implementing their Exchanges, we strongly encourage the federal government to require the use of national IT standards for data sharing between the Exchanges and health plans. The federal government should build off of the longstanding efforts to standardize the exchange of data between health plans and providers and between health plans and employers and utilize the Health Insurance Portability and Accountability Act (HIPAA) electronic transaction standards. This will help keep down administrative costs, enhance the consumer experience and ensure that certain Exchange system-to-system interactions are as efficient as possible.

While we want to ensure Exchanges employ innovative models to make their coverage options available to consumers, whether in person, via phone, or online, the Exchange should convert the information collected from the consumer and other sources to a standard format for transmission to the plan and the plan should be required to return information using a standard format. As a best practice, the federal government should instruct Exchanges to minimize the use of paper. While consumers may fill out an initial application via paper form, this information should be immediately converted to electronic formats for review and distribution.

We recommend, as a general principle, that the Department stress the importance of using existing IT standards as appropriate. We recommend the Department work with Standard Setting Organizations and Standards Development Organizations, such as the Accredited Standards Committee (ASC X12), to build upon the 5010 HIPAA transaction standards. We recommend the Department adopt existing HIPAA standards for the following:

- For the transmission of a roster of individuals seeking coverage from the Exchange to the health plan the HIPAA X12 834: Enrollment and Disenrollment in a Health Plan;
- For the transmission of subsidy payments the HIPAA X12 820: Health Plan Premium Payment; and
- For the verification that an individual has been enrolled in a health plan the HIPAA X12 270/271: Eligibility for a Health Plan (request and response).

We understand that these HIPAA standards may not accommodate all the necessary data transfers or data elements required by Exchanges. As a first step, HHS should work with the recognized standards bodies (ASC X12) to determine if the transaction requirements for the



Exchanges can be accommodated. If that cannot be done, HHS should use its authority granted under Section 1104 of PPACA to adopt “operating rules” for these transactions to incorporate any necessary information not already included in the HIPAA standards. CMS’ Office of Electronic Standards and Services is well positioned to seek industry feedback on the applicability of these standards and associated operating rules and to consult with the applicable federal advisory committees where appropriate.

The federal government should encourage states to use a common language (standardized data dictionary) and use a common electronic format (a structured document format) for the transmission of the enrollment application and eligibility files. We recognize that the NAIC is actively working on recommendations with respect to the standardization of enrollment, eligibility and electronic data sets and encourage the Federal government to consider these standards as they are developed to help facilitate the operation of Exchanges across states. There also may be existing standards in use in other industries that may provide a ready-made solution.

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?

All data necessary to determine eligibility and enroll an individual or small group into health plans should be standardized. By this we mean that the federal government should guide states to use uniform definitions for terms, based on a common language (a standardized data dictionary) and utilize a common electronic format (a structured document format) to collect enrollment application information from the consumer. Collecting and utilizing information in standard formats will facilitate the exchange of information to necessary agencies and functional entities and streamline the process for consumers. We encourage the federal government to encourage states to adopt these standards as they are developed to help facilitate the operation of Exchanges throughout the states. The data should be transmitted using the HIPAA electronic transaction standards as described above.

The “front facing” application viewed by the consumer can vary from Exchange to Exchange to accommodate the various vendor systems. This variability will also afford an opportunity to test the best ways to achieve website ease-of-use. The data dictionary will provide the Exchanges with the essential design requirements that their system must accommodate for consumers to enter required data, as well as the behind-the-scenes document format (such as using a HIPAA 834 transaction) that should be used to exchange the consumer information with health plans, state agencies, and federal agencies.

It will serve all stakeholders to reach agreement on data, document, security, and communications standards to make system-to-system interactions as efficient as possible.

What kinds of systems are States likely to need to enable important Exchange operational functions (e.g., eligibility determination, plan qualification, data reporting, payment flows, etc.), to ensure adequate accounting and tracking of spending, provide transparency to Exchange functions, and facilitate financial audits?



We recommend states be required to implement IT systems that can access and exchange data securely over the Internet. This will aid health plans, consumers and others in connecting with the Exchange at the lowest possible cost. We recommend state systems conform to standard communications protocols used widely in industry today.¹ In addition to the existing HIPAA transaction standards used to exchange administrative data, much work to develop common standards for the exchange of clinical data has been developed through the efforts of the Office of the National Coordinator for Health IT (ONC), the National Institute of Standards and Technology (NIST) and CMS. We recommend these same standards are also applied to the secure exchange of information within an Exchange-environment where appropriate.

What are the relative costs and considerations associated with building Exchange operational, financial, and/or IT systems off of existing systems, versus building new standalone Exchange IT systems?

As discussed above, building off of existing HIPAA standards will minimize administrative costs and increase efficiency. However, many states are burdened with outdated legacy IT systems that have high operational costs and may not lend themselves to providing consumer-friendly operations. If a state has legacy systems that have been used predominantly to meet specific internal state needs with little or no experience exchanging data externally, particularly with the commercial market, they will likely need to purchase a new system or modify the existing systems to meet Exchange data transmission requirements. A new system should be designed to interface with the other essential state systems or a centralized data warehouse which archives common data used by the various systems that support business operations. Ideally these interfaces could be automated, but some manual work may be needed.

If a state has a robust set of systems that are capable of exchanging large volumes of data over the Internet, much less investment will be required. Only a consumer portal that will enable the “Exchange” functions to take place will be needed. This would be much less costly and offer the state the greatest flexibility to offer a consumer Exchange portal that can complement and coexist with other state portal applications.

Another area that will require significant IT investments is customer service. It is critical that the customer service features are seamless to the consumer. This will require integration of the state health programs’ customer service functions (web, call center, in-person offices) as well as the development of ways to effectively hand-off consumers between Exchanges and plans.

Consideration must also be given to providing appropriate and secure linkages to health care spending accounts such as Health Savings Accounts and Health Reimbursement Arrangements that may be used in conjunction with an Exchange product.

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

¹ For example, Secure Multipurpose Internet Mail Extensions (MIME)/ Simple Mail Transfer Protocol (SMTP) /X.509 Digital Certificates, Simple Object Access Protocol (SOAP), Web Services Description Language (WSDL)/X.509 Digital Certificates and secure File Transfer Protocol (FTP)



State environment? For what kinds of functions would it make more sense for States to build their own systems, or modify existing systems?

There is a distinction between the specific vendor and IT solution that a state chooses to use and the utilization of national IT standards for the exchange of information to keep administrative costs low and enhance the consumer experience.

As stated previously, while we do not believe it is appropriate for the federal government to dictate to Exchanges what vendor or IT systems they use to implement their Exchange, all data transmissions between health plans and Exchanges should utilize common standards. This includes adopting 5010 HIPAA data transaction standards uniformly across states and repurposing those standards to meet certain operational elements whereby HIPAA transactions have not been contemplated to date. In addition, the Department should utilize common data definitions so that all stakeholders interfacing with the Exchanges have a common understanding of terms. The Department should also evaluate the need for uniform financial transaction standards with respect to Exchange operations and administration.

Each state requires unique IT solutions that meet the needs of enrollees transferring in and out of state-specific implementations of Medicaid, CHIP and other state programs. To fit varying state-level needs, the Department should (1) establish the technical data standards, technology infrastructure and security standards and operating rules for Exchanges mentioned above; (2) make available a reference implementation of core state Exchange functions in an IT software implementation under an open-source license; (3) provide grants for planning and implementation of required capabilities based on state readiness and/or needs; and (4) provide management assistance to ensure a minimum level of system functioning in all locations across the country.

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?

Review of premiums should continue to be at the state level and build upon the states' traditional role of regulating health insurance premiums. The Health Insurance Premium Review Grants distributed to states by the Department to help them strengthen their oversight capabilities and establish oversight programs recognizes the role that states play in this arena.

Several provisions in PPACA focus on the Department's and states' role in oversight of insurance premiums. These include the Medical Loss Ratio, the provision requiring insurers to provide an explanation to state regulators and the Department of the review of rates and grant funds for states to help create or further expand upon reporting and review processes.



State insurance regulators are uniquely aware of the link between actuarial soundness and solvency. Thus we urge that the existing state regulatory agencies be responsible for the review of rates in the Exchange environment.

Review of premiums should be tied to principles of actuarial soundness and solvency and should be considered in the context of new regulations including the MLR requirements and carried out by the existing regulatory agencies.

Subsection D. Qualified Health Plans (QHPs)

Exchanges should offer consistent and objective participation criteria to allow for meaningful and high value choices to consumers. Exchanges should supplement but not replace existing markets to ensure that consumers can keep the coverage they currently have. While PPACA establishes specific certification requirements for qualified plans to participate in the Exchange, there is no requirement that Exchanges must establish a “bidding”, “selective contracting” or other such system or process for plans to participate. To that end, the states nor the Department should establish a model that requires bidding by plans or a selective contracting process. The process by which plans are reviewed and approved to participate in the Exchange is a flexible area in which States must balance interest in ensuring that plans meet certain standards while at the same time preserving a robust marketplace that encourages choice and innovation.

In considering this issue it is also important to recognize that Exchanges are fundamentally designed around the concept of greater transparency and ease of comparison for consumers. These are powerful forces that benefit consumers, and give them the power to choose among competing coverage options that best meet their needs. Consequently, a key goal of the Exchange should be to ensure that a robust set of choices exist among which consumers have the option to choose. Approaches that provide too much discretion to an Exchange to selectively choose participants run the risk of undercutting this fundamental tenet.

In order to maximize health plan and product choice, Exchanges should establish clear, criteria for participation. Participation criteria as outlined by PPACA should be built upon existing state legal and regulatory standards to the extent possible and not based on subjective determinations by the states or Federal government.

One particular challenge in establishing the Exchanges is ensuring choices for individuals and small businesses purchasing coverage in the Exchanges. Thus it is important to keep in mind that any additional requirements, particularly subjective requirements, could undermine plan participation and result in loss of choice. This is the exact opposite effect that the reform law, in general, and the Exchanges, in particular, were intended to have.

Specifically, the criteria for selection of health plans that participate in the Exchange should be limited to the following:

1. The requirements as stated in Section 1311(c) of PPACA which include the following:



- a. Marketing practices;
 - b. Network adequacy (ensure a wide choice of providers);
 - c. Accreditation (e.g., clinical quality measures such as the HEDIS and CAHPS Survey and patient information programs);
 - d. Quality improvement strategies that incorporate a payment structure that provides increased reimbursement and other incentives;
 - e. Uniform enrollment forms;
 - f. Standardized format for presenting plan options;
 - g. Quality measures for health performance endorsed under the Public Health Services Act.
2. The existing requirements of the State Department of Insurance or other related agency in order for a health plan to receive a certificate of authority and be licensed and in good standing in that State. This includes meeting market conduct and financial examinations as conducted by the State, complying with State insurance laws and regulations and meeting financial and solvency standards.

If a plan is seen to meet both certification standards described above, then that plan may participate in the Exchange. By meeting such standards, a plan then meets the requirements as set forth by PPACA in Section 1311(e) and is operating “in the interests of qualified individuals and qualified employers in the State or States in which the Exchange operates.” Having the same set of certification standards ensures a level playing field among health plan participants.

It is important to provide individuals and small employers with a broad range of choices including access to Health Savings Accounts and Health Reimbursement Arrangements that are offered in conjunction with a qualified health plan. These savings accounts and qualified plans are affordable health care options for both individuals and small employers. By design, these products encourage individuals to become more engaged consumers or purchasers of health care – directly impacting the efficiency of the health care system and ultimately reducing costs. By ensuring the availability of these plans in the Exchanges, many of the basic tenets of health care reform are addressed including consumer responsibility, health care system efficiency, cost reduction and continuous access to coverage.

In all cases, sufficient time should be allowed in order to ensure that plans can adequately come into compliance with participation criteria. These criteria must be communicated well in advance of the January 1, 2014 operational date when Exchanges are scheduled to be fully functional. If standards and expectations are not clearly disseminated prior to January 1, 2012, states will be unable to demonstrate their readiness to operate Exchanges by the end of 2012 and plans will not be able to complete all implementation and testing in time for members to begin to sign up for coverage during any initial enrollment periods to be held in the late summer or early fall of 2013. It will be critical that the Department and states are very clear about the level and type of standards that will be required, what information will be required to be reported and the mechanism to appeal decisions. Health plans should be allowed to appeal any adverse decision to participate in an Exchange and the rules for doing so should be fair and clear, at a minimum the appeal decision should be made by a qualified and independent third party that was not a part of the original adverse decision. The states should provide an open and transparent process by



which these standards are determined to allow a robust conversation with all stakeholders who will be impacted by these standards including health plans.

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 State 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?

The criteria by which health plans participate in the Exchanges should not vary based on the type of Exchange (e.g., individual vs. SHOP Exchanges, subsidiary, regional or interstate Exchanges or Exchanges operated by the Federal government) and all plans should be held to the same certification criteria standards. The certification process for participation in different Exchanges should be separate, so that health plans have the ability to elect to participate in some or all Exchanges and offer a variety of different product options in different Exchanges. Having the same set of certification standards ensures a level playing field among health plan participants.

What issues need to be considered in establishing a sufficient choice of providers and providing information on the availability of providers?

As the Department considers whether a health plan has met network adequacy standards in Exchanges, we recommend that regulators look first to the states' specific network adequacy standards as enforced by the Department of Insurance or other applicable regulatory agency. To the extent a state does not have specific network adequacy standards, or an Exchange may function across state lines, the Department should look to the NAIC Managed Care Plan Network Adequacy Model Act as a standard. The purpose of the Model Act is to “establish standards for the creation and maintenance of networks by health carriers and assure the adequacy, accessibility and quality of health care services offered under a managed care plan...”

The Model Act requires that plans maintain a provider network that is “sufficient in numbers and types of providers to assure that all services to covered persons will be accessible without reasonable delay.”

Reasonable criteria that may be considered to determine an adequate network could include provider coverage ratios by specialty, geographic accessibility metrics, waiting times for appointments with participating providers, hours of operation and the volume of technological and specialty services available in an area.

For the delivery system to work optimally, all stakeholders should be required to comply with requirements that allow plans to effectively establish an adequate network for their enrollees. For example, essential community providers should not be exempt from requirements in health plan contracts that allow the plan to screen, credential and monitor the provider's practice, nor from requirements that the providers meet standards based on quality, service, and cost. Rather than impose a broad based requirement that plans contract with “any willing essential community provider,”, the Department should require that plans demonstrate that their networks can serve these traditionally uninsured and underserved communities in a culturally sensitive



manner that assures them appropriate access. Essential community providers should be subject to the same contract requirements as other providers. Plans should be able to exclude from their networks providers who cannot demonstrate quality health care delivery and meaningful access to enrollees.

The Department should establish standardized file formats for reporting network providers that will apply to Medicaid health plans and qualified health plans operating in the Exchange. Doing so will streamline administrative processes and help to contain costs.

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

In considering this question, there must be a distinction made between the Exchanges' marketing strategy and the qualified health plan's marketing strategy.

With respect to the Exchanges, each Exchange should establish its own marketing campaign (although that is not required under PPACA). In addition, an Exchange must operate a toll-free telephone hotline and maintain a website through which enrollees and prospective enrollees may obtain standardized, comparative information on their choices of qualified health plans.

Any marketing related activity through the Exchange should be reviewed and regulated by the Department of Insurance, or other appropriate regulator, in that State to ensure such activity is complying with the Unfair Trade Practices Act and in some cases, specific product laws and regulations that may apply to the individual and small group markets in the participating state.

Any marketing related activity conducted by a QHP in that state will be subject to existing state regulations to ensure that such activity complies with the Unfair Trade Practices Act and/or specific product laws or regulations that may apply to the individual, small group markets.

What factors are needed to facilitate participation of a "sufficient" mix of QHPs in the Exchanges to meet the needs of consumers?

Ensuring consistent and objective participation criteria through the Exchanges will allow for an environment whereby plans will compete to offer meaningful, high quality and high value plan choices to consumers.

Exchanges should supplement, but not replace, existing markets to ensure that consumers can keep the coverage they currently have. While PPACA establishes specific certification requirements for qualified plans to participate in the Exchange, there is no requirement that Exchanges must establish a "bidding," "selective contracting," or other such system for plans to participate. The process by which plans are reviewed and approved to participate in the Exchange is a flexible area in which states must balance interest in ensuring that plans meet certain standards while at the same time preserving a robust marketplace that encourages choice



and innovation. States should leverage existing licensing and participation rules and not create new/separate rules for Exchange participation.

What kinds of factors are likely to encourage or discourage competition among plans in the Exchanges based on price, quality, value, and other factors?

There are key elements that drive competition in the market: (1) marketplace information for consumers that allows both for a wide variety of products and useful comparisons of key features of those products, (i.e., so that it is clear what product is being offered and how the product scores based on price, quality, value); (2) allowance of entry for new market entrants, especially through insuring that Exchanges or other regulatory costs or processes do not set up unnecessary barriers to entry; (3) a marketplace in which competition and innovation is not artificially limited by bidding processes or other means to restrict participation; and (4) a level playing field among health plans.

What health plan standards and bidding processes would help to facilitate getting the best value for consumers and tax payers?

While PPACA establishes specific certification requirements for qualified plans to participate in the Exchange, there is no requirement that Exchanges must establish a “bidding” process or other such system for plans to participate. The process by which plans are reviewed and approved to participate in the Exchange is a flexible area in which states must balance interest in ensuring that plans meet certain standards while at the same time preserving a robust marketplace that encourages choice and innovation.

As stated previously, the criteria for selection of health plans that participate in the Exchange should be limited to the following:

1. The requirements as stated in Section 1311(c) of PPACA which include the following:
 - a. Marketing practices;
 - b. Network adequacy (ensure a wide choice of providers);
 - c. Accreditation (e.g., clinical quality measures such as the HEDIS and CAHPS Survey and patient information programs);
 - d. Quality improvement strategies that incorporate a payment structure that provides increased reimbursement and other incentives;
 - e. Uniform enrollment forms;
 - f. Standardized format for presenting plan options;
 - g. Quality measures for health performance endorsed under the Public Health Services Act.
2. The existing requirements of the State Department of Insurance or other related agency in order for a health plan to receive a certificate of authority and be licensed and in good standing in that State. This includes meeting market conduct and financial



examinations as conducted by the State, complying with State insurance laws and regulations and meeting financial and solvency standards.

If a plan is seen to meet both certification standards described above, then that plan may participate in the Exchange. By meeting such standards, a plan then meets the requirements as set forth by PPACA in Section 1311(e) and is operating “in the interests of qualified individuals and qualified employers in the State or States in which the Exchange operates”.

What factors are important in establishing minimum requirements for the actuarial value/level of coverage?

The actuarial value should be based on the benefits a member receives (e.g., list of services) and the coinsurance obligations to the member. The actuarial value should be assessed based on the gross benefit (not offset by subsidies, credits, etc.) and should not account for items which prove to be variable throughout the plan year (e.g., changes in provider networks and formulary modifications).

In addition, the Department should take into consideration the amount of employer contributions to a Health Savings Account in determining actuarial value as permitted by the PPACA. HSAs provide a source of tax favored funding for individuals to use to help pay for medical costs.

What are some important considerations related to establishing the program to offer loans or grants to foster the promotion of qualified nonprofit health plans under CO-OP plans?

As a general rule, nonprofit CO-OP plans should be subject to the same capital requirements as other plans to ensure market stability.

To what extent are states considering setting up State Basic Health Plans under Section 1331 of the Act?

AHIP supports the flexibility provided by PPACA for states to establish Basic Health Plan programs. These programs allow low-income beneficiaries to enroll in health plans that meet their unique needs while providing states with the option of creating a bridge for beneficiaries with incomes above Medicaid eligibility thresholds who may currently receive coverage in state-funded programs. Our members are interested in working with states that select this option to contribute to addressing any challenges that may be encountered in coordinating eligibility and enrollment between Basic Health Plans and Medicaid, CHIP and the Exchange.

Subsection E. Quality

Section 1311(c) of PPACA lays out specific certification criteria that plans must meet including quality improvement strategies and accreditation standards. There is also a plan rating system that takes into account measures for health plan performance.

For plans that meet the certification criteria (including those around quality improvement strategies and accreditation standards) and are licensed and in good standing with the state they



should be approved as qualified health plans. There are some health plans that may offer coverage through a variety of delegated contractual relationships, such as provider networks and accredited quality and credentialing organizations. Such plans may meet the minimum quality criteria for certification through such delegated arrangements so long as applicable accreditation requirements are satisfied.

Health insurance plans strongly agree that qualified health plans should meet core quality standards that are equitable across states to be able to participate in the Exchange and in all cases the standards should be set in such a way to facilitate the greatest amount of consumer choice and promote improvement and innovation.

What factors are most important for consideration in establishing standards for a plan rating system?

Health plans believe that a number of factors should be taken into account as a health plan rating system is developed. The following factors should be considered to help ensure that consumers receive useful, accurate and up-to-date information about health plan performance.

- **Measures.** Measures should reflect processes that plans can influence and impact, and address areas which are of interest to consumers. These areas include:
 - Patient experience/satisfaction;
 - Customer service;
 - Network adequacy;
 - Transparency of benefit design; and
 - Targeted consumer care programs (e.g., disease management or wellness and prevention programs).

Additionally, measures generally should be stable, and changed only in warranted situations, such as if there are evidence changes. Stability would allow for the reporting of performance trends over time as well as reduce inefficiencies that may result from excessive and burdensome data collection.

- **Allowance for appropriate adjustments.** The rating system should allow for appropriate adjustments based on geographic and other appropriate factors (e.g., enrollees in plans that operate in rural areas where fewer providers reside face longer travel times to access certain providers). Such adjustments would allow consumers to make more accurate comparisons.
- **Approach to ratings.** The rating system should reflect plans' performance in meeting certain thresholds as well as in making improvements.
- **Plan engagement.** Plans should be actively involved in the development of the rating system. Additionally, there should be a process by which plans can request review of their ratings and the opportunity to present information that supports what they may believe to be inaccurate results. Results determined to be inaccurate after the



reconsideration process should be corrected. This process would best ensure that consumers receive accurate information.

- ***Transition period.*** There should be an appropriate transition period for plans with multi-year provider contracts to implement measures.
- ***Ongoing evaluation.*** The rating system should be regularly evaluated to assess its effectiveness and any unintended consequences.
- ***Public and private sector alignment.*** To reduce confusion and promote coordination, all requirements and processes included under an Exchange rating system should be equitably applied across the health care sector.

How best can Exchanges help consumers understand the quality and cost implications of their plan choices?

Health plans strongly believe that consumers should have useful data to make more informed choices. We believe that the following factors should be considered for any reporting system to avoid confusion and best provide consumers with actionable information:

- ***Providing meaningful comparative information.*** Consumers should be given information that is based on a core set of measures to allow for “apples-to-apples” comparisons. Additionally, multiple benchmarks should be used to better help consumers distinguish between high and low performers.
- ***Providing an appropriate context.*** Information should be provided to frame the purpose of the rating information, and help guide consumers on how to use the information appropriately for its intended purpose. Additionally, information should be provided to educate consumers on possible reasons for differences in plan/product costs, such as differences in plan networks and benefit design (e.g., whether there are in- and out-of-network options).
- ***Providing information that is understandable.*** Information should be displayed in a format that is easily accessible and understandable. Combining related measures can help avoid confusing consumers. Additionally, information should be designed for the cultural context, decision context, and literacy levels of consumers.

Are the measures and standards that are being used to establish ratings for health plans in the Medicare Advantage program appropriate for rating qualified health plans in the Exchanges? Are there other State Medicaid or commercial models that could be considered?

For several key reasons, we do not believe that the measurement set and methodology used under the Medicare Advantage (MA) program would be appropriate for rating plans in the Exchange. First, a different measurement set will be needed given that there are significant differences in the characteristics of the MA population and the population selecting insurers through the



Exchange. Additionally, development of a rating mechanism for QHPs provides a unique opportunity to design a rating system that focuses not only on the intended goals of providing consumers with accurate and useful information so they can make more informed choices among available health plans, but also contributes to national goals for quality improvement. To achieve these goals, measures should meet a number of criteria, including that they be evidence-based, reflect consumers' health needs and the population being served, and capture a variety of areas including prevention, population health, management of chronic conditions, patient safety and care coordination. We believe that establishing a new rating system for use in the Exchanges offers the best opportunity to incorporate all of these critical elements.

It may be appropriate to have different rating thresholds for plans in the Exchange given that the rating system for the Exchange is being developed for a different purpose than the rating system for the MA program. The Exchange rating system is designed to help consumers assess choices and make more informed decisions, while the MA rating system is currently evolving so that it will eventually be used to determine whether a plan will receive a financial incentive.

How much flexibility is desirable with respect to establishing State-specific thresholds or quality requirements above the minimum Federal thresholds or quality requirements?

States that want to go beyond the minimum criteria established by the Secretary for QHPs should be required to demonstrate that they are achieving sufficient plan participation and offering meaningful choice to consumers. States may want to further additional goals related to improving access and quality for certain subpopulations served by the Exchange, or fostering plans sponsored by safety net providers or CO-Ops, but these goals must be balanced against the goals of sufficient plan participation, provider capacity, and consumer choice.

What are some minimum standards or other factors that could be considered with respect to establishing quality measurement and improvement thresholds or quality requirements that should be met by qualified health plans?

While health insurance plans strongly agree that qualified health plans should meet minimum quality standards to be able to participate in the Exchange, we believe the standards should be set in a manner to facilitate the greatest amount of consumer choice.

We believe the following factors should be considered as minimum standards are developed:

- Whether the health plan is conducting activities that align with the Triple Aim priority areas (improved population health, improved patient experience, and lower per capita costs) and/or the IOM's six dimensions of quality care (safe, effective, patient-centered, timely, efficient, equitable).
- That the health plan is focusing efforts on addressing: areas that impact a significant number of individuals, high costs, areas of wide variation or high utilization, and/or areas where improvement can be made.
- That the health plan is using techniques that positively impact clinician and member behavior.
- That the health plan is using the following measures:



- Measures that reflects consumers' health needs and the population being served;
- Measures that are reliable, valid and based on sound scientific evidence;
- Measures that are based on where there has been strong consensus among stakeholders and predictive of overall quality performance; and
- Measures that are developed, selected and implemented through a transparent process.
- Measures that capture prevention, population health, management of chronic conditions, patient safety and care coordination.

To ensure that all key stakeholders are aligned in their efforts to achieve quality improvement, physicians, hospitals and other providers should likewise be subject to similar standards.

We agree, as the statute sets forth in Section 1311(c)(1), that health plans participating in the Exchange should meet accreditation standards. Such standards capture performance in a wide range of areas that are of utmost interest to consumers, such as quality of care, patient experience of care, customer service, network adequacy, transparency of benefit design, and integration of services. In a large majority of states, health plans that have been accredited by nationally recognized organizations, such as NCQA or URAC, are deemed to meet certain quality requirements of the state. In states that have recognized accreditation processes through this deeming approach, we believe that the minimum standards to be able to participate in the Exchange should be those accreditation standards. The remaining states - without such a deeming process - should set the minimum standards for participating in the Exchange. These states should be encouraged to use accreditation standards set by nationally recognized organizations, such as NCQA or URAC.

We urge the agency to consider the possible consequences of including additional minimum quality standards above and beyond accreditation. First, additional standards will result in the possible disruption of current state efforts, given that many states grant deemed status to plans that meet accreditation standards. Second and even more critical, an excessive number of minimum standards may result in fewer choices for consumers, the exact opposite of what policymakers were aiming to achieve under this legislation.

What other strategies, including payment structures, could be used by plans to improve the practices of plan providers?

A variety of strategies are and could be (and often are) used by plans to improve the practices of plan providers. These include implementation of quality improvement programs, programs that reward provider performance, consumer incentives and innovative payment models (e.g., bundled payments, global payments, patient-centered medical homes, accountable care organizations) which provide incentives to physicians, hospitals, and other health care professionals to improve delivery of care.

To date, no one technique or model has been determined to be the most effective at improving patient outcomes and provider performance. Health plans are continuing to explore and pilot test a variety of techniques and models. We urge the agency to allow health plans the flexibility to



continue to innovate and develop strategies that are most effective in positively changing their network providers' behavior and that best meet the needs of their members.

Subsection F. An Exchange for Non-Electing States

States should be given all the necessary tools and resources to act on their own to be prepared to serve the needs of those accessing coverage through a state-based Exchange by January 1, 2014. To that end, the Federal government should do everything possible, including giving states adequate financial resources, to enable states to execute their own Exchanges.

States are best positioned to implement Exchanges for two critical reasons. First, the states have the existing regulatory infrastructure and deep technical experience through their Departments of Insurance, state Medicaid Office, Departments of Health and other key state-level and local agencies in order to successfully implement a health insurance Exchange. Second, each state's population has different needs and states are best positioned to understand how to best design an Exchange infrastructure that meets the core needs of their population and serves to deliver high value, high quality health care to consumers.

States that have not already done so should pass enabling legislation establishing a Commission or Committee to evaluate the core issues and options to develop an Exchange as required by PPACA. Any Commission or Committee established should include representation from a wide spectrum of key stakeholders including consumers, providers, health plans and employers. Based on that analysis, a state should consider the resources required to establish an Exchange that meets the specific needs of that population. We encourage states to consider key design issues including:

1. Governance and structure of an Exchange including consideration of the role of existing agencies
2. Exchange regulatory authority and avoidance of duplicative regulatory structures
3. Product choices and innovation
4. Plan participation criteria
5. Key portal functions
6. Data standards and operation considerations
7. Eligibility determinations
8. Outreach and member education

As states continue their conversations with respect to establishing Exchanges, the health plan community stands as a resource on key design and operational issues that are critical to long-term success.

With respect to determining whether a Federal Exchange is a needed option in a State, the Federal government should first evaluate whether a state is ready to meet the requirements as set forth in Section 1311(d) of PPACA.

If the Federal government determines that a state is unable to establish an Exchange based on the requirements set forth in Section 1311(d) of PPACA, HHS should then conduct a secondary evaluation of the state's activity to date, including reviewing the existing regulatory and legal



authority within that state, and issue a report indicating areas where the state has gaps in readiness to implement. This secondary evaluation should include recommendations to the state and additional resources if available to facilitate the state establishing its own Exchange. The timelines for states to act should be reasonable and fair given the scope of the law.

If after this secondary evaluation and time to implement, the Federal government still deems it necessary to establish a Federal Exchange, that Exchange should be designed within the scope of the law and not extend its regulatory authority beyond. Specifically, we recommend that in the case where a Federal Exchange is established, the following principles apply:

1. Exchanges should be established in a way to meet the goals of reform which include focusing on increasing access to affordable, high quality health care for all Americans. As policymakers at the state or federal level consider establishing an Exchange, these goals should be kept in mind;
2. Exchanges should enhance consumers' choice and product innovation in the market;
3. The regulation of Exchanges should be streamlined and transparent so as not to add confusion or increase costs to the system. The Federal government should consider ways to use existing resources at the state level, even if establishing a Federal Exchange in that state, in order to avoid a duplicative regulatory environment;
4. Mechanisms should be in place to mitigate risk selection; and
5. Plans should be afforded consistent and objective participation criteria through any Exchange that is created, including a Federal Exchange.

Subtitle G. Enrollment and Eligibility

The new law requires Medicaid to remain functionally distinct yet administratively linked to state Exchanges. Development of coordinated eligibility and enrollment systems to facilitate the application of individuals for subsidies and state programs raises numerous challenges, requiring states to devote significant resources to revamping their Medicaid eligibility and enrollment systems. Health plans support initiatives to ensure states are provided with adequate resources to perform these critical tasks.

**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?**

The implementation of the Exchanges coincides with the effective date of other major PPACA provisions, including insurance market reforms, premium subsidies, and the individual coverage requirement. These reforms are deeply interconnected and their long-term success hinges directly on ensuring that as many consumers as possible are obtaining coverage under the reformed health care system.

Because the enforcement mechanism for the coverage requirement is weak, it will be extremely important to establish structured enrollment periods and other strategies for the individual market



(both inside and outside of the Exchange) that encourage people to buy coverage during a specific timeframe and not wait until they are sick. Without such elements, some families may decide to wait until they experience medical problems to purchase coverage, thus increasing premiums for other families that do purchase coverage. These strategies will serve to promote the formation of a balanced risk pool that will be vital to the ability of all Americans to obtain affordable coverage on a sustainable basis.

It also will be important to evaluate other strategies to support the goals of encouraging those who are eligible to enroll. This effort should be accompanied by a multi-faced consumer education effort to bring all Americans into the reformed health care system. Components of this education effort should include making information on coverage options available through web sites, coordinating with agents and brokers, and reaching out to insurance departments and community-based organizations that provide outreach and educational services on insurance options. The open enrollment period for the first year may need to be longer to allow for the learning curve of consumers who will be assessing their benefit options based on eligibility. Any enrollment period should be accompanied with clear and transparent information about coverage options to ensure a consumer is given the resources to make a well-informed choice.

What are some key considerations associated with conducting online enrollment?

As previously discussed we would like to see a state adoption of national data transmission standards that build upon existing HIPAA standards. This would provide the highest level of consistency across all Exchanges ensuring a streamlined and cost-effective process.

Exchanges should allow flexibility in how enrollment data are transmitted. Small businesses should be able to upload enrollee data from various HR systems, spreadsheet software, compensation systems as well as direct data entry. Ease of use will drive early adoption and cause the least disruption for small businesses. For individuals the data entry requirements should be easy to understand and input. Online tools explaining data requirements and the enrollment/disenrollment process should be made available.

Health plans have tremendous experience with online enrollment tools and are a resource to the Department when developing any consumer-facing websites to ensure a positive member experience.

How can eligibility and enrollment be effectively coordinated between Medicaid, CHIP and Exchanges? How could eligibility systems be designed or adapted to accomplish this?

The challenges associated with establishing coordinated eligibility and enrollment systems that work accurately and efficiently for consumers are considerable, and the scope of the state efforts necessary to meet these challenges varies. For example, many states will need to establish new linkages with the Federal government for eligibility determination and verification and across existing health subsidy programs (e.g., Medicaid and separate CHIP programs in states that operate them). Several will be doing so from platforms that are paper-based or rely on operating systems that have not been modernized in many years.



However, some states have developed “Express Lane” eligibility systems that allow them to screen and enroll children in Medicaid and CHIP by relying on information submitted in applications for other public assistance programs, such as school free and reduced price meal programs and other food assistance programs (e.g. the Supplemental Nutrition Assistance Program), and by making greater use of electronic means to demonstrate eligibility. Express Lane eligibility systems provide a practical and effective model for states that have not yet established coordinated enrollment processes. Federal requirements should be structured to encourage state initiatives to integrate Exchanges with Express Lane eligibility systems where they exist, and the Federal government should broadly disseminate lessons learned from early implementation of these systems to allow other states to adopt them.

The Federal government can facilitate the development of new coordinated systems in several other ways. First, it can establish model information systems for enrollment and eligibility functions and program interfaces that are based on available HIPAA standards. Such models would permit states to adapt elements to their individual needs. Finally, in recognition of the magnitude of ongoing state resource challenges, the Federal government should provide assistance to states to ensure implementation efforts are adequately funded and essential enrollment and eligibility processes can be in place to serve consumers in 2014.

What steps can be taken to ease consumer navigation between the programs and ease administrative burden?

It will be important for consumers submitting applications through Exchanges to be well-informed about the choices in the new marketplace. The challenges of keeping low-income individuals well-informed are complicated because individuals currently access the Medicaid program through a variety of avenues, including county social service and health departments, State Social Service agencies, tribal governments and food assistance offices. It will be important for county and state workers to have access to the new standard application form and to be sufficiently knowledgeable about the Exchanges to assist and/or refer individuals for assistance (e.g., through Navigators) in taking advantage of Exchange options and subsidies. Call centers at the Exchanges and State Medicaid/CHIP programs should be closely coordinated to ensure applicants receive consistent answers to their questions.

Other steps may also be helpful to ease consumer navigation of the new system. Several state Medicaid programs have experimented with web portals, and HHS should gather and disseminate lessons learned from these experiences. The new Exchange Navigator should provide clear information about Medicaid and CHIP to ensure individuals applying through Exchanges are well informed about these programs. Also, many state Medicaid and CHIP managed care programs have effectively used enrollment brokers to enroll beneficiaries in Medicaid health plans. These enrollment brokers should be provided the knowledge base to allow them to be integrated into the new system.

Smooth transitioning of individuals between Medicaid, CHIP, and Exchange subsidy programs will be a key challenge once the Exchanges are established. The Federal government should work with consumer representatives, states, health plans, and other stakeholders to identify



challenges and options that should be considered as a strategy is developed to address this key issue. Initial Federal action could include widely disseminating successful processes established by states that have simplified the Medicaid and CHIP redetermination processes and developed outreach strategies that increase beneficiary reenrollment. States should also, to the extent possible, align redetermination periods for Medicaid, CHIP, and Exchange low-income subsidies.

What are the key considerations related to States using Exchange or Medicaid/CHIP application information to determine eligibility for all three programs?

The primary consideration is the use of model applications and systems that are HIPAA-based and have a core of standardized elements but that can be adapted by the states to include the information necessary to determine eligibility for the programs available in the states. For example, Medicaid applicants must commonly provide the information necessary to determine whether a spouse is current on child support obligations and individuals applying for state programs that do not rely solely on the new modified adjusted gross income (MAGI) standard may be required to provide asset information.

Another complicating factor in coordinating eligibility for the programs is the application and enforcement of the new MAGI standard. Medicaid programs generally base income determinations on more current income information than previous tax returns, and the statute is clear that states may continue to do so. However, the law also states that eligibility for low-income subsidies in the Exchange will be based on tax return data “for the taxable year ending with or within the second calendar year in which the plan year begins.” It will be important for Federal rules to make it clear that the opportunity for individuals applying for the Exchange subsidy to provide additional information if they do not file tax returns or their circumstances have changed since the applicable tax year can also facilitate eligibility determinations for state programs.

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

Many states do not currently have the linkages with the IRS or the Department of Homeland Security that will be required for Exchange operations or linkages among state programs that provide health care coverage. The Federal government can take a leading role in fostering the establishment of these linkages by developing information systems that facilitate interoperability with specified Federal databases and can be adapted by states to meet their unique needs. The Federal government should pursue these steps promptly to allow states to focus their efforts on any modifications to their existing systems that may be necessary to transmit and receive data from the Federal databases.

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



It will be critical that clear guidance is given to plans with respect to the process by which Exchanges will communicate to plans eligibility for individuals and small group tax credits and subsidies and ultimately what premium exhibits plans will be expected to return to the individual or groups (e.g., gross or net premium amounts) for billing purposes.

The payment of cost-sharing subsidies and tax credits to health plans from the US Treasury should be made prior to final billing to the individual with respect to cost-sharing amounts owed to the plan. This means that payment should be made promptly and efficiently, building upon data platforms (e.g., electronic funds transfer) that are compatible with existing plan infrastructure.

Subsection H. Outreach

Introduction

As market reforms take effect in 2014, it is important to ensure that the regulatory environment is structured and executed in such a way to ensure the long-term success of the system in order for it to work well for consumers. As a part of this, outreach efforts will be critical to ensure individuals and small businesses are brought into the market, which will include Exchanges.

We highlight here that the initial transition period after which subsidies are available will likely be particularly challenging for those individuals who already have coverage. Additionally, small employers will be faced with choices about how to continue or begin providing coverage to their employees. We suggest that this transition period receive careful attention designed to minimize confusion and disruption and to maximize stability.

Absent this, a segmented smaller and high risk portion of the population could end up entering the market both inside and outside of the Exchange. This can be minimized through a strong outreach effort that provides the following information:

1. First, consumers must have clear and meaningful information that allows them to compare benefits from one plan to another and;
2. Consumers must be able to understand cost-sharing in a way that allows them to understand the cost of coverage.

As states begin to build consumer-facing tools such as a web portal, it will be critical to consider that the information provided includes information about benefit options and cost-sharing is clear, meaningful and accurate to ensure the best consumer experience in shopping for a health plan.

As a fundamental principle, any outreach effort should ensure at its core that meaningful information is available to consumers in a way that helps them make accurate comparisons about their coverage options.



To ensure consumers have as many resources as possible to access coverage and cost information in Exchanges, individuals and small businesses should be able to access multiple information sources including Navigators, websites, state and county agencies, call-lines and brokers and agents. In addition to outreach at the beginning of the purchasing process, an Exchange should build on lessons learned from existing public programs to ensure that consumers not only become enrolled in a health plan, but stay enrolled. Outreach and enrollment efforts that have been successful in maintaining an individual's enrollment in public programs include presumptive eligibility determinations and fewer renewal requirements to provide consumers with a convenient mechanism to enroll and re-enroll in health coverage.

As an entirely new experience for many American consumers, the ease and convenience of the new health insurance Exchange should be demonstrated early and often in both the planning and implementation processes. The health plan community has demonstrated a strong commitment to increased transparency and believes that providing consumers with meaningful information needed to make well-informed comparisons between health plans is an important step to ensuring the long-term success of an Exchange.

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 and the federal government should seek to utilize existing means of connecting with individual consumers and small businesses, and broaden them to include new and innovative ways of reaching all segments of a state's population to help access insurance coverage. This could include traditional channels of access such as through the tax filing process and business registration and licensure procedures, Medicaid agencies, local Social Security agencies, county-level agencies, Departments of Health and Departments of Insurance, providers, and brokers and agents. States should also consider more non-traditional methods of reaching this population including marketing campaigns, public service announcements and social networking outreach to complement other web-based activity and web-based portals that will connect consumers to information to enhance the shopping experience.

With respect to Exchanges, HHS and other agencies such as the IRS and the Department of Labor should consider allocating sufficient funding to the states as a means of enhancing outreach efforts separate from investment and planning grants to establish Exchanges. Additional assistance to the states could be utilized in a number of ways, from mailings to direct outreach to a coordinated web portal that may pre-date an Exchange portal. For example, information about "what is an Exchange" and "link to your state's activity" could be added to the new federally sponsored portal for consumer information. It is important that consumers are brought into the Exchange with an understanding of what it can do for them, in addition to alternatives outside of the Exchange market, from a variety of different points of entry, in addition to outreach aimed at specific segments of the population.



Any outreach and education targeted to consumers should take into account ongoing work related to health literacy to understand the best tools and methods for communicating concepts to individuals and businesses. The health plan community has significant experience in assessing effective health literacy as a means to improve the overall experience and quality of care delivered to consumers and stands ready as a resource in this area. Success in the area of enhancing health literacy and building on the benefits it provides to consumers will largely come from involvement by stakeholders that have existing expertise in this area. Efforts to develop consumer information and tools for purchasing coverage in the Exchange should involve contributions from these individuals and entities with expertise in the area of outreach to segments of the population with low health literacy. Specifically, state departments of aging, departments of consumer and information, and those agencies responsible for administration of public health programs have expertise in this area that should be sought out and considered throughout the consumer outreach process.

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

To minimize the cost burden imposed upon states, funding should be allocated in a manner that acknowledges the importance of a multi-pronged outreach effort and the success of an Exchange as an access point to a multi-channel distribution effort that allows for information regarding all coverage options in the commercial market and public programs such as Medicaid and CHIP.

Navigators will serve as another channel by which consumers may access their coverage options. As Navigators have a unique statutory charge, we recommend the Department outline specific standards which should apply:

1. First, entities applying to be a Navigator should demonstrate a substantial amount of experience including seasoned staff in performing outreach and education in the major medical health insurance space.
2. Navigators should have the skills and knowledge to reach the uninsured population and populations not typically reached by traditional distribution channels.
3. Navigators should demonstrate working knowledge of health plan operations including enrollment functions.
4. Navigators should not be able to require fees from health plans or be reimbursed by providers or consumers for their services in order to remain impartial with respect to consumer choices.
5. Navigators should be impartial to health plans and providers.

A crucial aspect of the Navigator effort will be utilizing existing resources and points of contact as a means of connecting with consumers, particularly those hard to reach consumers, and minimizing the additional cost burden placed on the States. Navigators may also be well positioned to help consumers enter the appropriate information into the initial standardized application as required by PPACA. This could be a very labor intensive process and one in which Navigators could be extremely helpful.



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?

Individuals and small businesses may have limited knowledge about the new coverage options and channels such as Exchanges. Past efforts to enroll eligible individuals in public programs following eligibility expansion (e.g., Medicare part D) show the importance of states casting a broad net, and suggest that innovative as well as traditional touch points are vital to success. In Massachusetts, outreach efforts to publicize the importance and availability of coverage focused on the social importance of health care coverage, reaching consumers at not only existing points of public assistance but also at professional sporting events and social forums at which consumers regularly gather.

It will be important for those involved in outreach to help consumers access their coverage options, to draw on the expertise of those who have conducted such outreach in the past, and for there to be a mechanism for states to share their experiences.

Within the Exchange environment, when an individual is identified through the standard application as qualified for tax credits and/or cost-sharing reductions, the Exchange must be nimble in bringing together various resources for consumers to find access to coverage. We recommend that the Department consider making available funding to support a federal and state led direct marketing campaign (“It’s Easy”) to explain the tax credit, and referring individuals to “their state’s Exchange” should also emphasize the potential value of the tax credit program in obtaining coverage. Any ongoing educational marketing should be run through the Exchange using various resources to reach consumers and small businesses including electronic and paper-based materials.

Subsection I. Rating Areas

When establishing premium rating standards, states have accepted the use of geographic rating factors as a normative standard in health insurance premium rate calculations. Geographic variations in cost are also recognized in the Medicare fee schedules and the Medicare Advantage payment system.

The variation seen in health care costs based on geography necessitates the need for area factor analysis. Geographic area rating factors typically reflect variables that drive geographic differences in health care costs including variation in practice patterns, variability in provider pricing and utilization patterns. For instance, provider prices are often higher in urban areas than in rural areas, due to differences in wages and operating costs.

Geographic area factor analysis generally requires a significant volume of information by the health plan to ascertain variation in health care costs by geography and that information is often reviewed by state regulators in rate filings. Generally, the requirement is upon the insurer to demonstrate the validity of their area rate factors.



It will be critical that current state rules are used for determining rating areas whether inside or outside an Exchange or Co-Op and that they are applied uniformly across all markets.

Subsection J. Consumer Experience

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? What kinds of enrollment venues are likely to be most helpful in facilitating individual enrollment in Exchanges and QHPs?

Any websites that are developed by the states to help consumers understand their coverage options should be simple and intuitive guide the consumer to the available options, including the options made available in the commercial market and in public programs such as CHIP and Medicaid. Once consumers choose an option, they should be linked seamlessly to plan websites containing carefully crafted tools that ensure simple and meaningful information is available to guide them through the enrollment process, understand cost-sharing, and all of the innovative tools at their disposal including, for instance, the availability of disease management programs.

As states think about the best way to direct consumers to explore their coverage options, design features should envision an application for “kiosks” that could be placed in public libraries, public health centers, and other sponsor locations, such as community colleges, for “information hubs” with public terminals or – “health exchange kiosks” where such information could be made available. The long-term success of an Exchange will rely on its ability to reach consumers in innovative and unique ways. While a portion of individuals and small businesses will access information and coverage options through electronic means such as an Exchange portal, it is important to address subsections of the population lacking access to online resources or facing other significant burdens to enrollment.

Consumers should be provided through Exchanges the ability to compare benefits among plans and access cost-sharing information in a simplified manner permitting them to weigh benefits of plans that have higher deductibles versus those with higher co-payments and lower deductibles. While information pertaining to plan premium is an important consideration when making choices regarding health coverage, consumers should have access to tools permitting them to see the full, accurate cost of health coverage, including co-payments and cost sharing features in addition to premium rates.

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)?

This will depend on the governance of the Exchange. If the complaints are related to functions of the Exchange itself, such as the Exchange’s speed of response, utility to groups or applicants,



etc., such complaints should be made public, listed on the Exchange website, with responses and reported to the appropriate state agency (e.g., DOI).

If the Exchange has operations managed by the state's insurance department, such complaints should be managed through the consumer complaints division, and tracked via the state's department of insurance.

If the complaints are with regard to the insurance policies sold through the Exchange, such complaints should go through the existing state's complaint database (NAIC) and tracked and reported that way. If the Exchange is fully separate from the state's insurance department, this would result in duplicative and redundant agency activity.

In all cases, the consumer complaint process with respect to Exchanges should be handled by the state.

Subsection K. Employer Participation

At its core, the Exchanges established in the market should serve as an additional distribution channel for employers to access when seeking coverage for their employees. A central objective related to the design of an Exchange should be to ensure stability in the employer-based system so that consumers continue to have access to the coverage options they have today, whether inside or outside of the Exchange. Policy decisions should be carefully considered regarding any incentive that could destabilize the employer market. Policymakers must carefully weigh issues relating to the operation and interplay of penalties, enrollment rules, the level of and availability of subsidies, cost of coverage and the array of benefit design options. As employers consider whether to offer coverage through the Exchange, all of these issues will come into play.

PPACA provides a great amount of deference to the states when determining the role of and standards for employer participation in an Exchange. When addressing critical issues such as employer group size permitted to participate through the Exchange, whether to merge the individual Exchange with the SHOP Exchange, and how to best facilitate coverage choices among individual employees, it is important to consider the role of employers in encouraging a competitive, diverse marketplace. An Exchange should address questions relating to employer participation by seeking to maximize innovative market choices and ensure transparency of information. Doing so will ensure that the process of providing health coverage to employees is as seamless and convenient as possible, further motivating employers to provide health care coverage.

What design features are likely to be most important for employer participation, including the participation of large employers in the future? What are some relevant best practices?

Exchanges will serve as one distribution channel among many for employers and individuals to access major medical coverage. There are several design features to be carefully considered by policy makers when designing Exchanges to ensure the stability of the employer-based system is



maintained. As a part of this, each design feature must be considered in the context of their interaction with other design features, and not in isolation.

In all cases, it is important to recognize the distinctions in the employer market with respect to the way in which employers offer major medical coverage (self-insured versus fully insured arrangements) and the size of the employer (small versus large group). Employers considering whether to participate in the Exchanges will be weighing the economic implications of the policy environment including what changes in coverage mean with respect to the distribution of risk for their covered population.

Choice and innovation in the market. To a large degree, employers have a great influence on the level of choices and innovation in the market today. As policymakers consider key issues that will influence employer's decisions to offer coverage, allowing for benefit variation inside and outside the Exchange will be critical. By way of example, the most recent AHIP small group survey found that among employees with small group coverage, 50 percent had a PPO plan in 2008, with both in-network and out-of-network benefits, 41 percent had health maintenance organization coverage and 7 percent had a health savings account benefit, with a qualifying high-deductible health plan. Of employees surveyed, 9 percent had a choice of two or more benefit plans.²

Employers should have access to a wide range of coverage options within an Exchange. Employers will continue to want to tailor their benefit packages to meet their employee population's needs and Exchanges should be established in such a way to ensure the greatest flexibility. This means encouraging Exchanges to permit a high level of product differentiation and options offered by participating health plans.

Operational efficiency. It will be important to consider developing an operational framework that ensures efficient and streamlined administration. Employers will have an interest that to the degree feasible, transactions are simple and non-duplicative with interactions they have with their health plans.

Merger of the markets. The law allows for states to require individual and small group insurance markets within a state to be merged if the state determines that merger appropriate. When considering whether to merge the markets, states should carefully consider the impact that merging of the markets will have on the cost of coverage to individuals and employers. Several states have examined this issue including Vermont, Oregon and Massachusetts. A study conducted on behalf of the Vermont Health Care Commission found that a merged market would most likely not lower average premiums appreciably and would not have a material impact on the number of uninsured residents in the state. Additionally, the report concluded that a merger could be very disruptive causing a large increase for some individuals buying insurance with significant adverse selection possible between the group and individual markets.³

² <http://www.ahipresearch.org/pdfs/smallgroupsurvey.pdf>

³ <http://www.leg.state.vt.us/CommissiononHealthCareReform/VT%20Merger%20Final%20Report%201-09.pdf>



States should be cautious in considering the potential disruption and increase in premiums possible when merging the small group and individual markets. Any effort to do so should ensure that the phase-in occurs over the appropriate time period to allow study of the issue and evaluation of its impact.

What factors are important for consideration in determining the employer size limit (e.g., 50 versus 100) for participation in a given State's Exchange?

States should consider carefully the implications of expanding the group size limit beyond 50 for purposes of determining the size of employer groups eligible to access the Exchange, and determine whether the Exchange is an appropriate channel for larger employers to access coverage in the market. Issues of transition are also very important, such that allowing larger groups (such as those above 50 into the Exchange prior to 2016) could prove disruptive - - especially taking into account that the establishment of a network of Exchanges has never been attempted before.

In addition, the large employer market may have very different products that are tailored to a larger employee base. In order to preserve stability in the market today, it is crucial that states take a measured and cautious approach to expanding the group size limit in order to preserve stability and choices in the market as they exist today.

A cautious approach to allowing larger groups into the Exchange will also allow greater experience and lessons to be learned. Consequently, states should be encouraged to conduct a study or engage a demonstration pilot to assess the impact of allowing groups beyond 50 to access the Exchange prior to 2016. Likewise, the decision by states to allow larger groups beyond 50 into the Exchange beginning in 2017 should also be undertaken very carefully and should fully incorporate lessons learned from earlier years in order to avoid unintended consequences that risk destabilizing existing coverage and disrupting coverage available in the Exchange itself.

Subsection L. Risk Adjustment, Reinsurance and Risk Corridors

PPACA provides for tools that are intended to mitigate risk between qualified health plans both inside and outside of the Exchange market. In all cases, we recommend that the Department help develop best practices for the states to consider when developing these tools. It will be important for the Department and the states to work with key stakeholders to develop accurate methodologies recognizing the complexity of the information that is required to ensure accuracy and predictability for all of these mechanisms and their inter-relationship to each other.

As a general matter it is important that these programs and mechanisms be implemented in a way that recognizes how they impact the implementation of other provisions in the statute and vice versa. In addition, while the combination of risk adjustment, reinsurance and risk corridors is, for example, found in the Medicare Part D program, it is very important that differences in the design, structure and purchase of commercial coverage be taken into account when implementing these programs outside the Medicare program and for non-Medicare populations.



While the Department is required to consult with the NAIC on developing a reinsurance program, we recommend the Department consult with other key stakeholders including the American Academy of Actuaries and health plans on a broad basis to provide technical and policy input with respect to risk mechanisms including reinsurance to ensure these mechanisms are established in such a way that is fiscally prudent and effective.

The following provides some issues for consideration as policymakers think about developing these programs.

Risk Adjustment. Risk adjustment is designed in PPACA to address adverse selection between plans inside and outside of the Exchange market. This differs from mechanisms (such as the temporary reinsurance program) that attempt to address adverse selection against a market including an Exchange.

When considering the design of a risk adjustor, policymakers should consider the following:

1. Opportunities for stakeholder input to help evaluate alternative methodologies;
2. The accuracy of a model in predicting the likely spending levels for groups of enrollees;
3. Administrative feasibility;
4. Costs and potential benefits of data required;
5. Complexity of initial implementation and the data needed to start the program;
6. Required frequency of updates;
7. Lead time necessary to implement appropriate data collection techniques; and
8. Interplay of risk adjustment with other provisions in the statute, including but not limited to the transitional reinsurance and risk corridor provisions.

Key questions to address are likely to include: 1) what level of data is required to ensure an accurate risk adjustor (e.g., diagnosis/procedure/place of service-level data), 2) how these data are then transmitted between the health plan and the entity managing the risk adjustment process and how often the transmission process occurs and 3) what, if any, will a final plan year settlement process look like and how will this impact other reporting requirements (e.g., those relating to the MLR).

Policymakers must also consider whether a prospective or retrospective risk adjustment method is the right approach, what the tradeoffs are in terms of the level of data and administrative complexity required to implement each approach, and consider whether these methods will garner confidence of payers when pricing coverage in order to facilitate stability in the market.

Reinsurance. Reinsurance is designed in the law as a three-year transitional program under which health insurers and third party administrators make payments to a non-profit reinsurance entity in order to support the coverage of high risk individuals in the individual market. This is intended as a temporary mechanism to help mitigate the cost impact to individuals during the transition to the 2014 market reforms.

Risk Corridors. The statute is very general in describing the operation of this program. It is important that when implementing this provision that significant attention be paid to the



interplay of this provision with other provisions in the statute. This includes both the risk adjustment and reinsurance provisions, but also extends to other provisions such as those relating to medical loss ratios. In this regard, it is important that potential sources of overlap and redundancy be carefully considered in order to avoid unintended consequences in implementation.

To what extent do States and other entities currently risk-adjust payments for health insurance coverage in order to counter adverse selection? In what markets (e.g., Medicaid, CHIP, government employee plans, etc.) are these risk adjustment activities currently performed? To the extent that risk adjustment is or has been used, what methods have been utilized, and what are the pros and cons of such methods?

States interest in, and use of, risk adjustment as an element of payment systems for Medicaid health plans has been increasing in recent years. Experience with these systems raises several issues that are likely to be relevant to design decisions for risk adjustment that will be used by the Exchanges. One threshold issue is the role of the Federal government in providing guidance to states on this issue. We recommend the Department consult with other key stakeholders including the American Academy of Actuaries and health plans on a broad basis to provide technical and policy “best practices” to states with respect to risk mechanisms including reinsurance to ensure these mechanisms are established in such a way that is fiscally prudent and effective.

Also relevant is that Medicaid managed care risk adjustment systems generally depend upon retrospective diagnosis data to project health care costs for the individuals who will be enrolled in Medicaid health plans in the upcoming year in order to establish plan-level adjustment factors. Many individuals who enroll in Exchange plans in 2014 will be previously uninsured, so there may not be a diagnosis or claims history that can be used to predict their anticipated costs of care. Potential elements of a strategy to address this issue may include risk corridors, phasing-in risk adjustment implementation, and other strategies. In addition, to the extent that diagnosis data are available, it is typically necessary to establish a data stream prior to implementation of a risk adjustment methodology. Preferably, this step generates twelve months of data as a basis for determining initial risk factors, but clearly, it will not be possible to begin data collection until the Exchanges are implemented in 2014. Other related issues States and Medicaid health plans have confronted in the development of Medicaid risk adjustment have included decisions about the length of the time lag between the data year on which prospective estimates are based and the payment year, the data elements that will be collected, systems development for the data transmission, the data validation process, and selection of the methodology for calculating risk scores. It will be critical to address these issues to arrive at a sufficiently accurate methodology that is not overly administratively burdensome for Exchanges and plans.

An additional consideration is that the effectiveness of Medicaid risk adjustment is affected by the lack of stability in beneficiary Medicaid eligibility and the corresponding lack of stability in Medicaid health plan enrollment. To the extent that consumers may move in and out of Exchange coverage (e.g., movement between subsidized Exchange coverage and Medicaid coverage) this factor will need to be taken into account. Consultation with key stakeholders will be essential to address this issue as well, particularly in the absence of past experience as a basis



for estimating the magnitude of this issue and its impact during in the initial years of Exchange operation.

Subsection M. Comments Regarding Economic Analysis, Paperwork Reduction Act, and Regulatory Flexibility Act

It is critical for the Department to undertake and make public an analysis of the economic impact of any Exchange rules subject to the requirements of the Regulatory Flexibility Act, Paperwork Reduction Act, Executive Orders, and other statutory provisions applicable to rulemaking. As noted, the Exchanges are being developed in the context of overall PPACA changes to the insurance market and it is important for all stakeholders to understand the collective effects of those changes. An accurate estimate of the costs and economic impacts associated with implementation provides public and private stakeholders with a better understanding of how the rules will affect the market and the scope of operational and administrative changes that are needed to implement the Exchange framework. As part of this analysis, the Department should share any internal analysis it has done or is undertaking that will serve as the basis of the impact statements published in any Notice of Proposed Rulemaking and Final Rule.

What policies, procedures, or practices of plans, employers and States may be impacted by the Exchange related provisions in Title I of the Affordable Care Act?

Health plans will need to develop and deploy administrative and operational systems to comply with Exchange participation requirements, including data transmission requirements, marketing and consumer interface processes, and product designs. Employers that choose to provide coverage through exchanges will be expected to maintain financial and compliance tracking systems and interfaces with the Exchange and state and federal agencies. States will need to create systems to administer Exchanges and related coverage options (e.g., Medicaid and CHIP).

It is also important that any economic analysis of the Exchange-related provisions take into account the overall market reforms that have been instituted to date and will be implemented in 2014. For example, employers can be expected to determine the costs and benefits of directly offering coverage to their employees or choosing the alternative of providing coverage through an Exchange. This decision will in turn impact the costs and administrative complexity of the Exchange as well as the costs and complexity of coverage offered to consumers and employers outside of an Exchange.

What direct or indirect costs and benefits would result?

Plans, employers and states could be expected to incur a number of costs in the development and operation of Exchanges, including the following:

Health Plans

- Creation of information technology and other systems to interface with Exchanges and state and federal agencies (e.g., IRS).



- Development of marketing and consumer outreach activities.
- Legal, actuarial, compliance and other activities for creation and maintenance of Exchange benefit options.
- Costs assessed for supporting Exchange operations.
- Reinsurance and risk corridor impacts.
- Impact on overall cost of coverage (e.g., cost of essential benefit packages and coverage options whether inside or outside of the Exchange).

Employers

- Development of administrative, compliance and technology systems to provide coverage through Exchange (e.g., tracking and making premium payments).
- Payment of subsidies and responsibility payments.
- Reinsurance and risk corridor impacts.
- Impact on overall cost of coverage (e.g., cost of essential benefit packages and coverage options whether inside or outside of the Exchange).

States

- Development and operation of Exchanges.
- Impact on state health coverage programs (e.g., Medicaid, CHIP, community health centers).
- Creation of IT and administrative systems to interface with consumers, employers and state and federal agencies (e.g., IRS).