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October 31, 2011

Department of Health and Human Services
Center for Medicare and Medicaid Services
Attention CMS-9989-P
P.O. Box 8010
Baltimore, MD 21244-8010
http://www.regulations.gov

Re: **Proposed Rule – Establishment of Exchanges and Qualified Health Plans (CMS -9989-P) – AHIP Comments**

Dear Sir or Madam:

I am writing on behalf of America's Health Insurance Plans (AHIP) to offer comments in response to the Department of Health and Human Services, Center for Medicare and Medicaid (CMS) proposed rule on the Establishment of Exchanges and Qualified Health Plans ("the proposed rule") published July 15, 2011 in the Federal Register. AHIP is the national trade association representing the health insurance industry. AHIP's members provide health and supplemental benefits to more than 200 million Americans through employer-sponsored coverage, the individual insurance market, and public programs such as Medicare and Medicaid. AHIP advocates for public policies that expand access to affordable health care coverage to all Americans through a competitive marketplace that fosters choice, quality, and innovation.

AHIP appreciates that the proposed rule seeks to strike a balance in achieving the Patient Protection and Affordable Care Act (ACA) requirements, while outlining the minimum requirements for a state to establish an Exchange and requirements for Qualified Health Plans (QHPs) and issuers and emphasizing areas for state flexibility. We note that the rule's goal, as stated in the introduction, is to "enhance competition in the health insurance market, improve choice of affordable health insurance," and note our strong support for choices for consumers and competition in the insurance market that provides a full range of options for consumers.

Our comments reflect the input, insights, and expertise of AHIP's members who, collectively, offer comprehensive major medical insurance coverage throughout the nation. This letter addresses our primary concerns with the proposed rules, followed by a detailed comment section.

Workability and Affordability. Our comments identify approaches to make an Exchange structural design more workable and coverage more affordable. To these ends, we recommend that the Exchanges and regulatory structure focus on making coverage affordable and streamlining processes to ensure efficiency. This is a significant concern, since the proposed rule envisions assessing insurers to pay for the operating costs of Exchanges – in effect adding to the cost of coverage.

Workability and Affordability Depend on Streamlined Functions. To assure workability and affordability, the proposed rules affecting Exchanges and federal regulatory oversight must focus on streamlining administrative functions, achieving efficiencies, and establishing a timely implementation schedule. An important way in which this can be achieved is by avoiding duplication of existing functions and relying on close coordination with existing agencies, especially state insurance regulators for oversight of policies, rates, and solvency.

Exchanges should also leverage the infrastructure, experience, and expertise of health insurance issuers and should not be required to conduct activities that would be more appropriately handled by health insurers. Key examples include: management of provider directories, customer service post-enrollment, and the provision of information on cost-sharing and payments with respect to any out-of-network coverage. We provide more information on these specific points and make specific recommendations in our detailed comments.

Short Timeframes Affect Workability and Affordability. The timeframe for states to establish their plans, identify the infrastructure and design needs, issue Requests for Proposals (RFPs) and contracts, and complete the building and testing of Exchange systems is already quite challenging. If final rules are delayed, the implementation timeframe should be re-evaluated in consultation with the states and the health plan community. In addition, the original schedule needs to be far more transparent with respect to Exchange infrastructure design details. We urge CMS to quickly make public the technical specifications that have already been issued to government contractors. This will provide additional information that states, agencies, and health plans need to move forward with Exchange implementation processes.

Exchange Decisions. We appreciate that the proposed rule has outlined requirements for functional transparency in Exchange decisions, selection processes, and governance. We also recognize the statute and the proposed rule allow Exchanges to be established in different ways. A state may establish an Exchange that is within an executive branch department, an independent agency, or a non-profit entity. Exchanges may be single state, regional, or local. Additionally, the ACA does not require states to establish an Exchange, but if a state elects to not establish an Exchange or the state's Exchange is not approved, then the U.S. Department of Health and Human Services (HHS) must establish an Exchange in that state.. States will also have the opportunity to participate in partnership exchanges. Regardless of the type of or approach to an Exchange, we

encourage CMS to ensure that the transparency requirements are met. To that end, states establishing an Exchange should be required to specify in their plans how they intend to address these requirements. Likewise, CMS should set out similar standards applicable to federally-facilitated and partnership Exchanges.

Given the scope of the task of designing and implementing exchanges, we strongly support the decision to include insurers and insurance experts on governance boards. Our members have a great deal of experience and operational know-how to offer Exchanges and will be valuable contributors to the governance process. If a state chooses to establish an Exchange in an executive branch department, we suggest that the state be required to create an advisory committee that brings in stakeholder expertise and input, including feedback by insurers and insurance experts.

In addition to good governance requirements, we believe it is crucial to ensure the final rule includes procedures for due process for Exchange decisions regarding health plan certification and selection. The rule should require the inclusion of these procedures as part of the standards for an Exchange and require the Exchange to provide health plans the criteria for certification and selection and the opportunity to appeal participation and decertification decisions. This would promote the concept of fair and open processes. We believe these due process rights should be afforded regardless of the structure of the Exchange, but suggest the rule provide flexibility in meeting these requirements in recognition of the differing Exchange structures.

Offering due process in these areas is consistent with other practices in state and federal law, and may be otherwise required, for example, by state law administrative procedure statutes. In this case, it is particularly important, because exclusion from an Exchange, or failure of an Exchange to follow a state's criteria, could have significant consequences on a health plan's viability in the reformed market.

Implementation of Exchange Functions. We support the proposed rule's structure to encourage fully state-initiated Exchanges or state Exchanges working in partnership with federal agencies to meet the aggressive implementation timeline. We note that CMS has provided limited technical specificity on the types of partnerships, although the release of interim information at their regulator-only meetings of September 19 and 20, 2011 has provided some additional insights. The additional supplemental material provided by CCIIO includes selected options for states to partner with the federal government in establishing partnership exchanges—including options for states to: (1) perform plan management functions; (2) perform selected consumer assistance functions; or (3) perform both selected consumer assistance and plan management functions. We recommend that CMS/CCIIO provide maximum flexibility to states in deciding which specific core functions they would seek to perform under these exchange partnership models. For example, a state may seek to perform eligibility and enrollment functions, while deferring to the federal government to perform other functions, such as financial management functions or consumer assistance. To the extent possible, CCIIO should provide states with flexibility to perform selected functions of the exchange, so that states

can effectively partner with the federal government to implement exchanges that builds on existing state expertise and experience with respect to exchange operations.
Likewise, the information on federally-facilitated Exchanges provided at those meetings contains some additional insight, but continues to lack necessary technical and operational details on how the Exchange structure will sync up with state agencies and programs (e.g., Medicaid and CHIP) and the regulated insurer community and QHPs. Given the short timeline for implementation and the significant impact this will have on stakeholders, including health plans, the lack of these details is of great concern.

Implementation of Federally-Facilitated Exchanges. The proposed rule, in keeping with the ACA, indicates that in the event a state does not seek to offer or qualify to operate an Exchange, CMS will establish a federally-facilitated Exchange – with an option for the state to later operate an exchange, subject to meeting certain transition criteria. We support the proposed rule providing a path for states to operate an Exchange in the future even if they are unable to do so as of 2014. Therefore, the development of any federally-facilitated Exchange should avoid reducing future state flexibility by the creation of a market mechanism that would lock a state into a particular approach. As an example, we strongly believe that a federally-facilitated exchange should not pursue an "active purchaser" model, not only because it would limit the range of consumer choices that market competition can provide, but also because it could change a state's health insurance market in a way that could eliminate future options.

Exchange Plan Approval Process. We support the proposed rule's inclusion of a conditional approval process, which would allow states with plans that indicate near readiness at the time CMS reviews the state plan the additional time needed to achieve implementation. At the same time, we are concerned that the proposed rule does not provide for sufficient transparency of Exchange plan reviews and allows too much time for the CMS review – 90-days each for the initial review period and follow-up period to assess additional information. Details on the results of readiness assessments would be helpful to other states, policymakers, and insurers as they undertake their own readiness assessments and shortening the review periods would assist in meeting the tight timeframe for implementation. We thus recommend that the details of CMS determinations be made public and that the 90-day review and follow-up periods be shortened to 45 days.

Exchange Plan Amendment. We are concerned that the proposed use of the current Medicaid Plan Amendment process is also not as timely or open a process as is needed to assist states in establishing an Exchange. Thus, we urge the use of a 45-day review period for such plan amendments as well.

Uniform Annual and Special Enrollment Period Standards. We support the proposed rule's requirements of uniform annual and special enrollment periods, providing consumers with the protection of known enrollment periods wherever they reside and the markets with some protection from adverse selection. With respect to the latter, we

recommend that enrollment outside of the annual enrollment in the individual market be permitted ***only*** when the individual qualifies for a special enrollment period. We have provided a number of additional technical comments on enrollment periods in the detailed comments section of our letter.

Small Business Health Options (SHOP) Approach. We generally support the CMS goals with respect to the SHOP Exchanges and the proposed rule's general framework. Successful SHOP Exchanges (as well as individual market exchanges) must operate efficiently, offer robust choices of health insurance plans, and provide coverage in a streamlined and effective manner. These design elements are vital in assuring that SHOP Exchanges can attract small business employer participation to be successful in the new marketplace. The proposed rule's approach that provides states with the flexibility to implement their SHOP Exchanges by providing employer choice of health plans to address their market most effectively, is the right balance to foster access and encourage competition.

Eligibility of MEWAs, Taft-Hartley Plans, or Church Plans to Participate in Exchanges. We provide a detailed analysis – based on the principle of fostering competitive markets, both inside and outside of Exchanges – of this issue later in this letter. The following are key elements supporting that principle, and we recommend CMS adopt these elements in the rule:

- The coverage would need to be offered by a health insurance issuer appropriately licensed under state law.
- The coverage would need to be subject to all the rules applying to QHPs certified to be offered on the Exchange.
- The MEWA, Taft-Hartley plan, or church plan seeking to sponsor or purchase coverage through an Exchange would need to constitute a "qualified employer," and coverage offered on the exchange would need to meet requirements and criteria necessary to constitute an "eligible employer sponsored plan."
- Access to Exchange coverage should be considered only for those MEWAs, Taft-Hartley Plans, or church plans that are in all instances subject to the ACA's adjusted community rating rules (applicable to the individual and small group markets) regardless of whether coverage is made available inside or outside an Exchange.

To summarize, we believe that the rules established should apply to all participants, without exception. Otherwise, the principal of fostering competitive markets would be turned on its head, with government picking winners and losers.

Uniform Federal Standards for Key Data Exchange. We urge the federal government to work with states and private market stakeholders to develop uniform federal standards for key data exchanges between participating agencies (e.g., Internal Revenue Service and state Medicaid agencies), Exchanges, and QHP issuers. Specifically, we recommend that

CMS work with health plans, states, and the necessary standards development organizations to develop standards for the data exchanges noted below. The use of these standards by Exchanges should be required in section 155.270 of the proposed rule and should include the following:

- Submission of the QHP information, including data on the required summary of benefits and coverage, transparency information, rates, quality improvement strategy information, etc.
- Data sent from Exchange to QHP issuer for enrollment
- Enrollment reconciliation
- Records of termination of coverage
- Enrollment standards for when an individual contacts the health plan and needs to be sent back to Exchange for an eligibility determination, as required under the proposed rule in section 156.265

As previously noted, the lack of detailed specifications on technical standards and other implementation criteria for Exchanges leads to these concerns, which must be addressed.

Privacy and Security of Information Standards. We support the proposed rule's serious consideration of this important issue, but have additional concerns with the proposal about safeguards for personal health and financial information. AHIP recommends that the Exchange be held to the Health Insurance Portability and Accountability Act (HIPAA) privacy and data security standards as a covered entity in order to assure the most robust privacy protection consumers expect of any entity that collects, uses, and discloses personally identifiable information. We believe that the Code of Fair Information Practice Principles (FIPP) standards – based on the 1973 Department of Health, Education, and Welfare (HEW) report recommendations – are ***not*** an appropriate standard for an Exchange. Greater consumer protections are necessary to safeguard consumer information.

HIPAA privacy and security provisions are complementary components and both are necessary to adequately protect consumers from security breaches. Applying the full range of HIPAA privacy and security protections to Exchanges is necessary to assure that individuals' protected health information and financial information will be maintained in a secure and sound manner. Therefore, we recommend that Exchanges be treated as covered entities for the purposes of safeguarding consumers' privacy and personal information, and that the proposed rule establish HIPAA security and privacy provisions as Exchange requirements, including those related to security breach notification and remediation.

Termination of Coverage Standards. We strongly recommend that CMS revisit the termination of coverage requirements – including the requirement for QHPs to pay all claims during the 90-day grace period and the prohibition on terminating coverage retroactively to the date for which premiums were paid – and the suggestion in the

preamble that an Exchange could choose to extend the 90-day grace period to individuals not receiving insurance subsidies

We recognize the ACA, under section 1412(c)(2)(iv)(II), included a requirement that the QHP "allow a three month grace period for non-payment of premiums before discontinuing coverage." However, the ACA ***did not*** include a requirement that health plans pay claims received during the period for which they have received no premiums, and it ***did not*** prohibit health plans from terminating coverage (after the exhaustion of the grace period) retroactively to the last paid date. Requiring health plans to pay claims for enrollees who do not pay premiums increases premiums for all enrollees, effectively requiring premium-paying enrollees to subsidize coverage of individuals who failed to pay their premiums.

We recommend that CMS take steps to minimize the risks and costs to enrollees, health insurers, and the federal government during the grace period by allowing QHP issuers to withhold payment on claims received when premium payments are delinquent for more than 30 days. This practice is consistent with applicable state laws. Exchanges should also have the flexibility to permit QHPs to terminate coverage on a basis that reflects the period for which premiums have been paid.

We are also concerned enrollees may choose to stop paying premiums in lieu of officially terminating their coverage with their QHP, and instead enroll in coverage elsewhere. This could also occur if there are lags in the state Medicaid agency notifying the QHP that the member has been enrolled in Medicaid. Both situations could create administrative challenges regarding what entity is responsible for claims payments and reconciliation of subsidies received – if the prior QHP is required to pay claims during a grace period. We recommend that Exchanges be required to promptly notify QHP issuers when enrollees have selected and enrolled in other coverage, including Medicaid, so that termination can occur promptly and unnecessary administrative issues can be avoided.

Common Approach to Quality. The proposed rule did not provide guidance regarding the quality requirements, but asked for comments on requirements to collect quality data, oversee enrollee satisfaction surveys, assess quality improvement strategies and rate and publicly report on quality. We recommend that CMS develop a common definition of quality improvement strategies that are consistent across Exchanges, advance common approaches to public reporting of quality data and allow flexibility in the quality improvement strategies implemented that best meet the needs of the population enrolled. The common definition of quality improvement strategies, consistently used across Exchanges, should be based on existing state, federal, or voluntary private accreditation standards. Exchanges may adopt additional strategies that only (a) reflect ongoing community-based initiatives and (b) are consistent with the three-part aim indentified in the National Quality Strategy: better care, healthy people and communities, and

affordable care.[1] In addition, it is important that public reporting of quality measurement and any required quality improvement strategies are appropriately phased in to account for the initial period of instability due to large numbers of uninsured seeking coverage. We recommend that measures are selected by 2013 and public reporting only begin in 2015 after a minimum period of data collection for reporting requirements, to help ensure validity and reliability of the reported data.

Health Plan Innovation with Provider Network Design. As QHP issuers design their QHP product offerings, a key consideration is how to balance affordability against the requirement to meet certain network adequacy requirements. One such challenge is the inclusion of essential community providers while ensuring the health plan's provider network meets high standards of quality care delivery. We recommend CMS not take additional steps to define network adequacy and "sufficient" essential community providers, but instead adopt existing state law requirements pertaining to network adequacy as well as existing accreditation standards which are required in ACA for QHPs. States are most familiar with market capacity and supply of providers and already have in place appropriate standards to ensure provider network adequacy. Relying on states' expertise is another way in which Exchanges can streamline their operations.

Transparency of Coverage Information. If implemented in its current form, the overly broad collection and disclosure of data related to transparency of coverage would create numerous unintended consequences and harm to marketplace competition, without adding value to consumers as a result of the data release. Thus, we recommend that transparency of coverage information required in the ACA and the proposed rule be treated carefully, afforded confidentiality, and not unnecessarily collected.

We recommend that CMS explicitly require Exchanges to collect information at the issuer level by state and not the QHP level, to ensure confidential information is protected. We note that some of the statutorily-required data elements are not appropriate for public release (e.g., enrollment) at a granular level due to potential harm to market competition. On August 5, 2011 the CMS Freedom of Information Act (FOIA) officer made a determination that several of the data provided to CMS for the purposes of populating the Healthcare.gov Insurance Plan Finder should not be publicly released. This included enrollment, disenrollment, and certain information about how health plans calculate rates. The final regulation should be consistent with this decision. Later in this letter we offer detailed recommendations on how CMS should define each transparency data element, based in part on the recommendations of the CMS FOIA officer.

We also urge CMS to provide confidential treatment of the prescription benefit management transparency information outlined in section 156.295 on "Prescription Drug Distribution and Cost Reporting". This reporting includes detailed information on

[1] Berwick, "The Triple Aim Care, Health and Cost". Health Affairs 27, No. 3 (2008) 759-569 and Department of Health and Human Services. Report to Congress: national strategy for quality improvement in health care. March 2011. Available at: http://www.healthcare.gov/center/reports/quality03212011a.html.

prescription drug distribution, pharmacy benefit manager (PBM) activities, rebate collections, and cost.

Additional Detailed Comments Follow. We have prepared detailed comments on all of these issues, as well as other technical elements of the proposed rule, which begin on the following page. We submit them with the goal of achieving workable, affordable new market structures for the individual health insurance Exchanges and the SHOP Exchanges. In addition to these comments, we urge federal and state regulators to continue to draw upon the technical expertise, systems knowledge, and best practices of our members.

We appreciate the opportunity to submit these comments and remain available to discuss these and any other implementation issues at your request.

Sincerely,

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Executive Vice President
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Colleen M. (Candy) Gallaher
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AHIP's Detailed Comments

Part 155 Subpart A – General Provisions

Question of MEWA, Taft-Hartley Plan, Church Plan Participation (Preamble FR page 41869) - The NPRM requests comments regarding a "inconsistency" between language in the ACA specifying that the term "health plan" shall not include a group health plan or multiple employer welfare arrangement (MEWA) to the extent the plan or arrangement is not subject to State insurance regulation under Section 514 of the Employee Retirement Income Security Act (ERISA).[2] At the same time, however, the NPRM notes that Section 514 of ERISA also specifically allows for state regulation of MEWAs.

In addition, the NPRM requests comments on whether there could potentially be coverage opportunities through Exchanges based on questions the Agency received about whether Taft-Hartley plans and church plans can participate in the Exchange.

Questions Regarding State Regulation - As the NPRM points out, MEWAs are generally subject to state regulation for purposes of applying state insurance laws, whether they are fully insured or self-insured (although in the context of self-insured MEWAs state insurance laws may not be inconsistent with Title I of ERISA).[3]

While not directly raised by the preamble, it should be noted that the same cannot be said of Taft-Hartley plans which fall into the category "multiemployer plans." Unlike MEWAs, multiemployer plans are subject to general preemption provisions of ERISA Section 514, such that a self-insured Taft-Hartley plan would not be subject to state insurance regulation (and presumably could not then be offered on an exchange in accordance with the ACA provision highlighted in the preamble).

Church plans that meet certain requirements are exempt from ERISA. Fully – insured church plans would be subject to state laws governing insurance.

Broader Considerations Important for Both Policy and Regulatory Reasons - The questions posed in the proposed rule preamble as highlighted above raise a range of technical and conceptual issues that go beyond the narrower question concerning the

[2] The ACA provision in question appears to be Section 1301 (b)(1)(B) which provides that the term "health plan" means health insurance coverage and a group health plan, except that "the term 'health plan' shall not include a group health plan or multiple employer welfare arrangement to the extent the plan or arrangement is not subject to State insurance regulation under section 514 of the Employee Retirement Income Security Act of 1974."

[3] In this regard, ERISA was amended in 1983 to add a special exception to allow for the application of state insurance laws to ERISA-covered welfare plans that are MEWAs. Prior to the inclusion of this special exception, the "deemer clause" under ERISA Section 514(b) effectively prevented the direct application of state insurance laws to MEWAs, consistent with general ERISA preemption principles.

status of state regulation. Working through this broader range of issues is important for both policy and regulatory reasons.

In general, taking this broader perspective, the issue of state regulation notwithstanding, there are a range of considerations that suggest CMS exercise great caution in determining whether based on any facts or particular circumstances a MEWA, Taft-Hartley Plan, church plan, or other type of specialized coverage arrangement could be offered on an exchange.

A key concern is whether allowing these type arrangements to be offered on an exchange invites adverse selection. The risk of inviting adverse selection would be especially high if these coverage arrangements were priced under the ACA's adjusted community rating rules when offered in an exchange, but were experienced rated or otherwise priced differently when offered outside an exchange. Such a dynamic would effectively replicate concerns related to large group coverage, where beginning in 2017 if large groups are permitted to access exchanges under state law there is a great potential that only those large groups with poor experience would seek to obtain community rated coverage on an exchange, while those with positive experience would seek to retain the benefit of their experience and stay outside the exchange.

For these reasons we recommend that in addition to the statutory issue concerning state regulation raised in the preamble, CMS consider and adhere to at least the following in considering whether MEWAs, Taft-Hartley plans, church plans or similar coverage arrangements could be offered through an exchange:

1. **The coverage would need to be offered by a health insurance issuer appropriately licensed under state law**.

   In this regard, the proposed rule makes a distinction between "health plans" and "health "insurance issuers."[4] MEWAs, Taft-Hartley plans, church plans or other forms of coverage, if anything, are referred to and constitute "health plans" (as distinct from health insurance issuers) under the proposed rule.[5]

2. **The coverage would need to be subject to all the rules applying to QHPs certified to be offered on the exchange.**

[4] *See* Preamble at 41869 ("for the sake of clarity we refer to the entity offering coverage as the issuer and the coverage being purchased as the health plan within this proposed rule").

[5] MEWAs can be fully insured or self-insured. In the case of a fully insured MEWA, the MEWA purchases coverage from an insurer that is qualified to sell insurance in a state. Alternatively, a MEWA may be self-insured, but the act of self-insuring does not transform the MEWA into a licensed health insurance issuer. Finally, it should be noted that it is possible for a MEWA to take the form of a state-licensed insurance company, but the salient point in such a case would be that the entity in question offering the coverage possesses the requisite licensing to qualify as a health insurance issuer, not that it is a MEWA.

3. **The MEWA, Taft-Hartley plan, or church plan seeking to sponsor or purchase coverage through an exchange would need to constitute a "qualified employer," and the coverage offered on the exchange would need to meet requirements and criteria necessary to constitute an "eligible employer sponsored plan."**

   Conceptually, the ACA contemplates that QHPs will be made available to individuals (who purchase coverage on an "individual market exchange") and qualified employers who may make plans available or "sponsor" coverage for their qualified workers through a SHOP Exchange or an exchange more generally (where a SHOP and individual market exchange are merged).

   A related question is whether to the extent the MEWA, Taft-Hartley plan, or church plan was considered an "employer", does the coverage made available to its "employees" constitute an "eligible employer sponsored plan," which may include considerations of whether the coverage is generally available on the exchange to qualified employers and employees (as opposed to being available to only those meeting certain criteria).

4. **Access to exchange coverage should be considered only for those MEWAs, Taft-Hartley plans, or church plans that are in all instances subject to the ACA's adjusted community rating rules (applicable to the individual and small group markets) regardless of whether coverage is made available inside or outside an exchange.**

   Other e.g., MEWAs that are not subject to these requirements – both inside and outside an exchange -- should be considered large group coverage and should not be considered for access to an exchange until at least 2017.

   Thereafter, granting exchange access to these plans should trigger the "Special Rule for the Large Group Market" (see ACA Section 1201 amending Section 2701 of the PHSA), such that if a MEWA, Taft-Hartley plan, or church plan were allowed to offer coverage through an exchange, the pricing and rating rules applying in the exchange would need to be applied to all such coverage offered in the state.

Part 155 Subpart C—General Functions of an Exchange

Financial Support for Continued Operations (§155.160)

We recommend that any assessments or fees charged to health insurers be limited to the minimum amount necessary to pay for the administrative costs of the operation of the Exchange – and strongly recommend that states be encouraged to seek consideration of other available funding. We recommend that any Exchange assessments on health insurers be treated as a state regulatory assessment, and considered outside the MLR calculation, consistent with the provisions of §2718(a) of the Public Health Service Act. We again urge that Exchange administrative costs be streamlined, recognizing that

assessments on plans ultimately increase the cost of coverage and premiums, affecting the affordability of Exchange plans. And finally, we recommend the proposed rule specifically exempt HIPAA excepted benefit plans and the premiums associated with such plans from any assessments, recognizing that it may be appropriate to assess stand-alone dental plans and associated premiums, since such are permitted to participate in Exchanges.

Required Consumer Assistance Tools and Programs of Exchange (§155.205)

Streamlining Exchange and QHP Call Centers – CMS seeks comments on ways to streamline and prevent duplication of effort by the Exchange call center and the QHP issuers' customer call centers. We recommend that there is a clear delineation for how calls are handled pre and post enrollment to mitigate any unnecessary handoffs between the Exchange and QHPs. Consumer/applicant inquiries regarding eligibility determinations for "insurance affordability programs" prior to enrollment should be directed to the Exchange call center, so long as the option afforded to QHP issuers per §156.265 permitting applicants to initiate enrollment directly with issuers is maintained. We note that depending on the arrangement of the state regarding the delegation of responsibility between the Exchange and Medicaid program, additional coordination (per §435.1200(d) of the Medicaid Eligibility proposed regulation) may be required.

Once a consumer chooses their QHP and receives their member ID, there should be a seamless transition to the QHP having the responsibility to respond to the enrollee's questions. However, QHPs should be able to do "warm handoffs" to the Exchange call centers if questions arise about eligibility and insurance subsidy issues. It is also critical that health plan customer service staff have a method to view information regarding an individual's eligibility and subsidy level.

Exchanges should be required to have a robust customer service training program that ensures consistent communications are provided across the call center, internet web site, any Exchange marketing materials, navigators and other applicable state programs (Medicaid, etc.).

Use of HealthCare.gov for Plan Comparison Functionality for Exchanges – CMS seeks comment on the use of the HealthCare.gov website for plan comparison functionality for Exchanges. We recommend that the Exchange internet website and Healthcare.gov website (as required by §1103(b) of the ACA) should remain independent of each other. However, the HealthCare.gov website can include links to Exchange websites where information on available QHPs would be available.

Internet Website (§155.205(d))

The Exchange internet website is required to provide the summary of benefits and coverage (SBC) established under §2715 of the Public Health Service Act (PHSA). We support the exchange using the same set of data as required by the SBC final regulations to ensure health plans do not have to support separate data requirements inside and

outside of the Exchange. The SBC data submitted to the Exchange should be submitted using a common standard that is developed by the federal government and not unique to each Exchange.

Provider Directory – The Exchange website is required to include the provider directory made available to the Exchange by the QHP issuers pursuant to §156.230. To ensure the most accurate and up-to-date information in the provider directory, we recommend that this information requirement should provide state flexibility. One acceptable model should be for the information to be hosted at QHP issuer websites with the link provided by the Exchange. Health plans have existing dynamic provider directories that should not be duplicated at the Exchange. Maintaining the frequent updates on an Exchange website would add unnecessary administrative costs for the Exchange and the health plans. As a long term goal, Exchanges could provide more seamless integration with health plan provider directories.

For those Exchanges that include the provider directory we recommend that the requirement to identify providers that are not accepting new patients be eliminated. This requirement would be administratively difficult and potentially costly to collect and implement. At this point, most insurers are not equipped to collect this information from their physician network except during credentialing or re-credentialing periods. Using existing processes, health plans would not be able to provide the consumer with accurate, up-to-date information, and health care providers would need to constantly share and update their information with all of the insurance companies with whom they participate.

Regarding the provision of a hard copy of the entire provider directory upon request, we recommend that QHP issuers be permitted to provide print outs of relevant providers from their online provider directory. This approach eliminates the significant cost and administrative burdens that QHP issuers would be forced to incur if they were required to republish the entire provider directory book each time a provider was added or dropped, or other changes made.

Development of a Model Cost of Coverage Calculator – CMS seeks comments on whether states would benefit from a model calculator and suggestions on its designs. We recommend that CMS develop a model Exchange calculator (for the individual market only) to facilitate the comparison of available QHPs after the application of advance payments of the premium tax credits and cost-sharing reductions. The calculator should also allow the applicant to compare different options related to individual and family coverage. Having each Exchange build a separate calculator would add unnecessary costs.

It is critical that the calculator have access to the individual's eligibility for the premium tax credit and cost-sharing subsidy information, including references to the information necessary to compute the premium tax credit (e.g., premium for the benchmark plan as described in the IRS proposed regulation on the implementation of the health insurance

premium tax credit.) Having a user-friendly calculator would eliminate costly switches between plans during the initial or annual open enrollment periods. CMS should also consider technical approaches where QHP issuers could link to or access the calculator via their own websites' applications. We recognize that the information displayed on the calculator would only be an estimate, should not represent a real-time binding rate quote, and would need to include the appropriate disclaimers.

We also do not recommend a calculator as a required feature of the SHOP Exchange, because the calculator is primary required to advise the individual market of potential premium costs after the application of premium tax credits.

Finally, we recommend CMS clarify the relationship between the Exchange internet website and the internet website required in the Medicaid proposed rule at **§** 425.1200(d).

Applicant and Enrollee Storage of Personal Account Information - The Preamble to the proposed rule at page 41876 indicates CMS is considering a requirement that would allow applicants and enrollees to store and access their personal account information and make changes, so long as these standards are consistent with the standards developed pursuant to **§**3021(b)(3) of the PHSA Act, as added by **§**1561 of the ACA. We recommend that this ***not*** be a priority first-year activity, but may be necessary in future years to show what the applicant has previously signed up for (especially in light of the required annual redeterminations proposed in **§**155.330). We recommend that at this point, states have the flexibility to determine whether they will adopt such features.

Customer Service/Outreach and Education Requirements – CMS proposes that the Exchange conduct outreach and education activities. At a minimum, eligibility and enrollment experts, caseworkers, Navigators, agents and brokers, and other application assisters should have access to the same information that consumers are able to view online when they are going through the application and enrollment process. We do not recommend that federal regulations require that Exchanges are have detailed customer service system requirements.

Navigator Program Standards (§155.210)

Navigators must be knowledgeable about all insurance affordability programs and health plan offerings. Our reference to insurance affordability programs is as defined in the CMS proposed rule released August 17th on Exchange Functions in the Individual Market Eligibility Determinations; and Exchange Standards for Employer ("the August 17th Exchange proposed rule") where insurance affordability programs mean advance payments of premium tax credit, cost-sharing reductions, Medicaid, CHIP, and the Basic Health Program, as applicable.

While Navigators are required to assist consumers in navigating the new Exchange environment and in understanding the options available to them, we note that there may be times during the pre-enrollment period that Navigators may have questions best

answered by QHP issuers. We recommend that the duties of a Navigator do not preclude formal contacts between Navigators and QHP issuers, especially since they will need to be facilitating access to information.

We also note that post-enrollment, the primary consumer touch points should be the QHP issuer and not the Navigator(s). Thus we recommend that Navigators should be required to transfer enrollees' calls to their QHPs to assure enrollees inquires are handled appropriately.

Finally, we recommend that further clarity regarding potential conflicts of interest or standards related to brokers that are also Navigators is needed. We note our support for inclusion of brokers in Exchanges, and representing QHPS sold both through and outside of Exchanges.

Payment of Premiums (§155.240)
We support the requirement that the Exchange must allow a qualified individual to pay any applicable premium owed by such individual directly to the QHP issuer as this is a requirement of §1312(b) of the Act. For the individual Exchange, we recommend that the requirement in subsection (d) that Exchanges may establish payment facilitation should remain optional. We note that health plans will be establishing a direct relationship with the enrollees, and will be receiving the advance premium tax credit directly from the federal government.

Privacy and Security of Information (§155.260)
Under the proposed rule, health insurance Exchanges must establish and follow security standards for collection, use, disclosure, and disposal of personally identifiable information and provide administrative, physical, and technical safeguards for the information that are consistent with security standards applicable to covered entities under 45 CFR §164.306, §164.308, §164.310, §164.312, and §164.314.

Exchanges must also establish and follow privacy standards consistent with applicable law and that establish acceptable parameters for proper collection, use, disclosure, and disposal of personally identifiable information. The preamble to the proposed rule notes that CMS is considering requiring each Exchange to adopt privacy policies that conform to the Code of Fair Information Practice Principles (FIPPs).

We recommend that an Exchange be held to the HIPAA standards as a covered entity in order to assure the most robust privacy protection consumers expect of any entity that collects, uses, and discloses personally identifiable information. We believe that the FIPP standards—as suggested in the proposed rule—are not an appropriate standard for the Exchange and believe greater consumer protections are necessary to safeguard consumer information.

HIPAA privacy and security provisions are complementary and both are necessary to adequately protect consumers from security breaches. Applying the full range of HIPAA privacy and security protections to Exchanges is necessary to assure that individuals protected health information and financial information will be maintained in a secure and sound manner. Therefore, we recommend that the proposed rule establish HIPAA security and privacy provisions as a federal floor for the Exchange, including requirements related to security breach notification and remediation.

We also recommend the following standards related to security and privacy of information apply to Exchanges:

- Recommended procedures related to identity theft to address cases where an applicant or enrollee reports that someone has fraudulently submitted information in their name;
- Require that patient Navigators sign business associate agreements with the Exchange, since Navigators may gain access to significant protected heath information (PHI) or personally identifiable information (PII); and
- Prohibit Exchanges from engaging in data mining activities not expressly allowed under the statute or regulations.

Applying the same privacy and security standards to the Exchange will help assure a level playing field and assure that consumers' information is adequately protected—regardless of the entity responsible for safeguarding protected health information and other sensitive information. To that end, Exchanges should be held to the same privacy and security standards as health insurance issuers, especially as it relates to functions that insurers currently perform such as eligibility and enrollment certifications and receiving PHI and PII in call centers.

Use of Standards and Protocols for Electronic Transactions (§155.270)

We support the requirement that Exchanges (to the extent they exchange electronic records with a covered entity) use the standards, implementation specifications, and code sets adopted in 45 CFR parts 160 and 162, and the interoperability and security standards and protocols developed pursuant to §3021 of the PHSA.

We also recommend that CMS work with health plans, states, and the appropriate standards development organizations to develop standards for the following data exchanges. The use of these standards by Exchanges should be required in § 155.270 and should include the following:

- Submission of the QHP information, including data on the required summary of benefits and coverage, transparency information, rates, quality improvement strategy information, etc.
- Data sent from Exchange to QHP issuer for enrollment
- Enrollment reconciliation

- Records of termination of coverage including a standard format to express the reason for termination (e.g., non-payment of premiums)
- Enrollment standards for when an individual contacts the health plan and needs to be sent back to Exchange for an eligibility determination per §156.265.

We look forward to working with CMS on its activities related to standards development and are interested in providing technical expertise to assist with this process.

Part 155 Subpart E

Enrollment of Qualified Individuals into QHPs (§155.400)
As noted above, we recommend the development of a common standard for an Exchange to submit an applicant's information to a health plan for purposes of enrollment into the selected QHP. At a minimum the data exchange must include the relevant data from the single streamlined application, eligibility information (including if the applicant is changing QHPs due to a special enrollment period, or was previously uninsured), information about covered dependents, and whether the individual had a condition that would merit special accommodations if termination of coverage was necessary as specified in §155.430(c)(3).

To implement the risk adjustment mechanism, we recommend that QHP issuers be notified if the applicant was previously uninsured and the source of that coverage (e.g. commercial insurer, Medicaid, etc.). The identification of new enrollees without previous health insurance coverage is critical so that their risk score is adjusted accordingly, in the same way that any other demographic factor might be considered.

We recommend that the current threshold of when an Exchange must send eligibility and enrollment information to the QHP is more specific than "on a timely basis". During the initial or annual open enrollment periods we recommend more frequent daily transmissions. While we would agree that in the future we would want the Exchange submission of enrollment and the health plan's response to be in "real-time", this is not a realistic first-year requirement for the Exchange and the QHP issuers. During less busy times, a timeliness metric could be less than daily.

Initial and Open Enrollment Periods (§155.410)
We support the initial open enrollment period taking place from October 1, 2013 through February 28, 2014. However, we recommend that the cut-off date for when applications received by the Exchange are required to have a coverage effective date of January 1, 2014 be moved to December 7, 2013 to give QHPs adequate time to process the new enrollments. This is particularly important, since we anticipate heavy workloads at this time, given many employers, issuers that also offer Medicare Advantage plans, and Medicare Supplement plans also hold open enrollment at this time.

CMS requests comments on whether there should be auto-enrollment in several circumstances (a QHP is no longer being offered and the individual does not make a new selection, mergers between issuers, etc.). In cases where members have to select a new QHP, they should have to make an affirmative choice and not be auto-enrolled in a new QHP. We recommend that in circumstances where there is no change, the individual can be kept in their same plan. This approach assumes that coverage will always be auto-renewable if there is no enrollee initiated change.

Regarding the timeframe of the proposed annual enrollment period for benefit years on or after January 1, 2015, we recommend that the annual enrollment period is shortened and takes place between October 15 and November 30 instead of December 7, as was included in the proposed rule. The longer the open enrollment period, the more likely a person will delay purchasing coverage until her or she experiences, or expects, a change in health status. This shorter period encourages people to purchase coverage when it is offered.

Special Enrollment Periods (§155.420)
We recommend that the length of the special enrollment period is shortened from 60 days to 30 days. This would be consistent with the existing requirements outside of the Exchange under HIPAA. The thirty-day period encourages people to purchase coverage when it is offered, and provides enough time to make a thoughtful decision.

We support the list of triggering events as included in the proposed rule. We do not support the addition of pregnancy as a trigger which is considered in the Preamble to the proposed rule at page 41885. However, it does raise some issues in that pregnancy is one of the Medicaid eligibility categories. Thus, a pregnant women coming to the Exchange could require screening for Medicaid eligibility but would not be eligible for a special enrollment period to seek subsidized coverage through the Exchange or to change her existing QHP unless one of the other triggering events occurs or she is deemed eligible for Medicaid.

A key special enrollment trigger occurs when an individual is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a QHP. In these situations we recommend it is appropriate for a qualified individual to change levels of coverage, but we recommend this be limited to movement up or down one level only to minimize the risk of adverse selection – with exception only made for the silver –metal tier, when that is the level required for cost-sharing reductions. We also recommend that this trigger is applied consistently across all Exchanges.

We are closely examining the link between the triggers for a special enrollment, and CMS requests for comments in the August proposed rule on eligibility, as well as the CMS request for comment on whether there should be a percent threshold to prevent unnecessary eligibility determinations by the Exchange. While we recognize the

importance of enrollees being in the plan that is affordable to them, we recommend it is appropriate for steps to be taken to minimize the number of special enrollment periods that could potentially take place for an individual or family. Unnecessary special enrollment periods and redeterminations will add administrative costs for the Exchange and for QHP issuers.

Termination of Coverage (§155.430)
The proposed rule states that the Exchange may terminate an enrollee's coverage in a QHP in certain circumstances, including when the QHP terminates, is no longer offered through the Exchange or is decertified as described in section 155.1080. This presumes that if a QHP is no longer available through the Exchange, that the enrollee could no longer maintain this coverage, whether inside or outside of the Exchange. We recognize that HIPAA standards of guaranteed renewability require that if such an event would occur, the QHP issuer would still be required to continue to renew the coverage as long as the enrollee continued to pay the premiums, with the recognition that the enrollee may no longer be eligible for insurance subsidies.

We have concerns regarding the requirements in subsection (c)(3) that Exchanges establish standards for termination of coverage that require QHPs to provide "reasonable accommodations" to enrollees with certain conditions before they are terminated from coverage. In some cases, the QHP issuer would not be aware of the presence of one of these conditions and thus would be unable to provide such accommodation. As an alternative, we recommend that questions about these conditions and the ability to designate a "competent adult representative" be included on the single streamlined application. Using this information, QHPs can be required to identify a competent adult to communicate on behalf of such individual so that steps can be taken to ensure that unnecessary terminations will not take place.

The proposed rule requires the QHP issuer to provide a grace period of at least three consecutive months if an enrollee receiving advance payments of the premium tax credit has previously paid at least one month's premium. During the grace period, the QHP issuer must:

- pay all appropriate claims submitted on behalf of the enrollee;
- apply all payments received during such period to the first billing cycle in which payment was delinquent; and
- continue to collect advance payment of the premium tax credit on behalf of the enrollee from the Department of the Treasury.

We recommend that the statutorily required grace period only apply to those enrollees who are receiving the premium tax credit, and we do not support the language in the Preamble to the proposed rule at page 41902 that the "Exchange could choose to require QHP issuers to provide all enrollees with such a grace period, regardless of advance payment status." Given QHP issuers will not be receiving funding, it is important to take steps to reduce the risk associated with unpaid premiums.

In those cases where the QHP issuer is receiving the advance payment of the premium tax credit on behalf of the enrollee from the Department of the Treasury, we recommend that the CMS take steps to minimize the risks and costs to health insurers and the federal government during the 90-day grace period. We recommend that QHP issuers are permitted to withhold payment on claims (i.e., "pend" claims) submitted on behalf of the enrollee when payments are delinquent for more than 30 days. This practice is consistent with applicable state laws and would eliminate the administrative costs and burden associated with having to recover payments from providers for individuals who have been terminated from coverage. Given the potential abuse that could from the 90-day grace period we recommend that CMS consider providing Exchanges with the option to permit QHP issuers to terminate coverage back to the last paid date of coverage. Another approach would be to require individuals to repay any unpaid premiums before being permitted to enroll in another QHP through the Exchange.

In the event of retroactive termination of non-payment of premium, the QHP issuer would also be required to track the tax credits received from the Treasury Department and return them to the Treasury Department.

As a practical matter, there is a close link between the required eligibility determinations (during the benefit year, and on an annual basis as proposed in section 155.330 of the eligibility proposed rule) and the termination of coverage requirements. We are concerned that during the redetermination process enrollees may just stop paying their premiums in lieu of officially terminating their coverage with their QHP, and instead enroll in coverage elsewhere. This could also occur if there are lags in the state Medicaid agency notifying the QHP that the member has been enrolled in Medicaid. Both situations could result in instances where individuals would be enrolled in more than one health insurance affordability program at the same time which would create administrative challenges regarding claims payments and reconciliation of subsidies received. Thus, we strongly recommend that Exchanges be required to promptly notify QHP issuers when enrollees have enrolled in other coverage, including Medicaid, so that termination can occur promptly, and such costly administrative challenges be avoided.

The proposed rule, as crafted, creates disincentives for individuals to pay premiums or to notify their QHP that that they have sought other minimum essential coverage elsewhere, because claims would continue to be paid. These disincentives would increase administrative costs for Exchanges and QHP issuers, with an impact on the affordability of insurance coverage when health plans would have to factor in the potential for significant non-payment of premiums in their rate calculations.

Effective Dates for Termination of Coverage **(§155.430(d))**
The proposed rule permits an enrollee to terminate coverage with appropriate notice to the QHP on a termination date specified by the enrollee so long as the Exchange and the QHP have a "reasonable amount of time." While enrollees may face numerous situations that would require termination of coverage a key goal of the regulations should be to

eliminate gaps in coverage while providing for administratively simple processes. We recommend that in most cases, termination of coverage should always be effective on the last day of the month if the notice of termination was received from the enrollee prior to the fourteenth day of the month. For notices of terminations received after the fourteenth day of the month, the effective date for termination should be the last day of the following month.

Part 155 Subpart H - Small Business Health Options Program (SHOP)

We support the development of small business (SHOP) Exchanges as a way to provide small firms and their employees with additional health insurance options and choices. Designed effectively, SHOP Exchanges hold promise in helping small firms and their employees better shop for coverage and compare options—through making available comparative information on health plans' benefit options and other consumer-assistance tools—as well as helping to reduce administrative burdens on small-firms seeking to provide health insurance to their employees.

Below are our specific recommendations and comments relating to the proposed rule's SHOP provisions:

Minimum participation requirements (Preamble, p. 41886-41887—Functions of a SHOP)

The preamble to the proposed rule invites comments on the issue of minimum participation requirements for small-group insurance coverage through the Exchange. Minimum participation requirements—recognized under the HIPAA (42 USC §300gg-11(e)(2))—are a commonly used tool for managing adverse selection in the small-group marketplace that is widely recognized under state insurance laws and regulations. Typically, minimum participation rules require that small-firms seeking coverage meet minimum standards for employee participation in the health insurance plan. For example, a state may set their minimum participation requirements at 75%--meaning that the small business must assure that 75% of their employees participate in the plan as a condition of receiving health insurance coverage. Without minimum participation rules, the small-group market is more vulnerable to adverse selection—as healthier employees may forego coverage—and could lead to a less balanced and costlier insurance pool, thereby driving up costs for everyone.

We recommend that SHOP Exchanges recognize the importance of minimum participation requirements and that states should establish these requirements (through state laws or regulations) for their small-group coverage provided through their SHOP exchanges. Therefore, the final rule should recognize states' minimum participation requirements and market standards, often developed to address adverse selection issues in current markets, and permit the application to the SHOP Exchange.

Employer choice requirements (§155.705(b)(2)(3))

The proposed rule states that the SHOP "must allow a qualified employer to select a level of coverage as described in section 1302(d)(1) of the Affordable Care Act, in which all qualified health plans within that level are made available to qualified employees of the employer. The proposed rule also notes the SHOP may provide flexibility for employers to make "one or more qualified health plans available to qualified employees" through alternative designs and arrangements.

The preamble to the proposed rule contemplates providing small businesses with maximum flexibility in arranging for and offering health insurance coverage to their employees—including allowing:

- Employees to choose any qualified plan offered in the state's SHOP at any benefit level;
- Employers to select specific benefit levels from which an employee may choose a qualified health plan;
- Employers to select specified qualified health plans from different levels of coverage from which an employee can choose a qualified health plan; and
- Employers to select a single qualified health plan to offer employees.

We do **not** support allowing an employee to choose from any plan offered at any level, as it would result in adverse selection. We do support the proposed rule's provisions that provide states with flexibility in designing their SHOP Exchange so that they can best develop policies that reflect the local marketplace and attract small business participation. We recommend the final rule also reflect this flexible approach.

Premium aggregation (§155.710(b)(4))

The proposed rule requires SHOP Exchanges to perform functions related to premium payment administration—including "premium aggregation" aimed at reducing administrative complexities for firms seeking coverage through the Exchange. Under premium aggregation, the SHOP Exchange would simplify billing and administration for small firms by sending a consolidated monthly bill to the participating employer reflecting total premium costs for the plans selected by the employees. The SHOP Exchange, in turn, would be responsible for receiving payment from the employer and allocating the premium amounts to the various plans or insurers offering coverage to employees of the firm.

The premium aggregation function is intended to reduce administrative burdens for small businesses by avoiding the need for the small firm to write multiple checks to multiple insurers every month. This function is particularly important for SHOP Exchanges and participating small firms that elect to implement an "employee choice" model—where the employee selects among a range of insurers and plans offered in the Exchange. In order to be successful, premium aggregation functions should be efficient and seamless in order to minimize administrative burdens for small employers and health plans.

A strong emphasis on efficiency is important to ensure that the premium aggregation function does not impose undue burdens on health plans and assures that premiums are paid in a timely manner—as funding flows from the small employer (including the employer and employee share of the premium) to the Exchange and to the participating health plans selected by the employees.

While an efficient premium aggregation function is important — particularly under the employee choice model — we recommend that the final rule allow a SHOP Exchange to delegate the premium aggregation function to the qualified health plan issuer, as an administrative option in an employer choice option. Health insurance plans are very well-suited to perform this important operational and administrative function under the employer choice option—as that is how they currently serve their customers in the small-group insurance marketplace today.

Qualified health plan availability in merged small-group and individual markets (§155.705(b)(8))

The proposed rule provides that a state *may* decide to merge individual and small-group market risk pools and in this section addresses standards for the availability of qualified health plans in a state's SHOP Exchange and special rules for making available health plans in states with merged risk pools.

We recommend that states carefully evaluate the impact on the market and premiums prior to deciding to merge the individual market and small-group market risk pools to determine whether the merged markets would represent a benefit or harm to consumers and the Exchange. States will want to consider the preferences of employer groups regarding their interest or concerns with enrollment in Exchanges with a merged risk pool. We also note that a merged risk pool in an Exchange could have a complicated risk adjustment mechanism when the market outside the Exchange continues to be a non-merged market.

SHOP expansion to the large group market (§155.705(b)(9))

The proposed rule includes standards relating to expansion of the SHOP Exchange to the large-group market. Specifically, the proposed rule requires the SHOP Exchange to permit large group health insurance issuers to offer such plans through the small business exchange beginning in 2017, provided the large employer meets certain requirements related to qualified employers.

We recommend that states avoid expanding eligibility to the large-group market. To assure cost-effective and efficient Exchanges, states should limit participation to small businesses in order to better manage operational and related costs. By making participation levels more manageable, SHOP Exchanges have a better opportunity to succeed in the marketplace.

Moreover, expanding eligibility to large employers invites problems associated with adverse selection—particularly as it relates to the SHOP Exchange where firm participation is strictly voluntary. SHOP Exchanges that allow large firms to participate could be at-risk for attracting large firms with older and sicker workers—thereby increasing premiums for the entire SHOP Exchange insurance pool. Large firms with relatively younger, healthier workers, in turn, would likely elect to continue to purchase outside the Exchange in the largely experience rated large group marketplace. This segmenting of the insurance marketplace could lead to a deterioration of the SHOP Exchange risk pool, create instability in the small-group marketplace, and cause premiums to rise for everyone. For all of these reasons, we recommend that SHOP Exchanges limit participation to small businesses.

Eligibility standards for SHOP exchanges (Preamble pps. 41877-41878—Eligibility Standards for SHOP)
The preamble to the proposed rule addresses the calculation of an employer's size for participation in the SHOP Exchange. Specifically, it notes that the PHSA definition of employer and ERISA definition of group health plan refer to at least one employee and therefore excludes "sole proprietors, certain owners of S corporations, and certain relatives of each above."

We agree with the CMS interpretation, and further recommend that states limit participation to small firms with up to 50 employees—which is consistent with most states small-group insurance laws and regulations. Unless state law defines "small group" as 1-50, participation should be limited to small employers with 2 to 50 employees.

Enrollment periods under SHOP exchanges (§155.725)
The proposed rule includes provisions that require SHOP exchanges to permit a qualified employer to purchase coverage for its employees at any point during the year. The employer's plan must consist of the 12-month period beginning with the qualified employer's effective date of coverage.

We support the proposed rule's requirements that provide for rolling enrollment in the SHOP exchange—as this is consistent with current practices in the employer group marketplace.

Application standards for SHOP exchanges (§155.730)
The proposed rule requires SHOP exchanges to use a single application to determine employer eligibility and to collect information necessary to for purchasing coverage. We support the proposed rule's focus on keeping application standards simple and straightforward. The development of an efficient application and enrollment process is critically important for assuring that small businesses can readily access small-group coverage through the new SHOP exchanges. In the development of the model application, it may be useful to provide additional information — including anti-fraud statements or state appeal or arbitration requirements.

Part 155 Subpart K - Certification of Qualified Health Plans

(And related sections in Part 156 Subpart C)

Quality Improvement Strategies

The proposed rule invites comments on requirements to collect quality data, oversee enrollee satisfaction surveys, assess quality improvement strategies and rate and publicly report on quality. While CMS has indicated that it will address specific requirements related to quality improvement strategies in future rulemaking, we have included some initial feedback as CMS develops its proposal in four areas:

- Recommended domains for quality reporting by QHP issuers;
- Recommended criteria for selecting measures;
- Definition of quality improvement strategies; and
- Considerations for public reporting.

Domains for Quality Reporting by QHP Issuers - There is considerable variation in the domains used for quality reporting programs across public programs. Domains identified in the MA Star Ratings, the National Quality Strategy as well as those used in various federal programs such as the Hospital Value-Based Purchasing (HVBP) Program, Meaningful Use, and proposed regulation on the proposed Shared Savings Program differ from each other. For example, there are many key differences between the proposed regulations for the Medicare Shared Savings and HVBP programs including differences in minimum achievement levels, different measurement domains and weighting of these domains; and higher standards of performance under value-based purchasing than under shared savings. Alignment across programs and initiatives would enable more meaningful comparisons. We recommend that the quality domains build on and be consistent across federal programs to maximize the impact across the entire health care system. We recommend that the following domains be used:

1) Staying Healthy – Prevention and Wellness
2) Management of Acute and Chronic Conditions
3) Enhance/Promote Patient Safety
4) Plan Responsiveness/Patient Satisfaction
5) Patient engagement

Criteria for Selecting Measures - Regarding quality measurement and reporting, we recommend a core set of measures that are (a) NQF-endorsed or preventive measures consistent with a USPTF A or B rating or recommended by the Advisory Committee on Immunization Practices (ACIP); (b) limited in number and reflect priority areas so that resources are used efficiently; (c) already field tested and proven to be reliable; (d) already being reported in private and public sectors; and (e) initially, available through clinically-enriched administrative data. It would be difficult to suggest actual measures at this time as we support phasing-in any measurement or reporting activities given the influx of the uninsured population and need for stable data over a sufficient period of time. The science of measurement and the evidence-based guidelines that form the basis

of measurement are continually evolving and therefore the actual measures to be used for each of these domains will need to be determined within a year of implementation. For example, measures should be selected by 2013 for reporting requirements in 2015. Additional measures should only be included if they meet the needs of the Exchange's population and the community has already successfully demonstrated effective use of the measure(s) being required by the Exchange. We recognize that there are priority areas where valid and reliable measures may not be available and effective use has not been demonstrated. We therefore recommend that there be a process for pilot-testing of measures to address these gap areas prior to public reporting. Pilot testing should include an evaluation of measures' validity, reliability, feasibility, and usability.

Definition of quality improvement strategies - We recommend CMS develop a common definition of quality improvement strategies that are (a) consistent across Exchanges and (b) based on existing state, federal, or voluntary private accreditation standards. Exchanges may adopt additional strategies that only (a) reflect ongoing community-based initiatives and (b) are consistent with the three-part aim indentified in the National Quality Strategy: better care, healthy people and communities, and affordable care. Additionally, reporting requirements pertaining to quality improvement strategies should be used to assess the level of plan engagement in the activities specified in ACA. Assessment of the results of quality improvement strategies will not be comparable across plans because of population differences (e.g. case mix and severity) and therefore would not be an accurate reflection of the effectiveness of such programs.

Considerations for Public Reporting - One of the challenges to quality reporting in the Exchange relates to the expected influx of individuals who have not previously had access to coverage. There will be a need to account for the instability of quality data during a transition period; given that these individuals will likely have unmet health needs that will affect initial efforts to improve quality. Quality reporting requirements should be phased-in to account for this initial instability. Measure selection should occur in 2012 and a phase-in of quality reporting requirements beginning in 2015 would allow for the collection of data for one year and enable the use of a set of quality metrics with a one-year look-back period. Additional measures should be phased-in over time.

Accreditation Standards for QHP Issuers (§156.275)

The process used by CMS to recognize accrediting entities should be modeled after the process used to identify such accrediting entities in the MA program. Additionally, plans that have met a state's existing accreditation standards should be deemed to have met the accreditation standards to participate in the Exchange. States that do not have formal accreditation standards should adopt standards similar to those set by nationally recognized accreditation organizations such as NCQA and URAC. CMS should consider new plan assessment models for the individual and small group market given that the current accreditation models are applicable for the large group products (e.g. HMO, HMO-POS, PPO).

Network Adequacy Requirements for Exchanges and QHP Issuers (§155.1050 & §156.230)

An Exchange is required to ensure that the provider network of each QHP "offers a sufficient choice of providers for enrollees." The proposed rule indicates that CMS intends to afford states considerable flexibility to define network adequacy based on geography, demographics, and local patterns of care and market conditions. While we support the approach in that states should have the flexibility in this area, we are concerned that states may adopt overly granular approaches that exceed existing state laws. If, in the final rule, CMS permits state Exchanges to apply additional network adequacy criteria, we recommend that these additional criteria be based on existing state network adequacy standards. Greater specificity beyond these existing standards is unnecessary, given that network adequacy and compliance with other standards will continue to be monitored through mechanisms such as existing accreditation standards, enrollee satisfaction surveys, complaint rates, and waiting times to access a provider.

Essential Community Provider Requirement for QHP Issuers (§156.235)

The ACA and the proposed rule require QHP issuers to maintain provider networks that include essential community providers. Specifically, a QHP issuer must include "a sufficient number of essential community providers, where available, that serve predominantly low-income, medically-underserved individuals." While a QHP issuer must include essential community providers, it only requires a QHP to include a "sufficient" number of essential community providers and CMS seeks comment on how to define sufficient.

We recommend that CMS clarify that essential community providers are subject to the same contract requirements as other providers and health plans are able to exclude from their networks providers who cannot demonstrate quality health care delivery and meaningful access to enrollees. Greater specificity on the definition of "sufficient" is unnecessary, given the network adequacy requirements for QHPs regulated by state Departments of Insurance.

Certification of QHPs (§155.1000)

Under the proposed requirements Exchanges may implement selection criteria beyond the minimum certification standards in determining whether a plan is in the interest of the qualified individuals and employers, such as additional criteria pertaining to quality improvement activities and provider network enhancements. We do not support the implementation of additional selection criteria beyond the minimum federal standards - which are extensive - and do not support further certification standards based on "whether a plan is in the interests of the qualified individuals and employers" We strongly believe that it is in the best interest of consumers to allow all health plans that meet the extensive requirements under the ACA to qualify as QHP issuers and be allowed to participate in Exchanges, as this will ensure more consumer choice and market competition.

We support Exchange participation conditioned upon (1) the certification standards set forth in ACA, (2) licensure by the state in which the Exchange operates, and (3) compliance with nationally established, consensus-based quality measures. While the "in the interests of" language is statutory, requiring an Exchange to *define* in advance the manner in which it will objectively determine *what is in the interest of* individuals and employer groups *is* consistent with statutory requirements. Conditioning participation on anything other than clearly-defined, objective measures and criteria could lead to inconsistency in decisions and possible appeals. Requiring that the selection criteria meet proven standards and validity measures with allow Exchanges to function in the interest of consumers, and demonstrate a fair and balanced approach with a focus on quality, value and consumer choice.

Certification of Stand-Alone Dental plans **-** Additionally we do not support the application of QHP quality improvement activities or other quality certification requirements to stand-alone dental plans. The primary certification requirement for those issuers is to be a licensed entity in good standing as an insurer marketing dental plans in the state. We also comment that to the extent stand-alone dental plans may be required to comply with certain standards to participate in an Exchange that this not be construed to imply that ACA requirements apply to any HIPAA excepted benefits, in accordance with the ACA provisions and confirmed in subsequent rules.

Stand-Alone Dental (§155.1065)
We also urge CMS to specify that a QHP offered in the outside Exchange market is not required to offer the pediatric oral health essential benefit, as long as there are stand-alone dental plans available that include the pediatric essential benefit. This would assist both stand-alone dental plans and QHP issuers by aligning the outside and inside Exchange markets on this point.

Treatment of Direct Primary Care Medical Homes (§156.245)
The proposed rule permits a QHP issuer to provide coverage through a direct primary care medical home that meets criteria established by CMS, provided that the QHP meets all other requirements of a QHP issuer. As we have previously communicated, a level playing field is important to ensure that the requirements placed on these potential new market entrants are the same as those requirements currently placed on health plans (e.g., licensing, reserves, etc.). We support CMS' decision (see the Preamble to the proposed rule at page 41900) to disallow the offering of a direct primary care medical home plan with separate wrap-around coverage. In our experience, medical home models work best when care is coordinated and/or integrated across all levels and settings of care.

156 Subpart C – Qualified Health Plan Minimum Certification Standards

Transparency in Coverage (§156.220)
Section 1311(e)(3) of the ACA establishes that Exchanges must require QHP issuers to submit transparency in coverage information to the Exchange, CMS, the State Insurance

Commissioner, and to the public (in plain language). Since June of 2010, CMS has collected similar information to populate the health insurance plan finder at Healthcare.gov ("Plan Finder") required by §1103 of ACA. Using this experience, we offer the following recommendations as CMS implements this ACA requirement.

We recommend that CMS explicitly require Exchanges to collect information at the issuer level by state and not the QHP level (or plan level). We support the language at §156.220 that requires transparency of coverage information to be provided by "QHP issuers." We interpret this to require issuers to report aggregated information that is not at the level of a "QHP" to ensure confidential information is protected. For example, ABC Insurance Company would submit information that applies to all of their individual and small group business in a particular Exchange service area.

It is important that data collected by the Exchange and CMS is the same as the data collected by State DOIs for rate filings. There must be a clear process for QHP issuers to designate their information as confidential for purposes of FOIA and applicable state law. In addition, Exchanges should be prohibited from selling this information for secondary uses. We note that some of the statutorily required data elements are not appropriate for public release at a granular level due to potential harm to market competition. On August 5, 2011 the CMS FOIA office made a determination that several of the data provided to CMS for the purposes of populating the Plan Finder should not be publicly released. This included enrollment, disenrollment, and certain information about how health plans calculate rates. As of this writing, the CMS FOIA office was still researching whether information regarding financial ratings and base rates should be designated as confidential and therefore protected from public disclosure under FOIA Exemption 4.

We offer the following specific recommendations on the transparency disclosures in §156.220:

(1) Claims payment policies and practices. We recommend this include general information on how to file claims (address, claims filing deadlines, etc.) if the consumer is responsible for submitting claims, how to file an appeal, customer service information, etc. The existing requirements for disclosing information about internal appeals procedures set out in the interim final rules on claims internal appeals and external appeals are a potential model.

(2) Periodic financial disclosures. For the Plan Finder data submissions, CMS requests information on the A.M. Best Rating, A.M. Best ID, and Rating Date of companies but this information is not publically disclosed on the Plan Finder. Therefore, we recommend that this information is not publicly disclosed. The CMS FOIA office has notified issuers that it is researching which health insurance issuer ratings are available in the public domain and which ones remain confidential, and we recommend that a similar approach is followed related to Exchanges.

(3) and (4) Data on enrollment and on disenrollment. Enrollment information should be collected at the issuer level. We do not recommend that CMS collect QHP or plan specific enrollment or disenrollment information which has been designated as confidential by the CMS FOIA office. In response to the FOIA requests and concern over the confidentiality of underlying enrollment data submitted for the Plan Finder, we support an approach that would aggregate all product level enrollment information and produce an enrollment count for a company in the individual market and small group market in each state. This approach further negates the need to collect plan level enrollment information. We do not recommend the collection of a separate figure for disenrollment. Changes in enrollment can be tracked using enrollment numbers.

(5) Data on the number of claims that are denied. We note that claims are denied for many reasons that are not the fault of the QHP issuers. One of the most common reasons for claims denials include insurance eligibility, duplicate claims, and denials due to inaccurate claims coding. An AHIP claims processing survey showed that nearly half of all claims were pended due to the submission of duplicate claims, lack of complete information or other information needed to justify the claim, or invalid codes. Twenty-four percent of pended claims were due to coverage issues, including no coverage based on date of service, non-covered or non-network benefit or service, or coordination of benefits.[6] A May 2011 GAO Report "Private Health Insurance: Data on Application and Coverage Denials" also confirmed that many claim denials, some administrative in nature, are ultimately paid. A definition of claims denial must factor these situations so consumers are not presented with misleading information about the QHP issuer.

(6) Data on rating practices. Collection of data on rating practices for health insurance in 2014 will no longer be relevant for consumers shopping for insurance and should not be used to determine if a health plan is qualified to participate on the Exchange. We recommend that CMS not collect any information on rating practices.

(*7) Information on cost sharing and payments with respect to any out-of-network coverage*. While the summary of the QHP on the Exchange can include general information about coverage, we recommend that Exchanges link to these tools on individual health plan websites which would provide more specific and tailored information in this area. Many health plans already provide these kinds of tools today. Regarding the requirement in **§**155.1040(c) that Exchanges monitor whether a QHP issuer has made cost sharing information available in a timely manner, we recommend that this is not an Exchange function but rather the function of the insurance regulator. If an Exchange receives a complaint, it should be shared with the applicable state regulator.

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[6] AHIP Center for Policy and Research, An Updated Survey of Health Care Claims Receipt and Processing Times, May 2006. Available at http://www.ahipresearch.org/pdfs/PromptPayFinalDraft.pdf.

(8) Information on enrollee rights under Title I of the Affordable Care Act. We recommend that CMS develop sample language on enrollee rights.

Given that most of the data elements are not related to coverage, we recommend that transparency in coverage information should not be used to determine whether or not an issuer is qualified to be a QHP.