Arkansas Insurance Department

Mike Beebe
Governor

Jay Bradford
Commissioner

October 31, 2011

The Honorable Kathleen Sebelius
Secretary
United States Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Dear Secretary Sebelius:

On behalf of the Arkansas Insurance Department's Health Benefits Exchange planning efforts made possible by funding from the federal government, we write to comment on the proposed Rule regarding the Establishment of Exchanges and Qualified Health Plans published in the Federal Register on July 15, 2011. We appreciate the opportunity to comment on the proposed Rule and welcome the general flexibility that the rule provides to states to establish Exchanges that meet the unique needs of residents and insurance markets. Further, we are pleased to see that the rule acknowledges the longstanding tradition of state-based insurance regulation and seizes upon the importance of its synchronization with Exchanges.

Flexibility is critically important as each state faces vastly different political, operational, and technological challenges to Exchange implementation. Indeed, Arkansas lawmakers have not yet provided the authority by which the state can implement an Exchange. Despite a lack of authority, however, a variety of stakeholders in Arkansas have assembled to assess the state's availability of resources, analyze the state's insurance market and the potential uptake among the eligible population, and craft a basic framework within which a state-based Exchange can flourish.

We are particularly pleased with the leeway provided by the conditional approval process (§155.105) and the ability of states to receive approval and assume responsibility for operation of Exchanges after 2014 (§155.106). The presence of this option is a relief for states that are at different stages of planning and implementation and evidences a desire on the part of HHS to work with states as they strive toward making state-based Exchanges viable in the short-term and sustainable in the long-term.

We are similarly pleased with the flexibility that the network adequacy provision (§156.230) provides to states to shape standards in order to meet differences in demographics and healthcare delivery systems. We further appreciate the proposed rule's attentiveness to the risk of adverse selection and the latitude that the rule provides to employers and employees on plan choice (§155.705). We request that the final rule include a provision that requires Qualified Health

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Plans (QHPs) to waive minimum participation rules to further facilitate employer and employee choice.

Although we applaud the overall flexibility that the rule provides to states, we have several recommendations that have the potential to improve the proposed rule so that Exchanges deliver on the promise to provide streamlined access to affordable coverage.

Essential Benefits Package

First, we emphasize that it is challenging for states to make thoughtful and informed decisions when details regarding the "essential benefits package" (EBP) have yet to be released by HHS. The lack of guidance on the EBP has proven to be a significant obstacle to us as we move forward with weighty policy decisions about Exchanges. The EBP is the touchstone for the Exchange; consequently, we are hopeful that the release of the EBP is imminent.

Exchange Plan Amendment

The preamble to §155.105 states that for the Exchange plan amendment (EPA) process HHS is considering the use of the State Plan Amendment (SPA) process in place for Medicaid. While we appreciate that an ongoing dialogue between states and HHS is important to achieve compliance with federal law—both in spirit and by the letter—we urge HHS not to adopt the SPA process in its entirety. At times the SPA process can be lengthy and cumbersome, and the EPA process should enable states to be responsive to changes in the insurance marketplace in a timely manner, especially when an EPA may be desperately needed prior to an open enrollment period. Instead of the SPA approval process, we propose—as the National Association of Insurance Commissioners (NAIC) has proposed—a 30-day advanced notice requirement so that HHS has the opportunity to review an EPA for compliance with federal law. We would also be in favor of a process by which states can seek waivers from certain regulations in order to address unforeseen contingencies.

Entities Eligible to Carry Out Exchange Functions

HHS has requested comments on whether it should place conflict of interest requirements on contracted entities that are enlisted to carry out Exchange functions (§155.110(b)). We are in full support of a requirement for conflict of interest oversight. We urge HHS to allow states authority to formulate and apply these requirements, however, so that such requirements are consistent with and do not supplant state requirements.

HHS has also requested comments on the extent to which categories of Exchange board members should be further specified and on the types of representatives who have potential

conflicts of interest ((§155.110(c)(3) and (4)). Again, we urge that further refinement in these areas is not necessary given the experience of states with establishing governing boards and would limit the flexibility of states to determine governance structures according to the peculiarities of a particular state. Indeed, states should be free to select members of its Exchange governing board among broadly-defined categories and should be provided the latitude to determine what real and potential conflicts of interest exist.

That being said, we understand the need for a governing board to adequately reflect consumer interests. We further understand that the healthcare and insurance industries have powerful interests and stakeholders, so much so that it can be difficult to ensure sufficient feedback and input from a broad range of consumers. Consequently, we recommend that should HHS provide further detail regarding the composition of governing boards, it should include a requirement that the governing board has majority consumer representation with voting power *and* majority representation with voting power "with relevant experience in health benefits administration, health care finance, health plan purchasing, health care delivery system administration, public health, or health policy issues related to small group and individual markets and the uninsured."

In addition, we recommend that HHS allow states to assemble Advisory Committees, bodies that would have a formal relationship with the Exchange governing board and would be comprised of members with special expertise, for example a Consumer Advisory Committee comprised of consumer advocates and non-profit organizations with relevant knowledge and expertise, and a Health Insurance Industry Advisory Committee comprised of representatives from health insurers, agents, brokers, or other individuals licensed to sell health insurance. In sum, adequate consumer and industry representation in Exchange board governance will ensure that decisions will rest on what is best for consumer access, quality, and cost, including prevention of adverse selection.

Federal-State Partnership Models

We appreciate HHS' willingness to provide options for states as we continue to navigate the political and practical mazes associated with implementing Exchanges, and we see the models as potentially viable and inviting options. We seek further guidance, however, on how Partnership models will work, as we have found it tough to convince policymakers on a state level to move forward with a Federal-State Partnership with scant information about the logistics. Accordingly, we request guidance regarding the questions below about the Partnership Model and federally-facilitated Exchanges.

1. Does the Partnership Model require a state to "elect" the Model when it applies for planning funding or at any point in the implementation process?

2. Will there be any opportunity for states electing to pursue the Partnership Model or federally-facilitated Exchange to apply for federal "development" funding beyond 2011?

3. When will guidance be available for sustainability planning for Qualified Health Plan, outreach/education and Navigator programs should a state elect the Partnership Model? Will HHS provide part of premium fees collected to fund the functions performed by the states?

4. What forms of Navigator roles does the Partnership Model plan to support (pay for enrollment, fee-for-service, salaried outreach/education)? How much flexibility will States have in design? What are plans for financing?

5. How will federal Call Center functions coordinate with state Consumer Services Divisions, given that many local consumers will call the Division and/or walk-in for services?

6. How will insurance risks be pooled in a federal Exchange?

7. Will a federal Exchange offer only Arkansas state-licensed health plans to Arkansas residents?

8. How will a federal Exchange adjust, if at all, for regional cost differences? How will the federal Exchange ensure that Arkansans are not paying disproportionately higher premiums given the relatively lower premiums that Arkansans pay currently?

9. For outreach/education, will HHS design materials for state use/modification, or will states assume full responsibility?

10. When will information be available for planning Arkansas information technology costs for the federal Exchange?

11. Will the federal Exchange determine *all* Medicaid eligibility for Arkansans, or only eligibility for newly eligible Arkansans as determined by Modified Adjusted Gross Income (MAGI)? Will the same be true in a Partnership model?

12. How does the federal Exchange plan to present Qualified Health Plan options? If the Plan is offered in multiple states does HHS expect to have that plan entered into the federal Exchange separately for each state?

13. Will the federal Exchange require the states to "upload" Qualified Health Plans, or does the federal Exchange expect to have the plans submitted by insurance carriers directly? If the latter, will the Plans then be shared with the state for evaluation?

14. What are the timeframes for availability of the Qualified Health Plan enrollment component of the federal Exchange? When does the federal Exchange expect the state evaluation period to start/complete for the first year and subsequent annual cycles?

15. Will there be additional federal Qualified Health Plan approvals after state approval?

16. What is the method of communication ("upload") of the Qualified Health Plan data (i.e. Website Portal, XML/Service-enabled interaction, etc.)?

17. What role will the state Qualified Health Plan process play in setting up the enrollment interface between the federal Exchange and the insurance carriers (i.e., approval qualifications/attestations, interface testing, etc.)?

18. Can a non-profit organization apply for Level One funding for core area/components development under the Partnership Model?

19. Is implementation authority—either legislative or executive—required by states to pursue any of the functions under the Partnership Model?

Ultimately, we recommend that models for Federal-State Partnerships (155.110) be determined individually (state by state) through a Memorandum of Agreement. Much like the requested flexibility for the remainder of the rules, we ask for flexibility in Federal-State Partnership Models, as no one model will be viable for all states seeking partnerships. More specifically, we urge HHS to provide more options with respect to the particular functions among which states may choose to assume responsibility.

Required Customer Assistance Tools

States naturally recognize the need for customer assistance tools to be available and accessible to a broad spectrum of customers. Accordingly, we acknowledge that in order to accomplish this goal call centers will likely operate outside normal business hours and include multilingual and culturally competent staff who will, via an appropriate medium, provide assistance on the full range of issues that affect whether customers can enroll in coverage and secure care.

We further acknowledge that the Exchange website(s) will be a primary source of health care and insurance information for families and individuals and should facilitate interaction between

and among individuals, employers, and navigators. The need for customers to customize their account information, record changes in circumstances, and to establish privacy controls are paramount concerns. Indeed, the ability of customers to customize their accounts is expected to maximize administrative efficiency and to catalyze frequent use of the website.
While we agree that these attributes are essential to the overall efficiency and—ultimately—the success of the Exchange, we believe that the flexibility to design these specifications should be left to the states. Therefore, the rule should avoid onerous staffing or technical requirements that fail to consider states' current levels of readiness.

Navigator Program

We are pleased that the proposed rule recognizes that states are in the best position to determine the eligibility, training, duties, certification, and conflict of interest provisions that are appropriate for navigators in order to protect consumers. While we agree that regulations should ensure program quality and accountability, standardization of the information provided by navigators would best be in the form of recommended guidelines rather than prescriptive text as the needs of consumers may vary widely.

Privacy and Security

We agree with requirement that states implement some form of authorization for ensuring that all entities and individuals interacting with Exchanges are who they claim. We request, however, that HHS be mindful that burdensome identification requirements have the potential to curtail consumer access.

Network Adequacy Standards

We agree with an approval process to ensure that an enrollee can obtain a covered benefit from an out-of-network provider at no additional cost *if no network provider is accessible for that benefit in a timely manner and the out-of-network provider meets quality standards.*

Statewide Coverage

We request that, if an Exchange is state-based, states have the option to require insurance carriers to provide statewide coverage in an effort to avoid market segmentation and to eliminate the risk that carriers will avoid regions in which health care costs might be greater. We further request that a federally-facilitated Exchange mandate that insurance carriers provide statewide coverage or, in the alternative, an approval process that highly scrutinizes any request to provide less than statewide coverage.

Certain regions in Arkansas historically have had a high chronic disease burden and limited access to health care and insurance coverage. Requiring statewide coverage will eliminate the potential for any one region to be further disadvantaged by having fewer coverage options available.

Rate Review

We recommend that the final rule defer to states with respect to review and approval of rates for Qualified Health Plans, as states have a long history of regulation in this area. Further, the rule should confirm that PPACA merely requires notification to an Exchange of rate increases. We do not disagree that an Exchange should be empowered to take into account a pattern of rate increases that have the potential to affect the market within an Exchange. The authority of an Exchange to act in such cases, however, should be limited to decertification of a Qualified Health Plan.

Stand Alone Dental Plans

We recommend that the Exchange require dental and medical plans to be offered and priced separately to ensure transparency, competition and access. Benefits provided by stand-alone dental benefit plans are treated as "excepted benefits" under federal law and PPACA. Consequently, they are not subject to the insurance market reforms or otherwise regulated in the same manner as comprehensive, major medical coverage.
Ninety-eight percent (98%) of dental benefit plans are sold as stand-alone plans separate from major medical plans, both in the current benefits market and in the market that will exist outside of an Exchange. In an effort to preserve existing family coverage in the market today, we request that the NPRM preamble include a statement noting that state regulators should not have to require a qualified health plan to offer the essential pediatric dental benefit in the individual and small-group (100 lives and under) markets outside an Exchange, or be faulted for failing to enforce such a requirement where a stand-alone dental plan is available. The separate offering and pricing of the pediatric dental benefit, as well as benefit disclosure, will promote consumer choice and comparison. These steps will ensure that dental benefits remain a viable and transparent option for consumers.

Best regards,

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State Insurance Commissioner

Cynthia Crone
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