Comments of the National Small Business Association on the Proposed Rule Regarding Establishment of Affordable Health Insurance Exchanges and Qualified Health Plans

Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-9989-P
Mail Stop C4-26-05
750 Security Boulevard
Baltimore, MD 21244-1850

To Whom It May Concern:

The National Small Business Association (NSBA) is pleased to provide these comments with respect to the proposed rule (RIN 0938-AQ67) regarding the establishment of affordable health insurance exchanges and qualified health plans implementing the Patient Protection and Affordable Care Act of 2010 (PPACA) [1] and the Health Care and Education Reconciliation Act of 2010.[2]

The NSBA was founded in 1937 to advocate for the interests of small businesses in the U.S. It is the oldest small business organization in the U.S. The NSBA represents more than 150,000 small businesses throughout the country in virtually all industries and of widely varying sizes.

The NSBA supports state level health insurance exchanges as a reasonable step designed to improve the competitiveness of health insurance market, to increase the information available to health insurance purchasers (whether individual consumers or small businesses) and to constrain health insurance costs provided that participation in the exchange is voluntary.

Background

Health insurance exchanges are, essentially, a structured marketplace where relatively standardized health insurance policies are offered by insurance companies and complete information disclosure is required in a standardized format. Section 1311(b) of the PPACA requires that states establish an "American Health Benefit Exchange" that meets approximately 10 criteria. If they do not, then the federal government will establish a federal health insurance exchange in the state.

[1] P.L. 111-148.
[2] P.L. 111-152.

On July 15, 2011, the Department of Health and Human Services (HHS) issued proposed regulations regarding establishment of affordable health insurance exchanges and qualified health plans implementing the Patient Protection and Affordable Care Act of 2010 (PPACA).[3]

Comments

State Flexibility

NSBA believes that state (or regional) flexibility is very important because health insurance markets are far from uniform around the country. We also believe that state governments are more likely to understand the health insurance markets in their state than the federal HHS. The proposed regulations state that "we aim to encourage State flexibility within the boundaries of the law" but then create page after page of detailed rules that govern how the states may structure their exchanges. We acknowledge that it is unfortunately the case that much of this detailed regulation of state exchanges is dictated by the many related provisions in the PPACA. However, we find one particular provision in the proposed regulation to be particularly problematic.

Propose section 155.105 (a)-(d) establishes the process whereby HHS will approve the initial structure of the each state's exchange. Section 155.05(e), however, potentially represents a major bureaucratic impediment to state flexibility and ability of states to respond to problems, difficulties or changes in health insurance market conditions.

Section 155.05(e) provides:

> (e) *Significant Changes to Exchange Plan.* The State must notify HHS in writing before making a significant change to its Exchange Plan; no significant change to an Exchange Plan may be effective until it is approved by HHS in writing.

This provision is a recipe for inaction even when action is needed to make the Exchange a success or to serve the interest of small businesses and consumers using the exchange. If HHS does not act with alacrity, serious problems will often remain unsolved for substantial periods of time (or conceivably indefinitely) because the state operators of the exchange will be unable to take needed action. This is likely to occur often, particularly early in this process because many changes will need to be made as plans encounter reality and because HHS will be overwhelmed by the complexities and sheer breadth of issues that will undoubtedly develop as the PPACA is implemented. By requiring every significant change by the exchange to be prior-approved by the federal government, the HHS is essentially mandating HHS micromanagement of the exchanges and substantially increasing the likelihood that they will fail to meet their goals because they will be unable to react as needed to solve problems. Moreover, there is no requirement that HHS **ever** approve or disapprove a proposed change.

[3] Federal Register, Vol 76., No 136, July 15, 2011, p. 41866-41927.

The proposed rule effectively assumes that states are not to be trusted. We, in contrast, think it is more likely that the government officials charged with operating the exchange on a daily basis and who interact with customers regularly are more likely to understand the needs of the exchange and the public better than the HHS. Moreover, they are more likely to have a personal stake in its success since they , not some unknown official at HHS, will be held accountable for the success or failure of the exchange.

Accordingly, we propose a new section 155.05(e), as follows:

> (e) *Significant Changes to Exchange Plan.* (1) The State must notify HHS in writing before making a significant change to its Exchange Plan (the "proposed significant change"). If the proposed significant change is not disapproved by HHS in writing within 90 days of said notice, then the proposed significant change may take effect.
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> (2) If a proposed significant change has taken effect and more than 90 days have elapsed since the notice provided by the State pursuant to subsection (e)(1), then the only reason that HHS may thereafter disapprove of the proposed significant change is that said proposed significant change is inconsistent with relevant statutes.

We realize that it is asking a lot of the HHS to cede this authority over state-run exchanges. But we believe that such delegation is essential if the exchanges are going to work in practice and be a success. Significant changes are going to be necessary. That is virtually inevitable. If state exchange operators have to wait around for the HHS to make a decision every time they want to make a meaningful change, it probably will not take long before the exchanges get so behind the marketplace, so unresponsive to the needs of consumers and so mired in bureaucracy, that they will become irrelevant to small employers and poor imitations of what the Congress hoped to achieve when it enacted the PPACA.

We believe that HHS should assume that states will operate in good faith and with reasonable intelligence and effectively delegate this authority. HHS would, under our proposed language, still be able to police the changes and, if a state is proposing something deeply at variance with HHS policy, disapprove of the proposed changes.

Small Business Representation

Section 155.110(e)(3) of the proposed rule regulates the governing boards of the exchanges. In particular, it requires that a majority of each board not be health insurance issuers, brokers or agents and that a majority have health care experience. In our judgment, given the importance of small employers and SHOPs to the exchange project, it should be required that small employers be represented on the governing board of the exchange. We do not want exchange government boards composed entirely of doctors, insurance companies and health care consultants. This lack of small business representation would be particularly egregious in the case of a Small Business Health Options (SHOP) exchange.[4]

[4] See Subpart H (sections 155.700-155.730) of the proposed rule at Federal Register, Vol 76., No 136, July 15, 2011, p. 41918-419921.

Plain Language and Simplicity of Use

The regulations are not written in plain English. Their (i) frequent incorporation by reference and cross references to statutes and other sections of the proposed regulation, (ii) use of jargon and (iii) use of ill-defined terms will make it difficult for those charged with implementing the proposed rule. Such language will make it impossible for ordinary consumers and business people to understand. It should not be the aim of the HHS to emulate the tax code and the regulations and guidance issued by the Treasury and IRS.

For the exchanges to succeed, they must be easy to use. The insurance options offered and the comparative information provided must be understandable without recourse to professional advice and without investing an exceptional amount of time. The beginning of this process is not particularly auspicious.

Quality Ratings

Section 1311(c)(3) of the PPACA requires that the HHS rate plans offered through the exchange. It also requires that the exchange post this information on its web site. Proposed rule section 155.205(b)(v) implements this requirement. Yet nothing is said about how HHS plans to undertake these ratings.

We understand how consumer surveys can be undertaken and disseminated (see rule section 155.205(b)(iv) and PPACA section 1311(c)(4)) but how the ratings can really be done is somewhat of a mystery. For example, if one plan is less expensive but offers fewer services, should that plan be rated higher or lower than a plan that is more expensive and offers more services. No matter what the decision, what is the basis for the rating? What about a plan that offers a larger provider network but covers a few less procedures? Or a plan that offers more preventive care but less coverage of cosmetic but important surgery (e.g. orthodontia)? How is an HHS rating supposed to make these inherent intangible and subjective judgment calls?

A poor rating process will inappropriately guide or misguide consumers (including small businesses) to the highly rated policies. This is fine if there is some objective reason for the high rating. This is inappropriate if the rating reflects only HHS employees' subjective preference among incomparable attributes.

Our recommendation is that HHS not provide a single rating but rate 10 or 15 attributes of each plan. Then, HHS will be much less involved in the business of comparing incomparables and more in the business of providing useful information.

Categories that might be rated include (but are certainly no limited to):

1. Breadth of provider network
2. Provider network quality
3. Coverage of hospital stays
4. Coverage of prescription drugs

5. Coverage of optional surgery
6. Coverage of preventative care
7. Claims payment speed
8. Customer service
9. Health advice provided
10. Etc.

Cost Estimates

The costs estimates contained in section III of the proposed rule are absurdly low.[5] They probably underestimate the cost that states will incur complying with the proposed rule by an order of magnitude and perhaps by a factor of 100. No state is going to be able to prepare a health exchange plan and submit it to HHS in 160 hours. It will probably take them that long to determine the basic requirements under the regulations, let alone develop a full plan, conduct the consultations required and submit it to HHS. It will take at least 1600 hours (a little under one person for a year) and we would not be shocked if it took ten times that (about 8 person years).

All of the other estimates of compliance or reporting time by states or health insurance issuers are also dramatically too low. The bottom line is that these costs will be higher than HHS claims and that these costs must be recovered by the exchanges either in the form of fees charged to customers or providers (who must then charge customers enough to recover costs) or in the form of tax money spent to comply and report.

It is important that as HHS goes forward with implementation that is understands the costs of this program are going to be vastly higher than the estimated $57 million and that HHS should not be casual about increasing costs by increasing red tape or reporting obligations.

Conclusion

The NSBA wants the health insurance exchange aspect of the PPACA to be a success. We are concerned that HHS micromanagement of the exchanges may cause them to fail to achieve their goals. It is clear that HHS does not understand the costs that it is imposing on states and insurance companies and that these costs must be recovered by insurers and paid for by the states. The proposed rule suggests that HHS may be unwilling to provide states the flexibility they need to meet customer needs. Finally, the proposed rule does not provide small businesses any assured representation in the governance of the exchanges (even SHOP exchanges).

Sincerely,

Todd McCracken
President

[5] Federal Register, Vol 76., No 136, July 15, 2011, p. 41905-41910.