Milliman

One Pennsylvania Plaza, 38th Floor
New York, NY 10119

Tel +1.646.473.3204
Fax +1.646.473.3199

milliman.com

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Submitted electronically to: http://www.regulations.gov

Mr. Jay Angoff
Director, Office of Consumer Information and Insurance Oversight
Department of Health and Human Services
Hubert H. Humphrey Building, Room 445 G
200 Independence Avenue, SW
Washington, DC 20201

Re: File Code OCIIO-9989-NC, Request for Comments Regarding the Exchange-related Provisions in Title 1 of the Patient Protection and Affordable Care Act

Dear Mr. Angoff,

Milliman is pleased to provide the enclosed comments in response to the Request for Comments Regarding the Exchange-related Provisions in Title 1 of the Patient Protection and Affordable Care Act (file code OCIIO-9989-NC), as published in the *Federal Register* of Aug. 10, 2010.

Milliman is one of the nation's largest independent actuarial firms and has the largest actuarial health consulting practice in the country. We provide services to 25 State Medicaid programs, most large health insurance issuers, as well as to healthcare providers, pharmaceutical companies, and employer- and union-sponsored group health plans. We work with Medicare in various capacities; this year we performed 1,300 bids for 90 clients. Milliman also performs healthcare consulting for federal government clients such as the Veterans Health Administration and the Congressional Budget Office.

The enclosed comments (in red) provide our perspective on many of the questions from the request for comments. In particular, our unparalleled expertise in plan design, market competition, and risk adjustment may be helpful to your office as you plan for the creation of State Exchanges.

Thank you for the opportunity to provide comments on this important topic. We stand ready to provide you further assistance or insights as you face the challenges in the months and years ahead.

Sincerely,

Catherine Murphy-Barron, FSA, MAAA
Principal and Consulting Actuary
Milliman, Inc.
One Pennsylvania Plaza, 38th Floor
New York, NY 10119
Tel +1.646.473.3204
Fax +1.646.473.3199

SUMMARY: This document is a request for comments regarding the Exchange-related provisions of the Patient Protection and Affordable Care Act (the Affordable Care Act), enacted on March 23, 2010. The Department of Health and Human Services (HHS) invites public comments in advance of future rulemaking and grant solicitations.

DATES: Submit written or electronic comments by October 4, 2010.

Milliman has provided answers to many but not all of the questions posed by HHS. All answers are in red. In our response, we have removed questions for which we are not providing an answer.

A. State Exchange Planning and Establishment Grants

Section 1311(a) directs the Secretary to make planning and establishment grant awards to States for activities related to establishing an Exchange. For each fiscal year, the Secretary must determine the total amount that will be made available to each State. Grants awarded under this Section may be renewed if a State is making sufficient progress toward establishing an Exchange, implementing other insurance market reforms, and meeting other benchmarks. The Secretary must make the initial grant awards under this Section no later than one year after enactment, and no grants shall be awarded after January 1, 2015.

1. What factors are States likely to consider in determining whether they will elect to offer an Exchange by January 1, 2014? To what extent are States currently planning to develop their own Exchanges by 2014 (e.g., become electing States) versus choosing to opt-in to an Exchange operated by the Federal government for their State? When will this decision be made? Can planning grants assist in identifying and assessing relevant factors and making this decision?

Factors:

- **States will consider the probability that the individual state will eventually assume financial responsibility for program costs (with no recourse) if it assumes operation of the exchange.**
- **Does the state want to be in control of the decision as to whether to merge the individual and small group markets?**
- **In these difficult financial times, will a state be able to reassign scarce human resources to plan an exchange? If the state assigns this task to the unit already administering health plans or Medicaid, is there existing staff that can be assigned for this purpose?**
- **Will the state be able to establish a self-supporting exchange? Will a federal government exchange be self-supporting?**
- **A state is more likely to consider operation of an exchange if it has previous experience with management of a managed Medicaid plan. That experience would form a base of knowledge from which an exchange could be built.**

- **Planning grants will help. Nationally, there are relatively few individuals who have direct experience in creating an exchange-like organization. So states will need to hire exchange planners.**

2. To what extent have States already begun to plan for establishment of Exchanges? What kinds of activities are currently underway (e.g., legislative, regulatory, etc.)? What internal and/or external entities are involved, or will likely be involved in this planning process?

a. What kinds of governance structures, rules or processes have States established or are they likely to establish related to operating Exchanges (e.g., legal structure (such as placement in State agency or nonprofit organization), governance structure, requirements relating to governing board composition, etc.)?

There will be 50 unique answers. State/executive agency or independent authority are the two most likely options. States may see this responsibility as too large and mission-critical to assign to a not-for-profit. If the state is charting a course as an independent authority, the board of directors may be appointed by a combination of the executive and legislative branches—so both sides share authority/power. Or the board may be appointed by one of the branches of government. The characteristics or composition of the board of directors may be designated in legislation.

3. What are some of the major factors that States are likely to consider in determining how to structure their Exchanges (e.g., separate or combined individual Exchanges and SHOP Exchanges; regional or interstate Exchanges; subsidiary Exchanges, State agency versus nonprofit entity)? What are the pros and cons of these various options?

Key factors for consideration by states include:

- **Homogeneity: The more homogenous the population, the more likely the state is to end up with a single exchange entity.**
- **Networks: What provider networks have been formed by carriers and are they homogenous within the region?**
- **Geographic: How does geography contribute to the provider network composition and population mix?**
- **Lack of industry: A state with a struggling industrial sector would have a greater proportion of uninsured and thus might be more likely to keep the individual market separate.**
- **Population characteristics**
- **Size of state**

- **Current regulatory structure: Some states face a steep climb to reach the regulatory requirements set forth in Affordable Care Act, while others are already most of the way there.**
- **Where is the state putting Medicaid? In the exchange or still separate?**

Regional vs. interstate considerations:

- **The participating states would need to negotiate sovereignty issues and sharing control of the new organization.**
- **Can the exchange recognize and care for the constituents of each state or region?**
- **Where will each state administer state employee health benefits? If the state is putting state employees in the exchange, does it really want another entity responsible for operations?**
- **There may be complications for metropolitan areas (Washington, D.C., for example) that are on state borders. How should states accommodate people who work in one jurisdiction and live in another?**
- **Any cross-border merging of exchanges may pose other complications as the Affordable Care Act comes online. For example, a state that already has guaranteed issue in place will have very different dynamics from a state that has not historically had guaranteed issue. Risk adjustment would be difficult in two states with such different starting points.**

Nonprofit considerations:

- **States are unlikely to turn over responsibility of something that they feel is crucial to their long-term budgetary and public health planning.**

4. What kinds of factors are likely to affect States' resource needs related to establishing Exchanges?

The responses to Section A, Question #2, also apply here.

b. To what extent do States have existing resources that could be leveraged as a starting point for Exchange operations (e.g., existing information technology (IT) systems, toll-free hotlines, Web sites, business processes, etc.)?

States are already financially stressed. Most states probably don't have excess resources.

Exchange operations are akin to Medicaid managed care programs; therefore some exchange systems could piggyback off existing Medicaid systems, e.g., eligibility, interaction with carriers.

c. For what kinds of activities are States likely to seek funding using the Exchange establishment and planning grants?

Grants may be used to improve Medicaid infrastructure if it is a direct link to the exchange. States often don't upgrade Medicaid because they don't have any money, so this is a reason to let the federal government run the exchange—turning over the exchange infrastructure to the federal government effectively transfers the resource problem to the federal government.

B. Implementation Timeframes and Considerations

Section 1321(b) requires each State that elects to establish an Exchange meeting the Secretary's requirements to have an Exchange operational by January 1, 2014. Section 1321(c) directs the Secretary to establish and operate an Exchange within each State that: (1) Does not elect to establish an Exchange; or (2) the Secretary determines will not have an Exchange operational by January 1, 2014, or has not taken the actions the Secretary determines necessary to implement the requirements in Section 1321(a) or the other insurance market reform requirements in Subtitles A and C of Title I of the Act. Additionally, the Affordable Care Act includes several statutory deadlines for the Secretary related to establishment of Exchanges, including: Issuing regulations and/or guidance relating to requirements for Exchanges, requirements for QHPs, and risk adjustment as soon as practicable; Awarding State planning grants no later than one year after enactment (March 23, 2011); Determining the dates of the initial open enrollment period by July 1, 2012; No later than January 1, 2013, determining States' readiness to have Exchanges operational and implement required insurance market reforms by January 1, 2014; No later than July 1, 2013, issuing regulations for health choice compacts and the CO-OP program, and awarding CO-OP program grants; and Having in place additional insurance market reforms and providing cost-sharing reductions beginning on January 1, 2014. In order to carry out the Federal implementation activities to ensure Exchanges are fully operational on January 1, 2014, the Department is seeking comments from stakeholders relating to implementation timeframes.

1. What are the key implementation tasks that need to be accomplished to meet Exchange formation deadlines and what is the timing for such tasks? What kinds of business functions will need to be operational before January 1, 2014, and how soon will they need to be operational?

Key tasks include:

- **Website development**
- **Organizational structure of the exchange including staffing and oversight**
- **Call center/service functions**
- **Administration (if the exchange will be involved in enrollment process)**
- **Plan approval to be on the exchange (if the exchange is taking on that role as opposed to, say, the Department of Insurance)**

None of these can begin to happen until a state has made some conceptual decisions about the exchange, so not much is going on yet to start these steps.

2. What kinds of guidance or information would be helpful to States, plans, employers, consumers, and other groups or sectors as they begin the planning process?

A federally established information-sharing resource for exchange creation that everyone can go to could be very helpful. It should be a place where those charged with exchange creation can seek peers and information, e.g., if there is a need to write an RFP for a Navigator, other people can be found who are doing or have done the same thing. Such an information-sharing capability should facilitate centralized resources and discussion. It should be a "how to" site rather than an HHS information site. The site might be operated and maintained by a national not-for-profit healthcare organization.

For real practitioners/planners, an appropriate venue might be housed within the HealthCare.gov website.

3. What potential criteria could be considered in determining whether an electing State is making sufficient progress in establishing an Exchange and implementing the insurance market reforms in Subtitles A and C of Title I of the Affordable Care Act? What are important milestones for States to show they are making steady and sufficient progress to implement reforms by the statutory deadlines?

Key milestones include:

- **Legislation: HHS could monitor legislative action in 2011 and 2012 for authorization to act.**
- **Governance: Following legislative action, HHS could evaluate whether states have created an entity and whether they have begun to hire or issue RFPs.**
- **Contracts: Has there been an RFP or contract for a Navigator?**
- **Budget: Has the state initiated a budget impact analysis?**

C. State Exchange Operations

Section 1311(b) requires an Exchange to be established in each State not later than January 1, 2014 that: Facilitates the purchase of QHPs; provides for the establishment of a SHOP Exchange that assists small employers in facilitating the enrollment of their employees in QHPs offered in the small group market in the State; and meets additional requirements for Exchanges outlined in Section 1311(d). The Act requires the Secretary to publish regulations relating to the requirements for operating State Exchanges as soon as practicable, and provides various types of flexibility for States. A number of additional programs established by the Act are closely related to the establishment of health insurance Exchanges, such as the Navigator program in Section 1311(i) and other consumer assistance programs. In addition, the insurance reforms, consumer protection

provisions, and premium rating requirements will apply to plans both inside and outside the Exchanges.

1. What are some of the major considerations for States in planning for and establishing Exchanges?

There is subject matter throughout this document that provides insight into the major considerations for planning and establishing exchanges. With regard to the claim component, some of the most important considerations can be found in Section L dealing with risk adjusters. With regard to the non-claim component, how the exchange develops systems and avoids "waste" will have significant impact on cost and pricing (and, therefore, competitiveness). Generally, the success of the exchanges will rest upon the ability to encourage participation while at the same time preserving basic actuarial and underwriting principles so that the exchanges can be financially self-sufficient and also foster an environment in which plan sold through the exchange can be competitive with plans sold outside of it.

2. For which aspects of Exchange operations or Exchange standards would uniformity be preferable? For which aspects of Exchange operations or Exchange standards is State flexibility likely to be particularly important?

Some degree of flexibility in any framework will be important in order to not stifle innovation. What works well in one part of the country may not work well in others. Flexibility can help accommodate local customs, structures, and expectations.

3. What kinds of systems are States likely to need to enable important Exchange operational functions (e.g., eligibility determination, plan qualification, data reporting, payment flows, etc.), to ensure adequate accounting and tracking of spending, provide transparency to Exchange functions, and facilitate financial audits? What are the relative costs and considerations associated with building Exchange operational, financial, and/or IT systems off of existing systems, versus building new stand-alone Exchange IT systems?

There remain many questions with respect to the types of systems that will be required by states to implement exchanges. It is likely that core functions such as eligibility determination, plan qualification, and payment flows will be available in turnkey solutions from vendors looking to penetrate this new market. It is likely that comprehensive solutions will be available to handle a majority of the core functions. While not identical, states may adopt comprehensive solutions to manage mission-critical functions in a similar manner to how a health insurance carrier invests in claim administration systems to manage many of its core functions.

The build versus buy decisions will certainly come into play. It is too early to predict the better option, and it seems likely the answer will differ from one state to another. It is likely that vendors that are committed to the exchange niche will have the ability to offer systems that are both comprehensive and robust while keeping

up with the ever-changing requirements of state exchanges. From that standpoint, it may make more sense, cost-wise, to implement a buy strategy.

4. What are the tradeoffs for States to utilize a Federal IT solution for operating their Exchanges, as compared to building their own unique systems to conform to the current State environment? For what kinds of functions would it make more sense for States to build their own systems, or modify existing systems?

This is an extension of the build-vs.-buy decision discussed in Section C, Question #3. Some interaction with legacy systems will be important, but whether that can happen in a new system or needs to occur as a build-out of an existing system will be dependent on the particular state.

5. What are the considerations for States as they develop web portals for the Exchanges?

One of the key purposes of the state exchanges is to help consumers purchase health insurance. Because states will likely take advantage of web-based technology, the websites or portals and the functionality they offer will play a critical role for consumers purchasing coverage.

The portals will be utilized not only by healthcare buyers (e.g., individual consumers and small businesses) but also by state exchange employees to handle functions such as eligibility, enrollment, and customer service. To truly serve the buyers, portals should at a minimum offer the ability to compare product options—in terms of both benefits and price. Much like automobile insurance can be purchased online todaystate exchanges can take advantage of modern, web-enabled technology that will allow the buyers and sellers to interact "live" during the purchasing process and ultimate transaction. For those carriers that offer insurance through the exchanges, prices and benefit plan descriptions should be available for comparison to the buyer.

In addition, consumers should be able to understand which physicians and hospitals are part of the network through a provider search function. They should also be able to view quality ratings. Today, many health insurance carriers offer members the ability to estimate the cost of certain treatments, as well as out-of-pocket costs, that one could expect in a given year based on the characteristics of that member. State exchanges should be able to offer these consumer-oriented tools as well.

6. What factors should Exchanges consider in reviewing justifications for premium increases from insurers seeking certification as QHPs?

1. **The role of the state department of insurance (DOI) and the exchange(s) should be clearly identified and roles not duplicated. In the private (commercial) market, the DOI typically has personnel (either internally or through a**

contracted qualified professional) who review the technical aspects of the proposed rate increase. This technical expertise need not be duplicated in the exchange. It could be conceived that the exchange(s) would act in a fashion akin to the U.S. Office of Personnel Management (OPM). The OPM also has actuaries who review rates and who negotiate with carriers related to rates and benefits for the Federal Employees Health Benefits Plan (FEHBP)—but this role is different from the analysis performed by insurance departments.

2. **Regardless of the respective roles of the DOI and the exchange, the justification certainly needs to consider the actuarial soundness of the rates.**
3. **From a technical perspective the rate justification review should follow the appropriate actuarial standards of practice (ASOPs). The standards can be viewed at http://www.actuarialstandardsboard.org/asops.asp.**

7. To what extent are Territories likely to elect to establish their own Exchanges? What specific issues apply to establishing Exchanges in the Territories?

Territory decision-making around exchanges will depend on several primary factors:

- **Size: Some of the territories are quite small and may not see the same kinds of economies of scale as larger territories and states.**
- **Location: Some territories are geographically isolated and may depend on "off-island" care that can create higher administrative costs.**
- **Desire for parity: Territories often receive less than states do for Medicaid and in some cases have been pursuing cost parity. The exchanges may create another opportunity to lobby for such parity by allowing territories to demonstrate their commitment and because exchanges require some reformulation of the federal/territory relationship.**
- **Existing Medicaid dynamics: Some territories, while they receive a lesser federal match than states, still have much of their population covered by Medicaid or other public health programs (such as the Commonwealth program in Puerto Rico). With a high percentage of low-income people already covered in these territories, the creation of the exchange is likely to impact a high percentage of the citizenry.**

D. Qualified Health Plans (QHPs)

Section 1311(d)(2)(A) requires Exchanges to make QHPs available to qualified individuals and employers, and Section 1311(d)(4)(A) requires Exchanges to implement procedures for the certification, recertification, and decertification of health plans as QHPs, consistent with criteria developed by the Secretary under section 1311(c). This certification criteria include, at a minimum: Meeting marketing requirements; ensuring a sufficient choice of providers and providing information on the availability of providers; including essential community providers within health insurance plan networks; receiving appropriate accreditation; implementing a quality improvement strategy; utilizing a uniform enrollment form and a standard format to present health benefit plan options; and providing quality information to enrollees and prospective enrollees.

1. What are some of the major considerations involved in certifying QHPs under the Exchanges, and how do those considerations differ in the context of individual and SHOP State Exchanges, subsidiary Exchanges, regional or interstate Exchanges, or an Exchange operated by the Federal government on behalf of States that do not elect to establish an Exchange?

Actuarial/underwriting criteria are directly dealt with in the following paragraphs:

- **Rating system: Paragraph (c)(3) says that the HHS Secretary "shall develop a rating system that would rate qualified health plans offered through an Exchange in each benefits level on the basis of the relative quality and price." "Quality" is defined largely as a result of enrollee satisfaction. Among other things, price will be a function of the provider network (breadth and reimbursement rates). Section 1311(c)(1)(C) requires that plan networks include "essential community providers, where available" but Section 1311(c)(2) allows the plan to not contract with any such provider if the provider "refuses to accept the generally applicable payment rates of such plan." Additionally, some demand models have predicted that there will be an insufficient number of primary care providers to meet the additional demand for service created by provisions of the Affordable Care Act. If that does occur, the reimbursement provisions of a plan may be driven up and this will affect pricing.**
- **Enrollment periods: An exchange is required to have an initial open enrollment, annual open enrollment periods and special enrollment periods. As noted in comments to Section C, Question #1, as well as in the comment immediately above, pricing and competitiveness will be a function of the morbidity risk of those enrolled in the exchange. In the commercial group market, having certain enrollment periods is common. To the extent that the practices in the exchange become more liberal than current commercial group practices, the risk is likely to become higher. The issue will be more important to the individual coverage, where morbidity risk is a direct result of the conditions of offering and enrollment.**

3. What factors are needed to facilitate participation of a sufficient mix of QHPs in the Exchanges to meet the needs of consumers?

The following provides factors that will be considered by carriers and are more likely to facilitate participation of a sufficient mix of QHPs in the exchanges:

- **Reasonable cost of participation in the exchange relative to other distribution channels (i.e., insurance sold outside the exchange)**
- **Sufficient enrollment at all levels of coverage**
- **Efficient certification process**
- **Effective process to approve benefit structures**
- **Effective process to approve pricing**
- **Risk-adjusted payments**

- **Administrative requirements (e.g., Are requirements onerous for carriers? Are systems compatible?)**
- **Profitability and solvency considerations**
- **Whether rules favor one type of provider reimbursement structure over others**
- **The ease of getting qualified startup insurers to participate in the exchange, which will help foster competition**
- **The ability of insurers to be innovative**
- **Structure of the exchange and the presence of multiple markets in the exchange (e.g., If multiple markets sold through the exchange, will a carrier need to participate in "3 of 4" markets to be viable competitively and/or financially? What if they are only currently in "1 of 4" markets?)**

The certification criteria, and other administrative requirements mentioned above, could lead to additional administrative burdens on insurance carriers, which would increase premiums and/or reduce the participation of insurance carriers in the exchanges. If at all possible, any such requirements should be synergized with existing state-level licensing requirements.

Ultimately, participation of insurance carriers in the exchanges will be driven by a carrier's ability to make a profit (or, in the case of not-for-profit entities, make enough to sufficiently cover a contribution to surplus or contingency reserves and thereby remain viable). Appropriate risk adjustment mechanisms will be necessary to reduce adverse selection and spread the risk evenly across health plans.

a. What timeframes and key milestones will be most important in assessing plans' participation in Exchanges?

The following provides some critical time frames and key milestones that will be important in a health plan's decision to participate in the exchange:

- **Completion of regulations and/or guidance related to:**
  - **Benefit requirements for qualified plans**
  - **Process/requirements for a carrier to be certified to offer plans in the exchange**
  - **Process/requirements for benefit plans to be approved by regulators**
- **Validation of provider networks**
- **Pricing with actuarial certification and approval process of plans**

b. What kinds of factors are likely to encourage or discourage competition among plans in the Exchanges based on price, quality, value, and other factors?

The following provides some factors that will encourage competition in the exchanges:

- **Sufficient enrollment at all levels of coverage**
- **Effective process to approve benefit structures and pricing modifications**
- **Fair system for assessing quality and value among providers of QHP**
- **Effective communication to consumers regarding quality and value measures**
- **Clear communication to consumers regarding managed care requirements**
- **Rules/processes that encourage participation of multiple carriers (see other answers to Section D, Question #3)**

By comparison, competition may be discouraged by burdensome administration, inadequate risk adjustment, or factors that contribute to an unlevel playing field.

4. What health plan standards and bidding processes would help to facilitate getting the best value for consumers and taxpayers?

The following offers some considerations for health plan standards that would create additional consumer value:

- **Availability of network providers (e.g., primary care physicians per 1,000, specialist coverage, etc.)**

  The health plan must ensure sufficient availability of providers while allowing the health plan flexibility to maximize opportunities available in efficient network development (coordination of care, effective providers, risk-sharing agreements, etc.). Consideration should be made for the concentration of available services in a given local area when evaluating a health plan.

- **Benefit structure/design**

  The health plan should be allowed to customize plans to their target market/populations. General parameters could be set regarding standards for minimum coverage as well as maximum cost sharing (to prevent discriminatory cost sharing practices). The health plan should be given room to innovate within these general parameters.

- **Provider payment rules**

  Include uniform rules related to the timeliness and accuracy of payments to providers.

- **Bidding process**

  Refer to Section D, Question #6 (below).

5. What factors are important in establishing minimum requirements for the actuarial value/level of coverage?

The following offers some considerations for establishing minimum requirements for the actuarial value of coverage:

- **"Actuarial value" has yet to be defined in any regulation. This measurement should be based on a standard demographic population (e.g., age, gender, geographic area) with consistent plan benefits.**
- **Requirements should determine maximum cost share levels for services that could be subject to discriminatory practices.**
- **Requirements should establish acceptable ranges of copay or coinsurance for major service categories by plan level.**
- **Requirements should consider average cost variations by region within a state.**
- **Requirements should allow flexibility for plans to design benefits tailored to consumer needs.**

In addition, consideration should be given to the complexity of health plans and how that impacts determining actuarial value when setting minimum standards. A Milliman paper was written on this topic, "Understanding Healthcare Plan Costs and Complexities," which outlines the ways in which plan designs impact costs and actuarial values. This paper is available at http://publications.milliman.com/research/health-rr/pdfs/understanding-healthcare-plan-costs-rr06-15-09.pdf.

6. What factors, bidding requirements, and review/selection practices are likely to facilitate the participation of multiple plans in Exchanges? To what extent should the Exchanges accept all plans that meet minimum standards or select and negotiate with plans?

The participation of multiple plans will be important. To the extent that rules and applicable bidding and selection processes are developed that create an overly complex/costly process, smaller competitors may be disinclined to participate.

Please see our response to Section D, Question #3, above for factors that will facilitate participation of multiple plans in the exchanges.

8. Are there any special factors that are important for consideration in establishing standards for the participation of multi-State plans in Exchanges?

Considerations in establishing standards related to multi-state plans include:

- **Uniformity of rules across states**

- **Multi-state certification (corporate issues) vs. validation of requirements for each state (network issues)**

E. Quality

The Affordable Care Act requires the Secretary to develop a health plan rating system on the basis of quality and prices that would be used by the Exchanges and to establish quality improvement criteria that health plans must meet in order to be qualified plans for Exchanges.

1. What factors are most important for consideration in establishing standards for a plan rating system?

- **Ability for plans to work towards improving rating**
- **Ease of communicating results to consumers**
- **Transparency**

Clear Definition of Quality

The first factor to determine is the definition of quality. It must specify domains to be included and how to measure results. We would certainly expect quality measures that relate to quality of care (e.g., National Committee for Quality Assurance [NCQA] HEDIS measures). However, it is also important to consider quality measurements for other important functions handled by health plans, including access to care (provider network), member customer service, and other operational performance measurement (e.g., claim payment timeliness). The financial position of the company should be included among these considerations.

Standard Industry Measurements

We would expect the use of standard industry measurements when available, especially those in widespread use such as the NCQA's HEDIS measures. After determining the domains to be measured and the process to measure them, an appropriate benchmark must be established for each. The selection of the benchmarks is also a key factor, as the effectiveness of the rating system relies on selecting benchmarks that accurately reflect the desired quality level. Each benchmark must be clearly understood by health plans, which should have the ability to design and implement strategies to improve their quality ratings.

Aggregation of Measurements and Communication of Results

Once the measurements and benchmarks are established, an aggregation process must be selected in order to facilitate the communication of results. The weighting assigned to each measurement will impact the significance it has on the overall rating, so the method used to blend results must be carefully considered. It is

important to develop a system that enables consumers to easily understand the meaning of the rating itself while also providing members with the ability to review results at a more detailed level in order to make informed decisions. For example, a person with a chronic condition would be better served by a plan with a very positive rating for treating that condition, even if its overall score is lower than other plans.

A rating system should provide both health plans and consumers with a transparent and effective method of comparing alternative health plans. It should provide the health plan a clear path to achieving higher quality standards, while empowering the consumer to make healthcare decisions based on an objective rating system.

Administrative Considerations

While a rating system should be thorough in its measurements and in its ability to capture critical factors for evaluating health plan quality, consideration should be made for the administrative requirements and costs to health plans of pulling together the required data. The process should be reasonable and efficient such that health plans are not discouraged from participating in the exchanges.

a. How best can Exchanges help consumers understand the quality and cost implications of their plan choices?

Quality and cost implications will be unique to each individual given the significant variation in consumer healthcare needs. As such, exchanges should serve as a facilitator of quality and cost measurements that enhance the ability of the consumer to make informed decisions. The consumer should have information available that enables the ability to evaluate plans based on individual criteria and preferences (e.g., services needed, financial position). Exchanges should also provide information on how quality and cost measurements are developed, in order to enable consumers to interpret results appropriately.

b. Are the measures and standards that are being used to establish ratings for health plans in the Medicare Advantage program appropriate for rating QHPs in the Exchanges? Are there other State Medicaid or commercial models that could be considered?

The Medicare Advantage measures and standards provide a good starting point for addressing some of the key factors listed above. However, they would need to be adjusted to reflect the differences in the population to be served, as well as the different sources of information available to collect and measure results.

c. How much flexibility is desirable with respect to establishing State-specific thresholds or quality requirements above the minimum Federal thresholds or quality requirements?

Flexibility in state-specific thresholds is important. There will be specific population needs and provider availability issues that will vary by state and should be considered so that consumers have access to quality healthcare that meets their needs.

2. What are some minimum standards or other factors that could be considered with respect to establishing quality measurement and improvement thresholds or quality requirements that should be met by QHPs? What other strategies, including payment structures, could be used by plans to improve the practices of plan providers?

We could devote many pages to this question alone. In general, the minimum requirements established should provide the consumer with some assurance of receiving the service and benefits promised by the health plan. By providing a health plan with clear guidelines on the quality measurements and the process used for each, health plans could strive to achieve higher quality standards. Therefore, measurements that provide a specific baseline or benchmark independent of other plan results will be more successful in improving health plan performance.

G. Enrollment and Eligibility

Section 1411 of the Affordable Care Act requires the Secretary to establish a program for determining whether an individual meets certain eligibility requirements for Exchange participation, premium tax credits and cost-sharing reductions, and individual responsibility exemptions. Additionally, Sections 1412, 1413 and 2201 contain additional requirements to assist Exchanges by making advance determinations regarding income eligibility and cost-sharing reductions; providing for residents of each State to apply for enrollment in, receive a determination of eligibility for participation in, and continue participation in applicable State health subsidy programs; and simplifying and coordinating enrollment in the Exchanges, Medicaid and the Children's Health Insurance Program (CHIP).

1. What are the advantages and issues associated with various options for setting the duration of the open enrollment period for Exchanges for the first year and subsequent years? What factors are important for developing criteria for special enrollment periods?

Conflicting objectives will dictate the length of the enrollment period. On the one hand, a shorter enrollment period may help limit adverse selection; on the other hand, a longer enrollment window will encourage greater participation and will allow for administrative processes (e.g., W-2s) to run their course. Keeping this balance in mind, we believe the initial open enrollment period should generally be no less than three months and no more than six. The longer initial period will allow

people sufficient time to sign up and allow carriers and the exchanges to work out the complexities within the system (e.g., appropriate consumer information, technology, etc.). In order to limit adverse selection, we envision that the first open enrollment period should start October 1, 2013, and go through March 31, 2014. Subsequent enrollment periods would be October through December, as is often the case with commercial group insurance. Similar to HIPAA provisions, special enrollment periods should be available for people who become eligible for the exchange mid-year (e.g., those losing employer coverage). The shorter the enrollment period, the more protection will exist against adverse selection.

Special enrollment factors should consider birth, marriage, loss of employment, etc.

Consideration also needs to be made for dealing with "late enrollees." Will Exchanges be willing to allow having these people go uninsured until the next open or special enrollment? Can or will health plans be given exemptions to medically underwrite late enrollees?

3. How can eligibility and enrollment be effectively coordinated between Medicaid, CHIP, and Exchanges? How could eligibility systems be designed or adapted to accomplish this? What steps can be taken to ease consumer navigation between the programs and ease administrative burden? What are the key considerations related to States using Exchange or Medicaid/CHIP application information to determine eligibility for all three programs?

Website and customer service functions should triage applicants, steering Medicaid-/ CHIP-eligible people to those programs, if not to that part of the exchange. Depending on the structure of the exchange, the enrollment process into the Medicaid or CHIP plans could be handled through the exchange website or service functions.

Consideration also needs to be made for dealing with "late enrollees". Will Exchanges be willing to allow having these people go uninsured until the next open or special enrollment? Can or will health plans be given exemptions to medically underwrite late enrollees?

I. Rating Areas

Section 2701(a)(2) of the Public Health Service Act, as added by Section 1201 of the Affordable Care Act requires each State to establish one or more rating areas within the State for purposes of applying the requirements of Title I of the Affordable Care Act (including the Exchange provisions), subject to review by the Secretary.

2. To the extent that States utilize premium rating areas, how are they established? What kinds of criteria do States and other entities typically consider when determining the adequacy of premium rating areas? What other criteria could be considered?

Rating areas differ from state to state. While several states currently set rating areas, many do not. Carriers may set their own geographic rating area. Carriers' typical boundaries are based on network composition, rural vs. urban, Metropolitan Statistical Areas (MSAs), contracting arrangements, county, zip code, etc. States should coordinate rating areas to avoid adverse selection if the area is defined on an interstate basis. In deciding about interstate, statewide, and sub-state areas, the state should consider the health insurance market throughout the state and develop areas accordingly. We envision small employers signing up for exchanges based on their business addresses and individuals based on their residence.

J. Consumer Experience

2. What kinds of information are likely to be most useful to consumers as they determine whether to enroll in an Exchange and which plans to select (within or outside of an Exchange)? What are some best practices in conveying information to consumers relating to health insurance, plan comparisons, and eligibility for premium tax credits, or eligibility for other public health insurance programs (e.g., Medicaid)? What types of efforts could be taken to reach individuals from diverse cultural origins and those with low literacy, disabilities, and limited English proficiency?

For most consumers, an online interactive tool to search for plans would be the preferred venue for obtaining coverage. For consumers who have trouble finding the website for the state/regional exchange, a national site should be available to link the consumer to the local exchange by simply entering a zip code. Once on the local exchange's site, consumers would choose a language, then enter their identification (name, Social Security number) and answer some basic questions to determine their eligibility for plans and premium subsidies. The site should also have information available such as FAQs. Once ready to choose a plan, consumers should be able to read information about all plans available in their geographic area, sort by price, search for plans with a specific benefit, learn about what managed care and cost containment requirements are incorporated in the plans, and find out if their doctor and/or hospital is in-network.

Ideally, the consumer should be able to enroll in the plan directly on the exchange, or access the health plan's enrollment site directly from the exchange. For those who are eligible for public health programs such as Medicaid, they should also be able to directly access that program's website. The goal should be to make this as seamless and paperless as possible.

A phone line should be available for those who have disabilities or limited access to a computer. The phone line should be able to provide eligibility, premium subsidy, and plan information. A consumer who wants more advanced searches or comparisons may be reminded of the website, but some basic plan information should be available by phone. The consumer should be given some next steps, such as the phone number for a health plan. Consumers should also be able to request that an enrollment kit be mailed to them.

To reach a diverse range of consumers, brochures should be available at public libraries in multiple languages that will provide basic information about exchanges and where to get more information by phone or online. Library staff, though not trained to give information about exchanges or health plans, would be able to guide consumers to public access computers.

K. Employer Participation

Section 1311(b)(1)(B) provides for the establishment of Small Business Health Options Programs, referred to as SHOP Exchanges, which are designed to assist qualified employers in the State who are small employers in facilitating the enrollment of their employees in QHPs offered in the small group market in the State. Section 1304(b) provides that for plan years beginning before January 1, 2016, States have the option to define ``small employers'' as those with (1) 100 or fewer employees, or (2) 50 or fewer employees. Section 1312(f)(2)(B) specifies that beginning in 2017, States may elect to include issuers of health insurance coverage in the large group market to offer QHPs through the Exchange, and for large employers to purchase coverage through the Exchange. In addition, employers that do not offer affordable coverage to their employees will also interact with the Exchanges including where their employees purchase coverage through the Exchange.

1. What Exchange design features are likely to be most important for employer participation, including the participation of large employers in the future? What are some relevant best practices?

Employers are likely to look for competitive benefits and evaluate the costs to provide those benefits. A significant question related to the costs is whether the employer's employee/dependent risk profile is considered in determining the rates charged to that employer. The risk profile recognition becomes more pressing as the size of the employer grows and the employer can consider becoming (or already is) self-funded. Therefore, if an exchange is open to larger employers, those employers will compare the premiums available through the exchange to their historical or expected costs through self-funding and choose accordingly.

2. What factors are important for consideration in determining the employer size limit (e.g., 50 versus 100) for participation in a given State's Exchange?

The size of the market is an important consideration in determining the size of the small group market, especially if the exchange is combined for the individual and small group markets. Extending insurance coverage to all potential insureds in the individual market will tend to increase premiums, because the move toward guaranteed issue and the removal of underwriting is likely to create upward cost pressure. On the other hand, while underwriting is currently used in most small group markets, it is limited by small group rating regulations. If the individual and

small group markets are combined, the overall impact of expanded coverage in the individual market will be subsidized by the small group market. The larger the small group market is relative to the individual market, the less the overall impact of the expanded coverage—which gets back to the question of whether to cap the small group market at 50 vs. 100 employees. The decision may need to be related to whether all employees are to be included in the count or just "eligible" employees (with or without "waivers" included).

In the Small Business Health Care Options Program (SHOP) exchanges, an important consideration in determining the employer size limit would be the likelihood for some employers to consider self-funding as an alternative. Given the rating restrictions that will be applied to both the exchange and non-exchange markets, employers will consider the insured premium level relative to possible self-funded costs.

L. Risk Adjustment, Reinsurance, and Risk Corridors

Sections 1341, 1342, and 1343 of the Act provide for the establishment of transitional reinsurance programs, risk corridors, and risk adjustment systems for the individual and small group markets within States.

1. To what extent do States and other entities currently risk-adjust payments for health insurance coverage in order to counter adverse selection? In what markets (e.g., Medicaid, CHIP, government employee plans, etc.) are these risk adjustment activities currently performed? To the extent that risk adjustment is or has been used, what methods have been utilized, and what are the pros and cons of such methods?

Risk adjustment has been used in Medicare Advantage (MA) and Medicare prescription drug plans to set payments to participating organizations. It is also used by 11 or more states in Medicaid managed care contracting, including Florida, Massachusetts, Michigan, and Ohio. Some states use diagnosis-based risk adjustment, while others use pharmacy-based risk adjustment. The choice of the risk adjustment system depends largely on data availability and accuracy.

In addition to Medicare Advantage and Medicaid managed care, there are state employee risk pools that have employed risk adjustment in budget allocation, risk trend analysis, and contract negotiation, including the Massachusetts Group Insurance Commission and the California Public Employees' Retirement System (CalPERS).

The Massachusetts Health Insurance Connector Authority has adopted diagnosis-based risk adjustment in setting the program payment rates to contracting managed care organizations that participate in the Commonwealth Care program (the subsidized pool).

Risk adjustment has been utilized in the commercial health insurance market for many years. The initial risk adjustment tool has been utilized in both individual and small group health insurance. The initial risk adjustment tool involved the use of a medical questionnaire and underwriting. The underwriting process utilized information to assign risk points to individuals based on the responses to the medical questions and protective information the insurer might procure such as medical records. These risk points determined how an individual would be rated. After many years of utilizing only the information found on the medical questionnaire, commercial health insurers began to utilize pharmacy and medical diagnosis information found in the claim data. The claim data has been utilized in risk adjusting and underwriting on a renewal basis for commercial health insurance.

In commercial health insurance, most Blue Cross and Blue Shield plans as well as Kaiser Permanente use risk adjustment for budgeting, provider efficiency and pay-for-performance evaluation, and provider contracting. They also employ a related set of tools, called predictive models, for case identification in medical management.

Risk adjustment has long been considered an effective tool to address adverse selection and risk aversion. Risk adjustment models assess the relative health status of insured members as compared to a benchmark population using standard health insurance claim data. The models use age, gender, medical diagnoses, and prescription drug information that is commonly available in health insurance claim data to calculate the expected individual healthcare spending, utilization, and health outcomes in the future year(s). As it leverages more information that is predictive of future healthcare cost and utilization, it is far more accurate than the traditional age- and gender-based adjustments for budget allocation.

Broadly speaking, there are two types of risk adjustment models currently used—diagnosis-based and pharmacy-based. Pharmacy-based risk adjustment models have been regarded as more easily gamed because prescriptions can be tied to utilization. Providers may have incentives to prescribe more drugs than necessary if payments are tied to prescriptions. Diagnosis-based systems are considered less easily gamed as medical diagnoses are less tied to utilization.

In our opinion, neither system is perfect. Risk adjustment itself will take a very long time to perfect. While we push for newer and better risk adjustment systems to replace the existing ones, we believe effective auditing and appropriate risk corridors will be helpful in curbing upcoding practices and other strategies for gaming the system.

2. To what extent do States currently collect demographic and other information, such as health status, claims history, or medical conditions under treatment on enrollees in the individual and small group markets that could be used for risk adjustment? What kinds of resources and authorities would States need in order to collect information for risk adjustment of plans offered inside and outside of the Exchanges?

Some states already capture information needed to perform risk adjustment, but others do not. If a state is not already capturing this information it will need to begin to do so, which will impose certain additional start-up challenges.

3. What issues are States likely to consider in carrying out risk adjustment for health plans inside and outside of the Exchanges? What kinds of technical assistance might be useful to States and QHPs?

Risk adjustment models are not perfect. They tend to over-predict for healthier people and under-predict for sicker people. It can take a very long time to improve the existing models and methods to correct these biases. If disproportionate numbers of sicker enrollees are inside an exchange, and other healthier people choose to stay outside the exchange, and if the same risk adjustment methodology is applied inside and outside the exchange, then the exchange will systematically underpay the plans participating inside the exchange and overpay plans outside the exchange. This will create a disincentive for plans to participate in the exchange, and drive up the premiums of the exchange even further down the road, which will affect the long-term sustainability of the exchange significantly. Alternatively, it is possible that the opposite could occur, especially at the outset of the exchange program. Less healthy people might hang on to their current coverage, suspicious of the new program, while healthier people who qualify for subsidies move to the exchange. There are statistical and regression methods to address the inaccuracies in risk adjustment to correct such problems. The first step is to understand the degree of under- or over-prediction of a risk adjustment in the exchange population. There are standard evaluation methods for this, such as the Society of Actuaries' 2007 Risk Adjuster Comparison Study. The next step will involve recalibrating the risk adjustment to the exchange's population.

Actuarial expertise is also critical in this process to help establish fairer payments in both the short and long terms. While technical expertise in use of risk adjustment tools is valuable, the ability to integrate the risk adjustment tool with the establishment of capitation rates and rating variables is an important aspect to the successful application of the risk adjustment results. The development of relative weights and risk scores for populations is not the only need for the use of risk adjustment. The application and use of risk adjustment also involves the development of capitation or premium rates that reflect consistent assumptions with the risk adjustment process. Further, consideration also needs to be given to the

other factors that may influence the level of the capitation rates. In today's environment, there often is deterioration in single blocks of business, while newer blocks of business have lower rates that are due to healthier lives. While some of this is addressed through the healthcare legislation, the exchanges will need to understand how new commercial carrier entrants in the market may adversely impact existing carriers in the exchanges.

Additionally, the exchanges will need to understand how turnover of populations influences the rate and risk adjustment processes. It should be anticipated that individuals will move into and out of the exchanges. This will occur as individuals move between employers, gain or lose employment, or other related factors that change the individual's healthcare insurance coverage. This turnover will influence the amount of data and information available longitudinally to determine changes in risk and comparability of rates between health plans.

M. Comments Regarding Economic Analysis, Paperwork Reduction Act, and Regulatory Flexibility Act

Executive Order 12866 requires an assessment of the anticipated costs and benefits of a significant rulemaking action and the alternatives considered, using the guidance provided by the Office of Management and Budget. These costs and benefits are not limited to the Federal government, but pertain to the affected public as a whole. Under Executive Order 12866, a determination must be made whether implementation of the Exchange-related provisions in Title I of the Affordable Care Act will be economically significant. A rule that has an annual effect on the economy of $100 million or more is considered economically significant.

In addition, the Regulatory Flexibility Act may require the preparation of an analysis of the economic impact on small entities of proposed rules and regulatory alternatives. An analysis under the Regulatory Flexibility Act must generally include, among other things, an estimate of the number of small entities subject to the regulations (for this purpose, plans, employers, and in some contexts small governmental entities), the expense of the reporting, recordkeeping, and other compliance requirements (including the expense of using professional expertise), and a description of any significant regulatory alternatives considered that would accomplish the stated objectives of the statute and minimize the impact on small entities.

The Paperwork Reduction Act requires an estimate of how many ``respondents'' will be required to comply with any ``collection of information'' requirements contained in regulations and how much time and cost will be incurred as a result. A collection of information includes recordkeeping, reporting to governmental agencies, and third-party disclosures. Furthermore, Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) requires that agencies assess anticipated costs and benefits and take certain other actions before issuing a final rule that includes any Federal mandate that may result in expenditure in any one year by State, local, or tribal governments, in the aggregate, or by the private sector, of $135 million.

The Department is requesting comments that may contribute to the analyses that will be performed under these requirements, both generally and with respect to the following specific areas:

1. What policies, procedures, or practices of plans, employers and States may be impacted by the Exchange-related provisions in Title I of the Affordable Care Act?

Insurers

Insurers will need to manage plans both inside and outside the exchange that could have different requirements or benefits. Insurers will need to change their underwriting and rating methodology procedures to comply with exchange requirements. Perhaps most importantly, insurers will likely need to revamp their distribution systems to incorporate the exchange into its sales strategy.

Insurers may need to implement new IT solutions, transfer HIPAA data, and collect premiums.

Employers

Employers will need to assess whether it makes sense to surrender their grandfather status, if they still have it. They may need to provide tax consultation and education to their employees, and to determine qualification requirements. Employers will also need to transfer HIPAA data. . Small employers have historically relied upon brokers and agents to provide advice regarding health plans. Unless the exchange information is well organized and does not demand a lot of the employer's time, he or she may still need the services of a broker or navigator. This may paid for by the insurer, or such costs will be shifted to the employer.

States

States will need to determine how to set up the exchanges. States will also need to file for grants to fund the development of the exchanges. Other exchange-related items include the following:

- **Hiring staff**
- **Choosing vendors**
- **Compliance**
- **Auditing**
- **Determining eligibility and subsidies**
- **Grievances, complaints, and appeals**
- **Solvency: exchanges must be self-sustaining by Jan. 1, 2015**
- **Monitoring for fraud, waste, and abuse**

States will also need to integrate/coordinate with other federal, state, and local programs such as Medicare, Medicaid, and CHIP, as well as coordinate rate reviews with the insurance department.

a. What direct or indirect costs and benefits would result?

Insurers

Costs for insurers include the following:

- **Subsidization that results from moving to 3:1 age band and gender rates**
- **Costs of guaranteed issue requirements**
- **The certification process**
  - **Marketing requirements, network development and provider contracting, and quality improvement strategy and measurement**
- **Implementation of risk adjustment, reinsurance, and risk corridors**
- **Possible additional costs if individual and SHOP are separated**
- **Pay assessments or user fees to fund exchange operations**

Benefits include a level playing field and possible exposure to a broader subscriber base. The insurer is likely to have concerns about balancing extra administrative costs that may be introduced by need to comply both with exchange requirements and with minimum medical loss ratio requirements. The exchange needs to assure insurers that its administrative requirements will not cost more than the underwriting and sales cost reductions that could result from the exchange operation.

Employers

Costs include employee and employer education, as well as increased reporting requirements introduced by the Affordable Care Act and possibly by exchanges. Other costs include those associated with determining eligibility for the exchange and penalties for employers with 50+ employees that do not provide health insurance. There is also a possibility that the employer's health plans could be adversely affected if healthy employees opt to get insured through the exchange as an individual rather than remain in the employer health plan. This could increase the cost of the employer health plan.

States

Main costs for states are related to the development and maintenance of the exchanges. These costs include the following functions:

- **Hire and educate staff**
- **Perform certification**
- **Develop and maintain IT systems and web portal**
- **Develop and assign ratings for health plans based on relative quality and price**
- **Educate exchange members regarding eligibility and subsidy requirements**
- **Integrate/coordinate with other federal, state, and local programs such as Medicare, Medicaid, and CHIP**
- **Establish, educate users on, and monitor a Navigator program**
- **Ensure that exchanges are self-sustaining by Jan. 1, 2015**

- **Collection of assessments or user fees to fund exchange operations**
- **Rate reviews**
- **Keep an accurate accounting of all activities, receipts, and expenditures to submit to the HHS secretary**
- **Handle grievances, complaints, and appeals**
- **Implement consumer protection standards**
- **Implement risk adjustment, reinsurance, and risk corridors**

One benefit for states is that they have some flexibility in how to set up the exchange and they can receive grants to offset the costs associated with developing the exchanges. To date, however, any internal work toward formation of an exchange has happened without additional funding or (in most cases) any dedicated staff. The preparation is being done by government employees on top of their preexisting jobs. This dynamic has limited states that may have sought a more proactive approach. The state grants may help in this regard but at some point the cost of the exchange will have to be borne by either the taxpayers in each state and/or by the people buying coverage from the exchanges.

b. Which stakeholders will be affected by such benefits and costs?

Affected stakeholders include states, taxpayers, health insurance companies, agents/brokers, Navigators, small businesses, employees, individual health insurance purchasers, and providers.

c. Are these impacts likely to vary by insurance market, plan type, or geographic area?

The individual insurance market is likely to see an impact that is due to anti-selection by members. Rating and underwriting impacts could vary by geographic area and/or plan type.

2. Are there unique effects for small entities subject to the Exchange-related provisions in Title I of the Affordable Care Act?

The following items could affect small employers more than large employers:

- **Employers and employees might have more education needs if they haven't provided or had health insurance coverage before.**
- **Time taken away from the core business to provide education will affect the bottom line.**
- **Some small employers may be less sophisticated. They might not even have Internet access.**

Small government entities and insurance plans might have higher costs to develop IT infrastructure that may not currently be in place. There is also a greater possibility for insolvency for smaller insurance companies.

3. Are there unique benefits and costs affecting consumers? How will these consumer benefits be affected by States' Exchange design and flexibilities and the magnitude and substance of provisions mandated by the Act? Please discuss tangible and intangible benefits.

Unique costs for consumers include the cost of health insurance coverage that is due to the individual mandate. Consumers will be obligated to purchase health insurance. In addition, consumers may feel that the benefits they receive are not commensurate with the premiums they are paying.

Consumers will also need to be educated on how the exchange works, how to complete the application, and determining eligibility and subsidy requirements.

States will need to design the exchanges to make it as informative and easy to use as possible for the consumer. Consumers must be able to see comparable plans and make informed decisions. Consumers will also need to know how to pay their premiums. Will payments by credit card be allowed? Will credit checks be needed?

States should try to limit exchange design decisions driven by political reasons only.

Signed at Washington, DC, this 27th day of July 2010.
Jay Angoff,
Director, Office of Consumer Information and Insurance Oversight,
Department of Health and Human Services.