MD EXCHANGE GROUP COMMENTS 9-29-10

Draft: 9/27/10
*A new model*

Comments are being requested on this draft on or before Oct. 6, 2010. Comments should be sent only by email to Jolie Matthews at jmatthew@naic.org.

# AMERICAN HEALTH BENEFIT EXCHANGE MODEL ACT

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## Section 1. Title

This Act shall be known and may be cited as the American Health Benefit Exchange Act.

## Section 2. Purpose and Intent

The purpose of this Act is to provide for the establishment of an American Health Benefit Exchange to facilitate the purchase and sale of qualified health plans in the individual market in this State and to provide for the establishment of a Small Business Health Options Program (SHOP Exchange) to assist qualified small employers in this State in facilitating the enrollment of their employees in qualified health plans offered in the small group market.

**Drafting Note:** States expanding the definition of "qualified employer" to include large employers, as permitted beginning in 2017 under the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) (Federal Act), should remove the reference to "small" employers.

## Section 3. Definitions

For purposes of this Act:

A. "Commissioner" means the Commissioner of Insurance.

**Drafting Note:** Use the title of the chief insurance regulatory official wherever the term "commissioner" appears. If the jurisdiction of certain health carriers, such as health maintenance organizations, lies with some state agency other than the insurance department, or if there is dual regulation, a state should add language referencing that agency to ensure the appropriate coordination of responsibilities.

B. "Educated health care consumer" means an individual who is knowledgeable about the health care system, and has background or experience in making informed decisions regarding health, medical and scientific matters.

C. "Exchange" means the [insert name of State Exchange] established pursuant to section 4 of this Act.

D. "Federal Act" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any amendments thereto, or regulations or guidance issued under, those Acts.

 

E. "Group health plan" means an employee welfare benefit plan as defined in section 3(1) of the Employee Retirement Income Security Act of 1974 to the extent that the plan provides medical care, as defined in subsection I, and including items and services paid for as medical care to employees, including both current and former employees, or their dependents as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise.

F. (1) "Health benefit plan" means a policy, contract, certificate or agreement offered by a carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

**NOTE:** The Statutory Language Team recognizes that the definition of "health benefit plan" needs to be revisited to ensure its consistency with definitions used in HIPAA and the Affordable Care Act.

(2) "Health benefit plan" does not include:

(a) Coverage only for accident, or disability income insurance, or any combination thereof;

(b) Coverage issued as a supplement to liability insurance;

(c) Liability insurance, including general liability insurance and automobile liability insurance;

(d) Workers' compensation or similar insurance;

(e) Automobile medical payment insurance;

(f) Credit-only insurance;

(g) Coverage for on-site medical clinics; or

(h) Other similar insurance coverage, specified in federal regulations issued pursuant to Pub. L. No. 104-191, under which benefits for medical care are secondary or incidental to other insurance benefits.

(3) "Health benefit plan" does not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:

(a) Limited scope dental or vision benefits;

(b) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or

(c) Other similar, limited benefits specified in federal regulations issued pursuant to Pub. L. No. 104-191.

(4) "Health benefit plan" does not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:

(a) Coverage only for a specified disease or illness; or

(b) Hospital indemnity or other fixed indemnity insurance.

(5) "Health benefit plan" does not include the following if offered as a separate policy, certificate or contract of insurance:

 

(a) Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act;

(b) Coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)); or

(c) Similar supplemental coverage provided to coverage under a group health plan.

G. "Health carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health services.

H. "Individual market" means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

I. "Medical care" means amounts paid for:

(1) The diagnosis, care, mitigation, treatment or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;

(2) Transportation primarily for and essential to medical care referred to in paragraph (1); and

(3) Insurance covering medical care referred to in paragraphs (1) and (2).

**Comment [rc1]:** It's very strange to define "medical care" as amounts paid. Usually the term refers to the services, and medical care expenditures refers to the amounts. In the uses in the bill, it seems to me that "amounts paid for" could and should be struck.

J. "Qualified employer" means a small employer that elects to make its full-time employees and, at the option of the employer, some or all of its part-time employees eligible for one or more qualified health plans offered in the small group market through the Exchange provided that the employer:

(1) Has its principal place of business in this State and elects to provide coverage through the Exchange to all of its eligible employees, wherever employed; or

(2) Elects to provide coverage through the Exchange to all of its eligible employees who are principally employed in this State.

**Drafting Note:** Beginning in 2017, the Federal Act permits States to expand eligibility for Exchange participation beyond small employers. States that do so should amend subsection J accordingly.

K. "Qualified health plan" means a health benefit plan that has in effect a certification that the plan meets the criteria for certification described in section 1311(c) of the Federal Act and section 7 of this Act.

L. (1) "Qualified individual" means an individual who:

(a) Is seeking to enroll in a qualified health plan in the individual market offered through the Exchange; and

(b) Resides in this State.

(2) "Qualified individual" does not include an individual:

(a) If, at the time of enrollment, the individual is incarcerated, other than incarceration pending the disposition of charges; or

(b) If, the individual is not, or is not reasonably expected to be, for the entire period for which enrollment is sought, a citizen or national of the United States or an alien lawfully present in the United States.

 

M. "Secretary" means the Secretary of the federal Department of Health and Human Services.

N. "SHOP Exchange" means the Small Business Health Options Program established under section 6 of this Act.

O. (1) "Small employer" means:

(a) For plan years beginning after December 31, 2013 and before January 1, 2016, an employer that employed an average of not more than 50~~100~~ employees during the preceding calendar year; and

(b) For plan years beginning on or after January 1, 2016, an employer that employed an average of not more than 100 employees during the preceding calendar year.

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**Comment [rc2]:** Counting issue needs to be addressed, given current state law, which counts employees differently.

**Drafting Note:** The Federal Act permits States to define "small employers" as employers with one to 50 employees for plan years beginning before Jan. 1, 2016.

(2) For purposes of this subsection:

(a) All persons treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as a single employer;

(b) An employer and any predecessor employer shall be treated as a single employer;

(c) If an employer was not in existence throughout the preceding calendar year, the determination of whether that employer is a small employer shall be based on the average number of employees that is reasonably expected that employer will employ on business days in the current calendar year; and

(d) An employer that makes enrollment in qualified health plans offered in the small group market available to its employees through the Exchange, and would cease to be a small employer by reason of an increase in the number of its employees, shall continue to be treated as a small employer for purposes of this Act as long as it continuously makes enrollment in qualified health plans available to its employees.

P. "Small group market" means the health insurance market under which individuals obtain health insurance coverage, directly or through any arrangement, on behalf of themselves and their dependents through a group health plan maintained by a small employer.

**Section 4. Establishment of Exchange**

A. The [insert official title of the Exchange] is hereby established as a [insert description and governance provisions here, either establishing the Exchange as a governmental agency or establishing the Exchange as a nonprofit entity].

**Drafting Note:** States have different options to consider when establishing the Exchange. This Act does not include any specific option for governance. Section 1311(d) of the Federal Act, requires that any Exchange established must be a governmental agency or nonprofit entity. As such, the Exchange could be located at a new or existing State agency. Some possible advantages to having the Exchange within a State agency include having a direct link to the State administration and a more direct ability to coordinate with other key State agencies, such as the State Medicaid agency and the State insurance department. Some possible disadvantages include the risk of the Exchange's decision-making and operations being politicized and the possible difficulty for the Exchange to be nimble in hiring and contracting practices, given most States' personnel and procurement rules. The Exchange could also be located at an independent public agency, or a quasi-governmental agency, with an appointed board or commission responsible for decision-making and day-to-day operations. Some possible advantages to establishing the Exchange as an independent public agency, or a quasi-governmental agency, include possible exemption from State personnel and procurement laws and more independence from existing State agencies, which could result in less of a possibility of the Exchange being politicized. The Exchange's enabling legislation would specify how the Board members would be appointed, including its size, composition and terms. The Board would also select the Exchange's Executive Director. Some possible disadvantages include the possible difficulty for the Exchange to coordinate health care purchasing strategies and initiatives with key State agencies, such as the State Medicaid agency and

 

the State insurance department and their employees because the Exchange would not be located at a State agency (unless those decisions are subject to the approval of a State official, such as the State insurance commissioner or the Governor). The Exchange also could be established by creating a non-profit entity. This means that most likely it would not be directly accountable to State government or subject to State government oversight nor would it most likely be subject to State personnel and procurement laws. Some possible advantages of establishing the Exchange as a non-profit include flexibility in decision making and less of a chance for those decisions being politicized and some possible disadvantages include isolation from State policymakers and key State agency staff and the potential for decreased public accountability. In addition, States can establish an Exchange using a combination of the options described above. The NAIC, through the Exchanges (B) Subgroup, intends to review the options for governance above and others related to establishing Exchanges and develop an issues paper on the topic to assist States in this area.

**Comment [rc3]:** Also, if the Exchange makes eligibility determinations in order to enroll someone in a public program, it's my understanding that eligibility determinations have to be made by state agencies… So that would be a potential advantage of an independent governmental entity.

**Drafting Note:** States should be aware that section 1311(f) of the Federal Act permits States, with the approval of the Secretary of the federal Department of Health and Human Services, to establish regional or interstate Exchanges. This Act does not specify how to establish these Exchanges or how they would operate. The NAIC, through the Exchanges (B) Subgroup, intends to review those issues and others related to establishing regional or interstate exchanges and develop an issues paper on the topic to assist those states that wish to establish such exchanges. States participating in interstate Exchanges or establishing regional Exchanges should modify the relevant portions of this Act accordingly.

**Drafting Note:** Depending on how a State establishes its Exchange, a State may need to consider whether the Exchange should be exempt from the State's insurance producer or consultant licensing requirements or whether the Exchange needs to obtain such a license.

B. The Exchange shall:

(1) Facilitate the purchase and sale of qualified health plans;

(2) Provide for the establishment of a SHOP Exchange that is designed to assist qualified small employers in this State in facilitating the enrollment of their employees in qualified health plans offered in the small group market in this State; and

(3) Meet the requirements of this Act and any regulations implemented under this Act.

C. The Exchange may contract with an eligible entity for any of its functions described in this Act. An eligible entity includes, but is not limited to, the [insert name of State Medicaid agency] or an entity that has experience in the individual and small group markets, but a health carrier is not an eligible entity.

**Drafting Note:** States should be aware that when establishing the Exchange they will have to include additional sections in this Act that set out the appointment process, powers, duties and other responsibilities of any board, committee or other entity that will have day-to-day responsibility for carrying out the duties and responsibilities of the Exchange, as provided in this Act.

D. The Exchange may enter into information-sharing agreements with federal and State agencies and other State Exchanges to carry out its responsibilities under this Act provided such agreements include adequate protections with respect to the confidentiality of the information to be shared and comply with all State and federal laws and regulations.

**Section 5. General Requirements**

A. The Exchange shall make qualified health plans available to qualified individuals and qualified employers beginning on or before January 1, 2014.

B. (1) The Exchange shall not make available any health benefit plan that is not a qualified health plan.

(2) The Exchange State shall allow a health carrier to offer a plan that provides limited scope dental benefits meeting the requirements of section 9832(c)(2)(A) of the Internal Revenue Code of 1986 through the Exchange, either separately or in conjunction with a qualified health plan, if the plan provides pediatric dental benefits meeting the requirements of section 1302(b)(1)(J) of the Federal Act.

 

C. The Exchange may make a qualified health plan available notwithstanding any provision of law that may require benefits other than the essential health benefits specified under section 1302(b) of the Federal Act.

**Drafting Note:** The Federal Act allows States to require additional benefits, but only if the State defrays the additional costs of premium and cost-sharing assistance to enrollees. States electing this option should modify subsection C accordingly, specifying the additional benefits required and the mechanism for payment to or on behalf of the enrollees.

**Section 6. Duties of Exchange**

**Drafting Note:** The provisions in this section are the minimum requirements of the Federal Act. States are encouraged to consider assigning additional duties, consistent with the Federal Act, to the extent appropriate to the State's market conditions and policy goals. Optional clauses are provided at the end of this section to facilitate uniformity among those States that elect to use their Exchanges to address certain widely shared concerns.

The Exchange shall:

A. Implement procedures for the certification, recertification and decertification, consistent with guidelines developed by the Secretary under section 1311(c) of the Federal Act and section 7 of this Act, of health benefit plans as qualified health plans;

B. Provide for the operation of a toll-free telephone hotline to respond to requests for assistance;

C. Provide for enrollment periods, as determined by the Secretary under section 1311(c)(6) of the Federal Act;

D. Maintain an Internet website through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on such plans;

E. Assign a rating to each qualified health plan offered through the Exchange in accordance with the criteria developed by the Secretary under section 1311(c)(3) of the Federal Act;

F. Utilize a standardized format for presenting health benefit options in the Exchange, including the use of the uniform outline of coverage established under section 2715 of the PHSA;

G. In accordance with section 1413 of the Federal Act, inform individuals of eligibility requirements for the Medicaid program under title XIX of the Social Security Act, the Children's Health Insurance Program (CHIP) under title XXI of the Social Security Act or any applicable State or local public program and if through screening of the application by the Exchange, the Exchange determines that any individual is eligible for any such program, enroll that individual in that program;

H. Establish and make available by electronic means a calculator to determine the actual cost of coverage after application of any premium tax credit under section 36B of the Internal Revenue Code of 1986 and any cost-sharing reduction under section 1402 of the Federal Act;

I. Establish a SHOP Exchange through which individuals employed by qualified employers may enroll in any qualified health plan offered through the SHOP Exchange at the level of coverage specified by the employer;

**Comment [rc4]:** I would strike this from the draft. Although the concept is in law, an optimal exchange should allow individuals to buy up [but not down?] from the level offered by the employer and thus the level on which the employer contributions are based.

**Drafting Note:** States may elect to operate a unified Exchange by merging the SHOP Exchange and the Exchange for the individual market, but only if the Exchange has adequate resources to assist these individuals and employers.

J. Subject to section 1411 of the Federal Act, grant a certification attesting that, for purposes of the individual responsibility penalty under section 5000A of the Internal Revenue Code of 1986, an individual is exempt from the individual responsibility requirement or from the penalty imposed by that section because:

(1) There is no affordable qualified health plan available through the Exchange, or the individual's employer, covering the individual; or

(2) The individual meets the requirements for any other such exemption from the individual responsibility requirement or penalty;

 

K. Transfer to the federal Secretary of the Treasury the following:

(1) A list of the individuals who are issued a certification under subsection I, including the name and taxpayer identification number of each individual;

(2) The name and taxpayer identification number of each individual who was an employee of an employer but who was determined to be eligible for the premium tax credit under section 36B of the Internal Revenue Code of 1986 because:

(a) The employer did not provide minimum essential health benefits coverage; or

(b) The employer provided the minimum essential health benefits coverage, but it was determined under section 36B(c)(2)(C) of the Internal Revenue Code to either be unaffordable to the employee or not provide the required minimum actuarial value; and

(3) The name and taxpayer identification number of:

(a) Each individual who notifies the Exchange under section 1411(b)(4) of the Federal Act that he or she has changed employers; and

(b) Each individual who ceases coverage under a qualified health plan during a plan year and the effective date of that cessation;

L. Provide to each employer the name of each employee of the employer described in subsection K(3)(b) who ceases coverage under a qualified health plan during a plan year and the effective date of the cessation;

M. Perform duties required of, or delegated to, the Exchange by the Secretary or the Secretary of the Treasury related to determining eligibility for premium tax credits, reduced cost-sharing or individual responsibility requirement exemptions;

N. Select entities qualified to serve as Navigators in accordance with section 1311(i) of the Federal Act and award grants to enable Navigators to:

(1) Conduct public education activities to raise awareness of the availability of qualified health plans;

(2) Distribute fair and impartial information concerning enrollment in qualified health plans, and the availability of premium tax credits under section 36B of the Internal Revenue Code of 1986 and cost-sharing reductions under section 1402 of the Federal Act;

(3) Facilitate enrollment in qualified health plans;

(4) Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under section 2793 of the PHSA, or any other appropriate State agency or agencies, for any enrollee with a grievance, complaint or question regarding their health benefit plan, coverage or a determination under that plan or coverage; and

(5) Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange;

O. Review the rate of enrollment in and premium growth for group health plans available to or offered by employers of various sizes, including group plans both within the Exchange and outside the Exchange and group plans that are fully insured and self-insured, and consider the information in developing recommendations on~~: whether to~~

(1) whether to expand the small group market to employers with up to 100 employees prior to January 1, 2016; and

(2) whether to continue limiting qualified employer status to small employers~~; and~~.

**Comment [rc5]:** Subsection J

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**Comment [rc6]:** Broader range of factors to consider, and consideration of the 50/100 issue as well as the large employer issue

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P. Credit the amount of any free choice voucher to the monthly premium of the plan in which a qualified employee is enrolled, in accordance with section 10108 of the Federal Act, and collect the amount credited from the offering employer; and

Q. Consult with stakeholders relevant to carrying out the activities required under this Act, including:

(1) Educated health care consumers who are enrollees in qualified health plans;

(2) Individuals and entities with experience in facilitating enrollment in qualified health plans;

(3) Representatives of small businesses and self-employed individuals;

(4) The [insert name of State Medicaid office]; and

(5) Advocates for enrolling hard to reach populations.

***[R.* et seq.:** ***Optional clauses specifying additional duties of the Exchange. The Exchanges (B) Subgroup Statutory Language Team preparing this initial exposure draft recommends that these clauses be developed with input from regulators and interested parties, and welcomes your suggested language.]***

**Drafting Note:** States should be aware of the interplay between the duties established for the Exchange under this Act and ERISA's fiduciary duties.

**Section7. Health Benefit Plan Certification**

A. The Exchange may certify a health benefit plan as a qualified health plan if:

(1) The plan provides the essential health benefits package described in section 1302(a) of the Federal Act;

(2) The plan provides at least a bronze level of coverage, unless the plan is certified as a qualified catastrophic plan, meets the requirements of the Federal Act for catastrophic plans, and will only be offered to individuals eligible for catastrophic coverage;

(3) The health carrier offering the plan:

(a) Is licensed and in good standing to offer health insurance coverage in this State;

(b) Offers at least one qualified health plan in the silver level and at least one plan in the gold level in the Exchange;

(c) Charges the same premium rate for each qualified health plan without regard to whether the plan is offered through the Exchange and without regard to whether the plan is offered directly from the carrier or through an insurance producer; and

(d) Complies with the regulations developed by the Secretary under section 1311(d) of the Federal Act and such other requirements as the Exchange may establish.

(4) The plan meets the requirements of certification as promulgated by regulation by the Secretary under section 1311(c)(1) of the Federal Act and by the Exchange pursuant to section 9 of this Act; and

(5) The Exchange determines that making the plan available through the Exchange is in the interest of qualified individuals and qualified employers in this State.

**Drafting Note:** States should consider whether the Exchange should delegate this function to the commissioner.

B. The Exchange shall not exclude a health benefit plan:

(1) On the basis that the plan is a fee-for-service plan;

(2) Through the imposition of premium price controls; or

(3) On the basis that the health benefit plan provides treatments necessary to prevent patients' deaths in circumstances the Exchange determines are inappropriate or too costly.

C. The Exchange shall require each health carrier seeking certification of a plan as a qualified health plan to:

(1) Submit a justification for any premium increase before implementation of that increase. The carrier shall prominently post the information on its Internet website. The Exchange shall take this information, along with the information and the recommendations provided to the Exchange by the commissioner under section 2794(b) of the PHSA, into consideration when determining whether to allow the carrier to make plans available through the Exchange;

**Drafting Note:** States with additional rate filing requirements should review the language in paragraph (1) above to ensure that it does not conflict with other applicable State law.

(2) (a) Make available to the public, in the format described in subparagraph (b) of this paragraph, and submit to the Exchange, the Secretary, and the commissioner, accurate and timely disclosure of the following:

(i) Claims payment policies and practices;

(ii) Periodic financial disclosures;

(iii) Data on enrollment;

(iv) Data on disenrollment;

(v) Data on the number of claims that are denied;

(vi) Data on rating practices;

(vii) Information on cost-sharing and payments with respect to any out-of-network coverage;

(viii) Information on enrollee and participant rights under title I of the Federal Act; and

(ix) Other information as determined appropriate by the Secretary; and

(b) The information required in subparagraph (a) of this paragraph shall be provided in plain language, as that term is defined in section 1311(e)(3)(B) of the Federal Act; and

(3) Permit individuals to learn, in a timely manner upon the request of the individual, the amount of cost-sharing, including deductibles, copayments, and coinsurance, under the individual's plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific medically-necessary item or service by a participating provider. At a minimum, this information shall be made available to the individual through an Internet website and through other means for individuals without access to the Internet.

**Comment [rc7]:** I'm concerned that the response would be read as "we will pay this amount," whereas the payment is of course contingent on whether the service is medically necessary. It is unclear in this language whether the answer is generic or whether it is specific to the patient and their current status with regard to the deductible. Health plans may want something in here about the additional information needed to provide this information (but not the CareFirst laundry list).

**Comment [rc8]:** IMO, we should also require disclosure of the payment the plan would make to a non-participating provider…

**Section 8. Funding; Publication of Costs**

A. The Exchange may charge assessments or user fees to health carriers or otherwise may generate funding necessary to support its operations provided under this Act.

B. The Exchange shall publish the average costs of licensing, regulatory fees and any other payments required by the Exchange, and the administrative costs of the Exchange, on an Internet website to educate

 

consumers on such costs. This information shall include information on monies lost to waste, fraud and abuse.

**Section 9. Regulations**

The Exchange may promulgate regulations to implement the provisions of this Act. Regulations promulgated under this section shall not conflict with or prevent the application of regulations promulgated by the Secretary under title I, subtitle D of the Federal Act.

**Drafting Note:** States that do not establish the Exchange in a governmental agency with rulemaking authority should substitute the agency responsible for the administration or oversight of the Exchange. As appropriate, the commissioner should be granted rulemaking authority to promulgate regulations to implement the provisions of this Act within the scope of the commissioner's authority, as provided under State law or regulations.

**Section 10. Effective Date**

This Act shall be effective [insert date].

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**From:** John Jenkins
**Sent:** Friday, October 01, 2010 9:31 AM
**To:** 'jmatthews@naic.org'
**Cc:** Jenkins John (john.jenkins@cobrapoint.com); Mark Waterstraat
**Subject:** Comment // American Health Benefit Exchange Model Act

Hi Jolie,
Good morning.

Would it be possible to clarify Section 8. Funding; Publication of Costs. The Model Act states "…or otherwise generate funding necessary to support its operations provided under the this Act."

Do you foresee the opportunity for the enrolled member to pay an administration fee, similar to the COBRA administration fee charged to Qualified Beneficiaries?

With thanks and kind regards,
JJ

**John Jenkins**
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Group Benefit Resources

Jolie Matthews

Thank you for this opportunity. Somewhere in the act, there should be a statement making it an absolute requirement that any entity using the exchange (company, union, association, individuals, etc.) must use a licensed health insurance agent or broker. Attached is a letter which will be published in November explaining the reasons why brokers are necessary.

As an addendum to the email sent earlier (copy below), I would like to add that NAIC has already endorsed the role of the agent/broker in health care reform. This fact should be incorporated in the Model Act.

Lynn Boardman
President, Group Benefit Resources

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Lynn Boardman
President

August 29, 2010

Mr. Bob Graham
Executive Editor
Insurance and Financial Advisor
10600 York Road, Suite 203
Hunt Valley, MD 21030

Dear Mr. Graham:

The last paragraph of your column "Publisher's Note," [Insurance and Financial Advisor, September 2010, page 2] really disturbed me. You wrote: "*The value of the insurance agent is largely to negotiate the paperwork and procedures to ensure the policy holder's interests are being met.*"

This statement tells me it has been a long time since you sold health insurance (or you never have). "*Negotiate the paperwork. . .*" You could not be more wrong or further from the truth; not even close to what we do!

- *Do you really believe the average guy on the street knows the difference between an HMO, a PPO, or an indemnity plan?*
- *Does he understand the difference between a copay, co-insurance and deductible; the meaning of maximum out-of-pocket? Policy year vs. calendar year?*
- *Does he know what managed care means?*

- *Can he decide if an HSA or an HRA is better for his business?*
- *Does the average consumer even know what an HSA is?*
- *Does he comprehend the differences between in-network and out-of-network benefits? COBRA or HIPAA?*
- *Does the consumer know the definition of "pre-existing condition," especially how the various insurance companies handle it (non group)?*
- *Does he fully appreciate what is meant by "consumer driven health care" and its impact on him, his family and his employees?*
- *Does he have someone to call to help with claims and appeals (as I assure you, insurance companies do not have the time or inclination to do so).*
- *When he receives a letter from his insurance company which uses technical and legal terminology, will he understand how it impacts him? And if not, who does he run to for an explanation?*

If you answered YES to any of these questions, Mr. Graham, then clearly there is a bridge in Brooklyn I want to talk to you about. The same goes for President Obama and members of Congress who share the same misguided faith in the intelligence of the average consumer.

Frankly, I do not understand the necessity or purpose of the "exchanges." If the goal is to help consumers navigate the complex world of health insurance, for crying out loud brokers and agents have been doing this for over 50 years (we used to call them "spreadsheets"), at no expense to the consumer. Why re-invent the wheel?

Moving on to Mr. Ross Schriftman's comment that agents are facing a future with "*less compensation and more work trying to explain the unexplainable.*" This statement is unprofessional at best and I am surprised that such a well respected gentleman would think so lowly of his colleagues. We all make a nice living from selling health insurance, Mr. Schriftman. Simply add this new knowledge to your marketing efforts.

Congress has historically subjected the health insurance industry to a barrage of laws and regulations – ERISA, COBRA, HIPAA, Small Group Reform - without listening to our warning that these will increase costs. The Obama health care plan is just one more hurdle. As Rob Poli pointed out, the new law makes the agent more valuable. And as you have so succinctly said, Mr. Graham, the state of Pennsylvania made a serious error when they did not use agents to guide consumers to less costly alternatives available.

NAHU and NAIC recently unanimously endorsed the role of the agent and broker in health reform. If there is any institution which understands the value of agents, NAHU and NAIC certainly qualify. They have reiterated this to legislators – contrary to your position that we are just "paper pushers."

I hope, Mr. Graham, that I have managed to open your eyes a little, and I expect your future comments will be more appreciative of the agent's role. Your paper is very influential and we would like to see it endorse the absolute necessity of the broker and agent's functions in health insurance. And, by the way, harness your paper's energies to addressing the real problem of rising costs, which the Obama health care law seems to have overlooked. That is the crux of the problem today.

Sincerely,

Lynn Boardman

Lynn Boardman
Gaithersburg, Maryland

MOLINA® HEALTHCARE

October 5, 2010

**VIA E-MAIL**

Jolie Matthews, jmatthew@naic.org
National Association of Insurance Commissioners
444 North Capitol Street NW, Suite 701
Washington, DC 20001

**RE: American Health Benefit Exchange Model Act**

Dear Ms. Matthews,

I am writing on behalf of Molina Healthcare, Inc. (MHI) to offer comments in response to the "American Health Benefit Exchange Model Act."

Molina Healthcare, Inc. has 30 years of experience serving patients who have traditionally faced barriers to obtaining quality healthcare, primarily individuals covered by Medicaid, the Children's Health Insurance Program (CHIP) and other government-sponsored health insurance programs. Molina Healthcare's operations in California, Florida, Michigan, Missouri, New Mexico, Ohio, Texas, Utah, Virginia, Washington, and Wisconsin currently serve approximately 1.5 million low-income vulnerable Americans who otherwise would be unable to obtain health insurance coverage. We also serve as the fiscal intermediary for the Medicaid programs in New Jersey, Louisiana, West Virginia, Idaho and Maine covering another 2.8 million beneficiaries.

Molina Healthcare offers the attached recommendations to aid in the development of standards for the establishment and operation of American Health Benefit Exchanges ("Exchange").

Thank you for the opportunity to comment on this important issue.

Sincerely,

John M. Puente
Vice President, Deputy General Counsel

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MOLINA® HEALTHCARE

September 24, 2010

U.S. Department of Health and Human Services
Centers for Medicare and Medicaid Services
Attn: OCIIO-9989-NC
P.O. Box 8010
Baltimore, MD 21244-8010

Re: Planning and Establishment of State-Level Exchanges; Request for Comments Regarding Exchange-Related Provisions in Title I of the Patient Protection and Affordable Care Act

Dear Sir or Madam:

I am writing on behalf of Molina Healthcare, Inc. (MHI) to offer comments in response to the "Planning and Establishment of State-Level Exchanges; Request for Comments Regarding Exchange-Related Provisions in Title I of the Patient Protection and Affordable Care Act." The proposed regulations were published in the *Federal Register* on August 3, 2010 (75 Fed. Reg. 45584).

Molina Healthcare, Inc. has 30 years of experience serving patients who have traditionally faced barriers to obtaining quality healthcare, primarily individuals covered by Medicaid, the Children's Health Insurance Program (CHIP) and other government-sponsored health insurance programs. Molina Healthcare's operations in California, Florida, Michigan, Missouri, New Mexico, Ohio, Texas, Utah, Virginia, Washington, and Wisconsin currently serve approximately 1.5 million low-income vulnerable Americans who otherwise would be unable to obtain health insurance coverage. We also serve as the fiscal intermediary for the Medicaid programs in New Jersey, Louisiana, West Virginia, Idaho and Maine covering another 2.8 million beneficiaries.

The Patient Protection and Affordable Care Act (PPACA) expands access to health insurance through the establishment of American Health Benefits Exchanges ("Exchange"). These state-based Exchanges create a marketplace for health insurance by offering a choice of plans, establishing common rules regarding the offering and pricing of insurance, and providing information to help consumers better understand the options available to them in the marketplace.

The PPACA also requires states to establish a state eligibility website to promote seamless enrollment in Medicaid, Children's Health Insurance Program (CHIP) or an Exchange-certified plan based on an applicant's income and eligibility status beginning in 2014.

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562-435-3666 • Fax: 562-951-1505

Molina Healthcare offers the following recommendations to aid in the development of standards for establishment and operation of these Exchanges:

**1. Optional Participation in Exchanges for Medicaid-only Health Plans**

Medicaid health plans should be given the option to participate in state Exchanges without negatively impacting their ability to contract with a state to provide Medicaid benefits for eligible beneficiaries. Experts anticipate a large number of participants will move between the Exchange, Medicaid, and CHIP, and some suggest this movement may be more seamless if Medicaid-plans are participants in the Exchange.

Molina Healthcare focuses exclusively on serving a vulnerable population that relies on government-funded health programs. As such, we are better equipped to provide the specialized care and services the Medicaid and CHIP populations require. Should health plans with Medicaid contracts in a particular state be required to participate in the Exchange, many not-for-profit and Medicaid-specialized health plans like Molina (that do not offer commercial products) may be pushed from the marketplace as they may not be able to compete against larger, multi-line plans with significantly more experience and back-office capacity in the commercial market. As a result, the quality and continuity of care, and access provided to the Medicaid population may be jeopardized.

**2. The Exchange Must be Responsible for Collecting Premiums**

The PPACA requires that individuals and families with incomes between 133% and 400% of the Federal Poverty Level (FPL) receive federal tax subsidies to help them afford health insurance premiums purchased on the Exchange. These subsidies will be paid to the plans in which the individual/family enrolls.

As the Exchange will be integral in determining health plan eligibility (Medicaid, CHIP and/or Exchange), we believe it should also be responsible for collecting premiums for enrollments in Exchange-sponsored health plans from the federal government in the form of tax subsidies and from individuals/families in the form of premiums. This process will help decrease administrative costs for health plans, consolidate all premium collection responsibilities under one entity and help previously Medicaid-only focused plans like Molina (should we choose to participate in the Exchange) better compete with the larger commercial health plans with longer history and expertise in premium collection processes.

**3. Individuals in the Exchange Must Have a Choice of Health Plans**

One of the central tenets of health reform is that individuals be guaranteed a choice of health insurance plans. Market-based competition and choice are primary drivers of improvements in quality and service, which directly benefit members and indirectly result in cost savings to the health care delivery system. Surveys consistently show that a wider choice of health plans results in greater enrollee satisfaction. Existing state laws that limit choice in certain geographical areas should be revisited in 2014 so that all Americans – regardless of whether they get their health coverage through Medicaid, CHIP or the Exchange – are given the opportunity to select which health plans best meet their personal health needs.

**4. The Exchange Should Act as a Market Organizer, Not a Selective Contracting Agent**
The Exchange should contract with all health plans that meet nationally recognized regulatory and legal requirements. It should act as an objective, impartial source of information on health plans that are available in the market, provide structure to the market to help consumers compare plans and purchase coverage, and serve as a broker of health insurance by handling premium billing and collecting. The Exchange should not attempt to influence the market by advocating one plan over the other.

**5. The Exchange Must Utilize Recognized Uniform National Quality Measures**

Uniform standards of care and management are an important policy mechanism to improve quality of care. Inconsistencies in standards across states make it difficult to compare outcomes, whereas standardized measures and data allow for state, regional and national analyses. Further, inconsistent measures lead to higher administrative costs for multi-state health plans like Molina.

**6. Exchanges Must Not Charge Fees on Government-funded Programs**

State Exchanges are required to be self-funded and will be allowed to charge fees to participating health insurers to support operational costs. The PPACA does not place a limit on this fee; rather the law states that they should be "reasonable and fair." Unlike commercial plans which will undoubtedly pass this cost on to the consumer, plans like Molina will be unable to do so. Ultimately, this recycling of taxpayer dollars will lead to higher costs. Applying such a fee onto government-sponsored programs will only add to the financial strain of states that are already cash-strapped.

**7. The Exchange Must Utilize Uniform Federal Administrative Standards**

***Coordinated Eligibility and Enrollment Systems***

The success of an Exchange will depend greatly on its ability to establish a streamlined enrollment and eligibility system that is seamlessly linked to Medicaid, CHIP or an Exchange-certified plan. The PPACA requires the federal government to establish a system that allows state residents to apply for "state health subsidy programs" which are broadly defined to include not only tax subsidies for private insurance, but coverage under Medicaid and CHIP programs as well. By 2014, individuals must be able to apply online for all three options using the same application.

Eligibility for state health subsidy programs should be determined annually and coordinated with similar eligibility periods for those individuals who receive tax subsidies to purchase insurance from an Exchange plan. The annual determination period will eliminate month-to-month churning of participants between fully subsidized state-based health plans and federal subsidized Exchange plans due to slight changes in an individual or family's income. Additionally, the Medicaid open enrollment period in the States should coincide with that of the Exchange.

Molina supports the development of uniform federal administrative standards and model materials that states may adapt to their individual requirements to further reduce states' resource burdens while meeting the needs of low-income individuals. We also support initiatives to ensure states are provided with adequate resources to perform necessary tasks.

**8. *Data Linkages between Federal and State Agencies***

States are required to establish, verify and update eligibility for participation in Medicaid, CHIP or an Exchange-certified plan using data matching arrangements.

The challenges to establishing coordinated eligibility and enrollment systems through data matching are considerable, and states' readiness to meet these challenges varies. States will need to establish new linkages with the federal government for eligibility determination and verification among existing health subsidy programs.

The federal government can assist in many ways. First, it can establish uniform federal administrative systems for application forms and program interfaces that are built off available HIPAA standards. It can also provide models for content on state Medicaid and CHIP enrollment and eligibility websites. Lastly, the federal government should be mindful of ongoing resource challenges by providing assistance to the states to ensure implementation efforts are adequately funded.

These provisions offer incredible promise to the millions of Americans who are Medicaid eligible who are often overwhelmed by the complex application and enrollment process.

Thank you for your consideration. We appreciate the opportunity to comment on these important regulatory proposals.

Sincerely,

Joseph M Molina MD

J. Mario Molina, MD
CEO and Chairman
Molina Healthcare, Inc.

ACAP
Association for Community Affiliated Plans

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Bob Thompson, Chairman | Margaret A. Murray, Chief Executive Officer

October 5, 2010

Sandy Praeger
Lead Regulator Kansas
Exchanges (B) Subgroup
Heath Insurance and Managed Care (B) Committee
National Association of Insurance Commissioners

Michael T. McRaith
Lead Regulator Illinois
Exchanges (B) Subgroup
Heath Insurance and Managed Care (B) Committee
National Association of Insurance Commissioners

*Sent via email to Jolie Matthews: jmatthew@naic.org.*

Dear Ms. Praeger and Mr. McRaith:

The Association for Community Affiliated Plans (ACAP) is pleased to have the opportunity to respond to Exchange (B) Subgroup's Exposure Draft for the American Health Benefit Exchange Model Act.

ACAP represents 52 non-profit Safety Net Health Plans in 25 states providing health care coverage to seven million people through public insurance programs, primarily Medicaid, the Children's Health Insurance Program (CHIP), and Medicare. Nationwide ACAP plans serve one of every four Medicaid managed care enrollees. ACAP plans are community-based, partnering with governments to deliver quality health services and provide an essential health care safety net.

The strong support and participation of Safety Net Health Plans has played a critical role in the expansion of health coverage. Under the Affordable Care Act, Safety Net Health Plans must be viewed as a full partner in meeting the coverage needs of Americans – whether they are eligible for Medicaid, the Children's Health Insurance Program (CHIP), or if they access coverage through the Exchange.

We noted in the Exchange Model Act that the NAIC staff will be preparing Issue Briefs and providing other technical assistance to states as they plan, develop and implement the Exchange. As such, enclosed please find a copy of our October 4, 2010, comment letter to the U.S. Department of Health and Human Services' Office of Consumer Information and Insurance Oversight (OCIIO). We hope you will consider ACAP's comments and

suggestions as you develop these resources for states and in your ongoing work with HHS.

In summary, ACAP's comments and questions can be summarized in the following five main themes:

- Exchanges must be designed to provide options that offer the best value for low income consumers, including individuals and families who will newly access coverage through the Exchange and those who may transition out of Medicaid in the future.
- Whether it is administered by a state or the U.S. Department of Health and Human Services, the Exchange structure must be flexible enough to ensure that Safety Net Health Plans are allowed to participate if they choose. That is, federal and state regulations should not erect barriers to participation that would disproportionately impact the ability of Safety Net Health Plans to participate in the Exchange.
- Exchanges should encourage and support continuity of coverage for individuals and families that may shift between the Exchange and other sources of coverage, such as Medicaid and CHIP.
- Exchanges should look to build on existing Medicaid and CHIP systems, processes, and policies, which are familiar to consumers who will be interacting with the Exchange.
- As the Exchanges are designed and developed for each state, there must be a robust process for stakeholder input which will allow for the design of a highly efficient Exchange that connects individuals with the most appropriate coverage.

ACAP and its members look forward to working with you to design the policies and framework for fully functioning Exchanges that will meet the needs of a diverse population, including vulnerable populations. Please do not hesitate to contact me at mmurray@communityplans.net or 202-204-7509, with any questions or if we can assist the NAIC in any way.

Sincerely,

Margaret A. Murray
Chief Executive Officer
Association for Community Affiliated Plans

Enclosure

October 4, 2010

Jay Angoff
Director
Office of Consumer Information and Insurance Oversight
Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201
*File code: OCIIO–9989–NC*

Submitted electronically via: *http://www.regulations.gov*

Dear Mr. Angoff:

The Association for Community Affiliated Plans (ACAP) appreciates this opportunity to provide comments in response to the request from the Office of Consumer Information and Insurance Oversight (OCIIO) regarding the Exchange-related provisions in Title I of the Affordable Care Act (ACA).[1]

ACAP is an Association of 52 not-for-profit and community-based Safety Net Health Plans.[2] Our member plans provide coverage to over 7 million individuals enrolled through Medicaid, Children's Health Insurance Program (CHIP) and Medicare Special Needs Plans for dual eligibles. Nationwide ACAP plans serve one of every four Medicaid managed care enrollees. The strong support and participation of Safety Net Health Plans has played a critical role in the expansion of health coverage. Under the ACA, Safety Net Health Plans must be viewed as a full partner in meeting the coverage needs of Americans – whether they are eligible for Medicaid, CHIP or if they access coverage through the Exchange.

ACAP's members have identified several issues critical to ensuring access to affordable quality health care coverage that will effectively meet the needs of individuals and families accessing health coverage through the new Exchanges. Our comments and questions can be summarized in the following five main themes:

[1] The Patient Protection and Affordable Care Act (P.L. 111-148) and the Healthcare and Education Reconciliation Act (P.L. 111-152) together are referred to in this letter as the Affordable Care Act (ACA).
[2] ACAP represents safety net health plans that are exempt from or not subject to federal income tax, or that are owned by an entity or entities exempt from or not subject to federal income tax, and for which no less than 75 percent of the enrolled population receives benefits under a Federal health care program as defined in section 1128B(f)(1) (42 USC 1320a-7b(f)(1)) or a health care plan or program which is funded, in whole or in part, by a State or locality (other than a program for government employees).

- Exchanges must be designed to provide options that offer the best value for low income consumers, including individuals and families who will newly access coverage through the Exchange and those who may transition out of Medicaid in the future.
- Whether it is administered by a state or the U.S. Department of Health and Human Services, the Exchange structure must be flexible enough to ensure that Safety Net Health Plans are allowed to participate if they choose. That is, federal and state regulations should not erect barriers to participation that would disproportionately impact the ability of Safety Net Health Plans to participate in the Exchange.
- Exchanges should encourage and support continuity of coverage for individuals and families that may shift between the Exchange and other sources of coverage, such as Medicaid and CHIP.
- Exchanges should look to build on existing Medicaid and CHIP systems, processes, and policies, which are familiar to consumers who will be interacting with the Exchange.
- As the Exchanges are designed and developed for each state, there must be a robust process for stakeholder input which will allow for the design of a highly efficient Exchange that connects individuals with the most appropriate coverage.

Value of Safety Net Plans in the Exchange

Safety Net Health Plans will add value to the options for coverage for many consumers who currently access their health care through these plans. Therefore, from the beginning there should be no limits on the type of health plans that enter the Exchange market – even if there are limits on the number of plans.

Safety Net Health Plans serve low-income and underserved populations and contract with providers, such as community health centers, safety net hospitals, and others who work with these vulnerable populations. Furthermore, Safety Net Health Plans are closely connected to their communities and frequently offer a wider array of services beyond health care in order to help with the overall well-being of the consumers they serve. Because of the role that safety net plans have played in serving vulnerable populations, they stand to have a natural and important function in the design and implementation of the Exchanges. This is especially true in the areas of coordination between the Exchange and Medicaid and CHIP, and designing products for the subsidized individual consumers, many of whom may have multiple touch points with the public health care programs.

Safety Net Health Plans participating in Medicaid must meet stringent state network requirements that require timely access to a network of primary care and specialty providers. In turn, access to care is a key component of the quality measurement set for health plans and ensures ongoing accountability. Safety Net Health Plans also are dedicated to high quality health care and transparency in quality measurement as a vital component of continuous quality improvement.

In addition, Safety Net Health Plans have the expertise necessary to help ensure continuity of care for persons moving among public programs due to income fluctuations, and to cover children in a family who may qualify for different programs due to age or citizenship status. This expertise will be particularly valuable given the number of individuals that are expected to fluctuate between Medicaid eligibility and subsidized coverage through the Exchange.

Administrative Simplification of the Exchange

To improve efficiency and effectiveness, the new Exchanges should adopt policies and administrative systems which simplify the experience for consumers. The Exchange has the potential to be confusing for many consumers who may be unfamiliar with insurance and may have difficulty choosing and enrolling in a health plan. Designating the Exchange as the single point of entry and "one-stop-shop" for health care coverage would help create a seamless experience for consumers. For example, in Massachusetts the exchange entity – the Health Connector -- collects premiums and processes enrollment which has simplified the process for individual consumers. Centralizing certain Exchange functions also will reduce duplicative administrative costs and, as a result, are likely to lower premiums for Exchange consumers.

Alternatively, another approach is for the state to assess its existing Medicaid program systems and functions to dovetail as many of the Exchange administrative functions as possible with the current Medicaid functions and requirements. For example, maintaining the same complaint and appeal process, the same telephone performance standards, the same provider access standards allows regulators to use existing measures, which are already in place for Medicaid and CHIP Plans. Streamlining administrative functions within the Exchange also would help to simplify the process for consumers and insurers.

In addition, the Exchange should work with plans, including Safety Net Plans, to identify and develop certain uniform data standards. For example, a uniform standard for the network file will be most effective, both for the plans and for the Exchange to evaluate the adequacy of plans' networks. Today, many States have such a format developed for their Medicaid Managed Care enrollment processes.

Comparability and Value in Benefit Design

Simplicity and clarity of product offerings on the Exchange are issues central to the consumer focus expectations of reform. Exchanges should require some measure of uniformity and limits around plan design to facilitate comparability of products and insurers so that consumers can make the best choices based upon price and quality. Standardized benefit packages will provide more clarity and more easily allow consumers to compare and contrast health plan options based on price, network, customer service, and other qualifications. To allow some degree of product differentiation that would benefit consumers, regulations should permit plans to offer value-added services in addition to the standard benefit package.

Qualified Health Plans – Access, Expertise and Value of Safety Net Plans

ACAP requests that federal Exchange regulations explicitly state that Medicaid managed care plans, including Safety Net Health Plans, are included in the universe of plans eligible to participate in the Exchange, provided all Safety Net Health Plans meet standards for quality, access, and affordability. Safety Net Health Plans currently cover 25 percent of people in Medicaid managed care; and this percentage has been steadily increasing over the last decade. Safety Net Health Plans are experienced in serving low-income and underinsured populations that will receive federal health care subsidies to access coverage through the Exchange.

Further, we strongly recommend that Exchanges leverage existing policies and procedures – and avoid duplication and the additional costs such duplication would bring – when determining whether a plan is a "qualified health plan" that can participate in the Exchange. For example, every state currently requires Medicaid and CHIP health plans to successfully complete rigorous certification processes and meet stringent quality and access standards in order to participate in either programs. While each state Medicaid agency has developed unique requirements, within many states the rigorous standards for Medicaid participation are likely to meet or exceed those for qualified health plans in the Exchange. Thus, Exchanges should be encouraged to cross-walk Medicaid and CHIP managed care requirements and other State regulatory or licensing requirements with the requirements of qualified health plans. If a plan meets the state's Medicaid and CHIP requirements the Exchange could "deem" it a qualified health plan, rather than requiring these existing plans to go through additional and unnecessary processes. This policy also should be extended to an Exchange that is administered by the federal government.

This process would help ensure a mixture of private, for profit, and not-for-profit plans that will facilitate a more robust competitive marketplace and allow consumers to choose the most appropriate plan for them based on quality, provider network, and other key elements. Deeming will also help make certain that low income and underserved populations accessing coverage through the Exchange have the option to enroll in a Safety Net Health Plan that may be designed specifically to provide the best care possible to individuals in their community.

Continuity of Coverage

Given the volatility of employment, enrollment churning in the Medicaid program and the state Exchange can be expected for low income populations. Moving on, off and between programs can disrupt a person's access to care, so minimizing churn can benefit enrollees, as well as reduce administrative burdens on the programs. To this end and given the growing body of research that has found that continuous eligibility translates into higher quality of care for the patient, ACAP is a strong supporter of providing 12-month continuous eligibility for Medicaid eligible adults.

In addition, Exchanges should adopt policies and tools for plan selection that facilitate continuity of coverage for consumers whose eligibility will be shifting between Medicaid and the Exchange.

It is widely expected that small changes in income will result in frequent changes in eligibility for Medicaid, CHIP, and subsidized coverage in the Exchange. And even a temporary loss of health coverage can have significant, adverse consequences. According to modeling conducted by the Lewin Group, nationally, on average 40% of low-income subsidized Exchange populations will be:

1. Previously enrolled in Medicaid/CHIP
2. Previously enrolled in a premium subsidy program
3. Previously uninsured (with our without family members in Medicaid)

Enrollment churning between subsidized coverage through the Exchange and Medicaid and CHIP could be disruptive to individuals' plan of care – especially important for those with chronic conditions. Medicaid Safety Net Health Plans are familiar with the churn of low-income individuals in and out of their safety net programs and the increase in service utilization that enrollment churn brings. They have programs and policies specifically designed to manage the continuity of care issues that are created by gaps in coverage. Thus, Safety Net Health Plans offer a turnkey solution to managing the effects of volatility in coverage that is possible as individuals and families cycle between the Exchange and Medicaid and CHIP. However, the best solution for consumers is to design the Exchange so that breaks in coverage and movement among various programs is minimized.

As noted above, individuals and families who were enrolled in Medicaid, CHIP or other premium subsidy programs but later access coverage through the Exchange may wish to remain with their plan. Providing this type of continuity allows families to remain under a single plan and eliminates the need to find new providers who may not know their medical history and the treatments and services that work best. Further, approaches that support continuity of coverage reduce the need for consumers to adjust to new plan policies and procedures each month, even as their income fluctuates.

*Simplified Enrollment Options for Consumers.* Exchanges should prioritize enrollment processes that minimize disruption in coverage for vulnerable populations. The difficult experience of transitioning dual eligibles from Medicaid to the Medicare Part D prescription drug program offers some insight into the types of policies, tools, and procedures that may be needed to accommodate the millions of individuals who will newly be eligible for Exchange-based coverage.

As noted earlier, evaluating the various Exchange based options and enrolling may be confusing for consumers; they will need assistance understanding and identifying the best coverage options for them. One approach would be for the Exchange to prospectively assign or "nudge" individuals to a plan based on where they received their care under Medicaid. That is, if they were enrolled in a Medicaid health plan that participates in the Exchange, they would be given information to make an informed choice about which plan to choose, including which Exchange

plans would allow them to keep their current providers. Enrollment material could be written to promote the idea of continuity of care with the same health plan. However, individuals would still be notified of their option to choose another plan.

In addition, the experience in Massachusetts demonstrates that families transitioning between the Exchange and Medicaid and CHIP will need assistance navigating the choices and identifying the best option for them. A similar prospective type enrollment process into a Medicaid health plan – with an opt-out—could be used to allow families to remain in a single plan, regardless of whether they are eligible for Medicaid, CHIP or subsidized coverage through the Exchange. For example, in a family whose income is 185 percent of the federal poverty level, the children would be eligible for CHIP and the parents eligible for subsidies in the Exchanges. However, many families will want to enroll in the same health plan. These families will need assistance in identifying their options and direction to the plan that meets these criteria.

Similarly, this option would also be useful in simplifying the re-enrollment process after an individual or family has a gap in coverage. Gaps in coverage may occur due to income changes, non-payment or delayed compliance with renewal requirements. In these situations individuals would automatically be enrolled into their previous plan or the plan of other household members, with the option to change plans.

ACAP also concurs with the recent statement by Cindy Mann, Director of the Center for Medicaid, CHIP, and Survey & Certification, that efficient enrollment in Medicaid and CHIP will require marrying the enrollment and renewal processes with that of the state health insurance Exchanges. In addition, Exchange Navigators will play an important role in helping low income individuals and families identify Safety Net Health Plans that have robust provider networks with federally qualified community health centers (FQHCs), public hospitals, clinics and other safety net providers in places that traditional insurance typically does not.

Quality Rating Systems

ACAP recommends that any standardized rating system for Exchange plans should account for the needs of the diverse population that will access coverage through this new entity, including low income, underserved individuals and families. Specifically, characteristics of these populations, such as individuals with multiple chronic conditions, who are homeless, have behavioral or mental health issues, or face socioeconomic or other barriers could require more plan management to improve outcomes. The Exchange rating system also should reflect the growing body of literature which documents that language, country of origin, education level, health literacy, as well as income may impact the ability to adhere to care standards and may increase plan care management requirements. Therefore, Exchange plans should not be penalized for attracting a higher proportion of such enrollees.

Regarding OCIIO's questions about current quality measures, ACAP notes that one of the challenges that Medicaid safety net plans currently are working to address is the fact that the

Healthcare Effectiveness Data and Information Set (HEDIS) measures are currently not risk adjusted. While many Safety Net Health Plans are NCQA-accredited and rank highly on national quality measurements for Medicaid, they have done so through concentrated efforts with difficult to manage populations. Risk adjustment for quality measures would level the playing field as Medicaid, including Safety Net Plans, which will likely serve higher-risk members, are rated against plans with lower risk enrollees.

We also note that the experience with dual eligible Medicare Advantage Special Needs Plans (MA-SNPs) shows a disproportionate share of enrollees with cognitive disorder, mental health and substance abuse diagnoses. While MA-SNPs serving dual eligibles score on average the same as general enrollment MA plans on the Consumer Assessment of Healthcare Providers and Systems (CAHPS) and plan operational measures (health plan responsiveness, customer service and member complaints), they score lower on HEDIS and Health Outcomes Survey measures due to the health challenges faced by of low income groups. Therefore, common quality ratings metrics such as clinical outcomes and measurements and consumer satisfaction may not be the best indicators of quality for plans that treat lower income populations or they may need to be modified.

In the Exchange marketplace, the Navigator program participants will advise consumers -- and employers – about how to use the Exchange system. ACAP recommends that this education should include information on different types of health plans in the Exchange and how to value plan elements, such as provider networks.

Safety Net Exclusion from the Annual Excise Tax on Insurers

ACAP supports legislative changes to ensure the annual excise tax on insurers is not a barrier to safety net health plan participation in the Exchanges. Under the PPACA legislation, Congress recognized the special role that Safety Net Health Plans have in the health care marketplace by exempting them from the health plan excise tax if their revenues from Medicare, Medicaid, and CHIP exceed 80 percent of total revenues. However, if these plans participate in the Exchange and serve the subsidized population, their revenue mix will change. Revenues from the subsidized population are currently *not* subject to the 80 percent calculation – making Safety Net Plans potentially subject to the annual fee even though they would still be serving a low-income, federally subsidized population. ACAP respectfully requests that the exclusion from the excise tax for Safety Net Health Plans' be broadened to include revenues from subsidized premiums and that it be extended to include for-profit subsidiaries of not-for-profit insurers (or health plans).[3,4]

[3] Ibid.

[4] The Healthcare and Education Reconciliation Act of 2010, included the following exemption from the annual excise tax on insurers at Section 1406 (a)(2)(C) "*any entity— ''(i) which is incorporated as a nonprofit corporation under a State law, (ii) no part of the net earnings of which inures to the benefit of any private shareholder or individual, no substantial part of the activities of which is carrying on propaganda, or otherwise attempting, to influence legislation (except as otherwise provided in section*

Accreditation Standards

ACAP encourages Exchanges to identify appropriate accreditation policies that are inclusive of the different types of plans that wish to participate. For example, the External Quality Review Organization (EQRO) could be one acceptable Exchange accreditation standard for Medicaid health plans in states that do not require NCQA or URAC accreditation for their state Medicaid program. Alternatively, EQRO could be a transitional accreditation as Safety Net Health Plans work towards obtaining the multi-year NCQA or other required accreditation.

Exchange Service Area

Policymakers also must thoughtfully consider how to define the market or rating area of the Exchange. For example, many states, particularly most large states, have multiple service areas within the state, defined by geographic variation or population. Regulators must allow the option of creating regional-based service areas within a state to allow participation from Safety Net Health Plans.

Decisions about the service areas should weigh the implications for consumers who may currently or wish to be enrolled in a community-based plan – a plan that by definition may not serve the entire rating area defined by the Exchange. Safety Net Health Plans are by definition state and local market specific. Most do not operate in multiple states. They are often more integrated into the fabric of their community social service infrastructure and provide a community focus and connection to services and supports that are needed by the lower income subsidized Exchange population.

Exchange Financing

One option to ensure the sustainability of Exchanges beginning in 2015 is to assess a fee on insurers that participate. ACAP recommends that federal guidance encourage, and state Exchanges adopt, a fee structure that is balanced with the need to promote diversity of plans in the Exchange.

Risk Adjustment Systems

Risk adjustment systems should include risk factors that are highly prevalent in lower income populations. Risk adjustment must take into account diagnoses as well as income, language barriers, and other barriers for the populations that will be covered through the Exchange. Such

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*501(h) of the Internal Revenue Code of 1986), and which does not participate in, or intervene in (including the publishing or distributing of statements), any political campaign on behalf of (or in opposition to) any candidate for public office, and (iii) more than 80 percent of the gross revenues of which is received from government programs that target low-income, elderly, or disabled populations under titles XVIII, XIX, and XXI of the Social Security Act."*

systems must also account for the proportion of a plan's network that is comprised of providers that serve higher risk populations, such as community health centers, hospital based clinics, and others. As noted previously many Safety Net Plans have a lot of members who receive health care services through community health centers. The cost for these services may well be higher than non-clinic providers because the Affordable Care Act requires that federally qualified health centers (FQHCs) be reimbursed as the prospective payment system (PPS) rates for Exchange products.

CO-OP program

Safety Net Health Plans are interested in exploring how they can meet the goals and criteria of the CO-OP program given their nonprofit status and community focus. Safety net plans already serve many of the needs that CO-OPs are intended to serve and may be interested in applying for the CO-OP program loans and grants. In fact, ACAP's "incubator plan," the Maine Primary Care Association, has applied for funding to explore options around the CO-OP program, and ACAP supported this application. Other ACAP plans or emerging plans are exploring the CO-OP option as it may be a more viable pathway to participate in the Exchange.

Additional Questions for Consideration

As you continue to develop federal Exchange regulations and guidance we hope you will consider the following questions:

Will it be possible for the federal government to provide a waiver to states from certain provisions of the law to ensure the participation of Safety Net Health Plans? Are states able to make this determination without federal approval?

What policies will be applied to determine the interaction between the Exchange and the Basic Health Plan in states that take up this option? Will OCIIO consider extending the same continuity of coverage policies recommended for Medicaid?

After the initial enrollment period, could renewal policies of the Exchange and Medicaid and CHIP be tied to the birth date of the head of household?

Safety Net Health Plans have developed expertise necessary to manage the range of concerns that may not be addressed by other health care delivery systems. Through partnerships with their safety net providers, including community health centers, public hospitals, children's hospitals, and primary care providers, Safety Net Plans ensure that Medicaid enrollees have regular access to appropriate, patient centered care and to connect enrollees with the social supports they need to maintain good health. Medicaid health plans have served as the vehicle for expansion efforts in state and county health coverage expansion reform initiatives. This

results in a natural fit with or extension of the mission of Safety Net Plans and the subsidized individual Exchange consumers.

ACAP and its members look forward to working with you to design the policies and framework for fully functioning Exchanges that will meet the needs of a diverse population, including vulnerable populations.

Sincerely,

Margaret A. Murray
Chief Executive Officer
Association for Community Affiliated Plans
Mmurray@communityplans.net

Cc:
Cindy Mann, Director, Center for Medicaid, CHIP, and Survey & Certification, Centers for Medicaid and Medicare Services

To: Jolie Matthews, NAIC
Fr: Georgia Maheras, Health Care for All
Sabrina Corlette, Georgetown University Health Policy Institute
Joe Ditre, Consumers for Affordable Health Care
Steve Finan, American Cancer Society Cancer Action Network
Tim Jost, Washington and Lee University
Stacey Pogue, Center for Public Policy Priorities
Wendell Potter, Center for Media and Democracy
Lynn Quincy, Consumers Union
Naomi Senkeeto, American Diabetes Association
Barbara Yondorf, Colorado Health Care Initiative
Date: October 6, 2010
Re: NAIC draft "American Health Benefit Exchange Model Act"

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Thank you for the opportunity to comment on the draft American Health Benefit Exchange Model Act (Model Act) exposed on September 29th. The creation of the Exchange is a key component of a state's implementation of the ACA and providing health insurance coverage for its residents. The ACA requires that Exchanges include many components, which have been laid out in this Model Act. Additionally, the ACA affords states the opportunity to customize their Exchange for their state and their insurance market. Many of these choices are highlighted in drafting notes throughout the Model Act. The Exchanges will be key to enrolling an estimated 29 million uninsured Americans into health insurance coverage. They also provide each state with the ability to increase competition among carriers and provide residents with affordable health plan options.

Our specific comments on the draft Model Act are below:

**Section 4. Establishment of Exchange**

*Operating the Exchange*

The exchange could be located within a state agency, as a quasi-state agency or a non-profit entity. Each of these governance structures presents different challenges and opportunities in the operation of the Exchange and each state will choose the format that best fits the needs of their residents. Regardless of the format chosen, the Exchanges should be accountable to the residents of that state. The Exchange should have to comply with open meeting laws, and public comment periods for rules and guidance that it develops. The Exchange should be a transparent entity that enables all stakeholders to understand and participate in the decisions being made. *We recommend emphasizing the levels of accountability and transparency available in each structure in the discussion of these structures in the drafting note on pp. 4-5.*

The drafting note on pp. 4-5 highlights the advantages and disadvantages of different exchange governance options. For states considering delegating responsibility for the exchange to a separate non-profit entity, *we recommend that the Drafting Note flag the possibility that in some states, constitutional non-delegation requirements could limit the viability of that option.*

*Exchange Board*
The drafting note on pp. 4-5 of this Model Act provides extensive discussion regarding governance of the Exchange. Meaningful consumer involvement is critical in design and governance of Exchanges. As the drafting note indicates, states may choose to operate Exchanges as an arm of state government, through quasi- governmental or contracted entities, or in regional collaboratives. In any case, the structure should provide for a strong consumer voice in decision-making and exclude representatives with conflicts of interest. Those involved with governance should also include key stakeholder-beneficiaries such as employers, but should exclude those with conflicts of interests because they have a direct financial stake in the health system--such as organizations and individuals representing hospitals, physicians, insurers and producers. State officials, such as the insurance regulator and the Medicaid director should have a formal role in the governance of a successful Exchange. Decisions by the Exchange must be perceived as free from conflicts of interest in order to gain wide acceptance as being in the best interest of the state. The governance should include a diverse group that provides balanced policy guidance to the Exchange and the Exchange staff. *We recommend a drafting note that reads:*

> **Drafting note:** In determining the composition of the Exchange Board, the State should consider including both the lead insurance regulator and the Medicaid Director as Board members. Additionally, the State should consider the financial conflicts of various types of Board members as they determine, which Board would provide leadership that is in the best interest of that State.

*Exchange Staff*
It is important that the Exchange be staffed with individuals who have subject-matter expertise in the programs that the Exchange is creating. The staff should also be able to evaluate overall market trends and data about the Exchange products to enable to Exchange to comply with the requirements of the ACA. The Exchange Board could select the Executive Director, but this person could also be appointed by someone else in the Government. *We recommend a drafting note that reads:*

> **Drafting note:** The staffing structure for an ACA should be designed to support staff who have subject-matter expertise and who are able to work within a complicated regulatory environment.

*Cross-agency Coordination*
For Exchanges to work effectively and provide a seamless, administratively simple avenue for individuals and small business owners to select and purchase insurance coverage, states will need to establish a structure that encourages cross-agency consultation and coordination. Exchange governance authorities should be required to

consult regularly with the state's insurance regulators, Medicaid agency, and, where appropriate, attorney general and public health officials. At the same time, states should amend their statute to require these officials to coordinate their activities with the Exchange. In addition, where appropriate, these state agencies should be required to lend expertise and resources to the Exchange.

**Section 5. General Requirements**

*Additional Benefits*
We request that you change the drafting note on the top of page 6 to read:

> The Federal Act allows States to require additional benefits, but only if the State defrays the additional net costs of premium and cost-sharing assistance to enrollees in qualified health plans. States electing this option should modify subsection C accordingly, specifying the additional benefits required and the mechanism for payment to or on behalf of the enrollees.

While the ACA does not specify whether the costs would be net or gross costs, we believe that the States should evaluate net costs. Some benefits, like prescription drugs, add to the premium, but the overall cost is offset significantly by the reduction in more expensive inpatient hospital care.

Additionally, States should consider establishing a process that would allow for an impartial, independent process that is free from conflict of interest to determine whether a particular benefit mandate adds any net costs to premiums, and if so, by what amount. For example, if a state is contemplating adding a mandated benefit requiring coverage of flu shots, the value of the flu shot in lowered health care costs should be compared to the cost of delivering the flu shot. *We recommend a drafting note that reads:*

> **Drafting note:** States should consider establishing a process that would allow for an impartial process to determine whether a particular benefit mandate adds any net costs to premiums, and if so, by what amount. This will allow a State to determine the value of the benefit to the State's residents.

*Market Rules Outside the Exchange*
Avoiding adverse selection will be one of the key challenges for an Exchange. In order to mitigate adverse selection between the Exchange and the market outside the Exchange, we believe that states should require plans to meet specified certification requirements in both markets. *We recommend adding the following drafting note:*

> **Drafting note**: The ACA requires participating QHPs to meet specified certification requirements, such as meeting network adequacy, marketing and accreditation standards. In order to ensure a level playing field with plans operating outside of the exchanges, States should consider applying the same certification requirements to all plans in the state. It will be particularly important for states to impose the same marketing and benefit design standards on plans both within and

outside the exchange. States should also require plans operating outside the exchange to offer at least silver and gold level coverage in addition to bronze level coverage in order to minimize adverse risk selection against the exchange.

**Section 6. Duties of Exchange**

This section of the Model Act identifies those tasks that an Exchange must undertake pursuant to the ACA. It also highlights some areas where the State has discretion. In deciding whether to run one or more Exchanges and what legal structure to use for an Exchange, states will consider whether they are going to merge small group and individual markets, the administrative costs of operating more than one exchange, regional difference in markets, what the appropriate balance between accountability and flexibility. In general, operating multiple Exchanges adds administrative cost and duplicates functions without providing commensurate benefit.

A State has the opportunity to use one Exchange to run the plans for SHOP and the individual market. Further, the State can choose to merge the two insurance markets together so that there is one small group/individual market, which would provide pooling benefits to both markets. Alternatively, the State could also continue with two separate markets, but sell both products within one administrative entity. In either case, an Exchange can only hold down insurer costs and move the system to offering plans with greater value and quality if it has sufficient market authority — and to have this, the Exchange needs to enroll a significant number of people. It's important to broaden, and not carve up, insurance markets to provide Exchanges with enough covered lives to be able to negotiate good prices and coverage with insurers. This is a reason to combine individual and Small Business Health Care Options Program (SHOP) Exchanges.

*We recommend a drafting note that discusses the pros and cons of merging the insurance markets:*

**Drafting note:** As a State creates its Exchange, it should consider the value of merging the small group and private insurance markets. Merging these two markets could mitigate adverse selection and promote cost savings in either or both of those markets.

We recommend adding the following concepts as options that are allowed to States under the ACA:

- An Exchange has the opportunity to be an 'active purchaser'. To do this, the Model Act should recommend express authority for the Exchange to limit participation, to the extent permitted by HHS, to plans that offer the best value — meaning the best combination of price and quality. Specifically, the Exchange should consider factors such as rates and rate increases, Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) scores, and implementation of payment mechanisms to reduce medical errors and preventable hospitalizations, reduce disparities and improve

As stated by the sponsor of the "active purchaser" language during the Senate debate on the ACA, Senator John Kerry (D-MA) said: "One of the key ingredients to the success of health reform in Massachusetts is the ability of the Connector to negotiate with health plans. This negotiation process saves 6 percent off the cost of premiums and places pressure on insurers to keep rate increases low overall. Empowering Exchanges to engage in active purchasing would lower premiums for all enrollees in the Exchange, as well as, lower the amount of subsidy paid by the federal government."[1]

- Exchange enabling legislation should require that the state's Medicaid and Insurance agencies coordinate with the Exchange to fulfill the requirements of the ACA. Integration between the Exchange and Medicaid and CHIP is critical. Exchanges are not just a marketplace for insurance but will serve as the gateway to premium tax credits and cost-sharing assistance for most of its participants. Many people will move between Medicaid and CHIP and the Exchange plans as their incomes fluctuate[2]. It is absolutely essential to have a seamless integration with Medicaid and CHIP not only at initial eligibility determination but also as people's circumstances change.

- In principle, operating Exchanges across states could provide some benefits in terms of administrative efficiencies, particularly for metropolitan areas in which many citizens work and live in different states. However, a concern with regional or interstate Exchanges is retaining adequate standards for insurers across state lines, where it may be unclear which entity (or state) has regulatory authority. An additional complication is the need for a single Exchange to interface with two or more Medicaid and CHIP programs. States should be advised to allow significant lead time to address these key accountability issues, market differences, and Medicaid and CHIP interface issues to make cross-state Exchanges feasible for a 2014 start.

- Navigators, a critical component of Exchanges, are required by the ACA to be culturally and linguistically competent to help vulnerable populations understand

[1] Kerry, J. F. (2009, November 13). Letter to Majority Leader Harry Reid. Retrieved from http://kerry.senate.gov/press/release/?id=717f01f6-8cc3-4c56-97c5-a278c8f8b54b.

[2] The Exchanges and Medicaid and CHIP must develop systems that make it easy for people to retain their coverage through transitions. Massachusetts has found that there is significant income fluctuation with certain categories of workers like seasonal workers and those with sporadic work. The state altered its application to reflect the unique challenges presented by these workers so people were not unnecessarily moved on and off of coverage. Massachusetts studied the affect of income fluctuation on individuals and found that the overwhelming majority of individuals were eligible for coverage within two to three months of losing coverage.3 There is significant administrative burden to a state to disenroll and re-enroll individuals, which should be evaluated as the enrollment systems are created.

their health options and choose the right plan for their family. Navigators should build off of the existing foundation of strong consumer assistance programs in states, especially those that partner with community-based organizations with experience working with the uninsured and other populations with language barriers. It is critical that the Exchange provide outreach and enrollment support, especially targeted to vulnerable communities to help them enroll in Exchange plans. Information about Exchange health plans should at the very least meet the federal government's standards, available through the HHS Office of Minority Health available at: http://minorityhealth.hhs.gov/assets/pdf/checked/finalreport.pdf .

**Section 7. Health Benefit Plan Certification**

Section A on page 8 indicates that the Exchange may certify a health benefit plan as a qualified health plan pursuant to the requirements of the ACA. Certification of plans will be the Exchange's 'seal of approval' and an outward sign to health insurance consumers that these plans meet a specific, high-value standard. It is the responsibility of the entire Exchange Board to ensure that this process is free of conflicts of interest. It is important that the state officials serving on the Exchange Board work with the Exchange staff to provide rigorous evaluation of products and no one Board member should be authorized to act on behalf of the Board to certify a plan.

Section C(1) of the model act provides that the Exchange shall require justification for premium increases. The Exchange should work in concert with the Insurance regulator and, where appropriate, the Attorney General for rate review proceedings. The Exchange may require stronger premium review standards than some state insurance departments currently employ. For instance, a state Exchange could consider factors such as premiums and rate increases, use of education tools to give providers information about quality, use of clinical decision support tools and price and quality information for consumers, quality measures such as HEDIS and CAPHS scores, and implementation of payment mechanisms to reduce medical errors and preventable hospitalizations, reduce disparities, and improve language access. Certification as a QHP should be something that demonstrates to the consumer that these plans have been evaluated by the Exchange and offer good value to consumers — an added layer of consumer protection.

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October 6, 2010

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Submitted via email: jmatthew@naic.org

**Re: Comments on the American Health Benefit Exchange Model Act**

Dear Ms. Matthews:

Aetna welcomes the opportunity to comment on the National Association of Insurance Commissioner's ("NAIC") September 27, 2010 draft model American Health Benefit Exchange Act ("Model Act"), implementing the Patient Protection and Affordable Care Act's ("ACA") requirements with respect to state based exchanges.

Aetna is one of the nation's leading diversified health care benefits companies, providing members with information and resources to help them make better informed decisions about their health care. Our programs and services strive to improve the quality of health care while controlling rising employee benefits costs. Aetna offers a broad range of traditional and consumer-directed health insurance products and related services for early retirees, including medical, pharmacy, dental, behavioral health, group life, long-term care and disability plans and medical management capabilities.

As a key stakeholder affected by the Affordable Care Act, Aetna is committed to developing reasonable and administrable standards for the implementation of American Health Benefits Exchanges ("Exchanges"). The proper establishment of state-based Exchanges is one of the most critical implementation activities in the Affordable Care Act. We are submitting these comments in response to the NAIC's request.

## I. Clarify SHOP Exchange Enrollment

**Recommendation:** Aetna recommends that the NAIC clarify in the Model Act that qualified small employers may select one or more health plans for eligible employees.

**Rationale:** For an employer to offer coverage to its employees through an Exchange, it must be "qualified." ACA § 1312(a)(2). Qualified employers are those that elect to make

all full-time employees eligible for one or more qualified health plans offered in the small group market through an Exchange. ACA § 1312(f)(2). This "employer choice" structure is similar to how small employers currently purchase health insurance coverage; employers choose one (or more) health plans to offer to their employees.

The Model Act employer enrollment provisions, however, only directs Exchanges to "[e]stablish a SHOP Exchange through which individuals employed by qualified employers may enroll in any qualified health plan offered through the SHOP Exchange at the level of coverage specified by the employer." Model Act § 6.I. The ACA does state that "[a] qualified employer may provide support for coverage of employees under a qualified health plan be selecting any level of coverage under section 1302(d) to be made available to employees through an Exchange." ACA § 1312(a).

Importantly, however, the ACA *allows* employers to provide support for a tier of coverage—it does not require employers to do so. Instead, as explained above, the ACA provides that employers may choose one or more qualified health plans, ACA § 1312(f)(2), or an employer may allow his or her employees to choose from all the health plans offered in a particular benefit tier, ACA § 1312(a)(2).

We recommend that the Model Act be revised to state as follows:

> I. Establish a SHOP Exchange through which qualified employers may make all full-time employees eligible for one or more qualified health plans offered in the small group market through an Exchange. The SHOP Exchange may establish a pilot program through which individuals employed by qualified employers may enroll in any qualified health plan offered through the SHOP Exchange at the level of coverage specified by the employer.

**II. Include Necessary ACA "Consumer Choice" Provisions:**

**Recommendation:** We recommend that the Model Act include relevant provisions of section 1312 of the ACA's "Consumer Choice" provisions in the text of the Model Act**.**

**Rationale:** The Model Act should explicitly provide that health insurance products may continue to be distributed outside the Exchange, including grandfathered and new ACA compliant products. The ACA states expressly that nothing in the ACA may be interpreted to prohibit the offering or purchase of health insurance coverage outside of an Exchange. ACA § 1312(d)(1). In addition, the ACA provides that an individual cannot be compelled to enroll in health insurance coverage through an Exchange. ACA § 1312(d)(3)(B). Because individuals are required to obtain health insurance coverage, but cannot be required to purchase Exchange-plans, it is clear that Congress intended for a non-Exchange market to continue. Moreover, if Congress wanted to limit the health insurance market to Exchanges, it would have done so clearly and expressly, as was done for Members of Congress. ACA § 1312(d)(3)(D).

We recommend the Model Act be revised as follows:

Section 5. D. Continued Operation of Market Outside Exchanges – This Act shall not prohibit a health insurance issuer from offering outside of an

Exchange a health plan to a qualified individual or qualified employer and a qualified individual from enrolling in, or a qualified employer from selecting for its employees, a health plan offered outside of an Exchange.

E. Voluntary Nature of an Exchange – Nothing in this Act shall compel an individual to enroll in a qualified health plan or restrict the choice of a qualified individual to enroll or not enroll in a qualified health plan or to participate in an Exchange.

F. No Penalty for Transferring to Minimum Essential Coverage Outside Exchange – The Exchange, or a qualified health plan offered through an Exchange, shall not impose any penalty or other fee on an individual who cancels enrollment in a plan because the individual becomes eligible for minimum essential coverage (as defined in 5000A(f) of the Internal Revenue Code of 1986).

## III. Provide Authority to Allow All Qualified Health Plans into an Exchange

**Recommendation:** The Model Act should provide that state Exchanges have the authority to allow all qualified health plans to be offered through that state Exchange.

**Rationale:** The success of Exchanges hinges on the participation of a wide variety of qualified health plans, in order to attract and retain a robust segment of the individual and small group markets. Participation of a broad array of qualified health plans requires two essential things: (1) objective and transparent criteria for certification; and (2) sufficient lead time to meet those criteria. All health plans that have invested the time and resources to meet an Exchange's certification criteria should be permitted to compete within that Exchange. Health insurance issuers are unlikely to invest the significant resources required to develop qualified health plans without some assurance that such efforts can be successful. Exchanges that limit the participation of qualified health plans will suppress competition, reduce consumer choice and may cause market instability. The ACA requires Exchanges to foster consumer choice and consumers deserve to have the largest mix of qualified health plans from which to choose.

We recommend the Model Act be revised as follows:

Section 7.A(5). The Exchange shall certify all health plans meeting the requirements under 1311(c)(1) of the Federal Act and section 9 of this Act as qualified health plans. The Exchange may refuse to certify a health plan only after consultation with the [state department of insurance] and a determination on the record that denying certification to the plan will not reduce competition or consumer choice in the Exchange and that offering the plan through the Exchange is not in the interest of qualified individuals and qualified employers in this State.

## IV. Clarify That State Insurance Departments Remain Primary Regulator of Health Insurance Coverage

**Recommendation:** When certifying qualified health plans to participate in an Exchange, Exchanges should not negotiate premiums or other issues.

**Rationale:** It is important that the Model Act make clear that state Insurance Departments are exclusively responsible for regulating health insurance and health insurance issuers. As just one example, the NAIC noted in testimony before the Senate Committee on Health, Education, Labor and Pensions in November 2009, the rate review process must consider whether the rates proposed and established are sufficient. A key responsibility of state regulators is to ensure that insurance companies are financially stable and able to pay claims when they are incurred. Exchange authority in this area should be clearly bounded; granting Exchanges discretion to regulate health insurance plans and health insurance issuers would undercut state regulatory authority.

We recommend the Model Act and Drafting Note be revised as follows:

Section 5. General Requirements

G. Preservation of Regulatory Authority – Nothing in this Act shall be construed to limit or supersede the health insurance regulatory authority vested with [state department of insurance.] To the extent that an Exchange regulation, policy or procedure conflicts with a regulation, policy or procedure of [state department of insurance] the [state department of insurance]'s regulation, policy or procedure will control.

Section 6. Duties of Exchange

**Drafting Note:** The provisions in this section are the minimum requirements of the Federal Act. States that consider assigning additional duties to the Exchange, consistent with the Federal Act, should do so only to the extent appropriate to the State's currently regulatory structure, market conditions and policy goals. Optional clauses are provided at the end of this section to facilitate uniformity among those States that elect to use their Exchanges to address certain widely shared concerns.

* * *

Aetna is pleased to have the opportunity to provide comments regarding the NAIC American Health Benefit Exchange Model Act and we thank you for consideration of our comments. Should you have any questions, please feel free to contact me.

Sincerely,

Steven B. Kelmar

American Hospital Association

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*Submitted Via E-mail*

October 6, 2010

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***Re: National Association of Insurance Commissioners Draft Language for American Health Benefit Exchange Model Act***

Dear Ms. Matthews:

The American Hospital Association (AHA) is pleased to submit comments regarding the National Association of Insurance Commissioners' (NAIC) draft model language (Model Act) related to the American Health Benefit Exchange. With more than 5,000 member hospitals, health systems and other health care organizations, and 40,000 individual members, the AHA is the largest advocacy and membership organization representing our nation's hospitals.

The Model Act reflects the provisions in the *Patient Protection and Affordable Care Act* (ACA) that require states to establish and operate health insurance exchanges (Exchanges). The AHA supports an Exchange, as contemplated by the ACA, which creates a marketplace to expand consumers' access to health insurance coverage and offers consumers the opportunity to choose among health plans that fit their needs. Our comments below focus on three sections of the Model Act – the establishment of the Exchange, duties of the Exchange, and Health Benefit Plan Certification criteria.

**SECTION 4: ESTABLISHMENT OF THE EXCHANGE**

As we have indicated in previous letters, the AHA opposes housing the Exchange in an existing governmental agency because it would create the perception that the Exchange's purpose is to operate government programs, rather than serve as a marketplace for private insurance. Therefore, the AHA recommends that an Exchange be an independent quasi-governmental or nonprofit entity. Either one of these options will help achieve the following important goals:

- Focus the Exchange on its primary mission: to create a competitive marketplace for consumers to purchase coverage;

- Enable the Exchange to have flexibility in hiring practices to ensure a professional workforce; and,

- Generate broad support from the private sector (i.e., insurers, business, providers and consumers) that is crucial to the Exchanges' future financial stability.

The Model Act has incorporated the considerable flexibility granted by the ACA to state, in how to structure, govern and operate the Exchange. The AHA recognizes that the state's decisions regarding the organization and governance of the Exchange will be critical to the success and sustainability of the new insurance marketplace envisioned by the law. We believe that the state's decisions need to be supported by a thorough vetting of the issues and the consequences of the various options.

The Section 4A Drafting Note attempts to outline the structural and governance options available to the Exchange and some of the considerations associated with each option; however, the discussion of advantages and disadvantages of each of the options in the Drafting Note is limited and could be interpreted as favoring one option over another. For example, some of the disadvantages cited in the Drafting Note with regard to the quasi-government and nonprofit options, e.g., "isolation from state policymakers and key state agency staff" and "decreased accountability," do not include any qualifying statement that these issues could be addressed and overcome.

Therefore, the AHA recommends that the Section 4A Drafting Note be eliminated or significantly edited to clarify that the state has a variety of structural and governance options, each with advantages and disadvantages, and the Exchange (B) Subgroup is developing an issue paper on the options to assist states. The AHA believes that the Exchanges' structural and governance issues are so complex and important that the NAIC should defer commenting on the options in the Drafting Note until the deliberations of NAIC's Exchange (B) Subgroup can produce a more complete and balanced review of the options facing states.

**SECTION 6: DUTIES OF THE EXCHANGE**

The AHA believes a state needs the flexibility to design and implement an Exchange that addresses the unique needs of its populations, insurance marketplace and stakeholders, including consumers, employers and providers. To ensure that an Exchange has the broad-based support it needs to function, the AHA recommends that Section 6Q be amended to add hospitals and health systems to the list of stakeholders with whom the Exchange should consult with regard to carrying on its activities.

Additionally, the AHA recommends a Drafting Note that the Exchange provides language services as part of its eligibility and enrollment functions so that limited English-proficient individuals can understand information and access insurance. According to the American

Community Survey (2006-2008), more than 24 million or 8.7 percent of the population, speak English "less than very well" and should be considered limited English proficient for health care purposes. And, almost 20 percent of the U.S. population speaks a language other than English at home. The Exchange is charged with determining eligibility and handling the enrollment of all eligible individuals in order to reduce the number of uninsured and under-insured, as well as to decrease the level of uncompensated health care services. Language barriers can prevent access to information needed to enroll; thus, it is imperative that the Exchanges be accessible to people with limited English proficiency.

**SECTION 7: HEALTH BENEFIT PLAN CERTIFICATION**

Under the ACA, an Exchange is responsible for certifying health benefit plans that are offered through the Exchange. The Section 7A Drafting Note suggests that states consider whether the Exchange should delegate the certification function to the insurance commissioner. While the Exchange might rely on and acknowledge the regulatory compliance determinations by the relevant state agencies with particular specialized expertise, including the insurance commissioner and the health department, the Drafting Note should clarify that the Exchange has the authority and responsibility to certify health benefit plans that are eligible to participate in the Exchange.

The Secretary of the Department of Health and Human Services (HHS) will be promulgating rules governing certification of health benefit plans, and the states may adopt more stringent certification requirements to ensure that health benefit plans are compliant. The AHA recommends that the Section 7C Drafting Note include a comment that states may expand upon the certification requirements promulgated by the HHS Secretary. The AHA recommends that the Model Act include examples of certification criteria, outlined below, that should be adopted by an Exchange to ensure that health benefit plans offered in the Exchange meet the requirements of the ACA:

- **Network Adequacy**. While the HHS Secretary will promulgate rules that will incorporate a criterion related to network adequacy, the AHA recommends that the Drafting Note include a requirement that the health plan/issuer demonstrate, as part of the application, that it has an adequate network with sufficient capacity to accept new patients both initially and throughout the plan year, and that consumers will be able to access necessary services at a reasonable distance and in a reasonable timeframe. The AHA recommends that the Drafting Note include examples of ways to demonstrate provider network adequacy, such as disclosure of the list of community providers, the number, mix and geographic distribution of providers and the actual provider access criteria that the plan used in forming its network.

- **Language Services**. Since plans participating in the Exchange will be receiving federal financial assistance in the forms of subsidies and additional payments to offset cost-sharing for low-income enrollees, they are subject to the nondiscrimination requirements of § 1557 of the ACA, as well as Title VI of the *Civil Rights Act of 1964*. The AHA suggests a Drafting Note that the state health benefit plan certification regulations require that all participating plans/insurers provide and pay for language services for applicants

and enrollees. Private insurers in California are already required to do so under state law. And without an explicit requirement to pay for language services, plans are likely to pass the responsibility – and costs – on to their network providers. This would virtually relieve plans of their responsibilities to prohibit discrimination while placing a difficult burden on many providers to provide language services.

- **Quality Measures**. The AHA recommends a Drafting Note that any quality measure or rating system used by the Exchange to evaluate health benefit plans should be based on nationally recognized, consensus-developed quality standards that can be consistently and uniformly applied and measured.

Section 7C outlines the information that the plan/issuer must submit to the Exchange, the HHS Secretary and the state insurance commissioner. The AHA recommends that the list be expanded to require plans/issuers to submit data regarding timeframes for processing claims for their entire network in order to demonstrate that they are capable of processing claims payment on a timely and accurate basis. The AHA also suggests that Section 7C require health plans/issuers to submit encounter data so that the relevant state agency can evaluate whether enrollees are actually receiving services and are not being required to travel unreasonable distances to do so. Regular monitoring of encounter data would help ensure that plans are not operating "shadow" networks (networks that list providers but do not ensure they are accepting new patients under that plan).

The AHA appreciates the opportunity to comment on the NAIC's Model Act. Clear guidance will go a long way in ensuring the successful implementation of the ACA and the establishment of the Exchanges. The AHA looks forward to working with you and your staff to meet this challenge. If you have any questions about our comments, please contact Molly Collins Offner, policy director, at mcollins@aha.org or (202) 626-2326, or Ellen Pryga, policy director, at epryga@aha.org or (202) 626-2267.

Sincerely,

/s/

Linda E. Fishman
Senior Vice President
Public Policy Analysis and Development

October 6, 2010

Co-Chair Commissioner Sandy Praeger
Co-Chair Director McRaith
NAIC (B) Committee Exchange Subgroup

CC: Jolie Matthews, NAIC Senior Health Policy Advisor and Counsel

Subject: **Proposed American Health Benefit Exchange Model Act**

Dear Commissioner Praeger and Director McRaith,

These comments are submitted on behalf of America's Health Insurance Plans (AHIP), the nation's trade association representing nearly 1300 member companies providing health, long-term care, dental, disability and supplemental coverage to more than 200 million Americans, and its member companies.

We are pleased to work with you on the regulatory implementation of reforms as a result of federal Patient Protection and Affordable Care Act (PPACA) in the states. We thus appreciate the opportunity to provide comments on the exposed draft of the American Health Benefit Exchange Model Act.

We have a few comments and recommendations on this exposed draft.

- First, we appreciate that the model takes two key approaches – it tracks closely to the requirements of the Federal act, and it recognizes the range of flexibility provided by that act for states to enact Exchanges consistent with their unique state's needs.

- The new model's purpose and intent language is clear. And the draft achieves its intent to focus on an Exchange to facilitate the purchase of qualified health plans in the individual market, and to establish the Small Business Health Options Program to assist small employers in facilitating the enrollment of their employees in qualified health plans offered in the small market.

- We note that in a later Drafting Note, the model act refers to development of an "issues paper" on elements for consideration by states on governance issues, and another issues paper on elements for consideration by states that wish to establish regional or interstate

exchanges. Like other stakeholders, our health plan community is interested in the NAIC's work on those issues. AHIP and health plans stand ready as a resource to help the NAIC as work moves forward on those issue papers.

Our comments on the specific sections follow.

In Section 3. Definitions:

§3 (F) "Health Benefit Plan" we appreciate that the language has been revised to ensure consistency with the definitions used in HIPAA and PPACA. We note that the reference to "carrier" here should be revised to refer to "health carrier" as defined and used elsewhere.

§3 (G) "Health Carrier" is a standard definition found in many NAIC models. In this case, we suggest a drafting note to be added, to refer to the requirement of "solvency", for health carrier's offering qualified health plans.

**Drafting Note**: It is important that all health carriers in an exchange be subject to the same requirements for licensure as a health carrier. There is not greater protection to consumers than requiring a carrier to be licensed as a condition of offering health benefits to the public. Important consumer protections include financial requirements to assure that a carrier has sufficient revenue and reserves to meet its contractual obligations, requirements to assure appropriate governance, requirement to assure that a carrier has an adequate network to meet the needs of its enrollees, oversight of the carrier's marketing strategies and materials, and processes for consumers to appeal coverage decisions by carriers. Unless all carriers within the exchange are subject to the same regulations and requirements, consumers can't be assured that they will have adequate protection and the licensed carriers could be put at a competitive disadvantage. .

If the drafting note is not accepted here, alternatively, we suggest that requirement be set forth in §7 (A)(3)(a) which requires a health carrier offering the plan to be licensed and in good standing to offer health insurance coverage in the state.

§3 (J) Qualified Employer includes language that is not consistent with the language of PPACA. Qualified employer (as defined in section 1312(f)(2) of the Patient Protection and Affordable Care Act) states:

*(2) Qualified Employers.—In this title:*

*(A) In General.—The term ''qualified employer'' means a small employer that elects to make all full-time employees of such employer eligible for 1 or more*

*qualified health plans offered in the small group market through an Exchange that offers qualified health plans.*

Thus, we recommend the proposed definition be modified to this version:

J. "Qualified employer" means a small employer that elects to make ~~its~~ all full-time employees ~~and, at the option of the employer, some or all of its part-time employees~~ eligible for one or more qualified health plans offered in the small group market through the Exchange provided that the employer:

(1) Has its principal place of business in this State and elects to provide coverage through the Exchange to all of its eligible employees, wherever employed; or

(2) Elects to provide coverage through the Exchange to all of its eligible employees who are principally employed in this State.

§3 (O) "Small Employer" is defined correctly, but missing the language of PPACA at the end of the sentence that says "and who employs at least 1 (one) employee on the first day of the plan year".

In Section 5. General Requirements:

§5 (C) discusses additional benefits which may be offered. The draft language uses the terms "other than", and the PPACA language refers to "additional". We believe the intent here is not to replace the PPACA requirements, but rather to reflect the options states have of offering additional benefits – even if it adds costs to states. Thus we recommend the language be changed to:

C. The Exchange may make a qualified health plan available notwithstanding any provision of law that may require benefits ~~other than~~ in addition to the essential health benefits specified under section 1302(b) of the Federal Act.

In Section 6. Duties of Exchange:

The Drafting Note, in its second sentence, states that "States are encouraged to consider assigning additional duties…" This appears to be stronger language than needed, and thus we suggest "are encouraged to" be changed to "may need to".

§6 (K) (2) (a) and (b) use terms not used in PPACA, thus we recommend they be stricken:

(a) The employer did not provide minimum essential ~~health benefits~~ coverage; or

(b) The employer provided the minimum essential ~~health benefits~~ coverage, but it was determined under section 36B(c)(2)(C) of the Internal Revenue Code to either be unaffordable to the employee or not provide the required minimum actuarial value; and

Finally, we note that the language in the model conforms to the language of PPACA to a high degree, and we appreciate that consistency.

As states move forward with their implementation of exchanges, there are some key considerations that will assist states, consumers, health plans and other stakeholders in achieving a robust state insurance marketplace. We will look forward to discussing those with the Exchange (B) Committee as well, as this process moves forward.

AHIP is committed to the successful implementation of the provisions and market reforms of PPACA, as you are. And we look forward to working with you on exchange development.

Sincerely,

C. M. (Candy) Gallaher
Vice President, State Policy

American Optometric Association
243 N. Lindbergh Blvd • St. Louis, MO 63141 Blvd • (314) 991-4100
FAX: (314) 991-4101

October 6, 2010

Sandy Praeger, Commissioner
Michael T. McRaith, Director, Illinois Department of Insurance
Lead Regulators, Exchanges (B) Subgroup
Health Insurance and Managed Care (B) Committee
National Association of Insurance Commissioners

Submitted electronically via jmatthew@naic.org

Subject: Proposed Model Legislation on Insurance Exchanges

Dear Commissioner Praeger and Director McRaith,

The American Optometric Association (AOA) submits our comments to the Exchanges Subgroup of the Health Insurance and Managed Care Committee of the National Association of Insurance Commissioners (NAIC) regarding state model legislation related to the development of health insurance exchanges as mandated under Title I of the Patient Protection and Affordable Care Act (ACA).

The AOA represents approximately 36,000 doctors of optometry, optometry students and paraoptometric assistants and technicians. Optometrists serve patients in nearly 6,500 communities across the country, and in 3,500 of those communities optometrists are the only eye doctors. Doctors of optometry provide more than two-thirds of all primary eye and vision health care in the United States. Without optometrists, the eye care needs of the American public cannot be met. Therefore, the AOA would recommend to the NAIC that in your model legislation you protect and promote access to optometrists in state health insurance exchanges.

While many provisions in the ACA will have an effect on the delivery of vision and eye health care in the United States, the AOA believes Section 1201 in Title I of the ACA is crucial to providing quality, affordable health care for all Americans participating in the state health insurance exchanges. The success of plans in meeting these specific requirements would be good criteria for rating the quality of care provided. Improved quality and affordability are the two major goals of the legislation and the AOA believes these goals should be reflected in the model legislation the NAIC is developing.

Section 1201 amends the Public Health Service Act to require, among other patient protections, that plans not discriminate among health care professionals based solely on their professional

degrees. The law prohibits a group health plan or an issuer offering group or individual health insurance coverage from discriminating, with respect to participation under the plan or coverage, against any health care provider who is acting within the scope of that provider's license or certification under applicable state law. This provision increases choice and access for patients by preventing plans from arbitrarily eliminating access to licensed practitioners based solely on their professional degree (and not based on their abilities). Many states have recognized this need and have adopted similar requirements or standards for plans in their individual and group markets. By increasing the pool of potential network participants, these non-discrimination provisions provide patients with more choices, increase market competition among providers, and incentivize all practitioners to further improve the quality and cost of the services they provide.

The AOA wants to ensure that non-discrimination laws and regulations which already exist in many states apply to plans participating in the state insurance exchanges. The AOA would recommend to the NAIC language honoring current state non-discrimination provisions be added to your model legislation as a *Subsection (6)* to Section 7(A) that defines health benefit plan certification:

> *(6) A plan must certify that it is in compliance with provider non-discrimination rules as mandated in state law and regulations developed by the insurance regulatory agency and reflected in Section 1201 of Title I of the Patient Protection and Affordable Care Act.*

The AOA wants to ensure that vision care services performed by optometrists are integrated in the health care delivery model and supports that this care be reimbursed in same manner as vision care services performed by ophthalmologists. Optometrists and ophthalmologists both provide medical eye and vision care in this country, and few general practitioners have the specialized training or equipment necessary to provide this care. In section 1861(r) of the Social Security Act, both optometrists and ophthalmologists are defined as physicians, thus demonstrating the importance of optometry in the delivery of primary vision and eye health care. Access to providers will be critical under the expansion created by exchanges. Ensuring that Section 1201 of the ACA and state non-discrimination laws are reflected in the exchanges will be an important aspect of the state health insurance exchanges.

Additionally, the AOA would propose an amendment to ensure that providers have a role in the governance structure and another amendment that will ensure the sharing of important participation information of providers participating in an exchange. In Section 6(Q), a series of stakeholders that are involved with assisting consumers obtaining insurance are listed and a requirement that the Exchange consult with these stakeholders regarding "the activities required under this Act." The AOA would maintain that all providers offering services in the exchange would have valuable feedback for the Exchange and could offer insight about covered populations. The AOA would recommend to the NAIC that you add a Section 6(Q)(6):

> *(6) State associations representing providers of health care services.*

The AOA's final recommendation is language that would assist the provider community in obtaining information that would aid in the enforcement of the recommended amendment to Section 7(A) by adding language to Section 7(C)(2)(a)(iii) that would require plans to report on the number of providers participating as well as the number enrolled. The AOA would recommend the language read:

*(iii) Date on consumer enrollment and provider participation;*

The above changes would not only benefit optometry but would benefit all providers of healthcare who are working to ensure that the patients who receive insurance coverage through the exchanges have access to the best of care by ensuring that the providers of the care are empowered with the information necessary to improve provider access.

On behalf of our membership and the tens of millions of Americans that our members serve, we thank you for considering these comments and using this feedback to help guide the development of the health insurance exchanges. Please contact Brian Reuwer, Assistant Director for Advocacy and Affiliate Outreach at breuwer@aoa.org or (703) 837-1343 if you have questions or need additional information about these comments.

Sincerely,

Bobby Jarrell, OD, FAAO
Chair, AOA State Government Relations Center Executive Committee

CC: Mike Kreidler, OD Insurance Commissioner, State of Washington

**Email: 10-6-10 ARKANSAS BLUE CROSS AND BLUE SHIELD**

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**From:** Welch, Shirl M. [mailto:SMWELCH@arkbluecross.com]
**Sent:** Wednesday, October 06, 2010 11:52 AM
**To:** Matthews, Jolie H.
**Subject:** Comments on Model Exchange Act from Arkansas Blue Cross and Blue Shield

Ms. Matthews,

Attached are the comments from Arkansas Blue Cross and Blue Shield concerning the Exchange Model Act.

In summary our changes include:

- Section 3.F.(4) - adding a bullet (c) to read "Limited Scope of medical benefit plans (mini-med)."
- Section 3.K - adding to the definition of a "Qualified Health Plan," statement, "or is a Federally Qualified HMO."
- Section 5.B.(1) - add to the sentence, "or is a Federally Qualified HMO."
- Section 7.A.(4) - add to the sentence, "is a Federally Qualified HMO."
- Section 8.A. We recommend you replace the current clause with:

  The Exchange shall add applicable exchange fees (assessments/user fees) to the premium costs of the health carriers and these fees should be transparent to applicants, health carriers will collect these fees and on a periodic basis forward these collected fees to the Exchange based on the per member per month or per policy per month exchange fee. The fee should not be included in the administrative fees of the health carriers.

We have included these changes in the document for your reference.

Thank you for your consideration of these suggested changes. If you have questions, please contact me.

Shirl Welch
Arkansas Blue Cross and Blue Shield
Project Manager
501-396-4054

# ARKANSAS BLUE CROSS AND BLUE SHIELD COMMENTS

Draft: 9/27/10
*A new model*

Comments are being requested on this draft on or before Oct. 6, 2010. Comments should be sent only by email to Jolie Matthews at jmatthew@naic.org.

## AMERICAN HEALTH BENEFIT EXCHANGE MODEL ACT

**Table of Contents**



### Section 1. Title

This Act shall be known and may be cited as the American Health Benefit Exchange Act.

### Section 2. Purpose and Intent

The purpose of this Act is to provide for the establishment of an American Health Benefit Exchange to facilitate the purchase and sale of qualified health plans in the individual market in this State and to provide for the establishment of a Small Business Health Options Program (SHOP Exchange) to assist qualified small employers in this State in facilitating the enrollment of their employees in qualified health plans offered in the small group market.

**Drafting Note:** States expanding the definition of "qualified employer" to include large employers, as permitted beginning in 2017 under the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) (Federal Act), should remove the reference to "small" employers.

### Section 3. Definitions

For purposes of this Act:

A. "Commissioner" means the Commissioner of Insurance.

**Drafting Note:** Use the title of the chief insurance regulatory official wherever the term "commissioner" appears. If the jurisdiction of certain health carriers, such as health maintenance organizations, lies with some state agency other than the insurance department, or if there is dual regulation, a state should add language referencing that agency to ensure the appropriate coordination of responsibilities.

B. "Educated health care consumer" means an individual who is knowledgeable about the health care system, and has background or experience in making informed decisions regarding health, medical and scientific matters.

C. "Exchange" means the [insert name of State Exchange] established pursuant to section 4 of this Act.

D. "Federal Act" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any amendments thereto, or regulations or guidance issued under, those Acts.

## ARKANSAS BLUE CROSS AND BLUE SHIELD COMMENTS

E. "Group health plan" means an employee welfare benefit plan as defined in section 3(1) of the Employee Retirement Income Security Act of 1974 to the extent that the plan provides medical care, as defined in subsection I, and including items and services paid for as medical care to employees, including both current and former employees, or their dependents as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise.

F. (1) "Health benefit plan" means a policy, contract, certificate or agreement offered by a carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

**NOTE:** The Statutory Language Team recognizes that the definition of "health benefit plan" needs to be revisited to ensure its consistency with definitions used in HIPAA and the Affordable Care Act.

(2) "Health benefit plan" does not include:

(a) Coverage only for accident, or disability income insurance, or any combination thereof;

(b) Coverage issued as a supplement to liability insurance;

(c) Liability insurance, including general liability insurance and automobile liability insurance;

(d) Workers' compensation or similar insurance;

(e) Automobile medical payment insurance;

(f) Credit-only insurance;

(g) Coverage for on-site medical clinics; or

(h) Other similar insurance coverage, specified in federal regulations issued pursuant to Pub. L. No. 104-191, under which benefits for medical care are secondary or incidental to other insurance benefits.

(3) "Health benefit plan" does not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:

(a) Limited scope dental or vision benefits;

(b) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or

(c) Other similar, limited benefits specified in federal regulations issued pursuant to Pub. L. No. 104-191.

(4) "Health benefit plan" does not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:

(a) Coverage only for a specified disease or illness; or

(b) Hospital indemnity or other fixed indemnity insurance.

(c) Limited Scope medical benefit plans (mini-med),

(5) "Health benefit plan" does not include the following if offered as a separate policy, certificate or contract of insurance:

(a) Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act;

(b) Coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)); or

(c) Similar supplemental coverage provided to coverage under a group health plan.

G. "Health carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health services.

H. "Individual market" means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

I. "Medical care" means amounts paid for:

(1) The diagnosis, care, mitigation, treatment or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;

(2) Transportation primarily for and essential to medical care referred to in paragraph (1); and

(3) Insurance covering medical care referred to in paragraphs (1) and (2).

J. "Qualified employer" means a small employer that elects to make its full-time employees and, at the option of the employer, some or all of its part-time employees eligible for one or more qualified health plans offered in the small group market through the Exchange provided that the employer:

(1) Has its principal place of business in this State and elects to provide coverage through the Exchange to all of its eligible employees, wherever employed; or

(2) Elects to provide coverage through the Exchange to all of its eligible employees who are principally employed in this State.

**Drafting Note:** Beginning in 2017, the Federal Act permits States to expand eligibility for Exchange participation beyond small employers. States that do so should amend subsection J accordingly.

K. "Qualified health plan" means a health benefit plan that has in effect a certification that the plan meets the criteria for certification described in section 1311(c) of the Federal Act and section 7 of this Act or is a Federally Qualified HMO.

L. (1) "Qualified individual" means an individual who:

(a) Is seeking to enroll in a qualified health plan in the individual market offered through the Exchange; and

(b) Resides in this State.

(2) "Qualified individual" does not include an individual:

(a) If, at the time of enrollment, the individual is incarcerated, other than incarceration pending the disposition of charges; or

(b) If, the individual is not, or is not reasonably expected to be, for the entire period for which enrollment is sought, a citizen or national of the United States or an alien lawfully present in the United States.

M. "Secretary" means the Secretary of the federal Department of Health and Human Services.

N. "SHOP Exchange" means the Small Business Health Options Program established under section 6 of this Act.

O. (1) "Small employer" means an employer that employed an average of not more than 100 employees during the preceding calendar year.

**Drafting Note:** The Federal Act permits States to define "small employers" as employers with one to 100 employees for plan years beginning before Jan. 1, 2016.

(2) For purposes of this subsection:

(a) All persons treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as a single employer;

(b) An employer and any predecessor employer shall be treated as a single employer;

(c) If an employer was not in existence throughout the preceding calendar year, the determination of whether that employer is a small employer shall be based on the average number of employees that is reasonably expected that employer will employ on business days in the current calendar year; and

(d) An employer that makes enrollment in qualified health plans offered in the small group market available to its employees through the Exchange, and would cease to be a small employer by reason of an increase in the number of its employees, shall continue to be treated as a small employer for purposes of this Act as long as it continuously makes enrollment in qualified health plans available to its employees.

P. "Small group market" means the health insurance market under which individuals obtain health insurance coverage, directly or through any arrangement, on behalf of themselves and their dependents through a group health plan maintained by a small employer.

**Section 4. Establishment of Exchange**

A. The [insert official title of the Exchange] is hereby established as a [insert description and governance provisions here, either establishing the Exchange as a governmental agency or establishing the Exchange as a nonprofit entity].

**Drafting Note:** States have different options to consider when establishing the Exchange. This Act does not include any specific option for governance. Section 1311(d) of the Federal Act, requires that any Exchange established must be a governmental agency or nonprofit entity. As such, the Exchange could be located at a new or existing State agency. Some possible advantages to having the Exchange within a State agency include having a direct link to the State administration and a more direct ability to coordinate with other key State agencies, such as the State Medicaid agency and the State insurance department. Some possible disadvantages include the risk of the Exchange's decision-making and operations being politicized and the possible difficulty for the Exchange to be nimble in hiring and contracting practices, given most States' personnel and procurement rules. The Exchange could also be located at an independent public agency, or a quasi-governmental agency, with an appointed board or commission responsible for decision-making and day-to-day operations. Some possible advantages to establishing the Exchange as an independent public agency, or a quasi-governmental agency, include possible exemption from State personnel and procurement laws and more independence from existing State agencies, which could result in less of a possibility of the Exchange being politicized. The Exchange's enabling legislation would specify how the Board members would be appointed, including its size, composition and terms. The Board would also select the Exchange's Executive Director. Some possible disadvantages include the possible difficulty for the Exchange to coordinate health care purchasing strategies and initiatives with key State agencies, such as the State Medicaid agency and the State insurance department and their employees because the Exchange would not be located at a State agency (unless

those decisions are subject to the approval of a State official, such as the State insurance commissioner or the Governor). The Exchange also could be established by creating a non-profit entity. This means that most likely it would not be directly accountable to State government or subject to State government oversight nor would it most likely be subject to State personnel and procurement laws. Some possible advantages of establishing the Exchange as a non-profit include flexibility in decision making and less of a chance for those decisions being politicized and some possible disadvantages include isolation from State policymakers and key State agency staff and the potential for decreased public accountability. In addition, States can establish an Exchange using a combination of the options described above. The NAIC, through the Exchanges (B) Subgroup, intends to review the options for governance above and others related to establishing Exchanges and develop an issues paper on the topic to assist States in this area.

**Drafting Note:** States should be aware that section 1311(f) of the Federal Act permits States, with the approval of the Secretary of the federal Department of Health and Human Services, to establish regional or interstate Exchanges. This Act does not specify how to establish these Exchanges or how they would operate. The NAIC, through the Exchanges (B) Subgroup, intends to review those issues and others related to establishing regional or interstate exchanges and develop an issues paper on the topic to assist those states that wish to establish such exchanges. States participating in interstate Exchanges or establishing regional Exchanges should modify the relevant portions of this Act accordingly.

**Drafting Note:** Depending on how a State establishes its Exchange, a State may need to consider whether the Exchange should be exempt from the State's insurance producer or consultant licensing requirements or whether the Exchange needs to obtain such a license.

B. The Exchange shall:

(1) Facilitate the purchase and sale of qualified health plans;

(2) Provide for the establishment of a SHOP Exchange that is designed to assist qualified small employers in this State in facilitating the enrollment of their employees in qualified health plans offered in the small group market in this State; and

(3) Meet the requirements of this Act and any regulations implemented under this Act.

C. The Exchange may contract with an eligible entity for any of its functions described in this Act. An eligible entity includes, but is not limited to, the [insert name of State Medicaid agency] or an entity that has experience in the individual and small group markets, but a health carrier is not an eligible entity.

**Drafting Note:** States should be aware that when establishing the Exchange they will have to include additional sections in this Act that set out the appointment process, powers, duties and other responsibilities of any board, committee or other entity that will have day-to-day responsibility for carrying out the duties and responsibilities of the Exchange, as provided in this Act.

D. The Exchange may enter into information-sharing agreements with federal and State agencies and other State Exchanges to carry out its responsibilities under this Act provided such agreements include adequate protections with respect to the confidentiality of the information to be shared and comply with all State and federal laws and regulations.

**Section 5. General Requirements**

A. The Exchange shall make qualified health plans available to qualified individuals and qualified employers beginning on or before January 1, 2014.

B. (1) The Exchange shall not make available any health benefit plan that is not a qualified health plan or a Federally Qualified HMO.

(2) The Exchange State shall allow a health carrier to offer a plan that provides limited scope dental benefits meeting the requirements of section 9832(c)(2)(A) of the Internal Revenue Code of 1986 through the Exchange, either separately or in conjunction with a qualified health plan, if the plan provides pediatric dental benefits meeting the requirements of section 1302(b)(1)(J) of the Federal Act.

C. The Exchange may make a qualified health plan available notwithstanding any provision of law that may require benefits other than the essential health benefits specified under section 1302(b) of the Federal Act.

**Drafting Note:** The Federal Act allows States to require additional benefits, but only if the State defrays the additional costs of premium and cost-sharing assistance to enrollees. States electing this option should modify subsection C accordingly, specifying the additional benefits required and the mechanism for payment to or on behalf of the enrollees.

**Section 6. Duties of Exchange**

**Drafting Note:** The provisions in this section are the minimum requirements of the Federal Act. States are encouraged to consider assigning additional duties, consistent with the Federal Act, to the extent appropriate to the State's market conditions and policy goals. Optional clauses are provided at the end of this section to facilitate uniformity among those States that elect to use their Exchanges to address certain widely shared concerns.

The Exchange shall:

A. Implement procedures for the certification, recertification and decertification, consistent with guidelines developed by the Secretary under section 1311(c) of the Federal Act and section 7 of this Act, of health benefit plans as qualified health plans;

B. Provide for the operation of a toll-free telephone hotline to respond to requests for assistance;

C. Provide for enrollment periods, as determined by the Secretary under section 1311(c)(6) of the Federal Act;

D. Maintain an Internet website through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on such plans;

E. Assign a rating to each qualified health plan offered through the Exchange in accordance with the criteria developed by the Secretary under section 1311(c)(3) of the Federal Act;

F. Utilize a standardized format for presenting health benefit options in the Exchange, including the use of the uniform outline of coverage established under section 2715 of the PHSA;

G. In accordance with section 1413 of the Federal Act, inform individuals of eligibility requirements for the Medicaid program under title XIX of the Social Security Act, the Children's Health Insurance Program (CHIP) under title XXI of the Social Security Act or any applicable State or local public program and if through screening of the application by the Exchange, the Exchange determines that any individual is eligible for any such program, enroll that individual in that program;

H. Establish and make available by electronic means a calculator to determine the actual cost of coverage after application of any premium tax credit under section 36B of the Internal Revenue Code of 1986 and any cost-sharing reduction under section 1402 of the Federal Act;

I. Establish a SHOP Exchange through which individuals employed by qualified employers may enroll in any qualified health plan offered through the SHOP Exchange at the level of coverage specified by the employer;

**Drafting Note:** States may elect to operate a unified Exchange by merging the SHOP Exchange and the Exchange for the individual market, but only if the Exchange has adequate resources to assist these individuals and employers.

J. Subject to section 1411 of the Federal Act, grant a certification attesting that, for purposes of the individual responsibility penalty under section 5000A of the Internal Revenue Code of 1986, an individual is exempt from the individual responsibility requirement or from the penalty imposed by that section because:

(1) There is no affordable qualified health plan available through the Exchange, or the individual's employer, covering the individual; or

(2) The individual meets the requirements for any other such exemption from the individual responsibility requirement or penalty;

K. Transfer to the federal Secretary of the Treasury the following:

(1) A list of the individuals who are issued a certification under subsection I, including the name and taxpayer identification number of each individual;

(2) The name and taxpayer identification number of each individual who was an employee of an employer but who was determined to be eligible for the premium tax credit under section 36B of the Internal Revenue Code of 1986 because:

(a) The employer did not provide minimum essential health benefits coverage; or

(b) The employer provided the minimum essential health benefits coverage, but it was determined under section 36B(c)(2)(C) of the Internal Revenue Code to either be unaffordable to the employee or not provide the required minimum actuarial value; and

(3) The name and taxpayer identification number of:

(a) Each individual who notifies the Exchange under section 1411(b)(4) of the Federal Act that he or she has changed employers; and

(b) Each individual who ceases coverage under a qualified health plan during a plan year and the effective date of that cessation;

L. Provide to each employer the name of each employee of the employer described in subsection K(3)(b) who ceases coverage under a qualified health plan during a plan year and the effective date of the cessation;

M. Perform duties required of, or delegated to, the Exchange by the Secretary or the Secretary of the Treasury related to determining eligibility for premium tax credits, reduced cost-sharing or individual responsibility requirement exemptions;

N. Select entities qualified to serve as Navigators in accordance with section 1311(i) of the Federal Act and award grants to enable Navigators to:

(1) Conduct public education activities to raise awareness of the availability of qualified health plans;

(2) Distribute fair and impartial information concerning enrollment in qualified health plans, and the availability of premium tax credits under section 36B of the Internal Revenue Code of 1986 and cost-sharing reductions under section 1402 of the Federal Act;

(3) Facilitate enrollment in qualified health plans;

(4) Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under section 2793 of the PHSA, or any other appropriate State agency or agencies, for any enrollee with a grievance, complaint or question regarding their health benefit plan, coverage or a determination under that plan or coverage; and

(5) Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange;

O. Review the rate of premium growth within the Exchange and outside the Exchange, and consider the information in developing recommendations on whether to continue limiting qualified employer status to small employers; and

P. Credit the amount of any free choice voucher to the monthly premium of the plan in which a qualified employee is enrolled, in accordance with section 10108 of the Federal Act, and collect the amount credited from the offering employer; and

Q. Consult with stakeholders relevant to carrying out the activities required under this Act, including:

(1) Educated health care consumers who are enrollees in qualified health plans;

(2) Individuals and entities with experience in facilitating enrollment in qualified health plans;

(3) Representatives of small businesses and self-employed individuals;

(4) The [insert name of State Medicaid office]; and

(5) Advocates for enrolling hard to reach populations.

***[R.* et seq.: *Optional clauses specifying additional duties of the Exchange. The Exchanges (B) Subgroup Statutory Language Team preparing this initial exposure draft recommends that these clauses be developed with input from regulators and interested parties, and welcomes your suggested language.]***

**Drafting Note:** States should be aware of the interplay between the duties established for the Exchange under this Act and ERISA's fiduciary duties.

**Section7. Health Benefit Plan Certification**

A. The Exchange may certify a health benefit plan as a qualified health plan if:

(1) The plan provides the essential health benefits package described in section 1302(a) of the Federal Act;

(2) The plan provides at least a bronze level of coverage, unless the plan is certified as a qualified catastrophic plan, meets the requirements of the Federal Act for catastrophic plans, and will only be offered to individuals eligible for catastrophic coverage;

(3) The health carrier offering the plan:

(a) Is licensed and in good standing to offer health insurance coverage in this State;

(b) Offers at least one qualified health plan in the silver level and at least one plan in the gold level in the Exchange;

(c) Charges the same premium rate for each qualified health plan without regard to whether the plan is offered through the Exchange and without regard to whether the plan is offered directly from the carrier or through an insurance producer; and

(d) Complies with the regulations developed by the Secretary under section 1311(d) of the Federal Act and such other requirements as the Exchange may establish.

(4) The plan meets the requirements of certification as promulgated by regulation by the Secretary under section 1311(c)(1) of the Federal Act and by the Exchange pursuant to section 9 of this Act; is a Federally Qualified HMO and

(5) The Exchange determines that making the plan available through the Exchange is in the interest of qualified individuals and qualified employers in this State.

**Drafting Note:** States should consider whether the Exchange should delegate this function to the commissioner.

B. The Exchange shall not exclude a health benefit plan:

(1) On the basis that the plan is a fee-for-service plan;

(2) Through the imposition of premium price controls; or

(3) On the basis that the health benefit plan provides treatments necessary to prevent patients' deaths in circumstances the Exchange determines are inappropriate or too costly.

C. The Exchange shall require each health carrier seeking certification of a plan as a qualified health plan to:

(1) Submit a justification for any premium increase before implementation of that increase. The carrier shall prominently post the information on its Internet website. The Exchange shall take this information, along with the information and the recommendations provided to the Exchange by the commissioner under section 2794(b) of the PHSA, into consideration when determining whether to allow the carrier to make plans available through the Exchange;

**Drafting Note:** States with additional rate filing requirements should review the language in paragraph (1) above to ensure that it does not conflict with other applicable State law.

(2) (a) Make available to the public, in the format described in subparagraph (b) of this paragraph, and submit to the Exchange, the Secretary, and the commissioner, accurate and timely disclosure of the following:

(i) Claims payment policies and practices;

(ii) Periodic financial disclosures;

(iii) Data on enrollment;

(iv) Data on disenrollment;

(v) Data on the number of claims that are denied;

(vi) Data on rating practices;

(vii) Information on cost-sharing and payments with respect to any out-of-network coverage;

(viii) Information on enrollee and participant rights under title I of the Federal Act; and

(ix) Other information as determined appropriate by the Secretary; and

(b) The information required in subparagraph (a) of this paragraph shall be provided in plain language, as that term is defined in section 1311(e)(3)(B) of the Federal Act; and

(3) Permit individuals to learn, in a timely manner upon the request of the individual, the amount of cost-sharing, including deductibles, copayments, and coinsurance, under the individual's plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider. At a minimum, this information shall be made available to the individual through an Internet website and through other means for individuals without access to the Internet.

**Section 8. Funding; Publication of Costs**

A.

A. The Exchange shall add applicable exchange fees (assessments/user fees) to the premium costs of the health carriers and these fees should be transparent to applicants, health carriers will collect these fees and on a periodic basis forward these collected fees to the Exchange based on the per member per month or per policy per month exchange fee. The fee should not be included in the administrative fees of the health carriers.

B. The Exchange shall publish the average costs of licensing, regulatory fees and any other payments required by the Exchange, and the administrative costs of the Exchange, on an Internet website to educate

consumers on such costs. This information shall include information on monies lost to waste, fraud and abuse.

**Section 9. Regulations**

The Exchange may promulgate regulations to implement the provisions of this Act. Regulations promulgated under this section shall not conflict with or prevent the application of regulations promulgated by the Secretary under title I, subtitle D of the Federal Act.

**Drafting Note:** States that do not establish the Exchange in a governmental agency with rulemaking authority should substitute the agency responsible for the administration or oversight of the Exchange. As appropriate, the commissioner should be granted rulemaking authority to promulgate regulations to implement the provisions of this Act within the scope of the commissioner's authority, as provided under State law or regulations.

**Section 10. Effective Date**

This Act shall be effective [insert date].

W:\Health Care Reform\Exchanges\Health Benefit Exchanges.doc

BlueCross BlueShield Association

An Association of Independent Blue Cross and Blue Shield Plans

***By Electronic Mail***

October 6, 2010

Honorable Sandy Praeger
Commissioner, Kansas Insurance Department

Honorable Michael T. McRaith
Director, Illinois Department of Insurance

**Re: Draft NAIC American Health Benefit Exchange Model Act**

Dear Commissioner Praeger and Director McRaith:

The Blue Cross and Blue Shield Association ("BCBSA") appreciates the opportunity to provide comments to the Exchanges (B) Subgroup of the Health Insurance and Managed Care (B) Committee of the National Association of Insurance Commissioners ("the NAIC") regarding the draft American Health Benefit Exchange Model Act ("Exchange Model Act").

BCBSA represents the 39 independent Blue Cross and Blue Shield Plans ("Plans") that provide coverage to nearly 100 million – one in three – Americans. Exchanges will create new marketplaces where tens of millions of Americans will shop for coverage, apply for subsidies, and enroll in health plans. As the leading providers of coverage for individuals and small employers across the nation, Blue Cross and Blue Shield Plans look forward to working with the NAIC in finalizing a model that will enable states to create Exchanges that will provide consumers with effective choices in 2014.

We commend the NAIC for acting quickly to develop an Exchange Model Act that outlines the basic federal requirements that states must take into consideration as they craft legislation that will best fit their market needs. In order for the health plans to effectively implement the enormous system changes needed to facilitate Exchanges, BCBSA recommends that Exchanges specify their operational requirements no later than 18 months prior to the beginning of enrollment. As such, it is critical for the NAIC to finalize this baseline model as quickly as possible.

The draft Exchange Model Act appropriately reflects the substantial flexibility given states by the Patient Protection and Affordable Care Act ("ACA") to develop Exchanges that meet their unique market needs. BCBSA supports state flexibility because health insurance markets, regulatory environments, and consumer preferences vary

substantially across states. State flexibility will be critical to harness state innovation to test which Exchange models provide the greatest value to consumers over time.

We commend NAIC for closely tracking the ACA in most areas and avoiding controversial policy positions that are best left to the states to resolve. In particular, we agree with the Exchange Model Act's purpose and intent to focus on facilitating the purchase of qualified health plans. There is no evidence that a selective contracting model would be more effective than a model that allows for the participation of all qualified health plans in ensuring consumer value. We are pleased that the model supports states that want to take a competitive approach to Exchange implementation.

Our comments and technical recommendations concerning specific Sections of the Exchange Model Act follow:

- **Clarify the Definition of Qualified Employer:** Section 3(J) includes language to clarify the state in which an employer may purchase coverage through an Exchange. We support this clarification, which is needed to set uniform rules to assure effective implementation of employer coverage. However, the term "principal place of business" is ambiguous and will create confusion for Exchanges, employers and health plans.[1] We recommend using the term "headquarters" instead of "principal place of business" to eliminate the possible ambiguity. Moreover, the term "principal place of business" could be used by employers to forum shop among Exchanges, a problem that would be compounded if larger employers are included in Exchanges.

  We also are concerned that the language in Section 3(J)(2) allowing employers to make all eligible employees who are principally employed in a state eligible for that state's Exchange would complicate the administration of benefits for employers that offer coverage in multiple states by requiring employers to contract with multiple Exchanges. Section 3(J)(1), as amended, is the better solution, allowing the employer to select a plan for their workers in an Exchange for all of its employees wherever they are located.

  We recommend the following changes to this definition:

  J. "Qualified employer" means a small employer that elects to make its full-time employees and, at the option of the employer, some or all of its part-time employees eligible for one or more qualified health plans offered in the small group market through the Exchange provided that the employer~~:~~

  ~~(1)~~ Has its ~~principal place of business~~ headquarters in this State and elects to provide coverage through the Exchange to all of its eligible employees, wherever employed~~; or~~

[1] The term "principal place of business" was most recently at issue in *Hertz Corp v. Friend*, 130 S. Ct. 1181 (Feb. 23, 2010), in which the United States Supreme Court said "the phrase 'principal place of business' has proved more difficult to apply than its originators likely expected." The Court concluded that the phrase "principal place of business" refers to the place where the corporation's officers direct, control, and coordinate the corporation's activities. The Court adopted the "nerve center" approach and said that the "nerve center" will typically be found at a corporation's headquarters.

~~(2) Elects to provide coverage through the Exchange to all of its eligible employees who are principally employed in this State.~~

- **Ensure that States can Allow Employers to Select a Plan for Their Employees on Exchanges:** We are concerned that Section 6(I) of the Model Act may tie states' hands in allowing employer groups to remain intact when they purchase coverage on an Exchange. If employers are forced to move to a defined contribution arrangement that individualizes the purchase of coverage, it would increase the administrative burden on Exchanges, create more confusion for employees, require complicated accounting and billing practices, and increase the potential for adverse selection which cannot be fully offset through risk adjustment.

  The ACA permits qualified employers to select the health plan they want for their employees (as they do today). Specifically, the definition of a "qualified employer" in section 1312(f)(2), is a small employer that elects to make all full time employees "eligible for 1 or more qualified health plans" offered through the Exchange. However, under the ACA, qualified employers who purchase coverage through an Exchange also have the option to select a level of coverage (bronze, silver, gold, or platinum) and allow an employee to choose among any plan offered at that level of coverage within an Exchange. Section 1312(a).

  The proposed Exchange Model Act correctly defines qualified small employers as an employer that elects to make its employees eligible for "one or more" qualified health plans offered through the Exchange (reflecting the definition in the ACA) in Section 3(J). However, Section 6(I) of the Model Act could prohibit states from allowing an employer choice option. We recommend that Section 6(I) be revised to ensure that employer groups remain whole unless employers opt for employee choice by specifying a level of coverage in which their employees may enroll. Our recommended language follows:

  I. Establish a SHOP Exchange through which individuals employed by qualified employers may enroll in ~~any~~ qualified health plans. The SHOP exchange shall provide employers the ability to select a health plan or plans through which their employees may enroll in coverage, or at the option of the employer, allow each eligible employee to enroll in any plan offered through the SHOP Exchange at the level of coverage specified by the employer;

  Corresponding changes should be made to Section 4(B) to ensure that the requirements for an Exchange reflect the option for employer choice. We recommend modifying the language as follows:

  B. The Exchange shall:

  (1) Facilitate the purchase and sale of qualified health plans to qualified individuals and employers;

  (2) Provide for the establishment of a SHOP Exchange that is designed to assist qualified small employers in this State in facilitating the enrollment of their employees in a qualified health plan or qualified health plans offered in the small group market in this State; and

  (3) Meet the requirements of the Federal Act, this Act and any regulations implemented under this Act.

- **Health Benefit Plan Certification should Ensure Choice, Competition and a Level Playing Field:** We appreciate that the Exchange Model Act provides broad flexibility for states to adopt a competitive model in which all health plans may participate if they meet defined, objective standards or a selective contracting model. We expect that some may recommend that the drafting note on at the bottom of Section 7(A) be expanded to talk about the merits of different design options. We would recommend against a protracted discussion of the merits of different options for the purpose of finalizing the Exchange Model Act.

  We also expect that some will recommend that the model be expanded to consider elimination of a market outside exchanges (i.e., requiring all consumers to purchase coverage through Exchanges). We believe that the NAIC has appropriately interpreted the ACA in avoiding any such requirement in their Exchange Model Act. The ACA clearly enumerates that it was not Congress' intent to force consumers to purchase coverage through Exchanges. We recommend that NAIC avoid any drafting note or amendment to the contrary in finalizing the model.

  Any requirements for health plans participating in an Exchange should ensure a level playing field between health plans participating in the Exchange. As such, there should be no exemptions from certification standards for any particular type of plan – whether traditional health insurers, Medicaid plans, provider-sponsored plans, or Consumer Operated and Oriented Plans (CO-OPs). Section 1252 of the ACA expressly forbids this type of favoritism. Accordingly, we recommend adding the following language to the end of Section 7:

  D. The Exchange shall not exempt any health carrier, regardless of type or size, seeking certification of a qualified health plan from state licensure, solvency regulation, or any additional criteria set forth in this Section.

- **Clarify the Different Roles of Exchanges and State Insurance Regulators in the Review of Rates.** Any effort to de-link review of insurance rates from solvency regulation could jeopardize a key consumer protection – the assurance that a health plan has adequate reserves to pay for enrollees' claims.

  We recommend modifying the Drafting Note after Section 7(C)(1) to explicitly recognize that the ultimate authority for approval or rates and regulation of solvency resides with state insurance commissioners, and that any consideration of rates by the state exchange should not conflict with these duties, as follows:

  7C. The Exchange shall require each health carrier seeking certification of a plan as a qualified health plan to:

  (1) Submit a justification for any premium increase before implementation of that increase. The carrier shall prominently post the information on its Internet website. The Exchange shall take this information, along with the information and the recommendations provided to the Exchange by the commissioner under section 2794(b) of the federal Public Health Service Act, into consideration when determining whether to allow the carrier to make plans available through the Exchange

**Drafting Note:** In drafting their exchange legislation, states should be aware that Exchanges' role in reviewing premium increases is separate from the initial certification of Qualified Health Plans. State Insurance Commissioners will remain responsible for oversight of rates filed by a carrier. States ~~with additional rate filing requirements~~ should review the language in paragraph (1) above to ensure that it does not conflict with other applicable State law. In drafting their exchange legislation, states should be aware that exclusion of a QHP from an exchange through the imposition of premium price controls is not permitted under the Federal Act.

- **Include Required Financial Standards and Add Fiduciary Duties:** The draft Exchange Model Act includes a Drafting Note directing states to be aware of the "interplay" between Exchange duties and ERISA fiduciary duties. Exchanges or their subcontractors could handle a significant volume of premium dollars as a result of free choice vouchers, premium assessments, or limited premium collection functions. As such, BCBSA recommends the inclusion of specific financial integrity language from the ACA, as well additional fiduciary requirements.

R. Meet the following financial integrity requirements and fiduciary duties,
(1) ACCOUNTING FOR EXPENDITURES - An Exchange shall keep an accurate accounting of all activities, receipts, and expenditures and shall annually submit to the Secretary, the Governor and the State legislature a report concerning such accountings.
(2) INVESTIGATIONS- An Exchange shall fully cooperate with any investigation conducted by the Secretary pursuant to her authority under the Federal Act and allow the Secretary, in coordination with the Inspector General of the United States Department of Health and Human Services, to investigate the affairs of an Exchange, to examine the properties and records of an Exchange, and to require periodic reports in relation to activities undertaken by an Exchange.
(3) PROHIBITING WASTEFUL USE OF FUNDS- In carrying out activities under this Act, the Exchange shall not utilize any funds intended for the administrative and operational expenses of the Exchange for staff retreats, promotional giveaways, excessive executive compensation, or promotion of Federal or State legislative and regulatory modifications.
(4) FIDUCIARY DUTIES AND LIABILITY-
(a) Any person who acts on behalf of an Exchange shall act as a fiduciary. Such person shall ensure that the Exchange is operated (i) solely in the interests of individuals participating in qualified health plans offered through the Exchange, and (ii) for the exclusive purpose of facilitating the purchase of qualified health plans.
(b) Any person who acts as a fiduciary on behalf of the Exchange who breaches any of their responsibilities, obligations, or duties imposed by this section shall be liable to make good to the Exchange, the qualified health plans offered through the Exchange, or participants of qualified health plans offered through the Exchange, any losses resulting from each breach, and shall be subject to such other legal or equitable relief as the court may deem appropriate, including removal of such fiduciary.

- **Funding and Publication of Cost:** The draft Exchange Model Act should include a Drafting Note after Section 8 that notes that assessments on health carriers are not the only source of funding for exchanges. We support states exploring broad-based funding options through new tax revenue, including tobacco taxes, grants from private stakeholders, and fees and assessments that could be applied broadly and not targeted solely to health insurers.

The Drafting Note should also mention that assessments used to finance the Exchange should be clearly disclosed by the Exchange and should not be included

as health plan administrative costs for the purpose of calculating medical loss ratios or rebates.

The Drafting Note should also clarify that the requirement of the ACA to publish the cost of licensure does not imply that Exchanges will have any role in licensing health carriers. This is a function that should be reserved for state insurance departments In addition, the drafting note following Section 4(A) could also list as an advantage that some states may leverage Medicaid funding for developing infrastructure for Exchange administration. The fourth sentence of the drafting note could be revised as follows:

> Some possible advantages to having the Exchange within a State agency include having a direct link to the State administration, the ability to leverage Medicaid funding for developing Exchange infrastructure necessary for administration (e.g. eligibility and enrollment systems), and a more direct ability to coordinate with ~~other~~ key State agencies, such as the State Medicaid agency and the State insurance department.

- **Regional Exchanges:** The draft Exchange Model Act notes that the NAIC's Exchanges (B) Subgroup will review issues related to regional exchanges and develop an issue paper on the topic. While we understand that some states may be interested in working together to plan or establish an Exchange on a regional basis, there are some major policy issues that need to be addressed prior to implementing a regional exchange, including:

    1. How the laws of each state would apply with respect to regional exchanges;

    2. Whether local health plans – which are not licensed or equipped to issue health insurance across multi-state regions – would be permitted to participate in regional such exchanges; and

    3. How regional exchanges would avoid inappropriate cross subsidies among states based on the wide variation in rates across geographic areas.

  BCBSA looks forward to working with the NAIC as it explores these and other policy issues regarding regional exchanges.

- **Technical Comment on Purpose and Intent Section:** The draft Exchange Model Act includes a drafting note after Section 2 regarding states expanding the definition of "qualified employer" to large employers. We recommend clarifying the sentence to assure that if coverage is made available to large employers than all other sections are amended appropriately, as follows:

  > **Drafting Note:** States expanding the definition of "qualified employer" to include large employers, as permitted beginning in 2017 under the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) (Federal Act), should remove the reference to "small" employers and amend any and all sections applicable to small employers.

* * *

We appreciate your consideration of our comments. If you have any questions, please contact me at (202) 626-4802 or joan.gardner@bcbsa.com.

Sincerely,

/s/

Joan Gardner
Executive Director, State Services
Blue Cross Blue Shield Association

cc: Jolie H. Matthews, Senior Health and Life Policy Advisor & Counsel (NAIC)

Center on Budget and Policy Priorities

820 First Street, NE, Suite 510 Washington, DC 20002
202-408-1080 Fax: 202-408-1056 center@cbpp.org www.cbpp.org



October 6, 2010

Jolie H. Matthews
Senior Health and Life Policy Advisor & Counsel
NAIC Government Relations Office
444 North Capitol Street N.W., Suite 701
Washington D.C. 20001

RE: Comments to the NAIC's Draft American Health Benefit Exchange Model Act

Dear Ms. Matthews:

The Center on Budget and Policy Priorities is a nonpartisan research and policy organization based in Washington, DC. Founded in 1981, the Center conducts research and analysis to inform public debates and policymakers about a range of budget, tax and programmatic issues affecting individuals and families with low or moderate incomes.

We appreciate the opportunity to provide comments on the NAIC's draft American Health Benefit Exchange Model Act. We believe that a key factor that states will have to consider in structuring the exchanges is how to limit the risk of adverse selection against the exchanges.

Adverse selection — the separation of healthier and less-healthy people into different insurance arrangements — will occur if a disproportionate number of people who are in poorer health and have high health expenses enroll in coverage through the insurance exchanges, while healthier, lower-cost people disproportionately enroll in plans offered through the individual and small group markets *outside* the exchanges.

If that occurs, the cost of exchange coverage will be higher than the cost of plans offered in outside markets, and that will drive up costs for consumers and small firms purchasing coverage through the exchanges. Higher premiums would depress participation in the exchanges by individuals and small businesses, particularly by those people and firms that can obtain better deals in outside markets (or people who may consider paying a penalty and remaining uninsured). That, in turn, could raise premiums even higher in the exchanges and ultimately could result in their failure over time.

States, however, could take a number of steps in how they structure their insurance exchanges and the outside individual and small group markets to minimize the risk of adverse selection. We recommend that a Drafting Note be added to Section 5: General Requirements that briefly discusses the risk that adverse selection poses to exchanges and outlines some of the options that states have to limit such risk, including the following:

- Making the rules for any insurance markets outside the exchanges consistent with

the rules that apply inside the exchange. States can simply apply the same standards that HHS sets for qualified health plans offered in an exchange to plans offered in markets outside the exchange. This would eliminate any disparities that might discourage carriers from participating in the exchange or might enable carriers operating outside the exchange to design benefit packages and marketing campaigns to attract healthier people away from the exchange.

- Requiring carriers to offer the same products inside and outside the exchange. Some carriers may decide not to offer coverage through an exchange because it is easier to operate in the outside markets if the rules there are weaker. They may also wish to offer products inside and outside the exchange that differ in ways that result in adverse selection against the exchange. States could require all carriers who wish to offer products in outside markets to also offer coverage in the exchange and to offer the same products (priced the same) both inside and out. For those states that opt to create a more selective or competitive process to determine which plans can be offered in an exchange, states can require carriers outside the exchange to offer products in the same coverage levels (at least the Silver and Gold levels) as is required for carriers participating in the exchange. States should also bar carriers from offering only the least comprehensive Bronze level plans or catastrophic plans outside of the exchange.

- Merging the individual and small group markets over time. This would increase the potential enrollment volume and make it more likely (but not guarantee) that the exchange would have a well-balanced risk pool. However, such a merger could take place several years after the Affordable Care Act's major market reforms, particular those related to premium rating rules, are instituted in 2014, which would limit the disruption that might occur when the markets are combined.[1]

* * *

Thank you for the opportunity to comment. If you have any questions, please do not hesitate to contact Edwin Park (park@cbpp.org)

Sincerely,

Edwin Park
Co-Director of Health Policy

[1] For a more detailed discussion of the options we recommend that states adopt to limit the risk of adverse selection, please see Sarah Lueck, "States Should Structure Insurance Exchanges to Minimize Adverse Selection," Center on Budget and Policy Priorities, August 17, 2010, available at http://www.cbpp.org/files/8-17-10health.pdf.

October 6, 2010

Jolie Mathews
National Association of Insurance Commissioners
444 North Capitol Street, NW
Suite 701
Washington, D.C. 20001

Via email to jmatthew@naic.org

Dear Ms. Matthews:

The Coalition for Affordable Health Coverage (CAHC) submits the attached comments to NAIC on the September 27, 2010 American Health Benefit Exchange Model Act. We support benefit exchanges as a way to provide additional coverage options to consumers and appreciate the NAIC's work to provide guidance to states in establishing the exchanges.

CAHC is a broad-based group with a diverse membership including organizations representing consumers, physicians, small businesses, large employers, insurers, brokers and agents. A list of our membership is attached to this letter, although this letter may not reflect the position of individual members. The Coalition maintains a singular focus: making health coverage more affordable for all, whether they have private insurance or access health services through a public program.

We appreciate the NAIC Model Act, especially the flexibility it affords states in establishing benefit exchanges. We agree that flexibility in implementation is necessary since each state market is unique and states are better able to judge the needs of its residents. We are also appreciative of the discussion included in Model Act that discusses the pros and cons of governance and whether to open exchanges to larger employers.

CAHC believes that consumer will have more options, and that those options will be more affordable, by creating exchanges that promote competition and market discipline. While there are many opportunities to make coverage more affordable through the establishment of exchanges, we are concerned that some may view the exchanges as an only option, and seek to limit the availability of other options outside the exchanges.

Congress recognized the value of a market outside the benefit exchanges. In Sections 1003 (Rate Review) and 1311 (Benefit Exchanges), Congress specifically lays out the required standards for plans operating outside of benefit exchanges, indicating the importance of an external market. In addition, Section 1312(d) (Empowering Consumer Choice) clearly states that nothing should prohibit a health insurance issuer from offering outside of an exchange a health plan to an individual or employer. The section goes on to note the voluntary nature of

exchanges and to prohibit the forced participation in an exchange. CAHC agrees with Congress that exchanges should be voluntary and that NAIC should make clear an external market for health plans is critical to empowering consumers and presenting more affordable options.

In addition, many employers will find exchanges a good source for new coverage options, but some will not. It is important to understand that many employers will seek the flexibility and options available outside of a benefit exchange structure. We note that in Massachusetts, the insured rate is about 97 percent. But just 3.5 percent of the insured are enrolled through the Massachusetts exchange (Massachusetts Health Connector). The 5.6 million others who found enrollment through options other than the Connector rely on the outside market for their choices. While the 3.5 percent who chose the Connector also likely find it of value, the point is that both groups should have an option of choosing one or the other.

As NAIC debates the Benefit Exchange issues further, we urge you to keep in mind that consumers value choices in selecting health coverage. We look forward to working with you on these important issues because a strong exchange and non-exchange market held to market disciplines will help promote more affordable options for employers, individuals and their families.

Sincerely,

/S
Joel C. White
Executive Director

**Coalition for Affordable Health Coverage**
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## CAHC Members

- **Aetna**
- **American Osteopathic Association**
- **Assurant Health**
- **Cigna**
- **Communicating for America**
- **Health Equity**
- **Healthcare Leadership Council**
- **International Franchise Association**
- **The Latino Coalition**
- **National Association for the Self-Employed**
- **National Association of Health Underwriters**
- **National Association of Manufacturers**
- **National Retail Federation**
- **Pediatrix**
- **Pharmaceutical Research & Manufacturers Association**
- **U.S. Chamber of Commerce**

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DELTA DENTAL

www.deltadental.com

October 6, 2010

Co-Chair Commissioner Sandy Praeger
Co-Chair Director McRaith
NAIC (B) Committee Exchange Subgroup

Cc: Jolie Matthews, NAIC Senior Health Policy Advisor and Counsel

Subject: **Proposed American Health Benefit Exchange Model Act**

I am writing on behalf of the Delta Dental Plans Association ("DDPA") to provide comments on the 9/27/10 version of NAIC's American Health Benefit Exchange Model Act ("Exchange Model"). In particular, our comments relate to the role of stand-alone dental benefits plans in the Exchanges to provide the pediatric dental benefit that is part of the "essential health benefits" package. We believe that the Exchange Model does not adequately address the role that dental coverage and dental carriers will play inside Exchanges. Currently, 86 percent of the over 93,000 employer groups DDPA member companies service have under 100 employees, and thus, could be greatly impacted by how the Exchanges are developed.

**Qualified Health Plans/Dental Benefits**

The Patient Protection and Affordable Care Act ("PPACA") provides that "if" a stand-alone dental plan is offered through an Exchange, then another health plan offered through the Exchange (a "qualified health plan") shall not fail to be treated as a "qualified health plan" solely because it does not offer the required "essential health benefits" pediatric dental benefit that is offered through the stand-alone plan. See PPACA §1302(b)(4)(F).

The definition of a qualified health plan should reflect the fact that a qualified health plan can consist of an integrated benefit package or it can comprise a separate medical benefit package and a free standing pediatric dental benefit package.

Related to this, the Exchange Model should also clarify that separate medical and stand-alone pediatric dental coverages must be purchased concurrently so as to meet the essential health benefit requirement. The term "pediatric" also needs defining.

The Exchange model should clarify that the waiver of "essential pediatric benefits" rule for qualified health plans applies both inside and outside the Exchange. Because health plans in the individual and small group markets must offer the "essential health benefits" package beginning 2014, the ability of qualified health plans to waive essential pediatric benefits inside the Exchange should carry through to "essential health benefits" offered outside the Exchange. This will ensure consistent and uniform administration of these benefits in alignment with the purpose of the "Stabenow-Lincoln" amendment to allow stand-alone dental plans to market essential children's dental benefits both inside and outside the Exchange.

Delta Dental Plans Association
1515 West 22nd Street, Suite 450
Oak Brook, Illinois 60523

Telephone 630-574-6001
Facsimile 630-574-6999

**Stand-alone Dental Plans**

PPACA provides that each Exchange shall allow a stand-alone dental plan (defined as meeting requirements for a "limited scope" dental plan under the Internal Revenue Code, i.e. that it must be offered separately) to offer dental coverage (either separately or in conjunction with a "qualified health plan") if the plan provides pediatric dental benefits meeting the "essential health benefits" requirements for such pediatric benefits. See Section 1311(d)(2)(B)(ii).

The Exchange Model should make it clear that stand-alone dental plans retain "excepted benefit" status. The statutory language refers to stand-alone dental plans that meet the "excepted benefit" standards for such plans and does not treat such plans as "qualified health plans."

In addition, the Exchange Model should clarify that the benefits which a stand-alone dental plan may offer: “pediatric” benefits only or also adult dental benefits. The statutory language requires that a stand-alone dental benefits plan in Exchanges include essential pediatric services for oral care, but does not *limit* stand-alone dental plans to essential pediatric services for oral care. If qualified health plans offer adult dental benefits, then it is critical that stand-alone dental plans also be permitted to offer adult dental benefits with the pediatric "essential health benefits."

The Exchange Model should be designed in a way so as not to disrupt or de-couple family dental coverage, which is currently the dominant dental coverage chosen by consumers. In the U.S. today, small group and individual consumers comprise 39 percent of the 176 million Americans with dental benefits, which include an estimated 1.65 million small employers, 43.7 million employees and 22.9 million children, many of whose coverage could be disrupted if the Exchange Model unnecessarily requires adult and pediatric coverage to be split so as to meet the “essential health benefits” requirement for pediatric dental.

**Transparency in Pricing**

DDPA believes that consumers benefit from transparency in premium pricing. It should be required that pediatric dental benefits must be offered and priced separately from other categories of essential health benefits. This provides consumers with important information in determining which array of benefits makes the most economic sense. In the employer-provided benefits market, dental benefits have historically been offered and priced separately from medical benefits. This should be continued within the SHOP Exchange. Individuals purchasing coverage directly through the Exchanges should also have this right.

The Exchange Model needs to clarify that if a qualified health plan offers pediatric dental benefits together with other categories of essential health benefits, the qualified health plan must also separately price the pediatric dental benefits so that Exchange purchasers can compare the terms of the offer and prices of stand-alone dental plans with the qualified health plan offer of "bundled" medical and pediatric dental benefits. In addition, a “bundled” medical-dental plan offering should not be permitted to shift costs from the dental plan into the medical plan so as to artificially lower the cost of the dental plan. Allowing this to occur would undercut competition and transparency within the Exchanges.

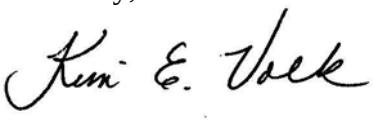
These separate pricing rules should apply both inside and outside the Exchange. Because health plans in the individual and small group markets must offer the "essential health benefits" package beginning in 2014, the offering and pricing rules for "essential health benefits" offered inside the Exchange should carry through to "essential health benefits" offered outside the Exchange to ensure consistent and uniform administration of these benefits.

**Preserving Existing Markets**

Finally, DDPA would oppose any initiative to eliminate the small group and individual markets outside the Exchanges.

Thank you for the opportunity to comment on this topic. If you have further questions, please feel free to direct them to our outside counsel, Chris Petersen, at (202) 408-5147.

Sincerely,



Kim Volk
President & CEO

About Delta Dental

Delta Dental is the nation’s largest, most experienced dental benefits company. Since 1954, Delta Dental has worked to improve oral health in the U.S. by emphasizing preventive care, and making quality, cost-effective dental benefits affordable to a wide variety of large and small employers and groups. A nationwide system of dental health service plans, Delta Dental offers custom programs and reporting systems that provide employees with quality, cost-effective dental benefit programs and services. Our nationwide network serves more than 54 million Americans in over 93,000 group plans across the nation.

Davis Vision, Inc.
159 Express Street
Plainview, NY 11803

*VIA ELECTRONIC MAIL*

October 5, 2010

**Nicholas Peterson, Esq.**
Regulatory Compliance
Phone: (516) 733-5469
Fax: (516) 733-5362

**RE: AMERICAN HEALTH BENEFIT EXCHANGE MODEL ACT**

Dear Commissioner Ario and Members of the Exchanges (B) Subgroup:

Davis Vision appreciates your work in developing standards to facilitate the purchase and sale of qualified health coverage under Sections 1311(b) and 1321(b) of the *Patient Protection and Affordable Care Act (PPACA).* We are pleased to submit our comment regarding the American Health Benefit Exchange Model Act to ensure and protect consumers' access to quality vision care.

Davis Vision, Inc. is a national stand-alone vision entity, and a Highmark, Inc. vision subsidiary. We have been providing fully integrated, comprehensive vision care services for over 45 years. Today, nearly 55 million members enjoy the extensive benefits of the Davis Vision program. We serve thousands of client groups, including many large national corporations, municipalities and thousands of small and mid-size groups, in all 50 states, the District of Columbia and Puerto Rico. In addition, Davis Vision also functions as the exclusive vision vendor on behalf of the entire Blue Cross and Blue Shield system for the Federal Employee Program (FEP) BlueVision® product for the Federal Government's Office of Personnel Management. Plan services are provided through a network of over 30,000 providers which include optometrists, ophthalmologists, our own proprietary vision centers as well as national and regional optical retailers.

Section 5B of the Model Act excludes all non-qualified health benefit plans, with the exception of limited scope dental benefits, from competing in the Exchanges to offer their valuable services directly to the consumers. Davis Vision respectfully requests your assistance to extend the accommodation afforded to limited scope dental plans to limited scope vision plans. We appreciate your consideration of the following modification to Section 5B:

- Amend Section 5B(2) to read, "The Exchange State shall allow a health carrier to offer a plan that provides limited scope dental or vision benefits meeting the requirement of section 9832(c)(2)(A) of the Internal Revenue Code of 1986 through the Exchange, either separately or in conjunction with a qualified health plan, if the plan provides pediatric dental or vision benefits meeting the requirements of section 1302(b)(1)(J) of the Federal Act."

It is essential to permit stand-alone, limited scope, vision plans to compete and participate in the Exchange. Much like its dental counterparts, vision plans have been the primary provider of these services for decades. Today, over 90% of vision and dental benefits are provided separately from comprehensive health plans. As a result, stand-alone vision plans have developed the expertise necessary to deliver the highest quality of care (e.g. robust benefits, meaningful provider networks, and cost efficiencies), which are unmatched by comprehensive health plans.

Further, most medical plans currently do not offer these services directly, and would have to develop new provider networks or subcontract with specialists to provide for pediatric vision services under the PPACA. This will add administrative costs and inefficiencies that are unnecessary and contrary to the

goal to reduce cost and promote access. Furthermore, the Exchange as structured under the Model Act disrupts a proven business model that continues to successfully deliver quality vision care to more than 176 million Americans. The success of stand-alone vision plans is noted by a recent study revealing consumers to prefer stand alone coverage by a margin of 9 to 1.

Congressional action to include pediatric vision care as a component to the essential benefits package underscores the importance of vision care. As such, I strongly urge you to consider stand-alone plans be permitted to offer its expertise by providing consumers with choice and access to a robust and comprehensive vision benefit.

Experience shows that when vision benefits are combined with comprehensive health, the use of these benefits declines by half as vision is lost within the full scope of medical benefits. Patients with stand alone plans, however, are more aware of their benefits and utilize those benefits to maximize the value of their coverage. On average, beneficiaries of stand-alone vision plans are twice as likely to utilize their benefit, promoting the patient's preventive health and providing early diagnosis of chronic diseases such as Type II diabetes and hypertension- both key goals of the reform legislation.

Furthermore, stand-alone vision plans have consistently demonstrated its ability to deliver quality care. Vision plans continuously enjoy 90 plus percent enrollee satisfaction while successfully controlling cost; both accomplishments unparalleled by its medical counterparts. In light of the vision industries' expertise and proven track record, we strongly believe it beneficial to the consumers and the market place to modify Section 5B(2) of the Model Act as recommended.

Davis Vision welcomes the opportunity to assist the Exchange (B) Subgroup in considering our proposed modification. Please do not hesitate to contact us for further discussion or to further your efforts in facilitating consumer access to quality health care.

Sincerely,

Nicholas Peterson
Davis Vision, Inc.

FLORIDA HOSPITAL ASSOCIATION
An Association of Hospitals & Health Systems

October 6, 2010

Jolie H. Matthews
Senior Health and Life Policy Advisor & Counsel
NAIC Government Relations Office
444 N. Capitol Street, N.W., Suite 701
Washington, DC 20001-1509

***Re: National Association of Insurance Commissioners Draft Language for American Health Benefit Exchange Model Act***

Dear Ms. Matthews:

The Florida Hospital Association (FHA) is pleased to submit comments regarding the National Association of Insurance Commissioners (NAIC) draft model language (Model Act) related to the American Health Benefit Exchange. FHA represents 183 hospitals and over 1400 individual healthcare professionals in Florida.

The Model Act reflects the provisions in the *Patient Protection and Affordable Care Act* (ACA) that require the states to establish and operate health insurance exchanges (Exchanges). FHA supports an Exchange which creates a marketplace to expand consumers' access to health insurance coverage and provides an opportunity for consumers to choose a health plan that fits their needs. Our comments below focus on three sections of the Model Act – the establishment of the Exchange, duties of the Exchange, and Health Benefit Plan Certification criteria.

**SECTION 4: ESTABLISHMENT OF THE EXCHANGE**

The ACA gives states considerable flexibility in how to structure, govern, and operate the Exchange that the Model Act has incorporated. The FHA recognizes that the state's decisions regarding the organization and governance of the Exchange will be critical to the success and sustainability of the new insurance marketplace. We believe that the state's decisions must be supported by a thorough understanding and vetting of the issues, options and consequences of selecting the various options.

FHA opposes housing the Exchange in an existing governmental agency because it would create a perception that the Exchange's purpose is to operate government programs, rather than a marketplace for private insurance. Therefore, FHA recommends that an Exchange be an independent quasi-governmental or nonprofit entity because either one of these options will achieve the following important goals:

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(850) 222-9800 Fax: (850) 561-6230

Regional Office
307 Park Lake Circle
Orlando, FL 32803
(407) 841-6230 Fax: (407) 422-5948

www.fha.org www.flacareers.com

- Focus the Exchange on its primary mission, that is, to create a competitive marketplace for consumers to purchase coverage;
- Grant the Exchange flexibility in hiring practices to ensure a professional workforce;
- Generate broad financial support that is crucial to the Exchanges' future stability; and,
- Increase the likelihood that the Exchange will attract a broad base of stakeholder support (i.e. insurers, business, providers, and consumers).

The Section 4A Drafting Note attempts to outline the structural and governance options available to the Exchange and some of the considerations associated with each option; however, the discussion of advantages and disadvantages of each of the options in the Drafting Note is limited and could be interpreted as favoring one option over another. For example, some of the disadvantages cited in regard to the quasi-government and nonprofit options, e.g., "isolation from state policymakers and key state agency staff" and "decreased accountability" do not include any qualifying statement that these issues could be overcome.

FHA recommends that Section 4A Drafting Note be eliminated or significantly edited to clarify that the state has a variety of structural and governance options associated with the establishment of the Exchange and each include advantages and disadvantages. The Drafting Note suggests that the NAIC, through the Exchange (B) Subgroup, plans to review the options for establishing the Exchange governance and develop an issue paper on the topic to assist states in this area. The FHA believes that the Exchanges' structural and governance issues are so important that the NAIC should defer offering guidance to states in the Drafting Note until the deliberations of NAIC's Exchange (B) Subgroup can be completed. Giving the Exchange (B) Subgroup time to review the governance and structural issues of the Exchanges and develop an extensive issue paper will allow for a more complete and balanced review of the options facing states.

**SECTION 6: DUTIES OF THE EXCHANGE**

FHA believes a state needs the flexibility to design and implement an Exchange that addresses the unique needs of its populations, insurance marketplace, and stakeholders, including consumers, employers, and providers. To ensure that an Exchange has the broad-based support necessary to function, the FHA recommends that Section 6Q be amended to add hospitals and health systems to the list of stakeholders that should be consulted about the activities of the Exchange.

Additionally, FHA recommends a Drafting Note that the Exchange provide language services as part of its eligibility and enrollment functions so that limited English proficient individuals can understand information and access insurance. According to the American Community Survey (2006-2008), more than 24 million, or 8.7 percent of the population, speak English "less than very well" and should be considered limited English proficient for healthcare purposes. And, almost 20 percent of the U.S. population speaks a language other than English at home.

The Exchange is charged with determining eligibility and handling the enrollment of all eligible individuals in order to reduce the number of uninsured and under-insured, as well as decrease the level of uncompensated healthcare services. Language barriers can prevent access to information needed to enroll; thus, it is imperative that the Exchanges are accessible to limited English proficient individuals.

**SECTION 7: HEALTH BENEFIT PLAN CERTIFICATION**

Under the ACA, an Exchange is responsible for certifying health benefit plans that are offered through the Exchange. The Section 7A Drafting Note suggests that states consider whether the Exchange should delegate the certification function to the commissioner of insurance. While the Exchange might rely on and acknowledge the regulatory compliance determinations by the relevant state agencies with particular specialized expertise, such as the insurance commissioner and the department of health, the Drafting Note should clarify that the Exchange has the authority and responsibility to certify health benefits plans which are eligible to participate in the Exchange.

The Secretary of the Department of Health and Human Services (HHS) will be promulgating rules governing certification of health benefit plans, and the states may adopt more stringent certification requirements to ensure that health benefits plans are compliant. The FHA recommends that Section 7C Drafting Note include a comment that states may expand upon the certification requirements promulgated by the HHS Secretary. Examples of certification criteria, outlined below, that should be adopted by an Exchange should be provided to ensure that health benefit plans offered in the Exchange meet the requirements of the ACA:

- **Network Adequacy**. While the HHS Secretary will promulgate rules that will incorporate a criterion related to network adequacy, FHA recommends that the Drafting Note include a requirement that the health plan/issuer demonstrate, as part of the application, it has an adequate network and sufficient capacity to accept new patients, both initially and throughout the plan year, and that consumers will be able to access necessary services at a reasonable distance and within a reasonable timeframe. FHA recommends that the Drafting Note include examples of ways to demonstrate provider network adequacy, such as disclosure of the list of community providers, the number and mix and geographic distribution of providers, and the actual provider access criteria that the plan used in forming its networks.

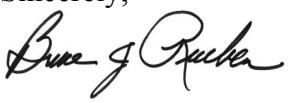
- **Language Services**. Since plans participating in the Exchange will be receiving federal financial assistance in the forms of subsidies and additional payments to offset cost-sharing for low-income enrollees, they are subject to the nondiscrimination requirements of § 1557 of the ACA as well as Title VI of the *Civil Rights Act of 1964*. FHA suggests a Drafting Note that the state health benefit plan certification regulations should include a requirement that all participating plans/insurers provide and pay for language services for applicants and enrollees. Without an explicit requirement to pay for language services, plans are likely to pass the responsibility – and costs – on to their network providers. This would virtually relieve plans of their responsibilities to prohibit discrimination while placing a difficult burden on many providers to provide language services.

- **Quality Measures**. FHA recommends a Drafting Note that any quality measure or rating system used by the Exchange to evaluate health benefit plans should be based on nationally recognized consensus-developed quality standards that can be consistently and uniformly applied and measured.

Section 7C outlines the information that the plan/issuer must submit to the Exchange, the HHS Secretary, and the state insurance commissioner. FHA recommends the list of data be expanded to include timeframes for processing claims to demonstrate that the plan has the capability of processing claims payment for its entire network on a timely and accurate basis. FHA also suggests that Section 7C require health plans/issuers to submit encounter data so that the relevant state agency can evaluate whether enrollees are actually receiving services and not being required to travel unreasonable distances to do so. Regular monitoring would ensure that plans are not operating "shadow" networks (networks that list providers but do not ensure they are accepting new patients under that plan).

FHA appreciates the opportunity to comment on the NAIC's Model Act. Clear guidance will go a long way in ensuring the successful implementation of the ACA and the establishment of the Exchanges. FHA looks forward to working with you and your staff to meet this challenge. If you have any questions about our comments, please contact Ralph Glatfelter, Senior Vice President, at ralph@fha.org or 850-222-9800, Paul Belcher, Senior Vice President, at paul@fha.org or 850-222-9800, or Kim Streit, VP Health Care Research & Information Services, at kims@fha.org or 407-841-6230.

Sincerely,



Bruce J. Rueben
President

c: Kevin McCarty, Insurance Commissioner, Florida Office of Insurance Regulation

BR:lb

THE HOSPITAL & HEALTHSYSTEM ASSOCIATION OF PENNSYLVANIA

October 6, 2010

Jolie H. Matthews
Senior Health and Life Policy Advisor and Counsel
NAIC Government Relations Office
444 N. Capitol Street, N.W., Suite 701
Washington, D.C. 20001-1509

***Re: National Association of Insurance Commissioners Draft Language for American Health Benefit Exchange Model Act***

Dear Ms. Matthews:

On behalf of The Hospital & Healthsystem Association of Pennsylvania (HAP), which represents approximately 250 member institutions, including 125 stand-alone hospitals and another 120 hospitals that comprise 32 health systems across the Commonwealth of Pennsylvania, HAP appreciates the opportunity to respond to the National Association of Insurance Commissioners' (NAIC) draft model language (Model Act) related to the American Health Benefit Exchange.

The Model Act reflects the provisions in the Patient Protection and Affordable Care Act (ACA) that require the states to establish and operate health insurance exchanges (exchanges). HAP supports an exchange, as contemplated by the ACA, which creates a marketplace to expand consumers' access to health insurance coverage and offer consumers the opportunity to choose among health plans that fit their needs. HAP's comments below reiterate, support, and expand upon those provided by the American Hospital Association and focus on three sections of the Model Act—the establishment of the exchange, duties of the exchange, and the Health Benefit Plan Certification criteria.

**SECTION 4: ESTABLISHMENT OF THE EXCHANGE**

The ACA gives states considerable flexibility about how to structure, govern, and operate the exchange that the Model Act has incorporated. HAP recognizes that, in Pennsylvania, the state's decisions regarding the organization and governance of the exchange will be critical to the success and sustainability of the new insurance marketplace envisioned by the law, and we believe that the state's decisions need to be supported by a thorough understanding and vetting of the issues, options, and consequences, of selecting the various options.

HAP opposes housing the exchange in an existing governmental agency because it would create the perception that the exchange's purpose is to operate government programs, rather than a marketplace for private insurance. As a result, HAP recommends that an exchange be an independent quasi-governmental or nonprofit entity, because either one of these options will achieve the following important goals:

4750 Lindle Road
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Harrisburg, PA 17105-8600
717.564.9200 Phone
717.561.5334 Fax
haponline.org

- Focus the exchange on its primary mission, that is, to create a competitive marketplace for consumers to purchase coverage.

- Grant the exchange flexibility in hiring practices to ensure a professional workforce.

- Generate broad financial support that is crucial to the exchanges' future stability.

- Increase the likelihood that the exchange will attract a broad base of stakeholder support (i.e insurers, business, providers, and consumers).

The Section 4A Drafting Note attempts to outline the structural and governance options available to the exchange and some of the considerations associated with each option; however, the discussion of advantages and disadvantages of each of the options in the Drafting Note is limited and could be interpreted as favoring one option more than another.

HAP recommends that Section 4A Drafting Note be edited to clarify that the state has a variety of structural and governance options associated with the establishment of the exchange and each include advantages and disadvantages.

The Drafting Note suggests that the NAIC, through the Exchange (B) Subgroup, plans to review the options for establishing the exchange governance and develop an issue paper on the topic to assist states in this area. HAP believes that the exchanges' structural and governance issues are so important that the NAIC should defer offering guidance to states in the Drafting Note until the deliberations of NAIC's Exchange (B) Subgroup can be completed. Giving the Exchange (B) Subgroup time to review the governance and structural issues of the exchanges and develop an extensive issue paper will allow for a more complete and balanced review of the options facing states.

**SECTION 6: DUTIES OF THE EXCHANGE**

HAP believes a state needs the flexibility to design and implement an exchange that addresses the unique needs of its populations, and insurance marketplace and stakeholders, including consumers, employers, and providers. To ensure that an exchange has the broad-based support it needs to function, HAP recommends that Section 6Q be amended to add hospitals and health systems to the list of stakeholders with whom the exchange should consult with regard to carrying on its activities.

Additionally, HAP recommends a Drafting Note that the exchange provide language services as part of its eligibility and enrollment functions so that limited English-proficient individuals can understand information and access insurance. The exchange is charged with determining eligibility and handling the enrollment of <u>all</u> eligible individuals in order to reduce the number of uninsured and under-insured, as well as decrease the level of uncompensated health care services. Language barriers can prevent access to information needed to enroll; thus, it is imperative that the exchanges are accessible to limited English-proficient individuals.

**SECTION 7: HEALTH BENEFIT PLAN CERTIFICATION**

Under the ACA, an exchange is responsible for certifying health benefit plans that are offered through the exchange. The Section 7A Drafting Note suggests that states consider whether the exchange should delegate the certification function to the commissioner of insurance. While the exchange might rely on and acknowledge the regulatory compliance determinations by the relevant state agencies with particular specialized expertise, including the insurance commissioner and the department of health, the Drafting Note should clarify that the exchange has the authority and responsibility to certify health benefits plans that are eligible to participate in the exchange.

The Secretary of the Department of Health and Human Services (HHS) will be promulgating rules governing certification of health benefit plans, and the states may adopt more stringent certification requirements to ensure that health benefits plans are compliant. HAP recommends that Section 7C Drafting Note include a comment that states may expand upon the certification requirements promulgated by the HHS Secretary. Further, HAP recommends that the Model Act include examples of certification criteria, outlined below, that should be adopted by an exchange to ensure that health benefit plans offered in the exchange meet the requirements of the ACA:

- **Network Adequacy**. While the HHS Secretary will promulgate rules that will incorporate a criterion related to network adequacy, HAP recommends that the Drafting Note include a requirement that the health plan/issuer demonstrate, as part of the application, that it has an adequate network and sufficient capacity to accept new patients, both initially and throughout the plan year, and that consumers will be able to access necessary services at a reasonable distance and in a reasonable time frame to address their particular health care needs. The criteria for network adequacy must be clear, measurable parameters that reflect the population and the region. They need to ensure not simply network participation, but actual provider access for consumers, and also should include a requirement of adherence to the network adequacy standards in an ongoing way for a health plan's continued participation in the exchange. HAP recommends that the Drafting Note include examples of ways to demonstrate provider network adequacy, such as disclosure of the list of community providers, the number and mix and geographic distribution of providers, and the actual provider access criteria that the plan used in forming their networks. Finally, HAP recommends that the Drafting Note include reference that a system for regular monitoring of the network adequacy be established through the exchange.

- **Language Services**. Since plans participating in the exchange will be receiving federal financial assistance in the form of subsidies and additional payments to offset cost-sharing for low-income enrollees, they are subject to the nondiscrimination requirements of § 1557 of the ACA as well as Title VI of the Civil Rights Act of 1964. HAP suggests a Drafting Note that the state health benefit plan certification regulations should include a requirement that all participating plans/insurers provide and pay for language services for applicants and enrollees. Without an explicit requirement to pay for language services, plans are likely to pass the responsibility—and costs—on to their network providers.

This would virtually relieve plans of their responsibilities to prohibit discrimination while placing a difficult burden on many providers to provide language services.

- **Quality Measures**. HAP recommends a Drafting Note that any quality measure or rating system used by the exchange to evaluate health benefit plans should be based on nationally recognized consensus-developed quality standards that can be consistently and uniformly applied and measured. Furthermore, HAP recommends that the exchange include information about the plan's performance (complaints, denials, and overturned denials, what amount of premium is spent on health care as opposed to health plan operations/profit) as well as some overall measures of how the plan's network performs on key indicators (prevention, core measures, physician quality measures, etc.) in its quality performance rating system. This would give consumers some idea of how the plan performs, and also the overall quality of its physician, hospital, and ancillary provider network. In addition, HAP thinks it is important that all plans in the exchange be included in the quality reporting—not just health maintenance organizations.

Section 7C outlines the information that the plan/issuer must submit to the exchange, the HHS Secretary, and the state insurance commissioner. HAP recommends that the list be expanded to require plans/issuers to submit data regarding time frames for processing claims for their entire network health plans in order to demonstrate that health benefit plans have the capability of processing claims payment for their entire network on a timely and accurate basis. HAP also suggests that Section 7C require health plans/issuers to submit encounter data so that the relevant state agency can evaluate whether enrollees are actually receiving services and not being required to travel unreasonable distances to do so. Regular monitoring would help ensure that plans are not operating "shadow" networks (networks that list providers but do not ensure they are accepting new patients under that plan).

Again, HAP appreciates the opportunity to comment about the NAIC's Model Act. Clear guidance will go a long way in ensuring the successful implementation of the ACA and the establishment of the exchanges. HAP looks forward to working with you and your staff to meet this challenge.

If you have any questions about our comments, please contact me at (717) 561-5344, or Robert Greenwood, HAP's vice president of health care finance and insurance, at (717) 561-5358, or Pamela Clarke, HAP's vice president of health care finance and managed care, at (215) 575-3755.

Sincerely,

Paula A. Bussard

PAULA A. BUSSARD
Senior Vice President for Policy and Regulatory Services


October 6, 2010

Jolie Matthews
National Association of Insurance Commissioners
*Submitted via email to jmatthew@naic.org*

**Re: American Health Benefit Exchange Model Act**

Dear Ms. Matthews:

MAXIMUS is pleased to provide comments in response to the NAIC draft "American Health Benefit Exchange Model Act." We are a company that supports government agencies in the health and human services area. Our primary focus is on the consumers of government programs. In this regard, we are the leading provider of Medicaid enrollment services and CHIP administrative services.

Our comments focus on several key provisions of the model act, as detailed below.

Section 2 (Purpose and Intent) and Section 6.N(3):
There should be consistent wording on the purpose of the American Health Benefit Exchange, SHOP Exchange, and Navigators. All should reference that the exchange should "facilitate the enrollment in qualified health plans." This consistency also underscores the provisions of the January 2005 Producer Licensing Model Act, in Section 4.B(2), which exempts from producer license the responsibility to secure and furnish information regarding plans and enrollment of individuals into plans. In other words, the model act should clarify that the Exchange is NOT the place where the sale of insurance occurs. Any purchase or sale takes place between the individual or employer/employee and the qualified health plan directly. The Exchange is the point where individuals, employers and employees are provided assistance; online, by phone, or in person; to connect to enrollment in qualified health plans.

Section 4.C (Contracting with Eligible Entities):
In this section, the model act addresses the definition of "eligible entities." We recommend that this definition be moved to Section 3 (Definitions) and include the following: "Eligible entity" includes, but is not limited to, the State Medicaid agency, an entity that has experience in the individual and small group markets, or an entity that has experience performing Medicaid and/or CHIP eligibility and enrollment, but is not an entity with a direct financial or material indirect financial interest with health insurance issuers (health carriers), qualified health plans, and/or health care providers (inside and outside the Exchange).

We recommend that the Drafting Note that follows Section 4.C be clarified as to what provisions it addresses. It appears that this note relates more to the governance issues in Section 4 than the preceding subsection that addresses eligible entities.

Section 4.D (Information-Sharing Agreements):
In this section the model act allows the Exchange to enter into information-sharing agreements with federal and state agencies and other state Exchanges. We recommend that language be inserted that


explicitly extends these agreements to the eligible entities under contract with the Exchange to perform services of the Exchange.

Section 6.B (Toll-free Telephone Hotline):
This section provides for the requirement to operate a toll-free telephone hotline to respond to requests for assistance. This hotline will serve a number of purposes, which include assistance with eligibility determination and to serve as a phone-based "Navigator". Therefore, the requirements in Section 6.N (Navigators) should apply to the staff in the toll-free hotline, most notably the requirements in Section 6.N(1)-(5). In addition, it should be clarified that the toll-free hotline does not sell, solicit or negotiate health insurance.

We hope these comments will be helpful to NAIC as the American Health Benefit Exchange Model Act is amended and refined. We welcome any opportunity to clarify or elaborate on our comments.

Sincerely,

Bruce L. Caswell

Bruce Caswell, President and General Manager
MAXIMUS Health Services
11419 Sunset Hills Road
Reston, VA 20190

Office: 703 2518460
Cell: 301 5298099
Email: brucecaswell@maximus.com

# Michigan Association of Health Plans



October 6, 2010

Jolie Matthews
National Association of Insurance Commissioners

Dear Ms. Matthews:

RE: American Health Benefit Exchange Model Act

On behalf of the Michigan Association of Health Plans and its member health plans, we want to thank you and the staff and members of NAIC for the ongoing efforts to provide a smooth implementation of the Patient Protection and Affordable Care Act. The development of a draft model act is consistent with this approach and provides to all observers, particularly those operating in a state government environment, a starting point to focus on a legislative structure for the "Exchange".

Our comments are intended to be our initial reaction to the draft model act knowing that furter iterations will be taking place and additional opportunities to provide comments. Further, we appreciate that the intent appears to be that the significant policy issues facing states are preserved in drafting notes without the Model Act taking a position per se. Such issues as governance structure, regional or multi-state exchange, or size of employer included, merger of individual and small group are all explicitly left for state variation. We appreciate this format as most states are still making their determinations regarding these key issues and will likely use the planning phase facilitated now by the planning grants to arrive at a consensus.

For purposes of this communication we are divided our comments into three different areas:

1. General Comments that would serve as the underpinning for any state legislation;
2. Specific comments on the draft model act draft langague; and
3. Omissions from the draft model act

**General Comments**

We believe the American Health Benefit Exchange model act for the the State implementation of the American Health Benefit Exchange should be based on the following concepts:

1. States are best positioned to implement the Exchanges and should not default to the federal government.
2. The implementation of an "Exchange" should not establish unnecessary and costly duplicative regulatory structures that currently exist including rate review and filings requirements, but should focus on features that will ensure a better, high value experience for the consumer.
3. While we believe many of the regulatory functions are best made at the state level, national standards are important considerations and will help facilitate implementation in key information technology areas. Health plan business decisions are now being made and major resources being expended to fully implement the transition to the HIPAA require transaction code set 5010 and move to ICD-10 by 2013. Operational efficiencies for "Exchanges" can be enhanced by establishing uniform standards for key data elements consistent with these national standards.
4. Structured enrollment periods are critical elements to help provide access to affordable health coverage in the individual market, given the presence of a very weak enforcement mechanism. At the same time, consideration should be given to enable other strategies and incentives that could ensure that all who are eligible participate.
5. "Exchanges" should preserve and enhance the ability of employers to offer coverage options to their employees and offer an important channel for individuals and businesses to access choices in the market. However, the existing market should be permitted to function outside of the "Exchange".
6. "Exchanges" should offer consistent and objective participation criteria to allow for meaningful choices.

## Specific Comments on the NAIC Model Act

### Section 2. Purpose and Intent:

This section may be too narrowly focused. The purpose and intent of the model act is not simply to facilitate the purchase of qualified health plans and to provide for the establishment of a Small Business Health Options Program. Additional purposes that states may want to state in legislation include:

- Meet the requirements of the federal act and all applicable federal guidance and regulations
- Reduce the number of uninsured by creating an organized, transparent marketplace for purchasing affordable, quality health care coverage, claiming available federal tax credits and cost-sharing subsidies, and
- For meeting the personal responsibility requirements imposed under the federal act.

**Section 3: Definitions**

1. Section 3 J Definition of "Qualified employer" -- pg 3
   This definition needs to be reviewed for consistency with the same term as defined in Section 1312(f) (2) of the ACA. As currently written, the model act definition appears to require a small employer to make at least some of its part-time employees eligible for SHOP Exchange coverage in order to be a qualified employer. The ACA definition only requires that ALL full-time employees be eligible for SHOP Exchange coverage. Also, the requirements for principal place of business and principal place of employment may be inconsistent with the ACA definition. Although it is more likely to happen with large employers, small employers may want to have employees covered through different state SHOP Exchanges if they are located in a border region. This appears to be allowed under the ACA.

   Subparagraph (1)
   - "Principal place of business" is not defined
   - An employer with its principal place of business in the state is a "qualified employer" only if it decides to have "all of its eligible employees" having coverage through the "Exchange". What if many employees live out of state?

   Subparagraph (2)
   - "Principally employed" is not defined and is capable of multiple definitions i.e., number of hours worked in the state; residency in the state; pays state income tax, etc.
2. Section 4 C Contract with eligible entities-- Pg 5

   ACA section 1311(f) (3) allows Exchanges to contract with "eligible entities" to carry out their responsibilities. However, there are a number of restrictions in this regard. The Model Act should specifically reference the Federal Act to pick this up.

3. Section 6 K(1) Reference to prior section-- pg 7
   It appears that the reference in this paragraph should not be to "subsection I" but rather to "subsection J".

4. Section 6 N—pg 7
   Under the ACA language "Exchanges" are to "award grants" to Navigators. The Model Act uses the language that the "Exchanges" will "select entities" to serve as Navigators. Perhaps language that says "select entities through the award of grants" would be better. Further, the restriction on funding from carriers for Navigators is understood to be a reference to direct or indirect funding. However, Section 8

suggests the main source of funding for the "Exchange" is from carriers. If that is true, then they are indirectly funding Navigators as well.

5. Section 6 N (4) Reference to Public Health Service Act—pg 7
   This section refers to "PHSA" without identifying the reference.

6. Section 6 Q Consultation with Stakeholders—page 7-8
   It would appear to be appropriate to list "carriers" to this subsection as a key constituent group for consultation on the "Exchange".

7. Section 7, paragraph A.(2)—pg 8
   Section 7(A) follows the federal law in stating that an "Exchange" "may" certify a plan meeting the various standards. This is the language that will eventually be used to support the power of "Exchanges" to selectively contract with plans. Even if a plan meets each and every listed criterion, the "Exchange" is not duty-bound to certify it as a qualified health plan since the language is permissive: may versus shall. Although the use of the term "may" as opposed to "shall" is consistent with the ACA, this does not mean that a state could not choose as a matter of state policy to require the "Exchange" to certify all plans that meet the listed criteria. In other words, states could eliminate the permissive ability of the Exchange to contract selectively. A drafting Note along the lines that states may choose to make certification mandatory if the plan meets the listed criteria should be considered.

8. Section 8, paragraph A. 2—pg 8
   This paragraph should reference 1302(d) of the Federal Act given that if refers to "bronze" level of coverage without any definition of what that means.

9. Section 7, paragraph A.(3)(b).—pg 8

   This section differs from ACA language in that the word "each" is not before the word "Exchange." This would matter depending upon whether the individual and small group exchanges were merged.

10. Section 7, paragraph A.(3)(c)—pg 8
    ACA uses words "agrees to charge" and the Model Act says "charges." This may be relevant upon formation of "Exchanges" since when "Exchanges" are formed there would be no history from which to conclude that a carrier "charges" as opposed to "agrees to charge."

    This same paragraph in the Model Act uses the term "insurance producer" whereas the ACA uses the term "agent". There is no drafting comment to warn drafter that whatever phrase is used should align with the state law.

11. Section 8, Funding. Pg 9.

See comments under # 5 above. It is recommended that this section simply indicate that the "Exchange" shall either be funded directly by the state or may generate funding necessary to support its operations provided under the act.

**Section 4: Omissions**

Either in new sections or more appropriately in the "drafting notes", NAIC should include in the model act provisions for how the following issues should be addressed—or simply a placeholder that indicates state law should address such issues:

1. How the development of methodologies to establish reinsurance and risk adjustment mechanisms that will serve to address adverse selection both inside and outside of the "Exchanges" will be handled.
2. ACA section 1311(g) requires that qualified health plans report to "Exchanges" that they have conducted a strategy to reward quality through market-based incentives. This is not included in the current draft.

3. Under ACA section 1311 (h) there is a requirement that starting in January 2015 qualified health plans may only contract with a hospital with more than 50 beds if they utilize a patient safety evaluation system specified in the Public Health Service Act. This applies to other provider as well in terms of having to have mechanism to improve health care quality. This is not noted in the Model Act.

4. Under ACA section 1311 (d) 5 (B) there is a specific requirement that an "Exchange" shall "not utilize any funds intended for the administrative and operational expenses of the "Exchange" for staff retreats, promotional giveaways, excessive executive compensation, or promotion of Federal or State legislative and regulatory modifications." Since this is mandated by ACA it should be referenced by the Model Act.

5. Direct Primary Care Medical Home Plans ACA section 1301(a) (3) provides that the Secretary shall permit qualified health plans to provide coverage through a primary care medical home plan certified by the Secretary. This is not noted in the Model Act.

6. Child Only Plans Under ACA section 1302 (f) an issuer offering any level of plan through the "Exchange" shall also offer coverage as a plan in which the only enrollees are individuals who are younger than 21. This is not included in the Model Act.

7. Under ACA section 1312(d) (1) there is language that notes that nothing in the ACA shall prohibit a health plan from offering coverage outside of an "Exchange". Perhaps a parallel provision should be contained in the Model Act to clarify that an insurer can continue to offer products outside of the "Exchange".

8. Similar to #6, above, a provision should be included that makes clear that the Model Act does not replace the state's insurance laws otherwise applicable to the insurance industry.

9. ACA section 1312(d) (4) specifically dictates that neither an "Exchange" nor a carrier can impose a fee on an individual for canceling coverage in the "Exchange" if they acquire minimum essential coverage through another source. This would be a good consumer protection provision to include.

10. Under ACA section 1322, CO-OPs are established and are intended to be participants in the "Exchanges". There would appear to be no mention of them in the Model Act.

11. Finally, several thoughts on additional drafting notes that could help consumers in their selection of carriers. Because there are innumerable ways a plan can design the benefit package and cost sharing to reach gold or silver status it may be useful for an "Exchange" to require carriers to offer at least one standard plan with common benefit packages and cost sharing arrangements in order to facilitate common comparisons. (A drafting note could at least identify this option.) Similarly, an "Exchange" could require that a certain benefit plan pay providers pursuant to a state-established fee schedule (provider rate parity). For example, the "Exchange" could require carriers to submit plans that require providers to be paid at a percent of Medicare (or some other multiple). Again, this would provide consumers with a more accurate comparison on performance of carriers and not focus on which carrier can leverage the steepest provider discount. This option could be mentioned in a drafting note.

We hope that these comments contribute to the ongoing refinement of the model act, and we look forward to working with NAIC and other interested parties to assure that the American Health Benefit Exchange Model Act represents a consensus framework for the legislature in Michigan and other states. Please feel free to contact me at MAHP for any further information regarding these comments. I can be reached at: Rmurdock@mahp.org or by phone at 517-371-3181. Thank you for your attention to our comments

Sincerely

Richard Murdock

Executive Director
cc. MAHP Executive Committee

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October 6, 2010
**Submitted via e-mail**

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***Re: National Association of Insurance Commissioners Draft Language for American Health Benefit Exchange Model Act***

Dear Ms. Matthews:

On behalf of the 148 hospitals and 17 health system members of the Minnesota Hospital Association (MHA), we appreciate the opportunity to respond to NAIC's draft model act for states' consideration as they pursue implementation of health benefit exchanges (Exchanges) as required in the *Patient Protection and Affordable Care Act* (ACA). At the outset, MHA supports the comments provided by the American Hospital Association (AHA) and we offer the following comments as a reflection of the priorities, concerns and positions of our members in Minnesota and the challenges they face.

MHA supports the creation of Exchanges. Although Minnesota has had one of the highest rates of insurance coverage, MHA and its members have supported and advocated for insurance market and financing reforms to make health coverage more affordable and accessible. Exchanges, if properly constructed and administered, will create new marketplaces for individuals and small businesses to purchase health insurance coverage, simplify insurance purchasing, administer subsidies, and lower the out-of-pocket costs to consumers. With the proper framework and guidance, the Exchanges will ensure the efficient operation of a marketplace for private health insurance.

MHA commends the NAIC for putting forward a draft model act. Although MHA has concerns and suggestions for improvement, as outlined below, we respect NAIC's attempt to create a starting point for the important discussions and deliberations each state must undertake with its health care providers, insurers, payers, consumers and regulatory agencies.

In any model act, policy choices are embedded in the proposed language and NAIC's draft is no different. MHA understands that drafting a model act for Exchanges is easier and more applicable across states if the governance and structure of the Exchanges lies in existing government agencies and bureaucracy. However, ACA gives states broad authority to go beyond traditional state agency governance structures and, if a state chooses, adopt alternative structures including nonprofit organizations, public-private partnerships or quasi-governmental bodies for

operating Exchanges. While some states might decide to authorize a state agency to operate their Exchanges, MHA believes that Minnesota and its residents would be better served by a different structure that leverages the strengths of our state's long tradition of public transparency and accountability with our private sector's spirit of innovation, efficiency and consumer-focused service.

Accordingly, MHA encourages the NAIC to treat ACA differently than traditional model act drafting exercises and put forward alternative model acts for states to consider. The format in the current draft might be acceptable for states interested in a government-run Exchange. An alternative draft for states interested in a nonprofit-run or quasi-government-run Exchange would be extremely valuable and would further ACA's purpose in explicitly allowing for state variation and experimentation with Exchange operations and governance.

Allowing state flexibility to innovate and experiment will require editing and rewriting some of the commentary contained in the draft model act. In particular, MHA echoes the suggestion made in AHA's comment letter:

> The AHA recommends that Section 4A Drafting Note be eliminated or significantly edited to clarify that the state has a variety of structural and governance options associated with the establishment of the Exchange and each include advantages and disadvantages. The Drafting Note suggests that the NAIC, through the Exchange (B) Subgroup, plans to review the options for establishing the Exchange governance and develop an issue paper on the topic to assist states in this area. The AHA believes that the Exchanges' structural and governance issues are so important that the NAIC should defer offering guidance to states in the Drafting Note until the deliberations of NAIC's Exchange (B) Subgroup can be completed. Giving the Exchange (B) Subgroup time to review the governance and structural issues of the Exchanges and develop an extensive issue paper will allow for a more complete and balanced review of the options facing states.

To make the most out of the deliberative process and oversight structure the NAIC's draft aims to achieve in section 6Q, it is critical that Exchanges benefit from the input of multiple stakeholders impacted by the ultimate rules and actions of the Exchange, as well as the insurance products available in the Exchanges. The draft act includes language identifying some of these important stakeholders that must be consulted, but neglects to explicitly identify representatives from hospitals and health systems.

Because hospitals and health systems will care for the individuals carrying insurance policies purchased through the Exchange and will need to make the claims and seek the recovery of benefits provided for under those policies, it is both prudent and necessary to specifically identify hospitals and health systems, as well as physicians, clinics and other provider groups, as represented stakeholders that must be consulted. It is foreseeable that the enumerated stakeholder in the draft model act (individual consumers, small businesses, the state's Medicaid director, and other advocates for hard-to-reach populations) will not have the data, direct experience or capacity to identify patterns or problems with provider network adequacy, claims processing and adjudication obstacles, prompt payment practices, or other actions that could result in undermining the quality or unnecessarily increasing the costs of products individuals and small employers purchase through the Exchange.

As health insurers seek to have their plans offered on the Exchange, it will be important to ensure that the plans offered are in consumers' best interest. MHA agrees with AHA's emphasis on the need for a mechanism to ensure that a health plan has an adequate provider network and sufficient capacity to provide consumers with meaningful access to necessary medical services at a reasonable distance and in a reasonable timeframe. The criteria could include requiring health plans to submit their encounter data to be evaluated to determine whether enrollees actually receive services and are not required to travel unreasonable distances to do so. In addition to requiring submission of encounter data, the model act should ensure that the Exchange and/or the state government have authority and responsibility for auditing the data. Regular monitoring should be designed to protect against the practice of plans operating "shadow" networks in which providers are listed as in-network but are not accepting new patients under the particular health plan and, therefore, are not available to new enrollees or other practices that decrease the practical value of plans sold through the Exchange.

In addition to consumer protection, Exchanges should provide a level of provider protection. Under Medicare Advantage, for example, Minnesota's hospitals and health systems experienced unreasonable practices by out-of-state Medicare Advantage plans delaying claims processing and paying far-below-market rates. In order to qualify to participate and remain in the Exchange, health plans should be required to comply with minimum prompt-pay guidelines and demonstrate adequate provider payment rates.

As stated earlier, in addition to the above comments, MHA agrees with and supports the comments raised by the American Hospital Association. If you have any questions about our comments, please feel free to contact me at your convenience.

Sincerely,

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