



**CONSORTIUM FOR CITIZENS
WITH DISABILITIES**

October 4, 2010

Mr. Jim Mayhew
Office of Consumer Information and Oversight
Department of Health and Human Services
Attention: OCIO – 9989 – NC
P.O. Box 8010
Baltimore, MD 21244-8010

RE: 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.

Dear Mr. Mayhew:

The Health Task Force of the Consortium for Citizens with Disabilities appreciates the opportunity to provide comments on the planning and establishment of state level exchanges. The health insurance exchanges are a critical component of making affordable health insurance coverage available to all Americans.

The CCD Health Task is a coalition of national consumer, service provider, and professional organizations which advocate on behalf of persons with disabilities and chronic conditions and their families. The CCD Health Task Force is working to ensure that the implementation of the Affordable Care Act results in all Americans, including people with disabilities and chronic conditions, having access to high quality, comprehensive, affordable health care that meets their individual needs and enables them to be healthy, functional, live as independently as possible, and participate in the community.

A. State Exchange Planning and Establishment Grants

General Comments

CCD believes that the Exchange Planning and Establishment Grants, required under Section 1311 of the Affordable Care Act (ACA), can help ensure that states have the resources they need to successfully implement health insurance exchanges that provide access to affordable, quality health coverage. The grants should of sufficient size to cover a variety of planning and start-up costs associated with any of the following range of required activities:

- certifying qualified health plans, providing required information and assistance to consumers, and determining eligibility for federal premium credits and cost-sharing reductions;
- operating a risk adjustment system and implementing the requirement that issuers calculate risk across all of their health plans inside and outside an exchange;
- implementing insurance market reforms;
- building capacity at the state level to enforce the new requirements;
- abiding by the non-discrimination requirements required under Section 1557;
- establishing extensive consumer education campaigns;
- expanding technical capabilities and creating accessible electronic information systems; and
- 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.

CCD urges HHS to be clear in all documents and guidance that the states, by virtue of the fact that they are accepting federal funds for planning and establishing the exchanges, are subject to the non-discrimination requirements of Section 1557 of the Act. Thus, they must not discriminate against individuals as prohibited under Section 1557. Equally important, the states should be cognizant of the fact that the exchanges, as entities established under the Act, are also subject to Section 1557. In particular, exchanges must set their requirements for insurer participation in the exchanges in a manner that ensures that individuals seeking to purchase insurance through the exchange will not face discrimination prohibited by Section 1557.

3. What are some of the major features that states are likely to consider in determining how to structure the exchanges?

CCD believes that a key factor that States will have to consider in structuring the exchanges is how to limit the risk of adverse selection against the exchange. 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 coverage through the insurance exchanges, while healthier, lower-cost people disproportionately enroll in plans offered through the individual and small-business markets *outside* the exchanges.

If that occurs, the cost of exchange coverage will be higher than the cost of plans offered in outside markets that would drive up costs not only for consumers and small firms purchasing coverage through the exchanges, but also for the federal government, which must provide premium subsidies to enable low- and moderate-income people to afford coverage in the exchanges. Higher premiums would depress participation in the exchanges by individuals and small businesses, particularly by those people and firms that can obtain better deals in outside markets. That, in turn, could raise premiums even higher in the exchanges and could ultimately result in their failure over time.

States, however, could take a number of steps in how they structure their insurance exchanges to further minimize the risk of adverse selection. HHS should explain the risk adverse selection poses to exchanges and the options states have to limit such risk, and also encourage states to take up these options:

- Making the rules for any insurance markets outside the exchanges consistent with the rules that apply inside the exchange. States can simply apply the same standards that HHS sets for qualified health plans offered in an exchange to plans offered in markets outside the exchange. This would eliminate any disparities that might discourage insurers from participating in the exchange or permit insurers operating outside the exchange to design benefit packages and marketing campaigns to attract healthier people away from the exchange.
- Requiring insurers to offer the same products inside and outside the exchange. Some insurers may decide not to offer coverage through an exchange because it is easier to operate in the outside markets if the rules there are weaker. They may also wish to offer products inside and outside the exchange that differ in ways that result in adverse selection against the exchange. States could require all insurers who wish to offer product in outside markets to also offer coverage in the exchange and to offer the same products (priced the same) both inside and out. For those states that may wish to create a more selective or competitive process to determine which plans can be offered in an exchange, states can require insurers outside the exchange to offer products in the same coverage levels (at least the Silver and Gold levels) as is required for health insurers participating in the exchange. States should also bar insurers from offering only the least comprehensive Bronze level plans or catastrophic plans outside of the exchange.

C. State Exchange Operations

1. What are some of the major considerations for states in plan and establishing exchanges?

States should establish an effective stakeholder process which includes people with disabilities and their representatives. This process should include the state agencies with which the exchanges must work, representatives of the legislative branch, health care providers persons with relevant expertise and other stakeholders. Stakeholder processes should also provide the opportunity for issue-specific working groups to be created and to give ongoing input into the process.

It is also critical that state laws for transparency, accountability and public participation should be followed. The work, budget, spending and any outside contracting of the exchange should be publicly reported and transparent. Meetings should be open and accessibility, with transcripts, agendas and meeting materials publically available.

Both governance and any stakeholder process leading to the creation of the exchange should be accountable to the public. Governing bodies and stakeholder processes must also provide the opportunity for public hearings to solicit input from the general public.

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

- Exchanges should use clear, concise language written at the lowest reasonable education level, and take steps to make sure information can be understood by individuals with low literacy, numeracy, and health literacy levels.
- Exchanges should use consistent terminology and plain language definitions of health care terms.
- Exchange planners/designers should create and utilize an Advisory Group as a regular and integral resource to provide input to design considerations, get feedback on proposals and share information with people with disabilities. This group should be diverse and include individuals with disabilities, family members and caregivers, and include representatives of all disability groups – sensory, physical, behavioral, mental and cognitive. The Advisory Group must have real ability to influence decisions.
- As federally funded entities, the Exchanges must comply with the Rehabilitation Act and section 1557 of the Act. Thus, all communications from the Exchange -- web-based information, advertisements, information kiosks, printed material and brochures, information lines, etc, -- must meet the federal government's Section 508 of the Rehabilitation Act standards for electronic and information technology and the ADA. Information about the Section 508 standards can be located at: <http://www.section508.gov/>. The goal must be reaching the highest level of accessibility – not just in the roll out of the exchanges but as part of the full time practice of these marketplaces.
- The insurance plans that are deemed eligible to sell through the Exchanges should be required to meet these standards in any of their communications with customers as a pre-requisite for eligibility and a requirement for operating in the pool.
- The Exchange's toll-free telephone hotline number should be clearly displayed on the website and at highly visible places in the community,
- There must be alternative means to enroll in the health plans beyond the web portal. People with disabilities may require in person assistance, well trained and staffed phone assistance, and other methods.
- Disability service and support providers must be educated about the laws and the exchanges and provide a link between individuals with disabilities and their representatives and the exchanges.

D. Qualified Health Plans

General Comments

Certifying, recertifying and decertifying health plans is an activity that requires the exercise of substantial discretion in applying government authority and decision making. The best way to ensure accountability and transparency is through the use of governmental staff who will carry out these functions without bias and conflicts of interests and in the best interest of the public.

The ACA prohibits plans from employing benefit designs that have the effect of discouraging people with significant health needs from enrolling. This is a not uncommon practice among insurers, and it will be important that HHS set minimum standards for this requirement, and encourage states to effectively monitor plans to ensure they are complying.

The ACA includes important patient protections that are designed to permit providers to fully discuss treatment options with patients and their families and permit the patient to render an informed choice as to their course of treatment. These patient protections are designed to ensure that the patient receives appropriate medical care and that the health care treatment is available for the full duration of the patient's medical needs. [See Statement by Congressman Pascrell, Congressional Record E463 (March 23, 2010)] Specifically, the Secretary may not promulgate any regulation that:

- Impedes timely access to health care services;
- Interferes with communications regarding the full range of treatment options between patient and the provider;
- Restricts the ability of health care providers to provide full disclosure of all relevant information to patients making health care decisions;
- Violates the principle of informed consent and the ethical standards of health care professionals; or
- Limits the availability of health care treatment for the full duration of a patient's medical needs. [See Section 1554 of the ACA]

In addition, ACA specifies that a group health plan and a health insurance issuer shall not discriminate with respect to participation in the group or individual health insurance plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable state law. ACA also specifies that health plans to be considered "qualified" by the Secretary must ensure "a sufficient choice of providers (in a manner consistent with applicable network adequacy provisions under section 2702(c) of the Public Health Services Act) and provide information to enrollees and prospective enrollees on the availability of in-network and out-of-network

providers” in order to ensure enrollee access to covered benefits, treatments and services under a qualified health benefits plan. [See Section 1311(c)(1)(B) of the ACA]

Thus, according to Congressman Pascrell “rehabilitative and habilitative services and chronic disease management services must be available from a full continuum of accredited programs and treatment settings at a level of intensity that is consistent with the needs of the patient.” [Congressman Pascrell, Congressional Record E463 (March 23, 2010)]

The treatment continuum is comprised of specific facility and specialty program types. Program types include acute care hospitals, inpatient rehabilitation hospitals and units, residential rehabilitation facilities, day treatment programs, outpatient clinics and home health agencies. Acute care hospitals provide acute medical treatment to arrest disease progression in the early minutes and hours after an injury. Acute treatment may be provided in the emergency room, trauma unit, intensive care unit, medical/surgical floor or similar hospital-based location. Post-acute treatment includes intensive medical rehabilitation services provided in inpatient rehabilitation hospitals and units. Residential rehabilitation and day treatment programs are critical components of this treatment continuum depending on the injury or illness involved. In all of these settings, high quality care should be provided by fully accredited programs. Accreditation (provided by CARF, JCAHO, and other appropriate accreditors) is an important mechanism to measure quality and accountability of health care provider and the services and devices they provide.

Ongoing medical management is also required to achieve durable medical outcomes, mitigate disease progression and optimize health and function. These services are offered in community-based settings such as medical offices but can also be provided in group homes, supported apartments, or similar living arrangements. It is also critical to recognize that recovery for many persons with chronic conditions is not necessarily a linear event. For example, brain injury, cancer, asthma, and diabetes may be stable for a period of time and then may become unstable. Persons with brain injury, for example, may attain a plateau in functional restoration prior to entering a secondary recovery phase. For this reason, individuals with certain chronic conditions may need renewed access at any point along the treatment continuum throughout their lives.

2(a) What issues need to be considered in establishing appropriate standards for ensuring a sufficient choice of providers and providing information on the availability of provider?

Reflecting the comments above, it is critical that network adequacy standards ensure that consumers have a choice of the providers they need, within a reasonable geographic proximity to their home or workplace and that these providers are located in facilities and offices that are architecturally accessible to people with disabilities. In addition, if a plan purports to cover a certain item or service, then it must also have in-network providers and suppliers that are able to provide that item or service. And plans should be encouraged to include Medicaid providers to facilitate continuity of care for families who may transition on and off of Medicaid. Insurance providers should regularly update an electronic

directory of contracting providers so that individuals and small businesses can search by health care provider name and see which plans include the provider in their network, and ascertain whether the provider is accepting new patients for a particular health plan and determine whether or not the provider meets accessibility standards in accordance with the ADA. Moreover, the issue of the extent to which contracting providers are aware of disabilities, (e.g., ASL interpreters, wheelchair accessible weight scales, height-adjustable exam tables, and materials in alternative formats) must also be addressed in standards for ensuring a sufficient choice of providers. Such standards would also compliment and facilitate collection of data required by the ACA concerning the number of health care providers with accessible facilities and equipment to meet the needs of individuals with disabilities.

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

CCD urges states to design their exchanges first and foremost to benefit consumers, so that they are consumer-friendly marketplaces in which consumers can be assured of adequate, affordable coverage. If they are designed in that manner, a sufficient mix of health insurance carriers will follow.

To achieve this, however, it will be critical for states to make the market rules inside and outside the exchanges the same, so there is a “level playing field” and all plans in the state are required to meet the same certification standards. States that do not do this, and allow the market outside the exchange to operate under substantively different rules, will have a difficult time attracting a healthy mix of insurance carriers to their exchange. This also raises the risk of adverse selection and could drive up premium costs for exchange enrollees.

The requirements for risk adjustment, and the temporary reinsurance and risk corridor programs, as well as the requirement that plans pool risk inside and outside the exchanges, are critical tools to limit adverse selection and encourage plans to participate in the exchange. However, these tools will not be sufficient if states do not apply the same rules to plans inside and outside the exchange. HHS should use grant support and technical assistance to help states enact the laws and rules necessary to mitigate adverse selection between the exchange and non-exchange markets.

G. Enrollment and Eligibility

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 for subsequent years? What factors are important for developing criteria for special enrollment periods?

- The first year will be a landmark opportunity to make the vision of this new law into a day-to-day reality for millions of Americans. To do this will require a high level of flexibility for people enrolling in the exchange to allow

time for individuals and families to learn what is available to them, to do the research to determine what plan will fit their needs. The longer the open enrollment period can last, the more likely the success of individuals and families at being able to find their way to the exchange, through the enrollment process and onto the plan best equipped to meet their needs and situation. Allowing enrollment after the January 1, 2014, implementation date may be the key to bringing as many people in given the wave of publicity likely to accompany the start date.

- In subsequent years, open enrollment periods will be the most effective if there is a standard time (the same months each year) and at least 90 days to sign up or change policies. It will also be important to follow the guidance of HIPAA and Medicare to establish the qualifying events that would trigger eligibility for special enrollment, these currently include:
 - Changes in family circumstances, such a marital status and change in number of dependents,
 - Pregnancy,
 - Loss of coverage,
 - Employment status change, including termination or change from part-time to full-time status or vice versa,
 - Change of residence.
- Other special enrollment/disenrollment periods will need to be established to respond to circumstances in which the chosen coverage becomes unaffordable or subscribers face a change in income that would alter the subsidy level or open eligibility to Medicaid/CHIP.
- Applications submitted outside of enrollment periods should be encouraged as the enrollment process can determine if an individual or family is eligible for Medicaid or CHIP which do not have enrollment periods.

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

Online enrollment can be a meaningful and effective tool to allow people entry to the new marketplace, but only if it is accessible to as many people as technologically possible. This will mean providing a range of tools so that high-end users can get what they need as well as those who are low literacy or ESL users. There is also the need to be accessible for people with disabilities and so any online effort should meet the requirements of the federal government's Section 508 of the Rehabilitation Act standards for electronic and information technology. Access to computers to allow for application may require making the computer itself available through kiosks in central locations of the training of individuals to assist with the process through community-based organizations.

Online enrollment will not be an option for all those who need to enroll through the exchange so strategies must also include opportunity for face-to-face discussions and applications through, for example, kiosks in central locations, mail, phone and the current Medicaid/CHIP enrollment options. These physical locations must meet the ADA requirements.

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 the Exchange or Medicaid/CHIP application information to determine eligibility for all three programs?

For those who will be applying through the Exchange, one of the key aspects of the new law is the call for the States to create a “no wrong door” process. The ACA clearly and explicitly states that the enrollment and renewal processes for exchange subsidies and Medicaid/CHIP be fully integrated. This is not just a call for the Exchange enrollment process to include referrals to other programs that might be options for an individual or a family, but is a requirement that Exchanges be capable of accomplishing the enrollment in Medicaid or CHIP. This process needs to be streamlined and seamless to the individual applying. Utilizing the Medicaid agency to process eligibility and enrollment forms may be the best solution to assuring that individuals are made aware of which programs they qualify for and are enrolled accordingly. Utilizing the support and expertise of the private sector, community agencies and the States together to inform and guide individuals and families will provide the collaborative effort necessary to propel applicants to the Exchange to successfully seek coverage.

This kind of coordination will require a strong information technology infrastructure and an interoperable system for eligibility determinations that allow linkages between the Exchanges, Medicaid and CHIP. There will need to be State resources to provide the support required to verify eligibility, information retained for renewal and be able to track individuals across different programs. There may need to be federal resources as well to assure the seamless process that will allow the ease of application and enrollment across programs and plans.

The need for seamless navigation will require a high level of coordination between the federal and state entities with the federal government providing guidance and technical assistance.

- The development of simple and efficient procedures for individuals and families to report “change of circumstances” when it is appropriate. With the consent of the applicant, automatic enrollment in an appropriate program should be available without requiring additional information. A one year federal eligibility for Medicaid/CHIP will reduce the “churning” effect of these programs.

- Identify ways to coordinate care as people move between systems. Achieving the best coordination possible between exchange coverage and Medicaid and CHIP may require that some plans in the Exchange also serve Medicaid and CHIP beneficiaries. This will allow for overlapping provider networks and if the plans are required to facilitate transition between plans, this will reduce the difficulty for those in the middle of treatment.
- Develop “safe harbors” of default Medicaid coverage for people that may be between Medicaid/CHIP and the Exchanges. An example would be when someone is deemed ineligible for Medicaid and exchange subsidies because of differences in how the programs calculate and verify eligibility data.

H. Outreach

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?**

Experience is often the best teacher, or at least one of the best tools, and states have had a great deal of experience in creating, implementing and managing enrollment programs, outreach activities and educational efforts through Medicaid and CHIP. While there is no one route to what is most effective and data is not as prevalent as we may wish on what works and what does not, experience should provide states with some sense of what a successful model may look like. There is support to show that a successful model will include one-to-one contact and accessible assistance for individuals and families. There is also experiential evidence to suggest that the use of community based organizations and application “assistors” are integral to getting to some of the harder-to-reach families who struggle with low literacy or may have limited English proficiency.

State need to find opportunities to share successful campaigns and efforts would allow for the dissemination of good and workable ideas. The informational efforts of the States should go beyond just exchange coverage to include insurance market reforms, premium tax credits and cost-sharing reductions but should also provide information on Medicaid/CHIP.

It will be necessary for the federal and state efforts to utilize materials and facilities in which activities will be conducted and all should be fully accessible to individuals with sensory, cognitive and physical disabilities and meet the federal requirements of Section 508 of the Rehabilitation Act and the ADA.

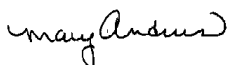
2. What kinds of outreach strategies are likely to be most successful in enrolling individuals who are eligible for tax credits and cost-sharing reductions to purchase coverage through an Exchange, and retaining these individuals? How can these outreach efforts be coordinated with efforts for other public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

A robust campaign based in Federal and state resources can be focused on community-based groups and assistance with the application process. This could be accomplished by working through advocacy groups, community based disability service providers, schools, churches, and labor unions. An important tool is creating trusted messengers such as teachers or health care providers to impart the messages in their communications and supplying employers with comprehensive information to be shared through the workplace. This also may include paid media to provide easily understandable and accessible information on enrollment and application.

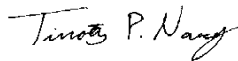
Other public programs can also be good sources of information and connection to application and enrollment. An application for unemployment benefits, for example, should trigger a review for other programs that maybe helpful such as Medicaid/CHIP. For example, the application for the Free School Lunch program should provide the information for an expedited route to health coverage. Streamlining the process should make the efforts more efficient, accurate and timely.

Thank you for your consideration of our comments. Please feel free to contact any of the Co-chairs of the CCD Health Task Force if you have questions.

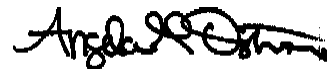
Sincerely,
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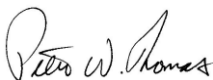
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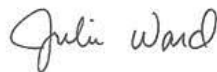
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