NEVADA’S QUESTIONS FOR OUR FEDERAL PARTNERS
UPDATED NOVEMBER 5, 2012

PURPOSE

This document provides a single location for all of the questions from the Silver State Health Insurance Exchange regarding implementation of a state based exchange. It provides both questions and concerns and includes answers that have been provided by the Federal Government.

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BACKGROUND

The Silver State Health Insurance Exchange is authorized by the State of Nevada by NRS Chapter 695I in response to the requirements of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (referred together as the Affordable Care Act or ACA). The Centers for Medicare and Medicaid Services (CMS) Center for Consumer Information and Insurance Oversight (CCIIO) has issued multiple proposed, interim final and final regulations to implement the ACA. However, complete guidance has not yet been issued.

The questions below are provided by the State of Nevada to clarify regulations that have already been issued, seek to understand the possible direction of future guidance and potentially influence future guidance. The information provided by the Federal Government in response to the ACA is voluminous. Therefore, in some instances, the questions have been answered by simple references to documents already published. Questions, concerns and confirmation requests are provided in bold text. The number of asterisks indicates the priority of the question. Items with five asterisks need to be answered within a month so that Nevada can maintain the implementation timeline. Four asterisks items need to be answered within two months, three asterisks items need to be answered within three months, etc.


**QUESTIONS REMAINING**

1. **ESSENTIAL HEALTH BENEFITS (EHB)**

   A. **PEDIATRIC DENTAL AND VISION ****

      i. **What, specifically, are pediatric services?** Are they simply services offered to children?

      ii. **What is the age limit?** *ACA § 1302(f)* applies to child-only plans and defines eligibility up to age 21. *ACA § 1001* Amends Section 2714 of the Public Health Services Act extends coverage to unmarried adult children until “the child turns 26 years of age.” Are pediatric services defined as services for individuals under the age of 21? 26? Some other age?

      iii. **Can a carrier impose restrictions on the types of services offered in pediatric dental and vision plans**

   B. **ADULT DENTAL AND VISION *****

      The list of EHBs do not include dental and vision services for adults. The 10 potential benchmark plans may or may not include dental and vision services. Dental and vision services may be a separate plan.

      i. **What is CMS’s plan to deal with these essential benefits and to “take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups” (ACA § 1302(b)(4)(C))?** For instance, Nevada Medicaid has added dental benefits for expecting mothers because studies have shown periodontal disease is linked to low birth weight and preterm births. This type of care could be considered maternity care (*ACA § 1302(b)(1)(D)*) or it could be considered adult dental care which is not one of the essential health benefits. Nevada requests the Secretary take into account these types of needs when reviewing state’s selected Essential Health Benefits packages.

   C. **DRUGS *****

      The first paragraph of page 13 of the Essential Health Benefits Bulletin issued December 16, 2011 indicates, “If a benchmark plan offers a drug in a certain category or class, all plans must offer at least one drug in that same category or class, even though the specific drugs on the formulary may vary.” *26 USC § 36B(b)(3)(D)* indicates that if a QHP includes a benefit beyond the set EHB established by the state, the additional benefit may not be taken into account in determining either the monthly premium or the adjusted monthly premium.

      i. This seems to indicate that if a benchmark plan and resulting EHB does not include a certain category or class of drug, then any QHP that offers a drug in that excluded category or class would be adding a benefit in addition to the set of
EHB. Would this be considered an added benefit to be excluded from the Advance Premium Tax Credit calculation?

ii. Verbal guidance from CMS has indicated that CMS intends to issue regulations that indicate that a QHP must provide an essentially equivalent number of drugs as is covered by the benchmark plan and resulting EHB, rather than at least one drug in each category and class. If a QHP covers a number of drugs that exceeds the essentially equivalent number of drugs included in the benchmark plan and resulting EHB for a given category or class, would this be considered an added benefit to be excluded from the Advance Premium Tax Credit calculation?

iii. All of Nevada’s benchmark plans include prescription drug formularies that cover certain variations of the categories and classes found in the U.S. Pharmacopeia Model Guidelines v5.0. Some of the potential benchmark plans cover all off-formulary drugs at higher cost sharing. Generally, the Essential Health Benefits Bulletin issued December 16, 2011 speaks to coverage of drugs by the benchmark plan and QHPs. However, page 13 of the Bulletin says, “If a benchmark plan offers a drug in a certain category or class, all plans must offer at least one drug in that same category or class, even though the specific drugs on the formulary may vary.” [emphasis added]. If Nevada selects a benchmark plan that covers all formulary and off-formulary drugs, this appears to indicate that the formularies of QHPs must include at least one drug in every category and class- that every category and class must be represented by the QHP formulary. Must the formularies match? Or must the QHPs simply cover an essentially equivalent number of drugs in each category and class provided in the benchmark plan and resulting EHB?

D. Time Line for Selection of EHB *****

On July 18, 2012, during Nevada’s Design Review, CCIIO indicated that, after a state submits to the Secretary of HHS its selection of EHB (and after all 50 state EHBs are compiled), there will be a 30 to 60 day comment period followed by 30 days to write the final regulations with an estimated completion date of the end of December 2012 for the final selection of EHB. Carriers need to know what the EHB are in the fall so they can begin their plan design creation and rate calculation for submission to Nevada’s DOI in the winter. The process described above will delay the plan design process. It has been suggested that the carriers could begin the process based on Nevada’s selection of EHB. However, if the Secretary determines that changes need to be made, carriers will need to make last minute adjustments to their QHPs. Nevada is extremely concerned about the potential delays to the QHP licensing process, especially given that all plan designs will be new and the DOI will need review plan designs and rates for all products in the market.

E. State Mandated Benefits with Dollar Limits and No Limits to Number of Services *****

Nevada law requires all health insurance plans sold in the individual and small group market cover applied behavior analysis for autism spectrum disorders (NRS 689A.0435,
NRS 689B.0335, NRS 689C.1655, NRS 695C.1717, NRS 695G.1645). The law requires a minimum benefit of $36,000 per year and does not allow a limit on the number of services. Nevada expects to select one of the seven non-Federal benchmark plans as its benchmark plan for EHB, all of which included this mandated coverage in the first quarter of 2012; all were limited to a maximum of $36,000. Therefore, ABA services for autism spectrum disorders will likely be part of the Essential Health Benefits package for Nevada.

Page 12 of the Essential Health Benefits Bulletin issued December 16, 2011 indicates that QHPs may make substitutions for dollar limits that are substantially equal using an equivalency standard that applies to plans under CHIP. Will the Essential Health Benefits package for the State of Nevada, as it pertains to ABA services for autism spectrum disorders, include an unlimited number of services or a number of services that is substantially equal to $36,000? Assuming no change to state law, if the EHB package includes a number of services that is substantially equal to the $36,000 limit, will the State of Nevada be required to pay for the cost of coverage for any services beyond the number of services that is substantially equal to $36,000?

F. DEFINITION OF DISCRIMINATORY BENEFIT DESIGN *****

In Nevada, all plans are required to cover applied behavior analysis for autism spectrum disorders (NRS 689A.0435, NRS 689B.0335, NRS 689C.1655, NRS 695C.1717, NRS 695G.1645). CCIIO has indicated coverage of a single type of habilitative services satisfies the statutory requirement to cover habilitative services. The state argues this satisfies the requirement that coverage be in line with the typical employer plan. However, there is concern this may violate the discrimination rules as discriminatory benefit design has not been well defined. What is considered discriminatory benefit design?

2. ADVANCED PREMIUM TAX CREDIT

A. ADDITIONAL BENEFITS *****

i. Most documentation and commentary regarding the premium tax credit and EHB indicates that any state mandated benefit that is not a part of the EHB package must be added to the premium; the state must cover the cost of the premium tax credit that would have been paid by the Federal Government for the added benefit. However, 26 USC § 36B(b)(3)(D) appears to be more comprehensive. It indicates that if a QHP includes a benefit beyond the set EHB established by the state, the additional benefit may not be taken into account in determining either the monthly premium or the adjusted monthly premium. This appears to indicate that a carrier cannot add any benefits beyond those set in the state’s EHB package without bearing the entire cost of the added benefit; that the carrier is not allowed to charge for any additional benefits they may choose to offer. Similarly, if a benefit is added that decreases cost, the carrier would not be allowed to decrease the premium due to the same portion of the Code. Please confirm whether the change in cost associated with a benefit added by the carrier may be charged to the consumer in the monthly premium and
whether the advance premium tax credit can be increased to pay for that increased service.

ii. The first paragraph of page 13 of the Essential Health Benefits Bulletin issued December 16, 2011 indicates, “If a benchmark plan offers a drug in a certain category or class, all plans must offer at least one drug in that same category or class, even though the specific drugs on the formulary may vary.” This seems to indicate that if a benchmark plan and resulting EHB does not include a certain category or class of drug, then any QHP that offers that excluded category or class would be adding a benefit in addition to the set of EHB approved by the state. Therefore, if this additional benefit may not be taken into account in determining either the monthly premium or the adjusted monthly premium pursuant to 26 USC § 36B(b)(3)(D), carriers may not charge consumers for any drug added to a formulary and part of a category or class that is not included in the state’s EHB. Please confirm whether this is correct.

B. RETIREES AND COBRA UNDER ELIGIBLE EMPLOYER-SPONSORED PLAN ***

26 USC § 36B(c)(2)(B) indicates an individual is not eligible for the Advance Premium Tax Credit if the individual is eligible for minimum essential coverage other than individual coverage. 26 USC § 5000(f) defines minimum essential coverage as coverage under:

(A) Government sponsored programs (Medicare, Medicaid, CHIP, TRICARE, VA, Peace Corps and other Federal Programs);
(B) Employer-sponsored plan coverage;
(C) Plans in the individual market;
(D) Grandfathered health plans; or
(E) Other Coverage (such as the State health benefits risk pool or other coverage as identified by the Secretary).

26 USC § 5000(f)(2) says that “employer-sponsored plan” means “with respect to any employee, a group health plan or group health insurance coverage offered by an employer to the employee” [emphasis added]. 26 USC § 5000(f)(5) indicates any term used in this section which is also used in Title 1 of the Patient Protection and Affordable Care Act shall have the same meaning as when used in such title. Title 1 includes the use of “employee” in multiple locations. Section 1551 of the Affordable Care Act indicates the definitions contained in section 2791 of the Public Health Service Act (42 U.S.C. 300gg-91) shall apply with respect to Title 1. Section 2791(d)(5) of the Public Health Service Act indicates the term “employee” has the meaning provided under Section 3(6) of the Employee Retirement Income Security Act of 1974 which indicates the term “employee” means and individual employed by an employer. Since retirees and COBRA enrollees are no longer employed by an employer, it would appear that retirees and COBRA enrollees who are covered under a plan offered by their previous employers are not covered under minimum essential coverage (if such coverage does not fall within the government sponsored or grandfathered categories) and are therefore eligible for the Advanced Premium Tax Credit if they enroll in individual coverage in the Exchange. Furthermore, if such an individual does not purchase individual coverage, the individual will be required to pay the tax penalty required pursuant to 26 USC § 5000, even if they maintain their former employer’s coverage.
i. Is this line of reasoning correct for retirees? If not, please provide statutory references that indicate otherwise. Does CMS intend to categorize retirees in the Other Coverage category provided in 26 USC § 5000(f)(1)(E)?

C. QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO) OR NATIONAL MEDICAL SUPPORT NOTICE (NMSN) ****

26 USC § 36B(c)(1)(D) indicates that no credit will be allowed for a dependent for whom a deduction under 26 USC § 151 is allowable for another tax payer in the tax year. Does this statute apply in the case of an individual who must cover a dependent pursuant to a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN)?

D. DEFINITION FOR ABORTIONS FOR WHICH PUBLIC FUNDING IS NOT AVAILABLE ***

ACA § 1303(b)(1)(B) as amended by ACA § 10104(c) provides a vague description for abortions for which public funding is and is not available. However, the ACA does not provide a statutory reference. What is the statutory reference that describes such services?

3. COST SHARING REDUCTIONS

ACA § 1402 as amended indicates that individuals between 100% and 150% FPL will receive cost sharing reductions and reductions to the out of pocket maximum so that the actuarial value (AV) of a silver plan is 94%; between 150% and 200% the AV is 87%; between 200% and 250% the AV is 73%. A plan’s AV is determined by the various levels of deductible, coinsurance, copayments and out of pocket maximums.

A. CHANGES IN COST SHARING DUE TO CHANGES IN INCOME *

The Actuarial Value and Cost-Sharing Reductions Bulletin issued February 24, 2012 indicates CMS intends to propose that if a carrier reduces a specific cost sharing provision, any increased cost sharing reduction may not have a higher cost sharing provision. For example, if the standard silver plan has a $2,000 deductible, and the carrier reduced the deductible to $1,800 to meet the 73% AV, the silver plan variations at 87% and 94% AV must have deductibles equal to or less than $1,800. Assume a person has income equal to 300% FPL and is enrolled in a silver plan with a $2,000 deductible as described above. Furthermore, assume that the individual has met his $2,000 deductible and has begun to pay into the coinsurance provisions of the plan. Finally, assume the individual has a loss of income down to 225% FPL and the deductible is reduced to $1,800 as described above.

ii. Does CMS contemplate adjusting the consumer’s out of pocket that has already been spent? If so, how would this be done?

iii. What if the individual starts out on a gold or platinum plan and then loses income and qualifies for a cost sharing reduction? Will the individual be
allowed to enroll in the silver plan due to the loss of income? Will cost sharing adjustments be made?

B. COST SHARING EFFECTS ON UTILIZATION AND RATING *

It has been well documented that cost sharing has a significant effect on utilization\(^1\). Individuals who must pay larger deductibles, coinsurance and copays are typically more aware of the costs of coverage, ask more questions about necessity and cost of procedures and generally utilize services to a lesser degree than those individuals with richer cost sharing plans. If a carrier sets a silver tier QHP at the appropriate AV of 70% +/-2%, one would expect a certain level of utilization and rates. However, if the same plan had an AV of 94% +/-2%, the carrier would likely assume a higher average medical spend. In the individual exchange, we are asking carriers to assume both AVs, or perhaps a blended AV to create rates. Because of this, we can expect higher rates in the individual silver QHPs that we would otherwise expect. This will increase the cost sharing reductions and the advance premium tax credit paid on behalf of Nevadans and will increase the potential for adverse selection between the exchange and non-exchange markets. Furthermore, this should affect the AV calculator contemplated to be provided by CMS. Please confirm whether the AV calculator will be built to include the effects of utilization.

4. ACTUARIAL CALCULATOR

The Actuarial Value and Cost-Sharing Reductions Bulletin issued February 24, 2012 indicates CMS intends create a publicly available actuarial value (AV) calculator that plans would use to determine AV. When will this calculator be available?

5. CARRIER REIMBURSEMENT FOR THE ADVANCE PREMIUM TAX CREDIT AND COST SHARING REDUCTIONS

ACA § 1401 as amended indicates that individuals between 100% and 400% FPL will receive advance premium tax credits. ACA § 1402 as amended indicates that individuals between 100% and 250% FPL will receive cost sharing reductions and reductions. How will carriers be reimbursed for these tax credits and cost sharing reductions? What is the frequency with which they will be reimbursed? How long is it expected to take for a carrier to reimbursed following application for reimbursement?

6. MINIMUM ESSENTIAL COVERAGE

A. DE MINIMIS VARIATION OF BRONZE PLAN ***

The Actuarial Value and Cost-Sharing Reductions Bulletin issued February 24, 2012 indicates CMS intends to propose a de minimis variation of +/- 2 percentage points in AV (e.g., a silver plan could have a value from 68% to 72%). It would follow then, that a bronze plan could have a value of 58% to 62%. 26 USC § 36B(c)(2)(C)(ii) indicates that

\(^1\) http://www.columbia.edu/~hs2166/Shigeoka_JMP.pdf
for purposes of minimum essential coverage, a plan must have a value of at least 60%. Therefore, a Qualified Health Plan could be offered in the SHOP Exchange that does not meet the minimum essential coverage threshold. **Does CMS intend to release guidance that indicates the de minimis variation of +/- 2 percentage points in AV also applies to the threshold provided by 26 USC § 36B(e)(2)(C)(ii)?** Or that the bronze plan actuarial valuation threshold will be 60% to 62%?

### 7. **USER FEES**

45 CFR § 155.160(b)(1) states that “States may generate funding, such as through user fees on participating issuers, for Exchange operations…” Additionally, page 18323 of the Federal Register / Vol. 77, No. 59 / Tuesday, March 27, 2012 / Rules and Regulations indicates:

“The Affordable Care Act directs Exchanges to be self-sustaining and provides flexibility for Exchanges to generate support for continued operation in a variety of ways, such as through user fees. Accordingly, we do not limit Exchanges’ options in the final rule by prescribing or prohibiting certain approaches. We believe that user fees parameters, as well as the need for other revenue-generating strategies, may vary by State depending upon several factors such as the number of potential enrollees and the Exchange’s operational costs.”

A. **FEE TO CARRIER ***

If an exchange charges a per member per month user fee to carriers and carriers include that user fee in the overall premium of the QHP, **can the consumer receive the Advance Premium Tax Credit (APTC) based on the overall premium cost?** Or would the APTC be based on the lower premium amount before adding in the exchange user fee?

B. **FEE TO CONSUMER ***

If an exchange charges a per member per month user fee directly to the consumer enrolled in a QHP on the exchange:

i. **Can the consumer receive the Advance Premium Tax Credit (APTC) based on the cost of the premium plus the cost of the user fee?** Or would the APTC be based on the lower premium amount before adding in the exchange user fee?

ii. **Can the Exchange charge only those individuals between 100% and 400% FPL?** Must the Exchange charge those individuals with incomes greater than 400% FPL? Must the Exchange charge employers the user fee?

### 8. **FEDERAL DATA SERVICE HUB**

A. **REAL TIME *****

As part of the requirements of ACA compliant state exchanges, 45 CFR § 155.305(c) indicates “the Exchange must transmit the applicant’s Social Security number and other identifying information to HHS, which will submit it to the Social Security Administration.” Regulations indicate the Federal Data Hub will receive the above eligibility information data request and transmit that data to the appropriate Federal
agency (such as the Social Security Administration). The regulations do not indicate how quickly the Federal Data Hub will respond to the information request.

CCIIO has indicated that the Federal Data Hub will return information in “Real Time.” However, during CCIIO’s Health Insurance Exchange System-wide Meeting in May, a Federal representative indicated that “Real Time” could be 24 hours. Current processes are designed based on a 15-30 second turnaround. Most, if not all health insurance exchanges in operation today offer their services in a few seconds. When a consumer contacts the call center or goes to the exchange’s website, an individual can typically receive an eligibility determination and enroll immediately. The State of Nevada is extremely concerned with the potential definition of “Real Time” that is greater than 30 seconds for the following reasons:

i. The vendor supporting Nevada’s web portal has indicated in the contract the assumption that eligibility information is readily available or can be retrieved within 15-30 seconds. Should the turnaround time be greater, its current information flows will need to be re-worked adding to implementation expenses. The delay in receiving the eligibility determination will require an additional touch, either by email, phone or letter. The additional touch by phone or letter will add to maintenance and operating costs.

ii. Today’s market requires instant determinations. If a consumer must wait longer than a minute, it is likely that the exchange will lose that customer, especially if the customer is above 400% FPL. A turnaround time greater than 15-30 seconds will reduce the number of customers, make sustainability more difficult and will make it more difficult to reach our enrollment goals.

Please confirm that “Real Time” will be defined as a turnaround time of less than 30 seconds, preferably less than 15 seconds.

B. 24/7 AVAILABILITY ***

Nevada was recently notified that “24/7 availability” of the Federal Data Hub may not mean continuous availability. Nevada would prefer if the Federal Data Hub could be designed with technologies that results in no down time. However, Nevada understands that IT systems often require scheduled down time to allow for updates and other system changes. Furthermore, it is recognized that problems may occur that result in unscheduled down time. However, there is concern about how frequent the scheduled down time may be as well as the duration of the down time. Anytime the Federal Data Hub is down, Nevada’s web portal will not be able to function as required, reducing the number of individuals who will obtain insurance. Furthermore, if scheduled down time is not communicated with the states, web portal down times will increase as each state manages their own IT solutions and may require down time of their own. To reduce the amount of scheduled down time and ensure maximum consumer grab, Nevada requests:

i. Scheduled down time of the Federal Data Hub be no more frequent than one hour per week, preferably one hour per month or quarter.

ii. Scheduled down time of the Federal Data Hub begin at 3:00 or 4:00 am EST (12:00 or 1:00 am PST) on Sunday morning and last no more than one hour. These down times will likely impact the fewest users nationwide.

iii. CCIIO publish the scheduled down time for the Federal Data Hub well in advance (at least one calendar quarter) of the actual down time. This will
allow each state to schedule the down time of their respective IT solutions (web portal, etc.) to coincide with the down time of the Federal Data Hub. If down times coincide, the total amount of down time will be reduced from the consumer’s perspective.

iv. **Any unscheduled down time be communicated to the states so each state may hold their vendors harmless for down times that originate at the Federal level.** Nevada is entering a contract with a vendor to provide a Software as a Service (SaaS) solution for its web portal, premium aggregator, SHOP Exchange, etc. The Service Level Agreements (SLAs) require the vendor to ensure unscheduled web portal down time be less than 0.1% (0.1% down time equates to 43.8 minutes per month or 8.76 hours per year). Down time of the Federal Data Hub may impact the vendor’s ability to meet these SLAs.

C. **DATA PROVIDED BY THE HUB ***

i. The answer to Question 1 of the Affordable Care Act Implementation Answers to Frequently Asked Questions Federal Data Service Hub (CALT Doc 1130, Federal Data Services Hub FAQs_092012, found in Medicaid State Collaborative Community, Documents Folder, “Information Re:Medicaid/CHIP/FFE (mid-Sept)”) indicates the hub will provide "Max APTC from IRS". While the max APTC is based on income and family size, it is also based on status as an American Indian or Native Alaskan and the cost of the second least expensive silver plan which can vary by age, geographic location (zip code) and number of dependent. Further complicating matters is that the APTC may be reduced if the total cost of coverage is less than the amount of the max APTC (usually because the individual has purchased bronze coverage). Due to these complicated calculations that require access to an enormous database of rates for each state and pursuant to Section 1311(d)(4)(G), it is the understanding of the State of Nevada that the requirements of the web portal for a state based exchange include the ability to calculate the APTC based on MAGI data and number of dependents on the latest income tax return provided by the enrollee and verified by the Federal Data Service Hub. **Is the inclusion of "Max APTC from IRS" included in this document in error? Will the Federal Data Service Hub include data regarding number of dependents?**

ii. During the Federal Data Services Hub Technical Work Group on October 1, 2012, the presenter indicated there will be an Incarceration Indicator Switch. If the Switch is set to False, it means that SSA has no prisoner data or the data cannot be released. **For purposes of Advance Premium Tax Credit eligibility, if the hub cannot release incarceration data for an individual, is the state supposed to assume the individual is not incarcerated?**

9. **INFORMATION TECHNOLOGY SECURITY

A. **IRS SAFEGUARD PROCEDURES REPORT REVIEW ****

During the Nevada requested “CMS Security MARS-E” conference call conducted on November 2, 2012, there were a number of challenges brought to Nevada’s attention.
The Management and Administrative Reporting Subsystem (MARS) document package contains two primary documents, the System Security Plan (SSP) and the Safeguard Procedures Report (SPR). The Nevada Division of Welfare and Support Services (DWSS) which has been tasked with the creation of a Health Care Reform Eligibility Engine (HCR-EE) currently submits their systems to annual IRS Safeguard audits due to the administration of Temporary Assistance for Needy Families (TANF) in Part A of Title IV of the Social Security Act (IVA) and Child Support Enforcement in Part D of Title IV of the Social Security Act (IVD).

It has been identified that the SSP must be modified to include the new access brought about by the creation of the Silver State Health Insurance Exchange due to the passage of the Affordable Care Act (ACA) and a new SPR will have to be created. The new SSP would include all programs (ACA, IVA, and IVD) showing the difference in boundaries. Once the SSP has been modified and the new SPR has been created, Nevada is required to upload the completed SSP and SPR to CALT. The CMS Security team will review the SSP and provide feedback to the State through CALT. When feedback is received Nevada will have three days to provide modifications and resubmit. The CMS SSP review turnaround time is 10 days.

Once the documents are approved by CMS they will be forwarded to the IRS for review. IRS turnaround time for SPR and SSP review is approximately 30 days. The IRS will not approve the SPR until the system is ready to test in production and no earlier than 45 days prior to the go live date of the production system. This does not give the State the time needed to correct any deficiencies found during the review.

i. CMS stated States will have to conduct their own security assessment; however CMS has not provided a list of vendors nor have they defined guidance regarding proof of testing. Further CMS stated they have not received the Federal Hub security guidance and does not know when it will be available. The above information creates a project timeline risk. The State of Nevada requests CMS 1) provide a list of vendors that may conduct security assessments, 2) provide guidance regarding proof of testing, and 3) publish guidance regarding Federal Data Services Hub security.

ii. The time window given for approval of the MARS-E document is impractical when coupled with the IRS onsite review. The State of Nevada requests either 1) the IRS implement an iterative approval process that allows for early recognition of deficiencies so that corrections can be made prior to go-live, or 2) the IRS allows conditional approval that allows corrections of deficiencies after go-live.

B. INFORMATION EXCHANGE AGREEMENT *

The Social Security Association’s Government Information Exchange website indicates the new 2010 Agreement Renewal Process is to ensure a national consistent, automated approach to the agreement renewals under the new Electronic Information Exchange (EIE) initiative. The Information Exchange Agreements establish terms, conditions, and safeguards under which SSA will disclose to the State Agency certain information,
records, or data (herein “data”) to assist the State Agency in administering certain federally funded state-administered benefit programs.

i. Do these Information Exchange Agreements apply to the state based exchanges? If not, when will an agreement be provided for state based exchanges?

ii. Do these Information Exchange Agreements allow the Exchange (through its IT vendor) to transmit this information to the insurance carriers for member enrollment purposes?

10. ELIGIBILITY VERIFICATION

A. EMPLOYER REDRESS AFTER EXCHANGE TIME LIMITATION ON APPEALS *

What is the procedure for an employer to prove that he does in fact offer minimum essential coverage after the completion of the Exchange appeal window?

B. INDIVIDUAL APPEALS – JUDICIAL REVIEW *

i. Will Eligibility appeals be subject to judicial review? If so, which court or entity has jurisdiction over APTC appeals? Federal Court? District Court? IRS?

ii. Will APTC amount appeals be subject to judicial review? If so, which court or entity has jurisdiction over APTC appeals? Federal Court? District Court? IRS?

C. INDIVIDUAL APPEALS – LIABILITY FOR INCORRECT APTC DETERMINATIONS *

i. Will the Exchanges assume any liability for incorrect redetermination of APTC derived from consumer supplied information (for instance, if the consumer receives a wage cut, etc.)?

11. AMERICAN INDIANS AND ALASKA NATIVES

Subtitle K of title II of the Affordable Care Act, Protections for American Indians and Alaska Natives, section 2901, extends special benefits and protections to Indians including limits on cost sharing and payer of last resort requirements for health programs operated by the Indian Health Service (IHS), Indian tribes, tribal organizations, and urban Indian organizations².

A. VERIFICATION OF AMERICAN INDIAN AND ALASKA NATIVE STATUS *****

i. Who is responsible (consumer or the Exchange or both) for obtaining and then verifying tribal enrollment documentation?

ii. How does an exchange verify tribal status if a tribe does not issue cards or membership certificates?

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iii. What documents will the Federally Facilitated Exchange accept to prove tribal membership?

iv. May the State use the I/T/U (Indian Health Services / Tribal Providers / Urban Indian Providers) member database provided by the local clinics to verify tribal membership?

B. TRIBAL PAYMENT OF INDIVIDUAL PREMIUMS *****

45 CFR § 155.240(b) indicates the Exchange may permit Indian tribes, tribal organizations and urban Indian organizations to pay aggregated QHP premiums on behalf of qualified individuals, including aggregated payment, subject to terms and conditions determined by the Exchange.

i. If the state elects to allow tribes to pay aggregated QHP premiums on behalf of qualified individuals and the tribe elects to do so:
   a. Can the exchange require the tribe to pay the full individual premium, or must the exchange allow a tribe to pay only a percentage of premium?
   b. Can the exchange require the tribe pay the individual premium for all qualified individuals who are members of that tribe, or must the exchange allow a tribe to choose for whom they are paying?

ii. If a Federally recognized Tribe uses funds it receives from Indian Health Services (IHS) to purchase policies for its members on the Exchange, what portions of the IHS funds may be used? Specifically, Tribal members in Nevada have questions regarding Contract Health Service (CHS) dollars. If the tribe pays for enrollment in a QHP on the Exchange, will the CHS dollars that Tribal Clinics receive be reduced by the dollar amount of the policies purchased? The Tribal leadership is in support of making a change to commercial insurance coverage, but wants to make sure tribal clinics continue to receive the funding required to operate since commercial carriers are not required to contract with tribal clinics.

12. DISCRIMINATION RULES FOR SHOP EXCHANGE

A. DISCRIMINATION TESTING *

26 USC § 125 describes cafeteria plans and the requirements that such plans do not discriminate in favor of highly compensated individuals. An employer who provides coverage in the SHOP Exchange may also participate in a § 125 plan if it deducts his/her employees’ share of premiums from their pay on a pre-tax basis. If the Exchange offers an Open SHOP Exchange in which employees may choose any plan from bronze through platinum (similar to the current Utah model), those employees who are more richly compensated will likely be able to purchase richer plans such as platinum and gold plans while employees who receive less compensation may only be able to afford bronze or silver plans. If an employer selects SHOP Exchange coverage for his employees, is that employer required to complete discrimination testing to ensure both highly compensated employees and other employees have the same benefits? How would an exchange assist small businesses in ensuring they pass applicable discrimination testing rules?
13. NATIONAL PLAN

ACA § 1334 (added by ACA § 10104) indicates the Office of Personnel and Management (OPM) will provide a national plan that will eventually be offered on every state exchange.

A. NATIONAL EHB

OPM staff has indicated that OPM intends to implement regulations indicating that a multi-State or national Qualified Health Plan (QHP) will meet the requirements of ACA §§ 1302 and 1334 if the QHP is consistent with either:

1. The state’s selected set of Essential Health Benefits (EHB); or
2. A national set of EHB selected by OPM.

However, all other QHPs in the state do not have the option of utilizing the national set of EHB. If OPM were to exercise the option to utilize a national set of EHB, the State of Nevada is extremely concerned about adverse selection created by this double standard afforded to national plans offered within the State of Nevada.

B. IT COMPATIBILITY WITH STATE EXCHANGES

ACA § 1334(d) indicates that a multi-state Qualified Health Plan (QHP) that is offered by the OPM shall be deemed to be certified by an Exchange for the purposes of ACA § 1311(d)(4)(A). However, Nevada envisions that part of the certification process will include demonstration by the QHP of the ability to communicate eligibility, payment, plan design or other information with the Exchange via an automated process designated by the Exchange. If a QHP cannot communicate the required information with the Exchange, it cannot be offered on the Exchange. Please indicate OPM’s willingness to include in its contract with the national QHPs the requirement to be compatible with the IT requirements of each state exchange.

14. PUBLICATION OF FINAL RULES AND ADDITIONAL GUIDANCE

A. INTERIM FINAL RULES IN CMS-9989-F

CMS-9989-F (Federal Register, Vol. 77, No. 59, Tuesday, March 27, 2012, p. 18311) indicates a portion of the rule is issued on an interim final basis. When does CMS anticipate providing further guidance on these issues? The rule indicates CMS is considering comments related to:

i. 45 CFR § 155.220(a)(3) – Agents and Brokers

Many states have been moving forward under the assumption that agents and brokers will be allowed to enroll individuals in the Exchange, which includes application for the advance premium tax credit. Changing this rule at this point would be detrimental to outreach and financial plans of the State of Nevada. As such, Nevada recommends little to no change to the current rule regarding Agents and Brokers.

ii. 45 CFR § 155.300(b) – Medicaid and CHIP
iii. 45 CFR § 155.302 – Conducting Eligibility Determinations

iv. 45 CFR § 155.305(g) – Eligibility for Cost Sharing Reductions

Page 10 of the Actuarial Value and Cost-Sharing Reductions Bulletin issued February 24, 2012 indicates future rules will address the requirement that a QHP issuer “eliminate cost sharing for an Indian, regardless of household income, for items or services furnished directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services, and prohibits the QHP issuer from reducing payments to any such entity for such items or services.” **When will such rules be published?**

v. 45 CFR § 155.310(e) – Timeliness of Exchange Eligibility Determinations

vi. 45 CFR § 155.315(g) – Verification for Applicants with Special Circumstances

vii. 45 CFR § 155.340(d) – Transmission of Tax Credit and CSR Data

viii. 45 CFR § 155.345(a)&(g) – Insurance Affordability Programs

B. **Model Standards ***

CMS-9989-F (Federal Register, Vol. 77, No. 59, Tuesday, March 27, 2012, p. 18331-18350) indicates CMS will be releasing in forthcoming guidance the following guidelines and model standards. **When does CMS anticipate providing these guidelines and standards?**

- Model conflict of interest standards for Navigators (p.18331)
- Model training standards for Navigators (p. 18331)
- Certification and licensure best practices for Navigators (p. 18331)
- Model standards related to linguistic and cultural competency for Navigators (p. 18333)
- Guidelines relating to standards for the accessibility, readability, and translation and oral interpretation of Exchange notices (p. 18337)
- Guidelines to assist States in developing and implementing privacy and security policies and protocols that fulfill the standards of 45 CFR § 155.260 (p. 18339)
- Guidance that will assist States in determining the applicability of HIPAA and other Federal laws to Exchanges (p. 18340)
- Guidance that addresses breach procedures (p. 18342)
- Guidance describing the approach for collection and storage of PII (p. 18342)
- Guidance identifying potential operational solutions for storing and tracking data, dentifying and preventing fraudulent submissions to the Exchange, and de-identifying data (p. 18342)
- Guidance to help States determine appropriate transmission standards and data exchange formats for their Exchanges (p. 18344)
• Guidance to clarify the term “incarcerated, other than pending the disposition of charges,” as used in § 155.305(a)(2) (p. 18345)
• Guidance regarding the rules regarding lawfully present individuals, with a focus on minimizing administrative complexity and burden (p. 18350)

C. RULES REGARDING ACTUARIAL VALUE AND COST SHARING ***

When does CMS anticipate providing proposed or final regulations regarding the topics found in the Actuarial Value and Cost-Sharing Reductions Bulletin issued February 24, 2012?

D. REINSURANCE & RISK ADJUSTMENT – HHS NOTICE OF BENEFIT AND PAYMENT PARAMETERS ****

The Bulletin on the Risk Adjustment Program: Proposed Operations by the Department of Health and Human Services issued May 1, 2012 and the Bulletin on the Transitional Reinsurance Program: Proposed Payment Operations by the Department of Health and Human Services issued May 31, 2012 indicates the notice of benefit and payment parameters would be issued in the fall of 2012. Verbal guidance had suggested this information would be available in mid-October. Nevada had hoped to use this information to create a baseline to better understand whether it should administer the reinsurance and risk adjustment programs. However, given this information is not available, it will be difficult to determine whether Nevada should administer these programs prior to the November 16, 2012 declaration deadline. When will these parameters be published?

QUESTION THAT HAVE BEEN ANSWERED

1. ESSENTIAL HEALTH BENEFITS (EHB)

A. EHB CATEGORY REQUIREMENTS

ACA § 1302(b)(1) provides a list of 10 EHB that each QHP must cover. If we have an EHB represented by a specific service, are we required to include in our EHB package other services? For instance, if we choose a benchmark plan that covers autism, but no other habilitative service, is that sufficient to satisfy the federal requirements?

During Nevada’s Design Review, CCIIO indicated that providing at least one service within an EHB category would satisfy the requirements of ACA § 1302(b)(1).

B. NUMBERS OF SERVICES

If a benchmark plan covers a service with a restriction on the number of services, do QHPs have to merely cover that service, or do they have to cover at least the minimum number of services as provided for in the benchmark plan? For instance, if a benchmark plan covers four services per year, can QHPs only cover three of the same service? If a benchmark plan covers a service with no limit, can the QHPs impose a limit on the number of services? The Essential Health Benefits bulletin issued on December
16, 2011 indicates (page 12; Benefit Design Flexibility) the QHP must offer benefits that are “substantially equal” to the benchmark plan. What is the definition of “substantially equal?” Must this be defined by the state?

During Nevada’s Design Review, CCIIO indicated that it will not provide a definition of “substantially equal.” CCIIO will leave the interpretation of “substantially equal” up to each state. However, Question 7 of the Frequently Asked Questions on Essential Health Benefits Bulletin Issued February 17, 2012 indicates a plan could substitute coverage of services within each of the ten statutory categories, so long as substitutions were actuarially equivalent, based on standards set forth in CHIP regulations at 42 CFR § 457.431, and provided that substitutions would not violate other statutory provisions.

C. ADULT DENTAL AND VISION

The list of EHBs do not include dental and vision services for adults. The list of the 10 potential benchmark plans may or may not include dental and vision services. Dental and vision services may be a separate plan.

i. Will the purchase of dental and vision services for adults be subsidized by the premium tax credit?

Plan benefits that are not included in at least one of the ten Essential Health Benefit categories provided in ACA § 1302(b)(1) cannot be subsidized by the premium tax credit. Generally, dental and vision services for adults are not considered an essential health benefit.

D. STANDALONE VISION PLANS

ACA § 1311(d)(2)(B)(ii) allows the issuance of a standalone dental plan. Other than requiring each QHP to offer pediatric vision benefits in ACA § 1302(b)(1)(J), the ACA does not include stand alone vision plans. Can an Exchange offer standalone vision plans in the same manner as standalone dental plans? If a standalone vision product is offered on the Exchange, can QHPs be offered on the Exchange if they don’t include vision services (in a manner similar to the allowance made by ACA § 1302(b)(4)(F) for dental plans)?

No. ACA § 1302(b)(4)(F) provides a specific exception for pediatric dental services indicating that a QHP shall not fail to be treated as a QHP solely because it does not include pediatric dental services, as long as the Exchange has a standalone dental plan. This exception is not provided for vision plans. Therefore, if a plan does not include pediatric vision services, it cannot be a QHP and therefore cannot be offered on the Exchange.

E. DRUGS

i. The Essential Health Benefits bulletin issued on December 16, 2011 indicates (page 12; Benefit Design Flexibility) “If a benchmark plan offers a drug in a certain category or class, all plans must offer at least one drug in that same category.”
category or class, even though the specific drugs on the formulary may vary.”

Does “category or class” refer to the 10 categories of essential health benefits? Or does it apply to the U.S. Pharmacopeial Model Guidelines categories and classes?

The categories and classes for drugs refers to the U.S. Pharmacopeial Model Guidelines categories and classes.

ii. How does CMS contemplate treating generic and brand drug coverage under EHB? For instance, if a benchmark plan is selected that only covers generics, would the minimum essential coverage then be the coverage of generics only?

No, there are no provisions for the treatment of generics versus brand drugs. However, certain categories and classes in the U.S. Pharmacopeial Model Guidelines may not be represented by generics and would therefore have to be supplemented by a brand drug that falls within that category and class.

2. ADVANCED PREMIUM TAX CREDIT

A. RETIREES AND COBRA UNDER ELIGIBLE EMPLOYER-SPONSORED PLAN ***

26 USC § 36B(c)(2)(B) indicates an individual is not eligible for the Advance Premium Tax Credit if the individual is eligible for minimum essential coverage other than individual coverage. 26 USC § 5000(f) defines minimum essential coverage as coverage under:

(F) Government sponsored programs (Medicare, Medicaid, CHIP, TRICARE, VA, Peace Corps and other Federal Programs);
(G) Employer-sponsored plan coverage;
(H) Plans in the individual market;
(I) Grandfathered health plans; or
(J) Other Coverage (such as the State health benefits risk pool or other coverage as identified by the Secretary).

26 USC § 5000(f)(2) says that “employer-sponsored plan” means “with respect to any employee, a group health plan or group health insurance coverage offered by an employer to the employee” [emphasis added]. 26 USC § 5000(f)(5) indicates any term used in this section which is also used in Title 1 of the Patient Protection and Affordable Care Act shall have the same meaning as when used in such title. Title 1 includes the use of “employee” in multiple locations. Section 1551 of the Affordable Care Act indicates the definitions contained in section 2791 of the Public Health Service Act (42 U.S.C. 300gg-91) shall apply with respect to Title 1. Section 2791(d)(5) of the Public Health Service Act indicates the term “employee” has the meaning provided under Section 3(6) of the Employee Retirement Income Security Act of 1974 which indicates the term “employee” means and individual employed by an employer. Since retirees and COBRA enrollees are no longer employed by an employer, it would appear that retirees and COBRA enrollees who are covered under a plan offered by their previous employers are not covered under minimum essential coverage (if such coverage does not fall within the government sponsored or grandfathered categories) and are therefore eligible for the
Advanced Premium Tax Credit if they enroll in individual coverage in the Exchange. Furthermore, if such an individual does not purchase individual coverage, the individual will be required to pay the tax penalty required pursuant to 26 USC § 5000, even if they maintain their former employer’s coverage.

i. Is this line of reasoning correct for COBRA enrollees? If not, please provide statutory references that indicate otherwise. Does CMS intend to categorize COBRA enrollees in the Other Coverage category provided in 26 USC § 5000(f)(1)(E)?

No. COBRA enrollees are covered under minimum essential employer-sponsored plan coverage pursuant to 26 CFR § 1.36B-2(c)(3)(iv) which indicates “an individual who may enroll in continuation coverage required under federal law or a state law that provides comparable continuation coverage is eligible for minimum essential coverage only if the individual enrolls in the coverage.”

3. COST SHARING REDUCTIONS

ACA § 1402 as amended indicates that individuals between 100% and 150% FPL will receive cost sharing reductions and reductions to the out of pocket maximum so that the actuarial value (AV) of a silver plan is 94%; between 150% and 200% the AV is 87%; between 200% and 250% the AV is 73%. A plan’s AV is determined by the various levels of deductible, coinsurance, copayments and out of pocket maximums.

A. SILVER PLAN VARIATIONS IN SHOP EXCHANGE

The Actuarial Value and Cost-Sharing Reductions Bulletin issued February 24, 2012 indicates CMS intends to propose that each carrier that provides a silver plan must also provide three variation plans that meet the requirements of the higher AV due to the cost sharing reductions. However, the cost sharing reductions do not apply to employees who select silver level plans in the SHOP Exchange. Please confirm that CMS does not intend to require carriers to submit the three silver plan variations for products sold on the SHOP Exchange.

ACA § 1402(b)(1) indicates an “eligible insured” means an individual who enrolls in a qualified health plan in the silver level of coverage in the individual market offered through an Exchange.

4. QHP ACCREDITATION BY NATIONAL ORGANIZATION

A. ACCREDITATION TIMELINE

ACA § 1311(c)(1)(D) and 45 CFR § 155.1045 indicates that the Exchange must establish a uniform period following certification of a QHP within which a QHP issuer that is not already accredited must become accredited. Discussions with NCQA indicated that accreditation could take as long as 18-24 months. During initial discussions with CCIIO, the Nevada team was under the impression that the timeline for QHP issuer accreditation would need to indicate a hard end date such as 2015 or 2016. Nevada was concerned that
in future years, new carriers that are working toward accreditation may not be able to provide QHPs on the Exchange. Depending on how successful the Exchange is, this could, in fact, bar new entrants into the market reducing competition. However regulations and the blueprint do not appear to require a hard date; they seem to allow a state to set a number of months from the date of initial certification of a QHP issued by a new issuer.

For instance: If a carrier is not accredited, the Exchange could require the carrier have a letter from the accrediting agency that includes an audit date to start the accreditation process. From the date of certification of the QHP (the first QHP certified for a given carrier), the carrier would have no more than 18 months to become accredited. This process (with additional detail) would be sufficient for both the Exchange start-up years (2014, 2015) as well as future years for new entrants. Please confirm that exchanges are not required to set a hard calendar date for accreditation; that the Exchange could follow a similar process in future years for new entrants.

During Nevada's Design Review on July 18, 2012, CCIIO indicated there is no set date for the creation of the timeline. The regulations allow for the creation of an accreditation timeline that takes into account future entrants into the market.

B. NOTIFICATION OF ACCREDITING ENTITIES

45 CFR § 156.275(c) indicates HHS will notify the public in the Federal Register that the NCQA and URAC are recognized as accrediting entities. What is the expected timeline for this recognition?

The timeline is based on the submittal of certification data from NCQA and URAC.

5. MEDICAL LOSS RATIO (MLR)

A. EXCHANGE FEES

45 CFR § 158.221(c) indicates carriers may exclude from the MLR calculation the issuer’s Federal and State taxes and licensing and regulatory fees, described in §§ 158.161(a) and 158.162(a)(1) and (b)(1). The Silver State Health Insurance Exchange Board expects to enact a regulation under Nevada Administrative Code Chapter 695I that assesses a per member per month fee for each enrollee in a given Qualified Health Plan (QHP). The assessment would be charged to each carrier based on the enrollment in the carrier’s QHPs. The assessment would be used to pay operating expenses of the Exchange. Can the Exchange assessment be excluded from the MLR calculation?

Yes. Pursuant to 45 CFR § 158.162, issued on December 2, 2011, Exchange user fees should be included in the licensing and regulatory fees that are subtracted from premium in the MLR calculations and are therefore excluded from the MLR calculation (see question #34 on the MLR guidance issued April 20, 2012 at: http://cciio.cms.gov/resources/files/mlr-qna-04202012.pdf#page=6.
A. **CREDIT CARD FEES**

Consumers pay premiums in multiple ways—credit cards, check, EFT, etc. While many consumers like to pay with credits cards, most carriers prefer to charge it as an added fee on top of the premium to persuade consumers to pay for premiums in other ways. **If the carrier passes through the credit card fee to the consumer, would that fee be included in the administration cap of 20% for the MLR calculation? Or can that fee be passed to the consumer without inclusion in the MLR calculation?**

*Credit card fees may be passed to consumers without inclusion in the 20% administrative MLR cap if the user has other ways in which to pay their premiums.*

6. **FUNDING BASED ON THE DEFINITION OF ESTABLISHMENT**

ACA § 1311(a) indicates that funding is available for the establishment of state exchanges through 2014. CCIIO has interpreted "establishment" to exclude maintenance and operations (M&O). This means that any cost that is M&O will have to be funded by means other than ACA grants and will likely be charged to the carrier, and ultimately the consumer, making coverage less affordable in the Exchange. This interpretation is found in the bulletin issued on November 29, 2011 and in the last Q&A pertaining to ACA finding in the regs issued in March (CMS-9989-F)—though it does not explicitly mention M&O.

Nevada’s consultants and demographers estimate enrollment will be lower in the first year of operations as consumers become more familiar with the Exchange. This will result in higher per member per month (PMPM) costs as fixed costs must be divided among a smaller number of enrollees. As enrollment increases, the PMPM costs will gradually decrease. Nevada estimates the PMPM fee will stabilize around calendar year 2017 or 2018. Staff is concerned that the initial high PMPM rate will serve to destabilize the market and make insurance less affordable.

Nevada interprets “establishment” to include establishing a sound economic environment with lower initial rates to allow consumers to ease into the new market conditions. Nevada requests this interpretation be expanded to include M&O so that states can charge lower rates in 2014.

*Question 3 of the Exchange Establishment Cooperative Agreement Funding FAQs released by CCIIO on June 29, 2012 indicates § 1311(a) grant funds are available to fully fund Exchange-related expenses (in the State’s approved work plan and budget) until: 1) the end of the start-up year that coverage is provided through the Exchange, 2) the time a State-based Exchange becomes self-sufficient, or 3) §1311(a) grant funds have been expended, whichever comes first.*

7. **LANGUAGE THRESHOLDS**

45 CFR 155.205(c)(2) requires language services be provided for those with limited English proficiency. We would like to know whether a threshold can be applied of the population served by the exchange. **For instance, if one person in Nevada speaks a foreign language, is the exchange required to translate its documents into that language? 5 people? 1% of the population? 5% of the population?**

*CCIIO indicated at the All Exchange Meeting in May 2012 that states would be required to provided documents in English and Spanish.*
8. ELIGIBILITY VERIFICATION

A. NATIVE AMERICAN STATUS

What are the accepted methods of verifying Native American status? Is attestation sufficient?

*No, attestation is not sufficient. 45 CFR § 155.350 describes the process for verification of Indian status. The process is generally that the Exchange must first look to electronic data sources, so long as they have been approved by HHS. If no data sources exist/are available, the Exchange must follow standard inconsistency procedures outlined in section 155.315(f), which means that the Exchange requests documentation from the applicant. CCIIO is investigating possible data sources for this information.*

B. ELIGIBILITY OF EMPLOYER SPONSORED AFFORDABLE MINIMUM COVERAGE

What are the accepted methods of verifying eligibility of affordable minimum essential health coverage through a person’s employer? Is attestation sufficient?

*No, attestation is not sufficient. However, CCIIO is considering allowing an Exchange to verify using limited pre-enrollment data available to an Exchange, and to accept attestation if none (or incomplete) information is available if the state also conducts a post-enrollment screen of a percentage of individuals deemed eligible for Advanced Premium Tax Credits (APTC). Also please refer to the Employer Sponsored Coverage Bulletin.*

C. LIABILITY TO EXCHANGE DUE TO MISSED EMPLOYER APPEAL OPPORTUNITY

An individual could have access to affordable minimum essential coverage through his employer, but not provide correct employer contact information to be able to notify the employer that the employer may be subject to a penalty. This would result in a misdirected notification to the employer and the employer would not have the chance to appeal the decision. **What is the liability to the exchange or the carrier if an employer misses the window of appeal for an incorrect determination of offering affordable minimum essential coverage?**

*CMS indicates there is no liability to the exchange or the plans if an employer misses the window of appeal for an incorrect determination of offering affordable minimum essential coverage.*

9. ACCESS LIMITED TO LAWFUL RESIDENTS

A. DEPORTATION OF ILLEGAL IMMIGRANTS

ACA § 1312(f)(3) indicates that access to the Exchange is not available to individuals who are not a citizen or national of the United States or an alien lawfully present in the United States. On Friday, June 15th, President Obama signed an executive order to stop
deporting certain illegal immigrants who came to the United States as children. The President indicated the order did not provide amnesty. Please confirm whether these individuals are still considered to be aliens not lawfully present in the United States and are therefore not eligible for coverage in the Exchange. This information is vital to create accurate enrollment processes and estimates.

The DACA (Deferred Action for Childhood Arrivals) process is designed to ensure that governmental resources for the removal of individuals are focused on high priority cases, including those involving a danger to national security or a risk to public safety, and not on low priority cases. Because the reasons that DHS offered for adopting the DACA process do not pertain to eligibility for Medicaid or CHIP, HHS has determined that these benefits should not be extended as a result of DHS deferring action under DACA. Concurrent with this amendment, CMS is issuing a State Health Official letter providing that individuals whose cases are deferred under DHS’s DACA process will not be eligible under the state option. As it also would not be consistent with the reasons offered for adopting the DACA process to extend health insurance subsidies under the Affordable Care Act to these individuals, HHS is amending its definition of “lawfully present” in the PCIP program, so that the PCIP program interim final rule does not inadvertently expand the scope of the DACA process.

Under the amended rule, individuals with deferred action under the DACA process are not eligible to enroll in the PCIP program. As the PCIP program definition of “lawfully present” is incorporated into the rules governing the Affordable Insurance Exchanges and the premium tax credits, individuals whose cases are deferred under the DACA process also will not be eligible to enroll in coverage through the Affordable Insurance Exchanges and, therefore, will not receive coverage that could make them eligible for premium tax credits under Treasury regulations (see 26 CFR 1.36-2(a)(1)) or for cost-sharing reductions starting in 2014. This is consistent with the rationale above.

10. DISCRIMINATION RULES FOR SHOP EXCHANGE

A. EMPLOYER SUBSIDY CALCULATION

Can an employer who provides his/her employees coverage through the SHOP Exchange provide a flat dollar amount of subsidy or must it be a percentage or premium?

Generally, employer subsidies must be calculated based on a percent of premium. However, if the Exchange were to aggregate all of an employer’s premiums into on blended rate, each employee would pay the same flat dollar amount. In this case, the employer subsidy is still a percent of premium that happens to be a flat dollar amount.

11. NATIONAL PLAN

ACA § 1334 (added by ACA § 10104) indicates the Office of Personnel and Management (OPM) will provide a national plan that will eventually be offered on every state exchange.
A. **EHB MINIMUMS**

ACA § 1334(c) indicates that a multi-State Qualified Health Plan (QHP) will meet the requirements of ACA § 1334 if the Director of the OPM determines the plan offers a benefits package that is uniform in each State and consists of the essential benefits described in § 1302. **Does this mean that the national plan must only include the list of ten Essential Health Benefits (EHBs) included in § 1302? Or does it mean that the national plan must include all of the benefits included in the set of EHB selected by the State through the State’s selection of the benchmark plan and any required addition of benefits so that the State’s EHB package meets the minimum requirements of § 1302?** There is concern that a national plan will have a pricing advantage if they are not required to include all of the state selected EHBs.

*OPM intends to implement regulations indicating that a multi-State QHP will meet the requirements of ACA §§ 1302 and 1334 if the QHP offers either:*
  1. A plan consistent with the state’s selected set of EHB; or
  2. A plan consistent with a national set of EHB selected by OPM.

B. **STAGED ROLL OUT**

ACA § 1334(e) indicates there will be a staged roll out of the national plan. **Which will be the first states to be required to include the national plan? When will Nevada be required to include the national plan?**

*The ACA only contemplates the number of states in which the national plan will be implemented each year. It does not include which states will be first. The roll out schedule will be based on the carriers and the markets in which they currently operate.*