Draft
9/23/11

Comments of
The California Health Benefit Exchange,
The California Health & Human Services Agency
The Managed Risk Medical Insurance Board
The California Department of Insurance &
The California Department of Managed Health Care

PROPOSED RULES FOR ESTABLISHMENT OF EXCHANGES AND QUALIFIED HEALTH PLANS

45 CFR PARTS 155 & 156
CMS-9989-P
RIN 0938-AQ67

Reg Page	Proposed Regulatory Requirement Note: Page numbers in this column refer to Preamble. Page numbers in column to the left are those of the actual regulations.	Federal Preamble Comments	California Observations/Comments
41911	**Part 155: Standards Relative to Establishment of Exchanges & Standards for Minimum Exchange Functions**		
41911	**1.Subpart A: General Provisions**		
41912-41913	**b. Definitions (155.20)** Pg 41869 "health plan": ACA states that "health plan" shall not include group health plan or MEWA to extent not subject to state regulation under Section 514 of ERISA. However, Section 514 allows for state regulation of MEWAs if it does not conflict with ERISA standards. "qualified health plan" is a health plan certified to	*HHS requests comment on how to resolve this inconsistency and on how Taft-Hartley and church plans participating in the Exchange could potentially provide coverage opportunities through Exchange.*	We are concerned about the

	be offered through an Exchange. It is a discrete combination of benefits and cost-sharing offered by an issuer into which a person can enroll. "qualified employer" is a small employer who elects to make, at minimum, all full-time employees eligible for coverage through SHOP.		implications of the definition of "qualified health plan." Under California law, issuers participating in the Exchange must offer the same plans at the same premium both inside and outside of the Exchange. The issue merits further exploration to ensure that the definition does not undermine our approach of requiring the sale of qualified health plans outside the Exchange. More time is needed to fully understand the implications of this definition for the California model. (Board principles 3 & 4)
41913	**2. Subpart B: General Standards Related to Establishment of Exchange by State**		
41913	Pg 41870 HHS is exploring different partnership models under which a state could have its own operations but also rely on business services developed by other states or the federal government.		California is interested in IT solutions that could be used by multiple states. California would like to know to what extent the state would bear the federal cost associated with any function that the federal government administers on behalf of a state or Exchange, particularly services associated with the data service hub or support system, risk adjustment, and reinsurance. (Board principle 7) Relatedly, California would benefit from knowing how the

			federal government will design its "fall-back" program. This would help inform states' thinking about key operational considerations and approaches. (Board principle 7)
41913	**b. Approval of a State Exchange (155.105)**		
41913	(b) Standards for approval: These include a requirement that a state seeking approval of an Exchange must agree to operate the reinsurance program and establish the program or contract with an "applicable reinsurance entity" to do it. A state may meet the requirement of covering the entire geographic area by having subsidiary Exchanges in distinct regions in the state.		(b) California would like the federal government to assist in the establishment of a multi-state entity that could operate the reinsurance program. (Board principles 2 & 7)
41913	Pg 41871 (c) Process HHS will use to approve a State Exchange A state must submit an Exchange plan to HHS. It should include copies of any agreements to carry out Exchange functions (re 155.110). HHS will conduct a readiness assessment process with grants monitoring process under the planning and establishment grants The procedure for submission is to be described in additional guidance; HHS will issue a template for this purpose. States are encouraged to leverage implementation plans associated with Exchange grant awards when preparing Exchange plan.		California suggests that this template be available as soon as possible but no later than July 1, 2012. (Board principle 7)
41913	Pg 41871 (d & e) States must obtain written or conditional approval for their Exchange. Because states will have systems development and contracting activities going on after the statutory deadline for		

	approval (1/1/13), HHS may issue conditional approval. This presumes that a state's Exchange will be operational 1/1/14 even if it can't demonstrate complete readiness on 1/1/13. HHS will monitor and either provide full approval or revoke the conditional approval. HHS is considering establishing a review process similar to that used for Medicaid and CHIP. There would be 90 days to approve, deny or request comment. If additional information is received from the state, HHS would have 90 more days to approve or disapprove plan. The Exchange must receive approval of significant changes before making them. Examples of significant changes are provided. HHS considering using a SPA process like that used for Medicaid and CHIP.	*HHS seeks comments on appropriateness of this process and timeline.* *HHS requests comment on this approach.*	(d & e) California is concerned that a 180-day review period for the initial plan could impair its ability to open the Exchange in a timely manner (although it is aware of the high priority the federal government is giving to doing so) (Board principle 7) Having to obtain prior federal approval of changes before making them will severely hamper the Exchange's ability to respond to market conditions and operational issues quickly and fluidly. California suggests the approach used for separate CHIP programs that provides for file and use. Alternatively, a process could be used whereby changes could be made without obtaining prior approval, within certain parameters. (Board principles 2, 4, 5 & 6)
41913	**d. Entities eligible to carry out Exchange functions (155.110)**		

41913	Pg 41872. (a) Codifying statute. Interpreting the statute to allow a Medicaid agency to determine Medicaid eligibility (via a contract). A state may authorize an Exchange to enter into an agreement with an eligible entity to carry out one or more responsibilities of the Exchange. HHS anticipates sharing of information and ideas between the federal government and states as each develops expertise and implements infrastructure.	*HHS welcomes comments on how to implement or construct a partnership model.*	California believes that the Exchange should be able to contract with other public entities not specified in this section (for example, the Department of Managed Health Care, Department of Insurance, and the Managed Risk Medical Insurance Board). (Board principles 2, 3, 5 & 7)
41914	(b) To the extent the Exchange contracts with outside entities, the Exchange is responsible for meeting all federal requirements related to contracted functions. States have flexibility to determine contracting entities within "legal limits."	*HHS invites comment on whether conflict of interest requirements should be applied to contractors.*	California requests that the application of conflict of interest provisions be left up to the state. (Board principle 2)
41914	Pg. 41872. (f) Propose that HHS may periodically review the accountability structure and governance principles of an Exchange.	*HHS requests comment on recommended frequency of reviews.*	Given that the federal government will be approving an Exchange's initial plan and reviewing significant changes to it, it is unclear why a separate provision authorizing periodic review of Board structure and principles is necessary. (Board principles 2 & 5)
41914	**I Financial Support for Continued Operations (155.160)** 41874. (b) A state must ensure the Exchange has sufficient funding to support ongoing operations as of 1/1/15 as follows:	(b) The preamble indicates that DHHS will require that states submit a funding plan, a requirement for federal approval of the Exchange, to demonstrate that sufficient funding has been provided.	

	(1) May fund by charging assessments or user fees on issuers (2) May otherwise generate funding (3) No federal funds provided for operations after 1/1/15. (4) A state Exchange must announce assessment of any user fees on health insurance issuers before the plan year.	(2) The preamble indicates that states can use broad based funding, including general state revenue, provider taxes, or other funding as long as it does not violate state or federal law. *(4) 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 annually.*	(2) On Page 41874, the preamble states that the use of revenue sources supporting the Exchange should not violate other federal law. What federal laws does the federal government identify as limiting the nature of these sources? (Board principle 1) (4) California suggests that the regulations not specify more rules for user fees to afford state flexibility in this area. Why, for example, should the federal government stop a state from assessing fees twice a year or monthly? (Board principles 2 & 5)
41915	**3. Subpart C: General Functions of an Exchange**		The provisions of this NPRM apply only to QHPs participating in an Exchange. California strongly encourages the federal government to apply the same market rules for all health insurance regardless of participation in Exchange to avoid adverse risk selection. (Board principle 4)

41915-41916	**c. Navigator program standards (155.210)**		
41915	Pg. 41877. (a) Exchange shall award grants to public or private entities to serve as Navigators.		California requests assurance that the word "grants" can apply to a diverse array of payment approaches. (Board principles 2 & 5)
41915	Pg. 41877. (b)(1) (b)(i-iii) Entities eligible to be Navigator. Must be able to carry out duties as specified; demonstrate to the Exchange that it has existing relationships with employers and employees, consumers (including uninsured and under-insured, or self employed); and meet any licensing, certification or other standards prescribed by the State or Exchange, if applicable. (b)(iv) Any entity that serves as a Navigator may not have a conflict of interest during the term as a Navigator. Any entity that might formerly have had a conflict is not excluded if the conflict no longer exists. For example, a non-profit community organization that previously received grant funding from a health insurance issuer is not excluded from serving as a Navigator. (b)(2) Exchange must include at least two of the types of entities listed in ACA Section 1311(i)(2)(B) as Navigators.	*(b)(iv) HHS seeks comment on whether Exchanges should have additional requirements to make determinations about conflicts of interest.* *(b)(2) HHS seeks comment about whether it should require that at least one of the two types of entities serving as Navigators include a community and*	(b)(iv) California will need flexibility to design a Navigator program that's responsive to state populations and cultural and linguistic needs. Thus California suggests that the final rule not include additional requirements, but leave them to states. (Board principle 2) (b)(2) California supports the suggestion that one of the two required types should be a community- and consumer-focused non-profit, noting that

		consumer-focused non-profit organization, or require that Navigator grantees reflect a cross-section of stakeholders.	flexibility provided to the state allows it to select other types of entities. (Board principle 6)
41915	Pg. 41877. (c) Health insurance issuers may not serve as Navigators and Navigators must not receive any consideration directly or indirectly from a health insurance issuer in connection with the enrollment of any qualified individuals or qualified employees in a QHP. Consideration includes, but is not limited to, monetary or non-monetary commission, kick-back, salary, hourly-wage or payment made to the Navigator from the QHP. This does not preclude a Navigator from receiving compensation from an issuer for enrolling in non-QHPs.	*HHS seeks comment on this issue and other ways to manage any potential conflict of interest that might arise.*	(c) California is concerned that a Navigator's ability to receive issuer compensation for business operating in the same markets as the Exchange would result in adverse risk selection for the Exchange. California believes that the prohibition on issuer compensation for Navigators should apply to all products, whether or not they are sold in the Exchange. (Board principles 2, 3, 4, 5, & 6)
41915	Pg. 41877. (d) Duties of a Navigator: Facilitate enrollment in a QHP through the Exchange; provide referrals to appropriate agencies for any enrollee with a grievance, complaint, or question regarding their health plan; provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange; and ensure that information provided is fair, accurate, and impartial and acknowledges other health programs.	*HHS welcomes comment on potential standards to ensure that information made available by Navigators is fair, accurate, and impartial.* *HHS seeks comment regarding specific standards or additional guidance on these requirements.*	(d) Generally, California requests no further guidance on specific requirements to ensure the state flexibility needed to craft a program best suited to the states' needs. (Board principles 2 & 5) California believes that Navigator duties also should include the ability to assist with eligibility determinations for premium tax credits. Agents and brokers are explicitly permitted to perform this function, but Navigators are not. (Board principles 2, 5 & 6)

41916	Pg. 41877-41878. (e) The Exchange must ensure that the Navigator program is operational with services available to consumers no later than the first day of the initial open enrollment period. Exchange is prohibited from supporting the Navigator program with Federal funds received by the State for the establishment of Exchanges.	*HHS seeks comment on this proposed time frame.*	(e) California, with its long experience with Navigator-like entities, is dedicated to development and maintenance of a strong Navigator role. However, it seems inequitable that the federal government prohibits use of federal funds for Navigator operations while insisting on a specific time period by which states must have the program in place. (Board principles 2, 5, & 7)
41916	**d. Ability of States to permit agents and brokers to assist qualified individuals, qualified health plans, or qualified employees enrolling in QHPs (155.220)**		
41916	Pg. 41878. (a) States may choose to permit agents and brokers to enroll qualified individuals, employers or employees into Exchange QHPs. They may assist individuals in applying for advance payments of premium tax credit and cost-sharing reductions in QHPs.	(a) Standards in this section would not apply to agents/brokers serving as Navigators.	(a) It is unclear how this provision and the Navigator program will work together. This arrangement could raise significant concerns about adverse selection.

	(b) An Exchange may display information about agents or brokers on its website or in other publicly available materials.	(b) Web-based entities and other entities with experience in health plan enrollment are seeking ability to assist in QHP enrollment in several ways, including contracting with Exchange for outreach and enrollment or by acting independently of Exchange to perform similar outreach and enrollment functions to the Exchange. If the Exchange contracts with them, they must meet requirements proposed for eligible contracting entities (and the Exchange is responsible for ensuring requirements met) *HHS seeks comment on the functions that such entities could perform, the potential scope of how these entities would interact with the Exchange and what standards should apply to an entity performing functions in place of, or on behalf of, an Exchange. HHS also seeks comment on 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.*	(b) The potential for web-based entities will vary from state to state depending on the approach each state takes in managing its operations. California's Exchange is authorized to act as a selective contractor, a role that may be incompatible with independently operating web-based entities enrolling Exchange customers. In states where the Exchange will play a less active role, independent outreach and enrollment by these entities may be beneficial and therefore the option should be maintained in the federal regulations.
41916	**e. General standards for Exchange notices (155.230)**		
41916	Pg. 41878. (b) Applications, forms, and notices should be written in a manner that meets the needs of diverse populations by providing meaningful access to limited English proficient individuals and ensuring effective	*HHS seeks comment about whether it should codify those examples as requirements in the final rule as well as other requirements it might consider to provide meaningful access to limited*	(b) California requests that the federal government refrain from further specificity in this area to allow for maximum state flexibility in constructing a

	communication for people with disabilities. The Exchange may provide access in many ways, including providing information about the availability and steps to obtain oral interpretation services, information about the languages in which written materials are available, and the availability of materials in alternate formats for people with disabilities.	*English proficient individuals and ensure effective communication for people with disabilities.*	program best suited to state needs and consistent with state law. (Board principle 2)
41916	**f. Payment of premiums (155.240)**		
41916	Pg. 41879. (a) The Exchange may require enrollees to pay premiums directly to issuers, facilitate collection of premiums by creating pass-throughs but not retain payments, or collect premiums and pay an aggregate amount to issuers. But it must always be an option to pay directly to the issuer.		(a) California appreciates the flexibility the proposed rule provides to states regarding how an Exchange collects premium payments for individual coverage, acknowledging that, per statute, enrollees always can pay a QHP directly. (Board principles 2 & 5)
41917	**5. Subpart E: Exchange Functions in the Individual Market: Enrollment in Qualified Health Plans (QHPs)**		
41917	**a. Enrollment of qualified individuals into QHPs (155.400)**		
41917	Pg. 41881. The Exchange must send QHP issuers enrollment information on a timely basis. Pg. 41881. The Exchange will develop a process by which QHP issuers verify and acknowledge receipt of enrollment information. The process is to be timely.	HHS anticipates future guidance on timing. *HHS wants this to occur in real time and seeks comment on whether it should codify a requirement for a specific frequency for enrollment transactions, such as real-time or daily.*	California requests that the federal government refrain from further guidance in this area to allow for maximum state flexibility in constructing a program best suited to state needs. (Board principle 2)

41917	**c. Initial and annual open enrollment periods (155.410)**		Enrollment periods should be identical for issuers operating inside and outside Exchange. (Board principle 4)
41917	Pg. 41882. (a) (2) Individuals can enroll in or change QHPs during **initial** enrollment, annual open enrollment, or special enrollment, as specified. Pg. 41882. (b) **Initial** OE period October 1, 2013 through February 28, 2014. Pg. 41882. (c) Effective date of coverage related to **initial** enrollment (as well as *open enrollment* and special enrollment). Where the Exchange receives QHP selection on or before 12/22/13, the effective date would be 1/1/14. Subsequently, a selection received between the first and 22nd day of a month, the effective date would be first day of following month. One received between the 23rd and last day of the month (between 12/13 and 2/28/14) the effective date would be the first day of the following month or the first day of the second following month. Pg. 41882. (d) The Exchange must send written	*(b) HHS seeks comment on this period. It notes that it is attempting to balance time for outreach & enrollment to individuals and time for information management systems to become operational with QHP desire for a full coverage year.* *(c) HHS notes that ACA allows for advance payment of premium tax credit only where an individual is enrolled with QHP on the first of the month. Thus, its proposal that QHP coverage begin on the first of the month. It seeks comment on whether it should allow for different effective dates (twice a month or daily).* d) HHS is considering codifying a	(b) California believes that the initial enrollment period should be longer given its experience in starting up the Healthy Families program and implementing Medicaid expansions. (Board principle 6) (d) California requests that the

	notification to enrollees about annual *open enrollment.*	requirement that notice be sent no later than 30 days before the start of open enrollment. Also, HHS is considering requiring that the notice contain the following information: 1) open enrollment period 2) where individuals can obtain information about available QHPs and 3) other (unspecified) information.	federal government refrain from further guidance in this area to allow for maximum state flexibility in constructing a program best suited to state needs. (Board principle 2)
	Pg. 41882. (e) Annual o*pen enrollment* period 10/15-12/7 starting 10/14 (for coverage effective 1/1/15).	*(e) HHS also considered 11/1-12/15. It seeks comments on the appropriate OE period.* *--HHS seeks comment on whether Exchange should automatically enroll individuals* *1) who receive advance tax credit and who fail to make a new selection when his/her QHP is longer offered;* *2) where there are mergers between issuers; or* *3) when a QHP offered through an issuer is no longer offered but the issuer has other options available.* *HHS also seeks comment on how far automatic enrollment should extend.*	(e) California requests that the federal government allow states to determine how best to use automatic enrollments (when necessary) to further plan contracting strategies. (Board principle 2)
	Pg. 41883. (f) Effective date of coverage for selections made during *open enrollment*: 1st day of the following benefit year.		
41917-41918	**d. Special enrollment periods (155.420)**		An extensive number of federally required special enrollment periods will limit a state's flexibility to protect

			QHPs in the Exchange from adverse selection. For example, to avoid adverse selection, the addition or deletion of dependents during the QHP plan year should not be a qualifying event that allows enrollees to access special enrollment periods. Enrollees should be allowed to add or drop dependents to their existing QHP during the plan year and then have the choice to change QHPs only at the next open enrollment period. (Board principle 2) If the federal government feels compelled to articulate all special enrollment circumstances, it should add assuming guardianship pursuant to court order to qualifying conditions.
41917-41918	Pg. 41883. (b) Effective dates of coverage. Same as those proposed for **initial** and *annual open enrollment* periods above. Specifically, 1st day of following month for QHP selections made by 22nd of prior month & 1st day of following month or first day of second following month for selections made between 23rd day and last day of month. Exceptions: For birth, adoption, or placement for adoption, coverage effective on date of these events.	The enrollment periods described in the rule are minimums. And they do not supplant provisions of other law requiring special enrollment rights from issuers.	

	Pg. 41883. (c) Length of special enrollment period: 60 days generally—see exceptions in (d). Pg. 41883-41884. (d) (1) Individuals and any dependents due to loss of other minimum essential coverage. If dependent loses such coverage, individual also eligible for special enrollment.	(1) *HHS seeks comment on specification to minimum essential coverage, noting that those with less than minimum might constitute an adverse risk threat if allowed to enter during a special enrollment period.* Loss of coverage examples: Decertification of a QHP outside of open enrollment; legal separation or divorce; end of dependent status (age); for dependents, upon death of enrollee; termination from employment or reduction in hours required to qualify for coverage; relocation outside QHP service area (Relocation includes relocation to US for US citizen, national or lawfully present individual who lived outside of US); release from incarceration, moving from one jurisdiction of the Exchange to another; termination of employer contribution for coverage; exhaustion of COBRA coverage, reaching lifetime limit on benefits in a grandfathered plan, termination of coverage in Medicaid or CHIP. *(1) HHS asks whether this should be expanded for gaining dependents through other life events.*	

	(2) Where a qualified person gains a dependent or becomes a dependent through marriage, birth, adoption or placement for adoption. (3) Upon gaining status as a citizen, national or lawfully present individual. (4) Qualified individual who experiences error in enrollment. (5) Where enrollee demonstrated that his/her QHP substantially violated a material provision of its contract (such as material misrepresentation during marketing). (6) Individuals newly eligible or newly ineligible for advance payments of the premium tax credit or a change in eligibility related to cost-sharing reductions. (7) Qualified individuals or enrollees who could enroll in a new QHP upon making a permanent move. This includes someone who continues to reside in his or her current plan's service area.	(3) – (7) Patterned on Medicare Prescription Drug Program. *(6) HHS notes that an individual cannot get the tax credit if enrolled in employer coverage. It asks for comment on whether the 60 day period should begin when an employee learns of a change in employer sponsored coverage or when the employee terminates coverage by the employer sponsored plan.* *(7) HHS asks whether this special enrollment period should begin on the date of the move or on the date an individual provides (reasonable) notification of the move. It also asks whether the length of the enrollment period be 60 days from the "start" date,*	

		or 60 days from the date of the move or the notice of the move.	
	(8)For Indians (defined as a member of a federally recognized tribe), the ability to join or change a plan once a month.	*(8) HHS asks for comment on potential implications on process for verifying Indian status.*	(8) The preamble notes that paragraph (d)(8) is designed to codify the requirement from ACA Section 1311(c)(6)(D) that Indians have a monthly special enrollment period. Section 1311(c)(6)(D) defines "Indian" with reference to Indian Health Care Improvement Act (IHCIA) Section 4. According to the preamble, IHCIA Section 4 defines "Indian" as a member of a federally-recognized tribe. California disputes this interpretation. IHCIA Section 4 does not limit the definition of "Indian" to members of federally-recognized tribes. Rather, that section defines "Indian" as a "member of an Indian tribe, as defined in subsection (d) of this section" and "Indian tribe" as "any Indian tribe, Band, nation or other organized group or community . . . which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians." Qualifying tribes

			under this definition include more than just federally-recognized tribes. Members of California tribes have been specifically recognized as eligible for Indian health care services provided by the United States by virtue of their status as Indians, even when their tribes are not federally recognized. *See*, *e.g.*, 25 U.S.C. 1679. The final rule should include as Indians members of all tribes fitting within the definition of IHCIA Section 4, not only federally-recognized tribes. (Board principle 5)
	(9) For exceptional circumstances as determined by the Exchange or HHS. These would be circumstances that impede an individual's ability to enroll on a timely basis through no fault of their own. Pg. 41884. (e): Loss of coverage does not include failure to pay premiums timely (including COBRA prior to expiration of COBRA coverage) or situations allowing for a rescission (under 45 C.F.R. § 147.128). Pg. 41885. (f) In a special enrollment period an enrollee can change plans only within the level	HHS notes that this rule would be a challenge for a woman enrolled in catastrophic coverage who becomes pregnant. It asks whether this should be another exception.	

	previously selected. (If the enrollee chose silver, the enrollee must stay within silver). Exception: new eligibility for advance premium tax credit or change in eligibility for cost-sharing. The Exchange will perform certain (specified) operations year round to accommodate special enrollment period and coverage through Medicaid and CHIP.		
41918	**e. Termination of coverage (155.430)**		
41918	Pg. 41885. (a): The Exchange must determine form and manner in which coverage in a QHP may be terminated.		Section 2703 of the Public Health Services Act limits when a health insurance issuer may terminate coverage. Lack of eligibility for the health plan is not a permissible reason for termination under this provision. While lack of eligibility is an important basis for the Exchange to terminate coverage in a QHP, the apparent conflict between these

			provisions must be resolved. California requests clarification on how these provisions can operate concurrently. Moreover, the grounds for termination of coverage inside the Exchange should be consistent with provisions affecting issuers outside the Exchange. (Board principle 4) It is not clear if this provision is an exhaustive list of when the Exchange may terminate coverage in a QHP. California requests clarification on this point. All termination dates under this section are prospective – including for rescission of coverage. However, rescission is a retrospective action as defined in section 147.128. It is unclear how a QHP can rescind coverage retrospectively pursuant to section 147.128 when subdivision (b) of section 155.430 requires prospective termination.

	Pg. 41885. (b) The set of events that would cause an enrollee's coverage to be terminated: (1) Election of enrollee. Enrollee must provide "appropriate notice" to Exchange OR QHP (2) Exchange may terminate and must allow QHP to terminate coverage when: (i) The enrollee is no longer eligible (ii) The enrollee becomes covered in other minimum essential coverage (iii) The premium payments cease (but there is a required grace period of three consecutive months for those receiving advanceable premium tax credits) (iv) The enrollee's coverage rescinded per Section 147.128 (v) The QHP terminates or is decertified (vi) The enrollee changes QHPs during open or special enrollment Pg. 41885. (c) Termination of coverage tracking and approval. Exchange must: (1) Have mandatory procedures for QHP issuers to maintain termination of coverage records. (2) Track the number of terminations and submit the data to HHS monthly. (3) Have standards that require QHP issuers prior to termination to provide reasonable accommodation to individuals with mental or cognitive conditions, including	(1) HHS anticipates that voluntary terminations occur in situations in which enrollee has obtained other minimum essential coverage.	

	mental and substance abuse disorders, Alzheimer's, and developmental disabilities. Pg. 41885. (d) Effective dates for termination of coverage: (1) Where termination is requested by enrollee, last date of coverage is termination date specified by enrollee if the Exchange and QHP have had a "reasonable" amount of time to process after notice of termination. If time is not "reasonable," the last day of coverage is the first day after the "reasonable" amount of time has passed. (2) Where coverage is terminated because enrollee has other minimum essential coverage, the last day of coverage is the day before the effective date of coverage (3) Where coverage is terminated because enrollee changes health plans, the last day of coverage is the day before the effective date of coverage (4) For any other termination, the last day of coverage is the 14th of the month if the	*(2) HHS seeks comments on how Exchanges can work with QHP issuers to implement this. HHS is trying to avoid double coverage as it makes a person ineligible for the premium tax credit.* HHS notes that in establishing procedures for termination of coverage notification to enrollees, it should consider how it will notify issuer of effective date of coverage termination.	

	notice of termination by Exchange (or termination is initiated by QHP) no later than 14th of the prior month: It is the last day of the month if these events occur no later than the last day of the previous month.		
41918	**Subpart H: Exchange Functions: Small Business Health Options Program (SHOP)**	Requirements for small business tax credit are addressed in separate rulemaking by Department of Treasury.	
41918-41919	**b. Functions of a SHOP (155.705)** Pg. 41886. (a) Specifies required functions: same as individual Exchange with exceptions for ones not relevant to SHOP, such as calculator. Pg. 41886-41887. (b) Specifies unique functions of SHOP 1) Must adhere to unique enrollment and eligibility requirements described below and conduct special enrollments per those detailed for individuals except no special enrollment for: • Non-lawfully present employees who become a new citizen, national, or lawfully present (as they weren't eligible for SHOP previously) • New eligibility for advanceable premium tax credit and cost sharing (employees not eligible) 2) Employer/employee choice • Codifies the ACA provision stating that the employer chooses level of coverage and the employee chooses the plan at that level. • Provides for additional options a SHOP can select : o Employees can choose any QHP at any	*HHS welcomes comments on various aspects of rules proposed in this section including:* *(b)(2) Special enrollment periods for the SHOP and how they might differ from those for the individual Exchange.*	

	level ○ Employer selects specific levels and employee chooses QHP from those ○ Employers select specific QHPs from different levels of coverage from which an employee can choose ○ Employers select a single QHP 3) SHOP options with respect to employer choice requirements.	*(b)(3) The statutory interpretation of Section 11312(a)(2)(A) relating to 1) employer specification of level of coverage 2) the requirement for employee choice within a metal level 3) providing SHOP's the option to offer broader employee choices among carriers. and 4) 1312(f)(2)(B) which permits an employer to limit employees to a single QHP* *HHS asks whether a minimum participation rule is desirable. If so, how should it be calculated and should it be codified in regulations?*	(b) (3) California appreciates the state options provided in this proposed rule. We want to ensure that we have flexibility to structure coverage choices to minimize adverse risk selection. (Board principles 1, 3 & 6) California suggests that the final rule not include any participation rule requirements. This is another area in which an Exchange would have to create policy based on practices in the outside market. (Board principle 2)

	4) Premium aggregation. SHOP must provide employers with single monthly bill for all QHPs in which employees enrolled and allow for payment of a single monthly amount. This includes where an employer offers multiple coverage options. SHOP can aggregate employer premium payments and distribute (or contract to) payments to issuers. 5) QHPs must meet certification requirements like those for the individual Exchange except: • Administration of advance premium tax credit and cost sharing reductions are not applicable. • There are specific standards for rate setting and premium payment and different enrollment period and process requirements. 6) Standards for rates and rate changes. • QHPs must make rate changes at uniform times set by Exchange (quarterly, monthly, annually). • Because there is rolling employer enrollment in SHOP, any QHP rate changes apply only to new coverage and annual renewals. Rates for a given employer may not change during the employers plan year—and are the rates relevant to the employee. • SHOP to consider rate changes subject to rate increase consideration rules for QHPs. 7) QHP availability in merged markets.	*(6) HHS invites comment on 1) whether the timeframe should be more permissive or restrictive and 2) what rates should be used to determine premiums during plan year.*	(b)(6) California suggests that the final rule not include a more restrictive timeframe nor dictate the rates used to determine premiums during the plan year. This is another area in which an Exchange would have to create policy based on practices in the outside market. (Board principles 2 & 4)

	8) QHP availability in unmerged markets. Employees can enroll only in QHPs in the small group market. 9) SHOP expansion to large group market. If state elects to expand SHOP to large group, then SHOP must implement it beginning 2017 to large employers making all full time employees eligible for QHPs offered to the large group market.		
41921	**Subpart K- Exchange Functions: Certification of QHPs**		
	a. Certification standards for QHPs (155.1000)		
41921	Pg. 41891. (a) Definitions: Codifies definition of multi-State plan. It is an issuer with whom the Office of Personnel Management (OPM) contracts to offer multi-State coverage in Exchanges. Benefit design standards must comply with ACA requirements in Section 1302, and the product must meet all requirements for QHPs as well as federal rating requirements in PHS Act Section 2701 (or a state's more restrictive rating requirements where applicable). Pg. 41891. (b) General requirements: Exchange can only offer QHPs and QHPs must have a certification from an Exchange. All references to QHPs must include multi-state plans. Pg. 41891. (c)(1) General certification criteria: Codifies ACA rule that issuer must demonstrate compliance with minimum requirements set forth in Part 156(c).	(a)ACA Section 1334 (c) (1) specifies that when OPM determines that such a plan offers a benefits package uniform in each states and meets requirements described, then (all) requirements satisfied. Guidance says OPM will offer at least 2 such QHPs through each Exchange in each state. (c)(1) In developing process to certify QHPs, the Exchange should identify standards from Part 156(c) needed to become certified as well as those that issuer needs to agree to as an ongoing condition of participation.	

	Pg. 41891. (c)(2) Codifies ACA rule that Exchange must determine that the plan offered by the issuer is in the interest of qualified individuals and employers. Exchange cannot exclude plan if it is fee-for-service, through imposition of price controls, or because it provides treatment necessary to prevent patient death in circumstances the Exchange deems inappropriate or costly.	(c)(2) Exchanges have discretion on how to determine what is in the interest of qualified individuals and employees. They may use an "any willing plan" approach or a selective contracting approach, or negotiate with issuers on case by case basis. In the latter case, the Exchange would not need to undertake a competitive bidding process with issuers but negotiate based on criteria related to market conditions in the state (or the Exchange's regions). States may also impose additional selection criteria beyond the federal minimums (such as reasonableness of costs, quality requirements, provider network enhancements etc.).	(c) (2) California, which has enacted an Exchange model that will use selective contracting, supports the broad range of approaches available to states under the NPRM.
	b. Certification process for QHPs (155.1010)		
41921	Pg. 41892. (a) Certification procedures: Codifies the ACA requirement that Exchanges establish procedures for QHP certification. Procedures must be consistent with Section 155.1000(c) above. Pg. 41892. (b) Exemption from certification process: Multi-state plans are deemed to meet certification requirements. Pg. 41892. (c) Completion date: Exchange must complete certification prior to open enrollment period.	(b) HHS interprets the law to preclude states from applying additional certification rules.	(b) Requiring a state to include federally negotiated issuers in its Exchange is inconsistent with California's statutorily established selective contracting approach—and unnecessary in the robust managed care market in California. This provision

	Pg. 41892. (d) Ongoing compliance. Exchanges must monitor issuers and QHPs for ongoing compliance.	d) If the issuer is out of compliance, the Exchange may want to remedy or take action against issuer.	fundamentally interferes with the Exchange's ability to determine the terms and conditions under which Exchange coverage is provided in California. The fact that such coverage would be phased in over time by state makes it impossible for the Exchange to even construct a negotiation plan. California's view is that the ACA allows HHS to prohibit a multi-state plan from being offered if doing so is in consumers' best interests. ACA Section 1334(a)(4)(D), (a)(5). Allowing the Exchange to negotiate the entirety of its coverage in California is very much in the interests of Californians as it would expand the value to an issuer of contracting with the Exchange and would ensure consistent, statewide issuer standards within the Exchange. Even the NPRM for CO-OPs allowed for application of state standards to those issuers.
	c. QHP issuer rate and benefit information (155.1020)		
41921	Pg. 41892. (a) Receipt and posting of rate increase justification. The Exchange must receive a justification for rate increase prior to		California's Exchange legislation requires plans participating in the Exchange to

	implementation of the increase. The Exchange will ensure the issuer has posted the justification on its website.		offer products in all five tiers. Plans in the more comprehensive tiers can be expected to attract adverse risk relative to the less comprehensive tiers. In order to ensure a range of product offerings at a competitive price, California believes that premiums charged in the small group and individual market should reflect the value of the benefits and not the just the risk of the consumers enrolled in the product. States should have flexibility to limit the ability of QHP issuers to establish rates for each benefit tier that exceed the difference in the actuarial value of the benefits between each tier. (Board principle 4)
	Pg. 41892. (b) Rate increase consideration. Exchange to consider justification above, recommendations from the state pursuant to 2794(b)(1)(B) of PHS Act, and excess rate of growth outside the Exchange.	b) Preamble states that HHS wants to avoid duplicating the state rate review process under Section 2794 of the PHS Act, if there is one. *HHS seeks comment how to best align Section 2794 of the PHS Act and Section 1311 (e)(2) of the ACA. It is considering the following: Where Section 2794 of the*	

		PHS Act applies, the Exchange may rely on justification submitted for that process. Where it does not, the Exchange could develop a less burdensome process that satisfies ACA Section 1311(e) (2). Where states have an effective rate review program, suggest that Exchange leverage it. For example, a state may consider that information collected during rate review process constitutes preliminary justification.	
	Pg. 41893. (c) Benefit & rate information. Annually, the Exchange will receive for each QHP information on rates, covered benefits, and cost-sharing requirements from issuers.	(c) HHS will specify form and manner of this information. It will seek to align with information available through state rate review process or rate filings. The information is needed for administration of the risk corridor program and for Exchanges to determine: premium amounts; the second lowest cost silver plan (premium tax credit subsidies are tied to this); whether QHP complies with a) required benefit design standards; and b) value requirements for cost-sharing reductions.	
	Pg 41983 (d) Ongoing compliance. Exchanges must monitor issuers and QHPs for ongoing compliance.		(d) Freezing enrollment can be an important tool in protecting plan solvency and therefore the integrity of the Exchange. California seeks assurance that the state would be permitted to do so. (Board principles 2 & 5)

41921	**g. Service area of a QHP (155.1055)** Pg. 41894. (a) County or group of counties , unless issuer demonstrates that serving a partial county is necessary, non-discriminatory, and in the interest of enrollees. Pg. 41894. (b) Anti-redlining.		California seeks additional flexibility in defining service areas. Under California law (the Knox-Keene health Care Service Plan Act of 1975, as amended), health plans are licensed to specific geographic service areas that are defined by ZIP codes. To receive approval for service areas, plans must demonstrate that a sufficient number of providers are geographically accessible to ensure enrollees have sufficient access to care. California law also provides for alternate standards for accessibility in rural communities, or where provider shortages may limit access to certain services. Many rural or medically underserved areas of the state lack any licensed health plans due to a lack of available providers. The failure of section 155.1055 of the proposed rule to take into account this reality by requiring that a service area of a QHP include the entire geographic area of a county, will limit California's ability to appropriately address the needs of its unique population and may result in less robust participation of QHPs in the Exchange. (Board principle 2)

41922	**Part 156 – Health Insurance Issuer Standards Under the ACA, Including Standards Related to Exchanges**		The provisions of this NPRM apply only to QHPs participating in an Exchange. California requests that the market rules for health insurance issuers be the same for all issuers regardless of participation in the Exchange to avoid adverse risk selection. (Board principle 4)
41922-41923	**Subpart A: General Provisions**		
41923	**Subpart B: Reserved**		
41923-41927	**Subpart C: QHP Minimum Certification Standards**		
41923	**b. 156.210 QHP rate & benefit information**		
	c. Transparency in coverage (156.220)		
41923	41897-88 (a), (b) Codifies ACA Section 1311(e)(3)(A), establishing a transparency standard for QHP certification. Required disclosures include 1) claims payment policies and practices; 2) periodic financial disclosures; 3) data on enrollment; 4) data on disenrollment; 5) data on the number of claims that are denied; 6) data on rating policies; 7) information on cost-sharing and payments with respect to any out-of-network coverage; and 8) information on enrollee rights under title I of the ACA. Enrollees include "participants."	*(a), (b) HHS seeks comment on whether issuers should be required to submit this information to the Exchange and other entities, or to make such information available to the Exchange and other entities.*	Subdivision (b) of section 156.220 refers specifically to the Insurance Commissioner in the reporting requirement. California's oversight of health insurance issuers is split between two regulators, with the bulk of California's enrolled population under the jurisdiction of the DMHC. California requests that the definition of "State Insurance Commissioner" include all appropriate state regulators of health insurance issuers.

	41898 (c) Plain language. 41898 (d) Provision of information.		
	d. Marketing of QHPs (156.225)		
41923	41898 (a) Compliance with state laws and regulations. 41898 (b) Codifies ACA Section 1311(c)(1)(A), prohibiting QHP issuers from employing marketing practices that discourage enrollment of individuals with significant health needs.	*(b)HHS seeks comment on the best means for an Exchange to monitor QHP issuers' marketing practices to determine whether they have discouraged enrollment of individuals with significant health needs. HHS seeks comment on applying a broad prohibition against unfair or deceptive marketing practices by all QHP issuers and their officials, agents, and representatives. HHS seeks comment on a requirement that QHP issuers do not misrepresent the benefits, advantages, conditions, exclusions, limitations, or terms of a QHP.*	(a) This section requires that QHPs comply only with state marketing laws. By specifying only state marketing laws instead of all applicable laws, this section may be interpreted to limit the ability of states to enforce all applicable state laws.
	e. Network adequacy standards (156.230)		(a) California requests that the final regulations for provider network access provide adequate flexibility to permit states to develop approaches that address

			their unique circumstances. In 2010, California adopted the first-of-its-kind in the nation regulation to require timely access to care. This regulation (1) establishes uniform waiting times for appointments with physicians; (2) requires timeliness of care in an episode of illness, including timeliness of referrals and obtaining other services; and (3) provides a uniform waiting time to speak to a physician, registered nurse or other qualified health care professional who is trained to screen or triage an enrollee who may need care. Health plans licensed under the Knox-Keene Act were required to fully implement the policies, procedures and systems necessary to comply with these regulations by January of this year. These new requirements built upon long-standing standards for geographic accessibility and ratios of providers to enrollees. However, as both an urban and rural state, California has found it challenging to adopt standards that can be applied uniformly. There are geographic regions and

			many communities with significant provider shortages; state law has needed to provide flexibility to address this challenge.
	f. Essential community providers (156.235)		
41924	41898 (a) Provider Networks. QHP issuers must include a sufficient number of essential community providers in their networks. 41898 (b) Types of Providers. Essential community providers include those referenced in statute as well as all providers defined in section 340B(a)(4) of the PHS Act and providers described in section 1927(c)(1)(D)(i)(IV) of the Act. Two provisions of the ACA regarding payment of essential community providers and payment of FQHCs may conflict. ACA Section 1311(c)(2) says that a QHP is not required to contract with an essential community provider if such provider refuses to accept the generally applicable payment rates of the plan. This may conflict with Section 1302(g), which requires a QHP issuer to reimburse FQHCs at each facility's Medicaid prospective payment system rate.	*(a) HHS solicits comment on how to define a sufficient number of essential community providers and whether to provide exemption for integrated delivery system* *(b) HHS solicits comment on the extent to which the definition should include other similar types of providers that serve predominantly low-income, medically-underserved populations and furnish the same services as the providers referenced in section 340B(a)(4) of the PHS Act. HHS invites comment on the issue of FQHC payment and solicits other potential approaches for resolving the potentially conflicting provisions. HHS invites comment on establishing requirements regarding reimbursement of Indian health providers qualifying under 340B (a) (4) of the PHS Act. IHCIA Section 206 requirements apply to QHP issuers; HHS invites comment on the payment*	(a) State should have flexibility to determine network adequacy standards, including sufficiency standards for essential community providers as the state is in the best position to determine what will best serve the interests of its population.

		requirement under IHCIA section 206 and how it might be reconciled with the essential community provider payment requirement. HHS invites comment on other special accommodations that must be made when contracting with Indian health providers. HHS invites comments on the applicability of special requirements to QHP issuers and potential use of a standardized Indian health provider contract addendum.	
	i. Rating variation (156.255)		
41924	41901 (a) Rating area premium variation 41901 (b) QHP issuer offering QHP rate 41901 (c) Family composition premium variations. Calculating a family premium by determining the age and tobacco-related premium for one member of the family and applying a multiplier to set the rating for the entire family is not permitted. HHS is considering whether to require QHP issuers to cover an enrollee's tax household, including for purposes of applying individual and family rates.	*(c) HHS seeks comment on how to structure the family rating categories while adhering to Section 2701(a)(4) of the PHS Act. HHS requests comment on how to apply four family categories when performing risk adjustment. HHS seeks comment 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. HHS seeks comment on potential issues with requiring QHP issuers to cover an enrollee's tax household.*	(c) California seeks clarification on how child-only QHPs will be rated.
	l. Termination of coverage for qualified individuals (156.270)		
41924-41925	41902 (a) Permissible reasons to terminate coverage		

	41902 (b) Notice of termination. Notice of termination must include content such as reason for termination and effective termination date. 41902 (c) Uniform policy for termination for non-payment	*(b) Request comment on other information that should be included in the termination notice.* *(c) There is no federal standard requiring QHP issuers to extend the three-month grace period to enrollees not receiving advance payments of the premium tax credit, although the Exchange can chose to require issuers to extend this grace period to other enrollees.*	
	41902 (d) Three-month grace period. 41902 (e) Notice for delinquent payments. 41902 (f) Exhaustion of grade period. 41902 (g) Records of termination. 41902-03 (h) Effective dates for termination.	(d) A three-month grace period is required for those receiving premium tax credits (if they have paid one month's premium). Insurers must pay costs during the three months.	(d) California suggests that the final rule not require issuers to pay claims for the full three-month grace period for those receiving advanceable premium tax credits. States should be allowed to require carriers to pay claims for shorter periods that are consistent with their market practices. Similarly, states should be free to establish grace periods for other enrollees that are compatible with their market practices rather than being

			limited to extending the three-month period.
	o. Additional standards specific to the SHOP (156.285)		
41926	41903 (a) Rating and premium payment requirements. 41903 (b) Requirements for QHP issuers consistent with SHOP enrollment periods. HHS is considering whether to require QHPs in the SHOP to allow employers to offer dependent coverage. 41903 (c) SHOP enrollment process requirements and timeline. 41904 (d) SHOP termination.	*(b) HHS solicits comment on potential requirement for QHPs in the SHOP to allow employers to offer dependent coverage.*	(b) California suggests that the final rule not include the requirement and leave it to state Exchanges to develop their own rules, taking into consideration state laws and market practices.