September 30, 2011

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9989-P
P.O. Box 8010
Baltimore, MD 21244-8010

Re: Response to request for comments on the Notice of Proposed Rule Making (NPRM): Patient Protection and Affordable Care Act: Establishment of Exchanges and Qualified Health Plans; 45 CFR Parts 155 and 156; CMS-9989-P and CMS 9975-P Standards Related to Reinsurance, Risk Corridors and Risk Adjustment

Dear Staff at the Department of Health and Human Services:

The Colorado Exchange Board (the Board) appreciates the opportunity to respond to the request for comments on the NPRM released July 15, 2011. As you know, Colorado has a long history of health coverage and access reforms and continues to be strongly committed to finding solutions to ensure sustainable financing of medical care for all families and businesses in Colorado.

Colorado was successful in enacting "Exchange" legislation this year, and doing so in a bi-partisan basis. The enabling legislation was co-sponsored by the Democratic Chair of the Senate Health and Human Services Committee and by the Republican Majority Leader in the House. As part of the state law, Colorado created a bi-partisan Legislative Implementation Review Committee. Members of the Board were appointed by both Republicans and Democrats, and represent consumer groups, small employers, physicians, health plans, and state government, all focused to establish an Exchange crafted to fit the specifics of Colorado consumers, businesses, and market dynamics.

In this light, the Board would like to comment on particular areas of the NPRM where Colorado's exchange could benefit from maximum flexibility to meet the unique needs of its state population and market conditions:

- **§155.20 definitions and l55.710 and Preamble, page 85**
  Since CO recognizes a business group of one (BG1) and allows for BG1s to purchase insurance in the small group market, a state should have discretion to allow BG1s the choice of purchasing insurance through the SHOP or the individual exchange. There seems to be inconsistency between the preamble language on this issue and the actual proposed rule so the conflict should be resolved. We do not believe that BG1s should be forced to come to the individual exchange but that the state should have the choice on this policy matter; that the state should have the ability to analyze the impact on the market and on possible adverse selection rather make a premature, forced choice.

- **§155.105 Approval of a State Exchange**
  (e)Significant changes to the plan. HHS is considering utilizing the State Plan Amendment process in place for Medicaid and CHP+ as a model for requesting and approval of changes to state exchange planning documents. SPA processes allow for dialogue and technical assistance as changes are being considered. Significant changes could include altering a key function of operations, changing timeframes for functions, changes to governance, QHP certification policies or process. Further guidance is expected on this but HHS is seeking comment on whether the SPA process is acceptable.

  The Colorado exchange is a quasi-governmental entity that is being designed as a public-private partnership. We have concerns that the current SPA process is too bureaucratic and takes too long for

a start-up organization with tight timelines; this is a marketplace that has to be built quickly and will need to make rapid improvements and changes as it evolves. We question why, after 2015 when the exchange is self-sustaining and no longer funded with federal grant dollars that we would be subject to this level of approval for something that has no federal financial support. We suggest working with state exchange officials to craft a less cumbersome and more nimble process for notifying federal officials when we make significant changes to our operations or governance, but that the ability of HHS to approve or deny such changes should be limited only to what is allowable through the Affordable Care Act.

- **§155.210** (e) **Navigator Program:**
  Although additional guidance or recommendations from HHS about the role of the navigator would be appreciated, Colorado requests maximum flexibility related to who could serve as a navigator as well as the training, certification, compensation, functions, and appropriate conflicts of interest policies that should govern the role of navigators.

- **§155.160** (b)(1) and (4) **Financial Support for Continued Operations:**
  Colorado requests HHS not issue a final regulation limiting how, when, or upon whom user fees may be charged, and whether such fees should be assessed on an annual basis. The way exchanges structure their fees should be determined at the state level, in order to best address the specific plans serving the state market, as well as any alternative funding mechanisms, that could vary from state to state.

- **§155.1000 QHP Certification**
  Multi-state plans sold in the exchange should be subject to the same market rules and consumer protection regulations as other QHPs selected to be sold in a state exchange.
  The Board is concerned about potential adverse impact on consumers and potential market disruption that may result from federal actions in establishing (at least) two multistate plans (approved by Office of Personnel Management).

  The two multistate plans must not result in existing state and regional health plans being adversely impacted. Disadvantaging carriers now serving thousands of people and businesses in Colorado could result in consumers and businesses having fewer choices and importantly could result in coverage disruptions to many Coloradans.

  In (a)(2)(i) we suggest that states be given flexibility to modify this policy as exchanges gain experience and market changes/forces come into play. We believe the permanent inclusion of fee-for-service plans in exchanges may inhibit states' ability to foster payment reforms and to reduce the overall cost of health insurance.

- **§155.1050 Network Adequacy:**
  Colorado requests exchanges be given maximum flexibility to develop policies that address network adequacy in order to be responsive to the unique needs of state geography, demographics, and market conditions. As such, Colorado requests HHS not develop additional quantitative and qualitative standards for exchanges to use in evaluating network adequacy. These are functions currently in place through the Colorado Insurance Commissioner, and standards for participation in the exchange should be developed in concert with other standards at the state level.

- **§156.270 Termination of coverage for qualified individuals:**
  (d) Payment grace period for recipients of advance payments of the premium tax credit. A QHP must provide a grace period of at least three consecutive months if an enrollee receiving advance payments of the tax credit has previously paid at least one month's premium. During the grace period the QHP

must pay all claims; apply all payments received during the period to the first billing cycle in which payment was delinquent; and, continue to collect advance payments of the tax credit on behalf of the enrollee from the Department of Treasury.
(f) If an enrollee receiving advance payments of the tax credit exhausts the grace period without submitting any premium payment, the QHP may terminate coverage effective at the end of the payment grace period.

It appears as if QHPs must maintain enrollment and pay premiums as long as the enrollee is attempting to make their share of the premium payments while the QHP is still collecting the tax credit from Treasury. We are concerned that this protection of a 90-day grace period provides an incentive to enrollees to continuously, or repeatedly, delay making their share of premium payments to QHPs with no consequence.

- **CMS 9975-P Standards Related to Reinsurance, Risk Corridors and Risk Adjustment**
The NPRM must allow for states to have maximum flexibility around risk corridors, risk adjustment, and reinsurance. Colorado's Insurance Commissioner has been developing principles regarding the management of the 3 R's program in Colorado, and our consumers would be best served by allowing the Board maximum flexibility to choose the best model for our state.

  We appreciate that you have extended the comment period and we intend to send additional comments regarding the partnership agreements. Consistent with our opening comments, we feel it is imperative that Colorado retain as much control of our exchange as possible. Flexibility from HHS is essential for us to be successful. We would prefer a more robust and specific list of opportunities for partnership – a "menu" – versus the bundled approach that was presented to states. It will also be very difficult for us to decide what if any areas benefit from a partnership agreement without cost data to help in our determination if it is more cost-effective to partner or not for a particular function of the exchange. Finally, we have concerns about how we would reconcile rules used in operating an exchange if there is one set of rules for the state operations and a different set for the partnership operations run by the federal exchange.

  Thank you again for the opportunity to offer comments, and for the extension.

  We look forward to working with you; if you have any questions or need addition information please contact:

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