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Executive Chamber
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Planning and Establishment of State-Level Exchanges; Request for Comments Regarding Exchange-Related Provisions in Title I of the Patient Protection and Affordable Care Act

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Comments provided to Office of Consumer Information and Insurance Oversight, Department of Health and Human Services

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New York currently intends to fully explore establishing a state-based Exchange. However, New York's primary concern is whether it will have sufficient resources and funding to set up an Exchange, given New York's current fiscal crisis. Federal funding is imperative. Simply put, New York will not be able to establish an Exchange without federal funding. The State therefore encourages HHS to provide maximum possible funding to states in the planning and establishment of Exchanges.

In addition to the federal resources and mechanisms necessary to secure a new or vastly improved eligibility and enrollment information system, New York also needs enhanced, easy access to federal and third party data sources and expedited administrative approvals necessary to successfully implement and operate an Exchange.

As HHS develops the rules and standards Exchanges will be required to meet, New York encourages HHS to create standardized federal minimums, with state flexibility to exceed those minimum standards. This is particularly important for New York, which has strong consumer protections; many of these consumer protections go beyond those required under the Patient Protection and Affordable Care Act.

New York needs guidance across several areas relating to Exchanges as the State moves forward with its examination of factors related to cration of an Exchange. First, HHS should adopt

guidelines that apply the same eligibility rules across the Exchange, Medicaid and Child Health Plus (CHP) programs; drastically simplify those rules; and makes the process seamless and "paperless" to the maximum extent possible. Guidance needs to address these and other critical elements that will allow Exchanges to function as "one stop shopping" for health insurance, minimizing referrals and maximizing access to seamless coverage. Second, New York needs guidance as to which specific services will be covered under the Essential Health Benefits Package through the Exchange. New York requests that HHS include a comprehensive set of services to be covered as Essential Health Benefits. The State encourages HHS to include all of New York's mandated benefits in the Essential Benefits Package. Further, federal rules should allow states to provide standardized additional benefits sold as supplemental to the Essential Health Benefits Package, as long as strong marketing and disclosure rules protect consumers.

New York thanks HHS for the opportunity to provide comments on the Exchanges during the implementation process of federal health care reform. The State's responses to specific questions included in the request for comments are included in the following pages.

A. State Exchange Planning and Establishment Grants

A1. What factors are States likely to consider in determining whether they will elect to offer an Exchange by January 1, 2014? To what extent are States currently planning to develop their own Exchanges by 2014 (e.g, become electing States) versus choosing to opt-in to an Exchange operated by the Federal government for their State? When will this decision be made? Can planning grants assist in identifying and assessing relevant factors and making this decision?

New York currently intends to fully explore establishing a state-based Exchange. However, New York's primary concern is whether it will have sufficient resources and funding to set up an Exchange, given New York's current fiscal crisis. Federal funding is imperative. Simply put, New York will not be able to establish an Exchange without federal funding, including resources for eligibility and enrollment information systems, as well as start-up costs. The State therefore encourages HHS to provide maximum possible funding to states in the planning and establishment of Exchanges.

New York will also require federal assistance in the form of clear rules that provide state flexibility to exceed federal minimums in order to successfully implement a state Exchange by 2014. Specifically, New York needs HHS/CMS to:

- Provide the resources and mechanisms necessary for states like New York to secure improved eligibility and enrollment information system(s); enhanced, easy access to federal and third party data sources; and expedited administrative approvals necessary to successfully implement and operate an Exchange. New York is experiencing significant projected state budget shortfalls, a continuing economic downturn, and an overall rise in the number of uninsured New Yorkers -- despite significantly increased Medicaid enrollment. In light of these difficulties, New York will require additional federal resources to put the staff, infrastructure and information systems in place needed to launch a state-based Exchange.
- Issue regulations and/or provide written guidance specifying that the same rules for determining and verifying income and other eligibility factors will be applied across Medicaid, CHP and Exchange. Such guidance should allow for significant simplification, alignment and integration of the Medicaid and CHP programs with private coverage options, processes and procedures under an Exchange. Examples would include allowing/providing for:

    - Reliance on federal tax returns as sufficient to establish income eligibility for Medicaid, while allowing individuals the option to demonstrate changed circumstances involving significant reductions in income, change in household size/composition, or loss of employment.
    - Reliance on the individual and employer penalties/mechanisms for coverage through an Exchange as an acceptable alternative to enforcement of medical support enforcement provisions in Medicaid.
    - Definitions and processes related to eligibility determinations and enrollment of "MAGI" and "non-MAGI" populations, that support the overarching goals of

significant simplification, alignment and integration of Medicaid and other Exchange options.

- Alignment between the audit requirements for Medicaid, CHP, and approved Exchange processes, expressly including simplified "paperless" verifications, data matching and electronic information transfers contemplated under the Patient Protection and Affordable Care Act (PPACA). The Medicaid audit requirements, as well as the security provisions for use of federal data (e.g., IRS data) must be aligned with the PPACA mandates and policy goals of simpler, expanded access to coverage, or else states will be unable to effectively "operationalize" the new opportunities and requirements.
- Mandatory and uniform guidance defining "lawfully present," for purposes of an Exchange. Such uniform definition should include, at a minimum, those adults (whether pregnant or not) and children within the categories defined as "lawfully residing" per CMS CHIPRA guidance dated July 1, 2010 (SHO # 10-006; CHIPRA # 17).

A4. What kinds of factors are likely to affect States' resource needs related to establishing Exchanges?

The State's resource needs will likely be affected by HHS's decisions regarding the extent of federal responsibility for determinations regarding MAGI income/household, as well as citizenship or lawful presence, that must be made at application and renewal. Such federal decisions will have a direct impact on the extent of needed additional state administrative resources and for new/enhanced eligibility and enrollment systems at the state level with the requisite decision logic and "smart" verification systems.

The resource demands on states will be lessened if HHS provides a uniform, national federal "front end" to the state Exchanges—including both a MAGI eligibility determination and verification of citizenship or lawful presence—that would allow the state Exchange to directly enroll such eligible individuals into either Medicaid or an Exchange product, with or without subsidy in accordance with the federal MAGI determination, and without the need for further state action. The federal "front end" data matching must not result in a lot of "discrepancies" requiring states to do further follow up to resolve.

States will also require significant additional resources to put the staff, infrastructure and information systems in place to support the following eligibility determination and enrollment functions as of January 2014:[1]

- Allow individuals to apply and have eligibility determined for coverage and any applicable subsidies either online (through the web portal), by telephone, by mail or in person.

[1] Small businesses must also have Exchange access in 2014; large employers may be able to participate starting in 2017. Since an electing state must be able to demonstrate sufficient progress by January 2013 towards implementing the Exchange, the resources needed to secure implementation by January 2014 will actually need to be available in prior fiscal year(s).

- Inform individuals of eligibility requirements for Medicaid, CHP, and other public programs and screen and enroll if eligible.
- Collect specified relevant information, such as applicant's name, social security number, date of birth, citizenship/immigration status, income, employer name, address, identification and information about employment (full/part time) and employer coverage (if relevant to determining eligibility for subsidies or exemption).
- Submit relevant information to HHS for verification against federal databases (e.g., Treasury, Homeland Security, and SSA) for individuals who request a determination of eligibility and consent, or who receive assistance from, a state health subsidy program (e.g., Medicaid, CHP, Exchange subsidies).
- Be able to receive and transmit information required for eligibility and enrollment determinations between Exchange, individuals, HHS, potentially other federal agencies (i.e., Treasury), Qualified Health Plans (QHP), and employers, in accordance with HHS standards.
- Meet interoperable, secure systems standards and protocols (to be developed by HHS by October 2010) to facilitate enrollment, as a condition of receiving HIT enrollment funds (which HHS may require). The HIT enrollment standards are to allow for consumer online review and updates of applications and eligibility information, including for recertification, and the re-use of stored data to facilitate retention. They are also to allow for the ability to expand the enrollment system to integrate new programs, rules, and functionalities, to operate at increased volume, and to apply streamlined verification and eligibility processes to other Federal and State programs, as appropriate. In addition, the standards are to provide for notices and communications regarding eligibility and recertification, which may include email and cell phones, and other functionality necessary to provide those eligible with streamlined enrollment processes.
- Create an electronic calculator to help an individual determine the annual costs of coverage under a particular plan/benefit level, based on his/her household size and income level.
- Certify exemptions/exceptions from individual mandate and penalties, including determinations of the availability of sufficient/affordable employer coverage, or affordable Exchange coverage.
- Transfer information to HHS/Treasury about exempt individuals and on employees receiving subsidies through Exchange due to employer failure to provide sufficient, affordable coverage.
- Transfer requests to HHS/Treasury for advance determination of income eligibility for individuals applying for subsidies.
- Provide information to employers on employees who cease coverage under an Exchange QHP, and on employees who qualify for a subsidy based on lack of sufficient and/or affordable employer coverage.
- Collect information for individuals who: 1) who are not required to file tax returns; 2) who may have experienced a change in marital status, family size, significant reduction in income,

or filed for unemployment insurance benefits insurance; or 3) where a "discrepancy" exists between reported information and verification.

- Provide notices, appeal rights regarding eligibility determinations and denials.

A4a. What is the estimated range of costs that States are likely to incur during the upcoming year (e.g., calendar 2010 through calendar 2011) for each of the major categories of Exchange activities? Which of these expenses are fixed costs, and which costs are variable?

New York's current fiscal crisis makes it untenable to plan and establish an Exchange without outside funding. To fully research and inform New York's decisions, market analysis and evaluations of modeling the market impact of different proposals for issues such as number of Exchanges within the State and merging small group and individual markets will need to be conducted. The $1 million HHS Exchange Planning Grant will facilitate work, but New York will need more federal support. The State is also seeking foundation funding for specific projects.

A4b. To what extent do States have existing resources that could be leveraged as a starting point for Exchange operations (e.g., existing information technology (IT) systems, toll-free hotlines, Web sites, business processes, etc.)?

New York needs HHS to provide more guidance as to the exact operational needs of the Exchange to determine the extent to which the State can leverage existing resources. New York may be able to leverage certain resources, such as the State Department of Health's initiative for a statewide Enrollment Center that uses an automated eligibility decision tool to assist eligible Medicaid enrollees with telephone and mail-in renewal options starting in 2011. New York, however, will be unable to operationalize an Exchange with current resources; outside funding is needed to do so.

A5. What kinds of questions are States likely to receive during the initial planning and start-up phase of establishing Exchanges? How can HHS provide technical assistance, and in what forms, in helping States to answer these questions?

The State anticipates receiving and has been receiving questions on the various issues outlined in the responses to A1 and A4, above (e.g., whether the Exchange, Medicaid and CHP will be using the same rules and verification processes for countable income, household composition, citizenship/lawfully present status). The State has requested and would greatly benefit from technical assistance, in the form of the specified written guidance, addressing these questions.

New York needs written guidance that applies the same eligibility rules across the programs, drastically simplifies those rules, and that makes the process seamless and "paperless" to the maximum extent possible. Guidance needs to address these and other critical elements that will allow Exchanges to function as "one stop shopping" for health insurance, minimizing referrals and maximizing access to seamless coverage.

New York also needs guidance as to which specific services will be covered under the Essential Health Benefits Package under Section 1302(b) of the Act available through the Exchange and, in particular, whether benefits mandated under New York law will be mandated for plans offered through the Exchange. New York requests that HHS include a comprehensive set of services to be covered as Essential Health Benefits. These covered services should be uniform among the levels of coverage (i.e., the precious metals in Section 1302(d) of PPACA). Thus, the services covered should not vary whether the level of coverage is platinum or bronze. The only distinguishing feature of the levels of coverage should be the consumer cost-sharing. By taking this approach, HHS can set a strong federal floor that will maximize the ability of consumers to comparison shop, reduce administrative costs, ensure that consumers do not underestimate their risk by choosing inadequate basic coverage, and force health plans to compete on quality and cost rather than on risk selection. In addition, HHS should consider including all of New York's mandated benefits in the Essential Health Benefits Package. Further, federal rules should allow states to provide standardized additional benefits sold as supplemental to the Essential Health Benefits Package, as long as strong marketing and disclosure rules protect consumers.

The State also requests guidance as to what extent will States be allowed to standardize products inside and outside the Exchange. New York supports federal standardization and state flexibility to extend standardization beyond what is required by federal law.

HHS guidance is also needed as to whether insurers will be regulated differently whether they are offering products inside the Exchange or outside the Exchange. New York supports consistent regulation and state flexibility to craft regulation to the state's particular markets and needs, so long as state regulations provide greater protection for consumers.

In addition, HHS guidance will be needed as to the role brokers in the Exchange and outside the Exchange, and whether commissions must be included in the premium or paid separately by the buyer. New York supports Federal guidance, but allowing states to decide the best role for brokers in accordance with state standards.

The State also seeks guidance regarding which state's laws apply when the insured lives outside the State. For instance, if someone lives in New Jersey but works in New York, which Exchange is applicable, or can either be used? New York supports rules that are consistent with laws that make applicable the law of the state in which the policy is delivered (situs of employer).

As to the mechanics for enrollee subsidies, New York supports standardized national process, with the ability to customize to meet state needs.

The State also needs guidance regarding whether or not merging the small group and individual markets or including them both in one Exchange would require employers to conduct eligibility verification on citizenship.

Guidance is also needed regarding what data is required to be disclosed by health insurers participating in the Exchange. A high level of data transparency (which could include information such as lists of prescription drug formularies, how insurers are spending premium dollars, and expected out of pocket costs for services provided by out of network providers) will

better educate both enrollees as they choose plans and providers as they choose whether to participate in an insurer's network.

B. Implementation Timeframes and Considerations

B2. What kinds of guidance or information would be helpful to States, plans, employers, consumers, and other groups or sectors as they begin the planning process?

Guidance New York needs is also described in A1 and A5.

New York needs guidance regarding delineation of the Essential Health Benefits Package under section 1302 of PPACA. This information is necessary to begin substantive analysis on a number of questions that will inform New York's choices for structuring the Exchange and benefits offered through the Exchange. Analysis of these issues cannot occur without guidance on the Essential Health Benefits Package.

Additional guidance needs include:

- Guidance on MAGI income and household composition rules, identification of categorical groups for whom MAGI methodology, and when other Medicaid rules must or may apply.
- Guidance/explanation regarding how HHS will:
    - determine MAGI eligibility for individuals/households for Medicaid and for the Exchange, including eligibility for subsidies (cost sharing and tax credits, including whether and to what extent non-custodial parents and/or stepparents will be eligible for tax credits/subsidies based on the provision of coverage to children); and
    - transmit that information to the states.
- If HHS is not going to determine MAGI eligibility or applicable cost sharing and tax credits ("Subsidy Determinations") for individuals, HHS must provide guidance and identify the specific systems, data elements, federal or other data bases for verifications, standards, requirements or other information ("Information") that HHS will make available to enable states/Exchanges to determine MAGI (income and household composition) for purposes of Medicaid and Exchange eligibility, as well as for applicable Subsidy Determinations.
- Guidance regarding how HHS will:
    - determine exemptions/exceptions from the individual coverage mandate for individuals/households; and
    - transmit that information to the states/Exchanges.
- If HHS is not going to determine exemptions/exceptions from the individual coverage mandate, provide guidance and information that HHS will make available to enable states/Exchanges to make determinations of exemptions/exceptions from the individual coverage mandate. HHS must also provide guidance on requirements that will apply to states/Exchanges in connection with determining and reporting exemptions/exceptions.
- Guidance for states on determinations and transmission of information regarding:
    - affordability of employer sponsored coverage, and whether and to what extent noncustodial parent and/or stepparent employer sponsored coverage will be

assessed for affordability, for purposes of exemption from the individual mandate; and
    - imposition of employer penalties for failure to provide affordable coverage for employees who qualify for a subsidy under the Exchange.
- Guidance that clarifies the respective roles/responsibilities of the federal Exchange and any state Exchange established by a state, with respect to the following types of assistance related to Exchange coverage within such a state (including Medicaid and CHP coverage):
    - outreach
    - information/referral
    - provision of navigation assistance
    - screening
    - eligibility determinations, including determinations of citizenship/lawfully present status, income, household size/composition
    - exemption/exception determinations
    - subsidy determinations
    - other cost sharing information/determinations (e.g., premiums for Exchange products, "share of cost"/spenddown under Medicaid, CHP product premiums or cost sharing, Medicare cost sharing/MSP subsidies)
    - enrollment functions
- Guidance that confirms which populations will be assisted by the federal Exchange, and what types of help will be available to specific populations (e.g., seniors, persons with disabilities, Medicare beneficiaries, persons with special health care needs including HIV/AIDS, persons in need of long term care services, pregnant women, MAGI populations, families receiving TANF, individuals receiving SSI, foster care children, small businesses).
- Similar guidance as outlined in the above bullet that confirms the populations that must or may be assisted by state Exchanges, and what types of help must or may be provided.
- Guidance which confirms how Medicaid determinations regarding the availability of "cost effective" employer sponsored coverage as a condition of eligibility will be handled by Exchanges, and how such determinations will relate to the required Exchange evaluations of individuals' access to sufficient and affordable employer based coverage. Exchanges are required to undertake these evaluations as part of the individual mandate exemption/exception determination process and for purposes of identifying individuals eligible for Exchange subsidies on the basis that they lack access to such coverage.
- Guidance that addresses whether or not state courts and/or Title IV D programs have a role in establishing and enforcing cash medical support obligations for parents that obtain coverage through an Exchange. As outlined in A1 above, New York supports reliance on the individual and employer penalties/mechanisms for coverage through an Exchange as an acceptable alternative to enforcement of cash medical support provisions in Medicaid.

<u>B4. What other terms or provisions require additional clarification to facilitate implementation and compliance? What specific clarifications would be helpful?</u>

The State needs confirmation that "point in time" income verification and "countable sources of income," for purposes of Medicaid (both inside and outside an Exchange), is satisfied by reliance on income reported for the individual/household on the most recently available income tax

return. In the case that the individual requests further review based upon a "change in circumstances" (such as significant loss of income, loss of employment, change in marital/parental status), or if no income tax return was filed for the individual/household within the last two years, this income tax return information would not be used.

Exchanges will be evaluating individuals' access to sufficient and affordable employer-based coverage, both as part of the individual mandate exemption/exception determination process, and for purposes of identifying individuals eligible for Exchange subsidies on the basis that they lack access to such affordable coverage. Medicaid has somewhat different, but similar, third party liability provisions that allow states to evaluate an individual's access to "cost-effective" employer sponsored coverage, in terms of potential Medicaid payment for such coverage. Guidance will be needed to help clarify the extent to which Exchanges must determine "cost effective" employer based coverage for purposes of Medicaid premium assistance programs and/or third party liability coverage, and regarding the relationship, if any, between the collection and transmission of data elements needed to support Exchange affordability determinations (which will include information collected by the program such as employer name, insurer, premium and cost-sharing amounts to support the decisions), Exchange affordability decisions, the data elements needed to support potential Medicaid third party coverage or premium assistance determinations, and Medicaid third party and/or premium assistance decisions.

C. State Exchange Operations

C1. What are some of the major considerations for States in planning for and establishing Exchanges?

The greatest concern is funding. As mentioned above, New York anticipates that it must receive significant outside funding to develop effective plans to establish an Exchange.

C2. For which aspects of Exchange operations or Exchange standards would uniformity be preferable? For which aspects of Exchange operations or Exchange standards is State flexibility likely to be particularly important?

New York supports setting a strong national floor for standardization in the Exchange, with flexibility for states to establish standards that do not conflict with national standards and provide greater consumer protections. This will be particularly important in the following areas:

Certification of Qualified Health Plans (QHPs). States should be permitted to set rules that provide greater consumer protections than HHS minimum standards. Similarly, the federal floor-not-ceiling approach should be taken with respect to sufficiency of provider networks, accreditation, quality improvement, and enrollment and eligibility requirements.

Premium Review. HHS rules should preserve the ability of states to provide greater protections to consumers, while establishing a uniform federal baseline. For example, any federal minimum rules regarding the federal age rating rules permitting 3:1 variance should allow flexibility to

states that require less variance, such as New York, which has pure community rating. Similarly, states should be allowed flexibility to require higher (but not lower) medical loss ratios, and to require prior approval of premium rates, even if such review goes beyond federal minimum rules regarding rate review.

Administrative Forms and Procedures. HHS should establish federal minimum standards of forms and procedures. For example, HHS should establish a national referral form to be used by all qualified health plans. HHS should work with states and stakeholders to develop a set of national minimum procedures for when and how a referral should be required. Uniformity will be important in premium billing, remittance and explanation of benefits forms. States should be allowed flexibility to provide greater consumer protections, such as to requiring health plans to respond to referral requests in fewer days than set forth in Federal law.

Reporting of health plan and provider data. There are numerous reporting requirements in PPACA, and it would be useful to have clear federal minimum rules requiring uniformity in the substance and form of what data needs to be reported and how it will be reported. However, states should retain the flexibility to require health plans, providers or other regulated entities to report information that does not conflict with federal minimum rules.

Rating of health plans and providers. HHS should set out minimum national standards for quality measurements. Uniform rules regarding which minimum measurements should be considered, and how to compile and weight those measurements in arriving at a rating, would provide great benefit for consumers. States should retain the flexibility to exceed those federal minimums by requiring additional measurements to rate health plans and providers, as long as the ratings did not conflict with federal minimums.

Uniformity would also be important in terms of MAGI definitions, standards, eligibility determinations, and mandatory definition of "lawfully present" as outlined in B4. Additional areas in which uniformity is preferable are included in A1.

C3. What kinds of systems are States likely to need to enable important Exchange operational functions (e.g., eligibility determination, plan qualification, data reporting, payment flows, etc.), to ensure adequate accounting and tracking of spending, provide transparency to Exchange functions, and facilitate financial audits? What are the relative costs and considerations associated with building Exchange operational, financial, and/or IT systems off of existing systems, versus building new stand-alone Exchange IT systems?

The types of systems support that are needed for eligibility and enrollment determinations are discussed in A4. It is critically important that Medicaid and Exchange eligibility and enrollment IT systems interface effectively so individuals can be enrolled in the appropriate coverage choice on the public/private continuum of available options. Specific Exchange operational system needs, costs, considerations (e.g., stand-alone vs. building off existing systems) and resources will need to be identified and secured through Exchange planning efforts, including federal planning and implementation grants.

C4. What are the tradeoffs for States to utilize a Federal IT solution for operating their Exchanges, as compared to building their own unique systems to conform to the current State environment? For what kinds of functions would it make more sense for States to build their own systems, or modify existing systems?

HHS should provide guidance to allow for significant simplification and alignment of Medicaid and Exchange coverage for the MAGI and non-MAGI populations. States should be provided with the resources to enhance their existing eligibility and enrollment systems to comply with the new PPACA requirements and to ensure consumers' access to the continuum of public/private coverage options for MAGI and non-MAGI populations. Given the diversity of types of families and households —some MAGI, some insured, some with special health care needs, some elderly, sometimes all mixed together in the same "tax filing unit," other times in separate units—states will need the resources to be able to enhance or replace their existing, often outdated and inflexible legacy systems in order to successfully implement the PPACA coverage expansions, mandated simplifications and coordination.

In addition, one of New York's highest needs areas is for a logic-driven verification system. Such a system would enable the state to more easily identify and address only those significant, material discrepancies from the available data that affect a condition of eligibility.

To the extent that HHS does not undertake a "national front end" approach, the states will need a verification program for MAGI populations and non-MAGI populations—one that compares relevant data, flags only material "inconsistencies" that require resolution under federal health reform, and tailors available data into the appropriate format for comparison. The program should be able to accommodate state-specific eligibility levels and provide a "friendly" user interface. It should not only include automated access and matching with reliable sources of federal data (e.g., IRS tax data, SSA data), but should also promote faster and more accurate eligibility determinations by making it easier to use and make sense of available data.

C5. What are the considerations for States as they develop web portals for the Exchanges?

It is important to have simple, user-friendly, comprehensive functionality that connects the consumer to the right place and the right kind of help. Information provided by Exchanges must be conveyed simply and clearly in "layman's" language. Online enrollment systems, in addition to being easy to navigate and meeting applicable standards for accessibility, must provide for family members, advocates or designated others to be able to assist individuals in the enrollment process.

Consumers and small businesses may start the process of getting coverage by "entering" through one or more of many doorways, including local welfare offices, health care provider/presumptive eligibility, community based facilitated enrollers, navigators or other community-based assistors (e.g., independent living centers), or calling or using web access to the Exchanges. Individuals often pursue multiple, simultaneous avenues to try to get help. They often submit multiple applications and sometimes are enrolled in multiple plans or programs, without necessarily understanding what they have or do not have in place. This confusion sometimes results from an inconsistent use of names for programs or products and health plans' different commercial and public coverage products. It is critical that a "no wrong door" approach does not result in further

confusion, since "no wrong door" only works if there is true integration behind the scenes—not only for information and data, but also with regard to responsibility for eligibility determinations, consumer communications, enrollment, claims administration, collection of premiums, and oversight.

New York also needs to know soon whether there will be a national web portal on which states can build or if HHS will provide states with standards that must be met in developing their own portals. If a national web portal is built, states need the flexibility to customize it for their Exchanges. New York also needs to know what funding will be available for creating its web portal.

C6. What factors should Exchanges consider in reviewing justifications for premium increases from insurers seeking certification as QHPs? How will States leverage/coordinate the work funded by the rate review grants to inform the decisions about which plans will be certified by QHPs?

It is important that the Exchange be subject to the various provisions of New York Insurance Law, in particular New York's prior approval law. This will ensure that premium rates inside and outside the Exchange will be reviewed by the same criteria.

C9. What factors should the Secretary consider in determining what constitutes as wasteful spending (as outlined in Section1311(d)(5)(B)?

New York needs guidance on Federal audits and the effect of non-compliance. For instance, will states be penalized or have a fiscal impact for erroneously determining an applicant was in a particular subsidy category? Additional comments on these audits are included in A1.

D. Qualified Health Plans (QHPs)

D1. What are some of the major considerations involved in certifying QHPs under the Exchanges, and how do those considerations differ in the context of individual and SHOP State Exchanges, subsidiary Exchanges, regional or interstate Exchanges, or an Exchange operated by the Federal government on behalf of States that do not elect to establish an Exchange?

Major Considerations in Certifying QHPs. New York requests HHS to maximize state flexibility to become an active purchaser in regards to certifying QHPs. Ultimate decisions regarding the number of permitted QHPs will impact coverage options, consumer choice, consumer confusion, pricing, health plan competitiveness, health plan viability and overall insurance market function inside and outside of the Exchange. However, limiting the number of health plans would increase the bargaining power of the Exchange, leverage competition, streamline product offerings, concentrate insurance risk in larger risk pools and possibly improve premiums.

Differences in Certification.

a. Individual and SHOP. New York requests that HHS provide state flexibility to require insurers to participate in certain markets. For instance, New York has a standardized, guaranteed issue, community rated individual market that has experienced much anti-selection. HMOs are required by law to participate in this market. New York's small group market, in contrast, is relatively competitive with numerous health plans carrying large existing books of business. If the Exchanges are not merged, consideration must be given to whether the newly available subsidies will be sufficient to encourage voluntary participation in the individual Exchange or whether forced HMO participation will continue to be required. This analysis may lead to a different process for certifying QHPs in the individual and SHOP Exchanges.

b. Subsidiary, Regional and Interstate Exchanges and Federal Operated Exchanges.

Certification considerations vary greatly depending on a state's choice between operation of a statewide Exchange, operation of multiple subsidiary Exchanges, participation in a regional or intrastate Exchange or participation in the federally operated Exchange. The certification process for the federally operated Exchange must give consideration to meeting the needs of citizens in vastly different insurance markets.

D2. What factors should be considered in developing the Section 1311(c) certification criteria? To what extent do States currently have similar requirements or standards for plans in the individual and group markets?

States should be provided the flexibility to standardize coverage options both inside and outside of the Exchange. Such standardization would facilitate consumer choice and comprehensive coverage while minimizing anti-selection within and outside of the Exchange. States should be provided with sufficient flexibility to ensure that stronger state consumer protections are not diminished. Individuals with special needs require access to care management to ensure that they are linked with general practitioners with appropriate experience and receive appropriate referrals to necessary specialty medical, mental health and habilitation services. Health plans that are designated as QHPs should also be able to demonstrate their capacity to provide effective care management and access.

D2b. What issues need to be considered in establishing appropriate minimum standards for marketing of QHPs and enforcement of those standards? What are appropriate Federal and State roles in marketing oversight?

New York supports strong federal minimum standards, with state flexibility to go beyond those standards. At a minimum, marketing of QHPs should not be misleading or deceptive. New York urges that states be permitted to review and approve marketing materials to ensure that consumer access is facilitated to the greatest extent possible through clear materials that provide appropriate disclosure to consumers.

D3. What factors are needed to facilitate participation of a sufficient mix of QHPs in the Exchanges to meet the needs of consumers?

State flexibility will be a key to ensuring a sufficient mix of QHPs. Consumers should have adequate choice of health plans, but the number of choices should be manageable for consumers to navigate. Federal and state regulators should develop rules that allow vigorous competition based on price and quality rather than risk selection, and that give the flexibility to make sure that enrollment is not concentrated with a single health plan whose ongoing participation is essential to meeting enrollee needs.

D3b. What kinds of factors are likely to encourage or discourage competition among plans in the Exchanges based on price, quality, value, and other factors?

Competition will be heavily affected by the requirements for coverage both inside and outside of the Exchange, any applicable risk adjustment mechanisms and the resultant incentives. New York supports standardization of benefits and qualified health plan rating for quality measurements.

D4. What health plan standards and bidding processes would help to facilitate getting the best value for consumers and taxpayers?

To ensure the best value for consumers and taxpayers, a set of qualification standards should be developed and required for plan participation in the Exchange. In addition to financial solvency requirements, health plan standards should focus on quality of care, enhanced consumer services, and network adequacy. Plans should also be assessed on their ability to offer enhanced consumer services such as internal grievance processes, multi-lingual services, and ability to meet ADA compliance standards.

In addition, there are a variety of mechanisms that should be used to assess the overall adequacy and capacity of plan networks and to disseminate information on availability to providers. Plans networks should be regularly reviewed to ensure that plans have the appropriate provider types, comply with appropriate standards, and can support enrollment.

Bidding processes should be developed to ensure transparency and engagement of all stakeholders including consumers, health plans, providers and government.

D5. What factors are important in establishing minimum requirements for the actuarial value/level of coverage?

HHS should provide federal minimum standards to determine actuarial value for a plan design. Differences between plan designs (e.g., due to differences in copay, deductibles, etc.) should be based only on the expected impact on the utilization of services and on the net claims cost.

D6. What factors, bidding requirements, and review/selection practices are likely to facilitate the participation of multiple plans in Exchanges? To what extent should the Exchanges accept all plans that meet minimum standards or select and negotiate with plans?

New York supports flexibility for the Exchange to be an active purchaser. HHS should provide guidance as to whether Exchanges will be allowed to schedule bids if enrollment becomes concentrated with a limited number health plans and to avoid disruption of coverage for existing enrollees.

D8. Are there any special factors that are important for consideration in establishing standards for the participation of multi-State plans in Exchanges?

Multi-State plans should not be permitted to sell coverage across state lines that do not meet relatively high New York consumer protection standards. Such plans should not be permitted to disrupt markets or anti-select against local markets by extending less comprehensive products with fewer consumer protections that will be attractive to relatively healthy individuals, leaving less healthy individuals purchasing coverage through existing State markets.

Additionally, community rated states, such as New York, are particularly vulnerable to marketplace disruption if the rating requirements applicable to the multi-State plans are not consistent with the rating requirements in-state. For example, if the multi-State plan offers age rated products that charge younger people a better premium rate, younger people are likely to leave the state's insurance pools while older people are likely to continue to purchase coverage through the state Exchange, creating upward pressure on premiums offered through the Exchange.

D9. To what extent are States considering setting up State Basic Health Plans under Section 1331 of the Act?

New York is very interested in exploring this option, but will need to understand and have clear written guidance on the availability, extent and permissible uses of the 95% subsidies in order to fully evaluate the option.

E. Quality

E1b. Are the measures and standards that are being used to establish ratings for health plans in the Medicare Advantage program appropriate for rating QHPs in the Exchanges? Are there other State Medicaid or commercial models that could be considered?

The general domains (Staying Healthy: screenings, test, and vaccines; Managing Chronic conditions; Rating of Health Plan responsiveness and care; Health Plan member complaints and Health Plan Customer Service) used to rate Medicare Advantage plans serve as a basis for the

QHPs. However, the measures under these domains would need to be expanded to reflect child and adolescent health concerns as well as those of young adults and pregnant women.

E1c. How much flexibility is desirable with respect to establishing State-specific thresholds or quality requirements above the minimum Federal thresholds or quality requirements?

States should be allowed maximum flexibility in establishing thresholds and quality requirements to ensure information collected reflects the unique population and health needs of each state.

E2. What are some minimum standards or other factors that could be considered with respect to establishing quality measurement and improvement thresholds or quality requirements that should be met by QHPs? What other strategies, including payment structures, could be used by plans to improve the practices of plan providers?

The QHPs should be held to quality measurement and improvement standards identical or closely similar to those already in existence within each state. Most states have fairly robust performance measurement systems in place; by not requiring states to redefine them for QHPs, HHS would acknowledge the fact that during the current economic downturn resources are scarce within most states insurance and health agencies.

F. An Exchange for Non-Electing States

F1. How can the Federal government best work to implement an Exchange in States that do not elect to establish or are unable to establish their own Exchanges?

The Federal government must work with states to understand state laws, local markets and market forces, and the history of those markets. For instance, New York's individual direct pay HMO market has suffered from adverse selection, resulting in drastically decreasing participation and increasing the number of uninsured. Any improvements to this market will necessarily depend on an understanding of the current state of this market.

The Federal government must also work with State insurance regulators in reviewing rates of plans offered through the Exchange and recognize the State's role in ensuring insurer solvency and how solvency review relates to premium oversight.

G. Enrollment and Eligibility

G1. What are the advantages and issues associated with various options for setting the duration of the open enrollment period for Exchanges for the first year and subsequent years? What factors are important for developing criteria for special enrollment periods?

Any person who is uninsured, loses coverage or may have employer-sponsored or other coverage but is seeking a subsidy or other Exchange private or public coverage options, should be allowed to enroll through an Exchange at any time.

The Exchange should allow open enrollment for the entire year for the first year, as individuals build experience with coverage, identify care needs, select and change providers. After the first year, individuals should be allowed to change plans once a year. An individual's enrollment period should begin on the one year date on which the individual enrolled in the plan and should last 60 days.

Special enrollment periods should additionally be allowed for the following situations:

- When someone loses employment or a substantial loss of income
- When someone becomes subsidy eligible (and, if there will be circumstances in which an individual could lose a subsidy other than at annual renewal, then at the loss of the subsidy)
- When someone becomes Medicaid eligible or loses Medicaid eligibility
- When someone has a change in family status (e.g., marriage, divorce, death, birth of child, no more children in household)

G2. What are some of the key considerations associated with conducting online enrollment?

States should have flexibility in using electronic enrollment through the Exchange. For instance, online enrollment should not be the exclusive means by which individuals may enroll. Also, the information that must be provided by the applicant should be the same whether the application is submitted in paper or electronic format. State laws should govern certain transactions, such as rules for electronic signatures.

In addition to this, online enrollment should provide for more than an electronic "capture" or transfer of data to populate an application. In order to facilitate quick, accurate and cost-effective enrollment processing, online tools should include decision logic and functionality that provides for automated eligibility, subsidy, and cost-effectiveness determinations, as well as for automated enrollment and generation of appropriate required notices. Any supplemental documentation needs related to "discrepancies" and collection of first payment are also considerations.

G3. How can eligibility and enrollment be effectively coordinated between Medicaid, CHIP, and Exchanges? How could eligibility systems be designed or adapted to accomplish this? What steps can be taken to ease consumer navigating between the programs and ease administrative burden? What are the key considerations related to States using Exchange or Medicaid/CHIP application information to determine eligibility for all three programs?

Effective coordination requires either radical simplification of all the underlying Medicaid eligibility rules, or failing that, access to logic-driven eligibility and verification systems that largely automate the eligibility process. New high functioning, flexible eligibility systems must

either replace, or allow states to work much more effectively in or around, existing legacy systems. Most Medicaid programs have adequate systems to track and pay for health care services largely because historically these systems have received the most federal attention, along with enhanced federal resources. States require resources to create eligibility systems for the Exchanges that can readily accommodate the new mandates for streamlined, expanded and integrated public/private enrollment, enhanced third party data matching and "paperless" verification processes. These new systems must enable states to get and keep eligible people enrolled in coverage across different public programs and private plans. They must provide better rules (or at the very least, better, more automated processes) to help minimize the costly and unnecessary interruptions in coverage and care that often occur when people move, become employed, switch jobs, or experience other changes in circumstances.

Exchanges must maximize uniformity of program rules for enrolling in Medicaid, CHP, and subsidized coverage. The extent to which people have to provide additional information for enrollment in different programs leads to gaps in coverage or no coverage.

The Exchange should ensure 12 month continuous coverage across all programs with limited exceptions. States have found 12 month continuous coverage to be an effective policy for insuring children. By ignoring small changes in family circumstances during the year, children can remain insured and experience improved health outcomes. New York recently received federal approval for 12 month continuous coverage for adults. The extent to which states can reduce loss of coverage among eligible adults and improve health outcomes using continuous coverage will be instructive for the Exchanges.

Exchanges are intended to be one-stop shopping for health insurance. Minimizing referrals to other entities will simplify enrollment and increase coverage.

Finally, Exchanges need the technology to electronically determine eligibility for all the programs in the Exchange, manage program transitions, and verify eligibility using third party data, thereby minimizing paper.

With the advent of Exchanges, transitions will become more numerous as the coverage options increase. Households will transition between public coverage, subsidized coverage and full private coverage, and between employer-based coverage and Exchange coverage. Exchanges have the potential to substantially reduce churning and facilitating program transitions by making it easier for eligible individuals to get and stay enrolled. However, this will be achieved only if the right rules, backed up by the right systems, are in place.

G5. How do States or other stakeholders envision facilitating the requirements of Section 1411 related to verification with Federal agencies of eligibility for enrollment through an Exchange?

States need to be able to easily match against federal data regarding identity and citizenship, immigration status and income. These mechanisms must be efficient and reliable, and must not create undue burdens or impose delays on states or on those seeking coverage. Additional comments regarding verification of eligibility for enrollment are included in A4 and C4.

H. Outreach

H2. What resources are needed for Navigator programs? To what extent do States currently have programs in place that can be adapted to serve as patient Navigators?

Significant federal resources should be devoted to navigator services, particularly in the first several years, and until there are simple, accessible, functioning pathways to coverage and needed care. Models exist in New York that help support patient navigation (such as facilitated enrollers, community health workers, independent living centers, and other independent community-based consumer assistance), but resources are limited. Additional resources are needed and will continue to be needed to accommodate the anticipated increased need.

I. Rating Areas

I1. To what extent do States currently utilize established premium rating areas? What are the typical geographical boundaries of these premium rating areas (e.g., Statewide, regional, county, etc.)? What are the pros and cons associated with interstate, statewide, and sub-State premium rating areas? What insurance markets are typically required to utilize these premium rating areas?

HHS should allow state flexibility in establishing rating areas to fit the particular markets in each state. For example, New York currently permits a variety of geographic rating approaches. Requiring a statewide rating area could put a company that operates in more than one region at a disadvantage. Some companies, especially HMO companies, operate only in a certain section of New York. Other companies may operate statewide or have multiple networks and have several rating regions.

The New York State Medicaid program, operating under the 1115 waiver, uses nine premium rating regions developed on a regional basis. These regions have been effective in addressing different utilization and cost patterns across the State.

I2. To the extent that States utilize premium rating areas, how are they established? What kinds of criteria do States and other entities typically consider when determining the adequacy of premium rating areas? What other criteria could be considered?

New York supports rules that would require a premium rating area to be: (1) contiguous counties and (2) have similar expected claim costs. This would be the usual criteria that an insurance company uses to determine its premium rating areas. New York has no established premium rating areas in the commercial market; each insurer decides its different rating areas.

New York's Medicaid Managed Care program has used premium rating areas that were developed by grouping counties together based on their relative costs (as observed in fee-for-service claims data) and geographic proximity to one another. Typically, a state might consider the following factors in determining premium rating areas:

- The nature of the program (i.e., acute care, behavioral health, or long term care; or full-risk managed care or PCCM);
- The number of plans participating in a proposed premium rating area;
- The other characteristics of the program's reimbursement structure (i.e., whether distinct rates will be paid for each aid category, the age or gender splits that will be employed, and if the rates will be risk-adjusted);
- The homogeneity of the covered population within each proposed premium rating area (i.e., whether there are significant differences in disease prevalence, utilization patterns, the cost of services and/or the availability of providers of services within a proposed premium rating area); and
- The size of the covered population within each proposed premium rating area (i.e., whether there are sufficient numbers of enrollees for each rate cell in a proposed premium rating area to establish statistical credibility).

Ultimately, the goal in developing premium rating areas is to minimize the variance of costs within each region while maximizing the variance between regions.

J. Consumer Experience

J3. What are best practices in implementing consumer protections standards?

Best practices should include:

- Standards that are easy to understand, meaningful and realistic. Protections that target a very small segment of the population are not well received if they have an impact on the majority of the enrollees.
- Consumer education. There needs to be an effective and efficient way to let consumers know that standards exist, what they are and where they can go for help. Many consumers accept the actions of health plans because they don't know what protections and help are available to them.
- An oversight agency or ombudsman to help consumers understand the requirements and how they are affected by them. There should be an adequate number of locations that are fully staffed by people well versed in the protections. The ability to obtain information via the internet and telephone is an important large component of this piece.
- Regular examinations of health plans to further ensure compliance with the standards. Such examinations would capture issues not reported by consumers.

J4. Given that consumer complaints can be an important source of information in identifying compliance issues, what are the pros and cons of various options for collecting and reporting Exchange-related complaints (e.g., collecting complaints at the Federal level, versus at the State or Exchange level)?

New York supports standardized Federal minimum standards to enhance reporting and broaden enforcement efforts. Data collection should be at the Exchange/state level to leverage each state's understanding of local or regional issues and to build on existing relationships between regulators and licensed entities. Federal funding will be needed to enhance state current capabilities.

K. Employer Participation

K1. What Exchange design features are likely to be most important for employer participation, including the participation of large employers in the future? What are some relevant best practices?

Cost is the most important design feature for employer participation. Low cost will encourage more employers to offer coverage and contribute more to premiums.

Comprehensive benefits are also important to employer participation. Simplification and standardization of the benefit packages will facilitate comparison shopping so employers can base their decision on factors such as price, customer service, provider networks, and complaint rankings.

K2. What factors are important for consideration in determining the employer size limit (e.g., 50 versus 100) for participation in a given State's Exchange?

States need flexibility. New York, like many states, defines small groups as groups of 50 or fewer. If all of the existing requirements (such as open enrollment, community rating, risk pool participation, commission restrictions) that presently apply in the small group market will also apply to an expanded small group market, some carriers may opt to drop out of the small group market and participate only in the more attractive large group market with groups of over 100 lives. New York needs more funding to determine market impact.

K3. What considerations are important in facilitating coordination between employers and Exchanges? What key issues will require collaboration?

Standardization of the employer voucher system and the necessary financial transactions will be required to facilitate continuity between employer-based and Exchange coverage.

L. Risk, Adjustment, Reinsurance, and Risk Corridors

L1. To what extent do States and other entities currently risk-adjust payments for health insurance coverage in order to counter adverse selection? In what markets (e.g., Medicaid, CHIP, government employee plans, etc.) are these risk adjustment activities currently

performed? To the extent that risk adjustment is or has been used, what methods have been utilized, and what are the pros and cons of such methods?

New York supports strong federal minimum standards, with state flexibility. Goals of risk sharing should be to prevent insurers from cherry picking good risk, while encouraging care management. As discussed below, New York has numerous risk adjustment mechanisms. HHS rules should permit New York to continue to apply any risk adjustment mechanisms that exceed the federal minimums.

New York has market stabilization pools for the individual and small group health insurance market. Originally the New York individual and small group market stabilization pools used a demographic-based pooling methodology and a specified medical condition pooling methodology. Currently the market stabilization pools use a pooling methodology that is based on the number of high cost claims. Health plans are either payers or recipients depending on their high cost claim ratio in relation to the industry average.

New York has a demographic-based market stabilization pool for Medicare Supplement insurance, funded by carriers offering Medicare Supplement insurance.

New York has two state-funded stop loss funds which operate on a calendar-year basis. These funds reimburse HMOs at a percentage of eligible claims paid on behalf of members covered under standardized individual enrollee direct payment contracts.

New York also has state-funded stop loss funds that operate on a calendar-year basis to reimburse health plans at a percentage of eligible claims paid under Healthy NY contracts. Healthy NY provides standardized health insurance coverage to qualifying small employers and individuals.

It is important that the market stabilization pools and the stop loss funds work in tandem. The market stabilization pools provide for equalization of premium rates and the stop loss funds provide subsidies to vulnerable markets.

New York's Medicaid and Family Health Plus programs utilize a regional average risk-adjusted payment methodology. Clinical Risk Groups (CRG) is the clinical model used to adjust rates. Utilizing the CRG grouper as the basis for payment has allowed New York to adjust payments to plans to recognize differences in the health status of enrollees among the health plans.