



**National
Business
Group on
Health**

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Creative Health Benefits Solutions for Today, Strong Policy for Tomorrow

April 21, 2011

The Honorable Robert McDonnell
Governor
Commonwealth of Virginia
Office of Governor Bob McDonnell
Patrick Henry Building
1111 East Broad Street, 3rd Floor
Richmond, VA 23219

Dear Governor McDonnell:

The National Business Group on Health appreciates this opportunity to present a model for the exchanges under the current law that underscores the need for the exchanges to aggressively focus on value, reduce the total cost of the coverage and care for all people and all payers, and improve the quality and safety of service for enrollees.

The model reflects the experiences of employers both in terms of practical lessons from operating our own internal company-level exchanges with health plan choices for employees and our efforts to improve the payment and delivery of health care.

As you are well aware, given the current law, having sufficient lead time and final guidance will be critical not only for the states, but also for employers and plans to meet the deadlines and assure that the exchanges run as smoothly as they can for consumers and all stakeholders involved. Specifically, employers are seeking guidance on how retirees, unions, temporary, part-time, or seasonal workers, workers here from other countries for summer employment, and others will interact with and access the exchanges. The more lead time employers have guidance on provisions that involve employers and transactions affecting employees and retirees, the easier it will be for them to plan for the changes and implement them in time.

Given the current law, wherever possible, we urge you to require exchanges to adopt national standards and uniform processes wherever state-by-state variation would add costs and complexity without adding significant incremental value. These areas include risk adjustment mechanisms, plan quality and efficiency standards, and data and process standards for common transactions including eligibility and enrollment and all of the interactions with employers.

The National Business Group on Health represents over 325 companies, including many of America's largest employers (66 of the Fortune 100) who voluntarily provide health benefits and other health programs to over 55 million American employees, retirees, and their families.

We look forward to continuing to work with you on this process. Please contact me or Steven Wojcik, the National Business Group on Health's Vice President of Public Policy, at (202) 558-3012, if you would like to discuss our comments in more detail.

Sincerely,



Helen Darling
President

cc:

Virginia Commissioner of Insurance Jacqueline K. Cunningham
Other State Governors
Other State and DC Insurance Commissioners
Mr. Dan Crippen, Executive Director, National Governors Association
Ms. Therese M. (Terri) Vaughan, Chief Executive Officer, National Association of Insurance Commissioners
Mr. Steve Larsen, Director, Office of Insurance Exchanges, Center for Consumer Information and Insurance Oversight (CCIIO)
Mr. Joel Ario, Director, Office of Insurance Exchanges, CCIIO
The Honorable Donald M. Berwick, M.D., Administrator, CMS
Ms. Marilyn B. Tavenner, Principal Deputy Administrator, CMS
Ms. Nancy-Ann DeParle, Deputy Chief of Staff, The White House
The Honorable Kathleen Sebelius, Secretary, U.S. Department of Health and Human Services

Enclosure: Model for State Exchanges

Model for State Exchanges

Business Group Interest in Exchanges and Relevant Experience

Business Group members have experiences and lessons learned as they continually strive to be as effective and efficient as they can in the administration of health care benefits for employees and plan participants.

- Expertise: The model reflects our members' experience in spurring plan innovation and operating company-level "exchanges." The Business Group represents the nation's leading private- and public-sector employer purchasers of health care benefits who are among the nation's leading innovators driving improvements in quality, safety and health care outcomes. In addition, because of their size, many large Business Group employers have operated "exchanges" for their own employees as they select from among a set of plan options during annual open enrollment periods.
- Alignment: The Business Group has a strong interest in assuring that the exchanges pursue strategies that are aligned with the innovative purchasing approaches of its members. For over 35 years, our large employer members have been strongly committed to ensuring quality, safe health care and investing in wellness programs, and benefits that actually improve the health of employees and their dependents. Assuring that the exchanges foster these health care quality improvements will reinforce our efforts to positively impact the health of all Americans.
 - Business Group members provide health care benefits in the same markets, through many of the same plans and providers, as the future exchanges. If we want to transform care and, in particular, lower spending and greatly improve quality, safety, and health outcomes, all participants in that system, employer purchasers, plans, and exchanges alike, need to pursue aligned strategies to reduce total costs of health care by improving the effectiveness and efficiency of health care delivery.
 - Business Group members and other employers may interact with the exchanges, in the short-term if they have eligible employees (full-time or part-time), dependents or retirees, beginning in 2014, and participate in later years, after 2017, if the States choose. Business Group members are deeply concerned about assuring that their employees and family members get the best, clinically appropriate care at a sustainable cost. That assurance of value is particularly important as eligible employees, retirees and family members may qualify for coverage in the exchanges even if employers do not participate in the exchanges.

Guiding Principles for Establishing and Operating Exchanges

The design of the exchanges is a critical component in the operation and ultimate success of the Affordable Care Act's provisions to expand access to coverage. It also presents an opportunity as a vehicle to change the payment and delivery of care to assure that all people, whether covered through the exchanges, other government programs, employers and other private payers, receive much more effective and efficient care than we currently receive. To achieve these aims, the Business Group proposes several principles reflected in this model and which we urge should guide future policy decisions.

Focus on value: If we want to make health care affordable for employers, individuals, families, and the government, the exchanges must adopt, as their primary mission, a focus on value. That means reducing the total cost of coverage and care (for both the plans and the participants and for plans and people outside the exchanges) and increasing the effectiveness, quality and safety of patient-centered care for all.

Be highly active purchasers: HHS must ensure that exchanges do not become passive facilitators or only "portals" for individuals and employers to select health care coverage. The exchanges must assume a strong role as active purchasers, not only for the exchange enrollees, but to align with other purchasers in the community to help providers become more effective and efficient in care delivery.

Standardize operations: HHS must standardize the operations of exchanges for employers, individuals and health plans wherever possible. Employers that operate in more than one state should not have to confront a confusing array of different rules among the exchanges in which their employees seek care. In addition, the federal government should only certify exchanges with high quality and very capable health information technology systems.

Provide clarity, transparency and simplification: HHS should ensure that the exchange policies and the health plans are clear to consumers, employers, the States and the federal government. That calls for clarity and simplicity. HHS should not micromanage participating health plans; but rather, provide a clear focus on innovative purchasing and a value agenda for health care in the community.

Ensure accountability: HHS should also structure exchanges to promote provider and plan accountability for the cost and quality of the coverage and care offered. The Congressional Budget Office (CBO) estimates that 29 million Americans will receive coverage through the exchanges by 2019, including 5 million with employment-based coverage, at an annual cost to federal taxpayers of more than \$100 billion per year for premium assistance tax credits and cost sharing subsidies. That demands accountability, and the resources and expertise to meet that level of accountability.

To assure state accountability, the States implementing exchanges should adopt a project manager approach typically used by large businesses implementing large-scale change

with lots of moving parts and long-term consequences. Such individuals can anticipate lead times and provide a valuable contact point for stakeholders such as the employer community, and assure responsibility and ultimate accountability.

Deter cost shifting onto private payers: Exchanges must fairly reflect actual costs so they do not shift additional costs onto employers or employees or through the exchanges' assessments or user fees on participating health insurance issuers for increased provider costs, additional state benefits or administrative costs, particularly when the exchanges become self-sufficient on January 1, 2015.

Practice continuous learning/improvement: Exchanges must focus on an ongoing process of continuous learning and improvement subject to evaluation and adaptation. This is largely a new enterprise, and even with a strong degree of national standardization, the States may take many different approaches in the exchanges with different capacities for management. HHS needs to couple rigorous standards with a process to evaluate, learn lessons from the successes and failures, starting with learning from the experiences with already existing state, local, and private exchanges, including employers' internal exchanges for their employees, and revise policy nationally and at the State level.

Specific Recommendations for State Exchanges

Organizational Form

RECOMMENDATION: STATES SHOULD SET UP NON-PROFIT ENTITIES TO ADMINISTER EXCHANGES RATHER THAN SET UP NEW STATE AGENCIES OR HOUSE EXCHANGES IN EXISTING STATE AGENCIES

The Business Group's experience is that while government needs to play a strong role in setting and enforcing the "rules of the road," independent, non-profit entities, and comparable health care benefit purchasing entities, accountable to their States and staffed by people with specific, relevant experience relevant to operating effective model health insurance exchanges are best equipped to administer and implement the exchanges. However, non-profit exchanges may contract with for-profit entities with successful records performing the functions outlined in our guiding principles for establishing and operating exchanges.

We also favor non-profit entities over state agencies because state contracting requirements are complex, expensive and administratively cumbersome. When states create new offices in state agencies, employers and others who have to deal with them often get passed back and forth between agencies within states' Departments of Insurance, working under the constraints of a number of rules and bureaucratic requirements. As a result it often takes a long time to receive a response which significantly impacts the cost and planning design of employer-sponsored benefits.

We also base our recommendation for states to set up non-profit entities to administer the exchanges because of the need for strong, activist exchanges as set out in our principles—a role that will require flexibility and adaptability in contracting and staffing that is difficult for many governmental entities to achieve. Non-profit entities are also more immune from political influence than state agencies and the model exchange also needs protection from political pressures, provider interests, or pressure from advocacy groups. Exchanges in our model would be called on to make important but difficult choices, such as negotiating with powerful interests, dropping health plans, and driving a value agenda.

RECOMMENDATION: WHEREVER POSSIBLE STATES SHOULD ALWAYS CONSIDER AND ESTABLISH MULTISTATE REGIONAL EXCHANGES AND COORDINATE EXCHANGE FUNCTIONS WITH OTHER STATES TO INCREASE THE EFFICIENCY OF RESOURCE USE, SAVE MONEY AND ENSURE MORE SEAMLESS EXCHANGE PARTICIPATION FOR FAMILIES AND EMPLOYERS WHO HAVE MEMBERS IN MULTIPLE STATES OR WHO MOVE.

Should states decide to coordinate exchange functions with other states or join regional, multistate exchanges; it also may be harder to do if states create new agencies or house the exchanges within existing state agencies. Historically, states talking to other states

does not work, which could complicate the regional exchange model. Non-profit entities may make it easier for states to work together with other states on exchanges.

RECOMMENDATION: EXCHANGE GOVERNANCE BOARDS SHOULD INCLUDE INDEPENDENT PLAN ADMINISTRATORS, AT LEAST 1 MULTI-STATE LARGE EMPLOYER PLAN SPONSOR, REPRESENT MULTIPLE STAKEHOLDERS AND BE MULTI-DISCIPLINARY WITH EXPERTS IN THE DIFFERENT FUNCTIONS OF THE EXCHANGES

The model exchange's governance board should be multi-disciplinary and represent multiple stakeholders—similar to Massachusetts'. Massachusetts' Health Connector includes stakeholders from the actuarial and consulting fields for the health care financing industry, union funds, experts from the economic and public health sector, the state's group insurance commission and other state government agencies. We recommend adding to this list of members of exchange governance boards to include, at a minimum, independent plan administrators with experience in managing health care plans and at least 1 multi-state large employer plan sponsor to assure that the exchanges are run as effective health care purchasers and succeed in providing effective, affordable and efficient coverage to exchange plan enrollees.

The governance board should also include stakeholders with specific experience in the core functions, oversight responsibilities and criteria for the certification of health plans defined in the Affordable Care Act. It should include stakeholders with experience in certification, recertification and decertification of plans; operation of toll-free hotlines; presentation of enrollee satisfaction survey results; establishing open enrollment periods; establishing network adequacy and information on the availability of in-network and out-of-network providers; quality improvement and reporting; and providing timely information to consumers.

The governance board standards for conflicts of the interest should not automatically exclude experts vital to creating effective, efficient exchanges. In many cases, they are the people who know how to operate exchanges and the functions that will be critical to the exchanges. Large employer plans and insurers have a lot to offer. Exchanges should take advantage of their expertise.

Operating Model

RECOMMENDATION: ALL EXCHANGES SHOULD BE HIGHLY ACTIVE PURCHASERS OF HEALTH CARE AND REQUIRE PARTICIPATING PLANS TO BE HIGHLY ACTIVE PURCHASERS AS WELL

Exchanges should not become passive facilitators or only "portals" or "clearinghouses" for individuals and small employers to select health care coverage. The exchanges must assume strong roles as active purchasers, not only for the exchange enrollees, but to align, to the extent they can by law, with other purchasers in the community and encourage exchange plans to be active purchasers as well.

Exchanges must orient their focus on the value equation noted before. Specifically, exchanges should try to improve the effectiveness and efficiency of health care providers, particularly hospitals and physician specialists, and encourage participating plans to do the same to improve efficiency and effectiveness of care for all, including enrollees, people covered outside the exchanges, and all other payers.

- Standard setters: HHS should provide guidance for exchanges, including setting national standards for the cost and quality of care and enforce those standards through both health plan participation requirements and encourage plans to do so in their payment policy. **Exchanges must not let every health plan participate—this is not an "any willing plan" model. However, exchanges should allow all plans that meet certification requirements to participate rather than limiting access to plans selected by the exchanges.** Exchanges should evaluate plans based on price, the ability of the plan and its providers to lower total costs in the system, eliminate waste and overuse and improve quality, safety, patient-centeredness and service.
- Negotiators: Exchanges must adopt approaches dealing with total costs and benefits with plans seeking to offer coverage. Policy leaders need to recognize that what is driving total costs and premiums is use of services and provider fees. The latter is particularly problematic in areas where some hospital systems and physician specialty groups hold market leverage. Plans can have competitive terms for administrative services, marketing, and distribution costs and profit or operating margins, but until we find ways to change the use of services through better health and alternative services, we will not control costs. The exchanges must maintain a rigorous focus, well beyond premiums and administrative costs, on reducing the total costs of care in the health care system by:
 - Driving down underlying costs;
 - Eliminating cost shifting to other payers;
 - Taking waste and overuse out of the system;
 - Focusing relentless attention on quality and safety;
 - Incorporating efficient and effective innovations in the delivery of care (primary care models, convenience care clinics, hospice care for end of life, appropriate use of nurse practitioners, etc.); and
 - Addressing administrative costs of health plans and providers.

All of these actions will help reduce the “spend” for both the plan and the plan member, including premiums and out-of-pocket costs at the point of service.

Using market leverage to reduce costs for exchange coverage by shifting costs to people outside the exchanges and to employer plans and insurers outside the exchanges would only be an illusory achievement that would do nothing to help our nation as a whole to reduce its unsustainable health care spending trajectory.

- Drivers of efficiency and preventing cost-shifting: The exchange administrators (governance boards) should know whether plans are meeting their premium targets through efficiencies or whether they are meeting them by offsetting losses through subsidies from other payers (cost-shifting). The exchanges should measure initially and on an ongoing basis changes in cost shifting as a result of the exchanges using a measure similar to the Commercial Index Ratio (CIR) to measure the degree of cost shifting onto patients, employers and other health plans. CIR measures the ratio of private payments to Medicare payments for specific services. Whatever measures exchanges choose, they should demonstrate constant or declining levels of cost-shifting. In its analysis of the effectiveness of the exchanges, HHS should evaluate the degree to which providers shift costs onto private payers. Unless HHS’ analysis goes beyond the plans to the providers, it may not show that cost-shifting has occurred. For example, plans in the exchanges may have similar rates in and out of the exchanges and may not show any evidence of cost-shifting, but hospital systems that contract with plans’ in the exchange may shift costs to other payers (employer plans, etc.). HHS’ analysis should also take into account the potential for cost shifting as a result of the impact of compliance with the medical loss ratio (MLR) requirements. HHS should share the results with the public and plan administrators and take action, if necessary, against provider networks contracting with exchange plans or with delinquent plans themselves by denying them certification, assessing fines, or providing them with a short-window to become compliant.

- Benefit design innovators: The model exchange should also emulate employer plan design, purchasing and consumer engagement strategies by requiring “qualified health plans” to do the following:
 1. **Plan Design**
 - Use plan design to drive evidence-based care and consumer engagement;
 - Cover services provided in alternative care settings, e.g., onsite clinics, retail clinics;
 - Use behavioral economics to support engagement strategies; and
 - Selectively use incentives, for example:
 - Based on satisfying participation requirements, e.g., participate in more activities (health assessment, biometric screening, disease management; program, etc.) and/or *complete* programs (health coaching, weight management, etc.); and
 - Impose surcharges for tobacco and inappropriate ER use.

 2. **Purchasing**
 - Source best in class providers, e.g., Centers of Excellence;
 - Emphasize primary care;
 - Promote transparency of cost and quality information; and
 - Pilot new payment models.

3. Consumer/Patient Information

- Invest in patient decision aids and online decision-support tools providing information that can be seen by both employees and benefit advisors on their computers in order to support shared decision making, e.g., expert medical consultations and health coaches in order to create a successful exchange experience;
- Rate plans for patient satisfaction using measures from the Hospital Consumer Assessment of Healthcare Provider and Systems (HCAHPS) survey;
- Leverage social networks in populations, e.g., healthy pregnancy, and in wellness through physical activity and weight loss competitions; and
- Utilize outreach management systems that send automated customizable communication materials such as welcome kits, enrollment guides, reminder postcards, emails, confirmation statements, and certified letters to exchange participants. Additionally, exchanges should use telephone systems that can notify participants of upcoming events with auto-dialed, pre-recorded messaging.

Exchanges should also encourage, and where appropriate, require health plans to implement value-based benefit design (VBBD). VBBDs factor in the effectiveness of services and the effectiveness and efficiency of providers in determining coverage, provider payments, and plan participants' cost-sharing. Plans use these tools to help assure that plan participants receive quality services and lower cost. For example, Consumer's Medical Resources worked with one large employer to implement medical decision support tools to engage employees and families diagnosed with serious, complex illnesses (3.5% of the population, driving 51% of costs) to make more informed care decisions. They wanted to reduce variation from best practices and unnecessary care (25% of surgeries unnecessary). As a result, they saved an estimated \$1.7 million in direct costs (not counting productivity savings and other potential savings).

In addition, as active purchasers, the exchanges should also encourage coverage of evidence-based preventive services.

Exchanges should also promote as much innovation as possible. For example, reference-based pricing is a growing benefit design that exchanges should encourage. In addition, the model exchange should incorporate best practices from high performing providers—for example, the Department of Veterans Affairs' efforts to reduce healthcare-acquired infections (HAIs) and improve provider quality.

- **Managers of enrollment and consumer choice:** Exchanges must actively manage the choices available, and the processes through which employers and individuals participate. Consistent with the exchange role as standard setters, exchanges must focus on real choice among a selected number of plans and models, and not just make available a large and confusing multiplicity of insurance products. We also recommend the exchanges permit more than two plan types—beyond just

individual or family—and permit plans that tier based on the number of dependents. In addition, exchanges should include Health Savings Account (HSA)-qualified consumer-directed health plans (CDHP) as plan options.

- **Monitors:** Exchanges must track and monitor the performance of the participating plans and providers and the cost and quality of the care to enrollees. The exchanges also need to minimize the disruption to consumers and employees who lose access to the providers who participated in their previous plans, but will not participate in the exchange plans' provider networks and for people switching plans both in and out of the exchanges as their status changes.

RECOMMENDATION: STANDARDIZE ACROSS ALL STATES ALL PROCESSES AND TRANSACTIONS INVOLVING CONSUMERS AND EMPLOYERS IN THE INDIVIDUAL AND SMALL BUSINESS EXCHANGES

The exchanges should be vehicles for simplification of a complex array of transactions for employers and consumers. These transactions include employee and/or employer plan selection through a “secure portal”; plan enrollment; processing employer and individual contributions (including HSA payments for the unemployed and those on COBRA); eligibility for and processing of tax credits for small employers; processing tax credits and cost sharing support for qualifying individuals; determining employer free rider assessments; seamless enrollment in Medicaid and the State Children’s Health Insurance Program (SCHIP); continuity of coverage rules, and transitioning participants moving among Medicaid, SCHIP, and private coverage as eligibility status changes with changes in income or circumstance. Employers, plans and all stakeholders would also find it easier to interact with the exchanges with uniform terminology, technology and processes. For example, the federal government should provide a standard definition and treatment of qualifying events for exchange coverage.

Processing Employer and Individual Contributions and Tax Credits for Qualifying Individuals

Employers support an electronic interface with a “secure portal” (preferably with one access point rather than 50 separate ones that state exchanges and employers can access)—similar to the federal government’s data collections for the Retiree Drug Subsidy (RDS), Early Retirement Reinsurance Program (ERRP), and other programs since employees’ tax subsidies will be based on their incomes, and employers will only be submitting a portion of the information required to determine employees’ eligibility (their current salaries). Without one standardized access point to act as a data integrator for exchanges, employers and the federal government, employers would likely need to create all new interfaces and departments to manage the data exchange with 50 potentially different formats.

The exchanges should use the one “secure portal” to send pertinent information back to employers—giving them the ability to pick up the information and load it into their payroll systems, take deductions and pay these funds back into the exchanges, identify

employees who are specifically eligible for exchange coverage and where and when employers would need to pay applicable free rider penalties. Most employers' payroll/benefits systems include information on employers' cost by coverage type, the amounts covered by employers and employees, employees' current employment status and their selected coverage. The exchanges should also recognize that employees and dependents could elect different plans, creating reporting challenges.

Employers and exchanges would also prefer to use the "secure portal" to transmit information back and forth in order to coordinate benefits between the exchanges and employers' coverage. Employers will need to interact with the exchanges to access the level of coverage, coverage periods, etc. for employees to coordinate workers' compensation, Family and Medical Leave Act (FMLA), disability benefits and a variety of other areas as well for exchange-eligible employees. These processes too should be the same nationally, not differ by state. Employees could be on disability or FMLA and not have employees' health care coverage because they have it through a working spouse or partner. Sufficient information on these benefits is vital to point employees in the correct directions when they have questions and to prevent dual coverage with workers' compensation (since it also provides health care benefits). It will also ensure that employers know what elections have been made by any employees eligible for their coverage so that they can monitor their exposure for re-enrollment and their risk for shifting of claims to other programs (e.g., workers' compensation or long term disability) when the corporate programs offer better coverage than the exchange plans their employees enroll in. The federal government should consider modeling the interactions and benefits coordination between the exchanges and employer plans on the earlier employer voluntary data sharing agreements (VDSA) under the IRS/SSA/CMS Data Match project to eliminate the administrative burden on employers and the exchanges, dual payments and improve service to both employees and exchange participants.

Uniform processes will also make it easier for people who move to different states, live part of the year in different states, or have families that straddle state borders and participate in more than one exchange (e.g. Maryland, Virginia, and the District of Columbia) to understand the coverage options available in the exchanges, how the exchanges work and any transitions between plans. For example, uniform processes and clarification from the federal government will help these employees and their employers determine when coverage begins (immediately or on the first of the next month) for employees who move from one state to another in the middle of a calendar month and then join exchange-based plans.

RECOMMENDATION: EMPLOYERS NEED AT LEAST 9 MONTHS OF LEAD TIME TO KNOW SPECIFIC REQUIREMENTS FOR COMMUNICATING NOTICES FOR ELIGIBILITY FOR THE EXCHANGES AND TAX CREDITS TO EMPLOYEES

The exchanges should consult with and share communications on the exchanges with employers' benefits departments. Employees are still likely to refer to their employers' benefits departments for questions on the rules for the exchanges and the exchange plans.

The exchanges should provide employers with FAQs and scripts for responding to questions so that employers can respond appropriately to questions from employees. Employees will still ask their employers questions even though the exchanges will determine eligibility for both tax credits and exchange coverage. At a minimum, employers will need 9 months to plan for their plans' call centers to learn new scripts and Frequently Asked Questions (FAQs) to respond to questions that employees may have about the exchanges and their potential eligibility.

They will need at least 9 months lead time to know specific requirements for notifying employees of their potential eligibility for tax credits and exchange coverage. The federal government should provide draft notices and materials well before the beginning of employers' 9 month preparations.

Including the notices in employers' open enrollment materials seems like a natural time to notify employees of their potential eligibility for tax credits and exchange coverage rather than March 1, 2013 as prescribed in the law. The early notice does not seem to provide any benefit to employees who are eligible since exchange coverage would not begin before January 1, 2014.

RECOMMENDATION: EMPLOYERS NEED TO KNOW SPECIFIC DATES AND REQUIREMENTS FOR PROVIDING DATA ON THE VALUE OF PLAN COVERAGE AND EMPLOYEE COSTS FOR COVERAGE TO EXCHANGES FOR CALCULATING EMPLOYEES' ELIGIBILITY FOR TAX CREDITS AND ACCESS TO THE EXCHANGES

Employers also need to know specific information for calculating the actuarial value of their plans and reporting this information along with the amounts employees pay in premiums so that exchanges can determine whether or not the employees qualify for tax credits for exchange coverage.

The federal government needs to provide employers with specific guidance on what employers, plans or actuaries and consultants need to do to determine the value of their coverage.

Risk Adjustment

RECOMMENDATION: THE FEDERAL GOVERNMENT SHOULD OUTLINE RISK ADJUSTMENT METHODS THAT ALL EXCHANGES MUST USE TO ASSURE ACTUARIAL SOUNDNESS. FURTHERMORE, THE REGULATIONS SHOULD REQUIRE THAT EACH EXCHANGE OBTAIN INDEPENDENT ACTUARIAL CERTIFICATION OF THE SOUNDNESS OF THEIR PLAN REQUIREMENTS AND RATING RULES

The future federal guidance on risk adjustment will be one of the most important factors in determining the ultimate success of the exchanges. There are only a limited amount of ways to risk adjust correctly. Some states' previous difficulty in applying risk adjustment

suggests that the federal government should develop the risk adjustment formulae options and not leave it up to the states. We believe that national standards and methods are preferable.

We further advocate that HHS require each exchange to obtain independent certification of the actuarial soundness of its risk corridors, plan requirements, rating areas, risk adjustment, and reinsurance rules from the American Academy of Actuaries, the Office of the Actuary of the Centers for Medicare and Medicaid Services (CMS), or a similar independent actuarial body. Such certification will benefit all participants, including the states, consumers, employers, insurers, providers, and the federal taxpayers. We will all benefit in assuring the long-term viability of the exchanges.

Performance Measures

RECOMMENDATION: EXCHANGES SHOULD REQUIRE THAT ALL EXCHANGES USE THE NATIONAL COMMITTEE FOR QUALITY ASSURANCE'S (NCQA) HIGHEST RATING FOR ACCREDITATION—“EXCELLENT”—AS THE STANDARD FOR PLANS PARTICIPATING IN THE EXCHANGES

The National Business Group on Health was pleased that the Affordable Care Act directs the HHS Secretary to develop a health plan rating system. The opportunity presents itself to set high standards for quality and service for plans seeking access to this large new market. If the Department does not focus on these standards now it will be difficult, if not impossible, to implement them in the exchanges in the future. **NCQA implemented health plan ratings used by employers, individuals and government years ago. States should require NCQA's highest accreditation standards - "Excellent" - for plans in the exchanges.**

Where using the highest standard permits a significant choice of plans, exchanges should use the NCQA “Excellent” standard as the threshold for participation. Where using this standard would result in limited choice of plans in the model exchange, exchanges should adopt the next highest NCQA standard, but require that plans meet the “Excellent” standard within 2 years. Because plans would have almost 3 years before this takes effect, 5 years to get to “Excellent,” such a requirement is reasonable and achievable.

RECOMMENDATION: EXCHANGE PLANS SHOULD USE THE WIDELY ACCEPTED NATIONAL QUALITY FORUM (NQF) ENDORSED QUALITY MEASURES TO EVALUATE PROVIDERS' PERFORMANCE

Plans in the model exchange should rate providers based on NQF standards for quality and efficiency. Exchanges must set high standards for the networks of providers that serve the enrollees with QHPs, to aggressively manage these total costs of care.

RECOMMENDATION: EXCHANGES SHOULD RATE PLANS FOR CONSUMER SATISFACTION USING THE HOSPITAL CONSUMER

**ASSESSMENT OF HEALTHCARE PROVIDER AND SYSTEMS (HCAHPS)
SURVEY AND REPORT RESULTS IN A USER FRIENDLY WAY**

The exchanges must provide consumer-friendly and easy-to-understand quality rating systems—otherwise consumers will not use them. A key example comes from Utah’s consumer exchange into the model exchange (keep it simple, don’t overwhelm consumers with too many choices, make sure employers and employees understand how it works, etc.). CMS’ star rating system for Medicare Advantage plans may also serve as a useful reference.

RECOMMENDATION: THE FEDERAL GOVERNMENT SHOULD REQUIRE ALL EXCHANGES AND PARTICIPATING PLANS TO ADOPT HHS DATA AND HEALTH INFORMATION TECHNOLOGY STANDARDS, REQUIRE INDEPENDENT AUDITS OF EXCHANGE OPERATIONS AND ADMINISTRATION, AND THAT EXCHANGES WORK WITH PRIVATE PAYERS AND THE CENTER FOR MEDICARE AND MEDICAID INNOVATION (CMMI)

It will be essential that exchanges and the participating plans adopt current HHS standards for health information technology and data collecting and sharing standards. This requirement will help accelerate the transition of our entire health care system to electronic information and facilitate improving its effectiveness and efficiency.

The federal government should also require independent external audits of the state exchanges on their performance on quality measures, ability to minimize administrative costs, etc.

The exchanges represent a remarkable opportunity for collaboration. The exchanges can and should work with other purchasers in the community, including business and other government purchasers, such as the new Center for Medicare and Medicaid Innovation (CMMI), to assure aligned incentives for the entire health delivery community.

RECOMMENDATION: EVERY EXCHANGE SHOULD APPOINT A CHIEF VALUE OFFICER TO MAINTAIN ORGANIZATIONAL FOCUS ON THE VALUE OF EXCHANGE AND HEALTH CARE SERVICES

The Chief Value Officer (CVO) will ensure that the exchanges focus on the “value” of health care services. The CVO should report to the governance board of the exchange or the HHS Secretary when no state based exchanges exist. On a quarterly basis, the CVO should report on the value of hospital, physician and medical services based on a cost value analysis and the latest clinical comparative effectiveness research. Most large companies use a Chief Risk Officer for audits, which exchanges should emulate for this new function. Small exchanges may not have the resources for a CVO and the federal government should allow these exchanges to independently contract out this function. The CVO should also provide an estimated impact of the “essential health benefit”

requirements and any additional state mandates on the value of plans in the model exchange.

The CVO will have a lead role in assuring that exchanges advance the value agenda. The value agenda and active purchaser model set out in the Business Group's principles require standards that focus on quality and the reducing total costs of care:

- Estimating the Total Costs of Care: Exchanges must aggressively negotiate the administrative and marketing costs that command so much current attention. However, at the most, these costs represent 15-20 percent of premium costs in the current market. It is the other 80-85 percent of costs—the cost of health care services, especially hospital care and certain physician specialties and subspecialties as well as diagnostic imaging—that require the most attention.
- Utilizing Technology and Decision Support Tools to Ensure Effective Choices: CVOs should incorporate on-line calculators and offer plan quoting, side-by-side comparisons and online decision support tools (Rx, Medical out-of-pocket costs) seen by both employees on their computers and exchange benefit advisors working for the CVOs. These tools would enable participants to evaluate their choice of coverage based on benefits, price, prescriptions, doctor of choice, and predicted out-of-pocket costs.
- Reducing Waste: As part of the value agenda and active purchaser model, exchanges should also set specific targets for the QHPs for reducing waste and overuse in the system. Here again, the focus is not just administrative waste, but wasteful health care spending as well.

State Choices

- Regional exchanges or interstate coordination of certain exchange functions

RECOMMENDATION: WHEREVER POSSIBLE, STATES SHOULD CONSIDER AND ESTABLISH REGIONAL EXCHANGES AND COORDINATE EXCHANGE FUNCTIONS WITH OTHER STATES

This action will not only increase the efficiency of resource use and likely save money, but will also ensure more seamless exchange participation for families and employers who have members in multiple states or who move.

- Whether to establish 50 employees as the cutoff for small group plans until 2016

RECOMMENDATION: SINCE SOME STATES HAVE A 100 EMPLOYEE DEFINITION FOR THE SMALL GROUP MARKET, STATE FLEXIBILITY IN DETERMINING THE CUTOFF WOULD MINIMIZE DISRUPTION OF THE

MARKET FOR STATES HAVING THE HIGHER CUTOFF IN THEIR CURRENT SMALL GROUP MARKET

In addition, the larger size limit will help assure a more stable risk pool for exchanges.

- Whether to require addition benefits beyond the “essential health benefits” package

RECOMMENDATION: WE STRONGLY URGE THAT STATES NOT ADD ADDITIONAL BENEFIT REQUIREMENTS AND URGE HHS TO ESTABLISH A MORATORIUM ON STATE MANDATES FOR EXCHANGE COVERAGE FOR AT LEAST 5 YEARS AND CONSIDER A PERMANENT BAN SINCE THE FEDERAL GOVERNMENT WILL BE PERIODICALLY REVIEWING AND UPDATING “ESSENTIAL HEALTH BENEFIT” REQUIREMENTS THAT ALL PLANS IN EXCHANGES MUST ADOPT

To the extent permitted by law, the moratorium will help exchanges focus on operational and startup issues without pressure from provider and other groups to add benefits. Such a moratorium will also promote national uniformity. Moreover, because the law creates new authority for HHS to define “essential health benefits”, state mandates would be unnecessary and redundant.

Exchanges should also follow California’s exchange legislation which prohibits their exchange from creating a liability for the state’s General Fund, which effectively precludes it from recognizing state benefit requirements that exceed the federal government’s “essential health benefits.”

If exchanges require plans to cover state mandated benefits, it should only do so at the beginning of a plan year because mid-year changes are too disruptive. Furthermore, before exchanges can adopt benefit mandates, they should conduct an independent economic assessment of their impact on exchange participants’ and plan costs.

- Whether to establish a competitive bidding process for plans

RECOMMENDATION: GIVEN THAT PLANS WILL BE OPERATING UNDER STRICT MINIMUM LOSS RATIO REQUIREMENTS, WITH CONSIDERABLY NARROWER RATING BANDS, AND WITH A HOST OF PRICE AND QUALITY TRANSPARENCY AND REPORTING REQUIREMENTS, AS WELL AS GUARANTEED ISSUE AND GUARANTEED RENEWAL, PLAN PRICES WILL BE REASONABLE AND COMPETITIVE BIDDING WILL BE UNNECESSARY

Competitive bidding will be unnecessary given that the Affordable Care Act subjects plans to a host of quality and efficiency rating requirements—a rating system developed by the HHS Secretary for qualified health plans in each level of coverage (bronze, gold,

silver, platinum) on the basis of the relative quality and price, the MLR, and a number of insurance market reforms (guaranteed issue, guaranteed renewal, no rescissions, maximum premium variation by tobacco use (1.5:1) , age (3:1), family size, geography, actuarial value of the benefit, etc.)

Moreover, competitive bidding could work against the goal of consumer choice if many plans decide to drop out because of the competitive bidding requirement.

Finally, competitive bidding among plans does not get at the real cost issue in many places if all plans must negotiate and accept into their networks local hospital systems and specialty physician groups that have monopolistic positions in certain geographies. It is better for exchanges and plans to focus on efficiency and effectiveness requirements for providers instead.

- Whether to extend some or all of the exchange-specific regulations to the outside insurance market

RECOMMENDATION: GIVEN THE VARIABILITY AND DIFFERENT SPECIFICS OF EACH STATE'S INSURANCE MARKET, WE BELIEVE THAT THIS DECISION IS BEST LEFT TO THE STATES. REQUIRING INDEPENDENT ACTUARIAL CERTIFICATION OF RULES WILL HELP ASSURE THE STABILITY OF BOTH THE EXCHANGES AND THE MARKETS OUTSIDE THE EXCHANGES AS WELL.

Each state will factor in what rules are necessary to create a stable market in both the exchange and the outside market.