Center on Budget and Policy Priorities

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June 18, 2012

Office of Management and Budget
Office of Information and Regulatory Affairs
Attn: CMS Desk Officer
OIRA_submission@omb.eop.gov

Re: Information Collection Request, Blueprint for Approval of Affordable State-based and State Partnership Insurance Exchanges, **Form Number CMS-10416, OCN:0938-New**

Dear Sir or Madam:

The Center on Budget and Policy Priorities is a nonpartisan research and policy organization based in Washington, D.C. Founded in 1981, the Center conducts research and analysis to inform public debates and policymakers about a range of budget, tax and programmatic issues affecting individuals and families with low or moderate incomes. We appreciate the opportunity to comment on the "Blueprint for Approval of Affordable State-based and State Partnership Insurance Exchanges."

The Blueprint will serve several critical purposes. It will help the Department of Health and Human Services (HHS) ensure that states operating their own insurance exchanges (or operating specified exchange functions under a Partnership agreement with HHS) are meeting all necessary standards and requirements under the Affordable Care Act. The Blueprint will also provide the public — including consumers served by an exchange in their state — transparent information about the policy and operational decisions being made related to exchange implementation. Finally, the Blueprint will clarify for states the work that must be done and the standards that must be met to obtain approval to operate an exchange or assist with the operation of a federally facilitated exchange (FFE) under a Partnership agreement. To adequately serve each of these purposes, the Blueprint should be sufficiently detailed and comprehensive, while being as simple as possible for states to fill out and for the public to understand. Each completed Blueprint document (whether related to a state-based exchange or a Partnership exchange) should be made available to the public in its entirety within a reasonable time after an exchange is approved or conditionally approved by HHS. As we have commented previously, in the interest of public transparency and accountability, in those states where the FFE operates, HHS should make publicly available a document similar to the Blueprint so that the public understands the federal policy and operational decisions related to operation of the FFE in that state.

The Blueprint also includes a Declaration Letter that each state seeking to operate a state-based exchange or a Partnership with the FFE would have to complete. The Declaration Letter provides a way for states to submit, by a date certain, basic information about major decisions related to exchange implementation.

Our comments address both of the main components of the Blueprint — the Declaration Letter and the Exchange Application — as well as the related instructions from HHS on how the Blueprint should be filled out and how it will be used. Please contact us if you have any questions.

Sincerely,

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Senior Policy Analyst	Senior Policy Analyst	Vice President for Health Policy	Vice President for Health Policy

General Comments

We support the option for states that submit the Declaration Letter early (at least 20 business days prior to submission of a Blueprint) to request a consultation to help with completion of the Exchange Application. We also support HHS' intent to provide technical assistance and consultation to states that indicate through early submission of the Declaration Letter that they intend to perform plan management functions either as part of operating a state-based exchange or under a Partnership with the FFE. We recommend that HHS also provide any necessary assistance and consultation to states seeking to handle select consumer assistance functions in Partnership with an FFE.

The Blueprint indicates that HHS will grant "conditional approval" to states that are not ready as of January 1, 2013 to operate an exchange but are making significant progress toward meeting all exchange requirements. Separate guidance related to the Blueprint from HHS indicates that "a State Exchange will remain Conditionally Approved until it meets all Approval requirements."[1] This approach has the potential to delay FFE-related preparations in states that are not fully ready to operate an exchange. A state with conditional approval might appear to be making sufficient progress during 2013, but if it is not able to obtain full approval at a certain point, we are concerned that it may not, in fact, be able to handle the initial open enrollment period slated for fall 2013 and that the FFE might not be able to step quickly enough.

Therefore, we believe that the Blueprint should be modified to include a clear deadline by when a conditionally approved exchange must demonstrate full compliance and readiness to operate as a fully state-based exchange or else default to the FFE. This deadline should be established to ensure that there is sufficient lead time for HHS to establish FFE operations in the state if the conditionally approved state-based exchange is not able to demonstrate readiness in time for operations in 2014 (including open enrollment starting in fall 2013).

Section I: Declaration Letter

To ensure transparency and allow for public input, we support the requirement that states seeking to operate their own exchange or to participate in a Partnership agreement with an FFE submit basic information that describes their major exchange plans and key decisions as part of the Declaration Letter. We support setting a deadline of November 16, 2012 for states to make a decision and demonstrate commitment towards a state-based exchange or Partnership with an FFE. We agree that if a state does not submit a Declaration Letter by November 16, 2012, HHS should proceed with implementation of an FFE in that state and assume that the state will not administer its own reinsurance program.

We recommend that the information included in the Declaration Letter be expanded to include the state's decision as to the entity that will conduct final eligibility determinations for Medicaid and CHIP for people who apply through the exchange. Each state should indicate in the Declaration Letter whether the exchange (regardless of whether it is state-operated or an FFE) will make the

[1] The Center for Consumer Information and Insurance Oversight, "Draft Blueprint for Approval of Affordable State-based and State Partnership Insurance Exchanges - Frequently Asked Questions," http://cciio.cms.gov/resources/factsheets/hie-draft-blueprint-states.html

final determination of Medicaid eligibility or whether the exchange will make an initial assessment of potential Medicaid eligibility with the final determination being made by the state Medicaid agency. We note that all states would need to submit this information, including states that are not operating their own exchange or electing to participate in a Partnership. If the Declaration Letter is not modified to require submission by all states, HHS should pursue another method for clarifying how a state not seeking a state-based or Partnership Exchange will coordinate Medicaid and CHIP eligibility determinations with the exchange.

It would be useful if the Declaration Letter were established as a standardized form or template that could be easily filled out by states. Many of the items a state must include are selections from a finite list of approved options, and so naturally lend themselves to a checkbox form. This can streamline the process and standardize the way in which information will be presented to make it more understandable to the public as well as to HHS.

Section II: Application for Approval of Affordable State-based and State Partnership Insurance Exchanges

Partnership FFEs

Stakeholder consultation: The application should be modified to ensure that a state seeking approval to assist an FFE through a Partnership (whether the Partnership apples to plan management, consumer assistance, or both) is responsible for ensuring stakeholder consultation related to the functions or responsibilities of the state under the Partnership. The state should submit a corresponding plan for stakeholder consultation as part of the application. HHS should require that a state's stakeholder consultation be coordinated with HHS's own planning and stakeholder engagement activities so that local feedback and expertise is provided related to all aspects and functions of the Partnership Exchange. In addition, the "Roadmap for Completing the Exchange Application," shown in Table I of the Application, should be modified so that row 2.1, "Stakeholder consultation plan," is checked for both Partnership columns.

Consumer Assistance Partnership — Additional Information: States involved in a consumer assistance Partnership should be required to indicate how they will comply with the various procedural and oversight responsibilities and privacy and security requirements pertaining to the relevant consumer assistance functions. Because the state will be overseeing the navigator program and other in-person assistance activities, the following responsibilities (as they relate to the state functions under the partnership) should be checked in the consumer assistance Column of the "Roadmap for Completing the Exchange Application" checklist:

- 10.1 Privacy and Security standards policies and procedures
- 11.1 Routine oversight and monitoring of the Exchange's activities
- 11.2 Track/report performance and outcomes metrics related to Exchange activities
- 11.3 Uphold financial integrity provisions including accounting, reporting, and auditing procedures

- 12.1 Contracting and outsourcing agreements

Consumer Assistance Partnership — Outreach and Education: As we recommend in response to the "General Guidance of Federally Facilitated Exchanges" released by HHS, states operating in a consumer assistance Partnership should have the option to perform additional functions related to outreach and education if approved by HHS. For example, a state may want to create state-specific outreach and education initiatives for the exchange and coordinate them with existing state outreach efforts for Medicaid and CHIP. State participation in outreach and education, if properly coordinated with national efforts and overseen by HHS, would benefit the overall performance of consumer assistance in a Partnership exchange. If this recommendation to HHS is adopted, then states opting to perform activities related to outreach and education should be required to submit a plan for such activities as part of the Blueprint. Such states should have to detail how the plan would be coordinated with federal efforts.

Consumer Assistance Partnership — Agents and Brokers: Currently the FFE Guidance and the Blueprint indicate that HHS will defer to state laws and requirements when defining the role that agents and brokers will play in an FFE exchange. For states in a consumer assistance Partnership with an FFE, it appears that HHS would determine the scope and content of agents' and brokers' role for the FFE. In our comments on the Guidance, we recommend to HHS that states in a consumer assistance Partnership be given the option to define the role of agents and brokers in the Partnership exchange, subject to federal standards and approval (including the requirement that states must meet or exceed the minimum federal requirements in this area). This would give states operating other in-person consumer assistance functions the ability to coordinate any work done by agents and brokers within this larger function. If our Guidance recommendation is accepted, then the Blueprint should be modified to ensure that states seeking approval from HHS to determine agent and broker roles related to the FFE (as well as compensation and training) should have to submit their plan for oversight of agents/brokers and detail how all related federal standards are being met or exceeded, and how any use of agents and brokers in the FFE will be integrated with other in-person consumer assistance efforts. In addition, the "Roadmap for Completing the Exchange Application" checklist would need to be amended so that 2.7 and 2.8 (related to agents and brokers and web brokers) are checked for consumer assistance Partnerships.

Nondiscrimination and Civil Rights Compliance

HHS should consider how states will comply with the nondiscrimination requirements of section 1557 of the ACA, Title VI of the Civil Rights Law and section 504 of the Rehabilitation Act as it reviews applications for state-based exchanges and state Partnership exchanges. HHS should ensure that all exchanges have specific plans and policies in place to reduce health disparities and provide equitable services, and are accessible to all groups, including individuals with limited English proficiency and people with disabilities. In addition, HHS should require that exchanges consult with a variety of groups, including women, ethnic and cultural minorities, seniors and people with disabilities, at all stages of the exchange planning and implementation process.

Therefore, the Blueprint should be expanded to require states to provide supporting documentation that outlines the policies and procedures a state-based exchange will use to implement and enforce section 1557 of the ACA, Title VI of the Civil Rights Law, section 504 of the Rehabilitation Act and other applicable civil rights laws. States seeking to operate certain

functions under a Partnership agreement should be required to provide this information as it related to the functions the state would perform. These requirements should apply throughout the exchange Blueprint, to consumer and stakeholder engagement and support; eligibility and enrollment; plan management, organization and human resources; finance and accounting; oversight and monitoring; and contracting, outsourcing, and agreements.

Eligibility and Enrollment

As we commented above, the Declaration Letter should be expanded so that it clarifies what entity will conduct the final Medicaid eligibility determinations for people who apply through the exchange. This issue will also need to be addressed in another way if only some states are required to submit a Declaration Letter. The handling of Medicaid eligibility determinations must be addressed for all states, including those with a fully federal exchange that may not submit a Declaration Letter.

States that are applying to operate a state exchange would have to fill out section 3.0 of the exchange application dealing with eligibility and enrollment. We recommend several additions to this section. First, to accompany section 3.2 related to the exchange's coordination strategy with other agencies on eligibility and enrollment, we recommend states be required to submit as supporting documentation a copy of either the agreement between the state exchange and the state Medicaid agency (if that agency is handling final Medicaid determinations for people applying through the exchange) or the agreement or memorandum of understanding between the state Medicaid agency and the federal government (if the state will rely on federally managed services for final Medicaid determinations through the exchange).

In addition, at section 3.5, states should have to submit (as part of the supporting documentation) the business rules that dictate how the data will be used and how the state will deal with cases where information obtained from different data sources are inconsistent.

Plan Management

In section 4.2d of the exchange application, states should be required to explain in supporting documentation what method will be used by the state to ensure that qualified health plans (QHPs) meet actuarial value (AV) and essential health benefit (EHB) standards. There are a variety of ways that states may ensure compliance with these requirements depending on federal guidance and standards. It will be important for HHS and the public to know how these important standards are being enforced. This supporting documentation should also specifically address how the state is ensuring compliance with the proposed "benefit design flexibility" for insurers in the EHB requirements, including if the state is limiting or restricting insurers' ability to vary from the EHB standards.

A section should be added to the plan management section of the application (perhaps as a new 4.2f) that would describe any efforts the state has made to create greater consistency in benefits or cost-sharing of QHPs. For example, some states are working to create standardized plans that would assist consumers in making "apples to apples" comparisons of the coverage options in an exchange, and such efforts should be reflected in the exchange application.

Additionally, a section should be added within plan management for the state to describe the efforts it is making to minimize adverse selection both between an exchange and the outside markets and among the plans within an exchange. Examples would be changes in insurance market rules the state is choosing to apply both inside and outside the exchange (such as applying QHP rules to plans offered outside the exchange or a consistent open enrollment period) or minimum offering requirements the state is applying beyond the federal minimum requirements (such as a requirement to offer at least silver and gold level plans outside an exchange, consistent with the federal requirement that applies inside the exchange).

Risk Adjustment and Reinsurance

As part of the supporting documentation submitted for section 5.1a, states should be required to provide additional information about their risk adjustment program, beyond merely specifying the entity or entities that will operate it. For example, states opting to administer risk adjustment should be asked to briefly describe the risk adjustment methodology (i.e. whether the federal methodology will be used or a separate state methodology), the data collection approach (distributed or intermediate model), and how the state will conduct data validation audits. We note that to avoid duplication and undue burden, such states would not be required to provide the same level of detail that they are required to provide in the Notice of Benefit and Payment Parameters but merely indicate the decisions they are making in the area of risk adjustment and/or reinsurance.

Finance and Accounting

In section 8.1, states would have to provide a "brief description" of the methods the exchange will use to generate revenue to support ongoing exchange operating costs after 2014. This request for supporting documentation should include specific information on the financing mechanisms that will be used, such as insurer fees (including details about which insurers are subject to the fees and how the fees are calculated), other types of assessments or premium taxes, general revenues, and any other sources of revenue such as from selling marketing and advertising space on the exchange web site (if permitted).

Privacy and Security

As supporting documentation for section 10.1, the state should be required to submit the written policies and procedures regarding how the state will comply with the privacy and security standards set forth in 45 CFR § 155.260(a) through (g). The policies should be made publicly available.

Public Transparency of Blueprint Submissions

The Information Request and related documents specifies that only certain sections of a state's Blueprint submissions would be made public within ten business days of being approved or conditionally approved. HHS and OIRA should ensure that each Blueprint submitted, as well as supporting documentation (with the exception of test files), be made publicly available, similar to the way that approved State Plans under title XIX (Medicaid) and title XXI (the Children's Health Insurance Program) of the Social Security Act are publicly available. Perhaps it would be necessary in some cases to allow more time than ten days from time of approval or conditional approval. But in the interest of ensuring that state-based and Partnership exchanges are operated in as transparent

manner as possible and fully accountable to the public, it is crucial to provide access to the complete set of information about how an exchange is being operated within a reasonable timeframe. This is especially true in light of the fact that HHS has elected not to require states to provide public notice and a public comment period for their exchange Blueprint application prior to submission to HHS.

HHS and OIRA should also ensure that all FFEs are similarly transparent and accountable to the public, by developing and making publicly available an exchange Blueprint or some other document for each state in which the FFE operates containing information similar to that required for the Blueprint. In states with a Partnership exchange, the information made publicly available should not be limited to just the functions and responsibilities performed by a state under a Partnership but also those performed by the FFE itself. It appears that a significant number of states may have an FFE, at least initially in 2014, and it is critical to ensure that the public understands the exchange policies that will apply in their states if the states have not adopted a state-based exchange.