New York State Comments on Proposed Rule: Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, 45 CFR Parts 155 and 156

File Code: CMS-9989-P

General comments: New York appreciates the balance that the proposed rules attempt to strike between the provision of national minimum standards for Health Insurance Exchanges and Qualified Health Plans and State flexibility throughout the establishment and implementation process. Comments on specific provisions of the proposed rules are below. Thank you for the opportunity to submit these comments.

Part 155, Subpart A, Definitions (§ 155.20): **Small Employer** - New York notes that the definition of Small Employer does not take into account Sole Proprietors. The preamble states that coverage for only a Sole Proprietor, certain owners of S corporations, and certain relatives of each of the above would not constitute a group health plan under ERISA section 732(a) (29 U.S.C. section 1191a(a)) and would not be entitled to purchase in the Small Group market under Federal Law. 76 FR 41868 – 41869. Exclusion of sole proprietors from the definition of small employers for the SHOP exchange is inconsistent with the way group size has been determined in several states since the passage of HIPAA in 1996. Additionally, it raises concerns and potential for marketplace inequities for states that currently allow sole proprietors to purchase coverage in the small group markets.

New York currently provides insurers with the option of treating sole proprietors as either individuals or small employers and requires insurers that participate in New York's association market to cover sole proprietors who are members of those associations, subject to no more than a 15% rate differential. In current markets, this approach has been a part of New York's effort to promote and support the innovation and entrepreneurship of Sole Proprietors in our business community. As our insurance markets go through extensive reform and change, New York believes it would be most appropriate to continue to provide States with the flexibility to allow Sole Proprietors and their families to access Small Group coverage. Such flexibility would permit States to be responsive to the needs of small businesses and avert marketplace disruptions. Moreover, fluctuations in the size of the smallest businesses could require the business to change which Exchange it purchases coverage through, likely resulting in a different QHP, premium, etc. At this time, it is simply too soon to know what will be best for consumers.

Additionally, New York's definition of small employer set forth in the New York Insurance Law differs from the federal definition of small employer. As a result, different employers would qualify for coverage under state and federal requirements. For example, New York counts group size on the date of application and renewal, whereas the federal definition considers "average" annual employment. New York allows small employers to cover only a subset of

their employees based upon "classes pertaining to employment" while the federal rule requires counting of all employees including full-time and part-time employees. Similarly, New York's definition does not require "all persons treated as a single employer" under the tax code to be treated as a single employer for the purpose of establishing a small group for the purposes of accessing small group coverage. New York is concerned that groups New York currently treats as "small employers" may not be permitted to access coverage through New York's SHOP exchange. Additionally, New York believes the definition of "small employer" should be consistently applied inside and outside of the SHOP exchange to avoid selection issues. Further, given New York's definition of small employer is tied to extensive consumer protections under State law (such as open enrollment and community rating), New York wishes to minimize any potential unforeseen consequences for small employers and our small group market that could result from transition to the new federal definition.

New York seeks clarification as to whether the definition of small employer set forth in federal statute and regulation is a minimum standard determining which small employers are entitled to access coverage through the SHOP exchange. Additionally, New York seeks clarification as to whether a state could extend coverage in the SHOP to a broader set of groups, beyond those that clearly meet the federal definition of small employer. Lastly, New York seeks clarification as to whether added flexibility is available to states in determining how to count employees for the purpose of determining "small employers" eligible to participate in the SHOP, between 2014 and 2016, when PPACA permits, but does not require, states to include small employers with up to 100 employees in the SHOP.

MEWAs - Comments have been requested on how to reconcile a perceived inconsistency in the definition of "health plan" that references MEWAs "not subject to state insurance regulation." Section 1301(b)(1)(B) of the ACA states that "the term 'health plan' shall not include a group health plan or multiple employer welfare arrangement (MEWA) to the extent the plan or arrangement is not subject to State insurance regulation under section 514" of ERISA. Section 514 of ERISA allows State regulation of MEWAs, provided that such regulation does not conflict with standards of ERISA. If the phrase "not subject to state insurance regulation under section 514" is intended to exclude only those fully- insured MEWAs that section 514 of ERISA prohibits the states from regulating as health insurance issuers, then it is consistent with the intent of the section 1301 definition of qualified "health plans" that may be offered on the Exchanges by state-regulated health insurance issuers. It is also consistent with how states currently regulate MEWAs. States do not regularly seek to regulate fully-insured MEWAs directly because they regulate the insurers providing the insurance to the fully-insured MEWAs. It is the insurer, in those cases, that is offering a "health plan" within the meaning of Section 1301(b)(1), and if it meets the standards for a QHP, the issuer may offer that health plan on the SHOP Exchange and offer it through one or more fully-insured MEWAs.

<u>Part 155, Subpart B, Approval of a State Exchange (§ 155.105):</u> New York recommends that the Department of Health and Human Services (HHS) adopt an alternative approach to the proposed Exchange Plan review process. To ensure that States have as much time as possible

to stand up an Exchange, we request that the Exchange Plan review process take no longer than 30 days and that if no action is taken within that time, the Exchange Plan be deemed approved.

The preamble to subsection (d) indicates that HHS is considering a 90 day review process, with the possibility of an additional 90 day period if supplementary information is requested and received by the State to approve a State Exchange. It is noted that this process would be similar to the one used for Medicaid and CHIP. 76 FR 41871. New York's experience with the process for Medicaid and CHIP reviews has been that they are paper-intensive, not very flexible or tailored to specific state circumstances, and often go well beyond 90 days with the time period stopping and starting as additional information is requested and reviewed post-submission.

With the severe time constraints that States are operating under to stand up an Exchange even a 90 day process is too long. The conditional approval process proposed in the rules acknowledges that many States may not be operational on January 1, 2013 which means that it will be critical for States to have as much of 2013 to work towards implementation as possible. Given that most States developing an Exchange are receiving federal Establishment Grant funds to become operational, the review process should be linked to and progress tracked through the reporting requirements associated with those funds. The relationship between Establishment Grant funding and this approval process is referenced in the preamble in the description of the Exchange Plan template to be issued along with additional guidance. 76 FR 41871. Establishment Grant awards require States to file quarterly reports keeping HHS apprised of Exchange implementation progress and the status of required milestones. The Exchange Plan template should be designed so that it can be easily populated by these submissions. A template that is an extension of the quarterly reports will be less burdensome on States and should require less time for HHS to review.

The proposed adoption in the preamble to subsection (e) of a process like the State Plan Amendment process used for Medicaid and CHIP for Exchange Plan changes will unduly limit State flexibility to make necessary changes to an Exchange Plan. 76 FR 41871. As stated above a process that often takes much longer than 90 days should not be replicated. HHS should adopt a process like the one used to evaluate Establishment Grant applications. To ensure that States are able to make necessary changes in a timely manner, we recommend that the review process for changes to the Exchange Plan take no longer than 30 days and that if no action is taken, the Exchange Plan change be deemed approved.

<u>Part 155, Subpart B, Entities Eligible To Carry Out Exchange (§ 155.110):</u> The preamble to this section notes that there may be ways in which an Exchange and the Federal government can work in partnership to carry out certain activities and welcomes comments on how to implement or construct a partnership model. 76 FR 41872. New York appreciates the opportunity to have a state-based Exchange that is supported by functions or services that can

be centralized and operated by the Federal government. One function that is critical to the success of state-based Exchanges and the federal Exchange is a robust Federal data hub. To maximize an Exchange's ability to make real-time eligibility determinations, States must be able to verify eligibility information quickly and accurately. To ensure that consumers have the "real time," streamlined, easy application process that we are striving to provide, Federal data matches must break down information on household members by individual (e.g., source(s) of income and amount of income and percent of Federal poverty level) and provide information about household relationships. In addition to detailed data from the anticipated Federal sources, the hub should include access to current wage reporting information from sources like WORK number and the ability to confirm residency via sources like PARIS match.

Beyond the data hub, services like identity management and tools like the cost calculator and plan comparison tool should be designed/developed on a shared basis for the Federal and State Exchanges. Finally, New York has identified potential plan management functionality through the National Association of Insurance Commissioner's System for Electronic Rate and Form Filing (SERFF) that should be jointly reviewed as a potential shared service for the state and federal Exchanges, along with CMS's Health Information Oversight System (HIOS).

Section 155.110(a) provides criteria for entities that are eligible to carry out Exchange functions and specifically mentions that a State Medicaid Agency is an eligible entity an Exchange can contract with to carry out Exchange responsibilities. Although New York believes that state insurance regulators clearly meet the criteria, we also believe it would be a helpful clarification to specify that state insurance regulators are able to carry out Exchange functions. This clear authority will assist with transition and help to avoid any duplication in functions.

Comments are requested regarding whether HHS should place conflict of interest standards on entities contracting with the Exchange consistent with Section 155.110(b). Such standards should be left to the states which have demonstrated experience and knowledge of market considerations.

Subsection (f) proposes to allow periodic review by HHS of Exchange accountability structures and governance principles. New York opposes a periodic review of the Exchange's governance principles. While the financial integrity provisions under the Patient Protection and Affordable Care Act (ACA) require an Exchange to maintain an accurate accounting of activities, receipts and expenditures and to provide annual report to the Secretary of such accountings, there is no requirement to report on governance principles. ACA 1313(a)(1).

The preamble restates the proposed rule and requests comments on the frequency of the proposed review. 76 FR 41873. Since States are responsible for full funding of Exchange operations beginning January 1, 2015 and the accountability structures will be unique to individual states, New York requests issuance of additional guidance detailing the standards for

the proposed review. The question of frequency of review is dependent on the standards to be applied and whether such review would be triggered by going below some minimum standard. In the absence of such a standard and in the interest of reducing duplication and administrative burden to states, we recommend that this proposed review process be part of an annual report to the Secretary under ACA 1313(a)(1), and not include reporting on governance principles as outlined above.

Part 155, Subpart B, Financial Support for Continued Operations (§ 155.160): Subsection (b)(4) proposes to require that Exchanges notify participating issuers of user fees in advance of the plan year. The preamble invites comment on whether the final regulation should otherwise limit how and when user fees may be charged, and whether such fees should be assessed on an annual basis. 76 FR 41874. States are responsible for developing and implementing operational plans for Exchange self-sufficiency. Creating an ongoing funding stream for the Exchange will be extremely challenging in this economic climate. It will require State-based individualized assessments and necessitate flexibility so that States can utilize available options and resources. New York appreciates the flexibility afforded in earlier sections of this provision and strongly recommends that no further restrictions be imposed in this area. A limitation on how and when user fees may be charged restricts States in a manner that was not intended by the ACA which gives the States the right to decide how to implement this requirement. ACA 1311(d)(5).

Part 155, Subpart C, Required Consumer Assistance Tools and Programs of an Exchange (§ 155.205): Subsection (b) proposes to codify ACA section 1311(d)(4)(C) which requires the Exchange to maintain an internet website. The preamble seeks comments on the extent to which the plan comparison functionality on the Exchange website on HealthCare.gov may meet the requirements of ACA sections 1103(b) and 1311(c)(5) which call for the Secretary to establish a standardized format for presenting coverage option information and to make available a model Exchange website template. 76 FR 41876.

As all States establishing an Exchange will be required to have an Exchange website, New York strongly supports the creation of a model website template that includes the functionality necessary to provide meaningful support to consumers. New York anticipates that such template will reflect the outcomes of the UX 2014 collaborative design process for a consumer and SHOP web portal currently underway, involving CMS, a number of states and foundations, and the IDEO design firm.

In addition, all Exchanges will need to provide consumers with a comparison tool that can assist them in evaluating plans based on multiple priorities. Consumers should be able to sort and prioritize their health plan options based on the factors that are most important to them. Under the proposed rule, a web based tool must be able to compare QHPs based on cost

(premium and cost-sharing) to consumer, benefits, QHP plan level, quality, consumer satisfaction, provider networks, medical loss ratio information and transparency of coverage measures. Other important health and wellness features that may be important for consumers to compare are the availability of medical homes, health homes and disease management. Given the very tight time frame under which Exchanges must become operational, the development of a tool that can be utilized by all Exchanges which offers the ability to sort and evaluate plan features based on an individual consumer's priorities should be a very high priority. It makes sense to create this functionality once, with flexibility for state adaptation--whether the tool is one designed and developed by HHS, or by one or more states in collaboration or working with vendors. The tool should incorporate appropriate recommendations from the UX 2014 collaborative project.

Subsection (c) proposes to codify ACA section 1311(d)(4)(G) which requires an Exchange to establish an electronic calculator to assist individuals in comparing the costs of coverage in available QHPs after the application of any advance payments of the premium tax credit and cost-sharing reductions. 76 FR 41876. New York appreciates the request for comments on the extent to which states would benefit from a model calculator. New York envisions the plan comparison tool to incorporate a calculator, to enable consumers to rank and select plans according to their specific criteria, and to be able to determine the applicable coverage costs associated with the various plan options/selections. Again, since this application is a shared function of all Exchanges there is no need for more than one calculator to be built. We strongly support the concept of a model calculator/plan comparison tool, and hope that this initiative will be a high priority for HHS, including incorporation of appropriate recommendations from the UX 2014 collaborative project.

<u>Part 155, Subpart C, Navigator Program Standards (§ 155.210):</u> Subsection (c) codifies that health insurance issuers are prohibited from serving as Navigators and a Navigator must not receive any consideration directly or indirectly from any health insurance issuer in connection with the enrollment of any qualified individuals or qualified employees in a QHP. However, navigators are not precluded from receiving compensation from health insurance issuers in connection with enrolling individuals, small employers or large employers in non-QHPs. The preamble to subsection (c) welcomes comments on this issue and whether there are ways to manage any potential conflict of interest that might arise. 76 FR 41877. Allowing commissions to be paid for enrollment in non-QHPs, but prohibiting commissions to be paid for enrollment in QHPs promotes conflicts of interest. To avoid such conflicts, the standards should address conflicts of interest relating to selling non-QHP products outside of the Exchange.

The preamble to subsection (d) welcomes comments on potential standards to ensure that information made available by Navigators is fair, accurate, and impartial. 76 FR 41877. We

strongly support the adoption of minimum standards. New York, for example, currently has standards in place for programs that are similar to the Navigator program. New York's community based enrollment through its facilitated enrollment program for Medicaid Managed Care, Family Health Plus, and Child Health Plus has standards in place regarding training, counseling enrollees based on their primary care provider and health needs, and providing information on plan choice in a neutral manner so the enrollee can make an informed decision. Should federal minimum standards not be adopted, New York should be allowed the flexibility to adopt its existing standards for the Navigator Program.

The preamble to subsection (e) requests comments on whether the Navigator Program should be required to be in place when the proposed initial open enrollment period begins October 1, 2013. 76 FR 41878. Although ACA section 1311(i) requires an Exchange to establish a Navigator program and Navigator duties include educating the public and facilitating enrollment in qualified health plans, there is no requirement as to when this program must begin. While we support the concept of a Navigator program, based on the restrictions under the ACA requiring states to fund the Navigator program without any federal assistance, New York opposes a requirement to begin this program October 1, 2013. ACA §§ 1311(d)(5), (i)(6). States should have the flexibility until January 1, 2015 to assess when the amount of non-federal funds flowing into the Exchange is sufficient to begin a Navigator program. Should the proposed start date be imposed, the lack of a Navigator program on October 1, 2013 should not be grounds for revocation of a conditional approval of an Exchange as described in proposed rule 155.105.

Part 155, Subpart D, Ability of States to Permit Agents and Brokers to Assist Qualified Individuals, Qualified Employers, or Qualified Employees Enrolling in QHPs (155.220): The preamble to subsection (d) requests comments on the role of web-based entities in enrolling individuals and employers in QHPs. Specifically, the functions that web-based entities could perform, the potential scope of how these entities would interact with the Exchanges and what standards should apply to an entity performing functions in place of, or on behalf of, an Exchange. 76 FR 4178.

New York recommends that, at state option, web-based entities be allowed to both subcontract with Exchanges to perform some functions (i.e., provider directory, plan selection) and operate alongside Exchanges, providing a referral source for individuals who may be eligible for advance payments of the premium tax credit and cost-sharing reductions. New York agrees that the eligibility determination for the advance payment of the premium tax credit and cost-sharing reductions should rest solely with the Exchange. However, the long experience of web-based entities in selling insurance could offer Exchanges referrals, and ultimately increase coverage. States should have the option of qualifying web-based entities provided they:

- Meet all the standards of the ACA, including requiring the web-based entity to list all plans listed by the state Exchange with the same premiums, same benefits, and part of the same risk pool to minimize adverse selection with respect to state Exchanges

- Is licensed at the option of a state and complies with any additional state licensing requirements

- Refer individuals to state Exchanges for eligibility determinations for the advance payments of the premium tax credit and cost-sharing reductions and allow such individuals to complete the plan enrollment either with the Exchange or the web-based entity.

Part 155, Subpart C, General Standards for Exchange Notices (§ 155.230): The preamble to subsection (b) requests comments regarding codifying examples of meaningful access for notices. 76 FR 41878. Since notices in plain language that are accessible to individuals with disabilities and limited English proficiency are required to be issued by all Exchanges, HHS should issue model notices as a minimum standard that Exchanges can use or build from. New York understands that HHS intends to develop and issue such model notices, in consultation with the states, and welcomes the provision of such model notices.

Model notices would also assist in the review proposed in the preamble to subsection (c). 76 FR 41878. With respect to this review, the proposed rule to "review applications, forms and notices on an annual basis and in consultation with HHS in instances when changes are made" will be excessively burdensome on Exchanges and States. New York recommends that this section be revised to include a review that occurs every three years or when technological advancements or statutory or regulatory changes have been made.

Part 155, Subpart C, Privacy and Security Information (§ 155.260): The preamble to subsection (b) seeks comments on the appropriateness of utilizing Fair Information Practice Principles (FIPPs) to help define the Exchange security and privacy framework and the best means to integrate FIPPs into the privacy policies and operating procedures of individual Exchanges while allowing for adaptability to each Exchange's particular structure and operations. 76 FR 41880. Exchanges will collect and distribute a variety of information related to consumers. As a consequence, the privacy and security of this information is critically important. While HIPAA and HITECH privacy and security requirements will apply to all protected health information (PHI) associated with the Exchange, a more expansive privacy and security framework is needed to protect personally identifiable information that will be held by the Exchange. FIPPs will provide an appropriate baseline of privacy protections for the broader information classification associated with personally identifiable information. It would be helpful to the

States if CMS provided more specific guidance as to implementation of each principle within the context of the Exchange.

Part 155, Subpart E, Enrollment of Qualified Individuals in QHPs (§ 155.400): While encouraging real-time processing, the preamble to subsection (b) requests comments on the frequency that Exchange must send enrollment information to QHPs and that QHPs must verify and acknowledge receipt of this information. The preamble also acknowledges that the parties involved may have different levels of functionality. 76 FR 41881. At least initially, New York recommends that states be allowed to determine frequency based on functional capabilities in that state.

Part 155, Subpart E, Single Streamlined Application (§ 155.405): The preamble to subsection (b) seeks comment on whether a requirement that applicants not be required to answer questions that are not pertinent to the eligibility and enrollment process should be codified. 76 FR 41881. To meet the time constraints of operability by October 1, 2013, the initial application created by HHS should contain only those eligibility requirements necessary for obtaining eligibility and enrollment for health coverage and any insurance affordability program through the Exchange with the potential for future modifications to offer applicants the option for screening and/or eligibility determinations for other programs. CMS should not veer from its longstanding policy of only allowing states to require information relevant to eligibility, and apply that policy to all insurance affordability eligibility determinations.

A request for comments regarding the requirement that an individual may file an application in person is sought in the preamble to subsection (c). 76 FR 41882. New York requests confirmation of state flexibility regarding the means used to provide telephone, in person, mail and web access as provided for under ACA 1413(b)(1)(A)(ii). We also recommend eliminating the new requirement to accept applications by fax in 42 CFR 435.907 of the proposed Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010. 76 FR 51191. Although New York no longer has a face-to-face requirement as part of its eligibility process for Medicaid, many individuals still prefer an in person meeting to complete their application. This in person meeting is often with a community based facilitated enroller. It would be helpful to have clarification as to what “in person” means in this context. Given the success of our facilitated enrollment program, New York recommends that the Navigator Program be one of the pathways for meeting this requirement.

Will a state have discretion, under section (c), to define "acting responsibly" for the purpose of an individual submitting an application on behalf of another individual? Does the proposed regulation require a different or higher standard for an individual to act as "an authorized representative"?

Part 155, Subpart E, Initial and Annual Open Enrollment Periods (§ 155.410): Subsection (b) proposes an initial open enrollment period for QHPs of October 1, 2013 through February 28, 2014. The preamble seeks comments on the duration of the initial open enrollment period. 76 FR 41882. To allow the proper amount of time for extensive outreach and education, which we believe is key to enrollment in QHPs, we suggest a longer initial open enrollment period. A longer period is more consumer friendly, especially in an open enrollment state, like New York, where consumers are used to enrolling in plans at any point in the year.

Subsection (f) proposes to require Exchanges to ensure that a qualified individual who enrolls during open enrollment has effective coverage in a QHP on the first day of the following benefit year. The preamble seeks comment as to whether an Exchange should automatically enroll individuals receiving tax credits into QHPs where such individuals fail to select a new QHP if theirs is no longer offered. They also propose to automatically enroll individuals in the event that issuers merge and a new QHP is offered, or when a QHP is no longer offered through an issuer but there are other QHP options through the same issuer. Comment is also sought on how far automatic enrollment should extend if it is provided. 76 FR 41883.

New York recommends that states have the flexibility and ability to auto assign individuals to avoid gaps in coverage, with appropriate consideration of the implications of any changes to advance premium tax credits and/or cost sharing reductions. Existing public programs where default coverage assignments occur (Medicare Part D, CHP) involve auto-assignment to fully or nearly fully subsidized, comparable coverage products. Examples below are potential scenarios for consideration by an Exchange, based on when plans merge or leave the market in our current CHP program:

> Two plans merge together (i.e., Plan A gets swallowed by Plan B)
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> The members from Plan A get transitioned to Plan B. In CHP's IT system, the transition occurs by disenrolling members from Plan A on the last day of the month and then enrolling them in Plan B on the 1st of the following month.
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> A Plan opts out of the market or shuts down operations completely.
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> Members from this plan can choose to enroll/transition to another plan that is participating or get auto-assigned based on specific parameters or by using an algorithm (e.g., factors considered in the algorithm include availability of plans in the county where member resides, health plan performance, etc).

If the member takes no action by a certain date, then s/he is auto-assigned to a health plan for the remainder of their 12 month CHP coverage.

Part 155, Subpart E, Special Enrollment Periods (§ 155.420): Subsection (d)(2) proposes a special enrollment period if a qualified individual gains a dependent or becomes a dependent through marriage, birth, adoption or placement for adoption. The preamble to this section notes that it is similar to the provision in section 9801 of the Internal Revenue Code and seeks comment as to whether States might consider expanding the special enrollment period to include gaining dependents through other life events. 76 FR 41883 - 41884. In addition to the life events included in this section, we recommend that HHS consider adding dependents gained through custody and guardianship proceedings. We also recommend that individuals receiving premium assistance with employer health insurance who lose Medicaid eligibility, be allowed to disenroll from their employer plan in order to find more affordable insurance through the Exchange.

Subsection (d)(8) proposes to codify ACA section 1311(c)(6)(D) which provides a monthly special enrollment period for Indians as defined under section 4 of the Indian Health Care Improvement Act. The preamble seeks comments on the potential implications on the process for verifying Indian status. 76 FR 41884. To ensure that Native Americans are afforded the same streamlining and simplification measures as other qualified individuals seeking coverage through Exchanges, data necessary to verify eligibility for special monthly enrollment periods, relief from the individual mandate and cost-sharing provisions must be included in the federal data hub. Currently, documentation of Native American status is a paper process, which means that enrollment will not be in real time for these individuals.

We request clarification of "other exceptional circumstances" as set forth in § 155.420(d)(9).

We also suggest codifying an additional special enrollment period that allows a qualified individual enrolled in a bronze-level QHP, and experiences a loss of income, to enroll in a silver-level QHP, so the consumer can take advantage of cost-sharing reductions for which they are now eligible.

Part 155, Subpart E, Termination of Coverage (§ 155.430): Subsection (d)(2) proposes that when an Exchange terminates an enrollee's coverage because the enrollee has obtained other minimum essential health coverage, termination of QHP coverage is the day before the new minimum essential coverage becomes effective. The preamble notes that the intent of this provision is to ensure that enrollee is not covered by two forms of minimum essential coverage simultaneously. Comments are sought regarding how Exchanges can work with QHP issuers to implement this proposal. 76 FR 41885. This rule should be aligned with subsequently issued eligibility rules. To avoid gaps in coverage, individuals should not be automatically terminated on the 14th.

We request Exchange flexibility in termination dates to not only avoid duplication of minimum essential coverage, but to also provide a seamless transition to new coverage. If coverage can terminate on the 14th of the month, it does not seem possible that a consumer can secure new coverage beginning the 15th of the month pursuant to effective date rules set forth in §§ 155.410 and 155.420. Additionally, if coverage terminates mid-month, we request that State return of premium payment rules apply, as premiums are typically billed monthly.

The rules pertaining to rescission of coverage provide that the coverage will be terminated at a future date (either the 14th of the month or the end of the month) after notice is provided. This is contrary to the concept of rescission, which is the cancellation of a contract in its entirety and differs from termination of coverage going forward.

Part 155, Subpart H, Functions of a SHOP (§ 155.705): Preamble to subsection (b)(3) invites comment about whether QHPs offered in the SHOP should be required to waive application of minimum participation rules at the level of the QHP or issuer; whether a minimum participation rule applied at the SHOP level is desirable; and if so, how the rate should be calculated, what the rate should be, and whether the minimum participation rate should be established in Federal regulation. 76 FR 41887.

New York's employers purchasing coverage in the small employer market must currently satisfy a minimum participation requirement of at least 50%. Given minimum participation standards in the small employer market vary by state, the introduction of a national standard would be disruptive. The regulations should allow the state to establish minimum participation rules for the Exchange. State flexibility will ensure consistency with minimum participation standards in the outside market and avoid adverse selection and market disruptions associated with inconsistent requirements.

If the regulations do proceed to establish minimum participation rules, they should be as flexible as possible to foster access to coverage without encouraging anti-selection against the Exchange or the outside market. Minimum participation standards must be calculated across carriers, by the Exchange, to allow employees of a single employer to be counted towards satisfaction of the participation standard without regard to which carrier they have selected. Additionally, if an employee has another source of coverage in place, that coverage should be counted towards satisfying any minimum participation requirement.

Part 155, Subpart H, Eligibility Standards for SHOP (§ 155.710): Under subsection (b)(1) to be considered a qualified employer for SHOP an employer must meet the definition of a small employer. To determine employer size, the preamble proposes to adopt the standard used in the PHS Act to determine employer size. This method counts full-time and part-time employees in the same manner and seasonal workers proportionately to the number of days worked. The

preamble invites comments on this approach, noting that states use a variety of methods to determine employer size and eligibility in the small group market, which may offer more specificity. 76 FR 41887 – 41888.

The regulations should defer to state law and regulations for the formation of employer groups. Failure to do so will result in unnecessary complexity with different employer group requirements inside and outside the Exchange. It may also result in adverse selection issues.

Part 155, Subpart H, Eligibility Determination Process for SHOP (§ 155.715): We recommend that states have the flexibility to establish policies regarding the "reason to doubt" standard. It would, however, be helpful if HHS provided examples of what may constitute "reason to doubt" without proscribing a particular policy to implement.

Part 155, Subpart H, Enrollment of Employees into QHPs under SHOP (§ 155.720): Subsection (g) proposes to require at a minimum monthly reconciliations by the SHOP of enrollment information and employer participation information with QHPs. The preamble seeks comments on whether HHS should set target dates or guidelines so that multi-state qualified employers are subject to consistent rules. 76 FR 41889.

The regulation should allow for state flexibility to require reporting as necessary to oversee the operations of the Exchange. Multi-state qualified employer trusts should be subject to state reporting requirements.

Part 155, Subpart H, Enrollment Periods under SHOP (§ 155.725): The regulations should allow states to establish open enrollment periods as it sees fit. Failure to do so may result in adverse selection and unbalanced markets inside and outside the Exchange. At a minimum, the regulations should allow for a special enrollment period in the event the employer reduces their contribution towards coverage so that the employee can switch to coverage they can afford.

Part 155, Subpart K, Certification Process for QHPs (§ 155.1010): Under subsection (b), multi-state plans are exempt from an Exchange's certification process and deemed as meeting the certification process for a QHP. While the preamble states that this subsection proposes to codify ACA 1334(d), it fails to address the requirement under 1334(b)(2) that multi-state plans must be licensed in each State and that they are subject to State law including standards and requirements that a State imposes that are not inconsistent with this title. 76 FR 41892. ACA 1334(b)(2) recognizes that insurance markets differ across the States and that States must be able to ensure that all QHPs in the State's Exchange are required to meet the same standards. Not addressing these State requirements could result in multi-state plans obtaining an

unintended advantage in Exchange markets which could be competitively harmful to regional carriers that do not offer multi-state plans.

Multi-state plans must be subject to the same rules that apply to all domestic companies. For example, multi-state plans should be certified separately by each exchange in which they operate. Multi-state plans should also be subject to any and all fees and assessments that apply to other companies. Further, multi-state plans should be subject to the rate review and solvency requirements of the individual states.

New York supports the concerns expressed in the attached letter from the National Association of Insurance Commissioners regarding the enormous potential for multi-state plans to pre-empt state laws providing important consumer protections; create an unlevel playing field; cause risk selection, increase the risk of insolvencies and cause consumer confusion.

Part 155, Subpart K, QHP Issuer Rate and Benefit Information (§ 155.1020): The proposed rule requests comment regarding the best way to implement requirements for state review and disclosure of potentially unreasonable rate increases and the requirement that QHPs must submit justifications of all premium increases to the Exchange and publish them on-line. States should be provided with necessary flexibility to implement these requirements in a manner that avoids duplication in efforts between the Exchange and state departments of insurance, which typically review rate increases. New York has extensive requirements in place regarding the review, approval, notice and disclosure of premium rate increases prior to implementation. New York anticipates using this existing process for rate increases within the Exchange.

Part 155, Subpart K, Establishment of Exchange Network Adequacy Standards (§ 155.1050): This section seeks to codify ACA 1311(c)(1)(B) by requiring an Exchange to ensure that the provider network of each QHP has sufficient choice of providers for enrollees. The preamble acknowledges that network adequacy standards should be appropriate to States' particular geography, demographics, local patterns of care and market conditions. It also notes that the standard provides Exchanges with flexibility to leverage existing State oversight and enforcement mechanisms. Comments are requested on minimum standards for the Exchange to use in evaluating network capacity and on a proposed additional requirement that Exchanges set standards that QHPs would be required to meet. 76 FR 41893 – 41894. We appreciate the flexibility afforded in the rule and agree that network adequacy standards should be State specific. In addition, the network adequacy standards for QHPs in the Exchange should be aligned with existing standards in the State. It will be important for States to ensure that consumers have access to a range of services including but not limited to pediatrics, ob/gyn, family planning, primary care, and a broad range of specialists.

Part 155, Subpart K, Stand-Alone Dental Plans (§ 155.1065): HHS seeks comment on whether dental plans should be priced separately from medical coverage, even when offered by the same issuer. New York supports transparency in this regard, and believes that separately identifying the premium will greatly assist consumers in making informed purchasing decisions. Masking the price of dental coverage when sold with medical coverage does not serve the intent of the PPACA to increase transparency. Given that several dental plans will likely be offered through the Exchange, full disclosure of premium will enable consumers to fully compare purchasing coverage on a combined basis, or separately. In response to HHS's concerns of added administrative burdens, we note that there would be little, if any, additional administrative tasks required in this regard. We support separate pricing.

Part 155, Subpart K, Recertification of QHPs (§ 155.1075): We appreciate the flexibility afforded an Exchange under the proposed rule to develop a recertification process. Since the needs of an Exchange will vary based on its market, it is necessary that the certification and recertification processes are structured to ensure that standards are maintained. In developing a recertification process the Exchange will need to assess how active the process must be based the ongoing reporting from and evaluation of QHPs. The level of communication with QHPs, consumer satisfaction and administrative resources for the Exchange will also inform decisions about the frequency of the process.

Part 156, Subpart A, QHP Issuer Participation Standards (§ 156.200): New York seeks guidance as to how the required child-only plans are to be rated within the Exchange. Specifically, PPACA requires a single risk pool for all coverage written by an issuer in the individual market (inside and outside of the Exchange). Additionally, PPACA limits age rating no more than a band of 3 to 1, but allows states to further limit rate bands. Our interpretation of Section 156.200(c)(2) is that for every plan that is required to be offered under Section 156.200(c)(1), a separate corresponding child-only plan must also be offered. Each such child-only plan must provide the same level of benefits as the Section 156.200(c)(1) plan to which it corresponds. Section 156.200(c)(3) further requires that the premium for a given plan must be the same whether that plan is sold inside or outside of the Exchange. New York requires community rating which would result in child only plans having the same level of benefits as well as the same premium as an equivalent plan sold to an individual that is age 21 or older. New York seeks guidance as to whether or not this is what was intended.

Part 156, Subpart A, Transparency in Coverage (§ 156.220): The preamble to subsection (b) seeks comment on whether QHP issuers should “submit” or “make available” cost-sharing information to the Exchange, HHS and the State Insurance Commissioner. 76 FR 41897 – 41898. Since this is necessary for obtaining and maintaining certification a QHP, issuers should be required to submit this information.

Part 156, Subpart A, Marketing of QHPs (§ 156.225): Preamble to subsection (b) seeks comment on: 1) the best means for an Exchange to monitor QHP issuers' marketing practices to determine whether they have discouraged enrollment of individuals with significant health needs; 2) applying a broad prohibition against unfair or deceptive marketing practices by all QHP issuers and their officials, agents and representatives; and 3) a standard that QHP issuers do not misrepresent the benefits, advantages, conditions, exclusions, limitations or terms of a QHP. 76 FR 41898. We recommend State flexibility in adopting procedures for discriminatory marketing practices. New York has experience with this in Medicaid Managed Care and CHIP.

Part 156, Subpart A, Essential Community Providers (§ 156.235): This rule proposes to codify ACA 1311(c)(1)(C) which requires the inclusion of essential community providers, where available, that serve predominantly low-income, medically underserved individuals in health plan networks as part of the certification process for qualified health plans. Subsection (a) of the proposed regulation adds "sufficient number" to the requirement including essential community providers and the preamble to subsection (a) seeks comments on how "sufficient number" should be defined. 76 FR 41899. Subsection (b) includes providers described in 340B(a)(4) of the Public Health Service Act and providers described in section 1927(c)(1)(D)(i)(IV) of the Social Security Act as essential community providers. The preamble to this section seeks comment on the extent to which other similar types of providers should be included in the definition. 76 FR 41899. States should have flexibility in the accreditation process to ensure that QHPs have providers in network that reflect commitment to providing high quality affordable health care services. We request additional guidance on what constitutes an essential community provider and how this standard relates to network adequacy. For example, we are concerned that without adequate numbers of ob/gyns in QHP networks, consumers purchasing through the exchange could experience waiting periods for these services.

Part 156, Subpart A, Termination of Coverage for Qualified Individuals (§ 156.270): PPACA provides individuals that qualify for a tax credit with a 90 day grace period for payment of premiums. The rule provides that the enrollee should have the benefit of this grace period if they have paid at least one month's premium. The rule further provides that issuers must pay all appropriate claims during the grace period. QHPs may terminate the coverage of those who fail to make "any" payment during the grace period "at the end of the grace period".

We seek clarification that the issuer is to provide full coverage to the enrollee during the full 90 day grace period. We further seek clarification that the termination of those that do not pay in full during the grace period is to be a prospective termination. We seek clarification that the issuer is not expected to recoup payments made to providers during the 90 day grace period and that the insurer should rather treat such losses as bad debt to be accounted for during the rate setting process.

Additionally, the preamble seems to be inconsistent with the rule. The preamble describes that unless "all" or full payment is made by the end of the grace period, the termination should be effectuated. Subsection (f) of the rule provides that an enrollee receiving advance payments would be terminated if they reach the end of the grace period without submitting "any" premium payment. Given the length of the grace, the fact that issuers will in some cases be at risk for a substantial share of the premium over and above what is paid by the federal government, and the fact that the cost for enrollees that fail to pay premiums will likely impact the cost of premiums for others in the market, we think the rule in the preamble is most appropriate. Most importantly, the rule should be clarified.

Part 156, Subpart A, Segregation of Abortion Funds (§ 156.280): The regulations should not be any more burdensome to insurers and consumers than is required under the ACA. With respect to the requirement for separate payments to be made for coverage for abortion services, New York would encourage administrative simplification for the health care consumer wherever possible. Simplification would be furthered by an interpretation of "separate payments" that allows consumers to make multiple payments with a single instrument – a single credit card charge, electronic transfer, check or withdrawal which insurers would deposit into segregated accounts. Transparency, in the form of a billing statement which details the separate payments and deposits, can be required. Coverage is best fostered by ensuring a good customer experience through the Exchange.

We also urge OMB and HHS to clarify that the requirement to make separate payments applies only to individuals who receive federal subsidies.

Part 156, Additional Standards specific to the SHOP (§ 156.285): In subsection (a)(2) , it appears that the reference to section 155.705(b)(5) should instead be 155.705(b)(6).