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

December 18, 2014

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9944-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 2016, as published on November 26, 2014, are submitted on behalf of the members of the National Association of Insurance Commissioners, which includes the chief insurance regulators in the 50 states, the District of Columbia, and the 5 United States territories.

Disclosure and Review Provisions

(§154.200)

- State regulators are concerned about the timing and potential impact of the proposal to require the review of all rate increases of 10% or more for "plans" rather than "products" for plan year 2016. Such a change will require far more rate reviews and programming changes in the URRT. It also appears to set up a situation where one plan under a product is deemed unreasonable and another is not, leading to additional confusion. Altering the criteria will be difficult for states and carriers, with little if any real benefit to consumers. While we support the intent of the proposal - to reduce gaming - we have concerns about the timing and resources need to meet this new standard, and would also note that states have procedures in place to prevent such gaming. We urge that CMS reconsider this change.

(§154.220 and §154.301)

- State regulators urge you to retain the option for states with effective rate review procedures to continue to link to the federal website (when it is operational) so consumers can review proposed rate increases and provide comments, as required by the regulations. To require all states to develop their own websites would be costly and unnecessary, especially considering that the federal government has or should have a system already in place for this activity. States would also have to fund this system into the future if the rules are adopted, without the aid of federal grant money since those funds are set to expire. This creates an additional unfunded mandate upon the states.

- State regulators strongly object to the proposal to require states to publish all final rates at the same time, but no later than the first day of open enrollment. This is not a requirement of the law, nor does it fulfill any recognized purpose of the Affordable Care Act. States have regulations and procedures in place that dictate when final rates are published - many are published when rates are finalized with no requirement that all be finalized at the same time - and these should not be preempted. It would be 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. We

also object to the requirement that states provide a 30-day notice to the federal government if rates are published before the first day of open enrollment. This is impractical and unnecessary.

- Likewise, state regulators oppose the draft requirement that all proposed rates be filed at the same time. This would place an onerous burden on carriers with plans outside the Exchange to file their rates much earlier, and also place a tremendous burden on state regulators to review all rates at the same time. In order to accommodate this new requirement states will be forced to either reduce the thoroughness of their rate reviews or require rates to come in much earlier, which means less information on which carriers can base rates. In the end, this is likely to result in fewer plans, higher administrative costs, and, possibly, fewer states partnering with the federal agencies. For these reasons we strongly recommend that this proposal be stricken from the final Notice.

- In addition, state regulators are concerned about, and therefore object to, the proposal to require the publishing of Parts I, II and III of the rating materials, except for information carriers deem proprietary. Again, states have regulations and procedures in place for defining proprietary information and for publishing information. These decisions and requirements should be deferred to the state.

- Moreover, the states object to the "tying" of the proposed system requirements to the overall concept of "effective rate review." States believe that effective rate review is accomplished by the successful adherence to state and federal law regarding rate setting by issuers as adjudged and justified by the totality of an issuer's rate submission and financial status that can be actuarially justified.

- Finally, the revision to 154.200(2)(c) defines threshold rate increases in terms of the change to the plan-adjusted index rate (as described in 156.80). Section 156.80 discusses permissible plan-level adjustments to the index rate but does not explicitly define the "plan-adjusted index rate". The Part III Actuarial Memorandum instructions define the "plan-adjusted index rate" as being calculated prior to calibration for age and geographic rating factors. Thus, the calculated rate increase for comparison to the threshold would incorporate changes in the actual or assumed demographic mix of the population in addition to the changes in rating factors that have traditionally been considered to define the rate increase on a given plan. Demographic changes could distort the rate increase calculation and obscure the impact of changes to the base rate and allowable rating factors that comprise the rate increase on a particular plan. For instance, in the case of a static block of business with no new enrollees or lapses the plan adjusted index rate would reflect the aging of the population by one year, artificially inflating the magnitude of the rate change. The threshold rate increase should be defined in terms of rating factors for a static population year over year excluding aging and changes in demographics related to age and changes in distribution within rating areas.

Essential Health Benefits

(§156.115 and §156.120)

- State regulators understand the reasoning behind the proposal to define "habilitative services" in cases where neither the benchmark plan nor state law defines it. However, we would suggest that the regulations go further by giving states the flexibility to define "habilitative services" when the chosen benchmark plan includes some habilitative services. There are cases where the benchmark plan's services are very limited or vague and states would like the option to further refine the benefits. Where states do not have authority to refine coverage of habilitative services, states request clear guidance in federal rules on whether the limited state definition will be required to apply to all diseases or conditions, or whether the federal definition will apply, and if the federal definition will apply, will it pre-empt the definition in state law to the extent that the state law addresses at least

some habilitative services. States request guidance on whether the application of the federal regulation could result in possibly two different "habilitative services" definitions in a plan – one for the limited circumstances required under state law, and one for everything else.

- State regulators also appreciate that the draft Notice does not make significant changes to Essential Health Benefits (EHB) in 2016 and retains the ability of states to participate in defining the state-based EHB package for 2017 and beyond. In finalizing the Notice, however, we would like clear language that any mandated benefits included in the benchmark plan chosen for 2017 would be part of the EHB package and not subject to the reimbursement requirement under the ACA. In addition, we would also appreciate more details on how the benchmark can be chosen for 2017 and the deadlines for decisions by the states.

Annual Open Enrollment Period

(§155.410)

- While state regulators understand the desire to move up the open enrollment period and conclude enrollment by December 15th, we have several concerns:
    - Beginning the open enrollment period on October 1st will significantly shift the deadlines for rate and form submission and review; transfer of final rates and forms; consumer notices; and agent/broker training and certification. Will all notices, regulations and templates be completed by the federal government in time for carriers and states to fulfill their obligations?
    - Moving up the rate submission deadlines to prepare for the October 1st date means carriers will have even less claims and other information from 2015 to assist in their development of rates.
    - If the uniform submission and posting requirements in Sections 154.200, 154.22, and 154.301 are retained (and we hope they are not) this new start date will cause a burden on plans throughout the market to meet very short deadlines, and compress the work and stress the resources of state regulators.
    - Also, ending open enrollment on December 15th means anyone who is auto-enrolled into a plan would not have a second chance to choose a plan that is better for them. This could become particularly problematic if the proposal to auto-enroll a person into different plan and/or carrier is approved.
- We suggest that you work closely with us and carriers to set the dates for the next open enrollment period and ensure the tools are available and timelines and procedures are reasonable to reach the opening date.

Annual Eligibility Redetermination

(§155.335)

- 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 removal of this proposal from the Notice.

Plan Suppression

(§156.815)

- State regulators understand that there may be some instances where plan suppression may provide some relief to carriers. However, we would like the final Notice to clearly state that this suppression will never be done in violation of state laws and regulations. In addition, in cases where states require plans to continue to be listed on the Exchange, consumers should be clearly informed about the situation of the plan.

Prescription Drug Benefits

(§156.122)

- State regulators are concerned that the proposed use of a "Pharmacy and Therapeutics" committee could result in wide variations in products and consumer confusion, exactly the opposite intent of the ACA. This proposal could also lead to additional administrative costs and enforcement issues for states. We recommend that this be dropped from the Notice.

Prohibition on Discrimination

(§156.125)

- State regulators do not agree that setting age limits for benefits are inherently discriminatory. In fact, it is quite common in both state and federal laws to set age limits for certain benefits. We strongly recommend that the final Notice not preempt state laws. States have the tools to identify and stop discriminatory practices. We do not believe broad bans like those in the proposed Notice are appropriate.

Termination of Coverage

(§155.430)

- State regulators support the proposal to allow for the termination of a plan during a state-set "free look" period and the allowance of a special enrollment period into a new plan if the individual does cancel the plan outside the open enrollment period.
- We do not believe Section 147.106 (guaranteed renewability) should be revised to address terminations related to state "free look" periods. Free look terminations are solely the option for the consumer and under no circumstances should an issuer consider such an option to be an exception to the issuer's obligation to renew existing coverage.

Special Enrollment Periods

(§155.420)

- State regulators agree that the current allowance of a special enrollment period for individuals with a non-calendar year plan should be extended into the future for consumers with non-calendar group plans that renew during the year.

- As for additional special enrollment periods to consider, the NAIC is currently reviewing its Network Adequacy Model Regulation and the issue of a special enrollment period when a plan's network or formulary is materially changed during the year has been raised. In some instances, consumers could be left with a plan that does not provide the same coverage for necessary prescription drugs or affordable access to the same providers. A special enrollment period for such consumers to switch plans during the year may be reasonable.

- As for the proposal to delay coverage for newborns and newly adopted or foster children, we note that many states have laws requiring coverage of such children from the moment of birth/adoption/placement, as well as laws governing coordination of benefits in any case where more than one plan is providing coverage. In effect, the Exchange may be required to offer an option that cannot be honored because a state law prohibits delaying the effective date of coverage for such children. The final Notice should clearly state that coverage of newborn/new adopted/foster children cannot be delayed in violation of state laws and regulations.

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.

Functions of the SHOP

(§155.705; §155.735 and §156.285)

- State regulators would rather the final Notice say that if the FF-SHOP provides assistance with the payment of COBRA premiums, the FF-SHOP <u>will</u> work with state authorities to include state-mandated requirements. State continuation of coverage rules vary from state to state and, if the federal system engages in this area, assistance with state protections should be a primary consideration.

- The draft Notice proposes to have the SHOP send notices of termination of coverage in case of plan decertification. (Sections 155.735 and 156.285). We note that regardless of whom sends notice (SHOP or issuers), decertification is not an exception to HIPAA guaranteed renewability requirements under state law, and should not result in any termination of coverage. This should be made clear in the final Notice.

Standards for HHS-Approved Vendors of FFM Training for Agents and Brokers

(§155.222)

- States are the regulators of agents and brokers. Under the state insurance producer license, agents and brokers are required to complete extensive training and to meet continuing education requirements. Some states are interested in including training on the FFM in their programs and we recommend that the final Notice include language allowing for states to incorporate federal materials in existing training and licensing programs to promote cost-effectiveness and efficiency.

Standards for Notification of Change of Ownership

(§147.106)

- State regulators agree that this issue should be addressed and there are many aspects to consider. However, we do not feel that we currently have sufficient information to provide an answer to this question. We strongly encourage you to look at state laws and consult with us as you consider the various options and we offer our assistance in the development of a final policy.

Reinsurance, Risk Adjustment and Risk Corridors

- State regulators support allowing excess funds from the reinsurance program to roll over into 2017 to help stabilize individual market premiums. We believe the additional stabilization may be needed because of the potential late entrance of transitional plans and the extension of some states' high risk pool plans.

- The reinsurance parameters appear to be set in a fashion to achieve greatest impact on rate setting and to minimize interference with current commercial reinsurance. However, due to poor experience, some insurers are unable to obtain commercial reinsurance and therefore are left unprotected from large losses that have resulted from implementation of the ACA requirements. This should be considered when setting the parameters.

- We support updating risk adjustment HCC factors for 2016 based on more current data, but we do not support applying those factors to the 2015 risk adjustment year. We further suggest that HCC factors may be more appropriately calculated and applied regionally.

- Please provide the rationale for the significant modification of the Child Transplant factors.

- The determination of whether to base the risk adjustment coefficients on pooled data from three sample years or blending coefficients from three separate estimates should consider statistical analysis best-practices.

- The draft Notice states that, "We would further clarify that member-months of enrollees in early renewal plans will not be counted towards the risk corridors transitional policy adjustment (that is, unless and until the plan becomes a transitional plan in a transitional State upon renewal in 2014). We believe that this approach for counting member months towards the risk corridors transitional adjustment is consistent with the intent of the transitional policy adjustment set forth in the 2015 Payment Notice <u>because issuers could have been able to account for the risk of early renewals in their 2014 rate setting</u>." This is incorrect because the CMS announcement did not occur until 11/15/13, which was too late to reflect in the rates which were finalized in July 2013. Member months in early renewal plans should be counted in the adjustment.

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.

Sincerely,

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