

**COMMENTS to the Department of Health and Human Services,
Centers for Medicare & Medicaid Services**

**RE: Patient Protection and Affordable Care Act;
Establishment of Exchanges and Qualified Health Plans: Proposed Rule**

CMS-9989-P

by the Utah Health Policy Project

October 28, 2011

The Utah Health Policy Project respectfully submits the following comments to the Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services (CMS) in response to the notice of proposed rule making, CMS-9989-P, Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans (QHP).

The Utah Health Policy Project (UHPP) is a nonpartisan, nonprofit organization dedicated to lasting solutions to the crisis of the uninsured and rising health care costs. Our mission is to create quality, affordable, comprehensive health care coverage for all people in Utah through research, policy development, education, and community engagement activities. UHPP has been involved in Utah's health reform, which began in 2006, and the creation of the Utah Health Exchange, launched in 2009, from the beginning. See our website for examples of our consumer advocacy and policy work around health reform and the exchange in Utah. <http://www.healthpolicyproject.org/CoverageInitiatives.html>.

We are focusing our comments on specific areas in which our state has experience and expertise to share with HHS. While these are not exhaustive comments, we wanted to weigh in on those issues that are critical to making Exchanges successful in Utah, as well as in those states that plan to follow Utah's bare-bones, "open market" approach.

Utah's Health Exchange (UHE), serving small businesses with 2-50 employees, has been in operation since 2009 and is considered by many across the nation as one of the "bookends" of how exchanges could work under the Affordable Care Act (ACA). UHPP is concerned with the spotlight that has been placed on the UHE for the following key reasons: 1) *the UHE has not appreciably increased access*. Utah is a small business state and only about 1/3 of Utah's small businesses offer health insurance to their employees. However, to date, the UHE has brought a mere 840 individuals into health insurance (approximately 80% of small business that get insurance through the exchange already offered insurance to their employees); 2) *the UHE has not brought down cost*; and 3) *quality has not been addressed*. See our recent position paper, "The State of the Utah Exchange" for a more detailed analysis of the failure of the UHE to impact *any* of the three pillars of health reform: access, cost, and quality. http://www.healthpolicyproject.org/Publications_files/State/TheStateOfUHEDash

[board.doc.pdf](#)

It is with this in mind that we offer comments on the proposed rule for Exchanges. As one of two states with operational exchanges, Utah has a unique perspective to lend to this rule-making process. Following are our detailed comments, by section of the Rule.

§155.110 Entities eligible to carry out Exchange functions

Board Composition

We applaud HHS for explicitly recommending that the majority of voting members on an Exchange board represent consumer interests. We also appreciate the opportunity to comment on Exchange governance issues. Our comments here address both exchange governance and the role of advisory committees.

Experience from Utah's exchange suggests that even exchanges housed within the state need good governance. We strongly recommend that *all* exchanges, no matter where they are housed, be required to have a formal governance board.

At the early stages of exchange development it is easy for discussions about the exchange to get lost in operations issues, and the consumer piece to be placed aside. This may well be why the UHE has not yet made a dent in the uninsured population of Utah, nor brought costs down for the employees of small businesses.

(http://www.healthpolicyproject.org/Publications_files/State/TheStateOfUHEDashboard.doc.pdf)

To respond to the request for comments on the types of representatives that should be on Exchange governing boards, we recommend that all Exchange boards be required to have at least *two* consumer advocates, unless the board is constituted wholly of unconflicted healthcare experts, in which case *one* consumer advocate might suffice. Consumer advocates can include individuals or nonprofit organizations with relevant knowledge and expertise. In addition, we recommend that the regulations specify that authorities making appointments to the board take into consideration expertise about health disparities and not only the current racial and ethnic diversity of the state, but the trend into the future. For example, Utah has one of the most rapidly growing racially and ethnically diverse populations in the nation

(<http://health.utah.gov/disparities/data/UtahLanguagesSpokenatHome.pdf>), but the health care system is still configured to serve the homogeneous population that Utah once had.

The tricky part is balancing expertise with conflicts of interest. It is vital that governance is free from conflicts of interest so that the consumer is well served. Thus, we request that HHS use a broader definition of "conflict of interest" for Exchange Board members. While we agree that "representatives of health insurance issuers or agents or brokers, or any other individual licensed to sell health insurance," have conflicts of interest, we believe that the following could also have conflicts of interest and therefore should be prohibited from representing a majority on Exchange boards: providers or anyone who consults with,

represents or is a member of an association of insurers, agents, providers, or people licensed to sell health insurance. We further recommend that a spouse of a conflicted party be prohibited from serving on Exchange boards unless his or her professional qualifications are clearly consumer oriented

One danger of not having a governance board is the concentration of decision making power into one or two individuals, without public accountability. The governance of the Utah Health Exchange is somewhat of a mystery to the consumer. Much of the operational decision making for the UHE lies in the position of the director (Patty Conner), who takes some operation decisions to the Risk Adjuster Board (RAB) for approval (although the RAB, by statute, is not invested with governance authority). Conner also works closely with the Governor's health reform director (Norman Thurston), who seems to hold some sort of decision making power also, but it is unclear to the consumer what this is. UHE decisions and the process to come to them are not public (transparent). An example of what a concentrated and non-transparent, not publically accountable governance structure can yield follows.

Example: Utah statute requires there be a Utah Health Exchange Advisory Board (http://le.utah.gov/~code/TITLE63M/htm/63M01_250600.htm). However, this Advisory Board was dissolved (and replaced) this summer, without any public input or discussion. The new advisory structure consists of 4 parts: separate closed-door insurer and broker roundtables; an *ad hoc* consumer advocate group, to date not yet formed; and an executive steering committee (which technically has all the seats required by statute for the consumer advisory board, plus some). The current "consumer seats" on the executive steering committee are occupied by the Senior V.P. of the state's largest insurer and hospital system, Intermountain Healthcare, a University of Utah CFO, CEO of Leavitt Partners, and the Regional CEO of Utah's Quality Improvement Organization, HealthInsight. While they may be sympathetic to consumer interests, none should be characterized as bringing the consumer perspective to the table.

The executive steering committee is charged with "high level visionary" input, while the roundtables are meant to address operational issues, and the consumer group consumer concerns. Based on Utah's experience with getting an exchange up and running, it is wise to have *all* the stakeholders around the table *together*. Insurers need to talk to brokers, who need to talk to state officials, who need to talk to small business owners, who need to talk to the uninsured, who need to talk to consumer advocates, who need to talk to the director of the exchange, and so on. This cross-communication can be key to forming the kind of cooperation necessary to *bring the uninsured into affordable quality health insurance coverage*. Everyone has to work together to make an exchange operational.

The recent dissolution, dismemberment, and replacement of Utah's advisory structure raises two important governance concerns for consumer advocates: 1) the cross communication that has been vital to the exchange development process has been dismantled and 2) closed-door meetings decrease the already limited transparency in the process. This advisory committee change is evidence of what concentrated and non-transparent exchange governance can yield. In addition, without a strong governance

board, continuity of exchange operations, decisions, and input is at risk when positions change hands (for example, were the exchange director leave and someone new hired into that position).

No matter what the governance structure looks like, we further recommend that all Exchanges be *required* to have a formal Consumer Advisory Committee that represents the diversity of consumers in the state, especially the lower income uninsured and under-insured. The Consumer Advisory Committee should be comprised of consumer advocates and nonprofit organizations with relevant knowledge and expertise, small business owners, and the uninsured (i.e., “real consumers”) in order to bring the everyday experience of consumers to bear on decisions about Exchange operations and implementation. This committee should have a formal relationship with the governing body of the exchange, that is, it should have authority to make specific recommendations to the Exchange. The advisory committee should not just be an exercise in meeting or venting, but an entity to which the governing body of the exchange is held accountable in measurable ways.

Experience from Utah’s exchange also suggests that both governance and advisory function meetings *must be transparent*. States should be *required* to make all governance and advisory functions public and publically accessible (advertised, held at hours and in a location convenient to consumers, and minutes posted with a forum for public comment). This transparency has been missing from Utah’s process, and this is why the Utah Health Policy Project supports an “Exchange Watch” page on our website—this is very time consuming for us and not an appropriate role for us to play (<http://www.healthpolicyproject.org/CoverageInitiatives.html>).

§155.130 Stakeholder Consultation

Consulting with Key Stakeholders

We support the proposed requirement that the Exchange consult on an ongoing basis with key stakeholders—and suggest adding “uninsured individuals” to the list. We also suggest that HHS formalize the expectation for Exchanges to consult with stakeholders on an “ongoing basis.” We propose that the Exchange be required, at a minimum, to hold a yearly public forum with all stakeholders present at which public comment is taken, to report on the progress of the Exchange in meeting the goals of actually covering the uninsured and ensuring that health insurance is affordable and that the consumer experience is seamless.

§155.210 Navigator Program Standards

Navigator Timeline

We support the proposed requirement that Navigator programs be operational no later than the first day of the initial open enrollment period.

Navigators and Conflicts of Interest

In response to the request for comments on determinations of conflicts of interest for

Navigators, we propose that HHS expand the list of parties that would be considered conflicted. In addition to prohibiting insurers from serving as Navigators, we recommend prohibiting the following types of entities from serving as Navigators: subsidiaries of insurers or insurer associations and entities that have a commercial interest in any given insurance product, including HSAs and HSA administration. Brokers could possibly serve as one type of navigator, but only with clear parameters around potential conflicts of interest (*see more on p. 6*). It is our understanding that Massachusetts has found ways to engage brokers so that they are a help and not a hindrance to the broader goals of reform.

Navigator Compensation

HHS has requested comments on Navigator compensation for enrolling individuals in plans inside and outside the Exchange. The regulations propose that “a Navigator must not receive any consideration directly or indirectly from a health insurance issuer in connection with the enrollment of any qualified individuals or qualified employees in a QHP.” We believe, and would like HHS to clarify, that this language will not preclude community based Navigators from receiving grants from insurers or the state for activities unrelated to enrolling individuals and employees in QHPs.

To be successful, Exchanges should discourage Navigators from intentionally or unintentionally guiding people with health conditions to certain plans and therefore increasing adverse selection in the Exchanges. Therefore, we recommend that Navigators be prohibited from receiving compensation from insurers for enrolling individuals or employers in private insurance plans outside the Exchange. This prohibition would not bar Navigators from receiving federal or state grants awarded for the purpose of enrolling individuals in Medicaid, CHIP or other public plans.

Types of Entities That May Serve as Navigators

HHS has asked for comments on the number and types of entities that may serve as Navigators. We recommend that Exchanges be required to have **at least one** consumer-oriented nonprofit organization as a Navigator. Well planned Exchanges will bring people in to private health insurance that have never had health insurance before. These people, along with other vulnerable populations such as people with disabilities, English language challenges, certain ethnic groups, and families with mixed immigration status, will need intensive and ongoing assistance applying for, enrolling in, and managing the costs associated with private health insurance. Those folks who will be moving between private and public coverage due to changing work status will need assistance beyond that which an insurance broker is equipped or prepared to provide. UHPP is just launching a consumer assistance program called Take Care Utah that will start in Title One schools, teaching the community about the importance of health insurance (public and private) and assisting families in enrolling into the right product through a “no wrong door approach.” Take Care Utah is an example of a community based organization as navigator because it will perform outreach and education to those vulnerable populations, and will provide on-going assistance to Utahns who need help over time to become prudent consumers of health insurance and health care. The program will be “on the ground” in the very communities that need health reform the most. We will be happy to share our experience with HHS as this program is implemented and grows.

Utah's exchange is a broker-dependent exchange. Ninety-six percent of groups that enroll in health insurance through the UHE use a broker, and generous broker fees are integrated into the exchange (those who chose not to use a broker do not get a discount). Brokers have a role to play in exchange enrollment—but *they do not replace community based nonprofit consumer oriented organizations in the navigator function*. It is beyond the scope of the broker's job to perform the outreach and education necessary for vulnerable populations to navigate all of their health coverage decisions. It is also beyond the broker's scope to be an on-going community resource for health and medical care decision making, linking to other community resources, and to provide the on-going support to teach people new to private health insurance how to budget into the future for cost-sharing. Utah's exchange so far has done marketing and outreach solely through the broker community. This may be part of the reason enrollment in the Exchange is so low (165 small businesses out of 67,000 in the state). It also might explain why utilization of the state's premium assistance program, Utah Premium Partnership (UPP), is so low.

At a minimum, brokers should be required to attend training about the exchange. We applaud Utah legislators for mandating that all brokers who sell on the exchange be trained by UHE about the exchange. In addition, UHPP was instrumental in expanding the broker education requirement to include mandatory training on UPP. It is very important brokers receive appropriate and continuing education about exchanges, but that they are not the only resource for the public to turn to for assistance in getting health insurance through Exchanges. We repeat: brokers play a role in exchanges *but they do not replace community based nonprofit consumer organizations in the navigator function*.

Cultural and Linguistic Competency Requirements for Navigators

In response to the request for comments on cultural and linguistic competency requirements for Navigators, we recommend that Exchanges develop Navigator programs that meet the following standards:

- Exchanges should be required to select Navigators with a demonstrated track record of conducting culturally competent and language appropriate outreach to the uninsured. Standards for CLAS (Culturally and Linguistically Appropriate Services) and means by which these standards will be enforced should be clearly spelled out in the final requirements for navigators.
- Communications used by Navigators must be available in languages common in the community. Furthermore, Navigators must publicize and post the availability of translated materials and interpretation services. This may be a daunting task for some states. For example, Utah is a refugee settlement state and as a result more than 40 languages are spoken in Utah households (<http://health.utah.gov/disparities/data/UtahLanguagesSpokenatHome.pdf>). It is *imperative* that language competency be required in navigator functions, so that newly insured do not find themselves in dire financial straits as a result of the non-premium costs of private insurance, like deductibles, co-pays, and not-covered services.
- The network of Navigators should be able to provide in-person, online, and

telephone support to potential enrollees. In-person support should be accessible by public transportation and ADA-compliant.

Finally, we applaud the suggestion that Navigators work with and refer to consumer assistance programs in states. We recommend that HHS further clarify the coordination between Navigators and consumer assistance functions to ensure that all consumers are served. Strong consumer assistance that informs people of their options to enroll in all types of coverage, including Medicaid and CHIP, is critical for the successful implementation of the Affordable Care Act.

§155.230 General standards for Exchange notices; §155.205 Required consumer assistance tools and programs of an Exchange; §156.250 Health plan applications and notices

Meaningful access to limited English proficient individuals

We commend the requirement that all applications, forms and notices be written “in plain language and provided in a manner that provides meaningful access to limited English proficient individuals.” Title VI and Sec. 1557 of the Affordable Care Act both prohibit discrimination on the basis of race, color or national origin in access to health programs supported with federal dollars. In response to your request for comments about setting out more specific requirements, we recommend that Exchanges be required to:

- Translate vital applications, forms and notices into all languages spoken by the lesser of 5 percent or 500 people in an Exchange service area. We draw the 5percent standard from the Department of Justice (DOJ) and HHS’ Limited English Proficiency Guidance, and the 500 person standard from the interim final rule established by the DOJ, HHS, and the Department of Treasury governing appeals documents in non-Medicare health plans.
- Include taglines on non-vital notices indicating the availability of translated material or oral interpretation in the top 15 languages spoken by people in an Exchange service area. This is the current standard used by Medicare and by the Social Security Administration.
- Provide access to trained oral interpreters or bilingual staff on request, regardless of whether thresholds for written translation are met.

We recommend that this threshold be applied to all Exchange communications, including notices regarding appeals of eligibility determinations.

Under **§156.250**, we recommend that you require standards similar to those suggested above for §155.230 for the translation and oral interpretation of materials issued by Qualified Health Plans to enrollees. For the plans, the standard we recommend is 5 percent of *plan enrollees* or 500 people.

Under **§155.205**, we recommend that Exchanges be required to place taglines and notices of the availability of oral interpreters on the Exchange website in the top 15 languages spoken by those using the Exchange.

Part 155, Subpart B – General Standards Related to the Establishment of an Exchange by a State

Federal Partnership Models

HHS has announced that it is exploring different partnership models between state Exchanges and the federal government. Although HHS is not explicitly seeking comments on this topic, and despite the new information released in September about how the state-federal partnership might look, UHPP would like to offer these comments for consideration.

In exploring partnership models, we urge HHS to be mindful of the needs of consumers.

The idea of a partnership, where the federal government provides a national support structure for state exchanges, for example, for eligibility and management of the advance premium tax credit, seems sound. It seems to make sense that some tasks fall more intuitively to the federal government, such as advance premium tax credit eligibility determination and management, since this is handled in the federal tax code. In the spirit of non-duplication of effort, the HHS should work closely with states to parse out federal vs. state responsibilities.

Utah has the experience to know that the IT backbone and the operation of an exchange is challenging. It is vital to the success of exchanges that there is seamless flow of information between the federal and state level *with strong privacy and data security built in*. In addition, partnerships between the federal and state governments should make every effort to appear seamless to consumers and should not create extraneous barriers to enrolling in Exchange plans. Additionally, the structure of these partnerships should be fully transparent to enable consumers to hold Exchanges accountable to providing high quality, affordable health care.

Without clear guidelines about what can be done at the federal vs. state level, it will be difficult for states to know the best way to move ahead.

In summary

HHS's proposed regulations grant a lot of flexibility to states, which will allow states to design exchanges suited to their population and market. Yet there are areas where regulation will protect consumers more than flexibility will. These include:

- Conflict of interest provisions, especially where governance, eligibility determinations, and navigator functions are concerned.
- Navigator requirements—at least one entity should be a community based organization that has demonstrated competence in serving language and cultural minorities and in providing assistance to those populations who may be enrolling in private health insurance for the first time.

In addition, HHS should set minimum quality standards for certifying QHPs and in determining network and provider sufficiency to ensure that having health insurance translates into access to quality health care.

The end result of the establishment of health exchanges should be that more people have health insurance (public or private), that all people can afford their health insurance, and that everyone's health insurance serves as a gateway to quality care: Access, Cost, and Quality.

Transparency is the linchpin to successful exchanges.

Please contact us with any questions.
Respectfully submitted,



Judi Hilman, MA
Executive Director
Utah Health Policy Project
judi@healthpolicyproject.org



Shelly Braun, PhD
Reform Initiatives Director
Utah Health Policy Project
shelly@healthpolicyproject.org

Utah Health Policy Project
508 E South Temple, suite 45
Salt Lake City, Utah 84102
801.433.2299