

## Responses to OCIIO provisions regarding the Exchange in ACA

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Department of Health and Human Services

Re: Level Exchanges; Request for Comments Regarding Exchange-Related Provisions in Title I of the Patient Protection and Affordable Care Act  
File code OCIIO-9989-NC

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### B. Implementation Timeframes and Considerations

#### 2. What kinds of guidance or information would be helpful to States?

The details of eligibility requirements, definition of MAGI, and decisions on aligning eligibility administrative requirements between Medicaid and the exchange are essential. If states are to modify or build new systems that have to be ready for testing July 2013 (in order to be ready to go live January 2014), we need some of the policy requirements before the end of 2010 in order to develop business requirements, estimate costs, hire developers and vendors, etc. For instance, it appears that the exchange will use tax records (historic income information) to determine eligibility for subsidies where Medicaid uses pay stubs, or self declaration with verification (real-time income information). It would be best to use one or the other, and to also align these requirements with other social services programs that families apply for including SNAP.

The easiest way to verify relevant data is electronically, where state agencies agree to give one another access to various databases. Some of these data are federal, or at least governed by federal requirements that make it difficult for state entities to share information. HHS should work with their sister agencies to ensure that relevant data can be shared even when those data are housed or controlled by other departments such as Agriculture or the IRS.

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### C. State Exchange Operations

#### 3. What kinds of systems are states likely to need...

Many states are working with decade-old systems that if it were not for the current economic crisis, states would be looking to upgrades or modernization of the systems. We encourage HHS to consider the efficiencies of building one eligibility system for the newly eligible (Medicaid and exchange) where states could then build portals and access the rules engines, data bases, etc. With the national policy for Medicaid eligibility being standardized after 2014 (raising the floor for the entire country), and the administrative requirements being the same for the entire country, the need for 50 different systems and processes is lessened dramatically. States would still need to manage eligibility for other categories of clients, but over time perhaps those systems could be consolidated as well. It would not make sense for a state that has recently build/bought a new system to be forced to change, but for states with old systems, or states that are going to re-procure a

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system in the near future, having a system to “buy into” vs building from scratch makes sense.

Although the systems and IT issues are the most pressing and need planning to begin immediately, states welcome guidance on the criteria HHS will be using to certify benchmark benefits packages as soon as possible. As states begin stakeholder and consumer input processes, this is the area consumers are most concerned about. In stakeholder meetings in Colorado we repeatedly hear that choice of products is important, but the choice must be meaningful. In other words, consumers need to know and understand the value of what they will be buying, and understand clearly the amount, duration and scope of benefits they will receive with each product in order to make the right choice for their family and their healthcare needs. Too many choices are likely to confuse people; too few choices will not make purchasing through the exchange an attractive option. Knowing what HHS is thinking about a set of benchmark packages would make early conversations with consumers, and state policy development and rule-making more effective and consistent with the intent of the legislation.

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### D. Qualified Health Plans

2. What are some of the major considerations involved in certifying QHPs under the Exchanges, and how do those considerations differ in the context of individual and SHOP State Exchanges, subsidiary Exchanges, regional or interstate exchanges,...

A qualified plan is a qualified plan; the mechanism or governance structure that markets and sells the plan should not matter. However consumers are buying their plan or whatever the subsidies they received, they should be able to clearly understand what they are choosing and buying in terms of benefits and total out-of-pocket responsibilities.

The factors that should be used to develop certification criteria should be standard, national quality indicators already familiar to the insurance industry, health plans, and safety net providers. Use of information technology towards meaningful use should be factored in the criteria.

Plans should also use standard, agreed-upon criteria to ensure that consumers have a sufficient choice of providers and that all health professionals should be allowed full scope-of-practice based on their academic training, certification, and licensure. Plans should be recognized and rated based on the use of efficient and effective service delivery models that offer geographic and market-driven flexibility to states and other purchasers. In other words, plans can be risk-based capitated models, or they can work off of an accountable care/medical home structure with quality and cost measures that reward providers for reaching pre-determined outcomes. Plans should be required to include traditional safety net providers in their networks.

5. What factors are important in establishing minimum requirements for the actuarial value/level of coverage?

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There are a number of important aspects of benefit design that will affect the care delivered and the costs to the system. The federal government should consider a benefit design or give states the flexibility to incorporate evidence-based benefits, consumer incentives for value-based purchasing, and other benefit features that promote appropriate utilization and high quality care.

States should have input on the essential benefit package content, and how additional benefits will be addressed. Decisions will have fiscal implications, as states will be responsible for costs related to any additional mandated benefits beyond the essential package. It would be important for states to be able to weigh in on the process for adding state mandated benefits to the essential package.

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### G. Enrollment and Eligibility

3. How can eligibility and enrollment be effectively coordinated between Medicaid, CHIP, and Exchanges? How could eligibility systems be designed or adapted to accomplish this? What steps can be taken to ease consumer navigation between the programs and ease administrative burden? What are the key considerations related to States using Exchange or Medicaid/CHIP application information to determine eligibility for all three programs?

The Exchange should be structured to maximize continuity of coverage and seamlessness between public and private health coverage. Efforts should be made to maximize continuity of coverage for consumers to enable consumers to stay with their health plan of choice over time and ensure easy transitions for consumers moving between public coverage and subsidized private coverage sold through the Exchange. The Exchange should be designed to manage statistically predictable transitions of populations groups, especially consumers who may transition between public health insurance coverage through Medicaid and CHIP+ and subsidized private coverage available through the Exchange.

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### L. Risk Adjustment, Reinsurance, and Risk Corridors

3. What issues are States likely to consider in carrying out risk adjustment for health plans inside and outside of the Exchanges? What kinds of technical assistance might be useful to States and QHPs?

A successful Exchange should maximize participation and minimize adverse selection of risk into Exchange based products. The exchanges must be protected against adverse selection. If only sick or high-risk individuals enroll in the plans offered, coverage will become expensive for participants and unattractive to insurers. A number of provisions of the Affordable Care Act seek to level the playing field inside and outside of the exchange, but states can further enhance protections against adverse selection. Examples of this are having defined open-enrollment periods or the same required compensation for brokers inside and outside the exchange. Another potential for adverse selection that deserves mentions has to do with the producers. States and HHS must be aware that financial incentives can be created for producers that will results in adverse selection. It is

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important that whatever commissions or producer compensation that is developed be structured in a way to maintain the level playing field inside and outside the exchange as well as among carriers within the exchange.

Thanks for your consideration of these issues,

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Comment Tracking Number: 80b6427f