

**Washington State Health Care Authority Comments on the Proposed Rules: *Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans***

The Washington State Health Care Authority (HCA) is pleased to submit comments to the U.S. Department of Health and Human Services (HHS) on the proposed rules for the establishment of exchanges and qualified health plans. The HCA is currently responsible for developing the Washington State Health Benefit Exchange. The responsibility for the exchange is passed to the Exchange Board on March 15, 2012. These proposed rules are a significant achievement for HHS and provide important guidance for the development of our state-based exchange.

**II. Provisions of the Proposed Regulation**

**2. Subpart B – General Standards Related to the Establishment of an Exchange by a State**

**b. Approval of a State Exchange (subsection 155.105)**

The HCA endorses a conditional approval process for exchanges in 2013. That process is a necessary tool for HHS to support the successful development of the Washington State Health Benefit Exchange. The initial approval of an exchange is a significant decision before an exchange “goes live.” The decision will invest HHS and Washington State in a set of expectations and a collaborative process that will guide the services delivered by the exchange.

The State Plan Amendment (SPA) process is an unacceptable way for HHS to monitor changes to an exchange, particularly after the exchanges are no longer dependent on federal grant funding. The SPA’s history is one of written jousting. Goals, objectives, and ultimately trust, are lost and sacrificed along the way toward decisions or conclusion by fatigue. The SPA has not fostered the collaborative relationship or collegial tone that needs to script the exchange’s consumer experience envisioned by HHS.

The HCA wholly recognizes the serious responsibilities that rest with the federal government. HHS cannot merely provide federal funds for tax credits and then idly monitor state-based activities. The HCA believes that HHS can use a results-oriented process to monitor changes in exchange functions.

The HCA proposes that HHS continue to work with Washington State and others to develop performance-based standards for an exchange. For example, a global performance standard could be adopted for increasing the number of insured individuals in a state, among others. HHS might find that different standards and rewards are more suitable for a successful exchange. However, the HCA believes that some form of performance standards are consistent with HHS’s desire to

develop a leading-edge consumer experience associated with affordable coverage and quality customer service. State exchanges that meet the standards could earn the right to forgo federal reviews.

**d. Entities eligible to carry out exchange functions (subsection 155.110)**

Governance was a significant topic in the enabling legislation for Washington State Health Benefit Exchange. The legislation established the exchange as a public-private partnership that is separate and distinct from the state.

HHS rules should not require that a majority of the voting members of governing boards represent the interests of consumers and small businesses. The HCA, however, does agree that exchanges should support consumers and small businesses.

The Washington State Legislature directed that the Exchange Board must include at least: one employee benefits specialist; one health economist or actuary; one representative of small business; and one representative of health consumer advocates. The remaining Board members must have expertise in: individual coverage; small employer health care coverage; health benefit plan administration; health care finance and economics; actuarial science; or administering of a health care delivery system. The Exchange Board will cover a vast amount of expertise and knowledge, however, no expertise or perspective is directed by the Legislature to hold a majority of the votes. It is unlikely that the Governor or the Legislature will revisit the Washington State Health Benefit Exchange Board composition in future legislative sessions.

This subsection of HHS's proposed rules also discusses conflict of interest. HHS should not adopt a requirement that majority of voting members that represent the interests of consumers and small businesses as a minimum standard to guard against conflict of interest. Forming a voting block of any membership does not address conflict of interest. Instead, creating a majority voting block of any membership typically leads to poor decision-making; no longer does that majority need to listen to the perspectives or options presented by the minority members. HHS rules should leave it to states to establish conflict of interest provisions in state legislation or exchange bylaws.

To guard against conflicts of interest, Washington State's enabling legislation begins by requiring the Legislature and Governor to combine their efforts to create a Board. The voting board members are nominated by the Legislature and appointed by the Governor. Further, no board member can be a member of the Legislature or a state employee. Finally, no board member can benefit his or her own financial interests or the financial interest of an entity he or she represents by sitting on the Board. The HCA believes these minimum standards will work well in Washington State.

**3. Subpart C – General Functions of an Exchange**

**b. Required consumer assistance tools and programs of an exchange (subsection 155.205)**

This subsection specifies that an exchange must establish and make available by electronic means a calculator to facilitate the comparison of available Qualified Health Plans (QHPs) after the application of the federal subsidies for individual plans. HHS should provide a model calculator that could be adopted or possibly used by all states. This comment also holds true for the calculator proposed for the SHOP under subpart H.

**c. Navigator program standards (subsection 155.210)**

Navigators should be a cross-section of stakeholders, including community and consumer-focused non-profit organizations. The choice of Navigators to fulfill these specifications should be left to the exchange.

The HCA also believes that it would be helpful if the Navigator program is operational by the first day of the initial open enrollment period. However, without a designated funding source, HHS should not require a start date for the Navigator program.

**d. Ability of States to permit agents and brokers to assist qualified individuals, qualified employers, or qualified employees enrolling in QHPs (subsection 155.220)**

The HCA does not oppose states having the option of using other web-based entities to assist individuals in enrolling in QHP and qualifying for available federal tax benefits and cost reductions. However, if this option is available, it is imperative that states be given wide latitude to assure that these entities meet state licensing and consumer protection standards, and that they work in a fashion that will support rather than threaten the operation and financial stability of the Exchange.

**e. General standards for exchange notices (subsection 155.230)**

The HCA agrees that an exchange must go to great lengths to serve diverse populations. However, HHS should codify the examples about the availability of forms and oral interpretation as guidelines and not as requirements. Different techniques and formats will surely be developed, and we would like not to be tied down by requirements to older technologies or forms.

Similarly, HHS should not require an annual re-evaluation of applications, forms, and notices in consultation with HHS. With all of the HCA's health care

programs, all communication devices are evaluated and revised at every major event, such as annual open enrollment.

The HCA encourages HHS to retain the payment option where the exchange collects premiums from enrollees and tax credits from the Department of Treasury, and pays an aggregated sum to the QHP Issuer. The Washington State Basic Health Plan and Health Insurance Partnership programs currently perform the aggregator role for participating issuers in Washington State, and we have been satisfied with playing that role.

#### **4. Subpart E – Exchange Functions in the Individual Market: Enrollment in Qualified Health Plans**

##### **a. Enrollment of qualified individuals into QHPs (subsection 155.400)**

The HCA concurs that real-time processing and acknowledgement of enrollment information is the goal an exchange should strive for, and yet, the HCA would urge HHS to encourage, but not require, a real-time processing standard in rule because too many circumstances outside the control of the exchange can impact implementation of information technology goals.

The HCA concurs that the exchange and Small Business Health Options Program (SHOP), as mentioned in subsection 155.720, maintain enrollment records and reconcile those records at least monthly with the QHP issuers. These enrollment records will assist the individual exchange, QHP issuers, HHS, and the SHOP exchange to ensure that federal subsidies are paid accurately and reliably. Also, accurate enrollment records will assist risk leveling programs to operate efficiently.

##### **b. Single streamlined application (subsection 155.405)**

HHS should consider acceptance of applications to a Navigator to be sufficient for meeting the exchange requirement of filing an application “in person.” Because the focus of the exchange is to facilitate web-based enrollment, HCA believes having Navigators serve the role of accepting “in person” applications will streamline exchange processes and allow for a more efficient exchange system. This solution improves access for applicants through Navigators and is more affordable for operating the exchange.

As directed by the ACA, the Washington State exchange will use a uniform application. HHS, however, does not need to approve an exchange’s alternative application to the application produced by HHS.

HHS should not adopt a requirement that applicants would never have to answer questions that do not pertain to enrollment in a QHP. The requirement should be

that HHS cannot include any questions on the application that do not pertain to enrollment in a QHP. Although the HCA has no need to clutter the application with extraneous questions, states should still have the option to ask a question on the application that does not pertain to enrollment in a QHP.

**c. Initial and open enrollment periods (subsection 155.410)**

The HCA supports requiring that an exchange implement auto-enrollment for the circumstances described in the proposed rule where an advance premium tax credit has been paid but the applicant or enrollee must then select a different QHP. In these circumstances, however, an exchange should have the authority and capability to place an applicant or enrollee in a QHP.

**d. Special enrollment periods (subsection 155.420)**

The HCA supports allowing individuals newly eligible or newly ineligible for premium tax credits to select among all QHPs in a special enrollment period. If not allowed, then enrollees will have an incentive not to report income changes.

**5. Subpart H – Exchange Functions: Small Business Health Options Program (SHOP)**

**a. Functions of a SHOP (subsection 155.705)**

HHS rules should allow an exchange to establish minimum participation standards for employee participation at the SHOP level. Those standards will likely take that state's small group market rules into consideration and likely align the exchange with the small group market. Because each state could have different minimum participation rules, it is best to allow each exchange to establish its own participation standard.

The SHOP should aggregate premium payments and distribute the payments to QHP issuers. In fact, the HCA believes that reliable, high-quality administrative services are necessary to attract small businesses to the SHOP.

**c. Eligibility standards for SHOP (subsection 155.710)**

The definition of small employer in Washington State (RCW 48.43.005) allows sole proprietors to purchase a small employer group plan. The definitions used for the SHOP, supplied by ERISA and HIPAA, do not align with our state's definition. If both definitions remain unaltered by 2014, then Washington State will implement a SHOP that has a different definition of small employer than our state's small employer group market and another policy difference will help to create markets inside and outside of the exchange that do not align.

**e. Enrollment of employees into QHPs under SHOP (subsection 155.720)**

The HCA concurs with HHS's proposal that the SHOP establish a uniform enrollment timeline and process to be followed by all employers and QHPs in the SHOP.

**6. Subpart K – Exchange Functions: Certification of Qualified Health Plans**

**a. Certification standards for QHPs (subsection 155.1000)**

HHS should give states the option of adopting selection criteria beyond the minimum certification standards in the Affordable Care Act. The HCA is currently analyzing and discussing with stakeholders the selection criteria for QHPs, including additional criteria that exceed those specified in the Affordable Care Act. Even if Washington State implements only the criteria specified in the Affordable Care Act, at some point the Washington State exchange might decide to apply additional criteria to the QHP selection process and then would need HHS rules to support the criteria.

**e. Accreditation timeline (subsection 155.1045)**

The HCA concurs that each exchange should establish a consistent deadline for accreditation with respect to each QHP Issuer's initial participation in the exchange.

**i. Recertification of QHPs (subsection 155.1075)**

The HCA would urge HHS not to establish requirements for the term length of recertification of QHPs. The certification and recertification processes are among the most vital to be implemented by an exchange. Setting standards for criteria as proposed earlier is necessary. However, the frequency for recertifying QHPs will depend on local factors such as the number of QHP issuers, the number of QHPs in the exchange, the level of competition between QHP issuers, and the number of plans inside and outside of the exchange to name a few. In the establishment of this policy, it is best to retain flexibility for the initial implementation of the exchange and for ongoing plan management in the exchange.

**B. Part 156 – Health Insurance Issuer Standards under the Affordable Care Act, including standards related to exchanges.**

**2. Subpart C – Qualified Health Plan Minimum Certification Standards**

**d. Marketing of QHPs (subsection 156.225)**

HHS rules should provide an exchange with the option to direct QHP issuers to comply with the marketing rules of that state. Also, the rules should allow the option for the state's insurance commissioner to regulate inappropriate marketing practices that do not comply with rules, thus, aligning the markets inside and outside of the exchange.

**p. Non-renewal and decertification of QHPs (subsection 156.290)**

An exchange should have the option to immediately offer other QHPs in that area when a QHP is decertified. Enrollees should have the option to continue receiving coverage from the decertified plan until the period of immediate offering and selecting of other QHPs has concluded.

**l. Termination of coverage for qualified individuals (subsection 156.270)**

This subsection should clarify that the exchange will not be required to pay an enrollee's premium contribution during a grace period. HHS should also reconsider whether the type of grace period described in this subsection is necessary.

Consistent with the proposed rules to be established through subsection 155.430 regarding the consistent application of terminating coverage, this subsection would require QHP issuers to provide enrollees with a three-month grace period for non-payment of premium prior to coverage termination. In the grace period, the enrollee would be covered, his or her premium contribution would not be paid, and the premium tax credit would be paid to the QHP issuer.

The HCA currently administers two programs that subsidize coverage for low-income individuals: the Basic Health Plan, which provides individual coverage to low-income enrollees, and the Health Insurance Partnership, which subsidizes low-income enrollees in private small group plans. An enrollee can pay a late premium, after the initial due date, in both programs. Both programs, however, do not allow state subsidies to cover a portion of the premium without a premium contribution paid by the enrollee.

A grace period that extends subsidies for coverage that does not include the enrollee's premium contribution is considered extending the state's credit, and Washington State law does not allow a state agency to extend the state's credit. However, both the Basic Health Plan and the Health Insurance Partnership have been able to implement enrollment schedules that allow an enrollee to make a late premium payment before subsidies are expended for coverage.

HHS should not pursue this model. It should be possible to develop a fair and reasonable premium payment schedule that does not necessitate a grace period as described in this subsection, and Washington State is available to participate in further conversations on this topic.

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