October 31, 2011

Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-9989-P,
P.O. Box 8010,
Baltimore, MD 21244-8010.

RE: File Code CMS-9989-P, Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans

Dear Sir or Madam:

As a diverse group of 151 organizations in 48 states and the District of Columbia that advocate on behalf of workers, self-employed entrepreneurs, small employers, women, children, people with low incomes, people with mental illness, people with disabilities, patients with chronic illnesses, and consumers of all kind, we are strongly committed to ensuring the many benefits of the Patient Protection and Affordable Care Act (ACA) are fully realized.

We welcome this opportunity to provide comments regarding the Notice of Proposed Rulemaking on health insurance Exchanges. The Exchanges, established by the ACA, will provide affordable, high-quality health insurance options to millions of individuals, employees of small businesses, and small employers. As state advocates on the front lines of linking people to coverage, we believe that strong federal standards are needed to ensure that Exchanges are implemented effectively in every state and the District of Columbia.

Among the many issues in the NPRM warranting comment, three items emerge as the most fundamental to effective implementation and the long-term success of the health insurance Exchanges:

1. Exchange Governance
2. Federal-State Partnerships in a Federally-facilitated Exchange
3. Effective Federal Standards for Exchange Operations

It will also be critically important that consumers have adequate enrollment opportunities and that streamlined enrollment for Medicaid, CHIP, and Exchange plans is made a reality. Many of our organizations will address these issues in separate comments on this and the subsequent NPRMs regarding Exchanges.

<u>1. Exchange Governance</u>

Section 155.110 of the NPRM discusses the governance of an Exchange that is established as an independent entity. An ethical, competent, and consumer-centered governance structure is critical to the successful development and implementation of an Exchange. While it is appropriate that each state tailor the Exchange model to meet the needs of its residents, the federal government must give firm guidance on governance for a few reasons. First, to date, many Exchange authorizing laws or proposals leave critical decisions to the Exchange governing board; thus the board's specific composition will shape its priorities, direction, and policies

during the formative years of the Exchange. Second, the board will make many decisions that will directly affect the cost of coverage offered in the Exchanges, which in turn will affect the federal government's costs for the premium tax credits and cost-sharing reductions it will be providing to eligible individuals. The federal government therefore has a duty to taxpayers to ensure that state Exchanges facilitate competition and reduce costs.

Every governing board should meet high ethical standards and have rules to protect against conflicts of interest. The standards proposed in §155.110 are a good start but are inadequate to fully protect consumers and ensure that Exchanges have a solid foundation for future decision-making. We recommend that HHS 1) prohibit people with conflicts of interest from serving on a governing board and 2) take further steps to ensure adequate representation of consumer interests.

We strongly recommend that HHS require all Exchange governing boards to prohibit membership for individuals with a conflict of interest. It is contrary to the goal of the Exchange to provide affordable health coverage to millions of individuals and small business employees and detrimental to taxpayers if Exchange boards include parties that have a financial interest in the provision of health insurance and would thus benefit from rising insurance premium costs. The final rule should explicitly define individuals with a conflict of interest as those affiliated with health insurance issuers, insurance agents or brokers, and practicing health care providers or health care facilities. Additionally, this prohibition should explicitly extend to individuals affiliated with trade associations or membership organizations comprised chiefly of the above industries, or with an entity whose primary line of business serves or whose clientele is largely comprised of individuals or organizations identified above as conflicted parties. This would include major vendors, subcontractors, or other financial partners of conflicted parties. Conflict of interest prohibitions should also cover immediate family members or spouses of anyone identified as a conflicted party.

In addition, HHS should clearly define representatives of consumer interests. Such a definition should include: individuals who purchase (or, if prior to 2014, are likely eligible to purchase) coverage through the individual Exchange; small business employees who purchase (or, if prior to 2014, are likely eligible to purchase) coverage through the SHOP Exchange; and non-profit organizations that have experience representing or advocating on behalf of the individuals in the categories mentioned above.

Additionally, for purposes of board membership, HHS should separately define representatives of small employers as small business owners who purchase (or, if prior to 2014, are likely eligible to purchase) coverage through the SHOP Exchange. HHS should perhaps include language in the regulations that permit this definition to be adjusted once a state permits larger employers to enter the SHOP.

If HHS intends, as stated in the preamble and in §155.110(c)(3), for Exchange governing boards to predominantly represent consumer interests, then the final regulation should make that an explicit requirement. Specifically, representatives of consumer interests should comprise a voting majority of the board, and at least one additional board member should be a representative of small employers. A precedent for such a requirement exists in 42 USC § 254b(k)(3)(H) regarding requirements of governing boards for Federally Qualified Health Centers, where a

majority of the board must be individuals being served by the health center. Adopting an analogous standard will help ensure that Exchange entities are governed by individuals committed to the goals of an Exchange and who are committed to being effective stewards of public and consumer dollars.

In 2011, several states have unfortunately chosen to accommodate insurers and other conflicted parties in their Exchange governance. As consumer health advocates in states affected by these decisions, we feel strongly that HHS should take action now to direct states to meet a high standard of conflict of interest protections in Exchange governance and set clear governance guidelines in the final rule.

If HHS ultimately does permit states to decide whether conflicted parties may serve on Exchange boards, boards should be required to have more representatives of consumer interests (as defined above) than individuals with a conflict of interest (as defined above); representatives of consumer interests should ideally still constitute a voting majority of the board.

To enforce effective governance standards, HHS should carefully review each state Exchange's proposed governance during the initial approval process and should review subsequent changes to the structure, composition, or major authorities of the governing body.

2. Federal-State Partnerships in a Federally-facilitated Exchange

Section 1321 of the ACA requires either the state or the federal government to "establish and operate" an Exchange in a state. In states that do not implement an Exchange or are not certified or conditionally approved by January 1, 2013 to do so, HHS is to set up a federally-facilitated Exchange. Recently, HHS has unveiled a variation on the federally-facilitated option: a Federal-State Partnership model. We believe that numerous opportunities already exist under the Affordable Care Act for state flexibility and federal-state collaboration in the development and operation of Exchanges. HHS has made clear that significant federal assistance, including technical systems and advice, is available in the coming years for states that opt to set up their own Exchanges but need support for some functions. The law also allows states that need more time to set up an Exchange the option to coordinate with HHS to transition from an initial federally facilitated exchange to a state exchange after 2014. Further, the law permits a federally facilitated Exchange to collaborate with the state on certain functions – such as by contracting with a state Medicaid agency for eligibility and enrollment services – when such arrangements are cost effective, benefit consumers, and enhance the operation of the Exchange.

We recognize the possible benefits of HHS working with a state to carry out certain functions or to otherwise collaborate with a state in which a Federally-facilitated Exchange will operate. However, given the opportunities that already exist under the Affordable Care Act for federal-state collaboration in the implementation of Exchanges, it should be clear that any Federal-State Partnership is still, in essence, a federally-facilitated Exchange. As such, HHS should maintain full decision–making authority and operational control of Exchange functions in a partnership model, and should only offer a very limited number of reasonable partnership options for states not administering their own Exchanges.

We support the concept described in HHS's September 19, 2011 presentation[1] at the CCIIO Exchange grantee meeting whereby HHS would, consistent with the law, retain control of an Exchange administered through a Federal-State Partnership model. Furthermore, we also support the limits on the number of partnership options presented. If HHS established vastly different arrangements with each partnership state based on the states' selection of functions from an extensive menu, the likely results would be increased administrative burden and duplication, fragmentation for consumers, and unclear lines of oversight and authority. Providing a defined number of options for division of Exchange duties ensures that HHS can maximize economies of scale by executing common partnership arrangements from a manageable menu of options. States for whom maximum flexibility and decision-making authority is of utmost importance still can retain such authority by establishing a wholly state-run Exchange.

The specific partnership models presented by HHS are: 1) for states to perform certain consumer assistance functions only, 2) for states to perform plan management functions only, or 3) for states to perform both. These options present opportunities to allow a state to take advantage of its strengths and capacities, while ensuring a clear delineation of duties. States interested in performing these or other functions through a partnership arrangement should still undergo certification and readiness review similar to that required for states administering their own Exchanges. Specifically, states should develop an Exchange Partnership Plan, which outlines in detail how the state would develop and perform the selected functions in their Federal-State Partnership proposal and how such operations would benefit consumers in the Exchange. States should describe and justify their policy decisions regarding how they will carry out the assigned functions. For example, if a state seeks to perform plan management and wishes to avoid using selective contracting, the state should justify how that approach could still ensure affordability, quality, and choice for consumers based on factors and data specific to the state. HHS should also establish mechanisms to measure state performance of any partnered functions as well as the performance of the partnership overall, including measures to ensure that consumers are not suffering due to the bifurcation of exchange operations between two levels of government. In the example of a plan management partnership, states should be evaluated to verify that the plans selected by the state are of high quality, provide good value, achieve high consumer-satisfaction ratings, and do not increase costs for consumers or the federal government (by raising the cost of the premium or premium tax credits and cost-sharing subsidies). HHS must also have the authority and a plan to intervene and resolve problems if an Exchange operated through a partnership is not adequately performing its required functions.

We also support the fact that HHS' proposed partnership model would not permit states to elect to operate just one of the SHOP or individual market Exchanges, with the federal government responsible for the other. Separate administration or governance of the individual market and SHOP Exchange functions is inconsistent with the Affordable Care Act and would lead to unnecessary duplication of effort, as the state and the federal government would separately carry out functions including certification of qualified health plans and information collection and reporting that are needed by both the SHOP and the Individual Exchange. In addition, it would be difficult to ensure seamless coverage for individuals who move between coverage in a state-operated SHOP and coverage in an individual-market Exchange operated by the federal government.

[1] Available at: http://cciio.cms.gov/resources/files/overview_of_exchange_models_and_options_for_states.pdf

Additionally, we believe that a Federal-State Partnership may be most suitable in states that are committed to implementing an Exchange but may not be fully prepared or have the capacity to perform all Exchange-related functions. HHS should carefully consider the appropriateness and scope of a partnership model and how it would enhance services to consumers in a state that has opted against running an Exchange or has not made reasonable progress toward fulfilling its responsibilities.

We recommend that HHS involve stakeholders from a state – including representatives of consumers, state officials, insurers, health care providers, and other relevant perspectives – in the planning processes for a Federal-State Partnership Exchange in that state. In addition, before a partnership Exchange is implemented, a joint Federal-state plan for that Exchange should be publicly available and contain all information required of a state Exchange plan, along with a clear delineation of which party is responsible for carrying out each function (with HHS ultimately responsible for ensuring the Exchange fulfills all required functions). The public should have opportunities to weigh in on the plan to ensure it adequately reflects the needs of consumers and residents of the state. Furthermore, public officials in a partnership state should not be permitted undue influence or authority to define a partnership with HHS that is not in the best interests of consumers.

Importantly, HHS should not permit any partnership model or state Exchange Partnership Plan that hampers consumers' ability to understand their options and purchase coverage or that unnecessarily or unduly increases premium costs. When the goals of simplification for consumers conflict with preferences of state officials, HHS should prioritize the needs of the consumer. Furthermore, any federal-state partnership Exchange should be focused on maintaining a seamless consumer experience. To that end, we support HHS's decision to maintain enrollment and eligibility functions across the Exchange and Medicaid under the leadership of a single entity. We support that in the case of a federally-facilitated or a federal-state partnership Exchange, the responsibility would lie with HHS, with a requirement that states accept Medicaid eligibility determinations made by the federally-facilitated Exchange. Individuals could still apply for Medicaid through the state's Medicaid agency, but applicants to the Exchange should be thoroughly screened for and enrolled in all of the available coverage programs for which they may be eligible, ensuring the "no wrong door" approach required by the ACA. Individuals could still apply for Medicaid through the state's Medicaid agency, but applicants to the Exchange should be thoroughly screened for and enrolled in all of the available coverage programs for which they may be eligible, ensuring the "no wrong door" approach required by the ACA.

As HHS continues to develop and finalize its proposal for Exchange partnership models, we urge that HHS ensure robust stakeholder engagement, particularly with representatives of consumer interests that operate at the state and local and national level.

3. Effective Federal Standards for Exchange Operations

While the NPRM sets minimum national standards for certain aspects of Exchange development, we are concerned about certain areas that are deferred to the states or Exchanges, where the lack of a national floor may be detrimental to consumers.

Throughout the preamble, HHS invites comments on whether additional standards are needed for a particular provision or should be left to states to decide. While we recognize the need to offer flexibility for states to design an Exchange, states should not be permitted to implement Exchanges that lack adequate protections for consumers, do not promote higher quality care furnished by health plans, and do not ensure the affordability of coverage. In certain states, particularly those where leadership has displayed opposition to the ACA, Exchanges may be established in a manner that disadvantages consumers. To prevent this, we believe that HHS should include more detailed minimum federal standards in the final rule regarding the following areas:

- §155.205- Required consumer assistance tools and programs of an Exchange – HHS should set performance standards to ensure that, for example, call centers answer their phones and resolve callers' questions within a reasonable amount of time.

- §155.210 – Navigator program standards – HHS should require at least one Navigator entity for each Exchange to be a community or consumer-focused nonprofit (as considered in the preamble) and should specify how Exchanges must license or certify Navigators so that a requirement to obtain a producer license is prohibited and training is appropriate for the Navigator role;

- §155.1000 – Certification criteria for QHPs – HHS should define what standards an Exchange must consider when determining if a health plan is "in the interest of qualified individuals and qualified employers" and should be offered through an Exchange;

- §155.1065 – Recertification of QHPs – HHS should provide greater detail regarding the frequency with which QHP recertification must occur, which should be no less frequent than annually;
- §155.1080 – Decertification of QHPs – HHS should outline at what point a QHP must be decertified rather than solely relying upon criteria established by a state Exchange as outlined in §155.1000;
- §155.1050, §156.230 – Network adequacy – HHS should set minimum standards for "sufficient choice of providers for enrollees;"
- §156.235 – Essential community providers – HHS should set minimum standards for the inclusion of a "sufficient number" of essential community providers in a QHP's provider network, where available;
- §156.225 – Marketing standards for QHPs – HHS should establish a benchmark for marketing standards that Exchanges must require of all QHPs;
- §155.1040, §156.220 – Transparency in coverage- HHS should provide greater detail regarding how and with what frequency a QHP must submit information required to be made transparent to the consumer; this should be required no less than annually; and
- §155.1020- Rate increase consideration- HHS should define the process states must complete to consider rate increases in QHP certification.

In addition to providing more explicit federal minimum standards in these proposed rules, we recommend that HHS take a similar approach in future Exchange regulations to ensure appropriate baselines that all states can exceed, but must not fail to meet. This is particularly

important for proposed regulations slated to be published later in 2011 regarding the Essential Benefits package, a critical element of ensuring effective coverage options for consumers.

We believe that enforcing stricter conflict of interest criteria for Exchange governance, outlining reasonable consumer-centered Federal-State Partnership models, and strengthening and clarifying Exchange minimum guidelines will help ensure that every individual and family, regardless of the state in which they live, will be able to connect with coverage through an Exchange that meets the high standard that everyone deserves.

Sincerely,

Alabama
Alabama Arise

Alaska
Alaska Center for Public Policy

Arizona
Children's Action Alliance

Arkansas
Arkansas Advocates for Children and Families

California
Asian Pacific American Legal Center, Asian American Center for Advancing Justice
California Black Women's Health Project
California Pan-Ethnic Health Network
Latino Coalition for a Healthy California
Western Center on Law and Poverty
Children Now
Health Access

Colorado
Colorado Center on Law and Policy
Colorado Health Initiative
Colorado Organization for Latina Opportunity and Reproductive Rights (COLOR)

Connecticut
State of Connecticut Office of the Healthcare Advocate
Universal Health Care Foundation of Connecticut

District of Columbia
Alliance for a Just Society
DC Fiscal Policy Institute

Florida
Florida CHAIN
Florida Legal Services, Inc.
Progress Florida

Georgia
Georgia Watch
Georgians for a Healthy Future

Hawaii
Hawaii Primary Care Association

Idaho
Idaho Community Action Network

Illinois
AIDS Foundation of Chicago
Campaign for Better Health Care
Health & Disability Advocates
Illinois Maternal and Child Health Coalition
Sargent Shriver National Center on Poverty Law

Indiana
Mental Health America of Indiana

Iowa
Child and Family Policy Center
Iowa Policy Project

Kansas
REACH Healthcare Foundation

Kentucky
Brain Injury Alliance of Kentucky - The Michael Quinlan Brain Tumor Foundation
Covering Kentucky Kids and Families

Kentucky Advocate Association
Kentucky Equal Justice Center
Kentucky Voices for Health

Louisiana
Health Law Advocates of Louisiana
Louisiana Budget Project
MQVN Community Development Corp.

Maine
Consumers for Affordable Health Care
Maine Equal Justice

Maryland
Advocates for Children & Youth
Maryland Citizens' Health Initiative
Maryland Women's Coalition for Health Care Reform

Massachusetts
Health Care For All
Massachusetts Law Reform Institute

Michigan
Free Clinics of Michigan
MichUHCAN

Minnesota
TakeAction Minnesota

Mississippi
Mississippi Health Advocacy Program

Missouri
Disability Coalition for Healthcare Reform
Health Care Foundation of Greater Kansas City
Legal Services of Eastern Missouri
Missouri Alliance for Retired Americans
Missouri Budget Project
Missouri Immigrant and Refugee Advocates
NAMI Missouri

OWL
Women's Voices Raised for Social Justice
Communities Creating Opportunity (CCO)

Montana
Montana Human Rights Network
Montana Organizing Project
Montana Small Business Alliance
Montana Women Vote
Planned Parenthood of Montana

Nebraska
Center for Rural Affairs
Nebraska Appleseed Center for Law in the Public Interest
Nebraska Chapter of the National Association of Social Workers
Nevada
Progressive Leadership Alliance of Nevada

New Hampshire
Institute for Health Law

New Jersey
New Jersey Citizen Action
New Jersey Policy Perspective
NJ Public Health Institute

New Mexico
Health Action New Mexico
New Mexico Center on Law and Poverty
New Mexico Voices for Children
State of Women's Health New Mexico

New York
Center for Independence of the Disabled, NY
Coalition for Asian American Children and Families
Empire Justice Center
Family Therapy Institute of Suffolk
Health Care Access Coalition
Metro New York Health Care for All Campaign
New York Immigration Coalition

New Yorkers for Accessible Health Coverage

North Carolina
Disability Rights NC
Hemophilia of North Carolina
North Carolina Justice Center

North Dakota
NDPeople.org
North Dakota Economic Security & Prosperity Alliance

Ohio
Alliance for Senior Action
Ohio Consumers for Health Coverage
UHCAN Ohio

Oklahoma
Oklahoma Policy Institute
Oregon
Children First for Oregon
Oregon Center for Public Policy
Oregon Health Action Campaign

Pennsylvania
Pennsylvania Budget and Policy Center
Pennsylvania Health Law Project
Public Citizens for Children and Youth

Rhode Island
Rhode Island Kids Count
The Poverty Institute

South Carolina
SC Appleseed

Tennessee
League of Women Voters of Tennessee
Mental Health Association of Middle Tennessee
Tennessee Citizen Action
Tennessee Disability Coalition

Tennessee Health Care Campaign
Tennessee Justice Center
Tri Cities Citizens for Improved Health Care

Texas

AARP
Alamo Breast Cancer Foundation
Center for Public Policy Priorities
Children's Defense Fund - Texas
Christ the Good Shepherd Catholic Community
Clear Lake Texas Health Care Advocates
Gateway to Care
Gulf Coast Interfaith
HCFAT
La Fe Policy Research and Education Center
NAMI Texas
National Association of Social Workers/Texas Chapter
Native American Health Coalition
Rio Grande Valley Equal Voice Network
SUMA/Orchard Social Marketing, Inc.
Texans Care for Children
Texas NAACP
The Jesse Tree

Utah

Utah Health Policy Project

Vermont

League of Women Voters of Vermont
Voices for Vermont's Children
Vermont Public Interest Research Group

Virginia

The Commonwealth Institute
Virginia Organizing
Virginia Poverty Law Center

Washington

Northwest Health Law Advocates

West Virginia

West Virginians for Affordable Health Care

Wisconsin

9to5 Wisconsin
Citizen Action of Wisconsin
Coalition for Wisconsin Health
Community Advocates
League of Women Voters of Wisconsin Education Network
SEIU Healthcare Wisconsin
Wisconsin Alliance for Retired Americans
Wisconsin Alliance for Women's Health
Coalition of Wisconsin Aging Groups
Wisconsin Council on Children and Families

Wyoming

Consumer Advocates: Project Healthcare