

February 15, 2019

Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-9926-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 2020 (Notice), as published in the *Federal Register* on January 24, 2019, 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.

General Comments

State regulators are concerned about the timing of this proposed Notice and hope in future years it will be published much earlier. For carriers to fully weigh their options and develop plans and rates they need to know the rules under which they will be operating. With the proposed Notice published in late January, and likely not finalized for another 60 days, carriers and state regulators will be forced to work quickly to prepare and review plans for 2020. We encourage the Administration to publish the proposed Notice for 2021 by the end of November and then provide a longer comment period to ensure a better regulatory environment.

Actuarial Loading (“Silver Loading”)

The Department of Health and Human Services (HHS) discontinued cost-sharing reduction (CSR) reimbursements in 2017 after a finding that Congress had not appropriated funds for them. Nonetheless, the requirement that issuers reduce cost-sharing for lower-income enrollees remains in place even though the issuers are no longer reimbursed for the cost-sharing reductions they provide. In response to the termination of CSR reimbursements, many state regulators directed insurers to use actuarial loading, also referred to as “silver loading,” and in other states issuers themselves chose to employ actuarial loading. Under this method, issuers increase premiums on silver level plans (often only within the exchange) to compensate for the increased actuarial value they provide to eligible exchange enrollees. For plan year 2019, only five states and DC use a method other than actuarial loading to price plans in the absence of CSR reimbursements.

The loss of CSR reimbursements threatened the exchange markets with immediate destabilization, which would have resulted in loss of coverage options and increased premiums. Through the use of actuarial loading, states were able to instead stabilize their markets and preserve the coverage options available to subsidized enrollees, preventing substantial increases in the premiums for bronze and gold plans that bear no relationship to the actual cost of coverage. Depending on their health needs, actuarial loading makes a bronze or gold plan comparatively more affordable for those with subsidies and keeps the price of silver the same. For those without subsidies who don’t purchase on-exchange silver plans, premiums are not increased to pay for cost-sharing reductions for others. Thus, actuarial loading made coverage more affordable, increasing participation in markets and improving their stability.

Since actuarial value is increased only for eligible on-exchange enrollees in silver plans, many state regulators have concluded the most equitable way to account for CSRs is to load only on-exchange silver plans. Within current law, regulators do not see an opportunity to fine tune the application of the CSR load. This does increase costs to taxpayers since the law ties premium subsidies to silver plan premiums. Because Congress chose this subsidy structure and it did not add an explicit appropriation for CSRs, NAIC believes the most appropriate way to address any adverse effects of actuarial loading is through legislative action.

The NAIC urges that, in the absence of Congressional action regarding resumption of CSR reimbursements, the Centers for Medicare and Medicaid Services (CMS) take no action by rulemaking to limit the tools available for state regulators in this area. Removing the state option for actuarial loading would destabilize insurance markets that have otherwise recently achieved a beneficial equilibrium. Such destabilization reduces insurer participation, reduces choice, increases costs, and would raise costs for many Americans who obtain coverage through the individual market.

Automatic Re-Enrollment

CMS requested comment on automatic re-enrollment, including the possible unintended consequences of the practice. CMS observed that consumers may be “shielded from changes to their coverage, which may result in consumers being less aware of their options from year to year,” and the risk that their tax credit information will be out of date. As CMS also observed, it is general industry practice in many lines of insurance for policies to renew automatically from year to year, as long as the policyholder continues to pay the premium. This is an important consumer protection that is often mandated by state law. Guaranteed renewability of many types of health coverage has been one of the most important aspects of federal health insurance regulation and has now been in effect for more than 20 years.

While it is important to remind consumers of the full range of coverage options that is available and to ensure that their income information and other eligibility data remains up to date, solutions to these concerns should not come at the expense of consumers’ legal right to keep the plans they have, or a comparable plan if their current plan is discontinued. The current plan, or its “cross-walked” equivalent, should always be the default option. CMS has developed an appropriate cross-walk hierarchy that we believe serves a large share of the consumers who are affected by it. While an enrollee’s current plan, or a cross-walked plan, might not be the best option for every consumer who is automatically re-enrolled, dropping the plan or changing it needs to be the consumer’s affirmative decision, not the government’s decision.

Further, automatic re-enrollment is an important complement to the limited open enrollment period. Without automatic re-enrollment, consumers who take no action during open enrollment may only learn they lack coverage when the new year begins. With open enrollment over, they may not be able to access a comprehensive plan. And the consumers most likely to let their coverage lapse in the absence of auto-reenrollment are those who are relatively healthy. Allowing them to drop from coverage by default would harm risk pools.

Despite some manageable flaws, automatic re-enrollment serves as an important stabilizing force for state markets and we urge CMS to maintain it for federally-facilitated exchanges.

Exchange User Fees (§156.50)

The NAIC applauds efforts by CMS to reduce the cost of operating the Federal Exchange and recognizes the value to enrollees in reducing user fees. It remains difficult, however, to evaluate whether the proposed user fees are appropriate without more detailed information on exchange costs. States would benefit from a breakdown of federal exchange expenses by functional area. We urge CMS to make available per enrollee or per state costs for eligibility and enrollment, plan management, customer service, and other exchange functions. Not only would this increase transparency around fees, it would aid states in determining whether it would be cost effective to move to a different exchange model. We will continue to work with you to better understand the fees and make efforts to reduce costs further in the future.

Mid-Year Changes to Drug Formularies (§147.106(e)(5))

State regulators support the deference to applicable state law in 147.106(e)(5). We are concerned, however, that mid-year formulary changes may place undue burden on enrollees without adequate notice. Changing a drug's availability or cost-sharing is disruptive and potentially costly for patients who are currently prescribed the drug. It may also complicate plan choice for consumers who select a plan after the formulary change. Enrollees who change plans or newly enroll after the formulary change should have up-to-date formulary information, but the proposal does not make clear how issuers and exchanges will update drug coverage information on Healthcare.gov and other purchase channels if a drug is removed from a formulary mid-year. We urge CMS to limit mid-year changes when generics become available to cost sharing amounts and/or the tiering of the brand drugs. Drugs should be permitted to be removed entirely from a formulary only between plan years.

Further, for cost sharing changes, we urge CMS to adopt a longer, two-step notice approach. When a generic equivalent drug is newly available and an issuer plans to change the terms for the equivalent brand drug within the coverage year, CMS should require that the issuer provide notice to covered persons of the availability of the generic drug as well as any cost advantage of switching to the generic. Recognizing that many enrollees fill prescriptions for 90 days at a time, regulations should require that 90 days must elapse after this first notice has been provided before the issuer may provide another notice, consistent with the proposed rule and NAIC's Health Carrier Prescription Drug Benefit Management Model Act, that changes to the brand drugs' cost sharing will occur. Only after 60 days have elapsed from the second notice would the issuer be permitted to change the brand drug's cost sharing. A multi-notice process would require issuers to first provide a more meaningful opportunity for enrollees to act to change prescriptions before the issuer acts to change the terms of the plan the enrollee purchased.

Drug Costs and Out-of-Pocket Maximums

The Notice would permit issuers, in individual, small, and large group markets, to exclude from the essential health benefits a brand drug when a generic is available, and full coverage for the brand drug has not been granted through the issuer's exceptions process. This would allow issuers to disregard the incremental out-of-pocket cost of the brand drug over the generic when determining whether enrollees have satisfied their out-of-pocket maximum. It would further would allow issuers to apply annual limitations on coverage for the brand drug unless the enrollee has qualified for an exception. Separately, the Notice would allow issuers to disregard the value of drug manufacturers' coupons in an enrollee's out-of-pocket maximum when a generic equivalent is available. While these policies would put downward pressure on manufacturers' prices for some prescription drugs, and thus on premiums, they would do so at the expense of enrollees.

If these proposals are adopted, the final language should expressly provide that these limitations on coverage only apply to the extent consistent with state law. States' authority to regulate insurance includes limitations on how issuers accumulate cost sharing and state regulators can best decide whether these particular tools for reducing prescription drug costs are appropriate for their states.

Premium Adjustment Percentage (§156.130)

State regulators recognize the value of using a broad measure of premium costs to calculate the premium adjustment percentage. However, regulators have concern that adjusting the percentage as proposed for plan year 2020 may harm state markets that have only recently achieved some stability. The proposed regulation estimates that this change would result in \$900 million less in premium tax credits and 100,000 enrollees leaving individual markets in 2020, a majority of whom are predicted to go uninsured. Reduced federal support and fewer enrollees would not be helpful for state markets as they remain vulnerable.

Regulators urge CMS to employ a more gradual transition to using individual market premiums in the formula for the premium adjustment percentage. Rather than moving in one year to a new measure of premium change, we recommend that CMS spread the change over the course of several years. As a transitional approach, CMS could blend the existing formula, using employer-sponsored insurance premiums, with the proposed formula, using the

broader measure of premiums for private health insurance (excluding Medigap and property and casualty insurance). Each year, the weight applied to employer-sponsored premiums could decline until it reached zero. This would help avoid a reduction in premium tax credits so large in any one year that it causes a significant number of people to become uninsured.

Navigators and Outreach (§155.210)

We support providing more flexibility for Navigators who are funded through the federally-facilitated exchanges. However, we remain concerned about reduced funding for both Navigators and for general outreach. State-based exchanges have proven that appropriately funded Navigator programs and outreach efforts yield significant gains. We urge CMS to review current funding for these programs and provide sufficient resources in 2019.

Request to reduce risk adjustment transfers in the Alabama small group market

The NAIC supports the request made by Alabama for a reduction in risk adjustment transfers for the state's small group market for the 2020 benefit year.

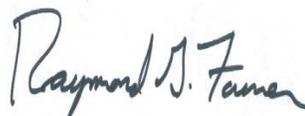
State-directed changes to risk adjustment support the state-based system of insurance regulation. Because risk adjustment transfers occur only within states, the state regulator in each state is in the best position to evaluate risk adjustment's effects on the competitive market. State regulators also evaluate and regulate the solvency of insurance companies, a responsibility the federal government does not share. When it adversely affects a market in a state, the federal risk adjustment formula should be modified. CMS has identified this dynamic and has adopted regulations at 45 CFR 153.320 (d) to reflect this need. We believe Alabama has met the requirements imposed by this regulation and encourage the Secretary to accept the request from Alabama.

Thank you for this opportunity to comment. As state regulators continue to review the draft Notice and its potential impact on market competition, premiums, and consumer protections, we will continue to provide comments. We are available to discuss these or other issues as the Notice is finalized.

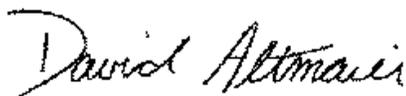
Sincerely,



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