



**National  
Business  
Group on  
Health**

50 F Street, NW, Suite 600  
Washington, D.C. 20001  
202.628.9320 • Fax 202.628.9244  
www.businessgrouphealth.org

---

*Creative Health Benefits Solutions for Today, Strong Policy for Tomorrow*

October 4, 2010

Mr. Jay Angoff  
Director  
Office of Consumer Information and Insurance Oversight (OCIIO)  
**Attention: OCIIO-9989-NC**  
Department of Health and Human Services  
Room 445-G  
Hubert H. Humphrey Building  
200 Independence Avenue, S.W.  
Washington, DC 20201

RE: Request for Comments Regarding Exchange-Related Provisions in Title I of the Patient Protection and Affordable Care Act (Affordable Care Act)

Dear Mr. Angoff:

The National Business Group on Health is pleased to respond to the Office of Consumer Information and Insurance Oversight's (OCIIO) Request for Comments Regarding Exchange-Related Provisions in Title I of the Affordable Care Act, published in the *Federal Register* on August 3, 2010 (75 FR 45584).

The National Business Group on Health (Business Group) represents approximately 298, primarily large, employers (including 64 of the Fortune 100) who voluntarily provide health care benefits and other health programs to over 50 million American employees, retirees, and their families.

We appreciate the extraordinary efforts of OCIIO and the Department of Health and Human Services (HHS), as well as the Departments of Treasury and Labor, in implementing the Affordable Care Act. The request for comment is particularly timely given the importance of the exchanges for implementing reform and for the long-term potential of exchanges as mechanisms for organizing choice for consumers.

### **Summary of Main Recommendations**

In order to assist you with the administration of the exchanges we make the following main recommendations, which reflect the suggestions and concerns of our members and are explained in more detail later in this letter:

The federal government should:

- Clarify, in easy-to-understand language, and in a timely way, the specific roles and responsibilities of employers vis-à-vis the state and possibly federally-managed exchanges (benchmarks, plan marketing guidelines, timelines, process, how people become eligible, nomenclature of benefits, etc.);
- Streamline/simplify employers' administrative tasks with their interactions with the exchanges;
- Align COBRA rules with the exchanges;
- Promote national consistency across the exchanges (standardization, a national exchange, uniform rules, and administrative simplification);
- Create a permanent Advisory Board of employers and independent plan administrators with experience running health care plans to advise the states and the federal government as they establish the exchanges;
- Include independent plan administrators with experience running health care plans on the exchange governance boards;
- Promote value and eliminate overuse and waste among exchange plans;
- Maintain clear and public accounting for the total cumulative cost burdens that the exchanges may impose on employers and individuals;
- Require that each exchange have a Chief Value Officer responsible and accountable for an organizational focus on aggressively managing the total costs of care for the effective and efficient operating of the exchange and the quality of participating plans;
- Use the National Committee for Quality Assurance's (NCQA) highest accreditation standards - "Excellent" - for participation of plans in the exchanges;
- Include consumer-friendly and easy-to-understand quality rating systems;
- Require independent external audits of the state exchanges on factors such as performance on quality measures, ability to minimize administrative costs, etc.);
- Work with other purchasers in the community, including business and other government purchasers, such as the new Center for Medicare and Medicaid Innovation, to assure aligned incentives for the entire health delivery community;

- Clarify how employers and exchanges will be required to deal with union, temporary, part-time, or seasonal workers, workers here from other countries for summer employment, and others;
- Clarify how exchanges will conduct outreach to employees and their families;
- Include the patient perspective measures from the Hospital Consumer Assessment of Healthcare Provider and Systems (HCAHPs) survey for the exchange plans with more than 500 enrollees; and
- Require that each exchange obtain independent actuarial certification of plan requirements, rating areas, risk adjustment, risk corridors and reinsurance rules.

### **Business Group Interest and Experience**

Employers have a strong interest in assuring the effective and efficient administration of the Affordable Care Act. Business Group members can provide their experiences and lessons learned as they continually strive to be as effective and efficient as they can in the administration of health care benefits for employees and plan participants.

- Expertise: Our comments reflect our experience in spurring plan innovation and operating company-level “exchanges”. The Business Group represents the nation's leading private- and public-sector employer purchasers of health care benefits who are among the nation's leading innovators driving improvements in quality, safety and health care outcomes. In addition, because of their size, many large Business Group employers have operated “exchanges” for their own employees as they select from among a set of plan options during annual open enrollment periods.
- Alignment: The Business Group has a strong interest in assuring that the exchanges pursue strategies that are aligned with the innovative purchasing approaches of its members. For over 35 years, our large employer members have been strongly committed to ensuring quality, safe health care and investing in wellness programs, and benefits that actually improve the health of employees and their dependents. Assuring that the exchanges foster these health care quality improvements will reinforce our efforts to positively impact the health of all Americans.
  - Business Group members provide health care benefits in the same markets, through many of the same plans and providers, as the future exchanges. If we want to transform care and, in particular, lower spending and greatly improve quality, safety, and health outcomes, all participants in that system, employer purchasers, plans, and exchanges alike, need to pursue aligned strategies.

- Business Group members and other employers may interact with the exchanges, in the short-term if they have eligible employees and dependents, beginning in 2014, and participate in later years, after 2017, if the States choose. Business Group members are deeply concerned about assuring that their employees and family members get the best clinically appropriate care at a sustainable cost. That assurance of value is particularly important as family members may qualify for coverage in the exchanges even if employers do not participate in the exchanges.

### **Guiding Principles for Establishing and Operating Exchanges**

The design of the exchanges is a critical component in the operation and ultimate success of the Affordable Care Act. Before commenting on the specific features of the exchanges, the Business Group proposes several principles that should guide future policy decisions.

Focus on value: If we want to make health care affordable for employers, individuals, families, and the government, the exchanges must adopt, as their primary mission, a focus on value: reducing the total cost of coverage and care (for both the plan and the participant) and increasing the effectiveness, quality and safety of patient-centered care.

The exchanges must maintain a rigorous focus, well beyond premiums and administrative costs, on the total costs of care:

- Driving down underlying costs;
- Taking waste and overuse out of the system;
- Focusing relentless attention on quality and safety;
- Incorporating efficient and effective innovations in the delivery of care (primary care models, 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 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.

The federal government also needs to ensure that plan premiums in the exchanges fairly reflect actual costs so that the exchanges do not shift additional costs onto employers or employees or through the exchanges’ assessments or user fees on participating health insurance issuers for additional state benefits, administrative costs, etc. when the exchanges become self-sufficient on January 1, 2015.

Active purchaser: HHS must ensure that exchanges do not become passive facilitators or only “portals” for individuals and employers to select health care coverage. 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. Exchanges must orient their focus on the value equation noted above.

- **Standard setters:** HHS should provide guidance for exchanges to set high standards for the cost and quality of care and enforce those standards through both health plan participation requirements and payment policy. Exchanges must not let every health plan participate-this is not an "any willing plan" model. Instead, exchanges should evaluate plans based on price, the ability of the plan and its providers to lower total costs, eliminate waste and overuse and improve quality, safety, patient-centeredness and service.
- **Negotiators:** Exchanges must act as active negotiators of premiums, network approaches dealing with total costs, and benefits with plans seeking to offer coverage. However, policy leaders need to recognize that what is driving total costs and premiums is use of services and provider fees. Exchanges can negotiate competitive terms for plan administrative services, marketing, and distribution costs and profit or operating margins, but until we find ways to change the use of services through better health and alternative services, we will not control costs.
- **Benefit design innovators:** Exchanges should encourage and, where appropriate, require health plans to implement value-based benefit design for enrollees. Value-based benefit designs factor in the effectiveness of services and the effectiveness and efficiency of providers in determining coverage, payment, and cost-sharing. Plans use these tools to help assure that plan participants receive quality services and lower cost.
- **Managers of enrollment and consumer choice:** Exchanges must actively manage the choices available, and the processes through which employers and individuals participate. Consistent with the exchange role as standard setters, exchanges must focus on real choice among a selected number of plans and models, and not just make available a large and confusing multiplicity of insurance products.
- **Monitors:** Exchanges must track and monitor the performance of the participating plans and providers and the cost and quality of the care that they are providing to enrollees.

**Standardization:** HHS must standardize the operations of exchanges for employers, individuals and health plans. Employers that operate in more than one state should not have to confront a confusing array of different rules among the exchanges in which their employees seek care. After initial implementation, the federal government needs to standardize data systems and data specifications, as later in the decade, beginning in 2017, larger employers might have the option to participate directly in the exchanges. In addition, the federal government should only certify exchanges with high quality and very capable health information technology systems. Employers, plans around the nation and all stakeholders will find it easier to evaluate what works and does not work for continuous quality improvement if the exchanges have more similarities (such as common terminology, technology and processes). It will also make it easier for people

who move to different states, live part of the year in different states, or have families that straddle state borders and participate in more than one exchange (e.g. Maryland, Virginia, and the District of Columbia) to understand the exchanges and effectively use them to purchase coverage that is right for them.

Clarity, transparency and simplification: HHS should ensure that the exchange policies and the health plans are clear to consumers, employers, health plans, the States and the federal government. That calls for clarity and simplicity. HHS should not micromanage participating health plans; but rather, provide a clear focus on innovative purchasing and a value agenda for health care in the community.

HHS needs to ensure that the exchanges are vehicles for simplification of a complex array of transactions for employers and consumers: participation and comparisons among plans; the availability of tax credits for small employers; free choice vouchers; tax credits and cost sharing support for qualifying individuals; seamless enrollment in Medicaid; and movement among Medicaid eligibility, tax credit eligibility and private coverage.

Accountability: With implementation of the Affordable Care Act, the federal government should also structure exchanges for accountability for the cost and quality of the coverage and care offered in their community. The Congressional Budget Office (CBO) estimates that 29 million Americans will receive coverage through the exchanges by 2019, including 5 million with employment-based coverage, at an annual cost to federal taxpayers of more than \$100 billion per year for premium assistance tax credits and cost sharing subsidies. That demands accountability, and the resources and expertise to meet that level of accountability. For example, exchanges will require access to expert actuarial support if they are to fulfill the functions noted above, as well as expertise in insurance and benefit design. The federal government should also require that the expertise is available and shared across the exchanges so that HHS does not waste federal tax dollars by duplicating services and products.

In addition, the Departments and States implementing exchanges should adopt a project manager approach typically used by large businesses implementing large-scale change with lots of moving parts and long-term consequences. Such individuals can anticipate lead times and provide a valuable contact point for stakeholders such as the employer community, and assure responsibility and ultimate accountability.

Continuous learning/improvement: Exchanges must focus on an ongoing process of continuous learning and improvement subject to evaluation and adaptation. This is largely a new enterprise, and even with a strong degree of national standardization, the States may take many different approaches in the exchanges with different capacities for management. HHS needs to couple rigorous standards with a process to evaluate, learn lessons from the successes and failures, starting with learning from the experiences with already existing state, local, and private exchanges, including employers' internal exchanges for their employees, and revise policy nationally and at the State level.

## **Business Group Recommendations**

### **Clarify, in easy-to-understand language, and in a timely way, the specific roles and responsibilities of employers vis-à-vis the state exchanges**

Employers remain concerned about the current lack of information on the specific roles and responsibilities of employers vis-à-vis the state and possibly federally-managed exchanges. Employers need to know what provisions will impact their benefits immediately, well before 2014, as they work to design affordable plans to meet the needs of their employees and their families.

The Affordable Care Act remains silent on numerous outstanding questions regarding the administrative roles and responsibilities of employers in their interactions with the exchanges. For example, what documentation employers will need to receive from the exchanges regarding employee eligibility for the exchange plans? How and if employers will verify employee eligibility for the exchanges? How and when (prospective, retroactive, monthly, quarterly) employers will make payments to the exchange plans if they participate or on behalf of any employees? What happens when employees with exchange coverage find jobs with coverage in the middle of a plan year? When will enrollment in the exchanges begin for off-calendar year plans? What tax withholding or implications fall on employers if employees do not use the entire employer voucher for health coverage?

These are just a few of the unanswered questions that call for direct and continued interaction among employer plans, the federal government and the state exchanges immediately, leading to clear, easy-to-understand language on the specific roles and responsibilities of employers.

The federal government should also require the exchanges to reach specific milestones or benchmarks with established updates to consumers, employers and the federal government. For example, the federal government needs to clearly define the marketing communications of exchange plans (timelines, process, how people become eligible, nomenclature of benefits, etc.).

### **Streamline/simplify employers' administrative tasks with their interactions with the exchanges**

The exchanges should continually focus on simplifying employers' administrative costs in their interactions with the exchanges and exchange plans in order to minimize both employers' and employees' costs.

Employers will need to interact with the exchanges and the federal government in dealing with exchange-eligible employees and coordinating with workers' compensation, disability benefits and a variety of other areas well before January 1, 2014. In addition, the federal government needs to coordinate with employers' benefits departments on the

exchanges as employees are still likely to refer to their employers' benefits departments for questions on the rules for the exchanges and the exchange plans. The federal government also needs to minimize the disruption of employees who lose access to the providers who participated in their employer plans but will not participate in the exchange plans' provider networks.

### **Align COBRA rules with the exchanges**

**COBRA rules, enacted as a stop-gap measure well before reform more than 25 years ago, now need to be aligned with how the exchanges will work.** In 2014, with full implementation of the provisions of the Affordable Care Act, exchange plans should act as alternatives to COBRA coverage.

### **Promote national consistency across the exchanges**

The federal government and the state exchanges need to think nationally with national solutions, similar to employers (a national exchange, uniform rules, and administrative simplification).

National uniformity under the Employee Retirement Income Security Act (ERISA) enables employers to offer and maintain uniform benefit plans across state lines and across local jurisdictions for their employees and retirees. It keeps benefit costs lower through greater economies of scale, purchasing leverage, and administrative efficiencies.

Similarly, employers support a strong set of national standards for state exchanges to promote similar uniformity and administrative simplification. While certain employers will provide access to additional coverage options to their employees through the multiple state exchanges, by allowing 50 different sets of rules and benefit levels, employers will have the nearly impossible burden of navigating a patchwork of regulation, significantly raising compliance costs and risks of noncompliance and may lose the ability to offer the most effective benefits to offer to employees. **Accordingly, in states with national exchanges, because they chose not to operate exchanges, and over the long-term, we recommend that the federal government form a single national exchange option for those states, rather than operating separate state exchanges administered by the federal government.**

### **Create a permanent Advisory Board of employers and independent plan administrators with experience running health care plans to advise the states and the federal government as they establish the exchanges**

Because of our concerns described above, we strongly recommend that HHS establish a permanent Advisory Board of employers and independent plan administrators with experience running health care plans to advise employers, the states and the federal government as they work to establish the state exchanges.

**At a minimum, the exchange governance boards should include independent plan administrators with experience in managing health care plans to assure that the exchanges are run as effective health care purchasers and succeed in providing effective, affordable and efficient coverage to exchange plan enrollees.**

**Identification and comment on specific questions in the OCIO request for comment**

The OCIO requests comments in a number of areas in its *Federal Register* Notice of August 3, 2010. Given the principles and major recommendations set out above, the Business Group offers comments on a number of these questions.

A. State Exchange Planning and Establishment Grants

B. Implementation Timeframes and Considerations

C. State Exchange Operations

These OCIO's first three requested comment areas are directed largely at the States developing and implementing exchanges. However, in light of the principles noted above the Business Group offers comments in several areas.

Governance structures: The Business Group'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 operating health insurance exchanges are best equipped to implement the exchanges. We base this recommendation on our view on the need for strong, activist exchanges as set out in our principles—a role that will require flexibility and adaptability in contracting and staffing that is difficult for many governmental entities. In addition, exchanges in our model would be called on to make important but difficult choices, such as negotiating with powerful interests, dropping health plans, and driving a value agenda. Accordingly, exchanges need protection from political pressures, provider interests, or pressure from advocacy groups. Rather, the federal government should ensure that the governance structure of the exchanges base their “qualified health plan” requirements on sound clinical evidence and medical research.

As stated earlier, at a minimum, the exchange governance boards should include independent plan administrators with experience in managing health care plans.

Implementation tasks and timeframes: HHS faces daunting implementation challenges and the Business Group believes that only with an aggressive timetable can HHS, and the States, fulfill the mandate for the exchanges to carry out the focus on value as an active and accountable purchaser as noted in our principles.

In addition to a need for more attention to real cost controls, we have the following concerns about the implementation of the Affordable Care Act:

- There are hundreds of individuals involved in writing important regulations, and countless more at the State level;
- Decisions will have substantial cost consequences, especially as we assess the cumulative burden of each discrete individual requirement; and
- We have already seen some of the impacts with the initial implementation of provisions in the Affordable Care Act, such as benefit requirements and external review standards, which impose administrative burdens and costs on employers and plans.

As the Departments implement the more comprehensive reforms called for by the Affordable Care Act in 2014, including the exchanges, those cumulative cost pressures will mount for employers and individuals. **We recommend that the Departments maintain clear and public accounting for the total, cumulative cost burden imposed.**

In determining whether an electing State is making sufficient progress in establishing and implementing an exchange, we urge HHS to set a firm deadline, well in advance of 2013, for purposes of deciding whether and where the HHS Secretary will need to implement a national exchange. Uncertainty is not an option for employers and individuals in those States.

In developing the timetables, we also believe it critical that the HHS and States assure that employers and their employees receive notification, well in advance of the initial open enrollment period, so that eligible employers and individuals can take advantage of this new approach. Employers must have time to communicate in a comprehensive manner about the changes-if there is one lesson from employers making changes in benefits; it is the need to communicate again, and again, and again.

#### D. Qualified Health Plans (QHPs)

#### E. Quality

The Business Group has linked these two areas of questions because the issue of standards for Qualified Health Plans (QHPs) and the quality and safety issues are directly related.

Standards for QHPs, including the quality standards, are among the most critical issues in implementing health reform for the federal government to improve coverage and transform the value of care, drive down health care costs and increase quality.

With millions of newly covered individuals in this new market, the federal government has an opportunity to hold QHPs to the highest possible standards in order for them to gain access to the exchanges. Now is not the time for a "least common denominator" approach.

- Exchanges should establish strong standards for participating plans. Exchanges must require a sufficient number of plans to assure real choice in each geographic

insurance market of a state, not just a large number of insurance products. In particular, the exchanges should include choices among several models of care-including tightly organized models and open network plans with value-based design.

- To facilitate that choice, especially in the early years of implementation, exchanges need to clearly identify health benefit packages to facilitate easy comparison by exchange participants so that the plans compete on costs and quality, not marginal and confusing changes in benefit design.
- Participating plans should also compete by driving innovation in health care delivery, organizational effectiveness, quality and safety of care in the community. For example, one Business Group member provides 100% coverage of certain health care services at model health care providers (Cleveland Clinic, etc.).
- The value agenda and active purchaser model set out in the Business Group's principles require standards that focus on total costs of care:
  - 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.
  - Exchanges must set high standards for the networks of providers that serve the enrollees with QHPs, to aggressively manage these total costs of care. **One option to strongly consider is to require a "Chief Value Officer" at each exchange to maintain an organizational focus on this issue.**
  - As part of the value agenda and active purchaser model, exchanges should also set specific targets for the QHPs for reducing waste and overuse in the system. Here again, the focus is not just administrative waste, but wasteful health care spending as well.
  - The exchanges must include effective quality-improvement provisions. The National Business Group on Health was pleased that the Affordable Care Act directs the HHS Secretary to develop a health plan rating system. The opportunity presents itself to set high standards for quality and service for plans seeking access to this large new market, and if the Department does not focus on these standards now it will be difficult, if not impossible, to improve these standards in the future. **NCQA implemented health plan ratings used by employers, individuals and government for years and the Departments should use NCQA's highest accreditation standards - "Excellent" - for participation of plans in the exchanges. The exchanges must also include consumer-friendly**

**and easy-to-understand quality rating systems—otherwise consumers will not use them.**

- **The federal government should also require independent external audits of the state exchanges on their performance on quality measures, ability to minimize administrative costs, etc.**
- Finally, the exchanges represent a remarkable opportunity for collaboration. **The exchanges can and should work with other purchasers in the community, including business and other government purchasers, such as the new Center for Medicare and Medicaid Innovation, to assure aligned incentives for the entire health delivery community.**

#### F. An Exchange for Non-Electing States

As mentioned earlier, rather than HHS' current plans for a fall-back option, we strongly support the establishment of one national exchange over the long-term that would operate in each of the non-electing States, and in those States that the HHS Secretary determines are not appropriately implementing the exchanges as required. As with the State exchanges, this national exchange option should include appropriate rating areas with health plans uniquely bidding in each State, run by a similar independent, non-profit group with key expertise in operating insurance exchanges.

But, the federal government should not duplicate the basic operations of the exchange over, and over again, in each state. The federal government should develop one standardized approach and set of processes for fulfilling the functions of the national exchange. This is particularly important for multi-state employers, who will face enough complexity with multiple State exchanges among electing States, especially in later years, beginning in 2017, if larger employers are allowed to participate.

#### G. Enrollment and Eligibility

The exchanges must manage a process of enrollment for individuals, employers and employees, with and without tax credits, and check for eligibility for Medicaid and the State Children's Health Insurance Program (SCHIP). HHS needs to identify and implement "best practices" to assure both maximum enrollment of those who are eligible and administrative simplicity for all stakeholders as we move forward. HHS must work with the Departments of Treasury and Labor to set up standardized national processes, common data platforms and integrated information systems to assure that the exchanges have clear and understandable rules for establishing eligibility and enrolling individuals and employers within each category, and to assure a seamless process to accommodate changes in employers, family situations, and incomes.

Employers want clear enrollment and eligibility rules for all employees and their dependents. **It is particularly important for the three Departments to provide clarity as soon as possible on the rules for the complex array of workers that make up our nation's workforce, not just the long-term, full-time, full year workers. Employers need specific clarity on how they and the exchanges will be required to deal with union, temporary, part-time, or seasonal workers, workers here from other countries for summer employment, and others.** HHS must standardize the policies so they do not vary by state as multi-state employers will not want to meet multiple standards for their employees and dependents. The federal government must clarify these rules, as soon as possible, so that employers and the exchanges can begin to develop appropriate policies and avoid the enrollment problems similar to those experienced with Medicare Part D.

Finally, it is essential for HHS to coordinate the requirements for employers, including reporting requirements, so they do not duplicate existing requirements, such as current ERISA requirements, and keep those elements essential for implementation. In all instances, HHS should include the current federal government requirements applicable to self-insured employers that have met the test of time.

#### H. Outreach

The questions raised in the section on "Outreach" focus on the federal grant programs for navigators, and broadened. **In particular, the employer community requires clarity on how the exchanges will conduct outreach to employees and their families.** This is an area of expertise of Business Group members, and employers will want to work with exchanges to assure that any communications are clear and helpful for those employees and families as they make their decisions.

In addition, the employer community would appreciate more clarity on its expected role under the Affordable Care Act in communicating with employees and families about the options available in exchanges well before March 1, 2013.

#### J. Consumer Experience

The consumer experience questions relate to many of the questions noted above, including the eligibility, enrollment and outreach issues-as well as the role of the exchange as an "active purchaser" pursuing quality measurement standards for QHPs, which must incorporate measures of consumer experience in the quality standards.

**The patient survey for exchange plans with more than 500 enrollees should also include the patient perspective measures from the HCAHPs survey.**

Again, the keys for consumers are:

- A clear set of distinct options to assure real choice-not every benefit plan that every insurer wishes to offer;
- Standardized national processes to assure that there are clear and understandable rules for the consumer's eligibility and enrollment, and to assure seamless movement among the categories of financing as employment, family situations and income changes; and
- A relentless focus on value, because the consumer experience is not just with the administrative apparatus of the exchange and QHPs. The consumer experience that is most important for the long term is access to appropriate and affordable health services.

### K. Employer Participation

Employers will participate in and coordinate with the exchanges in multiple ways. In the short-term, smaller employers will have the option to purchase through the exchanges; if the exchange model is successful, larger employers will be brought in the future, after 2017, as well. In addition, for employers with collectively-bargained employees, some unions may decide that rather than negotiating with employers over health benefits on behalf of their members, they may prefer exchange coverage and focus negotiations on compensation and other benefits.

In both the short- and long-term, some employees, former employees (including retirees), and in other cases, family members, will be accessing the exchanges. The Affordable Care Act provides direct incentives for employees to participate in the exchanges through refundable premium tax credits and employee free choice vouchers

Employees with incomes up to 400% or four times the federal poverty level (currently, up to \$43,420 for individuals and \$88,200 for families) who work for employers where their premium costs exceed their household incomes by 9.5% or the employers do not contribute at least 60% toward the plans' costs could receive refundable premium tax credits for purchasing coverage through the exchanges.

Employers who offer their employees health insurance coverage also must provide employees who spend between 8 and 9.8% of their incomes on premiums with "free choice vouchers" equal to the highest amount the employers would have paid to provide coverage to these employees under their plans. These employees could either choose the vouchers or refundable premium tax credits, but not both.

Please refer to our earlier comments for the "Business Group Recommendations" on employer participation in the exchanges.

L. Risk Adjustment, Reinsurance, Rating Areas and Risk Corridors

The Affordable Care Act requires the HHS Secretary to consult with the American Academy of Actuaries, along with the National Association of Insurance Commissioners (NAIC), to establish federal standards for the temporary early retiree reinsurance program. We would broaden and build on that required consultation and **require each exchange to obtain independent certification of the actuarial soundness of its risk corridors, plan requirements, rating areas, risk adjustment, and reinsurance rules from the American Academy of Actuaries, or a similar independent actuarial body.** Such certification will benefit all participants, including the exchanges and the federal taxpayers supporting the tax credits and subsidies in the exchanges, by building trust among employers, consumers, providers and insurers on the long-term viability of the exchanges.

The National Business Group on Health appreciates this opportunity to comment on the development of exchanges, and, in particular, the need for the exchanges to aggressively pursue a focus on value, the total cost of the coverage and care, and the quality and safety of service for enrollees. We look forward to continuing our work with the OCIIO and the States throughout this process. Please contact me or Steven Wojcik, the National Business Group on Health's Vice President of Public Policy, at (202) 585-1812, if you would like to discuss our comments in more detail.

Sincerely,



Helen Darling  
President

cc: The Honorable Kathleen Sebelius, Secretary, HHS  
Ms. Donna Laverdiere, OCIIO