BlueCross BlueShield Association

An Association of Independent
Blue Cross and Blue Shield Plans

December 28, 2012

Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Washington, DC 20201

Submitted via the Federal Regulations Web Portal, http://www.regulations.gov

Re: Comments on the Proposed Rule: "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014" [CMS-9964-P]

Dear Ms. Tavenner:

The Blue Cross and Blue Shield Association ("BCBSA") appreciates the opportunity to comment on the Proposed Rule on "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014" (or "Payment Notice"), as issued in the *Federal Register* on December 7, 2012 [*77 Fed. Reg. 73118-73218*].

BCBSA is a national federation of 38 independent, community-based, and locally operated Blue Cross and Blue Shield Plans ("Plans") that collectively provide health care coverage for 100 million – one in three – Americans. Blue Cross and Blue Shield Plans offer coverage in every market and every zip code in America. Plans also partner with the government in Medicare, Medicaid, the Children's Health Insurance Program, and the Federal Employees Health Benefits Program.

The Affordable Care Act ("ACA") will expand access to insurance for millions of Americans and also broaden insurance benefits. However, the new rules and expanded benefits will unavoidably result in higher costs. We offer our comments with three key objectives:

1. Mitigating premium increases to the extent possible to improve affordability.

2. Streamlining requirements so that states and issuers can implement in a timely manner.

3. Ensuring a level playing field to protect consumers and prevent adverse selection that would raise costs.

As described in the detailed recommendations that follow, BCBSA's priority recommendations on the Payment Notice are as follows:

I. Small Business Health Options Program ("SHOP") and Federally Facilitated Exchange Provisions

Blue Plans are committed to meeting the 2014 requirements under the ACA. However, the compressed timelines along with the lack of detailed guidance and final rules present significant challenges for health plans. Implementing SHOP presents additional complexity for product development, billing, payment, eligibility and enrollment functions that would present challenges even with adequate time for implementation. However, the current level of uncertainty regarding SHOP requirements that must be resolved, tested and functional within nine months drastically increases the level of risk inherent with implementation.

Given these risks, **we strongly recommend that CMS phase in implementation of SHOP post 2014 in the Federally Facilitated Exchange ("FFE")** in order to allow time for the necessary interactions between the government, issuers, premium aggregator and other related entities to be fully developed and adequately tested. SHOP requires significant resources for both issuers and the federal government that will detract from the objective of ensuring a smooth transition for the millions of consumers who will purchase on individual exchanges in 2014.

We have the following major recommendations regarding SHOP exchanges when they are implemented:

1. **Make SHOP participation optional in federally facilitated and partnership exchanges.** We strongly oppose the requirement in proposed §156.200(g) for issuers to participate in the Federally Facilitated SHOP ("FF-SHOP") as a condition of certification for participation in the individual exchange if they otherwise participate in the small employer health insurance market in a state. States with a plan management partnership should also be exempt from requiring issuers to be on both exchanges.

   Given the lack of SHOP specifications, business risk, and large system changes involved, some of our member Plans are concerned that they cannot execute the changes necessary for their participation in the SHOP in a way that will be effective for employers. Implementing a program of this scale under the existing timeframes not only increases the risk of potential errors and the overall costs, it detracts from the resources available to ensure successful implementation of the individual exchanges. Compelling SHOP participation could make it more difficult for issuers to participate in the individual exchange in 2014.

   As proposed in the Rule, issuers participating in FFEs would be responsible for financing the ongoing implementation costs of the individual and SHOP exchanges through user fees. While mandating issuer participation in SHOP may increase the level of resources available to CMS to finance implementation costs, it will also ultimately lead to higher administrative costs and premiums for small employers.

   Had Congress intended to link issuer participation in the individual exchange and SHOP together, they would have done so expressly. As discussed in our detailed comments, it is clear that Congress intended only that issuers commit to offer two plans in order to participate in either the individual or SHOP exchange. Further, tying the participation on SHOP to participation on the individual exchange is contrary to the Administration's assertion that it will not be an active purchaser in the FFE. Compelling issuers to

participate will not encourage the partnership between issuers and CMS needed to make SHOP successful over the long term.

2. **Release detailed operational requirements for SHOP at least 18 months prior to implementation of employee choice to ensure a successful transition.** The Administration has yet to issue operational-level guidance for implementing the core functions of a SHOP. In particular, details for the premium aggregation function will be critical. It would take at least 18 months for issuers to develop systems to support employee choice through SHOP effectively.

3. **Adopt a phased option for SHOP implementation in the initial years.** We strongly support the transitional strategy contemplated in the Rule in which the FF-SHOP would direct employers to select a single Qualified Health Plan (QHP) for employees once SHOP is operational.

   A phased approach will allow issuers and employers to use existing business processes while purchasing within the SHOP marketplace. A phase-in would help mitigate initial increases in premiums in the small group market because health plans would not have to price for the adverse selection resulting from employee choice or the increased administrative costs of implementing employee choice under accelerated deadlines. If CMS retains the pure "employee choice" requirement as proposed for the FF-SHOP, the added complexity and cost associated with employee choice would work against successfully ensuring competition on the FF-SHOP.

   Also, we expect many states that begin with an FF-SHOP to eventually transition to state-based exchanges. A transitional approach will not lock employers into an employee-choice-only SHOP model and will ease state implementation of the option in the ACA, allowing an employer to select one QHP for employees. To avoid federal-state discrepancies, any transitional approach taken by CMS should also be an option available to all states.

4. **Ensure a level playing field approach for certification on FFEs.** We are deeply concerned with the lack of coordination between the Multi-State Plan Program ("MSPP") regulation issued by the Office of Personnel Management ("OPM") and the FF-SHOP provision compelling participation in SHOP. As we discuss more fully in our detailed comments, MSPP issuers would be able to avoid offering SHOP coverage during an extended initial phase-in period, putting issuers that are now required to provide FF-SHOP coverage at a significant competitive disadvantage. CMS should avoid requiring FF-SHOP participation in order to ensure a level playing field for certification requirements for all QHPs and MSPs on exchanges.

   The proposed requirement for issuers to participate on the FF-SHOP would also favor the new CO-OPs, which would be exempt from the requirement to participate in both individual and SHOP exchanges. This situation will create an unlevel playing field, even though §1252 of the ACA expressly prohibits such exemption; §1252 generally provides that any federal or state standard developed pursuant to Title I of the ACA, "shall be applied uniformly to all issuers in each insurance market to which the standards and requirements apply."

   Further, by exempting issuers who are not currently in the small group market from the requirement to participate on SHOP, the Rule will create an unlevel playing field for

issuers that have withdrawn from the small employer market or have no intention of serving small employers. Rather than taking the forceful approach in the Rule, we recommend that CMS design the FFEs to attract competition for consumers and small businesses.

5. **Simplify rating for SHOP.** The Rule includes "safe harbor" employer contribution methods for employers participating in FF-SHOPs initially. Under the safe harbor approach, employer contributions will be based on the premium of a "reference plan," but employers will have the flexibility to use different contribution strategies and determine whether to base their contributions on a composite rate. Initial adoption of employer choice will avoid these problems and give issuers more time to develop systems to accommodate SHOP rating rules.

6. **Avoid creating incentives to undermine group coverage through creation of SHOP.** In creating the employee-choice SHOP structure, we are concerned that the Administration may exempt employers participating in SHOP from current ERISA group health plan requirements, even though employers would continue to contribute to SHOP coverage, just as employers contribute toward small group coverage today. This could provide unique advantages to SHOP that may be intended to attract employers, however, it could speed the demise of small employer health insurance coverage by encouraging small employers to pare back their commitment to such coverage.

In addition to our recommendations specific to FF-SHOPs, we offer the following recommendations for all FFEs:

7. **CMS should establish broad-based financing for the FFE and FF-SHOP.** We are concerned that the 3.5 percent user fee will further exacerbate affordability concerns for consumers and small employers if CMS does not rely on a broad-based financing approach to fund the FFE and FF-SHOP, which will benefit many other stakeholders in the insurance industry. If CMS retains such fees, all stakeholders should be able to access financial information on the FFEs and determine overall value and performance of the fees provided to CMS.

8. **CMS should ensure that user fees (if retained) are transparent and paid only by those consumers and small employers using exchanges.** We continue to recommend that exchange user fees be paid by those individuals and small employers that use the exchanges to purchase coverage. In the Preamble (FR 73182), CMS seeks comment on a proposal to pool exchange user fees (or potentially all administrative costs) across a particular market or product, which could be interpreted to require issuers to spread exchange related costs across all of their individual or small employer customers. We note that CMS relies upon Circular No. A-25R, which establishes federal policy regarding user fees, to support its proposed user fee. Circular No. A-25R specifically states that "It is the objective of the United States Government to: ... c. allow the private sector to compete with the Government without disadvantage in supplying comparable services, resources or goods where appropriate."[1] However, if issuers are required to charge non-exchange members a fee to support the provision of exchange coverage, CMS would effectively disadvantage issuers supplying non-exchange coverage in order to support governmental exchanges, as well as unfairly impose indirect assessments on consumers who receive no benefit from exchanges.

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[1] OMB Circular No. A-25R, Transmittal Memorandum No. 1,

II. Medical Loss Ratio ("MLR") Regulations for Community Benefit Expenditures and State Premium Taxes

9. **Treat tax-exempt and non-tax exempt non-profit issuers the same with respect to MLR calculations.** The rule proposes to allow tax-exempt issuers to deduct both state premium taxes and community benefit expenditures from their earned premium revenue in calculating the MLR, but would not provide the same advantage to issuers that are not tax-exempt. This preferential treatment undermines the goal of a level playing field and gives federal income tax-exempt health insurance issuers an unfair competitive advantage. It also does not recognize that many other issuers also make significant community benefit expenditures. We recommend that CMS allow all issuers to deduct both state premium taxes and community benefit expenditures. If CMS does not allow all to deduct both, then it must eliminate the unlevel playing field for tax-exempt HMOs.

III. Cost-sharing Reductions ("CSRs") and Advance Premium Tax Credits ("APTC")

10. **Limit CSRs to in-network essential health benefits ("EHBs").** BCBSA strongly recommends that the Final Rule limit CSRs to in-network EHBs only, consistent with the requirements for the annual limitation on out-of-pocket maximums and the calculation of actuarial value ("AV").

11. **Provide safe harbors and capitated payments for Indians' CSRs.** BCBSA recommends that CMS provide issuers a safe harbor for CSRs provided for Indians above 300 percent of the Federal Poverty Level ("FPL") for referrals under Contract Health Services. We further recommend that CMS establish a capitated payment schedule to reimburse issuers for CSRs provided to Indians above 300% FPL.

12. **Limit the number of plan variations that issuers must submit to the exchange for review and certification.** Issuers should not have to develop zero cost-sharing plan variations for all QHPs offered on the exchange. Instead, we recommend that issuers only be required to file a single zero cost-sharing plan variation for the bronze QHP, unless there are differences in prescription drug formularies, provider networks (e.g., HMO versus PPO), or covered benefits between metal-level QHPs.

13. **Expand the de minimis requirement to that which was proposed in the AV/CSR Bulletin.** The Rule's reduced de minimis requirement of +/- 1 percent will severely limit issuers' ability to design reasonably simple benefit plans. BCBSA recommends that CMS expand the de minimis requirement to +/- 2 percent as proposed in the AV/CSR Bulletin to allow the most flexibility in designing QHPs and their plan variations, while maintaining stability in the market.

14. **Provide additional flexibility for the variations in cost-sharing structures across silver plan variations.** BCBSA recommends that CMS provide issuers additional flexibility to vary cost-sharing structures across silver plan variations, and reconsider allowing issuers to increase co-payments, deductibles and coinsurance for the plan variations, if necessary, in order to meet AV requirements. In addition, issuers should be allowed to continue to utilize medical management policies, including pre-authorization requirements and medical necessity.

15. **Retain the proposed rules for advance payments and reimbursement for CSRs during special transitional periods.** BCBSA is pleased with the provision in this area, including grace periods and the 90-day additional verification period that holds issuers harmless for the CSR provided during these instances. We do request clarification that issuers may "pend" CSRs during months two and three of a grace period.

16. **Extend the "no fault" protection for issuers in cases where enrollees had an unreported mid-year change in eligibility.** In cases where an eligible enrollee experienced a change in eligibility for the CSRs but did not report it to the exchange, BCBSA recommends that issuers be held harmless for any paid claims and advance payments of the CSRs, and that CMS extend the "no fault" protection noted in the Preamble to situations where an enrollee had an unreported mid-benefit year change in eligibility and the issuer provided the CSR.

17. **Simplify the standards for reporting of CSR amounts.** CMS should establish a simplified reporting process for CSR reconciliation, at least for a transitional period. In addition, reporting of CSR amounts should account for all payments made to enrollees and providers.

18. **Do not adopt the alternative approach of retroactive payments for APTC amounts.** BCBSA strongly recommends against adopting the proposed approach of retroactive payments of the APTC. This approach could result in significant complexity for issuers, especially to the extent that such retroactive payments happen late in the tax year. BCBSA recommends that redeterminations of APTC amounts only be applied on a prospective basis.

IV. Risk Adjustment, Reinsurance and Risk Corridor Provisions

BCBSA is pleased that the Rule retains the use of a concurrent risk adjustment methodology (calculating current year scores based on current year claims) and a distributed data collection approach for both risk adjustment and reinsurance. A concurrent methodology improves risk assessment of new enrollees (and those who change carriers) whose data are not available, and recognizes that the under-65 commercial population experiences more variation in medical conditions than the Medicare population, which tends to have more chronic conditions. The use of a distributed data collection approach alleviates members' privacy concerns, retains issuers' control of proprietary data and minimizes issuers' data collection burden.

BCBSA also supports the proposed payment transfer formula that will account for age rating, allow state alternate age rating curves where applicable, recognize family rating limitations, and account for induced demand and geographic cost differences.

Additionally, BCBSA supports the proposed change to the due date for MLR reporting to accommodate inclusion of the risk mitigation program amounts. We agree that the timing of the MLR reports and rebates need to reflect the timing of the risk mitigation program settlements to ensure that proper rebate amounts are sent to members.

At the same time, however, several of the provisions in the Rule – as described in more detail below – raise significant concerns for BCBSA.

19. **Risk Corridor Program payments should be calculated at the QHP issuer level.** BCBSA strongly urges CMS to calculate risk corridor payments at the QHP issuer level for each market segment within a state, not the QHP level as currently proposed. BCBSA believes calculating payments at the QHP issuer level is most appropriate for several reasons, including the following:

    - Claims experience will be more statistically credible at the QHP issuer level.
    - The Risk Corridor Program incorporates numerous concepts from the MLR regulations, which rely upon aggregation at the issuer level for each market segment within a state. Incorporating concepts from the MLR regulation but applying these concepts at a different level creates discrepancies and inconsistencies in the Risk Corridor Program. Moreover, it is unclear why the Risk Corridor Program would reflect certain MLR constructs while at the same time move to a different level of analysis.
    - Capping allowable administrative costs at 20 percent of a QHP premium is an artificial cap that does not necessarily match with a specific QHP's administrative costs. Applying this 20 percent administrative cost limitation at the QHP Issuer level, however, avoids this artificial limitation while simultaneously matching the MLR regulatory limitation.
    - Issuers do not report administrative expense data at the QHP level. Calculating Risk Corridor Program payment calculations at the QHP level thus would impose on Issuers significant costs to either modify their information systems or manually prepare risk corridor data, and this all would occur for a temporary program.
    - Sharing gains and losses at the QHP level through the Risk Corridor Program is inconsistent with the implementation of single risk pools for the individual and small group markets within a state.

    We believe that ACA §1342 provides a basis for concluding that the use of the term "plan" is not intended to direct risk corridor payments to be conducted at the QHP level. Moreover, the statute is sufficiently ambiguous as to how these risk corridor payments are to be determined that CMS can and should exercise its administrative discretion to conduct risk corridor-related analyses in a manner that best achieves the goal of the Risk Corridor Program -- stabilizing premiums during the first three years of the market reforms.

20. **Interim estimates of issuer and market risk scores should be provided for financial reporting and rate development.** Interim estimates that provide early indications of an issuer's risk relative to the market are needed for financial reporting and for developing rates for the next calendar year. Accruals for risk adjustment on financial statements need to be based on valid available data. If interim estimates are not available, issuers may not be allowed to reflect risk adjustment accruals on financial statements, which will result in inaccurate financials.

21. **Risk adjustment model transparency.** CMS should provide issuers with the mapping of the ICD-9-CM codes to the HCC categories and make the risk adjustment model open-sourced for analysis and testing. In order to set rates for 2014, issuers need to have a detailed understanding of how the risk adjustment model works. Without access to the risk adjustment model and the ICD-9-CM mapping, issuers will have a more difficult time accurately predicting how the Risk Adjustment Program may affect their

cost and revenue streams in 2014. This uncertainty likely would be priced into premiums and may cut against the goals of the Premium Stabilization Programs.

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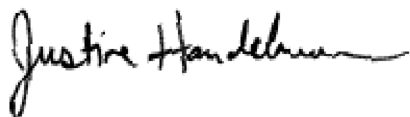
Our detailed comments on provisions related to the Proposed Rule, including responses to specific questions included in the Preamble, are set forth in the attached document.

We appreciate your consideration of our comments. We look forward to continuing to work with the Administration on implementation issues related to the Affordable Care Act. If you have any questions, please contact Kris Haltmeyer at (202) 626-4814 or at kris.haltmeyer@bcbsa.com.

Sincerely,



Justine Handelman
Vice President, Legislative and Regulatory Policy
Blue Cross and Blue Shield Association

BCBSA Detailed Comments on Proposed Rule: "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014"

I. Small Business Health Options Program ("SHOP") and Other Federally Facilitated Exchange Provisions

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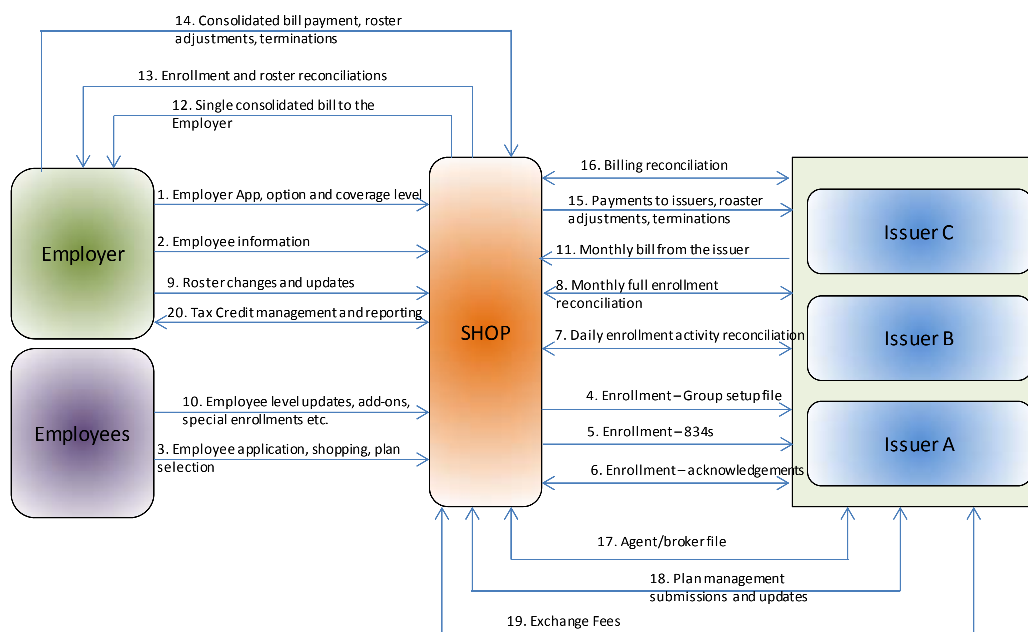
1. Phase-in SHOP in federally facilitated and partnership exchanges due to the operational complexities; CMS should release detailed operational requirements for SHOP at least 18 months prior to implementation

Issue:

Blue Cross Blue Shield Plans are committed to meeting the 2014 requirements under the Affordable Care Act ("ACA"). While we have sought to be a resource and a constructive partner in implementation, the requirement for health plans to participate in SHOP as a condition of certification in an FFE creates unacceptable implementation risks since operational plans for SHOP have not been released.

Two key features of SHOP – employee choice and external premium aggregation – are completely new to many issuers and will have significant operational impacts. In order to have SHOPs ready for enrollment in 2014, and in order for issuers to be able to devote information technology ("IT") and business resources to focus on other critical components of reform, detailed information on SHOP should have been released earlier in 2012. CMS could ensure a more effective transition for SHOP if it were to phase-in implementation post 2014 so necessary systems can be built and responsibilities for the new program can be more clearly defined.

To illustrate the basic challenges issuers face, the diagram below shows the basic operational interactions needed between employers, SHOPs, and issuers. There will be other manual and automated interactions for contracting, reporting, notifications, exceptions, and some reconciliation and service scenarios that are not addressed in this diagram.



Some of the complexities involving the SHOP exchange that raise concerns about initial execution include:

- **Premium aggregator / billing and payment.** Employee choice and an external premium aggregation service are completely new to many issuers. Today there are contracts between employers and issuers that delineate responsibilities of both parties, and it is unclear whether or how such contracts would be carried out through SHOPs. The employer has historically been the customer with group insurance, and group agreements obligate employers to perform certain functions. This becomes more difficult in an employee choice SHOP. Introducing a new entity with financial responsibilities will have a major impact on customer service and reconciliations.

  Billing and payment processes for small employers present unique challenges which are addressed through both manual and automated processes today. Introducing a premium aggregator into the existing system will require thoughtful planning to avoid errors and gaps in coverage. For example, it is not uncommon for small employers to communicate enrollment changes (e.g., new employees or dependents or terminations) with payments, sometimes on the back of the invoices. Issuers are accustomed to providing "soft cancellations" and reinstatements for situations in which the timing of a small employer's cash flow is out of sync with an issuer's billing cycle. SHOP rules and capabilities will need to account for these complex billing, timing and payments scenarios for employers and issuers in the planning, testing and implementation of new systems.

  The billing and payment cycle in an employee choice model involves several additional processing steps, such as consolidation of bills by the aggregator and splitting payments and adjustments for employee changes by issuers. When there are multiple issuers and many enrollment systems (SHOP, issuers, premium aggregator) involved, manual steps and exceptions can cause accuracy and timeliness issues for employees, and may impact access to needed care.

  Because employee choice and an external premium aggregation service are completely new to many issuers, health plans may have to make significant operational changes to accommodate the new requirements. In addition to the changes needed in the basic billing and payment functions within issuers' systems, a separate premium aggregation service would be required to be designed, tested and implemented across dozens of states to perform the following functions at a minimum:

  - Receive bills from issuers.
  - Reconcile and aggregate bills from multiple issuers.
  - Send consolidated bills to employers.
  - Receive payments from employers.
  - Reconcile and split payments by issuer.
  - Send payments to issuers.
  - Reconcile discrepancies.
  - Provide support and facilitate resolution of billing issues between issuers and employers.

- **Premium aggregation delinquency.** Premium aggregation services must have all logic necessary to handle delinquency and late payments. States and issuers must have policies that apply to claims processing (Hold, Deny, and Reinstate) in cases of employer

delinquencies that will need to be enforced. The timing of processing will be critical to employees' experience and care needs. Therefore it is critical the systems are fully developed and tested before issuers are required to offer employee choice SHOP coverage.

- **Group setup and enrollment:** SHOP must send group set-up information using workable transaction forms and standards (presumably using the HIPAA 834 formats) to applicable issuers. These transaction forms and standards will be critical to the success of enrolling employees and dependents (where applicable) through SHOP, yet they are currently in draft form for SHOP, which does not provide issuers the necessary guidance to ensure effective and efficient communication between issuers and SHOP next year. Process steps and standards must also be established for reconciliation and maintenance.

- **Agent portal:** In an employee choice model, agents' role must be redefined to assist employees with plan selection rather than employers. This will require a process to be established to ensure agents are approved to sell an issuer's products to employees. We presume brokers who are not appointed with a specific issuer would not be permitted to sell the issuer's products since there is not a contractual relationship. In addition, tools for agents to facilitate enrollment must be provided. SHOPs should provide the training and tools necessary for agents to fulfill this role.

- **Customer service:** SHOP must support employer and employee service and self-service requirements. In an employee choice model, SHOP will be responsible for supporting plan selection and maintenance for the employees. Employee choice and premium aggregation will also require SHOP to handle calls from issuers and employers related to billing, payments and delinquency.

- **System of record:** In an employee choice model, three systems (SHOP exchange, premium aggregation, and issuer enrollment) will be needed to coordinate and track enrollment status, and payment and these systems will need to be in sync at all times. Designing and enforcing a single-direction data flow with the compressed timelines will be challenging for states and issuers. There also must be a system of record for maintenance and updates and payments, to ensure that system anomalies and outages do not negatively impact the consumer experience and ability to receive needed treatment.

- **Out-of-state employees:** Billing and payment complexity is even greater given the option for employers to allow out-of-state employees to enroll in a SHOP serving their primary worksite. A system must be developed to coordinate out-of-state employee enrollment information and payment amounts with a premium aggregator to ensure accurate information is transferred among employers, issuers and SHOPs. Ideally, an employer should be permitted to submit a single payment (and receive a single bill), rather than work with multiple SHOPs, but it is not clear that there will be such capabilities.

  If an employer elects to require employees to enroll through the SHOP where the employer's principal place of business is located, the options available to out-of-state employees would be limited to issuers with the ability to provide coverage across states. Additionally, it is unclear what rating requirements would apply to out-of-state employees for developing premiums regardless of whether the employer elects for employees to enroll in the SHOP serving an employee's primary worksite or the SHOP serving an employer's principle place of business.

- **Issuer pricing:** Employee choice also significantly complicates SHOP pricing in addition to implementing the market reform requirements that have yet to be finalized. The population that is expected to enroll in SHOP coverage is not known and issuers should not be expected to base their rates on general information like census tables. Moreover, consideration of composite billing increases the complexity significantly. For example, one state is seeking to implement a "Get Quote" feature where the SHOP will reach out to the QHP with a group census and ask for a quote. This will be very difficult to establish particularly with the lack of Final Rules for developing member specific rates for SHOP. Phasing-in SHOP implementation post 2014 would allow issuers to gain experience, and CMS to develop forecasting models and employer outreach efforts, to better predict employer and employee behavior.

- **Employer registration, application and eligibility:** SHOP must allow employers to register, apply, obtain quote and submit employee information.

- **Tax credit eligibility:** Neither the Final Rule on exchange establishment nor the state blueprints lists small employer tax credit eligibility determinations as a required SHOP function. Beginning in 2014, eligibility for the small employer tax credit will be tied to enrollment in a QHP through SHOP. SHOPs are required in the Final Exchange Rule to provide the same consumer assistance functions as an individual exchange. The Final Rule applies this requirement by saying the "consumer assistance functions" of an individual exchange apply to SHOP. These functions include a web portal with a calculator for comparing qualified health plans ("QHPs"); however, the calculator requirement in §155.205(b)(6) of the Final Exchange Rule says the calculator is to "facilitate the comparison of available QHPs after the application of any advanced premium tax credit ("APTC") and any cost-sharing reduction ("CSR"). It is therefore unclear whether the web portal for SHOP is required to include a calculator showing employers the small employer tax credit amount. The CMS proposed data elements for employer eligibility for SHOP also did not address this issue in their supporting statement, nor did the data elements ask for information on employer income that is needed for credit eligibility (employers must have less than 25 FTE with less than $50K in annual wages).

Recommendation:

BCBSA recommends that CMS phase-in SHOP in the FFE post 2014 and release detailed operational requirements for SHOP at least 18 months prior to implementation to assure a successful transition. To avoid federal-state discrepancies, any delay or transitional approach taken by CMS for the FF-SHOP should also be an option available to all states. Eligible small employers could continue to receive the small business health care tax credit using current methods.

Rationale:

At this point, issuers and other key stakeholders lack most of the critical details needed to implement SHOP. Operational criteria have not been established and milestones for IT interconnectivity have not been set in the following areas:

- Premium collection and billing (premium aggregator processes).
- Account maintenance (communication of routine maintenance issues with employers and reconciliation between issuers and the SHOP).

- Verification processes to ensure agents/brokers have completed SHOP training and have an agreement in place with the SHOP.
- Call center processes for agents, brokers and employers related to customer support referrals.
- SHOP application and eligibility verification.
- Small employer tax credit eligibility determinations.
- SHOP website (for QHP shopping and selection) and call center.
- Enrollment (transmission of information on employees and dependents from employers to SHOP, as well as employee enrollment forms).
- Execution of agreements between the employer and issuer(s).

In addition, FF-SHOP participation criteria is in proposed form only, and state participation requirements at the SHOP level are unknown.

If SHOP is to be successful, it must have the commitment of issuers and work successfully for small business customers. Trying to force issuers to implement a complex program with significant business uncertainties will not create a successful program. Consumers – and ultimately small employers – would be better served if CMS and health plans focus on successful implementation of the individual exchanges and then take the time needed to make sure that SHOP is implemented in a workable manner.

2. Make SHOP participation optional in FFE/partnership exchanges. (§ 156.200(g))

Issue:

The Rule provides for FFEs to limit QHP certification to QHP issuers that meet one of the following conditions:

- The issuer offers through the FF-SHOP serving that state at least one small group market QHP at the silver level of coverage and one at the gold level of coverage.
- The QHP issuer does not offer small group market plans in that state, but another issuer in the same issuer group offers through the FF–SHOP serving that state at least one small group market QHP at the silver level of coverage and one at the gold level of coverage.
- Neither the issuer nor any issuer in the same issuer group offers a small group market product in the state. Thus, no issuer would be required to begin offering small group market plans to meet this requirement.

Recommendations:

CMS should make issuer participation optional in the SHOP exchanges administered by CMS or in partnership with states.

Rationale:

Given the complexities and degree of untested processes necessary for SHOP to be ready, as explained above, some of our member Plans are concerned that they cannot effectively execute requirements for a SHOP exchange. Under the compressed timeframes, Plans have justifiably focused on ensuring that products are available to consumers on individual exchanges.

It is critical to note that the ACA does not require that an issuer participate in the SHOP in order to offer coverage through the individual exchange. In our view, had Congress intended to link

participation in the individual exchange and SHOP together, they would have done so expressly. Instead, the statute requires only that an issuer that wishes to participate in an exchange "offer at least one qualified health plan in the silver level and at least one plan in the gold level in each such Exchange." ACA §1302(a)(1)(C)(ii). Further, the ACA presumes that these exchanges are separate unless a state acts to combine them. As a result, it is clear that Congress intended only that issuers commit to offer two plans in order to participate in the individual (or SHOP) exchange.

We recognize that Congress delegated many exchange-related implementation and operational duties to CMS, including setting standards for the certification of QHPs. In fact, Congress listed no fewer than eight criteria that CMS must consider when setting standards for the certification of health plans, (ACA §1311(c)(1)). Although the list is not exclusive, it is instructive of the considerations Congress believed critical when determining which QHPs should be offered through exchanges. The list is filled with minimum standards that plans that wish to be certified must meet, including marketing standards, quality improvement standards, and accreditation standards. None of the eight listed criteria even hint that a QHP issuer may only be certified if it agrees to participate in the individual and small group market, or offer coverage through both the individual exchange and the SHOP.

Generally, when interpreting a statute, "a word is known by the company it keeps ... This rule [is relied] upon to avoid ... giving 'unintended breadth to the Acts of Congress.'" *Gustafson v. Allyod Co., Inc., 513 U.S. 561, 575 (1995).* In this case, reading the statutory list of certification criteria "with the company it keeps" gives CMS (and a reviewing court) a principled limitation on the criteria the agency may impose for certification. Requiring issuers to participate in effectively twice as many markets as they may have intended, and offer twice as many plans as they may have planned, bears no reasonable relation to the certification criteria enumerated in the statute. Accordingly, we respectfully ask that CMS reconsider this proposed requirement.

Moreover, tying participation in the individual exchange to participation in SHOP will restrict market competition and undermine CMS' clear choice to avoid an "active purchaser" FFE. We are concerned that some issuers may forgo exchange participation entirely because they are not willing to participate, or simply unable to meet the unforeseen operational demands of participating in the SHOP with such short notice. This is particularly true in the FF-SHOP where CMS proposes all coverage to be offered on an employee choice basis.

In addition, we are also deeply concerned with the lack of coordination between the FF-SHOP proposed provision and the Multi-State Plan Program ("MSPP") regulation recently issued by OPM. Apparently, and as we discuss more fully below, MSPP issuers can avoid offering SHOP coverage during an extended initial phase-in period, putting issuers that are now required to provide FF-SHOP coverage at a significant competitive disadvantage.

3. Adopt a transitional strategy for SHOP implementation of employee choice (Preamble).

Issue:

The Preamble seeks comments on a transitional policy in which a FF-SHOP would allow or direct employers to choose a single QHP from those offered through the SHOP.

Recommendation:

While we support a phase-in of SHOP post 2014, we strongly support the transitional strategy contemplated in the Rule that would allow the FF-SHOP to direct employers to select one QHP for employees once SHOP becomes operational. We also continue to strongly recommend that all SHOPs allow employers to select one QHP on behalf of their employees. To avoid federal-state discrepancies, any transitional approach taken by CMS for the FF-SHOP should also be an option available to all states.

Rationale:

A phased approach will allow issuers and employers to use existing business processes while purchasing within the SHOP marketplace. This will allow exchanges and issuers to design and implement the necessary capabilities for employee choice without displacing valuable resources necessary to ensure successful implementation of the individual exchanges. If CMS retains a pure employee choice requirement for the FF-SHOP, the added complexity and cost associated with employee choice would work against successful implementation of the FF-SHOP.

Also, we expect many states that begin with an FF-SHOP to eventually transition to state-based exchanges. A transitional approach will not lock employers into an employee-choice-only SHOP model and will ease state implementation of an employer choice option upon migration to a state-based exchange.

A key factor in the ultimate success or failure of SHOP is its ability to attract small employers. One of the biggest barriers to employer participation in exchanges is the complexity of interaction with an exchange. An environment in which each employee is required to select his or her own health plan magnifies rather than reduces this complexity. Many small business owners serve as their own “Human Resources Department” and have to answer questions for their employees about their plans or coverage that become more burdensome when employees select many different QHPs from different QHP issuers.

Implementing employee choice requires exchanges and issuers to address several complex capabilities, including:

- Complex capabilities for enrollment and billing business processes (exchange and issuers).
- Duplicative billing and delinquency capabilities (exchange and issuers).
- Significant automated and manual steps for reconciliation and customer service (exchanges and issuers).
- Significant administrative burden to handle delinquency and terminations (exchanges and issuers).
- Administrative burden to keep a detailed accounting of each employee’s individual rates, plan choices, dependents and coverage additions/changes, which are needed for withholding purposes (employers).
- Robust plan comparison and decision support tools for employees (exchanges).
- Management support for the individual shoppers (exchanges).
- Management support to issuers on billing and payments (exchanges).
- Increased risk due to an additional entity with financial responsibilities (employers, employees, exchanges, issuers).

- Increased issues with access to care for employees, if adequate controls are not in place for handling employer payment issuers and enrollment/eligibility updates on a timely and accurate manner (employers, employees).
- Contracting between employer group and issuer(s).

Another complexity is that employers with out-of-state employees would be required to interact with multiple exchanges and employees would be presented with varying costs and premium amounts depending on the state in which they work. If an employer elects to require employees to enroll through the SHOP where the employer's principal place of business is located, the options available to out-of-state employees would be limited to issuers with the ability to provide coverage across states.

In addition to increasing complexity, employee choice will increase administrative costs due to lack of economies of scale on key functions such as enrollment and billing. Many are hedging substantially on the promise of new technological capabilities that claim to alleviate the complexities of a new individual choice approach. However, the operational feasibility, implementation costs and customer experience of such products have not been proven successful on a large scale.

A phased approach, in which the FF-SHOP implements a pure employer choice approach in the early years will give the FF-SHOP exchange the time necessary to pilot test the systems necessary to permit employee choice before implementation, and to ensure that this approach is feasible from a systems perspective.

Finally, the ACA specifically defines a "qualified employer" as a small employer "that elects to make all full-time employees of such employer eligible for one (emphasis added) or more qualified health plans offered in the small group market through an Exchange that offers qualified health plans." The very definition of an employer that may purchase coverage through an exchange is one that selects one or more qualified health plans for its employees. Congress specifically limited an employee's right to select coverage at a particular level to those employees whose employer has elected to provide support for a level of coverage. As such, we strongly urge HHS to provide employers seeking coverage in the FF-SHOP the option to select only one QHP for their employees.

4. Provide a level playing field within SHOPs (Multi-state Plan Program and Payment Notice NPRMs).

Issue:

The Proposed Rule for the MSPP contemplates allowing issuers to use a multi-year transition period to providing coverage through SHOP. We agree, as noted above, with a phase-in of SHOP. However, this MSPP transition policy is at odds with previous guidance from CMS and OPM, which assured issuers that MSPP issuers and QHP issuers would compete on a level playing field.

Recommendation:

CMS should align with the OPM proposed rule and allow a transition to SHOP for all QHPs, including those in the FFE and state partnerships. If CMS does not adopt a transitional policy, any certification requirement of an exchange (whether federal or state) should be applied equally to any QHP issuer, including issuers in the MSPP.

Rationale:

This provision conflicts with the approach taken in the MSPP NPRM, which permits issuers to decide whether to participate in the SHOP even if they decide to participate in the individual exchange. This difference in approach sets up an unlevel playing field, which may result in adverse selection and may discourage QHP participation in SHOPs.

Both CMS and OPM have assured issuers that they intend to work together, and with states, to ensure that although MSPs are regulated by OPM and QHPs are regulated by exchanges, both plans would be subject to the same requirements. We would also note that the MSPP statutory provision itself requires a MSP to "meet[] all the requirements of this title with respect to a qualified health plan." ACA §1334(c)(1)(B). If, to be certified in an FFE, an issuer must offer both individual and small group products, then it would seem that the statute also requires that an MSPP issuer be required to participate in both markets. Alternatively, if an MSPP issuer is not required to participate in both individual and SHOP exchanges, then it would seem the statute would not require any other QHP issuer to participate in both.

The proposed requirement for issuers to participate on the FF-SHOP would also favor the new CO-OPs, which would be exempt from the requirement to participate in both individual and SHOP exchanges because such entities are not currently offering coverage in the small group market. This situation creates an unlevel playing field, even though ACA § 1252 expressly prohibits such exemptions. It generally provides that any federal or state standard developed pursuant to Title I of the ACA, "shall be applied uniformly to all issuers in each insurance market to which the standards and requirements apply."

Further, by broadly exempting issuers who are not currently in the small group market from the requirement to participate on SHOP, the Rule will create an unlevel playing field for issuers that have withdrawn from the small employer market or have no intention of serving small employers. A number of issuers have withdrawn from the small group market in particular states since the enactment of the ACA and may face a ban on re-entry. In addition, some issuers that are not in the small group market today may be hesitant to begin offering new coverage to small employers as a consequence of this policy. Rather than taking the forceful approach proposed in the Rule, we recommend that CMS design the FFE to attract competition for consumers and small businesses.

5. Ensure that FF-SHOP criteria for determining employer size follows the transition policies for states (§ 155.20).

Issue:

We are concerned that the Proposed Rule's approach for determining employer size in states with a FF-SHOP will result in unnecessary complexity prior to 2016. The Rule defines full-time employees by reference to § 4980H(c)(4) of the Internal Revenue Code ("IRC") and determines the number of employees using the methods described in IRC § 4980H(c)(2)(E).[2] However, it establishes a transition policy for state-based SHOPs in recognition that most states currently

[2] **IRC § 4980(c)(4)** defines a "full-time employee" is an employee who is employed on average at least 30 hours of service per week. **IRC § 4980H(c)(2)(E)** provides that, "[s]olely for purposes of determining whether an employer is an applicable large employer under this paragraph [i.e., IRC § 4980H(c)(2) defining an "applicable large employer"], an employer shall, in addition to the number of full-time employees for any month otherwise determined, include for such month a number of full-time employees determined by dividing the aggregate number of hours of service of employees who are not full-time employees for the month by 120."

use definitions of a full-time employee and methods of counting employees to determine employer size that differ from the federal definition and counting method. While the Proposed Rule establishes a transition policy for state-based SHOPs to allow additional time to conform to federal definitions, the transition would not apply in states with a FF-SHOP.

- *Transition Policies.* For FF-SHOPs, the federal definition of full-time employee will be effective on October 1, 2013 (the start of the first open enrollment period.) For state-based exchanges, the definition will not apply until January 1, 2016.

  Thus, for 2014 and 2015, the Preamble indicates that CMS will not take any enforcement actions against a state-operated SHOP for including a group in the small group market based on a state definition that does not include part-time employees when the group should have been classified as part of the large group market based on the federal definition. Similarly, during 2014 and 2015, an employer and a state-operated SHOP may adopt a reasonable basis for their determination of whether they have met the SHOP requirement to offer coverage to all full-time employees, such as the definition of full-time employee from the state's small group market definition or the federal definition from IRC § 4980H.

  For the FF–SHOP, the Preamble indicates that FF-SHOPs must use a counting method that takes part-time employees into account. Specifically, the Preamble states, "To make an employer eligibility determination, the FF–SHOP will ask employers about the number of employees based on the full-time equivalent method used in § 4980H of Chapter 43 of the Code, as added by § 1513 of the Affordable Care Act. Thus, in FF–SHOP States, there may be a few employers who can purchase a small group market plan outside of the FF–SHOP (because they have fewer than 50 full time employees) but will not be eligible to purchase through the FF–SHOP (because they have more than 50 full-time equivalent employees)." CMS seeks comments on the proposed definitions and on the proposed transition policies.

Recommendation:

BCBSA supports the transition policy for states. However, we recommend that the Final Rule also follow any state rules in place in 2014 and 2015 when administering the FF-SHOP in a state.

Rationale:

As CMS notes in the Preamble, the proposed transition policy will lead to differences in employer eligibility for small group coverage inside and outside the exchange in some states, resulting in confusion and unnecessary complexity for consumers and issuers. Failure to follow state rules in place in 2014 and 2015 would mean that an employer could be considered a small group for participation on the FF-SHOP, but not the outside market, or vice versa.

Modifying the definition for one portion of the small group market (i.e., the FF-SHOP) but not for the remainder of the market (i.e., outside of the exchange) could result in stark differences in terms of the employers that participate inside versus outside the FF-SHOP, and would have significant unintended consequences for issuers. Below are some examples of the problems created by this discrepancy:

- **Premiums:** All of an issuer's small group plans must be considered a single risk pool, and premiums must be set accordingly. However, it is not appropriate to pool the risk of small

group plans inside and outside of the FF-SHOP if they are subject to different requirements and thus do not share similar characteristics in terms of firm size.

- **MLR:** The discrepancy between the FF-SHOP and outside market would create a small group definition that is inconsistent with the MLR reporting requirements. If MLR reporting requires the average number of full-time and part-time employees in previous calendar year, but the FF-SHOP definition requires full-time equivalencies, how would necessary MLR information for inside and outside an exchange be reported?

- **Out-of-State Employees:** If an employer's principal place of business is in a state with a state-based SHOP but the employer elects to allow employees to enroll through a FF-SHOP serving the employee's primary worksite, would the employer be required to follow the eligibility criteria for the state-based SHOP or the FF-SHOP for out-of-state employees?

6. Reduce adverse selection by avoiding the option for employers to provide employee choice beyond a single metal level. (Preamble).

Issue:

CMS requests comments on adding an additional "buy-up" employer option in the FFE. Under this option, employers would allow employees to choose from all QHPs at the level of coverage selected by the employer plus any QHPs at the next higher level of coverage *that a QHP issuer agrees to make available under this option.* QHP issuers could decide whether to offer QHPs at the next higher level of coverage under this option.

Recommendation:

BCBSA supports the Rule's approach of allowing employee choice within a single metal level when employee choice is implemented. However, we strongly urge HHS not to adopt its proposal to permit employees to "buy up" to the next higher level of coverage than the one chosen by their employer due to the significant additional complexity it would impose.

Rationale:

We recommend against allowing employee choice of any plan at any level, which would further exacerbate adverse selection in the employee choice model. Limiting choice to a single metallic level, as proposed in this Rule, should help mitigate the adverse selection impact of employee choice to at least some degree. We believe that allowing a "buy up" to the next coverage level will exacerbate adverse selection concerns.

Also, the "buy up" would require additional processes for the approach to work successfully. While the Proposed Rule contemplates allowing an issuer to opt into an employee "buy up" it is unclear operationally how an issuer would be provided with the opportunity to make such a declaration, and when to expect additional employee contributions from the premium aggregator. Within the employer and employee shopping experience, it is also unclear how an employer or employee would know whether any issuers elect to participate in the "buy up" and which QHPs, if any, would be available. Implementing this approach would increase administrative costs in addition to contributing to adverse selection.

7. Increase the threshold for minimum SHOP employer participation rules. (§155.705(b)(10))

Issue:

The existing SHOP provisions permit both state-based exchanges and FFEs to establish minimum participation rates, meaning that an employer may only purchase QHPs for its employees if a certain percentage of them enroll in coverage through the SHOP. The Rule proposes a minimum participation rate of 70 percent for FFEs. The rate will be calculated by dividing the number of qualified employees accepting coverage in the SHOP by the number of qualified employees offered coverage (excluding employees covered by another employer group plan or by a public program such as Medicare, Medicaid or TRICARE).

The Rule also provides an option for the FF-SHOP to apply a different minimum participation rate if:

- A state law sets a different rate.
- A higher or lower rate is customarily used by the majority of QHP insurers in the small group market outside the SHOP.

CMS requests comments on the default 70 percent minimum participation rate and the exceptions that will help ensure alignment with current state practice and standards inside and outside the SHOP.

The Preamble notes that the application of any minimum participation rate requirement is subject to finalization of a recently proposed CMS Rule that creates such an exception to the guaranteed issue requirement for small group issuers.

Recommendation:

BCBSA appreciates that the Rule acknowledges the importance of retaining employer contribution and participation requirements as a tool to combat adverse selection, and we further appreciate the flexibility the Rule provides for applying a standard other than the proposed 70 percent standard in states that either require or typically use a different standard. Given this reasoning, BCBSA recommends that that CMS increase its proposed participation requirement from 70 to 75 percent. BCBSA also requests that CMS clarify how SHOP exchanges will enforce employer participation requirements.

We also recommend that CMS permit SHOP exchanges to take additional steps to manage employee choice if necessary in order to manage selection and costs. Such additional management steps could include prohibiting access to multiple issuers in a SHOP exchange unless the employer has a specified number of employees. In addition, states should be permitted to limit the number of plans within a tier from which employees could choose, and designate groups of plans from which employees could choose.

Rationale:

Employee choice will create adverse selection that will result in increased costs for the majority of issuers participating in SHOP. Employer participation requirements and the other management steps recommended will protect the exchange from adverse selection that could arise if healthier members of a small employer obtain coverage through the individual exchange or select discriminately between issuers on the SHOP exchange. We are recommending that

CMS increase the employer participation standard from 70 to 75 percent because this level is more in line with the current industry standards.

Also, details on how SHOP exchanges will enforce participation and contribution requirements are needed and should be a requirement for SHOP exchanges to ensure employer participation requirements provide the intended protections against adverse selection. In addition, issuers need access to this information so that they can assist in the enforcement.

8. Simplify rating for SHOP: employer contribution safe harbor (§ 155.705(b)(11)).

Issue:

The Rule includes “safe harbor” employer contribution methods for employers participating in FFEs. While this is not the only allowable employer contribution mechanism, it is the only one that will initially be available through the FF-SHOP. Under the safe harbor approach, employer contributions will be based on the premium of a “reference plan.” Each employer:

- Will select a QHP within the coverage level it has designated for its employees that will serve as the reference plan on which premium contributions will be based.
- Will define a percentage contribution towards premiums for employee-only coverage, and, as applicable, dependent coverage, under the reference plan.
- May choose to establish different percentage contributions for different employee categories, to the extent permissible under state or federal law.
- May choose to base contributions on a composite rate (and state law may require that a FF-SHOP base contributions on a composite premium for the reference plan).

The Rule indicates that the composite rate would be generated by "add(ing) the per-member rates and dividing the total by the number of employees to arrive at the group's average rate." We are concerned about the administrative complexity of developing a composite rating mechanism in an employee choice environment and the lack of clarity for developing a composite rate that varies by the dependent tiers typically observed in the current small group market (single, employee and spouse, single parent, full family).

Recommendation:

BCBSA recommends that member level rating be the only choice in the FF-SHOP if employee choice is retained.

Rationale:

While composite rating has historically been the predominant approach to rating on the larger side of the small group market (group size for composite rating typically ranges from 10 to 25 employees) the presence of employee choice, to the extent it is required, in the SHOP exchange makes this rating approach impractical.

Composite rating is a rating system in which a group receives an average rate for each dependent tier option. In such a system, each group receives one rate for all employees electing single coverage, one rate for all employees electing single and spouse coverage, one rate for all employees electing single parent coverage and one rate for all employees electing family rates (assuming a four tier dependent option system) regardless of the age of the

employee. There are numerous algorithms employed in generating these average rates. These rates are known at the time individuals are initially enrolling and are applied to new employees throughout the year without re-calculations.

In the SHOP exchange, employees with different ages, family compositions and usage of tobacco products will select among different companies. If composite rating were used, then a complex process on the backend would be required to provide the issuer with what is in essence the member level premium for which they are due. The Proposed Rule pertaining to Health Insurance Market Rules and Rate Review ("Market Rule") indicates that an employer can elect a composite rating approach as long as the premium generated using the composite rating approach is identical to the premiums generated using the per member rating approach.

One significant challenge with composite rating is ensuring accurate premium payments to issuers in an employee choice environment, including ensuring the accurate and timely reconciliation of monthly premium levels generated using a per member approach and monthly premium levels generated using a composite rating approach.. Employee turnover is common in the small group environment. Dependents change often as well. In order to comply with the literal interpretation of this requirement, the SHOP would need to develop new composite rates every time there is a change in covered employees and/or dependents. Since the Rule appears to imply that the employer/employee contribution is going to be based upon these composite rates, the contribution levels will vary as well. This, in turn, could lead to employees deciding to change carriers and or modify the number of dependents covered with each change in composite rates. Administratively this would be very problematic.

The Rule indicates that the composite rate would be generated by "add(ing) the per-member rates and dividing the total by the number of employees to arrive at the group's average rate." Read literally, this process would not produce a composite rate that varies by the dependent tiers typically observed in the current small group market (single, employee and spouse, single parent, full family). This process would produce a single composite rate for all employees being covered, regardless of dependent coverage. In this situation, the premiums for single employees would be artificially high since they would be subsidizing premiums for employees with dependents. We are assuming this is not the intent.

It will be difficult to develop a composite rating mechanism in an employee choice environment that produces rates that are equitable for both employees and issuers and that do not significantly increase administrative complexity. Massachusetts tried to incorporate composite rating into its small employer exchange allowing individual choice in a pilot project. It is our understanding that this project was not successful because of the administrative complexities and costs.

The situation becomes even more complex when expanded to include dependent coverage. Are the composite rates for each tier of coverage based only on the employees enrolling in those tiers? If so, it is possible for the employee and spouse rate to be higher than the full family rate. This could occur in cases where the employees choosing employee and spouse are in the oldest category and the families are in the youngest categories.

9. Avoid creating incentives to undermine group coverage through creation of SHOP. (Preamble)

Issue:

We are concerned that in trying to create a viable model for SHOP, the Administration may waive requirements for employer coverage that could ultimately undermine the small employer market and erode consumer protections.

In creating the employee choice SHOP structure, we are concerned that the Administration may exempt employers participating in SHOP from current ERISA group health plan requirements, even though employers would continue to contribute to SHOP coverage, just as employers contribute toward small group coverage today. This could provide unique advantages to SHOP that may make it more attractive, but undermine the small employer health insurance market by encouraging small employers to pare back their commitment to health coverage.

Exempting employers from ERISA also obviously undermines the rights granted to employees by ERISA. As CMS is aware, ERISA itself was enacted to protect the benefit promises employers make to their employees. It would seem short-sighted to abandon those guarantees in an attempt to encourage employers to continue to provide benefits. Instead, we would encourage CMS to work with exchanges and the Department of Labor to make offering ERISA-covered SHOP plans as seamless as possible. This will ensure that individuals retain their ERISA rights, while encouraging small employers to continue to subsidize health insurance coverage for their employees.

Recommendation:

BCBSA recommends that employers that sign-up to offer coverage through SHOP and select a level of coverage – regardless of whether employee choice is provided –be considered to have established an ERISA plan and their employees be granted the same ERISA protections as if the employer provided coverage in the small employer market outside of the SHOP.

Rationale:

An ERISA-covered group health plan exists if the arrangement constitutes a (1) plan, fund or program, (2) "established or maintained" by an employer, and (3) for the purposes of providing medical, surgical or hospital benefits. ERISA § 3(1). Because any policy purchased through a SHOP exchange will be a policy that provides a comprehensive schedule of benefits, coupled with an ongoing scheme of administration, SHOP coverage will satisfy the plan, fund or program requirement in (1) above. Because the policy will provide medical benefits to participants and beneficiaries, the requirement in (3) will be met. Therefore, in determining whether ERISA would apply, the key issue is whether an employer would be deemed to have "established or maintained" the program such that ERISA coverage is triggered.

To determine whether an employer has established or maintained a plan generally requires looking at the level of involvement and endorsement the employer has with the arrangement. Key factors often include whether the employer selects the coverage offered or contributes to the coverage.

First, in the context of SHOP employee choice, although employers will not choose a specific plan, they will choose to offer coverage through an exchange, and choose a specific level of

coverage (the intended benefits) to offer employees. This involves an important element of endorsement because the employer elects a certain level of coverage for employees. Moreover, depending upon the exchange structure, choosing a level of coverage may be quite limiting: any particular exchange may make only a few plans available at any particular coverage level. In that instance, from the employee's perspective, choosing a plan within a level of coverage through an exchange may be virtually indistinguishable from selecting one of several plans offered by an employer through an exchange. In fact, courts have found an ERISA plan was formed when the employer exercised a similar amount of control over an employee's choice of coverage. In Brundage-Peterson, the Seventh Circuit considered a case where an employer selected two different insurance companies to offer health insurance coverage to its employees. It appears that the employer had no involvement in the content or cost of the plans offered; it is clear that employees were free to choose between either insurer. Nevertheless, the court held "this rather barebones plan" was nonetheless an ERISA plan. *Brundage-Peterson v. Compcare Health Services Ins. Corp., 877 F.2d 509, 510-11 (7th Circ. 1989).* The court noted that the offering a choice of plans, even from different insurers, did not change the result. Key to the court's decision was that "[t]he choice offered [to the employees] remained a distinctly finite one … and is not the same as leaving the procurement of insurance entirely to the employee." *Id. at 511 (emphasis added);* see also *Madonia v. Blue Cross & Blue Shield of Virginia, 11 F.3d 444, 447 (4th Cir. 1993)* ("The fact that MNA's plan respects an employee's choice of carrier does not render the plan too ill-defined under ERISA"); *Russo v. B&B Catering, Inc., 209 F. Supp. 2d 857, 860 (N.D. Ill. 2002)* ("If the arrangement favors a finite set of plans over employees shopping for insurance in the open market, the favored plans are considered to be have been established by the employer."). Similarly here, even under the employee choice option where the program "respects an employee's choice of carrier," an employee's choice of insurance coverage remains "distinctly finite" as a result of the employer's decision to offer coverage through the exchange and selection of a level of coverage.

Second, employers in the employee choice program will continue to determine what employees are eligible (the class of beneficiaries). Clearly, determining plan eligibility is a key aspect of plan design and a central element to establishing a plan. *DOL Adv. Op. 80-22A (April 17, 1980); Brundage-Peterson, 877 F.2d at 511.*

Third, the source of financing will often involve employer contributions. Any employer contribution to the cost of coverage is a significant factor in demonstrating the existence of an ERISA plan. *Kidder v. H&B Marine, Inc., 932 F.2d 347 (5th Cir. 1991).*

Finally, any small employer participating in the employee choice program will be providing ongoing administrative functions, including eligibility determinations, providing payroll deductions and making premium payments. *Fort Halifax Packing Co. v. Coyne, 482 U.S. 1, 12 (1987).* This level of employer involvement in the ongoing administration of the program further favors the conclusion that this arrangement is likely an ERISA plan.

Where SHOP plans are considered ERISA plans they would be subject to a number of additional federal protections. Those requirements are described in detail below. Importantly, it is apparent that any ERISA obligations imposed upon a plan are not incompatible with obligations imposed under the ACA or state law. It further appears that many ERISA obligations have now been incorporated into the ACA and are therefore effective for any coverage purchased through an exchange. The ERISA requirements that are not incorporated into the ACA are not onerous and are protective of plan participants. ERISA protections include the following:

- **Fiduciary duties and civil enforcement rights.** ERISA requires individuals who make discretionary decisions on behalf of a plan to discharge those duties solely in the interest of the participants and beneficiaries of the plan, including with respect to handling plan assets like employee contributions to premium. ERISA § 404(a)(1). ERISA fiduciaries are personally liable for losses caused by a breach of fiduciary duty. In addition, ERISA beneficiaries may bring suit in federal court to recover benefits due, to enforce rights under the plan, to enjoin practices that violate ERISA, or other appropriate equitable relief to redress violations or to enforce provisions of ERISA. ERISA § 502(a).

- **ERISA disclosure requirements**. ERISA requires that a "plan administrator" provide certain disclosures to plan participants, including a summary plan description and summaries of any material modification or material reduction in benefits. ERISA § 104(b); 29 CFR § 2520.104b-1, -2. However, the ACA also imposes significant plan disclosure requirements, including the requirement that a summary of benefits and coverage explanation must be provided by group health plans and health insurance issuers to participants. PHSA § 2715. It is likely that the documents provided by health insurance issuers offering coverage through an exchange to fulfill their obligations under PHSA § 2715 will largely meet ERISA disclosure requirements. Nonetheless, there may be other, additional information that a participant has the right to request under ERISA that would not have been otherwise provided under PHSA § 2715. Establishing an ERISA plan would therefore establish additional disclosure protections for employees.

- **5500 filing.** ERISA requires a plan administrator to file an annual report (the form 5500) with the Department of Labor, which includes information about benefits provided under the plan during the prior year. ERISA § 103(a)(1). The obligation to file the 5500 would fall on the small employer; however, ERISA provides an exception from the form 5500 filing requirements for fully insured plans with fewer than 100 participants that meet certain premium payment and refund requirements. 29 CFR § 2520.104-20(a). To the extent that a filing is required, the health insurance issuer that provided coverage through the exchange would be obligated to furnish underlying information within 120 days after the end of the plan year so that the plan administrator could complete the filing.

- **COBRA.** COBRA requires a "plan sponsor" of a group health plan to offer continuation coverage when participants or beneficiaries lose coverage due to certain qualifying events, such as termination of employment, death, divorce, or loss of dependent status. ERISA § 601 et seq. COBRA defines "group health plan" to mean an employee welfare benefit plan that provides medical care. ERISA § 607(1). The obligation to provide notices of COBRA benefits would fall on the employer, but the applicability of COBRA would benefit participants by allowing former employees to continue coverage at the employer group rate, rather than at an individual rate as a qualified individual through an exchange.

10. CMS should not rely solely on user fees to fund FFEs. If retained, CMS should assure that user fees are transparent and apply only to those who purchase through exchanges (§ 156.50(c)).

Issues:

- *3.5 percent user fee.* The Rule requires issuers to remit a user fee to CMS each month based on a percentage of premium paid for "billable" members enrolled in the issuer's QHP on an FFE. ("Billable members" are defined as each family member in a policy, with a limit of three family members under age 21.) The 2014 user fee rate is set at 3.5 percent of premium, a rate targeted to align with user fees charged in state-based exchanges. CMS indicates that this rate may be adjusted in the Final Rule to take into account user fees charged in state-based exchanges.

- *User fee collection.* CMS will provide further guidance on the process for collecting user fees, but proposes that such fees will be deducted from "exchange-related program payments" (which likely refer to APTC and CSR payments to issuers for enrolled members eligible to receive such payments); the Rule indicates that if an issuer does not receive any exchange-related program payments, the issuer would be invoiced for the user fee on a monthly basis. CMS seeks comment on its proposed methods for collecting user fees.

- *Application to partnership exchanges.* The Rule is silent with respect to how user fees will be applied in state-partnership exchanges.

- *Pooling of user fees (Preamble at FR 73182).* CMS seeks comment on its proposal to pool exchange user fees (or potentially all administrative costs) across a particular market or product. While user fees would be collected only from issuers participating in the FFEs, CMS appears to be considering a requirement that issuers spread user fee costs evenly to all of their plans both inside and outside of the exchange. CMS suggests that such pooling may provide further protection against adverse selection and ensure that the costs of exchange user fees are spread evenly so as not to create pricing differences for products inside and outside of exchanges.

  CMS is also considering allowing issuers an adjustment to the index rate for the pooled, expected exchange user fees for the set of health plans offered in a particular market. CMS seeks comment on this policy, including whether it should apply to a broader set of administrative costs, such as both exchange user fees and distribution costs, or all administrative costs. CMS also asks for comments on an alternative approach, under which the proposed risk pooling would apply across all health plans within a product (defined as a specific set of benefits), rather than across a market.

Recommendation #1: CMS should establish broad-based financing and not rely solely on issuer user fees. BCBSA opposes the sole reliance on issuer user fees to finance FFEs. We continue to support broad-based financing, which will allow an exchange to secure the most predictable funding without increasing costs for consumers. Such broad-based financing would include assessments on all healthcare industry entities, user or membership fees that are not included as premium, and state revenues and assessments on any entity providing an aggregator function, to the extent a state provides the function.

If CMS retains user fees as the sole source of financing for FFEs, we strongly recommend that CMS reevaluate the fee over time to reflect efficiencies in the agency's contractual cost to operate the FFE.

Rationale:

All stakeholders in the healthcare industry will benefit from the coverage of currently uninsured individuals and small employers through state health insurance exchanges. Relying on health insurers alone to pay the cost could undermine the key exchange goal of making more affordable coverage options available for those populations least likely to have such access today – individuals and small employers.

Adding 3.5 percent to premiums that already will increase due to certain ACA provisions will further exacerbate affordability concerns for consumers and small employers. ACA provisions that will increase costs include: the health insurance tax and other taxes and fees, the expansive essential health benefit benchmark proposal, limits on varying premiums based on age, the ban on varying rates based on health status, and guaranteed issue provisions without any preexisting conditions limitations. While the availability of new federal subsidies will help many Americans pay for their coverage, because these subsidies depend on a person's income, many others will not be eligible. The Congressional Budget Office estimates that more than 40 percent of the people purchasing coverage in the individual market will not be eligible for premium subsidies.

User fees should fall over time, given start-up costs for the FFE are likely to result in higher operating costs in the initial years than in subsequent years. We believe that the proposed 3.5 percent of premiums is too high and will have a negative impact on affordability of coverage.

Recommendation 2: User Fees and Other Administrative Costs Should Be Allocated to Exchange Users

We would like further clarity regarding HHS' proposal (in the Preamble at *FR* 73182) to permit issuers to make an "adjustment to the index rate for the pooled, expected exchange user fees for the set of health plans offered in a particular market." If CMS is proposing that issuers would be permitted to charge higher premiums on the exchange to account for user fees, we support this proposal because it reflects the additional value added (in terms of services and eligibility assessments) provided to exchange enrollees. BCBSA supports allowing issuers to adjust the index rate for exchange user fees and other administration costs. We also support applying these adjustments at the product level rather than at the market level, because distribution costs vary too much across markets to estimate overall costs accurately.

However, we are concerned that, as an extension of the single risk pool provisions of the Market Reform proposed rule, CMS is considering requiring issuers to allocate user fees and other administrative costs across all products an issuer offers. As noted above, we continue to recommend that exchange user fees be paid only by those individuals and small employers that use the exchanges. We do not believe that it would be fair ask these individual and small business customers to subsidize the operations of exchanges. In addition, requiring issuers to that participate in exchanges to charge user fees to all of their members may cause some marginal players to avoid participation on exchanges.

Rationale:

Although the language describing the proposals by CMS is unclear, it appears that CMS may be considering a policy that would require issuers participating in the FFE to pool exchange user fees (and possibly distribution and other administrative costs) across all products an issuer offers in a particular market (individual, small group or combined). If this is correct, user fees for exchanges would be spread across a health plan's customers in the individual and small employer markets, regardless of whether they enroll in products offered on the exchange.

We believe there are several reasons that CMS should not require all health insurance consumers to bear the costs of operating FFEs.

First, the concept of a "user fee" is more limited than the broadly applicable tax that would be spread across markets. ACA section 1311(d)(5) permits an exchange to charge "user fees" to participating health insurance issuers (as well as other methods) to finance the operation of exchanges. The term "user fee," which is the method proposed by CMS to fund operation of the FFE, implies that the fee will be paid by those who use exchange services rather than a tax on all individuals purchasing health insurance regardless of whether they use an exchange or not.

A 2008 report on user fees by the Government Accountability Office (GAO) included an insightful analysis of the differences between user fees and taxes:

> "In general, a user fee is related to some voluntary transaction or request for government goods or services above and beyond what is normally available to the public, such as a request that a public agency permit an applicant to practice law or medicine or construct a house or run a broadcast station. Taxes, on the other hand, arise from the government's sovereign power to raise revenue and need not be related to any specific benefit, and payment is not optional; when Congress imposes taxes, it need not consider benefits bestowed by the government on an individual but may base taxation solely on an individual's ability to pay. The Supreme Court has ruled that a tax is "an enforced contribution to provide for the support of government." The legal distinction between a "fee" and a "tax" can be complicated and depends largely on the context of the particular assessment. Whether a particular assessment is statutorily referred to as a tax or a fee is never legally determinative. Instead, federal courts will examine the structure and the context of the assessment's application."[3]

Further, CMS relies upon Circular No. A-25R, which establishes federal policy regarding user fees, such as this one. However, the Circular applies in cases where a recipient receives a "special benefit" from the federal government. It is this rationale that CMS relies upon to justify charging health insurance issuers a fee to offer coverage through the FFE. If CMS believes that offering exchange coverage is a "special benefit" that accrues to health insurance issuers then surely the purchase of exchange coverage is also a "special benefit" to exchange-covered customers. In that case, there is no justification for forcing health insurance issuers to assess all customers—including those who have received no "special benefit" from the exchanges—to pay for their operation.

Second, assessing the entire market is unnecessary as exchanges are expected to serve a large enough base of consumers to fund their operations. Further, as we recommended above, we continue to support financing exchanges through broad-based financing, rather than

[3] United States Government Accountability Office: "FEDERAL USER FEES: A Design Guide", GAO-08-386, May 2008.

assessing only health insurance issuers and consumers, to ensure that all stakeholders who benefit from affordable exchange coverage share the cost of providing it.

Third, Circular No. A-25R specifically states that "It is the objective of the United States Government to: ... c. allow the private sector to compete with the Government without disadvantage in supplying comparable services, resources or goods where appropriate." Circular No. A-25R, Objectives. However, by requiring issuers to charge non-exchange members a fee to support the provision of exchange coverage, CMS will effectively disadvantage issuers supplying non-exchange coverage in order to support governmental exchanges.

Fourth, CMS appears to rely, at least in part, on the ACA's single risk pool provision, section 1312(c), to justify assessing exchange user fees on customer's outside of exchanges. We do not read the single risk pool requirement that broadly. The statute directs **issuers** to treat all enrollees in the individual market (inside and outside of an exchange) as part of a single risk pool. Similarly, issuers must treat all enrollees in the small group market as part of a single risk pool. **States** may "merge" the two markets, creating a single risk pool. States may not require grandfathered health plans to be considered part of the new single risk pools. Nowhere in the single risk pool provision is any authority or responsibility specifically delegated to HHS.

Although risk pools are not defined in the statute, it is generally accepted that the "risk" is the risk of adverse medical conditions or events and the "pool" is the group of individuals for which the "risk" is being measured. Generally speaking, the larger the pool, the more predictable the medical risk. HHS appears to recognize this in the preamble to the proposed rule, suggesting that the risk pool provision requires pooling "the claims experience of all enrollees" in a particular market. 77 Fed. Reg. at 73182. What neither interpretation suggests is that pooling risk requires that issuers to pool fees assessed for services provided—like the assessment of eligibility for federal subsidies—only to a subset of the pool.

We recognize that insurance generally, and risk pooling particularly, effectively require healthy individuals to subsidize the coverage of less healthy individuals. However, this bargain is stuck with the understanding that at some point, the healthier and less healthy individuals may switch places. In contrast, requiring individuals to subsidize the cost of the "special benefits" they receive through exchanges is not the same, because exchange enrollment is voluntary and limited. The ACA specifically provides that individuals cannot be forced to enroll in coverage through an exchange. ACA 1312(d)(3)(B). Further, many individuals, like those employed by employers with more than 50 employees, cannot access employer-sponsored coverage through exchanges (at least until 2017, when states may make larger groups eligible). As a result, CMS' proposal would require individuals who cannot (or do not wish to) take advantage of exchange benefits to subsidize those who can and do.

In addition, given the specific reference to state—not federal—authority to merge markets, the provision implies that any enforcement of the single risk pool is first reserved to the states, as is typical for the market reforms included in the PHSA. As a result, only if a state is failing to ensure that issuers are treating all enrollees in a market as members of a single risk pool should HHS even be involved with the enforcement of this provision. We believe that HHS should not issue rules that interfere with state authority in this area.

Recommendation 3: Any User Fee Should Be Clearly Designated As a Fee

We believe that it is critical for there to be transparency regarding the costs of the exchange to encourage exchanges to be efficient and minimize user fees, distribution costs, and other administrative costs.

Rationale: As the GAO commented, "Because user fees represent a charge for a service or benefit received from a government program, payers may expect a tight link between their payments and the cost of providing services and have expectations about the quality of the related service."

It is particularly critical that the user fee be clearly identified as such if CMS requires issuers to spread the cost of the FFE across all markets. If issuers are not permitted to differentiate user fees and other exchange-related costs, then these costs would be unknowingly shouldered by individuals and small employers that will not directly benefit from exchanges. Particularly because of the costly changes to health insurance coverage required by the ACA in 2014—including the essential health benefits package and modified community rating—it is appropriate, and critical, that health insurance customers understand their premium. In fact, other provisions of the ACA specifically require more transparency in health insurance coverage, including data on rating practices, ACA section 1311(e)(3)(iv), and rate increases, PHSA section 2794. In order to accurately inform customers of the basis of the overall cost of coverage, the user fee should be specifically designated as a line item fee attributable to FFE operations.

Recommendation #4: CMS should develop performance metrics, publicly disclose accounting and financial information, ensure funding collected is dedicated solely to exchanges and ensure any unspent funding is returned to health plan issuers.

Rationale:

Given the billions of dollars CMS proposes to collect for financing the FFEs, it will be critical for issuers and consumers to be able to assess the value of the services provided by an exchange. § 1313 of the ACA requires an exchange to keep an accurate accounting of all activities, receipts, and expenditures, and report annually to HHS with such information. Although HHS will be operating the FFEs and FF-SHOPs, we recommend that this requirement for reporting continue to apply and that financial reports on exchange costs be publicized.

Other government programs that also rely heavily on industry user fees are held accountable to performance goals. However, there has been no indication from CMS on the timelines for developing metrics that could be used to assess results and value for consumers. As the FFE and FF-SHOP are implemented, we encourage CMS to broadly solicit input from stakeholders in developing performance metrics for the FFEs and FF-SHOP. Timeframes for QHP certification, call center performance, accuracy of eligibility verifications, or enrollment and financial transaction performance are examples of exchange operations that may be considered in developing such metrics.

Finally, issuer participation on an exchange may be determined on a year-to-year basis and it will be important to ensure any user fees paid in surplus of the administrative costs to operate the FFEs and FF-SHOPs are refunded back to issuers. Issuers seeking to be certified for participation on the exchanges could either be refunded or receive a credit for future funding.

11. Avoid establishing rules for agent and broker commissions in FFEs (§ 156.200(f)).

Issue:

The Rule requires issuers to pay similar broker compensation for QHPs offered through an FFE or FF-SHOP to what the issuer would pay for similar health plans in the outside market.

CMS requests comments on whether ''similar health plans'' is a sufficient standard and if not, which factors should be considered in identifying ''similar health plans.'' CMS also requests comment on how this standard might apply when small group market product commissions are calculated on a basis other than an amount per employee or covered life or a percentage of premium.

Recommendation:

BCBSA recommends that CMS allow issuers to differentiate distribution costs on an off an FFE and FF-SHOP and that CMS avoid establishing detailed requirements on commissions.

Rationale:

Issuers should have discretion in determining agent and broker compensation amounts within the parameters already established. The Final Exchange Rule requires issuers to ensure premiums do not vary with respect to products sold through agents and brokers. In addition, the Proposed Rule on Rate Review permits issuers to vary premiums only for a very limited number of plan-specific factors.

As reflected in our comments on proposed §156.809(d) in the Proposed Rule on Rate Review submitted on December 21, 2012, BCBSA opposes any restriction on an issuer's ability to adjust pricing factors following the initial pricing, so long as those factors are actuarially justified. We are concerned that the proposed approach would restrict an issuer's ability to make adjustments to reflect differences for distribution costs, e.g., whether a product is sold via a broker or directly, inside or outside an exchange. To ensure the approach reflects the different roles agents and brokers will play based on the tools available for coverage provided inside an exchange versus outside an exchange, it should provide sufficient flexibility to issuers.

Additionally, especially in an employee choice environment, it will be important for state licensure and appointment laws to be followed so issuers are able to ensure agents and brokers accurately receive agreed upon compensation amounts.

12. Technical correction (§ 156.285)

Issue:

The Rule adds language to §156.285(c)(7) requiring QHP issuers participating in a SHOP exchange to enroll qualified employees if they are eligible for coverage. This correction aligns SHOP enrollment with enrollment standards for the individual exchanges.

Recommendation:

BCBSA supports the technical change.

II. Proposed Amendment to Medical Loss Ratio (MLR) Regulations for Community Benefit Expenditures and State Premium Taxes

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Issue:

The proposed rule (amendment to 45 C.F.R. § 158.162(b)(1)(vii) and (viii), 77 Fed. Reg. 73217 (December 7, 2012)) would permit federal income tax exempt health insurance issuers to deduct both community benefit expenditures and state premium taxes from the calculation of premium revenue for the MLR, while health insurance issuers that are not federal income tax exempt (including such issuers that are nonprofit entities) must choose between deducting either community benefit expenditures or state premium taxes from the calculation of premium revenue for the MLR.

Recommendation:

CMS should not create a special provision for Federal tax exempt issuers to deduct both state premium taxes and community benefit expenditures from their earned premium revenue. If CMS retains this provision, it must also allow health insurance issuers that are not tax exempt to deduct from the premium revenue calculation both their state premium taxes and community benefit expenditures to assure a level playing field.

Rationale:

Health care reform is built on the premise that all health insurance issuers must operate under the same rules to promote true competition. Indeed, the preamble to the proposed rule states that allowing federal income tax exempt issuers to deduct both community benefit expenditures and state premium taxes in calculating the MLR "…would help level the playing field because it would allow a Federal income tax exempt issuer to deduct its community benefit expenditures in the same manner that a for-profit issuer is allowed to deduct its Federal income taxes." 77 Fed. Reg. 73188 (December 7, 2012).

However, this conclusion is misguided. The special MLR treatment for federal income tax exempt health insurance issuers merely gives these issuers another unfair competitive advantage. These issuers are already exempt from federal income taxes and many of these issuers also will receive a 50 percent discount on the annual health insurance tax (ACA § 9010(b)(2)(B)) that other health insurance issuers will not receive. Instead of leveling the playing field, the proposed rule tilts it further in favor of tax exempt health insurance issuers.

We are very concerned that this proposed rule greatly undermines the goal of a level playing field and gives federal income tax exempt health insurance issuers an unfair competitive advantage. In addition, the proposed rule could create a disincentive for issuers that are not tax exempt to make community benefit expenditures,. See 75 Fed. Reg. 74864, 74878 (Dec. 1, 2010); 76 Fed. Reg. 76574, 76579 (Dec. 7, 2011). At a minimum, there must be parity in the treatment for MLRs regarding federal income tax exempt issuers and health insurance issuers that are not exempt from federal income tax.

Health insurance issuers that are not exempt from federal income taxes may incur expenses for state premium taxes, community benefit expenditures, and federal income taxes. Federal tax

exempt issuers, by contrast, may incur expenses for state premium taxes and community benefit expenditures only. Thus, federal tax exempt issuers already have a significant tax advantage over non-tax exempt issuers. Further, the stated premise for allowing only tax exempt issuers to deduct community benefit expenditures in addition to state premium taxes – *i.e.*, to allow such community benefit expenditures to "take…the place of a federal income tax deduction" otherwise allowed in determining a non-tax exempt issuer's premium revenue for MLR purposes – is flawed. Because both tax exempt and non-tax exempt issuers incur community benefit expenditures, there is no need to provide a special additional deduction to tax exempt issuers to take the place of federal income tax expenditures.

It is also important to point out that the amount expended on community benefits by both tax exempt and non-tax exempt issuers is not available to be used to cover health care costs for their subscribers. This is another reason why both tax exempt and taxable issuers should be permitted to exclude these expenditures. State premium taxes and federal taxes should be excluded for all issuers for the same reasons, i.e., these amounts are also unavailable to cover health care costs of their subscribers. This approach would ensure a more level playing field, and continued incentives to make community benefit expenditures (beyond those that some issuers may be required to make in lieu of federal or state taxes).

III. Cost-sharing Reductions and Advance Premium Tax Credits Provisions

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14. Limit Cost-Sharing Reductions (“CSRs”) to in-network essential benefits (§ 156.400).

Issue:

In the Preamble, CMS notes that the definitions of “cost-sharing” and “cost-sharing reductions” apply only to essential health benefits (“EHBs”) “without regard to whether the EHB is provided inside or outside a QHP’s network.” BCBSA is concerned that CMS may be interpreting CSRs to apply to both in- and out-of-network EHBs. This would be inconsistent with other EHB-related provisions, including the calculation of actuarial value and the standard and reduced annual dollar limitations on out-of-pocket (“OOP”) spending, both of which are limited to in-network EHBs.

Recommendation:

BCBSA strongly recommends that the Final Rule limit CSRs to in-network EHBs only, consistent with the requirements for the annual dollar limitation on out-of-pocket maximums and the calculation of actuarial value.

Rationale:

Expanding the application of CSRs to out-of-network providers will have significant impacts on both enrollee cost-sharing and provider contracting. As noted in the AV/CSR Bulletin issued in February 2012, CSRs would not apply to balance billing for out-of-network providers; as such, low-income enrollees who seek care from out-of-network providers would likely be subject to balance billing, thereby increasing their OOP spending. Given the likelihood that many members of this vulnerable population will churn back and forth from Medicaid into exchange coverage, it is misleading to provide short-term incentives for them to seek care from out-of-network providers by expanding the application of point-of-sale CSRs. Such an expansion may result in them being subject to balance billing, something they have not previously been exposed to under Medicaid. The resulting balance billing will only confuse and anger the CSR-eligible enrollees and deprive them of the ultimate goal of the CSRs: lower health care costs.

Additionally, expanding the definition of cost-sharing reductions to include out-of-network providers will severely limit issuers’ ability to negotiate pricing and control quality. Issuers generally have little ability to control provider costs other than through negotiation over network participation. By expanding the definition of cost-sharing reductions, there will be little to no incentive for providers to join networks because issuers would not be able encourage low-income enrollees to seek treatment from in-network providers. In addition, many issuers require in-network providers to meet certain quality standards that promote efficient, effective care. Issuers have no mechanism to assist members in receiving high quality, coordinated care from out-of-network providers.

CMS has previously recognized the value of encouraging the use of network providers. For example, CMS applies the requirement to provide preventive care services with zero cost-sharing only to in-network providers. For preventive care services provided by out-of-network providers, issuers are allowed to apply cost-sharing. As with the CSR provisions, the preventive care provision in the ACA (PHSA § 2713) does not directly address the question of applicability to network providers. CMS, DOL, and Treasury considered the issue and determined that

requiring coverage by out-of-network providers at no cost-sharing would result in higher premiums. The policy underpinning this decision is the same as that which would apply to the CSRs. The Departments wrote:

> "Plans and issuers negotiate allowed charges with in-network providers as a way to promote effective, efficient health care, and allowing differences in cost sharing in- and out of-network enables plans to encourage use of in-network providers. Allowing zero cost sharing for out-of-network providers could reduce providers' incentives to participate in insurer networks. The Departments decided that permitting cost sharing for recommended preventive services provided by out-of-network providers is the appropriate option to preserve choice of providers for individuals, while avoiding potentially larger increases in costs and transfers as well as potentially lower quality care."[4]

The same policy implications should dictate a similar result for any rulemaking on the CSRs. As evidenced by the preventive services IFR, the agencies have authority to promulgate such a policy even in the absence of specific statutory language.

15. Special CSR rules for Indians (Part 156)

Issue:

The Rule includes several provisions to implement the special CSR rules for Indians in ACA §1402(d). The Rule proposes that issuers develop zero cost-sharing plan variations for Indians under 300 percent of the federal poverty level ("FPL") and limited cost-sharing plan variations for Indians above 300 percent of FPL for items or services furnished directly by the Indian Health Service (IHS), an Indian Tribe, a Tribal Organization, or an Urban Indian Organization, or through referral under Contract Health Services ("CHS"). While BCBSA is supportive of providing the CSRs to members of the American Indian/Alaska Native ("AI/AN") populations, there are a number of significant operational challenges with implementing the provisions described in the Rule. In an effort to meet the ACA's goal of providing zero and limited cost-sharing to AI/ANs, while also limiting administrative complications and burden for issuers, BCBSA provides the following recommendations:

Recommendation #1: Provide issuers a safe harbor for CSRs provided for Indians above 300 percent of FPL for referrals under Contract Health Services.

Rationale:

For the limited cost-sharing plan variation, BCBSA strongly recommends that CMS establish a "safe harbor" for issuers who waive cost-sharing for AI/ANs who receive services under a referral from CHS. There will be a number of significant operational challenges with implementing this benefit – including but not limited to tracking such referrals, uncertainty about the timing and processing of referrals by CHS, and issuer unfamiliarity with the CHS program given that currently only providers are involved in the program. Therefore, at least until CMS has developed a system that allows issuers to accurately verify referrals at the time of service, issuers should be held harmless during reconciliation of advance payments for the limited CSRs provided for all CHS referrals received from providers. Because cost-sharing will need to be eliminated at point-of-service for such referrals, issuers should be allowed to accept the referrals

[4] 75 Fed. Reg. at 41738.

as valid once they receive the claims from providers. Until the CHS program establishes an online, verifiable tracking system for referrals, issuers should be permitted to rely upon the information given them.

In addition, to avoid manual processing of CHS referrals, BCBSA recommends that providers who have CHS referrals be required to include the Indian Health Service ("IHS") referral number on the existing HIPAA claim form under the existing referral field so issuers know immediately that an AI/AN enrollee has a referral. Issuers will need to know the logic behind the CHS referral numbers to track in their systems in order to identify such referrals as they come in. If a CHS referral cannot be identified through the current structure of the referral number, we recommend a prefix or suffix (e.g., CHS) or other indicator that will allow payers to easily identify a CHS referral.

Again, until an accurate, online verification process has been established, CMS should hold issuers harmless during the reconciliation process for all CHS referrals that are received for which health plans received a CHS referral number. In the future, we recommend that the IHS develop an automated system for issuers to use to verify CHS referrals. As an alternative, IHS could identify the issuer at the time of a CHS referral request and alert that issuer in advance to expect claims when a referral has been granted.

Recommendation #2: Establish a capitated payment schedule to reimburse issuers for CSRs provided to Indians above 300 percent of FPL.

Rationale:

BCBSA appreciates that the Rule provides issuers flexibility in determining how to be reimbursed for the limited cost-sharing plan variations. Given the significant operational complexities associated with these plan variations, in an effort to reduce some administrative burden, BCBSA recommends that issuers instead receive capitated monthly advance payments as reimbursement for the waived cost-sharing. The capitated payment would be based off the actuarial calculation of the rate differential that issuers would determine prior to the start of the benefit year. No additional reconciliation process would take place. Due to the anticipated small number of AI/ANs that may enroll in the limited cost-sharing plan variations nationally, a reconciliation process will be administratively burdensome and complex. Further, such complexities appear to outweigh the risk of over- or under payments to issuers for this program.

16. Plan variations (§ 156.420)

Issue:

The Rule proposes that issuers design plan variations for low-income members determined eligible for CSRs. For each of the income categories described in ACA § 1402, issuers will be required to design a silver plan variation that meets the required maximum OOP limit and enhanced actuarial value ("AV") level. Similarly, under the special rules for Indians, issuers will be required to design zero cost-sharing and limited cost-sharing plan variations for each QHP offered on the exchange. BCBSA believes that developing the plan variations is the most straightforward and cost-effective way to implement the CSRs for low-income enrollees and AI/ANs and recommends that CMS retain this approach in the Final Rule and for benefit years in 2016 and beyond. To implement the CSR requirements, particularly the special rules for AI/ANs, in another manner would be administratively complex, resource intensive and costly,

given the difficulty associated with applying member-based cost-sharing rules for QHPs. To ensure that issuers are able to develop the required plan variations and meet the associated requirements, BCBSA provides the following recommendations:

Recommendation #1: Limit the number of plan variations that issuers must submit to the exchange for review and certification.

BCBSA does not believe that issuers should develop zero cost-sharing plan variations for all QHPs offered on the Exchange. Instead, we recommend that issuers only be required to file a single zero cost-sharing plan variation for the bronze QHP, unless there are differences in prescription drug formularies, provider networks (e.g., HMO versus PPO), or covered benefits between metal-level QHPs.

Rationale:

In order to meet the plan variation requirements proposed in the Rule and other recently released proposed regulations, it appears that issuers will need to file 30 QHPs and plan variations for every QHP product design, inclusive of the metal levels, as illustrated below:

- One Bronze QHP = Six submitted QHPs/plan variations
  - One Health-only QHP
    - One zero cost-sharing plan variation
    - One limited cost-sharing plan variation
  - One embedded-dental QHP
    - One zero cost-sharing plan variation
    - One limited cost-sharing plan variation

- One Silver QHP = 12 submitted QHPs/ plan variations
  - One Health-only QHP
    - Three silver plan variations
    - One zero cost-sharing plan variation
    - One limited cost-sharing plan variation
  - One embedded-dental QHP
    - Three silver plan variations
    - One zero cost-sharing plan variation
    - One limited cost-sharing plan variation

- One Gold QHP = 6 submitted QHPs/ plan variations
  - One Health-only QHP
    - One zero cost-sharing plan variation
    - One limited cost-sharing plan variation
  - One embedded-dental QHP
    - One zero cost-sharing plan variation
    - One limited cost-sharing plan variation

- One Platinum QHP= 6 submitted QHPs/ plan variations
  - One Health-only QHP
    - One zero cost-sharing plan variation
    - One limited cost-sharing plan variation
  - One embedded-dental QHP
    - One zero cost-sharing plan variation
    - One limited cost-sharing plan variation

Total for One QHP product design per metal level = 30 submitted QHPs/plan variations.

Because many issuers are planning to offer multiple product designs on the exchange, issuers may end up having to develop and file with exchanges, state Departments of Insurance and CMS potentially hundreds of QHPs and required plan variations. Reviewing and certifying such a large number of QHPs and the required plan variations submitted by every issuer planning to offer QHPs on an exchange will be a significant task for the exchanges, state Departments of Insurance and CMS. Moreover, the effort will be for little benefit, because unless there are differences in prescription drug formularies, provider networks (e.g., HMO versus PPO), or covered benefits between metal-level QHPs, there will be no reason for individuals eligible for CSRs to enroll in a more expensive plan, because the only difference between plans is cost-sharing and for these individuals, there is no cost-sharing imposed.

In addition, we note that CMS is considering a “meaningful difference” test as part of the certification process for the federally facilitated exchange (FFE). If CMS adopts a meaningful difference standard that limits the number of QHPs that health plans can offer in the FFE, we would strongly recommend that plan variations required by the CSR provisions not be considered distinct QHPs for determining outlier plans under this standard.

At least as a transition strategy – to streamline the QHP certification process in the first couple of years of full ACA implementation – CMS should limit the number of plan variations issuers need to submit for approval. Issuers should be allowed to submit only the zero cost-sharing plan variations for the bronze QHPs offered on the exchange unless there are material differences in the metal-level QHPs offered by that issuer. It is highly unlikely that an AI/AN under 300 percent of FPL will choose to purchase the more expensive QHP that provides the same benefits and networks as the bronze QHP with zero cost-sharing and we believe that the exchange will likely steer these individuals to the lowest-cost plan with the highest cost-sharing for which they are eligible. Alternatively, to ensure uniformity with the non-AI/AN CSR provisions, CMS could require issuers to submit zero cost-sharing variations for the standard silver QHP. In either case, there does not appear to be any added value in requiring issuers to submit zero cost-sharing variations at every metal level for certification.

<u>Recommendation #2</u>: Expand the de minimis requirement to that which was proposed in the AV/CSR Bulletin.

BCBSA is concerned that the reduced de minimis requirement of +/- 1% that is included in the Rule severely limits issuers’ ability to design reasonably simple benefit plans. BCBSA recommends that CMS expand the de minimis requirement to +/- 2% as proposed in the AV/CSR Bulletin to allow the most flexibility in designing QHPs and their plan variations while maintaining stability in the market.

<u>Rationale:</u>

BCBSA endorses flexibility in plan variation benefit design, as it allows for innovation, consumer choice, and the development of products to meet market demand. We are concerned that a narrow de minimis value will stifle this ability to innovate, and result in limited choice for consumers. And, considering the state regulations related to guaranteed renewability, a narrow de minimis value will create disruption for consumers and higher administrative costs by requiring products to be retired frequently.

<u>Recommendation #3</u>: Provide additional flexibility for the variations in cost-sharing structures across silver plan variations.

BCBSA supports the three-step process for design of cost-sharing structures for the silver plan variations as a reasonable approach to implementing the ACA's requirements. However, BCBSA is concerned that the requirements under step three unduly restricts issuers' flexibility in designing the plan variations. Thus, BCBSA recommends that CMS provide issuers additional flexibility to vary cost-sharing structures across silver plan variations, and consider allowing issuers to increase co-payments, deductibles and coinsurance for the plan variations, if necessary to meet the AV requirements. In addition, issuers should be allowed to continue to utilize medical management policies, including pre-authorization requirements and medical necessity.

<u>Rationale:</u>

BCBSA is pleased with the flexibility CMS provides issuers with regard to designing the silver plan variations, including using all available cost-sharing tools (e.g., co-payments, deductibles and coinsurance, as well as OOP limits) to meet the CSR requirements. We also appreciate the flexibility to vary cost-sharing across providers and benefits, subject to applicable non-discrimination and network access requirements. Such flexibility will help enable issuers to innovate and develop products that best meet the needs of the low-income population.

However, BCBSA is concerned that, even with this flexibility, issuers may still have significant difficulty designing both standard silver QHPs and the related plan variations that are able to accommodate both higher and lower income members, respectively, given the constraints of the other statutory requirements.

To meet the enhanced AV limits for the silver plan variations, the statute describes a two-step process: QHP issuers must first reduce the OOP limits and then make other adjustments to cost-sharing. For the second step, issuers will be prohibited from increasing the cost-sharing for any benefit or provider as the AV increases. The proposed restriction appears incongruent with the statutory requirements and significantly limits an issuer's ability to develop silver plan variations that meet the enhanced AV levels. Under this approach, issuers will have significant difficulty designing silver plan variations that meet both the de minimis requirement and restriction against increasing cost-sharing for a particular benefit or provider as the AV increases across silver plan variations.

<u>Recommendation #4</u>: Ensure that QHP issuers have sufficient notice of the annual maximum OOP limits.

To ensure that issuers have sufficient time to develop their silver plan variations, BCBSA recommends that the annual notice of maximum OOP limits be published no later than July 1st of the year prior to open enrollment, in line with the deadline for state selection of the benchmarks for EHBs for 2014 and 2015. QHP issuers should also have a meaningful opportunity to provide input on the annual notice that adopts the concept but exceeds the 45-day notice provided for Medicare Advantage.

<u>Rationale:</u>

For benefit years 2015 and beyond, CMS intends to publish, in an annual notice of benefits and payment parameters, the reduced maximum OOP limits for individuals with incomes 100-250

percent of FPL. The annual notice will include a summary of CMS' analysis of the effect of the reduced maximum OOP limits on a model silver-level QHP, along with a description of the model CMS used in its analysis. Issuers will be required to apply the annual maximum OOP limits to the silver plan variations designed for their cost-sharing subsidy-eligible members. However, the Rule does not provide a timeline for when the annual notice will be published; nor does it provide information on whether issuers will have a meaningful opportunity to provide input on the annual notice. Issuers cannot develop compliant products without this information and must be provided enough time to meet development and filing deadlines.

17. Rules for family policies should encourage families that are eligible for similar cost-sharing subsidies to purchase coverage together (§ 155.305(g)(3)).

Issue:

The Preamble specifically recognizes that to the extent that family members are eligible for different levels of CSRs, they may enroll in separate QHPs and plan variations in order to receive the maximum CSRs available to them and that the exchanges will be expected to educate members about their options. While it is important that eligible members receive the highest level of CSRs for which they are determined eligible, this amendment to current regulation may have the unintended effect of encouraging families to unnecessarily purchase multiple policies.

Recommendation:

BCBSA recommends that, for purposes of the shopping portal, exchanges strongly encourage traditional families to purchase coverage together, except in cases where family members are eligible for different cost-sharing subsidies.

Rationale:

BCBSA appreciates that, by this amendment, CMS will not require issuers to cover families in which only one or more (but not all) members are AI/AN on one family policy and provide the CSRs at the member level at point-of-service. Such a requirement would be incredibly difficult to administer and would require issuers to make additional significant changes to their claims systems because currently issuers are not able to administer member-based cost-sharing rules.

However, BCBSA is highly concerned that this amendment may result in families unnecessarily splitting themselves up and purchasing separate QHPs, which could lead to significant adverse selection and higher overall cost-sharing exposure in some cases. Exchanges should strongly encourage families to stay together and purchase family coverage to the extent possible, except when individual family members are eligible for different CSRs such as the case for families with one or more (but not all) AI/AN members.

18. Apply mid-year changes in eligibility for CSRs prospectively (§ 156.425).

Issue:

When a member experiences a mid-year change in circumstances and the exchange re-determines his/her eligibility for the CSRs, the Rule proposes that such changes be applied by

issuers prospectively on the effective date provided by the exchange. Issuers will only be required to accumulate claims that occurred prior to the eligibility change if a member switches plan variations for the same QHP (or re-enrolls in the same QHP in the benefit year). However, if a member switches to another QHP (either by the same or different issuer), then the issuer will not be required to accumulate those claims which would be covered by another QHP.

<u>Recommendation</u>:

BCBSA recommends that the Rule retain the proposed requirement that mid-year redeterminations for CSR eligibility be applied prospectively. We also support the requirements related to a change in assignment to a different plan variation, and the flexibility granted to issuers to determine how to handle cost-sharing accumulation in circumstances in which an enrollee changes QHPs mid-year but stays with the issuer, provided the circumstances are addressed uniformly across all enrollees.

<u>Rationale:</u>

BCBSA appreciates that mid-year redeterminations for CSRs eligibility will be applied prospectively and recommends that the Final Rule retain this requirement. Given the likelihood of significant operational challenges, retroactive re-adjudication of claims should not otherwise be required. Claims should be processed based on the silver plan variation that an eligible member is enrolled in at the time the claim is incurred.

It would be much clearer to the enrollee, and simpler to administer for the issuer, if, when an eligible member experiences a mid-year change in CSR eligibility, the member is only permitted to switch to a different variation in the same QHP offered by the same QHP issuer. That way the eligible member will not mistakenly forfeit credit for his or her previously paid out-of-pocket expenses. The eligible member would be permitted to switch QHP issuers during the annual open enrollment period, if he or she desired. However, if the member is allowed to switch QHPs (including QHPs offered by another issuer), BCBSA supports the proposed requirement related to a change in assignment to a different plan variation as a reasonable approach to implementing this provision. Provided that the exchange is explicit in its communication to issuers regarding the QHP (or plan variation) change, the proposed approach will be workable.

19. Payment for CSRs (§ 156.430)

<u>Issue</u>:

The Rule proposes that CMS make monthly advance payments to issuers to cover the projected CSR amounts and reconcile the advance payments at the end of the benefit year to the actual CSRs provided by the issuers. CMS proposes that issuers submit a per member per month ("PMPM") estimate for the CSRs, accompanied by supporting documentation validating the estimate, to the exchange for approval by CMS. CMS will then make advance payments to issuers based on the PMPM estimate and enrollment data from the exchange. Issuers will develop the estimate using the methodology specified by CMS in the applicable annual notice of benefit and payment parameters. For benefit year 2014, issuers must use the payment estimate formula included in the Rule.

BCBSA has considered the payment estimate formula for benefit year 2014. Based on our initial analysis, we find the formula to be appropriate and believe it will likely result in accurate

estimations of the PMPM advance payment for the CSRs. However, we also believe it may be operationally difficult to administer, given that the formula will produce results that may vary based on the member rating factors, e.g. age, area, tobacco use, QHP, subsidy tier, region, etc. While BCBSA has not had adequate time to fully evaluate the payment estimate formula, we preliminarily recommend that CMS provide issuers demographic data and allow issuers to calculate the required payments at an aggregate level. Any difference in the mix (e.g. age, tobacco use, region, etc.) can be reconciled during the reconciliation process. We further recommend that CMS consider additional comments on the payment estimate formula for at least an additional 30 days after the close of the comment period, in order for stakeholders to have adequate time to fully evaluate the payment formula.

Recommendation #1: CMS should establish a safe harbor for issuers that submit cost-sharing information in good faith.

Rationale:

Although we appreciate that CMS has issued proposals for how to implement CSRs, the CSRs are a new program and as such, there are many issues that have not been fully addressed in these regulations and data affecting government payments is likely to have some inaccuracies as a result. In addition, as issuers implement these provisions, we expect that additional issues may arise. Because neither CMS nor issuers have experience with this program, at least for a two-year transition period, we strongly recommend that CMS issue an explicit safe harbor for issuers that submit information regarding CSRs in good faith.

CMS should also expressly recognize that compliance and data accuracy in the initial years of the program are likely to be adversely affected, and that issuers are expected to be taking good faith steps toward implementation, but are not expected to have completed the process and achieved the same levels of compliance and data accuracy as may otherwise be expected in connection with government payments. Without such recognition, issuers will face an unfair risk of False Claims Act liabilities based on compliance expectations that do not reflect the challenges and realities of the initial implementation period. Subsequent CMS guidance and attestations should be drafted in a way that reflects these realities.

Recommendation #2: Retain the Rule's provisions for advance payments and reimbursement for the CSRs during special transitional periods.

BCBSA is pleased with the proposals for the advance payments and reimbursement of the CSRs provided during special transitional periods of coverage, including grace periods and the 90-day additional verification period that holds issuers harmless for CSRs provided during these instances. However, we ask that CMS clarify that issuers may if they choose, during months two and three of a grace period, "pend" CSRs such that during those months, enrollees will not receive CSRs at the time of service. Should such enrollees become current in their premium payments, issuers would reimburse them for any CSRs they should have received while the issuer was pending claims. The issuer would then be reimbursed by CMS for the actual cost of the reimbursement during reconciliation.

Rationale:

Issuers will be providing CSRs to eligible enrollees based on an exchange's eligibility determinations. Provided that issuers provide the CSRs in accordance with the regulations and in line with the exchange's eligibility determinations, issuers should not be penalized for

providing CSRs to enrollees during grace periods or 90-day additional verification periods. Because issuers will be allowed to pend claims during the second and third months of a grace period and retroactively terminate coverage at the end of the grace period if premiums are not paid, BCBSA finds it reasonable that issuers should be required to return the CSR advance payments paid to them for the second and third months. Similarly, we believe it is reasonable that issuers be paid in full for CSRs provided to enrollees during the 90-day additional verification period, even if the enrollee is later determined by the exchange to not be eligible for the CSRs. In this case, issuers provided the CSRs based on information provided to them by the exchange and should not be faulted for any wrong or inappropriate eligibility determinations.

Recommendation #3: Extend the "no fault" protection for issuers in cases where enrollees had an unreported mid-year change in eligibility.

The Proposed Notice is silent on how CMS intends to handle instances where mid-year changes in eligibility go unreported by eligible enrollees and are discovered during the premium tax credit reconciliation process. As noted above, CMS intends to provide issuers with advance payments for the cost-sharing based on issuers' PMPM estimates and enrollment data from the Exchange. However, there may be instances where during the premium tax credit reconciliation process it is determined that an eligible enrollee experienced a change in eligibility for the CSRs but did not report it to the Exchange. In this instance, a QHP issuer would have already paid claims for the eligible enrollee and received the advance payments for the CSRs, but was not aware of the enrollee's change in eligibility.

BCBSA recommends that, in these instances, issuers be held harmless for any paid claims and advance payments of the CSRs, and that, in the Final Notice, CMS extend the "no fault" protection noted in the Preamble to issuers in cases where an enrollee had an unreported mid-year change in eligibility and the issuer provided the CSR.

Rationale:

The Proposed Notice reiterates that the Exchange is responsible for determining an enrollee's eligibility for the CSRs and that the advance payments to issuers for the CSRs will be partially determined by the QHP enrollment data provided to CMS by the Exchange. Issuers will be responsible for implementing the CSRs for enrollees determined eligible by the Exchange and for paying claims in accordance with the requirements established by CMS. As far as issuers are concerned, the initial determination of enrollee eligibility for reduced cost-sharing is determinative, and only in cases where a change in eligibility has been clearly communicated to issuers with appropriate notice should the issuer change the enrollee's plan variation. Issuers should bear no risk and have no accountability for clawing back CSRs payments to eligible enrollees whose income at the end of the year ends up being higher than what the Exchange used to determine eligibility. Further, issuers should not be held liable for any changes in eligibility that have not been reported to them by the Exchange when they have already reduced cost-sharing and paid claims for eligible enrollees.

Recommendation #4: Simplify the standards for reporting of CSR amounts.

Additionally, some of the information CMS proposes issuers report, specifically "what enrollees paid" to providers, is not information that issuers have available. For covered services, issuers know the amounts that are not covered by insurance due to cost-sharing and/or contracted rates for in-network providers, and amounts that exceed maximum allowable charges for out-of-network providers (i.e. amounts subject to balance billing). Enrollees are generally liable for

cost-sharing and amounts subject to balance billing. What providers ultimately collect from patients for these amounts is between the patient and provider. Issuers do not bill enrollees on behalf of providers for outstanding amounts, and are not aware of the final outcome of such collections. BCBSA proposes that CMS establish a simplified reporting process for CSR reconciliation at least for a transitional period. One suggested process that would be administratively feasible is as follows: reconcilation would be performed on an aggreggate claims basis for each silver plan variation against the standard silver QHP. The calculation would compare the actual AV of the standard silver QHP against the actual AV of the silver plan variation. This calculated amount would be applied to the allowable claims amount for the silver plan variation to detemine claims paid in excess of the standard silver QHP. This claims amount would be then compared to the CSR advanced payments to determine whether the issuer is owed money or needs to reimburse CMS for any excess payments.

20. Provide guidance on handling of Rx drug EHBs for purposes of allocating rates and claims costs for advance payments of CSRs and the premium tax credit (§ 156.470)

Issue:

The Rule directs issuers to allocate the rate or expected premium for each metal level QHP and stand-alone dental plan offered on the exchange and the expected allowed claims costs for the metal level QHPs, among EHBs and additional benefits. While BCBSA fully understands the reasoning behind this proposed requirement, we are concerned that the proposed allocation methodology would make the required reporting quite challenging, particularly in certain categories, such as prescription drugs.

Recommendation:

BCBSA recommends that CMS provide clear, detailed guidance on how issuers should handle prescription drug EHBs for the purposes of allocating rates and claims costs for the advance payments of the CSRs and the premium tax credit.

Rationale:

BCBSA understands that CMS proposed the allocation methodology in order to determine reimbursement for the CSRs and applicability of the premium tax credits. However, issuers will have some complications using the allocation formula for prescription drug EHBs. Within the Proposed Rule on EHBs, formularies are not set in stone. Therefore, when attempting to allocate for EHBs and additional benefits, it is not clear what will be considered EHBs, how many drugs will be covered, how changes to formularies during the benefit year (e.g., from brand name drug to generic or if a drug gets pulled from the formulary) will be addressed and what the reporting requirements related to any changes will be. Reporting on the allocation or rates and expected claims costs could be very complicated.

21. Provide guidance on requirements for claims adjudication and reconciliation of CSRs.

Issue:

The CSRs are an entirely new benefit that will be provided to eligible low-income and AI/AN enrollees beginning in benefit year 2014. While BCBSA is pleased that CMS has released proposed guidance on the implementation of this new benefit, there are still a number of

outstanding issues, including operational guidance on the recommended adjudication of claims for the CSRs that were not addressed in the Rule. The resolution of these outstanding issues will directly affect issuers' ability to implement the CSRs and address the inherent complexities associated with administering the CSRs.

BCBSA is very concerned about the lack of guidance on issuer adjudication of claims and the reconciliation process for the advance payments of the CSR amounts, including detailed issuer data submission requirements.

Recommendation:

BCBSA strongly encourages CMS to issue clear operational guidance on issuer adjudication of claims for the CSRs.

Rationale:

When adjudicating claims for the cost-sharing reductions, in the simplest case where an eligible enrollee's plan variation covers only the essential health benefits, without clear guidance, issuers may need to anticipate the most complex reconciliation process where the issuer will need to track and process all benefit claims twice. In this instance, claims would need to first be adjudicated on an ongoing basis in order to pay benefits under the applicable plan variation and then be re-adjudicated at the standard plan actuarial value in order to calculate the difference of CSR for reimbursement by CMS. Depending on their claims processing systems, for some issuers double adjudicating claims will not be very challenging; however, for many others, such process will be operationally burdensome and administratively infeasible. Issuers need clear operational guidance on how CMS intends for claims to be processed for CSRs and the associated data requirements for reconciliation, as well as the expected treatment of non-essential health benefits offered through the plan variations. Alternatively, CMS should provide issuers a safe harbor allowing them to use any reasonable method to adjudicate claims. Either way, CMS should continue to work with issuers on the data models for issuer adjudication of claims for the CSRs, including facilitating operations meetings and technical assistance calls.

22. Require only the submission of aggregated claims data using the distributed model for the advance payment reconciliation process (§ 156.430(d)),

Issue:

The Rule notes that CMS will "periodically" reconcile the advance payments made to issuers for the CSRs they provide to eligible enrollees. Although the Rule does not provide specific details on the reconciliation process, we anticipate that, as part of the process, issuers will be required to submit claims data for eligible members to CMS as noted in §156.430. The claims data will be needed to reconcile the advance payments, which will be based on estimated PMPM costs and enrollment data, with issuers' actual expenditures for the cost-sharing subsidy.

Recommendation:

For the reconciliation of the advance payments for the CSRs, BCBSA recommends that issuers make aggregated member-level claims data available to CMS using a distributed model on an annual basis.

Rationale:

Making aggregated member-level claims data available to CMS using a distributed model, as codified in the Final Rule on the Standard Related to Reinsurance, Risk Corridors and Risk Adjustment, would significantly simplify administrative processes for CMS and issuers alike, and reduce the burden of collecting, accessing and analyzing large quantities of member claims data. Additionally, aggregated claims data would more accurately reflect issuer spending on the CSRs than would detailed claims data alone, given the various payment arrangements QHP issuers have with providers, e.g., pay-for-performance and capitation payments. At least on a transitional basis, during the first couple of years of the CSRs subsidy, CMS should allow for the availability of aggregate member-level claims data both to test the appropriateness of such claims data, as well as to provide issuers with time to further modify their IT systems to fully accommodate the processing and adjudication of the CSRs. In instances where CMS has questions regarding the data sets, CMS could in real-time obtain access to the detailed claims data from individual issuers.

23. Do not adopt alternative approach of retroactive payments of APTC amounts (§ 155.330),

Issue:

The Preamble to the Proposed Notice solicited comments on a proposal to pay retroactive premium tax credit amounts to issuers in situations where a midyear eligibility redetermination results in an increase in advance payments of the premium tax credit.

Recommendation:

BCBSA strongly recommends against adopting this approach. Retroactive payments of the APTC could result in significant complexity for issuers, especially to the extent that such retroactive payments happen late in the tax year. BCBSA recommends that redeterminations of APTC amounts only be applied on a prospective basis. Any additional amounts owed to an individual, should be settled as part of the reconciliation process when the individual files his or her tax return.

Rationale:

Retroactive payments of the APTC would require issuers to either provide a premium credit or issue a check to members to return the difference between what the member paid originally and the amount now covered by the APTC payment. This would require the creation of a process at the issuer level that would be duplicative of a process to reconcile the APTC credits as part of the individual's tax return. Such duplicative processes create additional, unnecessary burdens for issuers.

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24. Require the state notice of benefit and payment parameters by March 1, 2013 (§153.100(c))

Issue:

The Rule requires, for the 2014 benefit year only, that states issue a state notice of benefit and payment parameters by the later of March 1, 2013 or 30 days after the final CMS Notice of Benefit and Payment Parameters. A state is only required to issue a state notice of benefit and payment parameters if the state chooses to implement a state supplemental reinsurance program or a state-operated risk adjustment program.

Recommendation:

States should be required to issue a state notice of benefit and payment parameters by March 1, 2013. CMS should not provide states with an additional 30 days after the final CMS Notice of Benefit and Payment Parameters to issue the state notice if such date occurs after March 1, 2013, as this would not give issuers sufficient time to react to states' policies with respect to the finalization of benefit packages and premium rating prior to state filing deadlines.

Rationale:

BCBSA appreciates the significant challenges created by the compressed timeframe to implement the Premium Stabilization Programs. These time pressures, however, will only become more acute if states are permitted to release state notices of benefit and payment parameters after March 1, 2013. To the extent a state chooses to implement a state supplemental reinsurance program or a state risk adjustment program, issuers need sufficient time to evaluate and incorporate these policies and requirements into 2014 product design and pricing. If the release of a state notice occurs later than March 1, 2013, issuers will not have time to determine appropriate pricing, submit rates to states for approval, and have states and/or CMS complete the rate review process in time for the launch of open enrollment on October 1, 2013.

Risk Adjustment Program Provisions

25. Retain provisions on risk adjustment covered plans (§ 153.20)

Issue:

The Rule proposes that a risk adjustment covered plan would include health insurance coverage offered in the non-grandfathered individual or small group markets, except for certain specific types of coverage excluded from the Risk Adjustment Program. Health insurance coverage that is not subject to the 2014 market reforms, such as guaranteed availability and premium rating requirements, would not be eligible for the Risk Adjustment Program. Therefore, health insurance coverage issued in 2013 that is not subject to the 2014 market reform requirements until renewal would be excluded from the Risk Adjustment Program until renewal.

The Rule proposes that student health plans will not be subject to risk adjustment and also proposes to risk-adjust catastrophic plans in a separate risk pool than the metal level QHPs.

Finally, since the Risk Adjustment Program transfers funds within a state market, health insurance coverage will be included in the risk adjustment pool in the state where the coverage is issued and delivered.

Recommendation:

BCBSA supports all of these proposals.

Rationale:

Premium rates for health insurance coverage that is not subject to the 2014 market reforms does not (or will not) reflect risk adjustment-related assumptions, and issuers of this coverage may medically underwrite, deny applicants for coverage, and take other steps to eliminate actuarial risk (subject to applicable state law). Such coverage does not need the protection offered by the Risk Adjustment Program.

As discussed in the BCBSA Market Reform comment letter, BCBSA recommends that student health plans should not be included in the individual risk pool. Excluding student health plans from risk adjustment is consistent with this proposal and will result in premiums reflective of the characteristics of this limited distribution product and in comparable premiums with issuers that only write student health plans.

Additionally, we believe that placing catastrophic plans in a separate risk adjustment pool will make these plans more affordable to the younger population that they are intended for. Maintaining a separate pool for catastrophic plans will prevent catastrophic plan enrollees from subsidizing higher-risk plans through risk adjustment payments. This will in turn help to avoid catastrophic plans from having to increase premiums to cover their risk payment obligations.

Finally, policies are designed, rated and reviewed in compliance with the state requirements where they are issued, so it makes sense to apply risk adjustment based on the state of issue. This approach is also consistent with the MLR regulation and the single risk pool requirement.

26. Retain concurrent risk adjustment model (Preamble, beginning at FR 73127)

Issue:

The Preamble to the Rule discusses CMS's decision to adopt a concurrent risk adjustment model where diagnoses from a given period are used to predict costs in that period.

Recommendation:

BCBSA strongly supports this proposal.

Rationale:

BCBSA recommends using a concurrent model for the following reasons:

- In the initial years there will be many new entrants without prior year data. Risk scores can be assigned to these new entrants if current year data are used instead of prior year data.
- On an ongoing basis (initial and later years), individuals will move between markets and carriers resulting in limited claims experience with the same issuer. It is likely that risk scores can be assigned to more individuals if current year data are used than if prior year data are used.

- Concurrent risk scores are more accurate in predicting plans' actual costs and will contribute to more equitable risk adjustment transfers, thereby allowing issuers to accept high-risk members with more confidence.

27. Incorporate claims costs for prescription drugs into the risk adjustment model (Preamble, at FR 73128)

Issue:

The Preamble to the Rule notes that CMS will exclude prescription drug claims as a predictor in the CMS risk adjustment model.

Recommendation:

BCBSA believes that prescription drug claims should be incorporated in the risk adjustment model and encourages CMS to incorporate this data as a future enhancement.

Rationale:

Prescription drugs are a potential predictor for risk and may provide earlier indications of conditions during a benefit year than other medical services. These data therefore would enhance the accuracy of interim risk adjustment estimates because issuers would have indications of present conditions earlier in the benefit year. This claims data would also improve the accuracy of risk scores for members enrolling in the middle of a benefit year. To prevent any adverse incentives to modify discretionary prescribing, CMS could limit included prescription drug claims to certain high-impact drugs that treat select conditions.

Including prescription drugs in the risk model may also reduce incentives for issuers to encourage office visits as a way to collect diagnosis information for members enrolling mid-year, since prescription claims may provide the same or similar information. This decrease in office visits likely would offset any marginal increase in discretionary prescribing caused by the inclusion of pharmacy claims. Whenever risk adjustment is based on claims data, there is a risk that it will encourage utilization, but this concern is no more acute with respect to prescription drugs than any other covered service. Given the increased accuracy that would result from including prescription drug claims, CMS should include this claims data in the risk adjustment calculation as a future enhancement.

28. Provide issuers with the mapping of the ICD-9-CM codes (Preamble, beginning at FR 73128)

Issue:

The Preamble discusses how CMS adapted the hierarchical condition category ("HCC") classification system for the Medicare risk adjustment model for use in the CMS risk adjustment model. CMS mapped every ICD-9-CM diagnosis code and categorized it into a diagnostic grouping.

Recommendation:

CMS should provide issuers with the mapping of the ICD-9-CM codes and make the risk adjustment model open-sourced for analysis and testing.

Rationale:

In order to set rates for 2014, issuers need to have a detailed understanding of how the risk adjustment model works. Without access to the risk adjustment model and the ICD-9-CM mapping, issuers will have a more difficult time accurately predicting how the Risk Adjustment Program may affect their cost and revenue streams in 2014. This uncertainty likely would be priced into premiums and may cut against the goals of the Premium Stabilization Programs.

29. Develop factors for age 65+ members and generally determine age of enrollees as of the last day of the benefit year (Preamble).

Issue:

The Preamble notes that CMS will calculate member risk scores based on reported HCCs as well as a member's age and gender. If an individual does not have any HCCs, then his or her risk score would be based entirely on demographic factors. For the calibration of the data set, 19 percent of adults, 9 percent of children, and 45 percent of infants have HCCs included in the risk adjustment model.

There are nine age categories for adults, which are generally five-year brackets with age 60+ in a single grouping. Age is determined as of a member's last day of enrollment in a risk adjustment covered plan in the applicable benefit year.

Recommendation:

BCBSA encourages CMS to develop factors for age 65+ members that would be applied to their risk scores in order to adequately predict expenditures. These factors could be developed separately for Medicare-secondary, Medicare-primary, and non-Medicare eligible individuals to recognize the differences between the member's cost among the Issuer and other payors.

CMS should calculate the age of newborn infants based on the attained age at the time of diagnosis. For all other age bands, BCBSA recommends that age be determined as of the last day of the benefit year rather than the last day with the issuer within the benefit year.

Rationale:

Initially the number of individuals over the age of 65 enrolling in health insurance coverage in the small group market in 2014 may be relatively small with the group health plan paying primary and Medicare secondary. However, over time, issuers may experience higher enrollment of non-Medicare eligible individuals age 65+ in the individual and small group markets due to the presence of subsidies, the limitation on age rating factors, guarantee issue and prohibition of rating for health status. Since the risk model was calibrated using data from individuals age 0-64 and the top age band for risk adjustment begins at 60, the current risk adjustment model may not accurately predict cost levels for individuals over age 65. It is important that the risk adjustment model accurately predict age 65+ risk since issuers will not able to adjust premiums to reflect the additional risk due to the 3:1 age rating limitation.

Under the proposed age counting system, infants could be counted as 0 years for one month of a benefit year while others will be counted as 0 years for 12 months, depending on when the infant's diagnosis is made. By using age attained as of the diagnosis to apply the age factor for newborn children between 0 and 1, this effect would be limited leading to more alignment between the resulting infant risk scores and the model calibration.

30. Clarify treatment of mother and infant bundled claims if CMS requires separate infant claims for risk adjustment (Preamble).

Issue:

To reflect the clinical and cost difference for each group of members, the Preamble notes that CMS will provide for separate adult, child and infant risk adjustment models. When mother and infant claims are bundled so that infant diagnoses appear on the mother's claim, CMS is considering whether it is possible to associate those codes with the appropriate infant. Another alternative would be to require issuers to provide a separate infant and mother claim when the Issuer receives a combined claim.

Recommendation:

BCBSA requests clarification on how mother and infant bundled claims would be treated if CMS chooses to require a separate infant claim for risk adjustment, and whether issuers would be expected to create a new claim for the infant or if a code will denote a split claim.

Rationale:

Submission of an unbundled infant claim that is different than the claim reimbursed by the Issuer may not meet the proposed standard for data validation under the Risk Adjustment Program. CMS should make clear whether unbundling mother and infant claims is expected.

31. Provide additional transparency on generation of plan type liability risk scores (Preamble).

Issue:

In the Preamble, CMS notes it will estimate plan liability risk scores using standardized benefit design parameters for each metal level. This results in separate adult, child, and infant risk adjustment models for each metallic plan type.

Recommendation:

BCBSA requests that CMS provide more transparency regarding how it generated plan type liability risk scores and what standardized benefit designs it employed.

CMS should also consider how to ensure any actuarial value adjustment takes into account that the Issuer does not receive health savings account ("HSA") or health reimbursement arrangement ("HRA") revenue in premium but employer contributions are included in the actuarial value calculation.

Rationale:

Providing additional transparency regarding how risk adjustment models are derived for each metal level will permit issuers to more accurately design and price products for 2014. The more certainty issuers have regarding the operation of the risk adjustment model, the less risk they will need to price into their premium.

Employer contributions to an HSA/HRA are included in the determination of the actuarial value. However, the Issuer does not receive any of those funds nor does the Issuer incur liability for the benefits covered by the employee's account.

32. Support adjustments to risk adjustment model for CSRs but revise the factors used for adjustments (Preamble)

Issue:

CMS proposes to adjust the risk adjustment model for CSRs to account for higher utilization due to decreased member liability but not to account for the federal transitional reinsurance program (Reinsurance Program). The induced utilization factor would apply to non-Indian CSR recipients with incomes between 100-200 percent of the FPL and to Indian cost-sharing recipients with incomes under 300 percent of the FPL.

Recommendation:

BCBSA agrees with the proposal to adjust for induced utilization from CSRs for non-Indian individuals with incomes between 100-200 percent of the FPL. We also agree with the adjustment for Indian cost-sharing recipients with incomes under 300 percent of the FPL. However, the factors included in the Notice in Table 7 for the Indian CSR Recipients are 1.15 for platinum and grade down to 1.00 for bronze. We believe that these factors should be reversed, with the 1.15 at the bronze level and 1.00 for platinum.

BCBSA supports the proposal not to adjust for the Reinsurance Program.

Rationale:

The cost-sharing subsidies received by individuals likely will cause them to utilize health care services at a higher rate than they would in the absence of CSRs. If an induced utilization factor is not included for these individuals, issuers with a disproportionate share of these members will be penalized. The Indian cost-sharing recipients receive 100% actuarial value plans when enrolling at any metal level. Thus, the difference in induced utilization between a bronze base plan and the 100% AV plan should be greater than the difference between a platinum plan and the 100% AV plan. Table 17 at Federal Register 73180 shows the Induced Utilization Factors for Advance Payments for Cost-Sharing Reductions for Indians with a bronze plan factor of 1.15 and the other metals grading down to a platinum factor of 1.00. We believe that the factors in Table 7 should be consistent with Table 17.

BCBSA believes it is important to balance the need for accurate risk adjustment results with the desire for reduced complexity, especially given that reinsurance is a temporary program (2014-2016). In addition, due to the imperfect correlation of risk scores to actual health care expenses, BCBSA does not believe that over-compensation for high-risk individuals will occur. Generally, risk adjustment models tend to underestimate costs for high-risk claimants and therefore, in our opinion, it is unlikely that reinsurance payments will result in overcompensation. If overcompensation did occur, it most likely would be recouped through the risk corridor program.

33. Provide examples for the proposed transfer formula that determines an Issuer’s net payments under the Risk Adjustment Program (Preamble).

Issue:

CMS proposes a transfer formula that determines an issuer’s net payments under the Risk Adjustment Program.

Recommendation:

BCBSA supports the proposed transfer formula and requests that CMS provide several numerical examples of how the proposed transfer formula would be applied in order to enhance the transparency and clarity of this proposal. It would be very helpful to see a simplified version in an excel sheet so that the formulas can be viewed with two or three carriers each offering two metallic plans in each of two different regions. That would create eight to twelve columns, which should be sufficient to capture the necessary elements. The example could also illustrate definitions of each of the factors used. For instance, the determination of each plan's geography factor for the calculation could be shown.

Rationale:

BCBSA agrees that the risk adjustment calculation should compare actual risk to the risk allowed to be reflected in pricing according by the ACA. We believe the proposed transfer formula will equitably value risk against allowable premium rating factors. A numerical example will help illustrate how the payment transfer formula works in practice and will provide issuers with more certainty on how the risk adjustment system will work.

34. Retain adjustments to plans' average risk scores for family rating limitations (Preamble).

Issue:

CMS proposes to apply an adjustment to an issuer's average risk score to account for the family rating rules, which limit rating adjustments for individuals under age 21 to three. This adjustment is calculated by summing all individuals' risk scores and dividing by only billable member months.

Recommendation:

BCBSA supports the proposal to adjust an Issuer's average risk score to account for the rating limitation of three individuals under age 21. However, we note that issuers will need to track non-billable and billable member months in order to implement.

Rationale:

Consistent with the concept of the Risk Adjustment Program, since issuers are not allowed to rate for more than three individuals under age 21, the risk scores need to reflect the additional uncompensated risk.

35. Retain use of state average premium as the basis for calculating payment transfers (Preamble).

Issue:

CMS proposes to use the state average premium as the basis of calculating payment transfers. The average premium would be based on the total premiums assessed to members.

Recommendation:

BCBSA supports this proposal. We believe it would be more appropriate to base risk adjustment transfers on claim cost plus adjudication expense, but understand the simplicity inherent in the state average premium baseline.

Rationale:

The simplicity offered by this proposal outweighs the potential benefit of increased accuracy that might be achieved from using claim cost plus adjudication expense as a baseline for risk adjustment transfers.

36. Retain adjustments for age rating (Preamble)

Issue:

CMS proposes an allowable rating factor that will only account for age rating while tobacco use, wellness discounts, and family rating requirements would not be included in the payment transfer formula. If a state has an alternate age rating curve, the CMS risk adjustment methodology will use the state curve.

Recommendation:

BCBSA supports this proposal. We agree with the age rating proposal and are pleased that state alternate age rating curves will be used if applicable.

Rationale:

We believe that tobacco use should not be adjusted as a rating factor initially, in part because we do not have confidence in the integrity of smoking status reporting (which is self-reported by applicants). Tobacco use should be considered as a possible future enhancement to the risk adjustment methodology. We have concerns on the data integrity of smoking status and lack of experience data to set rating factors.

We believe that the family rating restrictions are addressed in the calculation of the Plan Average Risk Score.

37. Retain use of the same induced demand formula as for the AV calculator (Preamble).

Issue:

CMS proposes to use the same induced demand formula for the payment transfer formula as it uses for the AV calculator.

Recommendation:

BCBSA supports this proposal. The inclusion of induced demand in the allowable rating factor portion of the payment transfer implies that CMS assumes that issuers are allowed to include the effects of induced demand in the pricing differentials between metal levels.

Rationale:

Clarity on allowed rating variations is needed so that issuers can price 2014 plans and anticipate the effect the factors will have in the calculation of the payment transfers.

38. Retain adjustments for geographic area cost variation (Preamble).

Issue:

CMS proposes to apply a geographic cost factor for each rating area calculated based on the average silver plan premiums in a geographic area relative to the statewide average silver plan premiums.

Recommendation:

BCBSA supports geographic cost adjustments. The BCBSA comment letter on the Insurance Market Reforms outlined our issues with defaulting to a single rating area for a state and recommends that either commercial state rating area guidelines or the EHB benchmark plan be used to set rating areas. If a single rating area is used for a state which includes areas with disparities in average costs, then CMS should consider including geographic adjustments within the rating area to account for these cost differences.

Rationale:

Based on the proposed rating requirements, a state could have only one rating area or up to seven different rating areas. If rating areas within a state are drawn in a manner that combines areas with disparate cost levels, then geographic adjustments may not be effective and will create an unlevel playing field for regional issuers compared to state-wide issuers. For this reason, geographic adjustments should align with differences in cost levels between different areas.

39. Clarify that CMS will use a three-month claims run-out for risk score calculations (§§ 153.310(e), 153.730).

Issue:

The Rule proposes that claims used in risk score calculation be made available to CMS by April 30 following a benefit year. CMS will run risk score calculations and notify issuers of risk adjustment payments by June 30.

Recommendation:

BCBSA supports the proposed timeframe, but requests that CMS confirm and clarify that there will be a three-month claims run-out period as part of the schedule. Accordingly, claims used for risk adjustment must be paid by March 31 with the remaining time to be used for preparing the data and servers.

Rationale:

It is important that all issuers are using the same claims run-out period for claims data made available to CMS. A three-month claims run-out period with an additional month for preparation of the data creates a level playing field and ensures the data reviewed by CMS is accurate. It also would be consistent with the three-month claims run-out period used in other contexts, such as MLR and risk corridor reporting.

40. Risk adjustment data validation (§ 153.630)

Issue:

The Rule outlines the proposed data validation process. CMS will validate a statistically valid sample from each issuer each year. The expected sample is approximately 300 enrollees. Under the proposed data validation methodology, CMS would make prospective adjustments to member risk scores based on the risk score error rate determined during the data validation process. For 2015 and 2016 (reflecting 2014 and 2015 benefit year data), CMS proposes that no payment adjustments would be made. This approach is intended to provide issuers with the opportunity to improve their familiarity and understanding of the Risk Adjustment Program and validation process before payment adjustments are made.

Recommendation #1: CMS should begin adjusting risk adjustment payments in 2016 (reflecting 2015 benefit year data).

Rationale #1:

BCBSA appreciates some leeway regarding penalties related to this new program. We understand that the complexity of the Risk Adjustment Program and the data validation process necessitate issuers and CMS having some experience before payment adjustments are made. We believe that one year should be sufficient to refine the process. Furthermore, because the Risk Adjustment Program transfers funds among issuers, imposing prospective payment adjustments based on 2015 benefit year data would reward issuers that effectively implement the necessary administrative and IT systems changes to accurately capture and report member risk scores.

Recommendation #2: BCBSA requests additional information on the statistical validity of the expected sample size of 300, including the confidence interval and expected error rate tolerance.

Rationale #2:

If the sample is too small, issuers may be penalized unfairly. Issuers expect to earn small margins for health insurance due to competitive pressures and ACA requirements, so errors in prospective settlements may have large impacts on margins.

Recommendation #3: Provide for a dollar adjustment instead of a percent adjustment to risk scores.

The Rule does not describe how the prospective adjustments for risk adjustment errors will be applied. We recommend a dollar adjustment instead of a percent adjustment to risk scores. We would like clarification on whether the error adjustment applies both ways, for example if an issuer under-reports its risk scores.

Rationale #3:

We prefer a dollar settlement rather than an adjustment to risk scores due to anticipated changes in the size of the markets over the first few years and possible changes in mix of business.

Transitional Reinsurance Program

41. Contributing entities and excluded entities (§ 153.400)

Issue:

The Rule describes the self-insured group health plans and health insurance coverage that constitute a "contributing entity." Contributing entities must provide reinsurance contributions for major medical coverage in their commercial books of business that are issued on a form filed and approved by a state. Coverage offered by a contributing entity that does not meet this standard is not subject to the reinsurance contribution requirement.

Recommendation #1:

Do not limit coverage subject to reinsurance contributions to coverage that is filed and approved by a state. CMS should eliminate the exclusion for coverage that "is not issued on a form filed and approved by a State." Furthermore, CMS should revise §153.400 by collapsing subsections (a)(1) and (2) to make a single list of the self-insured group health plans and health insurance coverage for which no reinsurance contributions would be required. The regulation could be revised to read as follows:

§153.400

(a) *General Requirement*.

(1) Each contributing entity must make reinsurance contributions annually: at the national contribution for all reinsurance contribution members, in a manner specified by CMS, and at the additional state supplemental contribution rate if the State has elected to collect additional contributions under §153.220(d), in a manner specified by the State.

(2) A contributing entity must make reinsurance contributions for its self-insured group health plans and health insurance coverage except to the extent that:

(i) Such plan or coverage is not major medical coverage;

(ii) In the case of health insurance coverage, such coverage is not considered to be part of an Issuer's commercial book of business;

~~(iii) In the case of health insurance coverage, such coverage is not issued on a form filed and approved by a State.~~

~~(2) Accordingly, as specified in paragraph (a)(1) of this section, a contributing entity is not required to make contributions on behalf of the following:~~

(iii) A self-insured group health plan or health insurance coverage that consists solely of excepted benefits as defined by section 2791(c) of the PHS Act. …

[The remainder of the regulation would remain in place, although renumber consistent with the renumbered scheme above.]

Rationale #1:

Limiting contributions by contributing entities to health insurance coverage that is filed and approved by a state – and expressly excluding from the definition of a contributing entity those issuers of coverage that are not filed and approved by a state - could result in the exclusion of certain fully-insured commercial major medical coverage that Congress likely intended to make contributions. For example, there are states which do not require large group insurance policies to be filed or approved by the state. Also, CMS recognizes in the Preamble that federal, state, and tribal employee plans are commercial coverage; however, Federal Employee Program

coverage offered by BCBS Plans is not filed or approved by a state. Given the large variation in state filing and approval requirements and the fact that this limitation is not reflected in ACA §1341, there are likely to be other types of major medical coverage that may be inadvertently excluded from the scope definition of coverage subject to the reinsurance contribution by this subsection (a)(1)(iii) despite Congressional intent to the contrary. If CMS is concerned that certain expatriate policies might be included in the definition of major medical coverage, an explicit exclusion for expatriate coverage (and any other coverage types to be excluded) could be added in a manner similar to other types of coverage enumerated in current §153.400(a)(2).

Similarly, CMS could eliminate existing §153.400(a)(2) because both (a)(1) and (a)(2) list self-insured group health plans and health insurance coverage that is excluded from the list of coverage for which reinsurance contributions must be made. A single, comprehensive list, set forth as a new (a)(2) of §153.400 seems to provide a simpler approach to identifying plans and coverage that is excluded.

In addition, plans or coverage offered to employees by the Federal government, a state government, or a Tribe would be considered to be part of an Issuer's commercial book of business under the Reinsurance Program and therefore subject to reinsurance contributions.

Recommendation #2: Retain provision subjecting coverage offered to state, federal and tribal employees to reinsurance contributions.

Rationale #2:

We agree that all employer-sponsored health plans established for the benefit of the employees should be contributing entities whether or not the employer is a government entity.

42. Retain national contribution rate with changes to accommodate Issuer enrollment reporting systems (§153.405)

Issue:

CMS proposes a national per capita uniform contribution rate calculated annually. This contribution rate would be calculated by dividing the sum of the reinsurance pool, the U.S. Treasury contribution, and CMS' administrative costs by the estimated number of members for whom reinsurance contributions must be made. For 2014, CMS proposes the national contribution rate to be $5.25 for each reinsurance contribution member.

Issuers would be permitted to count reinsurance contribution members using one of four approaches. One – the "snapshot count" method – would permit an issuer to count the number of members on any date the issuer chooses. For the second and third quarters, the date used must be within the same week of the same corresponding month of the quarter as the date used in the first quarter. The aggregate number of members would be divided by the total number of days used to determine the number of members for contribution purposes.

Recommendation:

BCBSA supports CMS's proposal regarding the national contribution rate for 2014 and recommends that CMS amend the proposed snapshot count method so that issuers would be permitted to use the same date in the first month in each quarter for counting members in addition to being able to use any date within the same week of the quarter.

Rationale:

Our proposed revision would accommodate issuer enrollment reporting systems that are currently set up to report enrollment on a set date.

43. Retain administration of the Reinsurance Program on a nationwide basis with annual reporting and collection of reinsurance contributions (§§153.220, 153.405)

Issue:

The Rule provides for collection of reinsurance contributions in all states. Contributing entities must make reinsurance contributions and report the number of reinsurance contribution members on an annual basis. The number of reinsurance contribution members will be calculated based on the first nine months of the applicable benefit year.

Recommendation:

BCBSA supports these proposals to administer the Reinsurance Program on a nationwide basis with annual reporting and collection of fees. We request that CMS confirm that the base of members for determining the reinsurance contribution will be members enrolled in the first nine months of each year during the Reinsurance Program (and will not be calculated on a twelve-month basis for the second and third years of the Reinsurance Program).

We note that some states are interested in continuing their existing high risk pool programs after January 1, 2014. Sec. 1341(d) of the ACA allows states to coordinate the State high-risk pool with the reinsurance program. However, state high risk pools may not provide insurance coverage that might otherwise qualify for reinsurance payments. We recommend that HHS permit states that wish to continue their high risk pool programs to apply to receive federal reinsurance payments for eligible participants. As we have commented in the Market Reform proposed rule, encouraging the gradual transition of state high risk pools – especially in states with very large high risk pools -- could moderate premium increases in the individual health insurance market.

Rationale:

National collection and reporting is the most efficient approach for a three-year program, while coordinate with state high-risk pools could further mitigate the potential market disruption in 2014 through 2016.

44. Increase the cap on reinsurance payments to $500,000 (Preamble)

Issue:

The Rule imposes a reinsurance cap of $250,000 for the Reinsurance Program on the basis that commercial reinsurance typically has attachment points of $250,000.

Recommendation:

BCBSA recommends increasing the national reinsurance cap to $500,000. We recognize that the $60,000 attachment point and/or the 80 percent coinsurance rate may need to be adjusted accordingly, given the limited funds available under the Reinsurance Program.

Rationale:

Commercial reinsurance typically has a much higher attachment point than $250,000. Setting the reinsurance cap at $250,000 would thus create a gap in reinsurance coverage available to issuers, and could force inclusion of a risk premium to account for this higher risk liability. We recognize that increasing the national reinsurance cap will require increasing the attachment point and/or decreasing the coinsurance rate.

45. Retain uniform adjustments to reinsurance payments if funds are insufficient to meet requests (§ 153.230(d)).

Issue:

The Rule adjusts reinsurance payments to issuers by a uniform, pro rata adjustment rate in the event requests for reinsurance exceed the reinsurance contributions collected during a benefit year. In considering the total amount of reinsurance contributions, CMS includes reinsurance contributions from previous years that are not used during the previous benefit years.

Recommendation:

BCBSA supports making a pro rata adjustment to the reinsurance payment rate in the event requests for reinsurance exceed the reinsurance contributions collected during a benefit year. BCBSA requests, however, that CMS clarify in the regulatory text the timing for when reinsurance payments will be made. It is not clear whether CMS intends to make reinsurance payment estimates on a rolling basis throughout a benefit year or only after all reinsurance payment requests have been submitted.

Rationale:

Since the reinsurance pool of funds is limited, pro rata adjustments are necessary to keep the total sum of payments within the limited funding.

Temporary Risk Corridors Program Provisions

46. Definitions (§ 153.500)

Issue:

The Rule requires QHP issuers to make separate risk calculations for each QHP they offer, rather than a single risk corridor calculation at the QHP Issuer state and market level. CMS stated in the March 2012 Final Rule addressing Standards Related to Reinsurance, Risk Corridors and Risk Adjustment, in response to recommendations to aggregate risk corridor calculations at the QHP Issuer level, that the agency believes the statute requires risk corridor calculations to be at the QHP level.[5]

In addition, the rule revises the definition of "profits" to allow for a minimum three percent profit margin after taxes. The examples in the Preamble, however, appear to incorrectly calculate this minimum profit margin based on total premiums earned, rather than based on an Issuer's after tax premiums.[6]

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[5] 77 Fed. Reg. 17220, 17238 (Mar. 23, 2012).
[6] 77 Fed. Reg. at 73164.

<u>Recommendation #1</u>: BCBSA strongly recommends that CMS require QHP issuers to make risk corridor calculations at the QHP Issuer state and market level (i.e., for each market segment within a state) rather than the QHP level currently proposed.

<u>Rationale #1:</u>

- **An aggregated approach is permitted by the statute**. ACA § 1342(a) directs the Secretary to establish and administer a risk corridor program for calendar years 2014, 2015, and 2016 under which "a qualified health plan offered in the individual or small group market *shall participate in a payment adjustment system* based on the ratio of the allowable costs of the plan to the plan's aggregate premiums." The rest of ACA § 1342 uses the term "plan" when referring to the risk adjustment calculations that must be completed.

  Importantly, the statute only requires that a QHP "participate in a payment adjustment system." If CMS aggregates the risk corridor calculations at the QHP Issuer level, all of an Issuer's QHPs would "participate" in the risk corridor calculation as required.

  In the March 2012 Final Rule, CMS also differentiated the risk corridor statute and its references to QHPs from the MLR statute, as a basis for requiring QHP-level adjustments for the Risk Corridor Program. CMS stated that the MLR statute "requires the calculation of a ratio with respect to an Issuer."[7] However, the statutory MLR provision also states that the MLR calculation must be done at the "plan" level, just as the risk corridor statute provides; the MLR statute requires that beginning on January 1, 2014, the MLR "shall be based on the averages of the premiums expended on the costs described in such subparagraphs and total premium revenue for each of the previous three years for the *plan*."[8] This reference to the term "plan" within the MLR provision, which CMS has interpreted as requiring an Issuer-level analysis, demonstrates that the use of the term "plan" in the statutory language for the risk corridor program similarly can be interpreted to refer more broadly to a QHP Issuer and does not have to be limited to a QHP.

  In addition to references described above, the risk corridor provision states that "a participating plan shall pay to the Secretary" certain risk corridor-related payments, or alternatively the Secretary "shall pay to the plan an amount."[9] In both instances the term "plan" is used to refer to the QHP Issuer since a QHP – a plan benefit package – is not able to make or receive payments.

  In light of the above, the risk corridor statute as written is at the very least ambiguous regarding who is the appropriate "actor" under the statute and the level at which risk corridor calculations should occur. Given this ambiguity, CMS has significant discretion to adopt a reasonable interpretation of the statute. The operational and policy benefits of conducting risk corridor calculations at the QHP Issuer level suggest this would be a reasonable and appropriate interpretation.

- **Claims experience is more statistically credible at the QHP Issuer level.** If QHPs are defined at the benefit option level, there may not be enough members enrolled in every QHP to provide statistically credible experience. As a result, the risk corridor payments would reflect statistical volatility rather than adjusting for true over- or under-pricing by the QHP Issuer. Given that credibility was a well recognized issue at the Issuer level for MLR

[7] 77 at 17238.
[8] PHSA §2718(b)(1)(B)(ii) (emphasis added)
[9] ACA §1342(b)(2).

purposes, it seems odd that CMS is not taking credibility into consideration in establishing the Risk Corridor Program.

- **Applying the risk corridors at the QHP Issuer/market level is more consistent with the MLR rules.** BCBSA agrees with CMS' application of much of the structure of the MLR regulation to the Risk Corridor Program. Notably, however, the MLR rules apply at the Issuer level (specifically, at the legal entity level by market segment, by state). In other words, CMS appears to have imported a structure – including an administrative cost target of 20 percent as well as definitions of key terms – designed to apply at an aggregate level, but creates a disconnect within the Risk Corridor Program by applying the calculations at the QHP level.

- **Capping allowable administrative costs at 20 percent of premium at the benefit option level requires issuers to price each QHP at a level that does not match actual expenses.** Higher- cost plans (such as platinum and gold level QHPs) generally will have lower administrative costs as compared to lower cost QHPs (such as bronze-level) when expressed as a percent of premium. Capping administrative expenses at 20 percent of the after-tax premiums measured at the benefit option level would preclude a QHP Issuer's lower metal level plans from recovering their full administrative expenses. Calculating risk corridors at the QHP Issuer/market level would allow premiums to be priced with the expected administrative costs measured at the benefit option level, while the 20 percent limit on administrative expenses would be consistent with the MLR administrative cost limitation measured at the Issuer/market level.

- **In today's market, issuers do not report administrative expense data at the benefit option level.** A benefit option may only have a handful of members, and as a result, allocating expenses at the benefit option level may not be meaningful. Moreover, issuers across markets today report administrative expenses at more aggregate levels; IT systems are not set up to collect and report expense data at the more granular, benefit package level. Given that the Risk Corridor Program is only temporary and is limited to only exchange participants – and considering the numerous system upgrades QHP issuers would be required to finance to accommodate this proposal – issuers are unlikely to change their systems to accommodate this temporary program. As a result, the data will likely be collected and reported manually, which will add considerably to QHP issuers' administrative and compliance burdens.

- **Sharing gains and losses at the benefit option level through a risk corridor mechanism is not consistent with the concept of a single risk pool for each market segment.** The ACA requires issuers to treat each market segment as a single risk pool, with states having the option to combine the individual and small group markets into a single risk pool. As a result, the pricing for all benefit options will be adjusted based on the overall experience of the pool, with the expectation that gains and losses at the benefit option level will offset each other if the pricing is accurate in the aggregate. If these expected gains and losses at the benefit option level are shared through the risk corridor calculation with each plan option having a 20 percent cap on allowable administrative expenses, then the gains and losses may not offset.

- **Calculation at the benefit option level rather than in aggregate may provide an incentive to develop loss-leader plans.** Plans that are under-priced will be subsidized by the Risk Corridor Program even if the Issuer's other plans are priced within the +/-3 percent

non-sharing corridor. Risk Corridor Program calculations made at the QHP Issuer level should mitigate some of this market strategy.

Recommendation #2: Retain the definition of "profits," which allows for a minimum 3 percent profit margin after taxes

Rationale #2:

Inclusion of a profit allowance in the target amount calculation will provide appropriate protection for issuers and will ensure that the risk corridor program fulfills its policy goals.

47. Retain July 31 reporting data for risk corridor data (§ 153.510).

Issue:

The Rule requires QHP issuers to submit the required risk corridor data to CMS by July 31 of the year following the benefit year that is being measured.

Recommendation:

BCBSA supports this proposal.

Rationale:

This timeframe should be workable since issuers can gather much of the data prior to the reporting of the risk adjustment and reinsurance amounts on June 30.

48. Retain risk corridors data requirements (§ 153.530).

Issue:

The Rule requires QHP issuers to submit data regarding their premiums earned, allowable costs, and allowable administrative costs. CMS proposes to specify the manner in which this data is provided in future guidance.

CMS also proposes that CSRs received by a QHP issuer that are not reimbursed to a provider furnishing the item or service would be reported as a reduction in the QHP Issuer's allowable costs under the Risk Corridor Program. CMS states that this proposal is based on its belief that a QHP Issuer will retain CSR payments rather than passing these payments to capitated providers. Instead, CMS predicts, the Issuer will provide a comparable increase in the capitation amount paid to the provider to account for this additional revenue.

Recommendation:

BCBSA agrees with the proposal regarding the type of data necessary to administer the Risk Corridor Program. We also agree that CSR payments retained by a QHP Issuer should be an offset to allowable costs, although we do not believe this is likely to be a common practice.

Rationale:

Plans report that in many instances CSR payments received by an Issuer are and will be passed through to providers paid under FFS or capitation payment arrangements.

49. Make Modifications to data collection and submission requirements (§§ 153.700-730)

Issue:

The Rule uses a distributed data collection model to collect information on member-level and claims-level data that is stored on an Issuer's dedicated environment. Issuers must make this data available to CMS in a specified electronic format. The dedicated data environment must be established by October 2013 with implementation to begin in March 2013.

In a state where CMS operates the Risk Adjustment or Reinsurance Programs, as applicable, all claims data submitted by an issuer must have resulted in payment by the issuer in order to be accepted by CMS.

CMS has not given any indication that it is planning to provide interim estimates of risk adjustment scores or national reinsurance contributions.

Recommendation:

CMS should provide issuers with the EDGE server requirements and specifications as soon as possible so that issuers can begin implementation in March 2013.

For risk adjustment purposes, BCBSA recommends that CMS accept all diagnoses that are submitted with an eligible claim, even if the claim does not result in payment by the issuer or occurs within the benefit year but prior to the member converting to a risk adjustment eligible plan.

We also recommend that CMS create a process for providing interim risk adjustment estimates, such as quarterly, prior to the end of the benefit year. The reports should provide information on the market risk scores, the issuer's risk scores, and the state average premium.

Finally, we recommend that CMS amend the Reinsurance Program regulations to make clear that CMS will provide quarterly interim reports on the expected requests for reinsurance payments.

Rationale:

There could be instances where a valid claim will not result in payment from an issuer, such as where a deductible applies and the member is 100 percent responsible for payment. Also, there could be other coverage that is responsible for paying a claim (e.g., other liability coverage) where the diagnoses associated with the claim would still be relevant to the member's expected costs throughout the year. Such claims should be accepted by CMS for risk adjustment purposes. It may be appropriate to limit accepted claims for the Reinsurance Program purposes to claims paid by the issuer, but for risk adjustment purposes, the important factor is whether the diagnosis is valid because that is the medical cost predictor.

BCBSA understands that issuers are not eligible to receive risk adjustment payments for coverage that is not subject to the 2014 market reforms. It is not clear, however, whether claims data from periods in a benefit year prior to a member's enrollment in a market reform-compliant plan could be submitted for risk adjustment purposes. We understand that coverage not subject to 2014 market reforms may not receive risk adjustment payments; claims data from those periods for market reform-compliant members is still relevant, however, to determining expected claims costs during that specific benefit year.

Regarding interim reporting, it is important that issuers have early information on risk relative to the rest of the market. Interim reporting will permit issuers to estimate transfers for financial reporting and set rates for the following year. This need is recognized by CMS in the Preamble where it acknowledges that interim reports "assist in development of premiums and rates in subsequent benefit years."[10]

With respect to the quarterly reinsurance reports, the proposed regulation only references quarterly reports in § 153.240(b)(2)(ii), which discusses state supplemental reinsurance payment parameters. The regulations do not explicitly indicate that interim reports will be provided relating to Reinsurance Program payment requests. Furthermore, it seems as though CMS, rather than states, should be responsible for providing quarterly information regarding reinsurance payment requests since CMS will be responsible collecting and distributing national reinsurance contributions.

50. Revise risk adjustment data requirements (§ 153.710)

Issue:

The Rule requires issuers to provide CMS with access to member-level plan enrollment data, member claims data, and encounter data specified by CMS. The data collection period includes enrollment and services provided during an applicable benefit year, consistent with the proposed concurrent risk adjustment approach. In the Preamble, however, CMS proposes that claims may only be submitted for institutional and medical claims where the discharge date or through date of service occurs in the applicable benefit year.[11]

The Rule also requires that claims must be from acceptable provider types to be accepted by the Risk Adjustment or Reinsurance Program. The acceptable provider types are certain hospital inpatient facilities, hospital outpatient facilities and physician providers.

Recommendation:

To ensure that risk adjustment data reflects all services provided during an applicable benefit year, CMS should accept institutional and medical claims where the admission date or from date of service occurs in the applicable benefit year, even if a discharge date is in the following benefit year. In addition, diagnoses should be accepted from interim bills for inpatient hospital stays beginning prior to the end of the benefit year, paid by March 31, but not discharged by March 31.

CMS should clarify which providers will be excluded from the risk adjustment data and provide an explanation of why they will be excluded.

Rationale:

If adopted, the proposed approach would result in claims being excluded where members are admitted before December 31 but are not discharged until the following benefit year. This is inconsistent with the concurrent risk adjustment model where diagnoses from a given period are used to predict costs in that same period. It is also inconsistent with the way issuers process and record claims on their financial statements. Since claims liability or cost is established

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[10] 77 Fed. Reg. at 73163.
[11] 77 Fed. Reg. at 73183.

based on the date of admission or the date of service, data on admissions beginning in a benefit year should be included in the risk adjustment model.

51. Treatment of premium stabilization payments, and timing of annual MLR reports and distribution of rebates (§§ 158.130, 158.221, 158.240)

Issue #1:

The Rule proposes that issuers move the premium stabilization amounts from premium revenue (as is reported to HHS) to incurred claims when calculating the MLR. The proposal is intended to establish consistency between the MLR formula and the risk corridor program by treating the reinsurance and risk adjustment amounts as in the risk corridor calculation. The reinsurance amounts would be net of the contributions.

Recommendation #1: Retain reinsurance contributions and risk adjustment transfers as adjustments to premiums within the denominator, and make reinsurance recoveries and risk corridor payments or charges adjustments to claims in the numerator

Should it be determined that all amounts need to stay together, we recommend that all premium stabilization amounts be adjustments to premiums for both reporting and the MLR calculation.

Rationale #1:

Although we agree that reinsurance recoveries and contributions should be adjustments to claims and thus belong in the numerator, the contributions already fit under the definition of regulatory fees and should be an adjustment to premiums in the MLR denominator.

CCIIO bases the risk adjustment transfer amounts (both payments and charges) off actual state average premiums rather than an expected claims cost. Therefore, risk adjustment transfers should be treated as an adjustment to premiums in the denominator of the MLR formula. Since the risk adjustment program is permanent it is more important that it align with the denominator of the MLR than trying to establish consistency with the temporary risk corridor program.

Issue #2:

Beginning with the 2014 MLR reporting year, CMS will change the due date for issuers to provide MLR reports from June 1 to July 30 in the year following the MLR reporting year. This will permit Issuers to account for risk adjustment and reinsurance payments, which are to be known by June 30 in the year following the MLR reporting year, and risk corridor calculations, which must be reported by July 31 in the year following the MLR reporting year. Rebates will be due September 30 rather than the current August 1 requirement.

Recommendation #2: Give issuers until August 15 to submit MLR reporting forms beginning with the 2014 MLR reporting year and make rebates payable September 30.

Rationale #2:

Providing an additional 15 days for submitting the MLR reports will provide issuers sufficient time to calculate and allocate Premium Stabilization Program payments. It also will ensure that the MLR reporting date does not overlap with the submission date for risk corridor calculations. Overlapping deadlines, particularly in the early years of the Premium Stabilization Programs, could create administrative burden for issuers. Also, by leaving the date for rebates as proposed at September 30, the additional time for MLR reporting will not harm consumers.

Issue #3:

CMS proposed to merge the individual and small group markets for risk adjustment if a state elects to merge those markets into a single risk pool for rate development.

Recommendation #3:

CMS should merge the individual and small group markets for all purposes if a State elects to merge those markets into a single risk pool for rate development. This includes risk adjustment, risk corridor and MLR.

Rationale #3:

If this is not done, then one market will end up subsidizing the other market and result in MLR rebates being paid from one market to the other or from risk corridor payments going from one market to the other.

Issue #4:

CMS included Exchange fees of 3.5% of billable premium and risk adjustment fees of approximately $1 per risk adjusted member per year.

Recommendation #4:

These fees should be considered as Taxes and Regulatory Fees for both the MLR and risk corridor formulas and not subject to the 20% allowable administrative cap.

Rationale #4:

These are regulatory fees instituted by a government agency to defray its operating costs.