CPPP CENTER for PUBLIC POLICY PRIORITIES
WORKING FOR A BETTER TEXAS™

June 18, 2012

Steve Larsen
Director, Center for Consumer Information and Insurance Oversight
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Via email to FFEcomments@cms.hhs.gov

Re: Federal Guidance on Federally-facilitated Exchanges

Dear Mr. Larsen:

We appreciate the opportunity to submit comments to the Center for Consumer Information and Insurance Oversight (CCIIO) on the General Guidance on Federally Facilitated Exchanges released on May 16, 2012.

The Center for Public Policies is a nonpartisan, nonprofit 501(c)(3) policy institute established in 1985 and committed to improving public policies to better the economic and social conditions of low- and moderate-income Texans. Improving access to health care for Texans has been at the core of our mission and activities since our founding. We have worked closely with statewide advocacy networks, state decision-makers, and our state Medicaid and CHIP programs to improve access to care for Texans and to seek solutions to Texas' severe uninsured problem.

Because Texas has chosen to delay planning for an exchange, we anticipate that Texas will have a Federally Facilitated Exchange (FFE) in 2014 (and possibly longer). We appreciate the guidance issued on FFEs and Partnership Exchanges, which helps stakeholders in Texas understand the likely path forward to an exchange that will be prepared to begin enrolling Texans in coverage as of October 2013. The creation of an effective and user-friendly exchange in Texas will be fundamental to expanding coverage in the state, where one of four people is uninsured. We offer the following recommendations on how the federal guidance can be strengthened so that FFEs better serve consumers needs.

Plan Management

Leveraging states' traditional roles in health plan oversight for FFE plan management functions makes sense only if and when states can demonstrate that their reviews used for certifying

Qualified Health Plans (QHPs) meet all federal standards. To ensure that consumers in an FFE or Partnership Exchange can choose among quality plans and federal subsidies only go to plans that are truly qualified to be a QHP, HHS must retain strong oversight of the QHP certification process and step in to directly perform functions when a state cannot or will not meet federal standards.

HHS should confirm that state-level reviews are performed using standards that are at least as strong and protective of consumers as federal standards. The current rate review process in Texas provides an instructive example of why HHS should not simply rely on the fact that a state has a review process in place, but must go further to ensure that reviews are being conducted in a manner that conforms with or exceeds federal standards. Texas has received a federal rate review grant, and HHS deemed Texas to have an effective rate review process, but Texas' rate review process does not appear to be compliant with federal rule. Texas does not provide justifications on rate increases that exceed 10 percent on the Texas Department of Insurance (TDI) website, nor does TDI provide a mechanism for the public to comment on rate increases. Furthermore, Texas has not completed any rate reviews. No rates have been deemed reasonable or unreasonable, and the oldest filing has been pending at TDI for more than seven months.

We are disappointed that the FFE will not use active purchasing for QHP selection in the first year to drive better value for consumers and taxpayers; however, we are glad that the guidance leaves this as an option for future years. We strongly support the FFE's use of a meaningful difference standard for QHP certification to help ensure that consumers can chose among a manageable number of distinct plan options. We also support the use of a plan-level analysis for discriminatory benefit design. We encourage the FFE to utilize consumer surveys, focus groups, or other means of input to analyze consumer experience with plan selection in the FFE and use the findings to improve the consumer experience.

Finally, along with other commenters, we urge HHS to use the QHP certifications process to ensure that the FFE includes plans with cost-sharing structures that will work for low- and moderate-income families. Plans that "front-load" costs with high deductibles may make accessing health care prohibitively expensive for low- and moderate-income families. HHS should ensure that insurers offer QHPs with low deductibles within the required actuarial value so that families, both those that qualify for cost-sharing assistance and those that do not, have the ability to choose plan designs that do not place most cost-sharing requirements up front.

Accreditation and Quality Reporting

We understand that the phased approach to accreditation and quality reporting reflects the difficulty of accomplishing associated tasks and the many other demands faced by states and the federal government to get exchanges off of the ground. We believe it is essential that exchange consumers be able to utilize a quality rating system based on standardized metrics

that is easy to understand and allows consumers to compare quality across QHPs. While that system is under development, we are glad that HHS proposes to display existing CAHPS data on patients' experience. We urge HHS to also require reporting and display of HEDIS quality measures in phase one, so consumers also have access to quality data from a clinical perspective.

Eligibility for Insurance Affordability Programs and Enrollment in the Individual Market

We believe that the clear intent of the Affordable Care Act is to establish a simple, unified pathway to health coverage for consumers. The exchange will be critically important to ensure that millions of Texans have a family-friendly and seamless experience enrolling in the correct coverage – QHPs, Medicaid, CHIP, or the Basic Health Plan (if applicable). We have concerns about federal rules that allow states to separate the eligibility processes for Medicaid, CHIP, and the Exchange. Though these provisions accommodate a variety of state-specific arrangements between state Medicaid and CHIP agencies, state-operated Exchanges, and FFEs, they increase the likelihood that 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.

HHS needs to put strong standards in place and coordinate closely with states to ensure that "hand offs" between an FFE and state Medicaid/CHIP programs do not undermine the goal of a streamlined system. States with an FFE that choose to maintain authority for the final Medicaid eligibility determinations should be required to first demonstrate the capacity to conduct determinations in full compliance with the ACA, transfer cases electronically, and quickly resolve discrepancies in determinations. For cases transferred to the state Medicaid agency, the state should not be allowed to ask for information already provided to the FFE or re-verify data already verified by the FFE.

To ensure that applications from low-income families do not bounce back and forth between the FFE and Medicaid, it is critical to eliminate differences in how the FFE conducts eligibility assessments and how the state conducts determinations. The FFE should utilize the same data sources, the same business rules, and the same definition of reasonable compatibility as states.

We believe that the Navigator program will be important to the success of the FFE and are pleased to see that HHS intends to have a fully operational Navigator program—with trained and certified Navigators—in every FFE in place by October 2013. We urge HHS to set up Navigator programs in FFEs that are sufficient in scope to effectively serve the uninsured population. An FFE in Texas would need contract to build a Navigator program that is sufficient in number to help reach out to over 6 million uninsured Texans, geographically diverse enough to have statewide reach, and capable of providing linguistically and culturally appropriate assistance. We urge FFEs to work with state stakeholders on outreach to help ensure that all eligible individuals and families, including those who are low-income, uninsured, hard-to-reach, and/or experience health disparities, are aware of the coverage expansions and FFE starting in 2014. We also urge HHS to issue standards for the FFE Navigator program that will prevent conflicts of interest.

The guidance clarifies that an FFE will permit agents and brokers to enroll individuals in QHPs through the Exchange (to the extent permitted by the state), but does not address whether agents will be working for and receive payments set by the exchange or insurers. We urge HHS to consider ways to reduce conflicts of interest and prohibit steering of consumers when answering these and other questions about how agents and brokers will function within an FFE. We recommend that HHS administer training for agents and brokers working with the FFE that includes information on Medicaid and CHIP as well as insurance affordability programs related to QHPs. Finally, we urge HHS to maintain strong oversight of agents and brokers working with an FFE to discourage and detect inappropriate steering and aggressive or deceptive practices.

Stakeholder Input

We appreciate the commitment in the guidance to working with state stakeholders. Along with other commenters, we recommend that HHS incorporate stakeholder input into FFE planning and implementation in a manner that is robust, meaningful, and ongoing. We do not recommend the “listening session” model HHS used previously for essential health benefits and exchanges. We participated in these listening sessions and found that they did not foster discussion and it is not clear if the feedback contributed to decision making.

We do not recommend that HHS defer to the NAIC or a state’s Insurance Commissioner to oversee stakeholder input in states with an FFE because these entities tend to have close ties to industry and are unlikely to have relationships with groups that primarily focus on Medicaid and health care issues for low-income populations. Instead, we recommend that HHS directly develop a formal advisory group structure similar to those adopted in states moving forward with exchange planning. Consumer advocacy organizations and other groups that have experience working with the uninsured and people with serious health care needs and complex family coverage scenarios should have a seat at this table. Through the advisory group, stakeholders should have the opportunity to provide written and verbal input on specific FFE policy and operational decisions.

Thank you for considering these comments and recommendations as you continue the challenging and important work of setting up health insurance exchanges. If you have any questions about these comments, please contact me at (512) 320-0222 or pogue@cppp.org.

Sincerely,

Stacey Pogue
Senior Policy Analyst

For More Information

For more information or to request an interview, please contact Brian Stephens at stephens@cppp.org or 512.320.0222, ext. 112.

About the Center

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