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May 11, 2011

The Honorable Kathleen Sebelius, Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

RE: Comments on Interim Final Portions of the Regulations to Establish Exchanges, CMS–9989–F

Dear Secretary Sebelius:

We appreciate the opportunity to comment on the interim final provisions included in the regulation establishing Exchanges published in the Federal Register on March 27.

We believe that the clear intent of the Affordable Care Act is to establish a simple, unified pathway to health coverage for consumers. These rules are critically important to ensure the successful implementation of the ACA and that consumers have a family-friendly and seamless experience in the years ahead. We strongly support the rules' provisions to promote modernized eligibility systems that will rely primarily on electronic verifications, eliminate duplicate requests for information, and strictly limit the use of requirements for paper documentation.

However, we are concerned about provisions of the Exchange (and Medicaid) final rules that allow states to separate the eligibility processes for insurance affordability programs by letting the Exchange hand off "initial assessments" of applications to Medicaid and CHIP agencies for a final eligibility determination. These provisions are intended, presumably, to accommodate a potential wide variety of state-specific arrangements between state Medicaid and CHIP agencies, state-operated Exchanges, and federally facilitated Exchanges. However, based on our experience here in Texas and our observation of practices and outcomes in other states, we fear that without revisions adding greater clarity to coordination requirements and more specificity and rigor to minimum performance standards, low- and moderate-income Texans may experience delays in eligibility and gaps in coverage.

We have seen such problems in Texas, where the state maintains different eligibility and enrollment systems for Medicaid and CHIP. Despite the fact that state law and rule nominally require seamless referrals between the programs, since 2000 the use of two separate systems in practice has too often resulted in confusion, delays, and abandoned applications. Our observation of Texas Medicaid eligibility policy over more than two decades has been that, absent clear and enforceable minimum performance standards, states may foster delays, understaffing, burdensome paperwork, and poor performance in enrollment and renewal of benefits as a means of slowing or reducing Medicaid and CHIP enrollment.

In Texas, we have also experienced in recent years periods of grave failure in our eligibility systems, which were attributable to poor performance by both contractors and public employees, exacerbated by serious staffing shortages. Poor training and IT failures also contributed to precipitous disenrollment in children's Medicaid, enormous backlogs of several months in applications and renewals, and errors in determinations. These factors resulted in dramatically sub-standard timeliness statistics for Texas Medicaid. Because federal law and rule provided the Secretary with such limited tools for enforcing Medicaid timeliness standards, our state did not make a serious effort to address the systemic problems until financial sanctions were imposed by USDA for the poor Food Stamp/SNAP performance that mirrored the Medicaid processing problems in Texas' integrated public benefits eligibility system.

We believe that lessons learned in Texas Medicaid and CHIP will be instructive when setting up eligibility and enrollment structures for all insurance affordability programs under the ACA. We are concerned that letting the Exchange hand off initial Medicaid assessments creates multiple opportunities to fragment what should be a seamless eligibility system. We urge the Secretary to use this opportunity with the interim final rule provisions to eliminate additional avoidable sources of coverage gaps and delays from any source.

The safeguards HHS has included in the final rule must be maintained and further strengthened to ensure the most streamlined and accurate eligibility and enrollment system possible. Our comments are intended to eliminate several ways in which components of a divided system could make it more difficult for families to enroll in coverage, and thus reduce the potential for applications to "ping-pong" between the Exchange, CHIP, and Medicaid. We have also provided comments on the additional consumer protections needed in the interim final rule provisions related to agents, brokers, and web-based brokers.

§155.220(a)(3) Improve Consumer Protections Related to Agents and Brokers

Exchanges are intended to be consumer-friendly marketplaces where families find important, unbiased information. Agents and brokers can play a constructive role in this new system if they serve consumers without conflicts of interest and can meet all of a family's needs. The Urban Institute estimate that 75 percent of parents who qualify for subsidized Exchange coverage will have children who qualify for Medicaid and CHIP. Because so many families will have members covered by different insurance affordability programs, it is important that agents and brokers that work with the Exchange not only understand Exchange subsidies but also Medicaid and CHIP, and the Basic Health Plan, if applicable.

We support requirements in the rule that agents and brokers register with the Exchange before helping consumers, receive training, comply with privacy standards, and abide by state law. However, we feel that stronger standards are needed in this area. In states that allow agents and brokers to assist with Exchange enrollment and insurance affordability programs, agents and brokers should be held to the same high standards as navigators. Specifically, agents and brokers should be required to demonstrate to the Exchange that they: (1) can serve the needs of low-income and hard-to-reach populations, and (2) will abide by conflict of interest standards that ensure they act in the best interest of their client and prevent steering enrollees toward specific plans or other activities that could cause adverse selection in the Exchange. Brokers and agents should also be required to meet privacy, conflict of interest, and training standards developed by the state.

States that allow agents and brokers to assist Exchange consumers should be required to develop rules specifying when, how, and what agents and brokers must disclose to consumers regarding: (1) any financial compensation provided, (2) any conflicts of interest the agent or broker has and (3) the fact that consumers are not required to use an agent or broker to apply for insurance affordability programs, compare plans and coverage options, receive other benefits of the Exchange, or enroll in a QHP.

We are concerned that web-based brokers may promote some insurance products over others, which could steer consumers into products that are not in their best interest and lead to adverse selection. HHS should set standards regarding how Exchange plan information must be organized and displayed by web-based brokers to prevent steering. Web-based brokers should also be required to show information on plans' quality ratings from the Exchange and post a disclaimer that they are not the official Exchange that directs consumer to the official Exchange.

In addition, states that opt to permit brokers to serve the "assistance" function outlined in §155.220(a)(3) should be required to include in their Exchange Blueprint or other similar document details of the compensation arrangements with these brokers. States should be required to describe how they will monitor and minimize adverse selection and prohibit directing enrollees into coverage for reasons unrelated to the consumers' best interests.

§155.302 and §155.345 Active Approval Process, Elimination of Duplicative Eligibility Determinations, and Transparency

HHS standards must set a high bar for states to demonstrate that that their chosen arrangement for determining Medicaid and CHIP eligibility of applicants entering via the Exchange "door" can be achieved without harming families. HHS should conduct a readiness assessment for all states opting for bifurcated eligibility systems, as well as for Exchange-operated systems and those of Exchange contractors.

Readiness reviews can ensure that states do not elect the "initial assessment hand-off" model in an attempt to reduce or slow enrollment by eligible families, and that all states have functional systems in place to implement their choice. States should be required to actively demonstrate their operational readiness to implement the more complicated hand-off structure by:

- establishing for HHS via the use of test cases and other means that their Medicaid IT systems can accept and use data transferred from the Exchange in a secure, electronic format;
- demonstrating that their Medicaid agency has the capacity to conduct prompt determinations of Medicaid and CHIP eligibility for individuals who are determined by the state or federal Exchange to be potentially eligibility for Medicaid/CHIP in full compliance with the final Medicaid eligibility rules, including provisions requiring electronic verification of income; and
- showing that they can and will agree to all of the coordination protections included in the final rule, including the requirement that they not ask families for information that they already have provided and refrain from unnecessarily re-verifying any data already verified by the Exchange.

We strongly urge HHS to adopt an active approval process and oversight of states' readiness and ongoing performance. States should not be allowed to simply check boxes on an Exchange Blueprint document saying that they intend to do all of these things. States should be required to actively demonstrate their operational capacity to do so.

We encourage you to ensure that the final rule minimizes the degree to which states can conduct duplicative eligibility determinations by requiring states, to the maximum extent possible, use a single shared system between the Exchange and Medicaid/CHIP so that eligibility determinations need to be made only once.

All agencies involved in eligibility determinations for a state should abide by the same rules and procedures when assessing or determining Medicaid and CHIP eligibility in order to ensure accurate and consistent eligibility determinations. This will help minimize the need for further verification once an application reaches the Medicaid agency and minimize the number of applicants who are bounced between programs or fall through the cracks. If states are not utilizing a shared system, the final rule should require Exchanges to conduct Medicaid assessments using a state's Medicaid eligibility rules (rather than a generic version of the rules that fail to take a state's policy choices into account), as well as using the same data sources as the state Medicaid agency.

We agree with other commenters that interagency agreements should be specific and detailed. In addition to the standards for agreements between the Medicaid agency and Exchange in §155.302(b)(6), agreements should cover how each program will determine or assess eligibility, document all processes for transferring cases and resolving disputes, and set forth which party will be responsible for notices, appeals and consumer assistance. Eligibility process agreements should be available to the public and subject to public review and comment before they are finalized.

§155.310(e) and §155340(d) Strengthen Timeliness and Performance Standards

We are concerned that the rule's requirement that the Exchange "must determine eligibility promptly and without undue delay," is too vague, but understand that HHS intends to issue more specific standards in the future. We recommend that the final rule require eligibility determinations to occur within a few days if electronic data are available to verify eligibility. Moreover, under no circumstances should eligibility determinations take more than 30 days. This standard should be uniform across the Exchange, Medicaid and CHIP, and should be measured from the date an application is submitted for any insurance affordability program to the date a final determination is made.

When eligibility systems are bifurcated (the hand-off model), the Exchange's eligibility assessment should be completed within three days, and any necessary application transfer should be achieved in one day. Requiring a quick assessment and electronic transfer will addresses concerns that applications transferred late in the process will not allow the receiving agency sufficient time to make a determination within a 30-day window.

Exchanges should be required to regularly report publicly on their performance in accordance with the timeliness standards adopted in the final rule. HHS should periodically review and update standards for acceptable processing performance to keep up with the degree to which best practices and evolving technology will increase the speed at which accurate determinations can be made.

Thank you for consideration of our comments on these important rules. Any questions regarding these comments may be addressed to Stacey Pogue at pogue@cppp.org or (512) 320-0222 ext. 117.

Sincerely,

Stacey Pogue
Senior Policy Analyst