October 4, 2010

Jay Angoff, Director
Office of Consumer Information and Insurance Oversight
United States Department of Health and Human Services
Attention: OCIIO-9989-NC
P.O. Box 8010
Baltimore, MD 21244–1850.

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

Dear Mr. Angoff:

Thank you for requesting comments on the design of state-based Exchanges consistent with the provisions of the Affordable Care Act (ACA). Community Catalyst (CC) is a national advocacy organization that has been giving consumers a voice in health care reform for more than a decade. CC provides leadership and support to state and local consumer organizations, policymakers and foundations that are working to guarantee access to high-quality, affordable health care and health coverage for everyone. Health Care for All (HCFA) seeks to create a consumer-centered health care system that provides comprehensive, affordable, accessible, culturally competent, high quality care and consumer education for everyone, especially the most vulnerable. We work to achieve this as leaders in public policy, advocacy, education and service to consumers in Massachusetts.

HCFA and CC have worked closely with the Massachusetts Health Connector (Connector) and have formulated lessons learned from these experiences. In addition, CC works closely with consumer advocates in states across the country, which provides us with insight into the challenges of creating Exchanges in many different political environments. We appreciate the opportunity to provide our comments on Exchanges to the United States Department of Health and Human Services (HHS) and hope that this is the beginning of a process of working with other stakeholders to develop strong policy on Exchanges.

A. State Exchange Planning and Establishment Grants

2. To what extent have States already begun to plan for establishment of Exchanges? What kinds of activities are currently underway (e.g., legislative, regulatory, etc.)?What internal and/or external entities are involved, or will likely be involved in this planning process?

Many states have begun developing plans and creating commissions to design Exchanges. However, most states do not have a formal, meaningful role for consumers or advocates representing consumers. We recommend that the renewal of Exchange grants to states be conditional on demonstrating formal participation by consumer advocates. In fact, the ACA specifically grants HHS the authority to establish benchmarks or criteria — such as consumer representation — as a condition of grant renewal.[1]

In addition, decision makers on any formal Exchange design process should be free of conflicts of interests and not have a direct financial stake in the health system. Organizations and individuals representing hospitals, physicians, insurers, and brokers may be able to participate in an advisory capacity, but ought not have any formal decision-making authority in the state Exchange design processes (e.g., these organizations and individuals should have a vote in any process to finalize policy choices).

2.a. What kinds of governance structures, rules or processes have States established or are they 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.)?

Meaningful consumer involvement is critical in design and governance of Exchanges. States may choose to operate Exchanges as an arm of state government, through quasi-governmental or contracted entities, or in regional collaboratives. In any case, the structure should provide for a strong consumer voice in decision-making and exclude representatives with conflicts of interest. Those involved with governance should also include key stakeholder-beneficiaries such as labor and small business but should exclude those with conflicts of interests because they have a direct financial stake in the health system. This includes organizations and individuals representing hospitals, physicians, insurers and brokers.

A good model is the Connector, which has been governed by an independent board that includes four state officials (representing the Executive Office for Administration and Finance (responsible for the state budget), Medicaid, Division of Insurance and Group Insurance Commission (responsible for health insurance state employees)), and six citizens. Three of the citizen members are chosen for their expertise—an actuary, health economist, and benefits specialist—and three are chosen as representative of primary stakeholders—consumers, labor, and small business. The diverse group provides balanced policy guidance to the Exchange, and debates are focused on finding pragmatic consensus solutions to challenges. By excluding representatives of the health industry, Connector decisions have been insulated from conflicts of interest and gained wide acceptance as being in the best interests of the state.

3. What are some of the major factors that States are likely to consider in determining how to structure their Exchanges (e.g., separate or combined individual Exchanges and

[1] Patient Protection and Affordable Care Act (THE ACA), § 1311(a)(4)(A)(ii).

SHOP Exchanges; regional or interstate Exchanges; subsidiary Exchanges, State agency versus nonprofit entity)? What are the pros and cons of these various options?

In deciding whether to run one or more Exchange and what legal structure to use for an Exchange, states will consider whether they are going to merge small group and individual markets, the administrative costs of operating more than one exchange, regional difference in markets, what the appropriate balance between accountability and flexibility. In general, separating Exchanges adds administrative cost and duplicates functions without providing commensurate benefit.

An Exchange can only hold down insurer costs and move the system to offering plans with greater value and quality if it has sufficient market authority — and to have this, the Exchange needs to cover a significant share of people. It's important to broaden, and not carve up, insurance markets to provide Exchanges with enough covered lives to be able to negotiate good prices and coverage with insurers. This is a reason to combine individual and Small Business Health Care Options Program (SHOP) Exchanges.

For example, the Connector operates a combined Exchange for both individual and small group plans. The combined market was seen as an attractive business opportunity for all of the major insurers in the state, and they all bid to be included in the Exchange. By conditioning its seal of approval to plans that met its quality and value standards, the Connector was able to incentivize plans to focus their efforts on improving consumer value. The size of the market assured plans that sufficient lives would be available, and minimized the opportunity for adverse selection between plans offered in and out of the Exchange.

In principle, operating Exchanges across states would provide additional benefits, however, a concern with regional or interstate Exchanges is retaining adequate standards for insurers across state lines, where it may be unclear which entity (or state) has regulatory authority. An additional complication is the need for a single Exchange to interface with two or more Medicaid and CHIP programs (This last problem could be attenuated, though not eliminated, if HHS established a single national IT protocol for enrollment). As a practical matter, it may not be possible for states to work out all of the accountability issues, market differences, and Medicaid and CHIP interface issues to make cross-state Exchanges feasible for a 2014 start.

B. Implementation Timeframes and Considerations

2. 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?

In general, a list of FAQs and/or best practices could provide guidance to states as they navigate the challenges of developing an Exchange that serves consumers best. This list could be culled from the successful and unsuccessful experience in other states and provided back to states by HHS as a guiding document.

More specifically, states need to consider how they will choose adequate health plans for individuals and small businesses. HHS could provide states with greater information on the rating system for health plans and what the state's role will be in implementing and enforcing this rating system (e.g., will a state be able to create a stronger rating system than defined by HHS?). Additionally, HHS could provide clarity to states about the state's ability to negotiate with health plans and exclude certain health plans that do not meet value or quality standards.

Finally, additional information about how the federal fallback Exchange will operate would also be useful as would more clarity about what is expected of insurers in the Exchange in pushing the system toward quality, value and the elimination of disparities.

C. State Exchange Operations

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

Affordability

One of the biggest challenges of state Exchanges will be to maintain overall affordability over time. To do this, the Exchange should act as an active purchaser; limiting participation, to the extent permitted by HHS, to plans that offer the best value — meaning the best combination of price and quality. Specifically, the Exchange should consider factors such as rates and rate increases, Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) scores, and implementation of payment mechanisms to reduce medical errors and preventable hospitalizations, reduce disparities and improve language access. Value-based purchasing that provides the maximum value for consumers consistent with limits defined by HHS should also be considered provided that cost-sharing does not create barriers to treatment for lower-income enrollees.

As stated by the sponsor of the "active purchaser" language during the Senate debate on the ACA, Senator John Kerry (D-MA) said: "One of the key ingredients to the success of health reform in Massachusetts is the ability of the Connector to negotiate with health plans. This negotiation process saves 6 percent off the cost of premiums and places pressure on insurers to keep rate increases low overall. Empowering Exchanges to engage in active purchasing would lower premiums for all enrollees in the Exchange, as well as, lower the amount of subsidy paid by the federal government."[2]

In addition, all insurers should contribute to its operations even if some insurers are allowed to operate outside of the Exchange. This will ensure that any plans that operate outside of the Exchange do not gain a competitive advantage from doing so. Logistically, funding an Exchange is easily accomplished through administrative fees charged on the policies sold by each insurer. The Exchange will be sustainable so long as this fee is fair

[2] Kerry, J. F. (2009, November 13). Letter to Majority Leader Harry Reid. Retrieved from http://kerry.senate.gov/press/release/?id=717f01f6-8cc3-4c56-97c5-a278c8f8b54b.

and offers a good balance between providing value to the consumer and paying for the operational expenses of the Exchange. A planning grant can assist a state in determining the best way to structure this funding mechanism.

Adverse Selection

It will be critical for states to reduce adverse selection by keeping similar insurance rules in and out of the Exchange. Ideally at a minimum, the entire individual market would run through the Exchange. But, since the ACA creates a class of people who cannot, even with their own money, buy a privately supplied product through the Exchange, this path should not be taken at this time. Instead several steps should be taken to guard against adverse selection in the Exchange, beyond what is already in the ACA.

One step would be to not allow the lowest tiers of coverage to be sold outside the Exchange except by insurers that also sell the same plan for the same price in the Exchange. This would prevent insurers that do not operate in the Exchange from trying to attract healthier risk with low-benefit options. For example, in Massachusetts, the lowest level plan available on the market is a bronze and this is sold at the same rate inside and outside the Connector. In addition, the state should require plans sold outside the Exchange to adhere to all the same rules with regard to benefits, cost-sharing and patient protections as plans within the Exchange. Other measures that can help limit adverse selection include prohibiting brokers from steering enrollees to particular plans inside or outside the Exchange (if brokers are allowed in the Exchange at all), establishing annual open enrollment periods, designing and implementing a practical and accurate risk adjustment system, the temporary reinsurance and risk corridor programs required by ACA, and the ACA requirement that plans pool risk inside and outside the Exchanges.

Ease of Enrollment

Exchanges should also consider ways to make information and enrollment easier for consumers — including creating standardized plans (and possibly grouping plans by criteria beyond actuarial value for apples to apples comparisons). Over the past four years, the Connector has offered a variety of plans and sought to simplify the choices so consumers could understand the significance of a deductible plan versus one with co-insurance. Consumer focus groups have prompted many of the changes and proved invaluable in finding what was best for this market. Navigators, especially those run by community-based groups with experience working with uninsured and vulnerable populations, will also be important in aiding consumers with the new health system.

Integration with Medicaid and CHIP

Finally, integration between the Exchange and Medicaid and CHIP is critical. Exchanges are not just a marketplace for insurance but are the key entities facilitating access to subsidies for most of its participants. This is because the majority of Exchange enrollees will be accessing subsidized coverage and so it absolutely essential to have a seamless integration with Medicaid and CHIP not only at initial eligibility determination but also

as people's circumstances change. Many people will move between Medicaid and CHIP and the Exchange plans as their incomes fluctuate. The Exchanges and Medicaid and CHIP must develop systems that make it easy for people to retain their coverage through transitions. Massachusetts has found that there is significant income fluctuation with certain categories of workers like seasonal workers and those with sporadic work. The state altered its application to reflect the unique challenges presented by these workers so people were not unnecessarily moved on and off of coverage. Massachusetts studied the affect of income fluctuation on individuals and found that the overwhelming majority of individuals were eligible for coverage within two to three months of losing coverage.[3] There is significant administrative burden to a state to disenroll and re-enroll individuals, which should be evaluated as the enrollment systems are created.

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

We support strong federal standards for Exchanges that act as a floor — with states able to exceed federal regulation in all areas to enhance consumer protections. States are likely to look for flexibility in choosing health plans and rating these plans within the Exchange. Also, states have the option to create a Basic Health Program (BHP), a coordinated plan for people below 200 percent federal poverty level (FPL), and will likely seek flexibility in plan design.

For instance, a state may want to encourage insurers who operate Medicaid managed care organizations (MCOs) to participate in this plan given their experience with serving this population. These insurers may not offer individual plans or small group plans. The state should have the flexibility to permit these insurers to participate in part of the Exchange. Additionally, even if a state chooses not to operate a BHP, it should have the flexibility to allow some group of plans (e.g., Medicaid MCOs) to sell only to those below a certain FPL (e.g., 200 percent or 300 percent). This type of flexibility is important because a state's experience with particular subsets of insurers may strongly suggest that some are better suited than others to the meet needs of low-income populations.

5. What are the considerations for States as they develop web portals for the Exchanges?

State Exchanges should provide easy-to-understand information about health plans that helps people make informed choices about their coverage, and the web portal should facilitate easy comparisons. The web portal should create greater administrative ease in purchasing insurance through transparent information, and allow for "one-stop shopping" for consumers. It should consider language access and consumers with low literacy levels. The portal should be translated into major languages, have "babble fish" notice, and directions for free help. Finally, the portal should be focus group tested to ensure it is the most consumer-friendly product that the Exchange can develop.

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[3] Enrollment and Disenrollment in MassHealth and Commonwealth Care by Robert Seifert, Garrett Kirk, and Margaret Oakes published April 2010. Available at http://massmedicaid.org/~/media/MMPI/Files/2010_4_21_disenrollment_mh_cc.pdf.

6. What factors should Exchanges consider in reviewing justifications for premium increases from insurers seeking certification as qualified health plans (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?

The Exchange may require stronger premium review standards than state insurance departments employ. For instance, a state Exchange could consider factors such as premiums and rate increases, use of education tools to give providers information about quality, use of clinical decision support tools and price and quality information for consumers, quality measures such as HEDIS and CAPHS scores, and implementation of payment mechanisms to reduce medical errors and preventable hospitalizations, reduce disparities, and improve language access. Certification as a QHP should be something that demonstrates to the consumer that these plans have been evaluated by the Exchange and offer good value to consumers — an added layer of consumer protection.

The Exchange should work very closely with the state's insurance department to ensure that the state rate review proceedings are consistent and efficient across all plans offered. This will be important even if the Exchange operates as a part of the department itself. If the same plans are offered both inside and outside the exchange, it is important that the rate review be consistent so consumers are protected.

Provider payment policies for Exchange plans should be reasonable related to the cost of providing quality care, and safety-net providers should be reimbursed at adequate levels, at least at the Medicare rate.

The Exchange should also negotiate with insurers, including on oversight of premium increases, marketing and profits. To monitor the impact of these requirements, Exchanges should collect data on compliance and make this information available to the public.

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

Navigators, a critical component of Exchanges, are required by the ACA to be culturally and linguistically competent to help vulnerable populations understand their health options and choose the right plan for their family. Navigators should build off of the foundation of strong consumer assistance programs in states, especially those that partner with community-based organizations with experience working with the uninsured and other populations with language barriers. It is critical that the Exchange provide outreach and enrollment support, especially targeted to vulnerable communities to help them enroll in Exchange plans. Information about Exchange health plans should at the very least meet the federal government's standards, available through the HHS Office of Minority Health available at: http://minorityhealth.hhs.gov/assets/pdf/checked/finalreport.pdf.

D. Qualified Health Plans

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

Under the ACA, Exchanges are responsible for certifying, recertifying and decertifying health plans, pursuant to certification requirements addressed in statute and subsequent HHS regulation.[4] An important overall consideration is what share of the insurance market is within the Exchange. The greater the share of the market operating inside the Exchange, the more leverage the Exchange has to push insurers toward more robust qualified health plan (QHP) standards. In general, Exchanges are likely to capture a greater share of the individual than small group market (if those markets remain distinct) and so have a greater ability to influence plan quality and value.

At a minimum, the federal certification criteria should set a floor for states and states should be encouraged to hold plans to even higher standards if they determine it to be in the best interest of consumers. Many of the factors related to premium increases above also should be used in the decision to certify. Exchanges could also require participating plans to demonstrate an ongoing, formal process for consumer input into the operation of the plan. For instance, plans could create an independent enrollee organization and ombudsman program accountable to members rather than plan management.

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

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

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

[4] THE ACA, § 1331(d)(4).

The statute requires development of certification criteria on a range of issues. We recommend considering the following factors:[5]

- **Accreditation:** We applaud the ACA's requirement that the entity accrediting participating health plans must assess performance based on clinical quality measures such as HEDIS, patient experience ratings such as CAHPS, as well as plan performance on consumer access, utilization management, quality assurance, provider credentialing, complaints and appeals, and network adequacy. Measures collected for accreditation purposes should be supported by evidence and meet National Quality Forum standards for validity, reliability and feasibility. To the extent possible, all types of health plans, whether based on an HMO, PPO or other type of delivery model, should be held to the same rigorous standards.

- **Quality Improvement:** Health plans can play a critical role in improving the quality of care and should be expected to do so. They can benchmark providers against each other to stimulate improvements, reward high quality care, provide data to understand patterns of care and opportunities for improvement, help patients manage their own conditions, reduce readmissions, encourage adoption and use of health information technology (IT), and reduce health care disparities. HHS and states could evaluate health plans based on those quality improvement measures being reported on for the medical loss ratio standards. Regarding health care disparities, specific reduction metrics need to be employed in order to measure progress, as this aspect of the ACA could play a major role in addressing health disparities.

  In general, HHS should set clear metrics for the quality improvement strategies outlined in § 1311(g)(1) of the ACA. Plans should be held accountable for their results — with clear goals and benchmarks — so that consumers and employers will know whether plans are hitting the quality improvement and cost containment targets over time.

- **Use of Standard Benefit Format:** We applaud the certification requirement that plans use a standard benefit format that consumers and small business owners can use to make informed purchasing decisions. Insurers should also have available to consumers more detailed information on benefits and coverage upon request and as an easily accessed linked resource on the Exchange website.

- **Quality Information for Enrollees:** The information provided to consumers on plan quality measures must be relevant, digestible, and actionable for them to make informed purchasing decisions. Providing a laundry list of performance measures is not as valuable for consumers — most will want some form of composite rating and there should be a clear and simple explanation of how the measures were determined. However, HHS should require insurers to provide "layers" of information through a web-based interface, so that consumers seeking

[5] Network adequacy and marketing certification criteria are discussed in response to questions D.2.a and D.2.b, below.

more detailed information about performance on specific quality and consumer experience measures can access it. And consumers will need to be able to make apples-to-apples comparisons among health plans.

The ACA also prohibits plans from employing benefit designs that have the effect of discouraging people with significant health needs from enrolling. This is not an uncommon practice among insurers and it will be important that HHS set minimum standards for this requirement as well as encourage states to effectively monitor plans to ensure they are complying. It is particularly important to note that states will have to enforce the same standards on plans outside the Exchange as well or risk adverse selection.

2a. What issues need to be considered in establishing appropriate standards for ensuring a sufficient choice of providers and providing information on the availability of providers?

It is critical that network adequacy standards ensure consumers have reasonable choice of the providers they need, when they need them, within a reasonable geographic proximity to their home or workplace. Such standards may vary based on specialty type (i.e., a plan will not need the same number and availability of subspecialists as it will of primary care providers). In addition, reasonable geographic proximity will vary depending on whether the enrollees live and work in a rural or urban area. At a minimum, however, if a plan purports to cover a certain item or service, then it must also have accessible in-network providers and suppliers that are able to provide that item or service.

Network adequacy standards should include explicit minimum requirements for (1) numbers and types of providers required in the network, (2) time and distance standards for availability of services and (3) appointment availability standards. The standards should include provisions requiring service availability for behavioral health and special needs populations. They should also require routine monitoring of provider networks, including reports from insurers, provider and member surveys related to access to providers and corrective action plans. Additionally, the standards should provide clear information on how to complain about provider access. For out-of- network providers, we believe that the standards should require plans to ensure out-of-network or out-of-area providers because they are necessary to provide reasonable access to services.

Plans should be encouraged, to the extent possible, to include Medicaid providers to facilitate continuity of care for families who may transition on and off of Medicaid. In addition, we applaud the requirement in recently enacted California Exchange legislation, AB 1602, that requires insurers to regularly update an electronic directory of contracting providers so that individuals and small businesses can search by health care provider name and see which plans include the provider in their network and ascertain whether the provider is accepting new patients for a particular health plan.

We also applaud the language in this statute that requires plans to include in their network, where available, essential community providers that serve medically

underserved and low-income populations. Ensuring that consumers in the Exchanges have access to these providers will help achieve continuity of care for those recently uninsured who receive care from these providers, as well as those who transition off Medicaid because of income fluctuations. In addition, these providers can help address expected primary care workforce shortages and help address disparities in access to care among communities of color. Ensuring access to essential community providers can also help with outreach and enrollment efforts among low-income populations and those who face cultural and linguistic challenges in accessing care. States should be encouraged to set standards for adequate payment to these critical safety-net providers and all providers should be bound by the representation of availability unless they can show they informed an insurer that their practice was closed and the insurer did not update its provider directory to reflect this fact.

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

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

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

- Insurers should be required to provide standardized information in a standardized format to prospective and new enrollees, including:
    - Information on benefits, limitations, exclusions, restrictions on use of services and plan ownership
    - A summary of physicians' financial incentives, written in terms that the average consumer will understand
    - The stability and composition of the provider and practitioner network, including a list of participating physicians and hospitals and their credentials, as well as participating pharmacies. Such lists should indicate whether the provider or practitioner is accepting new patients covered by the plan.
    - Comparative information that is standardized on patients' experience with care in the plan and, to the extent possible, the plan's clinical performance and comprehensive information reflecting standardized metrics to

compare the performance of participating physicians and other health professionals, hospitals, post-acute care facilities and home health agencies

- Accreditation information
- Disenrollment experience
- Data on grievances and appeals filed by enrollees
- The plan's current status with respect to compliance with statutory and regulatory requirements

- All marketing materials should be approved by the Exchange and/or the state before their use, written at a sixth-grade reading level or lower, and available in languages other than English when the plan serves or will serve substantial numbers of enrollees whose native language is not English[6]

- To avoid the possibility of discrimination against population groups based on place of residence, participating plans should be required to serve a complete market area (i.e., they should not be allowed to "gerrymander" their market area)

- Exchanges should also monitor and regulate the conduct of insurance agents and brokers. There should be a uniformity of commissions for selling qualified health plans, and the following activities should be prohibited:
  - Door-to-door solicitation
  - Offering potential consumers financial or other inducements to enroll in certain plans
  - Discriminatory activities designed to discourage sicker-than-average enrollees and encourage healthier-than-average enrollees

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

We recognize that many states have little or no competition in their individual and small group markets among insurers, and each state will face unique challenges in trying to

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

attract and retain a sufficient mix of qualified insurers within the Exchange. However, we believe that, over the long term, if states design their Exchanges first and foremost to benefit consumers, so that they are attractive, consumer-friendly marketplaces in which consumers can be assured of adequate, affordable coverage, a sufficient mix of health insurance insurers will follow.

To achieve this, however, it will be critical for states to make the market rules inside and outside the Exchanges the same, so there is a "level playing field" and all plans in the state are required to meet the same certification standards. States that do not do this and allow the market outside the Exchange to operate under less stringent rules will have a difficult time attracting a healthy mix of insurers to its Exchange. This also raises the risk of adverse selection and could drive up premium costs for Exchange enrollees.

The requirements for risk adjustment, the temporary reinsurance and risk corridor programs, and the requirement that plans pool risk inside and outside the Exchanges, are critical tools to limit adverse selection and encourage plans to participate in the Exchange. However, these tools will not be sufficient if states do not apply the same rules to plans inside and outside the Exchange. HHS should use grant support and technical assistance to help states enact the laws and rules necessary to mitigate adverse selection between the Exchange and non-Exchange markets. For example, states could enact laws prohibiting the lowest tiers of coverage from being sold outside the Exchange except by insurers that also sell the same plan for the same price in the Exchange.

HHS may also need to consider a process by which new plans, which face considerable barriers to market entry, could effectively participate and compete in state Exchanges. While consumer protection and quality standards should not be relaxed for these plans, Exchanges should be empowered to implement innovative ways to foster the development and growth of new plans, particularly in states that have little meaningful competition among insurers. For example, in Massachusetts the Connector relaxed its rules requiring all plans to meet state reserve requirements in order to permit Medicaid MCOs sponsored by safety-net hospitals to participate in the Exchange. The Connector allowed the hospital parent's financial guarantee to substitute for the reserve minimum. This allowed the Connector to offer all of the Medicaid MCOs' plans to subsidized enrollees in the Exchange.

It is also important to acknowledge that even the most nimble Exchange may still have difficulty attracting a sufficient mix of QHPs in states where there is minimal competition among insurers. In these states, HHS should consider supporting co-ops, multi-state plans and where feasible, public plan options to increase the number and quality of choices for consumers. At a minimum, where appropriate, a co-op and public option, along with two federal plans would guarantee at least four insurers in an Exchange. This should be sufficient in the event that commercial insurers do not want to participate in an Exchange market that emphasizes value and quality rather than risk selection and claims avoidance. And, of course, it is important to remember more insurers are not necessarily better. In fact, administrative costs increase as the number of insurers increases. Additionally, more insurers will add complexity to the risk adjustment process.

Finally, dynamics may be different for the individual and small group markets if those markets remain separate. A large portion of the individual market will be in an Exchange, giving most insurers powerful incentive to participate. However, the share of a separate small group market in an Exchange will likely be much smaller unless states take additional steps to strengthen incentive for small group participation either by offering additional financial incentives to small businesses that choose to purchase coverage through the Exchange or by prohibiting some or all of insurers offering in the small group market to operate outside of an Exchange. The fundamental point is that without a strong customer base, insurer interest in the Exchange will be attenuated.

3b. What kinds of factors are likely to encourage or discourage competition among plans in the Exchanges based on price, quality, value, and other factors?

Exchanges as envisioned under the ACA provide a critical opportunity to encourage plans to compete for consumers based on the value of their product and not on risk selection. The ACA provides important tools to achieve that goal and it will be critical that these are well-integrated into the design and operation of the state Exchanges.

First, consumers and small business owners need greater transparency on the price and quality of the product they are buying. In implementing the ACA's requirements for greater data collection from plans and standardized benefit forms, HHS should ensure that Exchanges are committed to conveying plan price, coverage, quality and consumer experience data in consumer-friendly language, in easily-accessible formats, and so consumers can effectively use the data to make informed purchasing decisions.

Second, Exchanges should be required to encourage plans (possibly through bidding or other negotiation processes or through the rating system) to develop and implement effective cost containment, care management, health IT, and quality improvement activities. Exchanges should be authorized to develop "reward" systems for plans that effectively use payment reforms and quality improvement tools to deliver better health care to more people at a more affordable price, including making necessary investments to build a strong foundation of comprehensive, well-coordinated primary care and reducing racial and ethnic disparities. This could be done through the rating system that will be developed for plans, or, if the Exchange requires plans to bid to participate, could be taken into account in the bidding process.

Third, states should be encouraged to set up effective processes for close coordination between their Exchange and their insurance department, so that state regulators' efforts to review rate increases and enforce the ACA's medical loss ratio requirements reinforce and support efforts by the Exchange to negotiate with plans and keep premium costs affordable for families and small businesses.

Fourth, having a strong Navigator program to educate the public and raise awareness of the availability of QHPs will also encourage consumer interest and participation in the Exchange. To support true consumer choice, it will also be important that Navigators

meet the requirement in the ACA for distributing fair and impartial information, maintain cultural and linguistic competency, and continue to work with vulnerable populations.

4. What health plan standards and bidding processes would help to facilitate getting the best value for consumers and taxpayers?

Allowing Exchanges to negotiate with plans on price is a critical cost containment tool. The ACA explicitly contemplates — and encourages — Exchanges to act like "active purchasers" in the marketplace to deliver premium discounts and better quality products to consumers and employers.[7]

At a minimum, HHS should prohibit states from requiring Exchanges to accept all eligible insurers without any negotiation or competitive process. Even in states where an "Exchange as active purchaser" model may be challenging because of a lack of insurer competition, the Exchange should not be precluded from implementing such a model when and if it becomes in the best interests of policyholders and taxpayers to do so.

The ability to actively purchase the plans that participate in the Exchange will greatly assist states in providing high-quality, affordable plans to their residents (as well as keep federal costs lower, as the premium tax credit amounts are tied to the cost of Silver plans offered through the Exchange). As stated by the sponsor of the "active purchaser" language during the Senate debate on the ACA, Senator John Kerry (D-MA) said: "One of the key ingredients to the success of health reform in Massachusetts is the ability of the Connector to negotiate with health plans. This negotiation process saves 6 percent off the cost of premiums and places pressure on insurers to keep rate increases low overall. Empowering Exchanges to engage in active purchasing would lower premiums for all enrollees in the Exchange, as well as, lower the amount of subsidy paid by the federal government."[8]

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

The ACA requires greater standardization of health insurance products by establishing four tiers of coverage — bronze, silver, gold, and platinum — based on various actuarial values.[9] First, it is critical HHS establish a uniform methodology to calculate actuarial values for purposes of demonstrating plan compliance within these four tiers that will be used by all states and plans. HHS must also set the standard population that will be used in applying this methodology to allow accurate comparisons of the relative comprehensiveness of plans' benefit designs. Finally, HHS should set relatively strict guidelines in allowing *de minimus* variation; otherwise, allowing even modest differences in the actuarial value of plans within the same tier could lead to greater risk of adverse selection.

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[7] THE ACA, § 1311(e)(2).
[8] Kerry, J. F., op. cit.
[9] THE ACA, §1302(d).

Second, states and the governing body of the Exchange may conclude that even greater standardization of products is needed to combat adverse selection among plans participating in the Exchange or between plans inside and outside the Exchange. The experience of Massachusetts in this area is very instructive. Initially, the Connector tiered its gold, silver, and bronze plans by actuarial value and the Exchange included dozens of plan designs. The Connector conducted extensive consumer research, including focus groups and feedback sessions with small employers and individuals, and learned that the concept of equivalent actuarial value was not understood. Users were confused by the multitude of benefit variations. Consumers reported being inhibited from obtaining coverage due to the bewildering choices. In 2009, the Connector altered its offerings to require plans to conform to standard benefit configurations, reducing the number of offerings to seven. Consumers can now make a true apples-to-apples comparison between plans with similar benefits.

Third, Exchanges, states and the federal government will need resources to closely monitor and enforce plan compliance with the requirements for standardization of benefits, particularly since federal tax dollars are at stake.

E. Quality

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

We recommend considering the following factors:

- **Accreditation:** We applaud the ACA's requirement that the entity accrediting participating health plans must assess performance based on clinical quality measures such as HEDIS, patient experience ratings such as CAHPS, as well as plan performance on consumer access, utilization management, quality assurance, provider credentialing, complaints and appeals, and network adequacy. Measures collected for accreditation purposes should be supported by evidence and meet National Quality Forum standards for validity, reliability and feasibility. To the extent possible, all types of health plans, whether based on an HMO, PPO or other type of delivery model, should be held to the same rigorous standards.

- **Quality Improvement:** Health plans can play a critical role in improving the quality of care and should be expected to do so. They can benchmark providers against each other to stimulate improvements, reward high quality care, provide data to understand patterns of care and opportunities for improvement, help patients manage their own conditions, reduce readmissions, encourage adoption and use of health information technology (IT), and reduce health care disparities. HHS and states could evaluate health plans based on those quality improvement measures being reported on for the medical loss ratio standards. Regarding health care disparities, specific reduction metrics need to be employed to measure progress, as this aspect of ACA could play a major role in addressing health disparities.

In general, HHS should set clear metrics for the quality improvement strategies outlined in § 1311(g)(1) of the ACA. Plans should be held accountable for their results — with clear goals and benchmarks — so consumers and employers will know whether plans are hitting the quality improvement and cost containment targets over time.

- **Use of Standard Benefit Format:** We applaud the certification requirement that plans use a standard benefit format that consumers and small business owners can use to make informed purchasing decisions. Insurers should also have available for consumers more detailed information on benefits and coverage upon request and as an easily accessed linked resource on the Exchange website.

- **Quality Information for Enrollees:** The information provided to consumers on plan quality measures must be relevant, digestible and actionable for them to make informed purchasing decisions. Providing a laundry list of performance measures is not as valuable for consumers — most will want some form of composite rating and there should be a clear and simple explanation of how the measures were determined. However, HHS should require insurers to provide "layers" of information through a web-based interface, so consumers seeking more detailed information about performance on specific quality and consumer experience measures can access it. And consumers will need to be able to make apples-to-apples comparisons among health plans.

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

Relevant quality and cost data should be presented to consumers in a succinct way during the process of choosing a QHP. The law requires the Exchange to provide information on cost-sharing to consumers, including scenarios for out-of-pocket costs for certain common procedures. Consumers should have input in the development of this information, which should be presented in lay language.

In Massachusetts, the Connector web portal has evolved over time to include more quality and cost information for consumers. The evolution is the result of focus group testing and requests by consumers who interface with the portal. The portal now features clear information on cost-sharing for consumers that can be compared across plans. The next version of the portal will include a tool that provides information on scenarios for common procedures allowing more details for consumers to make an informed decision.

F. An Exchange for Non-Electing States

Some states will not be able or willing to create and administer their own Exchange. In setting up a federal Exchange, HHS should run a robust Exchange that acts as an "active purchaser" of quality health plan options. The federal Exchange should be a model that negotiates both price and value with carriers, supports consumer engagement, encourages

robust navigator programs that facilitate coverage of traditionally underserved populations, and coordinates effectively w/ Medicaid to provide seamless coverage.

G. Enrollment and Eligibility

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

The key principle that should govern decisions about the coordination between Medicaid, CHIP and the Exchanges should be the creation of a "no wrong door" system of enrollment. This means that a streamlined application form and eligibility process should be put into place that will allow consumers to seamlessly access whichever program they are eligible for, regardless of their initial application.

Both the Exchanges and Medicaid and CHIP rules and verification requirements should be aligned as much as possible. Consumers are likely to move from Medicaid to subsidized Exchange plans as their income fluctuates, and eligibility systems need to make this process as seamless as possible. There should also be a simple process put into place for consumers to indicate any "changes of circumstance" during initial enrollment, renewal and throughout the coverage year. This process will make it easy for consumers to transfer coverage if changes in circumstance result in changes in program eligibility.

In Massachusetts, the Medical Benefit Request Form is the single application residents use to apply for subsidized health coverage. The state then makes the determination what program the applicant is eligible for: oftentimes, it is either MassHealth (the state's Medicaid program, which also administers CHIP) or Commonwealth Care (the subsidized health insurance program operated by the Connector). The renewal application works in a similar manner. Because it is a single application, it encompasses all of the requirements for eligibility for all programs and has limited the information needed from the applicant through electronic data matches.

However, Medicaid and the Connector's enrollment policies are different. Medicaid enrollment goes back to the date of application, whereas Commonwealth Care enrollment starts on the first of the month after the applicant is deemed eligible. Oftentimes, this causes a gap in coverage for the applicant, which could have implications not only for the person's access to care but also for meeting the requirements of the individual mandate.

Federal guidance should be provided on best practices for eligibility systems and assistance should be provided to states to help them make their systems work as effectively as possible for consumers. Two possible options include: retaining consumers' coverage through a transitional Medicaid program until eligible for an

Exchange plan, or making Exchange plan coverage retroactive to the date of application for enrollment.

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

Massachusetts currently shares data with several federal and state agencies. Most notably, the eligibility determination system gets data from the Department of Revenue, the Registry of Births and the Social Security Administration. The information provides income and employment confirmation, as well as disability status and proof of citizenship. Electronic linkages can reduce the amount of paper needed to process an application making the enrollment faster and less administratively cumbersome for the state. Exchanges, with their Medicaid partners, can work to identify the specific information needed and have a single point of entry for that information for use by both agencies.

6. What are the verification and data sharing functions that States are capable of performing to facilitate the determination of Exchange eligibility and enrollment?

Collaboration between the state and the Exchange is invaluable. In Massachusetts, the state's Office of Medicaid determines eligibility for both MassHealth and Commonwealth Care. MassHealth and the Connector are in constant communication and information is shared between the agencies on a daily basis. Medicaid notifies the applicant with next steps needed to complete the enrollment process once they have been approved for a program. Applicants who are notified of their Commonwealth Care eligibility must call the Connector (or enroll online) to choose a plan, and pay their premium for the first month of coverage (if required according to income level). Commonwealth Care enrollees' coverage starts the first of the next month after enrollment.

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

Massachusetts established a tiered cost-sharing system depending on the income of the individual who qualifies for Commonwealth Care. Those with an income below 100 percent FPL have very limited cost-sharing mirroring the Medicaid program. For example, the prescription drug co-payments between the two programs are identical for this population. As an individual's income increases, the premium charged as well as the co-payment for treatments increase. The Connector also has co-payment and premium waiver processes in place for individuals whose financial situation is not fully captured by the eligibility form. These waivers are taken on a case by case basis.

H. Outreach

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

Outreach and enrollment strategies need to happen from the "bottom up." This means working directly with community based organizations familiar with the populations who need to be enrolled. Using established community-based groups can help tailor outreach and services to meet each community's needs and help increase enrollment. Moreover, outreach and enrollment efforts must reflect the communities targeted — which means creating enrollment events and materials that are culturally and linguistically appropriate.

For example, the MassHealth Outreach Grant program (http://www.outreachgrants.org) continues to be an integral vehicle for consumer enrollment, outreach, education and coverage retention. The Massachusetts Office of Medicaid disseminates grants to 51 community-based organizations throughout the state.

Grantee organizations are:

- Trusted resources in their communities
- Culturally and linguistically competent, often members of the communities they serve
- Able to reach and engage individuals and families that are not easily reached through mainstream efforts
- A valued first hand source of information for the State about community needs, successful outcomes and barriers to care

As we have seen in Massachusetts, the need for consumer assistance remains after health reform implementation is well underway. Grantee organizations continue to assist a high volume of people — including more than 245,000 individuals in calendar year 2009 alone. Community organizations serve as valuable resources to help individuals and families navigate the health care system and maintain appropriate coverage as their life circumstances change.

In addition, as Massachusetts health reform was being rolled out, the Connector embarked on an ambitious outreach and marketing campaign, leveraging relationships with the Boston Red Sox and media outlets to get the message out about new health insurance options for Massachusetts residents. This type of broad campaign is also essential to reaching as many consumers as possible.

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

Navigators are key to helping consumers and small businesses enroll in coverage through the Exchange. The Navigator function should be merged with the consumer assistance programs and be performed by independent consumer oriented non-profit organizations.

Since consumer assistance funds are scheduled to be awarded in October 2010, it makes sense to build off this existing structure in creating Navigators in 2014 to continue providing assistance. Successful models of consumer assistance, especially those that have demonstrated experience working with vulnerable populations, will provide lessons to ensure Navigators serve the uninsured and others seeking coverage and tax credits through the Exchange.

Navigators must be designed carefully to ensure their independence. For example, there should be no conflict of interest from government agencies or the insurance industry. We are pleased the ACA requires Navigators to be culturally and linguistically competent, and we recommend they meet the federal government's standards at: http://minorityhealth.hhs.gov/assets/pdf/checked/finalreport.pdf.

Navigators and consumer assistance programs need to have a sustainable funding source. Federal investment is key to creating effective patient Navigator and consumer assistance programs. State Exchanges alone may not have the resources to support these programs.

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

Outreach and enrollment strategies needs to work directly with community-based organizations that work with populations who need coverage. Using established community-based groups can help tailor outreach and services to meet each community's needs and help increase enrollment. HHS should permit states to allow providers to engage in enrollment activities as well. Hospitals and community health centers (CHCs) will be an integral part of reaching target populations. Finally, consumers also benefit from large scale efforts and outreach enrollment from the government using paid media, technology and other strategies that reach a broad audience.

J. Consumer Experience

1. What kinds of design features can help consumers obtain coverage through the Exchange? What information are consumers likely to find useful from Exchanges in making plan selections? Which kinds of enrollment venues are likely to be most helpful in facilitating individual enrollment in Exchanges and QHPs?

For consumers, perhaps the single most important principle that should inform the way the Exchanges are run is that the most basic purpose of the Exchanges is to facilitate the expansion of coverage. HHS should use its authority to ensure states adhere to this principle in all of their decisions regarding the Exchange.

2. What kinds of information are likely to be most useful to consumers as they determine whether to enroll in an Exchange and which plans to select (within or outside of an Exchange)? What are some best practices in conveying information to consumers relating to health insurance, plan comparisons, and eligibility for premium tax credits, or eligibility for other public health insurance programs (e.g., Medicaid)? What types of efforts could be taken to reach individuals from diverse cultural origins and those with low literacy, disabilities, and limited English proficiency?

To help consumers have adequate information to choose the right health plan for them and their families, health plans must be presented in a way that allows an "apples to apples" comparison when choosing their plans. In addition, there should be a clear, easy to read rating (e.g. a "star system") on each health plan in the market that indicates not only whether a plan meets Exchange minimum standards but also the overall value of the plan to consumers (both in terms of cost and quality).

In Massachusetts, the insurers were required to include a simple symbol, a check mark, on their policies indicating whether the plan met Minimum Creditable Coverage Standards or not. The disclaimer then directed the individual to their employer or the Connector to purchase appropriate coverage. Additionally, the state used the Department of Revenue to send mail reminding all residents of the need to enroll in coverage. There were several reminders that directed individuals to the Connector to obtain health insurance and also explanations of the individual mandate.

Finally, consumer assistance programs and Navigators should be equipped to convey information and help consumers enroll in plans — including those of diverse cultural origins and those with low literacy, disabilities and limited English proficiency. Navigators that specialize in working with communities of color and bridge issues with language access are critical to the Exchange.

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

An Exchange governance board should include formalized and meaningful consumer representation. In addition, governance of a state Exchange should be free from conflicts of interest and instead should represent policyholders supplemented with technical experts. The Exchange should require all board meetings to comply with open meeting laws and provide agendas, information and data from the meetings in writing and make them available to the public.

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

The Navigators and consumer assistance programs can be very useful in gathering information about what is and isn't working on the ground in the Exchanges and the

health plans. The state and federal government should set up an organized “feedback loop” where these entities provide information back to the state to better their programs and ensure the information provided to consumers is useful.

The HCFA Helpline has established a feedback loop with the state on multiple levels. There is a monthly meeting to discuss larger, long-term operational issues like the calculation of income for seasonal workers or customer service challenges. The Helpline also captures data that is useful to the state in determining where to put their resources for IT changes. The Helpline serves as an early warning sign of glitches in the system that are unexpected consequences of a policy or operation change by the state. This information supplements that generated by insurers, providers and through the state’s own complaint system to provide a full picture of how the program operates. Most consumers will not go to the trouble of filling out a formal complaint or find the state intimidating, the Helpline and other Navigators enable consumers to share their concerns and problems.

If feedback on implementation goes to both state and federal levels, it will make it easier for the appropriate public agencies with oversight to respond and make adjustments to ensure the Exchange is successful in enrolling consumers and employees of small business.

K. Employer Participation

1. *What Exchange 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?*

It may be difficult to attract many small businesses to the Exchange — this has been a challenge with the Connector in Massachusetts. Marketing and other incentives will be necessary to convince small businesses that the Exchange is a smart idea for them and their employees.

2. 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?

All things being equal, the larger employer size limit is preferable because of its potential to create a larger risk pool but simply increasing the size of employers allowed to participate will not address lack of incentive to do so.

4. What other issues are there of interest to employers with respect to their participation in Exchanges?

The most important issue for employers is, and is likely to remain, the cost of insurance premiums. If Exchanges are able to meaningfully address the issue of cost relative to plans available outside the Exchange, employers will find this to be a strong incentive to participate. Otherwise (as Massachusetts experience suggests) participation is less likely to be robust.

L. Risk Adjustment, Reinsurance, and Risk Corridors

1. 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?

The Massachusetts Connector risk adjusts payments for the Commonwealth Care program. This is done because the Connector pays the insurers a capitated rate each month and a significant portion of the population is auto-assigned by the state into different insurers. The risk adjustments are based on the overall population covered by the program so that no one insurer bears significantly more risk than other. The Connector has worked with the insurers over the past four years to define the characteristics of this risk adjustment so there is no incentive to deny treatment to patients to avoid significant losses.

2. To what extent do States currently collect demographic and other information, such as health status, claims history, or medical conditions under treatment on enrollees in the individual and small group markets that could be used for risk adjustment? What kinds of resources and authorities would States need in order to collect information for risk adjustment of plans offered inside and outside of the Exchanges?

Massachusetts currently collects some of this information for use in risk adjustment. The state is intending to collect more of this information to assist in risk adjustment for the Connector as well as for payment reforms that will lower overall health care costs.

We appreciate the opportunity to comment on Exchange design and would be pleased to provide additional information in any of these areas. Please contact Christine Barber at cbarber@communitycatalyst.org or Georgia Maheras at gmaheras@hcfama.org with any further questions. Thank you.

Sincerely,

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