Comments on Federal Proposed Rules

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State of California
DEPARTMENT OF INSURANCE
DEPARTMENT OF MANAGED HEALTH CARE
CALIFORNIA HEALTH BENEFIT EXCHANGE

December 26, 2012

Submitted electronically via www.regulations.gov

Honorable Kathleen Sebelius, Secretary
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–9972-P
P.O. Box 8012
Baltimore, MD 21244-1850

Re: CMS-9972-P; Comments to Notice of Proposed Rulemaking on Patient Protection and Affordable Care Act Health Insurance Market Rules and Rate Review

Dear Secretary Sebelius:

On behalf of the State of California and many of the entities responsible for implementing the Patient Protection and Affordable Care Act (Affordable Care Act) in the state -- the Department of Insurance, the Department of Managed Health Care, and the Health Benefit Exchange ("the departments") -- California submits the enclosed comments on the proposed rules for Health Insurance Market Rules and Rate Review. California appreciates the opportunity to comments on these important regulations.

California appreciates the significant effort involved in establishing the standards relating to fair health insurance premiums, guaranteed availability and renewability, single risk pools, and catastrophic plans, as well clarifying applicability to student health plans and the role of CMS enforcement with regard to the requirements of the Public Health Service Act. California also acknowledges the additions and revisions to the rate increase disclosure and review process. However, it is critical that, to the extent possible, the final market rules minimize the rate and market disruption that may occur with implementation of the Affordable Care Act's market reforms. In these comments, which are presented in chart format, the departments offer suggestions to further this goal.

In particular, California has significant concerns regarding the potential market disruption that would result from the proposed rule limiting a state's geographic rating areas to seven unless a state receives CMS approval for another approach. Due to the size and health care market diversity of our state, California would like to consider designating a larger number of geographic rating areas in order to minimize rate shock. While the proposed rule provides an approval process for a larger number, California strongly recommends the proposed rule be changed to allow states to determine their own geographic rating areas without having to first seek approval from CMS.

While we support the policy of establishing age rating bands with a maximum 3:1 ratio, we have concerns about the potential rate impact that this may have on younger individuals who are purchasing coverage in the individual market. If it is determined that the Secretary has the authority to consider state specific implementation options, we would welcome an opportunity to discuss transitional approaches.

The enclosed comments reflect the consensus of all the signatories to this letter. Should you have questions concerning our comments, please direct them to all three agencies. Thank you for taking these comments into consideration as you finalize the rules and as California approaches the full debut of the Affordable Care Act, which the departments have all worked diligently to successfully implement.

Sincerely,

Dave Jones, Insurance Commissioner

Brent Barnhart, Director, California Department of Managed Health Care

Peter V. Lee, Executive Director, California Health Benefit Exchange

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	I. Executive Summary			
	C. Costs and Benefits			
1	70586		We solicit comments on additional strategies consistent with the Affordable Care Act that CMS or states might deploy to avoid or minimize disruption of rates in the current market and encourage timely enrollment in coverage in 2014. For example, these strategies could include instituting the same enrollment periods inside and outside of Exchanges (as proposed in this rule) or a phase-in or transition period for certain policies. Additionally, we are examining ways in which states could continue their high risk pools beyond 2014 as a means of easing the transition. Ensuring premiums are affordable is a priority for the Administration as well as states, consumers, and insurers, so we welcome suggestions for the final rule on ways to achieve this goal while implementing these essential consumer protections. (P. 11)	The overarching goal of the Department of Managed Health Care (DMHC), California Department of Insurance (CDI), and California Health Benefit Exchange (Exchange), (together "California") in implementing the Affordable Care Act's health insurance market rules is to minimize disruption of health coverage rates for consumers. To this end, California seeks flexibility in implementing these market rules in order to minimize rate and market disruption.
	III. Provisions of the Proposed Regulations			
	A. Fair health insurance Premiums (Proposed §147.102)			
	1. State and Issuer Flexibility Related to Rating Methodologies			
2	70590		We welcome comments on the areas where and the extent to which state and issuer flexibility in rating methodologies versus a more	California is concerned that the proposed rules do not afford states and issuers sufficient flexibility in rating methodologies to help mitigate

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			standardized approach is desirable.	the expected rate shock as markets transition to the ACA's rating rules. California suggests allowing states the flexibility to address these transition issues in a manner that helps to mitigate the potential impacts.
	2. Small Group Market Rating			
	No comments			
	3. Family Rating			
3	70591, 70611*	**§ 147.102(c)** Application of variations based on age or tobacco use. With respect to family coverage under health insurance coverage, the rating variations permitted under paragraphs (a)(1)(iii) and (a)(1)(iv) of this section must be applied based on the portion of the premium attributable to each family member covered under the coverage. (1) Per-member rating. The total premium for family coverage must be determined by summing the premiums for each individual family member. In determining the total premium for family members, premiums for no more than the three oldest family members who are under age 21 must be taken into account.	We solicit comments on the use of the per-member build-up methodology for individual and small group market coverage. In addition, we request comments on the appropriate cap, if any, on the number of child and adult family members whose premiums should be taken into account in determining the family premium and the appropriate cut-off age for a per-child cap (for example, whether this should be aligned with the extension of dependent coverage to age 26 instead).	California requests modification of the proposed rule to allow state flexibility to adopt family tiers. California law currently in effect for small groups (and which will continue after 2014 for grandfathered health plans) allows using no more than the following family size categories: 1) single, 2) married couple (or registered domestic partners), 3) one adult and child or children; 4) married couple (or registered partners) and child or children. Finally, California requests clarity regarding rating for family members who reside in different geographic rating areas, for example, in the case of a dependent who attends school in another location.
	4. Persons Included Under Family Coverage			
4	70592	**§147.102 Fair health insurance**	We request comments on whether	California requires state flexibility in

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	70611*	**premiums.** (a) In general. With respect to the premium rate charged by a health insurance issuer for health insurance coverage offered in the individual or small group market-- (1) The rate may vary with respect to the particular plan or coverage involved only by determining the following: (i) Whether the plan or coverage covers an individual or family. …	the final rule should specify the minimum categories of family members that health insurance issuers must include in setting rates for family policies, or whether we should defer to the states and health insurance issuers to make this determination. We also request comments on the types of individuals who typically are included under family coverage currently, including types of covered individuals who would not meet the classification of tax dependents. We note that any family member not covered under a family policy would be eligible for an individual policy pursuant to guaranteed availability of coverage under PHS Act section 2702.	defining family members. The final rule should allow states to define a family member to include a registered domestic partner. Under California law (Family Code Section 297.5), registered domestic partners must be treated the same as spouses.
	5. Rating for Geography			
5	70592 70611*	**§147.102 Fair health insurance premiums.** (a) In general. With respect to the premium rate charged by a health insurance issuer for health insurance coverage offered in the individual or small group market-- (1) The rate may vary with respect to the particular plan or coverage involved only by determining the following: … (ii) Rating area, as established in	We solicit comments on the maximum number of rating areas that may be established within a state and the potential standards for determining an appropriate maximum number.	California would strongly prefer that the final rule not establish minimum geographic size and minimum population requirements for rating areas. If the final rule establishes these requirements, the final rule must allow states to request federal approval for more than seven rating areas in order to minimize disruption of rates. California enacted 2012 conforming legislation that established a greater

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		accordance with paragraph (b) of this section.		number of geographic rating areas than the seven in the proposed rule, AB 1083 (Chap. 852, Stats. 2012). California requires this number of rating areas due to the state's large population, large geographic area, diversity of rural and metropolitan areas, the established health care systems in various counties, and the fact that California's health plans and health insurers have not historically had the same geographic rating areas. Without state flexibility in this area, a significant number of consumers will experience significant rate shock based solely on the creation of the new rating areas. In order to minimize rate disruption, California will request approval for a greater number of rating areas (than the seven in the proposed rule) if the proposed regulation is not changed to permit states to establish their own rating areas without seeking approval from CMS.
6	70592 70611* 70612*	**§147.102 Fair health insurance premiums.** (b) Rating area. (1) A state may establish rating areas within that state for purposes of applying this section and the requirements of title XXVII the Public Health Service Act and title	We request comments regarding the use of these proposed standards for rating areas, as well as comments regarding other options for standards for geographic divisions and other relevant factors that could be used for developing rating areas. We request	The inclusion of the requirements listed in section 147.102(b)(3) in the proposed rule impedes state flexibility. We recommend paragraphs 147.102(b)(2), (3), and (4) be deleted or modified to permit greater state flexibility. These

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		I of the Patient Protection and Affordable Care Act. A state that establishes rating areas shall submit to CMS information on its rating areas in accordance with the date and format specified by CMS. (2) If a state's rating areas are not consistent with paragraph (b)(3) of this section, or if a state does not establish rating areas, the standard under paragraph (b)(3)(i) of this section shall apply unless CMS establishes rating areas within the state applying one of the standards under paragraph (b)(3)(ii) of this section. (3) A state's rating areas will be presumed adequate if one of the following requirements are met: (i) There is only one rating area within the state. (ii) There are no more than seven rating areas based on one of the following geographic divisions: counties, three-digit zip codes, or metropolitan statistical areas/nonmetropolitan statistical areas. (4) Notwithstanding paragraph (b)(3) of this section, a state may propose to CMS for approval other existing geographic divisions on which to base rating areas or a number of rating	comments from states that already have standard rating areas regarding what changes, if any, would be necessary to meet one or more of the proposed standards and the proposed limit of having no more than seven rating areas. We also request comments on whether the final rule should establish minimum geographic size and minimum population requirements for rating areas and whether state rating areas currently in existence should be deemed in compliance with this provision.	criteria seem restrictive and unsuitable, especially for states with large, diverse markets that have not been subject to uniform rating areas in the past, and are likely to result in significant market disruption. In general, a state should have the flexibility to define rating areas in order to minimize market disruption in 2014. California legislation, AB 1083 (Chap. 852, Stats. 2012), established 19 geographic rating areas for the small group market. In addition to minimizing market disruption, a greater number of geographic rating areas than the 7 in the proposed rule also provide for greater transparency in provider network costs, which may give health plans greater ability to negotiate affordable provider arrangements. California will request approval for a greater number of rating areas if the proposed regulation is not changed to permit states to establish their own rating areas without seeking approval from CMS.

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		areas greater than seven.		
7	70593 70611* 70612*	See **§147.102 (b)** above.	We request comments on appropriate schedules and procedural considerations related to rating area designations for plan years after 2014.	Since California intends to request approval for a larger number of rating areas to minimize rate disruption, California requests the final rule include timely and clear guidance for states to submit such requests.
	6. Rating for Age			
8	70593 70595 70611*	**§147.102 Fair health insurance premiums.** (a) In general. With respect to the premium rate charged by a health insurance issuer for health insurance coverage offered in the individual or small group market-- (1) The rate may vary with respect to the particular plan or coverage involved only by determining the following: ... (iii) Age, except that the rate must not vary by more than 3:1 for like individuals of different age who are age 21 and older and that the variation in rate must be actuarially justified for individuals under age 21, consistent with the uniform age rating curve under paragraph (e) of this section. For purposes of identifying the appropriate age adjustment under this paragraph and the age band in paragraph (d) of this section	Accordingly, we propose to allow rates to vary within a ratio of 3:1 for adults (defined for purposes of this requirement as individuals age 21 and older), and that rates must be actuarially justified based on a standard population for individuals under age 21, consistent with the proposed uniform age curve discussed later in this section. We request comment on this approach.	California is concerned that the proposed rules do not afford states and issuers sufficient flexibility in rating methodologies to help mitigate the expected rate shock as markets transition to the ACA's rating rules. California suggests allowing states the flexibility to address these transition issues in a manner that helps to mitigate the potential impacts.

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		applicable to a specific enrollee, the enrollee's age as of the date of policy issuance or renewal shall be used. Nothing in this paragraph prevents a state from requiring the use of a ratio narrower than 3:1 in connection with establishing rates for individuals who are age 21 and older. A state that uses a narrower ratio shall submit to CMS information on its ratio in accordance with the date and format specified by CMS.		
9	70593 70611*	**§147.102(a)(iii)** …For purposes of identifying the appropriate age adjustment under this paragraph and the age band in paragraph (d) of this section applicable to a specific enrollee, the enrollee's age as of the date of policy issuance or renewal shall be used….	We request comments on whether other measurement points (for example, birthdays) might be more appropriate.	California believes enrollees' and insureds' rates should not change mid-policy/plan year.
10	70593 70612*	**§ 147.102 (d)** Uniform age bands. The following uniform age bands apply for rating purposes under paragraph (a)(1)(iii) of this section: … 2) Adult age bands. One-year age bands starting at age 21 and ending at age 63.	Second, with respect to adults ages 21 to 63, we propose one-year age bands so that consumers would experience steady, relatively small premium increases each year due to age. Although five-year bands are currently common in the small group market, we are also proposing to apply the same age-band structure to the small group market to align with our proposal that the per-member rating buildup approach be used in both the individual and the small	California agrees that one-year age bands are preferable to five-year bands as a strategy to minimize rate shock. California is concerned that the proposed rules do not afford states and issuers sufficient flexibility in rating methodologies to help mitigate the expected rate shock as markets transition to the ACA's rating rules. California suggests allowing states the flexibility to address these

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			group markets. We request comment on this approach.	transition issues in a manner that helps to mitigate the potential impacts.
	7. Rating for Tobacco Use			
11	70595 70611*	**§147.102 Fair health insurance premiums.** (a) In general. With respect to the premium rate charged by a health insurance issuer for health insurance coverage offered in the individual or small group market-- (1) The rate may vary with respect to the particular plan or coverage involved only by determining the following: ... (iv) Tobacco use, except that such rate shall not vary by more than 1.5:1 for like individuals who vary in tobacco usage. (See § 147.110, related to prohibiting discrimination based on health status and programs of health promotion or disease prevention.) Nothing in this paragraph prevents a state from requiring the use of a ratio narrower than 1.5:1 in connection with establishing rates for individuals who vary in tobacco usage. A state that uses a narrower ratio shall submit to CMS information on its ratio in accordance with the date and format specified by CMS.	**If a state anticipates adopting narrower ratios for tobacco use, we propose that the state submit relevant information on their ratios to CMS no later than 30 days after the publication of the final rule.**	California law, AB 1083 (Chap. 852, Stats. 2012), does not permit rating variation by tobacco use for the small group market. Allowing rating variation for tobacco use will make coverage less affordable.. Accordingly, California's "ratio" for tobacco use in the small group market is 1:1. [A1]
12	70596	See **§147.102 (a)(iv)** above.	We are proposing that states or	California supports the proposed

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	70611*		issuers have the flexibility to determine the appropriate tobacco rating factor within a range of 1:1 to 1:1.5, consistent with the wellness requirements discussed below. We seek comments on this approach.	rule's flexible approach. California has already enacted small group premium rating provisions which do not permit tobacco use rating.
	B. Guaranteed Availability of Coverage (Proposed §147.104)			
13	70597 70612*	**§ 147.104(a)** *Guaranteed availability of coverage in the individual and group market.* Subject to paragraphs (b) through (d) of this section, a health insurance issuer that offers health insurance coverage in the individual or group market in a state must offer to any individual or group market in the state all products that are approved for sale in the applicable market, and must accept any individual or employer that applies for any of those products.	Accordingly, beginning in 2014, even non-grandfathered "closed blocks" of business would be available to new enrollees, subject to the limited exceptions discussed below. We welcome comments on this proposal.	California seeks clarification regarding the proposed regulation's assertion that guaranteed issue across the market prohibits health insurance issuers from closing blocks of business.
14	70597 70612*	**§ 147.104(b)** (1) Open enrollment periods – (ii) Individual market. A health insurance issuer in the individual market must permit an individual to purchase health insurance coverage during the open enrollment periods described in § 155.410(b) and (e) of this subchapter, with such coverage becoming effective consistent with the dates described in § 155.410(c) and (f) of this subchapter.	We solicit comments on whether this proposal sufficiently addresses the open enrollment needs of individual market customers whose coverage renews on dates other than January 1 and whether aligning open enrollment periods with policy years (based on a calendar year) in the individual market is more desirable.	California supports consistency between the open enrollment periods in the individual market outside California's Exchange with the open enrollment periods inside California's Exchange.
15	70598	**§ 147.104(b) (2) –** *Special enrollment*	The proposed rule directs that the	California supports requiring the

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	70613*	*periods.* A health insurance issuer in the group market and individual market shall establish special enrollment periods for qualifying events as defined under section 603 of the Employee Retirement Income Security Act of 1974, as amended. Enrollees shall be provided 30 days after the date of the qualifying event to elect coverage, with such coverage becoming effective consistent with the dates described in § 155.420(b) of this subchapter. These special enrollment periods are in addition to any other special enrollment periods that are required under state law.	election period would be 30 calendar days, which is generally consistent with the HIPAA standard. However, we request comment as to whether another standard, such as 60 calendar days, generally consistent with the Exchange standard, is more appropriate.	election period outside the Exchange to be consistent with the federal 60-day rule standard [45 CFR § 155.420(c)] inside the Exchange.
16	70598 70613*	See **§ 147.104(b) (2)** above.	We also request comments on whether health insurance issuers in the individual market should provide to enrollees in their products a notice of special enrollment rights similar to what is currently provided to enrollees in group health plans (§146.117(c)).	California supports requiring health insurance issuers to provide enrollees in the individual market with notice of their special enrollment rights. In this regard, California recently enacted legislation, AB 792 (Chap. 851, Stats. 2012) that requires health plans and health insurers, beginning January 1, 2014, to provide a notice to individuals who cease to be enrolled in individual or group coverage that they may be eligible for reduced-cost coverage through California's Exchange or no-cost coverage through Medi-Cal

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				(California's Medicaid program). It is critical that individuals who lose coverage receive timely notice of the availability of coverage through the Exchange, since, to the extent individuals fail to obtain coverage through a special enrollment period; they may be unable to obtain any health coverage until the next annual enrollment period.
17	70598		PHS Act section 2702 does not include an explicit guaranteed availability exception allowing issuers to limit the offering of certain products to members of bona fide associations. … While the guaranteed availability exception for bona fide association coverage is not allowed under the statute, we are interested in whether and how a transition or exception process for bona fide association coverage could be structured to minimize disruption while maintaining consumer protections. We seek comment on this issue.	Given the opportunity to use association coverage as a means of risk selection, California suggests HHS issue regulations to impose some limitation on inappropriate denials. Such regulations could also include the requirement for annual filings to state regulators regarding the number of individuals who have been denied association coverage.
18	70612*-70613*	**§ 147.104(c)** *Special rules for network plans.* … (2) An issuer that denies health insurance coverage to an individual or an employer in any service area, in accordance with paragraph (c)(1)(ii) of this section, may not offer		The federal regulation states that an insurer may not offer coverage in the individual or group market, as applicable, for a period of 180 calendar days after coverage is denied. California requests clarity as to whether the "as applicable" language intends to forbid insurers

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		coverage in the individual or group market, as applicable, within the service area to any individual or employer, as applicable, for a period of 180 calendar days after the date the coverage is denied. This paragraph (c)(2) does not limit the issuer's ability to renew coverage already in force or relieve the issuer of the responsibility to renew that coverage.		only from selling in the same market in which coverage was denied, or if this is a broader prohibition against selling in any market. California further suggests that the federal regulation require the state regulator to approve the insurer's reentry into the market.
19	70613*	§ 147.104(d) Application of financial capacity limits. ... An issuer that denies group health insurance coverage to any employer or individual in a state under paragraph (d)(1) of this section may not offer coverage in the group or individual market, as applicable, in the state before the later of either of the following dates: ...		As with the network capacity exception, California requests clarity as to whether the "as applicable" language means that insurers are only forbidden from selling in the same market in which coverage was denied, or if this is a broad prohibition against selling in any market.
	C. Guaranteed Renewability of Coverage (Proposed §147.106)			
20	70613* 70614*	**147.106(b)** *Exceptions.* An issuer may nonrenew or discontinue health insurance coverage offered in the group or individual market based only on one or more of the following: *(1) Nonpayment of premiums:* The plan sponsor or individual, as applicable, has failed to pay		Under proposed § 147.106, a health insurance issuer may refuse to renew or continue coverage *only* under six enumerated bases. However, federal regulations regarding the state Exchanges also permit QHP issuers to terminate coverage in additional

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		premiums or contributions in accordance with the terms of the health insurance coverage, including any timeliness requirements. *(2) Fraud. …* *(3) Violation of participation or contribution rules. …* *(4) Termination of plan. …* *(5) Enrollees' movement outside service area. …* *(6) Association membership ceases. …*		circumstances, such as loss of eligibility for coverage in a QHP or decertification of the QHP. (45 C.F.R. 155.430.) To provide clarity, proposed § 147.106 should specifically incorporate the Exchange regulations pertaining to termination and nonrenewal of coverage under a QHP in the Exchange. Additionally, California suggests clarifying the conditions of guaranteed renewability in the group market to allow for nonrenewal based on the eligibility of enrollees and dependents (e.g., loss of employee status, divorce), and, as applicable, in the individual market. Federal regulations implementing the ACA's prohibition on rescission indicated that issuers may cancel a group enrollee's coverage based on "eligibility," such as an employee no longer meeting the group's work-hour requirements. Other statutes implicitly allow issuers to terminate or discontinue enrollment after an enrollee exhausts certain statutory eligibility requirements (e.g. exhaustion of COBRA continuation coverage or a dependent child reaching age 26). However, the lack

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				of clarity regarding eligibility-based terminations of enrollment creates ambiguity. In the absence of federal guidance, California presumes states have the authority to regulate issuers' terminations of enrollment based on "eligibility."
	D. Applicability of the Proposed Rules under PHS sections 2701, 2702, and 2703 and Section 1312(c) of the Affordable Care Act to Student Health Insurance Coverage			
	No Comments			
21	70600 70616*	**§ 156.80(a).** *Individual market.* A health insurance issuer shall consider the claims experience of all enrollee in all health plans (other than grandfathered health plans) subject to section 2701 of the Public Health Service Act and offered by such issuer in the individual market in a state, including those enrollees who do not enroll in such plans through the Exchange, to be members of a single risk pool.	Under this proposed rule, student health insurance coverage would be included in an issuer's individual market single risk pool, as described below. Nonetheless, given the differences between the student health insurance market and other forms of individual market coverage, we solicit comment on whether the final rule should allow issuers to maintain a separate risk pool for student health insurance coverage. We also seek comment on whether the final rule should provide any modifications with respect to the generally applicable individual market rating rules in connection with student health insurance coverage.	California supports a separate risk pool for student health insurance. Including students in a single individual risk pool would likely result in a significant increase in premiums for students.
	E. Single Risk Pool (Proposed §156.80)			
21	70601 70616*	**§156.80 (d)** *Index rate.* (1) In general. Each plan year or policy year, as applicable, a health insurance issuer shall establish an	The index rate, the market-wide adjustment based on total expected payments and charges for the risk adjustment and reinsurance	In the event the PCIP extends beyond 2014, California suggests that the final rule include clarification whether a state HIPAA-guaranteed

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		index rate for a state market based on the total combined claims costs for providing essential health benefits within the single risk pool of that state market. The index rate shall be adjusted on a market-wide basis based on the total expected market-wide payments and charges under the risk adjustment and reinsurance programs in that state.... (2) Permitted plan-level adjustments to the index rate. For plan years or policy years beginning on or after January 1, 2014, a health insurance issuer may vary premium rates for a particular plan from its index rate based only on the following actuarially justified plan-specific factors (i)... (ii)...(iii)... (iv)...	programs, and the variations for individual plans would have to be actuarially justified. Furthermore, all such actuarially justified adjustments would have to be implemented by issuers in a transparent fashion, consistent with state and federal rate review processes. We seek comment on the approach described above, and on the proposed plan specific adjustments to the index rate. This proposed rule would apply both when rates are initially established for a plan and at renewal. We expect that percentage renewal increases generally would be similar across all plans in the same risk pool, but might differ somewhat due to the permitted product differences described above. We are considering allowing additional flexibility in product pricing in 2016 after issuers have accumulated sufficient claims data. We request comments on this approach.	issue and/PCIP claim costs are included in the single risk pool for the individual market.
	F. CMS Enforcement in Group and Individual Insurance Market (Various Provisions in Parts 144 and 150)			
	G. Enrollment in Catastrophic Plans (Proposed §156.155)			
			No comments requested	
	H. Rate Increase Disclosure and Review (Part 154)			
22	70602 70615*	**§154.215 Submission of rate filing justification.** (b) The Rate Filing Justification must consist of the following Parts: (1)	We request comments through the corresponding PRA comment process on the proposed information collection authorized under §154.215,	Proposed §154.215 requires insurers to file all rate increases, regardless of size, with CMS. However, states with effective rate review programs

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		Standardized data template (Part I), as described in paragraph (d) of this section (2) Written description justifying the rate increase (Part II), as described in paragraph (e) of this section (3) Rating filing documentation (Part III), as described in paragraph (f) of this section. (c) A health insurance issuer must complete and submit Parts I and III of the Rate filing justification described in paragraphs (b)(1) and (b)(3 of this section to CMS and, as long as the applicable State accepts such submissions, to the applicable State for any rate increase....	as proposed to be amended, and the additional burden, if any, it would impose on health insurance issuers and the states.	must retain flexibility to use their own templates and formats for requesting information from insurers in order to maintain effective rate review. The proposed rule would require insurers to file rates using different templates and formats than currently provided by the state. This would be unnecessary for issuers. For states deemed to have an effective rate review program, a requirement that the rate filing be submitted to the state, but not to CMS, will provide the necessary degree of regulatory oversight that is required by the ACA.
23	70603 70615*	**§154.215 Submission of rate filing justification.** (a) If any product is subject to a rate increase, a health insurance issuer must submit a Rate Filing Justification for all products on a form and in a manner prescribed by the Secretary	We also welcome comments on the need for and impact of the extension of the reporting requirement below the review threshold and whether alternative approaches to monitoring and oversight should be considered (e.g., auditing).	Monitoring and oversight should remain with states that have an effective rate review program. Duplicating state oversight is burdensome for health insurance issuers.
24	70603 70616*	**§154.301(a)(4) CMS's determinations of effective rate review programs.** ... (xii) Other standardized ratio tests recommended or required by statute, regulation, or best practices. ... (xiv) The impacts of geographic factors and variations.	We also propose to add new paragraphs (xii), (xiv), (xv), and (xvi) to §154.301(a)(4)... Comments are solicited on the impact on states created by these proposed changes and whether there are additional factors that should be considered in reviewing rate increases starting in 2014.	Proposed paragraph § 154.301(a)(4)(xii) seems to inadvertently replace an existing factor under existing paragraph § 154.301(a)(4)(xii) regarding an issuer's capital and surplus, with a new factor regarding "other standardized ratio tests recommended or required by statute, regulation or best practices." The

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		(xv) The impact of changes within a single risk pool to all products or plans within the single risk pool. (xvi) The impact of Federal reinsurance and risk adjustment payments and charges under sections 1341 and 1343 of the Affordable Care Act.		proposed rule then adds new paragraphs (xiv) through (xvi), skipping paragraph (xiii). The preamble states these new factors are additions to, rather than revisions of, the existing Effective Rate Review criteria for a state's examination of rate review filings. This appears to be an inadvertent numbering error, but the proposed section as written would delete an existing component and leave a gap in the numbering.
	IV. Collection of Information Requirements			
	A. ICRs Regarding State Disclosures [§147.102(a)(1)(iii), §147.102(a)(1)(iv), §147.102(b)(1), §147.102(c)(2), §147.102(c)(3), §147.102(e), §156.80 (c)]			
25	70603 70611* 70612 70616	**§147.102(a)(1)(iii):** A state that uses a narrower ratio (than 3:1) shall submit to CMS information on its ratio in accordance with the date and format specified by CMS. **§147.102(a)(1)(iv):** A state that uses a narrower ratio shall submit to CMS information on its ratio in accordance with the date and format specified by CMS. **§147.102(b)(1):** A state that establishes rating areas shall submit to CMS information on its rating areas in accordance with the date and format specified by CMS. **§147.102(c)(2):** A state that establishes uniform family tiers and	We seek comments on how many states are likely to submit their own rating and risk pooling rules.	California anticipates submitting rating and risk pooling rules.

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		corresponding multipliers shall submit to CMS information on its uniform family tiers and corresponding multipliers in accordance with the date and format specified by CMS. **§147.102(c)(3):** A state that requires premium based on average enrollee amounts shall submit to CMS information on its election in accordance with the date and format specified by CMS. **§147.102(e):** Each state must establish a uniform age rating curve for rating purposes under paragraph (a)(1)(iii) of this section and submit to CMS information on its uniform age rating curve in accordance with the date and format specified by CMS. If a state does not establish a uniform age rating curve by a date specified by CMS, a default uniform curve established by CMS shall apply in that state which takes into account the rating variation permitted for age under state law. **§156.80 (c):** A state may require the individual and small group insurance markets within a state to be merged into a single risk pool if the state determines appropriate. A state that requires such merger of risk pools shall submit to CMS information on its election in accordance with the date		

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		and format specified by CMS.		
	B. ICRs Regarding Rate Increase Disclosure and Review (§154.215, §154.301)			
	V. Regulatory Impact Analysis			
	Other Provisions			
26	70611	**§ 144.102(c)** Coverage that is provided to associations, but not related to employment, and sold to individuals is not considered group coverage under 45 CFR parts 144 through 148. If the coverage is offered to an association member other than in connection with a group health plan, or is offered to an association's employer-member that is maintaining a group health plan that has fewer than two participants who are current employees on the first day of the plan year, the coverage is considered individual health insurance coverage for purposes of 45 CFR parts 144 through 148. The coverage is considered coverage in the individual market, regardless of whether it is considered group coverage under state law. If the health insurance coverage is offered in connection with a group health plan as defined at 45 CFR 144.103, it is considered group health insurance coverage for purposes of 45 CFR parts 144 through 148.		Proposed § 144.102(c) would provide for potentially inconsistent treatment of a group health plan with fewer than two employee participants depending on whether the plan was sold through an association or obtained directly from an issuer. This seems inconsistent with the statutory definitions in 42 USC §§ 300gg-91(e)(4) and 18024(b)(2), which define small group as 1-100 employees. It is also inconsistent with § 300gg-91(e)(1)(B), which grants states the option to treat "very small groups" (with fewer than two employee participants) as small group market coverage. This discrepancy also seems to controvert prior HHS guidance, CMS bulletins, and existing federal rate review regulations (45 CFR § 154.102) which stated that the market classification of coverage sold through an association is determined at the plan level by considering the plan's characteristics as if it were not sold through an

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				association.

State of California
DEPARTMENT OF INSURANCE
DEPARTMENT OF MANAGED HEALTH CARE
CALIFORNIA HEALTH BENEFIT EXCHANGE

December 26, 2012

Honorable Kathleen Sebelius, Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: CMS-9980-P; Comments to Notice of Proposed Rulemaking on Patient Protection and Affordable Care Act Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation

Dear Secretary Sebelius:

On behalf of the State of California and many of the entities responsible for implementing the Patient Protection and Affordable Care Act in the state -- the Department of Insurance, the Department of Managed Health Care, and the California Health Benefit Exchange -- we submit the enclosed comments on the proposed rules for Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation. California appreciates the opportunity to comment on these important regulations.

California applauds the significant effort involved in memorializing the benchmark approach described in the Essential Health Benefits Bulletin, as well as finalization of the method for calculating actuarial value originally described in the Actuarial Value and Cost Sharing Reductions Bulletin. California also appreciates the development of the actuarial value calculator, a tool that will facilitate compliance with, and enforcement of the levels of coverage requirement. We request that states be allowed to use state-specific data sources for actuarial value calculation beginning in 2014. Without this flexibility, California consumers will likely face higher cost sharing because benefit designs will be priced at a national average that does not take into account California's lower utilization and unit cost for health care services.

Based on the benchmark approach described in the Essential Health Benefits Bulletin, California enacted two statutes that selected a small group HMO plan, the Kaiser

Foundation Health Plan, Inc. Small Group $30 Copayment Plan, as California's base-benchmark plan. The statutes, Insurance Code section 10112.27 (S.B. 961, Stats. 2012, Ch. 866) and Health and Safety Code section 1367.005 (A.B. 1453, Stats. 2012, Ch. 854), provide the framework the state will use in implementing the essential health benefits requirement in California. The statutes provide that California will supplement the base-benchmark plan with the Children's Health Insurance Program benefit for pediatric dental services and Federal Employees Dental and Vision Insurance Program for pediatric vision services. Also, California chose to define habilitative services and require parity with the base-benchmark plan's coverage of rehabilitative services.

In these comments, which are presented in chart format, we offer some suggestions for the proposed rules. Due to the short time frame in which to comment, it is possible that additional comments will be forthcoming early next year. Because the enclosed comments reflect the consensus of all the signatories to this letter, please direct any questions regarding the comments to all three agencies.

Thank you for taking our comments into consideration as you finalize the rules and we approach the full implementation of the Patient Protection and Affordable Care Act, which we have all worked so diligently to successfully implement.

Sincerely,

Dave Jones, Insurance Commissioner

Brent Barnhart, Director, Department of Managed Health Care

Peter V. Lee, Executive Director, California Health Benefit Exchange

HEALTH INSURANCE ESSENTIAL HEALTH BENEFITS, ACTUARIAL VALUE AND ACCREDITATION 45 CFR PARTS 147, 155 AND 156				
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II. Provisions of the Proposed Regulations				
A. Part 147 – Health Insurance Reform Requirements for the Group and Individual Health Insurance Markets 1. (a)Coverage of EHBs - § 147.150				
1.	70646, 70668*	(a) Requirement to cover EHB benefit package - Issuer offering coverage in individual or small group market must ensure such coverage offers the EHB package		California suggests including a cross-reference to 45 CFR § 156.20, as "essential health benefits package" is defined there.
B. Part 155 – Exchange Establishment Standards and Other Related Standards Under the Affordable Care Act				
1. State Required Benefits (Mandates) § 155.170				
2.	70647, 70668*	(a)(1) – state may require QHP to offer benefits in addition to EHBs (a)(2)State-required benefits enacted on or before 12-31-2011, are not considered "in addition to" EHB.	Should state make mandate-defray payments based on • statewide average cost or • on each QHPs issuer's actual cost if different issuers report that a particular additional benefit costs a different amount.	
3.	70647	[***Preamble only***] *even if not effective until a later date...* (italics not in regulation)		§ 155.170 (a)(2) does not include language to support the Preamble's comment that mandates enacted before 12-31-2011, *even if not effective until a later date* may be considered EHB (as in, not "benefits in addition to EHB subject to state defrayment of costs) Please see p. 70647. California requests that HHS include language regarding the effective date in the text of § 155.170(a).
4.	70647, 70668*	§ 155.170 (a)(3) Exchange shall identify which state mandates are in excess of EHB		All states operate differently in terms of oversight. States should be permitted to determine what state entity will identify

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				state mandates in excess of the EHB. In California, the Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI) are the regulatory agencies with jurisdiction over health issuers, while the Health Benefit Exchange is a separate entity and not a regulator.
5.	70647, 70668*	§ 155.170 (b) the state must make payments to defray the cost of additional required benefit specified in (a) to one of the following: (1) individual enrollee (2) directly to the QHP issuer on behalf of the individual in (b)(1)		
6.	70647	[***Preamble only***] "We interpret state-required benefits" = specific to care, treatment and services state requires issuers to offer to enrollees. (no obligation to defray costs for state mandates re: provider types, cost sharing, reimbursement methods)		The term "state-required" benefits is used multiple times in the preamble and in § 155.170(a)(2), but is not defined in the regulation text. California recommends the definition in the preamble be included in the regulation as a definition for "state-required benefits," or benefits "in addition to EHB." The preamble does not have any force of law. It is very important to differentiate between types of "state required benefits" that will be considered in cost defray requirements. California also believes it is essential that HHS exclude from the definition of "state-required benefits" or "benefits in addition to

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				EHB" any changes in state law that reflect scientific advances in medicine and thereby alter a benefit mandate enacted before 12-31-2011. For example, under California law and specified in regulation under title 28, California Code of Regulations section 1300.74.72, enacted prior to 12-31-11, California's base-benchmark plan, is required to cover medically necessary mental health services when the treatment is for mental disorders identified in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM IV). If and when the American Psychiatric Association publishes the DSM V, it is essential that California be permitted to update existing state law to define mental disorders pursuant to DSM V without triggering mandate cost-defrayment requirements.
7.	70647, 70668*	§ 155.170 (c) (1)QHP to calculate amount of cost attributable to additional state-required benefit in (a). (2) a QHP issuer's calculation shall be:(i) based on an analysis performed in accordance w/ generally accepted actuarial principles & methodologies; (ii) Conducted by a member of the	QHP generates the necessary data regarding claims, utilization, trend and other issuer-specific data typically used to calculate the cost of a benefit.	

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		Amer. Acad. Of Actuaries; and (iii) Reported to the Exchange.		
	2. Accreditation Timeline §155.1045			
C. Part 156 – Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges				
	1. General Provisions – Definitions§ 156.20			
8.	70648, 70669*	***[Preamble Only]*** – We propose to define "AV" as the percentage paid by a health plan of the total allowed costs of benefits (using the term percentage of the total allowed costs of benefits" that we also propose to define here). In general, AV can be considered a general summary measure of health plan generosity §156.20: • **Actuarial Value** = percentage paid by plan of the percentage of the total allowed costs of benefits		California suggests revising the definition of actuarial value in § 156.20, as it refers to percentage twice and is therefore inaccurate and confusing. California proposes amending the definition to read: "Actuarial Value means the percentage of the total allowed cost of benefits paid by a health plan."
9.	70648, 70669*	• **Percentage of total allowed costs of benefits** = anticipated covered medical spending for EHB coverage paid by a health plan for a standard population: health plan's cost sharing divided by the total anticipated allowed charges for EHB coverage – expressed as a percentage		
10.	70648,	• **Base-Benchmark Plan** = plan		

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	70669*	selected by a state from options described in §156.100(a), or default benchmark plan, prior to adjustments to meet benchmark standards described in § 156.110		
11.	70648, 70669*	• **EHB-Benchmark Plan** = standardized set of EHB that must be met by QHP or other issuer as required under § 147.150		
12.	70648, 70669*	• **EHB Package** = scope of benefits and associated limits of a health plan offered by an issuer		California suggests being more explicit about what "associated limits" means by replacing "limits" with "limitations on coverage," as that is the term used in 45 CFR § 156.115(a)(1)(ii).
2. EHB Package				
a. State selection of Benchmark § 156.100				
13.	70648, 70669*	§ 156.100 (a) Standards for selection [*refers to §156.110*] (1) small group market plan (2) state employee health plan (3) FEHBP Plan	Is the default base-benchmark plan that will apply to the states, the largest plan by enrollment in the largest product in state's small group market, an appropriate default base-benchmark plan for the territories?	.
14.	70649, 70669*	Appendix A: list of proposed EHB Benchmarks & proposed default plans	If state wishes to make a selection or change previous selection it must do so by the end of the comment period	Appendix A omits that California is supplementing the pediatric vision category with FEDVIP pursuant to the state's EHB laws. California requests correction of this omission in the final rule.
15.	70649, 70669*	§ 156.100 (b) Standard for approval of state-selected EHB-benchmark plan (ACA §1302(b)(4)(G) & (H)) – to become an EHB-benchmark plan as		As in the definition of "essential health benefits package," here the word "limits" is used. If "limitations on coverage" is what is intended, we suggest replacing "limits"

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		defined in § 156.20 – a state-selected base-benchmark plan must meet the requirements for coverage of benefits and limits described in § 156.110		with that phrase and note that limitations on coverage are discussed in 45 CFR § 156.115(a)(1)(ii), not § 156.110.
16.	70649	[*preamble only*] – ACA calls for Secretary to periodically review the defn of EHB, report findings, and update the EHB definition as needed to address gaps in access to care or advances in relevant evidence base. Propose state's benchmark plan selection would be applicable for 2014 & 2015	What process should HHS use to update EHB over time?	California suggests HHS use the following to update EHB over time: • State input/experience • Analysis of new state mandates • State reporting • Determination of whether appropriate cost/ comprehensiveness balance • Affordability
17.	70649, 70669*	§ 156.100(c) – if state does not make a selection, one will be made for them (default base-benchmark plan) – largest plan by enrollment in largest product in state's small group market		
b. Determination of EHB for Multi-State Plans **§ 156.105**				
18.	70649, 70669	Multi-state plan must meet benchmark standards set by OPM		It is essential that OPM require multi-state plans to provide the EHB package required in each state in which the plan is sold. Failure to require this will potentially disrupt operation of California's Health Benefit Exchange and harm the viability of California's competitive market.
c. EHB Benchmark Plan Standards **§ 156.110**				

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19.	70649, 70669*	Categories of benefits (a) EHB-benchmark plan must provide coverage of at least the following categories (list from § 1302 ACA) [***Preamble Only***] "pediatric services" = recommend services for individuals under age 19 years – states have flexibility to extend pediatric coverage beyond proposed 19 year limit		California requests that preamble language regarding state flexibility to determine the period of "pediatric coverage" be included in the text of the regulation. As part of the base-benchmark identification process, HHS created templates that required the state to list benchmark benefits according to 30 or more benefit categories. California notes the 30+ categories of benefits in the EHB templates do not precisely track the 10 ACA § 1302 categories. States uploaded these templates for public comment via HIOS. However, California believes these templates are for information purposes only and CCIIO should not use them to determine compliance with § 1302.
20.	70649-70650, 70669*	§ 156.110 (b) A base-benchmark plan not providing any coverage in one or more of the categories described in (a) ***must*** be supplemented by addition of entire category of benefits offered under any other benchmark plan option in §156.100(a).] [emphasis added] (1) General supplementation methodology (2) Supplementing pediatric oral		California state law enacted September 30, 2012, selected California's base-benchmark plan and supplemented the base-benchmark plan pediatric vision services with coverage under the Federal Employees Dental and Vision Insurance Program vision plan (FEDVIP), and pediatric dental services with the Healthy Family Program 2011-2012 dental plan (CHIP). Please confirm through clarification of the proposed regulation that California's benchmark plan which

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		services- A base-benchmark plan lacking the category of pediatric oral services ***must*** be supplemented by the addition of the entire category of benefits from the following… (3) Supplementing pediatric vision services – a base-benchmark plan lacking the category of pediatric vision services ***must*** be supplemented by the addition of the entire category of such benefits from one of the following…		includes the Kaiser Foundation Health Plan, Inc. Small Group $30 Copayment Plan and is supplemented by the FEDVIP and CHIP does not result in the creation of a new state mandate that will require the state to assume the cost of such coverage pursuant to section 1311(d)(3)(B)(ii).
21.	70650, 70670*	§ 156.110 (c) A *default base-benchmark plan* as defined in § 156.100(c) of this subpart that lacks any categories of EHB will be supplemented by HHS in the following order, to the extent that any of the plans offer benefits in the missing EHB category: (1) Largest plan by enrollment in 2d largest product in small group market. (2) Largest plan by enrollment in 3d larges product in small group market (3) Largest nat'l FEHBP plan by enrollment across states … (4) Plan described in (b)(2)(i) re: pediatric oral care.		

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		(5) Plan in (b)(3)(i) w/ respect to pediatric vision care (6) A habilitative benefit *determined by the plan* as described in § 156/115(a)(4)		
22.	70650, 70670*	§ 156.110 (d) No discriminatory benefit designs (e) Appropriate balance	Provide potential approaches to ensuring the EHB-benchmark plans do not include discriminatory benefit designs and reflect an appropriate balance among the categories of EHB.	.The state of California currently reviews benefit designs to ensure non-discrimination.
23.	70650, 70670*	§ 156.110 (f) *"Determining habilitative* services. If the base-benchmark plan does not include coverage for habilitative services, the state may determine which services are included in that category…" ***[preamble only]*** Habilitative - transitional policy – in order to define EHB, if the base-benchmark plan does not include coverage of habilitative services, the state may determine the services included in the habilitative services category. We believe this transitional policy, which provides states flexibility beyond what was initially outlined in the EHB Bulletin will provide a valuable opportunity for state to lead the development of policy in this area.	HHS welcomes comments on this proposed approach to providing habilitative services. If states choose not to define the habilitative services category, plans must provide these benefits as defined in § 156.115.	In the Essential Health Benefits Bulletin issued by the Center for Consumer Information and Insurance (CCIIO) Oversight on December 16, 2011, CCIIO noted at page 6 that "[t]here is no generally accepted definition of habilitative services among health plans, and, in general, health insurance plans do not identify habilitative services as a distinct group of services." CCIIO further commented on the uncertainty regarding what is included in the Habilitative services category on page 11. California believes § 156.110(f) is problematic in that it allows the state to define habilitative services ***only if*** such services are not included in the base-benchmark plan. However, as acknowledged by CCIIO in the Bulletin, many plans offer some services that fall

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				into this category, but few identify them as such. Therefore, California recommends HHS amend subparagraph (f) to provide that "the State may define habilitative services and determine which, if any, services provided under the base-benchmark plan fall into that category." Making this change provides the flexibility needed for states to "take the lead" in the development of this policy area (see preamble). As such, California has already defined habilitative services pursuant to state law, AB 1453 and SB 951.
d. Provision of EHB §156.115				
24..	70651, 70670*	(a) Provision of EHB means that a health plan provides benefits that: (1) are substantially equal to the EHB-benchmark plan including: (i) Covered benefits (ii) Limitations on coverage including coverage of benefit amount, duration, and scope; and (iii) Prescription drug benefit that meets the requirements of § 156.120…	Alternative to transitional approach – state may allow issuers and experience to define these benefits - Option based on state preference re: habilitative services	

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		(2) to satisfy EHB, mental health and substance use disorder services, including behavioral health treatment services under § 156.110(a)(5) **must be provided in manner that complies with parity standards** in § 146.136 – implementing Mental Health Parity and Addiction Equity Act of 2008 (3) ALL plans must demonstrate compliance with preventive service requirements – plans will not be considered to provide EHB if don't also provide preventive services required under PHSA 2713 (4) if the EHB-benchmark plan does not include coverage for habilitative services – a plan must include habilitative services that meet one of the following: i. Provide parity w/ rehabilitative services or ii. Determined by issuer and reported to HHS		
25.	70651, 70670*	§ 156.115 (b)Substitution of Benefits – benefit substitution is allowed if the issuer of a plan offering EHB meets the following conditions:	HHS seeks comments re: tradeoff between comparability of benefits and opportunities for plan innovation and benefit choice.	The preamble indicates a state may prohibit substitutions. However, the proposed regulation as written gives no indication a state may refuse to allow an

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HEALTH INSURANCE ESSENTIAL HEALTH BENEFITS, ACTUARIAL VALUE AND ACCREDITATION 45 CFR PARTS 147, 155 AND 156				
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		• (b)(1) – substitutes a benefit that meets the following conditions • (i) Issuers may sub benefits that are actuarially equivalent to benefits being replaced • (b)(1)(ii)Substitution only in benefit categories; and • (b)(1)(iii)Does not apply to prescription drug benefits • (b)(2) submits evidence of actuarial equivalence of substituted benefits to the state. The certification must: • (i) be conducted by member of Amer. Acad. of Actuaries • (ii) be based on an analysis performed in accordance w/ gen. accepted actuarial principles & methodologies and • Use a standardized plan population. • (b)(3) actuarial equiv of benefits is determined regardless of cost-sharing		issuer to substitute benefits even where the issuer has submitted a certification of actuarial equivalence and satisfied the other conditions included in the subsection. To the contrary, the words "benefit substitution is allowed if the issuer of a plan offering EHB meets the following conditions" suggests exactly the opposite. California believes it is essential that this subsection be revised to reflect the states' ability to prohibit benefit substitution, and if not prohibited, to deny an issuer's request for substitution.
26.	70651	*Preamble only*: "We clarify that under this approach, states have the option to enforce a **stricter standard** on benefit substitution or **prohibit it entirely**."		California recommends § 156.115 be amended to explicitly permit states to prohibit substitutions, consistent with the assertion in the preamble at p. 70651. This will ensure states have the ability to enforce EHB requirements in accordance with the state's determination of a base-benchmark plan.

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HEALTH INSURANCE ESSENTIAL HEALTH BENEFITS, ACTUARIAL VALUE AND ACCREDITATION 45 CFR PARTS 147, 155 AND 156				
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27.	70651	*Preamble only*: "In paragraph (c), we propose to clarify that a plan does not fail to provide the EHB solely because it does not offer the services described in § 156.280(d). Here we extend the statutory provision in section 1303(b)(1)(A), that allows a QHP to meet the standards for EHB even if it does not offer the services described in § 156.280(d), to health insurance issuers that offer non-grandfathered coverage in the individual or small group market. We note that this provision applies to all section 1303 services, including pharmacological services."		The proposed expansion of the ACA section 1303(b)(1) voluntary choice provision to plans sold outside the Exchange violates section 1303(c), which provides that nothing in the Affordable Care Act is meant to be construed as preempting state laws regarding abortion coverage. Additionally, expanding the voluntary choice provision beyond QHPs is unsupported by the statute and contrary to its purpose. Policies sold outside the exchange will not involve the use of federal subsidies to fund abortion coverage.
28.	70651, 70670*	§ 156.115 (c) plan does not fail to provide EHB if does not offer abortion services (§ 156.280(d))		California interprets this section, as well as related requirements in the ACA, as allowing states to require reproductive rights as part of the California EHB-benchmark plan.
29.	70651, 70670*	§ 156.115 (d) Routine non-pediatric dental & eye exam services, long-term custodial nursing home benefits may not be included in EHB	Solicit comment on exclusion of these benefits from EHB	California requests that § 156.115(d) be amended to allow inclusion of adult eye exam services if these benefits are included in the state's selected base-benchmark plan. HHS states in the preamble that ACA § 1302 requires the EHB package to include at least the 10 categories of EHB and be equal to the scope of benefits provided

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				under a typical employer plan. The Preamble then goes on to state that non-pediatric eye exams are often "excepted benefits" and are not covered by the "typical employer health plan. However, Kaiser Small Group Plan (Federal health product identification 40513CA035), identified by HHS as one of the plans from which California could select its benchmark plan, and designated in statute by the State of California as its base-benchmark plan, does provide non-pediatric routine vision screenings and eye exams for refraction to determine the need for vision correction and provide a prescription for eyeglass lenses.
e. Prescription Drug Benefits § 156.120				
30.	70652, 70670*	Health plan does not provide EHB unless: (a)(1) covers at least the greater of: i) One drug in every category and class or ii) the same number of drugs in each category and class as the EHB-benchmark plan; and		
31.	70652, 70670*	§ 156.120 (a)(2) – submits its drug list to Exchange, state or OPM [***Preamble Only***] reporting requirements for QHPs, plans outside the exchange, and multi-state plans re: drug list		The preamble indicates the intent of paragraph (a)(2) is that a "QHP must report its drug list to the Exchange, an EHB plan operating outside of the Exchange must report its list to the state, and a multi-state plan must report its drug list to OPM." The proposed rule should be

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				revised to require submission of drug lists for both QHPs and outside market plans to the state regulator, because state regulatory agencies, and not the Exchange, may be responsible for enforcing the essential health benefits requirements regardless of QHP status, as in California. The rule may separately require submission of QHP drug lists to the Exchange so it may independently verify QHP compliance, and to OPM for multi-state plans. California recommends HHS work with OPM to clarify the reporting process, including how MSPs will be notified regarding EHB-benchmark requirements.
32.	70652, 70670*	§ 156.120 (a)(1)(i) plan to use USP classification system		Regardless of which organizational/classification tool is used, California recommends HHS utilize readily available tools for providing plan information, including drug lists, to CCIIO.
33.	70652, 70670*	§ 156.120 (b) – does not fail to provide EHB Prescription drug benefits solely b/c does not offer drugs for abortion services		See comments regarding § 156.115(c).
34.	70652	[***Preamble* only**] Drugs must be chemically distinct to count toward the # of drugs in a category.		California asks that § 156.120 be amended to include language regarding requirements for chemically distinct drugs in each category. While this requirement is discussed in the Preamble, it is not included in the text of the regulation.

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				Additionally, § 156. 20 should be amended to include a definition for "chemically distinct."
35.	70652, 70670*	§ 156.120 (c) Plan offering EHB must have procedures in place to ensure enrollee access to clinically appropriate non-formulary drugs	Solicit comments re: requirement that plan offering EHB have procedures in place to ensure enrollees have access to clinically appropriate drugs that are prescribed by a provider but not included on the plan's drug list.	California, which enacted a similar requirement in 1998 (Health & Safety Code § 1367.24), supports this requirement and has built it into the state's base-benchmark selection legislation.
	f. Prohibition on discrimination § 156.125			
36.	70652	[***Preamble only***] States to monitor & id discriminatory benefit designs No prohibition on utilization management techniques – but cannot use such techs to discriminate v. certain groups of people	[***Preamble only***] Process intended to develop framework for analysis tools to facilitate testing for discriminatory plan benefits. HHS "believes analyses could include:" • Evaluations to id significant deviation from typical plan offerings • Unusual cost sharing and limitations for benefits with specific characteristics Welcome comments re: proposed approach to prohibiting discrimination	
37.	70653, 70670*	§ 156.125 (a) – An issuer does not provide EHB if its benefit design, or the implementation of its benefit design, discriminates based on an individuals age, expected length of life, present or		This paragraph does not distinguish between benign and invidious discrimination, which we believe could affect issuers' ability to design benefit packages to attract and serve populations

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		predicted disability, degree of medical dependency, quality of life, or other health conditions		with specific health needs, such as those with chronic health conditions. We recommend including the words "against an individual based on age, *etc.*" after the word "discriminates" to allow for such benefit designs without violating the letter of the regulation.
38.	70653, 70670*	§ 156.125 (b) Both § 156.200 [no discrimination on race, disability, age] and §156.225 [prohibits marketing practices/benefit designs that result in discrimination against individuals w/ sig or high cost health care needs] apply in providing EHB		California requests that HHS amend § 156.125 to include a reference to § 146.136, mental health parity.
		h. Cost sharing requirements § 156.130		
39	70653	[*Preamble only*] Annual limit on enrollee cost sharing - compliance by all QHPS and non-grandfathered issuers in individual/small group market "We discuss here the implications and rationale of setting these standards in the context of their application to QHPs and issuers of health plans in the individual and small group markets."		Please clarify that § 2707(b) applies to all policies sold in the small group and large group markets.
40.	70653, 70670*	§156.130 (a) ACA annual limitation on cost sharing 2014 + (1) Annual limit tied to enrollee		

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		out of pocket limit for high-deductible health plans (HDHP) as calculated per IRC 223(c)(2)(A)(ii). (2) Annual limit on deductibles for small group market (QHPs and non-grandfathered) self-only = $2000 and "non self-only" = $4000, increased by premium adjustment percentage.		
41.	70653	§156.130 (b) Annual limitation on deductibles: (1) annual limitation on deductibles in the small group market for plan year beginning in calendar year 2014 (2) for plan year beginning in cal. Year after 2014, annual deductible for health plan in small group market may not exceed factors at (i) & (ii)		California requests clarification with respect to whether the annual deductible for self-only coverage in the small group market may be reduced by amounts an employer makes available to employees under an HSA or HRA as opposed to an FSA. Specifically, California requests clarification as to whether the annual deductible may ever be higher than $2,000 and coverage other than self-only ever be higher than $4,000 if the deductible less the HSA or HRA amounts is under the limit. A significant portion of California's small group market enrollment has such an arrangement with a deductible over the limits in this proposed paragraph, but under the limits, if the HSA or HRA is taken into account. The preamble clarifies that amounts in an FSA may not be used to increase the deductible, but it does not

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				address HSAs or HRAs. HSAs and HRAs may warrant different rules because employers fund them, in contrast to FSAs, which are funded by the employee.
42.	70654	[***Preamble only***] – We propose to use a "reasonableness" standard. While it may be possible to develop plan designs to meet all of these constraints, we believe it could be difficult to develop plans with reasonable coinsurance or equivalent cost-sharing rates in the future, for example in bronze plans. Alternative would be to use actuarial value calculator in § 156.135 to determine reasonable increase to amounts described in (b) that can be used by all plans in the small group market.	Comments re: reasonableness standard: • What evidence or factors should be required from an issuer and considered in determining whether this [cost-sharing] standard is met with respect to insurance coverage subject to 2707(b) of ACA • Should specific variation threshold be identified? • If so, how should such threshold be established?	California believes it is essential that the state, which will be enforcing the benefit requirements, including cost-sharing requirements, be responsible for determining the appropriate variation threshold, if any, for cost sharing in the event a plan will not reach the required actuarial value level of coverage. Issuers should be required to demonstrate to the state regulator that the issuer's plan may not reasonably reach the actuarial value of a given level of coverage without exceeding the annual deductible limit. California plans to establish standard cost sharing provisions for QHPs.
43.	70653, 70671*	§156.130 (b)(3) *Reasonableness standard* – a plan may exceed the annual deductible limit if the plan may not reasonably reach actuarial value level of coverage. Defined in § 156.140 without exceeding the annual deductible limit.		
44.	70654, 70671*	Network Plans §156.130 (c) Cost sharing requirements for benefits from non-network provider don't count toward annual limitation on cost sharing or	Comment re: approach on cost-sharing for non-network services.	California recommends § 156.130(c) be amended to provide that if a particular out-of-network service is required by state law to be treated by the plan as "in-network," those benefits must be included in the

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HEALTH INSURANCE ESSENTIAL HEALTH BENEFITS, ACTUARIAL VALUE AND ACCREDITATION 45 CFR PARTS 147, 155 AND 156				
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		deductibles.		annual limitation on cost-sharing.
45.	70654	[***Preamble only***] Nothing in proposal explicitly prohibits issuer from voluntarily limiting out-of-pocket expenses for non-network services or states from requiring that issuers do so.		
46.	70654, 70671*	Increases in annual limitations §156.130 (d)-(h) (d) Plan years after 2014 - May only increase by multiples of $50 – must be rounded to next lowest multiple of $50 (e) Premium adjustment percentage – is the percentage (if any) by which the average per capita premium for coverage for preceding cal. Year exceeds such average per capita premium for insurance for 2013. (f) Annual deductibles do not apply to preventative care (g) Anti-discrimination (h) Emergency services – comply with cost-sharing requirements at 45 CFR 147.138(b)(3).		
i. AV Calculation for Determining Level of Coverage § 156.135				
47.	70655,	***[defined in §156.20]*** AV = measure of percentage of expected health care costs a plan will cover for a standard population and be considered general summary measure of health plan	Comment re: methodology for development of the AV Calculator & continuance tables developed based on standard population	

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		generosity. **[*preamble* only]** Proposed AV calculator = set of claims data weighted to reflect standard population projected to enroll in individual & small group markets for identified year of enrollment. Methodology available at http://cciio.cms.gov/resources/regulations/index.html#pm		
48.	70655	[*Preamble only*] Calculator available for both formal and informal calculations and may be used as tool to assist in design of health plans	Comment re: proposal to direct the use of the AV calculator and on parameters described for development of AV Calculator	
49.	70655, 70671*	§156.135 (a) To calculate AV of health plan – issuer must use AV calculator developed and made available by HHS (b) options for issuer whose plan designs do not permit calculator to provide accurate summary of plan generosity		
50.	70655, 70671*	§156.135 (b)(2) & (3) – two options to accommodate plans in (b)(1).		California believes it is essential to revise this section to specify provide that the actuarial certification must be submitted to the applicable state regulator, and to the Exchange for QHPs if the Exchange is a separate entity. This is because state

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				regulatory agencies, and not the Exchange, may be responsible for enforcing the essential health benefits requirements regardless of QHP status, as in California.
51.	70655, 70671*	§156.135 (c) standard for treatment of **employer** contributions toward HSAs and HRAs vis-à-vis actuarial value – ER contributions to HSAs and amounts made newly available under HRAs for current year in **small group** market are: 1. Counted toward total anticipated medical spending of the standard population that is paid by the health plan and 2. Adjusted to reflect the expected spending for health in benefit year so that: i. Any current year HSA contrib. are accounted for and ii. The amounts newly made available in HRA are accounted for.		This paragraph proposes that employer contributions to HSAs and HRAs be accounted for in the actuarial value calculation. California requests clarification as to how this would be operationalized. For example, if the employer selects a bronze plan, but makes available sufficient amounts under an HSA or HRA such that the actuarial value to the employee is equal to a gold plan, would the plan be considered a bronze or gold plan? Would the employer and employee pay bronze or gold premiums?
52.	70655, 70671*	§156.135 (c) Use of state-specific standard population for calculation of AV – beginning in 2015 if: • Submitted by state • Approved by HHS	Comment re: proposal to allow states to use state-specific data and criteria identified by American Academy of Actuaries Should AV calculator allow for variation between states (based on	Because there is variation in cost and use of services, the AV calculator should allow for variation between the states for states who submit this information to HHS.

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		• proposed criteria for acceptable state claims data: (1) supports calculation of AVs for full range of health plans available in market (2) Derived from non-elderly pop. & estimates those likely to be covered by private health plans on or after 1/1/2014 (3) large enough that (i) demographic and spending patterns stable over time & (ii) includes subst'l majority of state's insured population, subject to (d)(2) (4) is statistically reliable and stable basis for are-specific calculations (5) contains claims data on health care services typically offered in current market.	stat-specific data) Should HHS consider including up to three regional adjustments for geographic price differences?	
53.	70655, 70671*	§156.135 (d) Submission of state-specific data	HHS remains open to comments re: use of state data for 2014, but given time constraints propose the option for states to submit a state-specific standard population will begin for plan yrs starting 2015. "Expect" that submissions will be due in 2d quarter of year prior to benefit year.	California requests state flexibility to use state-specific data for the AV calculator in 2014. We request clarification regarding whether applications for use of state data will be accepted on a rolling basis or will there be a one-time opportunity to switch from the HHS standard data set?
54.	70655,	§156.135		

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	70671*	(e) HHS develop standard population to be used to calculate AV per 1302(d)(2)(A) of ACA		
	j. Levels of Coverage § 156.140			
55.	70567, 70671*	(a) Calculated according to § 156.135 – within de minimis variation to determine plan's level of coverage.		We suggest codifying the ACA section 1302(e) catastrophic plan exception to the levels of coverage requirement in this section.
	k. Determination of Minimum Value (MV) § 156.145			
	l. Application to Stand-Alone [pediatric] Dental Plans inside the Exchange § 156.150			
56.	70657	[***Preamble only***] § 1311 of ACA allows pediatric dental component of EHB to be offered through a stand-alone dental plan in an Exchange. If such a plan is available in an Exchange, the ACA allows QHPs to exclude coverage of the pediatric dental benefit. This is the ONLY exception to EHB coverage permitted under § 1302.		As indicated in the preamble, if a stand-alone dental plan is offered in the Exchange, QHPs are permitted to exclude coverage of the pediatric dental benefit. California asks that HHS clarify whether a state that permits a stand-alone dental plan to be offered in the Exchange may require all non-stand-alone plans to provide coverage for all 10 EHB categories, including pediatric dental benefits, as a condition of licensure to operate as an insurer/health plan. California also requests clarification regarding whether a state may require all plans operating outside the Exchange, other than stand-alone dental plans, to cover all 10 EHB categories, including pediatric dental benefits as provided under the state EHB-benchmark plan.

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				Finally, may the state permit stand-alone vision plans to be offered through the Exchange (and outside the Exchange) in the same manner as dental stand-alone plans?
57.	70657-70658, 70672*	(a) Separate annual limitation on cost sharing	Request comment on what should be considered "reasonable" annual limitation on cost sharing (in-network) • Alternative: exclude pediatric dental benefit from annual limit on cost sharing – but would treat stand-alone plans differently from plans that included pediatric dental among benefits. • Comment generally whether it is appropriate to apply annual limitations standard on cost-sharing for [pediatric?] stand-alone dental plans	Clarify HHS is describing pediatric dental plans throughout this section.
58.	70658, 70672*	(b) Actuarial value standards – stand-alone dental plans may not use AV Calculator in § 156.135 (b)(2) high and low value plans (b)(3) level of coverage must be actuarially certified	• Is de minimis variation requirement of +/- 2% feasible for stand-alone dental plans? • Are actuarial value standards for a 'high" and "low" plan appropriate?	California suggests revising subparagraph (b)(3), as it does not require submission of the actuarial certification to a state regulator. California believes it is imperative that the regulation require submission of the actuarial certification to the applicable state regulator and to the Exchange for QHPs if the Exchange is a separate entity.
3. Subpart C - Accreditation				
a. Accreditation of QHP Issuers § 156.275				

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[i] For the purpose of these comments, "California" refers to the Department of Managed Health Care, California Department of Insurance, and California Healthy Benefits Exchange.

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State of California
DEPARTMENT OF INSURANCE
DEPARTMENT OF MANAGED HEALTH CARE
CALIFORNIA HEALTH BENEFIT EXCHANGE

December 31, 2012

Submitted electronically via www.regulations.gov

Honorable Kathleen Sebelius, Secretary
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9964-P
P.O. Box 8016
Baltimore, MD 21244-8016

Re: CMS-9964-P; Comments to Notice of Proposed Rulemaking on Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014

Dear Secretary Sebelius:

On behalf of the State of California and many of the entities responsible for implementing the Patient Protection and Affordable Care Act in the state—the Department of Insurance, the Department of Managed Health Care, and the California Health Benefit Exchange — we submit the enclosed comments on the proposed rules for HHS Notice of Benefit and Payment Parameters for 2014. California appreciates the opportunity to comment on these important regulations.

California appreciates the significant effort involved in establishing the benefit and payment parameters for 2014 to ensure proper implementation of market stabilization programs outlined in the Affordable Care Act. California also appreciates the guidance that HHS has proposed with regard to all three premium stabilization programs and the medical loss ratio program of the Public Health Service Act. In these comments, which are presented in chart format, we offer suggestions for improvement of the proposed rules. As mentioned in the enclosed chart, California has concerns related to the proposed regulations to implement the Risk Adjustment and Temporary Reinsurance programs.

Although California intends to use federal services to perform the risk adjustment and reinsurance function, we strongly urge you to replace the proposal for a national

reinsurance pool with a system of collections and payment that are calculated state-by-state. Also, the proposed risk adjustment methodology, which uses claims data to determine risk adjustment payments, could significantly disadvantage California managed health care plans that pay for health care services through capitated arrangements rather than on a fee-for-service basis. Specifically, California strongly recommends using pharmacy data in addition to demographic and claims data when determining risk scores for health plans in states with a high proportion of capitated providers. Please see the attached chart for the details about specific issues and recommendations. We would welcome an opportunity to develop an approach to risk adjustment that works for California's health care delivery system and the managed care plans that operate in this state.

The enclosed comments reflect the consensus of all the signatories to this letter. Should you have questions concerning the comments, please direct them to all three agencies. Thank you for taking these comments into consideration as you finalize the rules and as California approaches the full debut of the Patient Protection and Affordable Care Act, which we have all worked diligently to successfully implement.

Sincerely,

Dave Jones, Insurance Commissioner

Brent Barnhart, Director, California Department of Managed Health Care

Peter V. Lee, Executive Director, California Health Benefit Exchange

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	HHS Notice of Benefit and Payment Parameters for 2014 45 CFR parts 153, 155, 156, 157, and 158			
Row #	Page Preamble/Reg*	Proposed Regulatory Requirement	Federal Preamble Request for Comments	Comment/Question
	III. Provisions of the Proposed HHS Notice of Benefit and Payment Parameters for 2014			
	B. Provisions and Parameters for the Permanent Risk Adjustment Program			
	3. Overview of the Risk Adjustment Methodology HHS Would Implement When Operating Risk Adjustment on Behalf of the State			
	b. Overview of the HHS Risk Adjustment Model			
1	73128	***Preamble only:*** *(3) Prescription Drugs* At this time, we have elected not to include prescription drug use as a predictor in each HHS risk adjustment model. While use of particular prescription drugs may be useful for predicting expenditures, we believe that inclusion of prescription drug information could create adverse incentives to modify discretionary prescribing.	We seek comments on possible approaches for future versions of the model to include prescription drug information while avoiding adverse incentives.	California strongly recommends using pharmacy data, in addition to demographic and claims data, when determining risk scores for health plans in States with a high proportion of capitated providers. California health plans regulated by the Department of Managed Health Care with capitated delivery systems have not traditionally reported encounter data as accurately as claims based data. The proposed risk adjustment model may lead to an unfairly low risk score for these health plans, and could unintentionally disadvantage the capitated delivery system relative to fee-for-service based provider networks.
	d. Overview of Data Collection Approach			
2	73145 73210*	**§ 153.20 Definitions.** * * * * * *Risk adjustment data collection approach* means the specific procedures by which risk adjustment data is to be stored, collected, accessed, transmitted, and validated and the applicable timeframes, data formats, and privacy and security standards. * * * * * **§ 153.340 Data collection under risk adjustment.** * * * * * **Subpart H—Distributed Data Collection for HHS-Operated Programs** **§ 153.710 Data requirements.** (a) *Enrollment, claims, and encounter data.* An	We welcome comment on this proposed data collection approach.	California health plans with a capitated delivery system have not traditionally received encounter data from these providers as accurately as data provided by claim-based providers. With the potential underreporting of encounter data, California recommends using pharmacy data, in addition to demographic and claims data, when determining risk scores for health plans in States with a high proportion of capitated providers. See comment in row #11. The proposed §153.710(c) would require a capitated health plan with a capitated delivery system to use a principal internal methodology to derive costs for applicable provider encounters. California recommends that the methodology used by capitated health plans be

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		issuer of a risk adjustment covered plan or a reinsurance-eligible plan in a State in which HHS is operating the risk adjustment or reinsurance program, as applicable, must provide to HHS, through the dedicated data environment, access to enrollee-level plan enrollment data, enrollee claims data, and enrollee encounter data as specified by HHS. (b) *Claims data.* All claims data submitted by an issuer of a risk adjustment covered plan or a reinsurance-eligible plan in a State in which HHS is operating the risk adjustment or reinsurance program, as applicable, must have resulted in payment by the issuer. (c) *Claims data from capitated plans.* An issuer of a risk adjustment covered plan or a reinsurance-eligible plan in a State in which HHS is operating the risk adjustment or reinsurance program, as applicable, that does not generate individual enrollee claims in the normal course of business must derive the costs of all applicable provider encounters using its principal internal methodology for pricing those encounters. If the issuer does not have such a methodology, or has an incomplete methodology, it must supplement the methodology in a manner that yields derived claims that are reasonable in light of the specific service and insurance market that the plan is serving.		subject to review and approval by the State and/or HHS.
	C. Provisions and Parameters for the Transitional Reinsurance Program			
	3. National Contribution Rate			
3	73155	***Preamble only:*** *Federal Administrative Fees* … we propose that HHS also collect reinsurance contributions from health insurance	We seek comment on this approach, and other reasonable, administratively simple approaches that may be used to calculate administrative	The paragraph states that HHS would transfer $0.055 of the per capita administrative fee to a State for purposes of administrative expenses

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		issuers, even if a State is operating its own reinsurance program. In this proposed rule, we estimate the Federal administrative expenses of operating the reinsurance program in 2014 to be approximately $20.3 million, or approximately 0.2 percent of the $10 billion in reinsurance funds to be distributed in 2014.	costs.	incurred in making reinsurance payments in the case that a State operates its own reinsurance program. The paragraph also states that administrative expenses for reinsurance payments will be distributed in proportion to the State-by-State total requests for reinsurance payments made under the national payment parameters. It appears that there are two different approaches and we request clarification as to which approach HHS expects to use.
	4. Calculation and Collection of Reinsurance Contributions			
4	73155 73206* 73207*	**§153.400 Reinsurance contribution funds.** (a) *General requirement.* Each contributing entity must make reinsurance contributions annually: at the national contribution for all reinsurance contribution enrollees, in a manner specified by HHS; and at the additional State supplemental contribution rate if the State has elected to collect additional contributions under §153.220(d), in a manner specified by the State. * * * * * **§153.240 Disbursement of reinsurance payments.** (b) *Notification of reinsurance payments.* For each applicable benefit year, (1) A State, or HHS on behalf of the State, must notify issuers annually of: (i) Reinsurance payments under the national payment parameters, and (ii) Reinsurance payments under the State supplemental payment parameters if applicable, to be made for the applicable benefit year no later than June 30 of the year following the applicable benefit year. (2) A State must provide to each reinsurance-	…we propose in §153.400(a) and §153.240(b)(1), respectively, to collect and pay out reinsurance funds annually to minimize the costs of administering the program and the burden on contributing entities…We note that this approach would delay the receipt of some reinsurance payments for individual market issuers, and solicit comment on the benefits and burdens for issuers, States, and other stakeholders of a more frequent collections and payment cycle.	We recommend the removal of §153.240(b)(2) because it is not clear why a requirement for the State to provide each reinsurance-eligible plan the expected requests for reinsurance payments is necessary. It is equally unclear how a State would do so, especially a state where HHS is operating the reinsurance program.

	HHS NOTICE OF BENEFIT AND PAYMENT PARAMETERS FOR 2014 45 CFR PARTS 153, 155, 156, 157, AND 158			
ROW #	PAGE PREAMBLE/REG*	PROPOSED REGULATORY REQUIREMENT	FEDERAL PREAMBLE REQUEST FOR COMMENTS	COMMENT/QUESTION
		eligible plan the expected requests for reinsurance payments made under: (i) The national payment parameters, and (ii) State supplemental payments parameters if applicable, from such plan on a quarterly basis during the applicable benefit year in a timeframe and manner determined by HHS.		
	7. Uniform Adjustment to Reinsurance Payments			
5	73160 73205*	**153.230 Calculation of reinsurance payments made under the national contribution rate.** (d) *Uniform adjustment to national reinsurance payments.* If HHS determines that all reinsurance payments requested under the national payment parameters from all reinsurance-eligible plans in all States for a benefit year will exceed all reinsurance contributions collected under the national contribution rate in all States for an applicable benefit year, HHS will determine a uniform pro rata adjustment to be applied to all such requests for reinsurance payments for all States. Each applicable reinsurance entity, or HHS on behalf of a State, must reduce all requests for reinsurance payments for the applicable benefit year by any adjustment required under this paragraph (d).	This uniform pro rata adjustment would ensure that claims are paid at the same rate out of the national reinsurance fund, and promote equitable access to the national reinsurance fund across all States while furthering the goal of premium stabilization under the Affordable Care Act. We invite comment on this policy.	We believe it is essential that HHS modify its plan to create a national pool for reinsurance collections and payments, and replace it with a system of collections and payments calculated state by state. This method ensures that reinsurance operates to stabilize markets locally, rather than being spread across the nation as if there were one national market. If HHS adopts our suggestion, it will need to clarify how collections from multi-state employers will be allocated by state.
	10. Reinsurance and Data Collection Standards			
6	73163 73206*	**§153.240 (b)** *Notification of reinsurance payments.* For each applicable benefit year, (1) A State, or HHS on behalf of the State, must notify issuers annually of: (i) Reinsurance payments under the national payment parameters, and (ii) Reinsurance payments under the State supplemental payment parameters if applicable,	HHS intends to collaborate with issuers and States to develop these early notifications. We welcome comments on this proposal.	Please see comment in row #4.

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		to be made for the applicable benefit year no later than June 30 of the year following the applicable benefit year. *(2) A State must provide to each reinsurance-eligible plan the expected requests for reinsurance payments made under*: (i) The national payment parameters, and (ii) State supplemental payments parameters if applicable, from such plan on a quarterly basis during the applicable benefit year in a timeframe and manner determined by HHS.		
7	73163 73209*	**§153.420 Data collection** (a) *Data requirement.* To be eligible for reinsurance payments, an issuer of a reinsurance-eligible plan must submit or make accessible all required reinsurance data in accordance with the reinsurance data collection approach established by the State, or by HHS on behalf of the State. (b) *Deadline for submission of data.* An issuer of a reinsurance-eligible plan must submit or make accessible data to be considered for reinsurance payments for the applicable benefit year by April 30 of the year following the end of the applicable benefit year.	We propose to add new §153.420(a) to address data collection issues, including the distributed data collection approach that HHS intends to use when operating the reinsurance program on behalf of a State…In §153.420(b), we propose that an issuer of a reinsurance-eligible plan submit data to be considered for reinsurance payments for the applicable benefit year by April 30 of the following year. The April 30 deadline would apply to all issuers of reinsurance-eligible plans, regardless of whether HHS or the State is operating reinsurance. We welcome comments on this proposal.	HHS intends to operate the reinsurance program on a calendar year basis with an April 30th deadline to submit data to be considered for reinsurance payments from the previous calendar year (deadline is from page 159). We request that HHS clarify how much run out they intend to allow. We also suggest that HHS include at least 2 months of run out for the calendar year claims so that claims that are incurred near the end of the year will be more fully represented, as the claims that are incurred earlier in the year.
	E. Provisions for the Advance Payments of the Premium Tax Credit and Cost-Sharing Reduction Programs			
	2. Exchange Functions: Certification of Qualified Health Plans			
8	73167 73212*	**§ 155.1030 QHP certification standards related to advance payments of the premium tax credit and cost-sharing reductions.** (a) *Review of plan variations for cost-sharing reductions.* (1) The Exchange must ensure that	We welcome comment on this proposed standard and alternative approaches.	We do not agree that providing advanced payment to issuers for cost sharing reductions, as described, is necessary. We believe that the cumbersome process to develop quarterly estimates and then reconcile them annually is

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		each issuer that offers or seeks to offer a health plan at any level of coverage in the individual market on the Exchange submits the required plan variations for the health plan as described in § 156.420 of this subchapter. The Exchange must certify that the plan variations meet the requirements of § 156.420. (2) The Exchange must provide to HHS the actuarial values of each QHP and silver plan variation, calculated under § 156.135 of this subchapter, in the manner and timeframe established by HHS. (b) *Information for administering advance payments of the premium tax credit and advance payments of cost-sharing reductions.* (1) The Exchange must collect and review annually the rate allocation, the expected allowed claims cost allocation, and the actuarial memorandum that an issuer submits to the Exchange under § 156.470 of this subchapter, to ensure that such allocations meet the standards set forth in § 156.470(c) and (d). (2) The Exchange must submit, in the manner and timeframe established by HHS, to HHS the approved allocations and actuarial memorandum underlying the approved allocations for each health plan at any level of coverage or standalone dental plan offered, or proposed to be offered in the individual market on the Exchange. (3) The Exchange must collect annually any estimates and supporting documentation that a QHP issuer submits to receive advance payments of		unnecessary and issuers should be reimbursed for cost sharing reductions after submitting actual data to HHS. We suggest that HHS remove the requirements to estimate then reconcile payment.

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		certain cost-sharing reductions, under § 156.430(a) of this subchapter, and submit, in the manner and timeframe established by HHS, the estimates and supporting documentation to HHS for review. (4) HHS may use the information provided to HHS by the Exchange under this section for the approval of the estimates that an issuer submits for advance payments of cost-sharing reductions, as described in § 156.430 of this subchapter, and the oversight of the advance payments of cost-sharing reductions and premium tax credits programs.		
	4. Health Insurance Issuer Responsibilities with Respect to Advance Payments of the Premium Tax Credit and Cost-Sharing Reductions			
9	73176 73215*	**§156.430(d)** Reconciliation of amounts. HHS will perform periodic reconciliations of any advance payments of cost-sharing reductions provided to a QHP issuer under paragraph (b) of this section against – (1) The actual amount of cost-sharing reductions provided to enrollees and reimbursed to providers by the QHP issuer for benefits for which the QHP issuer compensates the applicable providers in whole or in part on a fee-for-service basis; and (2) The actual amount of cost-sharing reductions provided to enrollees for benefits for which the QHP issuer compensates the applicable providers in any other manner.	We welcome comment on this proposal.	We do not agree that providing advanced payment to issuers for cost sharing reductions, as described, is necessary. We believe that the cumbersome process to develop quarterly estimates and then reconcile them annually is unnecessary and issuers should be reimbursed for cost sharing reductions after submitting actual data to HHS. We suggest that HHS remove the requirements to estimate then reconcile payment.
	G. Distributed Data Collection for the HHS-operated Risk Adjustment and Reinsurance Programs			
	3. Risk Adjustment Data Requirements			
10	73183 73210*	**§ 153.710 Data requirements.** (a) *Enrollment, claims, and encounter data.* An	No comments requested.	California health plans with a capitated delivery system have not traditionally received

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		issuer of a risk adjustment covered plan or a reinsurance-eligible plan in a State in which HHS is operating the risk adjustment or reinsurance program, as applicable, must provide to HHS, through the dedicated data environment, access to enrollee-level plan enrollment data, enrollee claims data, and enrollee encounter data as specified by HHS. (b) *Claims data.* All claims data submitted by an issuer of a risk adjustment covered plan or a reinsurance-eligible plan in a State in which HHS is operating the risk adjustment or reinsurance program, as applicable, must have resulted in payment by the issuer. (c) *Claims data from capitated plans.* An issuer of a risk adjustment covered plan or a reinsurance-eligible plan in a State in which HHS is operating the risk adjustment or reinsurance program, as applicable, that does not generate individual enrollee claims in the normal course of business must derive the costs of all applicable provider encounters using its principal internal methodology for pricing those encounters. If the issuer does not have such a methodology, or has an incomplete methodology, it must supplement the methodology in a manner that yields derived claims that are reasonable in light of the specific service and insurance market that the plan is serving.		encounter data from these providers as accurately as data provided by claim-based providers. With the potential underreporting of encounter data, California recommends using pharmacy data, in addition to demographic and claims data, when determining risk scores for health plans in States with a high proportion of capitated providers. See comment in row#11.
	I. Medical Loss Ratio Requirements Under the Patient Protection and Affordable Care Act			
	2. Deduction of Community Benefit Expenditures			
11	73188	***Preamble only:*** Commenters have suggested that a 3 percent	Comments are solicited on the proposed community benefit expenditures deduction	California is concerned about potential market manipulation resulting from the inclusion of

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		limit on the deduction from premium for community benefit expenditures would be sufficient to allow a tax exempt issuer to maintain its current community benefit expenditure. … In light of the NAIC model rule and the comments received, we propose to limit the deduction from premium for community benefit expenditures for issuers that are exempt from Federal income tax to the higher of either 3 percent of premium or the highest premium tax rate charged in a State.	limit.	community benefit expenditures in MLR calculation, because the MLR by market segment could be manipulated by disproportionate allocations of such expenditures by market segment – even with the 3% limitation. We suggest that HHS clarify how such expenditures are to be allocated by market segment, included allocations to self-insured business as well as to insured business segments.

January 10, 2013

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9962-NC
P.O. Box 8010
Baltimore, MD 21244-8010

Re: Request for Information (RFI) (CMS-9962-NC) Qualified Health Plan (QHP) quality management

Covered California appreciates the opportunity to respond to this Request for Information (RFI) and to share policies it has adopted relative to Qualified Health Plan (QHP) quality management. Covered California appreciates the opportunity to respond to the Request for Information (RFI) (CMS-9962-NC) Regarding Health Care Quality for Exchanges and share policies it has adopted relative to Qualified Health Plan (QHP) quality management.

California legislation authorizes Covered California to function an active purchaser that selectively contracts with QHPs so as to provide health care coverage choices that offer the optimal combination of choice, value, quality, and service and to establish and use a competitive process to select the participating health plan issuers.

In August 2012, Covered California adopted policy guidelines for the selection and oversight of QHPs including requiring QHPs assure access to quality care for consumers presenting with a range of health statuses and conditions. The guidelines were adopted by the Covered California Board as part of comprehensive set of staff recommendations, *Qualified Health Plan Policies and Strategies to Improve Care, Prevention and Affordability*. Among the recommendations are *Strategies to Promote Better Quality and More Affordable Care* detailed in a Board Recommendation Brief beginning at page 152 of this document. The brief outlines a five-part strategy to achieve the National Strategy for Quality Improvement in Health Care goals of better health, quality care and lower costs:

- Promote alignment with other purchasers to foster better care, lower costs and improved health.

- Collect standardized information on health plans performance and care delivery/payment practices to inform future work.

- Require certain health plan practices that promote better care or standards of performance for participation in the Exchange.

- Use value-elements in its Qualified Health Plan selection process considering a combination of outcomes (e.g. HEDIS and/or CAHPS scores) and practices (e.g. participation and support for pay-for-performance or medical home initiatives).

- Adhere to the Patient Charter for Physician Performance Measurement, Reporting and Tiering.

Covered California believes this brief generally addresses the questions presented in the RFI relative to the health insurance exchange marketplace and is pleased to share it with the federal government and other state exchanges and stakeholders.

Sincerely,

Peter V. Lee
Executive Director

State of California
DEPARTMENT OF INSURANCE
DEPARTMENT OF MANAGED HEALTH CARE
CALIFORNIA HEALTH BENEFIT EXCHANGE

January 4, 2013

John J. O'Brien, Director
Healthcare and Insurance
United States Office of Personnel Management
1900 E Street, N.W.
Washington, D.C. 20415

Sent Via Federal Web Portal

Re: Comments to Notice of Proposed Rulemaking on the Establishment of the Multi-State Plan Program (MSPP) for the Affordable Insurance Exchanges

Dear Mr. O' Brien:

On behalf of the State of California and many of the entities responsible for implementing the Patient Protection and Affordable Care Act ("ACA") in the state—the Department of Insurance, the Department of Managed Health Care, and the California Health Benefit Exchange ("the departments") —California submits the enclosed comments on the proposed rules for the Establishment of the Multi-State Plan Program (MSPP) for the Affordable Insurance Exchanges. California appreciates the opportunity to comment on these important regulations.

California appreciates OPM's stated commitment to balance state needs with its statutory obligation to implement and oversee the MSPP. However, California believes that key implementation challenges could be reduced if the federal government utilized existing state laws and regulatory systems to provide oversight and ensure consumer protections offered through each state's Affordable Insurance Exchange (Exchange) are in place for MSPs. As drafted, California is concerned

these proposed regulations do not clearly define state and federal roles in regard to regulating the MSPP. In addition, California has several general concerns related to the MSPP and OPM's selection of multi-state plans (MSP).

1. **Essential Health Benefits:** As enacted, ACA provisions regarding MSPs refer to the MSP's obligation to provide a "benefits package that is uniform in each State, and consists of the essential benefits described in section 1302 [42 U.S.C.S. § 18022]." However, guidance released in December 2011 by the Department of Health and Human Services, as well as proposed rules related to Essential Health Benefits (EHB) released in November 2012, allow each state to select its own "benchmark plan" that includes state-mandated benefits enacted before January 1, 2012. As stated in the preamble to the proposed rule, one of the objectives of the MSPP is to "ensure a level playing field between state-certified qualified health plans (QHPs) and MSPs." However, proposed section 800.105(b)(ii) would permit an OPM-selected EHB-benchmark plan different from the state's EHB benchmark plan. This difference in EHB benchmark plans could result in adverse selection against either the MSP or other QHPs in the Exchange. To help maintain a level playing field among plans participating in the Exchange, and to avoid the potential for adverse selection, the OPM should require that MSPP issuers and state-level MSPs to offer the state-specific EHB benchmark package.

   Additionally, the regulations should make clear that MSPs may not substitute benefits for EHB in states where substitution is prohibited.

2. **Cost Sharing Requirements and Levels of Coverage:** California plans to adopt standardized cost-sharing within a standard plan design and require that QHP issuer to offer one or more of those standardized benefit plan designs. To maintain a level playing field, an MSP in California should be required to offer one of the standardized benefit plan designs. Additionally, California state law requires QHPs to offer coverage at all coverage tiers to avoid adverse selection. MSPP offered in California should be required to

adhere to this state statutory requirement in order to keep the playing field level between state-selected QHPs and MSPs.

3. **Regulatory Oversight by States:** Section 1334(b) of the ACA provides that MSPs are subject to all state laws unless a state requirement is inconsistent with the ACA, and requires that MSPs be licensed in each state. However, the state's role in the ongoing oversight of the MSPP is unclear. California recommends the OPM build a state oversight component into the MSPP regulations at or around section 800.114 to ensure that MSPs, once certified, comply with both federal and state regulatory requirements. The OPM regulations also should clarify that MSPs must ***continue to meet*** requirements set forth in section 1334 of the ACA to retain the federal MSPP contract, and that failure to continue to meet state standards constitutes a breach of that contract, resulting in possible termination.

   A collaborative regulatory relationship between the states and the OPM will foster success for the MSPP. State regulators will be able to ensure that all health plans and health insurers, including MSPP issuers and MSPs, are compliant with the broad array of state consumer protection laws.

   By incorporating state oversight into the MSPP, and requiring that MSPs be subject to each state's regulatory framework as a condition for continued participation, OPM will be able to more effectively manage this program on a national level. States are in a better position to identify problems and alert OPM to them via existing state consumer assistance programs, regulator structured monitoring systems, and state regulatory enforcement action. Additionally, MSPP regulations should provide constant and consistent opportunities for program transparency, including notice to states regarding the OPM's intent to contract with an MSP or MSPP issuer under section 800.303, advance communication regarding OPM intent to find a state law inconsistent with the MSPP pursuant to section 800.114 or section 800.116, and OPM compliance actions imposed on MSPP issuer or MSP.

4. **Effective Rate Review Programs**: The final rule should reflect, at section 800.201(f), that the review of rates by states that HHS has deemed to have an effective rate review program should apply to premium rates proposed for MSPs, so long as the State's application of its reviews is not arbitrary, capricious, or an abuse of discretion. In order to support states in their reviews, the determination of whether the state's review is arbitrary, capricious, or an abuse of discretion should be determined through processes other than solely at the discretion of OPM.

5. **Certification, Recertification and Decertification of Qualified Health Plans:** California's Health Benefit Exchange (HBEX) will operate as an "active purchaser." Under the ACA, an Exchange must allow MSPs contracting with OPM to participate in the Exchange, regardless of its organizational structure. Federal regulations exempt MSPs from an Exchange's recertification and decertification processes. (45 C.F.R. §§ 155.1075 and 155.1080.) While MSPs are participating on the state Exchange through a contract with OPM and have therefore been "deemed" certified under section 1311 of the ACA, California regulators should be permitted to monitor all products being offered in the HBEX to California health consumers. OPM should develop regulations that require MSPs to remain compliant with each state's laws and regulations as a prerequisite for retaining a multi-state plan contract, and also establish a process for state monitoring of MSPs and communication with OPM regarding MSP compliance.

6. **Definition of Non-Profit Entity:** The proposed definition allows for companies that are for-profits in a particular state to be considered a non-profit for purposes of the MSPP, as part of a group of health insurance issuers, a substantial portion of which are non-profit entities. The intent behind the requirement that at least one MSP be a non-profit MSP was to create market competition and ensure consumer choice. However, where a for-profit carrier already has a significant market share in a state, allowing that carrier to be considered a non-profit MSP will not lead to further

competition or additional choice. Instead, this will actually lead to further market consolidation. Therefore we suggest that OPM eliminate part 2 of the proposed definition of "non-profit entity."

7. **MSP Assessments:** The proposed rule provides OPM the authority to assess user fees on MSPs to fund the multi-state program. California notes that state-based Exchanges will also incur administrative costs associated with MSPs which must be fairly and equitably supported by the MSPP issuers consistent with fees assessed on QHPs. California requests confirmation that state-based Exchanges may assess fees and clarification of the method for state-based Exchanges to assess fees on MSPP issuers.

8. **Phased Expansion of the MSPP:** California recommends that OPM use its phased expansion authority to focus the MSPP on states that have not established state-based Exchanges in the initial implementation years. Given the complexity of state laws and approaches by different state exchanges, OPM should focus its initial effort on MSPP implementation for states that have not yet established a state exchange. This approach would complement the launch of the Federal Facilitated Exchange (FFE) in these states. States that have Exchanges could also be allowed to "opt-in" during the three-year phase-in period. This phase-in approach provides state flexibility, and may allow additional time for Exchange states to build strong, competitive marketplaces into which an MSP could be added with reduced disruption.

In the attached comments, which are presented in chart format, the departments offer suggestions for improvement of the proposed rules. Due to the short time frame in which to comment, it is possible that the departments may submit additional comments early next year. Because the enclosed comments reflect the consensus of all the signatories to this letter, please direct any questions regarding the comments to all three agencies.

Thank you for taking these comments into consideration as you finalize the rules and as California approaches the full implementation of the Patient Protection and Affordable Care Act, which the departments have all worked diligently to successfully implement.

Thank you for your consideration.

Sincerely,

Dave Jones, Insurance Commissioner

Brent Barnhart, Director, Department of Managed Health Care

Peter V. Lee, Executive Director, California Health Benefit Exchange

ESTABLISHMENT OF MULTI-STATE PLAN PROGRAM FOR THE AFFORDABLE INSURANCE EXCHANGES 45 CFR PART 800				
	PAGE PREAMBLE/ REG*	PROPOSED REGULATORY REQUIREMENT	FEDERAL PREAMBLE REQUEST FOR COMMENTS	CALIFORNIA COMMENT/QUESTION
I. Background				
II. Proposed Regulatory Approach				
1.	72584	A. OPM Approach *[Preamble only]* • Create a program that will attract issuers to apply to offer new product in each Exchange in 50 states and D.C. • Balance state and federal regulatory interests in a manner that will enable MSPP issuers to offer viable plans on Exchanges while maintaining level playing field between issuers • Ensure level playing field such that neither MSPs nor plans offered by non-MSPP issuers are advantaged or disadvantaged on Exchange marketplaces	OPM seeks comment on whether these proposed regulations satisfy these goals	California strongly believes it will be difficult, if not impossible, to create a level playing field if MSPP issuers and MSPs are not required to provide state-specific EHB packages.
2.	72585	B. Governing Law *[Preamble only]* OPM recognizes potential MSPP issuers seek administrative simplicity and some uniformity of standards in the MSPP – accordingly in unusual circumstances may be necessary for Director to adopt standards or req. for MSPP that differ from standards/requirements applicable to QHPs under either state or federal law. This proposed regulation, however, reflects Director's intent for MSPs and MSPP issuers to adhere to all state		

ESTABLISHMENT OF MULTI-STATE PLAN PROGRAM FOR THE AFFORDABLE INSURANCE EXCHANGES 45 CFR PART 800				
	PAGE PREAMBLE/ REG*	PROPOSED REGULATORY REQUIREMENT	FEDERAL PREAMBLE REQUEST FOR COMMENTS	CALIFORNIA COMMENT/QUESTION
		and federal laws applicable to QHPs and QHP issuers, except to extent such laws are inconsistent with these regulations, OPM Guidance, or OPM's contracts with MSPP issuers		
3.	72585	Level Playing Field *[Preamble only]*	Three categories of law among 13 listed in 1324(b) for which OPM specifically soliciting public comment	
4.	72585	1. Appeals *[Preamble only]* OPM proposes to resolve external appeals pursuant to its own process, which will be similar to the disputed claims process used in the FEHBP, where OPM resolves all external appeals as part of its contract administration responsibilities. Provide enrollees avenue of redress for all claims. Departments will propose amendments to 45 CFR 147.136 regarding: appeals to apply to the MSPP process the same standards that apply to state external review processes.		
5.	72585	2. Rating *[Preamble only]* Proposed rule requires MSPP issuers, in proposing premiums for OPM approval, to use only rating factors permitted by PHSA § 2701. Also requires MSPP issuers to comply with state laws regarding: rating factors • OPM does not consider "rating" to	Whether this is appropriate approach and impact of this approach.	California requests that the language in the Preamble be changed to add the following: • "In the event state withholds approval of or finds a MSP rate unreasonable for reasons that are not arbitrary, capricious or abuse of discretion, the

ESTABLISHMENT OF MULTI-STATE PLAN PROGRAM FOR THE AFFORDABLE INSURANCE EXCHANGES 45 CFR PART 800				
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		be the same as "rate review" – OPM intends to conduct its own rate review process and provide analysis to each state in which MSP is operating. • Each state may also review MSP rates under its own process. If disagrees with OPM's determination OPM and state will attempt to resolve differences. • In the event state withholds approval of MSP rate for reasons OPM determines are arbitrary, capricious or abuse of discretion, director may make final decision to approve rates notwithstanding state approval.		decision of the state review agency will hold." • A dispute resolution process between the states and OPM that does not rely solely on the discretion of the Director of OPM.
6.	72586	3. Benefit plan material or info *[Preamble only]* MSPs will be subject to Federal and state laws regarding: benefit plan material or info – including the proposed requirements. in § 800.113. • OPM defined benefits and plan material or information to include explanations or descriptions, printed or electronic, that describe issuer's products • Term does NOT include policy or contract for coverage. • OPM expects MSPP issuers to comply with related state law	Is it appropriate to exclude policies and contracts from definition of "benefit plan material or information?"	

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		requirements for policy form review • OPM will review and approve policy or contract for coverage. • OPM may request review of benefits and plan material or information in addition to any state review		
7.	72586	*[Preamble only]* Process for disputes regarding state law: • May be state laws outside § 1324(b), 13 categories for which compliance would prevent OPM from administering MSPP. • State law requirements may be inconsistent with OPM regulations, guidance or contracts. • OPM proposing process for states to seek changes to OPM regulations, guidance, and contracts to bring them into compliance with applicable state law. • Targeted analyses of particular state law provisions and impact on OPM ability to administer MSPP.	OPM invites comments on this process: • Scope • Factors OPM should consider when determining whether state law is applicable or whether relevant market has been/will be disrupted by the inapplicability of state law • Whether process will be an effective way to resolve any such disputes	
8.	72586	*[Preamble only]* 13 categories - disputes	• Should OPM include in this process states' concerns regarding: MSPP issuer compliance with state law requirements in 13 § 1324(b) categories? • Has proposed rule met intent re: ensuring MSPP issuers comply with	

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			all state law requirements concerning § 1324(b) 13 categories? • Should the dispute resolution process also be available as another avenue for addressing such concerns?	
III. Provisions of the Proposed Regulations				
A. General Provisions and Definitions				
1. Definitions § 800.20				
9.	72587, 72601*	**MSP** – means *private [preamble only]* health plan offered under a contract with OPM pursuant to § 1334 of ACA & meets requirements of this part.		California recommends amending this definition to establish a clearer distinction between MSP and MSPP Issuer. Please clarify whether each MSP will be under separate contract with OPM or will contract through the MSPP Issuer.
10.	72587, 72601*	**MSPP Issuer** – means health ins. issuer or group of issuers, as defined, that has contract with OPM to offer health plans per § 1334 of the ACA and meets the requirements.		California recommends amending this definition to establish a clearer distinction between MSP and MSPP Issuer.
11.	72587, 72601*	**Non-profit entity** – 1. Organization incorporated under state law as a non-profit entity and licensed under state law as health insurance issuer, or 2. Group of issuers licensed under state law a substantial portion of which are incorporated under state law as non-profit entities.		These definitions allow companies that are for-profits in a particular state to be considered a non-profit for purposes of the MSPP. The intent behind the requirement that at least one MSP be a non-profit MSP was to create market competition and ensure consumer choice. However, proposed section 800.20 defines nonprofit to include carriers where "a substantial

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				portion...are incorporated under State law as nonprofit entities" which allows a for-profit company to be considered a non-profit for purposes of the MSPP. However, where a for-profit carrier already has a significant market share in a state, this will not lead to further competition or additional choice. Instead, this will actually lead to further market consolidation. It could even position the for-profit to temporarily underprice to gain market share which would ultimately reduce competition. Therefore California recommends, OPM should eliminate subsection (2) of this definition.
12.	72587, 72601*	**State insurance commissioner** means commissioner or other chief insurance regulatory official of a state.		California has a bifurcated regulatory system for health insurance issuers. The definition of "State insurance commissioner" should be broad enough to acknowledge the potential for multiple regulatory roles. For example, in California, the health care industry is regulated by both the DMHC director (re health care service plans) and the insurance commissioner (re health insurance products).
B. Multi-State Plan Issuer Requirements (Subpart B, §§ 800.101 – 800.116)				
1. General Requirements § 800.101				
13.	72587	*[Preamble Only]* – MSPP issuer must offer choice of plans (i.e. One of each at silver and gold levels of coverage)		California asks that OPM clarify the statement that the "MSPP issuer may choose to participate in the SHOP," is

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		on the individual Exchange and in the SHOP, *if the MSPP issuer choses to participate in the SHOP*. In addition, OPM proposes the MSPP issuer will, pursuant to contract, offer child-only coverage for each level that it makes available in each exchange. MSPP issuer must ensure all MSPs it offers meet the requirements of this rule.		a proposal to phase-in MSPP issuer coverage in SHOP (see p. 72588 *Preamble* comments.)
14.	72587, 72601*	MSP issuer must:		
15.	72587, 72601*	(a) Be licensed in each state where offers coverage;		
16.	72587, 72601*	(b) Have contract with OPM;		
17.	72587, 72601*	(c) Offer levels of coverage per § 800.107;		
18.	72587, 72601*	(d) Meet same requirements for eligibility, enrollment, and termination of coverage as those that apply to QHPs and QHP issuers per 45 CFR parts 155, subparts D, E, and H & 45 CFR parts 156.250, 156.260, 156.265, 156.270, and 156.285;	Comments: Any unique enrollment and eligibility issues that might affect MSPs.	
19.	72587, 72601*	(e) Ensure each of MSPs meets requirements of this part;		
20..	72587, 72601*	(f) Comply w/ all standards;		
21.	72587, 72601*	(g) Timely comply w/ OPM instructions, directions & will other		

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		applicable law;		
22.	72587, 72601*	(h) Meet other requirements as determined appropriate by OPM; and		
23.	72587, 72601*	(i) Non-discrimination.		
2. Compliance with Federal Law § 800.102				
24.	72587, 72601*	(a) PHSA – as condition of participation in MSPP – must comply with provisions of part A of PHSA (appendix A).		
25.	72587, 72602*	(b) MSP issuer must comply with provisions of title I of ACA (appendix B).		
26.	72588	*[Preamble only]* Preamble to 45 CFR parts 155, 156, 157 leaves to each Exchange discretion whether to require QHP issuer to participate in both SHOP and individual market Exchanges. • OPM proposing to allow MSPP issuers flexibility to phase in coverage to the SHOPs. • MSPP issuers may offer coverage in individual Exchange, and not the SHOP, throughout duration of phase-in period.	Solicit comments regarding: approach to SHOP participation, including whether participation in SHOP would be required from outset or MSPP issuers should be allowed to provide a plan that requires a period longer than the phase-in period to fully participate in SHOP.	The California Health Benefit Exchange requires that QHPs providing coverage in the individual market must also participate in the SHOP. To ensure competition and a level playing field, the same rules should be applied to MSPP issuers.
3. Phased expansion § 800.104				

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27.	72588	MSPP application for participation and renewal must include plan for offering coverage throughout the state. *[Preamble Only*] – OPM will evaluate MSP issuer to ensure locations in which they propose to offer coverage have been established without regard to racial, ethnic, language, health status-related factors or other factors that exclude high-utilizing, high-cost or medically underserved populations.		The preamble language regarding geographical choices for coverage should be included in text of § 800.104.
28.	72602*	(a) Phased expansion over 4 years . . . (4) With respect to each subsequent year, the health insurance issuer will offer the MSP in all States.		California does not agree with 800.104(a)(4). California believes the MSPP issuer should be allowed to operate in fewer than all 50 states and D.C. It should not be required to extend its operations to states that are already serviced by a significant number of carriers. California recommends that OPM use its phased expansion authority to focus the MSPP on states that have not established state-based Exchanges. OPM could also allow states to indicate when they want to "opt-in" to the MSPP. While this request would not be binding, it could inform the phased expansion of the MSPP while still allowing OPM to be in compliance with the annual phase-in targets.

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29.	72588, 72602*	§ 800.104 (b) Partial coverage within the state: OPM may enter into a contract with MSPP issuer even if the issuer's MSPs, for a state, covers fewer than all services areas specified for that state pursuant to § 800.110. • For each state in which MSPP issuer offers partial coverage, application for participation and renewal must include a plan for offering coverage throughout state. • OPM will monitor issuer's progress in implementing plan.	Requests comments: Should MSPP issuer be required to offer coverage statewide by fourth year of participation in MSPP, when coverage must be offered in each Exchange in 50 states and D.C.?	
30.	72588, 72602*	(c) Licensed where offered – OPM may enter a contract with MSPP issuer who is not licensed in every state, provided the issuer is licensed in every state where it offers MSP coverage through any exchanges in that state. The MSPP issuer must demonstrate to OPM it is making a good faith effort to become licensed in every state consistent with timeframe in (a).		California suggests OPM require some sort of certification or statement from state licensing authority that licensure is valid or in process. Again, failure to complete licensure by a date certain should be included here as grounds for termination of contract under § 800.404. This then becomes a non-negotiable term of the contract.
31.	72588, 72602*	*[Preamble only]* – OPM proposes to clarify that, during each year of the phase-in period, an issuer need only to be licensed in states in which it is offering coverage during that year.		California recommends that preamble language be included in the text of the regulation. Additionally, OPM should recognize that licensure takes a considerable amount of time in some

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				cases. OPM should most likely require updates regarding licensure status from state regulators.
4. Benefits § 800.105				
32	72589, 72602*	(a) (1) An MSPP issuer must offer a uniform benefits package, including EHB, for each MSP *within a state.*		California agrees with the proposed regulation, because unless OPM requires each MSP to provide the EHB-benchmark package required by each state, California does not see a way to provide a level playing field for health plans and issuers operating inside and outside the Exchanges.
33	72589, 72602*	(a) (2) Benefits package must comply with ACA § 1302 plus applicable standards set by OPM or HHS.		
34.	72589, 72602*	§ 800.105 (b) (1) MSPP issuer must offer a benefits package, in all states, that is substantially equal to:	OPM requests comments on these options – • Will either option will discourage or encourage issuer's participation in the MSPP • Will allowance of OPM benchmark option disrupt state level playing fields given substitution rules	California believes it is essential that MSPP issuers be required to offer the EHB package particular to the state in which the MSP is operating. • OPM and HHS need to include a definition for "substantially equal," which is also used in the EHB regulations at §156.115(a). Therefore, California requests OPM and HHS to use the following definition: ○ "Substantially equal" means the benefit offered in the corresponding benefit category of the EHB must cover the same condition
35.	72589, 72602*	(i) The EHB-benchmark plan in each state in which it operates; or		
36.	72589, 72602*	(ii) Any EHB-benchmark plan selected by OPM under (c) of this section.		

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				covered by the benefit in the EHB-benchmark plan and should be about the same actuarial value as the EHB-benchmark benefit. For example: if the benchmark plan offers in-house "weight loss programs" as part of its EHBs, then an MSP, QHP, or plan outside the exchange could offer a nationally recognized weight loss plan in lieu of an in-house program. • Consistent with HHS regulations, California, by statute, prohibits substitution. MSPPs will not, under state rules, be permitted to substitute benefits in any EHB category. • Given California's robust EHB-benchmark plan, it is likely that any deviation that allows MSPP issuers to provide a lesser benchmark will affect the level playing field in this state. • Failure to adhere to the state specific EHB-benchmark in each state could create adverse selection issues. For instance, if consumers perceive a MSP benefit

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				plan that is not the state EHB-benchmark plan to have greater benefits than a state-specific benchmark, the MSP could attract more unhealthy people making the MSP a high risk pool. The one way to truly avoid any adverse selection concerns is to require the MSPP issuers to offer state-specific EHB benchmark plans in MSPs. Therefore, paragraph 800.105(b)(1)(ii) should be deleted from the proposed rule.
37.	72589, 72602*	§ 800.105 (b)(2) Issuer applying to participate in MSPP must select one of two benefit package options in its application.		California would like to clarify that if an MSPP issuer selects option (b)(i), it e offer a different EHB-benchmark plan in each state in which it operates, based on THAT state's EHB-benchmark. California requests this be made clear in the text of § 800.105. While the preamble clarifies that a state must choose one approach or the other, the regulation is confusing and may lead an MSPP issuer to interpret the provision as allowing it to select one EHB-benchmark package and offer that package nationally.
38.	72589	[*Preamble only*] – No matter which option an MSPP issuer chooses, it would need to apply that benefits package option uniformly to each of the states in which the MSPP issuer proposes to offer MSPs. The proposed approach does not permit an issuer to use a state benchmark plan in some of the states in which it is operating and an OPM-chosen benchmark plan in others.		
39.	72589, 72602*	§ 800.105 (b)(1) OPM-selected EHB-benchmark plans are the three largest FEHBP plan options, as identified by HHS per § 1302(b) of ACA, and as		California believes it is imperative that Paragraph 800.105(c) be deleted from the proposed rule. Each MSP must use each state's EHB benchmark plan

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		supplemented per (c)(2) through (4) of this section.		in any state in which it is offered.
40.	72589	*[Preamble Only]* If MSPP issuer selects on of these three plans, must have a uniform benefit package in all states. As of March 31, 2012, three largest FEHBP plans: • Blue Cross Blue Shield (BCBS) Standard Option • BCBS Basic Option • Government Employees Health Association (GEHA) Standard Option OPM EHB-benchmark may lack state-required benefits – OPM proposing standards for supplementing proposed OPM-selected EHB-benchmark plans.		
41.				Clarify error - § 800.105 has only (c)(1)-(c)(4) – preamble miss numbered subdivisions on p. 72589. Regulation does not track preamble.
42.	72589, 72602*	§ 800.105 (c) (2) Supplement of pediatric oral and vision services from largest Federal Employee Dental and Vision Insurance Program options.	OPM solicits comments on; • Provision of pediatric dental services by MSPs to meet ACA EHB requirements [1302(b)(1)(j)] • One approach is to require MSP to cover pediatric dental services in conjunction w/ other bens in package – solicit comments on this approach. • How stand-alone dental plans offered	

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			on Exchanges should affect this requirement, if at all • limited scope dental plans	
43.	72589, 72602*	§ 800.105 (c) (3) MSPP issuer must follow state definition where state chooses to specifically define habilitative services category per 45 CFR 156.110(f)		California has defined "habilitative services" in state statute pursuant to Health and Safety Code § 1367.005(p)(1) and Insurance Code § 10112.27.
44.	72589, 72602*	§ 800.105 (c) (4) Any EHB-benchmark plan selected by OPM under (c)(1) must include, for each state, any state-required benefits enacted before December 31, 2011, that are included in state's EHB benchmark plan as described in (b)(1)(i) of this section, or specific to the market in which the plan is offered. *In the case in which a state chooses not to define this category, OPM proposes that if any OPM-selected EHB benchmark plan lacks coverage of habilitative services and devices, then OPM may determine what habilitative services and devices are to be included in that EHB0-benchmark plan. (Italics added to denote section that should move to (3).)*	*[preamble only]* – "at least for years 2014 and 2015"	In the event subparagraphs (b)(1)(ii) and (c) are not deleted as requested above, (see comments at rows 36 and 39) California suggests the following. The OPM proposed regulation found at 45 CFR § 800.105(c)(4) states that "any EHB-benchmark plan selected by OPM under (c)(1) must include, for each state, any state-required benefits enacted before December 31, 2011, that are included in state's EHB benchmark plan…." The HHS proposed EHB regulation allows states to require issuers to supplement the state's base-benchmark package with state-required benefits enacted before December 31, 2011. Those mandates are not considered to be in addition to the EHBs. (See 45 CFR § 155.170(a)(2).) Since these mandates

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				are not considered additional benefits, the states do not have to defray costs of these mandates (See 45 CFR § 155.170(b).) For purposes of consistency with 45 CFR § 155.170(a)(2), the language in §800.105(c)(4) should be amended to reflect that state mandates enacted before December 31, 2011, that are not in a state's base- benchmark, must be covered without an additional cost to the states. California recommends the sentence starting "in the case in which*…"* should be stricken from (c)(4) and included in (c)(3) above. (c) (4) seems to be about any state mandate, while the remainder seems to describe the process for supplementing habilitative services in the event that state has not specifically defined it. *(Italics added in column 3 to denote section that should move to (3).)*
45.	72589	[*Preamble Only*] – OPM is proposing that if an MSPP issuer chooses to use an EHB-benchmark plan selected by OPM in all states, the issuer will need to use a state-selected benchmark only in states that do not allow substitution for services at all within the benchmark benefits. [*Otherwise*?] MSPs using	Comment: OPM requests comments on this proposal.	California agrees with this proposal and urges OPM to include language in the regulation stating that MSPP issuers must select the state EHB-benchmark plan in states with "no substitution rules" in the text of the regulation. § 800.105

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		OPM benchmark in states that require all plans to offer the same set of benefits would be different from all the other plans offered on the market, potentially causing adverse selection.		
46.	72589, 72602*	§ 800.105 (d) OPM Approval – MSPP issuer's benefits package, including drug list, must be submitted *"to approved by"* OPM , which will review and determine whether package is substantially equal to EHB-benchmark plan described in (b)(1) pursuant to 45 CFR §§156.115, 156.120, and 156.125.		Please clarify there is a typo in (d). California strongly urges OPM to include language requiring that OPM collaborate with state regulators to determine whether the MSP benefit package is "substantially equal" to the state EHB-benchmark plan. Please clarify that this section is referring to "substantially equal" benefit provisions described in 45 CFR § 156.115(a).
47.	72589	*[Preamble Only]* Proposed 45 CFR 156.115(b) allows issuers to make benefit substitutions within each EHB category – directs issuers to submit evidence of actuarial equivalence of substituted benefits to a state.	OPM requests comments re: whether MSPP issuers should submit evidence of actuarial equivalence of substituted benefits to the OPM in addition to, or in lieu of, their submissions to a state.	California interprets § 800.105 (d) to address the issue of "substantially equal benefits" while the preamble request for comment at p. 72589 regarding "substituted benefits" (and related to § 156.115(b)) is not at this point included in the proposed rule. Please clarify that, consistent with HHS, OPM interprets substantially equal and substituted benefits to be distinct issues. In California, substitutions are prohibited per Health & Safety Code §1367.005(c) and (d) and Insurance Code § 10112.27(c) and

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				(d).
48.	72589, 72602*	§ 800.105 (e) Benefits in addition to benchmark package – state must assume the cost of such additional benefits by making payments either to the enrollee on to the MSPP issuer on behalf of the enrollee.		Subdivision (c) (4) provides that MSPs will have to include state mandates enacted before December 31, 2011, and that are a part of the EHB-benchmark package, while subdivision (e), requires the states to assume the cost of benefits that are in addition to the EHB-benchmark package. First, the proposed EHB regulations specifically state that states must defray the costs of benefits that are in addition to the EHB-benchmark, but also note that state mandates enacted on or before December 31, 2011, are not in addition to the EHB-benchmark. (45 CFR § 155.170(a)(2) & (b).) Therefore, states will not be required to defray the costs of these mandates for QHPs in the Exchanges. However, since the proposed MSP regulation requires that MSPs only cover state mandates that are included in the benchmark, states may be required to defray the costs of these mandates in MSPs, unless this requirement is made consistent with the EHB regulation. For consistency, California recommends states should not be required to defray the cost of state mandates enacted before December

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				31, 2011, in MSPs, even if they were not included in the EHB-benchmark. Second, under (c)(4), if a state-specific EHB benchmark is not selected by a MSPP issuer, that issuer will be required to supplement the EHB benchmark that is selected with any additional benefits that may be found in the state-specific EHB benchmark. To ensure that states do not have to pay for additional benefits and to ensure that there is no argument regarding whether a benefit has been supplemented appropriately, MSPP issuers should be required to use a state-specific EHB benchmark. Furthermore, states should be the ultimate arbiter of the scope of EHB benefits, and whether other benefits are "additional."
49.	72590	*[Preamble Only]* – OPM plans to review benefits packages for discriminatory benefit design – will work closely with states and HHS.		
50.	72590		OPM solicits comments on the provisions of proposed § 800.105, including provisions relating to the two EHB benchmark options and limited	

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			scope dental plans.	
5. Cost-Sharing Limits, Premium Tax Credits, and Cost-Sharing Reductions § 800.106				
51.	72590, 72602*	(a) MSPP issuer must comply with cost sharing provisions in the ACA.		If a State-based Exchange has adopted standardized cost-sharing within a standard plan design and adopted rules that require the QHP issuer to offer one or more of those standardized benefit plan designs, a MSPP in California should be required to offer one of those standardized benefit plan designs at all metal levels to maintain a level playing field.
52.	72590, 72602*	(b) For each MSP it offers, MSPP issuer must make premium tax credits available per ACA. MSPP must also comply with any applicable standards set by OPM or HHS.		
53.	72590	*[Preamble only]* – An MSPP issuer must also comply with any standards set by OPM or HHS in regulations concerning the administration *of these subsidies.* OPM may issue additional guidance.	OPM solicits comments regarding what additional guidance, if any, it should adopt to address unique issues faced by MSPs.	California recommends that OPM include preamble language regarding the administration of subsidies in the text of the regulation. If there is "additional guidance," we recommend including it now and making it available for public comment.
6. Levels of Coverage § 800.107				
54.	72590, 72602*	(a) At least one plan at silver and one at gold in each Exchange.		California state law requires QHPs to offer coverage at all coverage tiers; MSPP issuers and MSPs should be required to adhere to this statutory requirement in order to avoid adverse

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				selection and maintain a level playing field.
55.	72590, 72603*	(b) Leaves question re: whether a plan can offer bronze/platinum plans to contracting process.		
56.		(c) Must offer child-only plan to children under 21 in each level of coverage. *[Preamble Only]* – MSP issuer could satisfy this standard by offering same product for child-only that offers to consumers for adult/family coverage, as long as child-only coverage is priced in accordance with applicable rating rules.		California recommends OPM include preamble language regarding rating requirements for child-only plans in the text of the regulation.
57.	72590, 72603*	(d) Must comply with plan variation provisions in ACA 1402.		
58.	72590, 72623*	(e) MSPP issuer must submit levels of coverage and plan variations to OPM for approval.		California recommends State regulators should be involved in the approval of levels of coverage. MSPP issuers should be required to meet state-based Exchange plan design requirements to ensure a level playing field.
7. Assessments and User Fees § 800.108				
59.	72590, 72603*	(a) OPM may require an MSPP issuer to pay an assessment or user fee as a condition of participating in the MSPP.	OPM seeks comments on the use of assessments and user fees to fund the MSPP.	In addition to fees assessed by OPM, state-based Exchanges must assess an administrative fee on MSPs to meet the administrative costs of offering MSPs through state Exchanges. California requests confirmation that

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				state-based Exchanges may assess fees, and clarification regarding the method state-based Exchanges will use to assess fees on MSPs products sold in the Exchange. For example, will state-based Exchanges able to assess fees directly on MSPs or will OPM collect fees on a state's behalf?
8. Network Adequacy § 800.109				
60.	72590, 72603*	(a) MSPP issuer must: 1. Maintain network sufficient in number and types of providers to assure all services accessible without unreasonable delay. 2. Consistent with network adequacy provisions of PHSA 2702(c). 3. Includes essential community providers per 45 CFR 156.235.		California recommends MSPs should be required to comply with state-specific rules on network adequacy to ensure a level playing field and access to services.
61.	72590, 72603*	(b) Provider directory available on the Exchange & to potential enrollees in hardcopy upon request. Must id all providers not accepting new patients.	OPM is aware states have more specific rules on network adequacy and will consult with states to set more specific criteria with respect to network adequacy for the MSPP in future guidance. OPM requests comments on approach to network adequacy, including issues concerning NA as a condition of state licensure and any issues for MSP w/	California law at Health & Safety Code § 1367.26 requires a health care service plan to provide, upon request, a list of contracting providers within the enrollee or prospective enrollee's geographic area, including primary care providers, medical groups, independent practice assoc., hospitals, and all other available contracting physicians and surgeons, etc. to the

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			respect to state-specific network adequacy requirements.	extent their services may be accessed and are covered through plan contract. The statute does require that the list indicate whether provider is accepting new patients, which includes making information available re: provider's degree, certifications, and specialty qualifications. In California, MSPs will be required to follow these rules as well. The network adequacy regulations requirements found at 10 CCR 2240, *et seq,* require insurers to either provide information regarding all network providers or indicate where this information may be found on the internet. In addition, they are required to include a warning about limitations in the contract pertaining to network provider services, specify the differences between in-network and non-network coverage, and inform insureds about their ability to contact the Department of Insurance if they are unable to access health care in a timely manner.
10 Service Area §800.110				
62.	72591, 72603*	MSPP issuer must offer MSP within one or more service areas in state defined by each Exchange pursuant to 45 CFR 155.1055.	OPM seeks comments re: whether MSPP issuers should be required to offer MSPs in all service areas by the fourth year of participation in the MSPP.	MSPs should be required to cover geographic services areas in California where they are licensed, if their license is other than state-wide. MSPs should

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		If an Exchange permits issuers to define service areas, MSPP issuer must get OPM approval for proposed service areas. Per § 800.104, OPM may enter contract with issuer even if MSPs for a state cover fewer than all the service areas specified for that state. For each state in which MSPP issuer does not offer coverage in all service areas, application for participation and information to support renewal of contract must include plan for offering coverage throughout the state. OPM will monitor MSPP issuer's progress as part of contract compliance activities.	OPM believes along MSPP issuers time to develop capacity to offer coverage throughout service area will enhance competition in the MSPP, and invites comments on this approach.	be required to follow the same rules concerning partial rating regions as QHPs in California.
11. Accreditation Requirement § 800.111				
63.	72591, 72603*	(a) MSPP issuer must be or become accredited consistent with the requirements for QHP issuers specified in § 1311 and 45 CFR 156.275(a).	OPM requests comments on proposed accreditation requirements.	OPM should require that an issuer be accredited at the time of contracting. MSPs should be required to follow the same timeline with regards to accreditation as is required of California QHP bidders.
64.	72603*	(b) MSPP issuer must authorize accrediting entity to release to OPM and to the Exchange a copy of most recent accreditation survey,		

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		with any survey-related information OPM or an exchange may require, such as corrective action plans and summaries of findings.		
65.	72603*	(c) Timeframe – issuer not accredited as of date enters into contract must become accredited within timeframe established by OPM by 45 CFR 1555.1045.		
12. Reporting Requirements § 800.112				
66.	72591	*[Preamble Only]* – OPM proposes to use the FEHBP approach for reporting requirements. Examples: • Financial reports • Premium payment information • Enrollment reporting • Quality assurance information Necessary information to oversee MSPP contracts – agency will develop and issue guidance on this subject for MSPP issuers & potential issuers.	Requests comments on this approach	California recommends that if OPM plans to issue "guidance" that it be included here in formal regulation. California also recommends including at least a partial list of potential data and reporting required by OPM in this section. California requests that any information filed with OPM should also be filed with the state regulator.
67.	72591, 72603*	(a) OPM will specify the data and information that must be reported by MSPP issuer.		The California Health Benefit Exchange will be requiring specific data to be reported by QHPs in its model contract, much of it related to quality improvement. MSPs should be required to comply with Exchange data reporting requirements.
68.	72603*	(b) An MSPP issuer must comply with any standards required by OPM for reporting quality and quality		

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		improvement strategy, disclosure of quality measures to enrollees, and prospective enrollees.		
69.	72591-72592, 72603*		OPM requires FEHBP plans to report performance through Healthcare Effectiveness Data and Information Set (HEDIS) metrics and Consumer Assessment of Healthcare providers and Systems (CAHPS) surveys, independent of source of plan accreditation. OPM expects to take a similar approach to performance measurement in MSPs to facilitate oversight. OPM requests comments on the unique aspects of accreditation and reporting for MSPs as compared with accreditation for QHPs.	California suggests that if HEDIS and CAHPS measures will be used, these be included in the text of the regulation. The Exchange will be specifying required reporting using specified HEDIS and CAHPS for California QHPs and MSPs should be held to the same standard.
13. Benefit Plan Material or Information § 800.113				
70.	72952, 72603*	(a) MSPP issuer must comply with federal and state laws re: benefit plan material or information – including this section & guidance from OPM specifying its standards, process, and timeline for approval of benefits and plan material or information.		
71.	72592, 72603*	(b) Issuer must provide all applications/notices to enrollees in accordance w/ standards in 45 CFR 155.205(c). OPM may est.		

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		additional standards to meet the needs of MSP enrollees.		
72.	72592, 72603*	(c) Accuracy – issuer is responsible.		
73.	72592, 72603*	(d) Truthful but not misleading (no material omissions, written in plain language).		
74.	72592, 72603*	(e) Uniform Explanation of Coverage Documents & Standardized definitions.		
75.	72592, 72603*	(f) OPM review & approval of benefits and plan material or information – OPM reserves right to review & approve benefits and plan material or information to ensure issuer complies with federal & state laws.		Please clarify the interplay between state regulators who typically review benefits and plan material or information and OPM's review process. Will states review MSPP issuer and MSP materials as part of licensing process? Will OPM make recommendations to state regulators? Please provide more information about this process.
76.	72592, 72604*	(g) MSPP issuer may include statement in benefits and plan material or information that 1) OPM has certified the MSP as eligible to be offered on the Exchange; and 2) OPM monitors the MSP for compliance with all applicable law.	OPM does not view this as a violation of state law anti-endorsement provisions because it is a recitation of the fact the issuer is providing coverage pursuant to a contract with OPM.	
14. Compliance with state law § 800.114				
77.	72592, 72604*	(a) MSPP issuer must, with respect to each of its MSPs, generally comply with state law pursuant to § 1334(b)(2) of the ACA. However,		California strongly recommends § 800.114(a) be amended to read: (a) "MSPP issuer must, with respect to

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		MSPs need not comply with state laws that: 1. Are inconsistent w/ § 1334 of ACA; 2. Prevent the application of a requirement of part A of title XXVII of the PHSA 3. Prevent the application of a requirement of title I of the ACA		each of its MSPs, generally comply with state law pursuant to § 1334(b)(2) of the ACA. However, MSPs and MSP issuers need not comply with state laws *OPM has determined are* ~~that:~~" (b) Determination of inconsistency. (c) *The contract between OPM and an MSP issuer will enumerate state laws OPM has determined meet one of the categories identified in (a) above upon a final resolution of any state requests for reconsideration of a determination under § 800.116.* This change makes it clear that MSPs and MSPP issuers are not at liberty to make determinations regarding the applicability of state law.
78.	72592, 72604*	§ 800.114 (b) Determination of inconsistency – OPM reserves right to determine, in its judgment, as effectuated through an MSPP contract, these regulations or OPM guidance whether the standards set forth in paragraph (a) of this section are satisfied with respect to particular state laws. In making any such determinations, OPM will consider		California strongly recommends OPM build state participation into the process at the determination stage, including language in § 800.114 (b) to require OPM to consult with state regulators prior to its determination regarding state law applicability, to limit the use of the dispute resolution process. California also requests that OPM

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		whether the state law at issue: 1. Imposes on MSPP issuers/MSPs a requirement(s) that differ from those applicable to QHP issuers and QHPs offered on one or more Exchanges in that state; 2. Creates responsibilities, administrative burdens, or costs for an MSPP issuer that significantly deter or impede the MSPP issuer from offering a viable product on one or more of the Exchanges; 3. Creates responsibilities, administrative burdens, or costs for OPM that significantly deter or impede OPM's effective implementation of the MSPP; or 4. Prevents an MSPP issuer from offering an MSP on one or more Exchanges in that state.		clarify whether this section applies to all state laws, including those related to the 13 categories under § 1324(b) of the ACA. If it does not, we request that OPM draft regulations that describe the process for threshold determinations regarding laws related to those categories. California is very concerned about § 800.114(b)(2). These provisions seem overly broad and by their application the exception will swallow the whole. Similar to (b)(1), the scope of section (b)(2) should be limited to the particular state in question, not the entire nation. Subdivision (b)(2), as so amended, would read "responsibilities…for an MSPP issuer that significantly deter or impede the MSPP issuer from offering a viable product on one or more Exchanges *in that state*." In the alternative California suggests the following language which clarifies that the determination made with reference only to a specific state. Also, this proposed language provides that the determination of paragraph (b)(2) relates to potential discrimination between MSPP issuers and other QHPs in the state. Comparing the

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				MSPP burdens with those imposed on other QHPs in a state would serve to maintain a level playing field: "(2) Creates responsibilities administrative burdens, or costs *for MSPP issuers that are not imposed upon other QHPs in that state.* ~~significantly deter or impede the MSPP issuer from offering a viable product on one or more Exchanges~~" There are other compelling reasons why the determination of inconsistency should be confined within a particular state, rather than being determined on a nationwide basis. Given California's strong regulation of its health insurance market, MSPP issuers that have not historically operated in California may indeed find that California laws create responsibilities, including administrative responsibilities and costs, which "deter" them from doing business here. California's vigorous consumer protection regulations should not be cause for determining California laws "inconsistent" with the MSPP. If section (b)(2) is not amended consistent with these concerns, the MSPP process could become a means by which important state health insurance

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				protections could be avoided. If state laws related to the 13 categories of § 1324 benefits are not included in the dispute resolution process at § 800.116, then language must be included here to allow states to dispute OPM determinations under § 800.114(b). Such a process must require OPM to notify states in advance that it has made a preliminary determination that a particular law may be considered inconsistent with or otherwise preempted by federal law. Finally, depending on OPM's answers to the above comments, California recommends this section reference the dispute resolution process outlined in § 800.116. (please see comments below regarding § 800.116) The Exchange will expect MSPs to execute their QHP Model contracts with the Exchange, which may impose obligations above and beyond state law. These contractual obligations will be required of all QHPs operating in California and, in order to keep a level playing field, OPM should require MSPs to sign a contract with the Exchange. In the alternative, the regulation should be amended to

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				require that all MSPs must comply with all such contractual obligations of the Exchange.
15. Level Playing Field § 800.115				
79.	72592, 72604*	An MSPP issuer must, with respect to each of its MSPs, meet the following requirements in order to ensure a level playing field: (a) Guaranteed Renewal – Guarantee that an enrollee can renew enrollment in an MSP in compliance with PHSA §§ 2703 and 2742.		California request clarification. Is OPM indicating it will not find any law that meets the threshold test of belonging to one of the 13 categories in § 1324 "inconsistent" pursuant to § 800.114 or § 800.116?
16. Process for dispute resolution § 800.116				
80.	72592	[Preamble Only] – OPM proposes process for resolving disputes about the applicability to the MSPs and MSPP issuers of state laws not related to the categories set forth in § 1324. Under this process, a state may request that OPM reconsider a standard applicable to MSPs or MSPP issuers that is consistent with the state's laws for QHPS or QHP issuers. As discussed [in § 800.114] the state must demonstrate the law is *not inconsistent* with § 1334 or regulations issued to implement the section.	OPM requests comments re: • whether to have such a process • scope • factors OPM should consider when determining whether state law is applicable or whether the relevant market has been or will be disrupted by the inapplicability of state law and • whether process will be an effective way to resolve such disputes • Whether process should also be available for states to raise disputes concerning laws related to the 13 categories under § 1324(b) of the ACA.	The language of the preamble is not clear regarding the basis for a state request for OPM reconsideration. California strongly recommends: 1. The section should be amended to require that OPM start from a presumption that all state laws are consistent with the ACA and meet the requirements of § 1334. 2. The dispute resolution process should be amended to require that OPM provide notification to the states regarding decisions about state law in advance of contracting with MSP issuers to provide MSP services within a

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				state's Exchange. Such notice should include a statement regarding the specific law OPM believes violates the provisions of § 800.114(a) and (b), and grounds upon which OPM made such a determination. The dispute resolution process should include state disputes regarding laws related to the 13 categories of benefits from § 1324(b) of the ACA. If these disputes are not included here, a separate dispute resolution process should be provided in § 800.114.
81.	72592, 72604*	§ 800.116 (a) Determinations about applicability of state law under § 1334(b)(2) of the ACA. In the event of a dispute about the applicability to MSP or MSPP issuer of a state law not related to the 13 categories in section 1324(b) of the ACA, the state may request that OPM reconsider a determination, made under § 800.114 that an MSP or MSPP issuer not subject to such state law.		California believes it is essential that the first step in this dispute resolution process be notification by OPM to the state that it believes a law is preempted by federal law or otherwise meets one of the criteria listed in § 800.114(a) (1)-(3). California recommends this section should be amended to add a new subdivision (a) outlining such a notification process.
82.	72952, 72604*	§800.116 (b) Required demonstration. A state		Please clarify that OPM means to refer to "subparagraph (a)" rather than

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		making a request under subparagraph (1) must demonstrate the state law at issue: 1) Is not inconsistent with § 1334 of the ACA 2) Does not prevent the application of a requirement of part A of title XXVII of the PHSA; and 3) Does not prevent the application of a requirement of title I of the ACA.		"subparagraph (1)"? These three items are much narrower than the factors that go into OPM's determination regarding inconsistency in § 800.114(b).
83.	72592, 72604*	§ 800.116 (c) Request for review – the request must be in writing and include contact information, including the name….or persons whom OPM may contact regarding the request…the request must be in such form, contain such information, and be submitted in such manner and within such timeframe as OPM may prescribe. 1) The requestor may submit to OPM any relevant information to support its request. 2) OPM may obtain additional information relevant to the request from any source as it may, in its judgment, deem necessary. OPM will provide the requester with a		California strongly recommends timeframes be included in this § 800.116 for clarity and ease of administration. These timeframes need to be in place before OPM begins contracting with MSPP issuers and MSPs. The timeframe for a response in (c)(3) is confusing. California suggests amending (c)(3) to read the following: (3) OPM shall issue a written determination within 60 calendar days of receipt of the state request for reconsideration, or 30 days from the receipt of all information necessary to make a determination. California believes that all relevant information should be available for

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		copy of any additional information it obtains and provide an opportunity for the requestor to respond (including by submission of additional information or explanation). 3) OPM will issue a written decision within 60 calendar days after receiving the written request, or after the due date for response, whichever is later, unless a different timeframe is agreed upon. 4) OPM's written decision will constitute a final agency action that is subject to review under the Administrative Procedure Act in the appropriate U.S. district court. Such review is limited to the record that was before OPM when OPM made its decision.		judicial review of the final OPM determination.
17. Other Issuers				
84.	72593	Adjusted Community Rating [Preamble Only] - § 1334(c)(1)(D) requires that MSPP issuers offer MSP in all geographic regions and in all states that have adopted adjusted community rating (ACR) prior to	OPM proposes not to identify any specific states an MSPP issuer must cover in the initial years of the MSPP	California suggests that OPM provide a "Mock phase-in" plan to guide MSPP issuers in realistic phase-in processes. MSPP issuers may be inclined to defer implementation in all large states until later years, etc. OPM should provide

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		3/23/2010. Statute does not require that adjusted community rating states be included in the first year of the phase-in process for several reasons. 1. In 2014 all issuers in individual/small group market – in and outside the Exchange – must comply with ACR per PHSA § 2701. Therefore § 1334(c)(1)(D) states will not be unique. 2. OPM interprets phase-in to permit phase-in of compliance with (c)(1)(D) – OPM rationale is that MSPP issuer has four years to offer MSPs in each exchange in all states - § 1334(c)(1)(D) does not include requirements re: particular states MSPP issuer must cover at any of the phase-in years. 3. Potential issuers need flexibility to choose initial states and order in which they phase in other states.		guidance regarding what it believes to be a realistic timeline and strategy for phase-in.
C. Premiums, rating factors, medical loss ratios, and Risk Adjustment § 800.201-800.204				
1. General Requirements § 800.201				
85.	72593, 72604*	(a) OPM will negotiate premiums with MSPP issuer on state by state basis the premiums for each MSP offered by that issuer in that state. Such negotiations may include negotiations about cost-sharing provisions.	OPM intends that each MSP set its premiums on a state-by-state basis. Unlike the FEHBP there will not be any MSPs that are offered at one premium nationwide. Therefore, OPM intends to follow state rating laws as much as practicable so as not to distort local markets.	In California, the Exchange is standardizing cost-sharing and benefit plan design. Allowing MSPs to have different cost-sharing requirements will create an un-level playing field and could create adverse selection concerns. In states where cost-sharing is standardized in the Exchange, OPM should not negotiate cost-sharing provisions.

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86.	72593, 72605*	(b) Premiums in effect for 1 year		
87.	72593, 72605*	(c) OPM will issue guidance addressing methods for development of premiums for MSPP. Such guidance will follow state rating standards . . . to the greatest extent possible.		
88.	72593, 72605*	§800.201 (d) An MSPP issuer must calculate AV the same manner as QHP issuers under § 1302(d) of ACA as well as any . . . standards set by OPM and HHS.	*[Preamble Only]* OPM recognizes HHS requested comments on calculation of AV in proposed EHB rule . . . the proposed regulation state an issuer would use AV calculator developed by HHS to determine plan's level of coverage . . . OPM proposes in (d) that MSPP issuers calculate AV in same manner.	
89.	72593, 72605*	§ 800.201 (e) OPM rate review process. An MSPP issuer must participate in rate review process established by OPM to negotiate rates for MSPs. The rate review process et. By OPM will be similar to process est. by HHS per PHSA § 2794 & disclose and review standards established under 45 CFR part 154.		
90.	72593	*[Preamble Only]* In approving rates for MSPs, OPM intends to follow state rating standards w/ respect to rating factors generally applicable in a state.		

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		States have flexibility in applying narrower ratios for age and tobacco use and may require issuers to use pure community rating. § 1334 explicitly gives OPM authority to negotiate premiums, profit margins, and MLR. OPM intends to work closely with each state in approving a rate for the MSPs in that state and will consult with that state about patterns in its markets and about other rates an MSPP issuer might be proposing in that state for non-MSPs. However, the final decision regarding rates for MSPs rests with OPM, as required by statute. OPM proposes that MSPP issuers follow state rating standards, and OPM's process will meet the standards with respect to review and disclosure requirements for "effective rate review program" in federal regulations.		
91.	72594, 72605*	(f) State effective rate review – MSPP issuer is subject to state's rate review process including ERRP program est. by HHS per § 2794. HHS reviewing rates for a state – then will defer to OPM's judgment of MSPs proposed rate increase. In the event a state withholds approval	OPM intends to conduct its own rate review process, but intends to share its analysis with each state in which an MSP is operating. MSPP issuers are subject to a state's rate review process including a state's effective rate review program (ERRP)	California seeks clarification regarding which rates the state will be reviewing. Pursuant to the definitions, it appears, although it is not entirely clear, the MSPP issuer is the national organization, with the MSPs being the state-level health plans operating on the exchange. (Please see comments regarding definitions above.)

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		of MSP rate for reasons OPM determines, in its discretion, to be arbitrary, capricious, or an abuse of discretion, OPM retains authority to make final decision to approve rates for participation in MSPP notwithstanding absence of state approval.		The overlap of jurisdiction, coupled with the fact that both OPM and the state are conducting independent rate reviews that will need to be compared and reconciled, seems to be redundant. There is a great deal of detail regarding this process in the preamble that is not carried through in, and is sometimes in contradiction with, the regulations. California recommends OPM amend the regulations to include the process outlined in the Preamble. Otherwise, the regulations are confusing and will be difficult to administer. California requests that 800.201(f) be changed to add the following: • "In the event State withholds approval of or finds a MSP rate unreasonable for reasons that are not arbitrary, capricious or abuse of discretion, the decision of the state review agency will hold" • A dispute resolution process between the states and OPM that does not rely solely on the discretion of the Director of

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				OPM.
92.	72594, 72605*	*[Preamble Only]* Each state would have the opportunity to review the MSP rates under its own procedures and processes. If a state disagrees with OPM's determination to approve the MSP rates, OPM would work with the state to resolve the differences. OPM expects few such disagreements will arise and, if they do, that we will be successful in resolving them in a manner that is acceptable both to OPM and the state at issue. In the event a state withholds approval of an MSP rate for reasons that OPM determines, in its discretion, to be arbitrary…the Act authorizes the director to make the final decision to approve rates for participation in MSPP without state approval. OPM expects director will rarely, if ever, have to exercise this authority to approve MSP rates over the object of a state. After OPM and the MSPP issuer complete the rate negotiation process, and OPM approves the rates, an MSPP issuer will file rates with the Exchange, when necessary to post MSP premium and rate information to the Exchange portal, and with the State, when necessary to meet licensure requirements.	OPM welcomes comments on whether this is an appropriate approach and on the impact of this approach.	California recommends the proposed rule should be revised so that, for states that have been determined to have an effective rate review program and that review rates for the state-level MSPs, OPM will accept those rate review analyses and review them only for consistency. As with HHS, OPM should accept a state's review if that state has been determined to have an "effective rate review program. (see p. 81004 Fed Reg. Dec. 23, 2010, vol. 75, No. 246.)

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93.	72594, 72605*	(g) Single Risk Pool – MSPP issuer must consider all enrollees in an MSP to be in same risk pool as all enrollees in all other health plans ion individual market or small group market per § 1312(c) of ACA plus state and federal laws		
2. Rating Factors § 800.202				
94.	72594, 72605*	(a) Permissible rating factors (based on § 2701 of ACA)	OPM intends to follow state rating standards with respect to rating factors, including the application of tobacco use.	
3. Medical Loss Ratio § 800.203				
95.	72594, 72605*	(a) Required MLR – MSPP Issuer must attain 1) MLR required under § 2718 & HHS regulations 2) Any MSP-specific MLR that OPM may set in the best interest of MSP enrollees or that is necessary to be consistent with a state's requirements w/ respect to MLR.	OPM reserves authority to impose different, MSP-specific MLR threshold – i.e.. An MLR threshold based only on an MSPP issuer's MSP population in each state – if would be in best interests. Not OPM's intention to apply a national aggregate MLR. OPM requests comments on its proposal to set an MSP-specific MLR.	MLR ratios for each MSP must be determined and administered on a state-by-state basis. The MLR requirements for MSPs must be same as for other qualified health plans; California does not agree that OPM should have the authority to set MSP-specific MLR thresholds at Health & Safety Code § 1367.003, and Insurance Code § 10112.25.
96.	72594, 72605*	(b) Consequences – MSPP issuer fails to attain MLR in (a) – OPM may take any appropriate action…intermediate sanctions, suspension of marketing, decertifying in one or more states, terminating MSPP issuer's contract per § 800.404		
4. Reinsurance, risk corridors, and risk adjustment § 800.204				

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97.	72594, 72605*	(a) Transitional Reinsurance - MSPP issuer must comply with § 1341 of ACA . . . and any applicable fed/state regulations under that section that sets forth requirements to implement transitional reinsurance program for individual market.	For example – if state imposes additional reinsurance assessments on issuers, MSPs are subject to such assessments in order to maintain a level playing field.	California strongly agrees with 800.204(a).
98.	72594, 72605*	(b) Temp. risk corridors – MSPP issuer must comply with § 1342 of ACA . . .		
99.	72594, 72605*	(c) Risk adjustment program – MSPP issuer must comply with participate [sic] in the risk adjustment program		There is a typographical error in this § 800.204(c) in the phrase "comply with participate in." Please clarify: is this sentence intended to read "An MSPP issuer must participate in…"?
D. Application and Contracting procedures 800.301 – 800.306				
1. MSPP Contracting § 800.303				
100.	72606*	(a) Participation in MSPP		
101.	72606*	(b) Standard contract – OPM will establish a standard contract for the MSPP		OPM should require MSPs to enter into a contract with the Exchange, including the same non-negotiable terms that California QHPs are required to adhere to, or should amend the proposed regulation so that MSPs must abide by the same contractual provisions that the state Exchange requires of QHPs.
2. Term of the contract §800.304				
102	72606*	(a) Term		California recommends the term of the contract should align with open enrollment periods so individuals can more easily move to non-MSPs if the

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				contract is terminated.
E. Compliance				
1. Contract performance § 800.401				
103	72595, 72606*	(a) General		Generally, California strongly recommends including state performance evaluations in performance standard review.
2. Contract Quality Assurance § 800.402				
104		(a) General – section prescribes general policies and procedures to ensure services acquired under MSPP contracts conform to contract's quality requirements		OPM should require MSPs in California to adhere to the quality assurance terms that obligate all other California QHPs either through execution of a contract with the Exchange or by amending the proposed regulation so that MSPs must abide by the same contractual provisions that the state Exchange requires of QHPs.
3. Compliance Actions § 800.404				
105	72596, 72607*	(a) Causes for OPM compliance Actions 1) Failure to meet requirements in § 800.401 a & b 2) MSPP issuer's sustained failure to perform the MSPP contract in accordance with prudent business practices, as described in § 800.401(c) 3) Pattern of poor conduct or evidence of poor business practices such as those described in § 800.401(d) 4) Such other violation of		California strongly recommends including state performance evaluations in performance standard review. OPM should amend § 800.404 to specifically include the following in the list of causes for OPM compliance actions: failure to meet state law requirements, failure to meet state phase-in requirements and service area requirements.

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		law/regulation as OPM may determine		
106		§ 800.404 (b) Compliance Actions 1) OPM may impose compliance action against MSPP issuer at any time during contract term . . . 2) Compliance actions may include, but are not limited to: i. Corrective action plan ii. Intermediate sanctions iii. Performance incentives iv. Reduction of service area(s) v. Withdrawal of certification of MSPP issuer to offer MSP on exchanges vi. Nonrenewal of MSPP contract and vii. Withdrawal of approval or termination of MSPP contract		
107	72596, 72607*	§ 800.404 (c) Notice of compliance action		California feels it is essential that notice of a compliance action against an MSPP issuer be provided to the state or states in which the MSPP issuer's MSPs are operating or in all states if the MSPP has completed phase-in, at the same time notice is provided to the MSPP issuer.

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				California asks OPM to amend § 800.404 to include such notification in subparagraph (c). States should be given an opportunity to comment or make recommendations regarding appropriate action, including providing additional information regarding the MSPP Issuer.
4. Reconsideration of Compliance Actions § 800.405				
108	72596, 72608*	(a) MSPP issuer may request OPM reconsider determination re: withdrawal, nonrenewal, termination		California requests OPM provide notification of any MSPP issuer request for reconsideration to the state or states in which the MSPP issuer's MSPs are operating, or in all states if the MSPP has completed phase-in.
F. Appeals by Enrollees for Denial of Claims for Payment or Services				
§ 800.504 External Review				
109	72597, 72608*	(a) External review by OPM – OPM will conduct external review of adverse benefit determinations using a process similar to OPM review of disputed claims under 5 CFR 890.105(e).		OPM should rely upon a state's external review program when an effective state review process is in place. Many states rely upon their external review process to see trends that initiate regulatory reviews or enforcement actions. If OPM reviews these determinations and the state does not, it will make it difficult for states to see areas where MSP issuers are consistently violating state law and where state enforcement actions are needed. , At the minimum, California

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				recommends the regulation should provide the state will be informed about complaints, external reviews and the outcomes of OPM reviews.
G. Miscellaneous				
§ 800.602 – Consumer choice w/ respect to certain services				
110	72597, 72608*	(a) Assured availability of varied coverage. Consistent with § 800.104, OPM will ensure at least one of the MSPP issuers on each Exchange in each state offers at least one MSP that does not provide coverage of services described in § 1303(b)(1)(B) of the ACA		California believes this provision overrides state authority to require reproductive services and to choose which of those services should be available to state residents.
111	72597, 72608*	(b) State opt-out – an MSP may not offer abortion coverage in any state where such coverage of abortion services is prohibited by state law.		Proposed subsection (b) does not include the "termination of opt out language" specified in ACA section 1303(a)(2). In order to fully reflect the provisions of section 1303(a), California suggests deleting the language in subdivision (b) and replacing it with the following language: (b) A MSP issuer must comply with each State's law pertaining to reproductive services coverage in QHPs as specified in ACA section 1303(a) (42 USC 18023(a)).