



**National
Business
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Health**

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Creative Health Benefits Solutions for Today, Strong Policy for Tomorrow

November 23, 2010

Mr. Jay Angoff
Director
Office of Consumer Information and Insurance Oversight (OCIIO)
Attention: OCIIO-9989-NC
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

RE: Initial Guidance to States on Exchanges

Dear Mr. Angoff:

The National Business Group on Health applauds the Office of Consumer Information and Insurance Oversight's (OCIIO) Initial Guidance to States on Exchanges. As you are well aware, the more guidance and assistance that states have, and the earlier they have it, the greater the likelihood that exchanges will be and up and running effectively by January 1, 2014. This letter offers some comments on the issues that your guidance identifies for states to consider.

The National Business Group on Health (Business Group) represents approximately 298, primarily large, employers (including 64 of the Fortune 100) who voluntarily provide health care benefits and other health programs to over 50 million American employees, retirees, and their families.

We appreciate the extraordinary efforts of OCIIO and the Department of Health and Human Services (HHS), as well as the Departments of Treasury and Labor, in implementing the Affordable Care Act.

Issues for States to Consider in Establishing an Exchange

Organizational Form

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 operating health insurance exchanges are best equipped to implement the exchanges. We base this recommendation on our view on 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. In addition, 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. At a minimum, the exchange governance boards should include independent plan administrators with experience in managing health care plans 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.

Exchanges need protection from political pressures, provider interests, or pressure from advocacy groups. Rather, the federal government should ensure that the governance structure of the exchanges base their “qualified health plan” requirements on sound clinical evidence and medical research.

Operating Model

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. Exchanges must orient their focus on the value equation noted above.

- **Standard setters:** HHS should provide guidance for exchanges to set high standards for the cost and quality of care and enforce those standards through both health plan participation requirements and payment policy. Exchanges must not let every health plan participate—this is not an “any willing plan” model. Instead, exchanges should evaluate plans based on price, the ability of the plan and its providers to lower total costs, eliminate waste and overuse and improve quality, safety, patient-centeredness and service.
- **Negotiators:** Exchanges must act as active negotiators of premiums, network approaches dealing with total costs, and benefits with plans seeking to offer coverage. However, policy leaders need to recognize that what is driving total costs and premiums is use of services and provider fees. Exchanges can negotiate competitive terms for plan 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.
- **Benefit design innovators:** Exchanges should encourage and, where appropriate, require health plans to implement value-based benefit design for enrollees. Value-based benefit designs factor in the effectiveness of services and the effectiveness and efficiency of providers in determining coverage, payment, and

cost-sharing. Plans use these tools to help assure that plan participants receive quality services and lower cost.

- **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.
- **Monitors:** Exchanges must track and monitor the performance of the participating plans and providers and the cost and quality of the care that they are providing to enrollees.

Small Business (SHOP) Exchanges

HHS needs to ensure that the exchanges are vehicles for simplification of a complex array of transactions for employers and consumers: participation and comparisons among plans; employer contributions, the availability of tax credits for small employers; free choice vouchers; tax credits and cost sharing support for qualifying individuals; seamless enrollment in Medicaid and SCHIP; and movement among Medicaid and SCHIP eligibility, tax credit eligibility and private coverage. Employers will also need to interact with the exchanges and the federal government in coordinating workers' compensation, disability benefits and a variety of other areas well for exchange-eligible employees. These processes should be the same nationally and not differ by state. In addition, the federal government needs to coordinate with employers' benefits departments on the exchanges as employees are still likely to refer to their employers' benefits departments for questions on the rules for the exchanges and the exchange plans. The federal government also needs to minimize the disruption of employees who lose access to the providers who participated in their employer plans but will not participate in the exchange plans' provider networks.

Risk Adjustment

The future federal guidance on risk adjustment will be one of the most important factors in determining the ultimate success of the exchanges. We 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, or a similar independent actuarial body. Such certification will benefit all participants, including the exchanges and the federal taxpayers supporting the tax credits and subsidies in the exchanges, by building trust among employers, consumers, providers and insurers on the long-term viability of the exchanges.

Performance Measures

Standards for qualified health plans (QHPs) are among the most critical issues in implementing health reform for the federal government to improve coverage and transform the value of care, drive down health care costs and increase quality.

With millions of newly covered individuals in this new market, the federal government has an opportunity to hold QHPs to the highest possible standards in order for them to gain access to the exchanges. Now is not the time for a "least common denominator" approach.

- Exchanges should establish strong standards for participating plans. Exchanges must require a sufficient number of plans to assure real choice in each geographic insurance market of a state, not just a large number of insurance products. In particular, the exchanges should include choices among several models of care-including tightly organized models and open network plans with value-based design.
- To facilitate that choice, especially in the early years of implementation, exchanges need to clearly identify health benefit packages to facilitate easy comparison by exchange participants so that the plans compete on costs and quality, not marginal and confusing changes in benefit design.
- Participating plans should also compete by driving innovation in health care delivery, organizational effectiveness, quality and safety of care in the community.
- The value agenda and active purchaser model set out in the Business Group's principles require standards that focus on 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.
 - Exchanges must set high standards for the networks of providers that serve the enrollees with QHPs, to aggressively manage these total costs of care. **One option to strongly consider is to require a "Chief Value Officer" at each exchange to maintain an organizational focus on this issue.**
 - 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.

- The exchanges must include effective quality-improvement provisions. 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, and if the Department does not focus on these standards now it will be difficult, if not impossible, to improve these standards in the future. **NCQA implemented health plan ratings used by employers, individuals and government for years and the Departments should use NCQA's highest accreditation standards - "Excellent" - for participation of plans in the exchanges. The exchanges must also include consumer-friendly and easy-to-understand quality rating systems—otherwise consumers will not use them.**
- 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.
- Finally, 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, to assure aligned incentives for the entire health delivery community.

State Choices

- Regional exchanges or interstate coordination of certain exchange functions

Wherever possible, states should consider and establish regional exchanges and coordinate exchange functions. 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.

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.
- Whether to require addition benefits beyond the essential health benefits

We strongly urge that states not add additional benefit requirements and urge HHS to establish a moratorium on them for at least 5 years. 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.

- Whether to establish a competitive bidding process for plans.

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, plan prices will be reasonable and competitive bidding will be unnecessary. In addition, competitive bidding could work against the goal of consumer choice if many plans decide to drop out because of the competitive bidding requirement.

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

Given the variability and different specifics of each state's insurance market, we believe that this decision is best left to the states. Each state will factor in what rules are necessary to create a stable market in both the exchange and the outside market. Requiring independent actuarial certification of rules will help assure the stability of both as well.

The National Business Group on Health appreciates this opportunity to comment on the development of exchanges, and, in particular, the need for the exchanges to aggressively pursue a focus on value, the total cost of the coverage and care, and the quality and safety of service for enrollees. We look forward to continuing our work with the OCIIO and the States throughout this process. Please contact me or Steven Wojcik, the National Business Group on Health's Vice President of Public Policy, at (202) 585-1812, if you would like to discuss our comments in more detail.

Sincerely,



Helen Darling
President

cc: The Honorable Kathleen Sebelius, Secretary, HHS
Ms. Donna Laverdiere, OCIIO