

January 27, 2023

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9899-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 2024 (Notice), as published in the Federal Register on December 21, 2022, 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 five United States territories.

First, we appreciate the Department's effort to publish the proposed Notice somewhat 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 further appreciate the somewhat longer comment period—allowing more than 30 days gives NAIC, individual state regulators, and other organizations a greater opportunity to offer meaningful comments.

State Requests to Reduce Risk Adjustment Transfers

The proposed Notice would repeal the ability of states to request a reduction in risk adjustment state transfers, including for the state that has previously requested and been approved for a reduction. State regulators object to this change. State regulators recognize the importance of risk adjustment in maintaining predictable premiums and attracting issuers to markets. But unique dynamics in an individual state's insurance market can result in undesired outcomes when applying the federal risk adjustment methodology, which must be developed and applied nationwide. State regulators have the detailed understanding of their state markets necessary to recognize the rare instances when the federal risk adjustment methodology is inappropriate for a state's market.

Under current policy, states must apply for and receive approval from the Department of Health and Human Services (HHS) to reduce risk adjustment transfers. This approval process leaves the final determination up to HHS and allows for states to provide justification for reducing risk transfers when conditions warrant. Foreclosing the opportunity for states to apply for reductions in transfers pre-judges all future market conditions. State regulators believe it is preferable to retain the current approach and keep open the possibility for states to make applications. Because HHS has the authority to disapprove an application if a state fails to provide adequate justification, it is not necessary to disallow requests.

If the change in policy is finalized as proposed, state regulators support an ongoing exemption for the single state that has previously requested and been approved for reduced risk adjustment transfers. We also support Alabama's request to reduce its transfers for the upcoming year.

Navigator, Non-Navigator Assistance Personnel, and Certified Application Counselor Program Standards

The Notice proposes to remove some prohibitions on Navigators, non-Navigator Assistance Personnel, and Certified Application Counselors using door-to-door and other unsolicited means of direct contact to provide application or enrollment assistance to consumers. As state regulators, we appreciate HHS's well-intentioned proposal as a way to get more consumers enrolled in health coverage and to address health disparities by making it easier for consumers to enroll. However, several state legislatures have enacted laws requiring state licensure of assisters and many of these laws draw a distinction between the duties of an assister and the duties of a separately licensed insurance producer. HHS recognized the importance of state licensure in the current rules, requiring Navigators, non-Navigator Assistance Personnel, and Certified Application Counselors to comply with licensing, certification, or other standards prescribed by the state or exchange. We encourage HHS to specify that the removal of some of the prohibitions regarding door-to-door and other unsolicited means of direct contact do not preempt state law prohibitions against Assisters selling, soliciting, or negotiating health insurance unless also licensed as a producer.

Documentation Requirements for Agents and Brokers

The Notice proposes to adopt new requirements on agents, brokers, and web-brokers to document consumers' consent to representation as well as consumers' confirmation of the accuracy of submitted application information. State insurance regulators appreciate HHS' efforts to enforce protections against misconduct on the part of agents and brokers and we believe these requirements will both encourage stricter compliance with standards and aid in investigations of possible agent and broker misconduct. We encourage HHS to maintain the flexibility it has proposed in

operationalizing these requirements. Allowing agents and brokers to use different electronic means, forms, or recordings to document consumer consent will allow agents and brokers to comply with the federal regulation while also meeting any similar state requirements. We note that the 10-year retention requirement for such records may exceed state records retention policies, which may cause some confusion for agents and brokers. HHS may wish to align records retention periods with state policies when appropriate.

Reenrollment Hierarchy

The Notice proposes to give Exchanges authority to alter the reenrollment hierarchy. It would allow Exchanges to move enrollees in bronze plans who are eligible for cost-sharing reductions to silver plans (with the same issuer and product) in the next plan year if their net premium in the silver plan would be the same or lower. Exchanges would need to consider the similarity of different plans' networks when making reenrollments in several scenarios. State insurance regulators recognize the potential benefit to consumers of moving them to a silver plan variation that offers lower cost sharing with the subsidy. We support giving Exchanges the option of making these changes to reenrollment hierarchies so that state-based exchanges can choose whether the revised hierarchy is in the best interests of consumers and insurance markets in their states.

In operationalizing this authority for the federally-facilitated exchanges, we urge HHS to consult with state insurance regulators on any impacts of the change, particularly regarding network similarity. Some regulators are concerned that overriding an enrollee's prior choice of plan level may create disruptions, particularly when networks are similar but not identical. States may use different practices in setting policies for the assignment of network IDs, so it would be helpful for HHS to engage directly with states to better understand how networks differ based on ID. We appreciate HHS' ongoing engagement with NAIC and state regulators on provider network issues and anticipate using that engagement to enhance understanding on both sides.

SEP for Loss of Medicaid

As Medicaid continuous enrollment comes to an end, state agencies across the country will begin Medicaid eligibility redeterminations, which is expected to result in millions of individuals losing Medicaid coverage and seeking coverage through the exchanges. State insurance regulators support the proposed extension, from 60 days to 90, for reporting loss of coverage and enrolling in an exchange plan. This extended timeframe will serve as an additional safety net for individuals newly navigating tax credit eligibility and commercial plan options. Also appreciated are the proposed efforts to ensure consumers experience little to no gaps in coverage as

they transition from Medicaid to exchange plans. We are supportive of the flexibility provided to state-based exchanges in implementing these provisions.

FFE and SBE-FP User Fee Rates

State insurance regulators support a reduction in user fee rates. Consumers should see some benefit as lower fees are passed along in the form of lower premiums. We encourage HHS to continue to find efficiencies in the operation of the federally-facilitated exchanges and the federal platform so that it can further reduce rates in the future.

Non-Standardized Plan Option Limits

The Notice proposes to limit the number of non-standardized plan options issuers may offer through federally-facilitated exchanges. Issuers would be limited to two non-standardized plans per network type at each metal level. Alternatively, HHS would apply a meaningful difference standard and prohibit plans that are not meaningfully different from others offered by the same issuer, based largely on deductible amounts. State insurance regulators support a flexible approach that allows for variation based on market conditions in each state.

Some state regulators have concerns about the high number of plan options offered through their federally-facilitated exchanges and would support regulatory changes to limit the number of plan choices. When consumers are faced with dozens of plan choices it is more difficult for them to identify the plan that best meets their needs. Common plan search and display designs can hide plans from some issuers when other issuers market a high number of plans with only slightly different features. Thus, limiting plan offerings or assuring they are meaningfully different from each other can improve consumer outcomes and promote competition among issuers.

Other states, however, wish to promote competition by allowing issuers to innovate and offer the number of plans that best suits their markets, their customers, and their competitive strategies. Some regulators want to maintain issuers' ability to market plans that offer features some consumers desire, even when relatively few consumers choose a certain plan.

The number of plan offerings nationwide has increased in the last few years, but there remains significant variation by state and by service area. The numbers HHS cites in discussing its proposals to limit offerings are averages across all federally-facilitated exchanges. Many areas have fewer than the average number of plans. State regulators are best situated to understand the dynamics of their state markets and assess when limits on the number of plan options should be applied. Thus, state regulators recommend a more flexible approach to plan options than either alternative outlined in the proposal. At a minimum, HHS should allow states to opt out

of the plan limit and allow more plan offerings when the chief insurance regulator determines this would be in the best interest of the state's consumers. More flexibly, HHS could allow states to specify a different limit applicable in the state.

Flexibility could also be added to the meaningful difference alternative. HHS could allow a state to choose additional criteria on which plans could vary and be considered meaningfully different. For example, HHS could allow states to select one or more of the criteria in the 2015 meaningful difference standard, including cost sharing, provider networks, covered benefits, and Health Savings Account eligibility. A state may wish to allow differences in these plan features to distinguish plans as meaningfully different and permit more non-standardized plans to be offered side-by-side. More generally, HHS could consult with state regulators during the QHP certification process and collaborate with them in determining whether the plans offered by a particular issuer are meaningfully different.

State regulators support the state flexibility HHS proposes with regard to exchange type. Allowing state-based exchanges to make their own choices regarding non-standardized plan options supports the state-based exchange model. It recognizes the varied approaches states may choose to manage their QHP markets as well as the challenges presented by shifts in federal rules on plan offerings.

Plan and Plan Variation Marketing Name Requirements for QHPs

The Notice proposes a new requirement that QHP plan marketing names include correct information that is not misleading. State insurance regulators support this new requirement. We have observed plan marketing names that omit key information and can easily mislead consumers into believing that some services will be covered at no cost when important conditions and limitations apply. We anticipate continued collaboration with federal officials in enforcing this requirement once it is finalized. In considering standardization of plan marketing names, we suggest HHS include network type as one potential standardized element. The availability and relative cost of out-of-network benefits is an important consideration for some consumers and an indication in the plan name would be a prominent way to signal plan differences in this area.

Plans That Do Not Use a Provider Network: Network Adequacy

The Notice proposes to revise the network adequacy standards to state that all Stand-Alone Dental Plans (SADPs) across all exchanges must use a network of providers. The Notice recognizes that, if this proposal is finalized, it can be more challenging for SADPs to establish a network based on the availability of nearby dental providers in states like Alaska and Montana. The Notice seeks comment on whether HHS should finalize a limited exception to the network requirement for SADPs that sell plans in

areas where it is prohibitively difficult for the issuer to establish a network of dental providers.

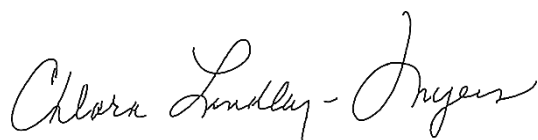
As explained in more detail in the separate comment letter submitted by Montana's Commissioner of Securities and Insurance, consumer choice of SADPs on the exchange would be negatively affected should the network requirement for SADPs be adopted because it would result in removal of three out of the five issuers currently offering SADPs on the exchange for Montanans. If this requirement is finalized, the NAIC supports HHS establishing a limited exception for SADPs that sell plans in areas where it can be prohibitively difficult for SADPs to establish a network of dental providers.

Compliance With Appointment Wait Time Standards

The Notice proposes to apply the network adequacy standard related to appointment wait times beginning with plan year 2024. State insurance regulators appreciate the decision in the 2023 Notice to delay this aspect of network adequacy reviews. However, we remain concerned with the availability and reliability of data to demonstrate compliance with this standard. HHS expects to rely on issuers' attestations of compliance with the standard. It remains unclear what data or measures on which issuers are expected to base their attestations. Neither state nor federal regulators have appropriate tools to assess whether attestations are accurate. While the waiting time until an appointment is a key aspect of access to care and an important indicator of network adequacy, state regulators urge more detailed development of related measures before robust enforcement of this network adequacy standard.

Thank you for the opportunity to comment on HHS' proposed updates to regulations in these areas. We appreciate your consideration of state regulators' perspective on the proposals and their potential impact on consumer protections and market competition. We are available to discuss these or other issues as HHS continues its work and the Notice is finalized.

Sincerely,

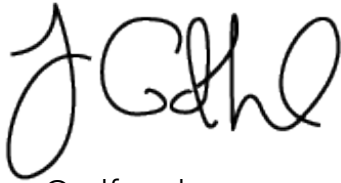


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