October 31, 2011

***Submitted Via Federal Rulemaking Portal: http://www.regulations.gov***

Office of Consumer Information and Insurance Oversight
Department of Health and Human Services
Room 445-G
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Attn: CMS-9989-P

***RE: Establishment of Exchanges and Qualified Health Plans; Proposed Rule***

To Whom It May Concern:

The U.S. Chamber of Commerce (the "Chamber") submits these comments in response to the Proposed Rule regarding the Establishment of Exchanges and Qualified Health Plans of the Patient Protection and Affordable Care Act ("Proposed Rule"), which was published in the Federal Register on July 15, 2011.[1] The Proposed Rule offers an implementation plan for the new "American Health Benefit Exchanges" ("Exchanges") required by Title I, Subtitle D of the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act ("PPACA"). This Proposed Rule was published by the Department of Health and Human Services ("the Department" or "HHS").

The Chamber is the world's largest business federation, representing the interests of more than three million businesses and organizations of every size, sector and region, with substantial membership in all 50 states. More than 96 percent of the Chamber's members are small businesses with 100 or fewer employees, 70 percent of which have 10 or fewer employees. Yet, virtually all of the nation's largest companies are also active members. Therefore, we are particularly cognizant of the problems of smaller businesses, as well as issues facing the business community at large. Besides representing a cross-section of the American business community in terms of number of employees, the Chamber represents a wide management spectrum by type of business and location. Each major classification of American business -- manufacturing, retailing, services, construction, wholesaling, and finance – is represented. Also, the Chamber

[1] Establishment of Exchanges and Qualified Health Plans; Proposed Rule, 76 Fed. Reg. 41,866-41,927 (July 15, 2011) (to be codified at 45 C.F.R. pts. 155 and 156) [hereinafter referred to as "Proposed Rule"].

has substantial membership in all 50 states. These comments have been developed with the input of member companies with an interest in improving the health care system.

## OVERVIEW

The Chamber and our member companies want quality health care to be readily available at an affordable price, a central goal of PPACA. The Chamber has long advocated for transparency of price, quality and information. We remain hopeful that state-based Exchanges will give Americans more access to affordable coverage options and make price and quality information readily available to them so that they can make optimal choices. Our comments include general thematic recommendations, comments on the economic impact analysis and specific responses to particular sections of the Proposed Rule.

## GENERAL RECOMMENDATIONS

We urge the Department to consider several general premises as it moves forward in promulgating regulations to guide states in creating Exchanges and insurers in developing qualified health plans ("QHPs"). We urge the Department to be apolitical, pragmatic, and permissive, to promulgate Exchange rules that give states substantial flexibility, and to issue guidance as promptly as possible, given the exceedingly short timeframe that states have to create Exchanges, and that health insurance issuers have to develop QHPs. Finally, we strongly recommend that the Department encourage participation which will expand consumer choice by allowing all plans that qualify to participate in the Exchanges.

### 1. "SPIN"

With the current politically charged environment and the very partisan views and opinions of the law, implementation of PPACA continues to be controversial. Despite what those that oppose the health law purport, state-based exchanges are not inherently bad merely because they are included as a part of PPACA. Similarly, although Exchanges hold great potential, they will not function in a vacuum - insurance and economic principles and dynamics will continue to affect these marketplaces. We urge the Department, as well as others charged with promulgating regulations to implement the law, to leave the spin to the politicians and issue guidance that is factual, correct, neutral and unbiased. The Proposed Rule is far too political.

#### *Exchanges Are Not Inherently Bad*

While many who oppose PPACA equate state-based Exchanges with the enactment of what they view to be a flawed and problematic law, the truth is that two states created similar exchange marketplaces *prior* to the law's enactment. While the Chamber opposed the passage of PPACA because significant elements will fundamentally harm businesses, we do continue to be cautiously optimistic that state-based Exchanges may create new coverage options and strengthen the individual and small group markets. Therefore, as we have in the past, we continue to advocate in favor of the potential these new insurance marketplaces may have to improve choice, facilitate transparency and ideally strengthen the individual and small group insurance markets. However, much remains to be determined with regard to how these

Exchanges will function and whether these marketplaces will even succeed. We are mindful that whether these Exchanges augment the current marketplace or become "inherently bad" will depend on how regulations to implement the statute are promulgated.

***Exchanges Are Not a Panacea***

Similarly, it is important not to oversell the possible success of the state-based Exchanges established under PPACA. Frequently, Administration Officials assert that in purchasing a plan through the Exchange, the enrollee will become part of one, vastly large risk pool. This is not true. In fact, the statute itself contradicts this assertion in two ways:

1. An enrollee is not required to purchase coverage through the Exchange to become part of this larger risk pool;[2] and

2. There is not <u>one</u> risk pool. The pools are bifurcated by market (individual vs. small group)[3] and by issuer (Aetna vs. Cigna).[4]

Specifically, section 1312(c)(1) of PPACA provides that all individuals in the individual market are treated as a single risk pool, regardless of whether coverage is offered inside *or* outside the Exchange. Similarly, section 1312(c)(2) provides that all employees of small employers are also treated as a single risk pool regardless of where coverage is obtained. In addition, the statute clearly indicates that the risk pools in each market will be segmented by the issuer offering plans in which individuals or employees are enrolled. In other words, individuals that purchase plans offered by Aetna in the individual market – whether inside or outside the Exchange and regardless of the type of plan purchased (bronze, silver, gold or platinum) – will be pooled together. The same is true is the small group market.

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[2] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1312(c)(1) and (2), 124 Stat. 119 (2010).
§1312(c)(1)"Individual Market - A health insurance issuer shall consider all enrolless in all health plans (other than grandfathered health plans) offered by such issuer in the individual market, <u>*including those enrollees who do not enroll in such plans through the Exchange*</u>, to be members of a single risk pool."
§1312(c)(2) "Small Group Market – A health insurance issuer shall consider all enrollees in all health plans (other than grandfathered health plans) offered by such issuer in the small group market, <u>*including those enrollees who do not enroll in such plans through the Exchange,*</u> to be members of a single risk pool."

[3] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1312(c)(1) and (2), 124 Stat. 119 (2010).
§1312(c)(1)"Individual Market - A health insurance issuer shall consider all enrolless in all health plans (other than grandfathered health plans) offered by such issuer <u>*in the individual market*</u>, including those enrollees who do not enroll in such plans through the Exchange, to be members of a single risk pool."
§1312(c)(2) "Small Group Market – A health insurance issuer shall consider all enrollees in all health plans (other than grandfathered health plans) offered by such issuer <u>*in the small group market*</u>, including those enrollees who do not enroll in such plans through the Exchange, to be members of a single risk pool."

[4] P L. No. 111-148, § 1312(c)(1) and (2). §1312(c)(1): "Individual Market - A health insurance <u>*issuer shall consider all enrolless*</u> <u>*in all health plans*</u> (other than grandfathered health plans) <u>*offered by such issuer in the individual market*</u>, including those enrollees who do not enroll in such plans through the Exchange, <u>*to be members of a single risk pool*</u>."
§1312(c)(2) "Small Group Market – A health insurance <u>*issuer shall consider all enrollees in all health plans (other than grandfathered health plans) offered by such issuer in the small group market*</u>, including those enrollees who do not enroll in such plans through the Exchange, <u>*to be members of a single risk pool*</u>."

We urge our partners in the Department and the Administration to be precise and factually accurate when describing the Exchanges. In order to avoid alienating potential partners with a variety of political opinions, it is important to avoid slanting the facts with "spin" and inaccurate assertions.

***Spin in the Proposed Rule***

To our dismay, the Proposed Rule's Executive Summary reads like a sales pitch. While the Chamber also hopes that Exchanges will improve choice and enhance competition, it seems a stretch to assert with any credibility at this point that, for example, the Exchanges will in-fact "give small businesses the same purchasing clout as large businesses."

To successfully inform and solicit constructive and appropriate feedback from health insurance issuers, states, employers and individuals (all of whom will have varying opinions of the law), we urge the Department to separate emotion and aspiration when promulgating regulations.

Typically, regulations begin with a summary that is intended to explain the purpose for promulgating the regulatory material. Oftentimes, this summary includes quotes from statutory provisions, including definitions contained in the law. We find it curious that in the very first sentence of this Proposed Rule the Department states, "The Proposed Rule would implement the new ***Affordable Insurance Exchanges ('Exchanges')***."[5] The term, "Affordable Insurance Exchanges" is never used in the statute. The law instead refers to "American Health Benefit Exchanges."[6] In capitalizing the phrase, the Proposed Rule insinuates that "Affordable Insurance Exchanges" is in-fact a statutory term or definition. While the Chamber certainly hopes that – as the statute states – there will be "affordable choices of health benefit plans"[7] offered in the Exchanges, and that in implementing Exchanges, insurance will be more affordable, we find the use of this new phrase in the regulatory context unusual and inappropriate.

The Executive Summary continues to use phrases that state "hope" as "fact" and use the fabricated term "Affordable Insurance Exchanges" as a statutory definition, beginning with the sentence: "Starting in 2014, individuals and businesses will be able to purchase private health insurance through State-based competitive marketplaces called Affordable Insurance Exchanges or 'Exchanges'."[8] The Executive Summary goes on to state <u>*as fact*</u> that, "Exchanges will offer Americans competition, choice and clout;" that "consumers will have a choice of health plans to fit their needs; " and that "Exchanges will give individuals and small businesses the same purchasing clout as big businesses."[9] These may be the goal of PPACA's Exchange requirements, but it is by no means clear that those goals will be achieved.

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[5] Proposed Rule, 76 Fed. Reg. at 41,866.
[6] P.L. No. 111-148, § 1311(a), (b).
[7] P.L. No. 111-148, § 1311.
[8] Proposed Rule, 76 Fed. Reg. at 41,866.
[9] Proposed Rule, 76 Fed. Reg. at 41,866.

While the Chamber hopes that Exchanges will offer competition and choice, whether they do or not will depend on how successful the state-based Exchanges are and how many plans are offered through these new marketplaces. Further, whether consumers will have a choice of plans to "fit their needs" will depend on how a QHP – which must cover the "essential health benefits" – is structured. In fact, we remain exceedingly concerned that a comprehensive and elaborate "essential health benefit package" will leave consumers will *no* plans that "fit their needs." In trying to protect consumers by mandating that all small group and individual plans cover excessive benefit packages, our fear is that the law and its implementing regulations will offer consumers no-choices, but instead, an array of fully-loaded plans that they cannot afford.

## 2. FLEXIBILITY VERSUS CLARITY

While the primary functions and many criteria and requirements for the establishment of the Exchange are defined by Subtitle D under Title I of the PPACA,[10] much of the framework remains yet to be determined. According to the Department, "the Proposed Rule: (1) sets forth the federal requirements that states must meet if they elect to establish and operate an Exchange; (2) outlines minimum requirements that health insurance issuers must meet to participate in an Exchange and offer QHPs; and (3) provides basic standards that employers must meet to participate in the Small Business Health Options Program (SHOP)."[11] However, many questions remain for health insurance issuers, states, employers and individuals who are desperate for clarity.

The Chamber appreciates and supports "the intent… to afford States substantial discretion in the design and operation of an Exchange."[12] We recognize the inherent tension between affording states flexibility and providing the much needed clarity for those entities that will serve and be served by the Exchange. This tension may be eased with an acknowledgement or statement that federal review of the state-based Exchange will be permissive, as opposed to prescriptive.

As the Department articulates that it intends to afford state discretion, this intent can be confirmed by revising the role given to HHS. Rather than requiring states to get approval from HHS and requiring plans to be certified as QHPs by the Secretary, the Department should demonstrate its intent to afford states flexibility by moving the burden of proof from the states to the Department. Specifically, instead of requiring states to demonstrate to HHS that the state's Exchange meets certain standards set forth under the law, states should be presumed to meet these standards unless the Secretary or the Department can demonstrate that the state is not complying with the statute. In other words, we encourage the Department to take a revised approach which ***presumes*** that state-based Exchanges comply with the requirements of the statute, instead of requiring states to get approval by HHS.

We appreciate that in some instances the statute requires the Secretary to act – as it does in section 1321(c)(1)(B) where it directs the Secretary to determine, on or before January 1, 2013, whether, for example, a State's Exchange will be fully operational by January 1, 2014. However

[10] P.L. No. 111-148, Title I Subtitle D.

[11] Proposed Rule, 76 Fed. Reg. at41,867.

[12] Proposed Rule, 76 Fed. Reg. at 41,867.

in other instances, the statute is less prescriptive. For example, while the statute requires the Secretary to set standards for meeting the requirements to set up an Exchange,[13] the statute does not require the Secretary to approve or certify that the state-based Exchange meets these standards. Therefore, as with state-based exchanges established prior to the enactment of PPACA, we urge the Secretary to ***presume*** that states meet the standards for establishing a state-based Exchange created under the new law. Only in instances where the Secretary or HHS can demonstrate that the state is not meeting the statutory standards should the Secretary intervene.

### 3. TIMELINE CRUNCH

States currently working to establish a state-based Exchange face many constraints. First, the political uncertainty surrounding PPACA and the prevailing politics in a state may be difficult to navigate. In addition, while HHS has provided many states with multi-million dollar grants, a significant number of states have budget constraints with regard to outsourcing functions/operations and maintaining fiscal sustainability come 2015 and beyond. Moreover, some states are finding that PPACA will have an adverse impact on its health insurance markets, thereby calling into question how they will be able to implement the law. The most significant constraint, however, is time. While the Chamber understands that the Department did not set the arbitrary deadlines that states are facing when it comes to establishing an Exchange – Congress did. We urge the Department to recognize that many states will not be able to meet the deadlines set forth in the statute. In this case, we request that the Department fashion rules that allow states to continue their work toward establishing their Exchange with minimal or no Federal intervention, even if the statutory deadlines are not met.

### 4. PERMIT ALL QUALIFYING PLANS TO PARTICIPATE IN THE EXCHANGES

In order to maximize the offerings of affordable coverage, we urge the Department to permit any health plan satisfying the statutory requirements for participating in the state-based Exchange marketplace, to offer coverage through the Exchange. The statute already includes many requirements that plans must satisfy to be eligible to participate in the Exchange. For example, a plan must include the "essential health benefits package"[14] which requires plans to (1) cover the "essential health benefits,"[15] (2) limit the cost-sharing under the plan,[16] and (3) provide for specified "levels of coverage."[17] The Secretary also must establish additional criteria for the certification of QHPs which will require, at a minimum, that plans conform to marketing, quality improvement, and quality performance measures.[18] Given the statutorily mandated requirements already in place, we urge the Department to permit any plan that qualifies to participate in the Exchange. We believe that this will improve competition and result in greater options for individuals.

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[13] P.L. No. 111-148 §1321(a).
[14] P.L. No. 111-148 §1302(a).
[15] P.L. No. 111-148 §1302(b).
[16] P.L. No. 111-148 §1302(c).
[17] P.L. No. 111-148 §1302 (d).
[18] P.L. No. 111-148 §1311 (c).

## ECONOMIC ANALYSIS

### ICR: RECORDKEEPING AND REPORTING REQUIREMENT BURDEN

The Department's proposal includes a total of 38 distinct recordkeeping and reporting requirements (also known as Information Collection Requirements (ICR)) with which state-based Exchanges and issuers of QHPs must comply. For each of these requirements, the Paperwork Reduction Act requires the Department to estimate the annual recordkeeping and reporting burden imposed in terms of labor hours and in terms of dollars based on the cost per hour of each category of labor required. The Act also requires the Department to include estimates of any additional costs for equipment, software, recordkeeping systems and materials otherwise required to comply with the requirements.

However, it seems that the Department's estimates of the labor time required to comply with each reporting requirement per Exchange or per QHP are uniformly not based on any empirical evidence or reasoned analysis. In every case, the Department's estimates appear to be no more than arbitrary numbers without any source or basis cited. In a number of cases, the Department justifies its presumptions about labor hour requirements by referring to estimates that the Department published previously for the recordkeeping and reporting time burdens for the Medicare Part D rule. However, examination of the record for those estimates reveals that those estimates too were arbitrary and not based on any empirical evidence or reasoned analysis.

Rather than recycling the unfounded estimates from the Medicare Part D rulemaking for the present analysis, the Department could have readily provided the public with a reasoned and empirical basis for estimating these reporting and recordkeeping burdens by conducting a survey of states and other parties affected by the Medicare Part D requirements to learn from their practical experience as to how much time was needed to produce the various records and reports required. Also, the Department could have surveyed or interviewed knowledgeable state officials and health insurance issuers to ask them to estimate the time that would be required to accomplish the various recordkeeping and reporting tasks described in this Proposed Rule. There is no evidence that the Department applied to the Office of Management and Budget (OMB) for clearance to conduct such surveys, and even without OMB clearance, the Department could have questioned up to nine qualified informants on each issue. The fact that the Department apparently made no effort to compile information based on real-world experience evidences a gross disregard for information quality and for the public's right to know the true burdens that the Federal government proposes to impose on states and the private sector. An accurate understanding of the true costs of these recordkeeping and reporting burdens is essential to gauge the impact of the program on health care costs, in general, and on the cost burdens that small businesses and individuals will bear under the program, specifically. This is even more critical given that the costs that these recordkeeping and reporting requirements will directly imposed on state Exchanges and on QHP issuers will ultimately be borne by small businesses and individuals who purchase health care plans through the Exchanges.

The Department's discussion of the various recordkeeping and reporting requirements shows a total ignorance of the most fundamental realities and operating principles of the organizations on

which these burdens are being imposed. For example, the first item discussed by the Department, the requirement that states develop and submit to the Department a proposed Exchange establishment and operations plan, is described as follows: "We estimate that it will take a state approximately 160 hours (approximately one month) for the time and effort needed to develop the plan and submit to HHS." This estimate fails to recognize the complexity of the decisions that states will need to make to choose among the many options and alternatives for Exchange structure and operations – a complexity that arises from the selfsame rule that is being proposed by the Department. The Department also fails to recognize the multiple layers of collaboration, deliberation and review of a plan that will be required within each state government bureaucracy before a plan can be approved for submission to HHS. The importance of the plan is of such high order that final review and approval by the governor is a reasonable expectation. It is inconceivable that 160 hours could account for the time of all of the officials who will be involved in the process. The Department needs only to look within its own bureaucracy and experience to see that this estimate is unrealistic. Perhaps, HHS should consider how many labor hours it took to develop and draft this Proposed Rule.

The Department even reveals some awareness of the inadequacy of its estimate by its statement that "We estimate minimal burden requirements for developing the Exchange plan, as states will be gathering most of the information needed for the plan through the planning grants provided by HHS." This too is an inadequate rationale because nowhere in its analysis does HHS examine in detail the amounts and purposes of those grants or analyze on a reasoned basis how much or little of the full planning and development labor effort the grants will cover. The Department is asserting here that the grants will cover all but 160 labor hours of the need, but that assertion is without any empirical evidence or reasoned analysis to support it. Given the diverse populations, geography and other characteristics of states, it is not reasonable to assume that costs associated with establishment of Exchanges will be the same for every state. At a minimum, the Department should present an itemized analysis for each state, comparing the grant amounts for which each state is eligible to the costs of planning, designing and establishing an Exchange that each state will reasonably be expected to face.

The second item analyzed by the Department, the requirement that states develop and disseminate to the public Exchange governance principles, similarly reveals a lack of understanding by the Department of the complexities of the tasks that have been assigned to the states and the extent of bureaucratic and official oversight and review involved in accomplishing these tasks. The Department estimates that the entire task of developing governing principles and disclosing them to the public will require a total of 40 labor hours. Considering that a single four hour meeting of 10 cognizant state officials and staff to initiate a discussion of the alternatives for formulating Exchange governing principles would consume the entire 40 labor hours budgeted by the Department for this task, it is obvious that the time and cost has been grossly underestimated by the Department. We recommend that the Department interview a sample of state officials who will likely be involved in this process to develop a more realistic and reasoned estimate for this item.

Throughout the Department's analysis, recordkeeping and reporting time and cost burdens are computed on a per Exchange basis. The Department determines total national time and cost

burdens by multiplying the per Exchange costs by 51 (50 states plus the District of Columbia). The Department mischaracterizes the results as an "upper bound" on the burden by assuming that burden would be avoided in the event that some states elect not to establish Exchanges. This is an erroneous assumption because the statute provides that in the event that a state declines to establish an Exchange, the Federal government will proceed to establish an Exchange. Whether the Exchange is established by the state or by the Federal government, the Exchange will still have to comply with the designated recordkeeping and reporting requirements. The burden of those requirements will be financed through fees paid to the Exchange by health insurance issuers and others and will ultimately impact the small businesses and individuals who use the Exchange through their premium costs. Rather than being an upper bound, the total burden calculated by multiplying the per Exchange costs by 51 is a lower bound. Because states will have the option to establish more than one Exchange (a large state may choose to establish regionally based Exchanges, for example) the total number of Exchanges established may greatly exceed 51. Since many of the recordkeeping and reporting cost elements are independent of the size of the Exchange in terms of number of clients served, establishment of multiple Exchanges will result in a higher multiplier to compute total time and cost burden.

Examination of every one of the Department's estimations of time and cost for information collection and reporting associated with the establishment and operation of Exchanges reveals similar naïve under-estimates of the likely time and cost burdens. Nowhere is there any analysis to show that the grants being offered to states will adequately cover the initial costs. Even if initial costs are partially covered by the Federal planning grants, the on-going costs of operating the Exchanges and of fulfilling the Federal reporting and recordkeeping mandates for Exchanges will create a burden that Exchanges must finance from fees charged to insurers or others.

It is important that the Department take its responsibility to estimate these costs seriously because these impacts may significantly impact the overall balance of costs and benefits that the program is able to achieve. The estimated costs reported by the Department total 1.1 million labor hours per year and $61 million per year in labor costs.[19] The time and cost parameters presented by the Department in the proposal are so clearly below credible levels, that it is reasonable to predict that the true burden could easily exceed three to five times those estimates. Rather than naively, and incorrectly, guessing at key time and cost parameters, the Department should conduct surveys, interviews with cognizant state officials and private insurers, and examine the actual experience data from previous similar efforts. Careful and serious research to gather real data will enable the Department to provide estimates of time and cost burdens that will be useful for its own policy decision-making and that will provide a sound basis for the affected public to gauge the expected costs and other economic impacts of the program.

## REGULATORY IMPACT ANALYSIS

The recordkeeping and reporting cost burden discussed above is only one element of the total economic costs of the proposed standards for establishment and operations of state health insurance Exchanges. The Department listed a monetized estimate of the total annualized costs

[19] Proposed Rule, 46 Fed. Reg. at 41,907.

of $410 million to $424 million per year, including planning and development costs and operating costs of the Exchanges over the 2012 through 2016 period. These costs included the $61 million per year previously discussed in relation to recordkeeping and reporting costs and additional costs of $334 million to $363 million per year to cover the costs of establishing the organizational infrastructure (office space, operational and administrative staff, information technology systems infrastructure, and equipment), as well as other operating costs to the Exchanges themselves and the affected insurance issuers. The Department's Regulatory Impact Analysis document makes it clear that the monetized estimate is only a fraction of the likely full costs. Understandably, the Department is unable to estimate many cost elements with precision because the actual costs incurred will depend on unknown factors, such as the number of insurance issuers and the number of small businesses and individuals who choose to use the Exchanges. The actual costs will also vary depending on the particular mix of alternative Exchange design elements that states choose to implement. The Department has chosen the more flexible of the two regulatory alternatives considered in order to promote innovation and testing of alternative approaches by states. This strategy may yield benefits in the future by promoting discovery and development of efficient and economical approaches, but it makes it difficult to forecast what the actual cost experience may be.

Given the uncertainty surrounding the Department's forecasts of the costs of establishing and operating Exchanges, it is all the more important that the Department include in its proposal a plan to collect and compile data and other information contemporaneously during the development and initial operations of the Exchanges. This will facilitate a thorough evaluation in the future to determine conclusively what the experience has been in terms of both costs and benefits. This critical element has been omitted by the Department in the present proposal.

The evaluation plan should be designed to enable researchers to compare the costs and benefits associated with different Exchange models, based on the variety of alternative options that states adopt. To ensure a meaningful evaluation of costs and benefits can be accomplished, provisions should be included in the proposed regulation for the measurement and collection of data items that will be needed to gauge program performance and to compare costs and benefits. Many of the needed data items may already be implicitly identified in the recordkeeping and reporting requirements embedded in the proposed regulation.

We encourage the Department to carefully consider the needs of a future program's evaluation cost and benefit analysis before issuing a final rule and to validate that all needed data items have been included in the recordkeeping and reporting requirements. In the future, a thorough and fact-based evaluation will help Exchanges and insurance issuers to identify the optimal operational design elements for their circumstances and to learn from the best practices of others. This factual resource could promote continuous quality and efficiency improvement as the program evolves and matures.

**UNFUNDED MANDATES**

The current threshold for the categorizing a Proposed Rule as a "major" rule under the Unfunded Mandates Act is currently $136 million in annual costs to states, localities, tribes or private

entities. Even by the Department's admittedly low estimate of $410 million to $424 million in annualized cost, that threshold is exceeded. However, the Department claims that the Unfunded Mandate Act is not applicable because no state is required to establish an Exchange.[20] Counter to this, it can be argued that because the Federal government will step in to establish an Exchange if a state does not, and because the Exchange, whether established by the state or the Federal government, is required to cover its operating costs (including recordkeeping and reporting costs) from fees collected from insurance issuers or other users of the Exchange, then regardless of who establishes the Exchange, the standards, options and requirements defined by this rule will result in an annual cost of at least $410 million (based on the Department's own calculations) per year on the private sector (insurance issuers, small businesses, and individual insurance purchasers) and likely more. Therefore, the Unfunded Mandates Act does in fact apply.

## SPECIFIC RECOMMENDATIONS

Many of the specific recommendations provide discrete examples of ways the Department can adopt our general thematic recommendations and remove political spin from the regulatory process, provide state flexibility and autonomy in creating state-based Exchanges, and consider the tight timeline states are facing. Other specific recommendations are in response to requests in the preamble for comments regarding particular issues.

### 155.20 – Definitions.

In section 155.20 of the Proposed Rule, the Department defines "employer" as having the meaning given to the term in section 2791 of the Public Health Services Act ("PHSA"). PHSA 2791 defines "employer" by cross-referencing the definition of employer under section 3(5) of the Employee Retirement Income Security Act ("ERISA"). Under each law, the term employer refers to at least one *employee*. The Department appears to indicate in the Proposed Rule that sole proprietors and certain owners of S corporations would not be considered an "employee" for purposes of health insurance coverage. This means that sole proprietors and certain owners of S corporations would not be able to purchase small group market coverage through SHOP.

The Chamber believes that this interpretation is contrary to Congressional intent. We believe the reason that Congress amended the definition of employer to include "one employee" was to include a "group of one" in the small group market. In this case, a group of one was intended to include sole proprietors and certain owners of S corporations.

A number of states define their small group market as including sole proprietors and certain owners of S corporations, which is another reason why we believe Congress changed the definition of employer for purposes of determining who may purchase coverage in, for example, the small group market. Therefore, taking the position that sole proprietors and certain owners of S corporations cannot purchase small group market coverage is not only inconsistent with

[20] Proposed Rule, 46 Fed. Re. at 41,910.

Congressional intent, but will create problems for states that already include these groups of one in the state's small group market.

In addition, the Chamber would like to ensure that all definitions addressed in the Proposed Rule promote a level playing field among health plans in the Exchanges. To meet this end, HHS should clarify that section 1301(b) of PPACA only applies to the term "health plan" for purposes of PPACA's definition of a "qualified health plan," as that term is defined under section 1301(a) of the statute. Further, the Department should clarify that section 1301 of PPACA does not exempt multiple employer welfare agreements ("MEWAs") from the otherwise applicable insurance market reforms. Section 1301(b) does not exempt MEWAs from the Public Health Service Act's ("PHSA's") definition of "group health plan," nor does it alter the PHSA's definition of "health insurance coverage."

We also ask HHS to clarify that Taft-Hartley and church plans are not eligible to offer coverage on an Exchange, given that they are not health insurance issuers and would be unable to comply with PPACA's guaranteed issue requirements.

**155.105 – Approval of a state Exchange.**

Section 155.105(d) of the Proposed Rule outlines the state Exchange approval process. We support the conditional approval designation and process and believe that it will help states that are struggling with the short timeframes to create Exchanges. However, the Chamber is concerned about the review process under consideration, as indicated in the preamble, which would give HHS 90 days to review the plan for either approval or denial, or request for comment, and another subsequent 90 day period to assess additional information.[21] The Chamber recommends that this timeframe be shortened to 45 days to allow states to comply given the tight timeline.

Section 155.105(e) requires states to notify HHS in writing before making a significant change to its Exchange plan and dictates that no such significant change may be effective until it is approved by HHS in writing. The Chamber believes that this arbitrary rule not only limits state flexibility unnecessarily, but the examples given of "significant changes" are overly prescriptive.[22] The Chamber is concerned that the proposed amendment process will hinder

[21] Proposed Rule, 76 Fed. Reg. at 41,871, providing that, "We also note that we are considering establishment of a review process for the Exchange Plan that is similar to Medicaid and CHIP for which there would be 90 days to review the plan for either approval or denial, or to request comment. If additional information is requested and received from the State, HHS would have 90 days to either approve or disapprove the plan. We seek comments on the appropriateness of this process and timeline."

[22] Proposed Rule, 76 Fed. Reg. at 41,871, providing that, "In paragraph (e), we propose that a State must notify HHS before significant changes are made to the Exchange Plan and that an Exchange must receive written approval of significant changes from HHS before they may be effective. We are considering utilizing the State Plan Amendment process in place for Medicaid and CHIP. We seek comment on this approach. By establishing an ongoing dialogue with each State, HHS will be able to provide technical assistance and support to ensure that each Exchange is operating in compliance with Federal requirements. Significant changes could include altering a key function of the Exchange operations, changing a crucial timeframe for certain functions, or other changes to the Exchange Plan that would have an impact on the operation of the Exchange. While not exhaustive, changes within

states' abilities to respond to challenges in implementing and operationalizing the Exchange. Consistent with earlier comments, we recommend that the approval process not place the burden on states, but instead should place the on HHS. More specifically, we recommend that HHS intervention only be triggered if changes to a state's Exchange plan result in a clear violation of federal law and or regulations.

**155.110 – Entities eligible to carry out Exchange functions.**

(c) Governing board structure

The Proposed Rule states that an Exchange's "overall governing board membership [cannot be] made up of a majority of voting representatives with a conflict of interest, including representatives of health insurance issuers or agents or brokers, or any other individual licensed to sell health insurance."[23] The Chamber appreciates the goal of protecting consumers and of limiting the likelihood that an Exchange board will be governed by people with a conflict of interest. However, there are other entities and individuals who are also likely to be at risk for a potential conflict of interest. We suggest that other categories should be included in this list. Individuals representing unions that operate a Taft-Hartley plan and consumers associated with entities that offer their own health insurance plans should similarly be considered as people at risk for a potential conflict of interest. Additionally, we caution that although protecting consumers is laudable, the success of Exchanges will be predicated on including individuals and entities from the health insurance industry, including agents and brokers who currently work with small businesses and individuals to purchase health insurance.

**155.130 – Stakeholder consultation.**

The Chamber supports the inclusion of the additional groups with whom Exchanges must consult as they establish programs and throughout ongoing operations. It is important to include health care providers, large employers, health insurance issuers and agents and brokers as key stakeholders with whom the Exchange must consult on an on-going basis.

**155.150 – Transition process for existing state health insurance Exchanges.**

We support the general proposal that a state operating an Exchange prior to the year when PPACA was enacted is presumed compliant with the statutory requirements. However, as a policy matter, the Chamber recommends an alternative to the proposed second measure which requires that a state insure a percentage of its population not less than the percentage of the population projected to be covered nationally after the implementation of PPACA. Instead of this requirement, which would work against those states that have higher than average percentages of uninsured, we would propose that the measure be based on the percentage

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this scope could also include changes to: (1) Exchange governance structure, (2) State laws or regulations, (3) IT systems or functionality, (4) the QHP certification process, and (5) the process for enrollment into a QHP."

[23] Proposed Rule, 76 Fed. Reg. at 41,914 (to be codified at 45 C.F.R. pt. 155.110(c)(3).).

improvement (or increase in coverage) the state has seen, compared to the percentage of increased coverage in the country at large.

Also, as noted above, the Chamber believes that the Department should apply the same "presumption of compliance" standard to states currently in the process of establishing a state-based Exchange under PPACA. In other words, only in instances where the Secretary or HHS can demonstrate that a state is not meeting the statutory standards for establishing a state-based Exchange should the Department intervene in the state's establishment process.

**155.160 – Financial support for continued operations.**

The statute states, "in establishing an Exchange, the state shall ensure that such Exchange is self-sustaining beginning on January 1, 2015."[24] Although the statute "allows the Exchange to charge assessments or user fees to participating health insurance issuers, or to otherwise generate funding, to support its operations,"[25] we caution that additional user fees and assessments on issuers will increase the cost of coverage. These fees will be passed on to consumers purchasing the plans that issuers will be offering through the Exchange, just as the law's annual fee on health insurance providers will be passed on to purchasers of insurance in the form of higher premiums. The Congressional Budget Office affirmed this in reviewing the law's proposed language in 2009 stating "new fees…imposed on providers of health insurance… would be largely passed through to consumers in the form of higher premiums."[26] In addition, the Joint Committee on Taxation ("JCT") concluded that a "very large portion of the fee on health insurance providers will be passed forward to purchasers of insurance in the form of higher premiums" and estimated that the premiums would be 2 to 2.5 percent greater than they otherwise would be for an average family health insurance policy in, for example, 2016.[27]

In addition to concerns over the financial sustainability of a state-based Exchange, questions remain as to how a federally-facilitated Exchange will be funded. We ask the Department to clarify how the federal government will be fiscally responsible in instances where a state chooses not to establish a state-based Exchange.

**155.705 – Functions of a SHOP.**

(b)(2) & (3) Employer choice requirements.

The Chamber has tremendous concerns with the preamble's discussion of the way employer options for offering coverage through the SHOP may be dictated by the Exchange/SHOP. The Administration has consistently asserted that PPACA will build on the existing employer-sponsored health system, and that Exchanges and SHOPs will create new coverage options to

[24] P.L. No. 111-148, § 1311 (d)(5)(A).

[25] P.L. No. 111-148, § 1311 (d)(5)(A).

[26] http://www.cbo.gov/ftpdocs/107xx/doc10781/11-30-Premiums.pdf

[27] Joint Committee on Taxation letter dated June 3, 2011, responding to a request from Senator Jon Kyl (R-AZ) to estimate the impact repealing the annual fee on health insurance providers would have on health insurance premiums.

help transform the small group health insurance market. It is important to emphasize that the employer-sponsored health system is voluntary. Under this voluntary system, employers may choose how they will offer health coverage to their employees. This choice is generally not constrained under the law.[28] For example, employers have the option to offer a wide variety of different coverage options and plan designs to employees, or alternatively, limit the employees' coverage options to one, single plan. Again, the decision is entirely up to the employer.

Unfortunately, the Proposed Rule departs from current practice by constraining employer choice and giving the Exchange/SHOP the ability to dictate how an employer will offer health care coverage to its employees. While the Proposed Rule requires a SHOP to offer employers the option to select a level of coverage from which their employees may choose a plan, the rule also offers additional options that permit Exchanges/SHOPs to allow employees to choose any QHP offered in the SHOP at any level, according to discussion in the preamble which expands on the regulatory proposal in paragraph (b)(3).[29] This is a marked change from the current system.

The Chamber is concerned that the preamble – which discusses four additional options for offering health coverage through a SHOP – could be interpreted in such a way that an employer's ability to select a level of coverage from which their employees may choose a plan as required by the statute may be negated. Specifically, the first option for offering health coverage indicates that an "employee may choose" any QHP…at any level, while the other three options articulated in the preamble allow "employers to select" how coverage may be offered to their employees. If this first option gives the employee the ability to choose any QHP at any level, then the employer's statutory ability to require its employees to, for example, choose a plan within a specified level under paragraph (b)(2) is undercut.

While the Chamber recognizes that the additional options for offering health coverage through a SHOP are intended to provide flexibility and promote employee choice among plans, the manner in which the Department implements this policy infringes upon the cornerstone of the voluntary employer-sponsored health system – *employer* choice. To be clear, we do not believe that the four possible choices discussed in the preamble are inherently problematic, but they must be revised to clarify that it is the employer and not the Exchange/SHOP which ultimately chooses how and which plans are offered to employees. While we favor employee choice and support a policy that allows employees to shop among a wide range of plans, it must be the employer that chooses whether or not employees may choose any QHP at any level. The Chamber urges the Department to make the appropriate clarification in the final rules.

[28] Employers, however, must offer health coverage within the framework of the Employee Retirement Income Security Act and other laws affecting employee benefits.

[29] Proposed Rule, 76 Fed. Reg. at 41,886 "In paragraph (b)(3), we provide flexibility for Exchanges and their SHOPs to choose additional ways for qualified employers to offer one or more plans to employees. For example, an *Exchange may allow employees* to choose any QHP offered in the SHOP at any level." (to be codified at 45 C.F.R. pt. 155.705(b)(3). Unique Functions of a SHOP.)

(b)(3) Defined contribution in consumer choice models.

The Chamber is encouraged that a number of States are considering offering a "defined contribution" model as an option that employers ***may*** choose when allowing employees to purchase health coverage through a SHOP Exchange. We believe that such an approach promotes employee choice, and empowers the employee to be an efficient purchaser of health insurance coverage. Specifically, a defined contribution model allows an employee to shop among a wide-array of health plans, ranging from high-cost-sharing plans to low- or no-cost-sharing plans, with specified dollars allocated to them by their employer. Such an approach should maintain the employer subsidy for health insurance, and allow an employee to choose a plan that best fits their needs. We also believe that a defined contribution model may reduce any administrative burdens associated with collecting premiums from an employer and transmitting those premium payments to the issuer insuring the employees' health risk. The Chamber urges the Department to add a defined contribution model as an additional choice among the options the employers have for selecting plans under paragraph (b)(3). Again, the employer – not the Exchange/SHOP – must be the entity able to choose a defined contribution approach as a way to offer coverage to its employees.

It is important to point out that the defined contribution model in this case would be utilized in the small group market, and therefore, employees purchasing insurance under this approach would, for example, remain in the small group market risk pool. The Chamber recognizes that there are defined contribution models that permit the purchase of health insurance in the individual health insurance market, which under this approach, would arguably contemplate employees purchasing health insurance in the Exchange for individuals. In the case of a SHOP Exchange, the defined contribution model would be used to purchase small group health insurance coverage.

(b)(2) and (b)(3) Minimum participation standards.

The Chamber recognizes that promoting employee choice may lead to adverse selection in the market. As the preamble points out, a common practice in the small group market is the use of participation minimums, which when utlitized by an issuer, is intended to protect the issuer against adverse selection. While the Chamber believes that minimum participation standards limit employee choice, implementing policies that mitigate adverse selection must be a priority. As a result, if a robust risk adjustment mechanism is not enough to combat adverse selection in cases where a SHOP offers employee choice, the Chamber believes that the imposition of participation minimums must be a tool that a SHOP can utilize to limit any adverse selection in the market.

In addition, notwithstanding our belief that participation minimums will limit employee choice, if minimum participation standards are utlitized by carriers offering plans outside of the SHOP Exchange, the Chamber believes that the same participation minimums must be imposed on QHPs offered inside the SHOP. The Chamber recognizes that if plans sold outside of the SHOP do not "play by the same rules" as plans sold inside of the SHOP, adverse selection will occur.

(b)(4) Premium aggregation

In section 155.705(b)(4), the Department proposes that a SHOP *must* aggregate the premium payments an employer otherwise owes to a health insurance carrier or carriers insuring the QHP or QHPs selected by the employer's employees. Specifically, the SHOP must send a monthly bill to an employer that indicates the total amount that is due to the insurance carrier or carriers, and the SHOP must collect these premium payments and send these amounts to the specified insurance carrier or carriers insuring the QHP (or QHPs) in which the employer's employees are enrolled.

The Department indicates that this Proposed Rule is intended to simplify the administration of health benefits among small employers. The Chamber agrees that such premium aggregation would indeed have the effect of easing any administrative burdens associated with offering health insurance coverage. We also believe that this approach would encourage employers to permit broader employee choice because an employer that allows its employees to, for example, choose any QHP at any level of coverage would not be required to pay multiple bills from multiple insurance carriers each month. If employers were required to send multiple bills to multiple carriers, employers would be less likely to offer employees a broad range of coverage choices. In addition, premium aggregation could encourage the adoption of a defined contribution model.

Notwithstanding our support for this Proposed Rule, the Chamber believes that requiring premium aggregation raises concerns that health care coverage could be adversely affected if the SHOP (or a third party administrator ("TPA") in the case where a SHOP contracts with a TPA to collect and distribute the premium payments) fails to timely remit the premium payments to the health insurance carrier/carriers insuring the QHP/QHPs selected by the employer's employees. In addition, in the case of the failure to timely remit the premium payments or, for example, the failure to collect the correct amount of premiums owed, there is question as to where fiduciary liability, if any, would lie (e.g., on the SHOP (or TPA) or the employer). Finally, there is no dispute resolution process that would (1) allow a health insurance carrier to recover unpaid premium amounts, (2) ensure that there are no breaks in health care coverage, or (3) to re-instate any coverage that was cancelled for the failure to pay premiums for such coverage.

We recommend that the Department detail rules to prevent any disruptions in coverage on account of willful or negligent failure of the SHOP (or TPA) to make premium payments on time. Also, the Department should identify whether the SHOP (or TPA) is a fiduciary.[30]

[30] Congress intended a QHP purchased through SHOP to be considered a "group health plan" under the Employee Retirement Income Security ("ERISA"). This, for example, allows the tax treatment available to an employee in the case of employer-sponsored health insurance to continue to be available to QHP coverage purchased through SHOP. Courts have held that employer and employee contributions for health insurance coverage under a group health plan is a "plan asset" for purposes of ERISA. Courts have further found that an entity that exercises "control" over plan assets is considered an ERISA fiduciary to which specific fiduciary requirements apply. In the case of a SHOP – or a TPA working on behalf of a SHOP – courts would likely find the collection and distribution of premiums for QHP coverage purchased through SHOP would make the SHOP or the TPA an ERISA fiduciary.

Moreover, the Chamber recommends that the Department clearly articulate what recourse a health insurance carrier may have for unpaid premiums, and more importantly, what recourse an employer or an employee may have for the loss of health coverage. The Chamber recognizes that these safeguards may add a layer of complexity to this Proposed Rule, but instituting rules to protect against breaks in coverage and providing clarity with respect to fiduciary status and a dispute resolution process outweighs the benefits of administrative simplification that premium aggregation provides.

(b)(9) State election to allow large group plans to be sold through the Exchange.

In section 155.705(b)(9), it appears that the Department proposes to codify the statutory rule set forth under section 1312(f)(2)(B)(i) of PPACA which allows a state to make an election to allow large group health insurance coverage to be sold through an Exchange beginning in 2017. There are several elements that we urge the Department to clarify with regard to this option.

First, as the Exchange structure is currently contemplated and prescribed, if a state elects to allow large group health insurance coverage to be sold though the Exchange, then the large group market in the Exchange should similarly remain distinct and separate from the individual and small group markets inside the Exchange. Such an Exchange would then have an Individual Exchange, a SHOP, and a "LHOP" – or a Large Business Health Options Program.

Second, if a state elects to expand the SHOP to allow large employers to purchase coverage through a LHOP, the large group market outside the Exchange and the LHOP would be part of the same risk pool and would be bifurcated by issuer, just as the SHOP and Individual Exchange markets are.

Third, since large group plans are not required to offer coverage of the "essential health benefit package," the definition of a qualified plan offered in a LHOP would be distinct from that of a QHP offered in SHOP or the Individual Exchange.

**155.715 – 155.725 – Lag time in effective date of health care coverage.**

The Chamber understands the difficulties that the Department faces when fashioning eligibility standards and determination processes for SHOP (as set forth under sections 155.710 and 155.715) and describing the rules relating to enrollment in QHPs through SHOP (as set forth under sections 155.720 and 155.725). However, we are concerned that the elaborate rules and multiple steps for processing employer and employee applications for coverage through SHOP, verifying eligibility, and ultimately enrolling employers in SHOP and employees in QHPs offered through SHOP, will take a significant amount of time relative to current practices in the small group market. As a result, employees seeking coverage through SHOP may be forced to wait an extended period of time before their health care coverage becomes effective.

In section 155.715(d), however, it appears that an employer – and the employees of the employer – may have an opportunity to enroll in coverage during the verification process, where such coverage would only be discontinued if the SHOP determines, after the entire verification

process is exhausted, that the employer or employee is indeed not eligible to enroll in SHOP coverage. The Chamber recommends that the Department clarify that an employee is eligible to enroll in a QHP immediately upon the employer's selection of QHPs offered through SHOP (or the employer's selection of the levels of coverage that are available to employees) and before a determination and verification of an employee's eligibility of enrollment through SHOP is completed. This would allow employees of small employers purchasing coverage through SHOP to begin coverage as soon as possible. If, after the verification process is exhausted, the SHOP determines that the employer and/or the employee was not eligible to enroll in such coverage, then the SHOP may take the necessary steps to discontinue coverage.

**155.1055 – Establishment of Exchange network adequacy standards.**
**(also 156.230 Network adequacy standards.)**

These two sections create another duplicative and unneeded requirement. We recommend that the existing state network adequacy standards be followed by the Exchanges. Again, if these Exchanges are intended to be state-based, we would urge the Department to leave these details to the states.

**155.1065 – Stand-alone dental plans.**

The Chamber requests clarification that indicates separate dental policies offered outside of Exchanges can be paired with medical policies to meet the requirement to provide "pediatric oral services," just as separate dental plans offered in the Exchanges can be joined with medical policies in the Exchange to meet this requirement. Small businesses must be able to provide their current dental coverage to employees outside of Exchanges.

**End Stage Renal Disease and the Medicare Seconday Payer Rule.**

Another critical issue which must be clarified involves the current Medicare Secondary Payer ("MSP") rule and how it will be applied to plans operating in the Exchange with respect to individuals with end stage renal disease ("ESRD").

Because of the legislative process and the lack of a conference report, this issue – along with others – was unintentionally left slightly unclear. However, the intent of the law *is* clear, as is the best fiscal and policy position on this issue: the MSP rule should be applied consistently inside and outside the Exchange for individuals with ESRD. There are numerous compelling fiscal arguments that support consistently applying the MSP rule to plans inside and outside the Exchange. For example, applying current MSP law to group health plans in an Exchange with respect to ESRD will save $1.3 billion over the next 10 years.

Permitting individuals with the option of remaining in subsidized Exchange plans until Medicare coverage is primary will save an additional $3.7 billion over the next 10 years. By providing that individuals with ESRD may retain their private group health plan as primary coverage for 30 months before Medicare assumes this responsibility, MSP has been a key component of the successful 40-year public-private partnership to care for individuals with ESRD. The Exchanges

should be designed to ensure that this partnership continues, which will provide significant savings for the Medicare program and protect the ability of individuals with ESRD to access the private coverage on which they rely for assistance with out-of-pocket costs.

In addition to these important financial considerations, there are several critical policy reasons for doing so as well. Two of the main promises of health reform were to ensure first, that people could retain coverage of their choice, and second, that individuals could no longer be excluded from health coverage solely because of a pre-existing condition. In other words, the intent of PPACA was to maximize and protect consumer choice. However, failure to apply MSP consistently would effectively eliminate consumer choice for a subset of individuals solely because they have ESRD. These individuals would lose the plans they currently enjoy and be banned from participating in the Exchanges solely because they are unfortunate to have developed ESRD. Therefore, we urge you to clarify that the MSP law will consistently apply to group health plans in and out of the Exchanges in order to ensure that individuals with ESRD in QHPs have the same protections as those in group health plans outside the Exchanges.

Specifically, we urge you to address this issue in the Exchange regulations in four ways:

1. Clarify that current Medicare Secondary Payer protection for individuals with ESRD apply to QHPs offered in the Exchange;
2. Allow individuals with ESRD to access Exchange subsidized coverage, if they do not file an application for Medicare benefits;
3. Require QHPs to offer a sufficient choice of providers for individuals with ESRD; and
4. Ensure through certification criteria that QHPs cannot employ risk avoidance techniques to drop individuals with ESRD.

**156.255 – Rating variations.**

The Chamber urges the Department to revise the proposed rating categories, as specified in paragraph 156.255(c)(1)-(4).[31] We strongly advise against requiring issuers to only vary premiums among four different types of family composition, as discussed in the preamble. Forcing issuers to vary premiums only according to four groups – individual, two adults, adult plus child or children, and a catch all family category for two adult families with a child or children – fails to allow issuers to base premiums on the number of covered enrollees.[32] Under this scheme, a family with one child would pay the same premium as a family with seven children. This would insulate large families from the true cost of their coverage and unnecessarily shift costs to those with smaller families.

**156.270 – Termination of coverage for qualified individuals.**

The statute requires QHP issuers to allow enrollees receiving advance payments of the premium tax credit "a three month grace period for non-payment of premium before discontinuing

[31] Proposed Rule, 76 Fed. Reg. at 41,924 (to be codified at 45 C.F.R. pt. 156.255(c).
[32] Proposed Rule, 76 Fed. Reg. at 41,901.

coverage," which the Department proposes to codify in paragraph 156.270(d).[33] While we appreciate the need to be sensitive to the lower income individuals receiving these tax credits, we urge the Department to revise this proposed provision. In order to prevent gaming of the system and codifying a circumstance where individuals could effectively "free ride" for three months with no repercussions, we recommend that some regulatory qualifications be placed on this grace period.

First, we suggest that the Department require individuals to pay all outstanding and delinquent premiums before they are permitted to re-enroll in a QHP through an Exchange again. Failure to impose this requirement would allow individuals to free ride for the last three months of a plan year and then apply to a new QHP the following plan year.

Second, the statute does not require issuers to "pay all appropriate claims submitted on behalf of the enrollee" received during that time-frame. We urge the Department to not legislate this additional burdensome requirement through the Proposed Rule and further exacerbate the shifting of costs for these delinquent premium payments.

Third, the statute does not prohibit health plans from terminating coverage back to the last paid date after the exhaustion of the grace period. Therefore, to minimize the shifting of costs to issuers and the federal government and further "free-riding," we recommend that QHPs be permitted to withhold payment on claims received (i.e. pend claims) when premium payments are delinquent for more than 30 days.

Finally, we urge the Department to allow Exchanges to permit QHPs to terminate coverage back to the last paid date of coverage.

## CONCLUSION

The U.S. Chamber of Commerce is optimistic about the development of state-based Exchanges as a mechanism for expanding access to affordable coverage. While this process will be complicated, we urge the Department to work carefully, pragmatically and cooperatively with the numerous stakeholders. For implementation to be successful, careful analysis of currently operating state-based Exchanges is critical. We look forward to assisting the Department in developing the Exchanges to effectively supplement current insurance markets.

Sincerely,

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[33] P.L. No. 111-148, §1412 (c)(2)(B)(iv)(II).