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HEALTH INSURANCE EXCHANGES: PROGRESS REPORT

HEARING

BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED THIRTEENTH CONGRESS

FIRST SESSION

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HEALTH INSURANCE EXCHANGES: PROGRESS REPORT

THURSDAY, FEBRUARY 14, 2013

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 9:48 a.m., in room SD–215, Dirksen Senate Office Building, Hon. Max Baucus (chairman of the committee) presiding.

Present: Senators Wyden, Cantwell, Nelson, Carper, Cardin, Casey, Hatch, Grassley, Crapo, Roberts, Enzi, and Isakson.

Also present: Democratic Staff: Amber Cottle, Staff Director; David Schwartz, Chief Health Counsel; and Tony Clapsis, Professional Staff. Republican Staff: Kim Brandt, Chief Healthcare Investigative Counsel.

OPENING STATEMENT OF HON. MAX BAUCUS, A U.S. SENATOR FROM MONTANA, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The hearing will come to order.

I apologize to everybody for the delay. Something unavoidable came up, but we are here.

In early 1964, just 2 months after the assassination of John F. Kennedy, President Lyndon Johnson delivered his first State of the Union address. He called on Congress to move forward with the late President's bold agenda. He said we have "a unique opportunity and obligation to prove the success of our system. If we fail, if we fritter and fumble away our opportunity in needless, senseless quarrels between Democrats and Republicans, or between the House and the Senate, or between the Congress and the administration, then history will rightfully judge us harshly."

Last summer the Supreme Court, once and for all, ruled the Affordable Care Act to be the law of the land, settling the issue. After nearly a century of Americans fighting for real health care reform, we finally passed the Affordable Care Act in 2010. Health insurance exchanges or marketplaces are one of the most vital tools created by the law to provide nearly every American with health care.

Now is the time for us to work together to ensure that the law and these marketplaces are implemented properly. These marketplaces are a new frontier and create a real opportunity for more Americans to get health insurance. For far too long, individuals and small businesses across the Nation, shopping for health insurance, were left to fend for themselves.

A Commonwealth Fund study found that nearly three-quarters of individuals looking for coverage on the individual market never

bought a plan, with 61 percent of those citing premium costs as a primary reason.

In preparation for this hearing, I did a little exercise and shopped around for health insurance online. I started, as most American families would, and typed into Google "individual health insurance plans." In 0.26 seconds—I love Google—106 million results appeared, everything from AARP, United, Blue Cross, CareFirst, Kaiser Permanente, and many others.

Needless to say, it was already a bit overwhelming. In fact, I think this is one application right here—we printed it out—for one person. I clicked on one insurance carrier's website and found an application for their individual and family health plan. This is it: 97 pages long: a 24-page questionnaire, followed by a 73-page disclosure form. Now, I went to law school, and this is Greek to me. With the marketplaces, there will be one simple web form application for consumers.

Before health reform, plans were too expensive, with little protections. Insurers were able to terminate coverage when patients had cancer simply because these patients did not disclose a teenaged bout with acne or a bump on the chin as a child.

Plans were described in legal jargon instead of plain English. Large companies, on the other hand, could use the leverage that came with their size to negotiate better plans at more stable prices. This inequality in the health care system created yet another case of the haves and the have-nots. But not anymore. The marketplaces created in health reform will help level the playing field. For the first time, individuals and small businesses will be able to pool their purchasing power to get better bang for their buck.

Consumers will have access to one-stop competitive shopping for affordable health care, just like they have on Orbitz or Kayak for airfare and hotels. These marketplaces will provide clear comparisons of quality and price across the plans. At least, that is the goal. We have to make sure that happens.

We already shop in competitive marketplaces for groceries, airline tickets, and cars. There is no reason the health insurance market should be any different. These marketplaces are scheduled to be up and running across the country on October 1st for coverage effective January 1, 2014.

Two other critical components of the health care law are paired with the marketplaces: first, consumers will no longer have to worry about being denied coverage due to a preexisting condition or when they get sick; and second, tax credits will be available to help American families and businesses purchase insurance.

I know the Department of Health and Human Services has been hard at work for nearly 3 years in preparation, but there are challenges. I want to make sure the Department is ready on day 1. It is important for the Congress and for the Finance Committee, on behalf of the American people, to closely oversee implementation of these new programs, especially the marketplaces.

I expect Senators to ask a lot of questions, because there are a lot of challenges ahead. That is why we are here today. I expect to hear about the significant progress that the Centers for Medicare and Medicaid Services and States have made in implementing the marketplaces.

I am pleased with the level of flexibility that CMS has provided to States in order to get marketplaces up and running. Instead of a one-size-fits-all solution, CMS has worked with States to craft customized marketplaces that fit the specific needs of their residents, because all of us in Montana can assure you that Montana is a bit different from New York.

CMS has told States they can run their own marketplace or share the responsibilities. If it prefers, it can let CMS facilitate the marketplaces. States are also free to make changes down the road.

This flexibility is key to making sure that marketplaces work in each State across the country. We will ask CMS today whether progress is on track, targets are being met, and what more can be done to realize the promise of the Affordable Care Act. We will also hear from three States, each of which will provide unique perspective on the opportunities and challenges in creating these new marketplaces.

So, as President Johnson urged in his State of the Union address, let us remember our obligation as we approach the marketplaces' launch this fall. We have a real opportunity here to help Americans access affordable health care in a consumer-friendly way for the first time in a century. So let us not "fritter and fumble away our opportunity in needless, senseless quarrels." Let us ensure that these marketplaces live up to their promise and deliver unprecedented access to high-quality health care.

[The prepared statement of Chairman Baucus appears in the appendix.]

The CHAIRMAN. Senator Hatch?

OPENING STATEMENT OF HON. ORRIN G. HATCH, A U.S. SENATOR FROM UTAH

Senator HATCH. Well, thank you, Mr. Chairman. Thank you for holding this hearing. I welcome this opportunity to join you in conducting congressional oversight on the implementation of the President's health law, and more specifically on the nature of health care exchanges.

It is no secret that the President promised that his plan to reform the health care system would reduce premiums by $2,500 for individuals. He made this promise more than once, and at the time I was skeptical, and I said so. As we are seeing now, I had good reason to be. We are already feeling the impact of the law as the cost of insurance premiums continues to go up.

In 2014, when the law will be fully implemented, premiums will skyrocket further as insurers scramble to meet all of the new mandates that go into effect. The question is, how high are these costs going to go? We have estimates from an Oliver Wyman study that suggest premiums in the individual market next year will increase an average of 40 percent.

The Society of Actuaries similarly estimates an average increase of 32 percent in premiums in the individual market, and, for many communities, it gets even worse. A recent survey of health plans reveals that premiums in the individual market in Phoenix, AZ could see an average increase of 157 percent; Milwaukee, WI will see an average increase of 190 percent.

If the point of the health care law was to reduce costs and increase access, these estimates show that it appears to have already failed. Some of the law's supporters will say that these premium increases will be mitigated by the new health insurance subsidies; however, the Oliver Wyman study that I referred to found that 40 percent of those covered in the individual health insurance market in 2011 would be ineligible for these subsidies in 2014.

It also found that 36 percent of those currently uninsured can expect to pay more out of pocket for single coverage than they would otherwise, even with the availability of premium assistance. These rate increases will have a significant impact on the ability of individuals to purchase coverage. It was bad policy when we debated it, it was bad policy when the Democrats rammed it though the Senate, and it is still bad policy today.

Now consumers are starting to see its impact just as they are about to be able to enroll in the new health exchanges. Today we are here to discuss these exchanges. As most of you know, I have a particular interest in this issue, because the State of Utah was one of the first States to establish a market-based State exchange prior to the passage of the law that met its unique demographic needs.

The administration claims that health insurance exchanges will allow plans to compete for business, and therefore the cost of health insurance will be reduced. Unfortunately, the exchanges, as designed in the law, will do neither. They will actually increase health care costs.

We know that State-based exchanges are being established in 18 States. Of those States, 13 have published studies providing annual budget estimates for establishing and maintaining State exchanges. Those annual budget estimates range from $6 million to $300 million and will be funded through the establishment of exchange user fees.

Similar to State-based exchanges, the federally facilitated exchange will be funded through the imposition of onerous user fees. The administration recently proposed a 3.5-percent fee on each plan offered through the exchange. This is no small amount. We all know the costs will be passed on to consumers in the form of higher prices.

So I am concerned about this, as you can imagine, and have been from the beginning. I do not mean to find fault with those who are trying to do what is right, but I just do not see how it is going to work, and I do not see how it is going to work in an efficient, cost-saving way.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

[The prepared statement of Senator Hatch appears in the appendix.]

The CHAIRMAN. I am pleased now to welcome our first witness, Gary Cohen, Director of the Center for Consumer Information and Insurance Oversight at the Centers for Medicare and Medicaid Services. Then, when we get to the second panel, I will introduce them at that time.

So, Mr. Cohen, why don't you proceed? Your statement will be in the record. You can summarize it in about 5 minutes. And do not

pull any punches. Tell us what is really going on—not a bunch of stuff, but what is going on.

Mr. COHEN. I will, Senator. Thank you.

The CHAIRMAN. All right.

STATEMENT OF GARY COHEN, DEPUTY ADMINISTRATOR AND DIRECTOR, CENTER FOR CONSUMER INFORMATION AND INSURANCE OVERSIGHT (CCIIO), CENTERS FOR MEDICARE AND MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Mr. COHEN. Thank you, Chairman Baucus, Ranking Member Hatch, and members of the Finance Committee, for the invitation to appear before you today. As Director for the Center for Consumer Information and Insurance Oversight at the Centers for Medicare and Medicaid Services, I oversee implementation of many of the provisions of the Affordable Care Act, including the exchanges or marketplaces.

I know the biggest questions on everyone's mind today are: are we making progress, are we on track, and will we be ready? I am very pleased to be here today to tell you that, yes, we are making great progress, we are on track, and we will be ready for people all across the country to obtain high-quality, affordable health care coverage beginning on October 1st.

I thought it would be helpful to describe for you how a person will experience the new health insurance marketplace, and, as I do, to give you an idea of where we are in the design and building of it.

Picture a consumer today. For example, a Mr. Smith, who is a resident of Montana, who is curious about his health insurance options under the health care law. He goes online. He types "healthcare law" into a search engine, and he finds *Healthcare.gov*. We relaunched the website recently with consumer-friendly videos and other information. Mr. Smith sees some helpful tips about the marketplace and the information he will need when he returns to the website to get enrolled in coverage this fall.

In October, Mr. Smith finds a single, streamlined application that will enable him to find out whether he and his family are eligible for Medicaid, CHIP, or for tax credits to help pay for his insurance premiums to a commercial insurer.

CMS has consulted with States, stakeholders, consumer groups, and the National Association of Insurance Commissioners, in developing this application. We conducted consumer testing to ensure that it makes sense to consumers at different income and educational levels.

Since the information that Mr. Smith provides can be shared with State Medicaid and CHIP agencies, Mr. Smith will only have to submit one application. On January 28th, the public comment period began on both applications for individuals and for small businesses, and we expect them to be finalized by April.

Now, Mr. Smith enters some basic information about himself and his family. CMS is building a data services hub that will access information from several sources, including the Social Security Administration, Department of Homeland Security, and the IRS, to

verify the information that Mr. Smith enters about his citizenship status, his income, and so forth.

This data is subject to strong privacy and security protections, and it is important to note that the hub will not store any consumer data. Its purpose is to allow a seamless flow of information from different sources. We have already completed the hub's technical design and reference architecture. We are establishing a framework for security across agencies and protocols for connectivity across agencies and with States, and we have begun testing the hub.

Mr. Smith finds out in real time that he is eligible for tax credits to help pay for coverage through the marketplace, and he starts shopping for a plan. We are well-along in the process of making sure that he will find a variety of affordable, comprehensive, qualified health plans to choose from. CMS is building a plan management infrastructure that will enable us to receive, review, and approve applications from issuers for plans to be sold in the Federal marketplace.

In November of last year, we provided issuers with a draft of the templates that they will use to submit their plans. We have gotten feedback on them, and issuers will begin submitting applications to us at the end of March. We will review those applications and will approve plans to be sold in the Federal marketplace by this summer. Issuers will then have an opportunity to review and make any corrections to the information about their plans that will appear on the website beginning in October.

Once Mr. Smith chooses a plan that he thinks is right for himself and his family, the marketplace website will electronically transmit his enrollment data directly to the issuer and will provide a link for him to the issuer's website, where Mr. Smith will be able to pay his first month's premium so his coverage will begin and be effective on January 1st.

Now, because Mr. Smith visited *Healthcare.gov* earlier in the year and was prepared with the basic information he needed, he was able to complete this entire application process in as little as 30 minutes. But we know that many people will need some help, and a number of resources will be available to them.

First, of course, a consumer may choose to work with an insurance agent or broker in his or her community or with an online web broker. For the marketplace that the Federal Government is managing, we are building a web portal for agents and brokers that will enable them to submit applications on behalf of individuals and small businesses.

Consumers will also be able to get help from a navigator, funded by a grant from CMS or by a State that is operating its own marketplace. Our first funding opportunity for navigators will be going out shortly. We will fund people in the community who will be trained and certified to provide fair, accurate, and impartial information to consumers.

Consumers will also be able to get help through a call center that will be available 24/7, will make assistance available in over 150 languages, and will have assistance for the hearing impaired. As you can see, we have made great progress. More work remains to be done, of course, and I look forward to continuing to work with

States, stakeholders, issuers, consumers, and this committee on readying the marketplace for open enrollment. I am confident that the marketplace will be open and ready for business on October 1st.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Mr. Cohen.

[The prepared statement of Mr. Cohen appears in the appendix.]

The CHAIRMAN. Of course, there are a million questions. Let me just start in one area. That is, what differences are there among the States? One State wants to access the marketplace. It begs the question whether it is State-based or federally run. Compare it with another State. To what degree will each person across the country, irrespective of States, experience the very same experience compared with not, because different States are different? What is going to be different among the States?

Mr. COHEN. So, among the States where CMS will be operating the marketplace, the application will be the same. So, the experience for all those people will be exactly the same. States have the option of using our application or of modifying the application if they choose to, but they need to comply with all of the same criteria and requirements as will be true with the application that we are creating. So we anticipate that the experience will be very much the same all across the country in terms of the experience of coming online and applying for coverage.

The CHAIRMAN. Could States change their minds? What happens when they change their minds? Can one State maybe be federally based and then decide it wants to be State-based? Can you go back? "We do not want to do that anymore; we want the Feds to do it." I doubt that is ever going to happen, but, nevertheless, what flexibility do States have in deciding whether they want to run these marketplaces compared with the Feds?

Mr. COHEN. As you know, we have encouraged States to operate their own marketplaces because we do believe that that gives them the most flexibility to serve their communities in a way that they believe is best for them. Not all States have been prepared to do that for 2014, but there will be opportunities beginning later this year to apply to operate a State marketplace beginning in 2015 and in years thereafter.

So States absolutely will have that opportunity, and we will have the ability to learn from the experience of the States that have moved along a little faster to operate their own marketplaces, and we will also benefit from a lot of the work done by those States, because one of the requirements of the grants that we are giving to States is that the work that they do and that their vendors do be made available to other States as well.

The CHAIRMAN. Could you give me the list of the various agencies where information has to be coordinated? You know, HHS, CMS, IRS. Just give me a list of all the other agencies where the box has to be checked.

Mr. COHEN. Social Security, IRS, Homeland Security, and there may be others. I may have to get back to you with the complete list, but those are the major ones.

The CHAIRMAN. I am a little surprised you do not know that, you cannot just rattle those off, bing, bing, bing, bing, bing, because

that is going to be key to the efficiency of these marketplaces. You cannot think of the others?

Mr. COHEN. Those are the main ones that I can think of at this moment, but I am happy to get you that list.

The CHAIRMAN. How are you going to be assured that the computers in all these different agencies are speaking the same language and they are all up and running? I mean, to tell you right off the top, two of those agencies you have already listed, I know have archaic computer systems today.

Mr. COHEN. So, I am encouraged by the fact that we actually have already begun testing with Social Security, with Homeland Security, and with IRS on exactly what you are raising, Senator, the flow of data back and forth. So we are well-along with that process and expect to be able to complete that testing by this spring. So, I do not think we are going to experience problems there.

The CHAIRMAN. What do you mean by "well-along?" What does that mean?

Mr. COHEN. We have begun that testing, and we have a process where we will continue testing, continuing from now until the spring when it will be completed.

The CHAIRMAN. How much information do you intend to share with this Congress as to how well this is progressing? That is, what happens if, in a month or two, you think, oh my gosh, we have a huge problem here. Is that information going to be shared with anybody, or are you just going to keep it to yourself?

Mr. COHEN. We are happy to work with you and provide you with the information that you request from us.

The CHAIRMAN. So, at this point, are there any "uh-oh" revelations?

Mr. COHEN. No, we are very much on track with a plan that will get us to open enrollment beginning on October 1st.

The CHAIRMAN. What about those different computer systems I asked about? Is it not true that almost all agencies have different computer systems that speak different languages?

Mr. COHEN. I think that is why we are building this data hub, and it is designed in a way that it can accept data from the different agencies, and it can verify information coming into the data hub that will be entered as part of the application process.

The CHAIRMAN. Well, my time is up.

Senator Hatch?

Senator HATCH. Thank you, Mr. Chairman.

Mr. Cohen, the CMS guidance document on partnership exchanges provides an aggressive time schedule of only 10 months between the plan application process and the first day of coverage. This is mostly due to a delay in issuing regulations, many of which have yet to be made final. In a little over 1 month, Americans will be able to enroll in plans that will start October 1st. We are literally over 1 month away from the application process really beginning.

Now, I recall that the Medicare Part D implementation timeline provided 2 years between the application process and the first day of coverage. We all remember some of the hiccups that occurred when the enrollment efforts first began.

Applying the lessons learned from the implementation of Medicare Part D, I have a hard time understanding how the administration expects to have exchanges up and running by October 1st, especially since we have no details on how the exchanges will work in over half the States. Now, with less than 8 months before open enrollment, how can you be confident that Americans will be able to enroll in plans starting October 1st?

Mr. COHEN. Well, Senator, the partnership really enables States to continue doing their traditional State regulatory function, as they have done historically, in reviewing plans and approving them for sale.

So it really does not call on States to perform a lot of very new functions. Their job is to have the issuer submit plans to them, to review those, and to make sure they meet the qualifications that are required under the law to be sold in the new marketplace.

The other aspect of the partnership is consumer assistance, which again is a very traditional function that States have historically performed very well and which enables them to tailor the operation of the marketplace, their outreach, and the assistance that they provide consumers, to their communities.

As far as the eligibility enrollment system goes, we are building a system that will function across all of the States where CMS will be operating the marketplace. As I said, we are well-along and on track and hitting our milestones to have that be ready for October 1st.

Senator HATCH. Mr. Chairman, I am going to have to go to Judiciary for a little while, but I am going to try to get back.

The CHAIRMAN. Sure.

Senator HATCH. That is how I will ask for additional time.

The CHAIRMAN. Fine. Thank you, Senator.

Senator Cantwell?

Senator CANTWELL. Thank you, Mr. Chairman. You asked our witness to just go at it and do not tell us a bunch of stuff, so I am going to try to encourage the same discussion. It kind of reminds me already, there is a maxim in politics: a campaign does not a candidate make. That means you do not make somebody just because you have a campaign. It sounds to me this morning a lot about, technology does not make a cost-effective health plan. The details of how to drive down costs make a cost-effective health plan.

So I am wondering if you can tell me why the Federal basic health option, which was supposed to be implemented in 2014 in conjunction with—not in the exchange but in conjunction with—is not being implemented.

Mr. COHEN. Thank you, Senator. I appreciate your interest in the basic health plan. I have heard a lot of interest in the basic health plan as I have gone around the country and talked to different States and different groups.

Given the scope of all of the coverage changes that States and the Federal Government will be implementing for January 1st and the value that we see of building on the experience that will be gained from those changes, we expect to issue proposed rules on the basic health plan for comment this year and make them final

in 2014, so the basic health plan would be operational beginning in 2015 for States that are interested in pursuing that.

Senator CANTWELL. Well, I know even the President has kind of weighed in and said this is important, and I certainly appreciate that. But the law says that you are supposed to implement this in 2014, so we are very concerned about the approach by the agency in trying to thwart this effort.

So my question is, can you promise this committee that the agency is not offering any deals to States to get them to take a population that they have been able to achieve a more cost-effective delivery system for and trying to shove them onto the exchange as opposed to doing the basic health plan?

Mr. COHEN. I think what we are doing is working with States to identify as much flexibility as we can to assure continuity of coverage as individuals' incomes change, and to make it possible to provide premium assistance for people to purchase coverage through the exchange.

Senator CANTWELL. Are you artificially raising the cost to all taxpayers by trying to lure people onto the exchange as opposed to giving them this option that is mandated by Federal law to be implemented in 2014?

Mr. COHEN. No.

Senator CANTWELL. You are sure of that?

Mr. COHEN. Yes.

Senator CANTWELL. So, if this committee asks for the specific details, it could get details?

Mr. COHEN. We will be happy to work with you to get you details. Yes, Senator.

Senator CANTWELL. And so, do you believe that you have a requirement to implement this by 2014? I get the feeling you are overwhelmed by the details of technology. I get that point. But I am trying to emphasize a very important point here.

This committee and many people on this committee are very knowledgeable about State health plans that have driven down the cost to their consumers, and so it seems as if the agency is taking, I do not know how many pages out of 900, and saying, that is the health plan. It is the health plan of exchange. Where is the health plan of CO-OPs? Where is the health plan of the basic health plan? As far as I am concerned, I think the President signed all 900 pages. I do not think he just said, it is just this one page.

What I am very concerned about is that the agency seems to be thinking that the technology of the exchange is somehow the Holy Grail, and you are trying to lure States out of pursuing these CO-OP or basic health plan options and lure them onto the exchange because you think it is some sort of magic, and you are ignoring 20 years of experience, at least from my State's perspective, of delivering 20 to 30 percent more cost-effective delivery plans than what these individuals were able to get in the private sector.

So we do not want to throw that away; we want it to be implemented. Our read of the statute is that you are supposed to do it in 2014 and not spend your time luring people into the exchange.

Mr. COHEN. Well, I do not think we are trying to lure people into the exchange. We have funded 24 CO-OPs, and we are working with them to be as successful as they possibly can be. And I agree

with you that they are an important element of this in providing additional competition in what in many States is a very concentrated market. We agree with you.

Senator CANTWELL. So you have no fear that these can stand alone and be separate?

Mr. COHEN. I am sorry?

Senator CANTWELL. You have no fear that a basic plan or a CO-OP can stand alone and not be part of the exchange?

Mr. COHEN. No.

Senator CANTWELL. All right. Well, we look forward to seeing the details of these other States proposals you have been working on.

Thank you, Mr. Chairman.

Mr. COHEN. Thank you.

The CHAIRMAN. Thank you, Senator.

Senator Nelson?

Senator NELSON. Mr. Chairman, the health care law is working. Now, there are a couple of big obstacles in the way. One is, in some of the States, like my State, the State legislature and the Governor refuse to expand Medicaid—that is 1 million people in the State of Florida who would otherwise have health care—and refuse to implement the health care law, refuse to accept the grants that have come. All right. That is one thing.

It is too bad that all the States did not comply, and the people of Florida are going to suffer because of the State government. But the fact is, the law says that there is going to be a health insurance exchange come 2014. So now we move to the next obstacle, which Senator Cantwell has just pointed out: the implementation of it.

Of all of these incentives in the law to drive down the cost, one of those incentives that we put in the law was the community-oriented health plans. A consumer-oriented board would run a health insurance company. It was estimated that these were going to bring down the cost of premiums to the consumer by 10 to 15 percent.

Mr. Chairman, in the 11th-hour negotiation on trying to avert financial disaster on December 31st, New Year's Eve, these guys negotiated away the Consumer Operated and Oriented health Plans, CO-OPs. That is the acronym for it: CO-OP. So I want to ask, why was that negotiated away? You have given grants into CO-OPs, approved applications for 24 States, but not the other remaining 26. There were applications in the pipeline, including applications from my State of Florida. Why was that negotiated away at the 11th hour?

Mr. COHEN. Senator, first, I want to say we are big supporters of CO-OPs. I mean, we are working——

Senator NELSON. No, the question is, why was that lost at the 11th hour, not that you are a fan of them. What is the answer?

Mr. COHEN. I do not have an answer for you.

Senator NELSON. Well, I can tell you that the representative of the Majority Leader, Kate Leone, in the negotiations, has told this Senator that, first of all, HHS had put CO-OPs on the table as a source of revenue.

At the 11th hour, the question was asked, "Are there any applications in the pipeline?" In those 11th-hour negotiations, the answer, according to the Majority Leader's office, was, "No, there are

no applications," when in fact, over the course of the last year, only 24 States' applications had been granted.

Obviously there were plenty of applications. There were applications out to be awarded right after the first of the year. So I want somebody to be accountable for this and, if it was a mistake, for somebody to own up to it. And then the question is, since you say you do not know, I would ask, Mr. Chairman, that this committee require an accounting that HHS respond to this question: how did it happen that it got negotiated away?

Now my question would be, what are you going to do about it since CO-OPs, in fact, are estimated to bring down the cost 10 to 15 percent for the consumers, for the premium-payers? What are we going to do to get those other 26 States into the system?

Mr. COHEN. Well, Senator, what I am going to do is make sure that the 24 CO-OPs that we have funded are successful and demonstrate the results that you are talking about in terms of providing additional competition and lowering costs in the health market. That is what I can do at this point.

Senator NELSON. So the answer is that the remaining 26 States get zero?

Mr. COHEN. As of the current situation, we do not have authority to make loans to any additional CO-OPs. That is correct.

Senator NELSON. Mr. Chairman, if we have this kind of implementation, then we are not going to fulfill the goal that we all set when we laboriously put together, in your committee, this health care bill.

The CHAIRMAN. Might I ask, Mr. Cohen, you are saying that CMS does not have the authority to give grants to these other CO-OPs but does for some CO-OPs? Why the difference? I do not understand.

Mr. COHEN. No. We have made loans to 24 CO-OPs, and, under the legislation that was passed at the end of the year, we no longer have authority or funding to make any more loans to new CO-OPs.

The CHAIRMAN. All right. That is my question. Is it that you do not have the money or do not have the authority?

Mr. COHEN. I think it is both.

The CHAIRMAN. I would follow up on the question Senator Nelson asked: why not the authority? I want the answer to that question as to what happened. Another answer is, what could the policy rationale be?

Mr. COHEN. My understanding of what was passed at the end of the year is that we no longer have funding authority to make loans to new CO-OPs.

The CHAIRMAN. I am not talking about money; I am talking about authority. All right. We will have to get to the bottom of this.

Senator Enzi?

Senator ENZI. I cannot thank you enough, Mr. Chairman, for holding this hearing. I cannot thank Senator Cantwell and Senator Nelson enough for the questions that they have asked. They are part of a series of questions that I had as well.

I am not sure how all this can come together, and part of it is because the States are not getting answers. My Governor wrote, on July 19, 2012, trying to find out enough about the exchange so that

our legislature could deal with the exchange. That is how we insist on doing it in Wyoming.

The Governor does not have blanket authority to do whatever he wants. He does point out in his letter that we are a real frontier State and he does know that Rhode Island and Delaware are making progress, but he also points out that Wyoming has half the population of Delaware or half the population of Rhode Island, and we are spread out over a much bigger geographic area.

Now, he wrote the letter in July 2012, and he got an answer. No, he did not get an answer; he got a letter in January of this year. Now, that is for getting an exchange done? Our legislature meets every year, but this is the year that they do law. Next year they just do budget and appropriation, so they needed the information before this session started in January. It just lasts January and February. Actually, it only lasts 40 days, and, in truth, it will only last 38 days. They do not use their full allotted time because they like to save 2 days in case the Governor vetoes something that is important to them so they can call themselves back into session.

So they have virtually no chance to work on the exchange. I guess that leaves the Federal exchange. I am not sure that they will have a problem with the Federal exchange except for all of the unanswered questions about a Federal exchange. I cannot believe that we are forcing every State in the Nation to try to write their own program. That has to have a cost. I mean, it probably costs just as much as doing a Federal exchange. I have no idea how much money we are putting into writing the programs for this Federal exchange.

I like what you described in the Federal exchange, but that is kind of what we are expecting each State to do at that State's cost. But you are providing the money for it, so my first question, I guess, would be, HHS is kind to give kind of a blank check, set sums as necessary, to implement the health exchanges. Will there be any cap on the amount of money the Federal Government will use to do this? If not, why not?

Mr. COHEN. The amount of money that we award in grants to States to plan and establish their exchange is based on an application that they submit to us and a thorough and rigorous evaluation of what the needs are in order to do that.

I think as time goes by, and if States choose to operate their own exchange in future years, they will benefit from a lot of the work that has already been done, because, as I mentioned, one of the requirements of these grants is that the work that vendors are doing for States now be made available to other States going forward.

Senator ENZI. It does look to me as though you are trying to force everyone into a Federal exchange. That may be our only option. I notice that it is to be paid for with user fees. Who pays that user fee, the individual, the State, the insurance company? How much is that going to be?

Mr. COHEN. What we have proposed is a user fee that would be 3.5 percent of premium owned by insurance companies selling products in the exchange.

Senator ENZI. So it would be the insurance company paying it?

Mr. COHEN. Based on the premium that they earn on selling their products in the exchange, yes.

Senator ENZI. Now, on this Federal exchange, one of the things I have suggested in the past is that there be some right to buy insurance across State lines. Will that be the case at the Federal exchange?

Mr. COHEN. The Federal exchange will—the products that will be sold on the Federal exchange will be sold within each State and will be approved by the State insurance departments of each State.

There is a provision in the law for a multi-State plan that the Office of Personnel Administration will be operating, and they have issued some proposed regulations on that, but that is not my program.

Senator ENZI. So, without those CO-OPs, there is not much opportunity to expand the amount of competition then. I see that my time has expired. I hope that the record will stay open so that we can submit questions.

The CHAIRMAN. Absolutely. It will be open for at least 48 hours.

Senator ENZI. I have another 100 questions that my State needs answered, and we need them answered quicker than 6 months like we got with the response from the Secretary.

The CHAIRMAN. On that point, Mr. Cohen, it would really be wise to answer these questions very promptly.

Mr. COHEN. And I would just say—and we will do our best to answer the questions that we get as quickly as we can—I will say, with respect to Wyoming, I have personally met and spoken with the insurance commissioner of Wyoming a number of times with respect to the exchange and the options available to Wyoming. I know that my staff is on the phone with every State, talking with them about their development and the choices that they are making, on a regular basis.

The CHAIRMAN. Thank you.

Senator Isakson?

Senator ISAKSON. Well, thank you, Mr. Chairman.

Mr. Cohen, the first question I want to ask is the same question that was asked by the ranking member and the chairman, who probably talked to their Governors as well as to what they would like to ask. That is, can you give us certainty that the federally funded exchanges will be up and running on October 1st? You answered that question with the example of Mr. Smith going to *Healthcare.gov* and the efficiency of that system.

I have a couple of questions on that. Have you tested *Healthcare.gov* with consumers?

Mr. COHEN. Yes.

Senator ISAKSON. And how has that test been done? Has it been done by the agency or by——

Mr. COHEN. We had focus groups, and we have had assistance with performing those consumer tests, and we have made changes to both the online application and to *Healthcare.gov* in response to that testing.

Senator ISAKSON. Have you made any calculation or any estimate as to how many people will be able to use the Mr. Smith example on *Healthcare.gov* and how many are going to need assistance from agents or representatives of insurance companies, or counselors, or whatever?

Mr. COHEN. I do not have a number for you, but I know that we are preparing to make available in-person assistance or telephone assistance to everyone and anyone who may need it. So the goal is to have these navigators who will be out there in the community, who will be local community-based organizations, who will be able to reach out into their local communities as well as the call center, which is more of a national thing. Then in addition to that, the website will have online chat capability as well.

Senator ISAKSON. Will the navigators be employees of CMS?

Mr. COHEN. They will be grantees of CMS but not employees.

Senator ISAKSON. So they will be independent contractors, but they will be paid by CMS?

Mr. COHEN. They will receive grants, yes.

Senator ISAKSON. All right.

Are you familiar with the medical loss ratio limitations of the Affordable Care Act?

Mr. COHEN. I am.

Senator ISAKSON. I understand some States have asked for waivers, and CMS has denied those waivers. But, if you have a substantial number of people, which I think you will, who will seek some type of human assistance rather than totally depend on technology, the medical loss ratio restrictions really eliminate a lot of people who currently provide that from being able to be compensated, primarily independent contractors for insurance agencies. Have you discussed that subject with anybody?

Mr. COHEN. We certainly are in communication with stakeholders, including the insurance industry, around the medical loss ratio. We did grant reductions in the ratio to a number of States. We did deny them to some where we found that there would not be a disruption in the market as a result of the medical loss ratio.

We found in 2012 that we returned over $1 billion in excess premiums to consumers as a result of the medical loss ratio. I think that the availability of the online website that we will provide, the call center that we will provide, will help insurance companies reduce their costs for some of this marketing that they would otherwise have to do to attract people to the marketplace.

Senator ISAKSON. Well, as someone who ran a business for a long time and, being dependent on the technological revolution, started transitioning consumer access to our services away from human beings and to technology access, you had better be sure you get it right the first time, because, if it crashes and burns on October 1st, you have a huge problem. When you talk about something affecting every American, it is tremendous.

I have another question. Forty percent of adults with income below $30,000 and 60 percent without a high school diploma do not use a computer at all, and that was as of 2010. So you are going to have a lot of people who are going to need that human assistance.

Are you familiar with the Preexisting Condition Insurance Program?

Mr. COHEN. Yes.

Senator ISAKSON. On January 31st, your office issued a report on the program, noting that while the enrollment had been substantially less than you anticipated, the costs per enrollee have been

much more expensive. Do you expect the Preexisting Condition Insurance Plan to run out of money before the end of 2013?

Mr. COHEN. We made a number of changes already this year to the benefits that are offered in the Federal PCIP program, and we are continuing to monitor expenses very carefully. We understand that we have a set amount of funding that we are able to use for that program, and we will not exceed it.

Senator ISAKSON. So that is the $5 billion, correct?

Mr. COHEN. Yes.

Senator ISAKSON. To that end, do you have a contingency plan, if you do run out before the end of the year, as to how you are going to transition these people?

Mr. COHEN. We are looking at all sorts of options, but running out of money before the end of the year is one that we are doing everything we can to avoid, and I believe we will get to the end of the year and transition people onto the exchanges.

Senator ISAKSON. Thank you, Mr. Cohen.

Mr. COHEN. Thank you.

Senator ISAKSON. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

Senator Hatch?

Senator HATCH. Thank you.

If I could just ask one other question. If you could give a "yes" or "no" answer on this, I would appreciate it. We are less than 9 months away from open enrollment. With five crucial regulations yet to be finalized and no details from the data hub that will facilitate all eligibility determinations, it is hard to believe that the exchanges will be ready by October 1st. You can see my skepticism there.

I am concerned about it, but a critical piece to eligibility determinations is a sharing of information between agencies. Now, has CMS assigned service-level agreements with IRS, SSA, Homeland Security, and all of the other agencies that will be providing information to the data hub?

Mr. COHEN. We have.

Senator HATCH. You have? You have signed agreements with them?

Mr. COHEN. Yes.

Senator HATCH. Will each Federal agency be able to provide accurate data in real time to the Federal Data Services Hub by October 1st?

Mr. COHEN. They will.

Senator HATCH. All right. I just wanted to make sure that is—thank you. Thanks, Mr. Chairman.

The CHAIRMAN. Thanks, Senator.

Senator Grassley?

Senator GRASSLEY. Mr. Cohen, I would like to have you help me pinpoint a date, but, before I get to the question, I have a lead-in I want to read. A day is coming when we are going to find out who is right and who is wrong about premiums for plans sold through exchanges under the Affordable Care Act.

Some of us think that there is going to be a real significant rate shock coming. The rate bands in the Affordable Care Act are too aggressive. The taxes and fees in the Affordable Care Act are too

inflationary, and the timetables for readiness are very compressed. There have been independent actuarial studies in several States that suggest the rate shock will be severe: Indiana, up 95 percent; Maine, 89 percent; Ohio, 85 percent.

Now, I know others would strongly disagree. They say that everything is going to work out all right. Of course, soon we will know who is right. Individuals are supposed to receive coverage, including even members of Congress. And many of the staff in this room will be covered under these exchanges by January 1, 2014.

So individuals should be allowed to enroll this fall, starting October 1st. Thinking further about the timeline, States have to have all the rules from HHS to finalize exactly how an exchange will work. Once everything is finalized, only then can States ask insurers if they intend to participate and what rates they expect to charge for coverage.

Insurers then need some time to make their decisions about rates. But that day is coming when insurers turn in their homework, when insurers say, these are the rates that we will charge, assuming they do choose to participate.

Now, here is my question. Mr. Cohen, while I will not hold you to a specific date, to the best of your knowledge, when will we know what premiums will be in the exchanges?

Mr. COHEN. Thank you, Senator. In the Federal marketplace, insurers will begin submitting their plans to us, including the rates, on March 28th. That opportunity will be open until April 30th. We will then review those and make determinations as to which plans will be sold in the Federal marketplace by July.

Senator GRASSLEY. All right. When you are saying by July, there is time where the administration and Congress can react if it is obvious that premium rate shocks are so severe in the exchange pool of some States that the market will go into some sort of fatal death spiral at that time?

Mr. COHEN. We will know by July what the bids are, yes.

Senator GRASSLEY. All right.

Thank you very much, Mr. Chairman. That is all I have.

The CHAIRMAN. Thank you, Senator.

Next, we have Senator Casey.

Senator CASEY. Thank you, Mr. Chairman. I appreciate the opportunity to participate in this hearing. I think it is critically important that the chairman and ranking member have planned this hearing, because we have to make sure that this works. Even though we still have great divisions about health care in this country in terms of the approach to it, some supporting the legislation, some not, those of us who supported it have to be determined to get it right. So, Mr. Chairman, I appreciate you gathering us together for this purpose.

Mr. Cohen, we appreciate your work and your service. I wanted to ask you about the particular situation that my home State of Pennsylvania faces where they have defaulted to a federally facilitated exchange, if that is the right terminology, or federally facilitated marketplace.

But in that instance, I guess I have at least two questions in the time that I have. One is, what efforts can you undertake, or have you undertaken, or what can our expectations be, as it relates to

the actions by the Federal Government to tailor a marketplace for Pennsylvania with all of the unique characteristics of one State versus the other, number one?

I guess the second question is the question of communication: how are you communicating with consumers in a State like Pennsylvania?

Mr. COHEN. Thank you, Senator. I appreciate the question. Since the Affordable Care Act was passed nearly 3 years ago, we have conducted a variety of stakeholder outreach consultations on implementation of the law, including meetings, calls, webinars, listening sessions, and, starting in March, we will begin a process to directly engage stakeholders in each of the States where CMS will be operating that federally facilitated marketplace.

This is obviously an important opportunity for us to hear directly from individuals and organizations in each State.

Senator CASEY. Let me stop you right there. On stakeholders, what is the kind of rough outline of who that is?

Mr. COHEN. So, we are going to begin with a very broad outreach: anybody who wants to come in, conference calls, and those sorts of things, and then we envision ongoing conversations in each State led by the CMS regional offices with our community, our consumer advocate community, to make sure that we are really getting the information that we need to operate the marketplace in the right way as it varies from State to State. We recognize that there are differences, obviously, geographically, demographically, in the insurance market, and so we recognize that it is a very important process for us to go through.

Senator CASEY. Your intention is to make sure it is tailored. Do you feel that you have the kind of flexibility and the resources to be able to do that?

Mr. COHEN. We certainly have the flexibility, and we are going to use our resources as best we can to make sure that we are providing a marketplace that is suitable for each State.

Senator CASEY. On the communication part of this with regard to consumers, is that something you can comment on?

Mr. COHEN. So I think that consumers are going to see in the beginning a campaign that is a media campaign that will be launched soon just to begin to increase awareness of the law and what the benefits are and what it can do for them. When I say "media," I mean, of course, all sorts of media: social media, the traditional media.

The purpose of that will be to try to drive people to *Healthcare.gov*, which really is the central source of information about the Affordable Care Act and the marketplaces in particular and will give people the information they will need to then come back in October when they can actually take action to get enrolled.

In addition, we anticipate that these navigators are going to really play a crucial role in outreach to local communities, ethnic communities, communities with limited English proficiency, and the funding opportunity for navigator grants will be going out very soon. The first grants will be awarded in June.

Senator CASEY. My time is running out and I was late, so I do not want to go over time. What I will do is, I will send you——

The CHAIRMAN. Go ahead, Senator, if you have a couple of more questions.

Senator CASEY. All right. Thank you, Mr. Chairman. That is nice to be able to have some extra time. I appreciate that.

Just really one final question I was going to send you in writing, but I will ask it now. A great concern that so many of us have is making sure that, with regard to both Medicaid and the Children's Health Insurance Program, that every eligible child gets enrolled and that we do not have any problems with that. What can you tell me about that in terms of your efforts as the marketplaces are being implemented?

Mr. COHEN. I think that one of the things that is very encouraging about that is that, when people come to either the website or sit across the table from someone in their community who is helping them, they can go through a single process that will determine whether they are eligible for Medicaid or CHIP, or whether they are eligible for subsidies to purchase coverage through the exchange. So, it is what we call "no wrong door."

So all of the outreach and education that we will be doing will be geared toward getting everybody into the door, and then where they end up will be determined through the process of measuring what they are eligible for. But we will be looking at the entire community that we are trying to reach and the entire population that we are trying to get into coverage, and then they will be sorted out through the process of applying.

Senator CASEY. Thanks very much.

The CHAIRMAN. Thank you, Senator.

Before we turn to Senator Wyden, I have to leave. Mr. Cohen, I would like you to, maybe just for a minute here, discuss with me what benchmarks, data, dates, that you have in mind as you proceed and begin to implement the statute. What do you want to have accomplished? And I want data here. I do not want just goals. How much in terms of numbers, by what date, in what subject?

Just give me those benchmarks. We need to know. I would like you to break it out in a good-faith way, basically the way that you are probably already implementing it. Maybe you have six, seven different subjects. You have dates, timelines by which you want X amount accomplished so we can measure to see whether we have or have not met those deadlines. I would like those to me and the committee by Tuesday when we get back after this next recess. Give me the list.

I want to know what you aim to accomplish, by what date, during this next year, in each of those subjects. I want it quantified so that, on down the road, maybe 2 months later, we can look and see how we are doing. We want to help you, but I think this will help you, answering the question I just asked.

We have to get moving here. We have to know what we are doing and what we are not doing. We cannot just talk. It is deeds, not words. If you could get that to this committee by Tuesday following, this coming Tuesday, close of business Tuesday, I think it is going to help us a lot here. Thank you.

Mr. COHEN. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Wyden?

Senator WYDEN. Thank you, Mr. Chairman.

Recently, Mr. Cohen, the IRS determined that affordability is going to be based on the cost of a worker's individual coverage, not the cost of family coverage. So we are going to have millions of spouses and dependents in a kind of regulatory no-man's land. During the health care debate, this issue was looked at, the whole question of affordability, particularly affordability for families, and a provision was added that would have allowed an employee to take their employer's contribution, either individual or family, and then be able to shop for a policy that best fit their needs at a price that they could afford.

Now, this is no longer available. As of now, this is no longer available. So, come January of 2014, we are going to have millions of families—not my characterization, it has been in the *New York Times*, all kinds of other places—really pinched. They are really in this kind of no-man's land where they are unable to afford the family coverage offered through their employers and ineligible for subsidies that could be used by dependents on the exchange.

What I would like to know is what you all are open to doing in terms of helping these people. This is not an abstract question; these are people who are going to get pounded here, middle-class families here, in a relatively short period of time. It seems to me, at a minimum, what you all ought to be doing now is looking at ways to give the States, through the exchanges, some flexibility to help people. Are you willing to do that?

Mr. COHEN. Yes, we are.

Senator WYDEN. All right. Now, I would like you to get back to me in writing with respect to specific ways in which you would like to work with the States to help people. I am encouraged by your answer. I know that this is something that you probably did not know would come up today.

But in effect, what we would be especially interested in is ways in which the State would allow an employee to take an employer's contribution to the exchange and be in a position to get more value for themselves and their family. Can you take a look specifically at that idea for me?

Mr. COHEN. We would be happy to take a look at it. I do not have an answer for you today, but we will be happy to take a look at that.

Senator WYDEN. All right. How long do you think it will take for you to get an answer to me on that? Can you say within a month?

Mr. COHEN. Oh, I would think so.

Senator WYDEN. All right. Very good.

Senator HATCH. Has everybody had a chance to ask questions? Senator Roberts?

Senator ROBERTS. Mr. Cohen, thank you for coming. Tough duty.

Mr. COHEN. It was my pleasure, Senator.

Senator ROBERTS. Stay in there.

In many regulations implementing the PPAC statute, stakeholders are being given the minimum amount of time—minimum, not maximum, minimum—to respond, 30 days, to sometimes hundreds of pages of regulations, often with many of these regulations being issued in the same week.

I cannot go to a stakeholder meeting comprised of all of our providers without somebody picking up a piece of paper and saying,

"Senator, what about this?" Then I do not know about it, they do not know about it, we have to ask, and we get into some real problems.

In these instances, the administration has had months, if not years, to draft and review, and OMB is given months to review as well. Will future regulations give stakeholders more than a minimal amount of time to review? It has been suggested by other nominees before the Finance Committee that 60 days would be a more reasonable time frame.

It used to be 30 or even 60 days, and then 90 if thousands of comments came in, to say this regulation does not work well for us, we can tweak it, we can do this, we can do that. Some would oppose it, but at least there was a time frame where you could then work the regulations to better fit all of the stakeholders and the providers.

In addition, we are getting feedback that many stakeholder groups do not believe the administration will take into account their comments when issuing the final regulations. I am talking about the final regulations now, that is, the subject of this hearing. I thank the chair and the ranking member for holding this hearing.

I would like to point out a letter I, along with many of my colleagues, sent to the Department of Health and Human Services and Treasury and the Department of Labor, outlining our concerns. In your response dated February 12th, the Department noted that they are reviewing these comments and will finalize the rule soon.

I would also note that the submissions for these rules to OMB show that they were submitted and received by OMB on February 8th. Now, that tells me that you have in fact completed your review of the rules and are not still considering them. That careful consideration of thousands of comments was given at the most a little over 40 days to complete, and I can see why stakeholders are very skeptical of whom you are listening to and what you have to say.

I would remind you that the traditional regulatory process, as described in both statute and executive order, calls for notice, comment, review, consideration of comments, and issuing of a final rule. What is being done to address this very troubling concern?

Mr. COHEN. Thank you, Senator. I would make two points. I think, first of all, our process with respect to the policy that is being set forth in these rules has been to provide guidance bulletins ahead of time so that, before we even put out the proposed rules, we have gotten a tremendous amount of input from the stakeholder community with respect to them.

So, as an example, the essential health benefits rule: we put out a bulletin well ahead of time. We got comments on the bulletin, and we incorporated those comments in what then became the proposed rule. In addition, I would say that, in all of the rulemakings that I have been involved with since I have been at CCIIO, we have very carefully considered comments we have gotten and, in many cases, have incorporated and made changes with respect to input that we have gotten from the stakeholder community. So I am disappointed that people are skeptical that we read them. We absolutely do. We do take them into consideration, and we have and will with respect to the rules that are becoming final now.

Senator ROBERTS. This, I think, raises an important question. The departments implementing PPAC have often referred to the subregulatory guidance documents such as you describe—the bulletins and the guidances and the postings on the website, the faxes, et cetera—to demonstrate stakeholder participation in the regulatory process. Here we have a question, and you are coming back with all of these bulletins and guidances and postings. I do not know who can keep up with all of that, but at any rate you are making the effort.

But it raises several concerns. As subregulatory guidance does not hold the force of law, it generally does not reach, through notification and other means, the same amount of stakeholder participants and is outside the traditional regulatory process. That really can confound stakeholders with limited resources, both time and money.

The rural health care delivery system does not have the folks out there to go through all of the bulletins, the guidances, the postings, the websites, and the faxes. Basically, we just have a situation where they cannot focus on what they need to focus on in regards to the regulatory mandates that they face.

So the traditional regulatory process, as described in both statute and executive order, calls for notice, comment, review, consideration of comments, and issuing of the final rule.

I think the administration is deviating severely from the normal rulemaking process, and it is a real problem with regard to the stakeholders. Now, I have made my speech, and I think you have responded. I am not sure we need to go into it any further. But this is a problem.

Just as, in the State of the Union address, the President indicated that basically, if we have a situation where the obstreperous Congress, all of us combined, we do not buy his agenda and do it in a specific amount of time, a reasonable amount of time, he will simply issue executive orders and more regulations.

Now, I will tell you what, that sent a chill through the entire health care industry, because we are drowning in regulations now, and, to my way of thinking, when you go into the subregulatory guidance documents as opposed to following the review and consideration of comments that is called for by executive order and statute—I know that it is convenient; I know that the regulations are so many and they are important and they are very comprehensive—that is a problem. So I would hope that we could get back to a more—just follow the law. Just follow the executive order and the statute.

Mr. COHEN. Senator, I would just say that, in my experience, stakeholders have welcomed and are grateful for the guidance that we put out, the frequently asked questions, et cetera, that are intended to clarify. We are not making law in those documents, and we are very careful to use the regulatory process when it is called for and necessary.

Senator HATCH. Thank you.

Senator Carper, I think you are the last one.

Senator CARPER. Yes. Thanks so much.

Mr. Cohen, welcome. I just came from a press conference over on the House side with the head of GAO. They just released their

high-risk list, the high-risk ways for wasting money in the Federal Government, and there were a lot of good ideas of things we can do we ought to put on our to-do list.

I quoted Mike Enzi, a venerable former mayor of Gillette, WY, who sits right over here next to Mr. Roberts. I quoted him again on the 80/20 rule. The 80/20 rule is Mike Enzi's—I do not know if he wrote it, but it is a great rule. It goes like this: we agree on 80 percent of the stuff, we disagree on 20 percent of the stuff.

What he says is, we ought to focus on the 80 percent where we agree, get that done, and set aside the other 20 percent and come back to that another day. I think 80 percent of the people—I think probably close to 100 percent of the members of the Senate and this committee—agree that one of the keys to bringing down costs and getting us better health care results for less money is to create large purchasing pools so that individuals, small businesses, families, even mid-sized businesses up to 100 or so employees, have the opportunity to really participate in a large purchasing pool like we do through the Federal Employees Health Benefit Plan, to get more competition, arguably better health care results, and lower administrative costs.

It is a great concept, and we are going to give this opportunity to every State to set up their own large purchasing pool, called an exchange. They can run it themselves, they can have the Federal Government run it for them, or they can be in a partnership where we do it together. We have to do it right. We have to get it right, and there is a lot that lies on the administration as we implement the Affordable Care Act.

Mr. Chairman, our congressional delegation—Senator Coons, Congressman Carney, myself with our Governor Jack Markell—are going to be holding a series of forums up and down the State. It is a little State, so it is not hard to do. We will have them on nights, we will have them on weekends, we will have them during recess periods, we will have teleconference calls, just invite the business community to join us in person or by phone to figure out, how is this going to work, how can we make it work for them, how can we make it work for their employees? But we need to make sure that, from the administration, we have regulations that actually facilitate systems, particularly computer systems, that make it possible for them to understand what is available here and to make sure we seize this opportunity.

Let me just ask the first two questions. The first one is—and I will ask you to be brief on this one if you will—how will the administration, how will the Department, be ensuring that businesses can comply with this new law? What are you doing? What can you be doing to better ensure that they can comply? Not just be dumbfounded by it, confused by it, but can actually comply?

Mr. COHEN. Thank you, Senator. I think what you will see, beginning now and through the rest of the year until October, is a real outreach and education campaign to make sure that the Affordable Care Act and what it provides and what it requires is known out there in the community so that people understand what their obligations are and will be able to comply with it.

Senator CARPER. All right. I am going to drill down on this a little bit. How are you planning to test the computer systems for the

exchanges to make sure that they work properly? Second, do you have a contingency plan to back up these computer systems when they run into glitches, and they probably will?

Mr. COHEN. So, the answer to the first question is that there are a number of different computer systems that are being established to determine eligibility enrollment: the data hub, to verify information that is provided by people when they are applying; the system that will enable us to accept the issuer's plans and review those to make sure that they comply with the law and are able to be sold in the marketplace.

Testing has already begun on a number of those and will continue throughout the spring and into the summer, and we will have all of that completed in time to operate by October 1st. We are looking at contingency plans for every eventuality.

Senator CARPER. All right.

I like to quote, not just Mike Enzi, but I like to quote Albert Einstein. Some of you have heard me do this before, but Einstein used to say, "In adversity lies opportunity." We have a huge adversity. We spend way more money on health care than any other country, as you know, and we do not get better results. This is like, Norway spends 50 percent less than us, and they cover everybody. We spend twice as much as the Japanese. They cover everybody, and they get better results.

So there is great adversity here, but there is great opportunity here. If we do not seize the advantage of this opportunity to address it through setting up the exchanges, running them well in a cost-effective way, getting better health care results for less money, we have really missed a terrific opportunity. We cannot let that happen. I would just urge you and your colleagues—and I will be talking with the Secretary later today, Secretary Sebelius later today—just to sort of underscore that point.

The last thing I would say to my colleagues is, some of us were supportive of the Affordable Care Act passing, some of us were not. I said from the start it is not perfect, but it is certainly better than what we have been doing, spending more money for health care, not getting better results, and not covering everybody. So, we have to do better than that. This is something that the Democrats and Republicans ought to be able to agree on. We ought to be able to agree with Governors and States to implement these exchanges, to implement them well.

The key here: better health care results for less money. We can figure that out and implement it, particularly with respect to programs like Medicare and Medicaid where we know we need to do better. We know we need to reform those programs in ways that save some money, do not savage old people, and save the programs for the long haul. So we look forward to working with you. You just need to be on your A game. You need to be on your A game every day.

Thank you, Mr. Chairman.

Mr. COHEN. Thank you, Senator.

Senator HATCH. Well, thank you, Senator. We appreciate you, Mr. Cohen. We appreciate you being here, and we look forward to seeing what you can do between now and October 1st.

Mr. COHEN. Thank you.

Senator HATCH. Thanks so much.

Well, our second panel will feature Don Hughes, Advisor to the Office of the Governor of the wonderful State of Arizona; Christine Ferguson, Director of the Rhode Island Health Benefit Exchange; and Bettina Tweardy Riveros, who is Advisor to the Governor and Chair of the Delaware Health Care Commission.

As a reminder, your written statements will automatically go into the record. If you could limit your opening statements to 5 minutes, we would appreciate it, but we are not going to be tough on that. So, it is up to you. We will start with you then, Mr. Hughes.

Senator CARPER. If I could, one of our committee witnesses, our third witness—I do not know if we are saving the best for last—but Bettina Tweardy was my deputy legal counsel, deputy policy advisor, in my second term as Governor. She was so smart, so able, so hard-working, and she still continues to serve the people of Delaware in a different role and for a different Governor. But it is great to see Bettina. We welcome her and the other witnesses. Thank you just for letting me say this. Happy Valentine's Day, Bettina.

Senator HATCH. You were lucky to have him as Governor.

We are happy to have you here.

Ms. TWEARDY RIVEROS. Thank you, Senator.

Senator HATCH. We will start with you, Mr. Hughes, and go from there.

STATEMENT OF DON HUGHES, ADVISOR TO THE OFFICE OF THE GOVERNOR, STATE OF ARIZONA, PHOENIX, AZ

Mr. HUGHES. Thank you, Ranking Member Hatch and members of the Senate Finance Committee. Thank you for the invitation to discuss Arizona's experience in planning and designing a State-based exchange and Governor Brewer's decision to defer to the federally facilitated exchange. My name is Don Hughes. I serve as Governor Brewer's Health Care Policy Advisor, and I am responsible for Arizona's health insurance exchange activities.

Arizona's goal was to explore all options available to the State and to allow maximum flexibilities and options to the Governor with respect to the health insurance exchange. The State's analysis concluded that the least risky options were to defer to the federally facilitated exchange or to leverage our existing State systems and fill gaps with new development. Both options presented the lowest cost to the State and provided the greatest likelihood of meeting ACA timelines.

Maximizing options was important to Governor Brewer as she explored ways to address the rising uncompensated care costs associated with the more than 1.2 million uninsured Arizona residents representing 19 percent of Arizona's population.

The State's research indicated that once an exchange was fully implemented, 587,000 uninsured people would find coverage in either private health insurance or Medicaid. The potential impact on the uninsured and uncompensated care made pursuit of a State-based exchange attractive.

Arizona intended to utilize as much flexibility as is afforded States under the Affordable Care Act and the exchange rules. The

goal is to design the most free market-oriented health insurance exchange in the country. Exchange planning and design work operated under the following principles.

First, build on Arizona's strong health insurance market; support the market facilitator approach; maximize consumer choice and competition; and impose minimal regulations and reporting requirements. With more than 35 health insurance companies actively writing in our small group market and more than 15 insurers actively doing business in the individual market, Arizona has a very healthy and competitive insurance market.

No insurer has more than 24-percent market share. The exchange design that we were working on was intended to transfer the same level of competition and consumer choices that exist in the current insurance market to the exchange. In designing a State-based approach, leveraging existing State systems and filling the gaps with products developed by private sector vendors was determined to be the option that had the lowest costs, was most likely to be ready on time, and would provide Arizona with the most control over the design and operation of the exchange.

For the past 10 years, the Arizona Health Care Cost Containment System (AHCCCS), Arizona's Medicaid agency, has operated a web-based application system called Health-e-Arizona to receive and process applications and renewals. AHCCCS receives more than 40 percent of applications and 50 percent of renewals online through Health-e-Arizona today.

Leveraging Health-e-Arizona with cutting-edge technology from the private sector to fill in the IT gaps presented the best option to meet the goal of providing a first-class consumer experience in reducing the uninsured rate in Arizona.

The Arizona health insurance exchange is being designed to be a fully integrated system that will allow consumers and small employers to find information, determine eligibility for, and enroll in Medicaid, CHIP, SNAP, TANF, and private individual insurance, including the Advanced Premium Tax Credits and small group insurance.

Arizona also believed in working collaboratively with the insurance industry to ensure an open-market approach. If Arizona had moved forward with a State-based exchange, there would have been more than 100 qualified health plans participating in the individual exchange and the Small Business Health Options Program (SHOP). This level of competition would have helped keep premiums affordable and maximized the choices for consumers.

Arizona exchange staffing consultants worked diligently on a State-based exchange model to maintain that as a viable option for policy-makers. However, too many uncertainties prevented Arizona from fully committing to a State-based exchange.

On November 28, 2012, Governor Brewer notified the administration that Arizona would defer to the federally facilitated exchange. The delay in releasing all necessary exchange and Medicaid rules were significant factors in the Governor's decision.

One large national insurance company commented that they would need 12 weeks from the time the rules were finalized to bring a product to market. The delay in issuing rules makes it dif-

ficult for insurers to meet the filing deadlines for qualified health plan (QHP) certification for the initial open enrollment period.

Also, the delay in finalizing the HHS Notice of Benefit and Parameters Payment Plan for 2014 impacts the risk adjustment, risk corridors, and transitional reinsurance programs and may cause insurance actuaries to be more cautious in setting premiums for the upcoming year.

Finally, the status of development of a number of Federal services that a State-based exchange would be required to use was also unclear to us. Those services included the Federal Data Services Hub, the Advanced Premium Tax Credit and Cost Sharing Subsidy Service, the Actuarial Value Calculator, Minimum Value Calculator, and the Modified Adjusted Gross Income Business Rules.

Arizona is now working collaboratively with HHS on the development of the FFE and how it will work in Arizona. It will monitor its efficacy, including costs, operations, and ease of use. I am happy to answer any questions.

Senator HATCH. Well, thank you, sir.

[The prepared statement of Mr. Hughes appears in the appendix.]

Senator HATCH. We will now turn to you, Ms. Ferguson.

STATEMENT OF CHRISTINE FERGUSON, DIRECTOR OF THE RHODE ISLAND HEALTH BENEFIT EXCHANGE, STATE OF RHODE ISLAND, PROVIDENCE, RI

Ms. FERGUSON. Senator Hatch, members of the committee, thank you for the opportunity to speak with you today to share our perspective from Rhode Island on the State-based health benefits exchanges under the Affordable Care Act.

On September 19, 2011, Governor Lincoln Chafee issued an executive order that created the Rhode Island Health Benefits Exchange within our executive branch. The exchange is guided by a 13-member community advisory board which is overseeing exchange planning and development efforts.

In June of 2012, I was appointed by the Governor to be the exchange Director. Since then, Rhode Island has continued to make progress in all areas of exchange benchmarks, with a rigorous inter-agency and stakeholder process that will continue to support the development and implementation of Rhode Island's exchange.

Our exchange will serve two important purposes: first, it will provide a robust marketplace for all Rhode Islanders to identify health insurance options and, for those eligible, to purchase coverage. Second, the exchange will negotiate for high-quality, affordable insurance options on behalf of small employers and individuals. Our exchange stands on Rhode Island's strong history of health care advances and the support we have received from our congressional delegation.

Senators Jack Reed and Sheldon Whitehouse have provided tremendous investment of time and support to ensure that Rhode Island is ready to implement the Affordable Care Act, and Congressmen James Langevin and David Cicilline have been unwavering in their support.

Governor Lincoln Chafee and Rhode Island Lieutenant Governor Elizabeth Roberts, who is chair of the State's Health Reform Com-

mission, have diligently coordinated all of the early work of our exchange, and the Lieutenant Governor continues to lead on broad health reform efforts.

Our exchange also rests on decades of investment in Rhode Island's health care infrastructure, including the Rhode Island Quality Institute founded by Senator Sheldon Whitehouse to promote health information technology, and the Rhode Island Chronic Care Sustainability Initiative, launched in 2008 by our Health Insurance Commissioner, Christopher Koller, to promote the patient-centered medical home, among dozens of other strong health care initiatives.

We have a robust Medicaid managed-care program with participation by both private and public sector programs, run by Steve Costantino. In addition, we have innovative activities on the part of our primary care providers and practices, our hospitals, and our insurers.

As a result, when our Exchange Advisory Board came together in 2011 to create our vision, mission, and goals, they were building on a strong history of collaborative work and commitment to Rhode Islanders' health.

The vision of the Exchange Advisory Board and the Governor's executive order is to support health reform efforts at the State and national level that provide Rhode Islanders well-being and provide increased access to high-quality, coordinated care at a reasonable, predictable cost.

Our mission is to serve as a robust resource for Rhode Islanders and Rhode Island businesses to learn about and easily compare the quality and affordability of their health insurance options, enroll in coverage, and, if eligible, access the Federal tax credit for coverage.

We have five guiding goals: the first is to improve the health of Rhode Islanders; second, to achieve near-universal coverage; third, to favorably impact health insurance cost trends; fourth, to favorably impact health care delivery system effectiveness and efficiency; and fifth, to add value to employer health insurance purchasing.

Why did we decide to create a State-based exchange? As we collected input from stakeholders, we heard again and again that high costs and unpredictable annual increases have made health insurance coverage unsustainable for most employers and out of reach for many individuals, from entrepreneurs taking the plunge into new ventures to those who are working multiple jobs.

We are building an exchange by Rhode Islanders for Rhode Islanders, one that benefits from and contributes to the work of other States but is created to meet Rhode Islanders' needs. The Affordable Care Act provides us with the tools to take advantage of Rhode Island's historic health care achievements, the strong relationships between our partners throughout the State, and our advisory board's carefully created vision.

Rhode Island leaders felt that a State-based exchange was the best choice for us to carry out our goals. By purchasing for so many Rhode Islanders together, our exchange will give new power to small businesses and individuals in the health insurance marketplace by negotiating with health insurance carriers on their behalf.

The work we are doing to create our exchange is complicated, and the timeline is pressing. Our very talented team is working

24/7 as hard as they have ever worked to get this done by the October 1st deadline. We are confident that we will meet this goal, and we are pleased with the help provided to us throughout the process by HHS and CCIIO.

In closing, Rhode Island has worked hard to overcome its economic challenges through these difficulties. Rhode Island has retained our tremendous medical talent with world-class universities and nationally recognized, innovative providers and leaders.

Our exchange can act as a catalyst for the necessary changes in our delivery system and our insurance markets to increase quality and transparency, support innovations that will keep Rhode Islanders healthy and more productive, and keep costs down.

The exchange also has the potential to improve the business climate in Rhode Island as we all work together to harness its possibilities. We are grateful for this opportunity to highlight our opportunities, and I thank you once again for inviting me to share this information.

Senator HATCH. Thank you, Ms. Ferguson.

[The prepared statement of Ms. Ferguson appears in the appendix.]

Senator HATCH. Ms. Riveros, we will take your testimony.

STATEMENT OF BETTINA TWEARDY RIVEROS, ADVISOR TO THE GOVERNOR AND CHAIR OF THE DELAWARE HEALTH CARE COMMISSION, STATE OF DELAWARE, WILMINGTON, DE

Ms. TWEARDY RIVEROS. Thank you, Senator Hatch, Senator Carper, and distinguished members of the Senate Finance Committee. Thank you for the opportunity to report on Delaware's progress in establishing a State partnership health insurance exchange.

Following a comprehensive stakeholder outreach process involving consumers, businesses, providers, brokers, carriers, and others, and a feasibility study, Delaware selected the State partnership exchange model due to concerns about the financial sustainability of a State-based exchange, given our State's small population.

This model provided the best opportunity to keep the cost of health plans as low as possible while maintaining State influence over our insurance market and consumer outreach, with the ultimate goal of making quality health care affordable and accessible to all Delawareans.

Beginning October 1st of this year, Delawareans will be utilizing the Federal exchange portal to enroll in the health insurance plan with coverage beginning on January 1, 2014. However, as a partnership exchange State, Delaware will be recommending health plans for certification and applying State certification standards, administering programs to help consumers understand the coverage options, and supporting our small business community.

In Delaware, we are a State of neighbors, and we believe this model, the partnership model, provides operational efficiency and financial stability while being highly responsive to local needs and stakeholder input.

As a partnership State, setting State-based qualified health plan certification standards and defining the consumer outreach strategy aligns the exchange with other State health policy goals, including ensuring access to care and coverage, and ensuring we

have the workforce to provide that care, supporting quality and population health goals, and advancing critical cost-containment and payment reform initiatives.

Foundational to all of these are supporting innovative technology and the DHIN—Delaware's Health Information Network—infrastructure created under the leadership of distinguished committee member and former Governor, Senator Thomas R. Carper.

Delaware's progress on exchange establishment has been significant, and HHS has been very supportive and collaborative as we work together to launch the State partnership exchange model.

In December, Delaware became the first State, true to form, conditionally approved to operate a partnership exchange. Today we can report that we are on track to complete State requirements necessary to support open enrollment on October 1, 2013.

In the plan management area, Delaware has defined our essential health benefits package, finalized State-specific criteria for certifying the qualified health plans, and will be ready to review and certify plans by late July and transmit approved plan information to the Federal exchange portal in time to support open enrollment in October.

Delaware also has made significant progress on the consumer assistance front, including finalizing certification requirements for Delaware's consumer assistance provided through marketplace assisters, and initiating procurement for those marketplace assisters with programming and training of those individuals slated for April. On the start of open enrollment, these individuals will be ready to help consumers understand their responsibilities and the coverage spectrum available to them.

Supporting Delaware's consumers also means supporting our businesses. Providing information and assistance to the Delaware business community and building on the strong broker and agent network is a key component of our consumer outreach strategy, and we will have significant activity, as Senator Carper noted, in the months to come.

Delaware is proud of our exchange establishment progress to date. We also understand there is still much work to be done before October, and we appreciate the collaboration of HHS with Delaware, including supporting our State-based outreach strategy for consumer assistance and education.

We continue to be eager for final HHS guidance on certain operational elements, including the final data collection templates that issuers will use to prepare and submit information for qualified health plan certification; how the multi-State plans will maintain consistency with State certification standards; and how the SHOP Exchange and navigators will refer small employers to agents and brokers.

Thank you for this opportunity to share with you Delaware's experience and progress on this important initiative and our shared goal of improved health for all Delawareans and Americans. Thank you.

Senator HATCH. Thank you.

[The prepared statement of Ms. Tweardy Riveros appears in the appendix.]

Senator HATCH. I appreciate the testimony of all three of you.

Let me just ask a few questions. Mr. Hughes, it is clear by your testimony that Arizona was very close to establishing a State-based exchange and could have had one up and running by October 1st, indicating little political opposition to establishing an exchange.

Now you, in your testimony, ended by stating that the decision to not establish a State-based exchange was made because of operational challenges, especially related to the lack of information coming out of HHS. You also note that the timeline established for plan certification did not provide issuers or Arizona enough time to be ready by October 1st.

Do you have any doubts about the ability of all exchanges to be fully ready to go on October 1st, especially due to the fact that, even if a State-based exchange is fully operational, it will still rely on the capabilities of the Federal Data Services Hub to make eligibility determinations?

Mr. HUGHES. Senator Hatch, we were concerned about the uncertainty and the various moving pieces that are out there on where the Federal Data Services Hub and some of the other services are. We have made enough progress to this point that we are doing some initial testing with CMS on the Federal Data Services Hub.

Our concern was, of the things that we could control, we would be ready on time, but there were simply things that were not in our control but were in the control of CCIIO or CMS, that we could not guarantee would be ready on time. It just seemed too risky for us to move forward.

Our timeline—if we had moved forward with a State-based exchange for accepting applications for qualified health plans—was, we would have accepted applications beginning January 2nd and concluded accepting applications by the end of March, giving us 2 months or 3 months to work with the carriers, to ensure that their applications were complete, and that they were ready to go. Rates would have been filed in May.

We felt that gave us sufficient time and gave the carriers sufficient time to move forward with qualifying for a qualified health plan, but it all depended upon having the final rules done, the essential health benefits actuarial value rules, the market rules, and the others, otherwise they would not have had enough time to build their products and price their products in order to submit their applications to the Federal exchange or to a State-based exchange. That was one of the reasons why we decided to defer to the FFE.

Senator HATCH. All right.

Ms. Ferguson, have you experienced any challenge as a result of the administration's delaying the issuance of regulations?

Ms. FERGUSON. We were fortunate in that we were one of the very first States to get the planning money and the first State to get a 2nd-tier establishment grant, so we have been working closely with CCIIO and HHS from really the very beginning of the process. We made a calculation that we believe they will be able to get us what we need in time to get the work done.

Senator HATCH. All right.

Ms. Riveros, your testimony referenced the ability of Delaware to have influence over plan certification and consumer assistance standards as one of the reasons to go with a partnership exchange. The CMS guidance document on State Partnership Exchanges

states that HHS "will approve State partners to perform plan management or consumer assistance functions and retain authority over inherently governmental functions."

What authority does the State of Delaware retain when the administration has final say in all decisions that are inherently governmental functions, and could Delaware approve the sale of a health insurance product on the exchange without the express approval of HHS? What benefit does the partnership model provide to the State that the FFE does not provide, other than access to grant funding under section 1311?

Ms. TWEARDY RIVEROS. Senator, first, the State of Delaware cannot approve a health plan for sale on the exchange that does not meet the Federal certification requirements. However, as a partnership State, Delaware has the opportunity to set requirements at the State level that will align our State health policy goals across this exchange.

For example, we have in our State certification requirements requirements for support for transition for those who move between commercial insurance plans and Medicaid. We have requirements to support our technology infrastructure, the DHIN, in our certification standards.

And we have other certification standards. For example, the business community sought a requirement that we require any issuer selling on our exchange to also offer for sale a bronze level, or 60-percent, actuarial value plan so that they would have a low-cost alternative in the market. Those are examples of specific ways that the State partnership exchange lets us influence our market, lets us align our State health policy goals through the exchange.

Senator HATCH. Well, thank you.

Senator Carper, if I can, I have one more question to all three, and then I am going to turn the gavel over to you, because I have to leave.

Senator CARPER. It is a dangerous thing, turning the gavel over to me. [Laughter.]

I will be on my best behavior.

Senator HATCH. I am counting on that.

Now, to all three of you, and let me start with you first, Mr. Hughes, we know that the law requires each exchange to be self-sustainable by January 1, 2015. Now, user fees had been proposed by States, and CMS has proposed a 3.5-percent user fee on all plans offered through the FFE.

Can each of the panelists please tell me if your respective States analyzed the impact of a user fee on health insurance premiums? If so, detail the results of your analysis, if you can. I just think it would be good for the record to ask you that question. Yes, sir?

Mr. HUGHES. Thank you, Senator Hatch. We did an analysis as to what our State-based exchange costs would be, both the IT costs and all of the other associated costs, with running a State-based exchange. We had made the decision, if we were moving forward, that we would do a flat dollar-amount fee rather than a percentage amount.

We felt that, based upon our enrollment projections over time, that would cover our costs. We were looking to keep the administrative fee as low as possible because it simply adds to the cost of

the premium that a consumer or small employer would have to pay.

In terms of the 3.5-percent assessment on insurance companies, that would be built into the premium and passed on to consumers. I have not seen a budget for the Federal exchange, so I do not know if that fee is going to cover the costs, because I do not know what their costs are going to be.

That is a bit of a concern, that we have not seen a budget yet for what those costs will be and whether the 3.5-percent assessment on Arizona insurance policies will be kept within Arizona and pay for Arizona costs, or will it just go into a larger Federal budget that will pay for the entire cost of the 25 States that are deferring to a Federal exchange.

Senator HATCH. All right.

Ms. Ferguson?

Ms. FERGUSON. We are in the midst of that analysis. We have a couple of different options in terms of approaches to covering the cost. We are happy to provide that analysis as it becomes available.

Senator HATCH. That would be helpful.

Yes, Ms. Riveros?

Ms. TWEARDY RIVEROS. In Delaware, we conducted that analysis in 2011 and early 2012. We analyzed the cost of a State exchange, a Federal exchange, and a partnership exchange, and we took a very serious look at our direct costs associated with operating a State-based exchange, especially in light of our low population.

Given our low population and the risk of low enrollment in particular, when we looked at the numbers, frankly, there was significant risk that we could not be financially self-sustaining, and that drove us to our decision to, among other reasons, support a State partnership exchange.

Senator HATCH. Well, thank you.

I am going to have to leave. You are the last person to question, so I will ask you to wrap up the hearing. But we are very happy to have the distinguished Senator on this committee. His experience as a Governor, his experience in many other ways, is just absolutely vital to this committee. I just really appreciate you being here, and I appreciate you.

Senator CARPER. Thank you. Thank you so much. It is my privilege to serve with you.

Senator HATCH. Thank you all for being here. I just want to personally thank you all for helping us to understand this better. Thank you.

Senator CARPER. Thank you, Mr. Chairman.

To our witnesses, thank you so much for joining us and sharing your testimony and responding to our questions. The record will remain open for, I think, about another 48 hours so that my colleagues who are not able to be here will have a chance to submit questions as well.

I am the last Senator sitting, not standing, but do not take this as a sign that my colleagues are not interested, are not connected, and do not understand the importance of us getting the exchanges right in all 50 States. We have a number of staff members here, Senators' staff, both minority and majority staff here, and a lot of folks are watching this by closed-circuit television. So your message

is getting out, and we will have an opportunity to ask some more questions, and I will have some as well.

Right now, an Environment and Public Works hearing is going on. David Walker, the former Comptroller General of the United States, is sitting out there waiting to meet with me. The chairman of the House Committee on Homeland Security is waiting to meet with me in my hideaway right now, so there is a lot going on.

That is just a sort of example of what all of us face here; it is rather frenetic. But I am delighted that you are here and especially delighted to see Bettina. I am grateful for the great work she has done for our State, not forever, but for a long time. So, thank you for that.

Bettina referred to something called the Delaware Health Information Network, which I signed into law in my last term as Governor. I do not think I understood how important it was at the time, but it is becoming more important.

Mike Leavitt, who was a former Governor from Utah, and Tommy Thompson, the Governor of Wisconsin, who later became Secretaries of Health and Human Services, were hugely supportive of our efforts in their roles as Secretary of Health and Human Services. Dr. Carolyn Clancy, who is going to be leaving us fairly soon in her service at the Department of Health and Human Services, has been a great supporter of our efforts. I would be foolish not to acknowledge those folks.

Let me just ask you, if I could, Ms. Riveros, when you look at what we are doing in Delaware with respect to the Delaware Health Information Network, how does it help provide better health care outcomes for less money, and what pieces of that might be transferrable to other States to try to replicate?

Ms. TWEARDY RIVEROS. Thank you, Senator. The Delaware Health Information Network is a health information exchange. As Senator Carper noted, we have, frankly, led the Nation, under his leadership beginning in 1997, and we have had an active health information exchange operational for nearly 6 years as of May of this year.

Having the health information exchange in Delaware enables health information from disparate health care providers all over the State, and frankly potentially across our State borders, to be aggregated and available at the point of care, enabling coordination of care that is so difficult to achieve right now and is so foundational to the cost savings and the reduced costs and improved quality of care that we all seek to deliver.

So having that health information exchange infrastructure, frankly, is like our highways are to transportation. It enables the transfer of data. But beyond that, it also enables us to better understand what the patient needs, what they have already had, whether they have already had an MRI 2 weeks ago and they do not need another one, so we can reduce costs in that way.

It enables us to build on that foundation and develop new innovations that can ensure that we are bringing best practices to the point of contact and delivering that care to those patients. It also provides support for the payment reform models. When all of us speak about payment reforms and how we actually reduce the cost of care and get better quality outcomes, we talk a lot about deliv-

ering value, we talk a lot about improving outcomes, and having outcomes-based reimbursement structures.

But we cannot have those reimbursement structures if we do not know how we are getting to the best outcomes, so the DHIN technology infrastructure actually provides a very solid foundation to support the data and analytics works that can, not only support care coordination, but also the payment reform models and outcomes-based reimbursement models. So those learnings are all transferrable, I would say, to other States, and certainly we are more than welcome to share our experience with those other States.

Senator CARPER. Please.

Ms. FERGUSON. Senator——

Senator CARPER. I am going to ask you to be brief, because I have all those other things going on, please. Jump right in, though.

Ms. FERGUSON. I just would be remiss if I did not, in the competitive arena that we are in in health care, support the fact that Senator Whitehouse originated our health information technology exchange in Rhode Island, the Rhode Island Quality Care Institute. So, as you are talking with him, I think everything that Ms. Riveros talked about is exactly the same benefit that we are seeing in Rhode Island, and I think we started at right around the same time.

Senator CARPER. You just never know what is going to come out of those little States, you know?

Ms. FERGUSON. Yes, I know.

Senator CARPER. That is good.

Ms. FERGUSON. We need to over-achieve.

Senator CARPER. That is great. Thank you for saying that.

We are blessed in our State, as all States are, with an entity that is part of the health care delivery system that is supported by Democrats and Republicans, whether the President is George W. Bush or happens to be Barack Obama. I think most of us support the exchanges; God knows I do.

But the other thing is the federally qualified community health centers. I think they are just a great way to try to get better health care results for less money, to ensure that we address the needs of the least of these, but in a cost-effective way.

I would ask you if I could, Chairwoman Riveros, could you just explain for us, just very briefly, how the federally qualified community health centers in our State—how they interact, or how do you expect that they will interact with our exchanges. Have you all given that much thought? If you have, any thoughts you have would be much appreciated.

Ms. TWEARDY RIVEROS. Yes, Senator. In Delaware, we have a very strong federally qualified health center network. In fact, we recently opened a new center, as the Senator knows. So, when we see the present uninsured Delawareans in our State—we have a little over 100,000 uninsured Delawareans—and we look at the opportunities to provide them subsidies through the exchange and the opportunities afforded through the expansion of Medicaid, we definitely see that a significant number of those individuals will potentially be served by our federally qualified health centers. In fact, we have reached out to them and spoken to them about their need

to really ramp up and be able to continue to support that newly insured population. So they play, I would say, a critical role in our health care delivery system.

In many ways, they have already developed the medical home models that we all talk so much about and are already working under those models. In fact, one of ours, West Side Healthcare, has been certified as a health home. So to me, they will be responsible for delivering care, and they have been successful in doing it in a cost-effective manner, and they will provide the capacity that we need to absorb this newly insured population.

Senator CARPER. All right. Thank you for that.

To each of you, Mr. Hughes, Ms. Ferguson, to Chairwoman Riveros, it is good to see you on this special day. February 14th comes around once a year. Since I get to be chairman, I get to do one of the things I most like to do, and it is to close a hearing with a musical reference. I was thinking, what could I possibly say on Valentine's Day that might be appropriate for this hearing?

The words of a couple of British guys, British lads named Lennon and McCartney, come to mind. I am not sure which album, whether it was the White Album or maybe Abbey Road, but the last words of the album go something like this—and this is really good for Valentine's Day: "And in the end, the love we take is equal to the love we make." I think one of the best ways to show the people of this country that we love and care for them is to make sure they have access to good health care, and we have an obligation to our taxpayers to make sure that we do it in a cost-effective way.

With that in mind, Happy Valentine's Day. This hearing is adjourned.

[Whereupon, at 11:35 a.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

Hearing Statement of Senator Max Baucus (D-Mont.)
Regarding Progress Building Health Insurance Marketplaces
As prepared for delivery

In early 1964, just two months after the assassination of John F. Kennedy, President Lyndon Johnson delivered his first State of the Union address.

He called on Congress to move forward with the late President's bold agenda. He said we have, quote:

"A unique opportunity and obligation to prove the success of our system....

"If we fail, if we fritter and fumble away our opportunity in needless, senseless quarrels between Democrats and Republicans, or between the House and the Senate ... or between the Congress and the administration, then history will rightfully judge us harshly."

Last summer, the Supreme Court once and for all ruled the Affordable Care Act to be the law of the land, settling the issue. After nearly a century of Americans' fighting for real health reform, we finally passed the Affordable Care Act in 2010.

Health insurance exchanges, or marketplaces, are one of the most vital tools created by the law to provide nearly every American with health care. Now is the time for us to work together to ensure that the law and these marketplaces are implemented properly.

These marketplaces are a new frontier and create a real opportunity for more Americans to get health insurance.

For far too long, individuals and small businesses across the nation shopping for health insurance were left to fend for themselves.

A Commonwealth Fund study found that nearly three quarters of individuals looking for coverage on the individual market never bought a plan, with 61 percent of those citing premium costs as the primary reason.

In preparation of this hearing, I did a little exercise and shopped around for health insurance online. I started as most American families would and typed into Google "individual health insurance plans." In .26 seconds, 106 million results appeared: everything from AARP, United, Blue Cross, CareFirst, Kaiser Permanente and many others.

Needless to say it was already a bit overwhelming. I clicked on one insurance carrier's web site and found an application for their individual and family health plan. It was 97 pages long. A 24-page questionnaire followed by a 73-page disclosure form.

Now I went to law school, and this was Greek to me. With the marketplaces, there will be one simple web form application for consumers.

Before health reform, plans were too expensive with little protections. Insurers were able to terminate coverage when patients had cancer simply because these patients didn't disclose a teenage bout with acne or a bump on the chin as a child. Plans were described in legal jargon instead of plain English.

Large companies, on the other hand, could use the leverage that came with their size to negotiate better plans at more stable prices.

This inequality in the health care system created yet another case of the haves and the have-nots. But not anymore.

The marketplaces created in health reform will level the playing field.

For the first time, individuals and small businesses will be able to pool their purchasing power to get a better bang for the buck.

Consumers will have access to one-stop competitive shopping for affordable health care, just like they have Orbitz or Kayak for airfare and hotels. These marketplaces will provide clear comparisons of quality and price across plans.

We already shop in competitive marketplaces for groceries, airline tickets, and cars. There's no reason the health insurance market should be different.

These marketplaces are scheduled to be up and running across the country on October 1 for coverage effective January 1, 2014. Two other critical components of the health care law will be paired with the marketplaces.

First, consumers will no longer have to worry about being denied coverage due to a preexisting condition or when they get sick.

Second, tax credits will be available to help American families and businesses purchase insurance.

I know the Department of Health and Human Services has been hard at work for nearly three years in preparation. But there are challenges, and I want to make sure the Department is ready on day one.

It is important for Congress — and the Finance Committee in particular — to closely oversee implementation of these new programs, especially marketplaces. Senators need to be able to ask tough questions to ensure the programs are on track. That's why we are here today. I expect to hear about the significant progress the Centers for Medicare and Medicaid Services and states have made implementing marketplaces.

I have been pleased with the level of flexibility that CMS has provided to states in order to get marketplaces up and running. Instead of a one-size-fits-all solution, CMS has worked with states to craft customized marketplaces that fit the specific needs of their residents. Because as all of us in Montana can assure you, Montana is quite a bit different than New York.

CMS has told States they can run their own marketplace or share the responsibilities. If they prefer, states can let CMS facilitate their marketplaces. States are also free to make changes down the road. This flexibility is key to make sure that marketplaces work in each state across the country.

We will ask CMS today whether progress is on track, targets are being met, and what more can be done to realize the promise of the Affordable Care Act.

We will also hear from three states, each of which will provide a unique perspective on the opportunities and challenges in creating these new marketplaces.

So as President Johnson urged in his State of the Union, let us remember our obligation as we approach the marketplaces' launch this fall.

We have a real opportunity here to help Americans access affordable health care in a consumer-friendly way for the first time in a century. So let us not fritter and fumble away our opportunity in needless, senseless quarrels. Let us ensure these marketplaces live up to their promise and deliver unprecedented access to high-quality health care.

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STATEMENT OF

GARY COHEN, J.D.

DEPUTY ADMINISTRATOR AND DIRECTOR,
CENTER FOR CONSUMER INFORMATION AND INSURANCE OVERSIGHT,
CENTERS FOR MEDICARE & MEDICAID SERVICES

ON

HEALTH INSURANCE EXCHANGES: PROGRESS REPORT

BEFORE THE

U.S. SENATE FINANCE COMMITTEE

FEBRUARY 14, 2013

U.S. Senate Finance Committee
Health Insurance Exchanges: Progress Report
February 14, 2013

Good morning, Chairman Baucus, Ranking Member Hatch, and members of the Senate Finance Committee. Thank you for the opportunity to speak with you about the implementation of the Affordable Care Act's health insurance Exchanges, now referred to as the Health Insurance Marketplaces. Millions of Americans will purchase affordable health care coverage through the Health Insurance Marketplaces. Since the passage of the Affordable Care Act, the Department of Health and Human Services (HHS) and the Centers for Medicare & Medicaid Services (CMS) have been working with States and other stakeholders to develop and ensure the Marketplaces are ready to provide a consumer-focused experience when open enrollment begins October 1, 2013.

Through the establishment of the Health Insurance Marketplaces, Americans will be able to purchase high quality, affordable private health insurance, regardless of pre-existing conditions, with financial help for those who qualify. The Marketplaces will allow individuals, families, and small businesses to find qualified private health insurance options and apply for financial help using a web site and a streamlined application that can be completed online. At the same time, the Marketplaces will make it easier than ever before to compare available qualified health plans based on price, benefits and services, and quality. The Marketplaces will also help eligible consumers receive premium tax credits or coverage through the Medicaid or the State Children's Health Insurance Program (CHIP).

Additionally, the Small Business Health Options Program (SHOP) will help small businesses who wish to do so provide affordable, quality coverage for their employees. Eligible small businesses will be able to access tax credits through the SHOP and obtain access to information about coverage and options. By pooling people together, reducing transaction costs, and increasing transparency and competition, the Health Insurance Marketplace for individuals and small groups will be more efficient and competitive. Individuals and small businesses can be

confident that the qualified health plan they purchase through the Marketplaces will cover their health care needs.

Since the passage of the Affordable Care Act, CMS has been building the infrastructure that will make the Health Insurance Marketplaces a reality. We have established the framework for the Marketplaces through regulations, guidance, and technical assistance to States.[1] We will continue to provide additional guidance about the Marketplaces as needed, and we will do everything possible to continue to answer specific questions and provide technical assistance to States and stakeholders. With the framework established, we are now focusing on establishing the Federally-facilitated Marketplace for States that do not elect to establish a state-based Marketplace by setting up the process to certify qualified health plans for consumers to choose from, creating and testing the user experience, ensuring the security of the Marketplace portal,[2] and conducting outreach and education so consumers who will buy coverage through the Marketplace know how to access and use it.

We have been hard at work to ensure the Marketplaces will be easy to use, when they become operational beginning October 1, 2013 for the initial open enrollment period. States can elect to run their own Marketplaces,[3] or the Federal Government will operate the Marketplace in States that decide not to operate their own. CMS is structuring the Federally-facilitated Marketplace in a manner that leverages States' knowledge and expertise, as well as existing State programs, laws, and the responsibilities of state insurance departments whenever possible. As of February 1, 2013, nearly half of States have applied to run part or all of their own Marketplaces.

A State may choose to partner with the Federal Government to operate a Marketplace. CMS will supply the infrastructure of the Marketplace when States choose to work with the Federal Government; a State may elect to manage certified qualified health plans, provide consumer assistance and outreach for its eligible residents, or do both This partnership can serve as a path

[1] Every regulation and guidance issued about the Marketplaces is available at http://cciio.cms.gov/resources/regulations/index.html#hie under the heading "Affordable Insurance Exchanges"
[2] Healthcare.gov will be the website for the Federally-facilitated Marketplace. Healthcare.gov will also be able to direct consumers who live in States that are running their own Marketplaces to the appropriate website.
[3] States that are conditionally-approved to run their own Marketplace to date: California, Colorado, Connecticut, District of Columbia, Hawaii, Idaho, Kentucky, Maryland, Massachusetts, Minnesota, Nevada, New Mexico, New York, Oregon, Rhode Island, Utah, Vermont, and Washington

for States that are transitioning towards running their own Marketplaces in future years. In each State that has chosen not to partially or fully run its own Marketplace, CMS will leverage States' knowledge and expertise, as well as existing State programs, laws, and the responsibilities of State insurance departments as much as possible.

Regardless of how the Marketplace is managed, consumers will be able to access the Marketplace with ease. All eligible consumers will be able to use a single streamlined application and select from a variety of qualified plans beginning on October 1, 2013.

Improving Coverage for Consumers through Market-wide Reforms

CMS is working to ensure the plans available for people shopping for individual and small group coverage are affordable and offer coverage for essential health benefits. On November 26, 2012, CMS published a proposed regulation in the Federal Register providing updated insurance rules and protections for people enrolled in non-grandfathered individual and small-group health plans.[4] These protections, such as making it illegal for insurance companies to discriminate against people with pre-existing conditions, will apply to all non-grandfathered policies in these markets, whether or not they are part of the new Marketplace.

In addition, on December 7, 2012, CMS published the proposed Notice of Benefit and Payment Parameters for 2014 in the Federal Register.[5] This proposed rule provides detail for issuers on three programs intended to stabilize premiums and the market while encouraging issuers to enroll all eligible Americans. The permanent risk adjustment program transfers funds from issuers with lower-risk enrollees to issuers with high-risk enrollees, enabling issuers to price their premiums for the average enrollee in the individual and small group markets. This is designed to reduce the incentive issuers have to avoid high-cost enrollees. The temporary reinsurance program makes payments to individual market issuers with higher cost enrollees. Finally, the temporary risk corridors program protects against inaccurate rate setting by limiting the extent of issuer losses and gains. In addition to these programs, the proposed rule provided detail to issuers about how the advanced payment of the premium tax credits and the cost sharing

[4] Health Insurance Market Rules: http://www.gpo.gov/fdsys/pkg/FR-2012-11-26/pdf/2012-28428.pdf
[5] Notice of Benefit and Payment Parameters for 2014: http://www.gpo.gov/fdsys/pkg/FR-2012-12-07/pdf/2012-29184.pdf

reduction payments are proposed to be made to issuers. We are working to finalize these proposed rules in the near term.

Beginning January 1, 2014, all non-grandfathered health insurance plans inside and outside the Marketplace must follow certain standards for plan coverage of essential health benefits. All non-grandfathered plans in the individual and small group markets will cover essential health benefits,[6] which include items and services in ten statutory benefit categories, such as hospitalization, prescription drugs, and maternity and newborn care. These benefits will be equal in scope to a typical employer health plan. These proposed rules for defining essential health benefits balance the statutory ten benefit categories and affordability while providing States – the primary regulators of health insurance markets – with flexibility. The benchmark plan approach creates options for each State that reflect the scope of benefits and services typically offered in the employer market in that State.

Non-grandfathered individual and small-group plans will also standardize the percentage of health care costs they will cover. The Affordable Care Act sets standards for the actuarial values, or the percentage of total average costs for covered benefits that a plan is required to cover. In general, actuarial value can be considered a general summary measure of health plan generosity. Each actuarial value corresponds to a "metal," such as silver or bronze, for ease of consumer comparison. The metal levels for plans in these markets are:

- bronze plan with an actuarial value of 60 percent, where on average, a consumer would be responsible for 40 percent of the costs of all covered benefits;
- silver plan, with an actuarial value of 70 percent, where on average, a consumer would be responsible for 30 percent of the costs of all covered benefits;
- gold plan, with an actuarial value of 80 percent, where on average, a consumer would be responsible for 20 percent of the costs of all covered benefits; and
- platinum plan, with an actuarial value of 90 percent, where on average, a consumer would be responsible for 10 percent of the costs of all covered benefits.

[6] Essential Health Benefits: http://www.gpo.gov/fdsys/pkg/FR-2012-11-26/html/2012-28362.htm

To streamline and standardize the calculation of actuarial values for health insurance issuers, CMS has released a publicly available actuarial value calculator, which issuers can use to determine health plan actuarial values, based on a national, standard population. The proposed rules would also allow States to submit data after January 1, 2015, so that the actuarial value calculator can use a "customized" standard population rather than the national standard population to reflect geographic differences in costs.

Providing Qualified Health Plans in the Marketplace

When consumers visit the new Marketplace on October 1, 2013, they will experience a new way to shop for health insurance plans. In order to build a robust and competitive Health Insurance Marketplace, CMS is working closely with issuers as they prepare qualified health plans that will be available to consumer within the Marketplace. It is important that consumers can select from a variety of high quality, affordable plans. We are also working with health insurance issuers offering coverage outside the Marketplace to ensure that consumers across the board have access to quality coverage.

From the beginning, CMS has been committed to flexibility for States. According to the Final Rule that CMS issued in March 2012,[7] a State that has chosen to run its own Marketplace may establish additional standards for qualified health plans offered in the Marketplace. States establishing their Marketplace are able to work with health insurance issuers to structure qualified health plan choices in the Marketplace that are in the best interest of the State's customers. This could mean that the State establishing its Marketplace allows any health plan meeting the standards to participate in the Marketplace, or it could mean that the State requires health plans to compete to gain access to customers purchasing coverage in the Marketplace. The Final Rule also allows state insurance departments to set specific standards to ensure each qualified health plan gives consumers access to a variety of providers within a reasonable amount of time. Each Marketplace may set the timeframes in which health insurance issuers need to become accredited for their quality performance (if they are not already), allowing

[7] Establishment of Exchanges and Qualified Health Plans Final Rule, http://www.gpo.gov/fdsys/pkg/FR-2012-03-27/pdf/2012-6125.pdf

consumers in the Marketplace to access new and innovative qualified health plans as they gain accreditation.

States have already had health insurance issuers express interest in operating in a State's Marketplace. States that are running their own Marketplaces are managing plans in different ways. For instance, in Massachusetts, qualified health plans offered in the Marketplace will have very specific features. In Nevada, any insurer offering qualified plans may sell its plans, while in California, there is a statutory requirement for the Marketplace to operate as large employers often do in using market leverage and the tools of managed competition to negotiate product offerings with issuers.

CMS has worked with issuers to ensure consumers will have access to many different types of qualified health plans when they come to each Marketplace to shop for health insurance. For example, since May 2012, CMS has consulted with issuers on technical matters related to the eligibility and enrollment process standards for the Marketplaces and has responded to issuer questions and listened to their ideas and feedback. CMS has also provided targeted, comprehensive issuer trainings. CMS has contracts in place to help certify the qualified health plans offered in the Federally-facilitated Marketplace.

Applying for Affordable Health Coverage in the Marketplace

CMS and our State partners have taken a number of steps to ensure that each Marketplace is ready to help consumers find and enroll in private health insurance plans. When consumers visit the website of their Marketplace on October 1, 2013, they will be able to submit an application, find the qualified health plans and financial support available to them; and compare and choose a qualified health plan based on quality, benefits, and cost. This is true regardless of how their Marketplace is run. Consumers can complete a single, web-based, streamlined application[8] to receive an eligibility determination for health benefits coverage and financial help. HealthCare.gov will guide consumers directly to the online application for their State. The

[8] Application Elements: http://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-10440.html

consumer will also be provided clear information about how to complete the application online, apply by phone, or access consumer support.

To develop the applications that individuals and small businesses will use to apply for health benefits coverage in the Marketplaces, CMS consulted with stakeholders, consumer groups, and the National Association of Insurance Commissioners (NAIC) and tested the applications with consumers. CMS released the model applications for public comment on January 28, 2013.[9] The applications will be available for use by States that are running their own Marketplaces, as well as for their Medicaid and CHIP agencies. This means that most individuals can use the same application, and provide information only once, no matter how the individual submits the application and regardless of which program receives the applications. This consumer-focused, unified approach will help millions of Americans enroll in affordable, high quality coverage, while minimizing the administrative burden on States, individuals, and health plans. The applications, along with guidance for States about the applications, will be available in the spring after the current comment period on the model application closes and additional consumer testing is completed.

After a consumer fills out the single, streamlined application, the Marketplace will verify applicant information with existing electronic data sources from Federal and State agencies and commercial entities; this information will be subjected to strong privacy and security protections and its disclosure among the Federal agencies will be subject to compliance with the Privacy Act and all other relevant confidentiality statues and regulations. Consumers will be able to notify their Marketplace of any changes in their status, including marriage, divorce, or a job or income change, that might affect their eligibility easily.

The Marketplace will verify information related to citizenship or immigration status, residency, access to minimum essential coverage, income, and other eligibility factors. Consumers also will be able to keep their coverage from year to year through a simple eligibility redetermination

[9] Video Demonstration of the Application for Comment: http://www.youtube.com/user/CMSHHSgov

process. The Final Rule establishing the standards for the Marketplaces[10] outlined the processes that will guide these eligibility determinations.

Regardless of who operates the Marketplace, CMS is working to ensure streamlined and secure access to a variety of information sources that are essential for operation. CMS is building a single Data Services Hub that all Marketplaces in every State can access. The hub will verify consumer information through one connection to the Social Security Administration, Department of Homeland Security, Internal Revenue Service (IRS), and other sources. The Marketplace will comply with the existing IRS safeguard program to ensure that this tax data is protected. Additionally, the hub will support information exchanges between States, CMS, and IRS to determine available premium tax credits. All verification will be subject to compliance with the Privacy Act and all other relevant confidentiality statutes and regulations.

In the hub, data will be routed, and not stored in the system, ensuring that the data flows where it is needed. The hub will access only the information needed to determine individual eligibility and will not be involved in the selection or certification of health plans.

We have completed the hub's technical design, and have almost completed the services related to Federal and State agency interactions. We have completed a framework for security across agencies and established protocols for connectivity. We have begun to test the hub across agencies and will soon begin to test the hub with States that are the furthest along with implementing their Marketplaces, and will continue testing throughout the year. The hub will begin officially supporting the verification of applicant information on October 1, 2013, when open enrollment begins.

Through these streamlined processes, consumers will be able to fill out an application quickly, receive information about whether they are eligible for premium tax credits or cost-sharing reductions or Medicaid, and begin shopping for qualified health plans, all in one sitting. Consumers can submit an appeal if they disagree with the eligibility determination they receive.

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[10] Establishment of Exchanges and Qualified Health Plans Final Rule, http://www.gpo.gov/fdsys/pkg/FR-2012-03-27/pdf/2012-6125.pdf

As set out in a in recent proposed rule,[11] a State that is running its own Marketplace has an option to establish an eligibility appeals process, in which case, CMS would provide a second-level appeal, if requested by an applicant. If a State chooses not to establish an eligibility appeals process under the proposed rule, then CMS would provide a single level of appeal for the State's Marketplace.

Choosing a Qualified Health Plan through the Marketplace

Eligible consumers will go through a streamlined system, either on the Marketplace website or through a toll-free call center, to choose health coverage that best fits their needs. Consumers will be able to research and compare the available qualified health plan options in the Marketplace so they can make informed choices about their coverage. States are customizing their Marketplace websites in order to best meet the needs of their residents. Similar to the eligibility process, the final Marketplace rule ensures Marketplaces develop and follow high standards regarding the privacy and security of personal information while following Affordable Care Act requirements regarding the use of data.

If a consumer or small business needs help understanding the coverage options offered in the Marketplace, a variety of services will be available to assist them, including online and telephone support. These services will be culturally and linguistically appropriate.

The Navigator program included in the Affordable Care Act will play an important role in educating and helping consumers. For the Federally-facilitated Marketplace, CMS will award the first grants for the Navigator program in June 2013, and training for the Navigator program is under development. Navigators will help consumers by maintaining an expertise about the Marketplace, and by providing information in a fair, accurate, and impartial manner. We will soon be releasing additional guidance on the Navigator program and other assistance programs that consumers will be able to access when shopping for coverage in the new Marketplaces. These programs will also provide help for Medicaid-eligible consumers by walking them through the Medicaid or CHIP enrollment process, or referring them to appropriate resources. Many State Medicaid and CHIP agencies have a long history of enabling providers and other

[11] CMS-2334-P http://www.ofr.gov/OFRUpload/OFRData/2013-00659_PI.pdf

organizations to serve as "application assisters" to provide direct assistance to individuals seeking coverage, and we plan to create similar capabilities for counselors to promote enrollment among individuals in the Marketplace.

Additionally, licensed agents brokers, and online brokers may assist consumers and employers with enrolling in a qualified health plan through the Marketplace. CMS will provide agents and brokers with a portal to the Federal Marketplace website, HealthCare.gov, if the agents and brokers meet the applicable standards required to assist consumers within the Federally-facilitated Marketplace. This Federal web portal will allow agents and brokers to help individuals apply for Federal financial help, and if applicable, select and enroll in a qualified health plan through the Federally-facilitated Marketplace. All agents and brokers who assist individuals and employers in enrolling in qualified health plans through the Marketplace must adhere to applicable State law and regulations.

Educating the Public about the Marketplace

CMS and our State partners are working hard to ensure that people who do not currently have employer-sponsored health insurance are aware of the new tools that will soon be available for them. On HealthCare.gov, people can learn about the Affordable Care Act, review health insurance basics such as understanding what their coverage costs, and interact with a checklist on how to prepare for shopping for coverage on the new Marketplace. On HealthCare.gov[12] and on the HealthCare.gov YouTube channel[13] there are several short videos explaining how shopping for qualified health plans in the Federally-facilitated Marketplace will work.

Our outreach goes beyond the internet. We are using CMS's experience from the implementations of CHIP and Medicare Part D along with input from States and stakeholders to create a consumer outreach and education plan rooted in consumer research, audience segmentation analysis, and State governments' knowledge about the best ways to reach their residents. We are challenging the States that are running their own Marketplaces and those that

[12] http://www.healthcare.gov/marketplace/index.html
[13] http://www.youtube.com/user/HealthCareGov

are working with the Federal Government to reach out to communities and consumers in innovative ways.

CMS is also enlisting allies in Federal agencies and the private sector to reach, engage, and assist potential enrollees. We have an inter-department working group with a wide range of Federal agencies to develop ideas and plans to encourage enrollment and distribute information. Other programs can provide Marketplace referral information in regular notices to clients, post Marketplace information on agency websites, and use local and regional offices to inform and reach out to specific populations. CMS is also working with private partners, including non-profits, provider and trade associations, advocacy groups, corporations and businesses, and faith- and school-based groups to distribute information, encourage enrollment, and support community engagement.

Conclusion

CMS, our State partners, and other stakeholders have been hard at work developing these new Marketplaces since the passage of the Affordable Care Act nearly three years ago. We are developing the architecture that will allow the Marketplace to function, and we are working to develop required systems that will ensure income and eligibility is verified correctly, and all data is secure and that consumers have a seamless experience. Additionally, CMS has been working closely with States that are running their own Marketplaces to provide technical assistance and share information about technology to ensure that every State can smoothly begin open enrollment on October 1, 2013. For example, in 2012 alone, CMS held hundreds of hours of webinars, teleconferences, and meetings, in which thousands of State employees have participated. The progress already made and the foundations we have developed give us confidence that the Marketplace will be ready for consumers on October 1.

As consumers begin to enroll on October 1, their experience will be streamlined, with one application to one Marketplace that provides a variety of high quality, affordable coverage options. Consumers can be sure a qualified health plan purchased on the Marketplace will cover important health care needs that will arise. If a family member has a pre-existing condition, coverage will be available. Work remains in the coming months, and I look forward to continuing to work with the Committee on implementing this important law.

United States Senate Committee on Finance
Public Hearing
"Health Insurance Exchanges: Progress Report"
February 14, 2013

Responses to Questions Submitted for the Record From Gary Cohen

Senator Max Baucus:

Exchanges Overview

Exchanges will allow individuals and eligible employers to compare and select from qualified health plans for their families and employees. While the Affordable Care Act (ACA) affords States the opportunity to run their own exchange, it defaults to a Federally Facilitated Exchange in those States that don't opt to run their own exchange. There are three types of exchanges: State-based exchanges; Partnership Exchanges; and Federally Facilitated Exchanges. In addition, States must establish Small Business Health Options Program (SHOP) exchanges for small businesses with up to 100 employees to purchase group coverage.

1) **Given there are different types of exchanges, and variation within each State, please describe the exchanges (State-based, partnership, federally facilitated and SHOP) and discuss CMS' approach in working with States to establish across each system.**

Answer: State-based Marketplaces are those that are operated by States within the framework established by the Centers for Medicare & Medicaid Services (CMS) through regulations, guidance, and technical assistance to States. States that are running their own Marketplaces are managing qualified health plans (QHPs) in different ways and are taking different approaches to governance and consumer outreach.

Partnership Marketplaces are those in which a State has chosen to partner with the Federal Government to operate certain portions of a Marketplace. Under a Plan Management partnership, CMS will supply the infrastructure of the Marketplace, including the eligibility and enrollment system; a State will conduct all analyses and reviews necessary to support QHP certification, collect and transmit necessary data to HHS, and manage certified QHPs. Under a Consumer Assistance Partnership, CMS will select and award grants to Navigators; a State will manage the Navigators on a day-to-day basis, will build an additional consumer assistance program, and may elect to conduct some marketing and branding activities. These partnerships can serve as paths for States that are transitioning towards running their own Marketplaces in future years.

A Federally Facilitated Marketplace (FFM) will be operated by CMS in States that do not elect to establish a State-based Marketplace. CMS is hard at work establishing the FFMs by certifying QHPs, creating and testing the user experience, ensuring the security of the Marketplace portal, and conducting outreach and education so consumers who will buy coverage through the Marketplace know how to access and use it. CMS is structuring the FFM in a manner that

leverages States' knowledge and expertise, as well as existing State programs, laws, and the responsibilities of States' insurance oversight departments whenever possible.

The Small Business Health Options Program (SHOP) Marketplaces will help small businesses that wish to do so provide affordable, quality health insurance coverage for their employees. Eligible small businesses will be able to access tax credits through the SHOP and obtain access to information about coverage options. By pooling people together, reducing transaction costs, and increasing transparency and competition, the Health Insurance Marketplace for individuals and small groups will be more efficient and competitive.

Regardless of whether a State chooses to operate its own Marketplace, partner with CMS, or use a FFM, CMS is working with States to prepare for open enrollment beginning on October 1, 2013. In November 2010, CMS issued initial guidance to States on the Marketplaces and their IT systems.[1] CMS has issued 14 formal regulations, 15 additional guidance documents, and 13 fact sheets. CMS is also working with States on the technical aspects and policy details of the Marketplaces. For example, CMS has offered States a total of 716 technical assistance opportunities, and is working with Consumer Assistance Programs and other available resources in States to assist with consumer outreach. In addition, the single, streamlined application has been released for public comment, and we are testing the data verification and communication technology.

2) **Based on these differences, what is CMS' plan for ensuring consumers in each State are afforded the same opportunities, information, and access to coverage through the different types of exchanges in each State? For example, ensuring that a consumer in Massachusetts (State-based exchange) has access to the same resources and outreach assistance as a consumer in Montana (Federally Facilitated Exchange).**

Answer: Regardless of how a Marketplace is managed, consumers will be able to access the Marketplace by a single, streamlined application, and select from a variety of QHPs starting on October 1, 2013, for coverage beginning January 1, 2014. All Marketplaces will have a call center and a Navigator program to serve as sources of unbiased assistance for consumers. All Marketplaces will also operate websites through which consumers can learn about QHPs and receive eligibility determinations.

3) **From the consumer perspective, describe how CMS envisions the exchange enrollment process working from start to finish.**

Answer: Starting on October 1, 2013, for coverage beginning January 1, 2014, a consumer will be able to log onto HealthCare.gov for each FFM or onto a website operated by a State-based Marketplace and find a single, streamlined application. After entering some basic information about themselves and their family members, including citizenship status and income, applicants will be able to find out whether they are eligible for Medicaid, the State Children's Health Insurance Program (CHIP), or for tax credits that will help with commercial insurance premiums. Consumers eligible for tax credits will be able to browse the Marketplace for their options for QHPs—affordable, comprehensive, high quality health insurance plans that have

[1] http://cciio.cms.gov/resources/files/joint_cms_ociio_guidance.pdf.

been certified by the Marketplace as meeting certain minimum standards. Upon choosing a plan, the consumer's enrollment data will be electronically transmitted to the issuer of the chosen plan, and the consumer will then be directed to the plan's own website to pay the first month's premium.

Outreach and Readiness

The exchanges are critical to ensuring access to affordable health care coverage for all Americans. It is vital that they are up and running on time so people can compare plans and shop for health insurance.

4) What types of consumer outreach is CMS conducting to ensure consumers know about the exchanges and are able to enroll October 1, 2013?

Answer: To prepare for October 1, 2013, CMS is conducting a number of activities to reach out to and educate consumers. CMS has developed HealthCare.gov, where consumers can learn the basics about health insurance and learn more about the Health Insurance Marketplace and other benefits of the Affordable Care Act. CMS is working with agencies including the U.S. Departments of Agriculture (USDA), Housing and Urban Development (HUD), Labor, and Veterans Affairs (VA), and the Small Business Administration (SBA), to educate Americans about their options for enrollment, consistent with those agencies' missions and objectives. CMS is enlisting Consumer Assistance Programs and their non-profit partners to assist with consumer education efforts, and will release Navigator grant awards in the summer of 2013. CMS is also planning to conduct a media campaign to educate consumers leading up to and throughout open enrollment (media includes: digital, radio, television, grassroots, and print).

In States with a FFM, CMS will begin a process in March of engaging with the individuals and organizations that will use the new Health Insurance Marketplace. Engaging with these stakeholders is an important opportunity for HHS to hear their input and communicate how the Marketplace will work and when it will be ready. This engagement, led by CMS regional offices, will be the start of ongoing conversations in the States with a FFM. The CMS regional offices have firsthand experience with starting large scale programs and working with State agencies and local partners.

5) What support, guidance, and tools has CMS given States to conduct such outreach activities?

Answer: CMS continues to provide technical assistance and information to State Consumer Assistance Programs, so they are equipped to assist consumers. CMS has also worked closely with States: in 2012, CMS hosted 213 events for States and held a two-day intensive program for State Marketplaces on January 28–29, 2013. Additionally, funding opportunities have consistently been available to States and territories, including Early Innovator, Exchange Planning, and Exchange Establishment grants.

To educate consumers and help them enroll in health insurance coverage, a Navigator funding opportunity announcement will be released to award these grants in the summer of 2013. State-based Marketplaces are required to provide grant awards to Navigators in their States.

There will be Navigator grants in all States, but direct Federal grants will only go to groups and organizations in States with FFMs, including partnership Marketplaces. The role of the State depends on their Marketplace model. States that choose to operate a State Consumer Partnership Exchange will conduct the day-to-day management of the Navigator program, including ongoing monitoring of Navigator activities and providing technical assistance to Navigators. In a State Consumer Partnership Exchange, Navigators will be funded through Federal grants. It is legally required that HHS retain ultimate authority over the Navigator grant process, including selecting Navigator grantees and awarding Navigator grants, and the approval of grantee activities and budgets.

In addition to Federal assistance, States are taking innovative approaches to hiring and funding consumer assistance programs—for example, some are applying for private foundation funding. We will soon be releasing guidance on Navigators and other consumer assistance programs.

Federally Facilitated Exchanges

26 States will utilize a Federally Facilitated Exchange. In these States, the Federal government will assume primary responsibility to operate the exchange.

6) **Montana will operate a Federally Facilitated Exchange. How is CMS working with States to ensure a sharing of information and resources in order to establish Federally Facilitated Exchanges?**

Answer: In March 2013, CMS will begin a process of engaging with the individuals and organizations in FFM States that will use the new health insurance Marketplace. Engaging with these stakeholders is an important opportunity for HHS both to hear their input and to communicate how the Marketplace will work and when it will be ready. This engagement, led by HHS regional offices, will be the start of ongoing conversations in the States. The regional offices have firsthand experience with starting large scale programs and working with State agencies and local partners.

7) **What types of resources are available to consumers in Federally Facilitated Exchanges to help with enrollment, eligibility, and general exchange-related questions and consumer needs?**

Answer: Regardless of how a Marketplace is managed, consumers will be able to access the Marketplace by using a single streamlined application and will be able to select from a variety of qualified plans beginning on October 1, 2013. In the summer of 2013, CMS will release the Navigator grant awards for FFM and Partnership States. These Navigators will help consumers through the application process. Finally, consumers will be able to either call a toll-free number with general questions about the Marketplace, or visit HealthCare.gov.

Federal Data Hub

A key function to the exchange readiness is the Federal data hub. This hub will transmit consumer information from Federal agencies to States and insurers to facilitate enrollment and eligibility.

8) How is CMS ensuring that the Federal data hub will be ready for open enrollment on October 1, 2013?

Answer: CMS is taking steps to ensure the readiness of the Federal Data Services Hub (Hub) for open enrollment. In January 2012, we awarded QSSI the contract to build the Hub. We have already begun interagency Hub testing: Internal Revenue Service (IRS) testing began in November 2012, testing with the Social Security Administration (SSA) and the Department of Homeland Security (DHS) will take place in the winter and in the spring of 2013, and testing for other agencies will begin in the spring of 2013.

9) What Federal agencies will feed information into this system? How will the transmission of this data from the Federal agencies operate in the exchange?

Answer: Federal agencies will respond to requests from Marketplaces for various authoritative data held by IRS, SSA, and DHS, as well as the Department of Defense (DoD), VA, the Office of Personnel Management (OPM), and the Peace Corps, to verify eligibility.

Transmission of data will operate in the exchange as follows:

During the process whereby a consumer is engaged in using the single, streamlined application for enrollment in a QHP and for insurance affordability programs, the Marketplace system coordinates a set of queries/requests for validating data that are routed via the Hub to the appropriate authoritative Federal source of information, and a response is then passed back through the Hub to facilitate the verification of information needed for the eligibility process. This information includes: validation of Social Security numbers, citizenship and immigration status, income, and access to Minimum Essential Coverage. The Hub will also provide a service for the calculation of the maximum amount of advance payments of the premium tax credit for which an applicant is eligible. All of the data transmissions are conducted in a secure fashion per Federal Information Security Management Act (FISMA) requirements and section 6103 of the Internal Revenue Code (confidentiality and disclosure of returns and return information).

10) How will CMS ensure consumer privacy in transmitting such data through the Federal exchange data hub?

Answer: It is important to understand that the Hub is not a database; it does not retain or store information. It is a routing tool that can validate applicant information from various trusted government databases through secure networks. The privacy and security of consumer data transmitted through the Hub is a top priority for CMS and other Federal and State agencies. Consumer data in the Hub is safeguarded and secured through processes, controls, and standards that will be used not only by CMS but also by Federal agency partners including IRS and SSA. CMS will use a layered security approach to protect personal information. This layered approach includes presentation of a secure web interface, use of secure transmission protocols, and validation of identity. Once information is captured, it is then protected through a wide variety of security measures and counter-measures during the entire time the data is being used within the Marketplace. CMS also reviews its internal security policies and procedures each year and updates them accordingly to ensure a comprehensive information security program is in place and remains relevant and responsive to today's emerging threats. In addition, CMS and

IRS have worked together to develop additional safeguards to protect sensitive tax return data that will be accessed in the Marketplace. CMS is also making use of commercial sources of information as an additional identity-proofing measure—an approach that has been successful with other Federal government websites, such as SSA's "my Social Security."

Senator Orrin Hatch

Agency Coordination and Inter-Departmental Implementation

11) In response to a question I raised at the hearing, you indicated that all agencies supplying information for the Federal Data Services Hub have signed service level agreements. Please provide a date for when those agreements were signed by each agency and a copy of each agreement.

Answer: In order to exchange data among Federal agencies, CMS needs to establish a series of agreements, business processes and formatting rules and protocols to ensure that data is exchanged securely and that interfaces between the Hub and our partner agencies work properly. There are multiple types and levels of agreements that work together to facilitate the exchange of data. These include:

- Service Level Agreements, which establish procedures for mutual cooperation between the relevant organizations;
- Business Service Definitions, which ensure that cross-agency business processes and data sharing are based on common understandings so that technology decisions and that agency systems development efforts are in-sync;
- Interface Document Controls, which provide a common set of formats, methods, and protocols to effectively define the interface between the Hub and other partner Federal organizations.

CMS began formalizing these processes and rules with our Federal partners in July of 2011 and has refined and updated them as the work to design and build the necessary interfaces has progressed.

12) In your testimony you state that there is an inter-departmental working group that includes a wide range of Federal agencies. Please provide a list of the agencies that are members or participants of the inter-departmental working group.

Answer: The purpose of the inter-departmental working group is to leverage available resources across the Federal Government to ensure that the goals of the Affordable Care Act are met. Since a wide variety of agencies may come into contact with uninsured individuals, they can help CMS reach the broadest audience possible, consistent with their own missions and objectives. Below is a list of the participating Federal executive departments and executive agencies or operating divisions assisting with efforts to educate Americans about the Affordable Care Act:

USDA
Department of Commerce
  Census Bureau
DoD (Tricare)
Department of Education
HHS
  Substance Abuse and Mental Health Services Administration
  CMS

DHS
HUD
Department of Justice
Department of Labor
Department of State
Department of Transportation
Department of Treasury
  IRS
VA
Corporation for National and Community Service
Environmental Protection Agency
Executive Office of the President
  Office of Management and Budget
  Office of National Drug Control Policy
General Services Administration
OPM
SBA
SSA
U.S. Agency for International Development
U.S. Postal Service
Government Accountability Office

13) The implementation of exchanges requires the development of complex software and data systems that determine eligibility, facilitate enrollment and manage conversations with the States and territories. Please explain how the Administration has organized itself to implement the exchange undertaking. Specifically, who has authority to finalize decisions related to policy issues, for translating those decisions into operational requirements, for communicating those decisions to the States and for executing the necessary interfaces with different State systems?

Answer: Marketplace implementation activities are mainly the responsibility of HHS, but for work that involves other Federal agencies, HHS works collaboratively with those relevant agencies. Marketplace implementation activities follow the same decision and clearance process as other activities relating to HHS programs where decisions are made by HHS and CMS leadership and then executed by various components within CMS. The work of implementing the Marketplace crosses several components in CMS. The Center for Consumer Insurance Information and Oversight (CCIIO) is responsible for implementing many provisions of the Affordable Care Act through developing regulatory guidance and coordinating the business side of building systems. The Office of Information Services works in collaboration with CCIIO to develop the IT infrastructure of the Marketplace systems. The Center for Medicaid and CHIP Services is responsible for implementing provisions affecting Medicaid and CHIP. In addition, Marketplace implementation requires cross-component work with the Office of Grants and Management, which is responsible for all contracts, and the Office of Communications, which manages the public-facing component of the Marketplace.

14) By what date do you intend to have finalized the development of all of the necessary software, the building of all necessary Federal information technology (IT)

infrastructure and the resolution of all database connectivity issues between Federal agencies and between the Federal government and the States and territories? Is this timeline consistent with the timelines that are considered standard industry practice for an undertaking of this nature? Have you built in a margin of error for various types of problems that may not be anticipated at this time but are common in a project of this scope and breadth, such as interoperability issues or software glitches?

Answer: By September 2013, CMS intends to have finalized the development and testing of the information technology infrastructure for the FFM, as well as for the Hub. Testing has already begun and is ongoing, which will ensure sufficient time to address any problems that may arise.

15) Will the eligibility determination for cost-sharing reductions (CSR) be aligned with the same eligibility criteria used by the Internal Revenue Service (IRS) for advance premium tax credits (APTC)? How will CSR payments be administered?

Answer: Section 1402 of the Affordable Care Act provides for the reduction of cost sharing for certain individuals enrolled in a QHP through a Marketplace, and section 1412 provides for advance cost-sharing reduction payments to issuers. Section 1402 further provides that eligibility for cost-sharing reductions is tied to eligibility for the premium tax credit, and uses the same methodologies for household size and household income as are specified for the premium tax credit. As proposed in the 2014 Payment Notice (77 FR 73118), issuers will reduce cost sharing for essential health benefits for individuals with household incomes between 100 and 250 percent of the Federal poverty level (FPL) who are enrolled in a silver level QHP through an individual market exchange and are eligible for advance premium tax credit payments. The statute also directs issuers to eliminate cost sharing for Indians (as defined in section 4(d) of the Indian Self-Determination and Education Assistance Act) with a household income at or below 300 percent of the FPL who are enrolled in a QHP of any "metal" level (that is, bronze, silver, gold, or platinum) through the individual market in the exchange. Monthly advance cost-sharing reduction payments will be made to issuers based on estimates of cost-sharing reductions for individuals enrolled in their plans. At the end of the year, the cost-sharing reduction amounts will be reconciled to actual cost-sharing reduced.

15a) How will CSR payments be administered?

Answer: In the Marketplace Establishment Rule (77 FR 18310), we set forth eligibility standards for cost-sharing reductions. When an individual applies for coverage through the Marketplace and requests an eligibility determination for insurance affordability programs, the individual's eligibility for cost-sharing reductions will be determined.

In the 2014 Proposed Payment Notice we proposed that individuals eligible for cost-sharing reductions will be offered variations of the QHPs, with the cost-sharing structures modified to reflect the actuarial value for which the individual is eligible (silver plan variations, zero cost sharing plan variation, or limited cost sharing plan variation).

Amounts estimated to cover the cost-sharing reductions associated with the specific plan variation would be paid in advance to the issuer. We proposed that this advance cost-sharing reduction payment to the issuer would occur monthly, and that after the end of the benefit year,

the Federal government would reconcile the advance cost-sharing reduction payments to actual cost-sharing reduction amounts.

16) How is CCIIO ensuring a level playing field with qualified health plans (QHPs) and Multi-State Plans (MSPs) offered under the Multi-State Plan program (MSPP) since the law states that the Office of Personnel and Management (OPM) has the authority to modify the requirements of plans as it relates to essential health benefits, actuarial value and numerous other authorities allowing for different plan standards?

Answer: CCIIO is working closely with OPM, which is charged by section 1334 of the Affordable Care Act with implementing the Multi-State Plan Program (MSPP). The goal of the MSPP is to foster competition among plans in the individual and small group Health Insurance Marketplaces in all States and the District of Columbia, without providing a competitive advantage or disadvantage to the Multi-State Plan (MSP) options. OPM has established working relationships with officials in State regulatory agencies and Marketplaces. These activities, among others, are designed to ensure that MSP issuers are neither advantaged nor disadvantaged over QHP issuers and other issuers.

OPM will establish a dispute-resolution process by which a State may request that OPM reconsider a determination that a State law does not apply to MSPs or MSP issuers. This process will offer a formal avenue for States to raise concerns about the MSPP to OPM and to have those concerns adjudicated. CCIIO is working closely with our colleagues at OPM to ensure a level playing field with QHPs in the Marketplace.

Federally Facilitated Exchange (FFE) Infrastructure and Operations

Information provided by CCIIO in response to my requests for information on the FFE has been insufficient. Below is a list of requests I have made that have either not been answered or not answered in full. Please provide the following information:

17) An annual budget estimate to maintain the FFE.

Answer: The President's FY 2013 Budget included an additional $1 billion for CMS Program Management, most of which was for CMS Marketplace costs.

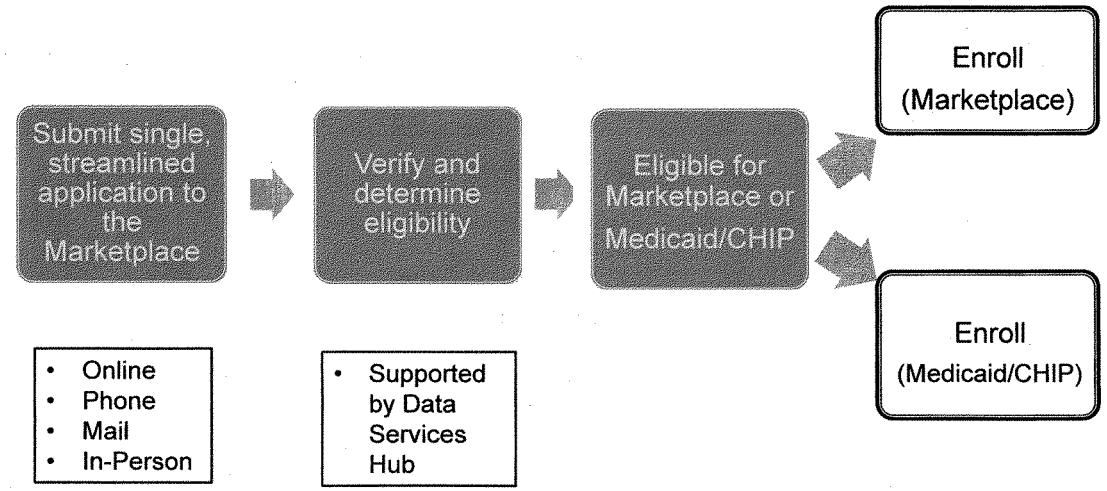
18) An accounting of all funds obligated related to the establishment of the FFE and the Federal Data Services Hub.

Answer: CMS has spent about $400 million on contracts to carry out activities to establish the Federally Facilitated Marketplace, the Hub, and other related activities.

19) A flow chart that describes what will occur once an individual application is submitted and begins to go through the eligibility determination process all the way through to when the application is approved.

Answer: Please see attached chart that provides an overview of the application and eligibility process. The electronic application process is designed to minimize burden on consumers by

APPLICATION AND ELIGIBILITY



integrating verifications as information is provided, and moving forward based on information provided by consumers and verified through Federal and other data sources dynamically.

At a high level, after an account is created and the application filer agrees to the privacy statement, the application filer indicates whether they are applying for insurance affordability programs (advance payments of the premium tax credit (APTC), cost-sharing reductions (CSR), Medicaid, and CHIP) for themselves and others in the household. This choice frames the information that will be captured on the application, as well as the verifications will occur. Whether applying for insurance affordability programs or not, the next step of the process is to collect necessary information regarding the individuals who are applying for coverage, as well as other individuals who are included in the household for the purposes of determining eligibility. This enables the Marketplace to determine the group of individuals whose income will be counted. During this step, the Marketplace will also collect and verify Social Security numbers, and confirm attestations of citizenship/immigration status with SSA and DHS for individuals who are seeking coverage.

If the application includes a request for an eligibility determination for insurance affordability programs, the next step of the process is income verification. In this section, the Marketplace will obtain available data regarding income from IRS, SSA, and a commercial data source, and will collect attestations from the application filer regarding projected annual household income and current monthly household income. The Marketplace will use automated rules to compare available data with the attestations and evaluate whether additional information is needed from the application filer to verify household income.

Based on the income process, the Marketplace will evaluate whether each applicant has income in the applicable Medicaid/CHIP range, or in the APTC/CSR range. From there, the dynamic application will solicit information specific to Medicaid/CHIP or APTC/CSR based on income. For an individual who has income in the APTC/CSR range, the application will collect information regarding access to various forms of minimum essential coverage, and verify this information using data from the SHOP, Medicare, Medicaid, CHIP, OPM, DoD (Tricare), VA, and the Peace Corps. The Marketplace will also collect an attestation regarding whether an individual is incarcerated, and use information obtained from SSA to confirm this attestation.

At this point, the Marketplace will have the information needed to make an eligibility determination for enrollment in a QHP through the Marketplace, an assessment or determination (based on the election of a State) for Medicaid and CHIP, and a determination for advance payments of the premium tax credit and cost-sharing reductions.

For those applicants who are determined eligible for enrollment in a QHP through the Marketplace, the Marketplace will check to see whether the window for plan selection is open, which will occur from October 1, 2013 through March 31, 2014 for the first year, from October 15 through December 7 for subsequent years, and also when life changes and other special events occur. For any individual who was assessed or determined eligible for Medicaid or CHIP, the Marketplace will transmit application and other information to the State Medicaid or CHIP agency, which will follow up with the applicant. In addition, the Marketplace will provide each application filer with a notice describing the outcome of the eligibility process, including

any situation in the Marketplace concluded that additional information is needed, along with instructions on how to resolve the outstanding issues.

If an applicant is determined eligible for enrollment in a QHP through the Marketplace and is within a plan selection window, this notice will also advise him or her regarding how to select a plan.

Please note that if an application does not include a request for an eligibility determination for insurance affordability programs, the Marketplace will not collect information or conduct verifications regarding household income and access to other health insurance, and will not evaluate eligibility for APTC, CSR, Medicaid, or CHIP.

20) An outline of the operational capabilities and functions of the Federal Data Services Hub.

Answer: The Hub is an important part of the infrastructure that will enable all Marketplaces, regardless of model, and State agencies administering Medicaid and CHIP, to provide accurate and timely eligibility determinations. Functioning as a sophisticated router system, the Hub will enable Marketplaces and State agencies administering Medicaid and CHIP programs to securely obtain information from Federal data sources such as IRS, SSA, and DHS to confirm key elements of the application, including citizenship status and income. The Hub will not store any personal information; it will merely route specific eligibility questions to the relevant Federal entity and provide responses to the Marketplaces and State agencies.

21) A list of agencies that will interact with the Federal Data Services Hub.

Answer: SSA, IRS, DHS, VA, OPM, DoD (Tricare), and Peace Corps.

22) A date for when we can expect to have the Federal Data Services Hub operational and available to stakeholders.

Answer: We expect the eligibility and enrollment services the Hub performs to be ready by October 1, 2013. Specifically, interagency testing with Federal agencies leveraging the Hub, including IRS, SSA, and DHS, has been underway since November 2012. Formalized testing that includes tracking readiness indicators will occur in approximately four phases beginning in mid-March 2013 with a small group of States.

23) How the FFE will interact with State Insurance Commissioners in States not implementing the law.

Answer: As CMS articulated in the May 2012 in the FFM guidance,[2] there are four guiding principles in the implementation of the FFM. They include: commitment to consumers, market parity, leveraging the traditional State role, and engagement with States and other stakeholders. To the greatest extent possible, CMS intends to work with States to preserve the traditional role and responsibilities of State insurance departments, and we will seek to harmonize policies in the

[2] http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/ffe-guidance-05-16-2012.pdf.

FFM. For example, CMS will not duplicate as part of its QHP certification process reviews conducted by State departments of insurance under State law and authority. CMS has been engaged in State-specific consultations with a variety of State staff, including but not limited to staff at State departments of insurance, to plan the QHP certification process and jointly identify potential interactions between State laws and processes and Federal standards. In addition, CMS continues to provide technical assistance to State departments of insurance to assist these staff in preparing for the 2014 plan year.

24) How the FFE will sell insurance in a State that will not approve a QHP.

Answer: As you know, State departments of insurance (DOIs) are responsible for the regulation of licensed issuers in a State. QHP issuers, like all other health insurance issuers in a State must be licensed to offer health coverage in a State; CMS cannot certify as a QHP any health plan offered by an issuer that is not licensed by the appropriate State regulator(s). We expect a State DOI to continue to perform its usual functions, including approval of policy forms and rates (if applicable) to ensure that licensed issuers can continue to do business in 2014, whether inside or outside an exchange.

25) If a decision is not provided in real time, how long consumers will need to wait for the agencies to reconcile enrollment application information and make a final decision.

Answer: We will process the vast majority of applications in real time. When there is an inconsistency between an applicant's attestation regarding a factor of eligibility and a data source, the Marketplace, Medicaid agency, or CHIP agency will notify the individual and provide him or her with a period of time to provide satisfactory documentation or otherwise resolve the inconsistency. This can include working with SSA or DHS, for example, to correct information in their records. The processes for inconsistency are laid out in the Exchange Final Rule at 45 CFR 155.315(f). When an inconsistency is related to a Social Security number, or citizenship or immigration status, the applicant has 90 days to resolve the inconsistency, with the possibility of a "good faith" extension (45 CFR 155.315(e)). The statute and regulations specify that, during this period, the applicant will receive a determination about eligibility for enrollment in a QHP, advanced premium tax credit (APTC), cost-sharing reduction (CSR), Medicaid, or CHIP. This is also the process specified in statute for inconsistencies that are related to other factors of eligibility for individuals who are otherwise eligible for enrollment in a QHP with or without APTC and CSR. For inconsistencies that are related to factors of eligibility other than a Social Security number, or citizenship or immigration status for individuals who are otherwise eligible for Medicaid or CHIP, pre-Affordable Care Act regulations provide for a shorter resolution period, and a determination regarding eligibility for Medicaid or CHIP is not provided until the inconsistency is resolved.

26) How application data will be protected to ensure no unauthorized access to such data.

Answer: It is important to understand that the Hub is not a database; it does not retain or store information. It is a routing tool that can validate applicant information from various trusted government databases through secure networks. The privacy and security of consumer data in the Marketplace is a top priority for CMS and other Federal and State agencies. Consumer data in the Marketplace is safeguarded and secured through processes, controls, and standards that

will be used not only by CMS, but also by Federal agency partners including IRS and SSA. CMS will use a layered security approach to protect personal information which includes presentation of a secure web interface, use of secure transmission protocols, and validation of identity. Once information is captured, it is then protected through a wide variety of security measures and counter-measures during the entire time the data is being used within the Marketplace. CMS also reviews its internal security policies and procedures each year, and updates them accordingly to ensure a comprehensive information security program is in place and remains relevant and responsive to today's emerging threats. In addition, CMS and IRS have worked together to develop additional safeguards to protect sensitive tax return data that will be accessed in the Marketplace. CMS is also making use of commercial sources of information as an additional identity-proofing measure. This approach has been successful with other Federal government websites, such as SSA's "my Social Security."

Other Functions

CCIIO has identified Section 1311(d)(5)(A) of the Patient Protection and Affordable Care Act (PPACA) as the statutory authority to collect user fees and indicated that funds provided through the user fee will be used for "qualified health plan certification, administration of APTCs, cost-sharing reductions, Navigators, and other functions."

27) Please provide a complete list of what CCIIO means by "other functions."

Answer: CMS has proposed collecting a 3.5 percent of premium user fee on participating issuers in the FFM-E as specified in the proposed 2014 Payment Notice, available at 77 FR 73118. The user fee may fund the following:

- Provision of consumer assistance tools;
- Consumer outreach and education;
- Management and operation of a Navigator program;
- Oversight of agents and brokers;
- Eligibility determinations;
- Administration of advance payments of the premium tax credit and cost-sharing reductions;
- Enrollment processes;
- Certification processes for QHPs (including ongoing compliance verification, recertification and decertification); and
- Administration of a SHOP exchange.

FFE

Your testimony highlights that States are given options between whether the exchange is an active purchaser or a passive market facilitator, and other specific policy decisions that are left up to the State related to accreditation and additional QHP standards.

28) When will the Administration outline the decision of the FFE as it relates to the options left up to each individual exchange?

Answer: CMS outlined the FFM purchasing policy for 2014 on May 16, 2012.[3] To ensure a robust QHP market in each State where an FFM operates, and to promote consumer choice among QHPs, in the first year, HHS intends to certify as a QHP any health plan that meets all certification standards. HHS will analyze the QHP certification process and may identify improvements or changes to this process, as appropriate.

CMS will release a Letter to Issuers outlining our planned approach for QHP certification, and how CMS will interact with States in the FFM and Partnerships. As noted in previously released guidance, Plan Management State Partnership Marketplaces have some flexibility in their application of QHP certification standards. States in which a State Partnership Marketplace is operating may use CMS's planned approach to conduct QHP certification reviews and arrive at certification recommendations, or adopt another approach that is consistent with the Federal standards.

CMS does not intend to duplicate reviews of potential QHPs conducted under State authority or as part of a State's enforcement of 2014 market reforms (*e.g.*, essential health benefits and actuarial value standards). CMS expects that States will enforce 2014 market reforms; accordingly, CMS expects to rely on States' reviews of market reforms as part of its QHP certification process. In the limited number of States that have indicated that they do not intend to enforce market reforms, CMS will be responsible for enforcement.

29) Will the decision be made in coordination with each of the 26 FFE States?

Answer: CMS is committed to stakeholder consultation as we implement the Affordable Care Act. We have undertaken extensive stakeholder consultation during the Marketplace rule making process, and solicited comments on FFM guidance. We will enhance our outreach and education efforts as we move toward open enrollment in 2013 and will seek to join State and local partners in that effort.

CMS will continue to issue guidance in the near future on stakeholder engagement, FFM operations, QHP certification, and issuer applications.

30) Will the decision be different for each of the 26 States?

Answer: Per section 1321(c) of the Affordable Care Act, CMS will establish the Marketplace if the States elects not to do so. CMS has to balance administrative economies of scale in the FFM with any potential State-specific decisions. CMS will continue to issue guidance in the near future on stakeholder engagement, FFM operations, QHP certification, and issuer applications. Please note, that the FFM will implement a number of State-specific eligibility rules for Medicaid and CHIP, and the State Medicaid and CHIP agencies will decide whether the FFM makes assessments or determinations of eligibility for Medicaid and CHIP based on modified adjusted gross income.

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[3] http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/ffe-guidance-05-16-2012.pdf.

Your Mr. Smith Example

The example you provided with Mr. Smith left me with a number of questions:

31) Is healthcare.gov the FFE website for all 26 States?

Answer: Yes.

32) Was the test-run for Mr. Smith completed using the same IT infrastructure that will be used October 1 for open enrollment?

Answer: The Mr. Smith example is a hypothetical example, intended to explain how consumers will interact with the Marketplace starting on October 1, 2013.

33) Is the FFE IT infrastructure complete and able to provide an individual an eligibility determination? If not, how was CCIIO able to conduct the test?

Answer: The FFM IT infrastructure is not yet complete, though testing has begun and will continue through Spring 2013.

34) Is the Federal Data Services Hub IT infrastructure complete and able to provide the exchange an eligibility determination? If not, how were you able to conduct the test?

Answer: The Hub is not yet complete, though testing has begun and will continue through Spring, 2013.

35) How many questions did Mr. Smith have to answer to determine eligibility for federally funded programs?

Answer: The Mr. Smith example was a hypothetical illustration. Models for the single, streamlined application were developed in consultation with stakeholders, consumer groups, and the National Association of Insurance Commissioners (NAIC), were tested with consumers, and were released for public comment on January 28, 2013. A video demonstration of the application is available at: http://www.youtube.com/user/CMSHHSgov.

Contingency Plans

You stated in response to a question at the hearing that you are looking at contingency plans for "every eventuality."

36) Please provide a comprehensive and detailed list of contingency plans CCIIO is considering.

Answer: We are moving forward with Marketplace implementation for open enrollment beginning on October 1, 2013. We are also working with States to provide the maximum amount of flexibility to enable them to perform the functions in their Marketplaces. A number of different systems will be in place by October 1 to accommodate open enrollment, including IT,

call center, and plan management systems, and we are carrying out the plans we have in place to ensure that all of these systems are operational and that the Marketplace will be available to all consumers on October 1.

We are also developing mitigation strategies for IT systems as provided in the guidance established by the National Institute of Standards and Technology, Special Publication 800–34, revision 1 (May 2010). The document provides guidance to help personnel evaluate information systems and operations to determine mitigation strategy requirements and priorities.

37) Are you currently planning to implement certain aspects of the exchanges in a manner that will require non-electronic communications, such as confirming an applicant's Medicaid eligibility status or incarceration status with a State or confirming immigration status or tax credit eligibility with Federal agencies? Can you provide a list organized by State of which of the various functionalities you expect to carry out on a non-electronic basis?

Answer: The Affordable Care Act authorizes a system of coordinated, streamlined processes to determine eligibility for enrollment in a QHP, advance payments of the premium tax credit, Medicaid, or CHIP. Marketplaces must first rely on electronic data to verify eligibility. CMS expects that that the majority of transactions related to eligibility determinations will be electronic. Specifically, with respect to incarceration status, 45 CFR 155.315(e) specifies that Marketplaces must verify applicant attestations regarding incarceration status by relying on electronic data sources; however, if an approved electronic data source is not available, the Marketplace must accept the applicant's attestation regarding incarceration status without further verification, unless it is not reasonably compatible with information from approved data sources, or with other information provided by the applicant or in the records of the Marketplace. If the attestation is not reasonably compatible with this other information, the Marketplace must follow the inconsistency resolution procedure provided at 45 CFR 155.315(f), which is also the procedure for verifying information any time required electronic data is not available. For incarceration, CMS will use electronic data obtained through the Hub from SSA regarding prisoner status.

38) How will manual enrollment work under the FFE model if some of the necessary activities to enroll an individual either cannot be accomplished in real time, require certain steps to verify information, or the individual chooses to not enroll through the FFE website? Who will be conducting manual enrollment activities?

Answer: In addition to the dynamic Web-based system supporting eligibility determinations for all insurance affordability programs, a paper application will be available, and eligibility workers will handle exceptions and manual processing, including for paper applications and in cases where verification documentation is needed (*e.g.*, immigration documents).

CMS will provide consumer support to help purchasers of QHPs obtain an eligibility determination and select a plan through the FFM. CMS will fund a Navigator grant program in FFM States to provide consumers with fair, unbiased help with determining if they are eligible for tax credits, comparing QHPs, and the application process for health coverage. Training modules are under development and Navigator grants will be awarded in the summer of 2013.

CMS will launch a website with chat capabilities and a 24 hour call center for the FFM that consumers can use to identify and compare QHPs, check their eligibility for affordability programs to help them pay for coverage, and enroll in a QHP. As with all Marketplaces, consumers will be able to submit an application online, over the phone, through the mail, or in person at certain locations.

39) Can you identify for each FFE the person in that State who has primary responsibility for working with the Federal government on implementation issues?

Answer: We have built relationships with every State, including FFM States. Each State and territory has a State officer managing communication from States to CCIIO experts, and from CCIIO experts back to States. Some States have offices that are responsible for working with CCIIO on implementation issues. In other States, CCIIO works with an individual or a few individuals from various State government offices. CCIIO has contacts and staff assigned to work with these contacts in every State and territory no matter what Marketplace model will be operating in the State come October 1, 2013.

Federal Data Services Hub

The Administration has contracted to develop the Federal Data Services Hub, which will be facilitating eligibility decisions between Federal agencies and exchanges, yet no guidance or regulations have been published defining the data hub's role or how it will operate and function.

40) Will the Administration issue any guidance or regulations on the data hub? If yes, when? If no, why?

Answer: The services that the Hub will provide to States are designed to support requirements that can be found in Marketplace and Medicaid/CHIP policy, including the requirements in 45 CFR 155.315(b)(1) (related to Social Security number verification); 45 CFR 155.315(c)(1) (related to citizenship confirmation with SSA); 45 CFR 155.315(c)(2) (related to citizenship and immigration status verification with DHS); 45 CFR 155.320(b)(1) (related to verification of eligibility for minimum essential coverage other than through an eligible employer-sponsored plan); 45 CFR 155.320(c)(1) (related to income verification); and 45 CFR 155.340(a)(1) (related to transmission of information to HHS necessary to implement APTC and CSR), among others.

CMS also issues periodic guidance on the Hub development including Business Service Definitions and technical specifications in the Service Repository at least monthly. CMS also provides guidance during webinars (such as quarterly releases on the Hub), conferences, and regularly scheduled State engagement (such as the Marketplace Early Innovators conference calls).

41) Please provide a comprehensive list of all categories of data that will be routed through the Federal Data Services Hub.

Answer: The following categories of data will be routed through the Hub:

- Identity Proofing
- Social Security number verification
- Income and Family Size
- Calculation of Maximum Tax Credit Amounts
- Citizenship and Immigration Status
- Enrollment in Insurance Affordability Programs and QHPs
- Minimum Essential Coverage
- Incarceration Status

42) Please provide a comprehensive report on Federal Data Services Hub testing activities, including a list of all tests, the date of the test, which agency or stakeholder tested the data hub in each event, the results of each test and when testing will be complete.

Answer: CMS is also working with our partners on external testing. CMS is undertaking 'Secure Communications' and the 'FEPS and Partner' functional testing with the IRS, which has been ongoing since October 2012. These tests have been successful in testing the services between IRS and CMS.

The following Federal agencies will begin similar testing in Spring 2013:

- DHS
- OPM
- Peace Corps
- SSA
- DoD's TRICARE Management Activity
- VA's Veterans Health Administration

Several State-based Marketplaces and FFM States will begin 'Secure Communications' and 'FEPS and Partner' in the spring of 2013. All States will participate in the 'Regression and End to End' Testing in August 2013. Plan issuers are scheduled to begin testing plan management templates in the spring of 2013.

Together, internal and external testing will validate system functionality. Performance Stress Testing will examine infrastructure capacity and scalability with the most active trading partners. Security Testing will take place in the same manner as with all CMS systems. Testing will continue once the system is operational.

QHP Approval Process

The guidance document on the State Partnership Exchange provides an outline of the timeline for approving QHPs. It has been suggested that plans will be able to submit applications to the Department of Health and Human Services (HHS) starting March 28.

43) Why has this timeline only been presented as guidance to State Partnership Exchanges? Does this timeline not also apply to plans offered in State-based exchanges and the FFE?

Answer: Plans may submit applications to HHS starting on April 1. This timeline also applies to the FFM. State-based Marketplaces each have their own timelines for approving QHPs.

44) The application process will have a significant impact on the ability of the exchange to offer plans starting October 1. Is March 28 still the start date for submitting applications? If it is pushed back, will the other deadlines such as the July 31st deadline for State recommendations, August 2013 deadline for HHS to approve QHPs and the October 1 deadline for open enrollment also be delayed?

Answer: April 1, 2013, is still the start date for submitting applications. CMS has no plans to push back the start date at this time.

45) It is my understanding that all QHPs, regardless of the exchange model, will be submitting plan and rate information to HHS through the Health Insurance Oversight System (HIOS). Can you please provide information on the capabilities and functions of HIOS? I am also interested in how HHS will be using the information collected from plans through HIOS. It has been said that information will be used to certify health plans, but that it will also be used for "other purposes." Please provide a comprehensive list of all "other purposes," and the statutory authority provided to use data for those purposes.

Answer: CMS will issue the final Letter to Issuers modeled after the Medicare Part D program call letter. In this letter, we will outline specific application requirements and the appropriate electronic system for QHP certification applications.

In States with FFMs, an issuer can submit QHP certification applications in the HIOS between April 1 and April 30, 2013. The QHP application will collect both issuer-level and plan-level benefit and rate data and information, largely through standardized data templates. Applicants will also attest to their adherence to the regulations set forth in 45 CFR parts 155 and 156, and other programmatic requirements.

In a Plan Management State Partnership Marketplace, issuers will work directly with the State to submit all QHP issuer application data in accordance with State guidance. Most States are using the SERFF system to collect and review QHP data. The State will review issuer applications for QHP certification for compliance with the standards described above and will provide a certification recommendation for each plan to CMS. In Partnership States, CMS will review and confirm the State's recommendations, coordinate Plan Preview, make final certification decisions, and load certified QHP plans on the Marketplace website for the relevant State Partnership Marketplace. CMS will work closely with States to coordinate this process.

The legal authority for any specific data collection has been articulated in rule making and guidance. Sections 1301 and 1311 of the Affordable Care Act contain the authority for QHP certification.

The HIOS has been used for various requirements in the Affordable Care Act such as www.healthcare.gov web submission, the medical loss ratio reports, and the rate review program, for example. Most issuers and States are familiar with the system and have already registered in HIOS. The system has multiple functional modules and has the capability of accepting QHP certification applications.

Program Integrity

46) The healthcare exchanges represent the largest program expansion in healthcare since the Federal healthcare programs were created. Given the vast amounts of healthcare fraud that exist under current programs, with estimates of at least $60 billion being lost each year to healthcare fraud, what program integrity efforts has Centers for Medicare and Medicaid Services (CMS) embedded as part of the infrastructure of the FFE?

Answer: CMS takes seriously its responsibility to monitor the implementation of these programs to protect consumers, prevent fraud and abuse, and ensure the programs achieve their goals. In addition to the program integrity efforts underway within CMS, CMS and IRS are working on a number of key operational issues which include program integrity matters. We will provide further detail on the oversight of Marketplace programs in future rulemaking and guidance.

In States in which a FFM is operating, CMS will focus on compliance concerns that are specific to the Marketplace and will look to existing State compliance and enforcement efforts for issues that fall under States' regulatory and enforcement authority.

47) Are there similar efforts being implemented at the State level with respect to State exchanges or the Partnership Exchanges?

Answer: Yes. CMS is working closely with State and partnership Marketplaces, State departments of insurance, and other regulatory bodies to prevent fraud and abuse, particularly in relation to Federal funds such as APTCs and CSRs. Program integrity and appropriate oversight are core activities required of all State-based Marketplaces, not only in regulations, but also in the Blueprint Application. No State can become a fully approved State-based Marketplace without demonstrating its abilities to perform activities in this area.

CMS has issued detailed security and privacy standards and controls through the *Minimum Acceptable Risk Safeguards for Exchanges*, on August 1, 2012, to make certain uniform requirements are applied across all program areas. CMS is also making available, for the first time through the Hub, a way for States to leverage a centralized remote identity proofing services which will combat identity theft, reduce risk of fraud, and provide an increased level of assurance in the identity of the on-line transaction.

48) Are there any requirements for program integrity efforts included in either the Federal exchange or Partnership Exchange guidances or regulations issued to date?

Answer: In 45 CFR 155.200, we note that Marketplaces must perform oversight and financial integrity requirements in accordance with section 1313 of the Affordable Care Act. We included information on QHP issuer compliance and oversight in both the Federal Marketplace and Partnership Marketplace guidances, as well.

49) Is there a comprehensive program integrity plan in place for addressing vulnerabilities in the Federal and/or State-based Exchanges?

Answer: CMS is actively working to establish appropriate mechanisms to ensure that Federal funds are safeguarded in the FFMs. As mentioned above, CMS is also actively collaborating with States—particularly State-based Marketplaces—to ensure appropriate safeguards are in place as a condition of their full approval.

50) Which entity within CMS is coordinating those efforts?

Answer: CCIIO is coordinating these efforts both within CMS and with States.

51) How is information obtained from early detection or other program integrity efforts being shared within CMS and what is the plan for developing corrective actions when those instances are identified?

Answer: CMS continues to promote collaboration across programs, has received helpful input from existing programs, and has assessed lessons learned from those programs.

52) How are CMS' program integrity efforts being coordinated with the IRS?

Answer: CMS and IRS have a strong working relationship, and have been working together through a collaborative process since the passage of the Affordable Care Act. Specifically, we have focused on information sharing on a variety of cross-cutting policy issues that include reporting and privacy matters. Additionally, in 2011 we created the CMS/IRS Executive Committee, which meets on a regular basis to discuss issues of concern between the agencies with regard to the implementation of the Affordable Care Act. Most recently, CMS and the IRS have entered into a Memorandum of Understanding (MOU) to work with one another on areas of operational overlap between the agencies. A workgroup co-chaired by senior CMS and IRS staff has been formed to implement the MOU. CMS and IRS are working on a number of key operational issues that include program integrity matters. We anticipate continuing our strong working relationship, especially regarding program integrity.

Eligibility Determinations

A good example of where program integrity will be critical is with respect to eligibility determinations. For those States under the FFE, there are two options: 1) let the FFE make all decisions of eligibility determinations or 2) let the FFE obtain the application and provide an assessment to the States, and the States can make the ultimate eligibility assessment. However, in both cases, my understanding is that the exchanges will rely 100% on the individual to self-disclose that they live in the State they claim to live in. While this may improve customer experience and make subsidies more easily accessible,

numerous Office of Inspector General (OIG) and the U.S. Government Accountability Office (GAO) reports have shown the fraud that occurs when self-reporting is allowed in programs of this size.

53) What steps will CMS and/or the IRS implement to verify that the self-reported information is accurate?

Answer: Section 155.320 of the Marketplace Final Rule, issued in March 2012 details the verification process that marketplaces must follow for verification of eligibility for insurance affordability programs including when marketplaces must request additional documentation if the information provided by an applicant is not reasonably compatible with information from approved data sources, or with other information provided by the applicant or in the records of the Marketplace.

54) If a recipient falsifies an application and receives tax credits, who will investigate that fraud?

Answer: Under section 1411(h) of the Affordable Care Act, any person who fails to provide correct eligibility information due to negligence or disregard of rules and regulations is subject to a civil penalty, unless the Secretary determines that there was a reasonable cause for the failure and the person acted in good faith. Any person who knowingly and willfully provides false or fraudulent eligibility information is subject to a civil penalty. These civil penalties under the Affordable Care Act are in addition to any other civil or criminal penalties for providing false or fraudulent information that may be available, depending on the factual circumstances.

Risk Programs

55) The proposed regulation pertaining to the Notice of Benefit and Payment Parameters eliminates the option for States to operate the temporary reinsurance program. Why was this change made?

56) What stakeholder comments were taken into account in making this determination?

Answer to #s 55 and 56: The proposed 2014 Payment Notice (77 FR 73118) does not eliminate the option for States to operate the transitional reinsurance program; States retain this option under 45 CFR 153.210.

57) Why are reinsurance funds collected and distributed nationally?

Answer: The Affordable Care Act directs that a transitional reinsurance program be established in each State to help stabilize premiums for coverage in the individual market from 2014 through 2016. The reinsurance program is designed to alleviate the need to build into premiums the risk of enrolling individuals with significant unmet medical needs and to lower premiums across the country. Federal collections will leverage economies of scale, reducing the overall administrative costs of the reinsurance program. The proposed payment policy provides reinsurance payments in an efficient, fair, and accurate manner, where they are needed most, to effectively stabilize premiums nationally. HHS proposes to make reinsurance payments in States

where HHS is operating reinsurance on behalf of the State, and distribute funds to States operating reinsurance.

58) Will not this lead to lower-cost States, like Utah, subsidizing higher-cost States?

Answer: The cost of medical care is one variable, but CMS analysis indicates that other variables are also important The proposed policy provides reinsurance payments in an efficient, fair, and accurate manner, where they are needed most, to effectively stabilize premiums nationally.

State Coordination

In public statements and guidance documents, CMS has said that it will try to harmonize exchange policy with existing State programs and laws whenever possible. However, with 26 States relying on the FFE, with limitations on resources and with time running out, it would seem difficult for the agency to tailor an exchange to meet each State's unique insurance market needs.

59) What are the specific details of the plan to harmonize these laws and regulations in States under the FFE model?

Answer: CMS has been coordinating plan management activities with States, including QHP certification, monitoring and oversight, account management, and recertification. States that are enforcing market-wide standards that are part of QHP certification will be able to submit their findings for the FFM for use in its QHP certification reviews; the FFM does not intend to duplicate those reviews. The FFM will work with the State to review the State's recommendation and to provide a coordinated application process.

CMS has worked with the NAIC to standardize the collection of data needed to certify QHPs. We have also already released the data elements that insurance plans will need to integrate into this application. CMS will continue to work with States to ensure coordination with State eligibility processes.

60) What are the necessary steps to ensure FFEs will be available to consumers in the 26 States as it relates to harmonizing State laws and regulations?

Answer: The Marketplace developed by CMS will be adapted to meet the needs of any State that chooses to utilize this model. The FFM will support the following operation functions; Eligibility and Enrollment, Plan Management, Financial Management, and Consumer Support.

CMS is already testing IT data information exchange functions and expects to complete testing in the spring of 2013. Consumer call centers are on track to open in the summer of 2013.

CMS is committed to stakeholder consultation as we implement the Affordable Care Act. We have undertaken extensive stakeholder consultation during the Marketplace rule making process, and solicited comments on FFM guidance. We have also begun consultation specifically in the FFM and partnership States through our regional offices. We will enhance our outreach and

education efforts as we move toward open enrollment in 2013 and will seek to join State and local partners in that effort.

QHPs

It is anticipated that plans will begin submitting QHP applications starting March 28th for approval either through the National Association of Insurance Commissioners' (NAIC) System for Electronic Rate and Form Filing (SERFF) and through HHS's Health Insurance Oversight System (HIOS).

61) Can you please explain the purpose behind plans submitting QHPs to both systems in States with State-based exchanges?

Answer: CMS will issue the final Letter to Issuers modeled after the Medicare Part D program call letter. In this letter, we will outline specific application requirements and the appropriate electronic system for QHP certification applications.

In States with FFMs, an issuer can submit QHP certification applications in HIOS between April 1 and April 30, 2013. The QHP application will collect both issuer-level and plan-level benefit and rate data and information, largely through standardized data templates. Applicants will also be required to attest to their adherence to the regulations set forth in 45 CFR Parts 155 and 156, and other programmatic requirements.

In a Plan Management State Partnership Marketplace, issuers will work directly with the State to submit all QHP issuer application data in accordance with State guidance. Most States are using the SERFF system to collect and review QHP data. The State will review issuer applications for QHP certification for compliance with the applicable standards and will provide a certification recommendation for each plan to CMS. CMS will review and confirm the State's recommendations, coordinate the plan preview period during which issuers may review their QHP data before it becomes public, make final certification decisions, and load certified QHP plans on the Marketplace website for the relevant State Partnership Marketplace. CMS will work closely with States in State Partnership Marketplace to coordinate this process.

62) Is this not duplicative, unnecessary, contrary to the goals of limiting administrative costs and an encroachment of State authority to regulation insurance in the State?

Answer: In States with FFMs, an issuer can submit QHP certification applications in HIOS between April 1 and April 30, 2013. The QHP application will collect both issuer-level and plan-level benefit and rate data and information, largely through standardized data templates. Applicants will also be required to attest to their adherence to the regulations set forth in 45 CFR Parts 155 and 156, and other programmatic requirements.

In a Plan Management State Partnership Marketplace, issuers will work directly with the State to submit all QHP issuer application data in accordance with State guidance. Most States are using the SERFF system to collect and review QHP data. The State will review issuer applications for QHP certification for compliance with the applicable standards and will provide a certification recommendation for each plan to CMS. CMS will review and confirm the State's recommendations, coordinate the plan preview period during which issuers may review their

QHP data before it becomes public, make final certification decisions, and load certified QHP plans on the Marketplace website for the relevant State Partnership Marketplace. CMS will work closely with States in State Partnership Marketplace to coordinate this process.

Application Counselors

The latest proposed regulation creates a new category of assisters called "Application Counselors." The proposed regulation says these assisters could be in hospitals or other provider offices.

63) Can you shed more light on what role these Application Counselors will play?

Answer: We proposed this category of assisters because we believe that making such assistance available for the Marketplaces will be critical to achieving a high rate of enrollment. State Medicaid and CHIP agencies have a long history of offering application assistance programs through which application counselors have had a key role in promoting enrollment for low-income individuals seeking coverage, and we believe that making such assistance available for the Marketplace will be critical to achieving a high rate of enrollment. Accordingly, the proposed regulation seeks to ensure that application counselors will also be available in the Marketplace to help individuals and employers apply for enrollment in Marketplace coverage and for insurance affordability programs. Under the proposed regulation, certified application counselors would provide help to consumers in applying for health insurance in the Marketplace. These counselors would serve as resources that individuals could turn to for help with filling out their applications and exploring their coverage options.

64) What would prevent such a counselor in a hospital from steering people to plans that benefit the hospital?

Answer: The proposed rule establishing this category of assisters also would establish certification standards that they must meet. Specifically, the proposed rule also would require that these counselors act in the best interest of the consumer and that they disclose all potential conflicts of interest, including relationships with QHPs or insurance affordability programs, to the Marketplace and to potential applicants for coverage. The rule would further require that these assisters be trained regarding QHP options, insurance affordability programs, eligibility, and benefits rules and regulations governing all insurance affordability programs operated in the State, as implemented in the State, prior to providing assistance. CMS is currently developing this training for assisters who will be operating in FFM States, and it will begin this summer.

Outreach and Education

Your testimony referenced outreach and education efforts, stating that CMS is challenging States to be innovative in their approach.

65) How has CMS challenged States as it relates to outreach and education efforts?

Answer: Because States know best how to reach their residents, States are using a variety of approaches to reach out to consumers and communities about the Marketplace. For example, States are preparing marketing materials in multiple languages and formats.

66) Will CMS fund outreach and education efforts in all 50 States and Washington, D.C.? If not, will outreach and education funding be based on the exchange model?

Answer: To prepare for October 1, 2013, CMS is conducting a number of activities to reach out to and educate consumers. CMS has developed HealthCare.gov, where consumers can learn the basics about health insurance and learn more about the Health Insurance Marketplace and other benefits of the Affordable Care Act. CMS has also developed outreach plans and partnerships with agencies including USDA, HUD, VA, and SBA, consistent with those agencies' missions. CMS is enlisting Consumer Assistance Programs and their non-profit partners to assist with consumer education efforts, and will release Navigator grant awards in the summer of 2013. CMS is also planning to conduct a media campaign to educate consumers leading up to and throughout open enrollment (media includes: digital, radio, television, grassroots, and print).

In States with a FFM CMS will begin a process in March of engaging with the individuals and organizations that will use the new Health Insurance Marketplace. Engaging with these stakeholders is an important opportunity for HHS to hear their input and communicate how the Marketplace will work and when it will be ready. This engagement, led by CMS regional offices, will be the start of ongoing conversations in the States with a FFM. The CMS regional offices have firsthand experience with starting large scale programs and working with State agencies and local partners.

To educate consumers and help them enroll in health insurance coverage, HHS will release a Federal Navigator funding opportunity announcement for FFM and State Partnership Marketplace States, and will award grants in the summer of 2013. State-based Marketplaces are required to use their own funds to provide grant awards to Navigators in their States.

There will be Navigator grants in all States, but direct Federal grants will go only to groups and organizations in States with FFMs, including partnership Marketplaces. The role of the State in the Navigator program depends on its marketplace model. State-based Marketplaces will award and manage the Navigator grants in their States. In State Consumer Partnership Marketplaces, Navigators will be funded through Federal grants. It is legally required that HHS retain ultimate authority over the Navigator grant process in federally facilitated and State Consumer Partnership marketplaces, including selecting Navigator grantees and awarding Navigator grants, and the approval of grantee activities and budget.

States are taking innovative approaches to hiring and funding consumer assistance programs—for example, some are applying for private foundation funding. We will soon be releasing guidance on Navigators and other consumer assistance programs.

67) What source of funding provided under PPACA or other laws will be used to fund outreach and education activities? What is the total budget for outreach and education activities?

Answer: CMS continues to determine how to effectively and efficiently implement the Marketplace based on available funds.

68) Are you developing a communications plan to guide the public and manage expectations prior to the October 1 or January 1 deadline for enrollment and coverage? If so, when would you be able to share that plan with the Committee?

Answer: CMS is developing and implementing an outreach and education plan to help ensure that Americans have access to quality, affordable health insurance. The plan seeks to raise awareness of the Marketplace as the source for finding affordable health coverage. A timeline describing the plan is attached.

Pre-existing Conditions Insurance Plan (PCIP) program

You commented in your testimony that the PCIP program will not exceed the limit of $5 billion in funding provided under the law. You noted that CCIIO has made changes to benefits under Federal PCIPs to ensure that funding would last through the end of the year.

69) What changes in benefits were made?

Answer: CMS has taken a variety of steps to ensure that the limited funds provided by the Affordable Care Act are applied efficiently in funding patient care until coverage becomes available to uninsured Americans with pre-existing conditions in January 2014. CMS announced several benefit changes to the federally run PCIP program in August 2012, including a change in provider networks and a change in payments for out-of-network benefits. Enrollees can avoid the risk of higher out of pocket costs by using an in-network provider. Additionally, in January 2013, CMS consolidated the Federal PCIP to one plan option with changes in co-insurance, deductibles, and out-of-pocket maximum amounts. With these steps, we aim to get the best value for taxpayer dollars while also minimizing the impact of any benefit change on enrollees.

Enrollment Process

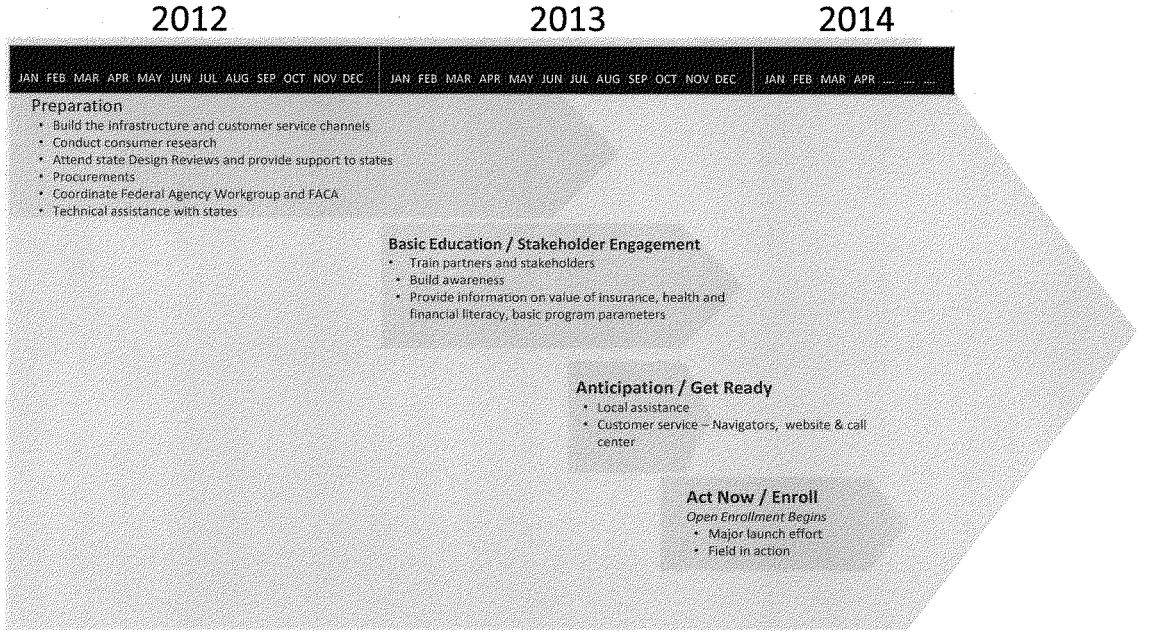
In your testimony you highlight the use of the streamlined application that will facilitate a seamless experience for people in between Medicaid, the Children's Health Insurance Program (CHIP) and exchanges. However the Administration recently proposed to delay the implementation of a combined eligibility determination.

70) How useful is the streamlined application if the determination will still be a fragmented process that requires multiple interactions with more than one agency?

Answer: A single, streamlined application will be useful to consumers because it will allow them to input their information only once to receive eligibility determinations from multiple programs.

71) Please explain how the Federal Data Services Hub, exchanges (of any type) and Medicaid eligibility system will interact.

Consumer Outreach Timeline



Answer: When consumers access the Marketplace and fill out the single, streamlined application, the information they provide, including income information, will, via the Hub, be verified against data originating with other Federal sources of information, including the IRS, DHS, and SSA. Every Marketplace will also use the Hub to connect to State Medicaid agencies to check whether an applicant is already enrolled in Medicaid. Data will be routed through the Hub, but will not be stored in it. The Hub will access only the information needed to determine individual eligibility and will not be involved in the selection or certification of QHPs. CMS has completed the Hub's technical design, has almost completed the services related to Federal and State interactions, and has already begun testing the Hub across agencies. When an applicant is assessed or determined eligible for Medicaid, the Marketplace will use the Hub to transfer the applicant's information to the State Medicaid agency to complete the process.

Data Security and Privacy

Your testimony highlights that information provided in the streamlined application will be subject to strong privacy and security protections, that IRS data used to verify eligibility through the Federal Data Services Hub will be used in a manner consistent with existing IRS safeguards and that the agency has completed the framework for security across agencies to establish protocols for connectivity.

72) Could you please elaborate on how information provided through an application, to the IRS for eligibility determinations and as other data shared between agencies will be protected from unauthorized uses?

Answer: The privacy and security of consumer data is a top priority for CMS and other Federal and State agencies. Consumer data is safeguarded and secured through processes, controls, and standards that will be used not only by CMS, but also by Federal partners including IRS and SSA. CMS will use a layered security approach to protect personal information. This layered approach includes presentation of a secure web interface, use of secure transmission protocols, and validation of identity. Data will be routed through the Hub, but will not be stored in it. A variety of security measures and counter-measures protect personal information while the data is being used within the Hub. CMS also reviews its internal security policies and procedures each year, and updates them to ensure an information security program remains comprehensive, relevant, and responsive to today's emerging threats. In addition, CMS and IRS have worked together to develop additional safeguards to protect sensitive tax return data that will be accessed through the Hub. CMS is also making use of commercial sources of information as an additional identity-proofing measure, an approach that has been successful with other Federal Government websites, such as SSA's "my Social Security."

Premiums

As I noted in my opening statement, a number of studies have been published showing dramatic increases in premiums starting in 2014, mostly due to changes under PPACA.

73) Has CMS commissioned or conducted any internal analysis of premium increases in 2014? If so, can you please share the findings of the analysis? If not, please explain why.

Answer: The Assistant Secretary for Planning and Evaluation released a research brief entitled "Health Insurance Premium Increases in the Individual Market Since the Passage of the Affordable Care Act" in February 2013. The study, which shows that there has been a decline in the proportion of rate filing increases of 10 percent or more since the passage of the Affordable Care Act, can be found at http://aspe.hhs.gov/health/reports/2013/rateIncreaseIndvMkt/rb.cfm.

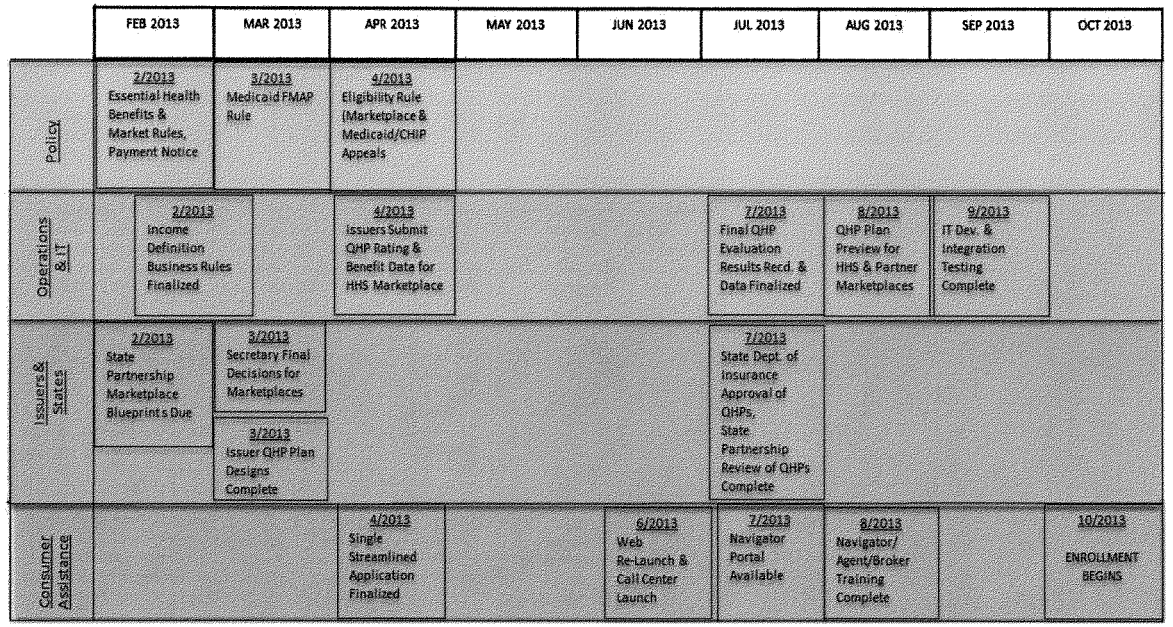
Regulatory Timeline

74) What is the timeline for completing work on rules, guidances and other policy decisions that have impact on the practical and technical aspects of implementing the exchanges?

75) In other words, by what date can the Administration tell us that all of the policy issues that need to be addressed in order to fully implement an exchange have been resolved and that settled issues will not be reopened?

Answer to #s 74 and 75: Please see the Marketplace Timeline on following page and at http://cciio.cms.gov/resources/files/marketplace-timeline.pdf.

Marketplace Timeline



CHIP: Children's Health Insurance Plan **QHP:** Quality Health Plan
FMAP: Federal Medical Assistance Percentages (Matching funds for Medicaid and other State-administered programs)

Senator Ron Wyden

76) I understand that the Department of Health and Human Services (HHS) has finalized its definition of essential health benefits. I am particularly interested in how HHS plans to thread the needle between assuring appropriate access while balancing affordability when it comes to prescription drug coverage?

a. Specifically, how will the out-of-pocket limitations work with benefits such as prescription drugs that are typically carved out?

Answer: The Affordable Care Act requires, and CMS's implementing regulations detail, essential health benefit requirements in ten statutory categories. One of these categories is prescription drugs. Section 1302(c)(1) of the Affordable Care Act, specifies that for the 2014 benefit year, out of pocket costs for essential health benefits to the enrollee out-of-pocket limit for high deductible health plans (HDHP), as calculated pursuant to section 223(c)(2)(A)(ii) of Internal Revenue Code of 1986 (the Code). This limit will change in future years. For the year 2013, the Code sets these amounts at $6,250 for self-only and $12,500 for non-self only coverage. Thus, covered services, such as the prescription drug category of essential health benefits are subject to these out of pocket limitations. It is important to note that the limit specified is for in-network benefits.

b. Will you allow plans to create a meaningful difference between the second and higher tiers in order for enrollees to get the true benefit of a drug formulary? I am concerned that if this is not addressed appropriately, generic and low-cost brand utilization will suffer.

Answer: Using the Actuarial Value Calculator developed by HHS, plans wishing to become QHPs can input certain information and cost-sharing parameters for covered benefits and generate an actuarial value for the plan. Actuarial value is an estimate of expected plan spending based on a standard population and will be used to help consumers compare health plans by providing information about relative plan generosity.

Plans generally must one of four specified metal tiers (bronze 60 percent actuarial value, silver 70 percent actuarial value, gold 80 percent actuarial value and platinum 90 percent actuarial value). Among the components that the actuarial value calculator uses to calculate the actuarial value of the plan are the cost sharing rules for up to four tiers of prescription drugs: generics, preferred brand drugs, non-preferred brand drugs, and specialty high-cost drugs. CMS's implementing regulations neither require nor prohibit that prescription drugs be covered on any particular tier, if a plan chooses to use a tier system in its formulary. Since the actuarial value calculation is based on the cost-sharing of the plan benefits, it will takes into account the differences in drug tier cost-sharing. In general, because a greater volume of utilization occurs on lower tiers; plans with greater coverage on lower tiers may achieve a higher actuarial value than plans with greater coverage on higher tiers.

Specialty Tiers

The final Essential Health Benefits rule neither specifically allows nor disallows the use of prescription specialty tiers by qualified health plans; however CMS included specialty tiers in its proposed "AV Calculator" as a drug benefit option. Specialty tiers have the potential to discriminate because drugs to treat rare diseases are almost exclusively relegated to a specialty tier with high cost-sharing requirements.

77) How is HHS prepared to handle the use of specialty tiers by qualified health plans, and will any consideration be made to protecting individuals with rare diseases to ensure that they receive meaningful and affordable coverage?

Answer: CMS's implementing regulations neither require nor prohibit that prescription drugs be covered on any particular tier, if a plan chooses to use a tier system in its formulary. Instead, the rule requires the plan to offer, at a minimum, the greater of: (1) one drug in every USP category and class or (2) the number of drugs in each USP category and class offered by the essential health benefits benchmark. However, the Essential Health Benefits Final Rule at 45 CFR 156.125, outlines non-discrimination standards for issuers offering essential health benefits, which apply to all essential health benefits including prescription drug benefits. The regulation provides that an issuer's benefit design, or the implementation of its benefit design, may not discriminate based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions. Lastly, the final rule requires that plans have an exceptions procedure for enrollees to request and gain access to a clinically appropriate drug not covered by the health plan.

Senator Debbie Stabenow

One question is how families will learn about the health insurance options available through exchanges, and how they will navigate the options available to them. Michigan is establishing a State partnership health exchange, so I am particularly interested in how this process will work for Partnership Exchanges, but I would also like to know how this will work for the Federally Facilitated Exchanges.

78) What kind of local and national outreach efforts is HHS undertaking to help families learn about the new exchanges, and how will local and State efforts be coordinated to assure that individuals are directed to the most locally appropriate resources?

Answer: To prepare for October 1, 2013, CMS is conducting a number of activities to reach out to and educate consumers. CMS has developed HealthCare.gov, where consumers can learn the basics about health insurance and learn more about the Health Insurance Marketplace and other benefits of the Affordable Care Act. CMS has also developed outreach plans and partnerships with agencies including USDA, HUD, VA, and SBA, consistent with those agencies' missions. CMS is enlisting Consumer Assistance Programs and their non-profit partners to assist with consumer education efforts, and will release Navigator grant awards in the summer of 2013. CMS is also planning to conduct a media campaign to educate consumers leading up to and throughout open enrollment (media includes: digital, radio, television, grassroots, and print).

In States with an FFM, CMS will begin a process in March of engaging with the individuals and organizations that will use the new Health Insurance Marketplace. Engaging with these stakeholders is an important opportunity for HHS to hear their input and communicate how the Marketplace will work and when it will be ready. This engagement, led by CMS regional offices, will be the start of ongoing conversations in the States with a FFM. The CMS regional offices have firsthand experience with starting large scale programs and working with State agencies and local partners.

79) Will there be direct Federal grants for Navigators in all States, and what kind of role will States play in the selection and coordination of Navigator consumer assistance efforts, particularly in the case of Partnership and Federally Facilitated Exchanges?

Answer: There will be Navigator grants in all States, but direct Federal grants will go only to groups and organizations in States with FFMs, including Partnership Marketplaces. The role of the State in the Navigator program depends on its marketplace model. State-based Marketplaces will award and manage the Navigator grants in their States. In a State Consumer Partnership Marketplace, Navigators will be funded through Federal grants. It is legally required that HHS retain ultimate authority over the Navigator grant process in federally facilitated and State Consumer Partnership Marketplaces, including selecting Navigator grantees and awarding Navigator grants, and the approval of grantee activities and budget.

States are taking innovative approaches to hiring and funding consumer assistance programs—for example, some are applying for private foundation funding. We will soon be releasing guidance on Navigators and other consumer assistance programs.

SHOP Exchanges

One of the important benefits of the exchanges comes from the opportunity that SHOP exchanges will provide to small businesses to leverage their buying power like larger employers. However, there has been a great deal of misinformation about the Affordable Care Act spread among small businesses, and the small business health insurance tax credit has been underutilized.

80) In States with Partnership Exchanges, are States serving similar roles with SHOP exchanges as they are with individual market exchanges, regarding plan management and consumer assistance?

Answer: Yes. States with a partnership marketplace will be serving similar roles with respect to SHOP marketplaces as they are with respect to individual marketplaces. If a State is a plan management partner, consumer support partner or both, it will manage those functions for both the individual market and the SHOP.

81) What outreach efforts are being undertaken either by States or HHS to combat misinformation and ensure that small businesses know about the SHOP exchange, and what resources will be available to assist small businesses to navigate the new insurance options and the tax credits?

Answer: CMS has been developing SHOP-focused training and materials to help small businesses understand the Affordable Care Act and the opportunities it presents to them. And we have a strong partner in SBA, which, consistent with its mission, has created its own educational sessions for small businesses that they will start offering in the spring. In addition, we are working with the IRS to promote the availability of expanded tax credits through SHOP beginning in 2014. We also expect agents and brokers to play a large role in working with the small business community. CMS expects that agents and brokers will serve as "on the ground" resources for small businesses.

Essential Health Benefits Rule

The final Essential Health Benefits rule indicates that for some of the 10 required benefit categories it will remain up to States to determine if Qualified Health Plans provide sufficient services in those categories to meet the requirement for EHB.

82) Can you describe what kind of verification HHS is undertaking to ensure that Qualified Health Plans are covering all of the 10 required benefit categories sufficiently?

Answer: CMS is using multiple methods to ensure compliance with essential health benefits. Under the essential health benefits proposed rule, States can select a base benchmark from up to ten base benchmark options for defining essential health benefits for their State. These base-benchmark plans must include coverage of all ten statutory categories of benefits. If a base benchmark plan, selected by a State did not include coverage for any services in a particular category, that category is required to be supplemented, in its entirety with the benefits from another base-benchmark plan option. In addition to the State benchmark, all issuers who wish to

participate in the new marketplaces must apply for QHP certification. This process is also used to ensure compliance. Lastly, as this requirement to cover essential health benefits is market-wide, State insurance departments review policies sold in their market. Under the HIPAA framework, if a State fails to substantially enforce requirements such as essential health benefits, CMS will directly enforce in that State.

83) How is HHS confirming, for example, that a Qualified Health Plan in a State covers enough maternity care services to be considered meeting the requirement to cover maternity care as a benefit category?

Answer: Under the essential health benefits proposed rule, States would be able to select from up to ten base benchmark options for defining essential health benefits in their State. These base-benchmark plans must include coverage of all ten statutory categories of benefits, including maternity and newborn care. If a base benchmark plan, selected by a State did not include coverage for any services in a particular category, that category is required to be supplemented, in its entirety with the benefits from another base-benchmark plan option. QHPs would be required to provide benefits that are substantially equal to the benefits contained in the base benchmark plan selected by the State including reflecting both scope of services and limits. We believe that this process would ensure coverage of all categories of items and services identified in the statute.

84) Does this include a full range of pre-natal and postpartum services as outlined by the Guidelines for Perinatal Care developed by the American Academy of Pediatrics and the American Congress of Obstetricians and Gynecologists?

Answer: Under the essential health benefits final rule, States would be able to select from up to ten base benchmark options for defining essential health benefits in their State. These base-benchmark plans must include coverage of all ten statutory categories of benefits. If a base benchmark plan, selected by a State did not include coverage for any services in a particular category, that category is required to be supplemented, in its entirety with the benefits from another base-benchmark plan option. QHPs would be required to provide benefits that are substantially equal to the benefits contained in the base benchmark plan selected by the State including reflecting both scope of services and limits. We believe that this process would ensure coverage of all categories of items and services identified in the statute.

Stand-alone Dental Plans

I was extremely glad to see that the final Essential Health Benefits rule clarified that stand-alone dental plans will be able to operate and meet the EHB requirements in combination with a traditional medical insurance. I greatly appreciate the exceptional diligence of the Secretary, Bill Shultz, and many at HHS for ensuring that this complicated issue was resolved. There are two remaining questions however.

85) First, given the lack of clarity in the statutory language, shouldn't the same system of medical issuers verifying that policy holders obtain stand-alone dental coverage be applied inside the exchange as it now applies outside the exchange?

86) Second, can you explain why the administration chose not to specify an out-of-pocket limit for stand-alone dental plans that could have ensured that they not face potentially higher out-of-pocket costs?

Answer to #s 85 and 86: We will work with the Committee to address these concerns.

Senator Benjamin Cardin

Maryland Progress on the Health Exchange

First, I would like to thank you for the work that your office has done so far with regard to health insurance exchanges, and particularly for your willingness to make CMS staff and resources available to Maryland's Health Secretary and other State officials.

Our State has chosen to operate its own health exchange, and it has had a very open process that I believe will help our Health Secretary make the best decision and identify missteps early so they can change course if necessary.

With regard to Medicaid, Maryland is working to integrate the exchange and Medicaid to create a seamless experience. They are also working to include popular aspects of the existing private insurance market.

87) My question has to do with your office's work on Federal exchanges in places where States are not going to do the work that Maryland has done. What steps are you taking to ensure a speedy and easily understood enrollment process for individuals and small businesses in health exchanges?

Answer: Regardless of how a Marketplace is managed, consumers will be able to access the Marketplace by using a single, streamlined application and will be able to select from a variety of QHPs beginning on October 1, 2013. There will be assisters in each Marketplace, such as Navigators, who will help the public apply for health coverage through the Marketplace, and these assisters will especially target possible enrollees in hard-to-reach populations. We expect that the Navigators and other assisters will be community resources whom enrollees can turn to for help with filling out their applications and exploring their coverage options.

88) Your testimony discusses the role of Navigators, and I am hopeful that they will be helpful in moving individuals and small business owners through the education and enrollment process. Please tell me more about the training that Navigators must receive and how they will be paid to provide services?

- **a. What type of input are you receiving from currently uninsured citizens, persons for whom English is a second language, persons who may face not only language but also cultural barriers, and persons who may not be health-literate?**
- **b. Are you confident that the ACA includes sufficient funding to provide enough qualified Navigators for the uninsured population?**
- **c. What additional resources do you need from Congress to make this program work?**

Answer: a. To develop a Marketplace outreach plan, CMS conducted qualitative research on branding, messaging, and tool development. Over 1,000 people, the vast majority of whom were uninsured and with incomes below 400 percent FPL, participated in focus groups and in-depth interviews. In addition, models for the single, streamlined application were developed in consultation with stakeholders, consumer groups, and the NAIC, were tested with consumers,

and were released for public comment on January 28, 2013. A video demonstration of the application is available at: http://www.youtube.com/user/CMSHHSgov.

b. Given that we don't yet have a full year appropriation for FY 2013, CMS is exploring many options to ensure sufficient consumer assistance in the first year of open enrollment. CMS has proposed that certified application counselors would extend the reach of the Marketplace Navigator program to target possible enrollees in hard-to-reach populations. We also expect that that licensed agents and brokers will continue to assist consumers in accessing health insurance, and we are currently working with agents and brokers to promote their active role in helping consumers enroll through the Marketplaces.

c. The Administration has requested support for Marketplace assistance programs as part of the President's FY 2013 Budget. We look forward to working with Congress to ensure that there will be sufficient resources for Marketplace Navigators and other outreach activities.

Eligibility of ESRD Patients for Premium Tax Credits in an Exchange

The ACA provides new premium credits and cost-sharing subsidies for the purchase of individual coverage in an exchange, but disallows such assistance for individuals with other "minimum essential coverage," including Medicare. Although Federal law allows individuals who are medically determined to have end-stage renal disease (ESRD) to enroll in Medicare, *they must first file an application under the law.* Allowing ESRD patients to choose subsidized exchange coverage is critical because otherwise individuals with ESRD would be forced to leave an exchange simply because of their diagnosis. Fortunately, the Premium Tax Credit Final Regulation notes that "the IRS and the Treasury Department expect to publish additional guidance . . . clarifying when or if an individual becomes 'eligible for government-sponsored minimum essential coverage' when the eligibility for that coverage is a result of a particular illness or condition." The Final Regulation already provides for exceptions in special circumstances (*e.g.*, certain veterans may be eligible for premium tax credits as long as they have not enrolled in the veteran's health program).

ESRD patients are uniquely treated under the Medicare program and do not have the same access to services as other Medicare enrollees. For example, ESRD patients generally are ineligible for Medicare Advantage and Medigap coverage.

89) Do you expect that the IRS will clarify in upcoming guidance that ESRD patients will be allowed to choose to keep their subsidized exchange coverage?

Answer: Treasury is best positioned to answer questions about the guidance issued by Treasury and the IRS.

Senator Johnny Isakson

Section 1311(d)(3)(B) of the Patient Protection and Affordable Care Act requires that, if a State requires insurance plans to provide any additional benefits that are not included in the Essential Health Benefits benchmark, the State must pick up the cost of these benefits. The proposed rule on Essential Health Benefits stipulates that this requirement applies to any new benefit mandates enacted by a State after December 31, 2011. In such a case, the State would be on the hook for any portion of exchange subsidy credits that are attributable to new mandated benefits.

Several proposals have been introduced in the current session of the Georgia Legislature to require health insurance plans to cover additional benefits, such as hearing aids for children and certain treatments for autism. Because of the lack of detailed guidance from HHS to date, officials in my State are facing considerable uncertainty about the budgetary implications should these proposals be enacted.

90) How does HHS plan to monitor new State benefit mandates and the costs associated with them?

Answer: In the essential health benefits proposed rule, CMS stated that Marketplaces will be responsible for identifying benefits that are in excess of essential health benefits. When Marketplaces identify benefits in excess of essential health benefits the calculations of the cost of additional benefits must be made by a member of the American Academy of Actuaries, in accordance with generally accepted actuarial principles and methodologies.

91) When might States expect to see additional regulations or guidance describing how these payments will be assessed?

Answer: As noted above, when Marketplaces identify benefits in excess of essential health benefits, the calculations of the cost of additional benefits must be made by a member of the American Academy of Actuaries, in accordance with generally accepted actuarial principles and methodologies. CMS believes that States may wish to take different approaches to calculating the additional cost of any State-required benefits in excess of essential health benefits, basing payments on either State-wide average or each issuer's actual cost. CMS did not establish a standard in the essential health benefits final rule but permit both options for calculating State payments, at the election of the State.

Notice of Benefit and Payment Parameters

On November 30, 2012, HHS issued a proposed rule on the Notice of Benefit and Payment Parameters for 2014. Among other provisions, this rule imposes an annual fee of $63 per covered life on all health insurance issuers, including self-insured group plans, to finance the transitional reinsurance program under Section 1341 of PPACA. The stated purpose of the transitional reinsurance program is to stabilize premiums in the individual health insurance market. According to the proposed rule, "It is expected that the cost of reinsurance contributions will be roughly equal to one percent of premiums in the total market in 2014, less in 2015 and 2016, and will end in 2017. In contrast, it is anticipated

that reinsurance payments will result in premium decreases in the individual market of between 10 and 15 percent."

I find this statement troubling because a number of independent studies have concluded that many individual market consumers will face substantial premium increases in 2014 as a result of PPACA. For example, a January 2013 survey of insurance carriers found that individual insurance premiums for relatively young and healthy individuals and small firms in five major U.S. cities will increase by more than 150 percent in 2014.[4] For a healthy 27-year-old man in Atlanta seeking individual coverage, the survey found that transitional reinsurance contributions would have a –9% impact on premiums, but that overall premiums would go up by 179%. The survey also notes that the small-group market, which is subject to the transitional reinsurance fee but does not benefit from payments, will face substantial premium increases. As a result, it appears that the transitional reinsurance fee merely forces people enrolled in employer-sponsored health plans to share in the pain of higher premiums, without actually preventing substantial premium increases in the individual market.

92) In light of this data, please answer the following questions:

a) **Is the claim of 10 to 15 percent decreases in individual market premiums relative to current market rates, or to the expected rates in 2014 if all provisions of PPACA except the transitional reinsurance program were implemented?**

Answer: In 2014, it is anticipated that reinsurance payments will decrease premiums in the individual market between 10 and 15 percent, compared to the expected premiums without reinsurance.

b) **Please provide the Committee with any calculations that HHS has made to estimate the overall impact on health insurance premiums in the individual, small group, and large group markets resulting from all provisions of PPACA, including the transitional reinsurance program.**

Answer: HHS has not estimated the impact of the Affordable Care Act provisions on health insurance premiums. But, in 2014, it is anticipated that reinsurance payments will decrease premiums in the individual market between 10 and 15 percent, compared to the expected premiums without reinsurance.

c) **The proposed rule states that group health plans are required to contribute to the transitional reinsurance program because they will benefit from "implementation of the range of reforms" in PPACA, specifically because "reforms should lead to fewer unreimbursed health costs, lowering the costs for all issuers and group health plans." However, a 2010 study found that the Massachusetts health reform plan increased premiums for employer-sponsored**

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[4] American Action Forum, "Insurance Premiums in 2014 and the Affordable Care Act: Survey Evidence," January 2013: http://americanactionforum.org/sites/default/files/AAF_Premiums_and_ACA_Survey.pdf.

health plans by an average of about 6 percent.[5] Are you aware of any empirical evidence supporting the claim that coverage expansion will reduce costs for group health plans?

Answer: As CBO calculated, there will be little to no change in small and large group market premiums. According to these same CBO estimates, Americans purchasing coverage in the individual market have the most to gain. Improved risk pooling is estimated to lower premiums by 7 percent to 10 percent, as an influx of enrollees with below-average spending for health care, who would purchase coverage because of the new subsidies provided and the individual responsibility requirement. Reforms that lower insurance companies' administrative costs and increase competition would lower premiums an additional 7 percent to 10 percent for the same coverage. In addition to the welcome relief on costs, Americans will also have better insurance options. CBO estimates that many people will take advantage of these better options, in part due to tax credits available to purchase coverage, and individuals will "buy up" to purchase better, more comprehensive plans than are currently offered in the individual market.

[5] John F. Cogan, R. Glenn Hubbard, and Daniel Kessler, "The Effect of Massachusetts' Health Reform on Employer-Sponsored Insurance Premiums," *Forum for Health Economics and Policy,* 2010. Accessed through http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3251220/.

Senator John Thune

Guidance for Federally Facilitated Exchanges

To date, there have been only 19 pages of guidance documents published by HHS on the creation of Federally Facilitated Exchanges. As you know, a majority of States have determined that they do not want to be in the business of running an exchange and opted for a Federally Facilitated Exchange.

93) When can States expect to receive additional regulatory guidance for Federally Facilitated Exchanges?

Answer: CMS is in ongoing dialogue with States and issuers as it develops the FFM. CMS is working with States to preserve existing State programs, laws, and responsibilities of the State insurance department whenever possible, and has been in communication with issuers as they develop plans to submit as QHPs for CMS review. CMS will continue to issue regulatory guidance on FFMs as appropriate. CMS recently released a draft letter to issuers in the FFM, which will be of interest to States as well. This document provides extensive guidance on the QHP certification process and standards, timelines, enrollment, consumer support, and other key topics. CMS plans to release the final letter soon.

94) Will you commit to providing that information to States in final rules instead of proposed rules or non-binding guidance documents? (Yes/No)

Answer: CMS will continue to issue regulatory guidance as needed and will continue to work closely with States and issuers.

Eligibility Determinations

Mr. Cohen, under the law exchanges and Medicaid programs are required to perform eligibility determinations for premium subsidies, Medicaid, CHIP and the basic health plan. The statute clearly does not contemplate a majority of States defaulting to the Federally Facilitated Exchange or FFE, and therefore does not specify how the Federal exchange will administer eligibility determinations for State-run programs.

95) With more than half of all States, including South Dakota, defaulting to the Federally Facilitated Exchange can you please explain how the FFE will make eligibility determinations as required under the law, particularly in light of the complexity and variation in each State's Medicaid and CHIP eligibility rules?

Answer: CMS has established the beginnings of a streamlined system of coverage that will be supported by modernized eligibility and enrollment systems and a new, data-based eligibility verification system that relies on existing data sources to confirm eligibility rather than requiring applicants to produce paper documentation. In States that are not building a State-based Marketplace for 2014, there are multiple interfaces between the Medicaid eligibility system and the Federal systems, both for verification of eligibility through the Hub and to transfer accounts back and forth with the FFM. The FFM will work with State Medicaid agencies to collect and

implement many State-specific eligibility rules for Medicaid and CHIP to enable the FFM to make accurate determinations or assessments of eligibility for Medicaid or CHIP based on Modified Adjusted Gross Income (MAGI) standards. Under the proposed January 2013 Medicaid and Marketplace eligibility rule, a State Medicaid or CHIP agency may choose to accept the finding of the FFM as a final determination or as an assessment subject to the State Medicaid or CHIP agency making the final determination.

96) Additionally, will the FFE have the technology and capacity to make MAGI eligibility determinations for the States or will it be limited to making eligibility assessments and forwarding that information onto the State's Medicaid/CHIP program for the eligibility determination?

Answer: Yes, the FFM will have the technology and capacity to make MAGI eligibility determinations. A State Medicaid or the Medicaid or CHIP agency can also choose to have the FFM make assessments, with the State agency retaining the authority to make final determinations, with standards to ensure that effort is not duplicated.

Senator Richard Burr

IT Infrastructure

Your testimony notes that CMS has been building infrastructure for the exchanges and the need for exchanges to be operational beginning October 1, 2013 for the initial open enrollment period. We've heard significant concerns from stakeholders regarding the readiness of the IT infrastructure necessary to support the exchanges, particularly with respect to the Federal data services hub.

97) What is the Administration's contingency plan if the exchanges and the hub aren't actually operational on October 1, 2013?

Answer: We are moving forward with Marketplace implementation for open enrollment beginning on October 1, 2013. We are also working with States to provide the maximum amount of flexibility to enable them to perform the functions in their Marketplaces. A number of different systems will be in place by October 1 to accommodate open enrollment, including IT, call center, and plan management systems, and we are carrying out the plans we have in place to ensure that all of these systems are operational and that the Marketplace will be available to all consumers on October 1.

We are also developing mitigation strategies for IT systems as provided in the guidance established by the National Institute of Standards and Technology, Special Publication 800–34, revision 1 (May 2010). The document provides guidance to help personnel evaluate information systems and operations to determine mitigation strategy requirements and priorities.

98) Have you released all of the details necessary for all of the entities that will depend upon connecting with the FFE and the hub to ensure that they are prepared to successfully do so later this year?

Answer: The CMS security team actively coordinates with Federal partner agencies on topics such as contingency planning. Coordination on preparations with Federal partner agencies will proceed ahead of finalized FFM and Hub Contingency Plans. A formal release of the FFM and Hub Contingency Plans will occur after the completion of the Authority to Operate.

99) Please detail what testing has occurred to date.

Answer: The Federal Exchange Program System (FEPS), which includes the Hub, is tested after every monthly software development cycle called a 'Sprint' and after every 3 Sprints, which constitute a "Release." There have been 14 month-long internal Sprint tests and 4 internal Release tests to date.

Each service will be tested internally and with external partners. Due care has been taken to ensure all test data is 'sanitized.' No real data will be used in these tests.

Like all CMS systems, independent security testing will be conducted to ensure system security. The overall design of the FEPS is such that sensitive information is not retained in the Hub.

Further, data stored within the FEPS will have robust security controls in place and will be tested independently as part of the overall testing activities.

The Secure Communication test ensures the physical systems connected to the Hub are in fact using secure communications at the network and application layers. Other functional tests will ensure the proper execution of the data flows.

The FFE and Data Hub are both required to comply with FISMA, which includes documenting the security policies, procedures, and configurations of the IT system. Both systems will be subject to independent third party testing of security controls, and they will be authorized for operation by an authorizing official within the agency. As a subset to FISMA, CCIIO has engaged in a robust software assurance program to ensure the code developed in a secure manner as part of the software development life-cycle. Furthermore, the system has been, and will continue to be, subject to automated and human-based security penetration testing techniques to assess and identify any security weaknesses.

Federal Data Services Hub

My understanding is that the Federal data services hub will determine consumer eligibility for Federal subsidies and connect with several Federal agencies, such as Homeland Security, Social Security, IRS, Treasury, and HHS. The hub will be sharing very sensitive data, such as Social Security numbers.

100) Has the hub been thoroughly tested to ensure that the data flows are accurate and sensitive information will be protected?

Answer: The FEPS, which includes the Hub, is tested after every monthly software development cycle called a 'Sprint' and after every 3 Sprints, which constitute a 'Release.' There have been 14 month-long internal Sprint tests and 4 internal Release tests to date.

Each service will be tested internally and with external partners. Due care has been taken to ensure all test data is 'sanitized.' No real data will be used in these tests.

Like all CMS systems, independent security testing will be conducted to ensure system security. The overall design of the FEPS is such that sensitive information is not retained in the Hub. Further, data stored within the FEPS will have robust security controls in place and will be tested independently as part of the overall testing activities.

The Secure Communication test ensures the physical systems connected to the Hub are in fact using secure communications at the network and application layers. Other functional tests will ensure the proper execution of the data flows.

The FFM and Hub are both required to comply with FISMA, which includes documenting the security policies, procedures, and configurations of the IT system. Both systems will be subject to independent third party testing of security controls, and they will be authorized for operation by an authorizing official within the agency. As a subset to FISMA, CCIIO has engaged in a robust software assurance program to ensure the code developed in a secure manner as part of

the software development life-cycle. Furthermore, the system has been, and will continue to be, subject to automated and human-based security penetration testing techniques to assess and identify any security weaknesses.

101) Has an independent audit been done to assure the validity of the data and system security to ensure sensitive information will be protected?

Answer: Like all CMS systems, independent security testing will be conducted to ensure system security. The overall design of the FEPS is such that sensitive information is not retained in the Hub. Further, data stored within the FEPS will have robust security controls in place and will be tested independently as part of the overall testing activities.

The FFM and the Hub are both required to comply with FISMA, which includes documenting the security policies, procedures, and configurations of the IT system. Both systems will be subject to independent third party testing of security controls, and they will be authorized for operation by an authorizing official within the agency.

Cost of Exchanges

102) What will be the annual budget costs for running the Federally Facilitated Exchange?

Answer: The President's FY 2013 Budget included an additional $1 billion for CMS Program Management, most of which was for CMS Marketplace costs.

103) What will be the annual budget costs for States implementing a Partnership Exchange?

Answer: There is no specific annual costs for Partnership Marketplaces since each State may choose a different combination of tasks (Plan Management, Consumer Assistance, or both) it will perform. States may use Marketplace Establishment grant funding to develop its capacity to participate as a Partnership Marketplace.

104) What will be the annual budget costs for States implementing State-based Exchanges under PPACA?

Answer: Costs for a State-based Marketplace annual budget vary widely based on the size of the State as well as the policy choices made in a particular State for the scope of its Marketplace activities. States are developing their 'steady state' 2015 budgets now.

Exchange User Fee

Last December, CMS issued a Frequently Asked Questions document that noted that CMS has proposed that issuers pay a monthly user fee to support the operation of the Federally Facilitated Exchange, specifically proposing a fee rate of 3.5 percent of premiums.

105) How much will this fee increase the cost of premiums for consumers receiving health insurance through the Federally Facilitated Exchange?

Answer: We do not have this information at this time. CMS will have this information once we receive and evaluate QHP certification packages from issuers.

106) Will this increase be more or less than the increase in premiums due to the health insurance tax under PPACA?

Answer: We do not have an aggregate estimate of the collections from the user fee at this time because we do not yet have a count of participating issuers in the FFM, nor have they submitted their premium bids.

Senator Tom Carper

Guidance for Businesses

Businesses need predictability and certainty before they can expand their operations, make new investments, and create new jobs. In Delaware, and many other States, we have been anxious to receive more regulatory guidance for businesses on how to comply with the Affordable Care Act.

107) Can you tell us how the Administration is planning to provide information to businesses on how to comply with the Affordable Care Act?

Answer: CMS has been busy implementing a 4 step plan for outreach. The Preparation phase began last year and continues until Open Enrollment begins. This includes conducting consumer research and building infrastructure for our customer service channels like the call center and website. The Education phase began in January 2013 and goes through June. It includes building awareness of the new Health Insurance Marketplace, by creating content for consumers, and training personnel and partners.

The Anticipation—or "Get Ready"— phase of work begins this summer. It includes additional details about program operations (like web and call center) as they come online, as well as training for navigators and other certified assisters who will help consumers through the enrollment process. The Enrollment phase will run from October 2013 to March 2014. It includes a major launch effort that will engage all media channels, as well as provide new customer service channels and in-person assistance.

To help educate small businesses, we plan to work with our regional offices to provide updates on recent rollouts and to conduct business outreach. We have scheduled meetings in March—in Dallas, TX and Atlanta, GA—and look forward to working with other regional offices to provide more specific information on the impact of the Affordable Care Act on businesses.

Trainings and Tour

For example, we have heard that the Department of Health and Human Services (HHS) is planning to train staff in the Small Business Administration to help provide guidance to businesses on how to comply with the Affordable Care Act. We also understand HHS is planning an extensive tour throughout several States in March and April to highlight the benefits and correct myths around the ACA for businesses.

108) Could you provide the schedule for these trainings and tour?

Answer: HHS plans to work with regions to provide updates on recent rollouts and to conduct business outreach in the regions. A meeting is scheduled for March 7–8 in Dallas, TX and another is scheduled for March 13–14 in Atlanta. We look forward to working with other regional offices to provide more information on the impact of the Affordable Care Act on businesses.

Computer Systems

I have heard significant concerns raised by private insurance providers about the delay in regulatory guidance with regard to the necessary computer systems requirements for participating in the State and Federal exchanges. I am concerned that without adequate testing of these systems, we will not have a chance to detect and fix potential problems with enrollment, data submission and data security.

109) How are you planning to test the computer systems for the exchanges to make sure they work properly?

Answer: The FEPS, which includes the Hub, is tested after every monthly software development cycle called a 'Sprint' and after every 3 Sprints, which constitute a 'Release.' There have been 14 month-long internal Sprint tests and 4 internal Release tests to date.

Each service will be tested internally and with external partners. Due care has been taken to ensure all test data is 'sanitized.' No real data will be used in these tests.

Like all CMS systems, independent security testing will be conducted to ensure system security. The overall design of the FEPS is such that sensitive information is not retained in the Hub. Further, data stored within the FEPS will have robust security controls in place and will be tested independently as part of the overall testing activities.

The Secure Communication test ensures the physical systems connected to the Hub are in fact using secure communications at the network and application layers. Other functional tests will ensure the proper execution of the data flows.

The FFM and the Hub are both required to comply with FISMA, which includes documenting the security policies, procedures, and configurations of the IT system. Both systems will be subject to independent third party testing of security controls, and they will be authorized for operation by an authorizing official within the agency. As a subset to FISMA, CCIIO has engaged in a robust software assurance program to ensure the code developed in a secure manner as part of the software development life-cycle. Furthermore, the system has been, and will continue to be, subject to automated and human-based security penetration testing techniques to assess and identify any security weaknesses.

110) Do you have a contingency plan to back these computer systems up in they run into glitches?

Answer: We are moving forward with Marketplace implementation for open enrollment beginning on October 1, 2013. We are also working with States to provide the maximum amount of flexibility to enable them to perform the functions in their Marketplaces. A number of different systems will be in place by October 1 to accommodate open enrollment, including IT, call center, and plan management systems, and we are carrying out the plans we have in place to ensure that all of these systems are operational and that the Marketplace will be available to all consumers on October 1.

We are also developing mitigation strategies for IT systems as provided in the guidance established by the National Institute of Standards and Technology, Special Publication 800–34, revision 1 (May 2010). The document provides guidance to help personnel evaluate information systems and operations to determine mitigation strategy requirements and priorities.

Wellness Programs

When we enacted health care reform three years ago, we included a provision that I co-authored designed to make it easier for employers to run effective wellness programs for their employees. Before health reform was passed, companies designed outcomes-based wellness plans that incentivize people to take better care of their health, in accordance with current regulations. The provision in the Affordable Care Act that I offered as an amendment codified wellness program regulations that had been in place since 2006 under HIPAA, and allowed for greater rewards for employees within the context of those rules.

Unfortunately, rather than supporting these proven approaches to wellness programs, the Administration's proposed rule published in November, entitled "Incentives for Nondiscriminatory Wellness Programs in Group Health Plans," would actually take a step in the opposite direction due to a substantial departure of the regulations that have been in place since 2006 and reinforced in the ACA. Our intent was to give companies the flexibility to expand outcomes-based wellness programs, but the proposed rule will actually undermine this goal.

111) Can you let us know which agencies in HHS worked with you on this proposed rule and provide assurance that HHS will work to ensure that companies that comply with the current rules can operate those plans and take advantage of expanded premium differentiation?

Answer: This rule was issued by HHS in coordination with Labor and Treasury. Within HHS, CMS is primarily responsible for the work to develop this rule. We expect to issue a final rule in the near future.

Exchange Final Rule

The Exchange Final Rule regulations provide that individuals do not have to terminate coverage and issuers must not terminate coverage when an individual becomes enrolled in other minimum essential coverage *unless* the individual requests a termination. These protections are a welcome clarification for individuals with significant health needs.

112) In cases where an individual chooses not to terminate their individual Exchange coverage upon enrollment in other minimum essential coverage, does HHS expect to release further guidance on the coordination of those benefits?

Answer: Individuals are not required to terminate coverage and QHP issuers must not terminate coverage when an individual becomes enrolled in other minimum essential coverage unless the individual requests a termination. However, if an individual is eligible for or enrolled in other minimum essential coverage, such individual may no longer be eligible for premium tax credits.

113) I assume, for example, if a patient chooses not to terminate their individual coverage that such a patient would want the option to choose to maintain that individual exchange coverage as their primary coverage?

Answer: If a patient chooses not to terminate their individual coverage they may maintain the individual Marketplace coverage as their primary coverage. However, the individual may no longer qualify for premium tax credits available through the Marketplace.

Senator Bill Nelson

26 States have said they will not build or co-run a health insurance marketplace in 2014 and will be using the Federally Facilitated Exchange (FFE).

114) How will CMS work closely with the States participating in the FFE to be sure that it properly suits the individual insurance market in each State?

Answer: Through an ongoing consultation process, CMS has sought input from States in both State Partnership Marketplaces and FFMs. In the FFM, CMS will coordinate its plan management activities with States' existing insurance oversight functions. CMS's activities will include QHP certification, monitoring and oversight, account management, and recertification. CMS does not plan to duplicate plan rate or benefit reviews performed by a State as part of CMS's QHP certification process, although CMS will make the ultimate QHP certification decision in all FFMs. Throughout the development of the FFM, CMS has sought, and will continue to seek, the input of stakeholders in each State.

115) Since even in non-partnership States CMS will still need to work with State and local regulators, what authority does CMS have to make sure that all necessary information is provided to ensure the marketplace functions properly?

Answer: CMS has worked collaboratively with States to enforce the early market reforms of the Affordable Care Act. The enforcement structure for these reforms is very much a partnership between the States and the Federal Government. As the primary regulators, States can use their existing enforcement framework and tools to monitor compliance with the market reform standards. Examples of such tools include policy form review, complaint investigation, market conduct examinations, and market analysis.

The Public Health Service Act establishes a framework for States and CMS to enforce the Affordable Care Act and other provisions. This enforcement structure contemplates that States will have primary responsibility for enforcing the Affordable Care Act market reform provisions.

Under this framework, CMS has the responsibility to enforce the market reform standards only when a State notifies CMS that it does not have legal authority to enforce or is not enforcing, or when CMS determines that the State is not substantially enforcing the standards. This State-Federal enforcement framework has been in place since 1996, and the Affordable Care Act builds upon it.

Senator Mike Enzi

User Fees

116) It is my understanding that the federally funded exchanges will be funded in the long term by user fees charged to plans who participate in an exchange?

Answer: Yes. For the 2014 benefit year, we proposed a monthly user fee rate equal to 3.5 percent of the monthly premium charged by the issuer for a particular policy under the plan.

117) What are the current user fee rates?

Answer: For the 2014 benefit year, we propose a monthly user fee rate equal to 3.5 percent of the monthly premium charged by the issuer for a particular policy under the plan.

118) Do you expect that these rates will remain constant, or will HHS have to increase them in the near future?

Answer: HHS proposed the 3.5 percent of premium user fee to fund FFM operations, which is aligned with rates charged by State-based Marketplaces, sought comment on this provision, and may adjust the rate in future benefit years.

119) What type of actuarial projections has the Administration done on the cost and growth of these user fees?

Answer: HHS has undertaken several budget projections and estimates to determine the appropriate FFM user fee amount. These estimates have several limitations, notably number of issuers participating in the FFM and the premiums the issuers will charge. As issuers enter into the QHP certification process, HHS will have additional data.

120) Are you concerned that these user fees will simply be passed along to consumers by the plans? Why or why not?

Answer: Maintaining a central marketplace where consumers can comparison shop for health insurance is an important mechanism for reducing costs. We believe that when insurers compete for business in the open marketplace and on a level playing field, costs will decrease. The MLR and rate review provisions of the Affordable Care Act also encourage insurers to deliver care more efficiently and keep administrative costs low. Plus, the marketplace will engage in certain operational functions like outreach that are usually left to the issuer, which will reduce issuers' overall spending. Those savings may be passed down to the consumers as well. These provisions, coupled with the influx of new enrollees via the marketplace, give insurers an incentive to control the cost of coverage.

IT Infrastructure

States are expected to have fully operational health exchanges for consumers by January 1, 2014. Many States are expected to struggle with developing entirely new and

comprehensive health information technology infrastructures. Many of the consumers that may need to navigate these exchanges will be new and old Medicaid patients. However, a 2011 Health Affairs study estimates that 50 percent of all adults with family incomes below 200% of the Federal poverty level will experience a shift in eligibility from Medicaid to an insurance exchange, or the reverse, in just the first year of the exchanges.

121) What is being done to address potential coverage issues for the most poor and vulnerable populations that cross eligibility thresholds during all of these major health system changes?

Answer: As you note there will be a population who shifts between the Marketplace and Medicaid during the year. Regulations prescribe a high degree of coordination between Marketplaces and State Medicaid and CHIP agencies, including robust assessments or determinations by Marketplaces of Medicaid and CHIP eligibility based on modified adjusted gross income. Marketplaces are responsible for the timely transfer of eligible or potentially eligible individuals to State Medicaid and CHIP agencies, while State Medicaid and CHIP agencies are responsible for timely transfer of potentially eligible individuals to Marketplaces. Proposed regulations also specify that the Marketplace and Medicaid and CHIP agencies will include coordinated content in eligibility notices for the first year of operations, and move to combined eligibility notices the following year, both of which will inform consumers when their eligibility changes and next steps to re-enroll. We are working to minimize the burden on individuals and their families while following the statute.

Senator Michael Bennet

Behavioral Health

The rules and regulations for behavioral health, including benefits and coverage, are considerably different for Medicaid and Medicare. As individuals can migrate from one program to the other or may be eligible for both, close alignment of these two programs is necessary for continuity of care and can encourage provider participation in both programs.

122) Are Federal officials working to align the rules and regulations for these two programs? If yes, how? And what more can be done to streamline these rules and regulations?

Answer: There are many opportunities to improve the alignment of behavioral health services covered by the Medicare and Medicaid programs for Medicare-Medicaid enrollees. A lack of sufficient care coordination may lead to increased incidence of duplicative services, contraindicated therapies and drugs, inefficiencies in care, and cost-shifting. To the extent current systems create waste, confusion or poor care, CMS seeks to reduce or eliminate their underlying sources, creating a more streamlined system that delivers appropriate, quality, cost-effective care.

To address such program inefficiencies, CMS has launched the Financial Alignment Initiative to facilitate development of a better, more cost-effective system of care that strengthens Medicare and Medicaid for beneficiaries, their caregivers, providers, States, and the Federal Government. Through the Financial Alignment Initiative, CMS offered two demonstration models for the States to test alignment of financing and service delivery between the Medicare and Medicaid programs while preserving or enhancing the quality of care furnished to Medicare-Medicaid enrollees. Both of these models encourage States to align behavioral health benefits and coverage, ensuring a full spectrum of behavioral health care to participating Medicare-Medicaid enrollees.

In addition to the Financial Alignment Initiative, CMS is looking to align other areas of mutual concern; including an initiative to help improve the quality of care for people in nursing facilities by reducing preventable inpatient hospitalizations. The Initiative to Reduce Avoidable Hospitalizations Among Nursing Facility Residents is focused on long-stay nursing facility residents who are enrolled in the Medicare and Medicaid programs.

ESRD

Guaranteeing network adequacy is a particularly important issue for individuals with ESRD, but the exchange final rules do not specify the minimum distances for access to providers or minimum time frames in which to access the providers. The lives of individuals with ESRD often depend on being able to access dialysis treatment at least three times a week, but research has shown that increased drive time to treatment is correlated with diminished health outcomes. Due to the geographic variability of many States, particularly in a State like Colorado, a single standard distance or time frame for all

providers may prove to be difficult. This concern must be balanced with network adequacy because it is a key indicator with respect to proper plan design.

123) Would HHS consider clarifying regulatory language to provide a range of acceptable network adequacy criteria so that ESRD patients do not have to travel more than 15–30 minutes to receive life-saving treatments?

Answer: CMS finalized network adequacy standards in the 45 CFR 155.1050 and 156.230. These provisions establish a minimum standard, and Marketplaces must ensure that QHPs comply with the regulatory standard. HHS did not establish specific national standards at this juncture because network adequacy commonly reflects local geography, demographics and patterns of care. Furthermore, network adequacy is typically regulated by States, and a national standard set in regulation could result in misalignment of standards inside and outside the Marketplace. Nothing prohibits States from applying more stringent standards or protections across their markets. Colorado has elected, and has been conditionally approved, to run a State-based Marketplace. As a result, the State will be responsible for determining network adequacy.

EHB Rule

The EHB Rule allows plans to have benefit substitutions within certain parameters and to have benefit scope and duration limits that are substantially equal, but not the same as, the benchmark plan.

124) How does the prohibition on discriminatory benefit design work with this rule? Specifically, in the case of individuals with significant health needs, are plans prohibited from imposing treatment limits that exceed the corresponding limits imposed by the benchmark plans and to what extent can they make substitutions for the benefits required to be covered under the benchmark plan?

Answer: Under the proposed regulations at 45 CFR 156.115(b) issuers would be permitted to substitute benefits within a benefit category as long as the benefits are actuarially equivalent and the substitution is not otherwise prohibited by State law. For example, an issuer could not substitute a benefit that was a State-required benefit. In addition, our proposed regulations at 45 CFR 156.125 proposes that an issuer does not provide essential health benefits if its benefit design, or the implementation of its benefit design, discriminates based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions.

125) Where a State enacts more restrictive legislation to prohibit substitutions or exceeding the State benchmark's limit, does that legislation apply?

Answer: Yes, generally, State laws that are more protective than Federal law and do not otherwise prevent the application of Federal law would not be preempted.

Senator Maria Cantwell

Basic Health Plan

Millions of people with low incomes are expected to move between Medicaid and the State exchanges; some of these individuals will change eligibility several times each year. This poses many difficulties both for individuals and States and the Federal government as they operate Medicaid and the exchanges. There are several options in the Affordable Care Act (ACA) and related regulations that would allow people continuity, including the Federal Basic Health Plan Option in section 1331 of the ACA, the "bridge" option described in Centers for Medicare and Medicaid Services' December 10, 2012 "Frequently Asked Questions," and various other policies, and we hope States will make use of these policies to improve continuity for the health care consumers in their States.

126) Because the practical application of the ACA undeniably requires clear coordination between Medicaid and the exchanges, implementing continuous eligibility in the Medicaid program could streamline operations in both programs. Would you support 12-month continuous eligibility in Medicaid to improve operations in State exchanges?

Answer: We agree that continuous eligibility is a positive strategy for minimizing churning and preventing unnecessary gaps in coverage. CMS will be carefully monitoring coverage under the Affordable Care Act to identify ways to improve continuity of coverage. Since 1997, States have had the option to guarantee a full year of coverage to children in Medicaid and CHIP by providing 12 months of continuous eligibility. In addition, we have worked with States to implement continuous eligibility for adults through section 1115 waivers, which are budget neutral to the Federal Government.

Senator Pat Roberts

On many regulations implementing the PPACA statute stakeholders are being given the minimum amount of time to respond (30 days) to the sometimes hundreds of pages of regulations, often with many of these regulations being issued in the same week. In these instances the Administration has had months if not years to draft and review and OMB is given months to review as well.

127) Will future regulations give stakeholders more than a minimal amount of time to review?

Answer: We have heard from stakeholders that thirty days has been adequate time to react to new rules. We are in constant contact with interested stakeholders about our progress, so interested groups were aware when the rules came out and were able to submit constructive criticism within the deadline. In total, we've received hundreds of comments on these rules, and are working on responses to the comments as we prepare the final rules.

128) It has been suggested but other nominees before Finance Committee that 60 days would be a more reasonable timeframe?

a. In addition, we are getting feedback that many stakeholder groups do not believe the Administration will take into account their comments when issuing the final regulations. I'd like to point to a letter I, along with many of my colleagues, sent to HHS, Treasury and the Department of Labor outlining our concerns. In your response dated February 12, the Department noted that they are "reviewing these comments" and "will finalize the rules soon." I would also note that the submissions for these rules to OMB showed them as being submitted/received by OMB on February 8 which tells me that you have in fact completed your review of the rules and are not still considering them. That careful consideration of thousands of comments was given at the most a little over 40 days to complete. I can see why stakeholders are skeptical that you are listening to what they have to say. I would remind you that the traditional regulatory process as described in both statute and executive order, calls for notice, comment, review and consideration of comments and issuing of a final rule. What is being done to address this very troubling concern?

Answer: I can assure you that the Administration has carefully reviewed comments received. In addition to reviewing and responding to stakeholder comments, we are also in constant contact with stakeholders throughout the implementation process and consider their informal feedback. In addition to proposed rules, we also provide guidance and bulletins for stakeholders to review.

Rulemaking and Guidance Process

I am very concerned by the lack of information coming from this Administration related to the Federally Facilitated Exchanges (FFE). For such a large task I believe I am not alone in expecting that the Administration would have established these exchanges through the traditional notice and comment rulemaking process. However instead we are told to refer

to the regulations establishing the State exchanges. To date there has been no clear explanation for how the FFE will operate, a timeline, costs associated with it, etc. My understanding is that HHS/CMS required State to complete Blueprints for exchanges which were due to HHS on or around December 14.

129) Where is the blueprint for the Federally Facilitated Exchanges?

Answer: Section 1321 of the Affordable Care Act requires HHS to certify States' plans to run their own Marketplaces. Blueprints were created to facilitate this process for States by providing a uniform application for approval by HHS. In States where an FFM operates without a State Partnership, HHS will carry out all Marketplace functions, including consulting with stakeholders and participating in formal consultation with Indian Tribes; certifying, recertifying, and decertifying QHPs; determining individuals' eligibility for enrollment in a QHP through the Marketplace and for insurance affordability programs; and supporting consumers, issuers, and other stakeholders through technical assistance and enrollment facilitation resources. HHS will administer these functions consistent with the Marketplace Final Rule, which established minimum Federal standards for major Marketplace business areas.

130) If you aren't going to do the rulemaking and we haven't gotten clear direction through any other means, could you at least provide the same level of detail you are requiring the States to submit? That would give us more detail than we currently have.

Answer: On May 16, 2012, CMS released guidance describing our approach to implementing an FFM. CMS has also released the elements of a streamlined, consumer-focused application that consumers in all States that choose an FFM will complete starting in the fall of 2013. The application will help individuals and families identify various insurance affordability programs that may be available to help them get and pay for health insurance.

In addition, all plans that health insurers want to offer in the marketplace must be certified as a QHP. The application that QHPs will use to become certified is near completion. CMS has worked with the NAIC to standardize the collection of data needed to certify QHPs. CMS has already released the data elements that insurance plans will need to integrate into this application.

The application for issuers to offer QHPs operating in the SHOP is being developed, as is the application for small employers that would like to provide coverage for their employees through the SHOP. CMS has already released the elements of the issuer application for SHOP. Also, CMS has outlined the parameters for managing payment processing across entities.

All of the guidance CMS has released is at http://cciio.cms.gov/resources/regulations/index.html.

Sub Regulatory Guidance Documents

HHS/CMS and many of the Departments implementing PPACA have often referred to sub regulatory guidance documents such as bulletins, guidances, postings on the website, FAQs, etc. to demonstrate stakeholder participation the regulatory process. This raises several concerns as sub regulatory guidance does not hold the force of law; generally does not reach, through notification and other means, the same amount of stakeholder participants; and is outside the traditional regulatory process, which can confound stakeholders with limited resources, both time and money, on where they should place their focus. The traditional regulatory process as described in both statute and executive order, calls for notice, comment, review and consideration of comments and issuing of a final rule.

131) Why is this Administration deviating from the normal rulemaking process and can we ever expect it to return to the more traditional notice and comment rulemaking?
   a. If not, do you plan to formally notify stakeholders of the new emphasis by this Administration on sub regulatory actions over the legally binding rulemaking process?

Answer: Sub-regulatory guidance such as bulletins, guidance, postings on the website, and FAQs are used to provide greater detail and clarify the application of statutes and regulations. These tools are a standard practice and have previously been used. Throughout the implementation of the Affordable Care Act, CMS has sought to engage stakeholders, help them understand the law and benefit from it. With the exception of a few rules issued as Interim Final Rules (IFRs) due to statutory deadlines shortly after the enactment of the Affordable Care Act and to respond to commenters, CMS has used the standard notice and comment rulemaking process. Even in the case of an IFR, the public is still able to comment after the promulgation of the IFR, before the rule is finalized. In addition, in some instances CMS has used tools like bulletins on essential health benefits and actuarial value to provide an additional avenue for stakeholder feedback and input in advance of the formal rulemaking process. These two bulletins were followed by proposed rules with public comment periods. We intend to finalize these rules soon.

Costs of Implementing Regulations

We have had a very hard time getting feedback from this Administration related to the costs of implementing their regulations. States and stakeholders continue to be concerned with the costs associated with implementing PPACA. There is no clear information related to these costs in many of the regulations and HHS has not be able to provide this information in response to my questions.

132) At a minimum when a regulation is determined through the review process with OMB to be economically significant will these regulations issued by HHS, either on your own or with other Agencies, contain clear quantifiable (not just qualitative) description of benefits or costs to reach the economically significant effects ($100 million or more in any 1 year)?
   a. Or if that is not possible, explain why the Administration is unable to quantify the costs/benefits?

Answer: As required by OMB, we include an analysis of the cost, benefits, transfers and burden of implementation for each economically significant regulation. Regulatory impact analyses are available on the CCIIO website under the "regulations and guidance" section. For example, for the March 2012 Marketplace Establishment Final Rule, we published a 50-page analysis that details our need for regulatory analysis, estimated outlay for the impact of the Marketplaces, the costs and benefits for the Marketplaces, and alternatives, assumptions, and limitations considered within this analysis.

Defining Significant Regulations

During briefings by HHS in implementing PPACA regulations staff have been unable to define why a regulation is considered significant, even when the regulation has been considered thus, or has met the economic threshold set by OMB. This is an obvious concern, when staff briefing the hill do not know specifics in their own regulations.

133) Will future significant regulations issued by your Department, either on your own or with other Agencies, include a clear definition (such as what of the four requirements are met) for why a regulation is considered significant?

Answer: Under Executive Order 12866, OMB's Office of Information and Regulatory Affairs (OIRA) is responsible for determining which agency regulatory actions are "significant."

Transition from Medicaid to Exchanges

134) What measures are you putting into place for continuity of care as members drift from plan to plan—from Medicaid to Exchanges—especially for those who drift from Medicaid to subsidized?

Answer: CMS' final eligibility rules published in March 2012 create a strong alignment between Medicaid, CHIP and the Marketplace. States and the Federal Government have already made great strides in identifying and enrolling eligible children in Medicaid and CHIP coverage and many of those successful strategies are carried forward to apply to the other insurance affordability programs. For example, as noted above, 12 months of continuous eligibility is a strategy that many States have already adopted for children and pregnant women and could be carried over to the new expansion population of low-income adults through waiver authority.

In addition, we have established the beginnings of a streamlined system for eligibility determinations and enrollment in coverage that will be supported by modernized eligibility and enrollment systems and a new, data-based eligibility verification system that relies on existing data sources to confirm eligibility rather than requiring applicants to produce paper documentation. All of these changes are fundamentally designed to minimize disruptions in coverage and to ensure smooth transitions between insurance affordability programs where appropriate.

135) For example, there has been discussion of a "bridge plan" that would allow plans to offer both a Medicaid and subsidized plan under certain conditions, which could

facilitate a smoother transition between Medicaid and the exchange. Is this something you are still evaluating, and are there other options that you may be considering?

Answer: Yes, CMS is considering whether a State could allow an issuer that contracts with a State Medicaid agency as a Medicaid managed care organization to offer QHPs in the Marketplace on a limited-enrollment basis to certain populations. Plans would be required to comply with applicable laws, meet QHP certification requirements, and demonstrate a commitment to work in the best interest of consumers.

Successful implementation of a Medicaid bridge plan will involve a high degree of coordination between the State Medicaid agency, department of insurance, and the Marketplace. States operating State-based Marketplaces will be best positioned to achieve the level of coordination needed to implement and support the offering of a Medicaid bridge plan on a Marketplace.

136) **Please talk to us about the vision for the eligibility systems with the exchange—how does the exchange eligibility system interface with the Medicaid eligibility system. Please explain some examples of best practices of how States are going to pulling off the interface between the exchanges and Medicaid eligibility systems.**

Answer: When consumers access the Marketplace and fill out the single, streamlined application, the information they provide, including income information, will, via the Hub, be verified against other sources of information, including the IRS, DHS, and SSA. Every Marketplace will also use the Hub to connect to State Medicaid agencies to check whether an applicant is already enrolled in Medicaid. In the Hub, data will be routed through but not stored in the system, while ensuring that the data flows where it is needed. The Hub will access only the information needed to determine individual eligibility and will not be involved in the selection or certification of health plans. CMS has completed the Hub's technical design, has almost completed the services related to Federal and State interactions, and has already begun testing the Hub across agencies. When an applicant is assessed or determined eligible for Medicaid, the Marketplace will use the Hub to transfer the applicant's information to the State Medicaid agency to complete the process.

Formularies

Many health plans do not have a process for adding new drugs to their formulary as they are approved by the FDA and become available to consumers. In some cases, these drugs provide a lifeline for individuals with critical conditions so it is important that these medications become available to insureds as quickly as possible. However, health plans may only update formularies on an annual basis, so it could be months before consumers have access to these medications.

137) **What protections will be provided consumers to ensure their health plans are adding new medications as they become available?**

Answer: CMS received comments in the response to the proposed rule on a similar question. While plans must offer at least the greater of one drug for each USP category and class or the

number of drugs in the essential health benefits benchmark plan, plans are permitted to go beyond the number of drugs offered by the benchmark without exceeding essential health benefits. In addition, proposed 45 C.F.R. 156.122(c) proposes that a health plan providing essential health benefits must have procedures in place that allow an enrollee to request and access clinically appropriate drugs not covered by the health plan.

Qualified Health Plans

The proposed rule neither specifically allows nor disallows the use of specialty tiers by qualified health plans, however CMS included specialty tiers in its proposed AV Calculator as a drug benefit option. Specialty tiers have the potential to discriminate based on factors such as an individual's health condition because drugs to treat rare diseases are almost exclusively relegated to a specialty tier with high cost-sharing requirements.

138) How is HHS prepared to handle the use of specialty tiers by qualified health plans, and will any consideration be made to protecting individuals with rare diseases to ensure that they receive meaningful and affordable coverage?

Answer: CMS' implementing regulations neither require nor prohibit that prescription drugs be covered on any particular tier, if a plan chooses to use a tier system in its formulary. The essential health benefits proposed rule proposes that plans offer at least the greater of one drug in every USP category and class or the number of drugs in each USP category and class offered by the essential health benefits benchmark. Additionally, the proposed essential health benefits rule at 45 CFR 156.125 outlines non-discrimination standards for issuers offering essential health benefits; it applies to all essential health benefits including prescription drug benefits. The regulation would provide that an issuer's benefit design, or the implementation of its benefit design, may not discriminate based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions. Lastly, the proposed rule proposes that plans have an exceptions procedure that allows enrollees to request or gain access to a clinically appropriate drug not covered by the health plan.

USP

HHS intends to use the United States Pharmacopeia (USP) as one reference point for determining the categories and classes of covered prescription drugs. The USP was developed for use by Medicare Part D plans and therefore the categories and classes do not sufficiently reflect the entire range of drugs that the broader population of patients requires.

139) How is HHS prepared to handle situations where the USP may not adequately reflect the needs of patients, especially those who suffer from rare diseases?

Answer: In situations in which a consumer needs access to a clinically appropriate drug that is not on a plan's formulary, the essential health benefits proposed rule at 45 CFR 156.122(c) would require that a health plan have procedures in place that allow an enrollee to request clinically appropriate drugs not covered by the health plan.

Ensuring Broad Provider Networks

Given the vital role medical specialists play in properly diagnosing and treating patients with rare diseases, a broad provider network is essential to ensuring meaningful and affordable coverage. Having a robust provider network is even more important to the affordability of coverage for individuals with rare, complicated and chronic diseases where out-of-network care does not count toward out-of-pocket maximums.

140) How will HHS ensure the provider networks are broad enough to ensure patients have an adequate number of in-network specialists from which to receive care?

Answer: The Marketplace Final Rule in 45 CFR 155.1050 and 45 CFR 156.230 sets forth network adequacy requirements for all Marketplaces. A QHP issuer must maintain a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay. CMS will use the QHP certification process to ensure network adequacy. Many States conduct network adequacy reviews a part of issuer licensing process. In such States, CMS will rely on State analysis and recommendations regarding issuer networks. In States that do not conduct network adequacy reviews as part of the licensure process, CMS will ensure that the issuer is appropriately accredited, or submits an access plan explaining how the issuer will ensure adequate access for all services, including specialty care services.

Senator Robert Casey, Jr.

CHIP Enrollment

141) Could you explain in greater detail how Federally Facilitated Exchanges will coordinate with State Medicaid and CHIP programs to ensure the following:

a. That every eligible child is enrolled in the appropriate health insurance program, based on the family's income?

b. That the transitions between Medicaid, CHIP and subsidized health insurance programs are smooth, especially as many children may move between CHIP, Medicaid and subsidized insurance as their family incomes change?

Answer: CMS' final eligibility rules published in March 2012 create a strong alignment between Medicaid, CHIP and the Marketplace. States and the Federal Government have already made great strides in identifying and enrolling eligible children in Medicaid and CHIP coverage and many of those successful strategies are carried forward to apply to the other insurance affordability programs. For example, as noted above, 12 months of continuous eligibility is a strategy that many States have already adopted for children and pregnant women and could be carried over to the new expansion population of low-income adults through waiver authority. Our regulations require at least a 12-month period of eligibility (subject to required reporting of changes in circumstances that could affect eligibility).

In addition, we have established the beginnings of a streamlined system for eligibility determinations and enrollment in coverage that will be supported by modernized eligibility and enrollment systems and a new, data-based eligibility verification system that relies on existing data sources to confirm eligibility rather than requiring applicants to produce paper documentation. All of these changes are fundamentally designed to minimize disruptions in coverage and to ensure smooth transitions between insurance affordability programs where appropriate.

Essential Health Benefits

142) I understand that CMS will have a certification process for plans being sold on Federally Facilitated Exchanges. If a State has additional mandated benefits, how will CMS take this into account when certifying new plans for sale in the health insurance marketplace? Will CMS take an active role in ensuring these plans meet the essential health benefits requirements and cover State-mandated benefits, or will CMS leave it up to the individual States?

Answer: CMS is responsible for ensuring that all QHPs sold in FFMs and State partnership marketplaces meet all the certification standards. However, State departments of insurance have historically been and will remain the primary regulators of health insurance products sold in their State. States will continue to evaluate all health plans for compliance with State law. In addition, the majority of States in which a FFM will operate will be enforcing market reforms, including coverage of essential health benefits. CMS intends not to duplicate reviews or enforcement

activities undertaken by a State, and expects to work collaboratively with State departments of insurance both throughout the certification process and during the coverage year.

Coverage of EHBs

As you know, fully insured small group and individual health plans offering coverage through an exchange must cover "essential health benefits" (EHBs) beginning January 1. I have a question regarding coverage of EHBs and the use of medical or pharmacy utilization management techniques by health plans.

The preamble to the EHB Final Rule decrees that the "EHB regulations do not prohibit issuers from applying reasonable medical management techniques," but that issuers could not use such techniques "in a manner that discriminates on the basis of membership in a particular group based on factors such as age, disability, or expected length of life that are not based on nationally recognized, clinically appropriate standards of medical practice evidence or not medically indicated and not evidence-based." As an example, the final rule suggests that a "reasonable medical management technique would be to require preauthorization for coverage of the zoster (shingles) vaccine in persons under 60 years of age, consistent with the recommendation of the Advisory Committee on Immunization Practices".

This example is insufficient with respect to pharmacy benefit design, where insurers use utilization management techniques beyond simply requiring prior authorization (*e.g.*, step therapy or specialty-tier pricing).

Furthermore, the final rule removed the proposed prohibition on discriminatory cost sharing, and elaborates that "nothing in this section shall be construed to prevent an issuer from appropriately utilizing reasonable medical management techniques".

143) Please advise the Committee as to how you intend to provide meaningful guidance on your expectations regarding enforcement of these non-discrimination provisions, especially with regard to pharmacy benefits, where UM techniques can be particularly frustrating for patients with chronic, rare diseases who have limited therapeutic options and in many cases have already had to overcome enormous challenges to obtain a proper diagnosis—sometimes several years from the onset of symptoms.

Answer: CMS expects to issue guidance covering a range of Marketplace topics, including approaches to ensuring non-discrimination in benefit design.

Senator Jay Rockefeller

Affordability of Health Plans

The determination of affordability under the Affordable Care Act must be done in a way that results in appropriate coverage options for everyone. Certainly, the law should not be interpreted in a manner that will undermine coverage for children and spouses under family plans. Nonetheless, the Administration recently decided to peg eligibility for subsidized coverage in the exchanges to the cost of individual health plan offered by an employer relative to a worker's income. Thus, many people seeking family coverage from their employer will not be eligible for subsidized coverage in the insurance marketplaces—even if they cannot reasonably afford the family health plan offered by their employer. I am concerned that this decision will leave hundreds of thousands of children without access to coverage.

144) What specific steps is HHS taking to resolve this issue?

Answer: The policy you describe is under Treasury's jurisdiction, so that Department would be best positioned to answer questions about it.

145) Please provide details on any options HHS is considering to encourage States to provide more relief for these families through the exchanges.

Answer: HHS is working with States to identify options for the design of coverage systems for 2014, to improve continuity of coverage as individuals' income changes. Additionally, some States with current Medicaid adult coverage expansions are considering offering additional types of assistance with premiums to individuals who will be enrolled in QHPs through the Marketplace. HHS will review all such ideas.

Premium Assistance

I have long been a champion of the CHIP and Medicaid programs. As regulations have been released, offering benefits that are nowhere near the guarantee of EPSDT and without the premium assistance that would permit an employee to purchase family coverage, it is clear to me that importance of these programs remains intact. In December 2012, HHS issued a guidance document expanding a State option that allows Medicaid and CHIP-eligible enrollees to use Federal funding as "premium assistance" to buy into private coverage. I am very concerned about the potential consequences of broadening this authority, particularly for children, who are likely to experience more gaps in coverage under private plans.

146) Can HHS clarify how much discretion States will be given in allowing Medicaid and CHIP enrollees to use premium assistance?

Answer: As described in law, States have the option to use Medicaid and CHIP dollars to purchase health insurance for beneficiaries in the private market. As we receive State proposals we evaluate them to ensure consistency with the law.

147) How will HHS monitor compliance with cost-effectiveness and wrap-around requirements?

Answer: CMS currently requires States that use premium assistance to make a showing that such an arrangement is cost effective. The statute allows for many factors to be considered when gauging cost effectiveness including access to providers and reducing public and private costs that arise when individuals "churn" between the Marketplace and Medicaid due to changes in family circumstances. CMS will continue to require States to show that cost-effectiveness is met. Additionally, to the extent that States are required to provide wrap-around benefits, CMS will continue its current practice of determining the type of wrap needed and of requiring the State to show how such services will be delivered.

148) Will States be permitted to use Section 1115 waivers to bypass wrap-around requirements?

Answer: As is current practice, CMS reviews submitted 1115 demonstrations to determine how the demonstration would promote the objectives of Title XIX of the Social Security Act. Our goal at CMS is to ensure a Medicaid beneficiary's access to required services.

Adverse Selection

It is imperative that the exchanges not be used to recreate adverse health selection that we worked so hard to eliminate in passing the ACA.

149) What specific steps is HHS taking to prevent adverse selection in health insurance markets in States that opt for the Federally Facilitated Exchange?

Answer: Several requirements for qualified health insurance plans will make it less likely that that insurers will have an incentive to avoid high-cost enrollees—that is, the problem of adverse selection. These requirements include plans' coverage of certain essential health benefits, standardization of the percentage of health care costs plans will cover through actuarial value metals, and rate-setting based on a single risk pool.

Additionally, CMS intends to work collaboratively with State departments of insurance, which will be performing market-wide reviews to ensure compliance with the Affordable Care Act's insurance market reforms.

150) How big of a threat does this problem pose to premium costs and overall the vitality of exchanges in these markets?

Answer: CMS' regulations are designed to limit the threat of adverse selection by changing the health insurance market in ways that reduce the cost of health insurance for all Americans, including those who will shop for coverage in the new Marketplaces. For example, the regulations' risk adjustment provisions, reinsurance and risk corridors programs are designed to reduce issuer incentives to avoid sicker Americans, lower premiums in the individual and small group markets, protect against uncertain rate setting, and make insurance more affordable.

Stakeholder Communication

Information is essential to a well-functioning market. While getting the exchanges up and running is a substantial undertaking, it is essential that there be open lines of communication among all stakeholders.

151) How is HHS working with States to establish "feedback loop" processes and procedures for navigators and other stakeholders to report problems within the exchange and the enrollment and eligibility processes back to government officials?

Answer: CMS will provide consumer support to help purchasers of health insurance determine eligibility and apply for a plan through the Marketplace, as well as report possible problems within the Marketplace, including problems with the enrollment and eligibility processes. CMS will launch a website with chat capabilities and a 24-hour call center for the Marketplace that consumers can use to identify and compare QHPs, check their eligibility for affordability programs to help them pay for coverage, enroll in a QHP, and report problems. Additionally, there will be an appeal process for any consumers who disagree with their final eligibility determination, which should help uncover any problems within that process.

152) Is there a way to share findings or generate a public report with policymakers and other interested stakeholders?

Answer: HHS is committed to public participation in the building of the new Marketplaces. Through an ongoing stakeholder consultation process, we have sought input from interested stakeholders, including States, issuers and consumers in State Partnership and federally facilitated Health Insurance Marketplace States.

Establishing Agreements

The intersection of CHIP, Medicaid and the exchanges raises many possible concerns. The exchanges are required to establish agreements with insurance affordability programs, like Medicaid and CHIP, in order to delineate responsibilities and standards, but there has been very little feedback from this process.

153) Are any concerns and issues surfacing in the development of these agreements?

a. I am specifically interested in concerns related to data integration and timely eligibility determinations.

Answer: CMS' final eligibility rules for Marketplaces, Medicaid and CHIP outline requirements for mutual agreements including the clear delineation of the respective responsibilities of programs in support of a coordinated and streamlined eligibility and enrollment process. There are additional agreements needed to exchange data among insurance affordability programs, and between States and the Federal Government in support of verifications. Development and finalization of those agreements is proceeding concurrently with operational and technical modeling and testing, and they will be executed and in place in advance of October 1, 2013.

Written Statement

Christine Ferguson, Director

Rhode Island Health Benefits Exchange

Before the

Committee on Finance

United States Senate

Health Insurance Exchanges: Progress Report

February 14, 2013

Mr. Chairman, Senator Hatch, and distinguished Members of the Committee:

Thank you for the opportunity to speak before you today to share my perspective as the Director of Rhode Island's state-based Health Benefits Exchange under the Affordable Care Act.

On September 19, 2011, Governor Lincoln Chafee issued an Executive Order that created the Rhode Island Health Benefits Exchange within our executive branch. The Exchange is guided by a 13-member Advisory Board, which has overseen Exchange planning and development efforts. In June 2012, I was appointed by the Governor to be the Exchange Director.

Since then, Rhode Island has continued to make progress in all areas of Exchange benchmarks including: financial planning and sustainability, development of a consumer support strategy and procurement of a technology infrastructure system. These accomplishments have grown out of a rigorous interagency and stakeholder process that will continue to support the development and implementation of Rhode Island's Exchange.

Our Exchange will serve two important purposes. First, it will provide a robust marketplace for all Rhode Islanders to identify health insurance coverage options and, for those eligible, to purchase coverage. Second, the Exchange will negotiate for high-quality affordable insurance options on behalf of small employers and individuals.

Our Exchange stands on Rhode Island's strong history of health care advances and the support that we have received from our Congressional Delegation. First, I would like to thank Senators Jack Reed

and Sheldon Whitehouse for the tremendous investment of their time and energy in ensuring that Rhode Island is ready to implement the Affordable Care Act. And we also thank Congressmen James Langevin and David Cicilline for their unwavering support for Rhode Island health care reform efforts.

Rhode Island Lt. Governor Elizabeth Roberts, Chair of the state's Health Care Reform Commission, has diligently coordinated all of the early work of our Exchange, and her office continues to lead on broad health reform efforts.

Our Exchange rests on decades of investment in Rhode Island's health care infrastructure. For example, we are building on our very successful RIte Care Medicaid program, implemented by both our Medicaid Department and our Department of Human Services, under the coordination of the Office of Health and Human Services. Secretary Steven Costantino and DHS Director Sandra Powell and Medicaid Director Elena Nicolella are all key partners in our shared effort.

The Rhode Island Quality Institute, founded by Senator Whitehouse in 2001, is a non-profit collaboration of Rhode Island health leaders using health information technology to transform and improve the quality of healthcare in Rhode Island.

The Rhode Island Chronic Care Sustainability Initiative (CSI), launched in 2008 by Health Insurance Commissioner Christopher Koller, promotes the patient-centered medical home model for chronically ill patients – and has developed one of the nation's first predominantly all-payer demonstrations of the medical home model of primary care.

And therefore, when our Exchange Advisory Board came together in 2011 to create our vision, mission and principles, which I've attached, they were building on a strong history of collaborative work and commitment to Rhode Islanders' health.

Our Exchange vision is to support health reform efforts at the state and national level that promote Rhode Islanders' well-being and provide increased access to high quality, coordinated care at a reasonable, predictable cost. Our mission is to serve as a robust resource for Rhode Islanders and Rhode Island businesses to learn about and easily compare the quality and affordability of their health insurance options, enroll in coverage and, if eligible, access the federal tax credit for coverage.

We are carrying out our work under five guiding goals. In Rhode Island, we will:

- Improve the health of Rhode Islanders
- Achieve near universal coverage
- Favorably impact health insurance cost trends
- Favorably impact health care delivery system effectiveness and efficiency
- Add value to employer health insurance purchasing.

Why did we decide to create a state-based exchange? As we collected input from stakeholders, we heard again and again that high costs and unpredictable annual increases have made health

insurance coverage unsustainable for most employers and out of reach for many individuals – from entrepreneurs taking the plunge into new ventures to those who are working multiple jobs. We want to build an Exchange by Rhode Islanders, for Rhode Islanders – one that benefits from and contributes to the work of other states but is created to meet Rhode Islanders' needs.

The Affordable Care Act provides us with tools to take advantage of Rhode Island's historic health care achievements, the strong relationships between our partners throughout our state, and our Advisory Board's carefully created vision by building a solution that will work for us. Rhode Island leaders felt that a state-based exchange was the best choice for us to carry out these dual goals.

As I noted above, the Exchange will play two key roles – first, as a comprehensive marketplace for all Rhode Islanders to identify health insurance coverage options and, for those eligible, to purchase coverage – and second, as a negotiator for high-quality affordable insurance options on behalf of individuals and small businesses.

By purchasing for so many Rhode Islanders together, the Exchange will give new power to small employers and individuals in the health insurance marketplace, transparently negotiating with health insurance carriers on their behalf.

To ensure that small employers and individuals are receiving quality coverage, we will provide them with access to new types of quality data which are typically only available to larger employers. Our Exchange customers can use this data to make decisions about their health care purchases. And on a state-wide basis, that information can be equally important as we look at broader health system issues.

The work we are doing to create our Exchange is complicated and the timeline is pressing. My very talented team is working as hard as they have ever worked – days, nights, and weekends – to get this done by the October 1 deadline. We are confident that we will meet this goal, and we are very pleased with the help provided to us throughout the process by the US Department of Health and Human Services and CCIIO.

In closing, Rhode Island has worked hard to overcome its economic challenges. Throughout these difficulties, Rhode Island has retained our tremendous medical talent, with world-class universities and nationally recognized, innovative providers and leaders. Our Exchange can help catalyze the necessary changes in our delivery system and our insurance markets to increase quality and transparency, support innovations that will keep Rhode Islanders healthy and more productive and keep costs down. The Exchange also has the potential to improve the business climate in Rhode Island as we all work together to harness its possibilities.

We are grateful for this opportunity to highlight our opportunities – and I thank you once again for inviting me to share this information with you today.

STATEMENT OF HON. ORRIN G. HATCH, RANKING MEMBER
U.S. SENATE COMMITTEE ON FINANCE HEARING OF FEBRUARY 14, 2013
HEALTH INSURANCE EXCHANGES: PROGRESS REPORT

WASHINGTON – U.S. Senator Orrin Hatch (R-Utah), Ranking Member of the Senate Finance Committee, delivered the following opening statement at a committee hearing examining the progress of health insurance exchanges established under the President's health law:

Thank you, Chairman Baucus, for holding this hearing. I welcome this opportunity to join you in conducting Congressional oversight on the implementation of the President's health law, and more specifically, on the nature of health care exchanges.

It is no secret that the President promised that his plan to reform the health care system would reduce premiums by $2,500 for individuals.

He made this promise more than once.

At the time I was skeptical. And, as we're seeing now, I had good reason to be.

We are already feeling the impact of the law as the cost of insurance premiums continues to go up.

In 2014, when the law will be fully implemented, premiums will skyrocket further as insurers scramble to meet all of the new mandates that go into effect.

The question is: How high are costs going to go?

We have estimates from an Oliver Wyman study that suggest premiums in the individual market next year will increase an average of 40 percent.

The Society of Actuaries similarly estimates an average increase of 32 percent in premiums in the individual market.

For many communities it gets even worse.

A recent survey of health plans reveals that premiums in the individual market in Phoenix, Arizona could see an average increase of 157 percent. Milwaukee, Wisconsin will see an average increase of 190 percent.

If the point of the health care law was to reduce costs and increase access, these estimates show that it appears to have already failed.

Some of the law's supporters will say that these premium increases will be mitigated by the new health insurance subsidies. However, the Oliver Wyman study that I referred to found

that 40 percent of those covered in the individual health insurance market in 2011 would be ineligible for these subsidies in 2014.

It also found that 36 percent of those currently uninsured can expect to pay more out of pocket for single coverage than they would otherwise, even with the availability of premium assistance.

These rate increases will have a significant impact on the ability of individuals to purchase coverage. It was bad policy when we debated it, it was bad policy when the Democrats jammed it through the Senate, and it is still bad policy today. And now consumers are starting to see its impact just as they are about to be able to enroll in the new health exchanges.

Today, we are here to discuss those exchanges.

As most of you know, I have a particular interest in this issue because the state of Utah was one of the first states to establish a market-based state exchange – prior to the passage of the law – that met their unique demographic needs.

The Administration claims that health insurance exchanges will allow plans to compete for business and therefore the cost of health insurance will be reduced.

Unfortunately the exchanges, as designed under the law, will do neither. They will actually increase health care costs.

We know that state-based exchanges are being established in 18 states. Of those states, 13 have published studies providing annual budget estimates for establishing and maintaining state exchanges. Those annual budget estimates range from $6 million to $300 million and will be funded through the establishment of exchange user fees.

Similar to state-based exchanges, the federally-facilitated exchange will be funded through the imposition of onerous user fees. The Administration recently proposed a 3.5 percent fee on each plan offered through the exchange.

This is no small amount and we all know that the cost will be passed down to consumers in the form of higher prices. Those who have doubts about this can ask the Joint Committee on Taxation or the Congressional Budget Office.

We also know that premiums are already increasing as a direct result of the new mandates under the law.

However, a number of questions remain.

For example, how much will user fees increase the cost of premiums and what impact will those increases have on individuals choosing to purchase a plan?

What is the annual budget of the exchange?

How will the federal data hub work?

What is the process for determining eligibility for the premium tax credits?

So, as you can see, many key details remain unanswered. And, in general, the Administration has provided very little detail on what the federally-facilitated exchange might look like even though the law was passed three years ago.

We have nearly 600 pages of regulations for the state-based exchanges, but only 19 pages of guidance on the contours of the federal exchange. Those 19 pages amount to little more than a statement of purpose from the Administration and exactly what the states can expect remains largely unknown.

I guess it is just another example of this Administration's unshakeable faith in the almighty federal government and its continued skepticism of our state governments.

Only 36 percent of the states have opted to establish a state-based exchange. That means more than half of the states have chosen to go with the federal exchange. However, surprisingly, the vast majority of the information provided by the Administration's is directed toward the minority of states that will be creating their own exchanges.

Of course, most of those states have Democratic governors, so perhaps it shouldn't be much of a surprise.

With individuals in states expecting to benefit from the so-called reforms passed in the health care law, it is critical that they have a clear understanding of how the federal exchange will work.

I expected the Administration to withhold details about the exchanges prior to the election, but we are now less than nine months away from open enrollment and the details necessary for the successful implementation of the plan are largely absent.

I think it is likely that the biggest reason these details have not been not provided is because many of them have yet to be agreed upon. If that is true, then I think it's fair to predict that a majority of Americans will not be able to access plans on the exchange come October 1, and a scenario for delay will soon be presented.

We have already seen proposed regulations pushing back the combined eligibility requirement to 2015.

I recommend that the Administration work with us to help us better understand the status of the exchange that will be providing insurance to over 13 million Americans.

With the announcement of nominations and the need to fill critical roles at the Treasury Department and HHS, it would be wise of the Administration to work with us and provide real answers to our questions. Sadly, so far, none of our letters regarding the exchanges have received a substantive response.

Chairman Baucus, since our committee has sole oversight jurisdiction on this important matter, I hope you will join me in asking for a renewed commitment on behalf of the Centers for Medicare and Medicaid Services, to answer our questions in a timely and substantive fashion. Pre-fabricated and boilerplate answers have no room in this important discussion. Ignoring this core responsibility is a huge disservice not only to the members of this committee, but more importantly to our hard working constituents in Utah and Montana who deserve these answers.

I look forward to hearing the testimony of Gary Cohen, Director of the Center for Consumer Information and Insurance Oversight and our witnesses from Rhode Island, Delaware and Arizona.

I thank the Chairman for calling this hearing and look forward to working with him on this important issue.

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STATE OF ARIZONA

JANICE K. BREWER
GOVERNOR

EXECUTIVE OFFICE

DON HUGHES

HEALTH CARE POLICY ADVISOR TO GOVERNOR JAN BREWER

AND ARIZONA EXCHANGE EXECUTIVE DIRECTOR

TESTIMONY REGARDING ARIZONA'S HEALTH INSURANCE EXCHANGE EXPERIENCE

BEFORE THE U.S. SENATE FINANCE COMMITTEE

FEBRUARY 14, 2013

Chairman Baucus, Ranking Member Hatch and Members of the Senate Finance Committee, thank you for the invitation to discuss Arizona's experience in planning and designing a State-based Exchange and Governor Brewer's decision to defer to the Federally-facilitated Exchange. My name is Don Hughes. I serve as Governor Brewer's Health Care Policy Advisor and am responsible for Arizona's Health Insurance Exchange activities.

Background

In September 2010, Arizona applied for and received a million dollar, one year Exchange Planning Grant. With the use of the planning grant funds, Arizona made considerable progress in planning for the required core Exchange functions with an emphasis on background research, IT infrastructure and the certification of qualified health plans. The result of the planning grant was a recommendation to Governor Brewer that Arizona apply for a Level One Establishment Grant and proceed with the planning, design and development of a State-based Exchange.

On November 28, 2011, Arizona received a Level One Establishment grant to further plan, design and develop the Arizona Health Insurance Exchange. All Exchange planning and design work was performed with the caveat that Governor Brewer had not made a final decision to move forward with a State-based Exchange. These planning

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and design activities were focused on meeting the requirements for certification by Center for Consumer Information and Insurance Oversight (CCIIO)and ensuring that an Arizona Health Insurance Exchange would be operational by October 1, 2013, should Governor Brewer decide to move forward with a State-based Exchange.

The Arizona Health Insurance Exchange was being designed to be a fully integrated system that would allow consumers and small employers to find information, determine eligibility for and enroll in Medicaid, CHIP, SNAP, TANF, individual insurance and small group insurance. The IT system design would have allowed consumers to easily and intuitively find the public or private health insurance options that best suited both their health needs and budget.

Arizona's Guiding Principles

Arizona intended to utilize as much flexibility afforded states under the Affordable Care Act and the Exchange rules. The goal was to design the most free-market oriented Health Insurance Exchange in the country.

Exchange planning and design work operated under the following principles:

- Build on Arizona's Strong Health Insurance Market.
- Support the Market Facilitator Approach.
- Maximize Consumer Choice and Competition.
- Impose Minimal Regulations and Reporting Requirements.

With more than 35 health insurance companies actively writing in the small group market and more than 15 insurers actively doing business in the individual market, Arizona has a very healthy and competitive insurance market. No insurer has more than 24 percent market share. The Exchange design was intended to transfer the same level of competition and consumer choices that exists in the current insurance market to the Exchange.

Stakeholder Engagement

Because no state has established a Health Insurance Exchange that is fully compliant with the requirements contained in the ACA, stakeholder involvement was a critical component of the Exchange planning and design process. To facilitate input on the Exchange core functions, Arizona formed the following stakeholder work groups:

- Health Plans and Health Insurance Associations
- Health Insurance Brokers and Agents
- Tribes and Tribal Organizations
- Consumer Advocacy Organizations

Each work group met frequently on the key design and operational issues in their respective areas and provided input to the Exchange Steering Committee for final decisions. The health plan work group developed recommendations on the qualified health plan certification, recertification and decertification process, essential health benefits, risk adjustment and transitional reinsurance and quality rating requirements. The broker and agent work group focused on broker certification, Navigator program and other marketing issues.

The consumer work group focused on the Navigator program, public education and outreach and ensuring the website design would be user friendly. Arizona has 22 federally recognized tribes, with more than 300,000 tribal members living on and off reservations. To ensure tribal issues were raised and addressed in the Exchange planning and design, a tribal work group lead by the Inter-Tribal Council of Arizona, with representatives from tribes was formed. The work group developed a tribal consultation policy, public education and outreach campaigns to educate tribal governments, health facilities, employers and tribal members on the Exchange.

By involving stakeholders in the planning and design process from the beginning ensured that operational and technical issues were raised and resolved prior to implementation. It also made it more likely that insurers, brokers and agents would participate in the Arizona Health Insurance Exchange. No Exchange model can be successful without the active participation from insurance companies, insurance agents and brokers.

The Exchange as a Tool to Address the Uninsured Rate

More than 1.2 million Arizona residents were uninsured in 2011. That represents 19% of Arizona's population. Uncompensated care costs at Arizona's hospitals have more than doubled over the past two years. Those costs are shifted to private health insurers and self-insured employers in the form of a hidden health care tax.

Our research indicated that a well designed, user friendly Health Insurance Exchange could cause a significant reduction in the number of uninsured Arizona residents. The Arizona Health Insurance Exchange could reduce the uninsured in Arizona almost in half. Once fully implemented, 587,000 uninsured people would find coverage in either private health insurance or Medicaid. The potential impact on the uninsured and uncompensated care made pursuit of a State-based Exchange attractive.

Focus on Infrastructure Development and Core Functions

To accomplish the goal of reducing the uninsured, Arizona focused its Exchange planning and design work on developing an IT infrastructure, call center and plan management system that would provide a first class consumer experience. These were

the most critical Exchange functions and most essential to get right for the Arizona Health Insurance Exchange to be successful.

IT Gap Analysis

Arizona initiated an IT gap analysis project early in the planning process to help Arizona hone its vision for implementing the Health Insurance Exchange in the most prudent and efficient manner. A national non-profit organization, Social Interest Solutions (SIS) was retained to do the following:

- Provide a detailed assessment of Federal reform requirements and incorporate updated Federal guidance;
- Inventory and assess relevant Arizona systems' readiness and gaps for meeting ACA requirements and complying with Federal guidance to determine functionality and potential for use in the Exchange and Medicaid expansion (mapping systems against current Federal IT systems guidance);
- Create a technology gap analysis to inform considerations of alternative options;
- Evaluate the potential for the Arizona Technical Eligibility Computer System (AZTECS) database to meet ACA requirements and assess the feasibility of using Health-e-Arizona as a front-end to AZTECS for users; and
- Provide options for consideration to implement an Exchange and Medicaid expansion, with cost projections and associated benefits and risks for each option.

Identifying Options

The IT gap analysis identified five options with an analysis of associated resources, estimated costs and risks. The options included:

1. Defer to the Federally-facilitated Exchange
2. Join a Multi-State Solution
3. Leverage Existing State Systems and Fill Gaps with New Development
4. Leverage Existing State Systems and Fill Gaps by Borrowing
5. Build a Solution from Scratch

The option analysis found the least risky options were defer to the Federally-facilitated Exchange and leverage existing state systems and fill gaps with new development. Both options provided the most likely chance of meeting the ACA timelines and were the least costly.

Design and Planning

In terms of a state-based approach, leveraging existing state systems and filling the gaps with products developed by private sector vendors was determined to be the option that had the lowest costs, most likelihood of being ready on time and would provide Arizona with the most control over the design and operation of the Exchange. For the past ten years, the Arizona Health Care Cost Containment System (AHCCCS), Arizona's Medicaid agency has operated a web-based application system called Health-e-Arizona to receive and process applications and renewals. AHCCCS receives more than 40% of applications and 50% of renewals online through Health-e-Arizona. Leveraging Health-e-Arizona with cutting-edge technology from the private sector to fill in the IT gaps presented the best option to meet the goal of providing a first class consumer experience and reducing the uninsured rate in Arizona.

Exchange planning and Establishment grant funds were utilized to design an Arizona Health Insurance Exchange that would integrate the Health-e-Arizona technology with the Individual and SHOP Exchange components into one IT system. On October 1, 2012, Xerox was awarded a contract to develop the Individual Exchange, SHOP and Consumer Assistance Center and integrate those components into the existing Health-e-Arizona system.

This would provide Arizona with a fully integrated Exchange that would meet the ACA requirements and enable consumers and small business owners to easily find the public or private health insurance most appropriate for their needs. The system was designed to allow an individual to quickly and easily determine their eligibility for and enroll in Medicaid and other public benefits programs.

For those individuals ineligible for Medicaid, the Individual Exchange plan selection tool would allow the individual to determine eligibility for Advanced Premium Tax Credits (APTC) and cost sharing subsidies. Consumers would be able to search for health insurance by geography, price, metallic tier, type of insurance product and doctor. Electronic payment could be made either through the Exchange or directly to the health insurance company.

The SHOP Exchange was designed to provide maximum choice and flexibility for both the employer and the employee. The employer would have been able to control their costs by moving to a defined contribution approach and provide employees with more choices of health plans than is typically offered in the small group market today. The goal was to reduce the administrative burden small employers face in providing health insurance for their employees and allow the employer to control their costs by allowing the employer to contribute a fixed dollar amount towards the total health insurance premium.

As essential as getting the IT infrastructure right, ensuring that there would be sufficient qualified health plans (QHP) participating on the Arizona Health Insurance Exchange was equally vital. Arizona began working with the health insurers almost two years ago on the certification, decertification and recertification requirements, process and timeline. The certification requirements and timeline were finalized in December, 2011 to give the insurance companies as much as possible to develop their QHP applications.

In line with the "impose minimal regulatory and reporting requirements" principle, the qualifications to be a QHP were based on the minimum requirements laid out in the ACA and state law. To the greatest extent possible, health insurers would provide information already submitted for other filings and attest that the QHP met the remaining requirements. The goal was to make the QHP process simple and not so burdensome that it would discourage health insurers from participating.

If Arizona had moved forward with a State-based Exchange, QHP applications would have been accepted beginning January 2, 2013 and for the initial open enrollment concluded on March 31, 2013. The Arizona Department of Insurance would evaluate the applications and work with the QHP issuer to resolve any questions or deficiencies in the application. Certifications would be issued in June, 2013, which would allow sufficient time to upload the QHP information to the Exchange website. August and September were reserved for the necessary testing to ensure the system was fully functional for open enrollment on October 1, 2013.

To further simplify the certification process, the Arizona Department of Insurance worked closely with the National Association of Insurance Commissioners (NAIC) to expand the System for Electronic Rate and Form Filing (SERFF) to handle QHP applications. The expansion of SERFF to perform the plan management function would have been the most cost effective approach for Arizona and other states.

By working closely with the commercial health insurers, AHCCCS managed care organizations and the Arizona CO-OP, preliminary estimates indicated that there would have been more than 100 QHPs participating in the Individual Exchange and the SHOP. This level of competition would have helped keep premiums affordable and maximize the choices and options for individuals and small employers. The web site and the consumer assistance center would have provided the decision support tools necessary for consumers to make an informed decision on their health insurance options.

To ensure that the Arizona Health Insurance Exchange would be fully compliant with the requirements of ACA and would be operational by open enrollment, Arizona Exchange staff and consultants participated in every conference, webinar, conference call and work group put on by CCIIO. Not only did this active participation allow Arizona to plan

and design a State-based Exchange that would have met all of the Exchange requirements, but it also allowed Arizona to keep stakeholders informed on the latest developments.

Arizona completed both the planning and the design reviews that were required by the Establishment Grant. Evidence of the significant progress Arizona had made in its planning and design configuration was demonstrated by the Exchange Progress letter, dated October 16, 2012.

Too Many Uncertainties to Move Ahead

Arizona Exchange staff and consultants worked diligently on a State-based Exchange model that would conform with Arizona's free market principles, meet the ACA requirements and be fully functional by October 1, 2013, the start of the initial open enrollment period. Based on the progress made, Arizona was well positioned to be ready with a State-based Exchange on time. This work allowed Governor Brewer to make a decision based on what was best for Arizona consumers and small employers, rather than have the calendar dictate that decision.

On November 28, 2012, Governor Brewer notified the Administration that Arizona would not pursue creation of a State-based Exchange and instead would participate in a Federally-facilitated Exchange. While Governor Brewer is a strong advocate of local control, there were too many unknowns about how a State-based Exchange would operate for Arizona to proceed.

The delay in releasing all necessary Exchange and Medicaid rules were a significant factor in the Governor's decision to not move forward with a State-based Exchange. The Notice of Proposed Rule Making for the Health Insurance Market Rules; Rate Review and the Standards Related to Essential Health Benefits, Actuarial Value and Accreditation were issued on November 26, 2012. The HHS Notice of Benefit and Payment Parameters for 2014 was issued on November 30, 2012. The Office of Personnel Management issued Notice of Proposed Rulemaking for the Establishment of the Multi-State Plan Program for the Affordable Insurance Exchanges on November 30, 2012.All three draft rules are essential to Exchange operations, but are likely to change when the final rules are issued.

Not only are these Draft Rules important to Exchange operations, but are necessary for insurance companies to develop products for the individual and small group insurance markets on and off the Exchange. One large, national insurance company has commented that they will need twelve weeks from the time the Rules are finalized to bring a product to market. The delay in issuing these Rules will make it difficult for insurers to meet the filing deadlines for QHP certification for the initial open enrollment

period. The delay in finalizing the HHS Notice of Benefit and Payment Parameters for 2014 impacts the risk adjustment, risk corridors and transitional reinsurance programs and may cause insurance actuaries to be more cautious in setting premiums for the upcoming year.

It was also unclear the status of development of a number of federal services that a State-based Exchange would be required to use. These required federal services include:

- Federal Data Services Hub
- Advanced Premium Tax Credit and Cost Sharing Subsidy Service
- Actuarial Value Calculator
- Minimum Value Calculator
- Modified Adjusted Gross Income Business Rules

All of these services are required as part of any Exchange model. While Arizona has been working with HHS on some initial testing for the Federal Data Services Hub, it was not certain what the overall status and timeline for completion was. The actuarial value calculator was projected to be ready on March 28, 2013. Health insurers cannot price their QHP products without using the actuarial value calculator. A completion date of the end of March would not give insurers sufficient time to submit their QHP applications by Arizona's QHP certification timeline.

In November, 2012, the NAIC informed Arizona and other states that the expanded SERFF plan management tool would not be available in December, 2012 as planned. The plan management templates would not become available from CCIIO until March 28, 2013. This would either have shortened Arizona's QHP certification timeline by three months or force us to develop a work around process.

Governor Brewer's decision to not move forward with a State-based Exchange and instead participate in the Federally-facilitated Exchange was made primarily for operational reasons. While Arizona had made significant progress and would have been ready with a fully compliant State-based Exchange, the delay in issuing the necessary Exchange Rules, uncertainty on the status of required federal services and other delays made proceeding with a State-based Exchange too risky at the present time.

Arizona is working collaboratively with HHS on the development of the Federally-facilitated Exchange. As more information becomes available on the Federally-facilitated Exchange including its costs, operations and ease of use, Arizona may revisit the decision to participate in the Federally-facilitated Exchange.

Statement of Bettina Tweardy Riveros

Advisor to Governor and Chair of the Delaware Health Care Commission

Progress in Establishing the Delaware State Partnership Exchange

Testimony to the United States Senate Committee on Finance

February 14, 2013

Chairman Baucus, Ranking Member Hatch and distinguished members of the Senate Finance Committee, thank you for the invitation to report on Delaware's progress in establishing a Health Insurance Exchange under the "State Partnership Exchange" model.

The State Partnership Exchange model was first put forward by the U.S. Department of Health and Human Services in September 2011. This model permits the state of Delaware to partner with the federal government in administering the state's health insurance exchange, with the ultimate goal of making quality health care and coverage affordable and accessible to all Delawareans.

Beginning October 1 of this year, Delawareans will be utilizing the federal exchange portal to enroll in a health insurance plan with coverage beginning on January 1, 2014. As a partnership exchange state, however, Delaware will be recommending plans for certification, evaluating plans under state certification standards, administering programs to help consumers understand their coverage options, and supporting our small business community. In Delaware, we are a state of neighbors, and we believe this model provides operational efficiency and financial stability while permitting the state to evaluate plans, set state certification requirements and advise consumers in ways that are most responsive to local needs.

Establishing the Best Exchange for Delaware

Under the direction of Governor Jack A. Markell and Secretary of Delaware's Department of Health and Social Services Rita Landgraf, Delaware began its Exchange planning by completing a comprehensive feasibility study to determine the optimal approach to meet the state's needs.

The study's financial analysis raised concerns about the financial sustainability of a state-based Exchange in light of Delaware's small population. Our analysis indicated that the cost of operating a state-based Exchange, including a state-specific eligibility and enrollment system and call center, had the potential to significantly impact premium costs for consumers. Based on this analysis, Delaware decided the State Partnership Exchange model provided the best opportunity to achieve our goals of keeping the cost of health plans as low as possible while still giving Delaware influence over plan certification and

consumer assistance standards. We appreciate the efforts of HHS leadership and staff in creating and supporting Partnership Exchanges and for their work with Delaware as a leader in the Partnership Exchange model.

Ensuring a voice in setting qualified health plan (QHP) certification standards gives Delaware the opportunity to leverage the Exchange to promote state health policy goals. We cannot underscore enough the importance of integrating state activity across multiple initiatives: ensuring access through the Exchange, Medicaid and CHIP programs; supporting innovative technology and a health information exchange infrastructure; enabling quality and population health goals; supporting workforce development; and advancing critical cost containment and payment reform initiatives.

For example, the Affordable Care Act (ACA) requires health plans sold inside the Exchange to adopt a quality improvement strategy, defined as payment reforms intended to result in improved health care outcomes. In establishing state certification standards for Exchange health plans, Delaware is requiring issuer participation in a coordinated quality improvement workgroup and in innovation initiatives. These efforts are intended to standardize plan strategies to maximize their alignment with state public health goals and reduce the burden on providers by streamlining performance benchmarks.

Delaware views our direct relationship with Exchange QHP issuers as critical to our shared long term objectives to reduce costs and improve health outcomes. Central to this initiative is Delaware's Health Information Exchange (HIE) technology infrastructure, the Delaware Health Information Network (DHIN). The DHIN was a vision ahead of its time that became law in 1997 due to the leadership of distinguished committee member and former Governor of Delaware, Senator Thomas R. Carper, and the Delaware legislature, and continues to advance through the strong support of Governor Jack A. Markell.

The DHIN technology foundation is a statewide HIE that supports the aggregation of health information from disparate health care providers, enabling true coordination of patient care to achieve the best possible outcomes, reducing duplication of services and supporting a broadened use of "health homes" or advanced primary care practices. In addition to improving care, the DHIN provides the foundation for innovation, population health research, new outcomes-based payment models, and a cost and claims database that can ultimately support reduced health care costs. The State Partnership Exchange provides an opportunity to ensure continued support and utilization of the DHIN infrastructure via the State's QHP certification requirements.

Delaware has been working closely with our federal counterparts to design our Exchange. In December 2012, Delaware became the first state HHS conditionally approved to operate a Partnership Exchange. Today, we can report progress of being on track to complete state requirements necessary to support Exchange open enrollment on October 1, 2013.

Plan Management Progress

Delaware has already completed a number of key milestones necessary to establish our QHP certification process. We defined our essential health benefits package by selecting a benchmark plan last September. We finalized state-specific criteria for certifying the QHPs last November. In December, the Delaware Department of Insurance (DOI) published a bulletin documenting certification standards. The bulletin also provided an expected certification timeline and invited potential QHP issuers to submit a letter indicating their intention to apply to sell health plans inside the Exchange.

The DOI has established an internal policies and procedures manual providing staff with an understanding of the role they will play in plan certification. DOI staff are also working with technical staff at the National Association of Insurance Commissioners (NAIC) to customize the software issuers will use to submit their plan information for state review.

The NAIC has indicated their software will be capable of accepting plan applications in late March. Delaware is poised to support that timeline. We will be ready to review and certify plans by late July, as required. We will be ready to transmit approved plan information so that it can be uploaded to the federal Exchange portal in time to support October 1 open enrollment.

When we do so, we will be sending plans to the federal portal that reflect local decisions made in Delaware. For example, the essential health benefits will be consistent with one of the largest small group plans in the state and the state certification standards will reflect Delaware's comprehensive health care strategy.

Consumer Assistance Progress

Delaware also has made significant progress on the Consumer Assistance front, including finalizing certification requirements for Delaware Marketplace Assisters (MPAs). MPAs will be the main outreach arm into the communities they serve, acting as the first point of contact for the majority of consumers. Less than two weeks ago, Delaware released a Request for Proposal to contract with a wide variety of organizations to serve as Delaware Marketplace Assisters.

On the start of open enrollment, the MPAs will help consumers understand their enrollment responsibilities and the coverage spectrum available to them.

Delaware's MPA program reflects the close cooperation of state agencies in managing Exchange administration. All MPA entities will be managed by a multi-agency organization, consisting of the Delaware DOI and the Division of Medicaid and Medical Assistance (DMMA). The DOI will handle the main program management duties associated with the MPA program, while DMMA will provide support for training and administer MPA entity grants.

Delaware is currently on track to select its MPAs by mid-March and begin working with selected agencies in April to establish programs and train staff. Delaware MPAs will be ready to support October 1 open enrollment.

Supporting Delaware's consumers also means supporting our small businesses, and our business community overall, in understanding the requirements of the Affordable Care Act and minimizing disruption to current insurance. For Delaware's small employers, the Small Business Health Options Program, known as the SHOP Exchange, provides an opportunity to help make covering employees easier and potentially more affordable, pending the impact of market reforms. Delaware has sought to address any potential impact of one reform, the essential health benefits requirement, by selecting the market leading small group plan as the benchmark essential health benefits plan.

In Delaware, the small group market is generally well-served by existing distribution channels including a private exchange-like purchasing option for small employers and an active agent and broker community. Delaware's small employers have long relied on agents and brokers to help them find the right plan for their business. Based on our stakeholder outreach we anticipate that agents and brokers will continue to play an important role in advising the small business community. Providing information and assistance to this community also will be a key component of our consumer outreach strategy.

Implementation Risks

While Delaware is proud of our Exchange establishment progress to date, we also understand there is still much work to be done before October 1. We appreciate the intense pressure our federal partners inside the Department of Health and Human Services (HHS) are under as they work to successfully launch dozens of exchanges and appreciate their close collaboration with Delaware on the Partnership Exchange.

For example, following discussion of Delaware's plans for consumer assistance and education in the State Partnership Exchange model, HHS revised their stance and deferred to Delaware the development and management of the outreach strategy for consumer assistance and education.

We continue to be eager for final HHS guidance on operational elements that remain unclear. For example, Delaware still has questions regarding how the federal Navigator program and customer relationship management (CRM) solution will integrate with Delaware's MPAs and DOI in providing consumer assistance.

We are eager to see the final data collection templates from HHS that issuers will use to prepare and submit information needed to conduct QHP certification. Delaware's understanding is that finalization of these templates is a critical path item to enable Delaware to receive proposed QHPs. We also would like to know more about how the federal government will assure that the "multi-state plans" certified by the United States Office of Personnel Management will maintain consistency with state-specific certification standards and protect against financial advantages for these plans.

Delaware looks forward to HHS guidance on the SHOP Exchange, including expectations for how the federal SHOP exchange call center and eligibility portal will refer small employers to agents and brokers who request information comparing plans. We also need to better understand how Navigators will refer small employers to agents and brokers. We are also eagerly awaiting further guidance from the United States Department of Labor regarding employer noticing requirements and templates and guidance from the Internal Revenue Service on potential health plan valuation tools to support employer shared responsibility compliance. We also seek further, detailed guidance from the Internal Revenue Service on how temporary employees factor into employer size calculations.

As of today, Delaware's progress on Exchange establishment has been significant and HHS has been very supportive as we work together to launch the State Partnership Exchange model. State processes are on track and we are cautiously optimistic that enrollment will successfully open October 1.

Thank you again for this opportunity to share with you Delaware's experience and progress on this important initiative, implementation of Delaware's State Partnership Health Insurance Exchange.

COMMUNICATION

February 25, 2013

The Honorable Max Baucus
Chairman
Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Orrin Hatch
Ranking Member
Senate Committee on Finance
219 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Baucus and Ranking Member Hatch:

We appreciate the opportunity to offer comments in response to the hearing held on February 14, 2013, regarding the implementation of the Health Insurance Marketplaces as established by the *Patient Protection and Affordable Care* Act (ACA). We continue to believe the marketplaces will be a strong equalizer in stabilizing health insurance premiums, making them affordable to a greater percentage of the overall population and offering new consumer protections for many Americans, particularly those in the 50-64 age range who often pay the most for coverage.

We share the interest raised in the hearing in obtaining more timely guidance from HHS regarding *Federally-Facilitated Exchanges* (FFEs). Although we are disappointed that more states have not opted for state based marketplaces, many Americans will now have the option to purchase insurance through an FFE. Having more information and guidance regarding how FFEs will operate and what opportunities stakeholders and others will have for input into decisions and activities in their states is of paramount concern to AARP and our members. We urge the committee to continue to request action to this end and stress the importance of having timely and integral guidance for the implementation of all marketplaces prior to open enrollment later this year.

Also raised in the hearing was a desire for release of regulations regarding Basic Health Plans (BHPs). Several states, including Washington and Minnesota, were anticipating taking advantage of this option having previously demonstrated real results in linking quality and cost in public programs. Additionally, states researched and planned for the inclusion of the BHP option as they established protocols that would implement the ACA by the statutorily defined deadlines. The delay of regulatory guidance governing the establishment of BHPs, as well as other key implementation issues, creates unnecessary challenges. We ask members of the committee to look more closely at this area and continue to urge CCIIO/CMS/HHS to release quickly and prudently the remaining federal proposed rules and regulations that are necessary for the successful implementation of the health reforms that the ACA mandated for 2013 and beyond.

The *Consumer Operated and Oriented Plan* (CO-OP) Program had been estimated to achieve potentially 10 to 15 percent in cost reductions. According to CMS, the CO-OP program will "foster the creation of qualified nonprofit health insurance issuers to offer competitive health plans in the individual and small group markets." To date, 24 CO-OPs have received loans from HHS. Unfortunately, the New Year's Eve fiscal cliff agreement eliminated HHS' authority to make new loans to CO-OPs. AARP believes that efforts such as CO-OPs that are designed to bring down premium costs while improving care – especially important for 50-64 year olds - should be considered. We urge the committee to reauthorize this loan program.

We also share the concerns raised regarding recent regulations that would determine ability to afford coverage based on individual premium levels, rather than family coverage. We do not believe that such a rubric appropriately reflects affordability for many American families. This is of particular concern for those in the 50 to 64 year old cohort who provide health coverage to their children or grandchildren. We would ask that the Committee examine these regulations and consider options that would use the more appropriate family determination, as is applicable, rather than restricting determinations to the individual level.

We are also concerned about the recent announcement that enrollment will end on March 1, 2013, in the pre-existing condition insurance plan (PCIP). This program has a particular impact on our members and other older Americans as those between ages 50 and 64 could face acute challenges finding insurance coverage outside of the PCIP prior to the opening of the marketplaces. AARP asks the Committee to continue to monitor this program and consider alternatives for both those with coverage through the PCIP and individuals who may need it in the future in order to ensure those with pre-existing conditions can continue to receive the care they need.

The ACA contains important insurance market reforms to ensure affordability, including limits on how much insurers can vary policyholders' premiums based on age. This critical consumer protection has recently received some attention over concerns that restraining the rates paid by those aged 50+ may adversely affect younger Americans. While some younger Americans may see rates rise slightly, many of these increases will be mitigated by the subsidies provided by the ACA, as well as the ability to remain on a parent's plan until age 26. Further, the plans which will be available to all consumers in the marketplace will include new consumer protections and benefits that seek to improve overall health and are intended to reduce costs. Should the age rating limits established by the ACA be expanded above the 3:1 ratio, the potential "rate shock" would be disproportionately harmful to the 50-64 year old population. AARP strongly supports maintaining the current 3:1 policy as written in statute and supported in final regulatory guidance published on February 22, 2013. Moving forward, we would oppose any legislative effort to expand the age band or to statutorily phase it in that would modify its January 1, 2014 implementation date.

Finally, in the run up to the start of the Marketplace initial open enrollment period beginning October 1, 2013, AARP fully supports as much communication and public outreach as possible from HHS to the public. AARP stands ready to partner with elected officials and HHS in the states to assist in any way we can. We support HHS' position that communicating with ethnic communities and those with limited English proficiency is critically important to these efforts. AARP is committed to helping ensure the success of the marketplaces by assisting in the education and outreach to all Americans eligible to purchase insurance through the new marketplaces.

AARP looks forward to working with the Committee as it provides critical oversight to ensure the marketplaces enjoy a smooth open enrollment for comprehensive and affordable health insurance coverage for millions of Americans. If you have any questions, please feel free to contact Andrew Schwab of our Government Affairs staff at 202-434-3770 or aschwab@aarp.org.

Sincerely,

Joyce A. Rogers

Joyce Rogers
Senior Vice President
Government Affairs

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