



September 26, 2011

Mr. Steve Larsen
Director
Center for Consumer Information and Insurance Oversight (CCIIO)
Centers for Medicare & Medicaid Service (CMS)
U.S. Department of Health and Human Services
Attention: CMS-9989-P, RIN 0938-AQ67, CMS-9975-P
P.O. Box 8010
Baltimore, MD 21244-8010

Dear Director Larsen:

The National Business Group on Health appreciates the opportunity to comment on the initial proposed rule on the health insurance exchanges and Qualified Health Plans (QHPs). We applaud the CCIIO for many of the provisions in the proposed rule that would promote administrative simplicity, national uniformity, competitive marketplaces and potentially transform the health care delivery system.

In addition to this letter, we also plan to comment on the separate rules published in the *Federal Register* on August 17, 2011 and due on October 30, 2011 regarding eligibility for the health insurance premium tax credits and the eligibility determinations and exchange standards for employers.

The National Business Group on Health represents over 329 companies, including many of America's largest employers (67 of the Fortune 100) who voluntarily provide health benefits and other health programs to over 55 million American employees, retirees, and their families.

Many of our members and other employers may interact with the exchanges if they have potentially eligible populations (individuals with coverage that is "unaffordable" or not "comprehensive", early retirees, COBRA eligibles, spouses, dependents or contract, part-time or temporary employees) in 2014 and if states or the District of Columbia permit them to participate in 2017. In addition, the exchanges represent a unique opportunity to transform the way we pay for and deliver health care. Therefore, our members want to assure that the exchanges promote high quality, affordable, clinically appropriate and evidence-based care.

Accordingly, we make the following recommendations to the initial proposed rule, which reflect the specific suggestions and concerns of our member companies:

The National Business Group on Health applauds the following provisions in the proposed rule

- **Requiring the exchanges to consult with large employers and include board members with the relevant experience necessary to set up the exchanges**
- **Creating a single, national eligibility application for exchange, Medicaid and the Children’s Health Insurance Program (CHIP) coverage**
- **Encouraging states to establish regional exchanges and coordinate exchange functions with other states**
- **Requiring exchange plans to meet national accreditation standards similar to Medicare Advantage plans**
- **Establishing uniform coordination of coverage**
- **Streamlining premium collection from employers and distribution to plans**

The National Business Group on Health has the following recommendations where the proposed rule specifically asks for comments

Establishing the Structure and Governance of the Exchanges

- **Encourage states to set up non-profit entities to administer exchanges rather than base them at new or existing state agencies—If they are government agencies the government should insulate the exchanges from politics when they make decisions**

Transitioning to and from State-led or Federally-led Exchanges

- **Require states to meet a high bar if they want to take over federally-led exchanges after 2014**
- **Require states taking over the federally-led exchanges after 2014 to administer business functions jointly with the federal government**

Allowing States to Administer Business Functions Jointly with Other States and the Federal Government

- **Require states to administer exchange business functions jointly with other states and the federal government**
- **Require states to share eligibility and enrollment information between their individual and SHOP (small employer) exchanges**
- **Require states to merge eligibility and enrollment information and other administrative functions when they have multiple exchanges in one state or offer access to exchanges in multiple regions or more than one state**

Allowing Multistate Plans to Meet Federal Office of Personnel Management (OPM) Standards, Not State Criteria

- **Require multi-state plans applying to OPM to offer the same national, uniform plan in all of the exchanges they wish to enter**
- **Deem multi-state plans currently offered to employees before 2014 as “qualified” multi-state plans as long as they meet federal certification requirements**
- **Allow OPM to provide a waiver from the “essential health benefits” mandate for at least one multi-state plan as long as the plan still meets the “affordable” and “comprehensive” standards**
- **Allow OPM to provide the administrative functions of the multi-state exchange plans for multi-state employers**

Promoting Administrative Simplicity

- **Permit exchange plans to limit rate changes to once annually (plan rates should apply through the entire year for those already covered)**

Structuring Exchange Enrollment Periods

- **Provide “maximum flexibility” for COBRA-eligible populations to participate in exchange coverage**
- **Limit exchanges’ annual enrollment periods to a maximum of 3 weeks**
- **Align Section 125 enrollment “grace” periods with the exchange plans**
- **During special enrollment periods, allow individuals participating in the exchanges to change only their coverage levels (single to family), but not their plan elections**
- **Establish a residency requirement for eligibility for exchange coverage for a permanent move under a special enrollment period that is stronger than Medicaid’s lax “intent to remain” standard**

Improving the SHOP (Small ER) Exchanges

- **Allow participating employers 90 days from July 1 to choose the level of coverage and specific plan (s) they want to offer to their employees in the exchanges**
- **SHOPs should not prohibit eligible employers from offering exchange coverage to all of their employees**
- **Minimize the information that employers must submit to the SHOPs**

Giving States Ample Time to Review the Federal Risk Adjustment Methodology

- **Provide a minimum 90-day timeframe to allow states time to review the proposed federal risk adjustment methodology to promote greater uniformity and market stabilization for the exchange plans**

The National Business Group on Health has the following recommendations not specifically requested in the proposed rule

Promoting High Quality Plan Selection in the Exchanges

- **Require exchanges to act as highly active purchasers**
- **Continually set high quality standards for plans to participate in the exchanges**
- **Require that all exchanges use the National Committee for Quality Assurance's (NCQA) highest rating for accreditation—"Excellent"—as the standard for QHPs participating in the exchanges**
- **Require exchanges maintain a rigorous focus, well beyond premiums and administrative costs, on reducing the total costs of care in the health care system**
- **Require every exchange to appoint a Chief Value Officer to maintain organizational focus on the value of the exchanges and health care services**

Promoting National Uniformity

- **Establish one single set of exchange rules rather than potentially 50 or more separate ones**
- **Adopt national standards and uniform processes wherever state-by-state variation would add costs and complexity without adding significant incremental value**
- **Provide model communications and templates as-soon-as-possible to help states avoid wasteful spending and rework**

Streamlining Financial Transactions with the Exchanges

- **Allow employers to submit exchange plan premiums to one central hub for the individual and SHOP exchanges**
- **Ban paperwork for financial transactions in the exchanges and use electronic methods exclusively**
- **Allow a "grace period" for employees and employers on behalf of employees to make payments to the exchanges/exchange plans as long as they make a "good faith" effort**

We look forward to continuing to work with the CCIIO on this process. Please contact me or Steven Wojcik, the National Business Group on Health's Vice President of Public Policy, at (202) 558-3012, if you would like to discuss our comments in more detail.

Sincerely,

A handwritten signature in cursive script that reads "Helen Darling". The signature is written in black ink and is positioned above the printed name.

Helen Darling
President and CEO

cc: Ms. Nancy-Ann DeParle, Deputy Chief of Staff, The White House
The Honorable Kathleen Sebelius, Secretary, U.S. Department of Health and
Human Services

Details of The National Business Group on Health's Recommendations on the Proposed Exchange Rules

The National Business Group on Health applauds the following provisions in the proposed rule

- **Requiring the exchanges to consult with employers and include board members with the relevant experience necessary to set up the exchanges**

The proposed rule requires the exchanges to regularly consult with large employers; health insurance issuers; health care providers, agents and brokers; public health experts; Indian tribes; state Medicaid and CHIP agencies; small employers and self-employed individuals; advocates for enrolling hard-to-reach populations; individuals and entities with experience in facilitating enrollment in health coverage; and consumers enrolled in exchange plans. The majority of the board members can not include those who sell health insurance and must represent consumer interests and have relevant experience in health benefits administration, health care finance, health plan purchasing, health care delivery system administration, public health, or health policy issues related to the small group and individual markets and the uninsured. The proposed rule specifically asks for comments on the types of representatives that should be on the exchange governing boards to ensure they represent consumer interests and that the exchange boards have the necessary technical expertise to ensure successful operations.

We strongly support CCIIO's decision to add large employers to the list of stakeholders that exchanges must consult with as they establish programs and throughout ongoing operations. Many large employers have operated "exchanges" for their employees to select from among a set of plan options during annual open enrollment periods. These employers have years of experiences and lessons learned from administering effective and efficient health care benefits for employees and plan participants. We also recommend CCIIO require the exchanges to include representatives from the health insurance industry who will likely possess the relevant expertise necessary to answer a number of the hundreds if not thousands of technical decisions necessary to build the exchanges.

- **Creating a single, national eligibility application for exchange, Medicaid and the Children's Health Insurance Program (CHIP) coverage**

The proposed rule requires the Secretary of Health and Human Services (HHS) to create a single, streamlined application form for determining eligibility for exchange tax credits, cost-sharing reductions, Medicaid, CHIP and the Basic Health Plans (BHP) if states choose to offer them. HHS plans to create both a paper-based and web-based application. HHS will only approve alternative applications that meet federal standards and will allow individuals to file applications online, by telephone, mail or in person.

We strongly applaud CCIIO's efforts to create a single, streamlined application form to determine eligibility for exchange tax credits, cost-sharing reductions, Medicaid, CHIP and the BHPs if states choose to offer them. We also support CCIIO's proposed

streamlined application for employer participation in the SHOPs (small employer insurance exchanges).

We also recommend that CCIIO require applicants to complete their applications using a central federal hub. Doing so will help accomplish your goal to simplify the application process so applicants do not have to fill out multiple forms or deal with different state application processes. Establishing one central hub for exchange applicants should reduce, if not eliminate the collection of duplicate information.

We also recommend that CCIIO require all applicants to file electronic applications. From our experience, paper based applications only increase administrative costs and the risks to receive partial, inaccurate or illegible information from applicants. Exchanges can easily verify electronic information and it makes it easier and much more cost effective if the exchanges need to transmit applicants' information to the other exchanges, employers, states or applicants and their family members.

- **Encouraging states to establish regional exchanges and coordinate exchange functions with other states**

The proposed rule allows states to establish regional exchanges and coordinate exchange functions with other states.

We strongly applaud the CCIIO for encouraging states to establish regional exchanges and recommend the states coordinate exchange functions (administration and governance) with other states as much as possible. Establishing regional exchanges will promote consistency, avoid duplicating existing efforts, reduce administrative costs and minimize confusing people eligible for coverage in the exchanges.

- **Requiring exchange plans to meet national accreditation standards similar to Medicare Advantage plans**

The proposed rule requires exchange plans to meet national accreditation standards similar to Medicare Advantage plans.

We applaud the accreditation of exchange plan issuers by HHS and strongly recommend that exchanges implement a rigorous accreditation process similar to the National Committee for Quality Assurance (NCQA). Accreditation helps employers and consumers distinguish between health plans based on quality and value. NCQA's accreditation process evaluates not only the core systems and processes that make up a health plan, but also the actual results that the plan achieves on key dimensions of care, service and efficiency.

- **Establishing uniform rules for coordination of coverage**

The proposed rule states that when individuals are no longer eligible for exchange coverage because they become eligible for other coverage (e.g. employer coverage), the last day of their exchange coverage is the day before the effective date of the new (employer or other) coverage.

We strongly support the uniform coordination of coverage rules. Establishing uniform coordination of coverage will help prevent dual coverage or gaps in coverage and smooth transitions from one type of coverage to another.

- **Streamlining premium collection from employers and distribution to plans**

To simplify the administration of health benefits among small employers, the proposed rule allows the exchanges to compile a single monthly bill for participating employers for all of the QHPs that their employees enroll in and to pay a single monthly amount that the exchanges will distribute to the appropriate QHPs.

We strongly support requiring the exchanges to calculate and submit one monthly bill to employers for their employees enrolled in exchange plans. Without this option, employers participating in the exchanges would have to pay multiple bills from different QHPs each month and incur higher administrative costs.

If the exchanges take on the responsibility for the collection and payment of premiums, they should also ensure that these payments are distributed to the exchange plans. Employers entering the exchanges through the SHOPS should not have to worry that the SHOPS will handle the financial transactions for their employees one year and then possibly shift this burden back onto employers in the future.

The National Business Group on Health recommendations where the proposed rule specifically asks for comments

Structure and Governance of the Exchanges

- **Encourage states to set up non-profit entities to administer exchanges rather than base them at new or existing state agencies—If they are government agencies the government should insulate the exchanges from politics when they make decisions**

The proposed rule grants states complete flexibility to establish exchanges in a number of ways, including: existing state executive branch agencies or new independent public agencies; existing state non-profits or new non-profits; by partnering with other states to form regional exchanges; by establishing multiple subregional (smaller) exchanges within the states that serve geographically distinct areas; or by establishing separate or joint governance and administrative structures for their individual and SHOP exchanges. The proposed rule specifically asks for comments on the accountability structure and governance of the exchanges.

We prefer that CCIIO require states to set up non-profit entities to administer the exchanges—our primary goal is to insulate the governing entities from politics when they make decisions. The National Business Group on Health’s experience is that while government needs to play a strong role in setting and enforcing the "rules of the road," independent, non-profit entities, and comparable health care benefit purchasing entities, accountable to their states and staffed by people with specific, relevant experience to operating effective model health insurance exchanges have the necessary tools to administer and implement the exchanges. We also recommend allowing exchanges to contract with for-profit entities with successful records performing the business functions of the exchanges.

We also favor non-profit entities over state agencies because state contracting requirements are complex, expensive and administratively cumbersome.

We also base our recommendation for states to set up non-profit entities to administer the exchanges because of the need for strong, activist exchanges—a role that will require flexibility and adaptability in contracting and staffing that many state governmental agencies have difficulty achieving.

Non-profit entities also have more immunity from political influence than state agencies and the exchanges need protection from political pressures, provider interests, or pressure from advocacy groups.

We also support the proposed rule’s strong sunshine laws, conflict of interest rules and requirements for ethical codes of conduct for its board members and recommend CCIIO annually review the accountability and structure of the exchange governance boards.

Transitioning to and from State-led or Federally-led Exchanges

- **Require states to meet a high bar if they want to take over federally-led exchanges after 2014**

The proposed rule allows states to apply to operate an exchange after 2014, even if a state is not approved or conditionally approved, or if they initially choose not to, as long as they have an approved or conditionally approved exchange plan by January 1 of the year prior to operating the exchange.

We recommend that CCIIO require states to meet the same high standards required in the federally-led exchange before allowing states to take over the exchanges after 2014—including the ability to enforce high quality health plan standards and implement payment structures that reward quality by providing increased reimbursement for improving health outcomes by implementing activities for quality reporting, effective case management, care coordination, chronic disease management, medication and care compliance initiatives, the medical home model, activities to prevent hospital readmissions, improve patient safety and reduce medical errors and implement wellness and health promotion activities.

- **Require states taking over the federally-led exchanges after 2014 to administer business functions jointly with the federal government**

The proposed rule allows federal-state partnerships that would encourage states to conduct business functions of exchanges jointly with the federal government, including eligibility and enrollment; financial management; and health plan management systems and services.

We recommend that CCIIO require states taking over the federally-led exchanges after 2014 handle the administration of the exchanges' business functions jointly with the federal government (determining eligibility and enrolling people into exchange plans, seamlessly transitioning people between employers /exchanges/SCHIP and Medicaid coverage, processing financial payments, and choosing high value health care plans). This requirement will promote consistency and avoid duplicating existing efforts, increasing administrative costs or confusing employee populations eligible for exchange coverage.

Allowing States to Administer Business Functions Jointly with Other States and the Federal Government

- **Require states to administer exchange business functions jointly with other states and the federal government**

As mentioned above, the proposed rule encourages states to administer business functions jointly with other states and the federal government for eligibility and enrollment; financial management; and health plan management systems and services. The proposed

rule specifically asks for comments on how to implement or construct a federal-state partnership model. Under the federal-state model, HHS will allow states to choose to operate plan management functions and/or some consumer services. However, HHS would still manage call center operations, website management and written correspondence with consumers to support eligibility and enrollment. The federal-state partnership model may also classify as a federally-led exchange.

We strongly support the proposed rules encouraging states to combine and streamline business functions with other states and the federal government. However, HHS has limited the federal-state partnership model to plan management and some consumer assistance. Accordingly, we recommend that the federal-state partnership standardize as many business functions as possible (eligibility determinations (verifications, redeterminations of applicants' information); certification, recertification and rating of qualified health plans; billing, accounting and processing premiums; payment transfers; oversight and appeals; etc.) and build off the existing nationwide standards (enrollment periods, applications, etc.) to ensure states avoid duplicating existing efforts, increasing administrative costs or confusing employee populations eligible for exchange coverage. We also recommend that HHS only approve exchange applications that combine their business functions with the federal government.

- **Require states to share eligibility and enrollment information between their individual and SHOP exchanges and share governance functions**

The proposed rule provides each state with flexibility to merge its individual market exchange and SHOP (small employer) exchange under a single administrative or governance structure. Each state can also choose to operate these functions under separate governance or administrative structures. The proposed exchange rule also creates a uniform application for Medicaid/CHIP and eligibility for the exchange tax credits (regardless of state) for the individual exchanges and a separate uniform application for the SHOP exchanges.

We recommend that CCIIO require the states to share eligibility and enrollment information from their individual and SHOP exchanges to allow both the exchanges and employers to better identify individuals transitioning among different coverage. While the uniform applications will make it easier to identify individuals whose status changes as they gain jobs or better coverage to leave the exchanges or lose these and gain access to tax credits to enter the exchanges, not all states will integrate the eligibility and enrollment information of their separate exchanges which will make it more difficult to track employees transitioning among the exchanges and other coverage. We also recommend that CCIIO require individual and SHOP exchanges to share a single administrative and governance structure, which will lower administrative costs and increase consistency.

- **Require states to merge eligibility and enrollment information and administrative functions when they have multiple exchanges in one state or offer access to exchanges in multiple regions**

The proposed rule implements the law's provision allowing the states to create regional exchanges (operating in two or more states) and requires these states to consider how regional exchanges would work with participating states' insurance departments; provide a consistent level of consumer protections across the states; establish procedures for states to withdraw from regional exchanges, and how each state would finance the regional exchanges. The proposed rule specifically asks for comments on operations concerns for exchanges that cover areas across state lines.

We recommend that CCIIO require states with multiple exchanges in one state or in multiple regions to merge eligibility and enrollment and other administrative functions to streamline transactions, lower the administrative burden on employers and employees and promote national consistency. This requirement will allow both the exchanges and employers to better identify individuals transitioning among different coverage, avoid duplicating existing efforts, increasing administrative costs or confusing exchange eligible populations.

Allowing Multistate Plans to Meet Federal OPM Standards, Not State Criteria

- **Require multi-state plans applying to OPM to offer the same, national, uniform plan in all of the exchanges they wish to enter**

The proposed rule requires OPM to enter into contracts with health insurance issuers to offer at least two multi-state QHPs through each exchange in each state. The proposed rule also requires multi-state plans to offer a uniform benefits package in each state and deems multi-state plans certified to be offered in all of the exchanges. The proposed rule also phases in over four years when multi-state plans must offer coverage in every state.

Phasing in over four years when multi-state plans must provide access to coverage in every state means that employers' with exchange eligible populations in 2014 will not likely have access to a single, uniform, national QHP in every state unless CCIIO makes it a requirement. Accordingly, we recommend that CCIIO require multi-state plans applying to OPM to offer at least one national, uniform QHP in all of the exchanges (either state-led/or federal-led) that they wish to participate in. CCIIO has yet to clarify if employees of multi-state employers who currently enroll in insurance plans where they reside (potentially in different states) before 2014 and whose employers participate in the SHOP exchanges will have the opportunity to enroll in a single, uniform, national QHP in every state after the exchanges start in 2014.

- **Deem multi-state plans currently offered to employees before 2014 as “qualified” multi-state plans as long as they meet federal certification requirements**

The proposed rule states that employers with employees in multiple states can offer coverage in the SHOP (small employer) exchanges serving their employees’ primary worksites.

We recommend that OPM deem plans currently offered by multi-state employers to employees in more than one state before 2014 as qualified multi-state plans once the exchanges begin in 2014, as long as they meet federal certification requirements. Deeming multi-state plans operating before 2014 as “qualified” multi-state plans will ensure that multi-state employers can offer consistent coverage in the exchanges to their employees.

- **Allow OPM to provide a waiver from the “essential health benefits” mandate for at least one multi-state plan as long as the plan still meets the “affordable” and “comprehensive” standards**

The proposed rule requires the OPM to enter into contracts with health insurance issuers to offer at least two multi-state QHPs through each exchange in each state. Multi-state QHPs must offer a benefits package that is uniform in each state, includes the “essential health benefits” package and meets the other plan requirements for all other exchange plans (eliminating cost sharing for government-required preventive services, implementing HHS-approved internal review and external appeals processes, etc.). The proposed rule also deems multi-state plans certified to be offered in all exchanges.

We recommend that CCIIO allow OPM to offer a waiver from the “essential health benefits” package to at least one multi-state plan as long as the plan still meets the “affordable” and “comprehensive” standards. Employers will likely find flexible multi-state plans much more attractive when they consider entering the exchanges.

- **Allow OPM to provide the administrative functions of the multi-state exchange plans for multi-state employers**

The law allows OPM to establish separate units or offices to ensure the administration of multi-state plans does not interfere with the administration of the Federal Employee Health Benefits Program.

Since OPM can establish separate units to administer the multi-state plans, we recommend that CCIIO allow OPM to provide the administrative functions of the multi-state exchange plans for multi-state employers rather than deferring to the 50 or more different state exchanges. Employers will likely find multi-state plans administered from one federal hub to share information (employees’ lowest cost plan options and their cost share), verify employment and process financial transactions much more attractive when they consider entering the exchanges, if the states allow them to participate in 2017.

Promoting Administrative Simplicity and National Uniformity

- **Permit exchange plans to limit rate changes to once annually (plan rates should apply through the entire year for those already covered)**

Under the proposed rule, SHOPs and other exchanges will require all QHPs to make any rate changes at a uniform time that is either quarterly, monthly, or annually. Because employers will purchase coverage through the SHOPs at different times during the year (rolling enrollment), employers will encounter different rates based on the month or quarter they purchase coverage. Although QHPs may change rates during the year, those rates only apply to new coverage and annual renewals. The proposed rule asks for specific comments on whether the CCIIO should allow a more permissive or restrictive time frame for QHPs' rate reviews.

We recommend annual intervals for rate setting of QHPs in the SHOPs so employers will have more useful rate comparison information when choosing exchange plans for their employees. While employers might receive lower rates when they decide to enter the SHOPs, they could also face higher rates and restricting the rate setting of QHPs in the SHOPs to annual changes will add stability to QHP rates for employers to decide if they want to participate in the exchanges.

Structuring Exchange Enrollment Periods

- **Provide “maximum flexibility” for COBRA-eligible populations to participate in exchange coverage without special enrollment restrictions**

The proposed rule creates special enrollment periods for exchange coverage in QHPs when individuals lose their eligibility for “minimum essential coverage” which includes “exhaustion of COBRA continuation coverage.”

We believe the federal government should eliminate COBRA by 2014 because it will be unnecessary because of the exchanges. COBRA-eligible populations will likely find exchange coverage more affordable, particularly if they receive a tax credit. As a secondary option, we recommend that the federal government provide “maximum flexibility” for COBRA-eligible populations to participate in exchange coverage. Therefore, we strongly urge the federal government to allow COBRA-eligible populations already enrolled in COBRA to drop their existing COBRA coverage and gain access to the tax credits (if eligible) and the exchange plans.

Without action by the federal government, state-led exchanges could require COBRA eligibles to “exhaust” their COBRA coverage before they enroll in exchange coverage.

- **Limit exchanges' annual enrollment periods to a maximum of 3 weeks**

The proposed rule includes the following enrollment periods for the initial, annual, and special open enrollment periods for exchange coverage:

- Initial Enrollment: October 1, 2013 to February 28, 2014
- Annual Enrollment: October 15 to December 7, for plans beginning Oct. 2014
- Possible Alternative: November 1 to December 15

The proposed rule specifically asks for comments on the proposed initial, annual and special enrollment periods.

We recommend that exchanges' annual enrollment periods run for a maximum of 3 weeks. Employers know from experience that deadlines encourage eligible individuals to sign up for coverage. More time does not always equal higher enrollments and most people often wait until the last minute to sign up for coverage or even enroll during plans' unpublished grace periods. We also recommend CCIIO and the exchanges implement an information campaign for eligible populations before an annual enrollment period. If necessary, the exchanges/HHS should also consider an additional information campaign for an additional 2 week enrollment (correction/grace) period.

- **Align Section 125 enrollment “grace” periods with the exchange plans**

The proposed rule specifically asks for comments on the proposed initial, annual and special enrollment periods.

We recommend aligning 125 enrollment periods and the exchange plans' enrollment periods for consistency. Many employers allow their employees to submit an enrollment form for Section 125 plans during a “grace” period of 30 days after the actual plan start date. If exchange plans have different “grace” periods it would likely confuse employees.

- **During special enrollment periods, allow individuals participating in the exchanges to change only their coverage levels (single to family), but not their plan elections, during qualifying events for special enrollment periods**

The proposed rule requires exchanges to allow existing QHP enrollees that qualify for a special enrollment period to only change plans within the existing level of coverage. The proposed rule specifically asks for comments on the requirements to maintain a single level of coverage throughout the year to avoid adverse selection.

We support the proposed rule and recommend allowing employers' eligible populations participating in the exchanges to only change coverage levels (single to family) during qualifying events for special enrollment periods, but not their plan elections. Employer-sponsored plans already have this requirement to avoid adverse selection. We recommend the exchanges maintain the same requirement in order to promote consistency with employer-sponsored coverage and to avoid confusing employees transitioning between employer-sponsored coverage, exchange plans, Medicaid and CHIP.

- **Establish a residency requirement for eligibility for exchange coverage for a permanent move under a special enrollment period that is stronger than Medicaid’s lax “intent to remain” standard**

In addition to the usual “qualifying events,” the proposed rule creates several other 60 day special enrollment periods for populations eligible for exchange coverage including moving outside of plan or exchange area either the date of the permanent move or on the date these individuals provide notification of a permanent move. The proposed rule asks for specific comments on the special enrollment period for exchange coverage resulting from permanent moves.

We recommend the exchanges establish a residency requirement to avoid “gaming the system” under the special enrollment period when exchange eligible populations move. In particular, employers recommend that exchanges establish a stronger residency requirement than Medicaid’s lax “intent to remain” standard where individuals only have to sign a statement saying they intend to remain at a certain address.

Individuals could easily “game” the system by moving from Philadelphia, PA across the Delaware River to Camden, NJ; that move would change their choice of plans, thus triggering a “special enrollment period.” Some individuals may already be “moving” by utilizing mailing addresses in other nearby jurisdictions to obtain lower premiums. It’s possible to envision a scenario whereby an individual in Washington, DC could use a friend’s mailing address to “move” to Arlington, VA, and thus become immediately eligible for coverage and exchange subsidies.

Improving the SHOP (Small ER) Exchanges

- **Allow participating employers 90 days from July 1 to choose the level of coverage and specific plan (s) they want to offer to their employees in the exchanges**

Under the proposed rule, small employers in the SHOP exchanges and large employers whose states allow them to participate in 2017 can choose the level of coverage (bronze to platinum) or specific plans they want to offer to their employees. However, the SHOP exchanges remain responsible for sending the enrollment transactions to the exchange plans. Employers participating in the SHOP exchanges must choose their plans before the conclusion of their current plans and before employees’ annual open enrollment period for the following year. The proposed rule asks for specific comments on the ability of employers’ participating in the SHOPS to choose the plans available to their employees.

We recommend that CCIIO require the SHOP exchanges to allow participating employers 90 days from July 1 to choose the level of coverage and specific plan (s) they want to offer to their employees in the exchanges. Without this requirement, many states may not tell employers their exchange plan choices until September 1 which will not leave them with a sufficient timeframe to choose which plan (s) they want to offer to their employees.

- **SHOPs should not prohibit eligible employers from offering exchange coverage to all of their employees**

The proposed rule states that small employers with employees in multiple states can offer them coverage in the SHOP (small employer) exchanges serving their employees' primary worksite. However, state SHOPs can also set eligibility criteria (such as the level of full-time employees that employers must cover to participate in the exchanges) which could exclude some multi-state employers' employees from accessing their local exchanges and exchange plans.

We recommend that CCIIO prohibit state SHOPs from placing eligibility criteria on multi-state employers that might prohibit them from offering QHP coverage to their employees in states' small employer exchanges. Otherwise, employers who choose to participate in one state's SHOP exchange may have a number of employees who can not access the local SHOP exchange at their primary worksites.

- **Minimize the information that employers must submit to the SHOPs**

The proposed rule requires minimum employer information that SHOPs must collect on employers' exchange applications including employers' names and addresses; the number of their employees; Employer Identification Numbers (EINs); and the list of qualified employees and their social security numbers. The proposed rule specifically asks for additional information the CCIIO should require SHOPs to collect from employers.

We do not recommend burdening employers with any additional requirements to submit supplementary information not mentioned in the initial proposed rule. Employers already have a lot of documentation requirements under COBRA, ERISA, HIPAA and other federal laws and any new regulations to submit additional information in the current economy will almost certainly increase employers' costs and further strain benefit resources.

Giving States Ample Time to Review the Federal Risk Adjustment Methodology

- **Provide a minimum 90-day timeframe to allow states time to review the proposed federal risk adjustment methodology to promote greater uniformity and market stabilization for the exchange plans**

A separate proposed rule from CCIIO includes a 30-day timeframe between federal publication of the proposed risk adjustment methodology and the finalization of the methods that each state must use which may encourage states to develop their own approach without reviewing the federal methodology first.

We recommend CCIIO implement a new 90-day timeframe to allow states ample time to review the federal risk adjustment methodology to allow greater uniformity and consequently greater market stabilization for the exchange plans. CCIIO's proposed 30-

day timeframe may pose challenges for multi-state plans and will undermine national uniformity in risk adjustment methods.

The National Business Group on Health recommendations not specifically requested in the proposed rule

Promoting High Quality Plan Selection in the Exchanges

- **Require exchanges to act as highly active purchasers**

The proposed rule allows state exchanges to use a combination of the following 4 methods to certify participating health plans, including: 1. Allowing all qualified plans that meet high quality and other criteria to participate; 2. Competitively bidding; 3. Selectively contracting to limit exchange participation to only those plans that rank the highest in terms of certain exchange criteria (value and quality objectives); 4. Negotiating on a case-by-case (individual) basis with plans; and requiring specific quality and cost requirements (selection criteria) for each plan.

We recommend that the exchanges allow all plans that meet certification requirements to participate rather than limiting access to plans selected by the exchanges. However, CCIIO must ensure that exchanges do not become passive facilitators or only "portals" for individuals and employers to select health care coverage.

CCIIO should only allow the exchanges to choose high value plans based on the ability of the plans and their providers to lower costs, eliminate waste and overuse and improve the quality, safety, patient-centeredness and service of our nation's health care delivery system. The exchanges must assume a strong role as active purchasers, not only for the exchange enrollees, but to align with other purchasers in the community to help providers become more effective and efficient in care delivery. The exchanges will not duplicate existing state regulatory structures that already review and approve rates and regulate solvency if the federal government (federally-led exchange) establishes strong national active purchaser standards.

- **Continually set high quality standards for plans to participate in the exchanges**

The proposed rule allows exchanges to implement selection requirements beyond federal requirements for plan participation in the exchanges, including health plans' quality improvement activities; past performance; enhancements of provider networks including the availability of network providers to new patients; service areas of QHPs (the size of a service areas and the amount of choice afforded to the consumers within those service areas); estimated premiums and cost-sharing levels; and premium rate increases in the years before the operation of the exchanges.

While we support allowing state exchanges to require quality and cost standards for exchange plans beyond the current federal requirements in the proposed rule for participation; we strongly recommend that the federal exchanges continually set the bar higher in establishing these standards. Exchanges must actively manage the choices available, and the processes through which employers and individuals participate. We believe that the federal government must act as the standard setters and provide national

standards for the cost and quality of care and enforce those standards through both health plan participation requirements and encourage plans to do so in their payment policy.

- **Require that all exchanges use NCQA’s highest rating for accreditation—“Excellent”—as the standard for QHPs participating in the exchanges**

As stated above, the proposed rule grants the states considerable flexibility in determining the selection requirements for plan participation in the exchanges.

We strongly recommend that CCIIO require NCQA’s highest accreditation standards—“Excellent”—for plans in the exchanges. Where using this standard would result in limited choice of plans, exchanges should adopt the next highest NCQA standard, but require that plans meet the “Excellent” standard within 2 years. Accordingly, plans would have 3 years to get to “Excellent.” If CCIIO does not focus on these QHP standards now, it will find it difficult, if not impossible, to implement them in the exchanges in the future.

We also recommend that CCIIO incorporate the NCQA “Excellent” ranking into the HHS Secretary’s health plan rating system for the exchanges.

- **Require exchanges maintain a rigorous focus, well beyond premiums and administrative costs, on reducing the total costs of care in the health care system**

The proposed rule states that insurance companies will compete for business in the exchanges driving down costs, but does not provide a specific requirement for the exchanges to reduce the “total” costs of care.

We recommend the exchanges maintain a rigorous focus, well beyond premiums and administrative costs, on reducing the total costs of care in the health care system by:

- Eliminating cost shifting to other payers;
- Establishing **specific targets** for the QHPs for reducing waste and overuse in the system;
- Focusing relentless attention on quality and safety;
- Incorporating efficient and effective benefit design innovations in the delivery of care (primary care models (medical homes), convenience care clinics, hospice care for end of life, appropriate use of nurse practitioners, etc.); and
- Addressing administrative costs of health plans and providers.

All of these actions will help reduce the “spend” for both the plan and the plan member, including premiums and out-of-pocket costs at the point of service.

Exchanges must aggressively negotiate the administrative and marketing costs that command so much current attention. However, at the most, these costs represent 15-20 percent of premium costs in the current market. It is the other 80-85 percent of costs—the

cost of health care services, especially hospital care and certain physician specialties and subspecialties as well as diagnostic imaging—that require the most attention.

- **Require every exchange to appoint a Chief Value Officer to maintain organizational focus on the value of the exchanges and health care services**

The proposed rule recommends setting specific requirements to ensure QHPs in all exchanges meet a consistent minimum standard of quality and value, but it does not specify that each exchange must have a Chief Value Officer (CVO) to ensure that the exchanges focus on the “value” of health care services.

We recommend that every exchange appoint a CVO to maintain organizational focus on the value of the exchange and health care services. The CVO should report to the governance board of the exchange or the HHS Secretary when no state based exchanges exist. On a quarterly basis, the CVO should report on the value of hospital, physician and medical services based on a cost value analysis and the latest clinical comparative effectiveness research. Most large companies use a Chief Risk Officer for audits, which exchanges should emulate for this new function. Small and SHOP exchanges may not have the resources for a CVO and the federal government should allow these exchanges to independently contract out this function. The CVO should also provide an estimated impact of the “essential health benefit” requirements and any additional state mandates on the value of plans in the exchanges.

Promoting National Uniformity

- **Establish one single set of exchange rules rather than potentially 50 or more separate ones**

The proposed rule grants states a considerable amount of flexibility to operate their state exchanges and to transition to and from state-led and federally-led exchanges. Even if states do not have an approved or conditionally approved state-led exchange by January 1, 2013, they can still operate an exchange past 2014, as long as they have an approved or conditionally approved exchange plan by January 1 of the year prior to operating the exchange.

While state innovations are certainly welcome that reduce costs and increase efficiency, one single set of exchange rules will also ease the transitions among the exchange plans, employer-sponsored coverage, and Medicaid coverage or between exchanges.

- **Adopt national standards and uniform processes wherever state-by-state variation would add costs and complexity without adding significant incremental value**

The proposed rule allows states considerable flexibility to establish plan quality and efficiency standards, data sharing and process standards for common transactions with employers (plan payments, employee verification, etc.).

We strongly recommend that CCIIO establish national standards with uniform terminology, technology and processes to ease exchanges' interactions with employers, plans and all other stakeholders' interactions with the exchanges.

- **Provide model communications and templates as-soon-as-possible to help states avoid wasteful spending and rework**

The proposed rule does not provide model communications or templates for the state exchanges to comply with the law.

We recommend CCIIO provide model communications and templates as-soon-as-possible to help states avoid wasteful spending and rework for exchange applications, including eligibility determinations (verifications, redeterminations of applicants' information); certification, recertification and rating of qualified health plans; billing, accounting and processing premiums; payment transfers; oversight and appeals, etc. Without clear, standard, model communications and templates states may duplicate federal efforts and increase bureaucracy, costs and confusion. We also strongly recommend CCIIO grandfather states' or participating employers' existing communications that meet or exceed any new requirements under the law. For example, we strongly urge CCIIO to create a standardized model notice for employers to send to their employees about their potential eligibility for the exchanges/tax credits and allow employers to send this notice electronically and annually with employees' existing Summary Plan Descriptions (SPDs).

Streamlining Financial Transactions with the Exchanges

Under the proposed rule, beginning in 2014 for small employers and possibly beginning in 2017 for large employers, exchanges can handle employer premium payments in several ways. Exchanges can decide to:

1. Take no part in the payment of premiums and require that enrollees/employers pay directly to the plans; or
2. Create an electronic "pass through" of premiums to the individual exchange plans without retaining any of the payments; or
3. Establish an option where they collect the premiums from enrollees/employers and pay an aggregated sum to the exchange plans—this does not make the exchanges liable for payment.
4. The exchanges may choose to submit one monthly bill to employers for their employees enrolled in exchange plans.

Exchanges must always allow enrollees to make direct payments to the exchange plans if they want to regardless of what process exchanges choose.

- **Allow employers to submit exchange plan premiums to one central hub for the individual and SHOP exchanges**

Under the proposed rule, depending on the individual state or federal exchange rules, employers participating in the exchanges in 2017 may need to submit premium payments to the exchanges or directly to the plans.

We recommend that CCIIO allow employers to submit exchange plan payments to and from one federal source which then subsequently would transfer payments to the state-led exchanges, the federal exchange and the QHPs. The federal government could use the COBRA subsidy infrastructure as the model to process employer payments for their employees and eligible populations participating in the exchange plans. It would also make it easier for exchanges to the federal government to reconcile overpayment/underpayments/late payments, payment appeals, etc.

- **Ban paperwork for financial transactions in the exchanges and use electronic methods exclusively**

The proposed rule does not specify if the exchanges will only use electronic methods for financial transactions.

We recommend that the exchanges ban paperwork for financial transactions and use electronic methods exclusively to lower administrative cost and allow quick feedback (possibly in real-time depending on the exchanges' IT infrastructures) between the exchanges, employers, exchange enrollees and the federal government to reconcile overpayment/underpayments/late payments, handle payment appeals, etc.

- **Allow a “grace period” for employees and employers on behalf of employees to make payments to the exchanges/exchange plans as long as they make a “good faith” effort**

The proposed rule does not specify when employers must make payments to the exchanges.

We recommend allowing a “grace period” for employees and employers on behalf of employees to the exchanges and the exchanges/exchange plans as long as they are making a “good faith” effort. Exchanges with different levels of information technology may not be able to process payments from employees or employers on behalf of employees to exchange plans in a timely manner causing late or delayed payments. Delays could also occur for any number of reasons including determining if exchange plan enrollees can use Health Reimbursement Arrangements (HRAs) or Health Savings Accounts (HSAs) coupled with High Deductible Health Plans (HDHPs) in the exchanges to cover certain services; individuals or employers awaiting the outcomes of appeals; etc. The “grace period” could follow current COBRA rules (within 45 days of initial election and 30 days after the following due dates). OCIIO should not allow the exchanges to hold employers responsible for employees other exchange eligible populations who enroll in the exchange plans and do not make their payments on time.