

February 28, 2020

Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-9916-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 February 6, 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.

General Comments

State regulators wish to again express concern about the timing of this proposed Notice and urge the Department of Health and Human Services (HHS) to publish it much earlier in future years. 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 early February, and likely not finalized for some time, carriers and state regulators will be forced to work quickly to prepare and review plans for 2021. We encourage the Administration to publish the proposed Notice for 2022 by the end of November and then provide a longer comment period to ensure a better regulatory environment.

Risk Adjustment

Data Recalibration

We support HHS's proposal to move to using EDGE data for risk adjustment coefficients and we also support the continued use of three years of rolling data.

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 2021 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. HHS 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.

Further, we urge HHS to consider moving to a multi-year approval for state changes to risk adjustment to ease burden on states.

Risk Adjustment User Fee

State regulators support the proposal to set the user fee at \$0.19 PMPM and do not believe that raising the fee by \$0.01 PMPM will have a significant effect. However, we urge HHS to clarify how it will handle any overages in user fee collections and how the financing of the program will be affected if the predicted decline in billable member months for benefit year 2021 does not occur.

Automatic Re-Enrollment

HHS is considering removing Advanced Premium Tax Credit (APTC) at re-enrollment for consumers whose prior-year APTC covered their full premium. We recognize the importance of being good stewards of taxpayer funds but oppose this proposal which could cause disruption to consumers and issuers by prompting large and potentially inaccurate premium bills. Sending a bill for the full premium amount would likely, as intended, encourage many enrollees to update their applications. But it is also likely to suspend premium tax credits for families who remain eligible, cause confusion for many consumers, and lead to some unnecessary disenrollments as consumers work to understand the changed process and provide the needed information. Disenrollments that could result from this policy would likely damage the risk pool, since the healthiest consumers will be those most likely to delay restoring their enrollment. In addition, federal rules should not require withdrawing the entirety of an enrollee's premium tax credits *before* an Exchange receives information that demonstrates changed eligibility.

State insurance regulators recommend that HHS take other steps over time to encourage enrollees to update their eligibility information. HHS should start by undertaking the same consumer outreach and education practices it contemplates under the policy of suspending premium tax credits. It should use fact sheets, email or mail outreach depending on preference, and education among issuers, agents, brokers, Navigators, and other assisters to explain the importance of updating consumer applications even in the absence of a threat of suspended tax credits. If HHS decides to adopt a policy of APTC reduction, we recommend doing so only after one or more Open Enrollment Periods with such outreach. Further, if HHS decides to reduce APTC for enrollees who have not updated their information, an Exchange should prioritize keeping the remaining balance for consumers relatively low to help minimize the risk of unnecessary disenrollment.

Further, state regulators oppose applying any specific procedure for re-enrollment or eligibility re-determinations on state-based exchanges. State-based exchanges should retain the flexibility to implement the redetermination processes that best serve each exchange's customers. If a state-based exchange determines that households with no out-of-pocket premiums present an increased risk of error, that exchange should have the ability to determine a solution rather than having one imposed by federal regulation.

Special Enrollment Period – Newly Ineligible for CSRs

We support the proposed change to allow consumers to select a plan of a different metal level when they become ineligible for cost-sharing reductions. Consumers who become ineligible for a higher actuarial value silver plan may find a better trade-off between premium and cost sharing in a bronze or gold plan and should be permitted to select one of the other metal levels.

Exchange User Fees – FFEs and SBE-FP

We appreciate HHS's consideration of lowering the user fees. Due to the rise in premiums in recent years, it seems likely that growth in user fees has exceeded the growth in exchange costs. However, in order to provide relevant comments on the proposal to maintain the current fees and the possibility of reducing them, state insurance regulators require more detailed information on how user fees are spent. As NAIC wrote in comments

to the proposed 2020 Notice of Benefit and Payment Parameters, “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 the Centers for Medicare and Medicaid Services (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.”

Mandated Benefits – Mandatory Annual Report from States

State insurance regulators have a number of concerns with the reporting requirements that would be imposed under the proposed § 156.111. First, it remains unclear to what use HHS will put the information it receives under the proposed reporting requirements. HHS states that reported information will “provide the necessary information to HHS for increased oversight over whether states are appropriately determining which state-required benefits require defrayal, whether states are correctly implementing the definition of Essential Health Benefits (EHB), and whether QHP issuers are properly allocating the portion of premiums attributable to EHB for purposes of calculating PTCs.” However, it does not outline what oversight activities it will conduct. Before a reporting requirement is finalized, states would like to understand potential liabilities the reported information could generate. For instance, if a state reports a benefit mandate that has been in effect for multiple plan years, is the state at risk for HHS oversight and remedial action?

Because states hold the responsibility for identifying which mandated benefits are in addition to EHB, we believe that federal oversight should remain limited. Keeping the responsibility for identifying additional benefits with states will help HHS avoid a circumstance in which a state and HHS reach differing conclusions about whether a mandated benefit is in addition to EHB. While the Affordable Care Act requires states to make payments to defray the cost of additional benefits, it does not provide for a process under which HHS’s conclusions about a benefit’s status as additional can be substituted for a state’s conclusion.

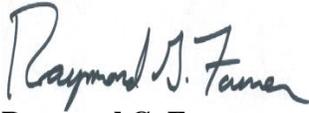
HHS seeks comment on whether it should amend 155.170(a)(3) to make Exchanges or HHS, rather than states, responsible for determining which state-mandated benefits are in addition to EHB. State insurance regulators oppose any such changes to paragraph (a)(3). The EHB selection process HHS has established appropriately relies on state choices to set the EHBs under federal guidelines. As the primary regulators of individual and small group markets, states maintain the authority to mandate certain benefits in those markets. Because they select their EHBs and define their own mandated benefits, states are the best positioned entities to determine which, if any, mandated benefits are in addition to EHBs. And, as stated above, keeping the responsibility for identification with the states prevents disparate conclusions about particular benefits.

Drug Coupons and Out-of-Pocket Maximums

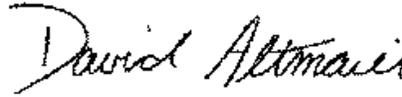
We support deference to state laws, regulations, and guidance on this topic. Federal regulations should not limit state policy with regard to drug coupons and co-pay accumulators. States should have the authority to require issuers to count drug coupons toward the annual limitation on cost sharing and toward deductibles, to prohibit issuers from doing so, and to permit issuers to decide for themselves how to treat drug coupons. State regulators further support the proposed definition of cost sharing that would exclude expenditures covered by drug manufacturer coupons.

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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