BlueCross BlueShield Association

An Association of Independent Blue Cross and Blue Shield Plans

June 18, 2012

Michael Hash
Acting Director
Center for Consumer Information and Insurance Oversight
Department of Health and Human Services
200 Independence Ave SW
Washington, DC 20201

Submitted via email: OIRA_submission@omb.eop.gov

Re: Draft Blueprint for Approval of Affordable State-based and State Partnership Insurance Exchanges (CMS-10424 and CMS-10416)

Dear Mr. Hash,

The Blue Cross and Blue Shield Association ("BCBSA") appreciates the opportunity to provide comments to the Centers for Medicare & Medicaid Services ("CMS") on the Draft Blueprint for Approval of Affordable State-based and State Partnership Insurance Exchanges.

BCBSA is a national federation of 38 independent, community-based and locally operated Blue Cross and Blue Shield Plans ("Plans") that collectively provide health coverage to 100 million – nearly one in three – Americans. Blue Cross and Blue Shield Plans offer coverage in every market and every zip code in America. Plans also partner with the government in Medicare, Medicaid, the Children's Health Insurance Program, and the Federal Employees Health Benefits Program.

BCBSA continues to support state establishment of exchanges, an approach which is more consistent with states traditional role in overseeing the individual and small group marketplaces. Therefore, we appreciate that the criteria for approval of state exchanges in the draft blueprint follows the approach in the exchange final rule which largely provides flexibility to states for meeting the Affordable Care Act's (ACA's) standards.

However, we are concerned that the draft Blueprint's requirement for a State Governor to sign "Declaration Letters" will significantly hinder the ability of certain states to engage in a partnership with CMS next year. This requirement – including both the requirement for a Governor's signature, and a deadline that is less than two weeks after this fall's elections, could result in fewer states establishing or participating in their own exchanges.

Instead, we recommend that CMS should recognize that state Departments of Insurance may have the authority to authorize state participation as state-based or State Partnership exchanges on behalf of their states. In many states, Insurance Commissioners have the authority and should be given the option to continue their progress in developing exchanges. By allowing a Commissioner to make the decision to continue with exchange development, more states are likely to meet the requirements for Conditional Approval and will have more

time to make an informed decision on whether to pursue a state-based, partnership, or federally facilitated exchange.

In addition, we also would like to make the following recommendations for your consideration:

CMS Should Provide States Autonomy to Certify QHPs in a Partnership FFE

Issue:
While the application for approval of a state partnership does not expand the certification criteria for qualified health plans (QHPs) in the ACA or the exchange final rule, we are concerned that CMS may adopt additional criteria that CMS included in the white paper, "General Guidance on Federally-Facilitated Exchanges." Specifically, page 6 of the white paper includes a chart that lists plan standards for reviewing new rates and for evaluating "meaningful difference". These standards exceed the requirements in the exchange final rule and the ACA and could detract states from engaging in a partnership approach.

Recommendation:
As recommended in our comments on the FFE white paper, HHS should defer to states to implement appropriate processes and standards for carrying out the plan management function. CMS should make it clear that under a partnership exchange, the QHP certification criteria would not expand beyond the criteria in the ACA and the exchange final rule.

Rationale:
This approach is consistent with CMS's stated intention: "To the greatest extent possible, HHS intends to work with States to preserve the traditional responsibilities of State insurance departments when establishing an FFE." Establishing overly specific and regulatory "parameters" for states to follow in carrying out the plan management function will undermine state autonomy and responsibility. As a result, states may be more reluctant to engage in partnerships with the federal government.

CMS Should Continue to Provide General Requirements for Conditional Approval

Issue:
HHS has framed the requirements for states to meet conditional approval for their state exchanges broadly, providing such approval for states that are making "significant progress" toward exchange approval requirements and that will be operationally ready for the October 2013 open enrollment period.

Recommendation:
BCBSA supports HHS' decision to allow broad/general requirements for states to meet conditional approval. We also support the transparency requirement that states should post their exchange applications on the CCIIO website after the approval decision.

Rationale:
Given the compressed timeframe in which state action to implement exchanges is required under the ACA, HHS should continue to allow states to meet broad/general requirements to secure conditional approval. This approach also provides flexibility in evaluating each state's unique situation and market needs.

CMS Should Allow for Employer Choice of Health Plans

Issue:
The draft Blueprint's section on the Small Business Health Options Program (SHOP) provides only for employers to "select a level of coverage…in which all QHPs within that level are made available to the qualified employees of the employer." (Section 6.1a). The Blueprint does not specifically allow for an employer to select a single QHP for its employees, as is permitted by the ACA and the Exchange Final Rule.

Recommendation:
HHS should clarify that SHOP can provide for employers to choose a single QHP for their employees.

Rationale:
This recommendation is consistent with both the ACA and the Final Exchange Rule, which allow exchanges to permit employer choice of a single QHP.

A key factor in the ultimate success or failure of state exchanges is their ability to attract small employers. One of the biggest barriers to employer participation in exchanges is 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. For example, employee choice requires more complicated accounting and billing practices to account for premiums that differ based on the characteristics of each employee -- which may force pure list billing, i.e., individual rates per employee rather than an aggregate, composite rate for the entire group.

The added complexity and cost associated with an employee choice approach may work against successful implementation of SHOP exchanges by encouraging employers to avoid the SHOP altogether, and purchase group coverage in the outside market, or by encouraging them to move to a defined contribution approach under which they'd simply give employees a defined dollar amount and send them to the individual exchange to purchase coverage.

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We appreciate your consideration of our comments on the Draft Blueprint for State-based and State Partnership Insurance Exchanges. We look forward to continuing to work with the Departments on implementation issues related to the ACA. If you have any questions, please contact Kris Haltmeyer at (202) 626-4814 or at kris.haltmeyer@bcbsa.com.

Sincerely,

Justine Handelman
Vice President, Legislative and Regulatory Policy
Blue Cross and Blue Shield Association