



April 1, 2013

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Center for Medicare and Medicaid Services  
Department of Health and Human Services  
Attention: CMS-9964-P2  
Mail Stop C4-26-05  
7500 Security Blvd  
Baltimore MD 21244-1850

**Subject: Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Small Business Health Options Program Proposed Rule – AHIP Comments - CMS-9964-P2**

We are writing on behalf of America's Health Insurance Plans (AHIP) to offer comments in response to the Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) Proposed Rule amending existing provisions of the Affordable Insurance Exchanges ("Exchanges") Final Rule on Establishment of Exchanges and Standards for Qualified Health Plans under the Affordable Care Act (ACA), specifically related to the Small Business Health Options Program (SHOP) published in the Federal Register on March 11, 2013.

Beginning January 1, 2014, health plans will begin to enroll qualified employees in qualified health plans (QHPs) in the SHOP. The proposed rule would amend the existing regulations in the Exchange Final Rule in several significant respects related to the employee choice option and premium aggregation function as well as triggering events and special enrollment periods for qualified employees and their dependents. In an attachment to this letter, we provide comments on behalf of AHIP member health plans regarding the impact of each of these specific proposed changes in policy and the operational considerations stemming from these proposed amendments.

Our recommendations are designed to assist with health plan implementation of the proposed changes, and improve the likelihood of a smooth launch of the SHOP. We appreciate CMS recognizing the complexity associated with the implementation of the employee choice and premium aggregation in the SHOP, and understand the decision to delay those functions. However, we note the administrative costs and impacts on issuers that have been steadily

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working to implement the previous approach are significant, and that changing the operational approach for SHOP this close to implementation places great operational burden on health plan customer service approaches, systems and plan operations.

As the Department finalizes these foundational rules and moves forward with implementation, health plan operations leaders preparing for the start of open enrollment on October 1, 2013 emphasize the need for CMS to focus on operability and streamlined implementation.

We appreciate the opportunity to submit comments and look forward to working with you over the coming months and discussing the implications of the proposed amendments to the SHOP program in greater detail.

Sincerely,

A handwritten signature in black ink, appearing to read "Colleen M. Gallaher", with a long horizontal flourish extending to the right.

Colleen M. (Candy) Gallaher  
Senior Vice President - State Policy

A handwritten signature in black ink, appearing to read "Jeanette Thornton", with a long horizontal flourish extending to the right.

Jeanette Thornton  
Vice President, Health IT Strategies



### **Functions of a SHOP (§155.705) – Comments on a Transitional Policy for the Employee Choice Option**

The Proposed Rule would amend §155.705 of the Exchange Final rule related to functions of a SHOP to implement a transitional policy regarding employees' choice of QHPs in the SHOP, making the requirement that SHOPS allow employers to permit employees to choose among QHPs at a selected metal level ("employee choice") optional until January 1, 2015. State-based SHOPS may choose to permit employee choice effective January 1, 2014, but the Federally-facilitated SHOPS (FF-SHOPS) would not. FF-SHOPS would instead assist employers in choosing a single QHP to offer their qualified employees for plan years beginning on or after January 1, 2014 and before January 1, 2015. The FF-SHOP will offer an employee choice option effective January 1, 2015.

As previously noted, the proposed delay in the employee choice option and the corresponding premium aggregation function (designed to assist employers whose employees are enrolled in multiple QHPs) in the FF-SHOP until the 2015 coverage year raises concerns for health plans related to eligibility and enrollment and premium billing and payment. Nevertheless, we continue to support building toward that option, while being required to implement the employer choice now outlined by the CMS.

It is critical that the operational model for the FF-SHOP be finalized as soon as possible so health plans can be administratively prepared to begin providing coverage to qualified employees in the 2014 coverage year. Health plans have been preparing to enroll individuals through the FF-SHOP using prior rulemaking, sub-regulatory guidance, and other communication from CMS that included an employee choice option and premium aggregation service. It is late in the game to make substantial changes to the FF-SHOP model and these amendments will have a significant impact on health plan operations to enroll qualified individuals through the FF-SHOP beginning this October.

Below are recommendations to respond to the operational implications of this Proposed Rule:

#### ***Eligibility, Enrollment & Effectuation of Coverage***

Health plans are seeking information regarding the processes for receiving enrollment files in the SHOP and effectuating enrollment for employers and eligible employees, especially as it applies to adhering to specific requirements such as waiting periods and other sources of employer-related coverage. In order to assure the smoothest implementation, as health plans have to pivot from one approach to this changed approach, we make the following recommendations.

1. **Recommendation:** The FF-SHOP should conduct full verification of eligibility for the SHOP Exchange. The FF-SHOP should receive applications and employer information, and



will send issuers appropriate enrollments, i.e., employers/employees who are eligible for enrollment.

2. **Recommendation:** The FF-SHOP should be responsible for applying waiting period rules and that the FF-SHOP send issuers effective dates of coverage that take into account applicable waiting periods for any new enrollment (including new hires).
3. **Recommendation:** The FF-SHOP, which administers enrollment and eligibility, should also be responsible for notifying the issuer if an employee is in a continuation for coverage employer group program. The FF-SHOP can administer COBRA, or receive that information from the employer group's COBRA administrator, and provide that information to issuers. We also recommend that the FF-SHOP recognize state continuation of coverage programs, sometimes called "mini-COBRA." Under this model, employers will be able to utilize the FF-SHOP to indicate that certain employees are eligible for continuation of coverage via the FF-SHOP web portal. FF-SHOP will send issuers an indicator to identify employees that are eligible for continuation of coverage. FF-SHOP will follow federal and applicable state continuation rules.

Further guidance or clarification is required to address other roles and responsibilities in this changed approach, where the issuer will collect the premium, not the FF-SHOP. Responsibilities need to be outlined, and the timing of transactions smoothly coordinated to assure that necessary enrollment/additions/deletions to the employer group file are sent timely to the issuer, in order for the issuer to develop the premium bill to send out.

4. **Recommendation:** We understand that CMS intends to send updates to issuers for all employees who are added to or terminated from the group via enrollment (834) files but that the group enrollment file will not be updated for these mid-year changes. We recommend, however, that the FF-SHOP send issuers updated group enrollment files for any mid-year changes to group-level information (i.e., demographic information, contact information), which will be critical for communications with the employer group and coordination with agents and brokers. Examples of such critical information include a change in the agent of record, change in employer location or contact information. Having up-to-date employer group-level information will assure health plans have the most accurate information about the employer to support billing, customer service and other regulatory requirements

We understand that under this revised SHOP model, the group enrollment XML file will still be used to send QHP issuers employer-level information. In this employer choice model, instead of the group enrollment file containing multiple plan IDs of the potential universe of QHPs that could be selected by the qualified employees in the employer group, it will now only contain the actual QHP selected by the employer. We anticipate that the FF-SHOP will notify the small employer of their acceptance, and the FF-SHOP will issue the Group Notice of Acceptance.



5. **Recommendation:** The FF-SHOP should be responsible for notifying the group that payment of premium to the issuer is needed to effectuate coverage, and it should provide notice to the group health plan no less than 2 weeks prior to the effective date of coverage.

Health plans are willing to continue discussions with CMS on the group enrollment file to determine any changes that must be made to accommodate the proposed SHOP model. We understand that the SHOP group enrollment file is near completion. A final version is needed as soon as possible so health plans can accommodate the files beginning in October.

Finally, CCIIO has previously indicated the FF-SHOP is the source of truth for enrollment information. Prior to the proposed rule, we understand that CMS had not contemplated an issuer sending an 834 with an enrollment update. Accordingly, we recommend that small employers be directed to provide updated enrollment information – additions or deletions – to the SHOP.

6. **Recommendation:** The FF-SHOP should remain the “source of truth” regarding any changes at the employer’s enrollment. Consistent with our previous discussions with CMS on the importance of a reconciliation process, health plans need to know the final process and how it will work as soon as possible. We note the bi-directional messaging originally proposed by CMS is of serious concern to health plans due to the potential to undermine the SHOP as the sole “record of truth” and creating a duplication of reconciliation efforts causing complex and potentially redundant or inconsistent information, creating considerable overhead for health plans that can be avoided by a more streamlined process.

### ***Billing and Premium Payment***

Under the previously proposed SHOP enrollment process, the FF-SHOP would send health plans employer group enrollment information only after receiving the initial premium payment from the employer group. Because the FF-SHOP is delaying premium aggregation for the first year of Exchange implementation until the 2015 plan year under the Proposed Rule, health plans would be responsible for collecting employer premiums and would receive group enrollment information without the initial premium payment. This process would require that the SHOP develop a process to refer the group to the issuer in order to make their first month’s premium payment for effectuation of coverage.

7. **Recommendation:** Health plans should have the flexibility to utilize their standard timeframes for bill generation and premium payment policies for an employer group. This will allow health plans to implement the operational systems and processes consistent with current small group market practices, thereby streamlining the process to the extent possible, and minimizing system changes.



8. **Recommendation:** CCIIO should develop a process to confirm effectuation of enrollment with the Exchange upon receipt of payment from the employer. This could be done mirroring the same process used for the Exchange (sending an 834 confirmation) or through another method. Health plans will also confirm effectuation directly with the Employer Group. (The ID cards to enrollees would be the vehicle for notification to employees.) Especially for employers electing coverage late in the year, establishing this process and payment cut-off dates will be critical.
9. **Recommendation:** CMS should not provide specific guidance for the timeframes issuers will use to effectuate and confirm enrollment. Given the short timeframe before open enrollment begins, issuers should have the flexibility to implement processes that do not require significant changes from current small group practices.

Since the issuers will be responsible for premium billing based on the 834 enrollment files provided by the FF-SHOP, issuers also anticipate they will administer any late premium payment scenarios, and notify the FF-SHOP of any terminations for non-payment of premium. This would include “short pay” premiums, where the premiums do not match to the covered enrollment under the group.

Health plans expect they will be responsible for the administration of delinquency rules and auto terminations. It is a statutory requirement that the FF-SHOP must notify each employee of their employer’s termination and advise the employee of available options for coverage in an employee choice model. In an employer choice model, it is expected that the health plan will administer grace periods and terminations for non-payment of premium. Health plans will need specific guidance that better outlines their responsibilities regarding the administration of delinquency rules.

10. **Recommendation:** Health plans should use 834 enrollment files to communicate cancellations due to the nonpayment of premium to the FF-SHOP.

### *Additional Considerations*

**Implementation:** Under the proposed amendments, the employee choice model is optional for State-based Exchanges in 2014 and will not be implemented in the FF-SHOP until the 2015 coverage year. We recommend that CMS provide guidance on how it will implement the employee choice model and how employer groups will be notified they can transition once employee choice becomes available in 2015. We also recommend the employer choice option continue for groups until they transition to employee choice per the provisions in the rules (45 CFR §155.705(b)(3)).



**Enrollment at end of waiting periods in SHOP:** We note that the proposed rules published on March 21, 2013 on the Prohibition on Waiting Periods that Exceed 90-Days<sup>1</sup> propose changes to prior guidance that recognized that the 90-day period may end prior to the beginning of the next calendar month, and that coverage effective at the start of the next calendar month will be viewed as compliant with the intent to provide coverage within the specified timeframe. We are concerned that the proposed rules make those changes, creating administrative challenges, and will be commenting accordingly.

We refer to this provision in the proposed rules:

*45 CFR §147.116(f) Special rule for health insurance issuers. To the extent coverage under a group health plan is insured by a health insurance issuer, the issuer is permitted to rely on the eligibility information reported to it by the employer (or other plan sponsor) and will not be considered to violate the requirements of this section with respect to its administration of any waiting period, if both of the following conditions are satisfied:*

- (1) The issuer requires the plan sponsor to make a representation regarding the terms of any eligibility conditions or waiting periods imposed by the plan sponsor before an individual is eligible to become covered under the terms of the employer's plan (and requires the plan sponsor to update this representation with any changes), and*
- (2) The issuer has no specific knowledge of the imposition of a waiting period that would exceed the permitted 90-day period.*

We will be submitting comments recommending that enrollment at the expiration of the waiting period be effectuated the first day of the next calendar month following that last day of that waiting period. However, in the event it is not, we recommend the following:

- 11. Recommendation:** The FF-SHOP should collect the information on employees in waiting periods, and should be responsible for notifying the issuers in advance of expected completion date, so that issuers can effectuate enrollment at the closest date to the 90-day expiration of the waiting period.

### **Enrollment Periods Under SHOP (§155.725) – Triggering Events and Special Enrollment Periods for Qualified Employees and their Dependents**

AHIP supports the alignment of SHOP provisions with those finalized in the 2014 Market Rule, published in the Federal Register on February 22, 2013, for triggering events and special

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<sup>1</sup> <http://www.gpo.gov/fdsys/pkg/FR-2013-03-21/pdf/2013-06454.pdf>



enrollment periods (SEPs). The Proposed Rule would revise provisions with respect to qualifying events and SEPs for qualified employees and their dependents. SEPs for the SHOP would be 30 days to align with SEPs in the group market established by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). SEPs for employees or dependents that become eligible for, or lose eligibility for, assistance under Medicaid or the Children's Health Insurance Program (CHIP), both SEP triggering events, would be 60-days to select a QHP under the Exchange.