Oct. 6, 2011

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9989-P
PO Box 8010
Baltimore, MD 21244-8010

Re: Proposed Rule—Establishment of Exchanges and Qualified Health Plans

To Whom it May Concern –

On behalf of the American Academy of Actuaries'[1] Exchanges Work Group, I appreciate the opportunity to offer the following comments to the Centers for Medicare & Medicaid Services (CMS) on the proposed rule for the establishment of exchanges and qualified health plans under the Affordable Care Act (ACA). The work group that developed this letter includes a broad cross section of health actuaries including consulting actuaries, government actuaries, and health insurance actuaries. We have a number of general comments, which are highlighted below. These are followed by our more specific comments on the proposed rule broken down by issue.

General Comments

Consistency Inside and Outside of the Exchanges
The work group believes that the market structure after implementation of the ACA should maintain consistency between in-exchange and off-exchange market environments.

The introduction of health insurance exchanges creates, in effect, two health insurance markets—one inside and one outside the exchange. Consistency between these two markets is highly recommended. Significant differences in regulations, benefit mandates, plan designs, and other requirements create the potential for adverse selection and an anti-competitive business environment. CMS indicates, for example, that the focus of the proposed regulation is on the market inside the exchange and not outside the exchange. If one goal is to control adverse selection and avoid disincentives both in- and off-exchange, then both markets should be considered in tandem.

Our understanding is that the intent of risk adjustment is to help mitigate adverse selection, but without essentially identical underwriting rules and regulations between these two markets, risk-adjustment mechanisms alone may not be sufficient to fully address selection bias. Stronger rules

[1] The American Academy of Actuaries is a 17,000 member professional association whose mission is to serve the public and the U.S. actuarial profession. The Academy assists public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualifications, practice, and professionalism standards for actuaries in the United States.

ensuring consistency for in- and off-exchange market practices—in areas such as network adequacy, marketing (including roles of agents and navigators), plan designs, and ancillary offerings—could help mitigate the degree of adverse selection.

We also encourage CMS to adopt stronger guidance regarding qualified health plans (QHPs) for both the in- and off-exchange markets. Under the section on rating variations, for example, the proposed regulation states "[w]e interpret this provision to mean that an issuer must charge a premium that uses underlying rating assumptions that account for all expected enrollees of a QHP, including individuals that enroll in the QHP outside of an exchange, and for all methods of enrollment, including through an Exchange, an agent or broker, or the issuer itself."[2] This implies to us that QHPs and the standards by which states will be regulating QHPs will apply to both in- and off-exchange product offerings. Clearer guidance on whether the same rules will apply in- and off-exchange should be provided.

Adverse Selection

Adverse selection, from an actuarial perspective, is a critical concern and requires careful study, evaluation, and risk management. There are several provisions and concepts in the current exchange-related provisions of the ACA that can exacerbate adverse selection. The amount of choice is one such consideration.

Employee choice in a small business health options program (SHOP) exchange creates unique and complex considerations. There are two main approaches to employee choice—each approach has advantages and disadvantages. In the first approach, the employer plays a much larger role. There are many variations, but the most basic is that the employer chooses the specific benefit plan from a single carrier. This is similar to what occurs in most small-group markets today. The only choice individual employees have in this circumstance is whether to purchase insurance and what type of dependent coverage they will elect. The advantage of this approach is that individual adverse selection generally is minimized and composite rating[3] can be retained. One disadvantage is that individual employees have no flexibility regarding the types of benefit plans and/or the provider network. A related example of this approach involves an employer choosing a specific carrier and allowing employees to choose among all plans offered by that carrier.

It is unclear from current CMS guidance whether composite rating is intended to be a permissible rating method within the exchange. We recommend CMS clarify the preferred rating methodology to be used in both SHOP exchanges and individual exchanges and ensure that the clarification is consistent for both the in- and off-exchange market environments.

---

[2] Federal Register (July 15, 2011), Section 156.255 (p. 41901):

[3] Composite rating is a rating methodology that calculates one rate, usually for each dependent option (single, two adults, adult and child or children, family) based on the demographic composition of the group as opposed to list billing, which reflects a different rate for each employee based upon their age and dependent option. Composite rates generally shield the individual employee from significant rate increases resulting from advancing into a different age category because the rates for the individual are not based upon his/her own specific age, but are based upon the average age of either the entire group or the average age of all employees who chose similar dependent options (practices vary by carrier). Elimination of composite rating will introduce more volatility in rates each year and will also result in higher rates for older employees, but lower rates for younger employees.

The second approach allows individual employees to choose across a wider spectrum of plans and benefit levels. In these cases, the employer can choose a specific benefit level (e.g., gold) and employees are allowed to choose among all the carriers offering gold plans. It is assumed that the employer will contribute a specific amount (defined contribution) and the employee must make up the difference depending on his or her choice. The advantage of this second approach is that employees have the opportunity to choose the health insurance plan most closely aligned with their own and/or their dependents' health care needs. One disadvantage of this approach is that it maximizes the potential for adverse selection, which will have to be adjusted for in any risk-adjustment model. There also is the possibility that this second approach would increase the administrative costs of the exchange, given the parsing of enrollment from within a group and the complexity associated with tracking individuals on a stand-alone basis or aligned within their group.

Health care plans typically offer single/family rates (or other family tier structures) in the small-group market. This will not be possible if an exchange allows employees and/or dependents to choose coverage from multiple plans. If rating by family composition is not possible within the exchange, this may affect the ability to regulate and manage the off-exchange market, especially if the intent is to maintain rate equivalency for similar benefit plans. Relying on individual rating factors used to develop composite off-exchange rates that are the same as those used for individual rating on the exchanges will be difficult to monitor accurately.

Administrative Costs and Regulation Complexity

Administrative costs and the complexity of the proposed regulations on exchanges are another primary consideration that deserves closer review. Clearer definitions and more transparency on administrative responsibilities (e.g., premium collection, quality monitoring, enrollment and eligibility determination) may be needed as a result.

The definition of "employer" in the ACA—sole proprietor, certain owners of S corporations, and certain relatives of each are not considered employers—presents some difficulties. Coordinating this classification with existing state laws that currently define sole proprietors as small employers is one example. As the proposed guidance stands currently, it is unclear whether CMS intends for sole proprietors to be treated as individuals and not be considered as part of the SHOP exchange. If sole proprietors are eligible for coverage in a SHOP exchange, careful consideration should be given to how the potential for adverse selection between the SHOP exchange and the individual exchange may be avoided.

Exchange operations will require timely and accurate communication of information between individuals and small groups, health insurance issuers, and state and federal agencies (i.e., departments of Health and Human Services, Labor, and the Treasury). Exchange operations for which specific procedures and infrastructure will need to be established include:

- Individuals covered
- Qualification for subsidies
- Receipt of premium from groups and individuals
- Remittance of received premium to appropriate issuers
- Receipt of premium subsidies from federal agencies
- Remittance of these subsidies to appropriate issuers

- Reimbursement and payment of reinsurance premiums and claims (even if the state contracts with another entity, the state is responsible for operations)
- Medicaid eligibility and the coordination between Medicaid, minimum benefit plans, and exchange eligibility
- Changes in Medicaid and subsidy/cost-sharing reduction eligibility (and the amount of subsidy/cost-sharing reduction), and the frequency of updates to these changes
- Exchange rules
- Sufficient and timely information regarding transfer of funds, reinsurance, etc., for issuers to reflect results in financial statements and pricing
- Agent and navigator permissions to charge consumers directly for their services (i.e., just not as part of a premium).

As a final general note, there are several complexities associated with the situation in which individual and small-group markets are merged (e.g., state regulations treat the direct pay and small-group market as one combined risk pool). The proposed regulations do not address this situation. We would welcome the opportunity to assist CMS as this issue is considered.

The following sections identify comments that are specific to sections of the proposed regulations.

Specific Comments on the Proposed Rule

Enrollment Periods (155.410, 155.420, 155.430, 155.720, and 155.725)—Traditional Exchanges

Initial/open enrollment

The proposed rule establishes an open enrollment period from Oct. 15 through Dec. 7 each year, with coverage to be effective Jan. 1 of the following year. It is important that an open enrollment period be long enough for individuals to examine and understand the options available to them. At the same time, it should not be so long as to invite adverse selection. With that said, the dates for the proposed open enrollment period seem appropriate; they allow approximately three weeks beyond the close of the period for carriers to ensure information for new enrollees is properly loaded into carriers' systems and ID cards are issued prior to coverage becoming effective.

The process of obtaining coverage through the exchanges will be a new concept for many consumers and small businesses in 2014. The anticipated volume of individuals enrolling is likely to strain state systems' capacities.

The longer initial enrollment period would allow consumers time to become familiar with the exchanges and, in particular, the new mode for purchasing coverage, comparing plans, and enrolling. Prospective consumers may not grasp key aspects of the new law fully—such as the choices for coverage, penalties for not having coverage, and how the premium and cost-sharing subsidies work. It likely will take additional time to educate consumers on these issues, even in light of strong consumer outreach prior to the initial open enrollment. The length of the initial open enrollment period from Oct.1, 2013 through Feb. 28, 2014 seems appropriate.

Effective dates
The draft regulation also proposes effective dates that occur only on the first day of each month. Some carriers in the individual market today offer effective dates on any day of the month following underwriting acceptance; others offer coverage effective dates on the first or 15th of the month following approval. The additional administrative costs associated with allowing mid-month effective dates may be significant, reflecting the need to pro-rate premiums and potentially track other manual adjustments to system-generated bills. We believe the proposal that coverage be effective on the first of the month following application for coverage, assuming the application is received by the 22nd of the month, and the first of the second following month if the application is received after the 22nd of the month strikes a reasonable balance between access and administrative complexity.

Adopting this approach helps avoid potential adverse selection that could result if an individual were to experience a gap in coverage. In many cases a loss of coverage could be the result of a qualifying event, such as an individual losing coverage due to divorce. Adverse selection in these situations may be less significant because of the unanticipated nature of the qualifying event. Adverse selection still may exist, however, based on the purchasing decisions of healthy versus less-healthy individuals, who may view the premium as less costly than the risk of remaining uninsured.

Notification of open enrollment period
It is important that consumers be aware of the annual open enrollment period. Navigating through an exchange will be a process that many insurance purchasers may find complex. It is important, therefore, to provide proper advance notice of the open enrollment start and end dates as well as notification of resources and references available to guide consumers through the process. Since the exchanges will be new, there is likely to be some flexibility for enrollment processes during the first couple of years as the effectiveness of processes initially put in place is evaluated and perhaps enhanced. The final rule should not be too specific with respect to the information required in the notices to allow for potential changes in the future.

Auto-enrollment
In the proposed regulation, CMS solicited comments related to auto-enrollment. Some individuals may be in jeopardy of losing coverage if the QHP in which they are enrolled no longer is offered. Without proper support from the exchange website, the navigator, or similar agent, consumers who are not adequately informed or do not fully understand the process could become unintentionally uninsured. Auto-enrolling these individuals in another QHP, or simply emphasizing the need to re-enroll through some other notification method, could address this situation.

An auto-enrollment process also may utilize an opt-out approach, which may result in greater participation that could lead to a broader risk pool and less selection. This could, in turn, lead to lower premium rates than an opt-in approach might produce. An auto-enrollment process for these individuals could be used, although it is important that the auto assignment of these members to new plans occur early enough in the open enrollment period so that consumers have ample opportunity to make alternate enrollment decisions within the open enrollment period.

An auto-enrollment process creates certain complexity if rules are not established. The exchange either should determine the plan into which individuals are auto-enrolled, keeping the insurer constant, or re-enroll the individual in a similar level QHP but with a different carrier. The former could result in a potential loss of coverage if copays, deductibles, or other plan design features and allowed benefits are materially different. The latter could result in individual insureds experiencing some disruption in the network of providers that may be utilized.

For those individuals who are eligible for a subsidy, auto-enrollment could be based on the lowest-cost plan within the benefit tier in which they currently are enrolled. It is important to recognize that this may not be the same plan or even the same carrier for all ages, which could add to administrative complexities. While the variance in rates by age is restricted to a 3:1 ratio under the ACA, carriers may be free (depending on exchange rules) to determine the slope of the age factors within this range. Carrier selection for auto-enrollment could be tied to quality scores to provide incentives to increase quality measures.

Special enrollment periods
For the proposed regulation, CMS solicited comments on whether states should be allowed to expand the special enrollment periods to include gaining dependents through life events (in addition to marriage, birth, or adoption). We agree that states be allowed to expand those periods, and we suggest that states be permitted to define such "special events."

In terms of the 60-day special enrollment period, we believe it should be tied to the date of the event that triggers the special enrollment, rather than the date of eligibility determination. If it is not, healthy individuals could delay enrollment and apply for eligibility at a time when they become sick (outside of the standard open enrollment period). This would increase adverse selection and premiums.

For the proposed rule, CMS also solicited comments on specific scenarios related to the beginning of a 60-day special enrollment period. In instances in which employer-sponsored coverage changes, the 60-day period should begin as of the coverage termination date, rather than when the employee learns of the impending termination. To reduce adverse selection, in instances in which an individual moves to a new location, the effective date should be tied to the date of the move instead of the date an individual provides notice of the move. As a final note, exceptions (e.g., for an individual in a catastrophic plan who becomes pregnant) to the requirement that individuals stay within a specific coverage level would create adverse selection and, in turn, increase premiums.

Enrollment Periods (155.720 and 155.725)—SHOP Exchanges
Restrictions could be placed on qualified employers offering coverage in the SHOP exchange to prevent them from changing coverage outside of their plan year anniversary. To allow coverage to change more frequently than once a year would invite more selection risk in the exchange environment. Changes in SHOP-based benefit plans should follow the same rules that apply to individual exchanges in which only one change per year is allowed.

Many small employers could attempt to align their plan year dates with Jan. 1, 2014, to obtain the available tax credits as soon as possible. With an expected concentration of January 2014

applications, consideration should be given to extending the timeline for the enrollment process in the first year. Otherwise, issues surfacing during this heavy enrollment month—especially the first enrollment offered—could pose significant challenges for delivering effective coverage on a timely basis.

CMS should consider establishing guidelines with respect to the enrollment timelines. In the absence of consistent timelines, multi-state employers will be challenged to meet the separate timeframes of each state within which it covers qualified employees. The situation may be further complicated for regional exchanges.

Termination of Coverage (156.270)

Termination of coverage should be as of the first of the month to reduce the burden of calculating refunds for partial months of premium. The idea of having any term date as long as "reasonable" time is given for termination could create a significant burden for all parties. If a reasonable time standard is required, however, CMS should clearly define that time period.

With respect to grace periods, we believe that the application of any grace period should be consistent for all enrollees regardless of whether they receive a subsidy. Except as required by law, we believe the current practice of a 30-day grace period should be maintained. Concerns raised by a 90-day grace period for those individuals receiving premium tax credits are discussed in more detail below. We note that the only obligation of the qualified individual to maintain coverage is to pay the required premium on a timely basis. This obligation should be enforced to maintain the viability and integrity of the QHP.

Consider the following example: a qualified individual purchases coverage during an open enrollment period effective Jan. 1 with a premium of $300 per month, and the individual pays monthly for each of the first nine months. Premiums for October, November, and December are never paid, but claims are paid on a timely basis (as required by law) and no claims are outstanding as of Dec. 31, even though coverage is terminated retroactive to Sept. 30. The individual received the benefit of 12 months of coverage for nine months' of premium. The individual then again takes advantage of open enrollment and starts coverage again as of the next Jan. 1. And the process repeats.

This scenario illustrates the type of inequity and gaming opportunities that an extended grace period creates. It also raises important issues that need to be addressed such as:

- Does the issuer have any recourse for collecting either the outstanding premiums or the claims paid under coverage for which premiums were never paid? If not, those added costs need to be included in the projected costs when determining required premium rates, increasing premium rates for everyone. Even if such recourse exists, it may be extremely difficult in many situations for an issuer to recoup funds from the individual.
- For individuals receiving the subsidy, will the qualified health plan issuer keep the subsidy and provide extended coverage at policy termination, or is the subsidy returned?
- How will this situation be treated for purposes of determining any penalty to the individual under Internal Revenue Code Section 5000A (as amended by the ACA)? Since the termination will be retroactive, how can record keeping be structured so that there is any

realistic chance of identifying and holding the individual accountable? Overall, the extended grace period will create an overwhelming complexity.

If the exchange is required to help monitor premium payments, the concerns with respect to these problems could be reduced. To help reduce bad debt and adverse selection, the exchange could prohibit individuals from participating in open enrollment if the individual either has outstanding premiums due or was terminated due to nonpayment at any time within the past six months. In addition, permitting retroactive terminations could exacerbate adverse selection (i.e., in the above example, the individual should not be allowed to call at the end of December and say that his/her intention was to terminate as of Sept. 30).

Functions of a SHOP Exchange (155.705)

Employer/employee choice in SHOP

In today's small-group market, employers typically select one or two specific plan options in which their employees can choose to enroll. To the extent that flexibility is added to this foundation, the risk-selection dynamics in the market will increase. As noted in the preamble of the proposed rule, the risk-adjustment program that will be established under the ACA *may* help to *mitigate* the impact of selection should broad employee choice be implemented (emphasis added). It is important to note that the risk-adjustment mechanism can adjust for an imbalance of risk between carriers in the market, but it will not protect against the selection experienced by the market as a whole.

Allowing a qualified employee to purchase any plan across benefit tiers will increase selection risk for the market, and this risk ultimately will be reflected in premiums. In addition, allowing for broad employee choice in the SHOP exchange may create more administrative complexity, and there will be an incremental cost associated with such complexity. Given the different characteristics of employer-choice and employee-choice plans, we suggest that the SHOP exchange require the employer to make the carrier or plan selection for all employees.

Minimum participation in SHOP

If employees are allowed to choose from any plan within a benefit tier, then minimum participation requirements at a QHP or issuer level seem to have little value. There still may be value, however, in having a minimum participation requirement at the SHOP level. The elimination of minimum participation requirements for employers would lead to affordability issues in the SHOP exchange because some level of selection would emerge against the market as a whole (not just between carriers). Enforcing a minimum participation requirement, therefore, could help ensure that a better balance of risks will enroll in SHOP. As exchanges are constructed, the potential for this type of adverse selection must be considered and addressed. We are not recommending a specific methodology for determining/calculating a minimum participation rate because such requirements should be established with an understanding of the existing market dynamics to preserve the dampening impact on selection. If federal guidance is desired, then a floor could be established from which states may deviate if it assists them in controlling selection.

In addition, states should create similar participation standards both on and off the exchange to control the selection between these two markets. If, for example, issuers can enforce minimum

participation rules outside of the exchange but not inside the exchange, then the exchange may be selected against.

Frequency of rate changes
The underlying costs of providing coverage change continuously due to new benefit mandates, new taxes and fees, new technology, and new prescription drugs, among other things. If issuers must set their rate at the start of a period and cannot change that rate for any employer enrolling within 12 months of that date, there will be greater risk associated with the premiums due to their static nature. In addition, if premiums are updated uniformly at the beginning of each calendar year, then a new group enrolling in December would have their rates increase on Jan. 1. As such, we recommend that CMS consider allowing health insurance issuers to change base rates as frequently as monthly and not be limited to changing them annually. This means that a new employer enrolling in March 2014 could have higher rates, all else being equal, than an identical group enrolling in January 2014.

In the current individual market, practices vary by company. It is common, however, to apply a rate increase across a block of business on a common effective date regardless of the date coverage actually was purchased. In some cases, rate guarantees are tied to the coverage effective date. The regulation could require that rate increases occur no more frequently than every 12 months on any particular category of business. Under this requirement, individuals in their first year of coverage could experience a rate increase in less than 12 months. If a plan routinely increases rates every July 1, for example, an individual purchasing coverage effective April 1 would see an increase three months after his/her initial effective date and every 12 months thereafter.

With respect to SHOP plans, it is common to tie rate increases to a plan anniversary date so that each employer would see an increase every 12 months. In this circumstance, an employer buying a plan on July 1 (with rates guaranteed through the next June 30) would expect to pay higher rates than if it had purchased the same plan on the prior Jan. 1 (with rates guaranteed through the end of the year). This is due to medical care cost trends, with the cost for identical coverages increasing over time. Carriers frequently reflect this effect by increasing new business rates (perhaps monthly or quarterly) with trend factors that would be filed and approved as part of their rate justification. The rule should clarify whether this practice is permitted.

Rating Variation (156.255)
While the proposed regulations require a QHP to charge the same premiums for the same benefit plan offered on- or off-exchange (individual or SHOP), there is the potential for a QHP to introduce minor differences between in- and off-exchange benefit plans, creating the opportunity to price the plans differently. The regulations may be strengthened by requiring any price differences to be commensurate with a minimum threshold difference in the actuarial values between in- and off-exchange benefit plans. The actuarial value comparison would be between individual plans (in- and off- exchange) and small-group plans (in- and off-SHOP)—not between individual and small-group plans.

Exchange-based rating rules and regulations regarding the family unit need to be clarified further. We suggest that individual-only rating be allowed—and that tiered rating not be

required—for those exchanges requiring family coverage. This appears to be more consistent with other parts of the ACA exchange requirements. If individual family members are allowed to opt for different QHPs, for example, there likely will be a limited market for family plans that cover all family members under one plan. It is noted that the current proposed rule requires family rates to be built up from individual rates, aggregating the appropriate age and smoker/non-smoker rates to each family member. As such, the nature and size of the family is not a limiting factor (i.e., the current proposed rule would appear to allow the insurer to charge separately for the number of adults in a family, except for disabled and children under 26). Similarly, the application of risk-adjustment calculations appears to be required at the individual level and not the family-tier level. Individual-level rating, therefore, has intuitive appeal. Furthermore, administratively the family-based tier rate structure being built from individual rate roll ups is consistent with the consumer-focused intent of the exchange.

There are some technical aspects regarding rating variations that CMS needs to consider. More clarity is needed from CMS, for example, regarding SHOP employees over age 65 for whom Medicare may be secondary. Demographic trends, such as extended work life and potential acuity issues, suggest that maintaining the required 3:1 age rating for those above age 65 may be administratively easier but likely will be unsustainable in the future. Similarly, totally- and permanently-disabled individuals and dual-eligibles also may require specific consideration in the proposed rule addressing rating variations.

One logistical issue is the reliance on the family unit being defined by the tax head of household, which suggests all adults filing income tax returns would be priced for and each individual member will be "tagged" for potential accumulation (i.e., whether the member is enrolled in an individual contract or as part of a family contract). In a circumstance in which there is little or no income to report, there may be a disconnect with the classification of "household."

Rate and Benefit Information (155.1020 and 156.210)

We have two comments on these sections. The first relates to the submission of rate justification and the possibility of a standard under which the exchange could determine the form and manner for such justifications. We note that the rate review and justification framework under the ACA already generally will require the QHP issuer to comply with both state and federal requirements for such rate justifications. If the state rate review and justification process is included during the rate-filing process for exchange-related reviews, it will be more efficient and reduce costs associated with the duplication of reporting. It would be easier to use similar formats for consistency and leverage the data collected for rate justification. The rate justification has to be prior to the implementation of the rates and needs to be posted on the exchange website for members to review. The states' departments of insurance (DOI) have considerable experience and knowledge about the insurance marketplace and dealing with carriers and consumer complaints. The exchange can benefit from this knowledge and leverage the information collected and work with the state DOI to develop standardized templates and communication to consumers to meet transparency and sharing of information.

Our second comment relates to what we perceive as ambiguity in the proposed rule with respect to rate guarantee periods. The rule makes use of the terms "plan year" and "benefit year" without providing definitions. Since current practices in the market vary by carrier, both with respect to

the nature of the guarantees and with respect to terminology, we believe additional clarification is needed.

Benefit plans typically are designed with calendar-year accumulators for deductibles and out-of-pocket limits. It is unclear whether the proposed rule is trying to change that approach, suggesting that a "benefit year" should accumulate deductibles and out-of-pocket limits based on the 12 months beginning with the coverage effective date. We believe the proposed rule should not prohibit calendar-year plan deductibles with non-calendar-year policy anniversaries.

Network Adequacy (155.1050 and 156.230)
It is important to establish network adequacy standards to meet the needs of consumers in both urban and rural areas as well as to ensure a reasonably robust network of all types of providers. This will be important as more consumers seek access to primary care services, and as there will be a pent-up demand for services across the nation with the expansion of health insurance coverage. The standards should be flexible to meet local patterns of care and include various primary service providers, such as physician assistants, nurse practitioners, and others to meet the needs and address some of the pent-up demand issues.

Carriers may use network design as a way to drive selection in their plan offerings. For example, carriers could minimize enrollment among individuals in high-cost areas by not including providers these individuals typically would access. Establishment of minimum standards—such as an access ratio of members to primary care providers and/or to a particular type of specialist and geographic access standards to ensure proximity to residence or workplace of members—will be critical. These standards should be monitored on an ongoing basis to ensure compliance and adequacy of networks. While it is desirable to have adequate networks in the underserved areas, it may not be an easy or practical process to establish networks in these areas.

Marketing (156.225)
The ACA requires plans to accept all applicants. It also requires that plans cannot vary premium among purchasers by health status. But selection still could occur if plans can use non-health status information to estimate individual health spending and target marketing materials to those with low expected health spending (and not to those with high expected health spending) relative to others in their premium rating category and/or risk-adjustment cell. Consumer information, for instance, is becoming increasingly available. Because risk adjustment will not be able to fully reflect the underlying risk of enrollees, CMS may wish to consider additional marketing or network adequacy requirements.

Issuer Participation Standards (156.200)
The proposed rule introduces a requirement that the QHP issuer be licensed and in good standing. To comply with this standard, the QHP issuer should be required to obtain a certificate from the state's DOI that would confirm that the QHP issuer meets this standard. Relying on public information to certify a QHP issuer may not be as effective. DOIs have more knowledge because they frequently work with licensed entities to resolve known problems without issuing any formal sanctions. In many cases, a DOI's concerns are kept confidential with the expectation of solving the issue without causing further disruption. But that type of information could be important to the exchange in determining whether to allow the entity to offer products through

the exchange. We would encourage the development (perhaps by the NAIC) of a standard certificate that would address key issues, including solvency, market conduct, and general compliance with all state requirements. In addition, the certificate should allow for the disclosure of any concerns that currently might exist. Service issues, for example, could have been identified and be in the process of being resolved. As another example, based on current capitalization, significant growth might have the potential to create solvency concerns, in which case the DOI may provide a qualified certification for a specified enrollment level.

Payment of Premiums (155.240)

The proposed rule allows an exchange to establish a variety of mechanisms to facilitate payment of premiums. The exchange can have individuals pay the issuer directly, it can create an electronic "pass-through" to the issuer, or it can collect the premiums and pay an aggregated sum to the issuers.

We expect an exchange likely will avoid conflicts of interest and have better fiscal control if it does not hold funds directly, but only acts to facilitate the transfer of funds. In addition, the regulations could be strengthened to stipulate when premium subsidy payments would be invoiced and processed. The regulations also may be strengthened more specifically to put responsibility for processing the premium subsidy payments for individuals in the centralized administration of the exchange. Coordination with insurers who receive payments directly from enrollees also should be stipulated. One suggestion is to have the premium payments from beneficiaries or small businesses trigger the subsidy payments from the federal government, which would synchronize the premium payment process.

The population of adults in the U.S. below 400 percent of federal poverty level (FPL) may not have bank accounts and/or credit cards, but their income status likely makes them eligible for a premium subsidy.[4] This population needs a mechanism for payment. Special consideration also should be given to the administrative complexity associated with the eligibility tracking for this cohort, as incomes may fluctuate enough to trigger frequent changes in eligibility, switching frequently between Medicaid, the basic health plan (if offered in the state), or subsidized coverage through the exchange. Approximately 50 percent of individuals below 200 percent of FPL currently are expected to shift eligibility from Medicaid to the exchange within a 12-month span.[5]

It may be necessary for an exchange to facilitate the collection of premiums from these individuals by offering some type of in-person payment facilities, similar to those offered by utility companies. Insurers receive the vast majority of their premium payments from businesses via direct wire transfer, and the remainder in the form of checks from small businesses and individuals. The collection of premium is critical to maintaining eligibility and coverage. The stability of the insured block of business can be increased if the cash-based premium collection process is maintained in a centralized manner, preferably by an agent of the exchange such as a bank, and reported daily to insurers.

---

[4] http://www.businessweek.com/magazine/content/05_06/b3919046_mz011.htm

[5] Sommers, Benjamin D. and Sara Rosenbaum. "Issues In Health Reform: How Changes In Eligibility May Move Millions Back And Forth Between Medicaid and Insurance Exchanges." *Health Affairs* (February 2011)

Since premiums for small employers will be aggregated for all their employees, there will have to be processes to identify for which members a premium payment applies; add new employees to the premium roster; delete terminated employees from the premium roster; and change the coverage status, or carrier, of existing employees on the premium roster.

As noted, we believe a 30-day grace period should be applied consistently for all enrollees, regardless of whether they receive a subsidy. The following, however, are issues that should be considered as CMS establishes consistent standards related to late and lapsed premiums:

- What are the penalties for late payment of premiums?
- What are the penalties for non-payment of premiums?
- What are an insurer's options and procedures for incomplete/insufficient premium payments?
- Is the premium subsidy paid during the grace period when members fail to pay their premiums?
- When does the grace period start and end?
- Must all missed premiums in arrears, plus the premium for the current month, be paid to reinstate coverage?
- Can a member reinstate coverage after the grace period has elapsed?
- Are QHPs, the exchange, or some other party liable for claims incurred within the grace period for which premiums are never collected?
- Are non-QHPs subject to this grace period with the same liability provisions as for QHPs?

As noted previously, rules need to be established to remove any incentive for members to pay premiums for one month and then take advantage of the grace period, only to enroll in a new plan to repeat the process. In addition, insurers need to know how to account for late, unpaid, uncollected, and uncollectable premiums as well as when they are able to write off the uncollected premiums.

Stand-Alone Dental (155.1065)

The proposed rule allows exchanges to require issuers of stand-alone dental plans to comply with any QHP certification requirement (e.g., quality reporting, transparency measures, summary of coverage information, provider network standard, etc.).

Because a stand-alone dental plan is a different type of benefit and risk, the requirements that apply to issuers for standard medical benefit plans may not be appropriate for dental plans. Dental services are likely to be planned in advance, creating the opportunity for adverse selection issues. Consideration should be given to requiring dental and other ancillary benefits that are offered in the market to have the same structure and scope of benefits for both in- and off-exchange purchasers. Minimum benefit plan designs/network coverage, quality measures, and other related reporting requirements do not appear to be consistent, however, with the design of these ancillary plans.

*****

We welcome the opportunity to discuss any of these comments with you at your convenience. If you have any questions or would like to discuss these items further, please contact Heather Jerbi, the Academy's senior health policy analyst (202.785.7869; Jerbi@actuary.org).

Sincerely,

Mark J. Jamilkowski, MAAA, FSA
Chairperson, Exchanges Work Group
American Academy of Actuaries