



1444 I Street, NW
Suite 1105
Washington, DC 20005
Ph. (202) 289-7661
Fax (202) 289-7724
nhelpdc@healthlaw.org

June 18, 2012

Office of Management and Budget
Office of Information and Regulatory Affairs

Attention: CMS Desk Officer

**RE: General Guidance on Federally Facilitated Exchange
and
Draft Blueprint for Approval of Affordable State-based and State
Partnership Insurance Exchanges**

Dear Sir/Madam,

The National Health Law Program (NHeLP) is a public interest law firm working to advance access to quality health care and protect the legal rights of low-income and underserved people. NHeLP provides technical support to direct legal services programs, community-based organizations, the private bar, providers and individuals who work to preserve a health care safety net for the millions of uninsured or underinsured low-income people. With the implementation of the new health reform law, it is critical to ensure that low-income and underserved individuals who are eligible for Advanced Premium Tax Credits and cost-sharing assistance, as well as Medicaid and CHIP, are found eligible for relevant subsidies and programs so they can fully benefit from the promises of health reform. We appreciate the ability to provide comments on the General Guidance on Federally Facilitated Exchanges (FFE Guidance) and Draft Blueprint for Approval of Affordable State-based and State Partnership Insurance Exchanges (Blueprint).

I. General Guidance on Federally Facilitated Exchange

The Guidance issued on May 16 articulates a vision for the federally facilitated exchange (FFE), which will operate in states that do not have a fully operational state Exchange in place by 2014. 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 and to reiterate the Department's commitment to thorough oversight of FFE plans. It is important that states do not interpret the principles related to market harmonization and state insurance regulation as willingness by HHS to compromise on the ACA's statutory and regulatory requirements.

OTHER OFFICES

3701 Wilshire Boulevard, Suite 750 • Los Angeles, CA 90010 • (310) 204-6010 • Fax (213) 368-0774
101 E. Weaver Street, Suite G-7 • Carrboro, NC 27510 • (919) 968-6308 • Fax (919) 968-8855
www.healthlaw.org

We recommend a few clarifications on issues that cut across several sections of the Guidance:

- **A single FFE, with necessary state customization:** The Guidance refers to the FFE alternately as a single entity and as state units, creating confusion. Some rules of the FFE will need to be implemented in state-specific ways to account for unique factors such as the number and variety of health plans, existing state market rules that are not altered by the ACA, or the state's participation in a Partnership Exchange. However, these should be state-specific variations on a common national FFE, not separate models, and as many rules as possible should be standardized across the national FFE. For instance, HHS should develop the agent, broker and Navigator standards as national models, with state customization for only certain components. To ensure transparency and accountability for the FFE in any given state, there should be a publicly available FFE document for each state (analogous to the Exchange Blueprint) that demonstrates how each exchange function will be performed in compliance with the ACA in the FFE, including a clear description of any functions that are customized for the state.
- **Market “harmonization”:** HHS should clarify that any harmonization of markets between the FFE and the outside market recognizes that ACA standards for exchanges may exceed those currently in place in state markets. The status quo of a state's existing market should not hinder the ability of the FFE to meet the ACA standards. Efforts to harmonize the markets should encourage the outside market to mirror the required standards of the FFE as much as possible. Similarly, attempts to leverage the traditional state role in regulating insurance should not compromise the required ACA standards.
- **Oversight:** HHS should clarify its plans for oversight in several areas. In the case of a Partnership Exchange, the Guidance reiterates that the federal government is ultimately responsible for the elements of Exchange implementation performed by the state partner, but HHS should also require a plan for monitoring state performance, promptly correcting any problems, and revoking the Partnership if necessary. HHS should also better explain how it will monitor day-to-day work, such as Exchange plan marketing, follow-through on referrals to Medicaid, agent and broker sales, and other “on the ground” activities.

A. 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. We agree that HHS should require states entering into a Partnership with an FFE to complete and submit an Exchange Blueprint showing both HHS and the public how the relevant functions will be performed.

i. Plan Management

In a Partnership on plan management, as HHS retains authority over the FFE, we urge HHS to maintain a hands-on approach related to the certification of specific qualified health plans (QHPs) and the enforcement of certification standards and other requirements that apply to QHPs. HHS should continue to ensure that state partners perform the plan management functions adequately and that QHPs a state partner certifies indeed meet the necessary standards. If a plan management Partnership is not meeting these standards and serving the needs of consumers, HHS should have a clear plan for stepping in to modify the arrangement or to handle plan management directly.

We note that the prohibition against discriminatory benefit designs will be new territory for many state insurance regulators. Those handling plan management functions through a Partnership with an FFE will need clear federal guidance on how to carry out this responsibility, and HHS will need to be vigilant to ensure states appropriately provide this important consumer protection. In addition, HHS will need to ensure that a state partner administers its responsibilities in a manner that does not put the exchange at a disadvantage or promote adverse selection. Over time, HHS should explore ways (through QHP certification or other methods) to simplify the plan offerings in an exchange to enhance consumer understanding of plan options and ensure that premiums are as affordable as possible. Federal exchanges that rely on state partners to conduct plan management should not be excluded from such efforts.

ii. Consumer Assistance

For Partnerships in which the state carries out selected consumer assistance functions, federal-state coordination will also be critically important. HHS will have to carefully coordinate the consumer assistance functions carried out directly by the FFE (the website and consumer hotline) with the in-person assistance handled by the state partner. These FFE-managed functions should also be able to refer consumers and small businesses to in-person assistance when appropriate. For example, the Exchange website should provide a directory of Navigator and consumer assistance entities in a state that consumers can search by zip code to find the type of assistance they need (e.g. Navigators that provide language services or accessibility aides for people with disabilities) in a location convenient for them. This type of tool will also help Exchange call center staff to easily identify and refer consumers to appropriate resources. The Exchange website should also provide a portal that Navigators can use

to submit online applications on behalf of consumers and small businesses they assist. When an FFE and a state share consumer assistance functions through a Partnership it will also be critical to ensure that HHS and the state provides robust technical assistance to Navigators. Further, the website and consumer hotline should be state-specific in providing information on the available coverage options (both public and private) and eligibility rules for those options in each state.

HHS should clarify exactly what responsibilities a state would have to fulfill if it enters into a consumer assistance Partnership with an FFE and ensure the federal and state efforts are well coordinated. The guidance lists as state responsibilities administering and overseeing the Navigator program and providing other in-person assistance to consumers. This includes help with filling out applications, receiving eligibility determinations, and reporting changes in circumstance during the year. But such activities are closely linked to other areas of consumer assistance. For example, HHS has indicated that insurance agents and brokers that meet applicable standards can assist consumers in FFE states, including enrolling them in a QHP through a special portal to the FFE Web site. The list of help available through consumer assistance should also include other issues, such as complaints and appeals; internal and external appeals processes; problems related to health care services, including care and service problems, denials, delays, and claims or payment problems; problems with obtaining premium tax credits or cost-sharing subsidies; and exemptions from the mandate penalty.

We recommend that states with an FFE be required to provide some consumer assistance through referrals to independent non-profit agencies and make it a priority to refer certain vulnerable populations for this assistance, such as low-income populations that require assistance with public and newly available private health insurance options. Independent consumer assistance should be provided by organizations that have a history of successfully working on health care access issues for these populations, have capacity for providing legal assistance, and can work on system-wide barriers. Where possible, local in-person assistance should be available.

In addition, it appears the FFE, not the state consumer assistance Partner, would handle consumer outreach and education, yet the Navigator program (administered by the state Partner) has responsibilities related to outreach and education as well. And, as the guidance notes, states already have relationships with local community and business organizations “that will be critical for effective outreach and assistance to consumers.” It is important to clarify what responsibilities the state Partner might have related to outreach and education and how the FFE will coordinate these responsibilities with or into the FFE’s outreach and education campaign.

Finally, HHS should establish quality measures and evaluation requirements for consumer assistance providers, including public agencies, navigators, brokers, contractors and non-profits. Quality measures and evaluation should apply to all three types of exchanges - FFEs, partnership models, and state run exchanges.

HHS should identify metrics such as processing and response times, which states should be required to track and report. States should also collect data on approvals, denials and the number of incomplete applications. Although we recognize that none of these alone necessarily indicates a poorly performing consumer assistance program, they could indicate deficiencies in the application process that the program should review and address.

States could also employ "testers" or "secret shoppers" who attempt to obtain assistance and services (such as LEP services), randomly monitor hotline calls, conduct qualitative semi-structured interviews, and convene consumer panels to periodically consult about the quality of care. States should require a corrective action plan if needed, and publicly post the results of the consumer assistance program evaluation.

Such measures are consistent with the guiding principles "to improve policies and processes" in pursuit of "a positive" consumer experience. For further discussion of quality measures, please see Section I.C.iv) below.

iii. Issues for Both Types of Partnerships

To provide greater clarity on state and federal responsibilities in a Partnership FFE, and to facilitate a seamless system for consumers in Partnership states, the FFE and relevant state agencies should sign a memorandum of understanding (MOU) or other written agreement when forming the Partnership. These documents should detail the division of labor and responsibilities for the exchange. The final document can enhance communication and coordination among the parties. Making such documents publicly available also would increase consumer understanding and public accountability of Partnership exchanges.

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.

B. 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 QHPs and does not extend to plans sold outside the Exchange. Some of the QHP standards 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, HHS must establish a clear process to ensure QHP standards are 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)."

i. 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 should not preclude the possibility of applying additional requirements to QHP selection and contracting to ensure high value plans.

Two 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. Research has shown that too many choices among products can be confusing for consumers and make it difficult for them to choose the product that best meets their needs.¹ CMS has found this to be the experience in Medicare. In the Medicare Advantage program, the number of plan choices has resulted in beneficiary confusion and difficulty in choosing a plan that meets the beneficiary's needs. This has also been an issue in Medicare Part D, and CMS will now approve only Medicare Part D plans that are "substantially different from those currently

¹ See, e.g., S. Seth-Iyengar and M.R. Lepper, "When Choice is Demotivating: Can One Desire Too Much of a Good Thing?" *Journal of Personality and Social Psychology*, Dec. 2000 79(6):995-1006; S. Seth-Iyengar, G. Huberman and W. Jiang, "How Much Choice is Too Much? Contributions to 401(k) Retirement Plans," in *Pension Design and Structure: New Lessons from Behavioral Finance* (O.S. Mitchell and S. Utkus, eds.) (New York: Oxford University Press, 2004), pp. 83-95.

on the market by the same insurer.”² A second standard included in the FFE Guidance would require confirmation that the service area of a plan 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 use the QHP certification process to ensure plan offerings include products with cost-sharing options that will work for individuals and families with low and moderate incomes, provide culturally and linguistically appropriate care and services, and meet the needs of individuals with disabilities. Although individuals and families under 250 percent of poverty will qualify for subsidies that limit cost-sharing, HHS will need to do more in their certification standards for QHPs to make sure that neither these families nor those who will not be eligible for cost-sharing assistance have to face all of their cost-sharing requirements upfront or otherwise face prohibitively high out-of-pocket requirements for services. For example, HHS could require insurers to offer products that have low deductibles within the required actuarial value limits and standardize cost-sharing for certain services. If only QHPs with very high deductibles are available, low- and moderate-income enrollees may not be able to access needed care. In addition, QHPs should, through the certification process, demonstrate how they will meet the needs of individuals with disabilities and individuals who are limited English proficient (LEP). For example, how will QHPs ensure physical access to providers, language services for LEP individuals in providers’ offices as well as during interactions with QHPs. It may also include documentation of how the QHP will provide materials in alternative formats that include, but are not limited to Braille, large font, and electronic formats such as Digital Accessible Information System (DAISY), e-text (rich text format, American Standard Code for Information Interchange (ASCII)), audio files (MPEG Audio Layer III (MP3), Waveform Audio File Format (WAVE or WAV), Media Player), and giving primary consideration to the preferred format of the individual with a disability

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.

The FFE should also be prescriptive and aggressive in requiring that QHPs offer robust and comprehensive preventive benefits, as they are both cost-effective and must be offered without cost-sharing. Section 2713 of the Public Health Services Act (added by

² CMS, 2012 Final Call Letter to Medicare Advantage Organizations, Prescription Drug Plan Sponsors and Interested Parties, Apr. 4, 2011, <http://www.cms.gov/MedicareAdvtgSpecRateStats/AD/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=descending&itemID=CMS1246529&intNumPerPage=10>.

ACA § 1001) requires coverage of four categories of recommended preventive health services, all of which are evidence-based and critical for securing the health of women, children, low-income individuals, and other vulnerable populations. HHS has issued guidance explicitly confirming that the preventive services of section 2713 are incorporated into the essential health benefits (EHB) that must be covered by all QHPs. The FFE must therefore require and monitor QHPs to ensure that they include the preventive services of section 2713 without cost-sharing.

In the reproductive health context, it is the patient who must make the ultimate informed decision regarding which treatments and services are appropriate. Enrollees seeking reproductive health care must have access to all necessary information to make informed decisions regarding their health needs. Benefits should never be restricted based on considerations outside of evidence-based medical standards.

The FFE must ensure that the provider network of each QHP is, in numbers and types of providers, able to assure that enrollees can access all covered services without unreasonable delay. Provider networks must also ensure meaningful access to providers of obstetric and gynecological services important to promoting healthy pregnancies and healthy births and gynecological health, including for adolescents. Minimum network adequacy standards should take into consideration the fact that many hospitals and clinics may, on religious and/or moral grounds, refuse to provide all of the covered services, and individual providers may refuse to offer covered services. These restrictions may limit access to comprehensive reproductive health services and information, as well as end of life care and information about treatment options. An adequate network must include providers that offer all covered services. Moreover, in the event that an enrollee is not able to access the reproductive health services that she needs within the network, in particular due to provider religious or moral objections, the FFE must require QHPs to allow the woman to access services out-of-network in a timely manner at no additional cost, including in the case of emergencies.

The FFE must also ensure a robust pediatric provider network to adequately meet the health needs of children, particularly for children and youth with complex or chronic health conditions. The benefits offered must meet the needs of children, and we are disappointed not to see a federal essential health benefits standard proposed for the FFEs. We urge HHS to develop a national standard for the FFEs that includes a comprehensive pediatric benefit with a “medical necessity” definition that is similar to Medicaid’s EPSDT standard, based on children’s unique health needs.

ii. 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, a state review of whether a plan is “in good standing” may not be publicly available. If a state does not forward documentation of this information to the FFE, we recommend HHS independently verify the information on a plan’s status.

Network adequacy is another 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 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.

iii. Plan Management Functions

The Guidance delineates two different levels of review in the QHP certification process: issuer level and plan level. At the issuer level, the Guidance assigns network adequacy and essential community provider standards; however, an issuer may meet either of these standards without doing so at the plan level. Therefore, HHS should also require that these reviews also occur at the plan level. The Guidance also suggests an FFE will accept attestations for compliance with marketing standards. However, how QHPs meet this standard and how HHS enforces it may directly affect adverse selection. We therefore recommend HHS require plans to go further than providing attestation, for example, to require filing of marketing materials with an FFE and doing audits or other independent confirmation that QHPs are meeting marketing standards.

At the plan level, QHP certification will include confirmation of essential health benefits and actuarial value standards. Although these standards will apply to plans outside an FFE and will fall under the responsibility of the state, these will be new standards in every state and regulators will have had no experience applying these standards. We therefore recommend HHS apply additional scrutiny to these standards, beyond simply confirming the state review. For example, HHS could conduct these reviews for QHPs, as it will for the discriminatory benefit design standard, which is another review not now performed by states. We also recommend HHS develop a plan for ongoing oversight of QHP compliance with these standards, with reviews occurring more frequently than annually, especially where QHPs make significant changes mid-year (e.g., changes in providers and/or benefits).

Given the level of coordination needed with state agencies, we recommend HHS adopt a requirement included in the Partnership model and require states with an FFE to identify the agency with primary responsibility to work with the FFE.

HHS must also ensure that QHPs maintain meaningful network adequacy standards. An exchange is required by 45 C.F.R. § 156.235 to contract with QHPs that include essential community providers in their networks and this should apply to the FFE. Essential community providers provide care to predominately low-income and medically-underserved populations who suffer from disproportionately high rates of illness and disability. In addition to providing more efficient and patient-centered care, the inclusion of essential community providers will support better continuity and coordination of health care, an underlying goal of the ACA.

It is essential that QHPs include the full range of potential essential community providers that currently comprise the safety-net of providers who provide health care to low-income communities. The FFE should require QHPs to contract with essential community providers for the full range of services they offer, rather than only offering access to certain subsets of services. Safety-net providers who have an established history of serving predominantly low-income and medically-underserved communities, include, but are not limited to: HIV/AIDS clinics, public hospitals, women's health centers, free-standing birth centers, federally qualified health centers (FQHCs), family planning clinics including Title X-funded reproductive health centers, and community health centers. In addition, as to the unique health needs of women, it is especially important that QHPs be required to contract with Title X clinics, women's health clinics, and other publicly-funded family planning providers for the full range of covered services that they provide. For example, the FFE should not permit a QHP to exclude contraceptive services that a women's health clinic offers. It is further critical that HHS prohibit QHPs from excluding a provider on the basis that the provider offers abortion services.

The FFE should also require QHPs to contract with essential community providers that routinely provide preventive health screenings and treatment including FDA-approved contraceptive drugs, devices and supplies consistent with HHS Required Health Plan Guidelines for those services.³ The FFE should require that QHPs contract only with essential community providers that offer unbiased, accurate, and timely access and/or referrals to, and information about, health care services.

The FFE must ensure strong security safeguards to ensure the privacy and security of personally identifiable information and follow existing Health Insurance Portability and Accountability Act (HIPAA) laws when transferring eligibility, enrollment and disenrollment information between health insurance programs, health plans, etc. The exchange should require that each QHP establishes and maintains systems to protect the confidentiality of sensitive reproductive health services for adolescents and adults.

³ See U.S. Dep't of Health & Human Servs., Health Resources & Servs. Admin., "Women's Preventive Services: Required Health Plan Coverage Guidelines," *available at* <http://www.hrsa.gov/womensguidelines>).

iv. Timeframes for QHP Application

We applaud the proposal to release for public comment a model application and recommend that the application clearly indicates what is required for compliance (via reference to regulatory language or other information) for each QHP standard. The application could also identify where state requirements for commercial plans differ from QHP requirements.

v. Other Plan Management Functions

The Guidance says HHS will support the ongoing operations of FFEs with user fees from participating insurers. However, this will build in a disadvantage for QHPs relative to non-participating plans. We therefore recommend HHS consider other sources of funding as well. The Guidance also says HHS will establish a process for decertification of QHPs that fall out of compliance with QHP certification standards, as required by the ACA. We recommend HHS also consider interim enforcement tools, short of decertification, since HHS and states will likely only use decertification rarely (as has been the state experience) and may be destabilizing to the FFE market. For example, HHS should develop a process for notifying QHPs when they fall out of compliance and subjecting such plans to a probationary period during which they must outline how they will come back into compliance on standards. HHS should also consider whether financial penalties or other sanctions should be used for plans that fail to come back into compliance within a limited time period.

C. Accreditation and Quality Reporting

i. Overall Comments

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, HHS is essentially using accreditation 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 HEDIS (or equivalent) quality measures (including 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.

ii. Accreditation Phase One

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 has not received accreditation must do so.

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 receive accreditation by completion of the second year of certification. The Guidance also indicates the FFE will accept 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 HHS will require all QHPs to be successfully accredited by an approved national accreditation organization by the end of the FFE's fourth year of operation and all QHPs must 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.

iii. Accreditation Phase Two

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.

iv. 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, 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.

HHS's initial approach to new quality reporting and display requirements is to require display of existing Consumer Assessment of Healthcare Providers and Systems (CAHPS) results from commercial and Medicaid product lines across all exchanges. While we believe this is a reasonable initial approach and provides a readily available method of displaying the same quality and satisfaction data in all exchanges, we strongly recommend that HHS also require reporting of HEDIS (or equivalent) quality measures (including CAHPS) in phase one. It is important that this type of quality information be available so that consumers can make decisions based on quality and value of coverage, not just cost.

For phase two, we recommend that HHS establish public reporting requirements for a standardized set of quality metrics – via the quality rating system, but with the ability to “drill down” to the specific measures – to ensure comparability across QHPs. Standard measures are critical for making quality data meaningful and useful to consumers and purchasers. HHS should require all commercial QHPs, irrespective of product type (e.g. HMO, HMO/POS, PPO), and Medicaid QHPs to report on the same measures in the same way. HHS should require QHPs to present quality information to consumers who are shopping for QHPs in an easy-to-understand format so they can make value-based decisions on their coverage and care. It is also important to distinguish between the CAHPS survey, which is a tool for collecting patient experience data, and the need for a separate consumer experience survey of exchange members. While we are strongly in favor of the public reporting of CAHPS data as part of the consumer assistance tools made available on exchange websites, the consumer experience survey will collect very different types of data about their exchange experience, such as accuracy of eligibility and tax credit determinations, effectiveness of the appeals process, and whether consumer assistance (via call centers, the Navigator program, etc.) is accurate, timely, effective, and easy-to-access. We would like to see HHS require QHPs to publicly report the results of the consumer experience survey as soon as possible, but again, this would be distinct from the CAHPS survey of health care quality experience.

Finally, the Guidance does not address how HHS intends to evaluate or enforce the requirement that QHPs participating in a FFE report their quality improvement strategies. This requirement on QHPs is independent of the accreditation requirement. Thus, even for plans that are fully accredited, HHS must independently review and assess their quality improvement strategies and outcomes. The ACA includes numerous provisions to spur innovation in our health care delivery system to curb costs and improve quality in Medicare and Medicaid. For example, the ACA includes policies that will link payment to quality and provider performance, creating much-needed incentives for quality improvement by hospitals, physicians, nursing homes, home health providers, and others. Exchanges are the critical hook to ensuring that these new models of care, along with investments in quality measure development and shared decision-making tools, are utilized by the private insurance market. HHS should provide guidance on quality improvement strategies that will encourage QHPs to align with these efforts and adopt similar programs.

We 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, HHS should require plans to stratify data by available demographic data to document reductions in health disparities.

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

D. 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 CHIP programs will be challenging. We intend our comments 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 clarifies 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 Exchanges and states evaluate and enroll individuals in the right coverage program.

The guidance also states, however, that the verification procedures used by the FFE may vary from 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 to implement the eligibility rules, is critically important to ensuring a seamless eligibility determination process.

To ensure that the assessments conducted by the FFE are as accurate as possible, we also recommend the following:

- Expanding the data sources that the FFE will use to electronically verify eligibility factors to include the data sources that the state Medicaid and CHIP agencies will use. The FFE's ability to make robust assessment of potential Medicaid eligibility will be limited if it is not able to tap into the same data sources that are used by the state Medicaid and CHIP agencies.
- Ensuring that the FFE and state Medicaid and CHIP agencies employ the same business rules regarding how to assess electronically verified data. To automate the eligibility and verification process, states will need to develop business rules that specify how to deal with situations where different data sources provide inconsistent information, and which data sources to tap first. To ensure accurate assessments, it is important that the FFE and state Medicaid and CHIP agencies apply the same business rules.
- Ensuring that the FFE and state use the same definition of reasonable compatibility. Even if the FFE and state Medicaid and CHIP agencies tap into the same data source, each entity could reach a different conclusion regarding some people's potential Medicaid eligibility if they employed different definitions of reasonable compatibility. Having a unified definition of reasonable compatibility that the FFE and the state Medicaid and CHIP agencies use would avoid such results.

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

- While the hope is that many applicants can complete the eligibility and enrollment process on-line and in real time, it is likely that applicants will have questions or complex situations that require personal assistance. Therefore, we strongly support the intent to couple an effective web-based system with a workforce that will be available to assist consumers. Whether provided through a call center or through in-person assistance, it is critical that interpreting services be available in all

languages in a state in which an FFE is operating and that the FFE provide appropriate communication assistance for persons with hearing disabilities.

- We also 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 interpreting 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). In all states, the FFE should meet minimum federal standards designed to ensure information is accessible to people with disabilities and LEP. In addition, 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 LEP individuals and people with disabilities, with consumer and stakeholder input.
- The guidance addresses FFE determinations/assessments of MAGI-based Medicaid eligibility but does not address assessments of non-MAGI Medicaid eligibility. We understand from the recent FAQ that the FFE will not be making determinations of non-MAGI eligibility. The FAQ also notes that the single streamlined application will include questions that are designed to identify individuals who may be eligible for Medicaid on a basis other than MAGI. We want to confirm that the FFE will be responsible for reviewing these questions that are geared toward identifying applicants who may qualify for non-MAGI Medicaid and for promptly referring such individuals to the state Medicaid agency for a determination of their eligibility.
- The guidance does not address the FFE's responsibility when its assessment results in a finding that the applicant does not qualify for MAGI-based Medicaid. The interim final regulations, at 155.302(b)(4)(ii)(B), provide that Exchanges refer such persons to the Medicaid agency if they wish to have a full Medicaid determination, but, in the meantime, be treated as ineligible for the purposes of an APTC determination. The recent FAQ appears to be inconsistent with this regulation, in that it states that the APTC determination will be held up in such instances pending the state Medicaid agency's determination of eligibility. The guidance should address this issue in a way that is consistent with the regulation and ensure that the choice whether or not to withdraw is truly voluntary and not influenced by the desire for immediate assistance.
- 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 so that the FFE must determine eligibility for advance payments of premium tax credits and cost-sharing reductions.

- The FFE guidance notes that requirements for notices and appeals will be forthcoming. We urge that guidance on notices and appeals and model notices be made available for comment as soon as possible. We recognize that the complexity of the eligibility determination process, which involves multiple programs and agencies, makes the design of notices and the appeal process especially challenging. For that same reason, allowing enough time for stakeholder involvement and comment on the plans for notices and appeals is especially important. Further, all due process procedures and policies used for the FFE and state Exchanges must comply with *Goldberg v. Kelly*.
- We also suggest that consumers and their advocates be included in the planning process intended to ensure coordination of the FFE and the state’s Medicaid and CHIP programs. In most states, consumer groups and community-based agencies provide assistance and support to applicants and beneficiaries. Their on-the-ground knowledge of the strengths and shortcomings of current processes would provide helpful input in developing interagency agreements and outreach plans for the launch of the FFE.
- 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.

E. Consumer Support, Outreach and Education

i. Navigators

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 qualified health plan (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, HHS should utilize assessments on participating insurers 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. We also suggest HHS involve consumer groups 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 as well as individuals with disabilities including those who have mental health, cognitive, or developmental disabilities, and thus will need to be tailored to the needs of the state.

FFEs should ensure that it integrates consumer assistance functions. For example, the Exchange website should provide a directory of Navigator and consumer assistance entities in a state that consumers can search by zip code to find the type of assistance they need (e.g. Navigators that provide language services or accessibility aides for people with disabilities) in the location closest to them. This type of tool will also help Exchange consumer hotline operators easily identify and refer consumers to appropriate resources. The Exchange website should also provide a portal that Navigators can use to submit online applications for coverage on behalf of consumers and small businesses they assist. FFEs should also ensure that robust technical assistance is provided to Navigators and may consider incorporating a toll-free helpline (with competent bilingual staff or interpreters for LEP callers) for Navigators into broader support functions, such as trained Exchange staff that conduct on-site visits and other trouble-shooting, especially during the first six months of Exchange operation.

ii. Outreach

The FFE should begin outreach and education early in 2013 and conduct outreach and education in a culturally and linguistically appropriate manner. 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 combat misconceptions and quickly build Exchange enrollment. For example, the FFE can conduct outreach through food assistance programs, community health centers, community hospitals, child care subsidy programs and other state and federal partnership programs. The FFE should facilitate PCIP participant transfer and enrollment 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.

In Massachusetts, the Connector partnered with various entities to help with media outreach such as sports teams, cable TV providers, faith-based organizations, state transportation authorities and the department of motor vehicles. The FFE could take a similar approach to ensure information is conveyed to varied audiences and reaches all residents in the state. Once an FFE has built the Exchange website, another way to engage consumers early is to provide visitors to the website with a mechanism to sign up to receive email alerts and updates (even before the Navigator program is functioning or open enrollment begins).

HHS must also research the demographic profiles of each state to fully understand who will likely qualify for coverage through the Exchange. This work should identify targeted audiences to prioritize outreach efforts, including but not limited to the outreach performed by Navigators. The FFE can use this information to prioritize building partnerships that can strategically target those in greatest need and prioritize other forms of awareness building. All partnerships that are formed should be accompanied with the appropriate media outreach to multiply their impact.

As a part of outreach planning, the FFE should conduct consumer research through interviews, focus groups and other research methods to learn the outreach strategies that will be most successful with the targeted populations. This work can help in developing messages and other outreach tools and priorities.

Whether the state or FFE performs the consumer assistance function, there should be common accountability measures to demonstrate what strategies have been attempted

and their success. This will help guide the state or FFE in future outreach and which can serve as models for other states.

iii. Agents and Brokers

The Guidance indicates that the FFE expects to engage agents and brokers to promote Exchange enrollment “to the extent permitted by a State.” It is unclear from this language whether a state must authorize the use of agents and brokers or what other rules HHS will permit states to create (e.g., can states also dictate the payment scheme for agents and brokers facilitating enrollment in an FFE?). HHS should set consistent standards and retain ultimate decision-making on whether and under what conditions the FFE may utilize agents and brokers, based on what services and policies provide value to consumers. HHS should not allow states that are not operating an Exchange or participating in a Partnership to make these payment and policy decisions for the FFE.

The significant decisions regarding agent and broker pay should be subject to public disclosure and comment. For instance, will agents and brokers be working for insurers or the Exchange, and will payment be based insurers’ own fee schedules or a fee schedule set by the Exchange? Will these factors vary by state or be the same across all states participating in the FFE? Will agents be paid on a flat-fee basis, as increasingly done by insurance companies, or as a percentage of premiums? Regardless of the form of payment, we urge the FFE to demand that agents and brokers accept this fee as full compensation and prohibit the charging of up-front fees that will discourage participation and sour consumers’ experiences.

Under any payment system, HHS must take steps to reduce conflicts of interest to ensure agents and brokers act in the best interest of the consumer and prohibit steering or other activities that undermine the stability of the Exchange. This should include rules against “dumping” potential enrollees who are suspected or determined to be eligible for Medicaid or CHIP. HHS can monitor inappropriate steering through the collection of data by the FFE to compare the enrollment trends of people enrolling on their own through the Exchange to those enrolling through agents and brokers to uncover patterns or evidence of steering.

We have concerns about the training and oversight of agents and brokers facilitating enrollment in an FFE. We urge HHS to develop a formal national agent and broker training program that it administers, as opposed to a less rigorous system of state attestations, for example. This training module should teach agents and brokers about Medicaid with the content developed in consultation with state Medicaid agencies.

Oversight of agents and brokers must be a priority. The experience of Medicare Advantage urges a very cautious approach to the use of agents and brokers. In March 2010, the HHS Office of Inspector General issued a report detailing the aggressive, deceptive and fraudulent marketing of agents and brokers in the Medicare Advantage

program. Among the abuses: agents were paid more than the CMS-approved compensation, plan sponsors used unqualified agents who were unlicensed or had not passed the required marketing exam, and beneficiaries were unknowingly enrolled in plans, were misled about plan benefits, and were victim of aggressive sales tactics. HHS must learn from these mistakes and make oversight a priority, either through federal oversight or a contractual agreement with state insurance offices.

Regarding Web-based brokers, we believe that paying a broker to duplicate HHS's own Exchange website would be a poor use of finite Exchange funding resources. This is particularly true given the identified need to secure sufficient for funding for Navigators, to provide critical on-the-ground, culturally and linguistically appropriate assistance to consumers. In addition, in the early days of Exchange operation, having multiple websites with different branding may create significant consumer confusion and dilute the "brand name" the Exchange is trying to establish.

F. Stakeholder Input

FFE 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's plan appears to replicate the "listening session" model used in the past, which was not the most meaningful or productive way to incorporate key stakeholder feedback and expertise. HHS should recognize the distinction between public input and stakeholder input. Listening sessions are more aligned with the former and can be politically paralyzing, particularly in states where opposition to the ACA is strongest (which are also most likely to be states with FFEs). Further, HHS should ensure that it incorporates stakeholder input into the planning process and ongoing operation of the FFE, including by being:

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

We believe that the time is short to solicit and incorporate stakeholder feedback prior to establishing FFEs, but this should not be an excuse for failure to engage stakeholders. On the contrary, assembling active working groups at the state level may expedite the process of getting the FFE established in the state.

i. Identifying Stakeholders

The exchange rules identify 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, small businesses. We support HHS' intent to consult with Tribes where appropriate to ensure that the FFE will best serve American Indians and Alaska natives. The guidance should also mention other natural partners when considering FFE-SHOP implementation, including small business employees and organized labor.

It is also important that HHS not limit stakeholders to these groups. The broader range of partners that participate in the creation of the FFE, the more credible the Exchange will ultimately 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.

ii. HHS technical assistance to FFE stakeholders

The FFE guidance states that HHS will “provide technical assistance to those stakeholders working with an FFE.”

HHS should ensure that “working with an FFE” is interpreted broadly, so that technical assistance is provided not only to those entities with a financial or contractual arrangement with an FFE but also to others impacted by FFE actions, such as consumers, health care providers and consumer advocates.

Further, HHS should specify what exactly it will include as technical assistance.

iii. Management of Stakeholder Engagement/FFE planning

The HHS guidance indicates that HHS is exploring with NAIC whether an advisory board structure can or should be created in states where such boards do not already exist. Relying on the NAIC alone would not ensure that stakeholder engagement and input in FFE planning is sufficiently broad. HHS should reach out to other organizations and entities, including consumer advocacy groups with state affiliates and networks, to ensure that stakeholder input is robust and broadly representative in all FFE states.

In states with a Partnership Exchange, HHS should defer to the designated agent(s) managing partnership functions in the state to oversee stakeholder engagement regarding those functions, including advisory groups. In these states, we believe the exchange standards outlined in the Final Rules for stakeholder engagement still apply to both the state and HHS, and so HHS should evaluate this as part of the Blueprint review and monitored by HHS throughout implementation.

In states that are not seeking a Partnership Exchange or are not otherwise showing any commitment to supporting an FFE, HHS should ***not*** automatically defer to NAIC or the Insurance Commissioner to oversee stakeholder engagement. In several such states, state officials (including insurance commissioners) have actively campaigned against Exchange implementation and blocked state personnel from engaging in planning activities. As such, it is highly inappropriate to entrust this activity to state leaders that have declined the opportunity to operate a state run or partnership exchange. Instead, HHS should manage the stakeholder engagement and planning process, which it conduct as outlined below in the section on FFE Planning via Advisory Groups.

iv. Ongoing FFE Stakeholder Input via Advisory Groups

The FFE guidance includes some information on stakeholder engagement but little to nothing on the concept of how the FFE could establish or tap into the input of state stakeholders on an ongoing basis. HHS should establish a meaningful, robust, and ongoing process of formal advisory groups, similar to those adopted by nearly every state that has made significant progress towards state exchange implementation. These groups provide input, feedback and recommendations to HHS on FFE policy decisions, operations, and how an FFE can best meet the needs of the state.

We suggest that HHS organize the workgroups around the following focus areas, each of which should have defined topics, objectives, and deadlines for delivering recommendations:

- **Plan management** - topics should include all of those listed on page 6 under Partnership Exchange “Overview of State Functions”);
- **Consumer assistance** – topics should include all of those listed on page 6 under Partnership Exchange “Overview of State Functions”) as well as agents, brokers and other non-Navigator application assisters; call center (including coordination with existing state-based consumer helplines); website; outreach and education/marketing; and assistance to individuals with disabilities and LEP individuals;
- **Eligibility and enrollment** – topics should include: the uniform application, verification requirements, coordination with Medicaid and CHIP, aligning verification requirements; and
- **SHOP** – topics should include employee choice models, contribution structure(s), premium calculator/tools, premium aggregation, customer service tools, etc.

Once HHS launches an FFE in a state, HHS may consider reorganizing or consolidating advisory boards in subsequent years based on the ongoing needs for local guidance and feedback and whether a state may transition to a state-based Exchange.

v. Transparency and Modes of Accepting Input

HHS needs to ensure that each state has a structured, transparent process should be developed. Stakeholders should have opportunities to provide written and verbal input on key decisions. For example, states planning state-operated exchanges have used conference calls and webinars open to all to permit maximum transparency and participation. HHS should create websites for each state with an FFE (presumably, they will be required to do this anyway, as part of the online application requirement). This website should include not only programmatic information but also minutes and handouts from all advisory group meetings.

G. Timeline

We understand that HHS can undertake only limited work to begin establishing an FFE in a state until after the Exchange certification process has run its course and HHS makes decisions based on the Exchange Blueprints states submit. However, this will make it very challenging to engage stakeholders in a meaningful way while still ensuring an FFE is ready to begin enrolling people by October 1, 2013.

We therefore recommend that HHS begin soliciting stakeholder input prior to the January exchange certification process. One entrée to this process might be for a state coalition to host a meeting in which its members could provide input directly to HHS staff, either in person or via phone or webcast. These coalitions already exist in many states, and in many cases these coalitions are eager to offer their collective wisdom to HHS on Exchange establishment issues in their state. HHS should also take steps to encourage states to officially declare their exchange model (FFE, state-based, or Partnership) earlier than the November 16, 2012 Blueprint deadline. HHS could require a letter of intent to submit a Blueprint from states by a date prior to the Blueprint deadline, such as August 31, 2012. HHS could then begin stakeholder engagement processes in states that do not meet this letter of intent deadline and are not engaging in their own stakeholder engagement processes prior to November 2012. In addition, we support HHS' invitation to states that will have an FFE to also submit a declaration letter (as described in the draft Blueprint), and urge HHS to actively encourage such states to do so, and to do so as early as possible. Earlier declarations of intent for a state to utilize an FFE will allow for HHS stakeholder engagement processes to begin sooner.

II. Draft Blueprint for Approval of Affordable State-based and State Partnership Insurance Exchanges

a. Exchange Blueprints and Declaration Letter are due November 16, 2012.

We support having a defined deadline by which a state must make a decision and demonstrate commitment towards a state-based exchange or partnership exchange

- b. Exchange blueprint indicates that HHS will permit Conditional Approval of a state's Exchange Blueprint if the state is not ready as of January 1, 2013 but is making significant progress toward all requirements. FAQ on the Exchange Blueprint indicates that "a State Exchange will remain Conditionally Approved until it meets all Approval requirements."**

HHS should specify when is the absolute last date by which a state must demonstrate that a "conditionally approved" Exchange achieves full compliance and readiness or else defer to the FFE. This deadline should provide sufficient time for an FFE to prepare to operate in a state.

- c. Exchange Declaration Letter – required as part of the Exchange Blueprint submission by November 16, 2012**

We recommend that HHS provide a form for states to fill out to simplify their efforts to respond.

The Declaration letter should ensure clarity around which entity will conduct final eligibility determinations for Medicaid for people who apply through the Exchange. Each state should be required to indicate whether the Exchange (regardless of whether the Exchange is state-operated or an FFE) will make the final determination of Medicaid eligibility that the state Medicaid agency will accept or whether the Exchange will make an initial assessment of potential Medicaid eligibility with the final determination being made by the state Medicaid agency.

- d. Exchange application consultation with CMS**

States that submit their Declaration Letter 20 or more business days prior to the submission of their blueprint are eligible to receive Exchange application consultation with CMS. We support HHS's decision to provide states that indicate their commitment early with such consultation and assistance.

- e. Roadmap for Completing the Exchange Application**

Table 1 includes a very useful checklist for state-requirements and responsibilities, depending on whether as state will operate a state-based exchange, handle plan management in Partnership with an FFE, and/or handle consumer assistance in partnership with an FFE.

The checklist currently includes "2.0 Consumer and Stakeholder Engagement and Support," which HHS should amend so that Stakeholder Consultation and Consumer

Assistance are separate sections to reflect the separateness of these functions. Items 2.1 and 2.2 should reside in the former, with items 2.3 – 2.8 with the latter.

Regarding state-based Exchange - Consumer Assistance, the checklist under 2.0 omits an area for which HHS should require the partnering state to provide information as part of its blueprint application. The Blueprint should require states with state-based Exchanges to provide information about how it will provide in-person consumer assistance services by adding in-person consumer assistance to the list of items under Consumer Assistance.

Regarding Partnership Exchange – Consumer Assistance, the checklist omits several areas for which HHS should require the partnering state to provide information as part of its blueprint application. The FFE guidance pertaining to consumer assistance Partnerships indicates that states entering into such arrangements would oversee and administer the Navigator program and provide a variety of in-person consumer assistance services. The Blueprint should require such Partnership states to provide greater detail about how it will provide these consumer assistance services including at least 2.1, 2.2, and 2.3. It currently requires submission only of information related to the Navigator program.

Regarding partnership exchange – plan management, the checklist should also require states in such arrangements to supply a Stakeholder consultation plan (Item 2.1).

f. Public Transparency

The Exchange Blueprint specifies that only certain sections of a state exchange blueprint be made public within ten (10) business days of an Approval or Conditional Approval.

HHS 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 for Medicaid and the Children’s Health Insurance Program are made available. Perhaps it would be necessary in some cases to allow more time than 10 days from time of approval or conditional approval, but in the interest of transparency, it is crucial to provide access to the complete set of information about how an exchange is being operated in a reasonable timeframe.

In addition, similar information should be made publicly available about the FFE; not just information about functions performed by a state in Partnership with an FFE, but also about the functions handled at the federal level.

In addition, we believe that HHS should develop and make publicly available an Exchange Blueprint or similar document for the FFE for each state in which it will operate. It appears that many states may have an FFE, at least initially, and it is critical

to ensure the FFE is as transparent in its operation and policy decisions as a state-operated Exchange must be.

g. Nondiscrimination and Civil Rights Compliance

As entities established under Title I of the ACA, all Exchanges must comply with the nondiscrimination provisions of §1557 of the ACA. Section 1557 of the ACA forbids discrimination on the grounds of race, color, national origin, sex, age or disability in health programs or activities that are receiving federal financial assistance or by programs administered by an Executive Agency or any entity established under Title I of the ACA. Because Title I of the ACA requires the establishment of the Exchanges, all Exchanges, whether administered by the federal government or by the states, must comply with § 1557. In addition most, if not all, plans offered through the Exchanges, will be subject to § 1557, by virtue of receiving federal financial assistance, including credits, subsidies, or contracts of insurance.

Since 49 states and the District of Columbia received federal funds to plan and implement their Exchanges, , Title VI of the Civil Rights Act of 1964 and § 504 of the Rehabilitation Act should apply (and § 508 of the Rehabilitation Act with regard to accessible websites). These should apply regardless of the type of Exchange. States that operate state-based Exchanges have directly received federal funds while a state that establishes a not-for-profit Exchange will be passing the federal funds to the non-profit so it would be subject to Title VI and § 504.

Under Title VI of the Civil Rights Act of 1964,⁴ no federal funds can be used in a discriminatory manner, whether intentionally, or, pursuant to federal regulations, through disparate impact. Title VI applies to all programs receiving federal financial assistance, including private entities. Congress has defined covered programs to include “an entire corporation . . . if assistance is extended to such corporation . . . or which is principally engaged in the business of providing education, health care”⁵ Discrimination under Title VI has been determined to include preventing meaningful access to federally funded services for “national origin minorities” with LEP (Title VI prohibits discrimination on the basis of national origin). In 1974, the Supreme Court concluded that programs with a discriminatory impact against individuals based on their language are akin to those which discriminate based on national origin.⁶ Since states received federal Exchange planning grants to establish their Exchanges, they are subject to Title VI. Further, under Executive Order 13166, HHS should require that Exchanges comply with

⁴ See 42 U.S.C. § 2000d (2006).

⁵ See 42 U.S.C. § 2000d-4a (2006).

⁶ See *Lau v. Nichols*, 414 U.S. 563 (1974).

HHS' "LEP Guidance" issued by OCR and work with OCR to determine the most effective ways to assist Exchanges in complying with these laws.⁷

Similarly, §504 of the Rehabilitation Act prevents discrimination against otherwise qualified people with disabilities under any program or activity that receives federal funds. Similar to Title VI, federal fund recipients may not discriminate against people with disabilities, including those who have mental health, cognitive, or developmental impairments. As one example, Exchanges should provide sign language interpreters or other augmentative or auxiliary assistance to applicants or enrollees who are Deaf or hard of hearing or have other hearing impairments to comply with § 504.

Further, HHS' final Exchange eligibility and enrollment regulations, at § 155.120, specifically require states and Exchanges to comply with applicable nondiscrimination statutes; and not discriminate based on race, color, national origin, disability, age, sex, gender identity or sexual orientation.⁸

Therefore, HHS should consider the nondiscrimination requirements of § 1557, Title VI and § 504 as it reviews applications to establish State-based Exchanges and State Partnership Insurance Exchanges. Specifically, HHS should work to ensure that the 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 disabilities. In addition, HHS should require that Exchanges seek out diverse representation from a variety of groups, including women, ethnic and cultural minorities, seniors and people with disabilities, at all stages of the planning and implementation process.

We thus recommend an addition to the Blueprint to the "Consumer and Stakeholder Engagement and Support" section that would require Exchanges to provide an attestation and supporting documentation outlining the policies and procedures the Exchange will use to implement and enforce § 1557, Title VI and §504. Specifically, Exchanges should attest and provide supporting documents demonstrating that they have:

- designated a person who will oversee compliance with § 1557, Title VI and §504, including investigating complaints and ensuring health plan compliance;
- established a system for reviewing health plan compliance with § 1557, Title VI and §504; and

⁷ See Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition against National Origin Discrimination Affecting Limited English Proficient Persons (HHS LEP Guidance), available at <http://www.gpo.gov/fdsys/pkg/FR-2003-08-08/pdf/03-20179.pdf>.

⁸ 77 Fed. Reg. 18310, 18447 (March 27, 2012) (see 42 C.F.R. § 155.120).

- established an outreach plan to inform consumers of their rights under § 1557, Title VI and §504 and how to report suspected violations.

h. Section-by-Section Comments

We greatly appreciate that HHS recognizes the importance of providing information in a culturally and linguistically appropriate manner and in alternate formats for individuals with disabilities. We suggest that HHS expand on the required attestations to require Exchanges to provide documentation as to how it will provide meaningful access to this information.

1.0 – Legal Authority and Governance

In 1.2b and 1.2c, we believe HHS should require states to submit documentation of their charter or by-laws and conflict of interest policies. HHS should review these to ensure that these documents appropriately protect the rights of consumers.

In 1.2f, we believe states should provide HHS with a list of the recent dates of their governing board meetings and public notice listings. With this information, HHS can ensure that the Exchange is indeed holding regular public meetings.

2.0 – Consumer and Stakeholder Engagement and Support

In 2.3, CCIO requires that the Exchange provide culturally and linguistically appropriate outreach and educational materials including auxiliary aids and services for people with disabilities. For individuals with disabilities, this may involve providing materials in alternative formats that include, but are not limited to Braille, large font, and electronic formats such as Digital Accessible Information System (DAISY), e-text (rich text format, American Standard Code for Information Interchange (ASCII)), audio files (MPEG Audio Layer III (MP3), Waveform Audio File Format (WAVE or WAV), Media Player), and giving primary consideration to the preferred format of the individual with a disability. For individuals with LEP, the Exchanges will have to provide both oral and written information in non-English languages. Yet the description of supporting documentation does not require an Exchange to actually detail or provide any information specific to how it will notify applicants and enrollees that culturally and linguistically appropriate information or assist individuals with disabilities is available. We suggest HHS amend this section to require Exchanges to provide specific information that HHS can assess to determine compliance with both § 1557 as well as 2.3.

In 2.4, HHS requires states to provide a brief description of the call center's strategy plan for providing ***translation*** services (emphasis added). We believe this is an inadvertent error by HHS. Translation is the conversion of a written text into a

corresponding written text in a different language.⁹ We believe HHS meant to ask for a call center’s plan for “interpreting services.” Interpreting is the process of understanding and analyzing a spoken or signed message, and re-expressing that message faithfully, accurately and objectively in another language, taking the cultural and social context into account.¹⁰ The purpose of interpreting is to enable oral communication between two or more individuals who do not speak each other’s languages.¹¹ We urge HHS to make this change so that it receives the relevant information from Exchanges about their call centers which will be primarily interacting with applicants and enrollees via oral communication. If a call center may subsequently send written materials to callers, then HHS should require Exchanges detail their plans for providing “interpreting and translation services” (or the broader term “language services” which encompasses both interpreting and translation).

In 2.4b, we appreciate HHS’s requirement that Exchanges provide translation and oral interpretation services and auxiliary aids. We suggest that HHS require supporting documentation to document the Exchanges’ relevant policies, procedures, and contracts to effectively comply with 2.4b. Another concern is that this requirement is a sub-requirement to 2.4 which focuses on call centers. Because both § 1557 and Title VI of the Civil Rights Act of 1964 apply to Exchanges, we believe the responsibility to provide translation and oral interpreting services transcends the call center and applies to *all* Exchange functions in which the Exchange interacts with consumers. Thus we suggest separating 2.4b into its own section or elevating 2.4b to 2.4 and changing the existing 2.4 to 2.4b.

We also suggest that HHS add a new requirement that a state attest and provide supporting documentation of how its’ Exchange will assist individuals with disabilities who interact with the Exchange, including through the call center. That is, an Exchange should have policies and procedures in place to respond to callers using TTD/TTY or video relay services as well as other services for individuals with hearing or speech impairments. Exchanges must also provide supporting documentation for how they will initially train and support representatives to provide such reasonable policy modifications to individuals with disabilities as additional time to gather supporting documentation or granting specific appointment times or windows when specific appointments might not be typically available.

⁹ NCIHC *The Terminology of Healthcare Interpreting – A Glossary of Terms* (October 2001, revised August 2008)

¹⁰ ASTM *Standard Guide for Language Interpretation Services* (F 2089-01 (reapproved 2007)).

¹¹ NCIHC *The Terminology of Healthcare Interpreting – A Glossary of Terms* (October 2001, revised August 2008). For more information on interpreting and translation, see *What’s in a Word: A Guide to Understanding Interpreting and Translation in Health Care*, available at <http://www.healthlaw.org>.

In 2.5c, we strongly support HHS's requirement that Exchanges' websites provide information in a manner that is accessible to individuals with disabilities and individuals with LEP. Again, we suggest that HHS require supporting documentation to ensure that Exchanges have needed policies, procedures, and contracts in place to effectively comply with 2.5c. A state should have to document in what languages the Exchange will translate all or part of its website, how it will provide information to LEP individuals if a website is not available in their language, and how the Exchange will provide accessible information to individuals with disabilities and fillable online forms, including how it will comply with § 508 requirements. The final Exchange regulations also specifically require Exchanges to provide accessible websites to individuals with disabilities and those who are LEP.¹² We strongly believe that Exchanges should utilize the thresholds for translation outlined in The Leadership Conference's prior comments – 5% or 500 LEP individuals in the Exchange's service area. For oral language services, we strongly believe that HHS should not implement a threshold but require oral language services for all LEP individuals, consistent with HHS' longstanding LEP Guidance.¹³ Exchanges should also provide sign language interpreters or other appropriate communication assistance for individuals with hearing impairments (since not all individuals with hearing impairments use sign language, other assistance may be needed including augmentative or auxiliary aids). We believe HHS should require states to identify their threshold languages for translation and detail their plans for providing translated materials and language services.

In 2.6, we appreciate HHS's attention to the development of the Navigator program. The ACA includes a specific requirement that Navigator programs provide information in a manner that is culturally and linguistically appropriate.¹⁴ And the final Exchange regulations specify, in the preamble, that because Navigators are third parties under agreement (that is, the grant agreement) with the Exchange, the non-discrimination standards that apply to Exchanges in §155.120(c) will also apply to entities seeking to become Navigators. We thus recommend that HHS add a new section 2.6d to require Exchanges to provide supporting documentation how the Navigator program will comply with these requirements, including the issues addressed above regarding translated materials and language services.

In 2.6c, we suggest that HHS require states to submit their conflict of interest standards for Navigators so HHS can review these to ensure that these documents implement the protections necessary to protect the rights of consumers.

3.0 – Eligibility and Enrollment

¹² 77 Fed. Reg. 18310, 18448 (March 27, 2012) (see 42 C.F.R. § 155.205(c)).

¹³ See footnote 4.

¹⁴ ACA § 1311(i)(3)(E).

In 3.3 and 3.3e, we support HHS's requirement that Exchanges have the capacity to receive information from applicants and enrollees who have disabilities or LEP. We suggest that HHS require supporting documentation so HHS can ensure that Exchanges have the needed policies, procedures, and contracts in place to effectively comply with 3.3.

In 3.4 and 3.4a, we appreciate HHS's requirement that Exchanges have the capacity to send notices in alternate formats and multiple languages. We suggest that HHS require supporting documentation, including actual notices in alternate formats and languages so HHS can evaluate them to ensure that Exchanges have complied with 3.4 and 3.4a.

In 3.6, we also recommend HHS require supporting documentation of the privacy protections. This is important for transparency and also so that HHS has the information necessary to evaluate these policies and monitor compliance. If Exchanges do not adopt and ensure strong privacy protections, consumers likely will have concerns about providing the personal information necessary for eligibility determinations.

In 3.7 the Blueprint requires Exchanges to document their capacity to determine eligibility. As we have expressed in prior comments, NHeLP is very concerned about the bifurcation of assessments and eligibility determinations for Medicaid between the Exchange and Medicaid/CHIP agencies and the impact this has on a streamlined eligibility process. We are also concerned, however, with upholding existing Medicaid law that only public employees make Medicaid eligibility decisions. In our recent comments on the Exchange eligibility final/interim final rule, we stated that it should be clear that use of a private exchange cannot interfere with or contradict the Medicaid single state agency requirement or the requirement that any streamlining of enrollment through an exchange must use a "public agency" to make the final eligibility determination for Medicaid. (See http://www.healthlaw.org/images/stories/NHeLP_Exchange_comments_FINAL_may_2012.pdf at p.8) To ensure compliance with these requirements, we urge HHS to require states to provide supporting documentation in their Blueprints designating who will make the eligibility determinations. Further, in states where the FFE only assesses an individual's eligibility for Medicaid and does not make a formal Medicaid eligibility determination, a state should have to document in its Blueprint the mechanics of how assessment decisions will transfer to the Medicaid agency, how the state will ensure that a formal decision will be made according to the timeliness provisions in the final Exchange regulation, and demonstrate the testing the state has done to ensure the process works in practice.

In 3.9, we commend HHS's requirement that Exchanges provide notices in plain language. Section 1311 of the ACA defines the term to mean language that individuals with LEP, among other intended audiences, can understand. We thus suggest that HHS require supporting documentation that either outlines the Exchanges' plans for ensuring information is provided in plain language or actual documents that HHS can evaluate to

ensure compliance with this requirement. We also suggest HHS require that Exchanges comply with any future guidance issued by HHS on these topics (as referred to in the response to comments in the Exchange regulation regarding assistance to LEP individuals, access standards and compliance with nondiscrimination standards).¹⁵

In 3.11, we encourage HHS to add requirements that the eligibility appeals process includes a capacity to receive information from and assist individuals with LEP and individuals with disabilities. As documented in 3.4 and 3.4a, providing notices in alternate formats and languages is a critical component but Exchanges must also develop the entire appeals process to be responsive to the needs of individuals with disabilities and LEP. This may require an Exchange to provide an interpreter during an appeals hearing, translate notices, or ensure that appeals hearings occur in an accessible space or that it provides augmentative or auxiliary aids for individuals with disabilities or enable individuals with disabilities to appear telephonically or via videoconferencing.

4.0 – Plan Management

Since the requirements regarding § 1557, Title VI and § 504 apply to Qualified Health Plans (QHPs) as well as Exchanges themselves, we suggest HHS add specific language in 4.0 so that QHP certification standards ensure QHPs' compliance with these laws. QHPs will receive federal funding for enrollees receiving advance premium tax credits (APTCs) or cost-sharing reductions and thus are subject to Title VI and § 504. Further, Exchanges must require QHPs to comply with § 1557 since Exchanges themselves must comply. The responsibility runs not only to the Exchanges themselves (as an entity created under Title I of the ACA and as federal fund recipients) but longstanding precedent exists that an entity directly subject to compliance with federal laws cannot then waive compliance with these requirements by its subcontractors. As HHS noted in the final Exchange regulations with regard to Navigators, because Navigators are third parties under agreement (that is, the grant agreement) with the Exchange, the non-discrimination standards that apply to Exchanges in §155.120(c) will also apply to entities seeking to become Navigators. We believe the same rationale applies to QHPs.

Specifically in 4.4b, we suggest HHS require Exchanges to document its process to monitor QHP performance and collect, analyze and resolve enrollee complaints. We also believe HHS should require Exchanges to post, at least annually, a report documenting the analysis and resolution of complaints so that consumers have access to this information when selecting QHPs. Ensuring effective consumer complaint processes is essential to protecting applicant and enrollee's rights as well as monitoring plan compliance with required regulations and procedures.

¹⁵ 77 Fed. Reg. 18310, 18314 col. 3; 18320 (col. 1); 18327 (col. 2) (March 27, 2012).

7.0 – Organization and Human Resources

In 7.1b, the Blueprint addresses hiring strategies. We suggest HHS add language regarding hiring of competent bi-/multi-lingual and bi-/multi-cultural individuals in public-contact positions who can provide services in a culturally and linguistically appropriate manner. Further, an Exchange must ensure that any bilingual individual hired who, as part of job responsibilities, will provide services directly in a non-English language or serve as an interpreter is competent to do so. Self-identification as bilingual is not enough and Exchanges should have policies in place to identify and document the competencies required for bilingual individuals.

8.0 – Finance and Accounting

We suggest that HHS add a requirement, 8.1b, for Exchanges to document their budgets for providing culturally and linguistically appropriate services and assistance to people with disabilities. We believe Exchanges must specifically budget for these services to ensure funds are available. Otherwise, many Exchanges may not have funds when needed to purchase language services (including interpreting or translated materials) or provide augmentative or auxiliary aids. Without specific budget line items or authority, we have witnessed that many health care providers or state agencies fail to provide these needed services, even when required to do so by federal laws.

10.0 – Privacy and Security

When consumers provide information to Exchanges, they must trust that the Exchange has the appropriate privacy and security policies and structures in place to protect from the disclosure of sensitive and private information. It is essential that HHS impose strong requirements on Exchanges regarding privacy and security and evaluate Exchanges' compliance to ensure overall consumer confidence in the Exchanges. We thus recommend that HHS require supporting documentation from Exchanges for 10.1, 10.2, and 10.3.

With specific regard to 10.3, we recommend that HHS specifically mention not only tax information but also immigration status. Protecting immigration status information that an Exchange may obtain through the Data Services Hub is essential to ensuring the confidence of immigrants and their families to apply for and receive care. Many individuals in mixed-status families may apply on behalf of eligible children or family members and the information Exchanges obtain from the Hub on immigration status must be kept confidential or these individuals likely will not apply for care for which they are eligible.

11.0 – Oversight and Monitoring

We appreciate the inclusion of 11.1 regarding oversight and monitoring. Since HHS recognizes that the provision of culturally and linguistically appropriate services and assistance to individuals with disabilities is critical for Exchanges, we suggest adding 11.1c to specifically require oversight and monitoring of the provision of these services. Without active oversight and monitoring, it is likely that disparities in access to care by underserved populations will continue despite eligibility for health insurance.

12.0 – Contracting, Outsourcing, and Agreements

As stated above, it is critical that all contractors of an Exchange comply with the same federal laws that Exchanges must follow. We suggest HHS specifically require that Exchanges include language in all contracts requiring contractors to comply with § 1557, Title VI, and § 504 among other relevant civil rights laws. We suggest HHS require Exchanges provide the relevant language included in their contracts as supporting documentation.

III. Conclusion

We greatly appreciate the opportunity to comment on the Guidance and Blueprint. Exchanges have significant potential to increase equity in our health care system by improving access and insurance coverage. However, unless conscious efforts are made to take advantage of these opportunities, individuals may not see the full benefits of Exchanges. We hope HHS will consider our suggestions regarding the Exchange Blueprint to ensure the Exchanges deliver on their promise to all populations. If you have any questions about these comments, please contact Mara Youdelman at youdelman@healthlaw.org.

Sincerely,



Emily Spitzer
Executive Director