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Statewide Parent Advocacy Network, Inc.
Empowered Families: Educated, Engaged, Effective!

**Family Voices-NJ Comments on 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
Submitted Oct. 4, 2010**

Thank you for the opportunity to comment on the state exchanges under the Patient Protection and Affordable Care Act. Family Voices is a national network that advocates on behalf of children with special healthcare needs and works to “keep families at the center of children’s healthcare.” Our NJ Chapter is housed at the Statewide Parent Advocacy Network (SPAN), NJ’s federally designated Parent Training and Information Center, Family-to-Family Health Information Center, and chapter of the Federation of Families for Children’s Mental Health. The NJ Coordinator also serves in a voluntary capacity as the NJ Caregiver Community Action Network representative for the National Family Caregivers Association for caregivers across the lifespan.

Supplementary Information

I. Background

A. General

We understand that under the Affordable Care Act (ACA) states can increase access for insurance through the use of American Health Benefits Exchanges (“Exchanges”). This will facilitate the purchase of qualified health plans (QHPs), provide for a Small Business Health Options Program (SHOP exchange), as well as meeting other requirements under ACA. We agree that the Secretary can establish exchanges in states that do not chose this option, won’t have them ready by January 1, 2014, or will not meet all the “required Exchange standards as defined by regulation”.

B. Requirements for Establishing and Operating Exchanges

We have reviewed the section in the regulations regarding “setting standards for meeting the requirements under Title I of the Act...” We strongly agree that states setting up their own exchanges must meet federal or “State law or regulation that implements the Federal standards”.

1. General Requirements for Exchanges

We agree that exchanges can be set up by either a “governmental agency or nonprofit...” The minimum functions would include procedures of certification, recertification, and decertification of QHPs; a toll-free hotline; website with comparative information; and assigning QHP ratings. We strongly agree with “utilizing a standardized format for presenting health benefits options”; informing/enrolling in Medicaid/CHIP if appropriate; a cost calculator; “granting certifications to individuals relating to hardship or other exemptions”; and establishing a Navigator program.

2. Requirements Relating to Plan Ratings and Internet Portals

We look forward to the forthcoming rating system from the Secretary. We strongly support an “enrollee satisfaction system” of evaluation for plans with more than 500 participants. Again, we strongly support the quality and satisfaction data inclusion in the portal. We agree that the Secretary should make a “model template available to Exchanges for an Internet portal”. We also agree that the Federal portal must be maintained and updated as well.

3. Requirements Relating to Navigator Programs

We agree that duties of Navigators include raising awareness; distributing information, including “premium tax credits and cost-sharing reductions”; referrals for complaints; and information that is culturally competent. A significant barrier to health care access is lack of cultural and linguistic competency; lack of language access is one of the most challenging barriers to overcome. NJ was the first state to pass a statewide mandate for cultural competency training for healthcare providers (see www.state.nj.us/lps/ca/bme/press/cultural.htm), which should be mandated nationally. AT&T language lines and IBM computer translation programs can assist in communicating with patients in other languages by phone and using the Internet. We would also suggest that the Family-to-Family Health Information Centers (F2F HICs) in states could collaborate with or serve as Navigators, and that at a minimum, navigators should be required to network with F2F HICs because of their expertise and experience.

4. Other Requirements Relating to Exchanges

We look forward to the Secretary’s determination on an initial enrollment period, annual enrollment, and special enrollment, and agree that this needs to be decided by July 1, 2012. We also agree that the deadline of January 1, 2015 allows state exchanges time to be “self-sustaining”. We agree that this could include exchanges to “charge assessments or user fees to...insurers... or otherwise generate funding to support their operations”. We are strongly opposed to any fees for consumers. We agree that exchanges need to keep accounting records to submit annually to the Secretary. We strongly support the notion that “the Secretary has certain enforcement authority if an Exchange...has engaged in serious misconduct...”

5. Establishment of Exchanges in the Territories

We strongly support the opportunity for the territories to have a choice on establishing exchanges.

II. Solicitation of Comments

We appreciate that the Secretary, in accordance with ACA, is consulting with stakeholders, including consumers and advocacy groups. We encourage the Secretary to not only consult with national stakeholder organizations, but also to reach out to consult with state and local community organizations representing a diversity of race, ethnicity, language, socio-economic status, and geography. Stakeholders “on the ground” have unique experiences, expertise, and perspectives that are critical to make appropriate decisions. We also appreciate that “it is not necessary for commenters to address every question...” and will address those in the most detail which are applicable to our organization and the families that we serve.

A. State Exchange Planning and Establishment Grants

We understand that the Secretary will grant awards to states. We agree that these should only be renewed “if a State is making sufficient progress toward establishing an Exchange, implementing other insurance market reforms, and meeting other benchmarks” and that no grants will be funded after January 1, 2015.

1. We feel that the factors in determining whether states will establish their own exchanges will include their current technological levels.
2. Some states are in a better position and have begun to plan. For example, UT and MA have had pilot exchanges prior to the ACT, and CA appears to be the first state that will establish the new exchange.
 2. a. We’re not sure what kinds of governance will be chosen but appreciate the flexibility of using either a state agency or non-profit.
 2. b. Some states have begun to establish budgets (e.g. NM estimated \$600,000 for set up) but there will be a range of costs depending on various factors, such as population.
3. The structure of the exchanges will depend on existing state laws. We would suggest however state as opposed to regional or interstate exchanges, but would support federal standardization. Again, we appreciate that the exchange can be either a state agency or non-profit and feel that this choice will depend on the status and involvement of the current non-profits in the state.
4. Factors related needed resources for states in establishing exchanges would vary by state (see below).

4. a. Estimated range of costs would vary by state (see NM estimate in 2.b. above).
4. b. Some resources that could be used would be existing databases and hotlines. For example in NJ we have registries for birth defects/autism, newborn screening, and immunizations. We also have an existing state, as well as consumer hotline for Medicaid/CHIP run jointly by the Community Health Law Project and Disability Rights NJ.
5. Technical assistance from HHS could include looking at existing IT, linkages, hotlines, etc. and how to connect them and multi-system database compatibility.

B. Implementation Timeframes and Considerations

We understand that exchanges need to be operation by January 1, 2014 and self sustaining the following year. We understand that prior to this the Secretary needs to issue “regulations and/or guidance relating to requirements for Exchanges”, award state grants, and by January 1, 2013 evaluate states’ “readiness”, as well as “having in place additional insurance market reforms”. We also understand that the Secretary will “no later than July 1, 2013, [be] issuing regulations for the health choice compacts and the CO-OP program, and awarding the CO-OP program grants...”

1. As far as key implementation, we feel that the choice of the state agency and/or non-profit must be made as soon as possible to plan ahead. This entity can then create a strategic plan with goals and steps to implementation including deadlines.
2. Guidance from HHS that would be helpful could be a standardized checklist of key requirements for all exchanges.
3. To determine state progress, HHS could look not only the deadlines but evidence of progress in each area.
4. To facilitate implementation, HHS must stress the “no wrong door” policy and require collaboration with Medicaid/CHIP. There might even be enrollment goals set for each state.

C. State Exchange Operations

We understand that the exchanges will “facilitate the purchase of QHPs...provide for the establishment of a SHOP Exchange that assists small employers...and meets additional requirements”. We understand that other requirements of the Act are strongly related to the exchanges such as the Navigator program as well as “insurance reforms, consumer protection provisions, and premium rating”.

1. Some of the major considerations in establishing exchanges would be linking with the Navigator program and monitoring insurance premiums as well as protections such as preexisting conditions and rescissions.

2. We agree for the most part that uniformity is preferable. The only areas in which there should be state flexibility would be where current state laws exceed the federal regulations (age of dependent coverage, mental health parity, guaranteed issue, etc.)
3. As far as systems that would enable operational functionality, we agree that eligibility information is key. Again, monitoring enrollment and establishing individual state goals would be useful in this area.
4. In states where their current regulations do not exceed federal rules or have weak technological systems, it may be easier for them to “utilize a Federal IT solution”.
5. As they develop portals, states must consider all populations served. They should simplify portals so that if individuals in the same family have the same eligibility, they can find which plan applies without having to do so individually. However, there should also be a mechanism whereby if an individual in that same family has a disability or special healthcare need, information specific to that individual can be entered without having to re-enter all the basic family data again. There should also be linkages to other eligibility programs for which that family is eligible such as in our state NJ Helps which links to applications at www.njhelps.org or the national www.benefits.gov . States should also consider health literacy when developing exchanges, as it is the single largest barrier to healthcare access.
6. As far as justifying premium increases, exchanges must have a monitoring capability as well as comparing to similar plans both in that state and similar states.
7. We would hope that territories would be likely to establish their own exchanges due to their unique issues.
8. We strongly agree that exchanges must be culturally competent and would suggest referring to resources both from NJ mentioned earlier in section I.B.3. above, as well as tools on from the National Center for Cultural Competency found at <http://nccc.georgetown.edu>. We would also request alternate formats (e.g. large print, compatibility with screen reader software etc.) for accessibility for people with disabilities.
9. Factors for consideration of wasteful spending would include anything that is not used towards the requirements in the regulations for exchanges.

D. Qualified Health Plans (QHPs)

We understand that there must be procedures in place for certification, recertification, and decertification of plans. The criteria include marketing, choice of providers, community providers, accreditation, quality improvement, uniform enrollment, and providing quality information to consumers.

1. We agree that some of the major considerations regarding certification would be a sufficient network of community-based providers; continuous quality improvement, monitoring, and reporting (including to the public); and statewide uniform enrollment forms but preferably federal standardization if possible.
2. Factors for consideration of certification could be based on current Medicaid enrollment forms but we would stress the use of simplified enrollment. For example in our state our renewal forms were originally 12 pages long, now reduced to a single page (one side English, one Spanish) and also available online in English and Spanish.
 2. a. Appropriate standards for ensuring a sufficient network would include both types of providers (e.g. specialty care, pediatric care, primary care) as well as geographic distance with a set number of miles, otherwise either the plan isn't eligible or must allow for out-of-network providers at no additional cost.
 2. b. Issues considered for appropriate marketing must be outreach beyond raising awareness, retention, and linkages through other systems such as Boards of Social Services, schools, TANF, WIC, etc. In NJ for example, despite a state mandate on coverage for all children, latest estimates showed half a million eligible children not yet enrolled in Medicaid/CHIP. Renewal must be simplified, as stated previously, to improve retention.
3. Factors needed to facilitate participation of a sufficient mix of QHPs could include a minimum number of plans available per county.
 3. a. Timeframes for assessing plans participating in exchanges could include a needs assessment 3 months prior to launch of the state exchange.
 3. b. Factors likely to encourage plan participation could include small financial incentives or provision of technical assistance for technology and startup, benefits of marketing through the exchange, and benefits of uniform enrollment forms (perhaps looking at enrollment data for plans).
4. Health plan standards (uncertain about bidding processes) that would facilitate best value would include consideration of cultural competency and health literacy for maximum access, cost-savings, and health outcomes.
5. Factors that establish minimum standards for the actuarial value/level of coverage could include those considered medically necessary under Medicaid, especially utilizing EPSDT standards for pediatric coverage.
6. We feel that all plans that meet the minimum standards should be accepted.
7. We feel that the CO-OP programs will not be able to be competitive with private insurers or be able to lower costs.

8. We would suggest either state, or if possible federal programs, rather than multi-state.

9. We think that State Basic Health Plans should be pursued because costs will be lowered through a competitive process.

E. Quality

We understand that ratings would be based on quality and pricing.

1. Factors in considering ratings should include consumer satisfaction.

1. a. Exchanges can help consumers by comparing available plans both in terms of cost and consumer survey results.

1. b. Although Medicare Advantage programs are good models, we would suggest the use of Medicaid standards, and particularly EPSDT for children as previously mentioned. Compliance with EPSDT standards should be a “care floor” for all children.

1. c. Although flexibility should be used, we agree that state standards exceeding federal standards should be developed.

2. Other considerations for quality improvement could also include provider ratings of plans. Strategies, including payment structures mentioned, could include incentives for providers who utilize the medical home model, which is not only cost effective but results in better health outcomes.

F. An Exchange for Non-Electing States

We understand that states have the option not to establish their own exchanges.

1. The federal government can assist states by using a standardized model, but include flexibility for those states that currently exceed federal regulations.

2. Exchanges not operated by states would need to consider factors such as monitoring and enforcement. Consumers should have the same protections and access whether the exchange is state run or not.

G. Enrollment and Eligibility

We understand that the Secretary will establish a program “determining whether an individual meets certain eligibility requirements...premium tax credits and cost-sharing reductions, and individual responsibility exemptions”. We also understand besides the additional requirements “to assist Exchanges by making advance determinations regarding income eligibility and cost-sharing reductions”, that there are also requirements for “simplifying and coordinating enrollment”.

1. Factors that are important with regards to special enrollment would be continuity of care. For example, consideration must be given if healthcare access would be delayed because of lack of coverage due to gaps in coverage. There needs to be a safety net type mechanism and flexibility in enrollment to prevent avoidable gaps in coverage other than those allowed in the regulations.
2. Considerations for online enrollment would include public awareness of availability, ease of use, and availability of languages other than English.
3. Eligibility and enrollment can best be coordinated with Medicaid/CHIP through the exchanges with linkages to other online applications based on program eligibility determination from the screener. This must also occur through the Navigator program.
4. Existing data linkages with Medicaid/CHIP depend upon the state. As previously mentioned, NJ has links to actual applications on the NJ Helps website.
5. Verification for enrollment eligibility and data sharing also depends on the state. There needs to be strong collaboration with the State Health Information Technology workgroup, Regional Extension Centers/grantees, and where they exist Beacon Communities pilots as model programs, and other stakeholders including consumers and advocacy groups. Data sharing would also depend upon existing state databases such as registries for birth defects, autism, newborn screening, immunization, etc.
6. Again the verification and data sharing functions that states are capable of performing would depend on their existing HIT as well as the collaboration of the entities mentioned in #5 above.
7. Clarification is needed on what is meant by “what considerations should be taken into account in establishing procedures for payment of the cost-sharing reductions to health plans”. We previously commented above on cost-sharing reductions to consumers.

H. Outreach

We understand that there will be grant programs for Navigators, public education about exchanges, and that exchanges must distribute and facilitate enrollment as well as make referrals for questions or complaints, including appeals.

1. Outreach activities in states should include linkages to existing resources including resources focused on health/mental health and other resources for families such as child care information and referral agencies, Head Start/Early Head Start, child welfare prevention agencies, substance abuse agencies, Parent Training and Information Centers, etc. For example, in our state we have NJ Helps www.njhelps.org (see #5 under C. State Exchange Operations above). We would hope there would also be links to the national www.benefits.gov site as well. Most important would be consistency in outreach. Perhaps technical assistance could have guidelines for outreach strategies.

2. Resources needed for Navigator programs would include compatibility between systems for information exchange. As previously mentioned, our state has both a state-run and consumer hotline for Medicaid/SCHIP enrollment, questions, and grievances. These can be expanded and adapted for the Navigator programs.

3. Outreach strategies for enrolling those eligible for tax credits and cost-sharing reductions should incorporate social services to reach those eligible for EITC. In our state we have county-based boards of social services which enroll families in benefits programs, including insurance. The outreach strategies must include linkages with social services. Retention is difficult and can be due to either the transient nature of the population or the renewal process. There could be cross referencing with existing databases which could have address updates or citizenship documentation that can be used for another program. Also, outreach should occur in colleges where employer based benefits for dependent care up to age 26 and is not considered taxable income. Renewals should be simplified. In NJ for example (as previously mentioned in #2 under D. Qualified Health Plans), our Family Care application renewal was originally 12 pages long. This was simplified to one page, and is also available online, as well as in multiple languages and outreach is done with English on one side and Spanish on the other. NJ also has an “express lane application” for initial enrollment. For employers, there should be outreach to small business owner associations.

I. Rating Areas

We understand that states are required to develop “one or more rating areas within the state”. We also understand that HHS is provided grants (www.healthcare.gov/news/factsheets/rateschart.html) to develop or enhance rate review activities in states. We strongly support the public reporting requirements as they relate to rates at unreasonable thresholds and justifications.

1. In NJ there will be contracted actuarial review and website development for easier access for public reporting (currently only available upon request).

2. In NJ, currently for the individual market, rates needed to be approved by the Department (55% minimum loss ratio). Rates vary by age, gender, and geographical status. For the small group market, carriers had to file with the Department (80% minimum loss ratio) and rates are set using the same factors in the individual market.

J. Consumer Experience

1. To determine the types of design features would help consumers obtain coverage we would suggest the inclusion of consumers and advocacy groups in development.

2. Kinds of information most helpful to consumers in determining whether to enroll in an exchange or decide on a plan can best be determined through diverse consumer input. We agree that there must be outreach to underserved populations with considerations to cultural competency, health literacy, and access for people with disabilities. This

would be enhanced again through representation of the various consumer stakeholders and advocacy organizations (national, regional, statewide, and local) in the development of outreach materials.

3. Best practices in consumer protections would again require both consumer and advocacy organizations input as well as once the protections are developed, there must be public awareness. Advocacy organizations can partner with the state by providing workshops on consumer protections.

4. We feel that there must be reporting of consumer complaints at both a state and national level. States can look at complaints to determine patterns by geographical area or plan. States can then be compared to each other nationally.

K. Employer Participation

We understand that there will be the establishment of the Small Business Health Options Programs (SHOP). We also understand that states can define “small employer” as either 100 or fewer, or 50 or fewer employees. Employers that do not offer coverage will provide information on exchanges and where to purchase coverage.

1. Design features for employers would again include ease of use by consumers with consumer input in development.

2. Factors in determining employer size may depend upon the state. However, we feel that the requirements should apply to small employers of 50 or less to maximize consumer coverage.

3. Considerations for coordination between employers and exchanges need to include employer awareness of consumer rights and their responsibilities. Key issues regarding collaboration would be health information privacy. We have heard cases where an employee wasn't initially hired or was fired due to health status.

4. Other issues may include raising awareness of employers that coverage results in cost savings, better health outcomes, and increased productivity.

L. Risk Adjustment, Reinsurance, and Risk Corridors

We understand that there will be “the establishment of transitional reinsurance programs, risk corridors, and risk adjustment systems” for individual and small group markets.

1. To counter adverse selection, NJ's Medicaid payment is based on risk adjustment for chronic conditions.

2. NJ's data collection for risk adjustment is based on age, sex, and geographical location (see #2 under I).

3. Issues states must consider in risk adjustment would include cost. Unfortunately NJ's Small Employer Health Benefits Program (SEHBP) and the Individual Health Care Program (IHCP) were on the brink of collapse and had some of the highest rates in the country.
4. Administrative options regarding risk adjustment should involve broad stakeholder input. In NJ, the elimination of the requirement for DOBI approval decreased delays in starting new plans. It was suggested that standardization of paperwork would streamline the process, reducing administrative costs and in turn reduce premiums. Further suggestions included limiting the number of employer plans to reduce adverse selection (see http://www.rockinst.org/pdf/health_care/2008-08-private_insurance_coverage.pdf).
5. Currently all states have applied and received the new grants for the reinsurance program to cover those not yet eligible for Medicare although we are unsure how this was offered previously in terms of contributions, coverage levels, and eligibility since we mostly work with children.
6. The list on NJ entities, including nonprofits, which could (but not limited to) be considered an "applicable reinsurance entity" can be found at www.healthcare.gov/law/provisions/retirement/states/nj.html .
7. Besides early retirees, we are unsure how individuals would be deemed high risk other than the ratings (age, sex, geographic location) and high risk pools mentioned previously.
8. Challenges relating to implementation of reinsurance in states would be that of cost primarily. In 2009, the number of NJ companies offering retiree health coverage dropped to 29%.
9. Risk corridors were being used in other programs such as Medicaid and Medicare. Research indicated that for Medicaid this resulted in program improvement over using tactics such as selection strategies (see <http://gateway.nlm.nih.gov/MeetingAbstracts/ma?f=102275500.html>).
10. We are unsure if there were other non-federal examples of reinsurance and risk corridors being used together previously.

M. Comments Re: Economic Analysis, Paperwork Reduction Act, Regulatory Flexibility

We understand that an assessment of the costs and benefits is required.

1. Policies affecting plans, employers, and states with regards to exchanges would be the requirements mentioned in section B above. Some states are already doing some of these requirements such as certification of QHPs, assigning ratings, hotlines, pilot

exchanges in 2 states, etc. Some states also already have benefits referrals systems to coverage for Medicaid/CHIP.

a. Direct/indirect cost challenges will be related to standardization for presenting health benefits options, connecting with the new Navigator programs, funding for sustainability, and referrals beyond enrollment to handle questions or grievances.

b. Stakeholders affected by benefits and costs would include all three: plans, employers, and states. The cost to states particularly would depend upon if they currently have procedures for ratings, hotlines, Medicaid enrollment linkage, etc.

2. There are unique benefits and costs for small entities re: exchange requirements. Benefits would be to “level the playing field” to offer equivalent services as larger entities. Costs would be staffing challenges to fulfill the requirements due to small size.

3. We feel there are benefits and costs for consumers. Benefits would be the ability of consumers to make a choice between plans. Costs to consumers could be the time it would take to thoroughly investigate all options, and extra cost if they do not pick the plan with all needed benefits. There must be a safety mechanism in place if consumers receive incorrect information and need to switch plans. For example, my family was told by a plan that a hospital was in network. However, when we called the hospital, only certain doctors in the hospital were participating providers. We then called another plan which also said that hospital was in their network and I clarified it wasn't just certain providers at that site, which was further verified by the hospital. Being able to switch to plans with in-network providers lessens financial hardship on families.

4. We do feel that there are definitely paperwork burdens related to the exchange provisions but are unable to provide an estimate as it will be variable depending upon the current infrastructure already in place for employers, plans, and states.

N. Comments Regarding Exchange Operations

We understand that the provisions regarding exchanges involve various stakeholders.

As the Family to Family Health Information Center in NJ, we work with families and professionals to help them collaborate to improve health care access and quality for children with special healthcare needs. Thank you again for the opportunity to comment on the state exchanges under the Patient Protection and Affordable Care Act.

Sincerely,

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Our Mission: To empower families and inform and involve professionals and other individuals interested in the healthy development and educational rights of children, to enable all children to become fully participating and contributing members of our communities and society.