



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

December 26, 2012

Honorable Kathleen Sebelius, Secretary  
U.S. Department of Health and Human Services  
200 Independence Avenue, S.W.  
Washington, D.C. 20201

Re: CMS-9980-P; Comments to Notice of Proposed Rulemaking on Patient Protection and Affordable Care Act Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation

Dear Secretary Sebelius:

On behalf of the State of California and many of the entities responsible for implementing the Patient Protection and Affordable Care Act in the state -- the Department of Insurance, the Department of Managed Health Care, and the California Health Benefit Exchange -- we submit the enclosed comments on the proposed rules for Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation. California appreciates the opportunity to comment on these important regulations.

California applauds the significant effort involved in memorializing the benchmark approach described in the Essential Health Benefits Bulletin, as well as finalization of the method for calculating actuarial value originally described in the Actuarial Value and Cost Sharing Reductions Bulletin. California also appreciates the development of the actuarial value calculator, a tool that will facilitate compliance with, and enforcement of the levels of coverage requirement. We request that states be allowed to use state-specific data sources for actuarial value calculation beginning in 2014. Without this flexibility, California consumers will likely face higher cost sharing because benefit designs will be priced at a national average that does not take into account California's lower utilization and unit cost for health care services.

Based on the benchmark approach described in the Essential Health Benefits Bulletin, California enacted two statutes that selected a small group HMO plan, the Kaiser

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Foundation Health Plan, Inc. Small Group \$30 Copayment Plan, as California's base-benchmark plan. The statutes, Insurance Code section 10112.27 (S.B. 961, Stats. 2012, Ch. 866) and Health and Safety Code section 1367.005 (A.B. 1453, Stats. 2012, Ch. 854), provide the framework the state will use in implementing the essential health benefits requirement in California. The statutes provide that California will supplement the base-benchmark plan with the Children's Health Insurance Program benefit for pediatric dental services and Federal Employees Dental and Vision Insurance Program for pediatric vision services. Also, California chose to define habilitative services and require parity with the base-benchmark plan's coverage of rehabilitative services.

In these comments, which are presented in chart format, we offer some suggestions for the proposed rules. Due to the short time frame in which to comment, it is possible that additional comments will be forthcoming 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.

Thank you for taking our comments into consideration as you finalize the rules and we approach the full implementation of the Patient Protection and Affordable Care Act, which we have all worked so diligently to successfully implement.

Sincerely,



Dave Jones, Insurance Commissioner



Brent Barnhart, Director, Department of Managed Health Care



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

HEALTH INSURANCE ESSENTIAL HEALTH BENEFITS, ACTUARIAL VALUE AND ACCREDITATION 45 CFR PARTS 147, 155 AND 156				
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<b>II. Provisions of the Proposed Regulations</b>				
<b>A. Part 147 – Health Insurance Reform Requirements for the Group and Individual Health Insurance Markets</b>				
1.	(a)Coverage of EHBs - § 147.150	(a) Requirement to cover EHB benefit package - Issuer offering coverage in individual or small group market must ensure such coverage offers the EHB package		California suggests including a cross-reference to 45 CFR § 156.20, as “essential health benefits package” is defined there.
<b>B. Part 155 – Exchange Establishment Standards and Other Related Standards Under the Affordable Care Act</b>				
1.	State Required Benefits (Mandates) § 155.170	(a)(1) – state may require QHP to offer benefits in addition to EHBs	Should state make mandate-defray payments based on <ul style="list-style-type: none"> <li>• statewide average cost or</li> <li>• on each QHPs issuer's actual cost if different issuers report that a particular additional benefit costs a different amount.</li> </ul>	§ 155.170 (a)(2) does not include language to support the Preamble’s comment that mandates enacted before 12-31-2011, even if not effective until a later date may be considered EHB (as in, not “benefits in addition to EHB subject to state defrayment of costs) Please see p. 70647. California requests that HHS include language regarding the effective date in the text of § 155.170(a).
2.	70647, 70668*	(a)(2)State-required benefits enacted on or before 12-31-2011, are not considered “in addition to” EHB.		
3.	70647	[Preamble only] even if not effective until a later date... (italics not in regulation)		
4.	70647, 70668*	§ 155.170 (a)(3) Exchange shall identify which state mandates are in excess of EHB		All states operate differently in terms of oversight. States should be permitted to determine what state entity will identify

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				state mandates in excess of the EHB. In California, the Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI) are the regulatory agencies with jurisdiction over health issuers, while the Health Benefit Exchange is a separate entity and not a regulator.
5.	70647, 70668*	§ 155.170 (b) the state must make payments to defray the cost of additional required benefit specified in (a) to one of the following: (1) individual enrollee (2) directly to the QHP issuer on behalf of the individual in (b)(1)	[ <b>Preamble</b> <b>only</b> ] "We interpret state-required benefits" = specific to care, treatment and services state requires issuers to offer to enrollees. (no obligation to defray costs for state mandates re: provider types, cost sharing, reimbursement methods)	The term "state-required" benefits is used multiple times in the preamble and in § 155.170(a)(2), but is not defined in the regulation text. California recommends the definition in the preamble be included in the regulation as a definition for "state-required benefits," or benefits "in addition to EHB." The preamble does not have any force of law. It is very important to differentiate between types of "state required benefits" that will be considered in cost defray requirements.
6.				California also believes it is essential that HHS exclude from the definition of "state-required benefits" or "benefits in addition to

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				<p>For example, under California law and specified in regulation under title 28, California Code of Regulations section 1300.74.72, enacted prior to 12-31-11, California's base-benchmark plan, is required to cover medically necessary mental health services when the treatment is for mental disorders identified in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM IV). If and when the American Psychiatric Association publishes the DSM V, it is essential that California be permitted to update existing state law to define mental disorders pursuant to DSM V without triggering mandate cost-defrayment requirements.</p>
7.	70647, 70668*	§ 155.170 (c) (1)QHP to calculate amount of cost attributable to additional state-required benefit in (a). (2) a QHP issuer's calculation shall be: (i) based on an analysis performed in accordance w/ generally accepted actuarial principles & methodologies; (ii) Conducted by a member of the		<p>QHP generates the necessary data regarding claims, utilization, trend and other issuer-specific data typically used to calculate the cost of a benefit.</p>

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		Amer. Acad. Of Actuaries; and (iii) Reported to the Exchange.	CALIFORNIA <sup>1</sup> COMMENT/QUESTION
<b>2. Accreditation Timeline §155.1045</b>			
<b>C. Part 156 – Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges</b>			
<b>1. General Provisions – Definitions§ 156.20</b>			
8.	70648, 70669*	<p><i>IPreamble Only</i> – We propose to define “AV” as the percentage paid by a health plan of the total allowed costs of benefits (using the term percentage of the total allowed costs of benefits that we also propose to define here).</p> <p>In general, AV can be considered a general summary measure of health plan generosity</p> <p>§156.20:</p> <ul style="list-style-type: none"> <li>• <b>Actuarial Value</b> = percentage paid by plan of the percentage of the total allowed costs of benefits</li> </ul>	<p>California suggests revising the definition of actuarial value in § 156.20, as it refers to percentage twice and is therefore inaccurate and confusing. California proposes amending the definition to read:</p> <p>“Actuarial Value means the percentage of the total allowed cost of benefits paid by a health plan.”</p>
9.	70648, 70669*	<ul style="list-style-type: none"> <li>• <b>Percentage of total allowed costs of benefits</b> = anticipated covered medical spending for EHB coverage paid by a health plan for a standard population: health plan’s cost sharing divided by the total anticipated allowed charges for EHB coverage – expressed as a percentage</li> </ul>	
10.	70648,	<ul style="list-style-type: none"> <li>• <b>Base-Benchmark Plan</b> = plan</li> </ul>	

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11.	70648, 70669*	<ul style="list-style-type: none"> <li>selected by a state from options described in §156.100(a), or default benchmark plan, prior to adjustments to meet benchmark standards described in § 156.110</li> </ul>		
12.	70648, 70669*	<ul style="list-style-type: none"> <li><b>EHB-Benchmark Plan</b> = standardized set of EHB that must be met by QHP or other issuer as required under § 147.150</li> <li><b>EHB Package</b> = scope of benefits and associated limits of a health plan offered by an issuer</li> </ul>		California suggests being more explicit about what "associated limits" means by replacing "limits" with "limitations on coverage," as that is the term used in 45 CFR § 156.115(a)(1)(ii).
<b>2. EHB Package</b>				
a.	<b>State selection of Benchmark § 156.100</b>			
13.	70648, 70669*	<p>§ 156.100 (a) Standards for selection [refers to §156.110]</p> <ul style="list-style-type: none"> <li>(1) small group market plan</li> <li>(2) state employee health plan</li> <li>(3) FEHBP Plan</li> </ul>	<p>Is the default base-benchmark plan that will apply to the states, the largest plan by enrollment in the largest product in state's small group market, an appropriate default base-benchmark plan for the territories?</p>	Appendix A omits that California is supplementing the pediatric vision category with FEDVIP pursuant to the state's EHB laws. California requests correction of this omission in the final rule.
14.	70649, 70669*	Appendix A: list of proposed EHB Benchmarks & proposed default plans	If state wishes to make a selection or change previous selection it must do so by the end of the comment period	As in the definition of "essential health benefits package," here the word "limits" is used. If "limitations on coverage" is what is intended, we suggest replacing "limits"
15.	70649, 70669*	§ 156.100 (b) Standard for approval of state-selected EHB-benchmark plan (ACA §1302(b)(4)(G) & (H)) – to become an EHB-benchmark plan as		

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			with that phrase and note that limitations on coverage are discussed in 45 CFR § 156.115(a)(1)(ii), not § 156.110.
16.	70649	defined in § 156.20 – a state-selected base-benchmark plan must meet the requirements for coverage of benefits and limits described in § 156.110  [preamble only] – ACA calls for Secretary to periodically review the defn of EHB, report findings, and update the EHB definition as needed to address gaps in access to care or advances in relevant evidence base. Propose state's benchmark plan selection would be applicable for 2014 & 2015	What process should HHS use to update EHB over time? <ul style="list-style-type: none"><li>• State input/experience</li><li>• Analysis of new state mandates</li><li>• State reporting</li><li>• Determination of whether appropriate cost/ comprehensiveness balance</li><li>• Affordability</li></ul>
17.	70649, 70669*	§ 156.100(c) – if state does not make a selection, one will be made for them (default base-benchmark plan) – largest plan by enrollment in largest product in state's small group market	b. Determination of EHB for Multi-State Plans § 156.105
18.	70649, 70669	Multi-state plan must meet benchmark standards set by OPM	It is essential that OPM require multi-state plans to provide the EHB package required in each state in which the plan is sold. Failure to require this will potentially disrupt operation of California's Health Benefit Exchange and harm the viability of California's competitive market.
<b>C. EHB Benchmark Plan Standards § 156.110</b>			

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19.	70649, 70669*	<p>Categories of benefits</p> <p>(a) EHB-benchmark plan must provide coverage of at least the following categories (list from § 1302 ACA)</p> <p><b>[Preamble Only]</b> “pediatric services” = recommend services for individuals under age 19 years – states have flexibility to extend pediatric coverage beyond proposed 19 year limit</p>	<p>As part of the base-benchmark identification process, HHS created templates that required the state to list benchmark benefits according to 30 or more benefit categories. California notes the 30+ categories of benefits in the EHB templates do not precisely track the 10 ACA § 1302 categories. States uploaded these templates for public comment via HIOS. However, California believes these templates are for information purposes only and CCIIO should not use them to determine compliance with § 1302.</p>	<p>California requests that preamble language regarding state flexibility to determine the period of “pediatric coverage” be included in the text of the regulation.</p>
20.	70649- 70650, 70669*	<p>§ 156.110</p> <p>(b) A base-benchmark plan not providing any coverage in one or more of the categories described in (a) <b>must</b> be supplemented by addition of entire category of benefits offered under any other benchmark plan option in §156.100(a.) [emphasis added]</p> <p>(1) General supplementation methodology</p> <p>(2) Supplementing pediatric oral</p>	<p>California state law enacted September 30, 2012, selected California’s base-benchmark plan and supplemented the base-benchmark plan pediatric vision services with coverage under the Federal Employees Dental and Vision Insurance Program vision plan (FEDVIP), and pediatric dental services with the Healthy Family Program 2011-2012 dental plan (CHIP). Please confirm through clarification of the proposed regulation that California’s benchmark plan which</p>	<p>*The proposed regulations are paraphrased for purposes of reference only. For full text please see proposed rule. Included are only those provisions regarding which California has a comment, or that provide necessary context.</p>

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		<p>services- A base-benchmark plan lacking the category of pediatric oral services <b>must</b> be supplemented by the addition of the entire category of benefits from the following...</p> <p>(3) Supplementing pediatric vision services – a base-benchmark plan lacking the category of pediatric vision services <b>must</b> be supplemented by the addition of the entire category of such benefits from one of the following...</p>		<p>includes the Kaiser Foundation Health Plan, Inc. Small Group \$30 Copayment Plan and is supplemented by the FEDVIP and CHIP does not result in the creation of a new state mandate that will require the state to assume the cost of such coverage pursuant to section 1311(d)(3)(B)(ii).</p>
21.	70650, 70670*	<p>§ 156.110</p> <p>(c) A <i>default base-benchmark plan</i> as defined in § 156.100(c) of this subpart that lacks any categories of EHB will be supplemented by HHS in the following order, to the extent that any of the plans offer benefits in the missing EHB category:</p> <p>(1) Largest plan by enrollment in 2d largest product in small group market.</p> <p>(2) Largest plan by enrollment in 3d largest product in small group market</p> <p>(3) Largest nat'l FEHBP plan by enrollment across states ...</p> <p>(4) Plan described in (b)(2)(i) re: pediatric oral care.</p>		

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22.	70650, 70670*	(5) Plan in (b)(3)(i) w/ respect to pediatric vision care (6) A rehabilitative benefit determined by the plan as described in § 156/115(a)(4)	Provide potential approaches to ensuring the EHB-benchmark plans do not include discriminatory benefit designs and reflect an appropriate balance among the categories of EHB.	The state of California currently reviews benefit designs to ensure non-discrimination.
23.	70650, 70670*	§ 156.110 (d) No discriminatory benefit designs (e) Appropriate balance  § 156.110 (f) “Determining rehabilitative services. If the base-benchmark plan does not include coverage for rehabilitative services, the state may determine which services are included in that category...”	HHS welcomes comments on this proposed approach to providing rehabilitative services. If states choose not to define the rehabilitative services category, plans must provide these benefits as defined in § 156.115.  <i>[preamble only]</i> Rehabilitative - transitional policy – in order to define EHB, if the base-benchmark plan does not include coverage of rehabilitative services, the state may determine the services included in the rehabilitative services category. We believe this transitional policy, which provides states flexibility beyond what was initially outlined in the EHB Bulletin will provide a valuable opportunity for state to lead the development of policy in this area.	In the Essential Health Benefits Bulletin issued by the Center for Consumer Information and Insurance (CCIO) Oversight on December 16, 2011, CCIO noted at page 6 that “[t]here is no generally accepted definition of rehabilitative services among health plans, and, in general, health insurance plans do not identify rehabilitative services as a distinct group of services.” CCIO further commented on the uncertainty regarding what is included in the Rehabilitative services category on page 11.

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California believes § 156.110(f) is problematic in that it allows the state to define rehabilitative services *only if* such services are not included in the base-benchmark plan. However, as acknowledged by CCIO in the Bulletin, many plans offer some services that fall

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				<p>Therefore, California recommends HHS amend subparagraph (f) to provide that “the State may define rehabilitative services and determine which, if any, services provided under the base-benchmark plan fall into that category.”</p> <p>Making this change provides the flexibility needed for states to “take the lead” in the development of this policy area (see preamble). As such, California has already defined rehabilitative services pursuant to state law, AB 1453 and SB 951.</p>
24..	70651, 70670*	d. Provision of EHB §156.115	<p>(a) Provision of EHB means that a health plan provides benefits that:</p> <ol style="list-style-type: none"> <li>(1) are substantially equal to the EHB-benchmark plan including:</li> </ol> <ul style="list-style-type: none"> <li>(i) Covered benefits</li> <li>(ii) Limitations on coverage including coverage of benefit amount, duration, and scope; and</li> <li>(iii) Prescription drug benefit that meets the requirements of § 156.120...</li> </ul>	<p>Alternative to transitional approach – state may allow issuers and experience to define these benefits - Option based on state preference re: rehabilitative services</p>

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		<p>(2) to satisfy EHB, mental health and substance use disorder services, including behavioral health treatment services under § 156.110(a)(5) <b>must be provided in manner that complies with parity standards</b> in § 146.136 – implementing Mental Health Parity and Addiction Equity Act of 2008</p> <p>(3) ALL plans must demonstrate compliance with preventive service requirements – plans will not be considered to provide EHB if don't also provide preventive services required under PHSA 2713</p> <p>(4) if the EHB-benchmark plan does not include coverage for rehabilitative services – a plan must include rehabilitative services that meet one of the following:</p> <ul style="list-style-type: none"> <li>i. Provide parity w/ rehabilitative services or Determined by issuer and reported to HHS</li> <li>ii. Determined by issuer</li> </ul>		
25.	70651, 70670*	§ 156.115 (b) Substitution of Benefits – benefit substitution is allowed if the issuer of a plan offering EHB meets the following conditions:	HHS seeks comments re: tradeoff between comparability of benefits and opportunities for plan innovation and benefit choice.	The preamble indicates a state may prohibit substitutions. However, the proposed regulation as written gives no indication a state may refuse to allow an

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		<ul style="list-style-type: none"> <li>• (b)(1) – substitutes a benefit that meets the following conditions <ul style="list-style-type: none"> <li>• (i) Issuers may sub benefits that are actuarially equivalent to replaced benefits being replaced</li> <li>• (b)(1)(ii) Substitution only in benefit categories; and</li> <li>• (b)(1)(iii) Does not apply to prescription drug benefits</li> </ul> </li> <li>• (b)(2) submits evidence of actuarial equivalence of substituted benefits to the state. The certification must: <ul style="list-style-type: none"> <li>• (i) be conducted by member of Amer. Acad. of Actuaries</li> <li>• (ii) be based on an analysis performed in accordance w/ gen. accepted actuarial principles &amp; methodologies and</li> <li>• Use a standardized plan population.</li> <li>• (b)(3) actuarial equiv of benefits is determined regardless of cost-sharing</li> </ul> </li> </ul>	<p>issuer to substitute benefits even where the issuer has submitted a certification of actuarial equivalence and satisfied the other conditions included in the subsection. To the contrary, the words “benefit substitution is allowed if the issuer of a plan offering EHB meets the following conditions” suggests exactly the opposite. California believes it is essential that this subsection be revised to reflect the states’ ability to prohibit benefit substitution, and if not prohibited, to deny an issuer’s request for substitution.</p>	<p>California recommends § 156.115 be amended to explicitly permit states to prohibit substitutions, consistent with the assertion in the preamble at p. 70651. This will ensure states have the ability to enforce EHB requirements in accordance with the state’s determination of a base-benchmark plan.</p>
26.	70651	<p><i>Preamble only.</i> “We clarify that under this approach, states have the option to enforce a <b>stricter standard</b> on benefit substitution or <b>prohibit it entirely</b>.”</p>		

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**HEALTH INSURANCE ESSENTIAL HEALTH BENEFITS, ACTUARIAL VALUE AND ACCREDITATION**  
**45 CFR PARTS 147, 155 AND 156**

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27.	70651	<p><i>Preamble only.</i> "In paragraph (c), we propose to clarify that a plan does not fail to provide the EHB solely because it does not offer the services described in § 156.280(d). Here we extend the statutory provision in section 1303(b)(1)(A), that allows a QHP to meet the standards for EHB even if it does not offer the services described in § 156.280(d), to health insurance issuers that offer non-grandfathered coverage in the individual or small group market. We note that this provision applies to all section 1303 services, including pharmaceutical services."</p>	<p>The proposed expansion of the ACA section 1303(b)(1) voluntary choice provision to plans sold outside the Exchange violates section 1303(c), which provides that nothing in the Affordable Care Act is meant to be construed as preempting state laws regarding abortion coverage. Additionally, expanding the voluntary choice provision beyond QHPs is unsupported by the statute and contrary to its purpose. Policies sold outside the exchange will not involve the use of federal subsidies to fund abortion coverage.</p>	<p>California interprets this section, as well as related requirements in the ACA, as allowing states to require reproductive rights as part of the California EHB-benchmark plan.</p>
28.	70651, 70670*	<p>§ 156.115 (c) plan does not fail to provide EHB if does not offer abortion services (§ 156.280(d))</p>		<p>California requests that § 156.115(d) be amended to allow inclusion of adult eye exam services if these benefits are included in the state's selected benchmark plan.</p>
29.	70651, 70670*	<p>§ 156.115 (d) Routine non-pediatric dental &amp; eye exam services, long-term custodial nursing home benefits may not be included in EHB</p>	<p>Solicit comment on exclusion of these benefits from EHB</p>	<p>HHS states in the preamble that ACA § 1302 requires the EHB package to include at least the 10 categories of EHB and be equal to the scope of benefits provided</p>

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		<p>under a typical employer plan. The Preamble then goes on to state that non-pediatric eye exams are often “excepted benefits” and are not covered by the “typical employer health plan. However, Kaiser Small Group Plan (Federal health product identification 40513CA035), identified by HHS as one of the plans from which California could select its benchmark plan, and designated in statute by the State of California as its base-benchmark plan, does provide non-pediatric routine vision screenings and eye exams for refraction to determine the need for vision correction and provide a prescription for eyeglass lenses.</p>	
30.	70652, 70670*	e. Prescription Drug Benefits § 156.120  Health plan does not provide EHB unless: (a)(1) covers at least the greater of: i) One drug in every category and class or ii) the same number of drugs in each category and class as the EHB- benchmark plan; and	§ 156.120 (a)(2) – submits its drug list to Exchange, state or OPM  [ <b>Preamble Only</b> ] reporting requirements for QHPs, plans outside the exchange, and multi-state plans re: drug list
31.	70652, 70670*		The preamble indicates the intent of paragraph (a)(2) is that a “QHP must report its drug list to the Exchange, an EHB plan operating outside of the Exchange must report its list to the state, and a multi-state plan must report its drug list to OPM.” The proposed rule should be

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**HEALTH INSURANCE ESSENTIAL HEALTH BENEFITS, ACTUARIAL VALUE AND ACCREDITATION  
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Row #	PAGE PREAMBLE/ REG*	PROPOSED REGULATORY REQUIREMENT*	FEDERAL PREAMBLE REQUEST FOR COMMENTS	CALIFORNIA <sup>i</sup> COMMENT/QUESTION
				revised to require submission of drug lists for both QHPs and outside market plans to the state regulator, because state regulatory agencies, and not the Exchange, may be responsible for enforcing the essential health benefits requirements regardless of QHP status, as in California. The rule may separately require submission of QHP drug lists to the Exchange so it may independently verify QHP compliance, and to OPM for multi-state plans.
				California recommends HHS work with OPM to clarify the reporting process, including how MSFs will be notified regarding EHB-benchmark requirements.
32.	70652, 70670*	§ 156.120 (a)(1)(i) plan to use USP classification system		Regardless of which organizational/classification tool is used, California recommends HHS utilize readily available tools for providing plan information, including drug lists, to CCIIO. See comments regarding § 156.115(c).
33.	70652, 70670*	§ 156.120 (b) – does not fail to provide EHB Prescription drug benefits solely b/c does not offer drugs for abortion services		California asks that § 156.120 be amended to include language regarding requirements for chemically distinct drugs in each category. While this requirement is discussed in the Preamble, it is not included in the text of the regulation.
34.	70652	[ <b>Preamble only</b> ] Drugs must be chemically distinct to count toward the # of drugs in a category.		

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HEALTH INSURANCE ESSENTIAL HEALTH BENEFITS, ACTUARIAL VALUE AND ACCREDITATION 45 CFR PARTS 147, 155 AND 156				
Row #	PAGE PREAMBLE/ REG*	PROPOSED REGULATORY REQUIREMENT*	FEDERAL PREAMBLE REQUEST For COMMENTS	CALIFORNIA <sup>1</sup> COMMENT/QUESTION
35.	70652, 70670*	§ 156.120 (c) Plan offering EHB must have procedures in place to ensure enrollee access to clinically appropriate non-formulary drugs	Solicit comments re: requirement that plan offering EHB have procedures in place to ensure enrollees have access to clinically appropriate drugs that are prescribed by a provider but not included on the plan's drug list.	Additionally, § 156.20 should be amended to include a definition for "chemically distinct."
36.	70652	f. Prohibition on discrimination § 156.125	[Preamble only] States to monitor & id discriminatory benefit designs  No prohibition on utilization management techniques – but cannot use such techs to discriminate v. certain groups of people	[Preamble only] Process intended to develop framework for analysis tools to facilitate testing for discriminatory plan benefits. HHS “believes analyses could include.” <ul style="list-style-type: none"><li>• Evaluations to id significant deviation from typical plan offerings</li><li>• Unusual cost sharing and limitations for benefits with specific characteristics</li></ul> Welcome comments re: proposed approach to prohibiting discrimination
37.	70653, 70670*	§ 156.125 (a) – An issuer does not provide EHB if its benefit design, or the implementation of its benefit design, discriminates based on an individual's age, expected length of life, present or		This paragraph does not distinguish between benign and invidious discrimination, which we believe could affect issuers' ability to design benefit packages to attract and serve populations

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		predicted disability, degree of medical dependency, quality of life, or other health conditions		with specific health needs, such as those with chronic health conditions. We recommend including the words "against an individual based on age, etc." after the word "discriminates" to allow for such benefit designs without violating the letter of the regulation.
38.	70653, 70670*	§ 156.125 (b) Both § 156.200 [no discrimination on race, disability, age] and §156.225 [prohibits marketing practices/benefit designs that result in discrimination against individuals w/ sig or high cost health care needs] apply in providing EHB		California requests that HHS amend § 156.125 to include a reference to § 146.136, mental health parity.
39	70653	<b>h. Cost sharing requirements § 156.130</b> <i>[Preamble only]</i> Annual limit on enrollee cost sharing - compliance by all QHPS and non-grandfathered issuers in individual/small group market		Please clarify that § 2707(b) applies to all policies sold in the small group and large group markets.
40.	70653, 70670*	“We discuss here the implications and rationale of setting these standards in the context of their application to QHPS and issuers of health plans in the individual and small group markets.” §156.130 (a) ACA annual limitation on cost sharing 2014 + (1) Annual limit tied to enrollee		

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Row #	PAGE PREAMBLE/ REG*	PROPOSED REGULATORY REQUIREMENT*	FEDERAL PREAMBLE REQUEST For Comments	CALIFORNIA <sup>†</sup> COMMENT/QUESTION
41.	70653	<p>§156.130 (b) Annual limitation on deductibles:</p> <ul style="list-style-type: none"> <li>(1) annual limitation on deductibles in the small group market for plan year beginning in calendar year 2014</li> <li>(2) for plan year beginning in calendar year after 2014, annual deductible for health plan in small group market may not exceed factors at (i) &amp; (ii)</li> </ul>		<p>California requests clarification with respect to whether the annual deductible for self-only coverage in the small group market may be reduced by amounts an employer makes available to employees under an HSA or HRA as opposed to an FSA. Specifically, California requests clarification as to whether the annual deductible may ever be higher than \$2,000 and coverage other than self-only ever be higher than \$4,000 if the deductible less the HSA or HRA amounts is under the limit. A significant portion of California's small group market enrollment has such an arrangement with a deductible over the limits in this proposed paragraph, but under the limits, if the HSA or HRA is taken into account. The preamble clarifies that amounts in an FSA may not be used to increase the deductible, but it does not</p>

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Row #	Page Preamble/ REG*	Proposed Regulatory Requirement*	Federal Preamble Request For Comments	California <sup>1</sup> Comment/question
42.	70654	[ <b>Preamble only</b> ] – We propose to use a “reasonableness” standard. While it may be possible to develop plan designs to meet all of these constraints, we believe it could be difficult to develop plans with reasonable coinsurance or equivalent cost-sharing rates in the future, for example in bronze plans.	<p>Comments re: reasonableness standard:</p> <ul style="list-style-type: none"> <li>• What evidence or factors should be required from an issuer and considered in determining whether this [cost-sharing] standard is met with respect to insurance coverage subject to 2707(b) of ACA</li> <li>• Should specific variation threshold be identified?</li> <li>• If so, how should such threshold be established?</li> </ul> <p>Alternative would be to use actuarial value calculator in § 156.135 to determine reasonable increase to amounts described in (b) that can be used by all plans in the small group market.</p>	<p>California believes it is essential that the state, which will be enforcing the benefit requirements, including cost-sharing requirements, be responsible for determining the appropriate variation threshold, if any, for cost sharing in the event a plan will not reach the required actuarial value level of coverage. Issuers should be required to demonstrate to the state regulator that the issuer's plan may not reasonably reach the actuarial value of a given level of coverage without exceeding the annual deductible limit.</p> <p>California plans to establish standard cost sharing provisions for QHPs.</p>
43.	70653, 70671*	§156.130 (b)(3) <i>Reasonableness</i> standard – a plan may exceed the annual deductible limit if the plan may not reasonably reach actuarial value level of coverage. Defined in § 156.140 without exceeding the annual deductible limit.		<p>Comment re: approach on cost-sharing for non-network services.</p>
44.	70654, 70671*	Network Plans §156.130 (c) Cost sharing requirements for benefits from non-network provider don't count toward annual limitation on cost sharing or		<p>California recommends § 156.130(c) be amended to provide that if a particular out-of-network service is required by state law to be treated by the plan as “in-network,” those benefits must be included in the</p>

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HEALTH INSURANCE ESSENTIAL HEALTH BENEFITS, ACTUARIAL VALUE AND ACCREDITATION 45 CFR PARTS 147, 155 AND 156			
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			CALIFORNIA <sup>1</sup> COMMENT/QUESTION
45.	70654	[Preamble only] Nothing in proposal explicitly prohibits issuer from voluntarily limiting out-of-pocket expenses for non-network services or states from requiring that issuers do so.  deductibles.	annual limitation on cost-sharing.
46.	70654, 70671*	Increases in annual limitations §156.130 (d)-(h) (d) Plan years after 2014 - May only increase by multiples of \$50 – must be rounded to next lowest multiple of \$50  (e) Premium adjustment percentage – is the percentage (if any) by which the average per capita premium for coverage for preceding cal. Year exceeds such average per capita premium for insurance for 2013. (f) Annual deductibles do not apply to preventative care (g) Anti-discrimination (h) Emergency services – comply with cost-sharing requirements at 45 CFR 147.138(b)(3).	i. AV Calculation for Determining Level of Coverage § 156.135  i. AV Calculation for Determining Level of Coverage § 156.135  Comment re: methodology for development of the AV Calculator & continuance tables developed based on standard population
47.	70655,	[defined in §156.20] AV = measure of percentage of expected health care costs a plan will cover for a standard population and be considered general summary measure of health plan	Comment re: methodology for development of the AV Calculator & continuance tables developed based on standard population

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		[ <b>preamble only</b> ] Proposed AV generosity.  calculator = set of claims data weighted to reflect standard population projected to enroll in individual & small group markets for identified year of enrollment.		
		Methodology available at <a href="http://cclio.cms.gov/resources/regulations/index.html#pm">http://cclio.cms.gov/resources/regulations/index.html#pm</a>		
48.	70655	[ <i>Preamble only</i> ] Calculator available for both formal and informal calculations and may be used as tool to assist in design of health plans	Comment re: proposal to direct the use of the AV calculator and on parameters described for development of AV Calculator	
49.	70655, 70671*	§156.135 (a) To calculate AV of health plan – issuer must use AV calculator developed and made available by HHS (b) options for issuer whose plan designs do not permit calculator to provide accurate summary of plan generosity		
50.	70655, 70671*	§156.135 (b)(2) & (3) – two options to accommodate plans in (b)(1).	California believes it is essential to revise this section to specify provide that the actuarial certification must be submitted to the applicable state regulator, and to the Exchange for QHPs if the Exchange is a separate entity. This is because state	

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HEALTH INSURANCE ESSENTIAL HEALTH BENEFITS, ACTUARIAL VALUE AND ACCREDITATION 45 CFR PARTS 147, 155 AND 156				
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51.	70655, 70671*	§156.135 (c) standard for treatment of <b>employer</b> contributions toward HSAs and HRAs vis-à-vis actuarial value – ER contributions to HSAs and amounts made newly available under HRAs for current year in <b>small group</b> market are:  1. Counted toward total anticipated medical spending of the standard population that is paid by the health plan and 2. Adjusted to reflect the expected spending for health in benefit year so that: i. Any current year HSA contrib. are accounted for and ii. The amounts newly made available in HRA are accounted for.	This paragraph proposes that employer contributions to HSAs and HRAs be accounted for in the actuarial value calculation. California requests clarification as to how this would be operationalized. For example, if the employer selects a bronze plan, but makes available sufficient amounts under an HSA or HRA such that the actuarial value to the employee is equal to a gold plan, would the plan be considered a bronze or gold plan? Would the employer and employee pay bronze or gold premiums?	regulatory agencies, and not the Exchange, may be responsible for enforcing the essential health benefits requirements regardless of QHP status, as in California.
52.	70655, 70671*	§156.135 (c) Use of state-specific standard population for calculation of AV – beginning in 2015 if: • Submitted by state • Approved by HHS	Comment re: proposal to allow states to use state-specific data and criteria identified by American Academy of Actuaries  Should AV calculator allow for variation between states (based on	Because there is variation in cost and use of services, the AV calculator should allow for variation between the states for states who submit this information to HHS.

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HEALTH INSURANCE ESSENTIAL HEALTH BENEFITS, ACTUARIAL VALUE AND ACCREDITATION 45 CFR PARTS 147, 155 AND 156				
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		<ul style="list-style-type: none"> <li>• proposed criteria for acceptable state claims data:           <ol style="list-style-type: none"> <li>(1) supports calculation of AVs for full range of health plans available in market</li> <li>(2) Derived from non-elderly pop. &amp; estimates those likely to be covered by private health plans on or after 1/1/2014</li> <li>(3) large enough that (i) demographic and spending patterns stable over time &amp; (ii) includes subst'l majority of state's insured population, subject to (d)(2)</li> <li>(4) is statistically reliable and stable basis for are-specific calculations</li> <li>(5) contains claims data on health care services typically offered in current market.</li> </ol> </li> </ul>	stat-specific data)  Should HHS consider including up to three regional adjustments for geographic price differences?	
53.	70655, 70671*	§156.135 (d) Submission of state-specific data	HHS remains open to comments re: use of state data for 2014, but given time constraints propose the option for states to submit a state-specific standard population will begin for plan yrs starting 2015.  “Expect” that submissions will be due in 2d quarter of year prior to benefit year.	California requests state flexibility to use state-specific data for the AV calculator in 2014.  We request clarification regarding whether applications for use of state data will be accepted on a rolling basis or will there be a one-time opportunity to switch from the HHS standard data set?
54.	70655,	§156.135		

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Row #	PAGE PREAMBLE/ REG*	PROPOSED REGULATORY REQUIREMENT*	FEDERAL PREAMBLE REQUEST FOR COMMENTS	CALIFORNIA <sup>1</sup> COMMENT/QUESTION
70671*		(e) HHS develop standard population to be used to calculate AV per 1302(d)(2)(A) of ACA		
		j. Levels of Coverage § 156.140		
55.	70567; 70671*	(a) Calculated according to § 156.135 – within de minimis variation to determine plan's level of coverage.		We suggest codifying the ACA section 1302(e) catastrophic plan exception to the levels of coverage requirement in this section.
		k. Determination of Minimum Value (MV) § 156.145		
		i. Application to Stand-Alone [pediatric] Dental Plans inside the Exchange § 156.150		
56.	70657	[ <i>Preamble only</i> ] § 1311 of ACA allows pediatric dental component of EHB to be offered through a stand-alone dental plan in an Exchange. If such a plan is available in an Exchange, the ACA allows QHPs to exclude coverage of the pediatric dental benefit. This is the ONLY exception to EHB coverage permitted under § 1302.		As indicated in the preamble, if a stand-alone dental plan is offered in the Exchange, QHPs are permitted to exclude coverage of the pediatric dental benefit. California asks that HHS clarify whether a state that permits a stand-alone dental plan to be offered in the Exchange may require all non-stand-alone plans to provide coverage for all 10 EHB categories, including pediatric dental benefits, as a condition of licensure to operate as an insurer/health plan.
				California also requests clarification regarding whether a state may require all plans operating outside the Exchange, other than stand-alone dental plans, to cover all 10 EHB categories, including pediatric dental benefits as provided under the state EHB-benchmark plan.

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Row #	PAGE PREAMBLE/ REG*	PROPOSED REGULATORY REQUIREMENT*	FEDERAL PREAMBLE REQUEST FOR COMMENTS	CALIFORNIA <sup>i</sup> COMMENT/QUESTION
57.	70657- 70658, 70672*	(a) Separate annual limitation on cost sharing	Request comment on what should be considered "reasonable" annual limitation on cost sharing (in-network) <ul style="list-style-type: none"> <li>Alternative: exclude pediatric dental benefit from annual limit on cost sharing – but would treat stand-alone plans differently from plans that included pediatric dental among benefits.</li> <li>Comment generally whether it is appropriate to apply annual limitations standard on cost-sharing for [pediatric?] stand-alone dental plans</li> </ul>	Finally, may the state permit stand-alone vision plans to be offered through the Exchange (and outside the Exchange) in the same manner as dental stand-alone plans?  Clarify HHS is describing pediatric dental plans throughout this section.
58.	70658, 70672*	(b) Actuarial value standards – stand-alone dental plans may not use AV Calculator in § 156.135 (b)(2) high and low value plans (b)(3) level of coverage must be actuarially certified	<ul style="list-style-type: none"> <li>Is de minimis variation requirement of +/- 2% feasible for stand-alone dental plans?</li> <li>Are actuarial value standards for a "high" and "low" plan appropriate?</li> </ul>	California suggests revising subparagraph (b)(3), as it does not require submission of the actuarial certification to a state regulator. California believes it is imperative that the regulation require submission of the actuarial certification to the applicable state regulator and to the Exchange for QHPs if the Exchange is a separate entity.
<b>3. Subpart C - Accreditation</b> <ul style="list-style-type: none"> <li>a. Accreditation of QHP Issuers § 156.275</li> </ul>				

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<sup>i</sup> For the purpose of these comments, "California" refers to the Department of Managed Health Care, California Department of Insurance, and California Healthy Benefits Exchange.

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