

December 21, 2015

Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-9937-P
P.O. Box 8016
Baltimore, MD 21244-8016

To Whom It May Concern:

The following comments on the proposed Notice of Benefit and Payment Parameters for 2017 (the Notice), as published on December 2, 2015, 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 5 United States territories.

General Comments

The comment period provided for the draft Notice is not reasonable. Its breadth and complexity merits a full comment period time of not less than 60 days from the date published in the *Federal Register*. Executive Order 12866, which was reiterated in President Obama's Executive Order 13563, appears applicable to this draft: "each agency should afford the public a meaningful opportunity to comment on any proposed regulation, which in most cases should include a comment period of not less than 60 days". Instead, the Department has provided only 30 days from public exposure and 19 days from publication in the *Federal Register* for public review and comment.

The draft Notice includes hundreds of policy and process changes that must be carefully considered not only for their own merits, but also for their impact on other regulations. In particular, the impact of proposals dealing with rate setting, solvency, and risk sharing programs must be carefully considered. We urge you to give the public additional time to fully review the draft Notice and provide comments.

State regulators are also concerned about the number of changes being made from year-to-year through the Notice. This is now the third such Notice and the Department of Health and Humans Services (HHS) is asking state regulators and carriers to once again make hundreds of changes, some of which have no relation to benefits or payments. We need more stability and any significant changes need to be thoroughly considered. The goal should be to foster competition and encourage participation in the Exchanges, while still protecting consumers. We fear that constant changes in the regulatory requirements will discourage participation in the Exchanges and not, ultimately, benefit consumers.

We are also concerned about the growing interference of the federal agencies into the oversight of health insurance plans and producers. We understand the need to set some standards to ensure the efficient functioning of the federal Exchange, but the Notice includes provisions that go far beyond that need. This proposal includes even more interference with state rate review processes, network adequacy review, agent/broker oversight, student health plan regulation, and state benefit mandates, just to name a few. The intent of the drafters of the Affordable Care Act (ACA), like the Health Insurance Portability and Accountability Act (HIPAA) before it, was to preserve state regulation of health insurance with federal activity limited to when a state chooses not to enforce the law. This Notice will lead to more confusion, dual regulation and unnecessary preemption of state laws.

A prime example of the regulatory overreach envisioned by this Notice, as well as the 2016 Notice, is the establishment of uniform deadlines for the submission, review and posting of rates. Establishing a deadline for final approval in states utilizing the federal Exchange is understandably necessary, but the additional requirements regarding submission, posting and review of plans both inside and outside the Exchange are excessive in states with an effective rate review process.

We hereby reiterate our objection to the requirement that states publish initial and final rates at the same time. This is not a requirement of the law, nor does it fulfill any recognized purpose of the ACA. States have regulations and procedures in place that dictate when rates are published - many are published when rates are filed or finalized with no requirement that all be posted at the same time - and these should not be preempted. It is, in particular, a tremendous burden on states to complete rate reviews for plans outside the Exchange by the deadline for plans inside the Exchange just so the final rates can be published at the same time.

Likewise, state regulators remain opposed to the requirement that all proposed rates be filed at the same time. This places an onerous burden on carriers with plans outside the Exchange to file their rates much earlier than necessary, and also places a tremendous burden on state regulators to review all rates at the same time. In order to accommodate this new requirement states have been forced to either reduce the thoroughness of their rate reviews or require rates to be submitted even earlier, which means less information is available for carriers to set base rates.

It is our understanding that Centers for Medicare and Medicaid Services (CMS) intends to announce by March 2016 a uniform timeline for submission, review and posting of preliminary and final rates. We propose CMS, instead, allow states to establish different timelines for rates subject to and not subject to review, on or off the Marketplace, or by market. We believe this does not adversely affect the Marketplace, as a majority of rate filings are either subject to review or are for participation in the Marketplace. Further, states vary in their authority to maintain confidentiality of preliminary and final rates. In many states, the proposed and final rates are publicly available upon receipt and final disposition, again as short as 30-60 days. These timeframes do not align with a uniform posting timeline established by CMS and could result in the release of rates much earlier than the uniform posting timeline and not on a uniform basis because of states' statutory review periods.

Due to this inconsistency and to allow for issuers to better evaluate their 2015 and early 2016 results, we suggest delaying the submission deadline to June or July if CMS continues with a uniform filing deadline. A later date in 2015 would have allowed states to consider the rate review items identified in the Center for Consumer Information and Insurance Oversight's (CCIIO's) July 21 letter. Many states had already approved rates by then in accordance with their statutory review periods because of the May 15 uniform filing deadline.

The timelines also create a problem for states with a State-Based Exchange. Requiring approved rates to be posted at a uniform time for an entire market does not serve to inform consumers or increase transparency when the state based marketplace requires the regulatory approval 65+ days prior to the beginning of open enrollment in order to load the website with certified Qualified Health Plans (QHP) and Multi-State Plan (MSP) data. Exchange plans are approved 30+ days ahead of the outside market. Holding the Exchange plan rates, in contradiction of state open records laws, does not increase transparency.

State regulators are also concerned about the impact the Risk Adjustment program has had on small and regional carriers. While we appreciate the draft Notice acknowledging this issue, we do not believe it goes far enough to resolve the problem. We ask that the Department work with state regulators and the small regional health insurers to improve the Risk Adjustment program and put meaningful protections in place for the 2015 cycle.

Specific Comments

Network Adequacy Standards (§156.230)

State regulators oppose this proposal and urge you to withdraw it and allow states time to address the issue by utilizing the updated network adequacy model developed by the NAIC. The updated NAIC model was crafted over many months with input from regulators and interested parties and it establishes strong standards for network adequacy, while balancing the need for states to establish specific standards that are effective for their markets and geography. The draft Notice is not based on such input and places unreasonable requirements on state regulators to implement thresholds that may not work for their state or have “one size fits all” national thresholds applied that we know will not work for them.

Over the past two years carriers have received notices from the Federally-Facilitated Marketplace (FFM) that their networks are “insufficient” based on criteria that neither they nor state regulators have been allowed to review. This criteria has been used to declare networks “insufficient” because they do not have specialists in the middle of a lake or in a remote area. While these issues have been worked out in most cases, it is an unnecessary regulatory burden that is placed on the carriers and demonstrates why national standards should not be applied. States have the information and expertise to set appropriate standards and work with carriers to ensure consumers are protected. Many states already have strong standards in place. Others will consider the best way to improve their oversight based on the updated NAIC model.

The NAIC model also includes protections for consumers who go to an in-network facility but receive care from an out-of-network provider, and subsequently receive an unexpected bill. The draft Notice attempts to address this issue, but we believe it falls short and would actually encourage providers not to contract with carriers. Again, we urge you to withdraw the proposal and allow states to act.

As for the proposal to develop a rating system for carrier network, we agree that this could improve consumer awareness and allow them to make more informed choices. However, we would need more information on how the ratings would be developed and we offer to work with you in the development of this tool.

Fair Health Insurance Premiums (§147.102)

The draft Notice requests comments on whether CMS should seek more uniformity in the size of rating areas or establish a minimum size for rating areas. State regulators believe that states have the unique ability to evaluate and identify appropriate geographic rating areas, consistent with historical practices, negotiated networks and medical case management, natural geographic boundaries, regionalization of certain issuers (HMOs), and other local customs and practice. Geographic areas should not arbitrarily be made uniform as to size or population, as this approach may conflict with natural boundaries for networks and service areas.

The Notice also seeks comments on making geographic rating areas and service areas consistent. As geographic rating areas are established by the state and service areas are established by issuers this could require an issuer to establish contracts with providers in areas where they may not have experience or established relationships. We believe this may lead to issuers exiting the entire geographic area rather than attempting to establish relationships in other parts of the rating area, due to the additional costs associated with establishing the broader network. As a result, we would strongly discourage CMS from aligning service areas and geographical rating areas. The proposed changes in rating areas could greatly destabilize markets within a state.

The Notice asks for feedback on the adequacy of the child factor. It is our belief that the child factor is set very low relative to adult factors. The actuarial community likely missed providing feedback on this issue because the factor as presented at 0.635 is very similar to what is normally experienced as a child factor when an age curve is normalized to 1.000. The problem is the HHS age curve is not normalized to 1.000; its normalization would fall somewhere between 1.450 and 1.550.

The consequence of setting the child factor too low is that older adults are subsidizing children and young adults; the age curve is off balance and nearly every factor is inappropriate, but especially at older ages.

Minnesota is one of a handful of states that adopted a unique age curve, where the only difference in Minnesota's curve versus the standard HHS age curve is the child factor (the child factor is set at 0.890 instead of 0.635). Feedback from Minnesota carriers was used to set the new child factor and, generally, the carriers agreed that the age curve was appropriate, except for the child factor.

It is important to point out that states generally do not have the benefit of having data to evaluate this issue on their own, and the data from Minnesota is outdated and in any case does not reflect the major demographic shift that has occurred in the individual markets across the nation. Thus, it is our recommendation that HHS use the existing data submitted by carriers in order to perform 2014 risk adjustment analysis through the EDGE server to determine what the appropriate child factor or factors should be. HHS could consider transitioning to the appropriate age curve over a period of time if the premium consequence is considered too abrupt, and should also consider what the possible loss of Children's Health Insurance Plan CHIP funding could do to the affordability of family coverage in many states.

Variation in experience by state is an interesting topic. States should receive feedback from HHS, based on 2014 risk adjustment EDGE server data, on what their unique child factor calibration would be if all else were equal, in case a state wishes to seek approval for a unique age curve. Variation in relative child cost by state is expected as differences in state mandates, children's hospital influences, provider prescribing patterns, and cultural and regional norms may play a large role in creating material relativity differences by state.

Student Health Insurance Coverage (§147.145)

The draft Notice requests feedback on the change in guidance relating to student health plans. State regulators take particular note of the policy reversals relating to metal level compliance and intra-school rating in this Notice.

We do not believe that CCIIO should remove the requirement that universities comply with the metal levels of the individual market using the Actuarial Value (AV) calculator. Metal level compliance achieves the major ACA goal of transparency and comparability and allows students and their parents to compare the prices offered by the university versus the prices offered in the individual or group markets.

We agree with the changed guidance that a carrier's risk pool now be school-specific, rather than prior guidance that carriers have a statewide risk pool for all insured colleges and universities. We believe that this is a logical change, given that there are important timing, geographic, and demographic differences for each school, and that frequent competitive bidding makes it impossible for a carrier to prospectively understand its statewide school pool enrollment.

The current proposal to use the index rate methodology for student health plans is unclear at best and potentially disruptive. Does CMS intend to treat student health plans for multiple institutions as a single index rate filing or will CMS require one filing per risk pool? CMS's concern about "rating factors" is unfounded and unenforceable. An insurer will be filing a single risk pool per institution. There is actuarially no difference between a reduction in rates due to higher participation and the same reduction due to improved credibility. There is no difference between a reduction for a renewed plan and lowering the projected administrative costs. All of these factors can simply be reflected in a change in the margin or trend and are based on actuarial analysis of risk.

It appears CMS is confusing the pricing of a student health plan risk pool with pre-ACA small group rating factors. By CMS's own admission, each student health plan should be rated based on the pool for that institution. This is the distinction between student health plans and the individual and small group markets. Fortunately, because the explanation is incorrect, rate setting will not be disrupted, and every component of rate development

should fit within the existing index rate format. CMS should consider removing any reference to “prohibited” rating factors. No violation has been identified.

Part 153 – Standards Related to Reinsurance, Risk Corridors, and Risk Adjustment under the Affordable Care Act

Risk Adjustment Sequestration III.D.1

We do not agree that risk adjustment transfer payments should be subject to sequestration. The payments are revenue neutral and the Federal Government is only acting as a facilitator in transferring payments from one issuer to another.

Risk Adjustment III.D.2.b

We would support the addition of prescription drug data to the risk adjustment calculation. We believe this will improve the accuracy of the calculation and help level the playing field for smaller insurance companies who are less aggressive or less experienced in ensuring all medical services are coded with all applicable diagnoses. We also recommend that CCIIO consider methods of tracking individuals across carriers within a calendar year. For individuals that have diagnoses that affect risk adjustment, all carriers should be compensated appropriately.

We further recommend that Table 1 and Table 3 be calculated regionally or specifically for each state. The risk adjustment is calculated at the state/market level and these factors most certainly are different from one state to another.

We recommend that CCIIO provide market level risk adjustment data to issuers more frequently so that issuers can better understand their risk relative to the market, calculate their risk adjustment liability, and incorporate the appropriate risk adjustment factors into their pricing sooner.

Risk Corridors III.D.4.a

We are comfortable with the proposed methodology to account for the difference between the reported and the actual cost-sharing reduction payments.

Risk Corridors III.D.4.b

We disagree with the proposal to deviate from the process used for Medical Loss Ratio (MLR) reporting of incurred claims in developing incurred claims for the risk corridor calculations. The risk corridor program is a temporary program while the MLR program is a permanent program. The results of the calculations for the risk corridor program enter the formula for the MLR calculations. To introduce this discontinuity may have unintended consequences for MLR rebates.

We disagree with your assertion that the lack of a true up could “have a significant impact on the accuracy of the risk corridors payment or charge calculation.” In fact, the potential “error” in the three month runout reserve would likely have an insignificant impact on the final results of the risk corridor program (see remarks concerning MLR runout for additional data supporting this assertion.) The risk corridor program in its current form is a transfer program, so errors would likely be self-correcting among companies participating in the program. The administrative burden placed upon companies would offset any benefit they might gain. Finally, any perceived increase in accuracy would be dwarfed by the mechanics of the transfer operation of the risk corridor program. Given the language in the Omnibus Appropriations bill recently passed by Congress prohibiting the use of non-risk corridor funds to cover any shortfall in the program, the shortfall in 2014 payments is not likely to be recovered prior to the end of the temporary program, so any increase in accuracy of the calculation would be illusory, theoretical and impractical.

Default Risk Adjustment Charge III.D.5.e

We believe moving the default risk adjustment percentile factor from the 75th percentile to the 90th percentile is overly punitive. The calculation already takes the absolute value of the plan risk transfer amounts, which includes some penalty for not participating. And while T_n is calculated based on enrollment, the percentile choice isn't. You could have a situation where 99% of the people are on a plan with a very low risk transfer amount and the other 1% is spread out over 100 plans that have high absolute risk transfer amounts. We feel the 75th percentile is adequately punitive and that changing to the 90th would add additional barriers to entry for new and smaller insurance companies.

We disagree with using a threshold of 500 billable member months, as this translates into approximately only 42 members. We would agree with the proposal if it were 500 members. We also recommend a graded approach to the default risk charge that would adjust the percentile factor from 50th to 75th for those issuers with 500 to 2,000 billable members (using a linear graduation) to allow the company more flexibility as they transition into participation on the EDGE server.

Reinsurance Program

The proposal to change reinsurance parameters at the end of the program, instead of identifying and updating the parameters as information is available, is disruptive. The proposal ignores the impact on states that exercised the option to create a supplemental reinsurance program. These states depend on knowing the federal parameters to set their own. States cannot begin their reinsurance payment work while the federal program remains undefined.

Rate Increases Subject to Review (§154.200)

We agree with the move away from using the increase in the plan-adjusted index rate for the threshold test, as this does not capture changes in rating factors. However, we cannot support this proposed change without additional information on how plan rate changes are calculated. In particular, any change in rating factors should be captured in the calculation of the plan rate changes. We request additional information and clarity on this.

Submission of Rate Filing Justification (§154.215)

The draft Notice would require justification to be submitted for all single risk pool product filings, not just those that have a plan with an increase. We oppose this provision and believe it oversteps the intent of the law which clearly states that the Secretary is to develop a process for reviewing all "unreasonable premium increases." Products without an increase, or even a decrease, could not reasonably be defined as an "unreasonable premium increase." This provision should be removed.

State Mandated Benefits (§155.170)

State regulators strongly disagree that Section 1252 of the ACA grants HHS the authority to require QHPs to comply with state benefit mandates that apply only to non-QHPs. The intent of Congress is clear that this section is to only apply to rating reforms; to apply this to benefit mandates is to ignore the law. Also, mandated benefits were deliberately excluded from the thirteen categories of state laws that must apply on and off the Exchange under the level playing field requirements of Section 1324.

We also disagree with the proposal to change the wording so that the State, rather than the Exchange, is to identify State-required benefits and that the quantification of the cost is to be sent to the State rather than the exchange. First, this proposal changes the rules in the middle of the game, after the Essential Health Benefits (EHB) for 2017 has been established and states have acted on mandates. Second, there are state laws that prevent the insurance commissioner from establishing a method for calculating or defraying costs associated with

additional benefits because this was the responsibility of the federal exchange. On the flip side, many states have not granted any state official the authority to make that determination. How would this requirement be enforced in such states? How would it be enforced in direct enforcement states?

Overall, the whole issue of defraying benefits in excess of the EHB is an area that still needs clarification and we request, as there is some precedent, that this requirement be non-enforced through plan year 2017. This will allow states time to adjust legislation and to better understand what is expected of the State when benefits in addition to EHB are required by the State.

Standards Applicable to Navigators (§155.210)

Some state regulators are concerned about the proposed requirement that Navigators provide certain post-enrollment assistance. While such assistance can be beneficial to consumers, we question whether there are sufficient federal resources and training for Navigators to perform these functions, and whether there are sufficient protections for consumers. Agents and brokers who provide this assistance are subject to a background check, must have Errors and Omissions insurance, and are under the oversight of state regulators who have many methods for protecting consumers and punishing bad actors. Individual Navigators are not subject to such requirements or oversight. Even in states that have Navigator laws the requirements on individual Navigators have been limited by federal regulation, and have been challenged in court. Before expanding the role of Navigators we must be sure consumers are protected; if not under federal law, then under state law.

We oppose requiring State-Based Exchanges to also expand the role of Navigators. This should be a choice of the state exchanges based on their resources and ability to protect consumers.

State-Based Exchange-Federal Platform (§155.200)

We believe the option to have a State-Based Exchange that utilizes the federal platform has been effective in several states and state regulators appreciate that the proposed Notice includes specific language regarding how these arrangements can be established.

As to the question of what federal requirements should be placed on plans sold through a State-Based Exchange with a federal platform, we strongly recommend that federal agencies refrain from overburdening states and carriers with requirements that are not necessary for the efficient operation of the federal Exchange. States who enter into such arrangements have proven their ability to protect consumers and create a competitive marketplace.

New Standards for Termination of Agent and Broker Agreements with the FFMs (§155.220)

State regulators agree that agents and brokers (as well as Navigators and other Assistants) must be held accountable for their actions and consumers must be protected from a few bad actors. This is why states oversee their activities and have many methods for disciplining those that violate state laws or standards of conduct. We object to the provisions in the draft Notice that would establish a separate federal system for oversight and discipline. Any complaints that the federal Exchange receives regarding agents and brokers who sell through the Exchange should be forwarded to the state regulator for investigation and action.

In particular, we are concerned about the ability of the Exchange to pull certification for an agent or broker for 90 days (which could be the entirety of the open enrollment) without due process. There is also no mention of the state regulator being notified of any suspicions or federal disciplinary actions.

We encourage the federal Exchange to work closely with the state regulator to ensure consumers are protected, and to allow the states to regulate agents licensed to do business in their state without interference. Proper Federal-State coordination would make these provisions unnecessary.

Verification Process Related to Eligibility for Insurance Affordability Programs (§155.320)

We have questions on this provision: How will the “reasonable threshold” test be done? How will it be accomplished? Will it be consistently applied and how will it be coordinated with Internal Revenue Service (IRS)? Will a Tri-Agency (HHS, Department of Labor, Treasury) regulation be required? How will the reconciliation take place with the company if overpayment was made due to a “random threshold”?

Medicare Notices

State regulators support the proposal to notify QHP enrollees turning 65 of their rights and options. This issue has been raised at the NAIC by consumer representatives and state regulators. We would also like to work with CMS to ensure all consumers turning 65, whether they purchase coverage on the Exchange or off the Exchange, are notified of their options.

We also ask CMS to take another look at the anti-duplication issue and whether or not there will be non-enforcement of that provision.

Annual Eligibility Redetermination (§155.335(j))

State regulators strongly object to implementing a system that could change a consumer’s plan and/or carrier without their review of that plan to determine whether it is truly better for them and their dependents. Changing plans can result in significant changes in networks, formularies, and cost-sharing. While a consumer may think it is a good idea to allow such changes to be made to make sure they have the lowest-cost plan, state regulators know that this should not be the primary goal in all cases.

State regulators would prefer more emphasis on consumer education and clear notifications that other options are available to the consumer, but automatic enrollment into a new plan could lead to dire consequences and possible violations of state laws. We recommend that HHS no longer pursue this option.

The draft Notice also requests comment regarding whether or not the federal rules should allow for auto re-enrollment into a plan not available through an Exchange. Such an option is not feasible on legal and technical grounds.

- There is no contract between the Exchange (or any other government agency) and insurance companies that addresses issuing coverage to anyone off the Exchange. What legal mechanism does an exchange have to compel an issuer to issue a policy to anyone outside the exchange, particularly on an automatic basis?
- Off the Exchange, there is neither a legal venue nor a legal obligation for the Exchange to assure the issuer’s compliance with HIPAA guaranteed renewability vis a vis that insured.
- Outside the exchange, an auto enrollment means there is no application for coverage for the insured, which could leave the insured without certain protections that arise from the state regulated and approved application.
- From a technical perspective, auto re-enrollment requires the ability to identify a plan in which to place the insured, and off the Exchange, what plan would be identified? How would it be identified? What insurer would be used? In the absence of the QHP application package of spreadsheets, there is no mechanism for CMS to identify an off-Exchange product into which to “auto re-enroll” anyone.

For these, and other, reasons, state regulators oppose these proposals.

Enrollment of Qualified Individuals into OHPs (§155.400)

We believe the draft proposal to give carriers additional flexibility to develop a uniform policy to address issues related to consumers who either fail to make a full first month's binder payment, or who fall into the grace period because they owe a small amount of premium, is a good additional consumer protection.

Annual Open Enrollment Period (§155.410)

While there are good reasons for moving the open enrollment start date and end date up, as suggested in the draft Notice, state regulators do not believe the earlier date will afford carriers and regulators sufficient time to develop, submit, review and approve rates and forms. This issue is exacerbated by the fact that risk adjustment, reinsurance, MLR, and risk corridor information is provided so late in the year. Until there is assurance that carriers will have the time and information they need to develop rates and forms, and regulators will have sufficient time to review them, the start date will need to remain the same.

As for the end date, we do not recommend shortening the open enrollment period at this time. State regulators have heard from many consumers who have had problems with auto enrollment or understanding their options and a shorter open enrollment period would make it more difficult to ensure consumers have the right coverage.

State regulators would also like to revisit the issue of setting a cap on enrollment for a carrier before open enrollment begins. The suppression option has not worked well in some instances and state regulators would find the option to set an enrollment cap an important tool for preserving the financial health of some carriers.

Special Enrollment Periods (§155.420)

State regulators are concerned that consumers are not required to provide documentation to substantiate their eligibility for a Special Enrollment Period (SEP). We have seen cases where a consumer's policy was cancelled for non-payment of premium and was allowed to choose a new plan (even with the same company) under an SEP, even though this is not an SEP trigger. There are instances where consumers have missed the open enrollment period and then applied for Medicaid knowing that they will be rejected so they can they can apply for private coverage under the SEP. We also know of many cases where individuals with serious medical conditions purchased coverage mid-year by simply checking the right box or using the right language, and their eligibility was not questioned. The lack of a requirement to provide documentation makes it impossible to verify whether these individuals are legitimate or are gaming the system. People who game the system drive up premium costs for everyone. We urge the federal Exchange to verify a consumer's eligibility for a SEP before they can purchase a plan, or at least allow carriers to do the verification, as they do for their non-exchange consumers.

We note that we are still awaiting guidance on some of the SEPs already in place, like domestic violence. Both carriers and regulators need such guidance in a more timely fashion to ensure the SEPs are being enforced correctly.

Eligibility Standards for Exemptions (§155.605)

We are concerned that some individuals purchasing coverage now (during the 2016 open enrollment period) believe their coverage provides an exemption to the minimum essential coverage requirement and may discover, when they file their taxes, that the IRS has a different opinion of what is exempt. We are concerned that these individuals will not be able to make a different choice if the 2017 Notice is finalized after the open enrollment period. It is also likely that the IRS will not clarify what it understands to be exempted coverage until after these individuals have made a choice with tax consequences that can't be readily undone.

Standardized Options (§156.20)

State regulators have some concerns with this proposal to allow carriers the option to sell plans that include nationally-standardized cost-sharing. Would this option be available to carriers in states that have established their own standardized plans? How would this be coordinated with states such as Arkansas, which have utilized standardized Marketplace plans as a way to further Medicaid Expansion? Would there be two standardized plans in such situations? This could lead to unnecessary confusion and additional administrative burdens.

States that have established standardized plans have found that considerable fine-tuning is necessary to find packages that consumers will purchase and that will meet additional Medicaid requirements. Could there be some flexibility for states to modify the standardized plans for their state, or to vary them for different areas of their state?

Prescription Drug Benefits (§156.122)

The draft Notice requests comments regarding the scope and application of State laws when appealing for coverage of non-formulary drugs. Several states adopted an earlier NAIC managed care model law that requires managed care plan utilization review procedures to be available for any person seeking coverage of a non-formulary drug. If these procedures result in an adverse determination, both standard and expedited appeal processes are available. The proposed change in this draft Notice is something we support.

AV Calculation for Determining Level of Coverage (§156.135)

The AV Calculator is a crucial tool and any updates can have material, and sometimes unintended, consequences. We applaud your efforts in introducing more flexibility in the timing of future updates, but we cannot support this proposal without more information on the timeline.

Termination of Coverage or Enrollment for Qualified Individuals (§156.270)

State regulators support the grace period change to ensure consumers do not lose protection if they lose their Advanced Premium Tax Credit (APTC). This is an issue regulators have identified as a growing issue and have sought relief for consumers caught in this situation.

Essential Community Providers (§156.235)

State regulators do not agree that Essential Community Provider facilities with multiple providers should be counted as just one provider. In many communities the local facility can have many providers that cover many areas of need. Carriers should receive credit for contracting with these facilities and covering care provided by all of their providers. This change should be made as soon as possible.

Enforcement Remedies in Federally-Facilitated Exchanges (§156.810)

How does HHS “reasonably” determine the financial solvency of a carrier on the FFM? The financial solvency of issuers is a serious matter regulated by the Department of Insurance in each state. Creating a dual regulatory environment is duplicative and unnecessary.

Patient Safety Standards for OHP Issuers (§156.1110)

The draft Notice would add requirements to assure that network hospitals meet patient safety standards. Exchange plans would not be allowed to contract with hospitals that don’t meet the new patient safety requirements. Regulators that oversee adequate access to participating hospitals need to be able to identify the potential for problems if hospitals are not qualifying under the new requirements. We request more detail about

how hospitals that meet the standard can be prospectively identified by plans, consumers and regulators: Does CMS collect and publish data on the patient safety evaluation system as defined in 42 CFR 3.20? What is the regulatory reference for “a comprehensive person-centered discharge program to improve care coordination and health care quality for each patient?” How is this tracked or published?

Reporting of Incurred Claims - MLR (§158.103 and §158.140(a))

We disagree with the proposal to extend the runout period for claims to six months from three months.

First, the case is made that the MLR reporting deadline is now July 31 rather than June 1. However, this change in deadline is associated with the requirements of a temporary risk corridor program and a temporary reinsurance program that are scheduled to end after 2016. It is inappropriate to immortalize this temporary constraint at the expense of delayed rebate payments to consumers into the future. Risk adjustment program reporting also occurs on July 31, but after the temporary programs end it is possible that reporting date could be moved. Consumers are best served by payments made as soon as is feasible, and should not suffer from a historical artifice. Just because reporting is now delayed compared to the first 2 years of the MLR program does not mean that it should continue to be unduly delayed. At the least, no change should be made prior to the time when only permanent programs are involved, not unnecessary constraints of temporary programs.

Second, the assumption is made that reserves calculated as of June 30 are accessible by July 31. Companies seldom would have quarterly statements available in time to prepare MLR and risk corridor reports by July 31. The original recommended definitions for the MLR program recognized this and established the June 1 date in light of company processes, recognizing that the three-month runout reserve would not be available at May 1. The NAIC evaluated the appropriate runout period and did decide that a quarter-end date was appropriate to allow regulatory and company audits. The runout should be three months, not six months, and most definitely not an interim date that cannot be audited.

Third, the NAIC considered in its recommendations for definitions of the MLR program the choice between using a three-month versus six-month runout. Supporting documents developed by the NAIC can be found at: http://www.naic.org/documents/committees_lhatf_ahwg_ppaca_ird_master.pdf, which includes specific reference to the resolution found on pages 19 through 22. We determined that the marginal gain from using a six-month runout versus a three-month runout was insignificant. The rate of improved accuracy in the reserve was significant from month 1 to 3, but then dropped off greatly.

We disagree with the proposal to change the treatment of fraud prevention expenses.

The NAIC, in its role to provide definitions of “reimbursement for clinical services provided to “enrollees” and “for activities that improve health care quality”, provided extensive analysis to the treatment of fraud expenses, obtaining input from industry, consumers, and regulators as well as other interested parties. The decision was reached that if a claim was paid due to fraud and the carrier later discovered this fraud and reversed the claim, then the carrier’s claims should reflect this net amount of claims. However, in the public interest, it was decided to not charge back those claims up to the amount expended in fraud detection activities. So the determination was made that only “claims” would enter the “reimbursement of clinical services” category. It was further decided that amounts expended on fraud detection activities did not constitute quality improvement expenses, and could not be counted. In short, the NAIC decided to treat fraud claim recoveries as a legitimate “reimbursement of clinical services,” but within a specific limit and to exclude fraud expenses as quality improvement expenses.

When HHS issued Interim Final Regulations (IFR), there was a difference in that language compared to the recommendation made by the NAIC. The IFR excluded fraud claims from consideration but included fraud prevention expenses as quality improvement expenses, but with the limit of only those expenses up to the amount of claims recovered. While this language had the same impact on the resulting numerator of the MLR, nevertheless, it codified fraud prevention expenses as quality improvement expenses.

Recognizing this error after discussion with interested parties including the NAIC, HHS corrected this misinterpretation in the final regulation. The final regulation followed the NAIC definition adopted by the Secretary and declared that fraud claim amounts up to the amount of the fraud expenses could be added back to claims.

The proposed Notice suggests that all fraud expenses should be counted as incurred claims. The NAIC specifically did not want to allow excessive fraud detection expenses to be included: this would be contrary to consumer interests. So if a company expended more on these expenses than it recovered, it was believed there might be some effort to deny appropriate claims rather than only those legitimately determined to be fraudulent claims. One stated goal of the passage of the ACA was to prevent such claim abuses. We therefore urge HHS to withdraw this proposal to define fraud expenditures as incurred claims.

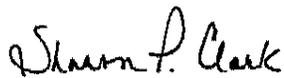
Sincerely,



Monica J. Lindeen
NAIC President
Commissioner
Montana Office of the Commissioner of Securities
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John M. Huff
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Senator E. Benjamin Nelson
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