



State of California
DEPARTMENT OF INSURANCE
DEPARTMENT OF MANAGED HEALTH CARE
CALIFORNIA HEALTH BENEFIT EXCHANGE

January 4, 2013

John J. O'Brien, Director
Healthcare and Insurance
United States Office of Personnel Management
1900 E Street, N.W.
Washington, D.C. 20415

Sent Via Federal Web Portal

Re: Comments to Notice of Proposed Rulemaking on the Establishment of the Multi-State Plan Program (MSPP) for the Affordable Insurance Exchanges

Dear Mr. O'Brien:

On behalf of the State of California and many of the entities responsible for implementing the Patient Protection and Affordable Care Act ("ACA") in the state—the Department of Insurance, the Department of Managed Health Care, and the California Health Benefit Exchange ("the departments")—California submits the enclosed comments on the proposed rules for the Establishment of the Multi-State Plan Program (MSPP) for the Affordable Insurance Exchanges. California appreciates the opportunity to comment on these important regulations.

California appreciates OPM's stated commitment to balance state needs with its statutory obligation to implement and oversee the MSPP. However, California believes that key implementation challenges could be reduced if the federal government utilized existing state laws and regulatory systems to provide oversight and ensure consumer protections offered through each state's Affordable Insurance Exchange (Exchange) are in place for MSPs. As drafted, California is concerned

these proposed regulations do not clearly define state and federal roles in regard to regulating the MSPP. In addition, California has several general concerns related to the MSPP and OPM's selection of multi-state plans (MSP).

- 1. Essential Health Benefits:** As enacted, ACA provisions regarding MSPs refer to the MSP's obligation to provide a "benefits package that is uniform in each State, and consists of the essential benefits described in section 1302 [42 U.S.C.S. § 18022]." However, guidance released in December 2011 by the Department of Health and Human Services, as well as proposed rules related to Essential Health Benefits (EHB) released in November 2012, allow each state to select its own "benchmark plan" that includes state-mandated benefits enacted before January 1, 2012. As stated in the preamble to the proposed rule, one of the objectives of the MSPP is to "ensure a level playing field between state-certified qualified health plans (QHPs) and MSPs." However, proposed section 800.105(b)(ii) would permit an OPM-selected EHB-benchmark plan different from the state's EHB benchmark plan. This difference in EHB benchmark plans could result in adverse selection against either the MSP or other QHPs in the Exchange. To help maintain a level playing field among plans participating in the Exchange, and to avoid the potential for adverse selection, the OPM should require that MSPP issuers and state-level MSPs to offer the state-specific EHB benchmark package.

Additionally, the regulations should make clear that MSPs may not substitute benefits for EHB in states where substitution is prohibited.

- 2. Cost Sharing Requirements and Levels of Coverage:** California plans to adopt standardized cost-sharing within a standard plan design and require that QHP issuer to offer one or more of those standardized benefit plan designs. To maintain a level playing field, an MSP in California should be required to offer one of the standardized benefit plan designs. Additionally, California state law requires QHPs to offer coverage at all coverage tiers to avoid adverse selection. MSPP offered in California should be required to

adhere to this state statutory requirement in order to keep the playing field level between state-selected QHPs and MSPs.

- 3. Regulatory Oversight by States:** Section 1334(b) of the ACA provides that MSPs are subject to all state laws unless a state requirement is inconsistent with the ACA, and requires that MSPs be licensed in each state. However, the state's role in the ongoing oversight of the MSPP is unclear. California recommends the OPM build a state oversight component into the MSPP regulations at or around section 800.114 to ensure that MSPs, once certified, comply with both federal and state regulatory requirements. The OPM regulations also should clarify that MSPs must *continue to meet* requirements set forth in section 1334 of the ACA to retain the federal MSPP contract, and that failure to continue to meet state standards constitutes a breach of that contract, resulting in possible termination.

A collaborative regulatory relationship between the states and the OPM will foster success for the MSPP. State regulators will be able to ensure that all health plans and health insurers, including MSPP issuers and MSPs, are compliant with the broad array of state consumer protection laws.

By incorporating state oversight into the MSPP, and requiring that MSPs be subject to each state's regulatory framework as a condition for continued participation, OPM will be able to more effectively manage this program on a national level. States are in a better position to identify problems and alert OPM to them via existing state consumer assistance programs, regulator structured monitoring systems, and state regulatory enforcement action. Additionally, MSPP regulations should provide constant and consistent opportunities for program transparency, including notice to states regarding the OPM's intent to contract with an MSP or MSPP issuer under section 800.303, advance communication regarding OPM intent to find a state law inconsistent with the MSPP pursuant to section 800.114 or section 800.116, and OPM compliance actions imposed on MSPP issuer or MSP.

4. **Effective Rate Review Programs:** The final rule should reflect, at section 800.201(f), that the review of rates by states that HHS has deemed to have an effective rate review program should apply to premium rates proposed for MSPs, so long as the State's application of its reviews is not arbitrary, capricious, or an abuse of discretion. In order to support states in their reviews, the determination of whether the state's review is arbitrary, capricious, or an abuse of discretion should be determined through processes other than solely at the discretion of OPM.

5. **Certification, Recertification and Decertification of Qualified Health Plans:** California's Health Benefit Exchange (HBEX) will operate as an "active purchaser." Under the ACA, an Exchange must allow MSPs contracting with OPM to participate in the Exchange, regardless of its organizational structure. Federal regulations exempt MSPs from an Exchange's recertification and decertification processes. (45 C.F.R. §§ 155.1075 and 155.1080.) While MSPs are participating on the state Exchange through a contract with OPM and have therefore been "deemed" certified under section 1311 of the ACA, California regulators should be permitted to monitor all products being offered in the HBEX to California health consumers. OPM should develop regulations that require MSPs to remain compliant with each state's laws and regulations as a prerequisite for retaining a multi-state plan contract, and also establish a process for state monitoring of MSPs and communication with OPM regarding MSP compliance.

6. **Definition of Non-Profit Entity:** The proposed definition allows for companies that are for-profits in a particular state to be considered a non-profit for purposes of the MSPP, as part of a group of health insurance issuers, a substantial portion of which are non-profit entities. The intent behind the requirement that at least one MSP be a non-profit MSP was to create market competition and ensure consumer choice. However, where a for-profit carrier already has a significant market share in a state, allowing that carrier to be considered a non-profit MSP will not lead to further

competition or additional choice. Instead, this will actually lead to further market consolidation. Therefore we suggest that OPM eliminate part 2 of the proposed definition of “non-profit entity.”

7. **MSP Assessments:** The proposed rule provides OPM the authority to assess user fees on MSPs to fund the multi-state program. California notes that state-based Exchanges will also incur administrative costs associated with MSPs which must be fairly and equitably supported by the MSPP issuers consistent with fees assessed on QHPs. California requests confirmation that state-based Exchanges may assess fees and clarification of the method for state-based Exchanges to assess fees on MSPP issuers.

8. **Phased Expansion of the MSPP:** California recommends that OPM use its phased expansion authority to focus the MSPP on states that have not established state-based Exchanges in the initial implementation years. Given the complexity of state laws and approaches by different state exchanges, OPM should focus its initial effort on MSPP implementation for states that have not yet established a state exchange. This approach would complement the launch of the Federal Facilitated Exchange (FFE) in these states. States that have Exchanges could also be allowed to “opt-in” during the three-year phase-in period. This phase-in approach provides state flexibility, and may allow additional time for Exchange states to build strong, competitive marketplaces into which an MSP could be added with reduced disruption.

In the attached comments, which are presented in chart format, the departments offer suggestions for improvement of the proposed rules. Due to the short time frame in which to comment, it is possible that the departments may submit additional comments early next year. Because the enclosed comments reflect the consensus of all the signatories to this letter, please direct any questions regarding the comments to all three agencies.

Director John J. O'Brien

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Thank you for taking these comments into consideration as you finalize the rules and as California approaches the full implementation of the Patient Protection and Affordable Care Act, which the departments have all worked diligently to successfully implement.

Thank you for your consideration.

Sincerely,

A handwritten signature in blue ink that reads "Dave Jones". The signature is written in a cursive, flowing style.

Dave Jones, Insurance Commissioner

A handwritten signature in blue ink that reads "Brent Barnhart". The signature is written in a cursive, flowing style.

Brent Barnhart, Director, Department of Managed Health Care

A handwritten signature in blue ink that reads "Peter V. Lee". The signature is written in a cursive, flowing style.

Peter V. Lee, Executive Director, California Health Benefit Exchange

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	PAGE PREAMBLE/ REG*	PROPOSED REGULATORY REQUIREMENT	FEDERAL PREAMBLE REQUEST FOR COMMENTS	CALIFORNIA COMMENT/QUESTION
I. Background				
II. Proposed Regulatory Approach				
1.	72584	<p>A. OPM Approach <i>[Preamble only]</i></p> <ul style="list-style-type: none"> • Create a program that will attract issuers to apply to offer new product in each Exchange in 50 states and D.C. • Balance state and federal regulatory interests in a manner that will enable MSPP issuers to offer viable plans on Exchanges while maintaining level playing field between issuers • Ensure level playing field such that neither MSPs nor plans offered by non-MSPP issuers are advantaged or disadvantaged on Exchange marketplaces 	OPM seeks comment on whether these proposed regulations satisfy these goals	California strongly believes it will be difficult, if not impossible, to create a level playing field if MSPP issuers and MSPs are not required to provide state-specific EHB packages.
2.	72585	<p>B. Governing Law <i>[Preamble only]</i></p> <p>OPM recognizes potential MSPP issuers seek administrative simplicity and some uniformity of standards in the MSPP – accordingly in unusual circumstances may be necessary for Director to adopt standards or req. for MSPP that differ from standards/requirements applicable to QHPs under either state or federal law.</p> <p>This proposed regulation, however, reflects Director’s intent for MSPs and MSPP issuers to adhere to all state</p>		

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		and federal laws applicable to QHPs and QHP issuers, except to extent such laws are inconsistent with these regulations, OPM Guidance, or OPM's contracts with MSPP issuers		
3.	72585	Level Playing Field <i>[Preamble only]</i>	Three categories of law among 13 listed in 1324(b) for which OPM specifically soliciting public comment	
4.	72585	<p>1. Appeals <i>[Preamble only]</i> OPM proposes to resolve external appeals pursuant to its own process, which will be similar to the disputed claims process used in the FEHBP, where OPM resolves all external appeals as part of its contract administration responsibilities. Provide enrollees avenue of redress for all claims.</p> <p>Departments will propose amendments to 45 CFR 147.136 regarding: appeals to apply to the MSPP process the same standards that apply to state external review processes.</p>		
5.	72585	<p>2. Rating <i>[Preamble only]</i> Proposed rule requires MSPP issuers, in proposing premiums for OPM approval, to use only rating factors permitted by PHSA § 2701. Also requires MSPP issuers to comply with state laws regarding: rating factors</p> <ul style="list-style-type: none"> • OPM does not consider “rating” to 	Whether this is appropriate approach and impact of this approach.	<p>California requests that the language in the Preamble be changed to add the following:</p> <ul style="list-style-type: none"> • “In the event state withholds approval of or finds a MSP rate unreasonable for reasons that are not arbitrary, capricious or abuse of discretion, the

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		<p>be the same as “rate review” – OPM intends to conduct its own rate review process and provide analysis to each state in which MSP is operating.</p> <ul style="list-style-type: none"> • Each state may also review MSP rates under its own process. If disagrees with OPM’s determination OPM and state will attempt to resolve differences. • In the event state withholds approval of MSP rate for reasons OPM determines are arbitrary, capricious or abuse of discretion, director may make final decision to approve rates notwithstanding state approval. 		<p>decision of the state review agency will hold.”</p> <ul style="list-style-type: none"> • A dispute resolution process between the states and OPM that does not rely solely on the discretion of the Director of OPM.
6.	72586	<p>3. Benefit plan material or info <i>[Preamble only]</i> MSPs will be subject to Federal and state laws regarding: benefit plan material or info – including the proposed requirements. in § 800.113.</p> <ul style="list-style-type: none"> • OPM defined benefits and plan material or information to include explanations or descriptions, printed or electronic, that describe issuer’s products • Term does NOT include policy or contract for coverage. • OPM expects MSPP issuers to comply with related state law 	Is it appropriate to exclude policies and contracts from definition of “benefit plan material or information?”	

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		<p>requirements for policy form review</p> <ul style="list-style-type: none"> • OPM will review and approve policy or contract for coverage. • OPM may request review of benefits and plan material or information in addition to any state review 		
7.	72586	<p><i>[Preamble only]</i> Process for disputes regarding state law:</p> <ul style="list-style-type: none"> • May be state laws outside § 1324(b), 13 categories for which compliance would prevent OPM from administering MSPP. • State law requirements may be inconsistent with OPM regulations, guidance or contracts. • OPM proposing process for states to seek changes to OPM regulations, guidance, and contracts to bring them into compliance with applicable state law. • Targeted analyses of particular state law provisions and impact on OPM ability to administer MSPP. 	<p>OPM invites comments on this process:</p> <ul style="list-style-type: none"> • Scope • Factors OPM should consider when determining whether state law is applicable or whether relevant market has been/will be disrupted by the inapplicability of state law • Whether process will be an effective way to resolve any such disputes 	
8.	72586	<p><i>[Preamble only]</i> 13 categories - disputes</p>	<ul style="list-style-type: none"> • Should OPM include in this process states' concerns regarding: MSPP issuer compliance with state law requirements in 13 § 1324(b) categories? • Has proposed rule met intent re: ensuring MSPP issuers comply with 	

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			all state law requirements concerning § 1324(b) 13 categories? • Should the dispute resolution process also be available as another avenue for addressing such concerns?	
III. Provisions of the Proposed Regulations				
A. General Provisions and Definitions				
1. Definitions § 800.20				
9.	72587, 72601*	MSP – means <i>private [preamble only]</i> health plan offered under a contract with OPM pursuant to § 1334 of ACA & meets requirements of this part.		California recommends amending this definition to establish a clearer distinction between MSP and MSPP Issuer. Please clarify whether each MSP will be under separate contract with OPM or will contract through the MSPP Issuer.
10.	72587, 72601*	MSPP Issuer – means health ins. issuer or group of issuers, as defined, that has contract with OPM to offer health plans per § 1334 of the ACA and meets the requirements.		California recommends amending this definition to establish a clearer distinction between MSP and MSPP Issuer.
11.	72587, 72601*	Non-profit entity – 1. Organization incorporated under state law as a non-profit entity and licensed under state law as health insurance issuer, or 2. Group of issuers licensed under state law a substantial portion of which are incorporated under state law as non-profit entities.		These definitions allow companies that are for-profits in a particular state to be considered a non-profit for purposes of the MSPP. The intent behind the requirement that at least one MSP be a non-profit MSP was to create market competition and ensure consumer choice. However, proposed section 800.20 defines nonprofit to include carriers where "a substantial

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				portion...are incorporated under State law as nonprofit entities" which allows a for-profit company to be considered a non-profit for purposes of the MSPP. However, where a for-profit carrier already has a significant market share in a state, this will not lead to further competition or additional choice. Instead, this will actually lead to further market consolidation. It could even position the for-profit to temporarily underprice to gain market share which would ultimately reduce competition. Therefore California recommends, OPM should eliminate subsection (2) of this definition.
12.	72587, 72601*	State insurance commissioner means commissioner or other chief insurance regulatory official of a state.		California has a bifurcated regulatory system for health insurance issuers. The definition of "State insurance commissioner" should be broad enough to acknowledge the potential for multiple regulatory roles. For example, in California, the health care industry is regulated by both the DMHC director (re health care service plans) and the insurance commissioner (re health insurance products).
B. Multi-State Plan Issuer Requirements (Subpart B, §§ 800.101 – 800.116)				
1. General Requirements § 800.101				
13.	72587	<i>[Preamble Only]</i> – MSPP issuer must offer choice of plans (i.e. One of each at silver and gold levels of coverage)		California asks that OPM clarify the statement that the "MSPP issuer may choose to participate in the SHOP," is

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		on the individual Exchange and in the SHOP, <i>if the MSPP issuer choses to participate in the SHOP</i> . In addition, OPM proposes the MSPP issuer will, pursuant to contract, offer child-only coverage for each level that it makes available in each exchange. MSPP issuer must ensure all MSPs it offers meet the requirements of this rule.		a proposal to phase-in MSPP issuer coverage in SHOP (see p. 72588 Preamble comments.)
14.	72587, 72601*	MSP issuer must:		
15.	72587, 72601*	(a) Be licensed in each state where offers coverage;		
16.	72587, 72601*	(b) Have contract with OPM;		
17.	72587, 72601*	(c) Offer levels of coverage per § 800.107;		
18.	72587, 72601*	(d) Meet same requirements for eligibility, enrollment, and termination of coverage as those that apply to QHPs and QHP issuers per 45 CFR parts 155, subparts D, E, and H & 45 CFR parts 156.250, 156.260, 156.265, 156.270, and 156.285;	Comments: Any unique enrollment and eligibility issues that might affect MSPs.	
19.	72587, 72601*	(e) Ensure each of MSPs meets requirements of this part;		
20..	72587, 72601*	(f) Comply w/ all standards;		
21.	72587, 72601*	(g) Timely comply w/ OPM instructions, directions & will other		

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		applicable law;		
22.	72587, 72601*	(h) Meet other requirements as determined appropriate by OPM; and		
23.	72587, 72601*	(i) Non-discrimination.		
2. Compliance with Federal Law § 800.102				
24.	72587, 72601*	(a) PHSA – as condition of participation in MSPP – must comply with provisions of part A of PHSA (appendix A).		
25.	72587, 72602*	(b) MSP issuer must comply with provisions of title I of ACA (appendix B).		
26.	72588	<i>[Preamble only]</i> Preamble to 45 CFR parts 155, 156, 157 leaves to each Exchange discretion whether to require QHP issuer to participate in both SHOP and individual market Exchanges. <ul style="list-style-type: none"> • OPM proposing to allow MSPP issuers flexibility to phase in coverage to the SHOPS. • MSPP issuers may offer coverage in individual Exchange, and not the SHOP, throughout duration of phase-in period. 	Solicit comments regarding: approach to SHOP participation, including whether participation in SHOP would be required from outset or MSPP issuers should be allowed to provide a plan that requires a period longer than the phase-in period to fully participate in SHOP.	The California Health Benefit Exchange requires that QHPs providing coverage in the individual market must also participate in the SHOP. To ensure competition and a level playing field, the same rules should be applied to MSPP issuers.
3. Phased expansion § 800.104				

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27.	72588	<p>MSP application for participation and renewal must include plan for offering coverage throughout the state.</p> <p><i>[Preamble Only]</i> – OPM will evaluate MSP issuer to ensure locations in which they propose to offer coverage have been established without regard to racial, ethnic, language, health status-related factors or other factors that exclude high-utilizing, high-cost or medically underserved populations.</p>		<p>The preamble language regarding geographical choices for coverage should be included in text of § 800.104.</p>
28.	72602*	<p>(a) Phased expansion over 4 years . . .</p> <p>(4) With respect to each subsequent year, the health insurance issuer will offer the MSP in all States.</p>		<p>California does not agree with 800.104(a)(4). California believes the MSP issuer should be allowed to operate in fewer than all 50 states and D.C. It should not be required to extend its operations to states that are already serviced by a significant number of carriers.</p> <p>California recommends that OPM use its phased expansion authority to focus the MSP on states that have not established state-based Exchanges. OPM could also allow states to indicate when they want to “opt-in” to the MSP. While this request would not be binding, it could inform the phased expansion of the MSP while still allowing OPM to be in compliance with the annual phase-in targets.</p>

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29.	72588, 72602*	<p>§ 800.104</p> <p>(b) Partial coverage within the state: OPM may enter into a contract with MSPP issuer even if the issuer's MSPs, for a state, covers fewer than all services areas specified for that state pursuant to § 800.110.</p> <ul style="list-style-type: none"> • For each state in which MSPP issuer offers partial coverage, application for participation and renewal must include a plan for offering coverage throughout state. • OPM will monitor issuer's progress in implementing plan. 	<p>Requests comments: Should MSPP issuer be required to offer coverage statewide by fourth year of participation in MSPP, when coverage must be offered in each Exchange in 50 states and D.C.?</p>	
30.	72588, 72602*	<p>(c) Licensed where offered – OPM may enter a contract with MSPP issuer who is not licensed in every state, provided the issuer is licensed in every state where it offers MSP coverage through any exchanges in that state. The MSPP issuer must demonstrate to OPM it is making a good faith effort to become licensed in every state consistent with timeframe in (a).</p>		<p>California suggests OPM require some sort of certification or statement from state licensing authority that licensure is valid or in process.</p> <p>Again, failure to complete licensure by a date certain should be included here as grounds for termination of contract under § 800.404. This then becomes a non-negotiable term of the contract.</p>
31.	72588, 72602*	<p><i>[Preamble only]</i> – OPM proposes to clarify that, during each year of the phase-in period, an issuer need only to be licensed in states in which it is offering coverage during that year.</p>		<p>California recommends that preamble language be included in the text of the regulation. Additionally, OPM should recognize that licensure takes a considerable amount of time in some</p>

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				cases. OPM should most likely require updates regarding licensure status from state regulators.
4. Benefits § 800.105				
32	72589, 72602*	(a) (1) An MSPP issuer must offer a uniform benefits package, including EHB, for each MSP <i>within a state</i> .		California agrees with the proposed regulation, because unless OPM requires each MSP to provide the EHB-benchmark package required by each state, California does not see a way to provide a level playing field for health plans and issuers operating inside and outside the Exchanges.
33	72589, 72602*	(a) (2) Benefits package must comply with ACA § 1302 plus applicable standards set by OPM or HHS.		
34.	72589, 72602*	§ 800.105 (b) (1) MSPP issuer must offer a benefits package, in all states, that is substantially equal to:	OPM requests comments on these options – <ul style="list-style-type: none"> • Will either option will discourage or encourage issuer’s participation in the MSPP • Will allowance of OPM benchmark option disrupt state level playing fields given substitution rules 	California believes it is essential that MSPP issuers be required to offer the EHB package particular to the state in which the MSP is operating. <ul style="list-style-type: none"> • OPM and HHS need to include a definition for “substantially equal,” which is also used in the EHB regulations at §156.115(a). Therefore, California requests OPM and HHS to use the following definition: <ul style="list-style-type: none"> ○ “Substantially equal” means the benefit offered in the corresponding benefit category of the EHB must cover the same condition
35.	72589, 72602*	(i) The EHB-benchmark plan in each state in which it operates; or		
36.	72589, 72602*	(ii) Any EHB-benchmark plan selected by OPM under (c) of this section.		

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				<p>covered by the benefit in the EHB-benchmark plan and should be about the same actuarial value as the EHB-benchmark benefit. For example: if the benchmark plan offers in-house “weight loss programs” as part of its EHBs, then an MSP, QHP, or plan outside the exchange could offer a nationally recognized weight loss plan in lieu of an in-house program.</p> <ul style="list-style-type: none"> • Consistent with HHS regulations, California, by statute, prohibits substitution. MSPPs will not, under state rules, be permitted to substitute benefits in any EHB category. • Given California’s robust EHB-benchmark plan, it is likely that any deviation that allows MSPP issuers to provide a lesser benchmark will affect the level playing field in this state. • Failure to adhere to the state specific EHB-benchmark in each state could create adverse selection issues. For instance, if consumers perceive a MSP benefit

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				<p>plan that is not the state EHB-benchmark plan to have greater benefits than a state-specific benchmark, the MSP could attract more unhealthy people making the MSP a high risk pool. The one way to truly avoid any adverse selection concerns is to require the MSPP issuers to offer state-specific EHB benchmark plans in MSPs. Therefore, paragraph 800.105(b)(1)(ii) should be deleted from the proposed rule.</p>
37.	72589, 72602*	§ 800.105 (b)(2) Issuer applying to participate in MSPP must select one of two benefit package options in its application.		California would like to clarify that if an MSPP issuer selects option (b)(i), it e offer a different EHB-benchmark plan in each state in which it operates, based on THAT state's EHB-benchmark. California requests this be made clear in the text of § 800.105.
38.	72589	<i>[Preamble only]</i> – No matter which option an MSPP issuer chooses, it would need to apply that benefits package option uniformly to each of the states in which the MSPP issuer proposes to offer MSPs. The proposed approach does not permit an issuer to use a state benchmark plan in some of the states in which it is operating and an OPM-chosen benchmark plan in others.		While the preamble clarifies that a state must choose one approach or the other, the regulation is confusing and may lead an MSPP issuer to interpret the provision as allowing it to select one EHB-benchmark package and offer that package nationally.
39.	72589, 72602*	§ 800.105 (b)(1) OPM-selected EHB-benchmark plans are the three largest FEHBP plan options, as identified by HHS per § 1302(b) of ACA, and as		California believes it is imperative that Paragraph 800.105(c) be deleted from the proposed rule. Each MSP must use each state's EHB benchmark plan

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		supplemented per (c)(2) through (4) of this section.		in any state in which it is offered.
40.	72589	<p><i>[Preamble Only]</i> If MSPP issuer selects on of these three plans, must have a uniform benefit package in all states.</p> <p>As of March 31, 2012, three largest FEHBP plans:</p> <ul style="list-style-type: none"> • Blue Cross Blue Shield (BCBS) Standard Option • BCBS Basic Option • Government Employees Health Association (GEHA) Standard Option <p>OPM EHB-benchmark may lack state-required benefits – OPM proposing standards for supplementing proposed OPM-selected EHB-benchmark plans.</p>		
41.				Clarify error - § 800.105 has only (c)(1)-(c)(4) – preamble miss numbered subdivisions on p. 72589. Regulation does not track preamble.
42.	72589, 72602*	§ 800.105 (c) (2) Supplement of pediatric oral and vision services from largest Federal Employee Dental and Vision Insurance Program options.	<p>OPM solicits comments on;</p> <ul style="list-style-type: none"> • Provision of pediatric dental services by MSPs to meet ACA EHB requirements [1302(b)(1)(j)] • One approach is to require MSP to cover pediatric dental services in conjunction w/ other bens in package – solicit comments on this approach. • How stand-alone dental plans offered 	

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			<p>on Exchanges should affect this requirement, if at all</p> <ul style="list-style-type: none"> • limited scope dental plans 	
43.	72589, 72602*	<p>§ 800.105 (c) (3) MSPP issuer must follow state definition where state chooses to specifically define habilitative services category per 45 CFR 156.110(f)</p>		<p>California has defined “habilitative services” in state statute pursuant to Health and Safety Code § 1367.005(p)(1) and Insurance Code § 10112.27.</p>
44.	72589, 72602*	<p>§ 800.105 (c) (4) Any EHB-benchmark plan selected by OPM under (c)(1) must include, for each state, any state-required benefits enacted before December 31, 2011, that are included in state’s EHB benchmark plan as described in (b)(1)(i) of this section, or specific to the market in which the plan is offered. <i>In the case in which a state chooses not to define this category, OPM proposes that if any OPM-selected EHB benchmark plan lacks coverage of habilitative services and devices, then OPM may determine what habilitative services and devices are to be included in that EHB0-benchmark plan. (Italics added to denote section that should move to (3).)</i></p>	<p><i>[preamble only]</i> – “at least for years 2014 and 2015”</p>	<p>In the event subparagraphs (b)(1)(ii) and (c) are not deleted as requested above, (see comments at rows 36 and 39) California suggests the following.</p> <p>The OPM proposed regulation found at 45 CFR § 800.105(c)(4) states that “any EHB-benchmark plan selected by OPM under (c)(1) must include, for each state, any state-required benefits enacted before December 31, 2011, that are included in state’s EHB benchmark plan....”</p> <p>The HHS proposed EHB regulation allows states to require issuers to supplement the state’s base-benchmark package with state-required benefits enacted before December 31, 2011. Those mandates are not considered to be in addition to the EHBs. (See 45 CFR § 155.170(a)(2).) Since these mandates</p>

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				<p>are not considered additional benefits, the states do not have to defray costs of these mandates (See 45 CFR § 155.170(b).)</p> <p>For purposes of consistency with 45 CFR § 155.170(a)(2), the language in §800.105(c)(4) should be amended to reflect that state mandates enacted before December 31, 2011, that are not in a state’s base- benchmark, must be covered without an additional cost to the states.</p> <p>California recommends the sentence starting “in the case in which...” should be stricken from (c)(4) and included in (c)(3) above. (c) (4) seems to be about any state mandate, while the remainder seems to describe the process for supplementing habilitative services in the event that state has not specifically defined it. <i>(Italics added in column 3 to denote section that should move to (3).)</i></p>
45.	72589	<p>[<i>Preamble Only</i>] – OPM is proposing that if an MSPP issuer chooses to use an EHB-benchmark plan selected by OPM in all states, the issuer will need to use a state-selected benchmark only in states that do not allow substitution for services at all within the benchmark benefits. [<i>Otherwise?</i>] MSPs using</p>	<p>Comment: OPM requests comments on this proposal.</p>	<p>California agrees with this proposal and urges OPM to include language in the regulation stating that MSPP issuers must select the state EHB-benchmark plan in states with “no substitution rules” in the text of the regulation. § 800.105</p>

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		OPM benchmark in states that require all plans to offer the same set of benefits would be different from all the other plans offered on the market, potentially causing adverse selection.		
46.	72589, 72602*	§ 800.105 (d) OPM Approval – MSPP issuer’s benefits package, including drug list, must be submitted “to approved by” OPM , which will review and determine whether package is substantially equal to EHB-benchmark plan described in (b)(1) pursuant to 45 CFR §§156.115, 156.120, and 156.125.		Please clarify there is a typo in (d). California strongly urges OPM to include language requiring that OPM collaborate with state regulators to determine whether the MSP benefit package is “substantially equal” to the state EHB-benchmark plan. Please clarify that this section is referring to “substantially equal” benefit provisions described in 45 CFR § 156.115(a).
47.	72589	<i>[Preamble Only]</i> Proposed 45 CFR 156.115(b) allows issuers to make benefit substitutions within each EHB category – directs issuers to submit evidence of actuarial equivalence of substituted benefits to a state.	OPM requests comments re: whether MSPP issuers should submit evidence of actuarial equivalence of substituted benefits to the OPM in addition to, or in lieu of, their submissions to a state.	California interprets § 800.105 (d) to address the issue of “substantially equal benefits” while the preamble request for comment at p. 72589 regarding “substituted benefits” (and related to § 156.115(b)) is not at this point included in the proposed rule. Please clarify that, consistent with HHS, OPM interprets substantially equal and substituted benefits to be distinct issues. In California, substitutions are prohibited per Health & Safety Code §1367.005(c) and (d) and Insurance Code § 10112.27(c) and

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				(d).
48.	72589, 72602*	<p>§ 800.105 (e) Benefits in addition to benchmark package – state must assume the cost of such additional benefits by making payments either to the enrollee on to the MSPP issuer on behalf of the enrollee.</p>		<p>Subdivision (c) (4) provides that MSPs will have to include state mandates enacted before December 31, 2011, and that are a part of the EHB-benchmark package, while subdivision (e), requires the states to assume the cost of benefits that are in addition to the EHB-benchmark package.</p> <p>First, the proposed EHB regulations specifically state that states must defray the costs of benefits that are in addition to the EHB-benchmark, but also note that state mandates enacted on or before December 31, 2011, are not in addition to the EHB-benchmark. (45 CFR § 155.170(a)(2) & (b).)</p> <p>Therefore, states will not be required to defray the costs of these mandates for QHPs in the Exchanges. However, since the proposed MSP regulation requires that MSPs only cover state mandates that are included in the benchmark, states may be required to defray the costs of these mandates in MSPs, unless this requirement is made consistent with the EHB regulation. For consistency, California recommends states should not be required to defray the cost of state mandates enacted before December</p>

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				<p>31, 2011, in MSPs, even if they were not included in the EHB-benchmark.</p> <p>Second, under (c)(4), if a state-specific EHB benchmark is not selected by a MSPP issuer, that issuer will be required to supplement the EHB benchmark that is selected with any additional benefits that may be found in the state-specific EHB benchmark. To ensure that states do not have to pay for additional benefits and to ensure that there is no argument regarding whether a benefit has been supplemented appropriately, MSPP issuers should be required to use a state-specific EHB benchmark. Furthermore, states should be the ultimate arbiter of the scope of EHB benefits, and whether other benefits are “additional.”</p>
49.	72590	<i>[Preamble Only]</i> – OPM plans to review benefits packages for discriminatory benefit design – will work closely with states and HHS.		
50.	72590		OPM solicits comments on the provisions of proposed § 800.105, including provisions relating to the two EHB benchmark options and limited	

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			scope dental plans.	
5. Cost-Sharing Limits, Premium Tax Credits, and Cost-Sharing Reductions § 800.106				
51.	72590, 72602*	(a) MSPP issuer must comply with cost sharing provisions in the ACA.		If a State-based Exchange has adopted standardized cost-sharing within a standard plan design and adopted rules that require the QHP issuer to offer one or more of those standardized benefit plan designs, a MSPP in California should be required to offer one of those standardized benefit plan designs at all metal levels to maintain a level playing field.
52.	72590, 72602*	(b) For each MSP it offers, MSPP issuer must make premium tax credits available per ACA. MSPP must also comply with any applicable standards set by OPM or HHS.		
53.	72590	<i>[Preamble only]</i> – An MSPP issuer must also comply with any standards set by OPM or HHS in regulations concerning the administration of <i>these subsidies</i> . OPM may issue additional guidance.	OPM solicits comments regarding what additional guidance, if any, it should adopt to address unique issues faced by MSPs.	California recommends that OPM include preamble language regarding the administration of subsidies in the text of the regulation. If there is “additional guidance,” we recommend including it now and making it available for public comment.
6. Levels of Coverage § 800.107				
54.	72590, 72602*	(a) At least one plan at silver and one at gold in each Exchange.		California state law requires QHPs to offer coverage at all coverage tiers; MSPP issuers and MSPs should be required to adhere to this statutory requirement in order to avoid adverse

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				selection and maintain a level playing field.
55.	72590, 72603*	(b) Leaves question re: whether a plan can offer bronze/platinum plans to contracting process.		
56.		(c) Must offer child-only plan to children under 21 in each level of coverage. <i>[Preamble Only]</i> – MSP issuer could satisfy this standard by offering same product for child-only that offers to consumers for adult/family coverage, as long as child-only coverage is priced in accordance with applicable rating rules.		California recommends OPM include preamble language regarding rating requirements for child-only plans in the text of the regulation.
57.	72590, 72603*	(d) Must comply with plan variation provisions in ACA 1402.		
58.	72590, 72623*	(e) MSPP issuer must submit levels of coverage and plan variations to OPM for approval.		California recommends State regulators should be involved in the approval of levels of coverage. MSPP issuers should be required to meet state-based Exchange plan design requirements to ensure a level playing field.
7. Assessments and User Fees § 800.108				
59.	72590, 72603*	(a) OPM may require an MSPP issuer to pay an assessment or user fee as a condition of participating in the MSPP.	OPM seeks comments on the use of assessments and user fees to fund the MSPP.	In addition to fees assessed by OPM, state-based Exchanges must assess an administrative fee on MSPs to meet the administrative costs of offering MSPs through state Exchanges. California requests confirmation that

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				state-based Exchanges may assess fees, and clarification regarding the method state-based Exchanges will use to assess fees on MSPs products sold in the Exchange. For example, will state-based Exchanges able to assess fees directly on MSPs or will OPM collect fees on a state's behalf?
8. Network Adequacy § 800.109				
60.	72590, 72603*	(a) MSPP issuer must: <ol style="list-style-type: none"> 1. Maintain network sufficient in number and types of providers to assure all services accessible without unreasonable delay. 2. Consistent with network adequacy provisions of PHSA 2702(c). 3. Includes essential community providers per 45 CFR 156.235. 		California recommends MSPs should be required to comply with state-specific rules on network adequacy to ensure a level playing field and access to services.
61.	72590, 72603*	(b) Provider directory available on the Exchange & to potential enrollees in hardcopy upon request. Must id all providers not accepting new patients.	OPM is aware states have more specific rules on network adequacy and will consult with states to set more specific criteria with respect to network adequacy for the MSPP in future guidance. OPM requests comments on approach to network adequacy, including issues concerning NA as a condition of state licensure and any issues for MSP w/	California law at Health & Safety Code § 1367.26 requires a health care service plan to provide, upon request, a list of contracting providers within the enrollee or prospective enrollee's geographic area, including primary care providers, medical groups, independent practice assoc., hospitals, and all other available contracting physicians and surgeons, etc. to the

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			respect to state-specific network adequacy requirements.	<p>extent their services may be accessed and are covered through plan contract. The statute does require that the list indicate whether provider is accepting new patients, which includes making information available re: provider's degree, certifications, and specialty qualifications. In California, MSPs will be required to follow these rules as well.</p> <p>The network adequacy regulations requirements found at 10 CCR 2240, <i>et seq</i>, require insurers to either provide information regarding all network providers or indicate where this information may be found on the internet. In addition, they are required to include a warning about limitations in the contract pertaining to network provider services, specify the differences between in-network and non-network coverage, and inform insureds about their ability to contact the Department of Insurance if they are unable to access health care in a timely manner.</p>
10 Service Area §800.110				
62.	72591, 72603*	MSPP issuer must offer MSP within one or more service areas in state defined by each Exchange pursuant to 45 CFR 155.1055.	OPM seeks comments re: whether MSPP issuers should be required to offer MSPs in all service areas by the fourth year of participation in the MSPP.	MSPs should be required to cover geographic services areas in California where they are licensed, if their license is other than state-wide. MSPs should

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		<p>If an Exchange permits issuers to define service areas, MSPP issuer must get OPM approval for proposed service areas.</p> <p>Per § 800.104, OPM may enter contract with issuer even if MSPs for a state cover fewer than all the service areas specified for that state.</p> <p>For each state in which MSPP issuer does not offer coverage in all service areas, application for participation and information to support renewal of contract must include plan for offering coverage throughout the state.</p> <p>OPM will monitor MSPP issuer's progress as part of contract compliance activities.</p>	<p>OPM believes along MSPP issuers time to develop capacity to offer coverage throughout service area will enhance competition in the MSPP, and invites comments on this approach.</p>	<p>be required to follow the same rules concerning partial rating regions as QHPs in California.</p>
11. Accreditation Requirement § 800.111				
63.	72591, 72603*	(a) MSPP issuer must be or become accredited consistent with the requirements for QHP issuers specified in § 1311 and 45 CFR 156.275(a).	OPM requests comments on proposed accreditation requirements.	OPM should require that an issuer be accredited at the time of contracting. MSPs should be required to follow the same timeline with regards to accreditation as is required of California QHP bidders.
64.	72603*	(b) MSPP issuer must authorize accrediting entity to release to OPM and to the Exchange a copy of most recent accreditation survey,		

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		with any survey-related information OPM or an exchange may require, such as corrective action plans and summaries of findings.		
65.	72603*	(c) Timeframe – issuer not accredited as of date enters into contract must become accredited within timeframe established by OPM by 45 CFR 155.1045.		
12. Reporting Requirements § 800.112				
66.	72591	<p><i>[Preamble Only]</i> – OPM proposes to use the FEHBP approach for reporting requirements.</p> <p>Examples:</p> <ul style="list-style-type: none"> • Financial reports • Premium payment information • Enrollment reporting • Quality assurance information <p>Necessary information to oversee MSPP contracts – agency will develop and issue guidance on this subject for MSPP issuers & potential issuers.</p>	Requests comments on this approach	<p>California recommends that if OPM plans to issue “guidance” that it be included here in formal regulation.</p> <p>California also recommends including at least a partial list of potential data and reporting required by OPM in this section.</p> <p>California requests that any information filed with OPM should also be filed with the state regulator.</p>
67.	72591, 72603*	(a) OPM will specify the data and information that must be reported by MSPP issuer.		The California Health Benefit Exchange will be requiring specific data to be reported by QHPs in its model contract, much of it related to quality improvement. MSPPs should be required to comply with Exchange data reporting requirements.
68.	72603*	(b) An MSPP issuer must comply with any standards required by OPM for reporting quality and quality		

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		improvement strategy, disclosure of quality measures to enrollees, and prospective enrollees.		
69.	72591-72592, 72603*		<p>OPM requires FEHBP plans to report performance through Healthcare Effectiveness Data and Information Set (HEDIS) metrics and Consumer Assessment of Healthcare providers and Systems (CAHPS) surveys, independent of source of plan accreditation.</p> <p>OPM expects to take a similar approach to performance measurement in MSPs to facilitate oversight.</p> <p>OPM requests comments on the unique aspects of accreditation and reporting for MSPs as compared with accreditation for QHPs.</p>	<p>California suggests that if HEDIS and CAHPS measures will be used, these be included in the text of the regulation.</p> <p>The Exchange will be specifying required reporting using specified HEDIS and CAHPS for California QHPs and MSPs should be held to the same standard.</p>
13. Benefit Plan Material or Information § 800.113				
70.	72952, 72603*	(a) MSPP issuer must comply with federal and state laws re: benefit plan material or information – including this section & guidance from OPM specifying its standards, process, and timeline for approval of benefits and plan material or information.		
71.	72592, 72603*	(b) Issuer must provide all applications/notices to enrollees in accordance w/ standards in 45 CFR 155.205(c). OPM may est.		

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		additional standards to meet the needs of MSP enrollees.		
72.	72592, 72603*	(c) Accuracy – issuer is responsible.		
73.	72592, 72603*	(d) Truthful but not misleading (no material omissions, written in plain language).		
74.	72592, 72603*	(e) Uniform Explanation of Coverage Documents & Standardized definitions.		
75.	72592, 72603*	(f) OPM review & approval of benefits and plan material or information – OPM reserves right to review & approve benefits and plan material or information to ensure issuer complies with federal & state laws.		Please clarify the interplay between state regulators who typically review benefits and plan material or information and OPM's review process. Will states review MSPP issuer and MSP materials as part of licensing process? Will OPM make recommendations to state regulators? Please provide more information about this process.
76.	72592, 72604*	(g) MSPP issuer may include statement in benefits and plan material or information that 1) OPM has certified the MSP as eligible to be offered on the Exchange; and 2) OPM monitors the MSP for compliance with all applicable law.	OPM does not view this as a violation of state law anti-endorsement provisions because it is a recitation of the fact the issuer is providing coverage pursuant to a contract with OPM.	
14. Compliance with state law § 800.114				
77.	72592, 72604*	(a) MSPP issuer must, with respect to each of its MSPs, generally comply with state law pursuant to § 1334(b)(2) of the ACA. However,		California strongly recommends § 800.114(a) be amended to read: (a) "MSPP issuer must, with respect to

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		<p>MSPs need not comply with state laws that:</p> <ol style="list-style-type: none"> 1. Are inconsistent w/ § 1334 of ACA; 2. Prevent the application of a requirement of part A of title XXVII of the PHSA 3. Prevent the application of a requirement of title I of the ACA 		<p>each of its MSPs, generally comply with state law pursuant to § 1334(b)(2) of the ACA. However, MSPs and MSP issuers need not comply with state laws <i>OPM has determined are that:</i>"</p> <p>(b) Determination of inconsistency.</p> <p>(c) <i>The contract between OPM and an MSP issuer will enumerate state laws OPM has determined meet one of the categories identified in (a) above upon a final resolution of any state requests for reconsideration of a determination under § 800.116.</i></p> <p>This change makes it clear that MSPs and MSPP issuers are not at liberty to make determinations regarding the applicability of state law.</p>
78.	72592, 72604*	<p>§ 800.114 (b) Determination of inconsistency – OPM reserves right to determine, in its judgment, as effectuated through an MSPP contract, these regulations or OPM guidance whether the standards set forth in paragraph (a) of this section are satisfied with respect to particular state laws. In making any such determinations, OPM will consider</p>		<p>California strongly recommends OPM build state participation into the process at the determination stage, including language in § 800.114 (b) to require OPM to consult with state regulators prior to its determination regarding state law applicability, to limit the use of the dispute resolution process.</p> <p>California also requests that OPM</p>

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		<p>whether the state law at issue:</p> <ol style="list-style-type: none"> 1. Imposes on MSPP issuers/MSPs a requirement(s) that differ from those applicable to QHP issuers and QHPs offered on one or more Exchanges in that state; 2. Creates responsibilities, administrative burdens, or costs for an MSPP issuer that significantly deter or impede the MSPP issuer from offering a viable product on one or more of the Exchanges; 3. Creates responsibilities, administrative burdens, or costs for OPM that significantly deter or impede OPM's effective implementation of the MSPP; or 4. Prevents an MSPP issuer from offering an MSP on one or more Exchanges in that state. 		<p>clarify whether this section applies to all state laws, including those related to the 13 categories under § 1324(b) of the ACA. If it does not, we request that OPM draft regulations that describe the process for threshold determinations regarding laws related to those categories.</p> <p>California is very concerned about § 800.114(b)(2). These provisions seem overly broad and by their application the exception will swallow the whole. Similar to (b)(1), the scope of section (b)(2) should be limited to the particular state in question, not the entire nation. Subdivision (b)(2), as so amended, would read “responsibilities...for an MSPP issuer that significantly deter or impede the MSPP issuer from offering a viable product on one or more Exchanges <u>in that state.</u>”</p> <p>In the alternative California suggests the following language which clarifies that the determination made with reference only to a specific state. Also, this proposed language provides that the determination of paragraph (b)(2) relates to potential discrimination between MSPP issuers and other QHPs in the state. Comparing the</p>

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				<p>MSPP burdens with those imposed on other QHPs in a state would serve to maintain a level playing field:</p> <p><i>“(2) Creates responsibilities administrative burdens, or costs for MSPP issuers that are not imposed upon other QHPs in that state. significantly deter or impede the MSPP issuer from offering a viable product on one or more Exchanges”</i></p> <p>There are other compelling reasons why the determination of inconsistency should be confined within a particular state, rather than being determined on a nationwide basis. Given California’s strong regulation of its health insurance market, MSPP issuers that have not historically operated in California may indeed find that California laws create responsibilities, including administrative responsibilities and costs, which “deter” them from doing business here. California’s vigorous consumer protection regulations should not be cause for determining California laws “inconsistent” with the MSPP. If section (b)(2) is not amended consistent with these concerns, the MSPP process could become a means by which important state health insurance</p>

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				<p>protections could be avoided.</p> <p>If state laws related to the 13 categories of § 1324 benefits are not included in the dispute resolution process at § 800.116, then language must be included here to allow states to dispute OPM determinations under § 800.114(b). Such a process must require OPM to notify states in advance that it has made a preliminary determination that a particular law may be considered inconsistent with or otherwise preempted by federal law.</p> <p>Finally, depending on OPM's answers to the above comments, California recommends this section reference the dispute resolution process outlined in § 800.116. (please see comments below regarding § 800.116)</p> <p>The Exchange will expect MSPs to execute their QHP Model contracts with the Exchange, which may impose obligations above and beyond state law. These contractual obligations will be required of all QHPs operating in California and, in order to keep a level playing field, OPM should require MSPs to sign a contract with the Exchange. In the alternative, the regulation should be amended to</p>

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				require that all MSPs must comply with all such contractual obligations of the Exchange.
15. Level Playing Field § 800.115				
79.	72592, 72604*	An MSPP issuer must, with respect to each of its MSPs, meet the following requirements in order to ensure a level playing field: (a) Guaranteed Renewal – Guarantee that an enrollee can renew enrollment in an MSP in compliance with PHSA §§ 2703 and 2742.		California request clarification. Is OPM indicating it will not find any law that meets the threshold test of belonging to one of the 13 categories in § 1324 “inconsistent” pursuant to § 800.114 or § 800.116?
16. Process for dispute resolution § 800.116				
80.	72592	[Preamble Only] – OPM proposes process for resolving disputes about the applicability to the MSPs and MSPP issuers of state laws not related to the categories set forth in § 1324. Under this process, a state may request that OPM reconsider a standard applicable to MSPs or MSPP issuers that is consistent with the state’s laws for QHPS or QHP issuers. As discussed [in § 800.114] the state must demonstrate the law is <i>not inconsistent</i> with § 1334 or regulations issued to implement the section.	OPM requests comments re: <ul style="list-style-type: none"> • whether to have such a process • scope • factors OPM should consider when determining whether state law is applicable or whether the relevant market has been or will be disrupted by the inapplicability of state law and • whether process will be an effective way to resolve such disputes • Whether process should also be available for states to raise disputes concerning laws related to the 13 categories under § 1324(b) of the ACA. 	The language of the preamble is not clear regarding the basis for a state request for OPM reconsideration. California strongly recommends: <ol style="list-style-type: none"> 1. The section should be amended to require that OPM start from a presumption that all state laws are consistent with the ACA and meet the requirements of § 1334. 2. The dispute resolution process should be amended to require that OPM provide notification to the states regarding decisions about state law in advance of contracting with MSP issuers to provide MSP services within a

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				<p>state's Exchange. Such notice should include a statement regarding the specific law OPM believes violates the provisions of § 800.114(a) and (b), and grounds upon which OPM made such a determination.</p> <p>The dispute resolution process should include state disputes regarding laws related to the 13 categories of benefits from § 1324(b) of the ACA. If these disputes are not included here, a separate dispute resolution process should be provided in § 800.114.</p>
81.	72592, 72604*	<p>§ 800.116 (a) Determinations about applicability of state law under § 1334(b)(2) of the ACA. In the event of a dispute about the applicability to MSP or MSPP issuer of a state law not related to the 13 categories in section 1324(b) of the ACA, the state may request that OPM reconsider a determination, made under § 800.114 that an MSP or MSPP issuer not subject to such state law.</p>		<p>California believes it is essential that the first step in this dispute resolution process be notification by OPM to the state that it believes a law is preempted by federal law or otherwise meets one of the criteria listed in § 800.114(a) (1)-(3). California recommends this section should be amended to add a new subdivision (a) outlining such a notification process.</p>
82.	72952, 72604*	<p>§800.116 (b) Required demonstration. A state</p>		<p>Please clarify that OPM means to refer to "subparagraph (a)" rather than</p>

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		<p>making a request under subparagraph (1) must demonstrate the state law at issue:</p> <ol style="list-style-type: none"> 1) Is not inconsistent with § 1334 of the ACA 2) Does not prevent the application of a requirement of part A of title XXVII of the PHSA; and 3) Does not prevent the application of a requirement of title I of the ACA. 		<p>“subparagraph (1)”?</p> <p>These three items are much narrower than the factors that go into OPM’s determination regarding inconsistency in § 800.114(b).</p>
83.	72592, 72604*	<p>§ 800.116 (c) Request for review – the request must be in writing and include contact information, including the name...or persons whom OPM may contact regarding the request...the request must be in such form, contain such information, and be submitted in such manner and within such timeframe as OPM may prescribe.</p> <ol style="list-style-type: none"> 1) The requestor may submit to OPM any relevant information to support its request. 2) OPM may obtain additional information relevant to the request from any source as it may, in its judgment, deem necessary. OPM will provide the requester with a 		<p>California strongly recommends timeframes be included in this § 800.116 for clarity and ease of administration. These timeframes need to be in place before OPM begins contracting with MSPP issuers and MSPs.</p> <p>The timeframe for a response in (c)(3) is confusing. California suggests amending (c)(3) to read the following:</p> <p>(3) OPM shall issue a written determination within 60 calendar days of receipt of the state request for reconsideration, or 30 days from the receipt of all information necessary to make a determination.</p> <p>California believes that all relevant information should be available for</p>

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		<p>copy of any additional information it obtains and provide an opportunity for the requestor to respond (including by submission of additional information or explanation).</p> <p>3) OPM will issue a written decision within 60 calendar days after receiving the written request, or after the due date for response, whichever is later, unless a different timeframe is agreed upon.</p> <p>4) OPM’s written decision will constitute a final agency action that is subject to review under the Administrative Procedure Act in the appropriate U.S. district court. Such review is limited to the record that was before OPM when OPM made its decision.</p>		<p>judicial review of the final OPM determination.</p>
17. Other Issuers				
84.	72593	Adjusted Community Rating [Preamble Only] - § 1334(c)(1)(D) requires that MSPP issuers offer MSP in all geographic regions and in all states that have adopted adjusted community rating (ACR) prior to	OPM proposes not to identify any specific states an MSPP issuer must cover in the initial years of the MSPP	California suggests that OPM provide a “Mock phase-in” plan to guide MSPP issuers in realistic phase-in processes. MSPP issuers may be inclined to defer implementation in all large states until later years, etc. OPM should provide

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		<p>3/23/2010. Statute does not require that adjusted community rating states be included in the first year of the phase-in process for several reasons.</p> <ol style="list-style-type: none"> 1. In 2014 all issuers in individual/small group market – in and outside the Exchange – must comply with ACR per PHSA § 2701. Therefore § 1334(c)(1)(D) states will not be unique. 2. OPM interprets phase-in to permit phase-in of compliance with (c)(1)(D) – OPM rationale is that MSPP issuer has four years to offer MSPs in each exchange in all states - § 1334(c)(1)(D) does not include requirements re: particular states MSPP issuer must cover at any of the phase-in years. 3. Potential issuers need flexibility to choose initial states and order in which they phase in other states. 		<p>guidance regarding what it believes to be a realistic timeline and strategy for phase-in.</p>
C. Premiums, rating factors, medical loss ratios, and Risk Adjustment § 800.201-800.204				
1. General Requirements § 800.201				
85.	72593, 72604*	(a) OPM will negotiate premiums with MSPP issuer on state by state basis the premiums for each MSP offered by that issuer in that state. Such negotiations may include negotiations about cost-sharing provisions.	OPM intends that each MSP set its premiums on a state-by-state basis. Unlike the FEHBP there will not be any MSPs that are offered at one premium nationwide. Therefore, OPM intends to follow state rating laws as much as practicable so as not to distort local markets.	In California, the Exchange is standardizing cost-sharing and benefit plan design. Allowing MSPs to have different cost-sharing requirements will create an un-level playing field and could create adverse selection concerns. In states where cost-sharing is standardized in the Exchange, OPM should not negotiate cost-sharing provisions.

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86.	72593, 72605*	(b) Premiums in effect for 1 year		
87.	72593, 72605*	(c) OPM will issue guidance addressing methods for development of premiums for MSPP. Such guidance will follow state rating standards . . . to the greatest extent possible.		
88.	72593, 72605*	§800.201 (d) An MSPP issuer must calculate AV the same manner as QHP issuers under § 1302(d) of ACA as well as any . . . standards set by OPM and HHS.	<i>[Preamble Only]</i> OPM recognizes HHS requested comments on calculation of AV in proposed EHB rule . . . the proposed regulation state an issuer would use AV calculator developed by HHS to determine plan's level of coverage . . . OPM proposes in (d) that MSPP issuers calculate AV in same manner.	
89.	72593, 72605*	§ 800.201 (e) OPM rate review process. An MSPP issuer must participate in rate review process established by OPM to negotiate rates for MSPs. The rate review process et. By OPM will be similar to process est. by HHS per PHSA § 2794 & disclose and review standards established under 45 CFR part 154.		
90.	72593	<i>[Preamble Only]</i> In approving rates for MSPs, OPM intends to follow state rating standards w/ respect to rating factors generally applicable in a state.		

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		<p>States have flexibility in applying narrower ratios for age and tobacco use and may require issuers to use pure community rating. § 1334 explicitly gives OPM authority to negotiate premiums, profit margins, and MLR. OPM intends to work closely with each state in approving a rate for the MSPs in that state and will consult with that state about patterns in its markets and about other rates an MSPP issuer might be proposing in that state for non-MSPs. However, the final decision regarding rates for MSPs rests with OPM, as required by statute. OPM proposes that MSPP issuers follow state rating standards, and OPM’s process will meet the standards with respect to review and disclosure requirements for “effective rate review program” in federal regulations.</p>		
91.	72594, 72605*	<p>(f) State effective rate review – MSPP issuer is subject to state’s rate review process including ERRP program est. by HHS per § 2794.</p> <p>HHS reviewing rates for a state – then will defer to OPM’s judgment of MSPs proposed rate increase.</p> <p>In the event a state withholds approval</p>	<p>OPM intends to conduct its own rate review process, but intends to share its analysis with each state in which an MSP is operating. MSPP issuers are subject to a state’s rate review process including a state’s effective rate review program (ERRP)</p>	<p>California seeks clarification regarding which rates the state will be reviewing. Pursuant to the definitions, it appears, although it is not entirely clear, the MSPP issuer is the national organization, with the MSPs being the state-level health plans operating on the exchange. (Please see comments regarding definitions above.)</p>

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		<p>of MSP rate for reasons OPM determines, in its discretion, to be arbitrary, capricious, or an abuse of discretion, OPM retains authority to make final decision to approve rates for participation in MSPP notwithstanding absence of state approval.</p>		<p>The overlap of jurisdiction, coupled with the fact that both OPM and the state are conducting independent rate reviews that will need to be compared and reconciled, seems to be redundant.</p> <p>There is a great deal of detail regarding this process in the preamble that is not carried through in, and is sometimes in contradiction with, the regulations. California recommends OPM amend the regulations to include the process outlined in the Preamble. Otherwise, the regulations are confusing and will be difficult to administer. California requests that 800.201(f) be changed to add the following:</p> <ul style="list-style-type: none"> • “In the event State withholds approval of or finds a MSP rate unreasonable for reasons that are not arbitrary, capricious or abuse of discretion, the decision of the state review agency will hold” • A dispute resolution process between the states and OPM that does not rely solely on the discretion of the Director of

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				OPM.
92.	72594, 72605*	<p><i>[Preamble Only]</i> Each state would have the opportunity to review the MSP rates under its own procedures and processes. If a state disagrees with OPM's determination to approve the MSP rates, OPM would work with the state to resolve the differences. OPM expects few such disagreements will arise and, if they do, that we will be successful in resolving them in a manner that is acceptable both to OPM and the state at issue. In the event a state withholds approval of an MSP rate for reasons that OPM determines, in its discretion, to be arbitrary...the Act authorizes the director to make the final decision to approve rates for participation in MSPP without state approval. OPM expects director will rarely, if ever, have to exercise this authority to approve MSP rates over the object of a state.</p> <p>After OPM and the MSPP issuer complete the rate negotiation process, and OPM approves the rates, an MSPP issuer will file rates with the Exchange, when necessary to post MSP premium and rate information to the Exchange portal, and with the State, when necessary to meet licensure requirements.</p>	OPM welcomes comments on whether this is an appropriate approach and on the impact of this approach.	California recommends the proposed rule should be revised so that, for states that have been determined to have an effective rate review program and that review rates for the state-level MSPs, OPM will accept those rate review analyses and review them only for consistency. As with HHS, OPM should accept a state's review if that state has been determined to have an "effective rate review program. (see p. 81004 Fed Reg. Dec. 23, 2010, vol. 75, No. 246.)

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93.	72594, 72605*	(g) Single Risk Pool – MSPP issuer must consider all enrollees in an MSP to be in same risk pool as all enrollees in all other health plans in individual market or small group market per § 1312(c) of ACA plus state and federal laws		
2. Rating Factors § 800.202				
94.	72594, 72605*	(a) Permissible rating factors (based on § 2701 of ACA)	OPM intends to follow state rating standards with respect to rating factors, including the application of tobacco use.	
3. Medical Loss Ratio § 800.203				
95.	72594, 72605*	(a) Required MLR – MSPP Issuer must attain <ul style="list-style-type: none"> 1) MLR required under § 2718 & HHS regulations 2) Any MSP-specific MLR that OPM may set in the best interest of MSP enrollees or that is necessary to be consistent with a state’s requirements w/ respect to MLR. 	OPM reserves authority to impose different, MSP-specific MLR threshold – i.e.. An MLR threshold based only on an MSPP issuer’s MSP population in each state – if would be in best interests. Not OPM’s intention to apply a national aggregate MLR. OPM requests comments on its proposal to set an MSP-specific MLR.	MLR ratios for each MSP must be determined and administered on a state-by-state basis. The MLR requirements for MSPs must be same as for other qualified health plans; California does not agree that OPM should have the authority to set MSP-specific MLR thresholds at Health & Safety Code § 1367.003, and Insurance Code § 10112.25.
96.	72594, 72605*	(b) Consequences – MSPP issuer fails to attain MLR in (a) – OPM may take any appropriate action...intermediate sanctions, suspension of marketing, decertifying in one or more states, terminating MSPP issuer’s contract per § 800.404		
4. Reinsurance, risk corridors, and risk adjustment § 800.204				

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97.	72594, 72605*	(a) Transitional Reinsurance - MSPP issuer must comply with § 1341 of ACA . . . and any applicable fed/state regulations under that section that sets forth requirements to implement transitional reinsurance program for individual market.	For example – if state imposes additional reinsurance assessments on issuers, MSPs are subject to such assessments in order to maintain a level playing field.	California strongly agrees with 800.204(a).
98.	72594, 72605*	(b) Temp. risk corridors – MSPP issuer must comply with § 1342 of ACA . . .		
99.	72594, 72605*	(c) Risk adjustment program – MSPP issuer must comply with participate [sic] in the risk adjustment program		There is a typographical error in this § 800.204(c) in the phrase “comply with participate in.” Please clarify: is this sentence intended to read “An MSPP issuer must participate in...”?
D. Application and Contracting procedures 800.301 – 800.306				
1. MSPP Contracting § 800.303				
100.	72606*	(a) Participation in MSPP		
101.	72606*	(b) Standard contract – OPM will establish a standard contract for the MSPP		OPM should require MSPs to enter into a contract with the Exchange, including the same non-negotiable terms that California QHPs are required to adhere to, or should amend the proposed regulation so that MSPs must abide by the same contractual provisions that the state Exchange requires of QHPs.
2. Term of the contract §800.304				
102	72606*	(a) Term		California recommends the term of the contract should align with open enrollment periods so individuals can more easily move to non-MSPs if the

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				contract is terminated.
E. Compliance				
1. Contract performance § 800.401				
103	72595, 72606*	(a) General		Generally, California strongly recommends including state performance evaluations in performance standard review.
2. Contract Quality Assurance § 800.402				
104		(a) General – section prescribes general policies and procedures to ensure services acquired under MSPP contracts conform to contract’s quality requirements		OPM should require MSPs in California to adhere to the quality assurance terms that obligate all other California QHPs either through execution of a contract with the Exchange or by amending the proposed regulation so that MSPs must abide by the same contractual provisions that the state Exchange requires of QHPs.
3. Compliance Actions § 800.404				
105	72596, 72607*	(a) Causes for OPM compliance Actions 1) Failure to meet requirements in § 800.401 a & b 2) MSPP issuer’s sustained failure to perform the MSPP contract in accordance with prudent business practices, as described in § 800.401(c) 3) Pattern of poor conduct or evidence of poor business practices such as those described in § 800.401(d) 4) Such other violation of		California strongly recommends including state performance evaluations in performance standard review. OPM should amend § 800.404 to specifically include the following in the list of causes for OPM compliance actions: failure to meet state law requirements, failure to meet state phase-in requirements and service area requirements.

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		law/regulation as OPM may determine		
106		§ 800.404 (b) Compliance Actions 1) OPM may impose compliance action against MSPP issuer at any time during contract term 2) Compliance actions may include, but are not limited to: i. Corrective action plan ii. Intermediate sanctions iii. Performance incentives iv. Reduction of service area(s) v. Withdrawal of certification of MSPP issuer to offer MSP on exchanges vi. Nonrenewal of MSPP contract and vii. Withdrawal of approval or termination of MSPP contract		
107	72596, 72607*	§ 800.404 (c) Notice of compliance action		California feels it is essential that notice of a compliance action against an MSPP issuer be provided to the state or states in which the MSPP issuer's MSPs are operating or in all states if the MSPP has completed phase-in, at the same time notice is provided to the MSPP issuer.

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				California asks OPM to amend § 800.404 to include such notification in subparagraph (c). States should be given an opportunity to comment or make recommendations regarding appropriate action, including providing additional information regarding the MSPP Issuer.
4. Reconsideration of Compliance Actions § 800.405				
108	72596, 72608*	(a) MSPP issuer may request OPM reconsider determination re: withdrawal, nonrenewal, termination		California requests OPM provide notification of any MSPP issuer request for reconsideration to the state or states in which the MSPP issuer's MSPs are operating, or in all states if the MSPP has completed phase-in.
F. Appeals by Enrollees for Denial of Claims for Payment or Services				
§ 800.504 External Review				
109	72597, 72608*	(a) External review by OPM – OPM will conduct external review of adverse benefit determinations using a process similar to OPM review of disputed claims under 5 CFR 890.105(e).		OPM should rely upon a state's external review program when an effective state review process is in place. Many states rely upon their external review process to see trends that initiate regulatory reviews or enforcement actions. If OPM reviews these determinations and the state does not, it will make it difficult for states to see areas where MSP issuers are consistently violating state law and where state enforcement actions are needed. , At the minimum, California

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				recommends the regulation should provide the state will be informed about complaints, external reviews and the outcomes of OPM reviews.
G. Miscellaneous				
§ 800.602 – Consumer choice w/ respect to certain services				
110	72597, 72608*	(a) Assured availability of varied coverage. Consistent with § 800.104, OPM will ensure at least one of the MSPP issuers on each Exchange in each state offers at least one MSP that does not provide coverage of services described in § 1303(b)(1)(B) of the ACA		California believes this provision overrides state authority to require reproductive services and to choose which of those services should be available to state residents.
111	72597, 72608*	(b) State opt-out – an MSP may not offer abortion coverage in any state where such coverage of abortion services is prohibited by state law.		<p>Proposed subsection (b) does not include the “termination of opt out language” specified in ACA section 1303(a)(2). In order to fully reflect the provisions of section 1303(a), California suggests deleting the language in subdivision (b) and replacing it with the following language:</p> <p>(b) A MSP issuer must comply with each State's law pertaining to reproductive services coverage in QHPs as specified in ACA section 1303(a) (42 USC 18023(a)).</p>