June 18, 2012

Steve Larsen
Deputy Administrator and Director
Center for Consumer Information and Insurance Oversight
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Ave SW
Washington, DC 20201

Re: Comments on General Guidance on Federally-Facilitated Exchanges

Submitted to: FFEcomments@cms.hhs.gov

Dear Mr. Larsen:

The National Small Business Association (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. NSBA wants the exchanges to work.

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.

On May 16, 2012, the Department of Health and Human Services' ("HHS" or "the Department") released the document entitled "General Guidance on Federally-facilitated Exchanges" (the "Guidance White Paper") which outlines the Department's approach to implementing a Federally-facilitated Exchange (FFE) in any State where a State-based Exchange is not operating. The document also addresses how states can partner with HHS to implement selected functions in an FFE and other matters. The Department sought comments from the public. NSBA is pleased to provide these comments.

The Guidance White Paper is not clear whether HHS intends for employers offering insurance through Small Business Health Options Programs (SHOPs) to be able to determine what insurance is being offered to their employees and on what terms. Small businesses should be provided the option to choose which plan or plans they will offer their employees. Retaining this degree of control over their health insurance costs, and the type of insurance offered, is very important to small firms. If they do not retain effective control over what insurance is offered, fewer small businesses will participate and the SHOPs are much less likely to succeed whether the SHOP is a federally facilitated SHOP or partnership SHOP. HHS should clarify that small business participants in the SHOP will be able to choose what insurance is offered to their employees. This recommendation is consistent with the Final Exchange Rule, which allows exchanges to permit employer choice of one or more QHPs. This is the single most important concern of small businesses.

The Guidance White Paper states that "[t]o ensure a robust QHP market in each State where an FFE operates, and to promote consumer choice among QHPs, at least in the first year HHS intends to certify as a QHP any health plan that meets all certification standards. In future years, HHS will analyze the QHP certification process and may identify improvements or changes to this process." (at page 8) NSBA supports allowing any QHP that meets all certification standards to sell insurance on the exchanges. We would urge HHS not to reverse this policy decision after the first year (as it appears to be considering). In fact, a permanent unrestricted market is likely to induce more insurance companies to offer insurance in more markets at lower costs since they will be assured that they will be able to recover their start up costs (notably design, actuarial, legal, training and regulatory approval costs) over a longer period. Thus, the sooner that HHS makes it clear that exchanges are permanently open to all QHPs, the better. It is hard to believe that any other policy will lead to lower health insurance costs. This is an example of a situation where enhanced insurance company profitability and lower consumer costs are achieved by the same policy.

The Guidance White Paper states that "HHS expects that licensed agents and brokers will continue to assist consumers in accessing health insurance, and will work with agents and brokers to promote enrollment through the Exchange." (at page 16) "HHS anticipates that agents, brokers, and other producers will be a primary channel small businesses use to access coverage through an FF-SHOP. In addition to providing assistance with enrollment activities, HHS anticipates that agents and brokers will continue to be a primary point of contact for a variety of administrative, billings, and claims-related issues, and will work with FF-SHOPs to assist their clients in resolving these issues." (at page 17)

Insurance agents and brokers are very important to helping make exchanges a success. They play a crucial role in educating their customers and constructively framing choices for small businesses. A vibrant and healthy role for them in the insurance marketplace should be retained.

The Guidance White Paper states that:

> QHP issuers participating in an FFE will be required to be accredited by an accrediting entity and comply with quality reporting requirements that HHS will specify in future rulemaking. HHS intends to propose a phased approach to

> accreditation and quality data reporting and display in an FFE to accommodate new QHP issuers and Medicaid plans without Exchange or accreditation experience.
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> HHS also intends to propose a phased process for recognizing accrediting entities. In phase one, the entities that HHS believes will be equipped to provide the statutorily required accreditation review by 2013 certification – the National Committee for Quality Assurance (NCQA) and URAC – would be recognized as accrediting entities on an interim basis subject to conditions. In phase two, we would adopt an application and review process for the recognition of additional accrediting entities. We intend to propose that an FFE will accept existing health plan accreditation from NCQA and URAC on issuers' commercial or Medicaid lines of business in the same state in which the issuer is seeking to offer Exchange coverage until the fourth year of certification (for example, 2016 certification for the 2017 coverage year). HHS intends to propose that QHP issuers without this existing accreditation must schedule this accreditation in their first year of certification and be accredited on QHP policies and procedures by the second year of certification. By the fourth year of certification, all QHP issuers must be accredited on the QHP product type having fulfilled the requirements to submit performance data to the accrediting entity. (p. 11)

This contemplated delegation of regulatory authority to various non-governmental actors raises the question of governance, and effective control, of the accrediting agencies. It is also not clear how open and transparent their decision-making process would be. We would caution against this delegation without a thorough discussion of who will effectively control these accrediting agencies and whether such delegation is advisable in the first place. We would also note that have an accrediting agency approval noted on the exchange web site is one thing (its seal of approval, if you will). Mandatory compliance and effective delegation of critical regulatory authority is another. Finally, it is not clear that the accrediting agencies will add much to the process other than an additional layer of compliance costs and regulation (in addition to state and federal regulation of insurance markets).

Sincerely,

David R. Burton
General Counsel