



October 4, 2010

The Honorable Kathleen Sebelius
Secretary
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Ave., SW
Washington, DC 20201

File Code OCIO-9989-NC

RE: Request for Comments Regarding Exchange-Related Provisions in Title I of the Patient Protection and Affordable Care Act

Dear Secretary Sebelius:

As a coalition of concerned Kentuckians including over 150 stakeholder organizations seeking to build a healthier Kentucky, we welcome the opportunity to comment on the Exchange-related provisions of the Patient Protection and Affordable Care Act (Affordable Care Act or ACA) and to offer our responses to specific questions identified by the Department of Health and Human Services (HHS). Kentucky is a poor state that stands to benefit greatly by the ACA, but only if consumer information is clear and trusted community groups are empowered to assist. In each case, that means building them into the process. Below are our comments according to the questions posed by HHS.

A. State Exchange Planning and Establishment Grants

General Comments:

Exchange Planning and Establishment Grants can help ensure that states have the resources they need to successfully implement health insurance Exchanges, provide access to affordable, good-quality health coverage, and make effective use of taxpayer dollars. The grants should of sufficient size and be available to cover a variety of planning and start-up costs.

Kentucky Voices for Health is most interested in ensuring appropriate funding for:

- establishing extensive consumer education campaigns, including education about how the new Exchanges will operate, how and where consumers will be able to access information about and enroll in Exchange plans, the availability of Navigators and consumer assistance programs, and the tax implications related to eligibility for premium subsidies; and

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- expanding technical capabilities and creating electronic information systems and interfaces needed to operate an Exchange and fulfill related requirements of the Affordable Care Act, such as creating eligibility and enrollment systems that are coordinated seamlessly with existing state-administered health programs and routing premium payments from individuals and small businesses to multiple insurers.

Ensuring that the grants can be used by states for a broad array of purposes is consistent with the Affordable Care Act which permits the use of the grant funds for any activities related to establishing an Exchange. This is critical because states will be commencing their health reform implementation efforts in earnest at the same time they are still facing deep budget deficits. Despite the recent extension of the temporary increase in federal Medicaid funding to states through the middle of 2011, as well as increased funding for education, states will continue to face severe budget deficits. As a result, state agencies will likely lack the resources they need for implementation and the Exchange Planning and Establishment grants may well be the only major source of funding they will have available to set up their Exchanges by 2014.

In addition to generally committing to establish an Exchange that meets the necessary federal standards and requirements, states should also have to agree to several specific conditions, including:

- sharing what is learned during Exchange implementation with HHS and other states, including provision to HHS (for public dissemination through www.healthcare.gov) of any grant-funded reports or research done internally or by consultants;
- establishing eligibility and enrollment processes that effectively build on and coordinate with other health coverage programs including Medicaid and the Children's Health Insurance Program, as required under the Affordable Care Act, and considering, in consultation with relevant stakeholders and consumer representatives, how to build on existing eligibility processes for such programs; and
- operating and funding a Navigator program to help provide outreach to individuals and small businesses (including the self-employed) who are potentially eligible for the Exchange, as required under the Affordable Care Act.

Question 3: What kinds of governance structures, rules or processes have States established or are they likely to establish related to operating Exchanges (e.g., legal structure (such as placement in State agency or nonprofit organization), governance structure, requirements relating to governing board composition, etc.)?

Kentucky attempted to create a health insurance exchange in the 1990s. Kentucky's health insurance exchange known as the health purchasing alliance was created by state law and governed by a board appointed by the Governor. As a result, decisions were often made based on political considerations rather than sound management practices, and the board was subject to legislative changes and gubernatorial pressure.

The Exchange governing board should be composed of experts who have actual experience in the health insurance marketplace and those who can well represent the users of the Exchange including consumers, employers, providers, public health, etc. Strict Conflict of Interest requirements must govern relationships with insurers, who should not be represented on the board.

Consumers play an important role in the success of health reform as patients and beneficiaries of a health care system. Consumers should be involved in planning and implementation to ensure that this unique and vital perspective is heard and they can attest for whether or not reforms are effective and can be understood on the individual level.

B. Implementation Timeframes and Considerations

Question 2: What kinds of guidance or information would be helpful to States, plans, employers, consumers, and other groups or sectors as they begin the (Exchange) planning process?

The Exchange planning process is difficult to understand from the Consumer perspective. Involving consumers in the implementation process will help to educate them early in the process. KY Department of Insurance has taken the initiative to hold roundtable discussions with the different constituencies including the Kentucky Voices for Health coalition as consumer representatives. Kentucky Voices for Health looks forward to this continued dialogue.

As states plan Exchange implementation, HHS guidance should ensure that the federal resources made available in ACA to expand coverage through the Exchanges do not undermine or supplant existing state investments in public health. In a difficult fiscal environment, the public health benefits to be gained through improvements in coverage may lead states to threaten to reduce their investments in public health. Although there will certainly be public health gains as more Americans access coverage, health insurance coverage alone cannot replace the role of public health in community prevention, infection control, disease surveillance and a host of other core public health activities. ACA recognizes the importance of investing in both coverage and public health by prioritizing both activities. HHS should use the full extent of its authority to limit states' ability to reduce or redirect current state public health investments in response to the federal investments in health coverage.

C. State Exchange Operation

Question 1: What are some of the major considerations for States in planning for and establishing Exchanges?

Stakeholder Processes in Exchange Planning – Outlining and demonstrating the existence of an established, widely accepted stakeholder process for creating an Exchange should be an integral requirement of future Exchange grant funding. This process should include state agencies, representatives of Legislative Committees, consumers, and individuals with significant experience in this area.

Exchange Governance: To provide the needed agility and speed to accomplish the timeline for health reform, it may be best to place the Exchange as an independent body. States should have the option of contracting with a third party administrator with experience in the health insurance marketplace. State laws pertaining to transparency, accountability, and public participation should be followed. Consumers should be engaged in the governance of the coalition. It is critical that the management team of the exchange have strong health insurance experience.

Adverse Selection: The separation of healthier and less-healthy people into different insurance arrangements – will occur if a disproportionate number of people who are in poorer health and have high health expenses enroll in plans offered through insurance Exchanges, while healthier, lower-cost people disproportionately enroll in plans offered through the individual and small-business markets outside the Exchanges. If the cost of the Exchange coverage is higher than the cost of plans offered in outside markets, costs will increase not only for consumers and small firms purchasing coverage through the Exchanges, but also the federal government.

Question 2: For which aspects of Exchange operations would uniformity be preferable?

It is essential to develop a standardized format for displaying plan options to consumers and for determining eligibility for Exchange participation, individual tax credits, and Medicaid/CHIP using a single portal. The guidance on the design of this single portal should also be uniform. The Navigator program for outreach and enrollment support should be standardized to help provide similar guidance to the consumer community.

Question 5: What are the considerations for States as they develop web portals for the Exchanges?

The Exchange will have to explain many complex topics to a variety of constituencies. Explaining these choices without debilitating complexity will be a significant challenge. States should be encouraged to use focus groups and other active feedback mechanisms in the web portal design process including a full array of consumers, businesses, etc. States portals should be consistent with and linked to the federal web portal. Once established, a web portal should have a way of gathering feedback from consumers and employers for continued refinement.

Question 8: What specific planning steps should the Exchanges undertake to ensure that they are accessible and available to individuals from diverse cultural origins and those with low literacy, disabilities and limited English proficiency?

Exchanges should develop strategic plans that establish specific targets for reaching and enrolling diverse eligible populations within their states. Exchanges should use clear, concise language written at the lowest reasonable education level to make sure that information is understood by individuals with various literacy levels. Exchanges' strategic plans should identify key strategies and tactics for achieving their enrollment targets, such as:

- Creating partnerships with community-based organizations to conduct outreach and education to culturally diverse populations, including diversity in race, ethnicity, gender,

age, disability, socioeconomic status, geography, language, sexual orientation and gender identity;

- Developing outreach and enrollment materials in diverse languages;
- Ensuring the cultural competency of providers in Exchange health plans' networks;
- Facilitating enrollment with the help of multi-lingual counselors/navigators;
- Partnering with public health departments, community health centers and other usual sources of care for lower income diverse populations to help facilitate access to and enrollment in Exchange plans; and
- Ensuring that Exchange health plan networks include primary and specialty providers who are located in diverse neighborhoods.

Exchanges should use standardized language. Accommodations should also be made to meet the needs of persons with disabilities, including through the use of assertive technologies. The Exchanges' contact information should be clearly displayed on the website and highly visible locations within communities. Community health, education and outreach workers with existing relationships in diverse communities should be incorporated into Exchange outreach efforts. Outreach efforts should consider how to reach people who are homebound or who lack time or ability to travel to a state office and a mail campaign should be employed. Outreach efforts involving partnerships with communities and public facilities should also be conducted to reach consumers in places they live and frequent. Exchange designers should also create and utilize an Advisory Group as a regular resource to provide input on proposals and sharing of information with people with disabilities.

D. Qualified Health Plans (QHPs)

Questions 2: What factors should be considered in developing the Section 1311(c) certification criteria (certifying plans as QHPs)? What issues need to be considered in establishing appropriate standards for ensuring a sufficient choice of providers and providing information on the availability of providers?

The certification criteria should be driven first and foremost by consumers' and small business employees' need for affordable, adequate and accessible health care coverage.

The Secretary of HHS is to establish criteria for certifying health plans as qualified health plans to be available in the Exchanges. The criteria will require that health plans include within their networks "those essential community providers, where available, that serve predominately low income, medically-underserved individuals." Many low-income and medically-underserved individuals who will enroll in Exchanges interact with the health care system through community health centers, public health departments, and other community providers. HHS should ensure that the definition of essential community providers includes these providers that provide health screening and monitoring to underserved populations.

Further, the HHS criteria should require that providers in the health plan networks be in reasonable geographic proximity to enrollees. Particularly in lower income, underserved communities, transportation to providers can be a considerable hindrance to seeking care.

Network adequacy standards should recognize and account for these challenges by factoring geographic proximity and public transportation options into the standards.

Ensuring access to essential community providers can also help with outreach and enrollment efforts among low-income populations and those who face cultural and linguistic challenges in accessing care.

E. Quality

Question 1: What factors are most important for consideration in establishing standards for a plan rating system?

The quality and price-focused health plan rating system to be developed by HHS and used by the Exchanges should include a focus on population health. Consistent with the National Health Care Quality Strategy and Plan under development by HHS, the ratings system for plans should include a focus on “Healthy People/Healthy Communities: Improving health and wellness at all levels through strong partnerships between health care providers, individuals, and community resources.” Measures should assess overall population health as well as plans’ impact on improving subpopulations’ health, such as people with chronic conditions such as diabetes and hypertension, or minority populations.

Exchanges can help consumers understand the quality and cost implications of their plan choices by being transparent in providing a comparison of benefits offered and objective information about the plans and their cost implication. Resources should be provided to educate consumers to better understand the coverage levels and assist them in becoming better health care consumers.

F. Enrollment and Eligibility

Question 1: 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?

In the first year, federal guidance should allow for greater flexibility for individuals enrolling in the Exchange so that families have time to learn about the options available to them under the new law and enroll in the plan that best meets their needs.

In subsequent years, guidance should ensure that open enrollment periods are available to families at least once a year during a standardized time period. Implementation should establish qualifying events that will trigger special enrollment periods for subscribers and dependents. Such changes would be: changes in family circumstances, pregnancy, loss of coverage, employment status change, and change of residence.

Legislation should also be considered to establish special enrollment periods for employer-sponsored insurance when a family becomes ineligible for premium tax credits and cost-sharing reductions.

Question 2: *What are some of the key considerations associated with conducting online enrollment?*

Online enrollment can be an effective enrollment tool but is critical that any system be user-friendly for consumers. It should be easily understood for users with low literacy, available in multiple languages, and accessible to individuals with disabilities. Kentucky Voices for Health recommends a simplified process with the minimum amount of steps in the process. Privacy and security policies should be made available to the consumer before and at the time of enrollment.

It is also crucial that Exchanges rely not only on online enrollment, but that they create additional avenues for people to apply in person, by mail and phone, and through existing Medicaid/CHIP enrollment structures. Online enrollment is only effective if users have Internet/computer access. Additional outreach may be necessary to broaden the availability of enrollment opportunities such as kiosks in central locations, mobile units to rural communities, training of community-based organizations.

Question 3: *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 navigation 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?*

The law explicitly requires that the enrollment and renewal processes for exchange subsidies and Medicaid/CHIP be fully integrated. Guidance is required to ensure states implement strategies that will facilitate a seamless system. These strategies would include co-location of Medicaid/CHIP staff at exchanges and placing Medicaid/CHIP consumers/advocates on the exchange governance board.

Implicit in this vision of an integrated eligibility process is an understanding that the eligibility determination process for Exchange plans is of inherently public. Federal requirements that Medicaid eligibility determinations be done by a public agency should apply to Exchange eligibility process, both in order to protect the public's interest and to ensure the creation of a seamless system that works for consumers.

H. Outreach

Question 1: *What kinds of consumer enrollment, outreach, and educational activities are states and other entities likely to conduct relating to Exchanges, insurance market reforms, premium tax credits and cost-sharing reductions, available plan choices, etc. and what federal resources or technical assistance are likely to be beneficial?*

Kentucky has had recent successes in simplifying the KCHIP enrollment process. States should be encouraged to build on their experience conducting consumer enrollment, outreach, and educational activities. Kentucky's experience indicates that the most successful model includes

one-on-one contact or assistance with children and families. Outreach should be coordinated with local public agencies and community organizations.

Federal technical assistance and resources could enhance states' efforts by supporting focus groups and other public opinion research to identify key messages that will resonate with the public to improve public knowledge about and use of preventive benefits. In addition, the federal government could create templates for consumer brochures, advertisements, inserts and other consumer-friendly tools that could be adapted for individual state use.

Question 2: 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?

Exchanges are to develop Navigator programs to conduct public education about qualified health plans; facilitate plan enrollment; provide referrals to consumer assistance offices; and, ensure that information is provided in culturally and linguistically appropriate ways. Federal guidance should stress the importance of utilizing a broad range of organizations that have a proven track record working in communities and with families at different income levels, including those now working on Medicaid, CHIP and Medicare enrollment. In developing Navigators, the Exchanges should consider the role that community-based organizations can play in providing outreach to underserved populations and their potential to be partners in helping to facilitate enrollment in qualified health plans. These community partnerships will help ensure that Navigators have the reach to disseminate culturally and linguistically appropriate materials to target populations.

Kentucky Voices for Health believes that education and outreach need to occur before Exchanges are up and running to ensure that consumers are informed about the 2014 implementation and enrollment period. Funding to the states may be needed for these efforts.

Question 3: What kinds of outreach strategies are likely to be most successful in enrolling individuals who are eligible for tax credits and cost-sharing reductions to purchase coverage through an Exchange, and retaining these individuals? How can these outreach efforts be coordinated with efforts for other public programs?

The most successful strategies for outreach include utilizing community-based groups to assist with applications. This might include creating trusted messengers by working through schools, churches, and health care providers. Media strategies are also critical. Public health programs will help connect both the Exchange and Medicaid/CHIP coverage.

J. Consumer Experience

Question 1: What kinds of design features can help consumers obtain coverage through the Exchange? What information are consumers likely to find useful from Exchanges in making plan selections? What kinds of enrollment venues are likely to be most helpful?

Consumers need clear, accurate, and easily understood information about their health insurance options. They need to be able to appropriately evaluate the comparisons of coverage option to find the coverage that best meets their needs. The enrollment process must be simple and easy to

follow. Explanations of the protections afforded to them and an easily understood and actionable recourse if they fail to receive these protections is also important. In implementing consumer protection standards, there must be clear accountability for compliance with the standards and a defined oversight function to monitor compliance.

Exchanges should use standardized language that is easily understood. All materials and processes need to be accessible for individuals from diverse cultural backgrounds and those with limited English proficiency. Accommodations should also be made to meet the needs of persons with disabilities, including through the use of assertive technologies. Plans that are not in compliance with consumer protections must be held accountable and failure to take corrective action in a timely way should be cause to remove a plan from an Exchange. The Exchanges contact information should be clearly displayed on the website and highly visible locations within communities

Exchanges should have an accessible, consumer-friendly website that serves as a resource for consumer education, comparison of health coverage options, eligibility determination, and enrollment. An Exchange website should be accessible to individuals with low literacy, disabilities, and limited English proficiency. Information should be downloadable to allow for information to be easily shared with consumers by coalitions such as ours that provides outreach support. Telephone support and in-person enrollment options should be available for individuals without internet access and consumers with low literacy.

The following information should be prominently presented in a clear and concise format, using standardized terminology and descriptions, on any Exchange website and in written materials for consumers without internet access. This information must be timely, reliable, and comprehensible.

- Provider networks, including information on provider quality.
- Descriptions of benefits and formularies, including any limits on health care services, supplies, equipment, drugs, etc.
- Premium costs and cost-sharing to allow consumers to estimate the total expected cost of coverage, including the premium and cost-sharing levels by income, for those eligible for premium tax credits and cost-sharing reductions. Cost-sharing levels should also be clearly differentiated between in-network and out-of-network care. Underwritten plans should offer an expected premium range to better inform consumers about the potential variation in premiums they could face due to age, smoking status, and family size.
- Coverage level (bronze, silver, gold, platinum); with a description of what these classifications signify.
- Plan accreditation status (including score) and HEDIS and CAHPS scores. This information should be coupled with consumer-friendly educational information about accreditation and quality measurement and should be presented in an easy to understand format that conveys overall plan value, such as star ratings.
- Information on chronic disease management programs or services offered.
- Sample cost and health benefit examples for common medical conditions, such as diabetes.
- Medical loss ratio and a description of what the ratio signifies.
- Actuarial value of health plans coupled with relevant educational information about what

- actuarial values represent and what they do not represent and how they are calculated.
- Plan financial information, including annual profit and CEO salary.

Exchanges should direct consumers to resources with information about how the health insurance system operates in their State. Consumers need information about when, how, and under what circumstances they can switch between plans, along with information on shifting eligibility between Medicaid, CHIP, and private coverage. Exchanges should alert consumers to the existence of and provide contact information for Navigators, consumer assistance grant recipients, hospital financial assistance programs, and other similar informational programs.

A multitude of venues should be available for consumers to enroll in Exchanges. Some consumers will need Exchanges to come to them where they live or work. The Exchanges should support mobile units that can travel to these venues and also target neighborhoods with low rates of insurance coverage. Exchanges should also conduct public-private marketing campaigns that involve community listservs and blogs, places of worship, community groups, etc, to get the word out about where, when, and how consumers can find such assistance.

Question 2: What kinds of information are likely to be most useful to consumers as they determine whether to enroll in an Exchange and which plans to select (within or outside of an Exchange)? What are some best practices in conveying information to consumers relating to health insurance, plan comparisons, and eligibility for premium tax credits, or eligibility for other public health insurance programs (e.g., Medicaid)? What types of efforts could be taken to reach individuals from diverse cultural origins and those with low literacy, disabilities, and limited English proficiency?

When considering health insurance options, consumers need readily accessible and clearly presented information on plans available to them, including premiums, cost sharing, and benefits (including non-dollar benefit limits) as well as enrollment windows and whether they qualify for subsidies (both premium tax credits and cost-sharing reductions) or public insurance. Employers should clarify whether the health insurance offered to employees will satisfy the individual coverage requirement, whether employers will automatically enroll employees into plans offered by the employer, and whether employers will be providing a free choice voucher. By 2014, consumers will need to clearly understand that they must make a choice regarding health insurance coverage in order to meet the individual requirement or face a tax penalty (unless they are exempt).

Before the Exchanges are operational, it is critical consumers have information about subsidies in the Exchange and the new tax implications. This information could be conveyed through commercial and volunteer tax preparers and software, the Internal Revenue Service, employers and others with tax knowledge, and federal and state websites.

To be most effective, efforts to convey accurate and individualized information to consumers should take many different forms. Enrollment activity should be preceded by a highly visible and sustained media campaign - including television, radio, print, and social media – to raise the public's awareness of the Exchanges. In-person opportunities for consumers to receive

individualized assistance and have their questions answered is the method most useful with hard-to-reach consumers.

Exchanges should take steps to ensure they are accessible to diverse populations. Information on Exchange websites should be available in multiple languages and be culturally sensitive and linguistically-appropriate. The Exchange's toll-free telephone hotline should be clearly displayed on the website and at highly visible places in the community. Telephone operators who speak a variety of languages should be available and able to refer consumers to local resources. Community health, education and outreach workers with existing relationships in culturally-diverse communities should be incorporated into Exchange outreach efforts. Outreach efforts should also consider how to reach people who are homebound or who lack time or ability to travel to a state office and a mail campaign should also be employed. Outreach efforts involving partnerships with community entities which include public facilities, hospitals, clinics and churches should also be conducted to reach consumers in places they live and frequent. States and other entities will need sufficient time and funding to train outreach workers and counselors to serve as resources to consumers in the Exchanges and establish effective outreach to culturally diverse populations.

Question 4: 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)?

Consumer complaints may be useful and relevant to the work at multiple levels. Regardless of whether principal responsibility for collecting complaint information rests with the state or federal government, information should be aggregated in a way that allows consumers and regulators to understand complaint trends and to track the resolution of complaints to ensure consistent application of the law across the country.

Consumer information also must be managed in a way that ensures consumer privacy, as complaints may contain personal, sensitive and identifiable information. To the greatest extent possible, consumer complaints should be de-identified, and regulators should develop comprehensive privacy policies governing the collection and treatment of complaints. Consumer complaints should be collected and aggregated at the state level. State-level assistance may provide expedited resolution of claims, and all states should determine an explicit timeframe for addressing complaints. State resolution of complaints can help regulators determine quickly whether a problem is specific to the enrollee, the health plan or the exchange. Information about complaints with insurers may allow states to issue corrective policy guidance.

Federal oversight activities also would benefit from the sharing of complaint information. The federal government has an obligation to ensure the fair operation of the exchanges, to enforce consumer protection and transparency rules, and to guarantee that taxpayer dollars used to subsidize the purchase of insurance are being accurately dispersed.

Thank you for the opportunity to share the Kentucky Voices for Health views on the development of the Exchanges. We look forward to robust Exchanges that provide meaningful health insurance coverage to individuals. If Kentucky Voices for Health can be a resource to you, please do not hesitate to contact me at 502-552-1406.

Sincerely,

Jodi Mitchell

Jodi Mitchell
Executive Director
Kentucky Voices for Health