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

Comments on the Draft Annual Letter to Issuers
January 15, 2016

Key Comments

State regulators continue to oppose the establishment of federal deadlines for the submission, review and posting of rates as outlined in this draft letter to issuers and the proposed Notice of Benefit and Payment Parameters for 2017. Establishing a deadline for final approval in states utilizing the federal Exchange is understandable but the additional requirements regarding submission, posting and review of rates for plans both inside and outside the Exchange are excessive in states with effective rate review processes.

We also reiterate our objection to the language dictating when states must publish both initial rate filings and final rates. This is not a requirement of the Affordable Care Act (ACA), nor does it fulfill any recognized purpose of the law. States have regulations and procedures in place that determine 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.

State regulators also 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 increase spending, 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. We propose that the Centers for Medicare and Medicaid Services (CMS) instead allow states to establish the appropriate timelines for rate submission and review, with only the final deadline being set by CMS for Federally-Facilitated Marketplace (FFM) states.

If CMS continues with a uniform filing deadline, state regulators suggest delaying the submission deadline to June or July to allow issuers time to better evaluate their 2015 and early 2016 results. 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. Other parts of the Qualified Health Plan (QHP) application may be filed earlier, if necessary.

As for the network adequacy requirements proposed in the letter to issuers, 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 National Association of Insurance Commissioners (NAIC). The updated NAIC model (attached) 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. Neither the draft letter to issuers nor the proposed Notice of Benefit and Payment Parameters are based on such input and they provide an unreasonable choice for state regulators: implement thresholds that may not work for their state or have "one size fits all" national thresholds applied that we know will not work.

Under the NAIC's rules, state regulators who vote in favor of a model are also agreeing to seek adoption of the model, in some form, in their state. The Network Adequacy Model was adopted unanimously. State regulators are clearly committed to protecting consumers and ensuring sufficient networks are established. Federal standards at this time are unnecessary and could be harmful in many states.

Finally, we urge CMS/CCIIO to work closely with state regulators and maintain timely communication. The draft letter to issuers includes language regarding federal review of marketing materials, standards for fraud

reporting, and general oversight of QHPs. It must be clear in the letter that any investigation or action taken by the federal government is communicated to state regulators in a timely manner. States have the primary responsibility and authority to review the market conduct of issuers. Coordination and communication are key to ensuring consumers any issues are addressed and consumers are protected.

Specific Comments

Following are more specific comments and questions from state regulators:

Chapter 1: Certification Process for Qualified Health Plans

Page 10, Table 1.1 - We ask for clarification regarding the September 8 date that was included in Table 1.1 of the draft letter for the FFM as the date on which "States Send CMS Final Plan Recommendations." This date only appears in the draft letter and does not appear in the separate document entitled, "Proposed Key Dates for Calendar Year 2016: QHP Certification in the Federally-facilitated Marketplaces; Rate Review; Risk Adjustment and Reinsurance" that provides additional information about SERFF Data Transfer Deadlines.

This appears to create include a new step in the QHP certification process - the transfer of final data from QHP applications by states prior to sending their QHP certification recommendations. Last year, the final QHP recommendation from states (State Plan Approval) was required on the same date as the final data transfer deadline. SERFF is configured so that states provide the certification recommendation along with the data transfer. It appears from the draft letter that the final SERFF data transfer will occur on August 23. It does not appear that any transfer of updated data will occur on September 8, noted as the date for State to "Send CMS Final Plan Recommendations." Please clarify whether state certification recommendations are expected by August 23, with the final data transfer.

Page 10 – Footnote 13 – The note indicates QHPs can be withdrawn from display (not offered on the exchange) up until 10/3-10/4/2016. We are concerned with the potential rate impact of a carrier withdrawing its QHPs at this late date after final rates have been certified.

Page 14, Table 1.2 – The table indicates that all petitions for service area changes or plan withdrawals must be submitted by August 9, 2016. Is a similar petition (and timing) required for plans that desire to change from On Exchange to be exclusively Off Exchange?

Page 14, Table 1.2 – The table indicates "No new plans may be submitted" 5/12/16-8/23/16. However, the narrative on page 15 indicates that after 8/23/16 issuers cannot add new plans to a QHP application. We need clarification as to whether no new plans can be submitted after 5/11/16 or 8/23/16. Last year, no new plans could be added following the QHP application submission deadline, which as proposed would be 5/11/16.

Page 18, Policy and Process for Recertification – In the 2016 filing year some of the Uniform Modification rules were relaxed due to general misunderstanding about how they worked. The draft letter to issuers indicates that a recertified plan for plan year 2017 "must use the same HIOS plan identification numbers that it used for its certification for plan year 2016." We believe that in order to meet Uniform Modification rules for 2017, some plans from 2016 will need to be assigned different plan ID's for 2017, even though the issuer will be recertifying the plan. For example, suppose an issuer had three plans in 2016 and filed them all under different product numbers even though the benefit structure, network, and plan type for all plans were the same. Really they should have filed three different plan numbers under the same product number. In 2017 this needs to be corrected. Under uniform modification, the issuer has to keep one of the plans (so they don't discontinue all products) and then migrate the other two plans so that they are under the same product number as the kept plan. This means getting a different plan ID number for two of the plans.

Page 20, Standardized Options – How will a plan be identified as a standardized option? Will it have to be filed under a separate product ID? Will all standardized plans for an issuer be filed under the same product ID or would it be possible to have multiple product ID's?

Also on page 20, the letter says that the standard options have already been "designed". Does this refer to Table 9 from the proposed Notice of Benefit and Payment Parameters? Are more details or guidance expected?

Chapter 2: Qualified Health Plan and Stand-Alone Dental Plan Certification Standards

Page 21, Service Area – The draft letter says, "Any change to the list of counties associated with a particular plan is considered a change in the service area… [C]hanging the service area ID associated with a plan from S001 to S002 constitutes a change to service area." Is this paragraph related to service area changes to a plan after the plan is filed for 2017 or is it comparing the service area of a plan in 2017 to the same plan in 2016? Are you saying that a company can't change the designation of which service area is represented by S001? For example in 2016 an issuer has two service areas, S002 = Area 1, 2, 3 and S001 = Area 4, 5, 6. Is this indicating that for 2017 the issuer can't change the labels so that S001 = Area 1,2,3 and S002 = Area 4,5,6 even if they assure that the same plans in 2017 have the same service area as 2016?

Page 23, Network Adequacy - The draft letter lists as one of the optional metrics: "The State prospectively verifies a minimum provider to covered person ratio for the specialties with the highest utilization rate for its State." How is the highest utilization rate to be defined? By claim count volume? By claim dollar volume? This assumes that the state has relatively granular claim data and enrollment data, which is likely not the case.

Page 25, Network Adequacy – It is not clear from where to where the times and distances should be measured. Is it expected that the state will have geo-coded addresses of all enrolled individuals for each issuer? Is the time and distance to be based from the borders of each county or is there some expectation of utilizing a population density weighted midpoint in a county?

Page 32, General Essential Community Provider (ECP) standards – The timelines for ECP petitions may put an issuer in a precarious position if they are counting on a petition to go through that is ultimately denied.

Page 46, Discriminatory Benefit Design -- With regard to the statement, "CMS continues to caution both issuers and States that age limits may potentially be discriminatory when applied to services that have been found clinically effective at all ages", please provide guidance on what legal grounds under the ACA or regulations adopted thereunder that a state can rely upon when arguing that a state statutorily adopted age limit associated with a mandated benefit is illegal and that the issuer must provide the coverage without regard to the age of the individual.

Page 50, Covered Benefits – The draft letters says, "CMS will not consider plans to be meaningfully different on the basis of covered benefits if the difference involves only benefits that are not displayed on the Healthcare.gov website." Riders are no longer allowed on ACA type plans. Some companies decided to embed these riders, at the suggestion of CMS. An issuer might have two plans – one with the rider embedded and one without the rider embedded. This would seem to suggest that such an arrangement would now be considered not meaningfully different, and therefore not allowed.

Sincerely,

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