



Guide to Responding to the HHS Request for Comments on Exchange Provisions in the Affordable Care Act

Introduction

The Department of Health and Human Services (HHS) Office of Consumer Information and Insurance Oversight (OCIIO) recently released [a notice in the *Federal Register*](#) requesting public comments on the Exchange-related provisions in the Affordable Care Act (ACA). Comments must be submitted no later than **October 4, 2010**.

OCIIO plans to use the input it receives to inform future rulemaking and grant solicitations on Exchanges. This request for comments provides a unique opportunity for consumer advocates to help shape HHS' thinking on a wide range of important issues on Exchanges.

Community Catalyst created this guide to assist state advocates with answering some of the questions posed by OCIIO. The guide focuses only on **a selection** of the questions that are likely to have a significant impact on consumers. Following each question are bullets that suggest ideas that advocates may wish to take into account when responding. The suggestions provided are not comprehensive but instead provide a framework and hit several key issues. Also included are additional thoughts to consider in answering the questions — specifically those that relate to lessons from your state.

Advocates may still consider reviewing all of the questions to ensure that there are not additional questions they wish to answer.

Community Catalyst will submit comprehensive comments to OCIIO and will share those when completed. In addition, Community Catalyst is available to provide additional assistance to those interested. Please contact Christine Barber at cbarber@communitycatalyst.org or Patrick Tigue at ptigue@communitycatalyst.org for assistance.

Questions¹

A.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?

¹ Please note that the numbering for the questions is taken directly from the *Federal Register* notice.

- There is a federal requirement for states to consult with consumers and other stakeholders on Exchange design. Highlight where consumers are (or are not and need to be) represented in a meaningful way in any processes in your state.
- Consider suggesting that the renewal of Exchange grants to states is conditional on demonstrating formal participation by consumer advocates.
- Other members of the Exchange design team should be free of conflicts of interests and not have financial stake in the health system.
- *Also consider: What legislative or administrative bodies has your state set up to design Exchanges? Are consumers represented?*

A.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 necessary in design and governance of the Exchange.
- Governance should also include key stakeholder-beneficiaries: labor, consumer, business, but should exclude direct participants in the system (who have conflicts of interest): insurers, hospitals, doctors.
- Exchange board members should be free from conflicts of interest and instead should represent policyholders as primary stakeholders, supplemented with technical experts (including an actuary, health economist, etc).

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

- An Exchange can only hold down insurer costs if it has market authority — and to have this, the Exchange needs to cover a significant share of people. It's important to broaden, not carve up, insurance markets to provide Exchanges with enough covered lives to be able to negotiate good prices and coverage with insurers. This may be one reason to combine individual and SHOP Exchanges, or to consider a regional Exchange.
- 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.
- States need to think about reducing adverse selection (keeping similar insurance rules in and out of Exchange), which may be more difficult in an interstate Exchange.

B.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?

- 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. (i.e. Will a state be able to create a stronger rating system than defined by HHS?)

- HHS could also 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.

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

- Quality and value of health plans, including using Health care Effectiveness Data and Information Set (HEDIS) measures and National Committee for Quality Assurance (NCQA) standards, looking at a plan's track record on premiums, requiring payment mechanisms to reduce medical errors and preventable hospitalizations, and reducing disparities
- Reducing adverse selection (keeping similar insurance rules in and out of Exchange)
- Help with consumer information and enrollment, especially through Navigators²
- Oversight of premium increases, marketing and profits of insurers
- Integration with Medicaid to maintain continuous coverage
- Creating of standardized plans (it may be helpful to group plans by criteria beyond actuarial value) to facilitate consumer choice of health plans.

C.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?

- Generally, we support strong federal standards for Exchanges that act as a floor — with states able to exceed federal regulation and 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 Plan, a coordinated program for people below 200% FPL, and will likely seek flexibility in plan design.
- *Also consider: What is your state's political and regulatory environment? How will the environment play into the operations and standards of the Exchange as well as state flexibility?*

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

- The Exchange 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.
- The law defines the levels of coverage through “tiers” based on actuarial values to facilitate comparisons by consumers. However, using actuarial values as a way to standardize plans still allows for major differences in benefit limits and cost-sharing (even among plans in the same tier) and makes comparisons difficult for normal people.

² Navigators are created in Section 1311(i) of the ACA. Navigators are funded by Exchanges to help provide information and assist consumers and small businesses with enrollment in health plans.

It may be helpful for web portals to provide further information on plans beyond actuarial value, such as specific health services provided and examples of cost sharing.

- The web portal should consider language access and consumers with low literacy levels.

C.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 the state Division of Insurance.
- The Exchange could consider factors such as premiums and rate increases, quality measures such as HEDIS scores and NCQA measures and implementation of payment mechanisms to reduce medical errors and preventable hospitalizations, reduce disparities, and improve language access.
- Value-based purchasing consistent with limits defined by HHS should also be considered provided that cost-sharing does not create barriers to treatment for lower-income enrollees.
- Provider payment policies for Exchange plans should be reasonable related to the cost of providing quality care.
- The Exchange should negotiate with insurers, including 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.
- Establishment of a public option and a co-op option would help promote value and cost-effectiveness within the Exchange.

C.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 are required by ACA to be culturally and linguistically competent.
- It is critical to provide outreach and enrollment support, especially targeted to vulnerable communities to help them enroll in Exchange plans.
- Navigators based out of consumer assistance programs and based in consumer health advocacy or community groups have experience working with vulnerable populations and would be critical to the Exchange.
- Information on Exchange plans is required to be linguistically and culturally competent, and should meet the federal government's standards, available at <http://minorityhealth.hhs.gov/assets/pdf/checked/finalreport.pdf>.

D.2. What factors should be considered in developing the Section 1311(c) [CC note: *This section refers to HHS's certification of plans as "qualified health plans."*] 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 consider: medical loss ratios, premium increases, consumer input and representation in health plans, and quality rating standards, such as HEDIS measures and NCQA standards. Also, require payment mechanisms to reduce medical errors and preventable hospitalizations and also strategies to reduce disparities.
- An Exchange could require health plans to show an ongoing, formal process for consumer input in the health plans. For instance, plans could create an independent enrollee organization and ombudsman program accountable to members rather than the plan management.
- *Also consider: Does your state have any model standards for health plans to highlight?*

D.2.a. 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?

- Network adequacy should be assessed by taking into account such factors as the number and types of providers, the time and distance consumers must travel in order to access services, and the availability of appointments as well as any other factors you identify as being particularly important in your state.
- Health plans participating in the Exchange should be required to have adequate provider networks.
- Network adequacy standards may need to vary based on specialty type and different geographic regions in a state (e.g., metro vs. rural).
- Exchange plans should include and provide adequate payments to safety net providers.

D.2.b. 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?

- Marketing standards should require that materials provide consumers with a clear, written description of rules, especially those relating to any limits on provider choice, benefits and services, cost-sharing, and procedures.
- The federal role for marketing standards should be to set a minimum floor that all Exchange plans must meet. States should have the flexibility to exceed these minimum standards if they so choose.
- There should be uniformity of commissions for selling qualified health plans, rather than allowing financial incentives to steer consumers to certain plans.
- *Also consider: If your state is a state that is lacking in strong oversight of the insurance market (see <http://www.healthcare.gov/news/factsheets/rateschart.html> for information on your state's capacity for regulating insurers), it would be important to note this and ensure that consumers can turn to federal authorities for additional enforcement standards.*

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

- A number of factors would need to be taken into account, including price, provider network, quality, payment structure, activities to eliminate disparities, and consumer input and information.
- The Exchange could require health plans to show an ongoing, formal process for consumer input in the health plans. For instance, plans could create an independent enrollee organization and ombudsman program accountable to members rather than the plan management.

E.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 their 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.

E.2. 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 QHPs? What other strategies, including payment structures, could be used by plans to improve the practices of plan providers?

- NCQA standards should serve as the minimum quality standards to be met by QHPs.
- Consumers should be provided with the NCQA's quality ratings for QHPs
- *Also consider: Share any quality standards that have been effective in your state.*

G.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 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.

- 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.

H.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 needs to happen from the “bottom up” and from the “top down.” This means working directly with community based organizations that work 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. In addition, it means large scale efforts and outreach enrollment from the government using paid media, technology and other strategies that reach a broad audience.
- Outreach and enrollment efforts must reflect the communities targeted — which means creating enrollment events and materials that are culturally and linguistically appropriate.
- *Also consider: Share any past enrollment or outreach strategies that have been effective in your state.*

H.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 function and be performed by an independent consumer oriented nonprofit organization or organizations. Since consumer assistance funds are scheduled to be rewarded in October 2010 it makes sense to build off this existing structure to help create Navigators to continue providing assistance in 2014.
- 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.
- Navigators need to be culturally competent and have multiple language capacity. Navigators are required to be linguistically and culturally competent, and should meet the federal government’s standards, available at <http://minorityhealth.hhs.gov/assets/pdf/checked/finalreport.pdf>.
- Navigators and consumer assistance programs need to have a sustainable funding source.
- Navigators need to have professional staff that have undergone training and have support.
- Technology—The Exchange should use programs that can track information and feedback as well as those that serve consumers quickly and effectively.
- *Also consider: Expand on this section with detailed state experiences.*
- *If your state has a consumer assistance program, talk about the role it has played and lessons learned that may be helpful in creating Navigators. This is an important section to talk about the importance of having mission driven non-profits take on this role.*

H.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 happen from the “bottom up” and from the “top down.” This means working directly with community based organizations that work 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. In addition, it means large scale efforts and outreach enrollment from the government using paid media, technology and other strategies that reach a broad audience.
- Outreach and enrollment efforts must reflect the communities targeted — which means creating enrollment events and materials that are culturally and linguistically appropriate.
- Enrollment and outreach strategies cannot be based on internet or advertising alone — focusing on community events will also be important.
- The enrollment and the application process needs seamless coordination with Medicaid. Medicaid and the Exchanges need to coordinate their application process because people may move between subsidized plans and Medicaid.
- *Also consider: Share any past enrollment or outreach strategies that have been effective in your state.*

J.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?

- Consumers should be represented in both the design and governance of the Exchange. Consumer input would help to answer some of these questions as the Exchange is developed and provide helpful feedback throughout the implementation to find out what is working and not working for consumers. Consumer input could be part of the design by creating seats specifically for the consumers on the Exchange board.
- The Exchange needs to provide easy-to-understand information about health plans that helps people make informed choices about their coverage. This creates greater administrative ease in purchasing insurance through transparent information, outreach and the website.
- Outreach and enrollment efforts must reflect the communities targeted — which means creating enrollment events and materials that are culturally and linguistically appropriate. Enrollment and outreach strategies must be based in the community and conducted by organizations that are known and trusted by consumers.

J.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?

- The kind of information provided needs to be the same so that consumers can make “apples to apples” comparisons when choosing their plans.
- There should be clear, easy to read disclaimers on each health plan that states whether it meets Exchange standards or not.
- Consumer Assistance Programs and Navigators should be set up to help and convey information to reach consumers — 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.
- It is critical to provide outreach and enrollment support, especially targeted to vulnerable communities, to help them enroll in Exchange plans.
- Navigators based out of consumer assistance and based in consumer health advocacy or community groups have experience working with vulnerable populations and can help facilitate enrollment.
- *Also consider: Using examples of outreach and enrollment from your state that have worked well for consumers.*

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

- The Board of Governance 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 to allow groups to gather information and hear about the decisions made by the board. Information like agendas and minutes from meetings and other supporting documents should be made available to the public.
- Create an Exchange governance board that includes formalized and meaningful consumer involvement.

J.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 Navigator and consumer assistance programs can be a way to gather issues about what is and isn't working in terms of the Exchange and any issues with 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.
- If feedback on implementation goes to both state and federal levels, it will make it easier for the appropriate public agencies to respond and make adjustments so the Exchange is successful.

N.1. What other considerations related to the operations of Exchanges should be addressed? If your questions related to the operations of Exchanges have not been asked, or you would like to add additional comments, you may do so here.

- *State any other concerns here that are important to consider in your state or for the communities you serve.*