THE STATE OF UTAH'S COMMENTS ON PROPOSED FEDERAL RULES RELATING TO THE IMPLEMENTATION OF EXCHANGES UNDER THE AFFORDABLE CARE ACT

These comments apply to the following proposed rules:

- ***CMS-2011-0139-0002*** *Department of Health and Human Services, 42 CFR Parts 431, 433, 435, et al.: Medicaid Program; Eligibility Changes under the Affordable Care Act of 2010; August 17, 2011*
- ***HHS-OS-2011-0020-0001*** *Department of Health and Human Services, 45 CFR Parts 155 and 156: Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; July 15, 2011*
- ***HHS-OS-2011-0022-0001*** *Department of Health and Human Services, 45 CFR Part 153: Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors and Risk Adjustment; July 15, 2011*
- ***HHS-OS-2011-0024-0001*** *Department of Health and Human Services, 45 CFR Parts 155 and 157: Patient Protection and Affordable Care Act; Exchange Functions in the Individual Market: Eligibility Determinations; Exchange Standards for Employers; August 17, 2011*
- ***IRS-2011-0024-0001*** *Department of the Treasury, Internal Revenue Service, 25 CFR Part 1: Health Insurance Premium Tax Credit; August 17, 2011*

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Preface

- Our most important priority is to encourage changes that recognize state sovereignty, differences in markets and allow more flexibility
- The proposed rules appear to be a slow movement to a comprehensive social program
- HHS continues to modify their explanations of what they think the proposed rules mean, making it hard to comment on a moving target
- We do not propose to re-write the language of the rules; we will point out what we think the rules need to accomplish
- The process for developing final rules and further decisions needs to involve states as partners, not as subjects

We appreciate very much the opportunity to respond to five distinct, but related proposed rules that apply to provisions of the Affordable Care Act. From a high-level perspective, it seems that these rules on the whole tend toward a more top-down, bureaucratic approach to implementation instead of allowing flexibility, creativity and market-driven approaches.

We strongly encourage the federal agencies to revisit each rule to consider ways in which states can be allowed to explore options and features that work best for them, learning from each other.

The rules appear to represent a slow movement toward a model for a health care system in which virtually every citizen will participate in some form of a social program.

We respectfully express significant pushback on that concept. As a state founded in independence and compassion, we appreciate that some citizens may be in need of temporary or permanent assistance when it comes to their health care; however, we maintain that this is a small fraction of the population. The role of free enterprise in the provision of health care provides the tools needed to ensure the highest long term performance, accountability, and most reasonably priced solutions for risk-sharing and financing. At most, the government role for the vast majority of its citizens in this context is to facilitate increased market interactions and provide reasonable consumer protections, and not to assume roles traditionally reserved for buyers and sellers in the marketplace.

We strongly encourage the federal agencies to allow states the freedom to utilize private sector and market solutions instead of forcing them to implement an ever-expanding social program.

In formulating these comments, we faced two major difficulties which may limit their effectiveness. First, of necessity, these proposed rules cover wide swaths of topics related to health reform. With our limited staff and limited time, we have found it difficult to become experts in every area of the proposed rules to the point of being confident in our ability to make useful comments.

Second, it appears that even the federal agency staff has had a difficult time fully understanding the depth and impact of these rules. Almost from the moment the proposed rules were

published, we have been inundated with requests to participate in listening sessions, grantee conferences, user groups, and other conference calls where federal agency staff attempts to explain the impact and meaning of the proposed rules. On many occasions, those explanations have not been consistent from one session to the next, depending on the staff making the presentation. Furthermore, those sessions are continuing, with some scheduled well beyond the October 31, 2011 due date.

Given our limited resources, the massive amount of material to cover, the relatively short time frame, and the appearance of a moving target, we are sure that there are many important areas that we will miss.

We strongly encourage federal staff to find a way to continue to listen to state experts and make continued improvements to the rules above and beyond what we are able to express here.

With this in mind, the following comments are not intended to be a comprehensive microanalysis of every point and issue in the rules. In most cases, where we have not been able to analyze the impact of the particular choice of wording or set of issues, we have instead chosen to express our needs as a state.

We strongly encourage federal agency staff to re-visit the minutia and particulars of the rules and re-write them in a way that conforms to the expressed needs of the states, even if the states have not been able to identify the specific language that needs to be changed.

Of course, we have appreciated the opportunity to be involved in the development process and we continue to be committed to providing federal agencies with helpful comments from our perspective. We are critical of any federal process that excludes states from being at the table in working out issues. We hope that as federal agencies attempt to address state concerns raised through this and other processes, the on-going relationships will continue.

We strongly encourage the federal agencies to involve state subject matter experts and experienced policy makers to be part of the formal process moving forward. Please take into account that the states are the foundation of the federal government, not its subjects.

1. Federal Micro-Managing Beyond the Statute

We start our comments with a critical observation: The proposed rules go far beyond the statutory requirements and would extend federal control and imposition of rules on states. States need more flexibility, not federal "standardization."

We strongly encourage the federal agency staff to re-write the rules to remove any extra specificity that will limit state options under the statute.

In this section, we highlight several examples where the proposed rules would impose requirements on states beyond the statute.

- Creating Boards and Defining Conflicts of Interest
- Navigator Programs
- Enrollment Periods and Effective Dates
- Grace period for non-payment or partial payment
- Stakeholder Consultation
- Certification of QHPs
- Required Secretary Approval of the Application Process
- Forcing States to Rely More on Self-attestation
- Risk Adjustment & Reinsurance

Creating Boards and Defining Conflicts of Interest – The proposed rules pretend to supplant states' centuries of wisdom in self-governance and sovereignty with the supposed experience of federal bureaucrats. When it comes to governance, please remember that from the beginning of their existence (which for some pre-dates the federal government), states have had to formalize governance issues. Every state has specific rules or statutes that guide how programs are established, overseen, and operated. States do not need federal guidance on dealing with conflicts of interest and the structure and nature of governing boards when it comes to exchanges and related entities.

We strongly encourage the removal of any restrictions or specific requirements on states as they contemplate the best way to set up and govern their exchanges.

Navigator Programs – Similarly, the proposed rules suggest artificial and unwarranted restrictions on states' ability to come up with navigator programs to meet local needs. Every state has different needs and resources to meet those needs.

According to the statute, the navigator programs are not federal programs, but state programs and as such, states must be accorded the ability to create those programs within the full latitude afforded by the statute. Considering the vast differences between states' geography, urban or rural composition, special needs, and linguistically diverse populations that already address quite effectively in various programs, decisions about what will work best and be most effective are best made at the state level, not to mention the important fact that states will be required to come up with a mechanism for financing the program.

We strongly encourage the removal of language in the proposed rules that specify

requirements on state navigator programs beyond those required in the statute.

Enrollment Periods and Effective Dates – The proposed rules over-step the natural division between state and federal regulation in the establishment of specific enrollment periods, effective dates, and other requirements on state insurance markets.

For several decades now, the regulation of private insurance products and markets has been the purview of state government. The proposed rules appear to be a backdoor attempt by the federal agencies to take control of state insurance markets under the guise of implementing a federal program.

In comments below (see Section 5) we discuss in more detail the apparent difference in vision about the nature of the proposed program. In every instance where a private individual is enrolling in a private insurance policy, regardless of any possible subsidy source, states need to have the ability to protect the vibrancy of their insurance market through decisions related to acceptable practices. We claim that the right level to make decisions about limitations on enrollment periods is at home, by the state, not the federal government.

We strongly encourage the removal of any restrictions or requirements on states to establish or not establish parameters for the effective and successful operation of private insurance companies that are the purview of state government.

Grace period for non-payment or partial payment – A specific example of insurance market regulation that is very problematic for our market, and likely that of many other states, is the language in the proposed rules related to grace periods for non-payment or partial payment. This is an area that is currently well-regulated by state practice. The language in the proposed rules presents a significant risk of harm to our insurance carriers and is an inappropriate and dangerous attempt to regulate insurance markets in a way that is not consistent with current law or practice.

Any language establishing federal requirements on states to implement grace periods for non-payment or partial payment must be removed.

Stakeholder Consultation – We are particularly disappointed to see proposed language that attempts to socially engineer our development process. As a state that has a long history of working on health system reform, we reject the notion that federal guidance is needed to help us better interact with our stakeholders.

Any language requiring states to engage in a specific process or manner for engaging stakeholders is inappropriate and should be removed.

Certification of QHPs – In our view (see Section 5 below), Qualified Health Plans or QHPs are specific types of products to be offered by private insurance companies whether inside or outside exchanges, and as such should be regulated, approved for sale, or certified by the appropriate state regulatory agency, in our case the Department of Insurance.

It is not acceptable for the proposed rules to impose, require or suggest any other possible process for certifying QHPs. Each state should be left to determine for themselves the proper manner and process for their certification. It is

also inappropriate to think that any multi-state plan could offer a QHP that is not subject to the same oversight and certification process as other QHPs to be offered in a state.

Any requirement that removes state autonomy for deciding the criteria and manner for approving QHPs must be removed.

Forcing States to Rely More on Self-attestation – In the proposed rules regarding Medicaid eligibility determination, states would be forced to rely more on self-attestation. In the past, HHS has allowed states that wish to do so to use self-attestation as a means of providing needed benefits where the likelihood of fraud or deception is minimal.

These proposed rules represent a paradigm shift from allowing states some flexibility to the paradoxical outcome of having flexibility forced upon them. For states that have found self-attestation to be in their interest in meeting policy objectives, this change will appear to have little impact, however, for states where self-attestation is problematic, this policy change can have significant impacts both on state policy goals and budgets.

The statute clearly does not require states to rely more on self-attestation, so we are quite perplexed by the decision to include this feature in the proposed rules.

The statutory requirements on income verification could be very burdensome. In fact, we agree that the requirements on income verification in the statute were not well thought out and should certainly be revised, as we will discuss later in our comments. However, in this case, it appears that when the staff was faced with a difficult technological and programmatic issue, instead of confronting the issue of income verification head on and accepting the limitations of the statute, they chose to pass the burden of this issue on to states by requiring *less* verification than the statute actually contemplates. We find this imposition to be inappropriate.

States must be allowed to determine processes for verification that meet local policy and operational objectives. A forced increase in reliance in self-attestation must be removed.

Risk Adjustment & Reinsurance – The proposed rules indicate that HHS will develop the methodology and parameters for risk adjustment and reinsurance. States can vary some parameters provided that they provide a timely notice to the issuers. States can propose alternative approaches that could be used only if certified by HHS.

We note that Section 1343(b) of the ACA requires HHS to establish criteria and methods for risk adjustment in cooperation with the States. "Criteria and methods" should not mean "a prescribed method". Having a "baseline" might mean that all other approaches will be evaluated by comparing the outcomes to the "baseline" rather than asking whether the approach meets broad criteria.

Given the complexities and peculiarities of each state's market and local circumstances, we are requesting as much flexibility as possible with respect to the reinsurance and risk adjustment piece of the equation.

Instead of wasting federal resources trying to figure out a method that will work everywhere, the federal agencies should put forth broad general criteria and stay out

of minutia and details and allow the states to experiment with different approaches.

2. Subjecting States to Unnecessary Federal Oversight

There seems to be a false notion that the system would be improved by increasing requirements on the states. It appears that this comes from applying the Medicaid mentality and approach to federal-state partnership to the exchange program.

In reality, the exchange program structure is very different from the Medicaid program and states need much more flexibility to meet their local needs. A state-based exchange is actually not a federal program according to the statute and it is puzzling why HHS in particular has felt the need to claim oversight for a program that once it is operational will not involve them.

The proposed rules contain multiple examples of subjecting states to unnecessary federal oversight. While we will highlight a few of the more egregious examples, we hope that the federal agencies will review the proposed rules to limit federal oversight to the minimum required in law.

- State Plan Amendment Process
- Proposed Federal Oversight of State Exchanges
- Essential Health Benefits
- Required Secretary Approval of the Application Process

State Plan Amendment Process – Many states have already pointed out in various settings that applying the State Plan Amendment (SPA) process used in Medicaid to the exchanges in unacceptable. As soon as this criticism became widely known, we started hearing from federal staff that this was an unfortunate application of a label to a process that was intended to be very different.

In reality, we do not understand why there should be a federal approval process at all. A purely state-based exchange would not be a state-federal partnership in the same way as Medicaid. While we understand the interest of HHS in ensuring that federal grant funds are used according to the requirements for which they are given, once the exchanges are operational, there will be no more federal financial interest.

We believe that any state-based exchange program should only be answerable to the statutory requirements and not to extraneous oversight by a federal agency. The process for certification of a state-based exchange should be simplified and streamlined to answer a single question – is the program in compliance with the statute? This certainly would not need to be an on-going and burdensome process like the Medicaid SPA process nor the process mentioned in the proposed rules.

The process for certifying a state-based exchange must be simplified in recognition of the fact that it is a state-owned and operated program. Any attempt to use the Medicaid SPA model will create unnecessary federal oversight and should be abandoned.

Proposed Federal Oversight of State Exchanges – Similarly, we do not accept the fact that there should be federal oversight and micro-management of state-based exchanges. In the statute, the opportunity for states to create and operate their own exchanges was intended to give states a non-federal option. If the state exchange is subject to federal rule-making and

other oversight, how can it be legitimately thought of as a state program?

There are many state programs across the country that must comply with federal laws. Many of those programs operate successfully without being subject to direct federal oversight.

While we understand the interest of the administration and the agencies in this particular effort, since it is a part of signature legislation, we also claim the opportunity and privilege for states to operate exchanges, if they so choose, according to the requirements of the statute without having unnecessary federal oversight imposed upon them.

The proposed rules must be modified to remove unnecessary federal oversight of state-based exchanges.

Essential Health Benefits – Each state has a unique marketplace, with a long tradition of regulatory decisions and rules. Every state has chosen to require private insurance companies to cover certain services and conditions in order to be approved as a health insurance product.

Utah, being a very healthy state, has chosen to have a fairly limited set of requirements on insurance carriers. As a result, Utah consistently ranks near the top when it comes to the affordability of our health insurance products.

As a matter of policy choice, the state legislature has opted to err on the side of affordability instead of implementing a broad set of required coverage. This has served our state very well, in part due to the fact that it is a policy solution that can be tailored and respond to local circumstances and needs.

We express major concern that the federal agencies will ignore this benefit to states as they develop the requirements for an Essential Health Benefit (EHB). Virtually every state stands to lose if there is a national standard for the EHB.

States that have chosen a high level of required benefits will lose because they will be forced to pay for any benefits that exceed the requirements of the EHB. States with a low level of required benefits will lose when they suffer sudden and significant cost increases to provide additional benefits.

While we can appreciate that some minimum definition of what a health benefit is, our recent observation of the "kitchen sink" mentality as it was applied to the definition of primary and preventive services, gives us great reason to fear what might be imposed upon us in regards to the EHB. Please also review a proposed action item from NCSL, included as Appendix A.

If for no other reason than this, we strongly urge the federal agencies to create a state-based (or market-based) version of an EHB that allows every state definition of "essential" to reflect the culture, values, health, market and sovereignty of that state.

Required Secretary Approval of the Application Process – In a recent conference call, it was explained by federal agency staff that the proposed rules would require every state to seek approval of the Secretary of HHS for their exchange application process. This is not required by statute and should not be allowed to happen to states. While we appreciate the desire for a perfect solution that every state could simply adopt, this quixotic dream is

simply not a feasible reality for those of us in the trenches.

To see why this is problematic, one has to look no further than the variety of state Medicaid eligibility requirements and systems. Currently, one would be hard pressed to find two states that use the same technology platform and have the same policy requirements for eligibility determination.

This suggests that every state will need slightly different information or information in a slightly different format. Reality suggests that given the option of using a standardized federal application or a customized application to meet state and local needs, the vast majority of states would opt for the later.

In this context, it begs the question as to why the Secretary needs to be involved in approving the application process. On the call in question, we were informed that the reason for this is to ensure compliance with "the program." However, as we have mentioned several times already, a state-based exchange is not and should not be a federal program, thus there is no program to be in compliance with, only a statute.

States that choose to operate a state-based exchange should have the flexibility and freedom to develop an application process that works best with their technology platforms and state eligibility rules.

3. State vs. Federal Operations

One of the on-going promises between the federal agencies and the states has been the notion of a state-based exchange that could rely on the federal agencies for modules to supply information or provide functionality that the states could not implement for practical or political considerations. As an example, we quote the commentary on Part 155, Subpart D:

> "One option that we considered was whether to establish a system in which the Secretary of HHS would determine eligibility for advanced payments of the premium tax credit, with other eligibility and enrollment functions remaining as the responsibility of the Exchange, since premium tax credits are fully Federally funded and the rules are the same across all states."

This almost to a tee describes conversations between our senior elected officials and Steve Larsen, Cindy Mann, and Joel Ario as late as August, 2011. Imagine our surprise to read the language in the proposed rules immediately following this paragraph:

> "However, we chose not to take this approach, because isolating one component of the eligibility determination process from the remaining eligibility and enrollment functions would pose significant challenges to ensuring a seamless experience for applicants… We solicit comments on this approach and alternatives."

We are profoundly disappointed that the early promise of cooperation and partnership was declared null and void in single sentence in the proposed rules. This statement and the subsequent presentations on this change in policy has set states farther back in terms of the decision to implement a state-based exchange than anything else in the proposed rules.

Further comment on this specific issue is found below, however, for emphasis on this specific issue, we are literally shocked at the failure of those writing the proposed rules to recognize the capability of technology to ensure a seamless experience for applicants regardless of the entity providing the back-side support.

As a practical matter, there are several functional areas where it makes much more sense to handle them at the federal level, especially anything having to do with the IRS or Treasury. This is true from various aspects, including the political realities we all face, the economic reality of paying for 54 variations of a system, and the unsatisfactory outcome for our citizens.

We encourage HHS to re-open the possibility of providing federal technology modules that can be re-purposed by states to meet required functions.

We also encourage you to review carefully the language of an Action Item from NCSL on this issue, included as Appendix B.

Here are several specific areas where it makes eminent sense to us for the federal agencies to do so:

- Advanced Payment of the Premium Tax Credit
- Administering and Enforcing the Individual Mandate

- SHOP-only and Individual-only options

Advanced Payment of the Premium Tax Credit (APPTC) – One of the most broad-based sweeping changes in the statute was the creation of a premium tax credit program that will bring millions of people into a new entitlement program based on income, not on need or ability to pay.

While we will not debate the social merits, costs, or benefits of the program as a whole here, we do have significant concerns about the proposed implementation of two aspects of that program and the potential impact on state-based exchanges – the calculation of the premium level and the process for implementing the advanced payments. We will limit our remarks to general comments in this section. Specific comments about the APPTC program are found in Section 8 below.

One of the major concerns that have been expressed by many states, including ours, is the difficulty in accurately estimating the amount of the credit for any given household. There is a similarity to other federal tax calculations (such as the Earned Income Tax Credit 'EITC' or W-4 based withholding), namely that the total amount of the credit is based on annual income; however, the unit of application (the insurance premium in this case) occurs monthly. It is surprising that the IRS has not chosen to pursue the same methods for implementing the APPTC program that they use for the EITC and W-4 programs.

Under the proposed rules, the IRS has created a Rube Goldberg system for evaluating, calculating, adjusting, and paying the APPTC that requires a long list of "what-ifs" and case examples. If this level of explanation is required for the proposed rules, imagine the complexity and amount of effort required to deal with the myriad of special cases and problems that will arise when the system goes live and millions of taxpayers attempt to get a correct estimate.

The most important comment we could make is to de-link the calculation of the APPTC from the Exchange process entirely. We strongly encourage the IRS to reconsider its basic approach and employ a system that mirrors the EITC or W-4 process.

Administering and Enforcing the Individual Mandate – Currently 26 states have been exempted by the federal judiciary from the individual mandate components of the ACA. While we recognize that the Supreme Court will likely take up the case and issue a decision at some point, experience shows that the Supreme Court acts on their own timeline, not ours. With this as a background, we wish to address provisions in the proposed rules that require states to cooperate with the federal government on the administration of the individual mandate program.

We do not feel that it is proper for the federal government to require states to administer this program. This program is federally designed and imposed, is the same across all states and territories and eventually is enforced on an annual basis through the IRS' tax filing system. We fail to see why it makes sense for 54 states and territories to come up with individualized approaches and systems to implement this program.

We strongly encourage the federal agencies to accept ownership for the federal individual mandate program, and remove all requirements for state-based exchanges to

administer this program on behalf of the federal government.

Specifically, states should not be required to:

1. Make determinations about who is exempt and who is not, or

2. Attempt to maintain a system to detect or report those who are in compliance and those who are not.

SHOP-only and Individual-only options – Currently, Utah is one of two states with an operational technology platform that fills some of the required functions of an exchange. Utah's technology has focused primarily on the implementation of a defined contribution program for small businesses, which is one of the features of a SHOP exchange under the proposed rules. Our current state statute (passed before the ACA) also envisions the development of a web-based portal to help individuals identify and enroll in appropriate coverage.

It might appear to the casual observer that Utah is well on its way to implementing state-based versions of both the SHOP and the individual (AHBE) exchanges envisioned in the ACA. However, it's not quite that simple. The proposed rules contain provisions for the AHBE that go beyond what the Utah statute originally conceived. When our statute was passed, there was no federal individual mandate, APPTC program, QHPs or federal oversight. As we continue to learn more about the requirements for a state-based AHBE to become certified, it is not at all obvious to us that Utah will want to comply with all of those requirements, especially if there is no option for the federal agencies to provide services that are not deemed appropriate by a state.

In addition, there is a significant amount of uncertainty in the federal government coming down the pike. A potential Supreme Court ruling on the individual mandate and severability, the 2012 presidential and congressional elections, and a possible change in cabinet-level positions in Washington could all affect the rules of the game. Should Utah be required to give up all of our progress in developing a solution for small businesses if we are not able to politically or practically implement an AHBE?

Now, consider the case of Massachusetts where their Connector has been very successful in enrolling individuals in subsidized insurance and government programs, but has struggled to provide a meaningful solution for small businesses. States like that may not be so excited about implementing a state-based SHOP exchange.

We strongly urge the federal agencies to allow state to build as much as they can, including just building a state-based SHOP or AHBE exchange if that is all they are able to do.

4. Vision of the SHOP Exchange

States need to be provided with a clear vision that the SHOP Exchange is intended to facilitate the sale of private insurance products to employers. The value of this program is not in the ability of the state to add new regulations, but in the ability to facilitate new types of transactions that increase consumer choice and accountability. States should be able to limit the role of the exchange to those tasks that would not or could not be provided by the private entities in the system.

- Roles of the Exchange (Government) vs. the Employers/Producers
- Employer Requirements

Roles of the Exchange (Government) vs. the Employers/Producers – Several proposed rules take responsibilities away from employers or private entities and give them to the Exchange, or require the Exchange to duplicate efforts. For example, the proposed rules would require the exchange to notify employees about open enrollment periods. There is black letter law that requires this of the employers.

We are sure that this was a combination of an unclear vision of what a SHOP exchange is or does along with a naïve understanding of the burden of federal law on employers and their representatives. This is exacerbated by the apparent view of some staff of the SHOP exchange being a public program instead of a market facilitator.

In reality, even if the rules require the Exchange to perform those functions the employers would not necessarily be exempt from performing them. This type of duplicity in the requirements is inefficient and would lead to confusion about liability claims when the functions are not performed. At the very least, it would create a legal dependency on the Exchange by employers that would not be appropriate.

The proposed rules must be modified to not require the exchange to perform any function that is the legal responsibility of an employer, broker/producer, or insurance carrier.

Employer Requirements – One particular proposed rule would require Exchanges to allow employers to limit the range of choice for their employees.

This rule makes absolutely no sense to us. In a true defined contribution setting, the employer gains no advantage from limiting choice since the employer's cost is independent of the employee's choice, but limiting the choice could hurt the employee whose preferred option is not available.

In our current defined contribution system, to date not a single employer has requested to limit the employee's choice. In fact, the concept of limiting choice runs counter to the major purpose of having a defined contribution market in the first place.

Any requirement on exchanges to allow employers in a defined contribution market to limit employee choice should be removed.

5. Vision of Qualified Health Plans (QHP)

There are two competing visions of the QHP program. It appears from the rules that HHS has in mind that the QHPs would function like Medicaid Managed Care programs. Under this model, the states would create relationships with the insurance carriers and own that relationship.

States need the ability to consider a very different model for running a QHP program that looks much more like a private market solution. Instead of thinking of the QHPs as a protected entitlement benefit, states may wish to think of them as regulated private insurance products that are available for purchase by individuals in multiple market settings.

- Government Program vs. Facilitated Private Market
- State Certification of Qualified Health Plans
- Dealing with the Volume in the System

Government Program vs. Facilitated Private Market – The proposed rules on QHPs seem to be too heavily weighted toward states that view them as a public program or entitlement versus those of us who envision a more market based approach.

In our interactions with HHS staff since the proposed rules were released, especially those with a Medicaid background, we have been disappointed at the tone that reflects a desirable state role for a variety of things, such as setting narrow benefits guidelines, negotiating prices or setting rates, and selecting winning bidders.

The market view of the QHPs can be summarized as follows. The state will grant access to insurance markets for carriers & plans that meet certain criteria. Once a plan is certified as a QHP, it can be offered freely to individuals with APPTC, employees participating in defined contribution arrangements, and perhaps other settings.

Under this view, the purpose of certification is similar to normal insurance department reviews to ensure compliance with state and federal law. There is nothing particularly "magic" about the QHPs and their ability to provide a useful benefit to enrollees other than the normal market oversight.

The role of the state-based exchange is to bring the buyers and the sellers to a common marketplace where private transactions can happen. By creating a vibrant marketplace with truly informed choice, competition will drive innovation and response to consumer needs.

The rules need to pay much more attention to the needs of states that view the QHPs as a market-based system.

State Certification of Qualified Health Plans – Under the proposed rules, there is some ambiguity about who must or can be allowed to certify a QHP.

In our view, states should be allowed to decide who the certifying entity is and must have the option to designate the Department of Insurance as the sole certifying entity.

Dealing with the Volume in the System – One area that has been overlooked in the proposed rules is the impact that having a QHP program will have on a state's system. In particular, we are very concerned about the woodwork effect,

the crowd-out effect, and other similar volume increases on the state's Medicaid eligibility system.

The proposed rules perpetuate the idea that anyone coming to the exchange must be informed of all of their options. This suggests that the system would have to conduct a Medicaid eligibility determination, at least at the MAGI level, for every person using the system.

Back-of-the-envelope calculations suggest that this requirement alone could easily quadruple the number of eligibility determination cases handled by our system. This seems to be an unnecessary burden to place on a system.

We ask for flexibility to create a system that conducts Medicaid eligibility on a request basis. We also ask for consideration and support in looking for alternatives to dealing with this massive increase in volume in creative and practical ways.

6. Vision of Seamless Interface

In discussions with HHS staff, there appears to be some concern that if the exchange system is not fully integrated, it cannot provide the best possible experience for the consumer. In reality, this ignores critical understanding of technology networks and systems.

States need to have the flexibility to explore cloud-like options where various functions required of the exchange can be performed on independent systems. This principle applies to all aspects of the exchange, including eligibility, enrollment, finances, and customer support.

One of the downsides of the proposed rules is that it appears that many of them were developed by staff that came from a Medicaid background. The end result is a set of rules that perpetuate a rigid, linear way of approaching problems.

The following examples show how the proposed rules could benefit from some out-of-the-box thinking about technology.

- Networked systems vs. Integrated systems
- Single Application & Verification
- Call Centers & Networked Customer Support
- Web-site requirements, functionality & access

Networked systems vs. Integrated systems – One of our major concerns with the proposed rules as explained by federal agency staff is that there is an outdated view that somehow the program would work better if everything could be operated on a single, integrated computer system.

In reality, that flies in the face of the last decade or so of technological innovation. More and more, computer systems are becoming modular and the focus in on providing networking interfaces instead of operating in silos. HHS IT people have mentioned the vision of a cloud-based system that seems to have been discounted in the formation of the proposed rules.

The very idea of cloud-based computing shows the new way of approaching the problem. Building a singular massive platform would require it to have an internally consistent set of rules capable of surviving changes to any particular component. A networked or interfaced approach permits a much more flexible and cost-effective design.

From our experience, a lot of the processes needed to integrate an exchange already exist in the private market, or possibly in government. Resources are far better spent figuring out how to facilitate a cross-system interface than develop base systems from scratch.

Another advantage of a networked, or cloud, approach is that states will find it much easier to share modules because the rules on any particular module will be internally consistent, but the system will be able to accept input from a variety of other networkable solutions.

The apparent concern about the applicant experience discussed in Section 3 is clearly misplaced. In reality, we anticipate that applicants will face a much better experience

on a networked modular system than on a leviathan integrated system.

The proposed rules should not limit state flexibility based on the assumption that an integrated system is the only acceptable approach. States should be allowed to pursue a networked or modular approach.

Single Application & Verification – In a recent presentation on the application and verification process conceived of by the proposed rules, the staff consistently referred to a "single application." This is clearly indicative of someone from a traditional Medicaid background where the frame of reference is a paper form.

While states may be required to accept applications in paper format, this should clearly be thought of as antithetical to the entire concept of the exchange. The system will be designed to have no wrong door, but certainly the paper application door will not be the one with the bright neon sign hanging over it.

The main value of the exchange is the ability to harness the power of networked technology solutions to improve the consumer experience. This will be most effectively done on a computer-based platform.

Therefore, the computer-based platform should become the new frame of reference. Instead of worrying about how to adapt the computer to handle the paper form, we should be focused on developing the very best computer-based application **process** (not form) possible.

This lack of vision by agency staff highlights our concern that too many people are approaching the exchange program as an extension of the Medicaid program.

The proposed rules need to consider that the exchange's primary modality for interacting with applicants will be a computer-based system. To the extent that there will be functionality to interface with applicants in other modes, those should be thought of as the exceptions to the preferred modality and dealt with accordingly.

Call Centers & Networked Customer Support – We experienced a similar concern in discussing with agency staff possible plans for meeting requirements on customer support.

Although the breadth of functionality in the exchange will far exceed the current Medicaid program, staff indicated that they thought the rules might require that any applicant be able to get a question answered by the first person to answer a toll-free hotline, regardless of the nature of the question.

Immediately, this shows that the agency staff is approaching this from a Medicaid perspective. This approach will neither be helpful nor workable under the exchange model.

With a networked system providing various functions ranging across state and federal assistance programs to facilitating private market transactions, it is simply not practical nor advisable to try to train a bank of public employees to be able to answer any potential question.

Our current call system begins with a triage function to help guide the person to the right subject matter expert depending on the caller's role and need. We also provide a triage expert in case the caller needs help defining the nature of their question. The beauty of the system is that it is networked, not integrated.

By leveraging the expertise of many individuals through a triage process, we are able to quickly get callers to true experts to answer their question. We accept that they may have to talk to different people to get different questions answered, but this results in a better customer experience because they can get reliable and accurate information.

One particular note about the customer support function that might highlight this issue is the difference between a Medicaid eligibility worker and a private sector broker.

Private sector brokers have a passing familiarity with state medical programs, however, they would not be empowered to give a definitive answer about whether the person qualifies for Medicaid.

Similarly, a Medicaid eligibility worker is not empowered to advise a client that might be trying to decide which private insurance plan to choose. Both of these roles require extensive training and certification or licensure. Requiring all brokers and all eligibility workers to cross-train and certify flies in the face of efficiency.

States should have the flexibility to design call centers and customer support in a networked fashion instead of requiring an integrated approach.

Web-site requirements, functionality & access – The proposed rules contain too many specifics about what the structure of how the web-site must be architected. Given the current private sector investment boom in developing public and private sector exchange technologies, the federal agencies should not try to pre-determine the outcome by placing requirements that are derived from past models.

Instead of prescribing technologies, the federal agencies should focus on minimum requirements for functionality and allow states and the contracted partners to develop creative solutions in the way they see fit.

States need the freedom to develop web-sites, platforms and architectures in a way that accomplishes state objectives within the broad guidelines of the statute and the required interface with the federal systems.

7. Lack of Clarity

We need to resolve the uncertainty. Perhaps just as important as what the proposed rules say is what they don't say.

While we appreciate that there is some uncertainty generated by the political and judicial timetables, there are many things that could be resolved at least for the time being.

Each state is faced with a tripartite decision – Should we implement an exchange according to what works best for our state and hope to be certified by working with HHS to deal with the pieces the state cannot develop? Should we accept the federal rules, but preserve some autonomy by implementing a state-based version with a promise that we will meet all federal guidelines? Or should we simply throw in the towel and accept the fully federal exchange?

In order to make that most basic decision, most states do not have the information they need, and we are now less than fifteen months from the certification deadline. How are state policymakers expected to make such a momentous decision without full information?

In order to make a rational and careful decision, states need to know what the federal exchange will look like and what their responsibilities and costs would be under various scenarios. Here is a summary of some of the major areas where the lack of clarity is getting in the way of state progress.

- Federal Exchange & State Expectations in that Model
- Timelines
- Essential Health Benefits
- Cost-Sharing Reductions
- Addressing Churning
- Federal Data Hub
- Final rules
- Questions that will be Required on the Single Applications
- Expectations of State Reporting

Federal Exchange & State Expectations in that Model – States need to know now what the federal exchange will look like, what approach it will take to facilitating markets or implementing entitlement programs, and pretty much every other detail that a state would have to consider in developing a state-based exchange.

In particular, one major question that has not been answered adequately is whether the federal exchanges can or will meet the same timelines that everyone else is looking at.

In addition to understand what the federal exchange would look like and do, it seems obvious that no state can really wash their hands completely of the exchange. The federal exchange will still need to interface with the state Medicaid system to refer cases, get eligibility information, and possibly other things.

We would also assume that the federal exchange must be self-sufficient like state-based exchanges. What fees will they change and to whom? Will states still have a financial obligation to the federal exchange?

A full description of the federal exchange, including critical policy decisions is needed immediately.

Timelines – One would think that the federal agencies are bound by the same timelines as the states, but that it clearly not the case.

States need more clarity about timelines and when they can expect various federal pieces to be functional.

Essential Health Benefits – Of course, one of the big policy issues is what the EHB requirements will be. We are not encouraged that this will be done any time soon based on the IOM report. States and insurance companies need to know what to expect from the EHB to figure out what's going to happen to prices and to understand if there will be any insurers left in the market.

The sooner the federal agencies can provide us with their final decision on EHB the better.

Cost-Sharing Reductions – While we have heard a lot of talk about the APPTC, we have heard very little about the cost-sharing reductions associated with them and how insurers will be expected to handle that.

More clear guidance on cost-sharing reductions is needed.

Addressing Churning – Churning seems to be a problem with no answers from the federal agencies. The rules certainly look like a dog chasing its tail on this issue.

Let us provide you with a concrete answer that could solve the problem. In 2008 we submitted a waiver request to allow us to use Medicaid funding to subsidize the purchase of private, individual insurance policies as an alternative to churning. The client would voluntarily take the Medicaid funding and use that money to buy an individual or family policy of their choice. As their income fluctuates, the policy stays the same, although their share of premiums might vary.

To this day, we are confused as to why this proposal would be denied. It is voluntary and it represents a real solution to the churning problem that is, at its core, the very same rationale as for the PTC subsidy program in the ACA.

With the massive influx of adults onto Medicaid that is about to happen, something like this is desperately needed in order to maintain access and diminish the adverse effects of churning.

We strongly encourage the federal agencies to immediately grant all states waiver authority to allow Medicaid clients to choose to take a subsidy for private individual insurance instead of staying on Medicaid.

Federal Data Hub – Nothing sounds so promising with so few details as the federal data hub.

States need to know what the federal data hub can and cannot do, what the format of the data interface will be, and be given some expectation of a timeline to be able to connect to it for testing.

Final rules – While we may have complained about the crunch in addressing the proposed rules, at least we have them. However, there are a lot of areas that are not addressed, which does not bode well for states. In some cases, we don't like what we see, but in every case not knowing is worse.

States need to get comprehensive and complete final rules as soon as physically possible.

Questions that will be Required on the Single Applications – As the "single application" is being developed, it sounds like states will be required to collect a particular minimal set of information.

The sooner we can get a comprehensive list of what the federal agencies think we have to collect on a single application, the better.

Expectations of State Reporting – Some of the proposed rules indicate a requirement for states to report.

States need to be given clarity on each required report, including timing, format, and content.

8. Issues with Administering the Premium Tax Credit (PTC)

There are several complications relating to the premium tax credit that have not been thoroughly thought through and represent significant issues in the current language of the proposed rules.

- A Proposed Workable Alternative
- A Federal Solution that Interfaces with a State-based Exchange
- Medicaid Eligibility Discrepancies
- Determining Affordable Coverage
- Safe harbors for employees & employers
- Operationalizing Cost-Sharing Reductions
- Flow of Funds for Individual Policies

A Proposed Workable Alternative – While we will not flesh out a detailed program for the IRS in this document, here is a brief description of how this program could be significantly simplified, reducing cost and improving the consumer experience.

Any consumer that wishes to claim an APPTC would use a simple calculator on the IRS web-site (or something similar that might be developed by the private sector, such as Intuit). This calculator would allow self-attestation (which seems to be popular with the feds) of household structure and income, just like the IRS calculator for W-4 withholding found here: http://www.irs.gov/individuals/article/0,,id=96196,00.html

Individuals would then submit a signed form, similar to the W-4 to their insurer which allows the insurer to claim the APPTC payment from the IRS.

In reality, the IRS won't need to issue checks to most insurers, because they can simply apply this amount as a credit to payments they owe to the IRS. Just like the W-4, individuals would be responsible to re-calculate the APPTC as their circumstances change, such as a pay increase, a job loss, or change to household structure.

Individuals using this process to claim a credit would be required to file a federal tax return by April 15, providing the IRS and the individual an opportunity to reconcile the total amount of APPTC claimed with the actual amount owed based on final annual incomes. Individuals that have over-claimed will have to pay it back, while those who have under-claimed can receive a payment or credit towards taxes owed. Individuals would also be provided in January of each year with a 1099-like certificate from the insurer to document the amount of time that they were enrolled in a QHP.

This is not a complete description of the required processes, but highlights the fact that it is a misguided effort to try to push the APPTC approach for payment determination and processing into a system where it really doesn't belong.

A Federal Solution that Interfaces with a State-based Exchange – It is safe to assume that despite our preceding suggestion being a much better way to handle the APPTC, it will probably not see the light of day. Therefore, the following comments are based on the practical assumption that the IRS and HHS will indeed

proceed with their misguided attempt to force a square peg into a round hole and require state-based exchanges to incorporate some functionality to calculate and administer the APPTC.

Our first, and most important, comment reflects our statements in the introduction to Section 3. It is a better solution both in terms of cost and consumer experience for the IRS to provide a single module for the determination of the APPTC that can be incorporated into state-based exchanges. Here is a vision of how this could happen.

An individual would come to the state-based exchange seeking coverage. At some point in the process, the individual would request a determination of the APPTC amount. At that point, the exchange technology would evaluate whether it has collected sufficient information from the individual for the IRS to make an APPTC determination.

If the exchange does not have the needed information, the individual is prompted to provide it at that point. Note that under the proposed rules, the exchange would need to have a determination that the individual is not eligible for Medicaid, at least under the MAGI rules, so that would have to be determined too.

With all of the needed information in hand, and a certification that the individual is not Medicaid eligible, the individual's information would be transferred through the Federal Data Hub to the IRS APPTC calculator.

The individual would be shown a screen with the IRS logo where the final APPTC amount could be calculated. The individual would also be given contact information at the IRS on how to appeal that determination and any other information that the IRS sees fit to provide in connection with the determination, such as the requirement to file a 1040, etc.

If the individual accepts the APPTC determination, the IRS feeds that information back to the state-based exchange through the Federal Data Hub and the APPTC amount (if any) becomes part of the individual's information set that can now be used to apply for and enroll in a QHP.

The shopping tool would be programmed to correctly show net prices and upon enrollment would feed the IRS certified APPTC amount to the chosen QHP issuer.

The key points here are:

1. Despite the belief of the staff that wrote the proposed rules, having the IRS calculate the APPTC would not "pose significant challenges to ensuring a seamless experience for applicants." We call on the federal agencies to recant their position and return to the partnership discussion with states on this issue.

2. The IRS must accept the responsibility for the determination of the APPTC amount, educate individuals about the need to re-calculate the APPTC when changes occur, and accept the heat that will come when individuals end up having to pay back significant amounts of money because they over-claimed the APPTC. It should be clear why states are not eager to assume any of these roles.

Medicaid Eligibility Discrepancies - One concern that has been raised in our discussions with federal agency staff is how to deal with discrepancies between the IRS determination of

Medicaid eligibility and the state's determination.

Our answer is quite simple – the IRS doesn't need to check Medicaid eligibility. Once the state has made that determination, the IRS can rely on that information. If the federal agencies have concerns about the states' ability to correctly determine eligibility, then the problem lies much deeper than this particular issue.

There is no need for a federal "re-check" of Medicaid eligibility in any system. The solution is for the federal agencies to pre-certify the rules or processes of the state system.

Determining Affordable Coverage – Another concern has to do with the determination of the availability of affordable coverage. We do not have a good solution to this problem, but would note that it is a major impediment to providing any sort of real-time determination.

Currently, our CHIP program has this requirement, and the best approach we have been able to come up with is to require some form of attestation by the employer about the availability of coverage to the child in question. This is not ideal in many ways, not the least of which is that the child's benefit can be delayed significantly if the employer is difficult to work with.

As the federal agencies attempt to address this issue, we wish them the best of luck in solving a problem that we have not been able to address adequately.

While it might seem like you could create a database of coverage availability, consider that in Utah alone, there are 67,000 small businesses. The possibility of creating a master system where an employee could identify their employer and the system could determine availability of affordable coverage seems daunting, to say the least.

Another proposed alternative would be to rely on self-attestation. However, as discussed earlier, there are philosophical problems for some states with regard to self-attestation. Then, we need to recognize that very few employees would actually have that information available to them at the time of application.

The determination of availability of affordable coverage is inherently incompatible with the goal of real-time determination. If there is a solution to this, it is much more likely to be at the federal level than at the state level.

As long as there is a requirement on an exchange to determine whether an individual has access to affordable coverage through an employer or other source, there can be no realistic expectation of a real-time determination of eligibility.

Safe Harbors for Employers and Employees – An area of public policy concern related to this program is the massive potential for fraud and abuse. While we understand that the goal is not to overly harshly penalize people who are acting on the best available information, the safeguards that are put in place in the proposed rules go too far.

By limiting the potential liability of any person in the system to what are termed to be reasonable amounts, the proposed rules actually remove most of the disincentive for fraud and abuse both by employers and by employees.

As mentioned, we do not have a good solution for the affordability determination piece that impacts employers, however, when it comes to the employee, the best approach is to follow the W-4 or EITC methodology.

While it is well known that there is some abuse in the EITC system because people can claim excessive advanced credits then not file the following year, this problem is more easily addressed for the APPTC program because there are more levers available to reinforce the need to file an accurate return than for the EITC.

The IRS needs to rethink their position on safe harbors because they create too much opportunity for fraud and abuse and dissolve the concept of individual sovereignty and responsibility.

Operationalizing Cost-Sharing Reductions – While little has been made known about the operation of the cost-sharing reductions, we do not feel that a state-based exchange should be involved in this process.

Under our proposal, the IRS would have a direct connection to the insurer that is created through the communication of the APPTC amounts. If there is also messaging related to the cost-sharing reductions, it could follow the same channel and not require additional state intervention.

More information about cost-sharing reduction plans is needed, but this should be an issue between the IRS and the insurer, not the state-based exchange.

Flow of Funds for Individual Policies – In a recent call, federal agency staff raised the issue and suggested that the state-based exchange could or should be involved in the flow of funds for individual policies, especially those that are subsidized through APPTC.

In our experience, there is great value in a state-based exchange handling the flow of funds for small employers in the defined contribution market. However, that value absolutely does not translate to the individual market.

The value in the small group market comes from the fact that a single employer can consolidate payment for many employees and the exchange can facilitate the premium adjustment and allocation process. This creates real value in the system.

In the individual market, that opportunity is not there. Payment must be collected directly from each individual or family. There is no need for a third party to consolidate those premiums and there is certainly no value in attempting to facilitate an adjusted premium.

The best approach for the individual market, including where the APPTC applies is the following.

The individual is shown their share of premium (net of APPTC). They arrange a form of payment with the carrier, preferably through some form of Electronic Funds Transfer or EFT.

The amount of the APPTC is communicated to the carrier so they can account for the entire premium payment (part to the individual and part to the APPTC program). The carrier reconciles the APPTC with the IRS through the designated tax credit or payment process described above. Any shortage in payment goes back to the individual.

This is such a simple process and it mirrors what happens today in the individual market, so there is little adjustment to core systems needed.

State-based exchanges should not be involved in handling any funds for individual policies purchased through and AHBE, regardless of any APPTC involved.

9. Other Technical Issues

There is a long list of areas that present technical challenges under the current language. Many of these have been identified and discussed by other organizations that will be commenting on the rules. However, it seems worthwhile to repeat those concerns here.

- Income Verification vs. Attestation
- Reconciling Household Definitions (HHS vs. IRS)
- Special benefits for Indians
- Requirement to evaluate quality improvement activities
- Access for individuals with Limited English Proficiency
- Alternate forms for application – mail, telephone, in person
- Requirements of Multi-state plans (NAIC)
- Incorporating stand-alone dental plans
- Defining minimum coverage for employers
- Dealing with Personally Identifiable information (FIPPS, HIPPA, etc.)
- Definition & practicality of real-time
- Automatic enrollment
- Procedures for transitioning people from the PCIP to the exchange
- Methodologies for Determining Federal Share of Medicaid Expenditures
- Eligibility for People with Disabilities

Income Verification vs. Attestation – As mentioned in Section 1, we are opposed to the requirement in the proposed rules that force states to rely more on self-attestation. We would like to propose that the federal agencies consider simple solutions that accomplish the same objectives. For example, a state-based exchange might establish a policy regarding what electronically available information is reliable and acceptable.

The exchange would then create the capability for any individual to access and review the electronically available information about their household income. With this capability in place, an exchange could function as follows:

1. An individual coming to the exchange that needs a MAGI based eligibility determination would authenticate their identity to the exchange. After authentication, the exchange would display to the person any acceptable electronically available measures of income.

If the individual is willing to accept and attest that the presented level of income is accurate, the system can proceed using that level of income. If the individual does not accept the presented level of income as accurate, then the state would need to determine whether to accept the self-attestation or not.

States should be allowed to determine the parameters regarding when the self-attestation is acceptable, such as establishing an acceptable percentage variance or other parameters.

In cases where the individual does not confirm and accept the electronically available information, and the state is not willing to

accept the self-attestation, a manual process would be triggered.

States already have in place manual processes for income determination, so no new federal rules or guidelines are needed. Furthermore, states understand that manual processes are costly, so they have an incentive to minimize the number of people required to participate in a manual process.

This simple process preserves the ability for most individuals to receive the advantage of using electronically available income information for eligibility determination. At the same time, the state is protected from the burden of accepting self-attestation, if that is not consistent with their operational and policy goals, but states are not precluded from using self-attestation if they so choose.

The federal agencies need to allow states that have access to electronically available information about individual income to define for themselves when they would accept self-attestation to an income level that is different than the best available electronic information.

Reconciling Household Definitions (HHS vs. IRS) – It is interesting that not only do the proposed rules propose a definition of "household" that is different than the one we currently use for Medicaid eligibility, there are actually two different definitions in the proposed rules – one for HHS and one for IRS. This raises two distinct sets of issues for us:

1. This will create a real change in the populations that are eligible for Utah Medicaid and CHIP. This adjustment will require significant time and resources, and it is not entirely clear whether this will result in more or fewer people on Medicaid at the end of the process.

2. We have a real concern that with the discrepancy in definitions between HHS and IRS, there will be low-income families that are not eligible for either Medicaid or the APPTC.

We strongly encourage the federal agencies to come up with a common, workable definition of household, and then fully reimburse states for the cost of implementing the new definition, including consideration for the potential impact on Medicaid and CHIP enrollment.

Special benefits for Indians – Utah is pleased and proud to work with our tribes on implementing health reform. We understand that in some cases Indians interact with the health care system in ways that are somewhat different than other Utahns.

However, the proposed rules as written create a significant administrative and operational challenge for us that may not really address the underlying issues that our tribes face. An example of this is the proposed requirement to allow an Indian to change insurance plans once a month. The difficulty of this requirement is that it cannot be handled as a manual process, like we possibly could for a Medicaid program.

Since our goal is to have a scalable, automated system, we would have to create the capacity to provide this service to everyone. In a system platform environment, it doesn't cost more to develop it for one person as it does to create it for everyone.

The upshot is that this seemingly reasonable accommodation for a small group of applicants

actually results in an expensive and major development cost on the whole system.

Furthermore, it is not clear to us that this requirement would provide a solution to underlying needs of the Indian population, and in fact creates serious potential to harm our insurance industry.

By allowing individuals to switch plans monthly, a person could easily enroll in a low cost plan while they are healthy. Once a health-care need is identified, they could switch to a plan with better coverage, then in any subsequent month, when things are looking better, they could switch back to the low-cost plan.

This is the classic case of adverse selection that carriers must account for in a system with guaranteed issue and no pre-existing conditions restrictions.

We kindly request that states be allowed to come up with their own special provisions to help address underlying challenges of the Indian population in a way that considers the impact on the state-based exchange and insurance market.

Requirement to evaluate quality improvement activities – Quality improvement activities needed to improve every state's market and coverage are especially unique to each state.

The requirement for states to evaluate quality improvement activities is logical in the sense that the state would be the appropriate entity to conduct such an evaluation. However, we are concerned that the required processes proposed for states could be quite burdensome and in a way counter-productive.

States need to have autonomy and flexibility in determining the best way to work with the private sector in establishing both general policy goals for quality improvement activities as well as the manner and method for evaluating them.

Access for individuals with Limited English Proficiency – We can appreciate that some of our citizens may not be able to use a computer-based system that is based exclusively on the English language. However, dealing with this problem is not new for us.

Every state has had to consider the needs of their citizens to access services and has come up with a plan that works for their local culture, markets, and resources.

We strongly encourage the federal agencies to allow states the flexibility to work within broad guidelines to meet the needs of their populations, including those with limited English proficiency.

Alternate forms for application – mail, telephone, in person – Accepting alternate forms of application such as those by mail, phone, and/or fax, has the potential to be cumbersome and expensive.

Each alternate form of application requires a separate business process to be created to ensure applications are properly routed and addressed. It's likely that many of the pathways for these alternate forms would require increased intervention by staff and would increase costs. Fewer alternatives are needed if the primary form of application is constructed sufficiently.

It's our recommendation that states be allowed flexibility to determine which

alternate forms of application, if any, benefits its communities.

Requirements of Multi-state plans – There appears to be some ambiguity regarding the role of state regulatory agencies when it comes to the multi-state plans that would be allowed to participate in exchanges.

We strongly encourage the federal agencies to clarify that multi-state plans are subject to the same requirements and approvals as state-based QHPs or other plans. Specifically, we wish to emphasize the role of the state insurance commissioner in overseeing products sold within the state's borders.

Incorporating stand-alone dental plans – The proposed rules appear to require state-based exchanges to allow individuals to purchase and enroll in stand-alone dental plans in addition to traditional health insurance.

We agree that this creates value to the consumer, and in fact could envision versions of a state-based exchange that provide an even broader range of employment-related benefits. However, we wish to point out that state-based exchanges need the flexibility to consider how the incorporation of additional benefits should work with their base technological architecture.

For example, we have already worked through the issues of how to get consumers accurate and final prices for health insurance in our defined contribution market. To add a stand-alone dental plan option for employees would require us to think about how to provide accurate and final pricing for those products.

Dental plans do not price the same way that health insurers price, so we would have to create a parallel system for accomplishing that task. While it is feasible, it also represents an additional cost to the system.

States need the flexibility to consider how stand-alone dental plans should be incorporated into the design of a state-based exchange.

Defining minimum coverage for employers – The ten categories of essential health benefits included in the law are general categories that are largely covered in employer plans. However, issues arise when specific diseases and treatments within these categories (for example, pediatric dental) are mandated.

Each additional coverage mandate may impact premiums by as little as 0.2% to upwards of 10%. Mandated coverage has historically been a means to address local issues, but does not necessarily address a need in another state.

The final determination of the essential health benefits coupled with community rating changes could easily cause rates to increase 20% or more.

States should be given significant flexibility to determine the local issues to be addressed, and the ability to assure stability in the market, including the definition of minimum coverage to be provided by employers.

Dealing with Personally Identifiable information (FIPPS, HIPPA, etc.) – TBD

Definition & practicality of real-time – Throughout the proposed rules there is an assumption that decisions and information will flow in "real time." However, it is not clear from the rules what that means – do decisions have to happen instantaneously, within a few seconds, minutes, or hours?

Clarification of this issue is critical in understanding the requirements of the technology, network and structures that states will need to meet.

As a practical matter, the ability of the computer systems to talk to each other and exchange information is the least of the concerns. A well-designed and architected system will have little problem meeting a reasonable definition of real-time.

The main practical problem in getting to real-time will be the issue of having access to the needed information. Any manual process or review will immediately halt the real-time process until the human intervention has taken place.

The best hope of getting to real-time for consumers is to simplify the process and eliminate manual processes. However, this may cause downstream implications for policy decisions as mentioned in this document. Expectations about real-time processes should be defined and tempered in the face of realistic issues.

Automatic enrollment – The proposed rules clearly envision a particular method for handling cases of individuals that for one reason or another could be enrolled but are not. Many states, including Utah, have had experience under various programs in handling these situations.

We request that the rules be re-written to give states the responsibility to handle all scenarios requiring an automatic enrollment according to their own experience and markets.

Procedures for transitioning people from the PCIP to the exchange – As federal agency staff are certainly aware, the populations that are enrolling in the PCIP programs around the country, though relatively few in number are phenomenally expensive.

In our own state-run PCIP, Federal HIPUtah, we are experiencing $8.50 in claims for every $1.00 in premiums collected from the 600 enrollees. In addition, we have another 4,000 enrollees in our existing state high risk pool. HIPUtah requires a direct subsidy because it experiences $1.50 in claims for every dollar in premium collected.

As we project forward to 2014, back of the envelope calculations suggest that the high risk pool programs could be requiring a total subsidy of nearly $100 million from state and federal sources under the new guidelines.

In Utah, the total amount of premium collected in the individual market is currently in the neighborhood of $250 million. When one thinks about the impact of moving this population to the individual market all at once, the reality of doing so while such a large subsidy evaporates begs the question of where the additional premium will come from.

The imbalance between premiums and claims is in part due to the nature of the program – attracting high-risk populations. However, it is made much worse by the fact that people can wait until they need catastrophic services to enroll, and then drop coverage after receiving needed care.

A simple example that is very common is maternity. We have a surprising number of women who have joined Federal HIPUtah very close to their delivery date. By timing it this way, they can pay just one or two month's

premium, but receive a significant benefit to pay for the delivery. If the baby is born healthy, they drop coverage immediately.

However, if there are problems, perhaps the baby needs expensive newborn ICU treatments, the mother can stay on Federal HIPUtah, paying the subsidized low premiums while the baby incurs hundreds of thousands of dollars of cost.

This pattern is likely to become the standard operating procedure for many individuals in the post-2014 world if things remain the same.

While nobody knows for certain the total impact of insurance market changes on prices and individual behavior, what we do know is that transitioning all current high-risk pool enrollees to the individual market and losing the subsidy funding would have a devastating impact on premiums in that market.

When you also consider the possible ways for people to game the system, with or without the individual mandate, we are very concerned that the resulting market would not even be able to remain solvent.

We recommend that federal agency staff take immediate action to allow states the flexibility to protect their individual markets from collapse associated with the ill-timed influx of large numbers of high-risk people. States need more flexibility to take actions to prevent permanent damage to the markets. The Federal government needs to commit to a less abrupt withdrawal of subsidy funds (including PCIP and Premium Assistance Subsidy funds) from the individual markets

Methodologies for Determining Federal Share of Medicaid Expenditures – We have a serious concern about the proposed rules' implications for how the federal match rates would be determined.

We had assumed that our Primary Care Network (PCN) Section 1115 waiver population would be eligible for an enhanced match rate of 100% because they do not have a benchmark plan. However, we have heard that the way that the proposed rules are written, the current PCN enrollees and those that would likely be eligible for PCN would not qualify for the higher match rate.

In particular, the language in the proposed rules that establishes the "newly eligible" definition appears to specifically exclude adults who under current State Medicaid eligibility rules qualify for a state expansion program, even if the program does not meet the benchmark standard, or operates with an enrollment cap or waiting list.

PCN would appear to be caught in this definition because it does not meet the benchmark standard, and is currently closed and not accepting applications.

We are especially concerned that we could have a sizeable population that should be considered as "newly eligible" under the statutory definition, but are determined to not qualify for the enhance match rates. We read in one commentary on the proposed rules, the following statement:

"Although Utahan adults enrolling in the ACA Medicaid expansion would be considered "newly-eligible" under statute because they weren't able to enroll in an existing comprehensive benefit plan, the state would not receive the enhanced federal matching payment for coverage of these adults."

In Utah, this could affect the entire population of adults with or without children that are below 150% FPL. The impact on the budget to the state would be staggering.

We strongly recommend that the definitions of "newly eligible" and "expansion state" be re-written to conform to the language of the ACA, so that states be allowed to receive the enhanced match for any adults that do not currently have access to a Medicaid program that meets that benchmark standard or that is not currently available because it has capped or limited enrollment.

Eligibility for People with Disabilities – There is a significant possibility that under the proposed rules, people with disabilities who can be determined eligible based on MAGI could be excluded from home and community-based programs that provide better services at lower costs.

It is important that states retain the ability to enroll people with disabilities in programs that best meet their needs regardless of the MAGI determination system.

10. Funding Beyond June, 2012

Budget and appropriations processes are unique to every state and depend on state rules and legislative time lines. States need some assurances about the availability of funding beyond June 2012.

Currently, there are no announced plans for states to gain access to federal funding beyond June 2012 even though it is conceivable that since the funding is intended to last through 2014, states may not know before June 2012 what their actual needs are.

In this section, we will comment on two situations that arise from lack of clarity on this issue.

- How to predict state-based needs that early
- What about states that choose the federal option?

How to predict state-based needs that early – As mentioned earlier, with all of the uncertainty swirling about our policy makers are hesitant to commit to any specific course of action. As a result we need to be prepared to deal with an eventual outcome and game plan that is significantly different than what we would envision today.

As a practical matter, given the state's federal grant processes, it is difficult for us to apply for and get permission to spend federal funds before we have a correct vision of where we are headed.

You will note that Utah has not applied for very much in the way of exchange planning and development funds. At the same time, we are doing our best to create the foundations for a state-based exchange that could serve our state well depending on the resolution of the uncertainty in the next fourteen months.

We strongly encourage the federal agencies to extend the time horizon for applying for federal development funds to allow states that have the need to apply incrementally beyond June 2012 to do so.

What about states that choose the federal option? – A related problem that is worthy of comment is the financial uncertainty relating to states that ultimately end up with federal exchanges. We do not believe that this will come at no cost to the states, however, there is no mechanism at present for states to apply for implementation funds to facilitate the implementation of a federal exchange, including the so-called partnership model.

We ask the federal agencies to clarify their vision for how states that end up implementing federal exchanges will be funded for their share of the burden.

11. Requesting Waivers or Accommodations to deal with the Unrealistic Timelines

The proposed rules assume everywhere that the current timelines must be followed without exception. In order for more states to have the opportunity to implement workable state-based solutions, it is becoming increasingly apparent that some flexibility on the timelines is needed.

In the face of massive uncertainty and a lack of immediate answers, states have been paralyzed in the planning process.

- Waiver process related to timelines
- What will be the federal strategy for states that have made progress, but will miss the deadline?

Waiver process related to timelines – Inevitably some states that would really like to have a state-based exchange will run into difficulties making it happen within the timelines outlined in the proposed rules.

The timelines outlined are completely unrealistic for most states, and it's not even clear based on current information available that the federal agencies can even meet those timelines.

It's interesting to observe that the federal agencies have created several proposed rules engineered to impose additional requirements on states above and beyond those required in the statute, however in this most critical aspect of all, where the states really could use some creative "rule engineering," the proposed rules are absolutely silent.

The federal agencies need to immediately develop a process to allow states some degree of flexibility with regard to the timelines.

What will be the federal strategy for states that have made progress, but will miss the deadline? – On a related note, another likely outcome is that one or more states that are committed to developing a state-based exchange will run into some form of difficulty in getting to the finish line on time.

States need to know what the impact of such a setback would be. For example, let's consider the case of a state that is on track in January 2013 sufficient to obtain a conditional approval from the secretary. Now suppose that this same state runs into logistical challenges in late 2013 to the degree that it becomes apparent that while they might be 90% compliant, there will be some elements that are not ready in January 2014.

This scenario raises a whole raft of questions, including:

1. What will be the federal response in this case?

2. Will the exchange be decertified and replaced on an urgent basis with a federal exchange?

3. If so, will the state be required to provide resources to facilitate the replacement with the federal exchange?

4. Will the state be allowed to keep the work that is developed at that point paired with additional modules from the federal government?

5. Will the state be allowed to request an extension and continue to the development of the remaining segments after the deadline?

6. Will the state be required to repay any federal development grant money used on an exchange that does not ultimately meet the final deadlines?

We strongly urge the federal agencies to clearly outline rules and procedures that they will follow for dealing with any state that is not fully ready to launch by January 2014.

12. Dealing with Disruption in Insurance Markets & Prices after 2014

One significant concern for many states that is not addressed in these rules is that states could be dealing with a significantly disrupted insurance market in 2014.

States need some assurance from HHS that if premiums continue to rise at near double-digit rates due to the requirements of the ACA, some relief would be available. States will not be excited to flip the switch on a system if premiums will be unreasonably high in either the small group or individual markets.

States need to hear more from the federal agencies on their estimates of the impact of the following changes in the rules for insurance market and their plans for softening that impact.

- The Individual Mandate
- Community Rating
- Discrete Movement from Existing System
- Eliminating health status rate bands
- Compressing the age ratio to 3:1
- Changing the family tier structure
- Elimination of the High Risk Pool & Premium Assistance funding
- Dealing with Churning, Jumping In & Out, Enrollment at Crisis Points

The Individual Mandate – It is not at all clear that the individual mandate will survive the legal challenge, and if it does, it's not clear that the individual mandate outlined in the statute will provide the intended protections from adverse selection.

What are the plans for addressing adverse selection if the individual mandate were to be stricken down or if it is determined that the enforcement provisions are insufficient?

Community Rating – Many states are very concerned about the impact of community rating on their markets. Experience has shown that states that adopt community rating or modified community rating have substantially higher insurance premiums that states that do not.

What are the federal agencies' plans for allowing state flexibility in those cases where the move to community rating will have the most impact on premiums?

Discrete Movement from Existing System – Another notable challenge for states is that the current proposals envision a discrete movement from the current system to the new system. It would seem to be unwise for any market to experience such an abrupt change in structure.

What are the plans of the federal agencies to ameliorate the impact of such a dramatic change on states where the impact is the greatest?

Eliminating health status rate bands – Rate banding is a common tool used to provide stability to the small group market place.

Are the federal agencies willing to allow states to continue to use rate banding techniques to help ensure stability in the small group market or will this protection be eliminated?

Compressing the age ratio to 3:1 – Another significant concern is that in many states the proposed changes will cause significant compression in the age dimension. The end result is that young people in particular can expect to see a disproportionate jump in premiums above and beyond the overall rates due to other factors considered here.

What plans do the federal agencies have for ensuring that young people will still be able and willing to participate in the new insurance market given the potential for dramatic premium increases?

Changing the family tier structure – Similar to the age compression, the changes in family tier structure in some states will result in unusually high increases in premiums charged based on the new definitions of family tier.

What plans to the federal agencies have to soften the blow to working families that see dramatic premium increases due to the change in the nature of the tiers?

Elimination of the High Risk Pool & Premium Assistance funding – A particularly problematic effect on premiums will be the elimination of the high risk pool and the introduction of high risk people back into the general market at guaranteed market average rates.

Our experience with the Federal PCIP has been that it is plagued by extremely expensive clients that have come to the pool only when costly care is needed. We fully anticipate this population to eagerly join the regular market if the community rates are anywhere close to what they see in the PCIP.

A further complication comes when one considers that the elimination of the high risk pool will also result in the elimination of federal funds for the Premium Assistance Subsidy for state-run high risk pools that helps keep the market sustainable.

Another observation is that it has become widely known that it is in the best interest of health care providers to help high risk patients get insurance. Some providers are willing to pay the premiums for high risk patients needing services.

What plans do the federal agencies have to soften the blow of the reintroduction of the highest risk population back into the risk pool, especially considering the probable loss of the Premium Assistance Subsidy funding?

Dealing with Churning, Jumping In & Out, Enrollment at Crisis Points – Health care costs remain a concern for all states, and it is well understood that the only effective chance we have for permanently addressing costs is to help people lead healthier lives.

Part of our state strategy for bending the cost curve is to pursue reforms that increase the time that people stay with the same insurance carrier. As individuals develop longer term relationships, carriers will be better able to come up with benefit features that create incentives for wellness and better consumer behaviors that will ultimately lead to a healthier population.

The proposed rules do not seem to take into account the desirability of fostering long-term relationships between patients and insurers. In fact, in the misguided attempts to "protect" the consumer from the insurers, the proposed rules create perverse incentives that will hamper the

ability of states and insurers to lower health care costs.

There are three specific problems that need to be more fully addressed by the federal agencies. The first is churning – the incentive for people to switch plans as their income fluctuates.

The second is the incentive for people to jump in and out of the insurance market as their health status or income changes.

Finally, the current rules create extra incentives for uninsured individuals to wait to enroll until they come to a crisis point, at which time, providers will have an incentive to help them enroll.

All three of these problems will lead to higher costs in two ways. Healthy individuals will be less likely to be insured, which raises the average risk of the pool and drives up premiums. More importantly in this context, people will have less incentive to form a long-term relationship with an insurer, frustrating the ability of insurers to devise incentives and plans to promote healthy behaviors and manage chronic conditions.

The federal agencies must consider how to reduce the impact of the new market regulations on the ability of states and insurers to find ways to reduce costs through long-term relationships.

13. Comments by Other Organizations

We have been in frequent contact with many other states and organizations representing states. We urge federal agency staff to look for common themes in the comments by state officials and the organizations that represent state officials.

From conversations with our counterparts, we are convinced that those who will have the obligation to work under the final rules have common concerns that transcend partisan interests.

In particular, we include three sets of comments here that we support and feel that they accurately reflect our concerns and sentiments. Please consider the comments in Appendices A through C as part of our formal comment on the proposed rules.

Appendix A. Proposed NCSL action item regarding Essential Health Benefits

How the U.S. Secretary of Health and Human Services implements the essential benefits provisions of the federal Patient Protection and Affordable Care Act (ACA) will be a significant factor in the cost of qualified health plans that must be offered under the Act, both inside and outside health insurance exchanges. Besides specifying general categories to be included as essential benefits, the Act states that "The Secretary shall ensure that the scope of the...benefits is equal to the scope of benefits provided under a typical employer plan...." The problem for states is that what's typical in one state may not be typical in another. Specifically, in addition to benefits already mandated by Congress, legislatures have required plans within their states to incorporate to one degree or another some 60 additional benefits. Which benefits are included by each state is a matter of local politics and not necessarily a reflection of evidence-based value. To avoid imposing the political choices of each state on 49 others, the Secretary should allow what's "typical" to be determined on a state-by-state basis. Or, in the case of a multi-state exchange, on a multi-state basis; and in the case of a sub-state exchange, on an exchange-level basis.

Therefore, NCSL recommends the Secretary allow states, through their exchanges, to spell out the definitional details of the general benefit categories listed in Section 1302 of the ACA. Or, if in the end the Secretary believes this would not be feasible, NCSL recommends the Secretary create a three-tier approach to establishing essential benefits:

• Tier 1 benefits would be limited to those provided under a typical employer plan offered within the geographic boundaries of an exchange.

• Tier 2 benefits would be designated by the Secretary of Health and Human Services and would include benefits that go beyond what employers typically offer within the boundaries of the exchange. Ideally, these would be benefits with strong evidence about delivery and value. States would elect, on a state-by-state basis, whether to adopt Tier 2 benefits as part of an essential benefits package.

• Tier 3 benefits would include any other benefits a state may wish to include in the essential benefits package.

• Exchange subsidies for Tier 1 and Tier 2 benefits would be fully funded by the federal government. Subsidies for Tier 3 benefits would be funded by the respective states.

Appendix B. NCSL Action Item Language on Exchanges

The federal Patient Protection and Affordable Care Act (ACA), requires the establishment and operation of an American Health Benefit Exchange in each state by January 1, 2014. Each state may either create a state-operated exchange certified by the Secretary of the U.S. Department of Health and Human Services to include functions in at least 16 major categories spelled out in the Act, or defer to the federal government to create and operate a similarly qualified exchange. Given the high degree of technical and political complexity associated with the creation of exchanges---either by individual states or the federal government---the Secretary should make every effort to streamline implementation of exchanges while preserving, and maximizing, state policymaking autonomy and flexibility.

To this end, NCSL urges the Secretary to work with states to determine which exchange functions might most appropriately be developed and, at a state's request, administered by the federal government rather than by the 50 individual states and territories. These functions would likely be characterized by significant reliance on federal data, use of federal structures for enforcement, or minimal need for variability across the states, and could include the determination of premium subsidy eligibility, the administration of premium and cost sharing subsidies, and the administration of individual and employer responsibility provisions.

Further, NCSL urges that any state-operated exchange which incorporates functions developed and/or administered by the federal government, and otherwise meets the requirements of the ACA, be certified by the Secretary. NCSL also urges that any exchange function administered by the federal government be fully funded by the federal government.

NCSL acknowledges the Innovator Grant process has the potential to produce technical solutions that will reduce the complexity of implementing an exchange, but is concerned states may still not be able to meet the 2014 implementation deadline due to the many technical hurdles that must be overcome. As regulatory implementation moves forward, a thorough review must be made as described above to determine what solutions should be developed and, if a state elects, administered and paid for by the federal government.

Appendix C. NGA Center for Best Practices Issue Brief – State Perspectives on Insurance Exchanges: Implementing Health Reform in an Uncertain Environment

The three major components of the Patient Protection and Affordable Care Act of 2010 (ACA) — insurance reform, Medicaid expansions, and the establishment of health insurance exchanges — are primarily the states' responsibilities to implement; together they impose a daunting workload. Because insurance exchanges must be wholly created in a very short time period, their implementation presents unique challenges. Additionally, the requirements for interconnected, automated systems to determine Medicaid and subsidy eligibility, pose major challenges. Tight deadlines, severely strained budgets, and human resources shortages further complicate implementation in nearly every state.

For these and other reasons, states have had a wide range of responses to the ACA exchange requirements and subsequent regulations. Some states started planning state exchanges even before adoption of the Act and have a reasonable chance of being ready by the law's implementation on January 1, 2014 (assuming many of the questions raised below are answered in time). Others have thus far chosen not to deploy a state exchange and expect to have a federal exchange implemented in their state, as the law allows. The majority of states are somewhere in between. Of them, many prefer state-run exchanges but are unsure of the implications on state operations, regulation, and finances, and are somewhat daunted by the challenge of extremely complex implementation. All of the states have concerns.

The National Governors Association (NGA) hosted a two-day workshop entitled, "Timelines, State Options, and Federal Regulations" to assist states in considering the many decisions and tasks associated with the creation of insurance exchanges and related changes to Medicaid. More than 120 state officials from more than 40 states and territories participated, including cabinet secretaries, governors' representatives, Medicaid and insurance department leaders, and exchange governing board and staff members. This meeting was designed to allow and promote the exchange of information and experiences among the many participating states. Following a day-and-a-half of working with experts and sharing experiences, lessons, and dilemmas, the group met with a panel of representatives from the U.S. Department of Health and Human Services (HHS) and the U.S. Department of Treasury to raise key issues and pose questions regarding the implementation of exchanges.

This summary is a reporting of the concerns voiced at the meeting, incorporating some of the recurring suggestions made by representatives that would allow their state to make informed critical decisions. Despite disparate views of exchanges and various steps of implementation, several major themes emerged from the discussions at the meeting:

- **A need for timely guidance**: Federal guidance has yet to be released or finalized on many issues, confronting states with a lack of clarity on many

issues – a problem frequently compounded both by insufficient detail and efforts to preserve apparently broad flexibility;

- **Uncertain and challenging timelines**: For many states, the resulting uncertainty creates significant challenges in defining the "critical path" and meeting the associated deadlines necessary to establish exchanges and obtain required federal approvals;

- **A lack of clarity and detail**: In many states, legislators and governors require more clarity about the policy issues and operational details involved in creating a state-run insurance exchange, pursuing a hybrid or "partnership" model, or accepting a federal exchange;

- **Concerns about costs**: States need to understand the short and long-term costs of exchanges under the various scenarios, which have implications for how states seek to design them; and

- **Delegating discretion to states**: Many states suggest limiting directive federal guidance to those areas where the statute specifies "shall," leaving discretion to the states in all other areas involving exchange design and in interpretation of the statute.

Moving Forward Amidst Uncertainty

The ACA apparently intended to give states broad discretion in designing health insurance exchanges and their governance. States may choose to make existing entities such as insurance or Medicaid departments responsible for their exchanges; they may contract functions, such as information technology systems to private vendors; and some functions may potentially be operated in partnership with the federal government, such as eligibility determinations for federal tax subsidies. Because of the policy implications and operational complexity of decisions regarding delegating functions, implementing any of those strategies requires ample lead time for planning and procurement. Given that the final federal regulations specifying the policies governing those activities have not been finalized or, in important instances, proposed, states are operating in a highly uncertain environment with looming deadlines.

Timely implementation places states in a position of needing to make basic decisions about how they will establish and implement insurance exchanges on the basis of incomplete guidance and regulations. At the meeting, state officials shared a concern about the capacity of the vendor community to provide timely, effective solutions to the business challenges posed by ACA implementation, especially as timeframes become increasingly compressed. The substantial ambiguity involving core elements of exchange and Medicaid implementation, especially in light of the controversies associated with ACA, greatly complicates discussions about how or whether to proceed in some states.

Nonetheless, most states are actively working to chart a provisional course forward, so that they can be operationally ready for political decisions made by their governor or legislature. Many are moving forward on the assumption that if they do not, it will be impossible to meet ACA deadlines, which would lead to a federally operated exchange in their state.

Most states began planning shortly after the passage of ACA in early 2010 with steps such as analysis of their insurance markets and information technology needs. They have conducted extensive stakeholder outreach to inform health plans, providers, employers, consumers, and others about exchange fundamentals and to solicit their suggestions and feedback. Some have developed detailed implementation plans with timetables for standing up their capacity to manage providers and plans in the exchanges; for training brokers, Navigator programs, and other consumer assistants; and for rolling out business processes for inter-agency coordination, meeting technology needs, and other vendor contracting.

Lack of Timely Guidance Creates Roadblocks to Moving Forward

Many challenges have emerged in the course of those undertakings, according to participants in the NGA meeting. Among the concerns heard:

- ACA implementation requires major changes in existing Medicaid eligibility systems, which need to operate seamlessly with the yet to be detailed federal data hub and exchange systems, providing real-time, online eligibility determinations (under significantly reformed Medicaid income, asset, and eligibility rules). The challenge of contracting for IT systems services is particularly acute and mission-critical for the establishment of exchanges. Vendor capacity and the IT workforce are strained, especially as system adoption among providers has increased as a result of economic stimulus subsidies. Some state representatives said vendors currently supplying states with Medicaid management information systems (MMIS) would be functionally able to meet exchange needs, but others said that MMIS vendors would not be able to take on expanded responsibilities. States also expressed concern that even in the best of circumstances the development of the information systems often takes longer and is more costly than anticipated. A number of states implementing MMIS changes agreed that the scheduled time to develop the necessary systems changes took 18 to 20 months after the issuance of an RFP, a step that in most cases has yet to be taken.
- Questions remain about whether a federal data hub currently under development will be ready by October 2013 to furnish the exchanges with real-time eligibility data such as income verification through planned links to the Internal Revenue Service and other federal agencies. Some unique data do not currently exist in a consistent, national repository. For that reason, there are significant concerns that the seamless, "no wrong door" eligibility and enrollment processes that offer consumers a single portal for eligibility determinations, applications for subsidies, and enrollment in plans, may not be logistically feasible.
- Retrospective reconciliation of inaccurate determinations of Medicaid and exchange plan subsidy eligibility could result in unwelcome surprises on

consumers, exchanges, and Medicaid agencies. States expressed concerns about how the federal government would compute error rates and determine liability arising under the new approaches envisioned for on-line eligibility determinations, especially given substantial policy, operational, and systems uncertainties.

- Federal rules for the Basic Health Plan have not been issued, leaving states unclear as to where that option could fit in their exchange design plans. Because decisions have ramifications for Medicaid and the size of the risk pool that participates in the exchange, many states said the lack of information on the Basic Health Plan was a major stumbling block for their planning process.

- Guidance on the essential health benefit package is pending, which may be an important consideration in deciding the type of purchasing model a state would elect. For many states, bills must be filed as early as November, making timely release of details on essential health benefits an imperative for creating legislative authority for an exchange in the upcoming session.

Lack of Clear Timelines Complicates Decisions

Many states have established exchange entities and applied for establishment grant funding, a process which entails the creation of work plans to guide progress. The details that must be spelled out in those plans underscore the extraordinary time pressures, both for states and the federal government. In many instances, the time available is less than the time normally required to procure major IT systems or amend Medicaid state plans. The shortened timelines and limited guidance currently available are increasingly affecting design and implementation decisions.

Procurement serves as an example. Time constraints weigh heavily on IT decisions for four reasons. First, IT systems design and development presupposes specifying *in advance* the policy requirements and resulting business processes. Second, the timelines for developing major systems typically requires years, in part because of public procurement rules designed to ensure fair and efficient expenditures of public monies. Third, the multiple new systems that are simultaneously being implemented require testing of both the individual systems and the interface of federal and state systems. States repeatedly cited concerns about the lack of sufficient capacity on the part of experienced vendors to meet the "peak load" demand for Medicaid and exchange systems development. Finally, experience suggests that systems contracts frequently underestimate costs and take longer than expected to complete.

States are considering a variety of strategies to deal with those challenges. One approach entails partnerships and outsourcing, allowing states to buy capabilities they feel they do not have time to build. Another potential strategy may involve bundling procurement needs into general or modular contracts, where vendors may bid on all or just parts of a request for proposals. States expressed interest in having the federal government designate a list of approved systems or vendors, which would

allow a streamlined approval process for any state adopting these systems.

But those strategies pose risks of their own, potentially presenting accountability problems, timeline disruption, and contract management headaches. States are wary that accelerating the procurement process could be costly because hastily issued RFPs could leave out or result in mismanaged important details which take more time and money to fix on the back end. State representatives expressed hopes that HHS might still be able to make some products, such as risk adjustment and eligibility and IT systems available to states as modules at minimum cost and with ready availability.

Lack of Clear Guidance: Exchanges and Medicaid Programs

Alongside the considerable challenge of greatly expanding their Medicaid programs, states are also charged by the ACA with creating a single, seamless point of entry for all of the insurance affordability programs affected by the Act – Medicaid, the Children's Health Insurance Program (CHIP), the Basic Health Plan (where offered), and advanceable tax credits for individual and Small Business Health Options Program (SHOP) exchange enrollees.

Because income changes will create constant movement in and out of those programs, it is necessary to have well-developed systems with tight integration between them. As previously discussed, systems challenges for creating integrated enrollment platforms could tax vendor capabilities in some areas and test the agility of the states that are already in the midst of Medicaid systems redesign.

Some states expressed worry that commercial plans participating in exchanges may reimburse providers more generously than Medicaid. That would aggravate problems with access to care by higher paying exchange plans drawing providers away from Medicaid.

Several states cited the importance of having more leeway to initiate meaningful beneficiary cost sharing in Medicaid before 2014. Given the expected frequency of beneficiary shifting between Medicaid, CHIP, Basic Health Plans (where available), and exchange plans, additional cost sharing would smooth transitions and facilitate cost containment in the post-ACA world.

States highlighted the need for a simplified path to gain HHS approval of exchange and Medicaid plans than the current state plan amendment process, which can be time consuming at both the state and federal levels. Additionally, some expressed concern arising from the lack of policy and operational clarity about how a federal exchange would function. For example, states worry that if a federal exchange were the single point of entry to all the state's insurance affordability programs, they may lose control of their Medicaid program.

Lack of Clear Guidance: SHOP Exchanges and Small Businesses

Depending on the regulations, the structure of the SHOP exchanges could lend itself to use of defined contribution plans. The predictability of premiums under defined contributions plans have made them increasingly popular with small businesses, many of whose employees tend to be lower income workers potentially eligible for tax credits. The degree to which a defined contribution is compatible with the

federal government's definition of affordable coverage is unclear, as is how eligibility for premium subsidies may be determined in that context.

Some states raised questions about the potential for discrepancies in the rules governing individual and SHOP exchanges, especially when aligning requirements for individuals and small business pursuing a defined contribution strategy. Many states commented that the attractiveness of the SHOP exchanges will ultimately depend on how well they control costs.

Lack of Clear Guidance: Exchanges and Impact on Insurance Markets

Most states report that they are undertaking efforts to understand the characteristics of their current individual and small group markets, as well as their uninsured population. After completing market assessments, they are analyzing the expected effects of ACA insurance reforms, which affect individual and small group plans operating inside and outside exchanges. The as yet unissued rules on essential health benefit plans have the potential to substantially change currently offered benefit plans, potentially resulting in price increases in many states. For some states, new community rating standards, which limit variation in premiums to a maximum of 3:1, represent a sharp departure from their current rules and could substantially change current pricing. Rate compression may occur even in states that already have some version of community rating in place. As a result, rates may increase for large segments of the population currently enrolled in individual and small group plans. In light of expected changes in many markets, states recognized the importance of creating robust communications and outreach plans to prepare the public.

A foundational decision facing states is whether they wish to create exchanges that operate, at one end of the spectrum, as an active purchaser (e.g., selectively contracting with a limited number of plans), or, at the other end of the spectrum, as a neutral market facilitator (e.g., a "Craig's List"). State preferences vary widely on this dimension, with some expecting to function as active purchasers, others as a neutral market facilitator, while some states are either undecided or expect to fall somewhere in the middle.

States may choose among tactics for qualifying plans to meet goals of promoting competition in the health insurance marketplace. Some states are looking at factors such as provider networks, IT capabilities, or readiness for payment innovation as criteria for participation. However, they also recognize the importance of carefully calibrating requirements to create viable markets.

Lack of Clear Guidance: Questions about Federal Role

State officials at the NGA meeting exhibited differing policy preferences on many issues, including fundamental choices such as whether to pursue a state-run exchange, a federal exchange, or a mixture of federal and state responsibilities. However, nearly every state raised questions about how the federal government will support the establishment and ongoing operation of exchanges.

For some states, having a detailed understanding of the proposed federal exchange would create a useful "straw man"

that would facilitate finalizing policy choices by their legislatures or governors. Other states that had already finalized key policy decisions viewed having a detailed understanding of the federal exchange as helping inform their operational decisions and implementation strategy.

States interested in sharing the responsibilities of establishing and operating exchanges with the federal government in a partnership model are eager to learn which functions states will unquestionably need to retain, and which they may be able to share, such as premium aggregation and management of a coverage appeals process for public programs. For states that may ultimately need to have the federal government fully operate their exchange or exchanges, states have large questions about what responsibilities and costs they will be asked to bear.

Concerns about Costs – Importance of No Surprises

In an opening session, a speaker from HHS raised the possibility that states would have to pay for information provided through the federal data hub. Throughout the meeting, states frequently expressed concerns about the costs of establishing and operating exchanges.

Attendees articulated the importance of having clearly and immediately identified any areas where the federal government will impose costs on states of which they are not currently aware. It is critical to states that any fees associated with interfacing with the federal government be stated clearly upfront, from both policy and operational perspective.

Limit Requirements to Those Imposed by ACA, Delegating Discretion to States in All Other Areas

Many states requested that federal rules and guidance to be directive only in those instances where the statute itself was directive. Some states also requested the authority to exercise discretion when the statute delegated discretion to the Secretary of HHS.

States expressed a mixed view of federal efforts to articulate state flexibility in proposed rules. On the one hand, states appreciated having flexibility and not having unnecessary prescription. On the other hand, allowing for a range of potential options without providing a clear decision-making authority to states greatly complicates state-federal relations and state-level policy-making. Some states indicated that this flexibility without clear transfer of authority from the outside translates into uncertainty, resulting in implementation difficulties, delays, and increased costs.

Conclusion

The states and territories participating in the NGA meeting ranged from those that will rely on a federal exchange to those that will implement a state-run exchange. States also varied on whether they have already created exchanges or still require enabling legislation. Similarly, states ranged from those awarded Early IT Innovator grants to those that have rejected federal funds. Despite these differences, many of challenges that state officials described were echoed throughout the meeting by the entire range states participating.

As a response to the challenges described in this report, some state representatives

expressed the view that states, given appropriate flexibility and guidance, may be able meet most ACA requirements with existing authorities and current capabilities. How that flexibility is applied may be a major determinant to how states address the challenges of the next two years.

To make informed decisions, states need as much clarity as possible, including details about essential health benefit requirements and the design of the federal exchange, among other specifics that are currently unavailable. Moreover, there is deep concern that if deadlines for federal guidance issuance move further back, states will be unable to make further progress. Addressing the issues summarized under the five themes discussed in this report, in a timely manner, would significantly enhance the chances for success.

SUMMARY OF MAIN POINTS OF EMPHASIS

Preface

We strongly encourage the federal agencies to revisit each rule to consider ways in which states can be allowed to explore options and features that work best for them, learning from each other.

We strongly encourage the federal agencies to allow states the freedom to utilize private sector and market solutions instead of forcing them to implement an ever-expanding social program.

We strongly encourage federal staff to find a way to continue to listen to state experts and make continued improvements to the rules above and beyond what we are able to express here.

We strongly encourage federal agency staff to re-visit the minutia and particulars of the rules and re-write them in a way that conforms to the expressed needs of the states, even if the states have not been able to identify the specific language that needs to be changed.

We strongly encourage the federal agencies to involve state subject matter experts and experienced policy makers to be part of the formal process moving forward. Please take into account that the states are the foundation of the federal government, not its subjects.

1. Federal Micro-Managing Beyond the Statute

We strongly encourage the federal agency staff to re-write the rules to remove any extra specificity that will limit state options under the statute.

We strongly encourage the removal of any restrictions or specific requirements on states as they contemplate the best way to set up and govern their exchanges.

We strongly encourage the removal of language in the proposed rules that specify requirements on state navigator programs beyond those required in the statute.

We strongly encourage the removal of any restrictions or requirements on states to establish or not establish parameters for the effective and successful operation of private insurance companies that are the purview of state government.

Any language establishing federal requirements on states to implement grace periods for non-payment or partial payment must be removed.

Any language requiring states to engage in a specific process or manner for engaging stakeholders is inappropriate and should be removed.

Any requirement that removes state autonomy for deciding the criteria and manner for approving QHPs must be removed.

States must be allowed to determine processes for verification that meet local policy and operational objectives. A forced increase in reliance in self-attestation must be removed.

Instead of wasting federal resources trying to figure out a method that will work everywhere, the federal agencies should put forth broad general criteria and stay out of minutia and details and allow the states to experiment with different approaches.

2. Subjecting States to Unnecessary Federal Oversight

The process for certifying a state-based exchange must be simplified in recognition of the fact that it is a state-owned and operated program. Any attempt to use the Medicaid SPA model will create unnecessary federal oversight and should be abandoned.

The proposed rules must be modified to remove unnecessary federal oversight of state-based exchanges.

If for no other reason than this, we strongly urge the federal agencies to create a state-based (or market-based) version of an EHB that allows every state definition of "essential" to reflect the culture, values, health, market and sovereignty of that state.

States that choose to operate a state-based exchange should have the flexibility and freedom to develop an application process that works best with their technology platforms and state eligibility rules.

3. State vs. Federal Operations

We encourage HHS to re-open the possibility of providing federal technology modules that can be re-purposed by states to meet required functions.

The most important comment we could make is to de-link the calculation of the APPTC from the Exchange process entirely. We strongly encourage the IRS to reconsider its basic approach and employ a system that mirrors the EITC or W-4 process.

We strongly encourage the federal agencies to accept ownership for the federal individual mandate program, and remove all requirements for state-based exchanges to administer this program on behalf of the federal government.

Specifically, states should not be required to:

1. Make determinations about who is exempt and who is not, or

2. Attempt to maintain a system to detect or report those who are in compliance and those who are not.

We strongly urge the federal agencies to allow state to build as much as they can, including just building a state-based SHOP or AHBE exchange if that is all they are able to do.

4. Vision of the SHOP Exchange

The proposed rules must be modified to not require the exchange to perform any function that is the legal responsibility of an employer, broker/producer, or insurance carrier.

Any requirement on exchanges to allow employers in a defined contribution market to limit employee choice should be removed.

5. Vision of Qualified Health Plans (QHP)

The rules need to pay much more attention to the needs of states that view the QHPs as a market-based system.

In our view, states should be allowed to decide who the certifying entity is and must have the option to designate the Department of Insurance as the sole certifying entity.

We ask for flexibility to create a system that conducts Medicaid eligibility on a request basis. We also ask for consideration and support in looking for alternatives to dealing with this massive increase in volume in creative and practical ways.

6. Vision of Seamless Interface

The proposed rules should not limit state flexibility based on the assumption that an integrated system is the only acceptable approach. States should be allowed to pursue a networked or modular approach.

The proposed rules need to consider that the exchange's primary modality for interacting with applicants will be a computer-based system. To the extent that there will be functionality to interface with applicants in other modes, those should be thought of as the exceptions to the preferred modality and dealt with accordingly.

States should have the flexibility to design call centers and customer support in a networked fashion instead of requiring an integrated approach.

States need the freedom to develop web-sites, platforms and architectures in a way that accomplishes state objectives within the broad guidelines of the statute and the required interface with the federal systems.

7. Lack of Clarity

A full description of the federal exchange, including critical policy decisions is needed immediately.

States need more clarity about timelines and when they can expect various federal pieces to be functional.

The sooner the federal agencies can provide us with their final decision on EHB the better.

More clear guidance on cost-sharing reductions is needed.

We strongly encourage the federal agencies to immediately grant all states waiver authority to allow Medicaid clients to choose to take a subsidy for private individual insurance instead of staying on Medicaid.

States need to know what the federal data hub can and cannot do, what the format of the data interface will be, and be given some expectation of a timeline to be able to connect to it for testing.

States need to get comprehensive and complete final rules as soon as physically possible.

The sooner we can get a comprehensive list of what the federal agencies think we have to collect on a single application, the better.

States need to be given clarity on each required report, including timing, format, and content.

8. Issues with Administering the Premium Tax Credit (PTC)

This is not a complete description of the required processes, but highlights the fact that it is a misguided effort to try to push the APPTC approach for payment determination and processing into a system where it really doesn't belong.

1. Despite the belief of the staff that wrote the proposed rules, having the IRS calculate the APPTC would not "pose significant challenges to ensuring a seamless experience for applicants." We call on the federal agencies to recant their position and return to the partnership discussion with states on this issue.

2. The IRS must accept the responsibility for the determination of the APPTC amount, educate individuals about the need to re-calculate the APPTC when changes occur, and accept the heat that will come when individuals end up having to pay back significant amounts of money because they over-claimed the APPTC. It should be clear why states are not eager to assume any of these roles.

There is no need for a federal "re-check" of Medicaid eligibility in any system. The solution is for the federal agencies to pre-certify the rules or processes of the state system.

The determination of availability of affordable coverage is inherently incompatible with the goal of real-time determination. If there is a solution to this, it is much more likely to be at the federal level than at the state level.

As long as there is a requirement on an exchange to determine whether an individual has access to affordable coverage through an employer or other source, there can be no realistic expectation of a real-time determination of eligibility.

The IRS needs to rethink their position on safe harbors because they create too much opportunity for fraud and abuse and dissolve the concept of individual sovereignty and responsibility.

More information about cost-sharing reduction plans is needed, but this should be an issue between the IRS and the insurer, not the state-based exchange.

State-based exchanges should not be involved in handling any funds for individual policies purchased through and AHBE, regardless of any APPTC involved.

9. Other Technical Issues

The federal agencies need to allow states that have access to electronically available information about individual income to define for themselves when they would accept self-attestation to an income level that is different than the best available electronic information.

We strongly encourage the federal agencies to come up with a common, workable definition of household, and then fully reimburse states for the cost of implementing the new definition, including consideration for the potential impact on Medicaid and CHIP enrollment.

We kindly request that states be allowed to come up with their own special provisions to help address underlying challenges of the Indian population in a way that considers the impact on the state-based exchange and insurance market.

States need to have autonomy and flexibility in determining the best way to work with the private sector in establishing both general policy goals for quality improvement activities as well as the manner and method for evaluating them.

We strongly encourage the federal agencies to allow states the flexibility to work within broad guidelines to meet the needs of their populations, including those with limited English proficiency.

It's our recommendation that states be allowed flexibility to determine which alternate forms of application, if any, benefits its communities.

We strongly encourage the federal agencies to clarify that multi-state plans are subject to the same requirements and approvals as state-based QHPs or other plans. Specifically, we wish to emphasize the role of the state insurance commissioner in overseeing products sold within the state's borders.

States need the flexibility to consider how stand-alone dental plans should be incorporated into the design of a state-based exchange.

States should be given significant flexibility to determine the local issues to be addressed, and the ability to assure stability in the market, including the definition of minimum coverage to be provided by employers.

The best hope of getting to real-time for consumers is to simplify the process and eliminate manual processes. However, this may cause downstream implications for policy decisions as mentioned in this document. Expectations about real-time processes should be defined and tempered in the face of realistic issues.

We request that the rules be re-written to give states the responsibility to handle all scenarios requiring an automatic enrollment according to their own experience and markets.

We recommend that federal agency staff take immediate action to allow states the flexibility to protect their individual markets from collapse associated with the ill-timed influx of large numbers of high-risk people. States need more flexibility to take actions to prevent permanent damage to the markets. The Federal government needs to commit to a less abrupt withdrawal of subsidy funds (including PCIP and Premium Assistance Subsidy funds) from the individual markets

We strongly recommend that the definitions of "newly eligible" and "expansion state" be re-written to conform to the language of the ACA, so that states be allowed to receive the enhanced match for any adults that do not currently have access to a Medicaid program that meets that benchmark standard or that is not currently available because it has capped or limited enrollment.

It is important that states retain the ability to enroll people with disabilities in programs that best meet their needs regardless of the MAGI determination system.

10. Funding Beyond June, 2012

We strongly encourage the federal agencies to extend the time horizon for applying for federal development funds to allow states that have the need to apply incrementally beyond June 2012 to do so.

We ask the federal agencies to clarify their vision for how states that end up implementing federal exchanges will be funded for their share of the burden.

11. Requesting Waivers or Accommodations to deal with the Unrealistic Timelines

The federal agencies need to immediately develop a process to allow states some degree of flexibility with regard to the timelines.

We strongly urge the federal agencies to clearly outline rules and procedures that they will follow for dealing with any state that is not fully ready to launch by January 2014.

12. Dealing with Disruption in Insurance Markets & Prices after 2014

What are the plans for addressing adverse selection if the individual mandate were to be stricken down or if it is determined that the enforcement provisions are insufficient?

What are the federal agencies' plans for allowing state flexibility in those cases where the move to community rating will have the most impact on premiums?

What are the plans of the federal agencies to ameliorate the impact of such a dramatic change on states where the impact is the greatest?

Are the federal agencies willing to allow states to continue to use rate banding techniques to help ensure stability in the small group market or will this protection be eliminated?

What plans do the federal agencies have for ensuring that young people will still be able and willing to participate in the new insurance market given the potential for dramatic premium increases?

What plans to the federal agencies have to soften the blow to working families that see dramatic premium increases due to the change in the nature of the tiers?

What plans do the federal agencies have to soften the blow of the reintroduction of the highest risk population back into the risk pool, especially considering the probable loss of the Premium Assistance Subsidy funding?

The federal agencies must consider how to reduce the impact of the new market regulations on the ability of states and insurers to find ways to reduce costs through long-term relationships.