IHPS
INSTITUTE for HEALTH POLICY SOLUTIONS

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

Preparation of this memo was supported by the California HealthCare Foundation, based in Oakland, California.

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*

Preparation of this memo was supported by the California HealthCare Foundation, based in Oakland, California.

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

Preparation of this memo was supported by the California HealthCare Foundation, based in Oakland, California.

§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."

Preparation of this memo was supported by the California HealthCare Foundation, based in Oakland, California.

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)]

Preparation of this memo was supported by the California HealthCare Foundation, based in Oakland, California.

§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

Preparation of this memo was supported by the California HealthCare Foundation, based in Oakland, California.

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

Preparation of this memo was supported by the California HealthCare Foundation, based in Oakland, California.

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

Preparation of this memo was supported by the California HealthCare Foundation, based in Oakland, California.

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.

Preparation of this memo was supported by the California HealthCare Foundation, based in Oakland, California.

§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]

Preparation of this memo was supported by the California HealthCare Foundation, based in Oakland, California.

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).

Preparation of this memo was supported by the California HealthCare Foundation, based in Oakland, California.

§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.)

Preparation of this memo was supported by the California HealthCare Foundation, based in Oakland, California.

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 that 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.

Preparation of this memo was supported by the California HealthCare Foundation, based in Oakland, California.

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.*

Preparation of this memo was supported by the California HealthCare Foundation, based in Oakland, California.

§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.

Preparation of this memo was supported by the California HealthCare Foundation, based in Oakland, California.

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)

Preparation of this memo was supported by the California HealthCare Foundation, based in Oakland, California.

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.

Preparation of this memo was supported by the California HealthCare Foundation, based in Oakland, California.

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

Preparation of this memo was supported by the California HealthCare Foundation, based in Oakland, California.

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.

Preparation of this memo was supported by the California HealthCare Foundation, based in Oakland, California.