BlueCross BlueShield Association

An Association of Independent Blue Cross and Blue Shield Plans

October 4, 2010

The Honorable Kathleen Sebelius
U.S. Department of Health and Human Services
Attention: OCIIO-9989-NC
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Submitted via the Federal Regulations Web Portal, http://www.regulations.gov

Re: Comments on the Requests for Comments Regarding Exchange-Related Provisions in Title I of the Patient Protection and Affordable Care Act

Dear Secretary Sebelius:

The Blue Cross and Blue Shield Association ("BCBSA") appreciates the opportunity to provide comments to the Department of Health and Human Services ("the Department") regarding the Request for Comments Regarding Exchange-Related Provisions in Title I of the Patient Protection and Affordable Care Act ("ACA"). BCBSA represents the 39 independent Blue Cross and Blue Shield Plans ("Plans") that provide health coverage to nearly 100 million – one in three – Americans.

Exchanges will create important new marketplaces where tens of millions of Americans will shop for health insurance, apply for subsidies, and enroll in health plans. Effective implementation of Exchanges – which will require partnership between the Federal government, the States, and participating health plans – will be essential to make these marketplaces work seamlessly to provide consumers with a choice of Qualified Health Plans ("QHPs") when they first enroll in 2013 for coverage effective in 2014.

As the leading providers of coverage for individuals and small employers across the nation, Blue Cross and Blue Shield Plans look forward to working with the Department in developing workable standards to facilitate effective health plan choices for consumers in Exchanges. Our response includes specific recommendations, as well as detailed comments on the Department's questions (included in the attached table).

BCBSA's specific recommendations for the Department are as follows:

Recommendation #1: Provide States with Maximum Flexibility in Designing and Implementing Exchanges

The Affordable Care Act (ACA) recognizes the important role states play in regulating insurance by maintaining the state-based enforcement structure of the Public Health Service Act, by encouraging states to develop Exchanges, and by providing states with substantial flexibility to develop Exchanges that meet their unique market needs. To help ensure such flexibility, federal regulations should provide room for a range of options for structuring Exchanges, allowing individual states to design the Exchange that works best for their consumers.

A state-based approach to designing and administering Exchanges builds on states' expertise as regulators of their health insurance markets. Health insurance markets, regulatory environments, and consumer preferences vary substantially across states. No Exchange model exists today that has been proven to effectively meet all the goals of improving access, controlling costs, providing choice and improving quality. State flexibility will be critical to harness state innovation to test which Exchange models provide the best value over time, ensure that Exchanges meet local consumer needs, and ensure that states are invested in creation and ongoing management of Exchanges.

While there are areas where the federal government should provide for some standardization, such as data transmission requirements and systems for eligibility verification and subsidy administration, where the ACA does not include explicit requirements for Exchanges, substantial flexibility should generally be provided regarding the design of Exchanges.

We appreciate the statements that the Administration has made to date that accommodate state flexibility. We recommend that regulations reiterate that the Department will provide substantial latitude in designing Exchanges under section 1321 of the Affordable Care Act and that a federal fall-back Exchange will be a last resort if a state fails to create an Exchange meeting the basic requirements of the law.

Recommendation #2: Allow States to Implement Competitive Exchanges that Permit All Qualified Plans to Participate and Assure Consumer Choice

BCBSA urges the Department to provide states with the flexibility to adopt competitive Exchanges that allow all interested health plans that meet QHP standards to participate. The ACA provides states with flexibility in the QHP certification process. States will be more likely to foster competition between health plans in Exchanges, and Exchanges will therefore be more likely to succeed, if they encourage the participation of all health plans that meet clear, objective and defined QHP standards.

This competitive model has several advantages, including:

- **Enhancing health plan participation:** The cost of developing plans for Exchange participation will be substantial. Assuring that all health plans that meet the clear, objective and defined QHP standards will be accepted for participation will increase the number of health plans willing to invest in the infrastructure to support Exchanges and therefore increase competition,

- **Delivering the choices consumers want:** A model where an Exchange limits the number of QHPs that may offer coverage would result in fewer choices for consumers

and less assurance that choices will evolve over time to continue to meet consumer expectations and needs,

- **Reducing duplication and regulatory confusion**: Creating an Exchange with regulatory powers to pick and choose among health plans may result in overlapping and conflicting regulation from insurance departments which will confuse consumers and health plans alike, and

- **Minimizing disruption for consumers:** Having Exchanges actively limit plan choices could have a significant impact on consumers by forcing them to change health plans on a year-to-year basis if plans selected for participation one year are barred from participation the following year, and in 2014 when many consumers will be migrating to Exchange health plans from their current health plans.

Exchanges are intended to be new competitive markets for health insurance that will enable consumers to meaningfully choose among competing health plans on an annual basis. Exchanges will be most effective in this role if they are facilitators of coverage options approved for sale by insurance regulators that meet QHP standards, not a new and potentially confusing regulatory entity that could limit the ability of consumers, whether young or old, healthy or sick, previously insured or uninsured, etc., to determine what health plan options they prefer in the marketplace.

Exchanges should allow individuals and employers to evaluate health plans among qualified options in an organized fashion. The standard plan comparisons required in the ACA will be very useful to help consumers compare health plans on cost and quality, benefits and other features. To help consumers navigate their choices on Exchanges, it will be important to provide plan selection tools and filtering programs that use preferences provided by the consumer to narrow available options to a tailored set of health plans to help consumers navigate their choices on Exchanges. Health plans should also be allowed to include information on other plan features that provide value for consumers, such as wellness programs, disease management initiatives, etc.

Some have argued that an “active purchaser” or “selective contracting” model is necessary to ensure high value choices for consumers. This approach would give Exchanges the authority to selectively pick and choose which health plans are available to consumers. We believe that Exchanges can meet the goal of ensuring high value choices for consumers by applying clear and objective standards for participation by QHPs that ensure both quality and value. Universal minimum standards to ensure competition/choice must be balanced with adequate QHP standards to guarantee market stability and consumer protection, such as assuring that only state-licensed health plans with a proven ability to bear risk may participate. These standards should be applied uniformly to all QHPs seeking to participate..

The competitive approach will ensure that objective criteria are established that health plans must meet to obtain certification and eliminate potential uncertainty that could dissuade health plans from making the required investment to participate. This competitive approach also removes Exchange participation from the political process which is inherent to the “active purchaser” or “selective contracting” model.

We recommend that regulations issued by HHS ensure that states have flexibility to interpret the requirement for Exchanges to certify health plans as in the best interest of participants in a manner that permits this competitive model. For the purpose of initial certification, Exchanges should be permitted to determine that a model that allows all health plans that meet QHP

standards to participate is in the best interest of participants for the purpose of initial certification.

Recommendation #3: Exchanges Should Not Determine Rates for Health Plans

While the ACA gives Exchanges authority to consider excessive or unjustified rate increases as a reason for excluding health plans from Exchange participation, Exchanges should not determine rates for health plans. Instead, to avoid duplicative regulation, Exchanges should work in concert with state insurance regulators to make such determinations within the rate review provisions of the ACA. As a condition of receiving rate review grants, these provisions require state insurance regulators to make recommendations to Exchanges regarding whether particular health insurance issuers should be excluded from participation based on a pattern or practice of excessive or unjustified premium increases.

The Exchanges' role in reviewing premium increases should be separate from the initial certification of QHPs for 2014. It is critical that rates be regulated *only* by the entity with authority to regulate solvency – typically a state's insurance department. Any effort to de-link rate regulation from solvency regulation could create conflicts between two regulators and uncertainty for health plans. It could also jeopardize a key consumer protection – the assurance that a health plan has adequate reserves to pay for enrollees' claims.

In addition, any effort by Exchanges to determine rates would effectively set prices for coverage outside of Exchanges because of the law's requirements for QHPs to charge the same premium for coverage inside and outside of Exchanges. The ACA clearly prohibits the government from forcing consumers to purchase coverage through an Exchange or imposing price controls.

Recommendation #4: Ensure that Consumers Have a Choice of Coverage Inside and Outside of Exchanges

The federal reform law makes it clear that purchasing health insurance coverage through an Exchange is voluntary, thereby guaranteeing that consumers will have their choice of whether to buy coverage inside or outside an Exchange. The overarching structure of the ACA ensures that there will be a marketplace inside and outside of the Exchanges and thereby guarantees consumers varied options for health insurance coverage.

Countless ACA provisions assume that a robust health insurance market outside of Exchange will continue. For example:

- Congress expressly stated in "Empowering Consumer Choice" that a market outside of Exchange should continue and that "Nothing in this title shall be construed to prohibit a health insurance issuer from offering outside of an Exchange a health plan to a qualified individual or a qualified employer;" [ACA Section 1312(d)(1)]

- Congress also expressly stated that "Nothing in this title shall be construed to compel an individual to enroll in a QHP or to participate in an Exchange;" [ACA Section 1312(d)(3)(B)]

- Congress required health insurers to have a single risk pool for all individual coverage inside and outside of the Exchange, and requires the same for small group coverage, whether sold inside or outside an Exchange; [ACA Section 1312(c)]

- Congress required health insurance issuers to ensure that any coverage offered in the individual and small group health insurance market include the same "essential health benefits package" required to be provided by Exchange plans; [PHSA Section 2707(a)]

- Congress prohibited Exchanges and Exchange plans from penalizing individuals who cancel enrollment in an Exchange plan to enroll in coverage outside of an Exchange; [ACA Section 1312(d)(4)], and

- Congress required the General Accounting Office to oversee the Exchanges, including collecting data on the market outside of Exchanges; [ACA Section 1313].

Thus, where HHS implements Exchanges in states, the Department should follow the ACA's clear structure and ensure that individuals and small employers have a choice of purchasing coverage either inside or outside of an Exchange. States should not have the flexibility to eliminate the market outside of an Exchange. Beyond forcing individuals to purchase Exchange coverage, the elimination of the insurance market outside of an Exchange conflicts with clearly stated Congressional intent to preserve and continue the health insurance market outside of an Exchange. [ACA Section 1312(d)(1)]

In addition, the elimination of a non-Exchange market prevents the effective implementation of ACA's express instruction to foster consumer choice. For instance, some states are considering establishing standardized products on their Exchanges. Consumers with different or additional needs should not be forced into these standard plans. A government-operated Exchange – especially one that substantially limits health plan choices – may not provide the choices and customer service that consumers demand better than the current marketplace. To preserve consumer's ability to choose among meaningfully different health insurance options, states must preserve the non-Exchange health insurance market.

Transforming an existing marketplace to one where consumer choice of private goods and services is limited to a government controlled venue would be nearly unprecedented in the American economy, (consumers traditionally shop within privately run venues where development, marketing and distribution of products is not controlled by the government although standards for the quality, safety or labeling of these private products may be set by government). When implementing an Exchange, regulators will need to consider their key priorities for defining the functions of an Exchange. Eliminating the market outside of an Exchange could present legal and administrative complexities, (e.g. legality of preventing insurer participation through selective contracting, and the possible requirement to compensate consumers for forcing them out of existing health plans), that would detract from other implementation goals.

The ACA requirement limiting availability of subsidies to coverage purchased through Exchanges will assure their critical mass without the need to mandate that all consumers purchase their health insurance through an Exchange. Moreover, preserving a marketplace outside of Exchanges would help assure an effective transition to Exchanges and reduce the potential for consumer dissatisfaction in the transition to 2014. Allowing those who are not subsidy eligible to continue to work with their insurance agents or health plans would reduce the pressure on state Exchanges to work perfectly when they first become operational and free them up to concentrate on the needs of the large population of uninsured individuals who will be purchasing insurance in 2014.

The primary reason cited for limiting choice to an Exchange-only market is the concern that allowing insurers to sell coverage outside of Exchanges will duplicate the experience of past state purchasing cooperatives, which often failed because of "adverse selection" – when healthier enrollees selected coverage outside of purchasing cooperatives, pushing up rates for those inside the purchasing arrangement. However, the ACA includes numerous specific provisions that will help to protect Exchanges from adverse selection, including:

- Applying all insurance rules (including rating and essential benefit rules) equally to coverage sold inside and outside of Exchanges,

- Requiring health plans to have a single risk pool for all individual coverage, whether sold inside or outside an Exchange, and a single risk pool for all small group coverage, whether sold inside or outside of an Exchange, which will make it impossible for insurers to offer lower prices for the same coverage offered outside the Exchange,

- Requiring premiums to be the same inside and outside the Exchange for any product offered on the Exchange,

- Requiring all health insurers in the individual and small group market—inside and outside of an Exchange—to participate in "risk adjustment activities" designed by HHS to transfer money from plans with low actuarial risk to those with higher actuarial risk, and

- Limiting the availability of subsidies to coverage purchased on the Exchanges. The substantial federal subsidies provided to Exchange plans will guarantee that a balanced risk pool enrolls in Exchanges.

As a result of these provisions, Exchange plans will be protected from adverse selection — and to the extent that adverse selection occurs, Exchange plans will be subsidized by plans offered outside of an Exchange.

Recommendation #5: Create Reasonable Standards for Qualified Health Plans to Facilitate Health Plan Participation and Consumer Value

BCBSA believes it is important to establish reasonable standards for participating health plans in order to assure that consumers have a choice of health plans in Exchanges when they first become operational. The ACA includes numerous, specific certification criteria for QHPs, including requirements in the areas of marketing, network adequacy, accreditation, quality improvement, and enrollment forms. The key idea behind Exchanges is to make the market more competitive. It is critical, then, that Exchanges not adopt an overly prescriptive approach. Standards for Exchange participation should ensure that consumers have a choice of valuable plans in Exchanges.

BCBSA recommends that state and federal officials establish clear, objective and reasonable standards for QHPs in order to ensure broad health plan participation beginning in 2014. As discussed in greater detail in answers to specific questions in the RFI, some Exchange requirements – including certain certification standards and IT infrastructure requirements may pose challenges for health plans. At the same time, QHP standards must guarantee market stability and consumer protection by assuring that only state-licensed health plans with a proven ability to bear risk may participate. Consumers will not be well served if undercapitalized or inexperienced players enter Exchanges and then fail.

It is important to allow states to establish standards and to not start with a federal floor. Such standards should recognize the enormous operational challenges health plans will face in implementing all of the 2014 reform requirements. Standards for QHPs can always be strengthened over time once Exchanges become well established.

In addition, such standards need to be in place in time for health plans to modify their operations in the lead up to the January 2014 effective date for Exchanges. Examples of processes that need to be modified include tracking subsidy eligibility, development of IT/website infrastructures, product design, outreach, and marketing.

BCBSA recommends that Exchanges specify their operational requirements for health plans as soon as possible and no less than 18 months prior to the beginning of enrollment. Plans will need to have an understanding of an Exchange's operational requirements no later than the late spring of 2012, in order to implement systems and budget for related expenses in 2013.

Recommendation #6: Ensure a Level Playing Field for all Competitors in the Individual and Small Employer Markets to Protect Consumers

For Exchanges to structure effective competition, all participating plans must compete on a level playing field concerning rules that ensure basic protections for consumers. There should be no exemptions from certification standards for any particular type of plan – whether traditional health insurers, Medicaid plans, provider-sponsored plans, or Consumer Operated and Oriented Plans (CO-OPs).

As a case in point, some Medicaid managed care plans have argued that they should be granted an exception from state solvency requirements, at least initially. It is particularly important that no waivers of state solvency requirements be granted. Such waivers would be a dangerous precedent that could expose consumers, providers, and Exchanges to potential health plan failure, unpaid claims, and substantial negative publicity. Weakened solvency standards could also burden state guarantee funds, participating health plans and their subscribers. The ACA expressly forbids this type of favoritism. Section 1252 requires that "[a]ny standard or requirement adopted by a State pursuant to [the ACA's Title I, which includes the insurance market reforms and Exchange provisions, among others], shall be applied uniformly to all health plans in each insurance market …" (emphasis added).

Consideration also should be given to adopting standards to prevent adverse selection against the insurance market and the Exchange marketplace. While the ACA includes numerous provisions to guard against adverse selection between health insurance plans offered in and out of the Exchange, there is ambiguity concerning stop loss coverage and other self-funded arrangements that could be offered to small employers or individuals that, unless clarified, could lead to substantial adverse selection against the entire market.

Recommendation #7: Implement Exchanges in a Manner that is Consistent with the Structure of the Insurance Marketplace

We have a number of comments on Exchange structure, including comments on the establishment of separate or joint Exchanges for the individual and small group markets, the definition of the employer market served by Exchanges; and the establishment of regional Exchanges. Exchanges should be designed to offer coverage in a streamlined manner and with administrative efficiencies in mind for health plans, consumers, and state and federal agencies that are involved.

Individual and SHOP Exchanges

While some states may want to combine their individual and SHOP Exchanges, states should recognize that the individual and small group markets vary in a number of important ways, and structure their Exchange administration accordingly. For example:

- Not all health plans serve both the individual and small employer markets;
- State and federal legal requirements vary between the individual and small employer markets (e.g., state benefit mandates, COBRA, legal remedies);
- Products are likely to differ between the individual and SHOP Exchanges in states that do not merge the individual and small group markets;
- Distribution channels may differ between markets, with small employers likely to rely heavily on agents in Exchanges; and
- Rating structures may differ between the two markets. For example, composite rating is common in the small group market, but has no corollary in the individual market. (Composite rating provides employers with a flat rate per employee, versus age-rated policies, which vary based on an individual's age.)

State consideration of combining Exchanges will correlate to decisions regarding whether to merge the individual and small employer markets. States will need to carefully evaluate the impact of such merger on policyholders, as merger of the markets may result in undesirable adverse selection and cross-subsidization of markets that would outweigh the perceived advantages of pooling these markets. The ACA specifically delegates this decision for each state to make individually, separate and apart from Exchange structural decisions, and Federal regulations should not limit state flexibility in this regard.

For states that choose to establish separate individual and SHOP Exchanges, we recommend that certification of health plans be handled separately for individual and SHOP Exchanges with no requirement for health plans to serve both Exchanges. Some states may find it more administratively efficient to use a single Exchange instead of separate individual and SHOP Exchanges. Where individuals and small employers obtain coverage through a single Exchange, states may want to consider separate administrative functions to accommodate differences between these markets. However, states could still leverage vendor contracts and achieve administrative efficiencies by keeping the Exchanges separate and allowing them to share certain services.

Size of SHOP Exchanges

Prior to 2016, states have the ability to define the small group market to groups of 50 or fewer employees. We recommend limiting SHOP Exchanges to this small group market (groups of 50 employees) initially because this approach would help ensure success by starting with more manageable levels of participation. Implementing Exchanges in the small employer market will be substantially more administratively complex than in the individual market. Only after state Exchanges are functioning well at serving small employers with up to 50 employees, should consideration be given to expansion.

Starting with small firms would also limit adverse selection that would cause higher premiums for individuals and small employers. Large employers have more substantial experience in evaluating benefit policies and will evaluate whether to self-fund or purchase coverage on an Exchange. If larger employers with higher costs disproportionately seek coverage through the Exchange it will undermine affordability of coverage on Exchanges.

While starting small might be perceived as having a smaller base across which to spread costs, the ACA's requirement that health plans' pool their Exchange and non-Exchange business will ensure that Exchange costs will be spread over the entire small group market – which, when combined, comprises a sizeable market in most states over which to spread total Exchange-related costs.

Regional Exchanges

We have a number of concerns with how health plans will interact with regional Exchanges. Since health plans will continue to be licensed and regulated at the state level under the ACA, it will be critical for certification to occur on a state-by-state basis. Most health plans are local and many do not serve entire states, let alone multiple states. These local plans are not licensed or equipped to issue health insurance across multi-state regions. Thus, requirements for certification must respect the service areas of health plans, otherwise community-based plans may not be able to participate.

It is unclear how regional Exchanges would operate. The level of state regulation, public program options and eligibility requirements, and the number and distribution of uninsured – just to name a few important market conditions – can vary dramatically among states, even contiguous ones. Regional Exchanges, with their overlapping state authority, could lead to regulatory confusion and complexity in the certification of QHPs. It is unclear how these differing laws would apply if health plans were offered across multi-state Exchanges. For example, which state's rules would prevail? Moreover, if regional Exchanges attempt to "pool" premium dollars, then there could be cross-subsidization of policyholders across states given the substantial variability in health care costs even in relatively small state regions. Given the initial operational work that needs to happen for a state-based Exchange, we recommend that substantial analysis be given to regional Exchanges before implementation.

We recommend that the Administration clarify the rules regarding the establishment of regional Exchanges to ensure adequate protection for consumers, and a level playing field for all health plans available to consumers in any given geographic area.

Recommendation #8: Ensure that States Permit Employer Choice of Health Plan to Streamline Administration for Small Employers

One of the biggest factors limiting employer participation in Exchanges is likely to be the complexity of interaction with an Exchange. This complexity is magnified in an environment in which each employee has the ability to select his or her own health plan. This individual choice approach:

- Increases the administrative burden for Exchanges by individualizing the purchase of health insurance. There were more than 4.8 million small employers with 50 or fewer workers employing more than 21 million full-time employees in 2009, according to data from the Medical Expenditure Panel Survey;
- Requires more complicated accounting and billing practices to account for premiums that differ based on the characteristics of each employee;
- Creates confusion for employers by making it difficult to handle employee requests for information and assistance with multiple plans; and
- Substantially increases the potential for adverse selection by individualizing the selection of health plans.

In Massachusetts, the Connector pilot tested employee choice and decided to abandon the approach for one in which employers select a health plan on behalf of their workers. Evidence from state purchasing cooperatives also demonstrates that employee choice has created confusion that has dissuaded small employers from using these programs.

The ACA permits qualified employers to select the health plan they want for their employees (as they do today). Specifically, the very definition of a "qualified employer" in section 1312(f)(2), is a small employer that elects to make all full time employees “eligible for 1 or more qualified health plans” offered through the Exchange. However, under the ACA, qualified employers who purchase coverage through an Exchange also have the option to select a level of coverage (bronze, silver, gold, or platinum) and allow an employee to choose among any plan offered at that level of coverage within an Exchange, [ACA Section 1312(a)].

Because Congress allowed employers to specify just one health plan for enrollment or to specify the level of coverage made available to their employees, SHOP Exchanges, employers, and health plans are faced with unique challenges that are not present in an individual Exchange. We note that some have interpreted section 1312(a) as allowing employees of qualified employers to choose any plan at the specified level and thereby prohibiting employers from selecting one or more plans for their employees. However, this provision is clearly permissive in that an employer is not required to specify a level of coverage – they “may” specify a level of coverage – and only if they do can employees choose among plans at that level of coverage. Moreover, the definition of a qualified employer makes clear an employer may select a plan (or plans) for its employees.

We urge HHS to clarify in regulation that states must allow employer choice and may provide employee choice of health plans. We also recommend that Exchanges pilot test the systems necessary to permit employee choice of health plans before implementation, should they wish to permit this option, to ensure that this provision is feasible from a systems perspective, and practical relative to the trade-off between choice on one hand, and administrative complexity and consumer confusion on the other.

Additional clarification is needed to address the substantial administrative problems that would be created for employers with employees in multiple states if employees were allowed to obtain coverage from the Exchange in the state in which they reside rather than the state where the employer is headquartered. As such, we urge HHS to clarify that a qualified employer will contract with the Exchange in which the employer is headquartered with respect to the employer choice option. This will ease administration and ensure that employers do not forum-shop for Exchanges and health plans.

Recommendation #9: Establish Effective Open and Special Enrollment Policies to Ensure a Stable Health Insurance Market in 2014 and Beyond

Open enrollment periods should be adequate in length to allow individuals time to make decisions and enroll in coverage, but should not be long enough to allow “just in time” insurance. The use of a limited period is intended to encourage individuals – including healthy individuals – not to delay enrollment given they are unable to predict health needs for extended periods of time. This in turn creates more affordable premiums because of a more balanced, stable insurance pool.

A longer open enrollment period in advance of 2014 makes sense given that the public will be need to become accustomed to the new system of Exchanges and subsidies. More public education will be needed for 2014 than subsequent years.

A reasonable approach would be to establish a 45-day initial open enrollment period. Based on experience implementing Medicare Part D, it may be necessary to begin this open enrollment period as early as August, with coverage effective January 1, 2014. In later years, open enrollment could occur during October, with a January 1 effective date.

A lag between enrollment periods and effective dates is essential for providing time for enrollment, billing, subsidy, and other information to be processed, as well as allow for consumers to receive identification cards and any necessary start-up communications between enrollees, insurers, Exchanges, the Internal Revenue Service, HHS, and other parties.

While the ACA requires initial Exchange coverage to be effective on January 1, 2014 and thus open enrollment periods logically must occur sometime in the late summer and early fall of 2013. Consideration should be given to moving subsequent open enrollment periods and coverage effective dates to other times of the year, and staggering such periods and effective dates for different markets so that health plans do not have all of their business turning over on the same date. Medicare Advantage, Medicare Part D and many large employers turn over on January 1st. Having small group market and individual market coverage also turn over on January 1st would place enormous strain on staffing and enrollment systems. Staggering open enrollment periods going forward would help relieve this strain, potentially enhancing customer service and achieving administrative efficiencies.

We recommend distinguishing between open enrollment periods in the individual market versus the small group market. A limited open enrollment period is critical to prevent adverse selection in the individual market. However, continuous guaranteed issue in the small group market has been the practice in all states since the 1990s. The regulations should clarify that carriers have flexibility to provide continuous guaranteed issue in the small group market while limiting open enrollment to a single 30-day period in the individual market. However, once employers enroll in Exchanges, their employees must select plans within 30 days (consistent with how employer plans generally address initial open enrollment today) and adhere to special enrollment periods outside of this period.

We recommend that HHS establish open and special enrollment periods that are uniform both inside and outside of Exchanges to simplify public education and limit insurers' and potential enrollees' ability to game enrollment periods.

Recommendation #10: Create a Robust Risk Adjustment System and Temporary Reinsurance Program to Ensure Broad Choice of Plans on Exchanges

An effective risk adjustment system is critical to assuring a broad choice of health plans to compete for consumers on Exchanges, as well outside Exchanges, when significant market reforms (e.g., guaranteed issue) go into effect in 2014. Experience with state purchasing cooperatives indicates that health plans offering higher benefit levels and broad networks are likely to suffer adverse selection. While risk adjustment may not fully be able to account for this selection, developing the most robust risk adjustment system possible will help assure consumers have a range of plan choices.

Extensive planning will be needed prior to 2014 to develop an effective risk adjustment system. While Medicare and Medicaid will provide valuable insights into developing risk adjustment systems for the private market, key differences between government programs and private markets such as source of payments and variation in benefit design, need to be taken into

account. The frequency with which enrollees will be expected to migrate in and out of individual and small group coverage also will pose design challenges.

Careful consideration should be given to how risk adjustment will interact with the temporary reinsurance and risk corridor programs, as well as other requirements affecting enrollee premiums and carrier finances (e.g., substantive rating rules, calculation of medical loss ratio rebates, timing of premium subsidy payments, etc.). It is noteworthy that different parties have different responsibilities for administering these programs and regulations. A failure to coordinate these requirements could be extremely disruptive to the marketplace. Consideration should also be given to the phase out of state and federal high risk pools. The initial influx of high risk members into Exchange and non-Exchange pools will cause highly volatile, unpredictable large loss scenarios for some if not all health plans and therefore should be included in the risk adjustment modeling.

BCBSA is in the process of developing detailed risk adjustment and temporary reinsurance program recommendations for consideration by the Department. We look forward to working with the Department to ensure that these critical features of the ACA are effective.

Recommendation #11: Exchange Governance Must Ensure Protection from Political Influence, Knowledge of Insurance Markets, and Fiduciary Accountability

Section 1311(d) of the ACA says Exchanges must be a government entity or a non-profit entity established by the state. In effect, states are presented with three basic options with respect to Exchange governance: a fully governmental approach (e.g., an arm of the state government housed within a state agency or governor's office), a quasi-governmental approach (like the Connector in Massachusetts), or a fully private non-profit entity.

While states are in the best position to determine the appropriate governance structure for Exchanges, we recommend consideration of the following factors:

- The Exchange should be designed and implemented in a manner that complements the functions of state insurance regulators. Exchange functions should not conflict with, overlap with, or build upon functions currently performed by insurance regulators, such as market conduct, review or approval of rates and forms, or solvency regulation;

- Exchanges should include a governance approach that provides for adequate formal input from key stakeholders with knowledge of the health insurance market, including health actuaries and health plans, and for appropriate accountability to a legislative or executive body within the state;

- Exchanges should be structured in a manner that ensures that they have a fiduciary relationship to enrollees. Exchanges could potentially handle billions of dollars in premiums annually. For example, although individuals may pay their premiums directly to a QHP, employers must pay Exchanges for "free choice vouchers" (and Exchanges must pay enrollees any excess from the voucher after purchasing coverage). Exchanges may also secure funding from fees on insurance plans and other sources. Therefore, specific fiduciary standards are necessary to safeguard the use of these funds and ensure that funds are not diverted for other purposes;

- Exchanges should be free from overt political influence concerning the plan choices available to consumers. Exchanges should develop governing documents that explicitly

incorporate ethics standards, accountability to members, freedom from conflict of interest and political interests, transparency and fiduciary standards.

Our comments on the specific questions included in HHS' request for comments are set forth in the attached chart.

* * *

We appreciate your consideration of our comments on request for information. We look forward to continuing to work with the Departments on implementation issues related to the Affordable Care Act. If you have any questions, please contact Kris Haltmeyer at (202) 626-4814 or at kris.haltmeyer@bcbsa.com.

Sincerely,

Alissa Fox
Senior Vice President
Blue Cross Blue Shield Association

BCBSA Detailed Responses:

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

HHS Office of Consumer Information and Insurance Oversight

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RFI Q&As

A. State Exchange Planning and Establishment Grants

1. Questions:

- **What factors are States likely to consider in determining whether they will elect to offer an Exchange by January 1, 2014? (A)(1)**
- **To what extent are States currently planning to develop their own Exchanges by 2014 (e.g., become electing States) versus choosing to opt-in to an Exchange operated by the Federal government for their State? (A)(1)**
- **When will this decision be made? (A)(1)**
- **Can planning grants assist in identifying and assessing relevant factors and making this decision? (A)(1)**

Response:

BCBSA supports broad state flexibility to implement Exchanges. Providing states with flexibility to structure their Exchanges to meet the needs of their residents – including critical design features such as criteria for qualified health plans and approach to selection of health plans – will enhance the likelihood that states will implement Exchanges.

We understand that some states have raised concerns about the need for clear guidance on federal funding to support development of Exchanges until they are self-sustaining. The federal government should support state efforts through flexible grant programs, communication of plans for development of minimum data and IT systems for the coordination of eligibility and subsidy payments, and continuing to send the message that it will be flexible with regard to state design and implementation of Exchanges.

As described in the answer to the next question, most states are in the early stage of discussions regarding Exchange development. The formal deadline in the statute for notification of intent to implement Exchanges is not until Summer 2012. However, states will need to begin work on Exchange development quickly to allow for enrollment in 2013 for January 1, 2014. We recommend that HHS continue to provide outreach to ensure that states have the tools to implement Exchanges successfully.

2. Questions:

- **To what extent have States already begun to plan for establishment of Exchanges? (A)(2)**
- **What kinds of activities are currently underway (e.g., legislative, regulatory, etc.)? (A)(2)**
- **What internal and/or external entities are involved, or will likely be involved in this planning process? (A)(2)**
  - **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.)? (A)(2)(a)**
  - **To what extent have States begun developing business plans or budgets relating to Exchange implementation? (A)(2)(b)**

Response:

Blue Cross and Blue Shield Plans have reported substantial activity at the state level to evaluate the development of Exchanges. During 2010, five states enacted laws to establish Exchanges or expand the operations of existing ones. BCBSA is aware that other states are in the process of holding informal cross-stakeholder discussion sessions to inform recommendations to their state

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legislators for 2011 action. States have created or are using Exchange planning grants to form Exchange Study Committees that will be holding hearings and making formal recommendations to their legislatures during their 2011 sessions. In addition, several states have pre-filed Exchange legislation for introduction next year. BCBSA will monitor Exchange development and passage of state legislation and would be pleased to share information with the Department on an ongoing basis.

We have heard that a variety of approaches related to governance are under discussion at the state level. While BCBSA has not recommended a particular structure regarding an Exchange as a state agency or non-profit, we recommend consideration of the following factors to ensure protection from political Influence, knowledge of insurance markets, and fiduciary accountability:

- Exchanges should be designed and implemented in a manner that complements, not duplicates, the functions of state insurance regulators. Exchanges should not conflict with functions currently performed by insurance regulators, such as market conduct examinations, review of rates and forms, or solvency regulation;

- Exchanges should include a governance approach that provides for adequate input from key stakeholders with knowledge of the health insurance market, such as insurance actuaries and health plans;

- Exchanges should be structured in a manner that ensures that they have a fiduciary relationship to enrollees. Exchanges may handle billions of dollars in premiums annually. For example, although individuals may pay their premiums directly to a QHP, employers must pay Exchanges for "free choice vouchers" (and Exchanges must pay enrollees any excess from the voucher after purchasing coverage). Exchanges may also secure funding from fees on insurance plans and other sources. Therefore, specific fiduciary standards are necessary to safeguard these funds and ensure that they are not diverted for other purposes; and

- Exchanges should be free from overt political influence concerning plan choices available to individuals and small employers. For example, while the ACA gives Exchanges authority to consider excessive or unjustified rate increases as a reason for excluding health plans from Exchange participation, Exchanges should not determine rates for health plans. As mentioned in the first bullet above, Exchanges should avoid duplicative regulation and work in concert with state insurance regulators. Exchanges should develop governing documents that explicitly incorporate ethics standards, accountability to members, freedom from conflict of interest and political interests, transparency and fiduciary standards.

3. Question:

- **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? (A)(3)**

Response:

BCBSA has offered detailed recommendations on Exchange design in response to subsequent questions in the RFI (see responses to question D(1)). However, some major factors states are likely to consider in determining how to structure their Exchanges include the following:

- *Single or separate Exchanges.* The bill gives states flexibility to determine whether to

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implement combined or separate Exchanges for individuals and small groups, according to which approach best meets the needs of their unique markets.

State consideration of combining Exchanges will correlate to decisions regarding whether to merge the individual and small employer markets. States will need to carefully evaluate the impact of such merger on policyholders, as merger of the markets may result in undesirable adverse selection and cross-subsidization of markets that may outweigh the perceived advantages of pooling these markets. The ACA specifically delegates this decision for each state to make individually, separate and apart from Exchange structural decisions, and Federal regulations should not limit state flexibility in this regard.

For states that choose to establish separate individual and SHOP Exchanges, we recommend that certification of health plans be handled separately for individual and SHOP Exchanges with no requirement for health plans to serve both Exchanges. Some states may find it more administratively efficient to use a single Exchange instead of separate individual and SHOP Exchanges. Where individuals and small employers obtain coverage through a single Exchange, states may want to consider separate administrative functions to accommodate differences between these markets. However, states could still leverage vendor contracts and achieve administrative efficiencies by keeping the Exchanges separate and allowing them to share certain services.

Regardless of whether a state establishes a single Exchange for both markets or separate individual market and SHOP Exchanges, states should be allowed to maintain separate individual market and small group market risk pools, health plans should be able to elect to participate in one or both markets, and health plans should be able to offer different products to the different markets.

- *Regional Exchanges*. We have a number of concerns regarding how health plans would interact with regional Exchanges. For example, the level of state regulation, public program options and eligibility requirements and the number and distribution of uninsured – just to name a few important market conditions – can vary dramatically among states, even contiguous ones. In addition, regional Exchanges, with their overlapping state authority, could lead to regulatory challenges if it is unclear which state's laws would prevail. Health plans should not be allowed to enter one market and operate under rules that are based in another jurisdiction that may be less stringent.

- *Subsidiary Exchanges.* States considering this approach should assess the cost-effectiveness of establishing multiple rather than a single, statewide Exchange as well as the impact of this decision on the number and type of health plans likely to participate in the Exchange.

4. Questions:

- **What kinds of factors are likely to affect States' resource needs related to establishing Exchanges? (A)(4)**
  - **What is the estimated range of costs that States are likely to incur during the upcoming year (e.g., calendar 2010 through calendar 2011) for each of the major categories of Exchange activities? Which of these expenses are fixed costs, and which costs are variable? (A)(4)(a)**
  - **To what extent do States have existing resources that could be leveraged as a starting point for Exchange operations (e.g. existing information technology (IT) systems, toll-free hotlines, websites, business processes, etc.)? (A)(4)(b)**
  - **For what kinds of activities are States likely to seek funding using the Exchange**

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establishment and planning grants? (A)(4)(c)

Response:

An Exchange could have significant budgetary implications for states, depending on the structure and duties of the entity. According to a white paper prepared by the National Governor's Association[1], the Massachusetts Connector, which was established as an entirely new quasi-public agency with its own staff and executive director, has a budget of about $30 million per year. This is far higher than the budget for either Utah or Washington (which has not yet launched its Exchange) – Utah's 2009 Exchange budget was about $600,000; the budget for the Washington state Exchange (not yet in operation) is expected to be about $1 million per year.

CMS actuaries estimate Exchange-related administrative functions will cost states $35.3 billion through 2019 based on the Massachusetts experience. Federal government Exchange administrative costs are estimated to be $2.4 billion in the same period.

It is important that development costs not undermine state efforts to implement Exchanges. The federal government should provide information on what kind of financial assistance states should expect with regard to establishment of new IT systems needed for purposes of enrollment and subsidies. To achieve some Exchange functions, it is possible that Health Information Exchanges (HIEs) currently in limited operation among states (to date the majority of states have only started planning for HIE infrastructures, and most functioning HIEs are still at early stages of functionality), will provide some of the infrastructure for plans and providers to transmit information to the new state Exchanges (e.g., providers might use the HIE to send information about patients' medical records to the Exchange for purposes of risk adjustment). However, it may be some time before the states and the federal government resolve important business and policy issues such as governance (e.g., who runs the HIE, who enforces "infractions"), privacy (e.g., how much control will individuals have over access to their sensitive information), and financial sustainability (e.g., few HIEs have developed a sustainable business model). Additional suggestions with regard to Exchange IT systems are provided in response to question C(4) below.

Beyond the HHS state Exchange planning and establishment grants that will fund start up costs, states will need to consider additional funding sources in order for their Exchanges to be self-sustaining by January 1, 2015. We support states exploring broad-based funding options through new tax revenue, including tobacco taxes, grants from private stakeholders, and fees and assessments that could be applied broadly and not targeted solely to health insurers.

Because Exchanges could eventually rely on funding from assessments on the premiums paid by consumers, it is critical that they be efficient and do not duplicate or supplant existing government functions currently funded in states. Premium assessments should be used only to support operation of Exchanges and HHS should ensure that states cannot support other functions of state government through assessments on consumer premiums as costs for operating an Exchange will ultimately be borne by taxpayers and policyholders.

5. Questions:

- **What kinds of questions are States likely to receive during the initial planning and start-up phase of establishing Exchanges? (A)(5)**
- **How can HHS provide technical assistance, and in what forms, in helping States to**

[1] "Establishing a State Level Exchange," an NGA Discussion Draft.
[2] Seifert, Robert, et. al., "Enrollment and Disenrollment in MassHealth and Commonwealth Care," April 2010. http://www.massmedicaid.org/~/media/MMPI/Files/2010_4_21_disenrollment_mh_cc.pdf

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answer these questions? (A)(5)

Response:

We expect that some of the primary questions states will have will concern operational issues for determining eligibility and subsidy administration.

HHS guidance should include federal requirements on how new eligibility systems will coordinate with current Medicaid eligibility systems and how state eligibility systems will need to communicate with federal systems for determining subsidy eligibility. Such guidance should also indicate whether the federal government will pay for the systems both initially and on an ongoing basis, and to what extent states should budget for necessary elements.

HHS should also provide clarity as to the definition of Modified Adjusted Gross Income (MAGI). New criteria will be used for determining household income for eligibility of the Exchange subsidies and Medicaid. States will need clear definitions and parameters for determining the MAGI in addition to coordinating enrollment among coverage in Medicaid, CHIP and private subsidized coverage.

We also recommend publication of information on the federal government's systems and processes to facilitate subsidy payment and how those systems will interact with Exchanges and health plans. We have provided detailed comments on the potential complexities related to subsidy administration in responses to subsequent questions.

Examples of health plan processes that will need to be modified for participation on Exchanges include tracking subsidy eligibility, development of IT/website infrastructures, product design, outreach and marketing. BCBSA recommends that Exchanges specify clear, objective and reasonable standards for participation of QHPs as specified in subsequent questions. Exchanges should specify requirements for health plans as soon as possible and no less than 18 months prior to the beginning of enrollment. Plans will need to have an understanding of an Exchange's operational requirements no later than the late spring of 2012, in order to implement systems and budget for related expenses in 2013.

B. Implementation Timeframes and Considerations

1. Questions:

- **What are the key implementation tasks that need to be accomplished to meet Exchange formation deadlines and what is the timing for such tasks? (B)(1)**
- **What kinds of business functions will need to be operational before January 1, 2014, and how soon will they need to be operational? (B)(1)**

Response:

Development of Exchanges to enable seamless enrollment, plan selection, and subsidy determination in the Fall of 2013 will be an enormous undertaking for the federal government, the states and health plans.

Implementation tasks and functions that will have to be operational by the third quarter of 2013 and no later than 2014 include:

- Definition of Minimum Essential Benefits as platform for building metallic products
- Eligibility/subsidy determination systems

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- Enrollment systems
- Financial systems, including subsidy reconciliation
- IT/Website infrastructure
- Data security and back-up systems
- Accounting and financial accounting systems
- Call center
- QHP procurement system
- Provider network search infrastructure and interface for consumers
- Risk adjuster/risk corridor and reinsurance methodology
- Comparison tools for consumers
- Reporting requirements

We urge state and federal regulators to publish the requirements for participating health plans no later than the late spring of 2012 to assure that health plans have time to implement the systems necessary to interface with Exchanges effectively for testing and open enrollment in 2013.

2. Question:

- **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? (B)(2)**

Response:

Clarification will be necessary regarding the functions that the federal government expects to perform or assistance provided to states concerning IT systems, information standards (e.g., for eligibility determination or any other minimum data sharing that will be required for the operation of Exchanges), minimum federal requirements for QHPs, guidance around metallic levels/actuarial equivalence standards, and operational issues regarding the structure of Exchanges. States and health plans will need to know the basic requirements for the federal government in these areas so that they can work with vendors to develop the systems necessary to make Exchanges work effectively.

We urge HHS to make this information available as quickly as possible, but provide an opportunity for public comment as part of the rulemaking process. Proposed standards and methodology should be issued by HHS for formal notice and comment under a Notice of Proposed Rule Making (NPRM) prior to finalization and adoption.

C. State Exchange Operations

2. Questions:

- **For which aspects of Exchange operations or Exchange standards would uniformity be preferable? (C)(2)**
- **For which aspects of Exchange operations or Exchange standards is State flexibility likely to be particularly important? (C)(2)**

Response:

As mentioned previously, BCBSA recommends that HHS give states substantial flexibility in their approaches to implementing Exchanges. Health insurance markets, regulatory environments, and consumer preferences vary substantially across states. State flexibility will be critical to harness state innovation to test which Exchange model provides the best value over time, ensure that Exchanges meet local consumer needs, and ensure that states are invested in creation and

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ongoing management of Exchanges.

While there are areas where the federal government will likely need to provide standardization, such as data requirements to facilitate enrollment and subsidy administration, substantial flexibility should be provided regarding the design of Exchanges where the ACA does not include explicit requirements for Exchanges. To minimize the administrative burden of sharing information on both the government and private plans, the minimum data necessary should be collected to operate Exchanges and risk adjustment programs. When considering development of standardized data sharing formats, existing industry standards should be used wherever possible.

While we support state flexibility, we also acknowledge that states will have to meet the requirements of the ACA, including implementing standards for QHPs. HHS should encourage states to develop and implement Exchanges by assuring that they will be given substantial latitude in designing Exchanges under Section 1321 (concerning state flexibility) and that federal enforcement of a federal fall-back Exchange will be an absolute last resort if a state fails to create an Exchange meeting the basic requirements of the ACA.

State flexibility will be especially important in the design of:

- How an Exchange selects health plans (in particular, states should be permitted to allow all qualified plans to participate in Exchanges subject to validation through market oversight),
- Standards for health plan benefits (e.g., flexibility for health plans to varying cost-sharing, care management, and wellness programs),
- Functions performed by the Exchange versus other state agencies (e.g., the insurance department),
- Customization of websites and shopping tools,
- Managing coverage transitions to and from an Exchange,
- Determining the number of Exchanges, and
- Whether individual and SHOP Exchanges should remain distinct or be consolidated.

3. Questions:

- **What kinds of systems are States likely to need to enable important Exchange operational functions (e.g., eligibility determination, plan qualification, data reporting, payment flows, etc.), to ensure adequate accounting and tracking of spending, provide transparency to Exchange functions, and facilitate financial audits? (C)(3)**
- **What are the relative costs and considerations associated with building Exchange operational, financial, and/or IT systems off of existing systems, versus building new standalone Exchange IT systems? (C)(3)**

Response:

Exchanges will need to develop systems for handling subsidy payments, eligibility determinations, health plan enrollment, and systems to ensure financial integrity and reporting. States will need to evaluate whether it would be sufficient for them to rely on systems already in place that support their Medicaid program, (e.g., for determining eligibility). However, these systems have limitations that likely will prevent them from performing all functions that will be necessary in the new Exchange environment. For example, today systems are not set up to determine eligibility based on the new Modified Adjusted Gross Income (MAGI), nor is there an established payment system for the new federal subsidies.

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4. Questions:

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

Response:

One particular issue that should be addressed through a federal approach is the need for uniformity of IT interfaces and data transmission standards with respect to how eligibility for subsidies and state public programs is determined, and how enrollment and subsidy eligibility data are communicated among states, health plans, and relevant federal agencies.

To achieve some Exchange functions, it is possible that Health Information Exchanges (HIEs) currently under limited operation among states, (to date the majority of states have only started planning for HIE infrastructures, and most functioning HIEs are still at early stages of functionality), will provide some or all of the infrastructure for plans and providers to transmit information to the new state Exchanges (e.g., providers might use the HIE to send information about patients' medical records to the Exchange for purposes of risk adjustment).

However, it may be some time before the states and the federal government resolve important business and policy issues such as governance (e.g., who runs the HIE, who enforces "infractions"), privacy (e.g., how much control will individuals have over access to their sensitive information), and financial sustainability (e.g., few HIEs have developed a sustainable business model).

Achieving HHS' goal of a Nationwide Health Information Network (NHIN) would not be possible if states were to build their own unique health information Exchanges (HIEs). Any state-based HIE should follow technical, privacy, and security standards adopted by the federal government to ensure interoperability. For example, states should use the standard format for transferring enrollment data that is required to be developed under Section 1561 of ACA.

That said, states should be permitted to tailor Exchange IT systems to their local environment to the extent that such tailoring does not create obstacles to interoperability or create additional administrative burden for health plans. For example, states may seek to include a HIE within their overall Exchange functionality and take different approaches to the underlying data architecture: some may want to base an HIE on a highly decentralized federated model, others may want to base an HIE on a model with a centralized data repository, others may want to take a hybrid approach.

Regardless of a state's approach, achieving the necessary performance level within the available timeframes will be a costly undertaking. Concerns have been expressed about states' ability to finance the IT solutions necessary for operating their Exchanges. Beyond the HHS state Exchange planning and establishment grants that will fund start up costs, states will need to consider additional funding sources in order for their Exchanges to be self-sustaining by January 1, 2015. We support states exploring broad-based funding options through new tax revenue, including tobacco taxes, grants from private stakeholders, and fees and assessments that could be applied broadly and not targeted solely to health insurers.

As discussed above in response to question C(3), some states may attempt to build out their existing Medicaid IT infrastructures to build the necessary capabilities. Given the economic pressures in states today, we are concerned that states may seek to fund the system development

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that will be necessary to enroll the Medicaid population through Exchange administrative costs. We strongly discourage this approach because it could ultimately lead to assessments on health plans and result in higher premiums for consumers.
5. Question: • **What are the considerations for States as they develop web portals for the Exchanges? (C)(5)** **Response:** Portal requirements should ensure clear reporting requirements and sufficient time for health plans to comply. This will be accomplished by providing: • Adequate time for health plan submissions, including product and rate filings and approvals from all regulatory agencies involved, • Sufficient training to ensure clear requirements are conveyed accurately; and • A defined schedule for validating and correcting problems within public and private data systems. Although ACA does not require a report on the lessons learned in establishing the HHS portal, such information would be valuable to states and health plans for implementation of state web portals. To ensure web portals are useful tools to consumers, careful planning needs to include consumer testing and ensure: • Ease of use for consumers, including the availability of an online tutorial, • Information is accessible by all audiences, • Plan comparisons allow for provider search capability, • Alignment with education and outreach efforts, and • Ability for members to identify non-benefit and non-plan design related services and capabilities of health plans. Portal designs should ensure that plans receive a balanced mix of risk. Some have suggested that information be provided as to how individuals with specific health conditions would fare across health plans. Given that risk adjustment is not likely to compensate health plans fully for adverse selection, especially in the early years, we recommend avoiding this level of specificity. If an index of out-of-pocket costs or network adequacy is provided on a portal, it should be general in nature and not take specific health conditions into account. If significant adverse selection develops, it may cause health plans to adjust benefits and networks to avoid attracting a disproportionate share of high cost individuals which could limit health plan choices. We also recommend that portals prominently display an after-subsidy or after-tax calculator to educate consumers and small employers who are eligible for federal assistance on their true cost for health insurance. Education on the value of subsidies will be especially important to ensure a balanced risk pool in the early years of implementation of the ACA as the personal responsibility requirements are phased-in. Additionally, a state may want to establish a tutorial for consumers to understand how to navigate between plans if necessary (e.g. Medicaid to a private health plan in an Exchange, or from a non-subsidized health plan to a subsidized health plan).

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6. Questions:

- **What factors should Exchanges consider in reviewing justifications for premium increases from insurers seeking certification as QHPs? (C)(6)**
- **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? (C)(6)**

Response:

While the ACA explicitly provides that Exchanges consider excessive or unjustified rate increases as a reason for decertifying QHPs, nothing in the ACA directs Exchanges to negotiate with health plans over premiums. The ACA's Exchange provisions should not subvert state regulatory authority by setting up an alternative rate regulator. It would be duplicative and burdensome to transfer this existing authority to a new Exchange entity, and thus we suggest that rate review authority, including the rate increase justification process, remain solely with the state insurance departments. State insurance departments can then work together with the Exchanges to determine whether a particular QHP should be excluded from an Exchange.

The ACA already provides rate review grants to states. The ACA's rate review function includes making recommendations regarding whether particular health insurance health plans should be excluded from participation in an Exchange based on a pattern or practice of excessive or unjustified premium increases. BCBSA recommends that Exchanges rely on the experience and knowledge of their own state insurance commissioners in reviewing premium increases, and defer to their judgment on what premium increases are unjustified.

It is critical that the state regulatory authority in charge of reviewing health plans' rates (generally the state insurance department) be the sole entity that determines whether a plan has proposed an "unreasonable" premium increase. Having an Exchange set rates would create policy and legal issues since the insurance regulator, not the Exchange, is responsible for approving rates and ensuring health plan solvency. State insurance departments have vast experience and understanding of their own market and are better equipped to determine whether any insurer's rate is "unreasonable" or whether limiting increases would destabilize the insurance market.

BCBSA recommends that states not make recommendations for exclusion of health plans in an Exchange based on comparison to pre-2014 rates. Coverage offered in 2014 will reflect a significant number of rate changes related to imposition of insurance reforms that will not allow for a fair comparison with rates for coverage in prior years, including:

- The effects of rate compression when modified community rating takes effect in 2014. While the ACA includes temporary reinsurance, there will still be substantial variability in rates in 2014 -- with younger and healthier people paying more and older and sicker individuals paying less than they do in the individual market in most states today;
- Required benefit packages, which are likely to be more comprehensive than coverage purchased in the individual market today;
- The end of the federal Pre-Existing Condition Insurance Plan Program and the possible entrance of those individuals into the Exchange; and
- Uncertainty regarding the relative claims cost of those who will purchase coverage in Exchanges initially given the weaker personal responsibility requirements in 2014 and 2015.

It is important that the market be allowed to adjust to the impact of reform for several years before historical information about rate increases is used as a basis by which health plans are excluded from participation in Exchanges.

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8. Question:

- **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? (C)(8)**

Response:

To minimize administrative burden and costs, we recommend that Exchanges conform to the most relevant federal rules regarding cultural and linguistic appropriateness, specifically the Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Internal Claims and Appeals and External Review Processes Under the ACA – to determine which non-English speaking individuals need assistance – and the current rule for Summary Plan Descriptions (29 C.F.R. § 2520.102-2) – to determine the nature of that assistance.

- **Methodology for "Threshold" Languages.** To meet the ACA requirement for linguistically appropriate notices, the appeals and external review rule requires that plans provide language assistance to individuals who are literate in a non-English language that meet a certain threshold. We recommend to the extent possible, that HHS use a standard methodology in ACA rulemaking for determining when non-English language notices and language assistance be given. It would be inefficient and significantly complex to require different methodologies for different notices or aspects of a health plan's business.

  Of greatest relevance to Exchanges would be the methodology for determining threshold languages in the individual market: a threshold language is one in which 10 percent or more of the population in the claimant's county is literate in the non-English language. The methodology should recognize that some health plans may not be aware or able to determine the language spoken by each member of a plan for purposes of evaluating whether non-English notices are required. Setting the thresholds by plan, rather than county, could result in an overwhelming burden for plans. Therefore, Exchanges should require that QHPs provide assistance in a non-English language in which 10 percent or more of the population residing in the geographic service area of the Exchange are literate only in the same non-English language.

  Technical guidance related to the appeals and external review rule for health plans in the individual market directs plans to use Census data to determine in which non-English languages they must provide notices. However, the data does not clearly specify the language in many instances. For example, one category is "Other Indo-European languages." In those cases in which the data indicates a category of languages rather than a specific language, we suggest that an issuer be permitted to demonstrate compliance by either providing notices in the most common language in the category for the state or surveying its membership in the state to determine which specific languages within the category meet the threshold requirements.

  Finally, given past experience, we recommend that non-English notices be provided to members only upon request. This would ensure that health plans do not offend members by providing non-English notices automatically.

- **Assistance.** The rule for Summary Plan Descriptions (SPD) requires that the plan administrator provide participants who speak a threshold non-English language with a notice in that non-English language offering participants assistance. The rule states: "The assistance provided need not involve written materials, but shall be given in the non-English language

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common to these participants and shall be calculated to provide them with a reasonable opportunity to become informed as to their rights and obligations under the plan." Therefore, Exchanges should require that QHPs give their members notices in the threshold non-English language that assistance in that non-English language is available that would give members a reasonable opportunity to become informed as to their rights and obligations under the plan.

As under the SPD rule, the Exchanges could require that plans provide a phone number that members could call at certain hours (the example given in the SPD rule is "8:30 A.M. to 5:00 P.M. Monday through Friday") to ask for assistance. Moreover, plans should have the flexibility to develop other approaches to meet the needs of diverse individuals, such as having open benefit meetings for family members (since younger family members are likely to be more fluent in English), or having bilingual or separate meetings via webcasts in another language or make translation services available as appropriate.

9. Question:

- **What factors should the Secretary consider in determining what constitutes as wasteful spending (as outlined in Section 1311(d)(5)(B))? (C)(9)**

Response:

The ACA states that no funding for Exchanges should be used for staff retreats, promotional giveaways, excessive executive compensation, or promotion of Federal or State legislative and regulatory modifications. We agree and also recommend that Exchanges be structured in a manner that ensures that they have a fiduciary relationship to enrollees. Exchanges may handle billions of dollars in premiums annually. For example, although individuals may pay their premiums directly to a QHP, employers must pay Exchanges for "free choice vouchers" (and Exchanges must pay enrollees any excess from the voucher after purchasing coverage). Exchanges may secure funding from fees on insurance plans and other sources. Therefore, specific fiduciary standards are necessary to safeguard the use of these funds and ensure that funds are not diverted for other purposes.

Beyond the HHS state Exchange planning and establishment grants that will fund start up costs, states will need to consider additional funding sources in order for their Exchanges to be self-sustaining by January 1, 2015. We support states exploring broad-based funding options through new tax revenue, including tobacco taxes, grants from private stakeholders, and fees and assessments that could be applied broadly and not targeted solely to health insurers.

Because Exchanges could eventually rely on funding from assessments on the premiums paid by consumers, it is critical that they be efficient and do not duplicate or supplant existing government functions currently funded in states. Premium assessments should be used only to support operation of Exchanges and HHS should ensure that states cannot support other functions of state government through assessments on consumer premiums as costs for operating an Exchange will ultimately be borne by taxpayers and policyholders.

D. Qualified Health Plans

1. Question:

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

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Response:

BCBSA believes it is important to establish reasonable standards for participating health plans in order to assure that consumers have a choice of health plans in Exchanges when they first become operational. The ACA includes numerous, specific certification criteria for QHPs, including requirements in the areas of marketing, network adequacy, accreditation, quality improvement, enrollment forms, and so on. It is important to allow states to establish standards and to not start with an approach that creates a federal floor beyond ACA certification criteria. The key idea behind Exchanges is to make the market more competitive. It is critical, then, that Exchanges not adopt an overly prescriptive approach.

In specifying the implementation of the ACA requirements, it is important to ensure standards can be met initially, recognizing the need for broad participation and the enormous operational challenges health plans will face in implementing all of the 2014 reform requirements. If necessary, standards for QHPs could be strengthened as Exchanges become established over time. For example, initial accreditation requirements related to clinical quality measurement could accept NCQA or URAC accreditation requirements developed for certification of QHPs. The initial accreditation requirements could be focused on ensuring certain processes are in place for measuring designated outputs, and later strengthened to require threshold outputs of QHPs.

While BCBSA recommends an approach that will maximize competition, QHP standards must guarantee market stability and consumer protection by assuring that only state-licensed health plans with a proven ability to bear risk may participate. Consumers will not be well served if undercapitalized or inexperienced players enter Exchanges and then fail.

QHP standards need to be in place in time for health plans to modify their operations in the lead up to the January 2014 effective date for Exchanges.

BCBSA recommends that Exchanges specify their operational requirements for health plans no less than 18 months prior to the beginning of enrollment. Plans will need to have an understanding of an Exchange's operational requirements no later than the late spring of 2012, in order to implement systems and budget for related expenses in 2013.

Individual and SHOP Exchanges.

While some states may want to combine their individual and SHOP Exchanges, states should recognize that the individual and small group markets vary in a number of important ways, and structure their Exchange administration accordingly. For example:

- Not all health plans serve both the individual and small group markets;
- State and federal legal requirements vary between the individual and small employer markets (e.g., state benefit mandates, COBRA, legal remedies);
- Products are likely to differ between the individual and SHOP Exchanges in states that do not merge the individual and small group markets; a
- Distribution channels may differ between markets, with small employers likely to rely heavily on agents in Exchanges; and
- Rating structures differ between the two markets. For example, composite rating is common in the small group market, but has no corollary in the individual market. (Composite rating provides employers with a flat rate per employee, vs. age-rated policies, which vary based on an individual's age.)

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State consideration of combining Exchanges will correlate to decisions regarding whether to merge the individual and small employer markets. States will need to carefully evaluate the impact of such merger on policyholders, as merger of the markets may result in undesirable adverse selection and cross-subsidization of markets that could outweigh the perceived advantages of pooling these markets. The ACA specifically delegates this decision for each state to make individually, separate and apart from Exchange structural decisions, and Federal regulations should not limit state flexibility in this regard.

For states that choose to establish separate individual and SHOP Exchanges, we recommend that certification of health plans be handled separately for individual and SHOP Exchanges with no requirement for health plans to serve both Exchanges. Some states may find it more administratively efficient to use a single Exchange instead of separate individual and SHOP Exchanges. Where individuals and small employers obtain coverage through a single Exchange, States may want to consider separate administrative functions to accommodate differences between these markets.

Differences by Exchange Type.

The RFI also asks whether considerations in certifying QHPs differ in the context of regional or interstate Exchanges. We have a number of concerns regarding how health plans would participate in regional Exchanges. Since health plans will continue to be licensed and regulated at the state level under the Affordable Care Act, it will be critical for certification to occur on a state-by-state basis. Most health plans are local and many health plans do not serve entire states, let alone multiple states. Thus, requirements for certification must respect the licensed service areas of health plans or some community-based plans may not be able to participate. Health plans should not be allowed to enter one market and operate under rules that are based in another jurisdiction that may be less stringent.

It is not clear how regional Exchanges would operate across states. State regulations, public program options and eligibility requirements, and the number and distribution of uninsured – just to name a few important market conditions – can vary dramatically among states, even contiguous ones. Regional Exchanges, with their overlapping state authority, could also lead to regulatory confusion and complexity in the certification of QHPs. For instance, which state laws would prevail? Moreover, if regional Exchanges attempt to “pool” premium dollars, then there will likely be undesirable cross-subsidization of policyholders across states given the substantial variability in health care costs among states in a given region. Additionally, one state would lack authority over another state’s health plan regulations. For example, in some states, out-of-state trusts have been a problem where regulatory authority resides with the commissioner in the health plan’s domiciliary state with varying degrees of regulation and rate authority.

Some states may consider a regional approach because they are concerned about the cost of implementing Exchanges. The Affordable Care Act provides substantial support for states. We recommend that the Administration publicize its plans to assist states with developing Exchanges as soon as possible. For example, assistance with regard to development of an IT infrastructure for facilitating eligibility determination, plan selection and enrollment in Exchanges will be important in addition to assistance of administering subsidies or risk adjustment programs.

Some have recommended a regional approach to serve small employers that have employees in multiple states. Health plans have systems for providing coverage to employees living in states other than where an employer’s contract is issued today. However, if Exchanges were required to provide for employee choice of health plan, would this mean that such an employer would have to

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deal with multiple Exchanges? A solution to this problem is to permit employers to select the health plan for their employees in such instances, as we have discussed previously, which would simplify the employer's interaction, making the employer-health plan arrangement more closely align with current arrangements. (We have included a detailed rationale for this approach in our answer to question K(3)). Another potential option would be to allow states that set up their SHOP Exchange under an employee choice model to allow out of state employees to select their coverage from the Exchange in which the employer is headquartered.

Other – Niche Players and Adverse Selection

For Exchanges to allow for effective competition, all participating plans must compete on a level playing field concerning rules that ensure basic protections for consumers. There should be no exemptions from any certification standards for any particular type of plan – whether traditional health insurers, Medicaid health plans, provider-sponsored organizations, or COOPs. Section 1301(a)(1)(C) requires that QHPs be offered by a health insurance issuer that is, "licensed and in good standing to offer health insurance coverage in each State in which such issuer offers health insurance coverage."

As a case in point, some Medicaid managed care plans have proposed that they should be granted, at least initially, an exception from state solvency requirements. Their proposal would effectively deem Medicaid managed care plans as QHPs for participating on an Exchange by not requiring them to meet all ACA requirements. Support for their proposal is based on concerns that other subsidized private health plans on an Exchange may not include the same providers in their networks that individuals with Medicaid and CHIP are accustomed to seeing. The combination of the Medicaid and eligibility for new federal subsidies will likely result in a substantial number of individuals enrolling and disenrolling (or "churning") between coverage in state public programs and subsidized private coverage. For example, in Massachusetts, 27 percent of case openings in MassHealth (Medicaid) and 67 percent of all case openings in the subsidized Commonwealth Care program moved from one of the state's other public programs (MassHealth or Commonwealth Care) or the states former uncompensated care program (Health Safety Net) from January 2008 through April 2009.[2]

States are currently implementing various strategies to ensure continuity of coverage for individuals with lower incomes. States could also consider new strategies without waiving ACA requirements, including applications for Medicaid demonstrations that could allow for wrap around coverage.

HHS regulations should ensure consumers do not experience gaps in coverage to the greatest extent possible while also ensuring consumers are clearly guaranteed access to coverage in Exchanges that meets ACA requirements. As states weigh options for ensuring continuity of coverage for lower income populations, they must also ensure consumers receive the level of protection required by the ACA. While collectively, BCBS Plans serve millions of individuals in Medicaid managed care, allowing health plans onto Exchanges without meeting the same level of ACA requirements as other QHPs would not be in the best interest of consumers. Specific BCBSA recommendations to address continuity of coverage are made below in response to question G(3) of the RFI.

It's particularly important that no waivers of state solvency requirements be granted to any plans. Such waivers would be a dangerous precedent that could expose consumers, providers, and Exchanges to potential health plan failure, unpaid claims, and substantial negative publicity.

[2] Seifert, Robert, et. al., "Enrollment and Disenrollment in MassHealth and Commonwealth Care," April 2010. http://www.massmedicaid.org/~/media/MMPI/Files/2010_4_21_disenrollment_mh_cc.pdf

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Weakened solvency standards could also burden state guarantee funds, participating health plans and their subscribers.

The ACA expressly forbids this type of favoritism. Section 1252 requires that "any standard or requirement adopted by a State pursuant to the ACA's Title I, which includes the insurance market reforms and Exchange provisions, among others, shall be applied uniformly to all health plans in each insurance market …" (emphasis added).

Consideration also should be given to adopting standards to prevent adverse selection.

While the ACA includes numerous provisions to guard against adverse selection between health insurance plans offered on and off the Exchange, there is ambiguity concerning other types of coverage that could be offered to small employers or individuals that, unless clarified, could lead to substantial adverse selection in the entire market.

2. Questions:

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

Response:

States already have regulatory processes in place for monitoring health plan market conduct and states should maintain those processes and oversight of health insurance. Section 1311(c)'s certification criteria should recognize the expertise of state insurance regulators and defer to that expertise.

Appropriate Choice of Providers:

Many states have network adequacy standards for health plans. Given the ACA's deference to state regulatory authority, HHS should defer to the states to set network adequacy standards for Exchange coverage that are appropriate in their areas.

Network access should be assessed or certified on a state by state basis. In other words, the networks in a particular state should be certified in and by that state. Federal network requirements are unnecessary and would not adequately address the diverse requirements in every state. For example, a federal requirement may set a minimum provider limit that is simply unattainable—and more importantly, unnecessary—in a particular region. Such strict requirements could have the unintended consequence of preventing new insurers from entering the market in specific geographic area, effectively stifling competition and ultimately hurting consumers.

Second, standards should provide an opportunity for health plans to offer consumers the choice of more tightly managed (i.e., narrower network) products, which often can be offered at a lower price point than products with broader networks. These narrower network products can offer significant

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savings in conjunction with higher quality to consumers because often these networks are comprised of providers that have demonstrated a history of best practices. Health plans should also be allowed to maintain or establish quality ratings for providers.

Finally, we recommend that HHS clarify the ACA's essential community provider requirements. Specifically, Section 1311 requires QHPs to contract with essential community providers, unless the provider refuses to accept the generally applicable payment rates of a health plan. Health plans should also be permitted to exclude providers that don't meet their contract requirements or quality standards, as is currently permitted under state laws. If the ACA's essential community provider provision is interpreted as a defacto any willing provider requirement, it will diminish the ability of health plans to manage their networks to ensure safety, quality and value for consumers. Such an interpretation would ultimately increase subsidy costs to the federal government.

Marketing Requirements:

The ACA requires a considerable level of standardization with respect to benefits, benefit templates, and benefit definitions – all of which will carry over into plan marketing efforts. However, BCBSA recommends that the Section 1311(c) certification also require minimum consumer protections in this area. For example, HHS should implement standards that prevent health plans from marketing to primarily healthy individuals. Similarly, it may be prudent to prohibit certain questionable marketing activities that have been used in other markets – such as free gifts and door-to-door sales.

As an example of best marketing practices, we recommend that regulators look at the procedures that apply in the Federal Employee Health Benefit Program (FEHBP). For example, if states generally require the filing of marketing materials, the state Exchange should allow plans to demonstrate compliance with the marketing requirements through the consistent adherence to the guidelines to "file and use" submitted materials, based on well-established practices from the FEHBP program.

In addition, marketing standards should provide flexibility for health plans to provide descriptions of related programs, such as wellness programs or disease management initiatives. Such information is crucial to consumers in differentiating health plans from one another.

3. Questions:

- **What factors are needed to facilitate participation of a sufficient mix of QHPs in the Exchanges to meet the needs of consumers? (D)(3)**
  - **What timeframes and key milestones will be most important in assessing plans' participation in Exchanges? (D)(3)(a)**
  - **What kinds of factors are likely to encourage or discourage competition among plans in the Exchanges based on price, quality, value, and other factors? (D)(3)(b)**

Response:

Factors to Facilitate Participation

There are several factors that are likely to encourage greater competition among plans on the Exchanges, including:

- Reasonable certification requirements that health plans can meet by 2013 to ensure that consumers have a choice of health plans in Exchanges when they first become operational.

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Requirements for certification should be provided as soon as possible to allow health plans to prepare for participation.

- Minimizing uncertainty for health plans, by assuring that Exchanges do not limit health plan participation. The cost of developing plans for Exchange participation will be substantial. Assuring health plans that they will be permitted to participate if they meet defined, objective QHP standards will increase the number of Plans willing to invest in the infrastructure to support Exchanges.

- An effective risk adjustment system that will support a broad mix of health plans to compete on the Exchange. The ACA anticipates the need for such risk adjustment systems for the proper functioning of Exchanges, but leaves much of the details of the required programs to the Department. Experience with earlier state purchasing cooperatives indicates that health plans with comprehensive benefits and broad networks are likely to suffer from adverse selection. This is a particular risk when the Exchanges are first established because states are required to modify or eliminate high risk pools during the same period. While risk adjustment may not fully account for this selection, developing robust risk adjustment systems, calibrated to certain geographic conditions, will be critical to assure plan choice.

- Limiting the potential for adverse selection through effective open enrollment periods. This will be important to prevent people from delaying purchasing coverage until they need it and pushing up premiums for those in Exchanges. Although the ACA prohibits waiting periods of longer than 90 days for non-grandfathered group health plans, the ACA permits waiting periods for coverage in the individual market. As a result, we recommend that Exchanges permit QHPs to establish waiting periods for individual health insurance coverage to discourage individuals from purchasing coverage only after they become ill or injured. We further recommend that states consider Exchanges be permitted to impose late enrollment penalties (like in Medicare Part D) for not purchasing insurance when first available to reduce this form of adverse selection.

- Assuring a level playing field for coverage offered on and off the Exchanges with regard to rating requirements. Specifically, the ACA requires that any standard or requirement adopted by a state, including rating reforms, must apply uniformly to all health insurers and group health plans in each insurance market to which the requirements apply, (regardless of whether an Exchange is state-based or a regional Exchange). This provision must be enforced vigorously and without exception. There should be no loopholes for any entity offering coverage to individuals and small firms to avoid health insurance reforms.

- Allowing QHPs to offer additional benefits and programs beyond the essential benefit requirements. Health insurance offered in the individual and small group market must include the essential health benefits, but nothing requires coverage to include only essential health benefits. While establishing a comprehensive baseline of minimum acceptable coverage and an effective template for consumers to compare plans is important, it is essential to innovation and consumer choice that health plans should be able to differentiate themselves based on cost-sharing, non-essential benefits, networks, wellness and other factors.

- Allowing QHPs to determine whether they offer coverage solely in the individual market, small group market, or both on their Exchanges. Nothing in the ACA requires that insurers offer coverage in both markets to participate in an Exchange and some insurers have developed particular expertise in providing benefits in one or the other market. ; Such flexibility is necessary to ensure that consumers are offered the most appropriate coverage.

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Timeframes and Key Milestones

- Ensuring adequate lead-time for health plans to understand an Exchange's operational requirements is essential to creating a competitive, robust Exchange environment.

- Offering coverage through Exchanges will require significant modifications within health plans to carry out enrollment, billing and subsidy transactions, as well as reconciliation processes for the new risk-sharing programs (reinsurance, risk adjustment and risk corridors). Program requirements need to be in place in time for health plans to modify their systems in the lead up to the January 2014 effective date for Exchange coverage. This is just one example; there are many more, including processes around determinations of subsidy eligibility, development of IT/website infrastructures, and outreach, marketing and advertising.

- BCBSA recommends that Exchanges specify their operational requirements for health plans as soon as possible, but at least 18 months prior to the beginning of enrollment. Plans will need to have an understanding of an Exchange's operational requirements (federal and state) by the late spring of 2012, in order to implement systems and budget for related expenses in 2013.

- Exchanges should have operational website/portals by at least October 2013, which will have comparative health plan information available to eligible individuals and businesses. As a result, the states will need all QHPs to be filed, approved and available by late summer of 2013 to finalize and test systems for processing enrollment and subsidies on Exchanges. State product filing approvals can take up to 18 months in some states and it is anticipated that the number of filings will increase as carriers submit insurance plans for the new metallic products establish by the ACA. It is unclear how much additional time will be needed for health plans to receive state QHP certification.

Competition among plans in the Exchanges based on price, quality, value, and other factors

- The key idea behind Exchanges is to make the market more competitive, while enhancing a consumer's ability to meaningfully choose between health insurance plans. We support robust competition under Exchanges to promote value for consumers and believe that all health plans should be held to reasonable standards to assure that they provide value.

- It is critical that Exchanges set clear, reasonable standards that will establish value for consumers without undermining competition and allow sufficient time for compliance by health plans. Exchanges should not adopt an overly prescriptive approach, for example, by requiring Exchanges to limit the number of participating carriers or health plans to be offered. Such limitations will stifle competition by reducing the number of plans willing to make the enormous investment to participate in Exchanges. At the same time, standards must assure that fly-by-night health plans who are not able to compete based on value, are not licensed or have no experience in the insurance market, or are undercapitalized do not participate in Exchanges.

- Standardized information for consumers will help them shop for coverage effectively; the ACA's uniform summary of coverage documents will ensure that consumers receive information necessary to make informed choices. While standardization of information is necessary, it is also important to allow for continued innovation in the market. Health plans should be able to differentiate themselves based on cost-sharing, non-essential benefits, networks, wellness and other factors.

- We recommend that shopping tools provide information on health plans networks, quality

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performance, balance billing protections and other important information in a manner that assures that consumers look at total value, not just price in making decisions about health plans. In addition, health plan brands should be visible to consumers, as brand is a clear differentiating factor that consumers look for when they shop for coverage.

4. Question:

- **What health plan standards and bidding processes would help to facilitate getting the best value for consumers and taxpayers? (D)(4)**

Response:

- The most important factor in facilitating value for consumers and taxpayers is to assure that consumers purchasing coverage through an Exchange have good information to make effective choices among health plans. The ACA's requirements for a uniform summary of coverage, and for benefit comparisons posted on Exchange websites will do much to advance this objective.

- The concept of a "bidding" process implies that Exchanges will select some, but not all qualified bidders, yet the law clearly provides states with flexibility to accept all QHPs that are in the best interest of the consumers in that state which we support.

- A "bidding" process also implies a role for the Exchange in negotiating prices with participating plans. We have a number of concerns with Exchanges playing such a role:

  - First and most important, it's critical that rates be regulated only by the entity with authority to regulate solvency – typically the state insurance department. Any effort to de-link rates from solvency regulation would create legal problems and potentially jeopardize a key consumer protection – the assurance that a health plan has adequate reserves to pay for enrollees' claims.

  - Second, the ACA prohibits price controls on coverage offered inside Exchanges. Exchanges are permitted to exclude health plans for "unreasonable" premium increases, but rejecting a QHP for a pattern of unreasonable premium increases is not bidding or negotiating. Negotiating price is controlling price. Controlling price is prohibited.

  - Third, any effort by Exchanges to negotiate rates for plan offerings would also de facto set prices for coverage outside of Exchanges. This is particularly troublesome because the law requires that individual and small group coverage include the essential health benefits package that must be offered by QHPs inside of the Exchange at the same premium as coverage inside Exchanges. If Exchanges were permitted to negotiate rates, purchasing coverage outside of an Exchange would be a formality—because of these requirements, the coverage would likely not be meaningfully different than coverage purchased through an Exchange. The language in the ACA clearly prohibits the government from forcing consumers to purchase coverage through an Exchange.

- In addition, there is no evidence that limiting health plan choice will improve value for consumers. State small employer purchasing cooperatives in the 1990s, where state governments negotiated with health plans, resulted in limited choices (typically just HMOs) and no cost savings.

- Finally, the highly regulatory bidding and payment process that exists under the Medicare Advantage and Medicare Part D programs is not appropriate for the private marketplace. These

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are government programs funded primarily by public dollars, whereas Exchange coverage will use consumer dollars coupled with subsidies.
5. Question: • **What factors are important in establishing minimum requirements for the actuarial value/level of coverage? (D)(5)** **Response:** QHPs must meet minimum actuarial value requirements (e.g., Bronze, Silver, Gold and Platinum levels) and offer at least Silver and Gold plans on Exchanges. However, health plans should be allowed to vary cost-sharing, care management, wellness, provider networks, and other provisions of the plan in a manner consistent with federal guidelines. Such flexibility will provide choices to consumers without negating the advantages of providing comparability between benefit offerings. It's important that the regulations provide enough choice to avoid "calcified" benefit plans that do not meet consumer needs over time while protecting against the use of benefit design to select healthier enrollees. It is also crucial that the ACA's requirement that actuarial value be based on the essential health benefits—and not any additional benefits that may be offered by an insurer or mandated by a state—be retained. This will allow consumers to compare the basic coverage offered in any benefit tier, while allowing QHPs the opportunity to provide innovative and valuable additional benefits without being limited by the actuarial value calculation. Another consideration is the interaction with the actuarial value requirements and state (and federal) individual market guaranteed renewability (and non-cancellability) requirements. Guaranteed renewal provisions limit the ability for health plans to change benefits from year to year. However, the essential health benefits requirements (which must be periodically reviewed and may be updated) and actuarial value requirements will require health plans to modify benefits on an ongoing basis in order to continue to meet the actuarial value tests (it is presumed the test will be updated every year as mix, new services and inflation affect values). Regulations implementing the guaranteed renewability requirements must provide some flexibility for plans to make uniform modifications to modify existing benefit plans to comply with specified actuarial value levels without running afoul of guaranteed renewability requirements. In addition, BCBSA recommends that the HHS utilize its authority to allow de minimis variations in actuarial value to avoid quirky benefit designs. For example, without such flexibility, a health plan may have to set a copayment at $31.24 or deductible at $203.14 to meet an actuarial value level of 80 percent. HHS should allow for adequate variation in actuarial values to permit rounding in copay amounts and other forms of cost-sharing that are sufficient to prevent nonsensical cost-sharing amounts. Finally, the methodology for determining actuarial value must be defined clearly. Clarity is necessary to assure consistent use across health plans, absent consistent use, consumers could be actively misled by the coverage tiers. Timeliness is necessary to allow insurers adequate time to develop products. The ACA requires HHS to issue regulations on how the level of coverage of a plan shall be determined using a standard population's experience. The methodology for determining actuarial value needs to be clearly articulated early so health plans can develop products. We recommend that HHS work with the American Academy of Actuaries to develop standards in this area. We also recommend that HHS provide sample data that will allow health plans to develop a standard population. The final definition should be published no later than the late spring of 2012 in order for insurers to be ready by October, 2013.

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6. Question:

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

Response:

The key idea behind Exchanges is to make the market more competitive. It is critical, then, that Exchanges not adopt an overly prescriptive approach. The ACA explicitly and specifically outlines the benefits that QHPs must provide, including the essential benefits covered, the actuarial value, and cost-sharing limits. In addition, and the subject of many of the Department's requests for comments regarding Exchanges, the ACA establishes additional minimum criteria that QHPs must meet. The ACA includes numerous, specific certification criteria for QHPs, including requirements in the areas of marketing; network adequacy; accreditation related to performance on clinical quality measures, consumer access, utilization management, quality assurance, provider credentialing, complaints and appeals, and network adequacy and access; quality improvement; enrollment forms; and so on. It is important to allow states to establish standards and to not start with an approach that creates a federal floor beyond ACA certification criteria. Over and above these criteria, insurers that offer QHPs must still meet all state licensing requirements.

Some groups have stated that aggressive negotiation with QHPs over certification is needed to assure value. BCBSA believes that a better approach is to establish clear standards for QHPs that achieve the specified goals for Exchanges and ensure consumers have a choice of health plans in when they first become operational. Some Exchange requirements – including certain certification standards and compliance with public-private IT infrastructure requirements - may pose challenges for health plans. The cost of developing health plans for Exchange participation will be substantial. Providing clear, objective and achievable standards that, once met, allow a health plan to participate in an Exchange will increase the number of Plans willing to invest in the infrastructure to support the necessary coordination with Exchanges.

In specifying the implementation of the ACA requirements, it is important to ensure standards can be met initially, recognizing the need for broad participation and the enormous operational challenges health plans will face in implementing all of the 2014 reform requirements. As mentioned previously, these can be strengthened if necessary based on the experience of Exchanges over time. For example, initial accreditation requirements related to clinical quality measurement could accept NCQA or URAC accreditation requirements developed for certification of QHPs. The initial accreditation requirements could be focused on ensuring certain processes are in place for measuring designated outputs, and later strengthened to require threshold outputs of QHPs.

This model—one of fostering competition on a transparent, level playing field—best implements the letter and spirit of the ACA's Exchange provisions. Exchanges are meant to foster consumer choice by facilitating the educated purchase of QHPs, not frustrate consumer choice by unduly limiting the purchase of QHPs to a select few.

A model where the Exchange selects a limited number of health plans that will be permitted to offer coverage will result in unnecessary costs to insurers that are not selected and may discourage health plan participation as they consider the operational business risk of pursuing Exchange participation. This could result in fewer choices for consumers, increased costs, and ultimately a missed opportunity to improve value through competition. In addition, such an approach could have a significant impact on consumers by forcing some of them to change health plans every year as

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plans are annually certified and decertified.

To assure maximum participation, the Exchanges should facilitate a wide choice of coverage options meeting the QHP standards in the ACA. Giving Exchanges the authority to hand-pick participating health plans would result in Exchanges acting as a new, additional regulator, rather than the preferred facilitators of choice.

7. Question:

- **What are some important considerations related to establishing the program to offer loans or grants to foster the promotion of qualified nonprofit health plans under CO-OP plans? (D)(7)**
- **How prevalent are these organizations today? (D)(7)**
- **What is the likely demand for these loans and grants? (D)(7)**
- **What kinds of guidance are they likely to need from HHS and what legislative or regulatory changes are they likely to need from States? (D)(7)**

Response:

BCBSA welcomes competition from CO-OP plans. It should be noted that the statute requires that CO-OPs compete on a level playing field. There should be no waiver of applicable standards for QHPs (e.g., solvency requirements, licensure, or guarantee fund requirements). Of particular concern would be any efforts to exempt such plans from state solvency requirements. As we have noted in our comments on QHPs, such an exemption would be a dangerous precedent that could expose consumers, providers, and Exchanges to potential health plan failure, unpaid bills, and substantial negative publicity.

There are some parallels here to the government's effort to support the creation of federally qualified HMOs in the 1970s. The 1973 HMO Act authorized a 5-year demonstration program to promote the development of new HMOs and expansion of existing ones through grants, contracts and loans, the employer offering requirement and removal of some restrictive state law requirements. Many of the HMOs funded by the HMO act failed to be viable. In 1979, the Government Accountability Office estimated that 30 percent of the HMOs it studied would not be financially independent and would need public funds to prop them up; only about 20 percent of those studied were said to have a "good chance" of operating without federal financial assistance within 5 years after qualification.

The regulations for CO-OPs should learn from the government's experience with the HMO Act, and include standards for such entities designed to ensure their ability to maintain fiscally sound operations. BCBSA recommends that grants and loans for CO-OPs be allocated based on sound long range business plans to minimize the number of CO-OPs that fail, limit the extent that health plan-funded guarantee associations are required to bail out failed CO-OPs, and minimize negative publicity for Exchanges. Because the ACA precludes health plans from qualifying as coops, these new insurers will tend to have little experience managing risk. Thus, in the initial years of start up, consideration should be given to additional financial reporting and monitoring for co-ops.

8. Question:

- **Are there any special factors that are important for consideration in establishing standards for the participation of multi-State plans in Exchanges? RFI(D)(8)**

Response:

BCBSA has a number of questions related to the design of the multi-state plan option. We look forward to working with HHS and OPM to clarify the information necessary to evaluate this option and how it will operate in connection with state Exchanges.

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9. Question:

- **To what extent are States considering setting up State Basic Health Plans under Section 1331 of the Act? (D)(9)**

Response:

The Basic Health Plan presents an option for states to fund enrollment of lower income populations between 133 and 200 percent of the federal poverty level in managed care arrangements. States may consider using this option and the required federal payments associated with the Basic Health Plan in lieu of federal subsidies to ensure individuals have seamless coverage between current Medicaid enrollment in a managed care plan and the new expanded coverage opportunities in the ACA. We do not currently have information to assess the level of interest in this approach at the state level.

E. Quality

1. Questions:

- **What factors are most important for consideration in establishing standards for a plan rating system? (E)(1)**
  - **How best can Exchanges help consumers understand the quality and cost implications of their plan choices? (E)(1)(a)**
  - **Are the measures and standards that are being used to establish ratings for health plans in the Medicare Advantage program appropriate for rating QHPs in the Exchanges? Are there other State Medicaid or commercial models that could be considered? (E)(1)(b)**
  - **How much flexibility is desirable with respect to establishing State-specific thresholds or quality requirements above the minimum Federal thresholds or quality requirements? (E)(1)(c)**

Response:

Sec. 10329 of the ACA calls on the Secretary, in consultation with relevant stakeholders, to develop a methodology for measuring health plan value, and report to Congress not later than September 23, 2011. It stands to reason that a plan rating system for Exchanges should be based on this methodology, which will take into consideration the overall cost of coverage to enrollees, the quality of care provided, the plan's efficiency, and other components of the plan's operations – all factors that are essential in establishing standards for a plan rating system.

Given the need to establish a rating system before 2014, BCBSA urges HHS to launch the process of developing this methodology. BCBSA and BCBS Plans stand ready to partner with HHS as part of the stakeholder consultation process required by law to develop a reliable, uniform approach.

Whatever the methodology that is developed under Sec. 10329, BCBSA believes that the government should take the following steps to adopt a rating system for Exchanges:

- *Use an NPRM Process.* Proposed standards and methodology should be issued by HHS for formal notice and comment under a Notice of Proposed Rule Making (NPRM) prior to finalization and adoption.
- *Data Collection and Measure Selection.* There needs to be a reasonable lead-time for collection of data associated with underlying measures used in the plan rating system. Data reported needs to be consistent in definition, collection methods, and needs to be audited. In addition, there should be consensus through an NPRM process on which measures to use. Measures should be meaningful to consumers and should mirror measures in the industry today

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such as those adopted by NCQA and other such accreditation organizations so that the measures are tested prior to adoption.

- *Level of Reporting.* To ensure meaningful comparisons, some measures should be aggregated to the organizational level as opposed to the plan or option level. This is necessary to address likely enrollment variations across plans that could result in small sample sizes, compromising the statistical validity of comparisons (e.g., a plan could have 500 people in one benefit level and thousands in another). Many functions such as call center efficiencies, complaints, and appeals are meaningful on an organizational level.

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

As stakeholders helping to develop a methodology for assessing health plan value, we recommend including measures in the methodology that address consumer experiences. Quality can be defined as related to medical services as well as consumer experiences (e.g. member satisfaction, complaints, appeals, number of third party reviews, etc.). We recommend that the measures be meaningful to consumers, allowing them to compare cost-sharing amounts, level of access to providers, and total premium costs.

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

Medicare Advantage (MA) measures are not appropriate for transfer to Exchanges. The MA STAR ratings are based on certain measures applicable to a Medicare population as well as components of the MA program. Stars are currently assigned at the contract level. Also, the utility of the current Star methodology for consumers is overshadowed by complex measurements. Plans are subject to "curves" and "thresholds" and "domains" as well as aggregate ratings, some of which combine two programs – MA and Part D. Today, the MA ratings are frequently revised with no formal comment process, making the process opaque and difficult to understand.

Because Exchanges will be new in the commercial markets in all states, it makes sense to look to current state measures at the organizational level and use those in the Exchanges' early years, until additional data are available from specific Exchange experience.

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

The answer to this will depend on the intent for Jan. 1, 2014, as all plans in the Exchange will be new (e.g., in enrollment and data collection) at that time. Given this, perhaps existing measures collected by States on a given organization can be used in the initial years, with subsequent revision over time. For example, initial accreditation requirements related to clinical quality measurement could accept NCQA or URAC accreditation requirements developed for certification of QHPs. The initial accreditation requirements could be focused on ensuring certain processes are in place for measuring designated outputs, and later strengthened to require threshold outputs of QHPs.

2. Question:

- **What are some minimum standards or other factors that could be considered with respect to establishing quality measurement and improvement thresholds or quality**

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requirements that should be met by QHPs? (E)(2)

- **What other strategies, including payment structures, could be used by plans to improve the practices of plan providers? (E)(2)**

Response:

The Institute of Medicine's (IOM) definition of quality has become widely accepted as the benchmark for quality improvement: it is "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."

Working from this IOM-based premise to develop criteria for the Medical Loss Ratio (MLR) standards, the NAIC called for designing health care quality improvement activities in ways that can be objectively measured and verified. The NAIC specifically eschewed calling for establishing improvement thresholds because rigid thresholds are not consistent with the IOM definition – what is important is measurement and transparency, not arbitrary benchmarks. Setting thresholds would have a chilling effect on innovation and hinder creative approaches to improving health care quality.

Health plans need the flexibility to innovate quickly, to design unique programs tailored to their particular markets around health disparities, to discard methods that do not work, and to swiftly carry out methods with promise. Prospective and uniform thresholds would pose insurmountable barriers.

Therefore, BCBSA urges that the Departments hold health plans accountable for objectively measuring and verifying their outcomes (consistent with the methodology developed pursuant to the ACA) without setting arbitrary thresholds for quality improvements. So long as quality improvement programs are designed in ways that can be objectively measured and verified – as they must be to meet the NAIC's MLR criteria – consumers will be able to assess comparative values, and plans will have a strong incentive to improve outcomes continually.

Quality Measurement

The ACA requires health plans in an Exchange to be accredited with respect to local performance on clinical quality measures in order to be certified as a QHP. However, health plans may not be able to use existing NCQA/URAC accreditation for new products under Exchanges. Thus, QHPs may not be able to become accredited as Exchange plans on day-one unless the agency, under section 1311(e)(1)(A) foresees accreditation as the same as meeting basic requirements in such areas as network adequacy, benefits, and other standards that are established as criteria for participation in an Exchange.

We recommend that regulations recognize that meeting accreditation standards could require a 3 year lead-time to provide adequate time to collect data for quality measures and complete a formal accreditation process on new Exchange enrollment. The ACA permits an accreditation period for QHPs so long as it is applied to all health plans equally. As a result, states should have flexibility to establish accreditation timelines that are consistent with local health plans' ability to achieve accreditation based on the development and issuance of appropriate modules by accreditation agencies. Time is then needed for each QHP to be able to go through an actual accreditation process.

We recommend that HHS, in drafting implementing regulations, provide flexibility for states to award "deemed" certification as QHPs to health plans that obtain accreditation from a recognized entity (e.g., a state entity or existing accrediting bodies, such as NCQA or URAC or the Joint Commission)

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for meeting specified standards. Furthermore, to avoid duplication of efforts, we recommend that the accreditation process serve as an on-going mechanism for a QHP to continue to serve as a QHP and encompass other ACA QHP certification criteria without additional audits and other oversight activities. In addition, specifying that any single accrediting entity be used by QHPs would create a captive market for that entity, which could then set its own fees and oversight authority, with requirements that are appropriate to their markets. Therefore, we urge HHS to offer multiple organizations for purposes of being accrediting bodies for QHPs in the Exchange.

Strategies to Improve the Practices of Plan Providers

Strategies to improve providers' practices may include partnering with providers on advancing clinical guidelines and best practices; providing on-going support for care management and case management activities; supplying data on readmissions and other performance measures; and implementing pay-for-performance programs and innovative payment mechanisms that provides optimal value to consumers.

Under QHP criteria, health plans should continue to have flexibility to experiment with the full spectrum of payment strategies as they promote an improved delivery system overall for consumers, employers, and providers.

F. An Exchange for Non-Electing States

1. Question:

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

Response:

The ACA envisions a system of state Exchanges, and provides for a federal fallback as a last resort. To support this intent, we urge broad flexibility and federal assistance to the states to minimize the potential for federal fallback to be triggered. However, in areas where a fallback becomes necessary, the task of coordinating the work of the Exchange and the functions of state government, such as insurance regulation, will be challenging. We urge that the fallback serve as a facilitator and perform the minimum functions necessary to implement the Exchange, while leaving the regulation of health insurance products to the states. The federal fallback Exchanges should provide maximum deference to state regulation to avoid overlapping or confusing oversight.

2. Question:

- **Are there considerations for an Exchange operated by the Federal government on behalf of States that do not elect to establish an Exchange that would be different from the State-run Exchanges? (F)(2)**

Response:

In general, most of the recommendations we have made with regard to state establishment apply to creation of a federal Exchange. We urge HHS to implement a competitive fallback approach that ensures robust health plan competition under a reasonable set of standards.

G. Enrollment and Eligibility

1. Question:

- **What are the advantages and issues associated with various options for setting the duration of the open enrollment period for Exchanges for the first year and subsequent**

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years? (G)(1)

- **What factors are important for developing criteria for special enrollment periods? (G)(1)**

Response:

Open Enrollment Periods

Open enrollment periods should be adequate in length to allow individuals time to make decisions and enroll in coverage, but not be so long as to allow "just in time" insurance. The use of a limited period is intended to encourage individuals – including healthy individuals – not to delay enrollment given they are unable to predict health needs for extended periods of time. This in turn creates a more viable, stable insurance pool.

A longer open enrollment period in advance of 2014 makes sense given that the public will be getting accustomed to the new system of Exchanges and health insurance options and subsidies. More public education will be needed for 2014 than subsequent years.

A reasonable approach would be to have a 45-day initial open enrollment period. Based on experience implementing Medicare Part D, it may be necessary to begin this open enrollment period as early as August, with coverage effective January 1, 2014. In later years, open enrollment could occur during October, with a January 1 effective date. All carriers in and out of an Exchange should be subject to the same rules.

While ACA requires initial Exchange coverage to be effective on January 1, 2014 and thus open enrollment periods logically must occur sometime in the late summer and early fall of 2013, consideration should be given to moving subsequent open enrollment periods and coverage effective dates to other times of the year, and staggering such periods and effective dates for different markets so that health plans do not have all of their business turning over on the same date. For example, both Medicare Advantage and Medicare Part D coverage turn over on January 1st, as does much large employer coverage. Having small group market and individual market coverage to also turn over on January 1st would place enormous strain on enrollment systems. Staggering open enrollment periods going forward would help relieve this strain, potentially enhancing customer service and achieving better administrative efficiencies.

A lag between enrollment periods and effective dates is essential for providing time for enrollment, billing, subsidy, and other information to be processed, as well as allow for issuing identification cards to members and any necessary start-up communications between enrollees, insurers, Exchanges, the Internal Revenue Service, HHS, and other parties.

Finally, a distinction should be made between open enrollment periods in the individual market versus the small group market. A limited open enrollment period is critical to prevent adverse selection in the individual market. However, continuous guaranteed issue in the small group market has been the practice in all states since the 1990s. The regulations should clarify that carriers have flexibility to provide continuous guaranteed issue in the small group market while limiting open enrollment to a single 30-day period in the individual market. However, once employers enroll in Exchanges, their employees must select plans within 30 days (consistent with how employer plans generally address initial open enrollment today) and adhere to special enrollment periods outside of this period.

Special Enrollment Periods

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Section 1311(c)(6) of the Affordable Care Act provides that Exchange-based coverage offer special enrollment periods during the periods specified under Section 9801 of the Internal Revenue Code and other periods similar to the those described provided by Medicare Part D. As a general principle, special enrollment periods are appropriate when individuals would like to obtain or would like to change coverage for reasons that are not necessarily connected to a change in health status. (If individuals could obtain or change coverage under a special enrollment scheme simply due to health-related reasons, an unsustainable level of adverse selection would be expected to occur.) Section 2702(b) of the Public Health Service Act (applicable to health insurance coverage offered inside and outside Exchanges) similarly provides that health plans may restrict enrollment to open and special enrollment periods under regulations to be promulgated by HHS. However, unlike Section 1311(c)(6), Section 2702(b) provides that special enrollment periods should be based on COBRA qualifying events. We recommend that HHS establish open and special enrollment periods that are uniform both inside and outside of Exchanges to simplify public education and limit insurers' and potential enrollees' ability to game enrollment periods. For example, HHS may want to consider the extent to which enrollment rules for cafeteria plans under Internal Revenue Code section 125 would provide a basis for uniform special enrollment rules. Lastly, anti-abuse rules may be needed to deter adverse selection if experience shows some individuals are routinely gaming open and special enrollment windows and dropping coverage early. In addition, rules for SEPs should address situations in which an Exchange-participating carrier becomes insolvent/goes out of business. Under existing law in some states, enrollees of insolvent HMOs are distributed among other carriers in the market. It would be preferable for such individuals to simply use the Exchange to select their own coverage, rather than being assigned to a carrier not of their choice.
2. Question: • **What are some of the considerations associated with conducting online enrollment? (G)(2)** **Response:** Key considerations include: • *Make it as easy as possible for consumers.* The application process and receipt of eligibility processes should be as efficient as possible for those who are subsidy eligible. It should be easy and require as few steps as possible for consumers. o In Massachusetts, the "virtual gateway" – a single on-line access point to program and services – was used to facilitate enrollment within the state's HHS department. The Gateway is an Internet portal designed to provide the public, providers and community-based organizations a single point of entry for information and online services on the Internet. o Another example of online enrollment that works well for consumers is the Medicare Part D program. • *Education and outreach is necessary.* Education and enrollment assistance will be necessary for subsidy-eligible individuals and the Medicaid and CHIP population. o Lack of insurance correlates with lower rates of technology use, including the Internet. A study commissioned by the California HealthCare Foundation found that individuals without

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health insurance are less likely than others to have internet access (69% internet access for insured versus 37% for uninsured).[1]
  - More than half of all successful applications for subsidized coverage in Massachusetts were completed for consumers by community-based organizations and health care providers.[2]
  - Outreach materials should allow flexibility with respect to literacy levels in mind. For example, using a general standard of a 5th grade reading level may be appropriate in some areas, but would not allow carriers to convey more complex insurance information – that may require an 8th grade reading level, for example.
  - BCBSA wants to work with HHS to consider ways to partner on education and outreach initiatives.

- *Need for funding.* Exchanges will need adequate funding to perform administrative functions associated with online enrollment.

3. Questions:

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

Response:

Implementation of the ACA should reduce unnecessary coverage gaps to the extent possible. The ACA envisions streamlined eligibility processes between state public programs and Exchange subsidies. A new Modified Adjusted Gross Income (MAGI) definition for determining eligibility is required for the federal subsidies and the Medicaid expansion population. In addition, a single form will allow eligibility to be determined among Medicaid, CHIP and subsidies, and electronic Medicaid enrollment will reduce current administrative barriers.

However, the combination of the Medicaid expansion, existing Medicaid eligibility levels and eligibility for new federal subsidies will likely result in a substantial number of individuals enrolling and disenrolling (or "churning") between coverage in state public programs and subsidized private coverage. For example, in Massachusetts, 27 percent of case openings in MassHealth (Medicaid) and 67 percent of all case openings in the subsidized Commonwealth Care program moved from one of the state's other public programs (MassHealth or Commonwealth Care) or the states former uncompensated care program (Health Safety Net) from January 2008 through April 2009.[3]

To address "churning," some Medicaid managed care plans and other stakeholders have proposed that states or HHS waive certain ACA requirements (e.g. state solvency requirements), effectively deeming them as QHPs for participating on an Exchange. Support for their proposal is based on concerns that other subsidized private health plans on an Exchange may not include the same providers in their networks that individuals with Medicaid and CHIP are accustomed to seeing.

[1] The California General Public Survey, conducted by the Harris Interactive between November 5 and December 17, 2007.
[2] The Secrets of Massachusetts' Success: Why 97 Percent of State Residents Have Health Coverage, State Health Access Reform Evaluation, November 2009.
[3] Seifert, Robert, et. al., "Enrollment and Disenrollment in MassHealth and Commonwealth Care," April 2010. http://www.massmedicaid.org/~/media/MMPI/Files/2010_4_21_disenrollment_mh_cc.pdf

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However, states are currently implementing various strategies to ensure continuity of coverage for individuals with lower incomes. States could also consider new strategies without waiving ACA requirements, such as applications for Medicaid demonstrations that could allow for wrap around coverage.

As states and HHS weigh options for ensuring continuity of coverage for lower income populations in the new Exchanges, they must also ensure consumers receive the level of protection required by the ACA. While collectively, BCBS Plans serve millions of individuals in Medicaid managed care, allowing health plans onto Exchanges without meeting the same level of ACA requirements as other QHPs would not be in the best interest of consumers.

HHS regulations should ensure consumers do not experience gaps in coverage to the greatest extent possible while ensuring consumers are clearly guaranteed access to coverage in Exchanges that meets ACA requirements. To achieve this, we recommend that HHS implement Exchange policies by:

- ***Requiring that States Allow Access to a Broad Choice of Options for Individuals with Lower Incomes.*** This would include health plan options that present a broader network of providers than what their Medicaid managed care plan typically provides. A broader network offering through a PPO, for example, would likely allow consumers expanded access to providers in addition to the possibility of keeping the providers they are accustomed to seeing. In addition, the increased volume of Medicaid eligible individuals will present problems for the lower income population in accessing their Medicaid services according to CMS actuaries.

- ***Clarifying that Loss of Coverage in Medicaid or CHIP Requires a Special Enrollment Period.*** Section 1311(c)(6) of the ACA requires HHS to require special enrollment periods under circumstances similar to such periods under Medicare Part D. In implementing Section 1311(c)(6), an individual covered under Medicaid or CHIP either has a change in household income that qualifies them for a federal subsidy or elects to receive employer sponsored insurance should be permitted a special enrollment period for enrolling into a private health plan in an Exchange. This would be similar to the Medicare Part D creditable coverage requirements. In that program, if an individual has minimum creditable coverage without a gap prior to the change in eligibility, the individual is allowed to make a coverage election without penalty, and Medicaid drug coverage is considered creditable.

- ***Preventing Consumer Confusion by Requiring Separate Distinguishable Exchanges for Any Health Plan Not Meeting ACA Requirements.*** If states are allowed flexibility to permit Medicaid managed care plans to participate on Exchanges without meeting the full set of QHP requirements, we strongly urge that a state make such coverage available through a sub-Exchange established separately for lower income populations who lose their eligibility in a state's public program. Sub-Exchanges should be clearly distinguishable from an Exchange that is in full compliance with ACA requirements. Requiring this approach will prevent confusion among consumers, allowing them to distinguish between which health plans participating on Exchanges are fully meeting the ACA requirements and those which are providing coverage that is different.

- ***Clearly Defining MAGI.*** HHS should provide clarity to states on the definition of Modified Adjusted Gross Income (MAGI). New criteria will be used for determining household income for eligibility of the Exchange subsidies and the Medicaid expansion population. HHS should address issues in the application of MAGI for eligibility purposes in Medicaid programs versus subsidy eligibility. Medicaid eligibility is determined based on current income, and other factors,

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while subsidy eligibly is based on prior year's income. Without clear guidance on how to implement the income determination requirements, challenges in preventing gaps in coverage will be exaggerated.

- ***Investing in IT Systems for Coordinated Eligibility Systems.*** Exchanges will need to develop systems for handling new subsidy payments, eligibility determinations, health plan enrollment, and systems to ensure financial integrity and reporting. Key to ensuring continuous coverage, are the federal-state systems for determining eligibility and securing premium payment for new subsidy enrollees.

  Current eligibility systems have limitations that likely will prevent them from performing all functions that will be necessary in the new Exchange environment. For example, the systems are not set up to determine eligibility based on the new Modified Adjusted Gross Income (MAGI), nor is there an established payment system for the new federal subsidies. While a state may attempt to build an Exchange infrastructure that mirrors Medicaid to the greatest extent possible, the familiarity of working with such systems and Medicaid managed care plans should not merit an approach that limits access for all subsidy-eligible populations to existing Medicaid managed care plans. Adequate funding should be provided to assure that consumers can choose a health plan that is not a Medicaid managed care provider.

  Finally, given the economic pressures states are facing, we are concerned that states may seek to fund the system development that will be necessary to enroll the Medicaid population through Exchange administrative costs. We strongly discourage this approach because it would ultimately lead to higher assessments on health plans that would translate into higher costs for private consumers.

- ***Continuing to Encourage State Adoption of Administrative Simplification Procedures:*** Churning among public and private coverage is not a new public policy challenge for states and individuals with lower incomes. State requirements pertaining to eligibility renewal vary among states and fluctuate within states, often depending on both their fiscal climates and desire to ensure program integrity in covering individuals who are eligible. Some states have adopted a combination of simplification and retention strategies in their Medicaid and CHIP programs to increase program retention. In the new Exchange environment, these strategies will play an enhanced role to ensure individuals have continuous coverage between public programs and subsidized private coverage. Such strategies include longer enrollment periods before eligibility redetermination, and the use of administrative data systems to verify eligibility. For example, 46 states and DC allow children to renew coverage annually, as opposed to more often, and 22 states allow 12 month continuous eligibility for children.[4]

4. Questions:

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

Response:

[4] Ross, Donna; et. al. A Foundation for Health Reform: Findings of a 50 State Survey of Eligibility Rules, Enrollment and Renewal Procedures, and Cost-Sharing Practices in Medicaid and CHIP for Children and Parents During 2009. http://www.kff.org/medicaid/kcmu120809pkg.cfm

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The requirement in the ACA for states in 2014 to use on-line enrollment for Medicaid eligible individuals will present new opportunities for streamlining state eligibility processes that build on existing state experiences. A 2009 report issued by the National Academy of State Health Policy reported that some states have begun using information from other public programs that serve low-income populations, like the National School Lunch Program (NSLP), the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), food stamp and cash assistance (now called "SNAP"), to identify and enroll low-income children in Medicaid or CHIP. Based on a survey of 38 states, 16 states reported that they link their on-line applications to other programs.[5]
5. Question: • **How do States or other stakeholders envision facilitating the requirements of Section 1411 related to verification with Federal agencies of eligibility for enrollment through an Exchange? (G)(5)** **Response:** • Section 1411 establishes a program for determining whether an individual is a lawful citizen or national of the United States, is eligible for premium tax credits and cost-sharing tax credits, whether an individual's coverage under an employer-sponsored plan is deemed unaffordable, and whether an individual is entitled to an exemption from the individual responsibility requirement. • These are critical functions that must be performed by the Exchange with support from specific federal agencies. Health plans do not have data on the citizenship or income of their members, nor do they have the administrative resources to assist with verification of eligibility for enrollment under Exchanges in light of the various limitations on health plan administrative costs in the ACA. We recommend that health plans have no obligation to identify subsidy-eligible individuals or determine who is subject to the personal responsibility requirement. • It is critical that health plans receive timely and accurate information on eligibility for Exchanges. Health plans should not be obligated, for example, to reduce cost-sharing prior to receiving notification from the government when the individual is eligible for cost-sharing subsidies. Moreover, health plans should be held harmless for errors in verifying eligibility made by the Exchanges. • In addition, data must be processed in a manner that allows for timely purchase of coverage for consumers. This includes time to appeal any eligibility determinations and time to enroll in a health plan with appropriate premium tax credits and cost-sharing reductions. • Finally, the eligibility verification process must be able to address changes in status that may trigger a Special Enrollment Period – because such changes also may impact eligibility for tax credits or cost-sharing subsidies.
7. Question: • **What considerations should be taken into account in establishing procedures for payment of the cost-sharing reductions to health plans? (G)(7)** **Response:** • Section 1402 of the ACA states that individuals with income below 400 percent of the Federal Poverty Level (FPL) and enrolled in silver level coverage through an Exchange will be eligible for cost-sharing subsidies. For those eligible, these cost sharing subsidies increase the actuarial

[5] Wachino, Vicoria; et. al, "Maximizing Kids' Enrollment in Medicaid and CHIP," http://nashp.org/sites/default/files/Max_Enroll_Report_FINAL.pdf?q=files/Max_Enroll_Report_FINAL.pdf

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value of the plan as well as set specific out-of-pocket limits. Sections 1411 and 1412 of the ACA set in place the basic procedures for determining eligibility and advance payment of cost sharing reductions and premium tax credits. These sections state that HHS will notify Treasury, the Exchange and the health insurance issuer of an individual's eligibility for a cost-sharing reduction. Treasury will make advance payment to the issuer as specified by HHS. The statute states that HHS may establish a capitated payment system which would include appropriate risk adjustments.

- The design of systems and processes for administering cost-sharing reductions will be a critical piece in assuring that subsidies work seamlessly for all parties. As noted above, it is the responsibility of Exchanges and the federal government to perform key eligibility verification functions. Insurers should not have any responsibility for administering or verifying eligibility for tax credits or cost-sharing subsides. Health plans should also not be obligated to reduce cost-sharing prior to receiving notification from the government that the individual is eligible for cost-sharing subsidies.
- Furthermore, the eligibility determination needs to provide adequate time for health plans to enroll individuals and process claims with the appropriate cost-sharing. At a minimum, this advance notice to insurers should mirror the timing between enrollment periods and effective dates as discussed in our recommendations to question G(1) above. Adequate advance notice is critical for specific enrollment functions such as inputting member information into the claims processing system and for issuing membership card to individuals so that providers can charge the appropriate co-pay or coinsurance at the time of receiving care.
- To reduce administrative cost and minimize errors, the overall process must be as simple as possible. The advance payment from the government to health plans for cost-sharing reductions and any reconciliation process must be as simple as possible to reduce administrative costs and potential for errors for consumers.
- This is particularly important with respect to retroactive eligibility. For example, an individual may appeal an eligibility determination that incorrectly deemed that person as ineligible for a cost-sharing reduction. BCBSA believes it will be extremely difficult for insurers to administer retroactive cost-sharing subsidies without a significant degree of error. If the regulations do provide for retroactive eligibility, then it should be the federal government, and not health plans, who should pay consumers for any subsidies they should have received. BCBSA recommends a once-a-year, year end reconciliation between the government and health plans.
- Also, procedures for cost-sharing payments to health plans must also recognize the administrative complexity for multiple cost-sharing designs for different income levels. Specifically, the ACA requires certain actuarial values and maximum out-of-pocket benefits for silver coverage that vary on a sliding scale based on a household income as a percent of the federal poverty level. The procedures for payment of cost-sharing reductions should recognize the complexity and work to make the overall process as simple as possible.

H. Outreach

1. Question:

- **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? (H)(1)**

Response:

Outreach efforts should be broad-reaching overall but tailored to particular communities. Market research should be conducted to understand audiences and create appropriate. For example, one successful outreach effort used in the past was a partnership with a major league baseball team,

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using games as a channel of communication with a broad audience base. In this example, information booths were set up, interviews televised along with a public service announcement by a player. This type of campaign can be complemented by a variety of other outreach efforts, including civic and corporate partnerships, grassroots enrollment events, direct mail, media outreach, educational forums and paid advertising across the state. The Medicare Part D initial enrollment period also had nationwide but local educational campaigns and outreach efforts.

States should consider whether Exchanges should be responsible for outreach and general communications regarding the benefits of broader health care reform, value of having insurance and generally promoting compliance with the coverage mandate. Although this messaging should not be the sole responsibility of an Exchange, Exchanges will play an important role, and will have opportunities to participate in coordinated campaign of states and many stakeholders with the possibility for federal funding to help pay for some of these crucial communications.

BCBSA wants to work with HHS to consider ways to partner on education and outreach initiatives.

2. Question:

- **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? (H)(2)**

Response:

States' use of enrollment brokers in Medicaid programs is an existing example of entities that will serve a similar function to the ACA's "Navigators." As discussed at a recent NAIC meeting, Navigators are likely to play much the same role as agents and brokers. There needs to be certification requirements to assure these entities are properly regulated.

Some potential issues for regulators to consider regarding Navigators include:

- Standards to prevent financial inducement: As specified by the ACA, those carrying out the work of Navigators should not be paid commissions – they should be salary or hourly positions.

- Navigator costs should be tightly controlled to maintain affordability. One potential model is to pay navigators set outreach budgets plus a margin.

- Navigators must be totally independent of health plans as well as providers. Certification standards also should address location of such entities – for example, they should not be allowed to be located in hospitals or in large provider practices or medical settings.

- Standards should prevent steerage of individuals with high cost health conditions to particular health plans. Navigators are intended to provide fair and impartial information about Exchanges. Particular care should be exercised if organizations representing individuals with a particular health condition are allowed to serve as Navigators to prevent steerage to more comprehensive plans in an Exchange. Given that risk adjustment is not likely to fully offset health plan issues, such steerage could quickly make these options unaffordable and cause them to be withdrawn from Exchanges.

- Consideration should be given to how Navigators function relative to agents and brokers. To maximize outreach, it may be desirable to have navigators focus on hard to reach populations that brokers do not typically interact with today.

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3. Question:

- **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? (H)(3)**
- **How can these outreach efforts be coordinated with efforts for other public programs? (H)(3)**

Response:

States should look to their CHIP and Medicaid populations for lessons on successful outreach strategies for subsidy populations. Building on current initiatives such as the Insure Kids Now campaign and other programs serving lower-income populations will also help Exchanges determine how to coordinate outreach efforts across Exchange and public programs. A 2009 report issued by the National Academy of State Health Policy reported that community-based institutions like schools, community health centers, health plans and local and religious organizations are playing a key role in outreach and enrollment. Additionally, assistance from community-based organizations can provide a vital link to public assistance for families who face language, cultural, literacy or numeracy barriers, or live in remote areas. [6]

BCBSA wants to work with HHS to consider ways to partner on education and outreach initiatives.

I. Rating Areas

1. Questions:

- **To what extent do States currently utilize established premium rating areas? (I)(1)**
- **What are the typical geographical boundaries of these premium rating areas (e.g., Statewide, regional, county, etc.)? (I)(1)**
- **What are the pros and cons associated with interstate, statewide, and sub-State premium rating areas? (I)(1)**
- **What insurance markets are typically required to utilize these premium rating areas? (I)(1)**

Response:

Section 2701 of the Public Health Service Act provides that states shall establish one or more rating areas within that state, subject to HHS review. HHS may establish rating areas if a state fails to act or HHS determines that a state's rating areas are not adequate. In addition, section 1301(a)(4) of the ACA provides that QHPs may vary premiums by rating areas. Section 1311(f)(2) provides that states may establish geographically distinct subsidiary Exchanges that must be at least as large as rating areas.

Extent of State Determination of Premium Rating Areas

- States generally do not establish standard rating areas for the individual and small group markets. Insurers set their own rating areas, which typically are not subject to state approval. However, a small number of states may require approval of rating areas or place substantive requirements for the development of rating areas, (e.g., minimum size may be no smaller than a county).
- In the individual and small group insurance markets, rating areas typically are based on groupings of counties or zip codes and are structured to reflect the cost and utilization of care in a particular area. These often mirror Metropolitan Statistical Areas (MSAs), although large

[6] Wachino, Vicoria; et. al, "Maximizing Kids' Enrollment in Medicaid and CHIP," http://nashp.org/sites/default/files/Max_Enroll_Report_FINAL.pdf?q=files/Max_Enroll_Report_FINAL.pdf

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MSAs may be divided into several rating areas. For example, an insurer may have a unique geographic rating factor for an area is served by a particularly high-cost hospital system. In addition, rural areas often have separate area factors reflecting lower utilization of high-cost services, given that such services are not as convenient to receive in rural areas and therefore may be recommended by providers more judiciously. For example, a rural provider may monitor a knee injury for a few days before recommending that a patient travel a hundred miles for an MRI.

- State Medicaid programs establish areas where reimbursements to managed care plans differ. These typically are built around MSAs and take into consideration the population density necessary to successfully operate a Medicaid HMO plan, as well as utilization differences.
- Reimbursement levels for Medicare Advantage plans vary by county, sometimes materially, so reflecting different costs by county even when adjusted for demographics and applying risk adjusters.

Setting Premium Rating Areas

- Rating areas should be developed to reflect the cost of care and patterns of care in an area.
- In many cases, cross-subsidization will occur systematically between different parts of a rating area due to provider practice patterns, referrals, provider and resource distribution, and reimbursement levels. The NAIC's *Guidance Manual in the Evaluation of Rating Manuals and Filings Concerning Small Employer and Individual Health Insurance* (2003) includes a table of "safe harbor" ratios for geographic variations that vary from 1.0 (i.e., no variation) to 1.9, depending on state. It is important to note that variations between certain states can be even greater.
- Rating areas should be able to take into account insurers' existing service areas. For example, regulations establishing rating areas should permit exceptions when rating areas do not perfectly overlap with health plans' licensed service area.

2. Questions:

- **To the extent that States utilize premium rating areas, how are they established? (I)(2)**
- **What kinds of criteria do States and other entities typically consider when determining the adequacy of premium rating areas? (I)(2)**
- **What other criteria could be considered? (I)(2)**

Response:

As discussed in the above response, individual and small group insurers generally establish their own rating areas. Rating areas typically are based on groupings of counties or zip codes and are structured to reflect the cost and utilization of care in a particular area. In Medicaid, a similar approach typically is utilized in establishing reimbursements for areas of the state after looking at utilization and cost in each area.

Rating areas generally should be consistent with other areas used for insurance regulation, including plan service areas and risk adjustment areas.

Rating areas should be the same for coverage offered inside and outside an Exchange. Otherwise, a company offering coverage outside an Exchange could gain an advantage by having different service areas, pricing aggressively in lower cost parts of the Exchange service area and higher in other parts of the Exchange service area. In addition, an insurer generally should be required to offer coverage in all parts of a rating area to avoid potential gaming, unless its established, historical service area was different.

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J. Consumer Experience

1. Questions:

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

Response:

Design Features

Helpful design features include those that will make it easy for consumers to navigate the site, such as:

- Inclusion of a standardized layout and navigation tool that provides for a common user experience.
- A design that allows information to be displayed quickly – with few clicks.
- Use of a sub-directory structure to divide content
- Inclusion of decision support tools or filters that provide consumers the ability to sort based on desired features, such as price, deductible, plan type, provider network, etc.
- Ability to search plans based on participating networks.

Enrollment Venues

While multiple enrollment venues can be successful in reaching individual consumers, it's also important to implement a system for providing answers to consumer questions. For example, Medicare provides both an 800 number for general eligibility questions and links to health plans' web sites where individuals can go with more specific questions.

2. Questions:

- **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)? (J)(2)**
- **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)? (J)(2)**
- **What types of efforts could be taken to reach individuals from diverse cultural origins and those with low literacy, disabilities, and limited English proficiency? (J)(2)**

Response:

Consumers are more likely to utilize tools that can provide information through decision filters that "customize" information based on their individual needs (e.g., the ability to input basic information about themselves and then see only insurance plans that match those criteria).

In addition, the standard plan comparisons provided for in the ACA should be very useful to consumers. The ability to compare health plans on cost and quality, benefits and other features will help consumers purchase coverage. Health plans should also be allowed to include information on other plan features that provide value for consumers, such as wellness programs, disease management initiatives, and so on.

Specific recommendations with regard to steps Exchanges undertake to ensure that they are

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accessible and available to individuals from diverse cultural origins are provided in response to question C(8).

3. Question:

- **What are best practices in implementing consumer protections standards? (J)(3)**

Response:

States are the best source of information on what approaches work best in implementing consumer protections because of their broad experience in implementing similar consumer protection standards included in ACA. BCBSA will gladly assist in providing information on an ongoing basis.

4. Question:

- **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)? (J)(4)**

Response:

States already have structures in place for dealing with consumer complaints with regard to health insurance, whether through state ombudsman or other similar programs. It makes sense to build on these programs, and keep the information collection and reporting at the state level. Overall enforcement responsibility with regard to health insurance also continues to reside at the state level. This supports continuing to address complaints at the state, rather than the federal level.

K. Employer Participation

1. Questions:

- **What Exchange design features are likely to be most important for employer participation, including the participation of large employers in the future? (K)(1)**
- **What are some relevant best practices? (K)(1)**

Response:

The ACA allows states to decide whether to limit the size of small employers eligible to purchase through an Exchange to firms with up to 50 employees until 2016, or to immediately start offering coverage to groups with up to 100 employees. Starting in 2017, states can decide to open up Exchanges to larger employers.

The inclusion of large firms in the Exchange will likely add greater complexity as they generally use sophisticated benefit consultants and thus less likely to need the services of an Exchange unless they find purchasing the coverage through an Exchange is to their advantage which likely results in adverse selection as discussed below.

The design features that would be important for employer participation depend on whether the employees are allowed to purchase from any company on the Exchange or not. The ACA permits employers to limit the choice of plan and company for their employees to a single company and we provide our rationale for this in our response to question K(3) of the RFI below. If employees are allowed to purchase from any company on the Exchange offering the level of coverage their employee has selected there are significant concerns about adverse selection as well as administrative questions that need to be addressed including:

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- How should payments be made to health plans in Exchanges given different ratings added to employees based on age, geography and other reasonable rating factors?
- Should there be a single interface for billing and membership changes in each Exchange for small groups?
- Who will assist employees in understanding their coverage options, including other available coverage such as spouse's coverage and SCHIP? This role has typically been performed by an agent or company representative; however, it is not clear how this would work in an environment where an employee can enroll with multiple insurers.
- Who will assist the employer if there are claims issues?
- How will employers handle multiple bills from multiple health plans?
- How would administrative problems for employers with employees in multiple states be addressed and which Exchange would "out-of-state" employees enroll in?

For the reasons explained in response to K(3) below, BCBSA believes allowing employer choice would be the best approach. We urge HHS to clarify in regulation that states have the option to provide for either employer choice or employee choice of health plans. We also recommend that Exchanges pilot test the systems necessary to permit employee choice of health plans if they proceed in that direction prior to implementation. In Massachusetts, the initial small employer pilot in 2009 required employee choice of a health plan, which proved administratively complex. The replacement program – Business Express – allows employers to select a plan for their workers.

2. Questions:

- **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? (K)(2)**

Responses:

The ACA allows states to decide whether to limit the size of small employers eligible to purchase through an Exchange to firms up to 50 employees until 2016, or to immediately start offering coverage to groups with up to 100 employees. Starting in 2017, states can decide to open up Exchanges to larger employers.

We recommend limiting SHOP Exchanges to the small group market (groups of up to 50 employees) initially because this approach would help ensure success by starting with more manageable levels of participation. Offering Exchanges in the small employer market will be substantially more administratively complicated than in the individual market. There were more than 4.8 million small employers with 50 or fewer workers employing more than 21 million full-time employees in 2009, according to data from the Medical Expenditure Panel Survey. Only after state Exchanges are functioning and serving small employers with up to 50 employees well should consideration be given to expansion.

Starting with small firms (up to 50 employees) would also limit adverse selection that would cause higher premiums for individuals and small employers. Large employers typically use sophisticated benefit consultants are may evaluate whether to self-fund or purchase coverage on an Exchange. If larger employers with higher costs disproportionately seek coverage through the Exchange it will undermine affordability of coverage on Exchanges.

3. Questions:

- **What considerations are important in facilitating coordination between employers and Exchanges? (K)(3)**
- **What key issues will require collaboration? (K)(3)**

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Response:
We urge HHS to clarify in regulation that providing employee choice is simply an option for employers obtaining coverage in Exchanges, not a requirement. Because Congress allowed employers to specify just one health plan for enrollment or to specify the level of coverage made available to their employees, SHOP Exchanges, employers, and health plans are faced with unique challenges that are not present in an Individual Exchange. One of the biggest factors limiting employer participation in Exchanges is likely to be the complexity of interaction with an Exchange. This complexity is magnified in an environment in which each employee has the ability to select his or her own health plan. This individual choice approach:

- Increases the administrative burden for Exchanges by individualizing the purchase of health insurance. There were more than 4.8 million small employers with 50 or fewer workers employing more than 21 million full-time employees in 2009, according to data from the Medical Expenditure Panel Survey;
- Requires more complicated accounting and billing practices to account for premiums that differ based on the characteristics of each employee;
- Creates confusion for employers by making it difficult to handle employee requests for information and assistance with multiple plans; and
- Substantially increases the potential for adverse selection by individualizing the selection of health plans.

Today, small employers, often with the assistance of a broker(s), typically evaluate multiple health plans during the purchase process, once the decision is made the small employer works with one health plan. Usually, once the health plan is selected the broker or a company representative assist the employees in evaluating their alternatives during their open enrollment period, which includes enrolling in the health plan offered by the employer or alternative coverage such as a spouses coverage or SCHIP for their children, if eligible. Once the open enrollment is complete, the small employer interfaces with a single health plan on issues such as premium payment, adding and dropping covered persons and claims issues. If an issue out of the ordinary arises, a broker or the company's sales representative assists the employer.

In 2014, once Exchanges become operational, states need to consider how they, or their vendors, will assist small employers to minimize the increased administrative effort required to deal with multiple health plans if they elect an employee choice option. Issues to consider include:

- How should payments be made to health plans in Exchanges given different ratings added to employees based on age, geography and other reasonable rating factors?
- Should there be a single interface for billing and membership changes in each Exchange for small groups?
- Who will assist employees in understanding their coverage options, including other available coverage (such as spousal coverage) and SCHIP? This role has typically been performed by an agent or company representative; however, it is not clear how this would work in an environment where an employee can enroll with multiple insurers.
- Who will assist the employer if there are claims issues?
- How will employers handle multiple bills from multiple health plans?
- How would administrative problems for employers with employees in multiple states be addressed and which Exchange would "out-of-state" employees enroll in?

The ACA supports allowing employers to select a single carrier and/or health plan for their employees (as they do today). Section 1312(f)(2) defining the term "qualified employer" to mean a small employer that elects to make all full time employees "eligible for 1 or more qualified health

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plans" offered through the Exchange. However, under the ACA, qualified employers who purchase coverage through an Exchange also have the option to select a level of coverage (bronze, silver, gold, or platinum) and allow an employee to choose among any plan offered at that level of coverage within an Exchange. (Section 1312(a))

We note that some have interpreted section 1312(a) as allowing employees of qualified employers to choose any plan at a specified level and thereby prohibiting employers from selecting their plan. However, this provision is clearly permissive in that an employer is not required to specify a level of coverage – they "may" specify a level of coverage – and only if they do can employees choose among plans at that level of coverage. Moreover, the very definition of a qualified employer is one who selects a plan (or plans) for its employees.

While risk adjustment will eliminate some risk, there is still concern that employers allowing for an employee choice option could exacerbate anticipated risk from adverse selection that would not be fully addressed by whatever risk adjustment process is used.

We urge HHS to clarify in regulation that states have the option to provide for either employer choice or employee choice of health plans. We also recommend that Exchanges pilot test the systems necessary to permit employee choice of health plans if they proceed in that direction prior to implementation. In Massachusetts, the initial Connector small employer pilot in 2009 required employee choice of a health plan, which proved administratively complex. The replacement program – Business Express – allows employers to select a plan for their workers.

Additional clarification needs to address the substantial administrative problems created for employers with employees in multiple states if employees were allowed to obtain coverage from the Exchange in the state in which they reside rather than the state where the employer is headquartered. For example, would a New York-based small firm with employees residing in Connecticut, Pennsylvania and New Jersey have to sign up with four or more Exchanges? We recommend HHS to clarify that a qualified employer will contract with the Exchange in which the employer is headquartered with respect to the employer choice option. This will ease administration and ensure that employers do not forum shop for Exchange and health plans.

L. Risk Adjustment, Reinsurance and Risk Corridors

1. Question:

- **To what extent do States and other entities currently risk adjust payments for health insurance coverage in order to counter adverse selection? (L)(1)**
- **In what markets (e.g., Medicaid, CHIP, government employee plans, etc.) are these risk adjustment activities currently performed? (L)(1)**
- **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? (L)(1)**

Response:

Several states make risk adjusted payments to insurers in connection with their Medicaid, CHIP, and certain other state-subsidized programs (e.g., Massachusetts' CommonwealthCare). New York State has had a risk adjustment program for its private individual and small group markets since the 1990s. While collections from and payments to insurers have been based on diagnosis and demographic factors in the past, the program's current rules require that insurers with lower than average high-cost claims pay into the program and those with higher than average claims receive funds from the program. Demographic and condition-related information is no longer collected.

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We understand that states have used a variety of risk adjustment methods in connection with their Medicaid and CHIP programs developed by private industry and universities. These programs generally take into account demographics and health status-related information of the enrolled populations.

In evaluating the appropriateness of any risk adjustment method, there are several factors we believe are critical:

- The specific purpose of the risk adjustment needs to be considered. We understand risk adjustment under the ACA is intended to equalize risk between insurers and otherwise alleviate the pressure that would exist to engage in risk selection. To this end, insurers will exchange funds through some intermediary. This purpose differs somewhat from the Medicare, Medicaid, and CHIP contexts where federal and state governments make payments to insurers that reflect the risks or health status of their enrolled populations.
- The general limitations of any risk adjustment method must be recognized. For example, risk adjustment systems tend to make overpayments for the healthiest individuals (who may not have any covered health costs at all in a given year), but make gross underpayments for those individuals who have catastrophic health events. The use of reinsurance can help address the issue of underpayments for extreme high-cost cases, but this program is temporary under the ACA.
- Similarly, insurers with broad provider networks may find that risk adjustment payments do not adequately compensate them for the higher costs associated with providing enrollees with greater choice of providers. In particular, it is important to recognize that less healthy enrollees are more likely to select broad network products.
- Data collection concerning enrollee diagnoses will raise several issues. Providers will need to accurately code diagnoses and chart reviews may be necessary if there are concerns regarding completeness and/or accuracy. Providers who are not used to reporting diagnoses in a systemic fashion may require initial outreach (e.g., a provider who is paid on a capitated basis may not have been as concerned about the completeness of coding in the past). Insurers may have an incentive to encouraging “upcode” to increase their enrollees’ risk scores and increase their likelihood of receiving funds or at least mitigating the amounts they might owe. A timely audit system may be required to deter gaming.

Lastly, the risk adjustment methodologies used should be transparent to regulators, insurers, and the public so that their effectiveness can be evaluated by those parties affected. It is essential that developers of risk adjustment methodologies be agreeable to such openness, notwithstanding the considerable investments they likely make in developing such methodologies. BCBSA would like to continue working with the Administration as risk adjustment methodologies are developed.

2. Question:

- **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? (L)(2)**
- **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? (L)(2)**

Response:

We are not aware of any states that currently collect such information. As mentioned, New York State previously collected such information, but no longer does.

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States likely will need to develop a new set of capabilities in order to implement risk adjustment. They will need to collect, either directly or with the assistance of contractors, standardized sets of information on the demographic (e.g., age and gender) and health-related (e.g., diagnoses, claims, institutionalized status, etc.) characteristics of enrollees in their individual and small group markets. Additional information, including premium data, government premium subsidies paid for certain enrollees, and product-related data (e.g., actuarial value, covered benefits, network size, etc.) also may be necessary and/or desirable. PHI and privacy will need to be taken into account in designing information collection and auditing processes. States may wish to collect similar risk adjustment information on enrollees in programs such as Medicaid and CHIP in the event these enrollees move into the individual or small group markets. This is particularly important to the extent that a risk adjustment program includes any prospective component. In that case, it will be important to maximize the number of enrollees with risk scores from the previous year. (However, as discussed below, we recommend that concurrent risk adjustment methodologies be considered.)
3. Questions: • **What issues are States likely to consider in carrying out risk adjustment for health plans inside and outside of the Exchanges? (L)(3)** • **What kinds of technical assistance might be useful to States and QHPs? (L)(3)** **Response:** In addition to data collection, warehousing, and analysis needs, states will need to consider how to set up the financial transaction systems needed to support risk adjustment. Timelines will need to be established for data collection and financial transactions. Coordination with other legal requirements and business functions (e.g., enrollment times, deadlines for claim submissions by providers, due dates for state-mandated accounting statements, medical loss ratio reporting, etc.) should be taken into account. While existing Medicare and Medicaid risk adjustment systems will provide some insights for the development of risk adjustment methods for the private insurance market, there are meaningful differences between government programs and private insurance markets that should be taken into account. These include: • Product design (e.g., covered benefits, actuarial value) for public programs exhibits less variation than product design in the private market. For example, the ACA allows actuarial value to range from 90% for platinum plans to less than 60% for catastrophic plans. • Enrollee turnover rates may differ, as well. For example, Medicare enrollees may be less likely to change Medicare plans or leave Medicare altogether – in contrast to the individual and small group markets where enrollees often change coverage due to new jobs, becoming eligible under a family member's plan, etc. High turnover would make it more difficult to track enrollee risk scores from year to year. • Enrollee health risk and demographic profiles obviously differ between Medicare and the private market. • The source of financing also would influence program design. In Medicare and Medicaid, federal and state governments are the primary sources of payments to insurers. In the private market, employers, individuals, and federal subsidies will be used to pay premiums. As discussed elsewhere, risk adjustment in the private market will require collecting and disbursing amounts from and to multiple parties. Care should be taken to ensure that costs associated with the risk adjustment program are reasonable. For example, under a prospective risk

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adjustment approach, there would be a need to track each enrollee across health plans with a unique identification number as the enrollee could move from one year to the next.

BCBSA strongly recommends that risk adjustment methodologies be developed and pilot tested prior to implementation in 2014. Active cooperation between the federal government, state regulators and the National Association of Insurance Commissioners (NAIC), the American Academy of Actuaries, the insurance industry, and other interested parties is needed in developing such methods.

BCBSA believes that HHS should allow states some flexibility in terms of choice of risk adjustment models. For example, HHS could set minimum federal requirements for risk adjustment models and/or allow a choice of "pre-approved" risk adjustment models. In either case, care must be taken to ensure that acceptable models are rigorously tested and sufficiently reliable. This would allow states to coordinate risk adjustment models with other state-based programs and legal requirements (e.g., the temporary reinsurance program under ACA section 1341 administered by non-profit entities established by or under contract with states, state-specific rating rules that allow varying levels of age-based premium differentials – which would impact the weight assigned to age under risk adjustment methods, etc.). In addition, states likely would want to calibrate the risk adjustment average score to each specific rating area rather than use a national average score not reflective of local conditions. BCBSA would like to continue working with the Administration as risk adjustment methodologies are developed.

4. Questions:

- **What are some of the major administrative options for carrying out risk adjustment? What kinds of entities could potentially conduct risk adjustment or collect and distribute funds for risk adjustment? (L)(4)**
- **What are some of the options relating to the timing of payments, and what are the pros and cons of these options? (L)(4)**

Response:

With respect to risk adjustment entities, it is unlikely that any government or private sector entity today has all of the capabilities needed to administer a risk adjustment program for the private insurance market both for the individual and small group market. Potential sources from which to draw the expertise needed to administer such programs might be found in state insurance departments or other agencies, state high risk pools (although state high risk pools themselves will be obsolete in 2014, it is possible their boards and staffs could transition to this new role), universities, and private actuarial firms. Partnerships between entities with different areas of expertise may be desirable.

Concurrent risk adjustment methods might be considered, given their tendency to provide more accurate risk assessments than prospective models and the likelihood that turnover in the individual and small group markets likely will cause many enrollees to not have risk scores from the previous year. Alternatively, prospective methods could be used, though this would necessitate use of personal identifies given routine changes in membership.

We recommend that financial transactions be structured in a way that quickly collect and disburse risk adjustment payments to minimize the need for a third party to hold these funds for any substantial length of time. Consideration should be given to making such collections and payments annually. However, reporting from insurers to the risk adjustment entity for purposes of estimating annual liabilities should be made more frequently (e.g., quarterly) to allow affected parties to do

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appropriate financial planning (e.g., insurers can withhold appropriate amounts as they collect premiums). Any funds held by a third party for purposes of risk adjustment payments should be segregated from all other accounts and held in trust (e.g., funds should not be available to temporarily finance other state government programs).

The interaction of the timing of risk adjustment payments and payments made pursuant to section 2718 of the Public Health Service Act should be considered. The calculation of rebates prior to reinsurance, risk corridor and risk adjustment settlements could result in inappropriate rebates. To avoid this, reinsurance, risk corridor and risk settlements for the calendar year should be made shortly prior to the point at which rebate amounts are calculated, which at this time appears likely to be in the second quarter of the year.

5. Questions:

- **To what extent do States currently offer reinsurance in the health insurance arena (e.g. Medicaid, State employee plans, etc.) or in other arenas? (L)(5)**
- **How is that reinsurance typically structured in terms of contributions, coverage levels, and eligibility? (L)(5)**
- **How much is typically taken in and paid out? (L)(5) Is the reinsurance fund capped in any way? (L)(5) ?**

Response:

We are generally unaware of any states maintaining reinsurance programs in connection with their Medicaid and state employees programs.

There is limited state experience with respect to state-sponsored reinsurance programs in the private market. For example, New York State has provided stop-loss funding within certain claims corridors in connection with health maintenance organization products in its individual market and in connection with the "Healthy New York" program for lower-income employees of small businesses, self-employed individuals, and individuals without access to employment-based coverage. In addition, some states have created reinsurance programs specifically for their small group markets. BCBSA sponsored a paper on these approaches in 2007, (see Mark A. Hall, *Government-Sponsored Reinsurance: Purposes and Performance* (October 2007).

In the private sector, insurers sometimes purchase reinsurance from property and casualty or other health insurers for certain blocks of business (e.g., their individual market book). Reinsurance premiums and coverage levels are negotiated between insurers and their reinsurers. Coverage typically is based on claims corridors (i.e., claims incurred within certain levels by particular enrollees), not the health status of the insurers' enrollees. Insurers often retain a portion of the risk within risk corridors (e.g., 10% of costs between $50,000 and $250,000) to ensure they continue to have incentives to manage care and obtain provider discounts. Reinsurers sometimes contractually require insurers to use disease management and high-cost case management programs. On a related note, claims thresholds and reinsurance payments could be based on an external reimbursement rate (e.g., Medicare reimbursement) to incent insurers to manage care effectively and negotiate favorable provider discounts.

Somewhat analogously, employers sponsoring self-funded group health plans often buy stop-loss insurance from insurers with aggregate or individual attachment points to protect against large, unforeseen losses.

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6. Question: • **What kinds of non-profit entities currently exist in the marketplace that could potentially fulfill the role of an "applicable reinsurance entity" as defined in the Act? (L)(6)** **Response:** Consideration could be given to whether state high risk pools or non-profit private reinsurers might be able to fulfill the necessary functions. However, it may be necessary for states to establish new entities.
7. Question: • **What methods are typically used to determine which individuals are deemed high-risk or high cost for the purposes of reinsurance? (L)(7)** **Response:** Some states use lists of medical conditions or risk assessment scoring systems (e.g., Washington State) to identify which individuals are eligible for state high risk pool coverage. In the private reinsurance market, payments generally are based on claims corridors, not enrollees' diagnoses. Consideration could be given to whether health status scoring for the risk adjustment program could be used for this purpose.
8. Question: • **What challenges are States likely to face in implementing the temporary reinsurance program? (L)(8)** **Response:** States may face several challenges in implementing the temporary reinsurance program. These include: • *Lack of Existing Models.* Current state reinsurance programs, high risk pools, and private sector reinsurance differ substantially from the ACA's temporary reinsurance program. • *Administration.* As noted, new entities may need to be established specifically for this purpose. • *Coordination.* Another challenge will be coordinating Exchanges with both the risk adjustment and risk corridor programs, e.g., determining priority of payments and avoiding gross under- or over-payments. In addition, each risk mitigation program may have a different entity administering it, which could complicate coordination. • *Coordination with Medical Loss Ratio.* The ACA requires insurers to calculate MLRs after accounting for risk adjustment, reinsurance and risk corridor payments. Substantive rules regarding timing, accounting, reconciliation, etc., will need to be developed.
9. Question: • **How do other programs (e.g., Medicaid) use risk corridors to share profits and losses with health plans or other entities? (L)(9)** • **How are the corridors defined and monitored under these programs? (L)(9)** • **What mechanisms are used to collect and disburse payments? (L)(9)**

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Response:

Some states (e.g., Florida) have used risk corridors as a transitional mechanism in connection with their Medicaid programs. There is some concern that risk corridors could encourage some insurers to underprice products, at least initially, in order to gain market share given that the federal government would be subsidizing their losses. The ACA does not appear to provide an aggregate limit on the amount the federal government will pay to subsidize risk corridor losses, and recouped amounts from insurers with profits would not necessarily fund all the pay-outs.

10. Question:

- **Are there non-Federal instances in which reinsurance and/or risk corridors and/or risk adjustment were used together? (L)(10)**
- **What kinds of special considerations are important when implementing multiple risk selection mitigation strategies at once? (L)(10)**

Response:

We generally are unaware of any non-Federal examples where reinsurance, risk corridors, and risk adjustment have been used together.

One important consideration is that the temporary reinsurance program – which effectively redistributes funds from the much-larger insured and self-funded group markets to the individual market – could create individual market premiums in 2014-2016 that will be considerably lower than the premiums in the individual market from 2017 and beyond. Thus, rate shock in the individual market could result in 2017 when the reinsurance program ends (or later, if some run-out reinsurance funds are distributed in later years, as permitted in the ACA). In addition, given that plans can be excluded from Exchange participation based on premium increases, it is important that foreseeable circumstances such as this not lead to exclusion.

In addition, to the extent that reinsurance payments for high-cost conditions mitigate insurer risks from 2014-2016, there will be less need for risk adjustment methods during this period (i.e., in order to avoid over compensation). Consequently, when reinsurance is phased out, it will put pressure on the risk adjustment program to more adequately compensate insurers for high-risk enrollees.

Other considerations include:

- The need to determine payment priority between the programs;
- The distinctive purpose of each program;
- Coordinating the programs to avoid under- and over-payments; and
- Interaction between these programs and other programs and legal requirements. For example, the timing of medical loss ratio reports and payment of rebates will be impacted by risk mitigation programs. Furthermore, insurance market rating rules will impact the design of risk adjustment methods.

M. Economic Analysis, Paperwork Reduction Act, and Regulatory Flexibility Act

1. Question:

- **What policies, procedures, or practices of plans, employers and States may be impacted by the Exchange-related provisions in Title I of the Affordable Care Act? (M)(1)**

Response:

New requirements for health plans and states. The Exchange requirements in the ACA are broad-ranging, imposing new requirements on states and health insurance plans in a wide variety of

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areas. The ACA requires states to establish and administer Exchanges that meet the detailed standards spelled out in the ACA. The ACA also specifies a host of new requirements for health plans that want to participate in state Exchanges, which will require changes to policies, procedures and practices virtually across the board. Specifically, states will have to develop the following systems in time for the 2014 effective date and health plans will need to implement and potentially develop new areas of compatibility with government systems in the following areas:

- Eligibility/subsidy determination systems
- Enrollment systems
- Financial systems, including subsidy reconciliation
- IT/Website infrastructure
- Data security and back-up systems
- Accounting and financial accounting systems
- Call center
- QHP procurement system

These state and health plan requirements will have a significant impact on virtually every facet of the health insurance market for small employers and individuals, affecting not only health insurance plans themselves, but the consumers in these markets.

The burden of various options for implementing these new systems on states and health plans should be accurately assessed as part of any economic impact assessment of the Exchange provisions in the ACA. This analysis should explicitly evaluate any assessment placed on health insurance premiums to fund the operation of Exchanges and any potential efficiencies that could be obtained by streamlining the interaction of Exchanges with functions already performed by state insurance departments (e.g., in the certification of health plans).

An economic impact assessment should also accurately reflect the cost of additional standards for qualified health plans imposed at the federal level. This should include evaluating the costs of various options for designing essential health benefits and the extent to which an overly broad definition would reduce participation in the insurance market. This provision should also evaluate the cost of essential community providers, quality requirements, and other mandates on QHPs that could increase the cost of coverage.

Economic assessments should also accurately evaluate the potential cost savings or additional costs for functions assumed by Exchanges. Exchanges may not provide the level of administrative efficiency that some policymakers hope and it will be important to have an honest assessment of where Exchanges can streamline administrative functions versus adding new ones in order to evaluate the potential impact on premiums.

State flexibility. Of critical importance, given the significant scope of the changes imposed by the new Exchange requirements, the ACA provides states flexibility to develop Exchanges that meet their unique market needs. This state-based approach to organizing and administering Exchanges is more likely to be responsive to consumers, capitalizing on states' understanding of the local insurance market, other state health insurance programs, and consumer preferences within a state. Deferring functions to the states would also limit federal costs. The relative cost to the federal government of assuming functions that could be performed at the state level should be fully considered in any economic impact assessment of the Exchange provisions of the ACA.

Impact on small employers. The Exchange provisions also could have a significant impact on how small employers administer their health plans. An employee choice model – where each employee selects their own health plan in the Exchange – would dramatically increase costs for

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administering small employer coverage. These potential costs should be evaluated in any economic impact assessment for implementing Exchanges.

Today, while small employers, often with the assistance of a broker(s), typically evaluate multiple health plans during the purchase process, once the decision is made the small employer typically works with one health plan. Usually, once the health plan is selected the broker or a company representative assist the employees in evaluating their alternatives during their open enrollment period, which includes enrolling in the health plan offered by the employer or alternative coverage such as a spouses coverage or SCHIP for their children, if eligible. Once the open enrollment is complete, the small employer interfaces with the single health plan on routine issues such as premium payment, adding and dropping covered persons and on claims issues. If an issue out of the ordinary arises, a broker or the company's sales representative assists the employer.

The ACA supports allowing qualified employers to continue to select the health plan they want for their employees (as they do today). However, employers who purchase coverage through an Exchange also have the option to select a level of coverage (bronze, silver, gold, or platinum) and allow an employee to choose among any plan offered at that level of coverage within an Exchange. This "employee choice" option will make the administration of health coverage for small employers significantly more complex and costly. This employee choice approach:

- Increases the administrative burden for employers by individualizing the purchase of health insurance. There were more than 4.8 million small employers with 50 or fewer workers employing more than 21 million full-time employees in 2009, according to data from the Medical Expenditure Panel Survey;
- Requires complicated accounting and billing practices (e.g., list billing) to account for premiums that differ based on the characteristics of each employee;
- Creates confusion for employers by making it difficult to handle employee requests for information and assistance with multiple plans; and
- Substantially increases the potential for adverse selection by individualizing the selection of health plans.

These impacts must be evaluated as part of any economic impact assessment on the Exchange provisions of the ACA. As noted previously, we have recommended that HHS clarify in regulation that states have the option to provide for either employer choice or employee choice of health plans. We have also recommended that Exchanges pilot test the systems necessary to permit employee choice of health plans if they proceed in that direction prior to implementation.