National Association of Insurance Commissioners
& The Center for Insurance Policy and Research

December 29, 2020

Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-9914-P
P.O. Box 8016
Baltimore, MD 21244-8016

Via Regulations.gov

To Whom It May Concern:

The following comments on the proposed Notice of Benefit and Payment Parameters for 2022 (Notice), as published in the Federal Register on December 4, 2020, are submitted on behalf of the members of the National Association of Insurance Commissioners (NAIC), which represents the chief insurance regulators in the 50 states, the District of Columbia, and the United States territories.

First, we appreciate the Department's effort to publish the proposed Notice earlier than in some prior years. As NAIC has noted in past comments, publishing and finalizing the Notice earlier gives health insurance issuers and state regulators more time to develop and review plans and rates for the relevant year. We continue to request a longer comment period—allowing more than 30 days would give NAIC, individual state regulators, and other organizations a greater opportunity to offer meaningful comments.

State-Mandated Benefits Reporting Process

As we have indicated in the past, state regulators remain concerned regarding the lack of justification and transparency related to the new process for reporting state-mandated benefits. Regulators urge CMS to immediately make available the proposed templates that states are expected to use in reporting "new" benefit mandates in the summer of 2021. States should be provided notice and the opportunity to comment on the reporting templates ahead of the required filing. In addition, state regulators respectfully request greater detail on the reporting and review process, including whether CMS intends to establish an appeals process for situations where there is disagreement between CMS and a state surrounding the scope of a benefit mandate or its status as an addition to essential health benefits.

Risk Adjustment Updates (153.320)

We support the use of 2016, 2017, and 2018 EDGE data for recalibrating the 2022 benefit year risk adjustment model. We also support the proposed approach to identify the three most recent years of data available for the annual recalibration of the risk adjustment models moving forward to allow the coefficients to be provided in the proposed rule. We support the continued application of the market pricing adjustment to plan liability for Hepatitis C drugs. We agree that the pricing adjustment should be reassessed with additional years of enrollee-level EDGE data.

We further support the continued use of an adjustment factor for cost-sharing reduction to recognize induced demand from enrollees in plans with higher actuarial value. We are not certain if 1.12 is the appropriate factor, though we support its continued use for 2022. We suggest that HHS consider other

factors in setting the induced demand multiplier, such as whether or not the state expanded Medicaid, or whether or not the state offers a basic health plan. The availability of expanded Medicaid or a Basic Health Program impacts the pool of individuals eligible for premium tax credits and thus who seeks coverage in a qualified health plan. We would like more information about how demand is affected by Medicaid expansion and basic health plans, and whether or not induced demand was affected when CSR payments were discontinued and silver loading was implemented.

Calculation of Plan Average Premium and State Average Premium Requirements for Extending Future Premium Credits

We support the proposed methodology of recognizing future premium refunds, holidays, or reductions in the risk adjustment program as the result of a public health emergency. We also support the proposed application of the methodology when a state requests a reduction of the transfer payments in the small employer market.

State Flexibility in Risk Adjustment

State regulators support the Department's proposals related to state adjustments to federal risk adjustment payments. We support approval of Alabama's request for an adjustment to its 2022 payments. Further, we support the proposal to allow states to request approvals for adjustments for multiple benefit years. Allowing for requests of up to three years will not only contribute to stability and predictability in state markets, it will also reduce burden on states and the Department in preparing and reviewing requests for adjustments. We believe the proposal contains sufficient flexibility to allow appropriate responses if a state's market conditions change during the course of a multi-year adjustment approval.

Audits and Compliance Reviews of Issuers of Reinsurance-eligible Plans (153.410)

We appreciate the need to perform audits and compliance reviews for the transitional reinsurance program, and for those reviews to be conducted as seamlessly as possible. States are well suited to assist HHS to ensure timely and accurate compliance. To provide such assistance, states would need to be made aware of upcoming reviews and be kept abreast of their progress as the reviews occur, including identification of those issuers that are non-responsive, those that are not conforming to prescribed data formats, or any other issues that impede the review. States should also be informed of the final results of such reviews in a timely manner, including notice of any moneys that are being refunded.

Exemptions from HHS-RADV (153.630)

While we fully support an exemption from risk adjustment data validation audits for issuers who are the sole issuer in the state market risk pool, we believe the Department should further consider the proposal to exempt issuers who only offer small-group carryover coverage in the benefit year. It is possible that the small-group carryover business could represent a significant portion of the marketplace for a calendar year. It is our understanding that HHS-RADV audits occur for an issuer on average every three years. We ask the Department to consider the case of an issuer with only carryover business and that has not been selected for a RADV audit within the past two years. Such an issuer should still be considered for audit during the year they are exiting. If the issuer has been selected for a RADV audit within the previous two years, we support excluding them from the audit in the year of exit.

IVA Requirements (153.630)

We agree there is a potential conflict of interest for an IVA entity to audit a company for which it serves as the issuer's TPA. We support the proposed controls over selecting an IVA entity to avoid such conflicts.

Timeline for Collection of HHS-RADV Payments and Charges

The Department proposes that the HHS-RADV timeline be adjusted back to what it used to be and that it would no longer allow an adjustment for HHS-RADV in the URRT. The need for an adjustment to the URRT to account for HHS-RADV has thus far been infrequent and difficult to justify. However, there may be reasonable and justifiable adjustments related to past HHS-RADV audits that affect future rating, and we ask that states continue to be allowed to determine if the adjustment is reasonable and justifiable.

EDGE Discrepancy Materiality Threshold (153.710)

We support increasing the minimum threshold from $10,000 to $100,000 (or 1% of the total estimated transfers in the market risk pool). We view a threshold of $10,000 to be too low to be material.

Definitions of QHP Issuer Direct Enrollment Technology Provider and Agent or Broker Direct Enrollment Technology Provider (155.20)

We also offer support for the proposal to require that QHP issuer direct enrollment technology providers be subject to the requirements applicable to QHP issuers and to HHS oversight. Technology providers play an important role in shaping the experience of consumers; their design and implementation choices impact the information available to consumers and the choices consumers make. State regulators have found that enforcing consumer protection laws with regard to technology providers and web-brokers can be challenging when insurance regulation is not directly applicable to them. Making regulations more clearly applicable when they act as downstream or delegated entities for QHP issuers will help hold technology providers accountable for key standards. We urge the Department to continue to work closely with state regulators on addressing inaccurate and misleading marketing practices from all entities, whether they are QHP issuer direct enrollment technology providers, web-brokers, or other organizations.

Direct Enrollment Entity Plan Display Requirements (155.221)

The Notice contains proposals to give direct enrollment entities greater flexibility in displaying information for qualified health plans on the same webpage as plans that are not qualified health plans. The proposal would allow display of both types of plans only when consumers indicate they have access to Health Reimbursement Arrangements with employers (and for dental plans). We recognize the need to provide consumers with access to HRAs information on all relevant options. Nonetheless, state regulators are concerned by the recent activity of market actors who mislead or confuse consumers about the attributes of plans that are not QHPs, including at times using terminology consumers may associate with QHPs, such as "Obamacare." We support the general prohibition on displaying QHP and non-QHP information on the same webpage. And while the limited exceptions proposed for 45 CFR 155.221(c) may be prudent, we urge the Department to enforce strict compliance with the limits to the exceptions as proposed. In particular, the proposed exception would permit the display of information for non-QHPs that fit the definition of health insurance coverage at 45 CFR 144.103. This would exclude display on the same page of QHPs and short-term, limited duration plans and the proposal would further exclude the display of excepted benefits. These two exclusions should be maintained and strictly enforced to reduce misleading marketing and consumer confusion.

Special Enrollment Period Verification (155.420)

We understand the Department's intent to reduce the potential for anti-selection effects by implementing pre-enrollment verification of eligibility for certain special enrollment periods (SEPs) and we have heard anecdotally from issuers that SEPs appear to be approved more often than expected. However, some states have concerns that such a policy could hinder or delay access to coverage unnecessarily for some applicants. CMS has not offered evidence to suggest that SEPs have negatively impacted individual market risk pools. We encourage CMS to provide such justification if it moves forward in supporting the federally-facilitated exchange implementing validation for 75% of new SEP enrollees. In addition, we ask for flexibility on the SEP pre-enrollment verification processes for state-based exchanges. SBEs may not have the $108 million in resources CMS expects to be required to implement rigorous validation for such a high percentage of enrollees. We ask that SBEs be allowed to set their own standards for the verification processes in a way that fits their current resources and market needs.

Rebating Premium if the Applicable Medical Loss Ratio Standard is Not Met (158.240)

State regulators also support the proposed change to allow issuers to pre-pay medical loss ratio rebates through premium credits prior to the MLR reporting deadline. The effects of the pandemic include both financial hardship for many enrollees and reduced medical losses for many insurers. Providing issuers another means to pay rebates early helps return excess premiums to consumers more quickly at a time when the need is great for many. We support requiring premium credits to be available as an option for paying MLR rebates only to the extent such credits are consistent with state law and are provided statewide in a non-discriminatory manner. We further support allowing pre-payment by premium credit for the 2020 MLR reporting year.

Sincerely,

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