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

December 19, 2012

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–9980–P
Mail Stop C4–26–05
7500 Security Boulevard
Baltimore, MD 21244–1850

To Whom It May Concern:

Thank you for the opportunity to comment on the proposed regulations on the Patient Protection and Affordable Care Act: Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, published in the *Federal Register* on November 26, 2012. We write as the chief insurance regulators of our respective states and members of the National Association of Insurance Commissioners. The National Association of Insurance Commissioners (NAIC) is the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, the District of Columbia, and five U.S. territories. Through the NAIC, state insurance regulators establish standards and best practices, conduct peer review, and coordinate their regulatory oversight. NAIC staff supports these efforts and represents the collective views of state regulators domestically and internationally. NAIC members, together with the central resources of the NAIC, form the national system of state-based insurance regulation in the United States.

General Comments

State insurance regulators remain concerned about the impact the upcoming reforms will have on premiums. While subsidies will provide some assistance, in most states premiums are expected to rise considerably in 2014. This potential "rate shock" could, in turn, result in younger and healthier populations leaving the marketplace, even with the penalties, which are quite low in the first years. States need as much flexibility as possible under the law to address this problem.

We are also concerned about the amount of data requested of issuers and the administrative burden and cost that is being placed on them. State insurance regulators work to ensure information collected from issuers is necessary to enforce laws and regulations, and that an undue burden is not placed on them. We encourage federal officials to continue to review the data and other information requested of issuers and work with state regulators to ensure they do not result in unnecessary costs.

Payments for State-Required Benefits

In the proposed regulation, HHS requested comment on whether states should make payments for required benefits not included in Essential Health Benefits (EHBs) based on the statewide average cost of the benefit, or based on each issuer's actual cost to provide the benefit. We recommend that states be given flexibility in determining the cost basis to be used. However, if a national standard is required, we recommend that such payments be made based on the average benefit cost for the relevant Geographic Rating Area (GRA). If payments are made based on each issuer's cost, issuer incentives to contain costs for these benefits may be reduced. Payment based on statewide average costs more appropriately aligns incentives and is more administratively simple; however, there can be significant variation in costs and demographics by GRA. Using an average cost by GRA captures this variation and is still more straightforward than calculating payments by issuer.

Future Changes to EHB

The proposed regulation invites comment on the process that HHS should use to update EHB over time. State insurance regulators strongly support a process that continues to rely on states and policies sold in the marketplace to determine the EHB.

Discriminatory Benefit Designs in the Benchmark

State insurance regulators continue to have questions regarding how the prohibition on discriminatory benefit design is to be defined and enforced. We need more clarity on what is a "discriminatory benefit design" if we are to be able to enforce this provision during the review process.

Definition of Habilitative Benefits

States are given broad authority to define "habilitative benefits" in the proposed rule, even broader than had been provided in earlier guidance. However, we are very concerned that states will not have enough time to take advantage of this authority. States must comment on the draft EHB benchmark by December 26, 2012. This is not enough time for states, whose legislatures are not even in session, to take advantage of this "valuable opportunity". We recommend that more time be given to states that notify CMS of their intent to define "habilitative benefits" to make their determination. Issuers must also be given clear timeframes for when they must define "habilitative benefits" if this task falls to them, and it must be clear that any such definition may be reviewed and approved by the state.

In addition, we object to issuers being allowed to convert dollar limits to visit limits for habilitative benefits, particularly when the dollar limits are incorporated into state law. Issuers do not have the authority under state law to do this; the state must decide who may convert the dollar limits.

Substitution

We request that you codify the statement in the preamble that "states have the option to enforce a stricter standard on benefit substitution or prohibit it completely." The proposed regulation as written gives no indication that the state, through legislation, may prohibit all benefit substitution – even when the issuer has submitted a certification of actuarial equivalence and satisfied the other conditions included in the subsection.

Prohibition on Discrimination

Section 156.125(a) does not distinguish between benign and invidious discrimination, which we believe could affect issuers' ability to design benefit packages to attract and serve populations with specific health needs, such those with chronic health conditions. We suggest including the word "against" after the word "discriminates" to allow for such benefit designs without violating the letter of the regulation.

Metal Levels and "de minimis" Variation

State insurance regulators remain concerned about the limited variation in actuarial value that will be allowed under federal regulations. Requiring issuers to meet specific actuarial value levels with only "de minimis" variation will limit consumer options and require plans to modify cost-sharing requirements every year. We recommend that states be provided more latitude to set cost-sharing options outside the Exchange and the cost-sharing variation level within a state-based Exchange.

Actuarial Value Calculation for Determining Level of Coverage

Section 156.135(b) should be revised, as it is not entirely clear that an issuer must choose one of the two methods presented and to which agency the actuarial certification must be submitted. We suggest requiring submission of the actuarial certification along with any requested documentation to the applicable state regulator, and separately to the Exchange for qualified health plans (QHPs).

Drug Coverage in EHB

Some plans may use formularies for the purpose of determining which specific drugs are covered under the plan ("Closed Formulary Plans"), and some use formularies only for the purpose of determining which cost-sharing tier apples to a given drug ("Open Formulary Plans"). An open formulary plan would cover any medically necessary drug, unless only usable for an indication for which there is a specific exception under the policy. Since the determination of whether a service or supply falls within the category of EHBs disregards the level of cost-sharing, we believe the requirement at §156.120 should not apply to Open Formulary Plans. Such plans would always meet the test in §156.120(a)(1); and submission of the drug list to the Exchange, the state and/or OPM would be a meaningless and burdensome exercise."

Actuarial Value Calculator

One concern we have with the AV calculator is that it does not account for family cost-sharing. Though there are limits on family maximum out-of-pocket amounts in both the individual and small group markets, and a maximum family deductible in the small group market, there do not seem to be any limits for family cost sharing in relation to individual cost sharing. We recommend that CCIIO incorporate family cost-sharing into the AV calculator.

Also, §156.135(c) of the proposed rule requires that employer contributions to health savings accounts (HSAs) and health reimbursement accounts (HRAs) be counted towards the total anticipated medical spending. This is information that the issuers will not have, as it is unrelated to the insurance contract. Each employer may decide to fund HSAs or HRAs at different levels or not to fund them at all. Issuers do not keep this information. Even if an issuer were to request anticipated funding in an application, they would not know if the employer actually makes the contribution because the funding of such accounts would not flow through the issuer, but instead would be made with some financial institution.

Dental Plans

State insurance regulators have expressed great concern about the different treatment of dental benefits inside and outside the Exchange. Inside the Exchange, a QHP does not need to include pediatric dental benefits (an EHB) if stand-alone pediatric dental coverage is <u>available</u> in the Exchange. There is no requirement that enrollees purchase the dental coverage, only that it be available. Meanwhile, outside the Exchange all plans must include pediatric dental coverage.

This difference in the treatment of pediatric dental benefits will impact rating and consumer choices, and will promote adverse selection against plans outside the Exchange and against stand-alone dental coverage. It should be clarified that states have the authority to resolve this issues in their states.

Data Collection

As stated earlier in our comments, we are concerned about the amount of data requested of issuers and the administrative burden and cost that is being placed on them. State insurance regulators work to ensure that the information collected from issuers is necessary to enforce laws and regulations, and that an undue burden is not

placed on them. We encourage federal officials to continue to review the data and other information requested of issuers and to work with state insurance regulators to ensure this data collection does result in unnecessary costs.

In addition, we do not believe it is sufficient that the cost calculation simply be reported to the Exchange. The issuer should also be required to certify the calculation is reasonable and provide documentation to the applicable regulator, if requested. Likewise, the actuarial certification along with any requested documentation must be submitted to the applicable state regulator, if required by the state. Section 156.135(b) should also be revised to make it entirely clear that an issuer must choose one of the two methods presented for calculating the AV for plans that are not compatible with the AV calculator.

We thank you for your consideration of our comments; we are available to discuss these in detail and would be happy to answer any questions. Full implementation in 2014 is fast-approaching and these reforms will dramatically change how health insurance is priced, marketed, and designed in our states. State insurance regulators need to have flexibility to implement policies and regulations that will protect all consumers and preserve competitive markets.

Sincerely,

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