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

July 12, 2017

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9928-NC
P.O. Box 8016
Baltimore, MD 21244-8016

To Whom It May Concern:

The following recommendations in response to the Request for Information regarding "Reducing Regulatory Burdens Imposed by the Patient Protection and Affordable Care Act &Improving Healthcare Choices to Empower Patients" published in the *Federal Register* on June 12, 2017, are submitted on behalf of the members of the National Association of Insurance Commissioners (NAIC). The NAIC represents the chief insurance regulators in the 50 states, the District of Columbia, and the 5 United States territories.

1. **Empowering patients and promoting consumer choice. What activities would best inform consumers and help them choose a plan that best meets their needs? Which regulations currently reduce consumer choices of how to finance their health care and health insurance needs? Choice includes the freedom to choose how to finance one's healthcare, which insurer to use, and which provider to use.**

   - Amend 45 CFR 155.210(c)(1)(iii)(C) and (D), 45 CFR 155.215(f)(3), and 45 CFR 155.225(d)(8)(iii), to allow navigators to "provide advice" without becoming licensed only if allowed to do so under state law. This regulation violates licensing statutes in some states.

   - Repeal 45 CFR §155.20, the Standardized Plan Options (Simple Choice Plans). While insurers can choose whether to offer standardized plan options, the federal government offering prescribed plan options attempts to limit consumer choice forcing them into a one size fits all federally designed marketplace.

   - Repeal the section of 45 CFR 144.103 Definitions, which defines Short-term, limited-duration insurance plans as having an expiration date of 3 month from the original effective date. This limitation restricts coverage for consumers who may be in-between jobs or otherwise have need of short-term coverage.

   - Delete language in the federal regulation "Exchange and Insurance Market Standards for 2015 and Beyond" relating to the sale of fixed indemnity plans to individuals with minimum essential coverage.

   - Grant states the option to allow transitional health plans to continue beyond December 31, 2018.

   - Amend 45 CFR 155.170(b) and (c), which require that the state defray the cost of state mandates enacted after December 31, 2011, to set a later deadline. This regulation unduly inhibits states from addressing health care needs without increasing costs to the state General Fund.

2. **Stabilizing the individual, small group, and non-traditional health insurance markets. What changes would bring stability to the risk pool, promote continuous coverage, increase the number of younger and healthier consumers purchasing plans, reduce uncertainty and volatility, and encourage uninsured individuals to buy coverage?**

- Fully fund the cost-sharing reduction payments and improve upon the Qualified Health Plan (QHP) agreement to provide clear safeguards for mid-year changes to include termination provisions and modifications to address the loss of Cost Sharing Reduction (CSR) funding.

- Generally, allow flexibility for states to enforce continuous coverage requirements, develop high risk pools to separately manage high risk individuals and develop state reinsurance programs. Defer to state mandated benefit laws and other plan design parameters states choose to use in defining their markets. State level regulation is necessary to balance consumer and insurer needs for a strong market that offers competition, affordable options and significant consumer choice. To accomplish this under the law, significantly reduce the requirements tied to 1332 waivers to allow more states to pursue this option and implement their state-based solutions more quickly.

    - Amend 31 CFR 33.108(c) and (d); 31 CFR 33.116(c); 45 CFR 155.1308(c)(1) and (3); 45 CFR 155.1308(d); and 45 CFR 155.1316(c) to reduce periods for the section 1332 waiver review and approval processes. We propose that the Secretary shall complete the initial review in 20 days (currently 45 days) and strive to complete the process and issue a decision in 90 days or less (currently allowed *up to* 180 days under 1332(d)(1) and federal regulations have adjusted this to a "180 day decision period," which does not incentivize expedited processing).

    - Repeal 31 CFR 33.120(c) and 45 CFR 155.1320(c) and allow the states to determine whether a post award public forum or other stakeholder input process is necessary to determine the progress and effectiveness of the section 1332 waiver. If a state determines the need to hold a public forum, it could incorporate any feedback into reports required under 31 CFR 33.124 and 45 CFR 155.1324.

    - Repeal 31 CFR 33.124(a) and 45 CFR 155.1324(a) to eliminate burdensome quarterly reporting requirements; require only annual reports for section 1332 waivers.

- In order to help keep some carriers in the market, fund federal obligations under the risk corridor program

- Permit states to choose to allow catastrophic plans to be sold to a broader group of consumers.

- Address the issue of Third-Party Payers and the need for clear and accurate information to be provided to consumers to ensure they are protected from possible harm.

- Address the issue of consumers eligible for other government coverage enrolling in Exchange plans

- Allow states to define the benchmarks for Essential Health Benefits (esp. in individual market).

3. Enhancing affordability. What steps can HHS take to enhance the affordability of coverage for individual consumers and small businesses?

- Work with the IRS to revise regulations so that the 3.5% Exchange fee is treated as a legitimate business expense and can be deducted for tax purposes.

- Ease compliance with the employer mandate by updating the Minimum Value (MV) calculator to incorporate the revisions that have been included in the Actuarial Value (AV) calculator. Insurers indicate the MV and AV calculators are out of synch. Some small group plans with AV calculator results in the silver plan AV range will have MV calculator results less than 60%, failing the minimum value test.

- Fix the "required contribution" definition in Section 5000A to correct the “family glitch".

- Revise Summary of Benefits and Coverage page limit to give carriers and employers more flexibility

4. Affirming the traditional regulatory authority of the States in regulating the business of health insurance. Which HHS regulations or policies have impeded or unnecessarily interfered with States' primary role in regulating the health insurance markets they know best?

- Repeal 45 CFR 147.102(b), which specifies rating areas in states. The state should be free to choose the most suitable rating areas without federal regulation.

- Amend 45 CFR 147.106, which requires insurers to provide discontinuation notices, "in a form and manner specified by the Secretary." Additional federal guidance has provided letter templates for companies to use, but restricts companies from editing the templates (updated Federal Standard Renewal and Product Discontinuation Notices, September 2, 2016). It would be more consumer friendly to allow companies to use templates with limited modifications for specific situations (e.g. market withdrawal when there is only one remaining company in the market). The authority to determine the appropriate template or modification of a template should be left to the state.

- Repeal 45 CFR 150.205(b),(c),(e)and (f). This regulation lists sources of information that may trigger an investigation of state enforcement of Public Health Service Act requirements. The list includes information learned during informal contact between CMS and state officials, news reports, information obtained during review of state legislation, and any other information that indicates a possible failure to adequately enforce CMS provisions. This regulation is counterproductive to open communications between state officials and CMS.

- Repeal 45 CFR 154.220(b)(2),which specifies filing dates. Allow states to set rate filing dates.

- Repeal 45 CFR 154.301(b)(1)(i), which requires states to post rates in advance of open enrollment. Allow states to determine the appropriate time to post rates to ensure that off-exchange companies do not receive an unfair competitive advantage.

- Repeal 45 CFR 154.301(b)(3), which requires all plans to post initial rates at the same time.

- Modify 45 CFR 154.210(b)(2),which requires states to notify CMS of a final rate determination within 5 business days. There is no need to have a narrow timeframe, and states may need adequate time to have the justification reviewed by legal counsel.

- Amend 45 CFR 154.215(a)(1) to specify the regulation is applicable to increases only. It appears that this regulation requiring the submission of the Unified Rate Review Template for all filings exceeds the scope of the federal statutes.

- Amend 45 CFR 155.130, which requires exchanges to consult with stakeholders. Recommend that state insurance commissioners be expressly included in this list.

- Amend 45 CFR 155.545(b)(1) and 45 CFR 155.555(k) to provide more consumer protection around appeals. Strike "as administratively feasible" to hold the appeal entity responsible for responding to a consumer appeal within 90 days.

- Eliminate the multi-state plan program which has not met statutory requirements.

- Amend 45 CFR 92 to clarify the scope and application of this nondiscrimination regulation. It is currently unclear and it is the position of state regulators that it should not apply to non-comprehensive insurance coverage (e.g. Medicare Supplement Insurance).

- Repeal 45 CFR 147.104(d)(2)(i), which provides a 181 day lockout from selling insurance upon a health insurance issuer reaching financial capacity (e.g. supervision, insolvency). The lockout provision is unnecessarily burdensome. The state should have the authority to allow a health insurance issuer to resume sales in less than 181 days if the issuer demonstrates financial reserves that meet state requirements.

- Eliminate 45 CFR 155.335(j)(3) which creates a federal process for re-enrolling consumers into a plan from another carrier. This decision should be left to the state regulators in compliance with state laws.

- Allow states to choose how best to apply the five year ban under the Public Health Service Act for a health plan company that leaves the market.

- Allow states to determine the annual open enrollment period.

- Cease Department of Health and Human Services (HHS) and Department of Labor (DOL) market conduct reviews in states that perform effective reviews in compliance with NAIC standards.

- Eliminate redundant federal plan certification reviews in states that perform the certification functions.

- Work with state regulators and insurance carriers to identify and eliminate duplicative data collection requirement and inconsistent definitions.

Thank you for this opportunity to comment. As state regulators continue to review the ACA and its 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 regulation is finalized.

Sincerely,

Theodore K. Nickel
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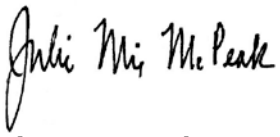

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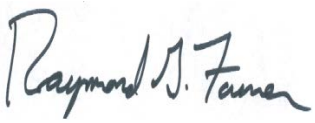

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