Center for Public Policy Priorities

October 31, 2011

Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attn: CMS-2349-P
P.O. Box 8016
Baltimore, MD 21244-8016

RE: Comments on the Proposed Rule on the Establishment of Exchanges and Qualified Health Plans (CMS-9989-P)

Dear Secretary Sebelius:

We appreciate the opportunity to comment on the proposed rule related to the Establishment of Exchanges and Qualified Health Plans (CMS-9989-P). We have also included comments on concept of the Federal-State Partnership Exchange as described in HHS' September 19, 2011 presentation available on CCIIO's website.

The Center for Public Policies (CPPP) 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.

The center is joined in these comments by the **La Fe Policy Research and Education Center, Texans Care for Children, and Children's Defense Fund–Texas.**

The **La Fe Policy Research and Education Center** works to continually improve the Bienestar (well-being) of Mexican Americans through policy analysis, education, leadership development, and civic involvement. Bienestar affirms our culture, community experience, values, and advocacy to achieve equality of opportunity through responsive social and health policies.

For the last twenty-five years, **Texans Care for Children** has served as the state's leading multi-issue child advocacy organization and now has a membership network of more than 240 organizations and individuals across Texas that build support for changes at the state level.

The **Children's Defense Fund** provides a strong, effective and independent voice for all the children of America who cannot vote, lobby or speak for themselves. CDF educates the nation about the needs of children and encourages preventive investments before they get sick, drop out of school, get into trouble or suffer family breakdown. CDF began in 1973 and is a private, nonprofit organization supported by foundation and corporate grants and individual donations.

We respectfully submit these brief comments in support of key aspects of then proposed rule which we believe will be especially beneficial for our state, and to identify some areas of concern where we think stronger guidance would be more effective in Texas.

§155.20 Definitions

The definition of "**applicant**" should be clarified to include only persons and employers seeking coverage for themselves; that is, to exclude an unqualified parent (e.g., unqualified due to an affordable ESI offer) who is completing an application form for a qualified family member, or an application assister such as a navigator completing an application on behalf of a qualified individual or household. This clarification is needed to align with the August 2011 NPRM definitions.

"**Lawfully present.**" We endorse this recommendation from the Georgetown University Health Policy Institute's Center for Children and Families:

> *Amend the definition of "lawfully present" by adding the following three categories: (1) individuals whose status makes them eligible to apply for work authorization under 8 C.F.R. sec. 274a.12, (2) victims of human trafficking who have been granted continued presence, and (3) individuals granted a stay of removal by administrative or court order, statute or regulations. Permit states to use existing administrative mechanisms for determining eligibility, provided that state rules are no more restrictive than federal law.*

§155.110 Entities eligible to carry out exchange functions

CPPP recommends that the rule explicitly prohibit membership on exchange governing boards by individuals with clear conflicts of interest, including individuals affiliated with health plans and agents or brokers. If HHS ultimately allows clearly conflicted parties to serve on exchange governing boards, CPPP supports the NPRM proposal that a majority of exchange board members should be free from conflict of interest. However, we recommend that this portion of the rule be further strengthened, because merely ensuring that a majority lack a conflict of interest (per §155.110(c)(3)) will not necessarily ensure that consumer interests are in fact represented. A board majority simply free from insurance industry representatives, for example, might still fail to represent broad consumer interests. Ensuring that consumer interests are represented will require an explicit majority of consumer representatives, and will be most effective if general guidance regarding credentials or qualifications to serve in that capacity is also included. We support this specific recommendation of Georgetown University Health Policy Institute's Center for Children and Families regarding adequate definitions of "consumer representatives."

> *"Consumer representatives" (should be) defined as someone who is 1) him/herself a customer of an exchange plan directly or on behalf of a family member (or reasonably expected to be once exchanges are operational), or 2) a representative of a non-profit organization that advocates for or represents constituencies served by the exchange, including but not limited to organizations comprised of or representing all consumers, children, children with special health care needs, low-income individuals, immigrant families, or those with a certain disease or condition.*

We further believe that if conflicted parties are allowed on governing boards, that "consumer representatives" must clearly be defined as people without conflicts of interest. Without this addition, it could be possible for states to appoint providers, agents, individuals who work for insurer trade associations, etc. as consumer representatives if they are enrolled in an exchange plan.

In our state's contemporary political culture, commercial interests are often afforded a greater role than consumer representatives in governance structures. Absent an explicit directive for a non-conflicted majority and/or for a majority of members representing clearly defined consumer interests, Texas would likely constitute its Exchange board with a majority of insurance industry representatives and only token consumer representation. Texas' (unadopted) Exchange legislation filed in 2011 could have allowed a voting majority of the Exchange board to be comprised of representatives

from insurers and/or agents (in part because the slot for an enrollee could have been filled by an exchange enrollee who was also an agent or health plan lobbyist, for example), and would have included just one consumer representative.

It is understandable and prudent that many states' Exchange governing boards will want to have access to the expertise held by individuals who have conflicts of interest. This should be accomplished by including insurers, agents, providers, and other on an advisory panel or other non-governing forums. ; But if the final rule allows conflicted members on governing boards, our recommendation is that the final rule ensure that consumer interests constitute the Exchange governance majority, and that governing structures will neither be dominated by parties with financial interests nor unduly hampered because substantial numbers of voting members must frequently excuse themselves from voting on issues in which they have a conflict of interest.

§155.110(e) States electing to merge their SHOP and Exchange administrations must ensure that the very distinct enrollment and eligibility requirements for the two components are correctly and distinctly applied within the merged structure.

§155.110(f) Include a requirement that a description of the governance structure must be included in the Exchange Plan submitted to HHS under 155.105(c).

§155.200(b) The rule should protect confidentiality of information for persons applying for certificates of exemption, which under statute may include individuals who are excluded from qualification to participate in the Exchange due to immigration status. In Texas, beyond clear humanitarian concerns, careful attention to how these policies affect mixed-immigration families is essential to protect the rights of the enormous population of US citizens and Lawful Permanent Residents who reside in mixed immigration families. The Urban Institute estimates that 30% of Texas children have at least one immigrant parent, and the Pew Hispanic Center estimates that Texas is home to between 1.4 and 1.8 million undocumented immigrant residents.

§155.205(a) Texas Medicaid and CHIP have experienced both good and poor call center models. Based on lessons learned, we recommend that Exchanges be required to establish, monitor, and enforce call center standards, and to report performance to the public. Classic call center benchmarks including time to answer, time in hold queues, call abandonment and busy/no answer rates must be included, but standards must also be developed to measure the actual resolution of caller issues, which is not guaranteed even where there is apparent prompt performance in the aforementioned measures.

§155.205(b) We strongly support requiring the inclusion in Exchange web sites of an individual "my account" option allowing consumers to access and update their personal coverage information and choices. While some consumers may always prefer a telephone assistance on in-person option, maximizing self-service capacity for those who desire that option is critical to keeping the costs of administration and staffing to a minimum. It is also critical that consumers be given the option to authorize access to their data by Navigators or other designated representatives.

§155.205(d) We strongly support enumerating in the rule all of the required consumer assistance functions including confidential assistance with eligibility, enrollment and renewal requirements and processes for Medicaid, CHIP, BHP (if applicable) and both subsidized and unsubsidized coverage in QHPs; premiums and cost-sharing; benefits and coverage limits; how to access services; QHP quality ratings and transparency of coverage measures; how to file a complaint, grievance or appeal; and information and referral for persons ineligible for the Exchange, Medicaid, CHIP or the BHP (if applicable).

§155.205(e) We recommend that an Outreach Plan description be a required component of the State Exchange Plan required under 155.105(c)(1). We further recommend that Exchanges be required to conduct outreach and education activities that target underserved populations and those who experience health disparities due to language barriers, low literacy, race, color, national origin, geography, or disability. Exchanges should be required to periodically identify populations which appear to be underserved by the Exchange and target additional outreach to these groups.

§155.210 We support a requirement that an Exchange's Navigator program be operational on the opening date of the initial open enrollment period.

Navigator programs should be robust enough to serve all individuals and small businesses in need of assistance in every area of the state. We recommend inclusion of a requirement that the Exchange Plan assess the extent to which Navigator services are available statewide, and that the location and extent of unmet need is reported. In addition, HHS should monitor Navigator programs to determine that they have sufficient funding to meeting the needs of all potential enrollees in need of assistance statewide.

Navigators' duties should include providing accurate information on both public and private coverage programs.

155.210(b)(2) Texas, like many other states is home to a range of dedicated and experienced consumer organizations providing health care application assistance. Historically, these entities have connected underserved lower-income children and pregnant women with public coverage under Texas Medicaid or CHIP, and other adults with local safety net programs for the uninsured. Texas also has a robust sector of insurance agents and brokers, who have extensive experience with the pricing and selection of commercial insurance—but little in the areas of under-served populations, cultural competency, or the complexities of Medicaid-CHIP eligibility.

We recommend that 155.210(b)(2) be amended to direct all states to include "community and consumer-focused nonprofit groups," as one of the two types of eligible entities states must select to serve as navigators. It will not be possible to perform the extensive community education and outreach needed in our state where one in four persons is uninsured today if we do not harness all of the existing capacity, expertise and resources we have built over the years. And, our Medicaid and SNAP Community-Based Organization (CBO) outreach and assistance providers are the only entities with real experience assisting families with means-tested applications.

We also recommend that **155.210(b)** clarify that if a state prescribes training or credentialing standards for Navigators, that these standards may not include a requirement that Navigators be licensed as insurance agents or brokers. HHS should provide a model training and certification program that states can use and adapt for their Navigator certification programs. The model should be based on effective existing programs such as the certification programs for Medicare SHIP counselors.

155.210(c) We support the proposed rule language prohibiting Navigators from receiving compensation or other considerations from insurers. We further urge HHS to include language in the final rule directing or encouraging states to ensure that neither Navigators nor Agent/broker/"producers" have any financial incentive to drive business to any health plan, or to the market outside of the Exchange.

155.210(d) We support the NPRM's inclusion of culturally and linguistically appropriate assistance, and ADA-compliant assistance as a duty of Navigators. Texas is home to roughly 4 million foreign-born residents, with the 6th highest percentage of foreign born among the states. Recent immigrants and households with limited English proficiency are over-represented among Texas' uninsured, and success in achieving new coverage levels here will depend heavily on our ability to support those under-insured groups through outreach and assistance.

We further urge HHS to explicitly include providing help with applications for premium tax credits and cost-sharing reductions among the duties of Navigators. Unless this responsibility is clearly included for Navigators, we fear that in some states there will not be adequate assistance resources available for applicants.

155.230(a) We strongly recommend that the rule require Exchanges to offer individuals the option to receive electronic notices. We have experienced in our state during past periods of sub-optimal eligibility and enrollment system performance in our public insurance programs that avoidable use of postal service mail can become a significant source of delays and errors that cause gaps in health care access. Exchange enrollees should be able to choose electronic communications instead (see also §155.205(b)).

We also support the addition of a requirement that notice systems must include more than a single attempt to contact an enrollee before any adverse action is taken that would interrupt or end coverage.

155.240(d) We recommend the rule be amended to require, not simply allow, the establishment of electronic premium payment options and that the rule should further direct state Exchanges to provide multiple options for payment designed to ensure access without additional cost burdens for "unbanked" individuals.

155.260 Extensive work has been done in Texas to ensure that eligibility and enrollment processes for Medicaid, CHIP and other public benefits comply with the federal HHS-USDA "tri-agency guidance" of 2000. If the tri-agency guidance is NOT specifically referenced in this Exchange rule, we are concerned that privacy protection policy and practice may not be consistent among the public benefit systems and the Exchanges.

We support the proposed rule's requirements at (b)(5) making clear that contractors and subcontractors are subject to all applicable privacy an confidentiality standards. We recommend that this section also clearly affirm specifically the obligation of Navigators, agents, and brokers to abide by all federal confidentiality and privacy rules for PII.

155.405(a) We strongly support the requirement for a single streamlined no "wrong door" application across the listed programs. We further recommend a clear prohibition of any required provision of information that is irrelevant to eligibility or qualification standards, including information about non-applicant household members. Failure to clearly align the new Exchange policy with the parallel requirements now in place for federal benefits could undermine protection of the rights of US citizens and LPRS in mixed immigration families.

155.405(c)(2)(iv). We strongly support the inclusion of an in-person application option among the tools required for Exchange applications, and we note that an assessment of the capacity of an Exchange to provide geographically statewide access to this in-person option should be a component of the Exchange Plan.

155.410(b) We urge HHS to amend the rule to extend the initial open enrollment period through April 30, 2014, to allow use of the most recent tax returns in applications.

155.420 and 156.285 We strongly support the structure of "special enrollment periods"—i.e., exceptions to the standard open enrollment periods—associated with certain classes of events.

People losing access to any type of minimum essential coverage should be entitled to a special enrollment period. We further recommend that the rule be amended to add qualifying events for (1) pregnancy; (2) individuals reaching the date when COBRA disability coverage extension will increase their premiums to 150% of the standard rate; (3) individuals leaving incarceration; and (4) situations in which changes to a health plan's provider network materially change access to care. We also recommend that an additional exception be established to allow a pregnant woman who is enrolled in catastrophic coverage to elect a higher actuarial value plan.

To help people enrolling in special enrollment periods prevent any gaps in their coverage, we recommend that they have the option to making their effective date the day they lost other coverage, provided they pay premiums back to that date. The retroactive application of COBRA coverage for newly-electing individuals may serve as a model for putting this policy in to operation.

155.420(d)(1) We urge HHS to clarify here that Medicaid and CHIP loss are included in this "loss of minimum essential coverage" event class.

155.430(d) We strongly recommend that HHS adopt a specific standard (i.e., not an undefined "reasonable amount of time") not to exceed 3 business days for termination of coverage when requested by an individual who will otherwise incur additional, possibly unaffordable, financial liability.

155.715 In NPRM language related to the SHOP, there is language referring to two distinct application forms and processes for employers versus employees, and there are references to required verification that an employee is confirmed by his employer to have been offered coverage. **At (c)(1)** the authority to ask for additional information when the attestation of the employee applicant is doubted should be explicitly limited to information relevant to the determination of eligibility. **At (c)(2)**, this same limitation should be made clear. In both instances, this change is needed to prevent implying that the Exchange or the SHOP have authority to impose new terms of eligibility not granted by the federal statute.

155.1050 We strongly recommend that this section be strengthened through the requirement that a state's Exchange Plan must include specific benchmarks for network adequacy that include explicit standards for geographical proximity and waiting times for appointments standards, or else adopt the standards in the NAIC Managed Care Plan Network Adequacy Model Act.

155.1065 We endorse the recommendation of Georgetown University Health Policy Institute's Center for Children and Families:

> "Each exchange should offer at least one child-only dental benefit, either as a part of a QHP or as a stand-alone plan, at every coverage level in the exchange. At a minimum, the final rule should require that each exchange must offer at least one child-only dental benefit, either as a part of a QHP or as a stand-alone plan, at the silver level. In addition, consumers must be able to pay for the pediatric dental essential benefit with premium tax credits."

156.235 We strongly support the NPRM requirement that essential community providers as defined in §340B(a)(4) of the Public Health Service Act. We agree with the recommendation of child health advocates that a strong system of quality measure standards and reporting will help incentivize high-quality care along with the inclusion of these critical safety net providers.

156.255 We are very concerned that the NPRM rule as drafted may not fully ensure that child-only or multiple-child-only coverage is available, and that pricing for that coverage is based on that age group (persons under age 21). In Texas, ESI rates are very low relative to the national average, and employer support for dependent coverage is rare. We anticipate large numbers of parents who have an offer of affordable employee-only coverage through their job, who will seek coverage for their child or children through the Exchange. We strongly urge HHS to amend this section to ensure ease of access and affordability of coverage for children in the Exchanges.

Partnership Model

We understand the need for state flexibility and applaud HHS' proposal to create a limited number of options states can choose from if they would like to partner with the federal government in running an Exchange. In particular, we strongly support the proposal that HHS will remain responsible and accountable for ensuring that a partnership Exchange meets all standards and fulfills all functions. HHS should have the authority to intervene and resolve problems if a partnership Exchange is not meeting all federal standards.

We support HHS' proposal to retain responsibility for eligibility and enrollment functions for the Exchange and Medicaid under partnership Exchanges. Requiring states to accept Medicaid eligibility determinations made by federal partners by a partnership Exchange is critical to ensuring a "no wrong door" approach for applicants.

We believe strongly that any federal-state partnership Exchanges must have the consumer's interests at their core. We question whether a state that is opposed to creating an Exchange and has made little progress in developing one can adequately run the functions available under the partnership model in a manner that best protects consumers. If a partner state does a poor job of plan management, consumers could face a dizzying array of plan options that do not offer maximum value, driving up costs for consumers, businesses, and taxpayers. If a partner state does a poor job of outreach and education, Navigator management, and in-person assistance, enrollment (especially of hard-to-reach populations) could suffer.

With the federal government operating some functions and the state others, it may be difficult for consumers in a partnership exchange to have a seamless experience. HHS must ensure that poor performance by a state partner does not reduce affordable coverage options, create barriers to coverage, or undermine the viability of the Exchange. To prevent this, we recommend that HHS only partner with states that explicitly agree they will take all necessary actions to work with HHS to ensure a seamless system and require states to undergo certification and federal approval of an partnership Exchange Plan in a manner similar to states developing their own Exchange.

We further recommend that HHS involve state stakeholders including representatives of consumers' interests in the planning for a partnership Exchange and allow public input on the federal-state partnership Exchange plan.

Thank you for consideration of our comments on these important rules. Any questions regarding these comments may be addressed to Stacey Pogue, Senior Policy Analyst (pogue@cppp.org); or Anne Dunkelberg, Associate Director, (dunkelberg@cppp.org), Center for Public Policy Priorities, 900 Lydia Street, Austin, Texas 78702.

Sincerely,

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