

State Health Reform Assistance Network

Charting the Road to Coverage

ISSUE BRIEF

August 2011

HHS Proposed Rules on Exchange Implementation Requirements

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On July 11, 2011, the U.S. Department of Health and Human Services (HHS) issued proposed rules on the American Health Benefit Exchange (“Exchange”) implementation: *Establishment of Exchanges and Qualified Health Plans (CMS-9989-P)*.

The regulations largely codify Affordable Care Act (ACA) requirements, with some notable exceptions. Embedded in the proposed regulations, and even more so in the accompanying commentary, are several significant policy shifts that will impact state planning and implementation of Exchanges. For example, the preamble introduces the new concept of a “State partnership model” in which states may choose to combine state-designed and -operated business functions with federally designed and operated functions. Whereas Exchanges previously had been articulated by HHS as either distinctly state-run or federally run, the state partnership model offers a hybrid approach to establishing and operating Exchanges. Relative to the other substantive areas, the proposed rule provides significantly more detail on the Small Business Health Options Program (SHOP), enrollment periods and effective dates in the individual market, and the Exchange establishment process and criteria.

The purpose of this memo is to highlight the provisions of the regulations and accompanying commentary that clarify or amplify the ACA, or provide new insight into federal guidance or the collective thinking that has dominated the national discussion on Exchanges to date.

The regulations focus on a subset of crucial issues, but are not exhaustive. The preamble explicitly notes that the proposed rules do not address several key issues which are expected to be in future rule making, including:

- Individual eligibility standards for: Exchange participation, advance payments of the premium tax credit, cost-sharing reductions, appeals of eligibility determinations and exemption from the individual responsibility requirement;
- Definitions of essential health benefits, actuarial value and other benefit design standards; and
- Quality reporting for Exchanges and Qualified Health Plan (QHP) issuers.

Guidance on these provisions—as well as on the Basic Health Plan, Medicaid eligibility and enrollment and Medicaid-Exchange interfacing—which are not addressed in the current issuance, are anticipated in the fall.

HHS will accept comments on the proposed rules within 75 days of publication in the Federal Register, on July 15. The proposed rules are available online at: <http://www.gpo.gov/fdsys/pkg/FR-2011-07-15/pdf/2011-17610.pdf>

EXCHANGE ESTABLISHMENT

- **Exchange Approval Process and Conditional Approvals.** (*Preamble: Sec. II.A.2.b; Regulatory Text: §155.105*) The proposed rule provides that states electing to establish an Exchange must (1) submit to HHS an “Exchange Plan” describing how its Exchange meets federal standards and (2) demonstrate operational readiness through a readiness assessment conducted by HHS. The rule articulates a new concept of “conditional approval,” allowing HHS to presume a State Exchange will be operational by January 1, 2014 where it is able to demonstrate progress toward, but not complete readiness for Exchange operations by the statutory HHS approval deadline of January 1, 2013. The concept of conditional approval is a departure from the expectation set by HHS to date that states must demonstrate full implementation capacity for all Exchange functions by 2013 or risk HHS intervention to establish a federal exchange in the state. HHS would work with and monitor conditionally approved states until they are fully approved or their conditional approval is revoked. A state electing to operate an Exchange as of January 1, 2014 must have an approved or conditionally approved Exchange Plan by January 1, 2013. Without such approval HHS will implement a federally facilitated Exchange.
- **Changes to Exchange Plans** (*Preamble: Sec. II.A.2.b; Regulatory Text: §155.105*). The rule requires that states notify HHS in writing of any substantial changes to Exchange Plans. Supporting commentary suggests that HHS is considering use of a State Plan Amendment (SPA) process similar to the process in place for Medicaid and CHIP as the vehicle for Exchange Plan changes. HHS seeks comment on the SPA approach.
- **Post-2014 Exchange Launch and Termination** (*Preamble: Sec. II.A.2.c; Regulatory Text: §155.106*). The draft rule presents a more fluid picture of the timeline for state election to run Exchanges than that articulated in statute. Specifically, the rule would permit states to begin or cease Exchange operations after 2014. This does not however change the ACA requirements that: (i) a “federally facilitated” exchange will be established in states that do not elect to operate exchanges in 2014; and, (ii) Exchange establishment funding is not available after 2014. States electing to begin or terminate its Exchange after January 1, 2014 would be required to work with federal officials to transition from or to the federally facilitated Exchange, beginning at least 12 months in advance of the change.
- **State-Federal Partnerships** (*Preamble: Sec. II.A.2*). Commentary supporting the proposed regulation articulates a new option for states to establish Exchange functionality through partnership with the federal government. Specifically, HHS contemplates partnership models through which states combine state-designed and operated business services with federally provided services. These models would reflect a hybrid of the two Exchange establishment options articulated in statute: State Exchange and Federal Exchange.
- **Governance** (*Preamble: Sec. II.A.2.d; Regulatory Text: §155.110*). The proposed rule articulates new guidance to states with respect to Exchange Governance Board composition.
 - **Conflicts.** States are prohibited from establishing Exchange boards where a majority of representatives have conflicts of interest. The regulations define conflicted members to include representatives of insurance issuers, agents or brokers or other individuals licensed to sell health insurance. HHS expresses these limitations as a minimum federal standard and invites comment on whether additional categories of representatives with potential conflicts of interest should be further specified.
 - **By-Laws.** The proposed rules also require Exchanges that are operating as independent state agencies or not-for-profits entities to have a governing board; formal, publicly adopted operating charters or by-laws; regular public meetings announced in advance; and publicly available governance principles addressing ethics, transparency, accountability and conflicts standards.
 - **SHOP Governance.** While the proposed rules acknowledge the option to create a separate governance structure for the individual and SHOP Exchanges, the preamble expresses a preference for a single structure, and the proposed rules requires coordination between the two.
- **Existing Health Insurance Exchanges** (*Preamble: Sec. II.A.2.h; Regulatory Text: §155.150*). The proposed rule codifies the ACA's compliance provisions with respect to existing State Exchanges. The ACA says that to be eligible for the presumption of compliance, existing Exchanges must “insure a percentage of the population not less than the percentage of the population projected to be covered nationally after the implementation of the ACA.” The preamble indicates that HHS will apply the projected coverage level of the U.S. population in 2016. The CMS Office of the Actuary currently estimates this level to be 93.6 percent while the Congressional Budget Office estimates the coverage level to be 95 percent.

- **Financing** (*Preamble: Sec. II.A.2.i; Regulatory Text: §155.160*). HHS proposes to require Exchanges to announce user fee assessments on issuers in advance of the plan year. HHS seeks comment on whether the final regulation should limit how and when user fees may be charged and whether such fees should be levied on an annual basis.

EXCHANGE FUNCTIONS

- **Navigator Program** (*Preamble: Sec. II.A.3.c; Regulatory Text: §155.210*). The proposed rule codifies the categories of entities that may function as Navigators including community groups, professional associations, unions and licensed brokers and agents. The rule further requires that the Exchange include entities from at least two of the eight categories specified. The proposed rule codifies the prohibition on using federal Exchange establishment funds to support the Navigator program. Notably, in the preamble discussion, HHS articulates that States may draw down federal Medicaid and CHIP administrative matching funds for Navigator activities targeted to Medicaid and CHIP populations.
- **Website** (*Preamble, Sec. II.A.3.b; Regulatory Text: §155.205*). The proposed rule provides further details on the information and services to be offered on Exchange websites and requiring that such information be available in plain language and accessible to individuals with limited English proficiency and disabilities. In the preamble discussion, HHS contemplates requiring functionality for users to store and access information on the website and seeks comment on this proposal. This feature would include allowing applicants and enrollees to store, access and update personal account information and application assisters – such as case workers, Navigators, agents and brokers – to maintain records of individuals they have assisted in the application process.
- **Individual Premium Payments** (*Preamble, Sec. II.A.3.f; Regulatory Text: §155.240*). The proposed rule articulates parameters for individual premium payments through the Exchange, while maintaining flexibility for Exchanges with respect to this function. The discussion articulates the three options for individual premium collection by the Exchange: (1) take no part in payment of premiums (individual pays premium directly to the QHP issuer); (2) create an electronic "pass-through" without retaining any of the payments; or, (3) collect premiums from enrollees and pay an aggregated sum to the QHP issuer. In all cases, Exchanges must permit enrollees to pay premiums directly to QHP issuers.
- **Privacy & Security** (*Preamble, Sec. II.A.3.g; Regulatory Text: §155.260*). The rule offers a number of general provisions related to privacy and security in lieu of detailed privacy and security standards. Specifically, the proposed rule clarifies that HHS will not adopt uniform privacy standards, rather it would allow each Exchange to comply with existing ACA and HIPAA guidelines as applicable and to tailor privacy and security policies. HHS also suggests that each Exchange engage in a "fact intensive" analysis of operations and functions in order inform development of those policies.

INDIVIDUAL ENROLLMENT

- **Open Enrollment Periods and Coverage Effective Dates** (*Preamble, Sec. II.A.4.c; Regulatory Text: §155.410*). The proposed rule specifies timeframes and parameters for initial and annual open enrollment periods. HHS proposes an initial open enrollment period of October 1, 2013 through February 28, 2014, noting that it extends beyond the January 1, 2014 to allow for sufficient outreach and education. For coverage starting January 1, 2015, the proposed rule specifies an annual open enrollment period of October 15 through December 7. However, in the preamble, HHS also discusses an alternative timeframe of November 1 through December 15 and seeks comment on this alternative.

The proposed rule also defines coverage effective dates. HHS limits coverage effective dates to the first of the month with specific exceptions for births and adoptions. This policy raises questions for maintaining continuity of coverage for individuals losing coverage at other times during the month.

- **Special Enrollment Periods** (*Preamble, Sec. II.A.4.d; Regulatory Text: §155.420*). ACA requires special enrollment periods for qualified individuals experiencing certain triggering events including loss of minimum essential coverage, change in citizenship or immigration status, change in eligibility for premium tax credits or cost sharing or other "exceptional circumstances." HHS imposes limitations on "loss of coverage" triggers for special enrollment periods and highlights two policies designed to mitigate against adverse selection. The preamble discussion notes that HHS has restricted its definition of loss of coverage to "minimum essential coverage" reasoning that those individuals enrolled in less than minimum

essential coverage could wait until experiencing a significant health care need to trigger the use of a special enrollment period to enroll. In addition, for individuals currently enrolled in a QHP seeking to change plans in a special enrollment period and who have not experienced a change in their premium tax credit or cost sharing reduction levels, HHS restricts their change in plans to QHPs within the same level.

- **Termination of Coverage** (*Preamble, Sec. II.A.4.e; Regulatory Text: §155.430*). The proposed rule outlines parameters on the termination of QHP coverage. HHS proposes to allow individuals to voluntarily terminate QHP coverage with adequate notice to the Exchange or the QHP. HHS also proposes conditions in which QHP coverage may be terminated for the individual, which include: ineligibility for QHP coverage; non-payment of premiums by the individual; and decertification or termination of the QHP. In the case of voluntary termination of coverage by the individual, effective date for the termination of coverage as a reasonable timeframe following notice of the individual. In the case of Exchange- or QHP-initiated termination of coverage, HHS proposes that the coverage end a month following notice of termination to the individual.

SMALL BUSINESS HEALTH OPTIONS PROGRAM (SHOP)

- **SHOP Flexibility** (*Preamble, Sec. II.A.5.b; Regulatory Text: §155.705*). The proposed rule provides new flexibility with respect to employer choice requirements in the SHOP. As required by the ACA, the SHOP must allow an employer to select a level in which all QHPs are made available to employees. The proposed rule further provides that the SHOP may permit participating employers to select one or more QHPs to offer as coverage to their employees. HHS specifically seeks comment on this latter provision, which in statute appears to apply to large employers, but in the proposed rule has been extended to small employers.
- **Uniform Enrollment Timeline** (*Preamble, Sec. II.A.5.e; Regulatory Text: §155.720*). The proposed rule delegates responsibility to the SHOP to establish a uniform timeline relating to employer enrollment in the SHOP and employee enrollment in QHP coverage. These activities include: determination of employer eligibility to purchase coverage in SHOP; employer selection of level of coverage and QHPs; and determination of employee eligibility for enrollment in QHP coverage. HHS notes in the preamble discussion that due to the rolling enrollment process for employers, the timeline will be standardized to the plan year as opposed to the calendar year timeline applicable to individuals.
- **Employer Enrollment Periods** (*Preamble, Sec. II.A.5.f; Regulatory Text: §155.725*). The proposed rule specifies that the initial open enrollment period for SHOP commences October 1, 2013. However, HHS notes in the preamble discussion that this date represents a "starting point" for employers to begin participation in the SHOP. The proposed rule further requires the SHOP to establish a rolling enrollment process so that employers are able to enter a SHOP at any point during the year. The rolling enrollment process is intended to match the enrollment process for the small group market outside of the SHOP and HHS reasons that small employers are more likely to join the SHOP with the flexibility of a rolling open enrollment period rather than a single annual open enrollment period. The proposed rule specifies that the employer's plan year consists of the 12-month period beginning with the coverage effective date.
- **Employee Enrollment Periods** (*Preamble, Sec. II.A.5.f; Regulatory Text: §155.725*). The proposed rule requires the SHOP to establish annual open enrollment periods for employees which, due to the rolling enrollment process, standardized to the plan year. HHS further requires the SHOP to ensure that employees hired outside of the open enrollment period are provided with a specified timeframe to seek coverage when they start their employment.
- **Premium Aggregation** (*Preamble, Sec. II.A.5.b; Regulatory Text: §155.705*). In contrast to the flexibility offered in the individual Exchange, the proposed rule requires SHOP to perform premium payment administration duties. The statute is silent in this regard, but the discussion indicates that HHS reasons this policy to be an administrative simplification for employers.
- **Rate Setting** (*Preamble, Sec. II.A.5.b; Regulatory Text: §155.705*). The proposed rule specifies standards for rates and rate changes. HHS requires that the SHOP confine QHP issuer rate changes to a uniform timeframe that is either quarterly, monthly or annually, with rate changes occurring during the year applying only to new coverage and annual renewals. HHS invites comment on whether it should allow more or less restrictive timeframes.

- **Minimum Participation Standards** (*Preamble, Sec. II.A.5.b*). In the preamble discussion, HHS contemplates issuers' minimum participation rules, a common tool used to protect issuers against adverse selection. HHS invites comment on whether QHPs offered in the SHOP should be required to waive application of these rules on an issuer or plan basis or whether application of minimum participation rules should be permitted, how that rate should be calculated, and whether that should be codified in federal regulations.

ACCREDITATION AND CERTIFICATION STANDARDS FOR QHPs AND QHP ISSUERS

- **Distinction Between Plans And Issuers** (*Preamble, Sec. II.A.6.e; Regulatory Text: §155.20*). The proposed rules make a distinction between a QHP that is certified to be offered through an Exchange and a QHP issuer which is an issuer that is subject to the requirements related to the offering of QHPs through the Exchange. In other words, a QHP is a product—an offering from an insurance issuer. This distinction is critical as discussed below with respect to the ACA's accreditation requirement.
- **QHP Accreditation** (*Preamble, Sec. II.A.6.e; Regulatory Text: §155.1045*). The preamble to the rules describes the accreditation requirement as a "seal of approval," indicating that a QHP issuer meets minimum standards of quality and consumer protection. The proposed regulations interpret the ACA's accreditation requirement as applying to issuers, not QHPs, and specifically requires states to establish an accreditation timeline. Noting that the ACA does not set a deadline by which a QHP issuer must be accredited, the preamble encourages states to provide a sufficiently long grace period to accommodate issuers that may be seeking accreditation for the first time. This interpretation allows pure-play Medicaid managed care entities to secure certification of their QHPs even while they seek accreditation as a QHP issuer.
- **Certification Criteria** (*Preamble, Sec. II.A.6.a; Regulatory Text: §155.1000*). The proposed rule provides minimum certification requirements to ensure that QHPs in all Exchanges meet minimum standards of quality and value, while allowing states to impose additional requirements tailored to local market conditions. Tracking the language of the ACA, the Exchange may only certify a QHP where it first determines that the QHP's participation in the Exchange is in the interest of consumers and small employers. The preamble suggests additional selection criteria a state might want to consider including: reasonableness of the QHP's cost; past performance of the issuer; quality improvement activities; enhancement of provider networks; service areas; and premium rate increases.
- **Recertification And Decertification** (*Preamble, Sec. II.A.6.i – II.A.6.j; Regulatory Text: §155.1075, §155.1080*). An Exchange must establish a process for monitoring and recertifying QHPs and decertifying QHPs that no longer meet Exchange certification requirements. The preamble notes that the Exchange has the discretion to recertify QHPs annually or on a less frequent basis and seeks comments as to whether CMS should impose set time limits for recertification.
- **Multi-State Plans** (*Preamble, Sec. II.A.6.b; Regulatory Text: §155.1010*). The ACA requires the Federal Office of Personnel Management to contract with health insurance issuers to offer at least two multi-state plans. HHS interprets the ACA's multi-state provisions to require Exchanges to accept these plans as QHPs without applying additional certification elements.
- **QHP Rate Increase Justification** (*Preamble, Sec. II.A.6.c; Regulatory Text: §155.1020*). QHP issuers must provide the Exchange with a justification for any rate increase for a QHP prior to implementing the increase and the Exchange must consider that justification in determining whether to certify or recertify a QHP. The preamble acknowledges that many state insurance agencies operate rate review programs and notes that such programs should be leveraged by the Exchange to avoid duplication and encourage collaboration.
- **Network Adequacy** (*Preamble, Sec. II.A.6.f; Regulatory Text: §155.1050*). The proposed rule compels QHPs to comply with network adequacy requirements established by the Exchange. The preamble notes that network adequacy requirements should be responsive to a state's particular geography, demographics and market conditions, and solicits comments as to whether additional federal quantitative or qualitative standards would be appropriate in evaluating QHP network sufficiency. Comment is also sought as to what additional standards might be imposed to ensure that enrollees in medically underserved areas have adequate access. Recognizing that primary care access may be a challenge, the preamble encourages states and Exchanges to consider broadly defining the types of providers that furnish primary care services.

- **Essential Community Providers (ECPS)** (*Preamble, Sec. II.B.2.f; Regulatory Text: §156.235*). A QHP issuer must include within its network a sufficient number of essential community providers, where available, who serve predominantly low-income, medically underserved individuals. The word “sufficient” does not appear in the ACA; the preamble discusses the rationale for the limitation and requests comment on how to define a sufficient number of ECPS. Comment is also sought as to the appropriateness of exempting staff model health plans from the ECP requirement.
- **Federally Qualified Health Centers (FQHC)** (*Preamble, Sec. II.B.2.f*). The rules seek comment on potential approaches for reconciling: (i) the ECP provision that QHPs are not required to contract with ECPs who refuse to accept the generally applicable payment rates of the plans; with (ii) the ACA provision requiring QHPs to reimburse FQHCs at each facility’s Medicaid prospective payment system (PPS) rate. PPS rates are paid on a per visit basis and are generally higher than generally applicable payment rates.
- **Quality Standards** (*Preamble, Sec. II.B.2.a; Regulatory Text: §156.200*). The regulations require QHP issuers to implement and report on their QHP quality improvement strategies and enrollee satisfaction surveys. Specific quality standards, however, are deferred to a future regulation.
- **Marketing Standards** (*Preamble, Sec. II.B.2.d; Regulatory Text: §156.225*). The ACA requires the Secretary to establish marketing requirements. The proposed rule requires QHP issuers to comply with state marketing rules and bars use of practices that discourage the enrollment of individuals with significant health needs. HHS seeks comment on the best means to monitor QHP issuers’ marketing practices and whether a broad prohibition against unfair or deceptive marketing practices is warranted. Again, HHS urges that Exchanges work closely with state insurance departments to ensure that issuers in and out of the Exchange are subject to the same minimum marketing standards in order to create a level playing field with equal consumer protections.
- **QHP Rating** (*Preamble, Sec. II.B.2.i; Regulatory Text: §156.255*). The ACA limits variation in rating for QHPs to four factors: whether the coverage is individual or family, rating area, age and tobacco use. The ACA also requires QHP issuers to offer a QHP at the same premium rate whether the product is offered through or outside of the Exchange. The proposed rule codifies these requirements, and provides new guidance with regard to the family size rating factor. The rule states that QHP issuers must cover all families through some combination of: (i) individuals; (ii) two-adult families (iii) one adult families with a child or children; and, (iv) all other families. HHS seeks comments with respect to whether entire tax households should be articulated as an additional rating unit, as the taxable household will be the unit for determining premium tax credit eligibility.

ABOUT THE PROGRAM

State Health Reform Assistance Network, a program of the Robert Wood Johnson Foundation, provides in-depth technical support to states to maximize coverage gains as they implement key provisions of the Affordable Care Act. The program is managed by the Woodrow Wilson School of Public and International Affairs at Princeton University. For more information, visit www.rwjf.org/coverage.

ABOUT MANATT HEALTH SOLUTIONS

Manatt Health Solutions (MHS) is an interdisciplinary policy and business advisory division of Manatt, Phelps & Phillips, LLP, one of the nation’s premier law and consulting firms. MHS helps clients develop and implement strategies to address their greatest challenges, improve performance and position themselves for long-term sustainability and growth.

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State Health Reform Assistance Network

Charting the Road to Coverage

RESEARCH BRIEF

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Analysis of HHS Proposed Rules On Reinsurance, Risk Corridors And Risk Adjustment

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INTRODUCTION & OVERVIEW

On July 11, 2011, the U.S. Department of Health and Human Services (HHS) issued proposed rules, titled "Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors and Risk Adjustment." The proposed rules implement standards for these programs for states and health insurance issuers ('issuers'). By compensating issuers for the risks related to the individuals they enroll, these provisions are designed to lessen the financial risk issuers and state health benefit exchanges (exchanges) will face under the Patient Protection and Affordable Care Act (ACA). This will mitigate the impact of adverse selection and encourage issuers to compete based on cost and quality, rather than attracting only the healthiest, lowest-cost enrollees. Thus, these provisions are critical to the successful implementation of the ACA's coverage expansion provisions.

This paper summarizes the proposed rules and provides our perspective on the implications. It is intended for policymakers and state officials familiar with the complexities underlying these issues. As with any papers produced shortly after proposed regulations are released, the comments in this paper may quickly become out-of-date as regulations are revised, clarifications are issued, and as the authors continue to discuss the issues and implications of these complex new rules. We encourage you to contact the authors directly for updates and further discussion on any of these topics. The opinions expressed in this paper are those of the authors, not of the Robert Wood Johnson Foundation or others at Wakely Consulting Group.

While a number of important details are outstanding and some critical questions and issues are raised by these proposed rules, our opinion is that these rules are a large step in the right direction. They allow states flexibility while still providing federal support. The programs provide significant financial protections which are necessary given the market and financial uncertainties created under the ACA. A critical issue for policymakers is the aggressive timeline required for implementation of these programs; a substantial amount of analysis and interaction with key stakeholders needs to be performed in a short period of time. In addition, even with good data, states, health insurance carriers, providers and members will face uncertainty.

For purposes of this paper, we do not refer to the rules as 'proposed' in each instance even though it is clear these are all proposed rules at this point. HHS is seeking comment and any of the rules may change based on the comments they receive. HHS has provided discussion and narrative preceding the proposed rules which we refer to as the preamble throughout this paper.

The following table shows which market segments each program affects and the administrative responsibility for each program:

ACA Provision	Sold within Exchange		Sold Outside Exchange			Who Administers	
	Individual	Small Group	Individual	Small Group	Grandfathered	State Run Exchange	Federal Run Exchange
Risk Adjustment	Yes	Yes	Yes	Yes	No	State or HHS ¹	HHS
Reinsurance	Yes	No	Yes	No	No	State	State or HHS ¹
Risk Corridor	Yes	Yes	No	No	No	HHS	HHS

¹State can decide to administer or allow HHS to administer. If HHS administers, all parameters will be federal.

Each of these programs is funded differently. Since Risk Adjustment is expected to be budget neutral, no funding is needed although administrative funding will be required for states that decide to administer the program. While Reinsurance only benefits the individual market, the entire insurance market, including self-funded plans, contributes to the funding on a percent of premium basis (or percent of medical costs for self-insured plans). To date, there is no mention of how the Risk Corridor program will be funded if the amount that HHS must pay to insurers exceeds the amount HHS receives from insurers.

The proposed regulations address a number of questions that states, health insurance carriers, providers and other stakeholders had when contemplating how to implement the ACA. The most important questions and the answers provided in the proposed regulations and accompanying narrative are addressed below (please remember—these are proposed rules, not final):

RISK ADJUSTMENT – KEY QUESTIONS & ANSWERS

1. Will each state have to administer their risk adjustment program or will risk adjustment be a federal program? Answer: Under the proposed rules, each state can decide whether to do it themselves or let HHS administer the program. States can develop state-specific risk adjustment models and/or weights, but these need to be filed in advance for approval by HHS.
2. Will the federal model be a distributed model where carriers just send in results or a centralized model where carriers send in detailed encounter data and states or HHS calculates results (the distributed model seems to be favored by some insurance companies and insurance company associations)? Answer: Under the proposed rules, HHS would require a centralized model, where issuers would submit raw claims to the state or HHS acting on behalf of the state. States will not have discretion as part of the choice of the model and methodology to change this basic approach. Therefore, if states decide to develop their own model, it will be necessary to begin the planning and assessment of the program soon since as noted in the Timing of Reinsurance and Risk Adjustment section. It is recommended that these states file their model by November 2012.
3. What data will be used (likely possibilities include demographic information, medical diagnoses codes [ICD-9's], pharmacy codes [NDCs] and income level)? Answer: While not in proposed regulations, the preamble accompanying the release states that HHS intends to use demographic, medical diagnoses and pharmacy codes.
4. Will states and HHS implement auditing procedures like that in the Medicare Advantage program (called risk adjustment data validation [RADV] audits)? Answer: Yes, although the intent of the regulations is that these audits would be budget

neutral across carriers, which is not the case with RADV audits. In the ACA's risk adjustment audit program, error rates (or rates of unsubstantiated codes) will be judged relative to the rates of other carriers, not on an absolute basis.

REINSURANCE – KEY QUESTIONS & ANSWERS

1. Assessments of the entire insurance market will pay for the reinsurance program. How will these assessments be calculated? Exactly who will be assessed? Answer: Under the proposed rules, a uniform percentage of premiums will be applied to all fully insured plans and all states (percentage of claims for self-funded employers). States have the option of increasing the assessment but may not decrease it.
2. Will the reinsurance provision be based on specific medical conditions with a general (not member specific) reimbursement amount assigned to each condition, or will it follow typical stop loss reinsurance provisions with the reimbursement to the insurance carrier depending on actual expenditures for that specific person? Answer: Under the proposed rules, the reinsurance provision will follow typical stop loss reinsurance provisions based on actual expenditures. However, unlike typical stop loss reinsurance, the attachment point will be relatively low compared to commercial reinsurance and allowable amounts will be capped at a commercial stop loss reinsurance amount. Therefore, this protection will not be for the highest cost individuals, but for a disproportionate share of 'higher' cost individuals. States have the option to change the attachment point, coinsurance rate and cap amount (including eliminating the cap) compared to the federal parameters.

RISK CORRIDOR – KEY QUESTIONS & ANSWERS

Any surprises in the risk corridor proposed rules? Answer: No—the risk corridor proposed rules are pretty straightforward and do not contain any surprises. HHS will provide pro-rata, aggregate reinsurance if health plan results are more than 3 percent different than target. From 3 percent to 8 percent, HHS will assume 50 percent of favorable or unfavorable results and above 8 percent, HHS will assume 80 percent of favorable or unfavorable results.

RISK ADJUSTMENT DETAILS

The risk adjustment program under the ACA is a permanent program that will begin in 2014. The risk adjustment program is intended to protect health plans operating in the individual and small group markets both inside the exchange and outside of the exchange from attracting a higher than average health risk after consideration of the allowable rating variables (age limited to 3:1, family size / composition, tobacco use and geographic area). Unlike reinsurance, states that establish a state-based exchange do not have to administer the risk adjustment program. They can either administer the program or outsource this function to HHS. Also different than reinsurance, HHS will administer the risk adjustment program if the state does not establish a state-based exchange.

The state can have the risk adjustment functions performed by the exchange or another eligible entity. Per the regulations, in addition to the state Medicaid agency, an eligible entity is one that:

1. Is incorporated in at least one state;
2. Has experience in the individual and small group markets; and
3. Is not or does not act as a health insurance issuer.

HHS will develop a federal model that states can use or HHS will use to administer the state's risk adjustment program if they choose. Alternatively, states can file their own model or use a model for which any other state has filed and received approval. The proposed rules provide some minimum criteria for the model including performance similar to or better than the federal model.

If a state decides to develop its own model or adjust the federal weights, it needs to do so at least as often as the federal model is updated.

State models must meet criteria based on principles that guided the creation of the hierarchical condition categories (HCC) model used in Medicare Advantage risk adjustment, including:

1. Accurately explaining cost variation;
2. Choosing risk factors that are clinically meaningful to providers;
3. Encouraging favorable behavior and discouraging unfavorable behavior;
4. Using data that is complete, high quality and available in a timely fashion;
5. Providing stable risk scores over time and across plans; and
6. Minimizing administrative burden.

HHS is requiring risk adjustment activity reports in the year after the benefit year showing average actuarial risk for each plan, the charges and payments, and likely additional information. While not stated in the proposed rules, likely information might include prevalence reports showing the drivers behind differences in the results and normalization factors. We would expect HHS to develop a standardized report, allowing states the ability to include additional information. The report structure would need to be able to accommodate state-specific risk adjustment methods and models.

Applying Risk Adjustment Results

The proposed rules include a discussion of important actuarial pricing issues regarding integrating risk adjustment results with allowable rating variables under the ACA. Carrier strategies with respect to setting their rating variables (or the state requiring carriers to use standardized rating variables) make this a complex topic.

The preamble to the proposed rules identifies two possibilities for the calculation of premium rates to be used in the application of risk adjustment results:

1. Calculating a statewide normalized premium by taking actual premiums and adjusting them to a 100 percent actuarial value, and then applying the actuarial value of each specific plan to that statewide normalized premium; or
2. Using actual premiums.

Approach one is intended to protect efficient health plans since it uses statewide premiums adjusted for differences in benefits only. This approach actually protects efficient health plans as compared to Approach two if they attract members with higher than average morbidity (i.e., sicker). It disadvantages them if they attract members with lower than average morbidity (i.e., healthier) since their payouts will be based on a higher average premium than their actual premium.

The discussion of these issues assumes the risk pool will be the entire state, which would prohibit states from calculating the standard risk by geographic area. This approach will cause area factors to reflect differences outside of risk, and cause a larger impact to premiums by area than would otherwise occur. For example, assume pre-ACA and risk adjustment, that premium rates in Chicago were higher than in Southern Illinois because individuals in Chicago were less healthy (and only because Chicagoans are less healthy). Under a statewide risk pool where premiums are based on the average statewide risk, ultimate risk adjusted revenue would not change but premium rates in Chicago will decrease and premium rates in Southern Illinois will increase.

The proposed rules assume that payments and charges will not be equal due to uncertainties in the parameters and 'standard risk'. This appears to be based on an assumption that transfers would occur according to fixed risk adjustment parameters rather than assuming the parameters themselves would be subjected to a normalization process. If the parameters themselves were subjected to this normalization process prior to payments and charges being calculated then, by definition, the results would be budget neutral.

Presumably, a state could perform this normalization before calculating payments and charges. However, if they do not and the federal approach does not, then a final reconciliation would need to take place. In those instances, if payments are greater

than charges, HHS has identified three possible methods without an indication as to which approach the federal methodology would use:

1. Decrease plan payments on prorated basis to equal plan charges;
2. Increase plan charges on prorated basis to equal plan payments; or
3. Split the shortfall and prorating in both directions.

If charges are greater than payments, HHS has identified two possible methods without an indication as to which approach the federal methodology would use:

1. Reduce gross plan charges on a prorated basis; or
2. Put excess plan charges in a reserve account for future use (risk adjustment only presumably).

Data Collection

It is somewhat unclear if states that establish a health insurance exchange must collect detailed claims encounter data, or if states can elect to have HHS collect the data. The proposed rules seem to indicate that states can have HHS collect data, but only if HHS provides all of the other risk adjustment functions. In other words, HHS will either perform all of the functions including data collection or none of the functions.

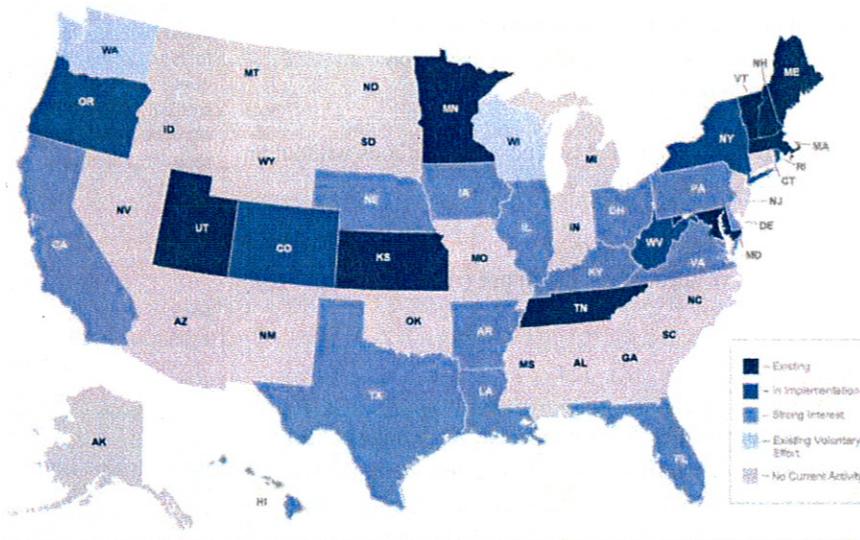
There are minimum standards governing collection of data. These include a standardized format for electronic transmission of all health care claims including enrollment and benefit information. Additionally, the state must ensure privacy of information by utilizing administrative, physical, and technical safeguards against unintended disclosure or use of individually identifiable information. Addressing these requirements will require significant resources.

States that have APCDs that are operational on or before January 1, 2013 are exempted from the minimum data collection standards described above. Eleven states have an APCD currently (two being voluntary systems not run by the state), with up to five states in the process of implementing one. The advantage of developing an APCD includes relatively lower administrative overhead as the state would not have to collect and conform to standards such as the National Council for Prescription Drug Programs (NCPDP) claim transaction or the HIPAA ASC X12N 837. These standards were developed for use within the context of an electronic data interchange (EDI) environment, and not all elements required by the standards are necessary for purposes of risk adjustment, reinsurance and risk corridor calculations.

RETROSPECTIVE OR PROSPECTIVE?

Will the federal model use 2014 data to develop risk adjustment results for 2014, or will data prior to 2014 be used? This is one of the key questions and the proposed rules do not explicitly answer it. The rules point strongly to a retrospective model with the example listed regarding claims run-out in the preamble ("For example, HHS may require that states complete risk adjustment activities by June 30 of the year following the benefit year"). However, this timing could also work under a prospective approach. A prospective approach could be developed in the few states that already have an all payer claims database (APCD), know quite a bit about their uninsured (or have a very low uninsured rate), and already mandate coverage of fairly comprehensive benefits. However, a prospective approach would require a leap of faith concerning the previously uninsured and inherently would not be able to capture potentially meaningful differences in the health status of previously uninsured across health plans. Further, a prospective approach would require the use of data prior to 2014 which would mean that health plans submitting data would need to be well aware of the payment implications of data submitted in 2012 and 2013. These hurdles are significant and we expect the federal model to be retrospective for 2014 and probably 2015. Further, we would expect states that wanted to use a prospective approach to be required to provide significant proof to HHS that such an approach accomplishes HHS' stated objectives for risk adjustment.

Chart – Status of APCD Efforts as of July 11, 2011¹



Risk Adjustment Auditing

The proposed rules require that the state or HHS on behalf of the state must audit data used in the risk adjustment process. The state or HHS on behalf of the state may (but appears are not required to) extrapolate the results of the audit on a statistically valid sample to all risk adjustment covered plans offered by that issuer. An appeals process must be provided.

A similar program in Medicare Advantage has created considerable controversy because the error rates are used on an absolute basis, rather than being compared to the error rate in the fee for service Medicare program on which the risk adjustment model is calibrated. Unlike in the Medicare Advantage program, the proposed rules indicate that the standard risk in the state would be adjusted for the results of the RADV audits. Therefore, if each and every plan in the state had a two percent error rate, the standard risk in the state would be adjusted downward by two percent and risk adjustment results across plans would not change because the error rates were uniform.

This approach appears fair, but creates some logistical issues. All plans would need to be audited over the same time period for this process to result in an equitable adjustment. State resources to perform these audits will therefore be strained.

Related to auditing, the proposed rules allow health plans to contract with providers to ensure that necessary risk adjustment data are received. This allowance is important since it permits health plans and providers to work together, and have formal financial arrangements to ensure all relevant data are being submitted.

REINSURANCE DETAILS

The reinsurance program under the ACA is a temporary program that will operate from 2014 through 2016. The reinsurance program is intended to protect health plans operating in the individual market from specific high-cost individuals. Unlike risk adjustment, states that establish a state-based exchange must administer the reinsurance program. They cannot outsource this

¹ Source: www.apcdouncil.org/

function to HHS. States that do not operate an exchange may still operate the reinsurance program or allow HHS to operate the program.

States can contract with or establish a reinsurance administrator subject to certain standards. The proposed rules include guidance that allows states to establish contracts with multiple reinsurance administrators, but requires their geographic coverage areas to be distinct and, in aggregate, cover the entire individual market. Subcontracting some administrative functions by the reinsurance entity is allowed, subject to review to ensure the contracts are appropriate.

Table 2 below shows the nationwide contribution requirements published in the law. These amounts represent minimum funding for the reinsurance program and general U.S. Treasury funding.

Program	2014	2015	2016
Reinsurance	\$10	\$6	\$4
U.S. Treasury	\$2	\$2	\$1

We have developed preliminary estimates of the assessment for reinsurance and the net impact to individual market premiums in Table 3 below. We have assumed 8.5 percent annual trend from 2014 to 2016.² The amounts listed are national estimates, are inherently uncertain³, and may vary significantly by state based on the market composition.

Description	2014	2015	2016
Net Assessment (Reinsurance Only—Not Treasury Contribution)	1.2%	0.6%	0.4%
Net Impact to Individual Market Costs	-5.6%	-3.4%	-2.3%

HHS will publish the actual minimum contribution rate in the advance notice in October 2012 (see Table 4 for complete schedule). States can increase this rate depending on a number of factors:

1. In that state, the size of the individual market (including previously uninsured joining the market) relative to the entire market will drive the level of coverage afforded by the national minimum assessment rate. The larger the individual market as a proportion of the total market, the lower the assessments available for reinsurance as compared to potential coverage.
2. The relative health of enrollees in the individual market post reform may suggest that some states with a relatively sick population will increase the HHS rate to provide the same level of coverage all else being equal.
3. Finally, states may increase assessments to cover administrative costs for operation of the reinsurance entity. It is important to note that states may not use the federal assessment rate and then allocate some of those collections to administrative expenses. If the state wants to fund reinsurance administrative expenses, they must increase the assessment.

² This is important since premiums will likely increase between 2014 and 2016, which decreases the calculated contribution rate.

³ Issues including the size of the individual and group markets, premium trend, enrollment, and other issues make the estimate of the reinsurance assessment and effect on individual premiums uncertain.

Sample Reinsurance Calculation

Reinsurance Parameters	State or Federal Reinsurance	Traditional Reinsurance
Attachment Point (paid claims threshold where reinsurance begins)	\$50,000	\$200,000
Coinsurance Rate (percent between attachment point and cap for which reinsurer is liable)	80%	85%
Reinsurance Cap (claims in excess of the cap are not eligible for reinsurance)	\$150,000	\$2,000,000

Example

Insurer Initial Paid Claim Amount = \$500,000

Net Insurer Liability* = \$50,000 + 20% x (150,000 - 50,000) + (200,000 - 150,000) + 15% x (500,000 - 200,000) = \$165,000

State or Federal Reinsurance Payment* = 80% x (150,000 - 50,000) = \$80,000

Traditional Reinsurance Payment = 85% x (500,000 - 200,000) = \$255,000

* Note that the State/Federal Payments may be prorated down for all insurers if the total payments exceed the available funds

HHS will publish the attachment point, coinsurance rate and reinsurance cap each year. Only costs related to essential benefits are eligible to be reimbursed (detailed definitions are pending on what constitutes essential benefits). States may modify these values, but must publish the modifications in a state notice by early March in the year before the effective date as outlined in the Timing of Reinsurance and Risk Adjustment section. It appears that the proposed rules would not allow states to modify the structure of the formula.⁴

States are responsible for collecting data to administer the program and for making sure that payments do not exceed contributions.⁵ Payments may be reduced on a pro-rata basis if, in the absence of such reduction, payments would exceed contributions.

States may coordinate the state high risk pool with the reinsurance program as long as it conforms to the other provisions of the proposed rules.

In the preamble, additional points are made:

1. If contributions exceed payments, states may retain those funds as surplus/stabilization funds or pay out the amounts on pro-rata basis (effectively increasing the coinsurance rate).
2. States can adjust the attachment point, coinsurance rate and reinsurance cap to manage the amount of payments from year-to-year (e.g., if collections in one year exceed payments, the state can increase coverage offered through the pool to increase payments in the next year).
3. States can alter reinsurance parameters to adjust the way payments are distributed across the three year period (e.g., to more heavily weight payments in the first year relative to the federal payment schedule).

⁴ States cannot modify the structure of the reinsurance formula: For example, to re-adjudicate claims at a percentage of Medicare prior to applying the formula, or to make fixed payments for certain medical conditions.

⁵ Proposed rules do not say that reinsurance contributions cannot exceed payments.

TIMING OF REINSURANCE AND RISK ADJUSTMENT

The proposed rules discuss the timing of the process for releasing benefit and payment parameters and for states to file proposed changes to those parameters. The following table shows the timing of the notice for 2014 through 2016. Future years will follow this pattern.

Annual Federal Notice	2014	2015	2016
HHS Publishes Advance Notice	Mid Oct 2012	Mid Oct 2013	Mid Oct 2014
Comment Period Ends	Mid Nov 2012	Mid Nov 2013	Mid Nov 2014
HHS Publishes Final Notice	Mid Jan 2013	Mid Jan 2014	Mid Jan 2015

If states plan to modify federal parameters, HHS proposes that they would need to issue a notice no later than early March in the year before the effective date (for example, in early March 2013 for 2014).

If the state does not issue a notice by the deadline, then the federal parameters would automatically go into effect.

If states plan to file an alternate risk adjustment model, the rules propose that they do so by November two years prior to the benefit year (i.e., November 2012 for 2014). HHS would commit to reviewing and notifying states within 60 days, at the time of publication of the Final Notice (see Table 4 above), whether such model was approved. After approval, any state could use the model. Updates to models would follow same process and timing.

The state and federal notices will include a full description of the risk adjustment model, including demographic factors, diagnostic factors, utilization factors (if any), the mapping logic to the risk group (i.e., which ICD-9's map to which condition categories), the weights for each category, required data, and timelines for data submission and factor determination.

Timing for risk adjustment transfers is not included in the proposed rules (when plans that owe to the pool would pay, and when plans that are owed from the pool would receive payment).

RISK CORRIDOR DETAILS

A federally-administered risk corridor program will limit the gains and losses of a Qualified Health Plan (QHP) operating in the exchange. This program will be in place for three years (2014-2016) and is intended to stabilize the market by sharing risk at a time when implementation of reform will make accurate rate setting challenging at best.

The risk corridor mechanism compares the total allowable medical costs for a QHP (excluding non-medical or administrative costs) to those projected or targeted by the QHP. If the actual allowable costs are less than 97 percent of the QHP's target amount, a percentage of these savings will be remitted to HHS (limiting gain). Similarly if the actual allowable cost is more than 103 percent of the QHP's target amount, a percentage of the difference will be paid back to the QHP (limiting loss). The QHP's target amount is defined as the plan's total premiums incurred less allowable administrative costs. Allowable costs are defined as the QHP's actual total paid medical costs, excluding allowable administrative costs, in providing the QHP's covered benefits.

The following table shows the percentages that are applied based on the comparison of a QHP's target amount and allowable costs.

Allowable/Target	Action	Amount Paid
Greater than 108%	HHS pays QHP	2.5% of Target + 80% of amount in excess of 108%
103% to 108%	HHS pays QHP	50% of amount in excess of 103%
97% to 103%	No action	No payment transfer
92% to 97%	QHP pays HHS	50% of difference between 97% of target and allowable cost
Less than 92%	QHP pays HHS	2.5% of Target + 80% of difference between 92% of target and allowable

The allowable costs are reduced for any direct or indirect remuneration (e.g., drug price concessions, discounts, grants) or cost sharing reductions received from HHS. For the target amount, QHP issuers would be required to submit *adjusted* premium data to HHS. Reported premiums are adjusted for any risk adjustment or reinsurance payments including user fees paid.

The following table shows an example of a risk corridor payment calculation.

Example: Allowable / Target less than 92%	
QHP Target	\$10 million
QHP Allowable Cost	\$8.8 million
Allowable/Target	88%
92% of Target	92% x \$10m = \$9.2 million
92% of Target - Allowable Cost	\$9.2m - \$8.8m = \$400,000
QHP pays 2.5% of Target	
	2.5% x \$10m = \$250k
+ QHP pays 80% of difference	
	80% x \$400k = \$320k
QHP total payment to HHS	\$570k
Revised Allowable / Target	((\$8.80m + \$0.57m) / \$10m) = 93.7%

On the question of timing, while HHS has not set forth any deadlines at this time, timeframes being considered include making payments within 30 days of receiving a notice from HHS (and HHS would make payments in a similar timeframe after HHS determines that a payment is owed to the QHP). Since the timing of the program adjustments may run concurrently, QHPs may need to estimate the reinsurance they expect to receive when reporting risk corridor premium information.

If HHS sets the allowable target equal to the minimum loss ratio as may be reasonably expected, the risk corridor program essentially prevents health plans from excess losses (50 percent or 80 percent protection depending on level of losses) while the minimum loss ratio program protects against excess profits (100 percent protection). This approach creates potentially unintended consequences, especially for health plans that have administrative loads below that required under the minimum loss ratio.

WHAT DO STATES NEED TO DO?

1. For both risk adjustment and reinsurance, develop a plan for which agency or organization will administer necessary functions.
2. Reinsurance—Model the funds available under various assessment rates and attachment point, coinsurance and cap options given those various assessment rates. States do not want to be in a position where funds from the assessments are insufficient to cover the stated coverage levels. The previously uninsured population and uncertainties surrounding this population will create significant uncertainty with these estimates.
3. Risk Adjustment—Key issues that states need to decide upon include:
 - a. Use the federal model or file a state model.
 - b. If the federal model is used, should the state or HHS administer it?
 - c. Develop an APCD in advance of federal requirements or wait for federal ‘push’?
 - d. How should the risk adjustment audit process function, including who will perform the audits and what the schedule and level of adjustments for payment transfers should be?
4. All Programs—States should create a stakeholder workgroup. The work plan should identify necessary steps, stakeholder feedback checkpoints and timelines. States should first meet internally to structure the stakeholder workgroup role and decide which decisions should be retained by the state versus delegated to the workgroup for recommendations. Potential workgroup members include individuals from the state exchange, department of insurance, health plans and providers.

FINANCIAL STATEMENT ISSUES FOR HEALTH PLANS

Valuation actuaries will be necessary and important in addressing ACA implications. The reinsurance, risk adjustment and risk corridor programs will create new actuarial assets and liabilities for health plans. These amounts may not be known until well after the year ends. The reinsurance and risk adjustment program results will depend not only on the health plan results, about which each health plan will know something, but also on the results for other health plans in the market. Since risk corridor results will depend on reinsurance and risk adjustment results, they will also be uncertain. Health plans, states (exchanges), departments of insurance and HHS will need to work closely together to develop appropriate timelines, methods, standards and flexibility in dealing with these important issues. Current Medicare Advantage Part D reinsurance and risk corridor financial statement rules will provide a useful frame of reference. For these programs, developing interim reporting will be critical in informing year end estimates.

WHAT DO HEALTH PLANS NEED TO DO?

1. Discuss forming a workgroup in your state to develop an APCD, and to identify the best approach for risk adjustment and reinsurance methods and processes. Timing will be critical and risk adjustment results need to be run well in advance of the summer of 2013, when premium rates will need to be developed and filed.
2. Review coding practices and provider agreements to make sure you will not be disadvantaged when risk adjustment is implemented.
3. Work with valuation actuaries and financial reporting teams to identify issues and timing with respect to reinsurance, risk adjustment and risk corridors. Work with the department of insurance to ensure compliance.

OUTSTANDING ISSUES

1. The proposed rules seem to indicate that the same federal assessment percentage, attachment point, coinsurance amount and cap amount will apply to all federally run exchanges (across states). Because each state will have a different proportion of business in their individual market and a different risk profile of members in the individual market, it seems necessary to have state-specific parameters that would be developed by HHS. As part of the federal notice, will HHS publish state-specific parameters?
2. Will the federal risk adjustment model be retrospective, prospective or will it offer both options?
3. Can states have HHS collect data while otherwise administering the risk adjustment function?
4. When will HHS require states to start collecting and testing data or, in states that elect to outsource the risk adjustment function, when will HHS start collecting and testing data?

5. Does HHS intend for risk adjustment calculations to be statewide, thereby adjusting current geographic differences in premium? Is there state flexibility in performing risk adjustment calculations by area?
6. Will HHS run simulated risk adjustment results in states where they are administering the risk adjustment program? If so, when will this work begin and when will it be completed?
7. Will HHS meet with carriers in states where they are administering the risk adjustment system? How will carrier questions be answered?
8. Is income being considered as part of the federal risk adjustment model? Including it as an optional variable as part of the core federal model, with state specific calibration, would offer states flexibility to address a particular concern with adverse selection in the exchange.
9. Will states be allowed to assess carriers to pay for the risk adjustment code audits and, more broadly, for the risk adjustment approach? This would align incentives for efficiencies since the risk adjustment program transfers funds across health insurance companies.
10. The target amount definition in the proposed rules indicates the 'target amount' is equal to premiums less allowable administrative expenses. Allowable administrative expenses would seem to be defined by health plans. Health plans will likely try to maximize these administrative expenses, subject to the Minimum Loss Ratio requirement. This would appear incentivize health plans to file premium rates using a target loss ratio equal to the minimum. Is HHS considering requirements that would prevent this approach or will the states need to address this issue?

OPERATIONAL IMPACT ON STATES

The regulations contemplate a significant role for states in the administration of both the reinsurance and risk adjustment programs. These functions can be run from the exchange or by another entity within the state. While funding for the reinsurance program can be included in the assessment from carriers, meaning no additional state or federal funding will be required to manage the program, the risk adjustment program, similar to other ACA responsibilities such as granting exemptions to the individual responsibility requirement, will create a state expenditure requiring a funding source. Some of the operational and cost considerations of this program are outlined below.

Of the two programs, the reinsurance program is less operationally complex. The role of the state in administering the pool will primarily be a fiduciary one of funds collection, management and disbursement, which will require an initial and ongoing emphasis on the development of policies and processes to ensure sound financial stewardship. Critical functions to manage this program include the establishment and periodic modification of reinsurance parameters; assessment collections and cash management; claim intake (summary level) and payment; analysis and reporting; and claims audit. These functions can be performed by the state or by an entity or entities contracted by the state, and can also be subcontracted. Funding for the administration of the reinsurance program can be included in the assessment on carriers, so no additional state or federal funding is required for the operation of the reinsurance pool.

Risk adjustment represents a more comprehensive commitment from the state. States choosing to develop and administer this program will need to develop the data collection and storage capabilities required to intake, securely store and analyze large volumes of carrier claims and enrollment data, including the acquisition of data warehousing hardware and software, along with a dedicated staff to manage, analyze and report on this information. Other key cost components will be software licensing fees for the risk adjustment tool selected by the state and developing the IT infrastructure and connectivity required to interface with carriers for the acquisition of data as well as product rating and premium information. The calculation process itself will require the development of normalized risk scores at the individual product and carrier level, and then translating these scores into payment and recoupment amounts. A portion of these activities (namely, the acquisition and analysis of carrier claims data and software licensing) will need to be performed prior to the state's decision regarding whether or not to rely on the federal model or to self-administer the risk adjustment program.

The total cost of managing this program will vary considerably depending on several factors:

1. Existing resources the state can rely upon, such as an existing APCD. The ability to leverage an existing data infrastructure will significantly reduce the cost to the state.

2. Existing familiarity with risk adjustment models in other state programs such as Medicaid Managed Care.
3. The level of state-specificity that states choose to pursue, including whether they wish to develop both their own model and administrative methodology, rely on the federal methodology but reweight based on a state-specific population, or rely on the federal model and only implement a state-specific payment adjustment methodology.
4. The size of the insurance market and the number and variety of carriers and products sold in the state. Risk adjustment will be far more complex and time-consuming for states with more than 10 licensed carriers than for states with fewer carriers.

Funding for this program is not contemplated in the proposed regulations, and states have options with respect to a source of funding. One approach is to place the administration of the risk and reinsurance programs in the state exchange, and use establishment grant funding to design, develop and build the required infrastructure. Ongoing cost, which should be modest relative to the start-up of the program, can be included in the exchange assessment. For states that use risk adjustment in their Medicaid Managed Care program, further efficiencies and cost offsets can be achieved by leveraging the newly developed exchange function to calculate and administer the Medicaid Managed Care risk program.

CONCLUSION

The proposed rules thoughtfully address many of the key issues associated with the risk adjustment, reinsurance and risk corridor programs although important details and decisions are still pending. As discussed in this paper, these programs will have a significant impact on premiums and the health insurance marketplace. HHS, states and health plans have a lot of work to do over the next two years. Careful planning, in-depth analysis and clear communication are critical to the success of these programs and the new health insurance marketplace.

ABOUT THE PROGRAM

State Health Reform Assistance Network, a program of the Robert Wood Johnson Foundation, provides in-depth technical support to states to maximize coverage gains as they implement key provisions of the Affordable Care Act. The program is managed by the Woodrow Wilson School of Public and International Affairs at Princeton University.

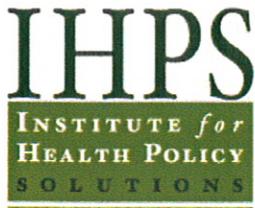
ABOUT WAKELY CONSULTING GROUP

Wakely Consulting Group is an actuarial and healthcare consulting firm specializing in government healthcare programs including state and federal reform, Medicaid and Medicare Advantage.

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For more information, please contact Ross Winkelman, FSA, MAAA at RossW@Wakely.com or at (720) 226-9801.



August 19, 2011

TO: California Health Benefit Exchange

FROM: Ed Neuschler and Rick Curtis

RE: Comments on Proposed Federal Regulations Dealing with Exchanges, Qualified Health Plans, Reinsurance, Risk Corridors and Risk Adjustment (45 CFR Parts 155, 156 and 153)

As part of our current project, "Analytic Support for ACA Implementation" (supported by the California HealthCare Foundation), we have reviewed the proposed federal regulations published July 15, 2011 (filed July 11, 2011) to identify implications for California.

This memo does not summarize or provide a comprehensive overview of the proposed regulations. Instead, its purpose is to identify unforeseen constraints on (or opportunities for) California's Exchange and areas (if any) where changes might be needed in authorizing legislation as a result of the regulations.

We did not identify any provision of these proposed regulations that would restrict any of the powers granted to the California Health Benefit Exchange (CHBE) in its authorizing legislation. With respect to market-wide provisions that affect both the Exchange and the outside market, additional legislation may be needed to bring California into compliance, but the need for such additional legislation was already known at the time SB 900 and AB 1602 were enacted.

Policy-wise, these proposed regulations provide little substantive direction beyond what was already known from the Affordable Care Act (ACA). Additional details are provided in some areas, such as enrollment periods and family size categories, among others. It should be noted, however, that these (July) proposed regulations do not include a number of issue areas that will be addressed in other proposed regulations or guidance. In particular, details of eligibility policy and the eligibility determination structure are addressed in separate proposed regulations that were not released until August 12, 2011. The August proposed regulations are not reviewed here, but will be addressed in a subsequent memo.

Operationally, these proposed regulations provide a structure, framework and timelines for how States, Exchanges and qualified health plans will interact. They also reference possible opportunities for "partnering" with the federal government and/or other states on operational systems. (However, as Exchange staff are no doubt already in touch with federal officials regarding the latter, it is not discussed further here.)

The following sections of this memo highlight those areas that we found to be among the more significant. Areas where the additional details, while necessary, seemed more obvious and not likely to be controversial, have been omitted, as have areas in which we have no special expertise.

45 CFR Part 155: Exchange Establishment Standards and Other Related Standards under The Affordable Care Act

§155.105 Approval of a State Exchange.

The preamble notes that HHS is considering establishment of a review process for the Exchange Plan that is similar to Medicaid and CHIP. Similarly, HHS is proposing that a State must notify HHS before significant changes are made to the Exchange Plan and that an Exchange must receive written approval of significant changes from HHS before they may be effective. For this purpose, HHS is considering utilizing the State Plan Amendment process in place for Medicaid and CHIP. Comments are sought.

IHPS comments: State officials have much more experience with the HHS/CMS review process for Medicaid and CHIP than we do. But we note that, especially in its early years, the Exchange will need to adapt expeditiously to unexpected problems and conditions. If a traditional public-program plan-amendment process caused delays in implementing needed changes, it could prove to be an impediment to such responsiveness. For that reason, using an Exchange-Plan-review that is “similar to Medicaid and CHIP” may be ill-advised.

§155.160 Financial support for continued operations.

The proposed language “provides States with broad flexibility to generate funds beyond charging the ‘assessments or user fees’ identified in the ACA. States may use broad-based funding (which may include general State revenues, provider taxes, or other funding that spreads costs beyond imposing assessments or user fees on participating issuers), as long as the use of such funding does not violate other State or Federal laws.”

HHS invites comment on whether the final regulation should otherwise limit how and when user fees may be charged, and whether such fees should be assessed on an annual basis.

IHPS comments: The State may wish to submit comments arguing against further restrictions on the grounds that they are unnecessary. Further, the Exchange may wish to collect assessments on a more regular basis, such as monthly.

§155.210 Navigator program standards.

The proposed rules [paragraph (c)] codify the statutory prohibitions on Navigator conduct in the Exchange. Consistent with ACA §1311(i)(4), health insurance issuers are prohibited from serving as Navigators and a Navigator must not receive any consideration directly or indirectly from any health insurance issuer in connection with the enrollment of any qualified individuals or qualified employees in a QHP. The preamble clarifies that “such consideration includes, without limitation, any monetary or non-monetary commission, kick-back, salary, hourly-wage or payment made directly or indirectly to the entity or individual from the QHP issuer.”

The preamble further notes that these provisions would not preclude a Navigator from receiving compensation from health insurance issuers in connection with enrolling individuals, small

employers or large employers in non-QHPs. [emphasis supplied] HHS seeks comment on this issue and whether there are ways to manage any potential conflict of interest that might arise.

IHPS comments: Thus, it appears that, for example, a broker/agent who serves as a navigator could also, at the same time, receive commissions from carriers for enrolling applicants in non-QHP individual or small-group plans. Such a structure seems ripe for abuse and potential adverse selection against the Exchange. (Note that states also have the option, discussed under the next major heading, to permit agents and brokers to continue in their traditional role, rather than serving as navigators.)

Another situation that might arise would involve a business or trade group that was serving both as a navigator for the (SHOP) Exchange and offering coverage to its member employers directly through an arrangement with a small-group carrier. Again, there is a potential conflict of interest and selection-risk for the Exchange.

We recommend that CHBE carefully consider whether navigators should be permitted to receive compensation from health insurance issuers in connection with enrolling individuals or small employers in any health plan, whether it is a QHP or not a QHP. They could continue to receive such compensation with respect to employer groups that are not eligible to participate in the Exchange.

§155.210(e) Funding for Navigator grants.

Paragraph (e) codifies the statutory requirement that funding for Navigator grants may not be from Federal funds received by the State to establish the Exchange.

However, HHS also notes that it is “considering a requirement that the Exchanges ensure that the Navigator program is operational with services available to consumers no later than the first day of the initial open enrollment period. Since consumers will likely require significant assistance to understand options and make informed choices when selecting health coverage, we believe it is important that Exchanges begin the process of establishing the Navigator program by awarding grants and training grantees in time to ensure that Navigators can assist consumers in obtaining coverage throughout the initial open enrollment period.”

IHPS comments: The need for early navigator assistance is obvious. But federal implementation grants cannot be used for this purpose, and state legislation only authorizes the Exchange to “[a]ssess a charge on the qualified health plans offered by carriers that is reasonable and necessary to support the development, operations, and prudent cash management of the Exchange.” [emphasis supplied] This phrasing presumably means that the Exchange cannot assess or collect any funds from carriers until it has selected and certified the QHPs that it will offer. And, until those QHPs have actual enrollment—which will not be known with certainty until the end of the initial open enrollment period—it is unclear on what basis the charge would be assessed. One possibility might be to assess an up-front charge on each QHP when it is certified. The up-front charge might be a flat amount per QHP or per issuer, or might be adjusted based on the issuer’s current market share. The up-front charge could be considered a pre-payment of the assessments due from the issuer on whatever basis is ultimately selected by

the CHBE (pmpm, percent of premium, etc.) Thus, actual assessments would be reduced, in whole or in part, until the up-front charge was fully amortized.

The Exchange would use the revenue from the up-front charges to fund start-up costs that cannot be charged to its federal implementation grant. For example, while the cost of training materials and Exchange-employed trainers can probably be charged to the federal implementation grant, it seems clear that navigator personnel could not be paid out of federal funds to participate in training sessions.

Alternatively, the Exchange could make use of its authority to borrow funds from the California Health Facilities Authority in order to comply with this (proposed) requirement. (And the loan would then be repaid by higher assessments on Exchange-participating QHPs.)

§155.220 Ability of States to permit agents and brokers to assist qualified individuals, qualified employers, or qualified employees enrolling in QHPs.

The proposed regulations simply repeat the statutory provision that a State may choose to permit agents and brokers to: (1) enroll qualified individuals, qualified employers or qualified employees in any QHPs in the individual or small group market as soon as the QHP is offered through an Exchange in the State; and (2) assist individuals in applying for advance payments of the premium tax credit and cost-sharing reductions for QHPs.

The preamble notes that this section does not apply to agents and brokers acting as Navigators and that any entity serving as a Navigator, including an agent or broker, may not receive any financial compensation from an issuer for helping an individual or small group select a specific QHP, as discussed under §155.210 above.

IHPS comments: These remarks clearly envision that agents or brokers acting in this more traditional role could receive compensation from QHP issuers. Because no federal guidance is given regarding such compensation, it appears that states remain free to develop whatever agent-compensation rules they feel are necessary to protect the Exchange against potential adverse selection.

The proposed regulations also allow an Exchange to elect to provide information regarding licensed agents and brokers on its website for the convenience of consumers seeking insurance through that Exchange. The preamble gives the purpose of this requirement as ensuring that individuals and small groups have access to information about agents and brokers should they wish to use one.

In an important preamble discussion, HHS notes that there are web-based entities and other entities with experience in health plan enrollment that are seeking the ability to assist in QHP enrollment in several ways, including: by contracting with an Exchange to carry out outreach and enrollment functions, or by acting independently of an Exchange to perform similar outreach and enrollment functions to the Exchange. [emphasis added]

To the extent that an Exchange contracts with such an entity, the preamble states, the Exchange would need to adhere to the requirements proposed for eligible contracting entities at

§155.110(a). And the Exchange would remain responsible for ensuring that the statutory and regulatory requirements pertinent to the relevant contracted functions are met.

HHS “understand[s] that such entities may provide an additional avenue for the public to become aware of and access QHPs, but ... also note[s] that advance payments of the premium tax credit and cost-sharing reductions may only be accessed through an Exchange.” HHS seeks comment “on the functions that such entities could perform, the potential scope of how these entities would interact with the Exchanges and what standards should apply to an entity performing functions in place of, or on behalf of, an Exchange.” HHS also seeks comment “on the practical implications, costs, and benefits to an Exchange that coordinates with such entities, as well as any security- or privacy-related implications of such an arrangement.”

IHPS comments: We understand that, in addition to industry recommendations, HHS has received communications from some states seeking the flexibility to allow and work with existing web-based entities or alternative internet entities. As noted, HHS emphasizes that “advance payments of the premium tax credit and cost-sharing reductions may only be accessed through an Exchange.” Nevertheless, a later section of these proposed regulations makes clear that, if an applicant applies directly to a QHP issuer for QHP coverage, then the issuer has to collect all the same information, transmit it to the Exchange, and wait for the Exchange to verify that the applicant is eligible to enroll in a QHP before actually enrolling the applicant. It could be argued that this suggests even QHPs sold by agents or brokers (including intermediaries that are web-based) or by the issuer’s own employees have arguably been “enrolled in through the Exchange” (as the ACA requires for payment of tax credits). This seems to provide an opening for existing internet-based agents to argue that they should be authorized to enroll people in QHPs and become eligible for tax credits.

The potential problems here are: (1) issuers can much more easily do selective marketing through agents and brokers than through a neutral exchange; (2) issuers can use financial incentives to encourage agents to sell the issuer’s own products rather than assist consumers in making an informed choice among competing QHPs; and (3) people who don’t come through the Exchange’s own website (or other process) may or may not have accessed all the comparative QHP information that is supposed to be made available through the Exchange.

§155.240 Payment of premiums.

The proposed rules codify the statutory requirement that the Exchange must allow a qualified individual to pay any applicable premium owed by such individual directly to the QHP issuer.

However, the preamble goes on to comment that “this requirement does not preclude an Exchange from facilitating or aggregating premium payments, if it chooses to do so;” and that “while we do not require or limit the methods of premium payment in connection with individual market coverage, we note that an Exchange generally has three options: (1) take no part in payment of premiums, which means that enrollees must pay premiums directly to a QHP issuer; (2) facilitate the payment of premiums by enrollees by creating an electronic ‘pass-through’ of premiums without directly retaining any of the payments; or (3) establish a payment option where the Exchange collects premiums from enrollees and pays an aggregated sum to the QHP issuers.”

IHPS comments: Aside from the individual option to pay a QHP directly (a clear requirement under the ACA), the proposed rule clarifies that the CHBE is free to choose whether or not to exercise its (permissive) state authority to collect premiums with respect to individual coverage made available through the Exchange. [GC §100504(a)(1) per AB 1602 §8] Given that the support for this proposed rule in the ACA is not entirely clear, the CHBE may wish to consider submitting formal comments in support of this provision.

§155.400 Enrollment of qualified individuals into QHPs.

The proposed rules [paragraph (c)] require that “the Exchange must maintain records of all enrollments in QHPs through the Exchange and submit enrollment information to HHS on a monthly basis.”

Related proposed provisions in §156.265, Enrollment process for qualified individuals, require that, even if an applicant initiates enrollment directly with the issuer for enrollment in a QHP, the QHP issuer must – (1) collect enrollment information using the standard application form; (2) transmit the enrollment information to the Exchange; and (3) enroll an individual only after receiving confirmation (from the Exchange) that the eligibility process is complete and the applicant has been determined eligible for enrollment in a QHP.

IHPS comments: We highlight these provisions because the statutory language of the ACA left the Exchange’s degree of control over the enrollment process somewhat unclear. At the time California’s Exchange-authorizing legislation was being drafted, therefore, there was uncertainty as to whether the Exchange would always have complete information about who was enrolled in a QHP at any particular time. This uncertainty had implications for, among other things, the Exchange’s ability to have the information it needed to assess charges on participating QHP issuers and to monitor the enrollment status of Exchange participants as well as QHP practices in this regard.. The proposed rules make it clear that the Exchange must, and will at all times have the ability to, know exactly who is enrolled in a QHP.

Two aspects of the proposed requirements here may be somewhat surprising to some. First, the Exchange will have to submit enrollment information to HHS on a monthly basis. This provision sensibly supports the integrity of federal payment of advance tax credits to QHPs.

Second, QHP enrollments not made through the Exchange will have to be reported to the Exchange and processed as if they had been made through the Exchange. That is, QHPs may only be issued to “qualified individuals” as defined in the ACA, regardless of how they enroll. This provision means that individuals who are not legal residents will not be able to purchase a QHP, even if they sought to do so through an agent or directly from a carrier, rather than through the Exchange. Such individuals will have to buy non-QHP products. Presumably, this interpretation was felt to be required by the ACA provision that an individual who is not a lawful resident “shall not be treated as a qualified individual and may not be covered under a qualified health plan in the individual market that is offered through an Exchange.” [ACA §1312(f)(3)]

§155.405 Single streamlined application.

The proposed rules require that the Exchange must use a single streamlined application to determine eligibility and to collect information necessary for enrollment for – (1) QHPs; (2) Advance payments of the premium tax credit; (3) Cost-sharing reductions; and (4) Medicaid, CHIP, or the BHP, where applicable. [emphasis supplied]

The preamble notes that use of a single streamlined application is intended to limit the amount of information and number of times an individual must make submissions to receive an eligibility determination and complete the enrollment process. HHS plans to create both a paper-based and web-based dynamic application, and anticipates that the electronic application will enable many applicants to complete the eligibility and QHP selection process in a single online session. [emphasis supplied]

IHPS comments: We highlight this provision because it makes clear that eligibility for a Basic Health Program (if any) will be determined using exactly the same information as is used for tax credits, cost-sharing reductions and Medicaid (Medi-Cal). Note that there are related provisions in the recently issued proposed Medicaid and tax-credit eligibility rules, which we will assess later. We understand those rules have important implications for the design of California’s eligibility systems, which have many considerations and implications beyond the scope of this memo.

Subpart H – Exchange Functions: Small Business Health Options Program (SHOP)

Earlier, in the definitions section (§155.20), the proposed rules define “employer” as follows:

“Employer has the meaning given to the term in section 2791 of the PHS Act, except that such term must include employers with one or more employees. All persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Code must be treated as one employer.”

The preamble notes that coverage for only a sole proprietor, certain owners of S corporations, and certain relatives of each of the above would not constitute a group health plan under ERISA section 732(a) (29 U.S.C. section 1191a(a)) and would not be entitled to purchase in the small group market under Federal law. [emphasis supplied]

IHPS comments: This is an important clarification. Legislation to conform California’s small-employer definition with the federal definition, particularly as regards “groups” of one employee, was not taken up last year. State conforming legislation will be needed.

§155.705 Functions of a SHOP.

Worker Choice of QHP

Two provisions of the ACA allowed for conflicting interpretations as to whether employers using the SHOP Exchange would be required to offer their workers a choice of QHPs. This key

issue required clarification. The proposed regulations make clear that the SHOP Exchange must at least make worker choice of QHP an option that the employer may select:

“(b)(2) Employer choice requirements. With regard to QHPs offered through the SHOP, 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 QHPs within that level are made available to the qualified employees of the employer.”

The proposed rules then permit a SHOP Exchange, at its option, to provide other ways that employers may offer coverage through the SHOP”

“(b)(3) SHOP options with respect to employer choice requirements. With regard to QHPs offered through the SHOP, the SHOP may allow a qualified employer to make one or more QHPs available to qualified employees by a method other than the method described in paragraph (b)(2) of this section.”

The preamble explains that this means that an Exchange may (1) allow employees to choose any QHP offered in the SHOP at any level; (2) allow employers to select [more than one] specific levels from which an employee may choose a QHP; (3) allow employers to select specific QHPs from different levels of coverage from which an employee may choose a QHP; or (4) allow employers to select a single QHP to offer employees. [emphasis supplied]

With respect to the fourth potential option, HHS welcomes comments on the statutory interpretation of the two ACA provisions in question: §1312(a)(2)(A), which speaks to employer specification of a level of coverage, and §1312(f)(2)(B), which may permit a single QHP selection by an employer.

IHPS comments: The proposed requirement [(b)(2)] that a SHOP at least offer employers the opportunity to give their workers choice of QHP is consistent with the California statute’s emphasis on employee plan choice. [GC §100503(w) per AB 1602 §7] The additional provision [(b)(3)] gives the Exchange Board flexibility to determine how best to serve the small-employer market, consistent with California law.

We note that worker choice of QHP may be essential to the SHOP’s unique value added and therefore to its ability to retain small-employer enrollment after its first two years (due to the two-year limit on use of the small-business tax credit.) We also note that scale economies will be important to cost-effective operation of worker choice. A single-employer-plan option could greatly diminish the SHOP’s core tax-credit population enrollment (after its first two years). CHBE might wish to comment in support of these proposed rules, which permit CHBE to offer only worker-choice plans and do not require the SHOP Exchange to also offer a single-employer-plan option.

Minimum Participation Rules

The proposed rules do not contain a specific provision dealing with minimum participation rules for group coverage, but the preamble discusses the issues and invites comments about whether QHPs offered in the SHOP should be required to waive application of minimum participation

rules at the level of the QHP or issuer; whether a minimum participation rule applied at the SHOP level is desirable; and if so, how the rate should be calculated, what the rate should be, and whether the minimum participation rate should be established in Federal regulation.

IHPS comments: CHBE may wish to comment on the need for flexibility to develop, adopt and adapt participation standards as deemed appropriate in the context of outside market rules and practices and related carrier willingness to participate in the SHOP. Participation rules have traditionally been an important tool for avoiding adverse selection in the guaranteed issue small group market, including in worker choice exchanges where carrier concerns about selection are already high. But they should be less critical in the context of broader market reforms such as the individual mandate, and could be more complicated to establish, calculate and administer given related factors such as some lower income workers' eligibility (via affordability waivers from the employer coverage "firewall") for tax credits via individual exchange enrollment.

Premium aggregation.

The proposed rules require that the SHOP must provide each qualified employer with a bill on a monthly basis that identifies the total amount that is due to the QHP issuers from the qualified employer; and collect from each employer the total amount due and make payments to QHP issuers in the SHOP for all qualified enrollees.

The preamble notes that the purpose of this requirement is to simplify the administration of health benefits among small employers, and further notes that HHS anticipates that most SHOPs will also include the employer and employee contribution for the QHP selected by each employee as a service to employers. The SHOP may contract out these functions.

IHPS comments: These provisions are entirely consistent with the CHBE's authorizing legislation.

Rates and rate changes

The proposed regulations would permit "rolling" enrollment in a SHOP. That is, qualified employers would be permitted to purchase coverage in QHPs at any point during the year. The premiums quoted at the time of the employer's initial purchase of coverage through the SHOP would apply for a full plan year. But, because employers will purchase coverage through the SHOP at different times during the year, they would be subject to different rates based on the month or quarter during which they purchase coverage. The proposed regulations require that the SHOP not vary rates for a qualified employer during its plan year and require all QHP issuers to make any change to rates at a uniform time that is either quarterly, monthly, or annually. (Although QHPs may change rates during the year, those rates only apply to new coverage and to annual renewals.)

The preamble notes that, by providing uniform intervals for rate setting, SHOPs will experience less administrative burden and qualified employers and qualified employees will have more useful rate comparison information. It also notes that, if an employee is hired during the plan year or changes coverage during the plan year during a special enrollment period, the rates set at the beginning of the plan year must be the rates quoted to the employee. HHS invites comments

on whether to allow a more permissive or restrictive timeframe than monthly, quarterly, or annually, and also invites comments on what rates should be used to determine premiums during the plan year.

IHPS comments: These provisions give important flexibility to the CHBE to adapt to the realities of the small-employer market.

The CHBE, DMHC and CDI may wish to ascertain whether these proposed federal regulations would permit current California rules governing rate increases in the small-group market to continue without change, or would instead require a change in state rules.

§155.720 Enrollment of employees into QHPs under SHOP.

(f) Records.

The proposed regulations require the SHOP to receive and maintain records of enrollment in QHPs, including identification of qualified employers participating in the SHOP, and qualified employees enrolled in QHPs. The preamble notes that such information must also be reported to HHS, consistent with the standards of §155.400(d), noted above.

IHPS comments: As above under §155.400, we highlight these provisions because the statutory language of the ACA left the Exchange's degree of control over the enrollment process somewhat unclear. See earlier comments for further details.

§155.730 Application standards for SHOP.

The proposed regulations, in paragraph (c), require that the SHOP use a single application for eligibility determination, QHP selection and enrollment for qualified employees.

The preamble clarifies that the SHOP will not be required to use the same, single streamlined application as the Exchange uses in the individual market, because the SHOP is not responsible for determining eligibility for advance payments of the premium tax credit, cost-sharing reductions, Medicaid or CHIP. [emphasis added] Though the preamble recommends using the same application “foundation” for employees and individuals (in order to streamline processes of developing applications and information sharing among the individual Exchange, SHOP, QHP issuers, and HHS), it also notes that “[t]he amount of information that will be collected about employees will be significantly less than that which is collected for applicants to the individual Exchange making the wholesale reuse of the individual application burdensome. [emphasis added] The preamble also notes that “[a] SHOP applicant applying online should only be asked questions relevant to an employee application.”

IHPS comments: We highlight these provisions because they clarify an important operational difference between the individual Exchange and SHOP Exchange that casual observers often overlook.

§155.1000 Certification standards for QHPs.

The proposed regulations provide Exchanges with (in our view, very broad) discretion on how to determine whether offering health plans is in the interest of individuals and employers. Possible approaches discussed in the preamble include:

- An “any qualified plan” strategy, under which an Exchange would certify all health plans as QHPs solely on the basis that such plans meet and agree to comply with the minimum certification requirements specified in paragraph (c)(1) of this section.
- A competitive bidding or selective contracting process, under which QHP participation would be limited to only those plans that ranked highest in terms of certain Exchange criteria.
- A negotiation approach, under which an Exchange would negotiate with health insurance issuers on a case-by-case basis. Health insurance issuers that meet the minimum certification standards could be asked to amend one or more specific health plan offerings to further the interest of qualified individuals and qualified employers served by the Exchange. The preamble further notes that the Exchange would not need to undertake a competitive bidding process to accomplish this negotiation. Instead, it could choose to negotiate with issuers on certain criteria based on the unique market conditions within the State or region served by that same Exchange.
- An Exchange may also implement selection criteria beyond the minimum certification standards in determining whether a plan is in the interests of the qualified individuals and employers.

The preamble further notes that some of these approaches are not mutually exclusive and may be implemented in combination.

IHPS comments: These proposed rules would accommodate a broad range of alternative state approaches and give the CHBE the flexibility to utilize the discretionary authority given it by California’s legislation. Given the likelihood that some interest groups will submit formal comments opposing the extent of flexibility given to state Exchanges, California officials may wish to submit formal comments endorsing these proposed provisions.

§155.1010 Certification process for QHPs.

“Multi-State” plans

The proposed regulations repeat the statutory provision that exempts multi-State plans (i.e., those contracted by the federal Office of Personnel Management) from the certification process established by the Exchange and deems them as meeting the certification requirements for QHPs.

The preamble further notes that multi- State plans will need to meet all the requirements of a QHP, as determined by OPM, but also states HHS’s belief that the intent of the statute is that each Exchange must accept multi-State plans as QHPs without applying an additional certification process to such plans. [emphasis added]

IHPS comments: The proposed regulations remain vague as to whether states can impose additional requirements on multi-State plans. One example would be California's requirement that QHP issuers must offer QHPs at all levels of coverage, not just gold and silver, in order to participate in the Exchange. The ACA [§1334(b)(2)] specifically subjects multi-State plans "to all requirements of State law not inconsistent with this section, including the standards and requirements that a State imposes that do not prevent the application of a requirement of part A of title XXVII of the Public Health Service Act [federal insurance market rules] or a requirement of this title." The ACA also specifically permits States to impose stricter age-rating limits than the 3:1 band permitted under federal rules.

California officials may wish to submit formal comments noting these provisions and requesting specific regulatory authorization to impose its additional uniform state requirements for participation in the Exchange on multi-State plans. The comments could further recognize that multi-State plans could not be denied participation on the basis of a competitive selection process, but ask for assurance that they would be subject to the same market rules as other Exchange-participating plans.

45 CFR Part 156: Health Insurance Issuer Standards under The Affordable Care Act, Including Standards Related To Exchanges

§156.230 Network adequacy standards.

Provider Directories

In paragraph (b) of this section, the proposed regulations require that a QHP issuer must make its provider directory for a QHP available to the Exchange for publication online pursuant to guidance from the Exchange and to potential enrollees in hard copy upon request. The regulations also require that the provider directory must identify providers that are not accepting new patients. [emphasis added]

The preamble further clarifies that Exchanges will have discretion to determine the best way to give potential enrollees access to the provider directory for each QHP, including through a link from the Exchange's website to the issuer's website, or by establishing a consolidated provider directory through which a consumer may search for a provider across

HHS also seeks comments on what standards it might set to ensure that QHP issuers maintain up-to-date provider directories.

IHPS comments: We highlight these provisions because they generally provide support for the section of California's authorizing legislation □[GC §100504(a)(9)] that authorizes the CHBE to require participating carriers to provide regularly updated information to the Exchange as to whether a health care provider is accepting new patients for a particular health plan.

The CHBE may wish to submit supportive comments which also seek assurance that the Exchange will have flexibility regarding specific priorities for consolidated directories (e.g., focusing on primary care physicians and clinics).

§156.235 Essential community providers.

The general requirement in these proposed regulations parallels the underlying statutory provision and requires that a QHP issuer must include within the provider network of the QHP a sufficient number of essential community providers, where available, that serve predominantly low-income, medically-underserved individuals. Also per the ACA, nothing in this requirement shall be construed to require any health plan to provide coverage for any specific medical procedure provided by the essential community provider.

The preamble states that HHS is considering and seeks comment on whether to provide separate consideration or an exemption for integrated delivery network health plans where services are provided solely “in-house,” such as plans where all providers are employees of the plan (“staff model”) and plans where the providers are part of an entity that furnishes all of the plan’s services on an exclusive basis. If such organizations were exempt from the essential community provider requirement, HHS suggests that the exemption could be contingent upon the organizations meeting other criteria, such as: evidence of services provided to low-income populations; compliance with national standards for provision of culturally and linguistically appropriate services (CLAS); or implementation of a plan to address health disparities.

IHPS comments: We highlight these provisions because of their particular relevance in California’s health insurance marketplace. CHBE may wish to comment if California would like to have flexibility to develop (and modify based on experience) its own alternative standards for integrated delivery systems.

§156.255 Rating variations.

Rating Areas

Pursuant to the ACA, the proposed regulations allow a QHP issuer to vary premiums by the geographic rating area established under section 2701(a)(2) of the PHS Act.

The preamble clarifies that HHS interprets that the rating areas will be applied consistently inside and outside of the Exchange.

IHPS comments: We believe the rating area requirements will require a change in California law. As we understand it, California carriers currently define their own rating areas, which apparently can be non-contiguous (based on some carrier materials we have seen). The new rating areas will clearly have to be uniform across carriers, and we expect that the geographic components of each rating area will have to be contiguous. (That is, there could not be an “island” of rating area B completely surrounded by rating area A unless that “island” constituted the entirety of rating area B.) (Note, however, that the rating area issue is separable from service area definitions for delivery-system-based plans, over which DMHC would presumably continue to have appropriate purview.)

Rating Categories

This provision speaks to the family categories or “tiers” that carriers may use. The proposed regulations state that a QHP issuer must cover all of the following groups using some combination of the following categories:

- (1) Individuals;
- (2) Two-adult families;
- (3) One-adult families with a child or children; and
- (4) All other families.

The preamble clarifies that QHP issuers must cover all of these four groups, but in doing so may combine some of the identified categories; for example, a QHP issuer may combine the second and third categories to include both two-adult families and families with one adult plus child or children. However, it appears that no other categories would be permitted.

IHPS comments: The ACA only referred to self-only and family coverage. If only these two “coverage tiers” were allowed, however, small families (e.g., childless couples, single parents with one child) would face an enormous “cliff” at 400% FPL. That is, small families just below 400% FPL would pay only 9.5% of income (for the “benchmark” silver plan), while those just above 400% FPL would pay the full cost for a family-coverage “tier” that also included much larger families and would therefore be considerably more expensive than a two-adult or one-adult-and-child policy would be, by definition, and would also represent a much higher percentage of a smaller family’s income at a given percentage of the poverty level. These proposed regulations (combined with the Treasury Department’s proposed regulations for health insurance tax credits) go a long way toward obviating this potential problem. CHBE may want to submit supportive comments in this regard.

We are not familiar with current California requirements regarding family-coverage “tiers” in the individual market. California policy makers will want to review the proposed four tiers for consistency with current California practice and determine if they would like to comment and request changes. It should be kept in mind, however, that, as discussed below, these definitions importantly relate to federal tax-credit policy and administration, as well as affordability issues for those just above tax credit eligibility level. These were not relevant considerations when the state adopted its current four tier limit for small employer coverage.

The preamble also notes the federal statutory requirement that any family premium using age or tobacco rating may only apply those rates to the portion of the premium that is attributable to each family member. HHS interprets that, as a result, calculating a family premium by determining the age and tobacco rated premium for one member of the family and applying a multiplier to set the rating for the entire family is not permitted. HHS seeks comment on how it might structure family rating categories while adhering to these statutory requirements.

HHS also invites comment on alternatives to four categories for defining family composition and on how to balance the number of categories offered by QHP issuers in order to reduce potential consumer confusion, while maintaining plan offerings and rating structures that are similar to those that are currently available in the health insurance market.

Also relevant is the fact that HHS is considering, and seeks comment on, whether to require QHP issuers to cover an enrollee's tax household, including for purposes of applying individual and family rates. This approach is under consideration because of the potential challenge of administering the premium tax credit, particularly for families filing with non-spousal adult dependents. HHS recognizes that such an approach would add non-spousal adult dependents to the family risk pool, but notes the impact of this configuration may be offset through risk adjustment.

IHPS comments: A six-family-tier structure, such as California recently considered (S.B. 890, 2010), would likely differ from current market practice and could be more confusing for enrollees, but it would make premiums even more specific to family size (which would further ameliorate the affordability problem for small families referred to above). And it could make the age-rating-by-person requirement easier to administer, as follows:

Age rating applies only to adults, not to children. Therefore, properly age-rated premiums would be easiest to construct if family tiers were based on three rating "components": adult, one child, and two or more children. The six "family tiers" could then be:

- *One adult*
- *One adult with one child*
- *One adult with two or more children*
- *Two adults*
- *Two adults with one child*
- *Other (in most cases, two adults with two or more children)*

With this sort of structure, it should be relatively easy to create accurate "family" premiums by simply adding up the premiums for the adults in the family group based on their individual ages and tobacco use patterns, and adding the appropriate "child" component (one v. two or more children, as applicable). (In its simplest form, this would mean no tobacco rating factor for children, which may be sensible as parents may not know that their children smoke.)

The cover-entire-household suggestion, if adopted, could result in more than two adults being covered as part of the family group. This might be accommodated within the tier structure by considering family groups with three or more adults to be part of the "two adults with two or more children" (or "other") tier. The number of such families should be small enough that the premium for that tier would not be greatly affected, and any differential impact across QHPs could, as the preamble notes, be offset by risk adjustment.

Before recommending such an approach, however, it would be wise to further assess and seek input about this concept from knowledgeable practitioners in the current market.

HHS also requests comment on how to apply four (or, presumably, more) family categories when performing risk adjustment. *IHPS has no immediate suggestion in this regard.*

§156.265 Enrollment process for qualified individuals.

The proposed regulations require that all QHP enrollments be reported to the Exchange, even if the applicant initiates enrollment directly with the QHP issuer and not through the Exchange. QHP issuers must collect the standard enrollment information and transmit it to the Exchange for eligibility determination. QHP issuers may actually enroll an applicant only after receiving confirmation that the eligibility process is complete and the applicant has been determined eligible for enrollment in a QHP [by the Exchange].

IHPS comments: This requirement assures that all QHP enrollments Exchange will be known to the Exchange, which is important for a variety of reasons, not the least of which is for the purpose of collecting the charge the Exchange is permitted to assess to fund its own operations. In view of possible objections from some carriers, California policy makers may wish to submit comments endorsing this provision.

One important drawback of this requirement is that undocumented persons will not be able to purchase QHPs, even directly from the issuer. If they want coverage, they will have to buy non-QHP policies.

§156.285 Additional standards specific to the SHOP.

The basic requirements here are unremarkable, but the preamble notes that HHS is “considering whether to require QHPs in the SHOP to allow employers to offer dependent coverage” and solicits comment on this potential requirement.

IHPS comments: Though small employers clearly cannot be compelled to contribute toward coverage of dependents, allowing QHPs serving the SHOP to refuse to cover dependents would force those dependents to obtain coverage elsewhere, thus splitting up families. This seems unnecessary and unwise. Also, allowing some QHPs to refuse to cover any dependents while other QHPs do offer them coverage would create unnecessary confusion for small employers and SHOP enrollees and could create opportunities for risk selection.

We understand that current California rules require carriers to offer dependent coverage except where a small employer chooses not to offer such coverage. (Employers may elect whether or not to offer dependent coverage as well as whether and at what level to contribute to dependent coverage. But note where small employers do not contribute toward dependent coverage, adverse selection is more likely, and could exacerbate carrier reluctance to participate in the SHOP Exchange’s worker-choice model). CHBE may want to comment seeking flexibility to develop its own approaches and standards consistent with state rules and responsive to market circumstances.

45 CFR Part 153

Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors and Risk Adjustment

Reinsurance

The proposed regulations use a very traditional reinsurance design. In order to ensure reinsurance payments are made on a comparable set of benefits, HHS proposes (§153.230) that payments be calculated for costs to cover the essential health benefits package, and solicits comments on alternatives to the use of the essential health benefits package.

IHPS comments: Application of reinsurance to the uniform essential health benefits package seems consistent with the purposes of market reform and the operation of the Exchange. CHBE may wish to comment supporting this approach.

Other Aspects of Reinsurance and Risk Adjustment

While IHPS does not have immediate substantive comments on the following sections, we highlight items that to us appear important to the success of CHBE and market reforms in California and that HHS has requested comment on:

- States “have discretion” to immediately (in 2014) move people from state high-risk pools into the individual market. Does this mean they have discretion not to do so?
- HHS proposes (§153.250) to allow a State that continues its high risk pool to coordinate its high risk pool with its reinsurance program to the extent it conforms to the provisions of this subpart. HHS seeks comment regarding whether a high risk pool that continues operation after January 1, 2014 should be considered an individual market plan eligible for reinsurance under this provision.
- States have flexibility in choosing applicable reinsurance entity. (§153.210)
- Reinsurance contributions are based on a national rate set as a percent of premium (but collected within state). (§153.220) HHS seeks comments on whether to do state-level allocation instead (or other than percent of premium).
- A state can charge more than the national rate if it thinks it will need more money to make reinsurance payments or to recover administrative costs of the applicable reinsurance entity. [emphasis added] (§153.220(b)) *Who (at the state level) would authorize this? The state? The reinsurance entity itself?*
- The reinsurance cap would be set at the attachment point of traditional reinsurance. HHS seeks comment on this approach. (§153.230)

Risk Adjustment

- Even if a state establishes an Exchange, it could choose to have HHS operate the risk adjustment system. The presumption is that the Exchange will operate risk adjustment, but a state can name another entity if other entity would be eligible to serve as the Exchange. (§153.310)
- A state can establish its own risk-adjustment methodology, if HHS approves it, or it can use the HHS methodology.
- HHS requests comment on virtually all aspects of these proposed regulations, including the two risk-adjustment methods it has identified [plan premiums v. state average normalized premiums, the latter preliminarily chosen], and any alternative methods that could be used to calculate payments and charges that would reduce uncertainty for plans. HHS also requests comment on any intentional and unintentional consequences from the use of either methodology, on the validity of its assumptions, and on its proposed data-collection approach.

Risk Corridors

- The risk-corridor program is run entirely by HHS. There are no operational requirements on states or Exchanges.

Additional, Lower-Priority Items from the Exchange and QHP Proposed Regulations

§155.20 Definitions.

The proposed regulations define “health plan” as follows [in accordance with ACA §1301(b)(1)]:

“Health plan means health insurance coverage and a group health plan. It does 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.”

The preamble recognizes that section 514 of ERISA allows State regulations of MEWAs, provided that such regulation does not conflict with standards of ERISA and requests comment on how to reconcile this inconsistency.

HHS has also received questions about whether Taft-Hartley plans and church plans can participate in the Exchange and requests comment on how such plans could potentially provide coverage opportunities through the Exchange.

IHPS comments: Given that the ACA requires health plans serving the individual market (inside or outside the Exchange) to guarantee-issue to all legal residents and also requires that individuals be free to choose any QHP offered in the Exchange, it is difficult to understand how a plan with a defined, exclusive membership could participate in the individual Exchange. Also, the ACA requires that QHP issuers be licensed by the State. Many Taft-Hartley plans are not licensed insurance carriers. Though there may be ways to thread this particular needle, it appears that, unless the ACA were amended, a church or Taft-Hartley plan would need to be substantially reorganized to comply with the ACA and state Exchange requirements.

We understand that some Taft-Hartley plans and church plans are interested in participating in the individual Exchange, where their members would qualify for individual tax credits if their employer stopped offering employment-based coverage. It is possible that some plans may also be interested in participating in the SHOP Exchange, if they have member small employers that could continue to receive small-business tax credits after 2013. In the latter case, they would still have to be licensed health insurance issuers and would have to issue coverage outside their usual membership, which is likely to be inconsistent with their governing documents.)

§155.100 Establishment of a State Exchange.

The preamble notes that “HHS has pursued various forms of collaboration with the States to facilitate, streamline and simplify the establishment of an Exchange in every State. These efforts have made it clear that for a variety of reasons including reducing redundancy, promoting efficiency, and addressing the tight implementation timelines authorized under the ACA, States may find it advantageous to draw on a combination of their own work plus business services developed by other States and the Federal government as they move toward certification. Some States have expressed a preference for a flexible State partnership model combining State-designed and operated business functions with Federally-designed and operated business

functions. Examples of such shared business functions might include eligibility and enrollment, financial management, and health plan management systems and services. We note that States have the option to operate an exclusively State-based Exchange. HHS is exploring different partnership models that would meet the needs of States and Exchanges.”

The preamble further notes “there may be ways in which an Exchange and the Federal government can work in partnership to carry out certain activities. ... As States, and the Federal government in connection with the Federally-facilitated Exchange, develop expertise and implement the infrastructure for Exchange operations, we anticipate sharing of information and ideas. We welcome comment on how to implement or construct a partnership model consistent with sections 1311(f)(3) and 1311(d)(5) of the Affordable Care Act.”

IHPS comments: We assume the CHBE and its staff are considerably more familiar than we are with what HHS is suggesting here. We include this item because of its potential importance. As implementation planning progresses, the CHBE may wish to carefully consider whether for which processes piggybacking on a federal or multi-state system might be more expeditiously feasible and efficient versus which processes it would prefer to develop and operate on its own.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

[CMS-9980-NC]

Request for Information Regarding State Flexibility to Establish a Basic Health Program

Under the Affordable Care Act

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Request for Information.

SUMMARY: This notice is a request for information regarding section 1331 of the Affordable Care Act, which provides States with the option to establish a Basic Health Program. This option permits States to enter into contracts to offer one or more “standard health plans” providing at least the essential health benefits described in section 1302(b) of the Affordable Care Act to eligible individuals in lieu of offering such individuals coverage through the Affordable Insurance Exchange (Exchange).

DATES: Comment Date: To be assured consideration, responses must be received at one of the addresses provided below, no later than 5 p.m. on [OFR--insert date 45 days after date of publication in the **Federal Register**].

ADDRESSES: In responding, please refer to file code CMS-9980-NC. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit responses in one of four ways (please choose only one of the ways listed):

1. Electronically. You may submit electronic comments on this regulation to <http://www.regulations.gov>. Follow the instructions under the "More Search Options" tab.
2. By regular mail. You may mail written comments to the following address ONLY:

Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-9980-NC,
P.O. Box 8016,
Baltimore, MD 21244-8016.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. By express or overnight mail. You may send written comments to the following address ONLY:

Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-9980-NC,
Mail Stop C4-26-05,
7500 Security Boulevard,
Baltimore, MD 21244-1850.

4. By hand or courier. If you prefer, you may deliver (by hand or courier) your written comments before the close of the comment period to either of the following addresses:

a. For delivery in Washington, DC--

Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Room 445-G, Hubert H. Humphrey Building,
200 Independence Avenue, S.W.,
Washington, DC 20201.

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without Federal government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

b. For delivery in Baltimore, MD--

Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
7500 Security Boulevard,
Baltimore, MD 21244-1850.

If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786-9994 in advance to schedule your arrival with one of our staff members.

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

For information on viewing public comments, see the beginning of the "SUPPLEMENTARY INFORMATION" section.

FOR FURTHER INFORMATION CONTACT:

Shaina Rood, (301) 492-4422.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been

received: <http://www.regulations.gov>. Follow the search instructions on that Web site to view public comments.

Comments received timely will also be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1-800-743-3951.

I. Background

Section 1331(a) of the Patient Protection and Affordable Care Act (Pub. L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152), referred to collectively as the Affordable Care Act, directs the Secretary of Health and Human Services (the Secretary) to establish a Basic Health Program under which States may enter into contracts with one or more standard health plans that provide health coverage to eligible individuals in lieu of offering such individuals coverage through the Exchange. For States choosing this option, section 1331(a)(2) of the Affordable Care Act provides that the Secretary certify that the amount of the monthly premium charged to eligible individuals enrolled in a plan under contract under this program, called a standard health plan does not exceed the amount of the monthly premium that an eligible individual would have paid if he or she were to receive coverage from the applicable benchmark plans (as defined in section 36B(b)(3)(B) of the Internal Revenue Code of 1986) through the Exchange. This section also directs the Secretary to certify that cost-sharing does not exceed the standards specified in section 1331(a)(2)(A)(ii) of the Affordable Care Act.

Section 1331(b) of the Affordable Care Act defines a standard health plan as one selected by the State that: (1) only enrolls applicants who are determined eligible using the eligibility standards specified in section 1331(e) of the Affordable Care Act; (2) covers at least the essential health benefits described in section 1302(b) of the Affordable Care Act; and (3) in the case of a plan that provides health insurance coverage offered by a health insurance issuer, has a medical loss ratio of at least 85 percent.

Section 1331(c) of the Affordable Care Act specifies that a Basic Health Program will establish a competitive process for entering into contracts with standard health plans, including negotiation of premiums, cost-sharing, and benefits in addition to the essential health benefits. The statute provides that the State include in its competitive process the inclusion of innovative features such as care coordination and care management for enrollees, incentives for the use of preventive services, and the establishment of relationships between providers and patients that maximize patient involvement in health care decision-making. The contracting process shall also take into consideration, and make suitable allowances for, the differences in the health care needs of enrollees and the differences in local availability of, and access to, health care providers.

Section 1331(c)(2) of the Affordable Care Act provides that the competitive process shall also include contracting with managed care systems, or with systems that offer as many of the attributes of managed care as are feasible in the local health care market. The competitive contracting process shall also include the establishment of specific performance measures and standards for issuers that focus on quality of care and improved health outcomes. Section 1331(c)(3) provides that a State shall, to the maximum extent feasible, seek to make multiple standard health plans available to ensure individual have a choice of such plans. It also provides

that a State may negotiate a regional compact with other States to include coverage of eligible individuals in all such States in agreements with issuers of standard health plans.

Section 1331(c)(4) of the Affordable Care Act directs a State choosing to establish a Basic Health Program to coordinate the administration of a Basic Health Program with Medicaid, the Children's Health Insurance Program (CHIP), and other State-administered health programs.

Section 1331(d)(1) of the Affordable Care Act allows the Secretary to transfer Federal funds to a State that establishes a Basic Health Program in accordance with the standards of the program under section 1331(a). Section 1331(d)(2) of the Affordable Care Act directs that a State establish a trust fund for the deposit of the Federal funds it receives for its Basic Health Program, and specifies that the amounts in the trust may only be used to reduce the premiums and cost-sharing of, or to provide additional benefits for, eligible individuals enrolled in standard health plans within a Basic Health Program.

Section 1331(d)(3) of the Affordable Care Act specifies that a State that operates a Basic Health Program will receive 95 percent of the amount of premium tax credits, and the cost-sharing reductions, that would have been provided to (or on behalf of) eligible individuals enrolled in standard health plans through a Basic Health Program, if the eligible individuals were instead enrolled in qualified health plans (QHP) through the Exchange and receiving premium tax credits and cost-sharing reductions. To determine the amount of payment, the Secretary shall take into account all relevant factors necessary to determine the amount that would have been provided to eligible individuals as specified in 1331(d)(3), including, but not limited to, whether any reconciliation of the credit or cost-sharing reductions would have occurred if the enrollee had been so enrolled.

Section 1331(d)(3) also provides that the determination shall also take into consideration the experience of other States with respect to participation in an Exchange and such credits and reductions provided to residents of the other States, with a special focus on enrollees with income below 200 percent of poverty. Additionally, the Secretary shall adjust the amount of payment for any fiscal year to reflect any error in the determinations for any preceding fiscal year.

Section 1331(e) of the Affordable Care Act specifies eligibility standards for a Basic Health Program. To be determined eligible for a Basic Health Program, an individual must:

- (1) be a resident of a State participating in a Basic Health Program;
- (2) be eligible for enrollment in a QHP through the Exchange but for the existence of a Basic Health Program;
- (3) not be eligible to enroll in the State's Medicaid program under title XIX of the Social Security Act (the Act), for benefits that at a minimum consist of the essential health benefits described in section 1302(b) of the Act;
- (4) have a household income that exceeds 133 percent but does not exceed 200 percent of the Federal poverty level (FPL), or, for a non-citizen lawfully present who is not eligible for Medicaid based on immigration status, a household income that is not greater than 133 percent of the FPL;
- (5) not be eligible for minimum essential coverage or is eligible for an employer-sponsored plan that is not affordable coverage; and
- (6) not have attained age 65 as of the beginning of the plan year.

Section 1331(f) of the Affordable Care Act directs the Secretary to conduct an annual review of each State Basic Health Program to ensure that it complies with the standards of

section 1331. Through this annual review, the State will provide information to demonstrate that its Basic Health Program meets: (1) eligibility verification standards for participation in the program; (2) standards for the use of Federal funds received by the program; and (3) quality and performance standards.

As specified in section 1331(g) of the Affordable Care Act, a standard health plan offeror may be a licensed health maintenance organization, a licensed health insurance insurer, or a network of health care providers established to offer services under the program; the statute provides authority for the State to determine eligibility to offer a standard health plan.

II. Request for Information

Section 1321(a)(2) of the Affordable Care Act directs the Secretary to consult with stakeholders to ensure balanced representation among interested parties in issuing regulations to implement programs pursuant to title I. The Department of Health and Human Services has consulted with stakeholders through regular meetings with the National Association of Insurance Commissioners, regular contact with States through the Exchange grant process, and meetings with tribal representatives, health insurance issuers, trade groups, consumer advocates, employers, and other interested parties. This consultation will continue throughout the development of guidance and regulations related to the Basic Health Program.

As such, we are requesting information to aid in the development of standards for the establishment and operation of a Basic Health Program. To assist in responding, this request for information describes the specific areas where input is particularly requested.

Specifically, we ask for responses to the questions below to provide the Secretary with relevant information for the development of guidance and regulations regarding the Basic Health Program. However, it is not necessary for respondents to address every question below and

respondents may also address additional issues about the Basic Health Program that are not listed here. Individuals, groups, and organizations interested in providing responses may do so at their discretion by following the above mentioned instructions.

A. General Provisions

1. What are some of the major factors that States are likely to consider in determining whether to establish a Basic Health Program? Are there additional flexibilities, advantages, costs, savings or challenges for the State and/or consumer that would make this option more or less attractive to States? If so, what are they?
2. What are key considerations for States in placing responsibility for a Basic Health Program within the State organizational structure?
3. What are the challenges and costs associated with managing a Basic Health Program?
4. Are States that are exploring the Basic Health Program considering implementation for 2014, or for later years? What are the key tasks that need to be accomplished, and within what timeframes, to implement the Basic Health Program in a timely fashion? What kinds of business functions will need to be operational before implementation, and how soon will they need to be operational? Are there opportunities to leverage existing systems and increase efficiency within the State structure? To what extent have States begun developing business plans or budgets relating to Basic Health Program implementation?
5. To what extent have States already begun to assess whether to establish a Basic Health Program? What internal and/or external entities are involved, or will likely be involved in this planning process?
6. What guidance or information would be helpful to States, plans, and other stakeholders as they begin the planning process? What other terms or provisions need additional

clarification to facilitate implementation and compliance? What specific clarifications would be helpful?

7. How can the Administration provide technical assistance? What form(s) of technical assistance would be most helpful to States?

B. Standard Health Plan Standards and Standard Health Plan Offerors

1. What additional standards, if any, should standard health plans participating in a State's Basic Health Program meet? What consumer protections should be included? How should quality and performance be measured?

2. What plan design issues should be considered? How likely is it for a State to consider an expanded benefit package beyond the essential health benefits for standard health plans participating in a State's Basic Health Program? What are the advantages and disadvantages of an expanded benefit package for standard health plans compared to qualified health plans?

3. What is the expected impact of standard health plans on provider payments and consumer access?

C. Contracting Process

1. What innovative features should States consider when negotiating through the contracting process with standard health plans to participate in a Basic Health Program?

2. What considerations exist in determining whether to utilize the regional compact authority in Section 1331(c)(3)(B) of the Affordable Care Act? Are States interested in pursuing this approach?

D. Coordination with Other State Programs

1. What is the expected impact of a Basic Health Program on the Exchange's purchasing power and viability? How might States organize a Basic Health Program with respect to purchasing structure?
2. What is the expected impact of a Basic Health Program on plans participating in the Exchange in terms of risk profile, enrollment, and premium stability? What is the expected impact on overall coverage?
3. What are some of the major factors that States are likely to consider in determining how to structure their Basic Health Program? Are States likely to structure the Basic Health Program as one component of its other public programs? Are States likely to consider a CHIP-like approach or other options? What are the pros and cons of these various options?
4. How can eligibility and enrollment be effectively coordinated between the Basic Health Program and other State programs to reduce churning between programs and promote continuity of care?
5. How could establishing a Basic Health Program affect the ability of an entire family to be covered by the same plan?
6. Are standard health plans likely to also participate in other coverage programs, such as the Exchanges, Medicaid, or CHIP? Should this be encouraged, and if so, how could CMS and States encourage it?

E. Amount of Payment

1. The statute specifies that amounts in the trust fund may only be used to reduce the premiums and cost-sharing of, or to provide additional benefits for, eligible individuals enrolled in standard health plans within a Basic Health Program. What options are States considering for

reducing premiums and cost-sharing, or providing additional benefits? What, if any, guidance is needed on this provision?

2. What are the likely administrative costs for a Basic Health Program? What factors, especially in terms of resources, are likely to affect a State's ability to establish a Basic Health Program? How are States likely to fund the costs associated with establishing and administering a Basic Health Program?

3. The statute specifies that in developing the financial methodology for the Basic Health Program, the determination of the value of the premium tax credits and cost-sharing reductions should take into consideration the experience of other States. What information would be most helpful to inform this methodology? Should implementation of the Basic Health Program be postponed until other States' experiences are available?

4. Other than those listed in the statute, what factors should be considered when establishing the methodology for determining the amount of Basic Health Program funding to States? How should the Federal government implement this calculation?

5. The statute specifies that the funding calculation is on a per-enrollee basis. How should the Federal government acquire the detailed information necessary to perform this calculation?

6. What are the best State-specific data sources to use in estimating the availability of affordable employer-sponsored insurance?

7. What methods should be considered to measure and monitor compliance with the 95 percent cap on funding? How should CMS implement the provisions in Section 1331(d)(3)(B) of the Affordable Care Act regarding corrections to overpayments made in any year?

F. Eligibility

1. What education and outreach will be necessary to facilitate a helpful consumer experience?

G. Secretarial Oversight

1. What process should the Secretary use to certify or recertify Basic Health Programs? How should this process be similar to or different from Exchange certification?

2. What should be considered when developing an oversight process for the Basic Health Program?

CMS-9980-NC

Authority: (Catalog of Federal Domestic Assistance Program No. 93.773, Medicare--Hospital Insurance; and Program No. 93.774, Medicare--Supplementary Medical Insurance Program)

Dated: July 27, 2011

Donald M. Berwick, M.D.

Administrator,

Centers for Medicare & Medicaid Services.

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