



October 4, 2010

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

RE: File Code OCIIO-9989-NC (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 Secretary Sebelius:

We appreciate the opportunity to respond to the Request for Comments on the Planning
and Establishment of State-Level Exchanges released August 3, 2010.

Georgetown University's Center for Children and Families (Georgetown CCF) is an independent, nonpartisan policy and research center whose mission is to expand and improve health coverage for America's children and families. Central to our work is providing research and policy assistance to state administrators and state-based organizations on strategies for covering children and their families in Medicaid and the Children's Health Insurance Program (CHIP). We also conduct research and analysis to inform federal and state policymakers about issues impacting children and families in health care reform and to improve Medicaid and CHIP, particularly around streamlining enrollment and renewal systems.

For families with children, we believe that the exchanges will offer an important new route to affordable coverage not available before on the individual market. While many of the decisions made about exchanges will have implications for the broader population, some will have specific ramifications for children with families. Of particular importance is the extent to which exchanges build seamless connections with Medicaid and CHIP, which serve one in three of the nation's children.

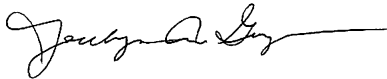
Children and families also will face some unique challenges in navigating this new health reform world. Children eligible for Medicaid and CHIP at the time of the bill's passage will continue to be eligible for that coverage until at least 2019. Since the majority of states already provide coverage to children up to at least 200 percent of the FPL, many of these children could have family members seeking coverage in the exchanges. In general, people will not necessarily know which program they are eligible for and many parents will face the additional burden of having to navigate multiple programs if they are to secure

affordable coverage for themselves and their children. In addition, due to changing family circumstances, children and families could quite frequently find themselves moving back and forth between exchange and Medicaid/CHIP coverage.

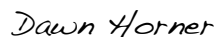
As such, our comments respond to the set of questions focused on Enrollment and Eligibility and Outreach. In answering these questions, we utilized the lessons learned by Medicaid and CHIP in establishing coordination strategies between the programs. We encourage you to make use of the expertise of state officials and advocates in establishing these procedures to help inform the development of the exchange enrollment and eligibility process moving forward.

We appreciate the opportunity to provide our input to these critical questions facing exchanges and look forward to working with you on them.

Sincerely,



Jocelyn Guyer
Co-Executive Director



Dawn Horner
Senior Program Director

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

The success of the exchanges, and more broadly, the health reform law will depend on the ability of individuals and families to easily access affordable coverage. To facilitate this goal, in the first year, federal guidance should allow for greater flexibility for individuals enrolling in the exchanges so that families have time to learn about the options available to them under the new law and enroll in the plan that best meets their needs. Specifically, guidance should allow for a longer open enrollment period prior to January 1, 2014, and ensure that families can enroll past the January 1, 2014 implementation date for a limited period of time (to take advantage of the publicity and greater public awareness of the availability of exchange coverage).

In subsequent years, guidance should ensure that open enrollment periods are available to families at least once a year during a standardized time period (such as September through early December, which generally lines up with the open enrollment periods for employer-sponsored insurance), that the period(s) last at least for 90 days, and that insurers fully

advertise the availability of coverage during these open enrollment periods. In addition, the law should follow HIPAA and Medicare guidelines in establishing qualifying events that will trigger special enrollment periods for subscribers and dependents into both subsidized and unsubsidized coverage in the exchanges.

Additionally, because the exchanges will be accepting applications from children and adults eligible for Medicaid and CHIP (which can enroll people into coverage at any time), it will be important that the exchanges do not unintentionally deter these individuals from applying. States should be required to encourage individuals seeking coverage through the exchange to apply, even if open enrollment is closed, as they may be eligible for Medicaid/CHIP or eligible for exchange coverage due to a qualifying event. Messaging to the different populations served by the exchanges will be critical to ensuring families obtain coverage when they are eligible for it.

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

Online enrollment can be an effective enrollment tool but it is critical that any system be built with a minimum set of user-friendly components. This includes ensuring that it is robust enough for high-end users but simple enough for low-literacy or limited-English proficiency users; that it is available in multiple languages; that it is accessible to individuals with disabilities; and that enrollment is achieved through a one-step process. Of particular importance is limiting the need to provide follow-up documentation or information and allowing for electronic signatures, as is required by the statute. In addition, consumers must be informed of how their information will be used and when and to whom it may be disclosed. Consistent with federal and state law, steps should be taken to ensure the privacy and security of consumer data. Privacy and security policies should be made available to the consumer before and at the time of enrollment. States should be required to track and monitor data from online enrollment to help inform future improvements to make it easier to enroll online, as well as to provide people with access to their own online application data so that they can check the status of their applications or renewal requests.

In addition, online enrollment is only effective when users have Internet/computer access, but some low-income and other underserved people disproportionately lack consistent, reliable access to the Internet. Strategies should be implemented to broaden access through the availability of kiosks in central locations, mobile units in rural communities, mobile technology, and training of assistors in community-based organizations, etc. It also is crucial, as explicitly recognized in the statute, that the exchanges rely not only on online enrollment, but that they create additional avenues for people to apply in person, by mail and phone, and through existing Medicaid/CHIP enrollment structures. These avenues should be as robust and as user-friendly as the web-based options.

3. How can eligibility and enrollment be effectively coordinated between Medicaid, CHIP and Exchanges? How could eligibility systems be designed or adapted to accomplish this? What steps can be taken to ease consumer navigation between the programs and ease administrative burden? What are the key considerations related to States using Exchange or Medicaid/CHIP application information to determine eligibility for all three programs?

Exchanges are expected to play a major role in determining eligibility for the new premium tax credits and cost-sharing reductions, as well as in screening people for Medicaid and CHIP and, if they are found eligible, enrolling them in coverage. According to the Congressional Budget Office, close to eight in ten people signing up for exchanges coverage – some 19 million people nationwide – are expected to receive subsidies. The number of people that will sign up for Medicaid or CHIP is almost as high – 16 million new people nationwide are expected to enroll in those two programs. The people seeking coverage in 2014 are unlikely to know whether they are eligible for a premium subsidy or for Medicaid or CHIP, and exchanges will have a vital role to play in fostering their enrollment in the right program so they can afford coverage.

As such, one of the most important aspects of the health reform law is the requirement that states create a “no wrong door” for individuals and families seeking coverage. The law explicitly requires that the enrollment and renewal processes for exchange subsidies and Medicaid and CHIP be fully integrated. A critical aspect is adhering strictly to the explicit statutory requirement (1311(d)(4)(F)) that exchanges conduct Medicaid/CHIP enrollment rather than simply referring people coming through the exchange door to Medicaid and CHIP -- which would result in eligible individuals and families falling through the cracks. This will require extensive collaboration of the exchanges with Medicaid and CHIP to allow eligible individuals to enroll in exchange coverage when applying through Medicaid/CHIP and vice versa. To facilitate this process, states should be encouraged to consider utilizing the Medicaid agency to conduct eligibility and enrollment processes for the exchanges, as the Massachusetts Connector has successfully done and is expressly contemplated in section 1413(d)(2). Alternatively, guidance should be issued to ensure states implement strategies that will facilitate a seamless system. These strategies could include co-location of Medicaid and CHIP staff at exchanges and/or placing Medicaid and CHIP consumers and advocates on the exchange governance board.

In addition, effective coordination will require a strong information technology infrastructure and interoperable system for eligibility determinations that allows linkages among the exchanges, Medicaid, and CHIP. The system must ensure real-time eligibility or presumptive determinations; databases that can be used to verify eligibility; information retained for renewal; and single client identifiers for tracking individuals across programs. States need extensive resources and technical assistance to build these systems. This will include the establishment of a federal uniform platform or open source technology that states can adapt, funding through the exchange grants, and the enhanced federal matching rate for ongoing Medicaid and CHIP system changes.

To ensure seamless navigation between the programs, federal guidance and technical assistance should specifically:

- **Develop simple and efficient procedures for families to report “change of circumstances” at the time of enrollment and during the enrollment year** (if differences in income would affect eligibility and/or subsidy levels). When a person’s eligibility changes, individuals should be automatically enrolled (with consent) in the appropriate program/subsidy level without requiring additional information from the consumer, though families should be clearly notified about how this change will affect them (i.e., differences in premiums, cost-sharing, provider networks, covered benefits, etc). In addition, to eliminate “churning” in Medicaid/CHIP, federal guidance should create a federal one-year continuous eligibility policy.
- **Help states align program and process requirements**, such as applying new MAGI and family size definitions to Medicaid and CHIP, determining how best to streamline eligibility rules to make the enrollment and renewal procedures as simple as possible for families, establishing a “paperless” application and renewal process, and applying old rules to carved-out populations without creating unnecessary hurdles to other populations.
- **Build coordination between the delivery systems used by the exchange and Medicaid and CHIP plans.** With people moving back and forth between subsidized exchange coverage and Medicaid and CHIP, it will be important to identify ways for promoting continuity of care. This could include ensuring that some plans offered in the exchange also serve Medicaid and CHIP beneficiaries, creating overlapping provider networks, and requiring plans to help facilitate transitions for those in the middle of treatment.
- **Develop “safe harbors” of default Medicaid coverage for people lost between Medicaid and CHIP and the exchanges**, such as when someone is deemed ineligible for Medicaid and exchange subsidies because of differences in how the programs calculate and verify income and other eligibility data (e.g., differences in the period of time for which income is considered).
- **Develop strategies to ensure that families with mixed immigration status apply for and obtain the coverage for which they are eligible.** This includes ensuring that the eligibility questions are designed so that a citizen child or spouse of an undocumented immigrant is not mistakenly denied benefits based on the immigration status of the undocumented family member. The questions should also be minimized and clear information should be provided so that mixed status families are not afraid to apply to the programs for fear that information they provide will be used by immigration officials.

4., 5., and 6. What kinds of data linkages do State Medicaid and CHIP agencies currently have with other Federal and State agencies and data sources? How can the implementation of Exchanges help to streamline these processes for States, and how can these linkages be leveraged to support Exchange operations? How do States or other stakeholders envision facilitating the requirements of Section 1411 related to verification with Federal agencies of eligibility for enrollment through an Exchange? What are the verification and data sharing functions that States are capable of performing to facilitate the determination of Exchange eligibility and enrollment?

State data linkages and verification systems vary significantly among states. Most states have linkages in places with other state systems, such as Department of Labor, and all states have access to the Social Security Administration (SSA) and other databases for verifying eligibility information. For the most part, states however have continued to rely heavily on paper documentation from families. Additionally, a number of states computer systems are outdated and without the interoperability required to connect to other databases, thereby relying on manual processes to conduct the verification process.

Ultimately, states have limited technology capacity to develop the verification linkages envisioned by the health care reform law. In addition, the development of 50 state verification models would not be an effective utilization of resources. As such, the federal government should develop the verification and database linkages required for the exchanges and Medicaid/CHIP agencies that states could then adopt. The Medicaid/CHIP and SSA citizenship documentation program is an effective example of where this model has been used most effectively.

For consistency, federal guidance should also establish standards, as required by the statute for exchange subsidies, whereby only the minimum necessary information is requested for Medicaid and CHIP purposes. Guidance should require that states obtain (at the consumer's option) eligibility data already held by federal systems, rather than requiring states to collect such data from the applicant first and verify it against the federal systems. This already is explicitly contemplated by health reform bill, which allows people the flexibility to elect to directly provide exchanges with access to their tax data for purposes of verifying their income.

7. What considerations should be taken into account in establishing procedures for payment of the cost-sharing reductions to health plans?

Federal officials should, as much as possible, standardize the cost-sharing schedule for individuals eligible for cost-sharing reductions for each of the actuarial value tiers across plans. Without such standardization families will face a baffling array of different cost-sharing levels and rules, making it literally impossible for them to understand their choices, the out-of-pocket costs they will likely pay, and otherwise navigate the system. Additionally, federal guidance must ensure that a system is developed to provide clear, understandable information for families to know what the reductions mean for them.

To implement the cost-sharing reductions, the Departments of Health and Human Services and Treasury should provide capitated payments to health plans offering silver plans to cost-sharing reduction eligible individuals, as suggested by section 1402(c)(3)(B). The plans, in turn, would reduce the cost sharing required to the standardized schedules set by the federal government. This is similar to how the Low Income Subsidy works under Medicare Part D.

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?

Outreach is only effective if it is based on informing people about and helping them through a simple enrollment system. It does no good to conduct outreach if people will then get trapped in a convoluted system, or lose coverage at renewal because of paperwork requirements. As such, some of the most effective outreach actions will include the development of simplified eligibility procedures with limited documentation requirements and 12-months continuous coverage.

Additionally, states have had many years of experience conducting outreach and educational activities through Medicaid and CHIP. States should be encouraged to build upon these successes. State experiences show that a particularly successful model includes working through community-based organizations or trusted messengers to reach individuals and families. This is also a critical avenue for enrolling those harder-to-reach families who have limited English proficiency or low literacy. States should be required to ensure that such activities not only involve exchange coverage, insurance market reforms, premium tax credits and cost-sharing reductions, but also provide information on Medicaid, CHIP, and if a state has elected that option, Basic Health.

Additionally, federal assistance is needed to develop effective and unified messages and standardized language that everyone is now eligible for coverage, provide models of outreach and enrollment programs that have worked, and create federal linkages with effective messengers (e.g., sports team and community leaders) that states could utilize.

2. What resources are needed for Navigator programs? To what extent do States currently have programs in place that can be adapted to serve as patient Navigators?

Federal guidance is required to set the parameters on the scope within which states must fund and implement the navigator program so that there is a minimal level of consumer assistance provided across states. Additionally, the guidance should stress the importance of utilizing a broad range of organizations that have a proven track record working in communities and with families at different income levels, including those now working on Medicaid, CHIP, and Medicare enrollment.

Federal guidance should also ensure that states undertake enrollment and outreach assistance, as envisioned under the navigator program, prior to 2014. Under the current language of the ACA, the navigator programs are to be funded once the Exchanges are up and running, and federal funds (such as planning grants) may not be used to support them. However, in order to effectively start enrolling individuals in exchange coverage in 2014, the outreach and enrollment must begin in 2013. Federal authorities should ensure that grant funding (or loans/advances) is available to states for this purpose.

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

As mentioned, the most successful strategy for enrolling individuals into coverage will be a simplified enrollment and renewal system. Only then will outreach efforts be successful in reaching eligible families. Outreach strategies that have been found to be most useful include utilizing community-based groups and application assistors; working through schools and churches; creating trusted messengers (doctors, teachers); and developing effective media strategies (such as working with ethnic media). Outreach strategies should also be data-driven. Data can help to identify groups to best target for outreach. Segmenting target audiences allows messages to be tailored to better resonate with those audiences.

Other public programs will be critical “connectors” to exchange and Medicaid/CHIP coverage. As much as possible, linkages with other public programs should be automatic. For example, when someone applies for unemployment insurance the system should trigger a review of their eligibility for subsidies or public programs. When a child or adult is enrolled in Free School Lunch or SNAP, there should be automatic or expedited routes to coverage. For example, millions of childless adults who will be newly eligible for Medicaid in 2014 are already enrolled in SNAP and eligibility information for SNAP could thus be used to enroll them in Medicaid once the Medicaid expansion takes effect.