American Heart Association | American Stroke Association

June 18, 2012

Mr. Steve Larsen
Director
Center for Consumer Information and Insurance Oversight
Centers for Medicare and Medicaid Services
200 Independence Ave SW
Washington, DC 20201

Submitted electronically via FFEcomments@cms.hhs.gov

RE: General Guidance on Federally Facilitated Exchanges

Dear Mr. Larsen:

On behalf of the American Heart Association (AHA), including its American Stroke Association (ASA) division, and more than 22 million volunteers and supporters, we appreciate the opportunity to offer our comments on key issues related to the Guidance issued on May 16, which articulates the Department of Health and Human Service's vision for the federally facilitated exchanges (FFE) that will operate in states that do not have a fully-operational state exchange in place by 2014.

The creation of state-based American Health Benefit Exchanges is a central element of the Affordable Care Act's (ACA) provisions to make affordable, high-quality health insurance coverage available to American consumers. Based on progress to date, it appears likely that many of the states with the largest numbers of uninsured Americans will have an FFE, at least initially. We want to work with you to ensure that these exchanges fulfill the promise and meet the needs of the millions of Americans with heart disease and stroke and those at risk for cardiovascular disease.

The Guidance articulates several guiding principles. We recommend that the first principle be broadened to state the Department's commitment that consumers in states with an FFE will receive the full ACA protections, just as people in states that operate their own exchanges will, and to reiterate the Department's commitment to thorough oversight of FFE plans. It is important that the principles related to market harmonization and state insurance regulation not be interpreted as a willingness to compromise on the ACA's statutory and regulatory requirements. Efforts to harmonize the markets inside and outside exchanges should encourage the outside market to mirror the required standards of the FFE as much as possible.

State Partnership in a Federally Facilitated Exchange

We support the Partnership concept to the extent that such arrangements foster coordination and efficiency between states and the federal government, serve consumers' interests, and maintain clear lines of accountability and authority. We appreciate that the Guidance defines a limited set of functions that could be subject to Partnerships, clarifies that the federal government retains the ultimate

responsibility for FFE implementation where Partnerships exist, and emphasizes the importance of an effective and seamless system for consumers and small businesses.

One issue left unresolved in the Guidance is how ongoing financing under Partnerships will work. It is clear that states entering in to a Partnership are eligible to receive federal exchange grant funding to assist them in planning and establishing the relevant functions through 2014. But it is not clear whether the federal government, the state, or a combination of both would be responsible for funding the ongoing operations of Partnership functions after that time. We urge HHS to clarify this issue as soon as possible.

Plan Management in a Federally Facilitated Exchange

As the Guidance notes, an FFE's role and authority are limited to the certification and management of exchange qualified health plans (QHPs) and do not extend to plans sold outside the exchange. Some of the QHP standards also apply to plans outside the exchange, but other standards apply only to QHPs. The Guidance therefore notes that the FFE will rely on reviews by state Departments of Insurance for some standards and will perform the review for others. Where plan management builds upon state functions, by confirming the outcome of state reviews for some standards, there must be a clear process to ensure QHP standards are being met, especially where those standards differ from state rules (for example, network adequacy, if it differs from state rules for plans outside the exchange). This greater level of scrutiny – to do more than automatically accept a state's determination for standards that apply to QHPs – is essential to ensuring only plans that fully meet the standards qualify for federal subsidies. As the Guidance notes on page 7, "HHS also has a responsibility to develop safeguards and processes to protect and oversee public dollars spend for advance payments of the premium tax credit (APTC) and cost-sharing reductions (CSR)."

Selective Contracting

To ensure robust plan participation, the Guidance notes HHS "at least in the first year" will certify as a QHP any plan that meets all certification standards. While this may be a practical approach in the first year of operation, HHS shouldn't preclude the possibility of applying additional requirements to QHP selection and contracting in order to ensure high value plans. Two such requirements noted in the Guidance are particularly important to help consumers make more informed decisions about the plans that will best meet their health care needs. The Guidance notes plan management will include a review of meaningful difference across QHPs offered by the same issuer to ensure a manageable number of distinct plan options are offered. One difference we recommend HHS consider in their review of this standard is whether the cost-sharing options available under different QHPs will work for individuals and families with low and moderate incomes. If only QHPs with very high deductibles are available, low- and moderate-income enrollees may not be able to access needed care. A second standard mentioned in the Guidance is to confirm that the service area is in the interests of consumers. Both of these standards are critical and we applaud HHS's inclusion of them in plan management of an FFE.

We also recommend HHS conduct a formal review of the need for more selective contracting beyond the first year of FFE operation. This review should include enrollee surveys to identify areas that warrant additional requirements. For example, surveys might indicate there are too many QHPs, too few differences in plans, or difficulty accessing providers within certain plans or geographic areas.

Reliance on State Reviews

The Guidance notes HHS expects states to play the primary role in areas of traditional state responsibility, with the FFE assuming primary responsibility for oversight in areas that fall outside of traditional state authority, are exchange-specific or where federal funds are involved. Within those areas of traditional state responsibility, there may be certain standards that warrant additional scrutiny. For example, network adequacy is a standard that falls under traditional state responsibility, but the rules applied to the commercial market may not apply to QHPs. Most state network adequacy standards apply only to HMOs but exchange standards apply to all types of plans. HHS will need to either extend those rules to QHPs or adapt them for application to QHPs. In doing so, HHS must balance the need for higher standards appropriate for QHPs that will receive federal subsidies with the need to protect the FFE against adverse selection. We recommend HHS monitor access to providers, costs and other indicators of adverse selection and make adjustments in the second year and beyond.

Accreditation and Quality Reporting

This Guidance proposes a phased approach to accreditation and the quality reporting required of QHPs offered in a FFE. In the early years of QHP certification, accreditation is essentially being utilized as a proxy for assuring quality until HHS issues future rulemaking to implement the more comprehensive quality-related provisions required by the ACA. We recognize the many demands placed on HHS and on states in getting the exchanges up and running and also the complexity of developing the standardized quality rating system for QHPs that is useful and easy-to-understand for consumers and allows comparability across plans. We therefore understand the phased approach being proposed by HHS; however, we do feel very strongly that HHS should adhere to the timelines they have laid out for accreditation and implementation of new quality reporting and display requirements and not allow for any further delays. In addition, given the delay in developing the quality rating system, we strongly recommend that HHS require reporting of existing Healthcare Effectiveness Data and Information Set (HEDIS,or equivalent) quality measures (including Consumer Assessment of Healthcare Providers and Systems, (CAHPS) in phase one so that consumers will have access to some quality information initially. Finally, we support applying the regulatory approach laid out in this FFE Guidance, with our recommended improvements, as minimum requirements to be adopted by state-based exchanges.

<u>Accreditation</u>

In general, we support using existing national accreditation organizations to provide the statutorily required accreditation and further agree with the establishment of a uniform period within which a QHP that is not already accredited must become accredited. Accreditation is an important tool for ensuring that QHPs are providing high quality care and good customer service, although not a substitute for the broader quality reporting requirements of the ACA. Nationally recognized accreditation frequently acts as a seal of approval that gives consumers and employers confidence in the product they are purchasing. A significant number of health plans have already demonstrated their commitment to quality by voluntarily obtaining private accreditation and reporting enrollee satisfaction and clinical outcomes publically. We also recognize the need to allow sufficient time for Medicaid plans and new entrants that want to offer a QHP to build the policies, procedures and infrastructure required to meet accreditation standards.

More specifically, we support HHS's plan to require non-accredited QHPs to schedule an accreditation in their first year of certification and to be accredited by completion of the second year of certification. The Guidance also indicates the FFE will accept National Committee for Quality Assurance (NCQA) or URAC accreditation of a commercial or Medicaid QHP in the same state in which the issuer is seeking to offer exchange coverage until the fourth year of certification. Our

interpretation of this proposal is that all QHPs will be required to be successfully accredited by an approved national accreditation organization by the end of the FFE's fourth year of operation and all QHPs will be required to submit the appropriate performance data to the accrediting entity and FFE. If this is correct, we believe the interim approach is reasonable, minimizes the administrative burden on the federal government, states and insurance issuers and will potentially increase the number of QHPs eligible to participate in the FFE in 2014.

The FFE Guidance proposes to adopt an application and review process for the recognition of additional accrediting agencies in the future. We support this proposal to provide greater choice and competition among accrediting entities, provided that any additional accreditation organizations recognized by HHS have standards that are at least as strong as those of the already approved national accreditation entities and meet all of the requirements for such organizations laid out in Section 1311(c)(1)(D)(i) of the ACA. We also urge that the process for recognizing additional accrediting entities be very transparent, including providing opportunity for public comment.

Quality Reporting

In addition to accreditation, the ACA requires exchanges and QHPs to meet and report on a number of other quality-related elements, including: 1) quality improvement strategies of QHPs; 2) quality measure data and ratings made available by exchanges for each QHP as part of consumer assistance tools; and 3) a consumer satisfaction survey. These are all separate and distinct and important types of information for consumers. We strongly encourage HHS to provide more specific information on its timeframe for issuing further regulations or guidance to implement these quality requirements, including providing additional information on the process(es) it intends to use to develop, test and administer these elements. When developing the public reporting requirements for a standardized set of quality metrics – which is important to ensure comparability across QHPs – we support the stated intent to align measures with existing programs. In addition, where feasible, we urge HHS to use measures that have been vetted and endorsed by the National Quality Forum (NQF).

We also urge HHS to spell out in more detail in future guidance or regulation what is possible to encourage health plans to offer high quality care and to encourage consumers to choose the highest value health plans and providers. HHS should set out clear metrics for all quality improvement strategies and exchanges should hold QHPs accountable for their results — with clear goals and benchmarks — so that consumers and employers will know whether plans are hitting the quality improvement and cost containment targets over time. In particular, plans should be required to stratify data by available demographic subgroups to document reductions in health disparities.

We look forward to providing further input as HHS issues future rulemaking on quality and reporting disclosure requirements.

Eligibility for Insurance Affordability Programs and Enrollment In the Individual Market

The Guidance on the FFE affirms that the process of determining eligibility and enrollment should be streamlined and seamless regardless of whether a state has an FFE or a state-based exchange. Clearly, coordinating the eligibility process conducted by the FFE with each state's Medicaid and Children's Health Insurance Programs (CHIP) will be challenging. Our comments are intended to enhance coordination and ensure that the process is seamless and streamlined.

To the greatest extent possible, it will be critical to minimize the differences in how the FFE conducts Medicaid and CHIP eligibility determinations and assessments, and how the state does the actual eligibility determination. As such, we support the recently released Guidance (in the form of responses to Frequently Asked Questions that were issued by CMS on May 22) that makes it clear that the FFE will use state's applicable Medicaid and CHIP eligibility rules for conducting both eligibility determinations and assessments. This will help ensure that individuals are evaluated for and enrolled in the right coverage program.

The Guidance also states, however, that the verification procedures used by the FFE may not be the same as those used by the state. We are concerned that even small differences in the verification procedures used by the FFE and by the state Medicaid and CHIP agency could lead to erroneous assessments or determinations of eligibility. We believe that alignment of the verification procedures used by the FFE and the state agency, which in large part determine how the eligibility rules are implemented, is critically important to ensuring a seamless eligibility determination process.

In addition to aligning the verification procedures, we have several other comments on the FFE Guidance on the eligibility determination:

- We support the plan to test notices and applications with consumers to ensure that they are understandable as well as the plan to ensure that information is accessible to people with disabilities and those with limited English proficiency (LEP). HHS should provide detailed policies and Guidance specifying how the FFE will provide language services (including translated materials and oral assistance) for LEP individuals and services to assist individuals with disabilities (including sign language interpreters, braille and large print materials, and other auxiliary aids and services or augmentative and alternative communication). Because the FFE will operate in multiple states with differing numbers and needs of people with disabilities and LEP, HHS should develop and implement state-specific plans for meeting the needs of individuals with limited English proficiency and people with disabilities, with consumer and stakeholder input.

- In footnote 6, the Guidance notes that state Medicaid and CHIP agencies will accept applications and make Medicaid and CHIP eligibility determinations and that the FFE also will assess or determine eligibility for individuals who apply to the FFE. We read this footnote as requiring that states maintain an "open door" at their Medicaid and CHIP agencies even when they choose to allow the FFE to make eligibility determinations for Medicaid and/or CHIP. Many individuals will continue to apply at the state agency particularly if they are seeking other assistance. States should not transfer their applications to the FFE for a determination unless it is determined that they are not eligible for Medicaid or CHIP.

- Finally, we want to commend HHS for its decision to allow further comment on the role of non-profits and private contractors in the eligibility process while ensuring that government employees determine eligibility for Medicaid. We look forward to commenting on the proposed rule.

Consumer Support, Outreach and Education

<u>Navigators</u>

The Navigator program is critical to public education and enrollment efforts and is a required element of exchanges. Navigators will conduct outreach and provide fair, accurate and unbiased

information to consumers regarding eligibility and enrollment requirements for the exchange or other health programs in the state. Navigators will also assist families in choosing a QHP that best meets their needs, and refer people to consumer assistance services for additional help. These will be critical roles, particularly in early years of the exchange when new insurance rules take effect and when many eligible families have limited or no prior experience in the purchase of health insurance. The FFE will have a special need for a robust Navigator program given its nascent on-the-ground presence.

Because of the importance of the Navigator program, in general, and its special importance for the FFE, we are particularly concerned that the Guidance caveats the availability of an FFE Navigator program due to possible federal funding limitations. Simply put, the FFE must have a Navigator program in every state in which it operates. The Navigator program is a statutory and practical necessity, and we expect the size, scope and training of Navigators in the FFE to be an important model for state-run exchanges. Securing the sales assistance of agents and brokers does not substitute for a well-functioning Navigator program. We encourage HHS to explore all available funding options for the start-up of this program, including the use of Medicaid/CHIP funds (to the extent that Navigators will also assist individuals through the completion of the Medicaid/CHIP eligibility process). As the FFE becomes operational, assessments on participating insurers should be used for sustained funding.

The Guidance does not describe the standards to prevent or minimize conflicts of interest in the Navigator program or the training standards. We encourage HHS to open these standards to public comment. Consumer groups might also be engaged in a working group to develop or review the training program. The Navigator program in an FFE should have the capacity to serve each state's particular population, including various income groups, linguistic groups, and geographical areas, and thus will need to be tailored to the needs of the state.

Outreach

The FFE should begin outreach and education as early as feasible in 2013. It will be important for the FFE in each state to consult with a variety of consumers, employers, patient advocates and others with specialized knowledge and varied perspectives which can help facilitate enrollment and the seamless operation of the exchange. The FFE education and outreach should broadly promote coverage for individuals, families, and small businesses in need of health coverage, and also target specific hard-to-reach populations, uninsured (including people who were previously priced out of the market due to pre-existing conditions), and those who experience health disparities due to language barriers, low literacy, race, color, national origin, geography or disability.

One way to begin is by forming alliances with likely state and local partners. This will help to combat misconceptions and quickly build Exchange enrollment. For example, outreach can be done through food assistance programs, community health centers, community hospitals, child care subsidy programs and other state and federal partnership programs. The FFE should facilitate transfer of participants in the Pre-existing Condition Insurance Plans into the exchange, and employ other proactive strategies to increase exchange enrollment and ensure vulnerable populations benefit from the exchange. Given that the majority of exchange enrollees will be eligible for premium tax credits, HHS should consider partnerships with the IRS and tax assistance programs in distributing information in early 2013 about the availability of premium tax credits in the following year.

Stakeholder Input

The Guidance indicates HHS will "continue to engage with the stakeholder community through forums and workshops" and will "convene implementation sessions and other venues for discussion about and input on FFE operations." HHS should ensure that stakeholder input is incorporated into the planning process and ongoing operation of the FFE, including by being:

- meaningful (actually contributing to the decision-making and policy-setting),
- robust (including a diverse set of stakeholders on specific, relevant focus area), and
- ongoing (not only at the initial stages or occasional but rather regular, with consistent meetings).

While we recognize that the time is short to solicit and incorporate stakeholder feedback prior to establishing FFEs, assembling active working groups at the state level may expedite the process of getting the FFE established in the state.

The final exchange rules identify the list of stakeholders that a state must consult with as part of their implementation process (§155.130). The FFE should include the same stakeholders as part of its planning activities. These include educated health care consumers who are enrollees in QHPs, advocates for enrolling hard-to-reach populations, and small businesses, etc. Stakeholders need not be limited to these groups. The broader range of partners that are able to participate in the creation of the FFE, the more credible the exchange will be. HHS should consider engaging with faith-based groups, tax preparation entities, chambers of commerce, and corporate entities, particularly in the outreach and enrollment aspects of the exchange.

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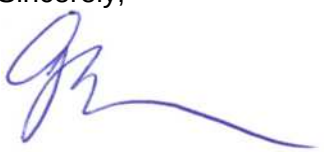
Thank you again for the opportunity to share our comments on these issues related to the implementation of FFEs. If you have any questions, please feel free to contact Stephanie Mohl, Government Relations Manager, at Stephanie.Mohl@heart.org or 202-785-7909.

Sincerely,



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