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

December 18, 2014

Hon. Katherine Archuleta
Director,
U.S. Office of Personnel Management
1900 E Street, NW
Washington, DC 20415

Re: NAIC Comments on Multi-State Plan Program NPRM (RIN 3206-AN12)

Dear Director Archuleta:

We write as the chief insurance regulators of our respective states and members of the National Association of Insurance Commissioners (NAIC) to provide comments regarding the Office of Personnel Management's proposed rule regarding the Multi-State Plan (MSP) Program. The 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 U.S.

The highest priorities of state regulators around the country are protecting consumers and promoting competitive markets for insurance products. Since the inception of the MSP Program, we have shared a deep concern that the imperative to attract issuers to participate in this program would lead to the creation of an unlevel playing field that gives regulatory advantages to those issuers participating in the program. These concerns were expressed in comments we submitted in December 2012 to the original proposed rule creating the program, to the proposed MSP Application in October 2012, and in response to a Request for Information in August 2011. Unfortunately, the proposed rule we are commenting upon today does little to allay these concerns and reinforces the impression that regulatory concessions are a tool that OPM will use to attract participation by insurers.

The fact that OPM asserts the discretion to allow participation by issuers who fail to meet statutory participation standards reinforces this perception: neither of the program's issuers currently meets the requirements[1] to offer MSP coverage in 31 states and 36 states in their first and second years of their participation, respectively. While this particular failure is limited to standards for insurer participation in the program and does not directly affect the coverage that is ultimately purchased by consumers in our states, the same cannot be said of the proposed revision to §800.105 regarding the benefits offered by MSP issuers, which would create an unlevel playing field by granting MSP issuers flexibility denied to every other issuer in the marketplace and would again violate statutory standards for coverage in the individual and small group markets and the for the MSP program.

Subsection 1302(b) of the ACA requires all QHPs to provide coverage for the essential health benefits (EHBs). This requirement is extended to all non-grandfathered individual and small group market plans by subsection 2702 of the Public Health Service Act, added by section 1201 of the ACA. In regulations issued by the Department of Health and Human Services, a process for defining EHBs was established, under which states were

[1] Affordable Care Act, 1334(e)(1) and (2)

given the opportunity to select one of ten EHB benchmark plan options that, when supplemented with any required benefits that were missing, would constitute the EHBs in that state.

When the original proposed regulations for the MSP program were issued in December 2012, the NAIC objected to the provision that would allow each MSP issuer to elect, on a nationwide basis, whether to utilize the EHB package specified by each state or one of three EHB benchmark plan options specified by OPM:

> *The NPRM proposes (800.105) to give MSPP issuers the choice of using the EHB benchmark package in each state or using one of three benchmark packages identified by the OPM. The NAIC does not support this proposal. While the OPM-designated benchmark plans may be very close to those in most states once actuarially equivalent substitutions of benefits have been taken into account, there will still be some differences that may drive consumers to either the MSP or to its non-MSP competitors based upon their health needs, resulting in adverse selection. In addition, the differences in benefits will complicate the comparison of health plans on Exchanges.*

While we fully stand by our earlier objections to the 2012 provision that was later finalized, the danger of adverse selection was mitigated to some extent by the fact that a nationwide EHB benchmark selection made it difficult for MSP issuers to use that flexibility to gain competitive advantage in any given state, as an advantage gained in one state would likely be offset by a disadvantage in another. The current proposal, on the other hand, would compound the problem by allowing MSP issuers to elect to use the state-specified benchmark package or one of the three OPM plans on a *state-by-state* basis and even to offer multiple plans using different benchmark packages in the same state. This proposal will encourage MSP issuers to select the particular benchmark package in each state that gives them the greatest competitive advantage over competitors who, under state and federal law, do not have that flexibility. It would also exacerbate consumer confusion over benefits provided by health plans, as MSP options sold by the same issuer in the same state could have different EHB packages and would put an MSP issuer in violation of the statutory requirement that MSPs offer "a benefits package that is uniform in each state and consists of the essential health benefits described in section 1302."[2]

It is difficult for us to understand any rationale for this provision beyond an attempt to attract new issuers to the MSP program. In the 2012 rule, the decision to allow nationwide selection of one of the OPM benchmark plan options was justified by citing the need for "administrative efficiencies" in order to offer a consistent package of benefits nationwide. [3] Allowing state-by-state elections of EHB benchmark plan options actually results in more administrative complexity, not less, and allowing multiple benchmark plan options to be used in a single state would further compound that complexity. We therefore urge that this provision not be finalized as proposed. We further recommend that §800.105 be revised to specify that MSPs sold in a state must utilize the same state-specified EHB package that is used by each of its competitors. This revision would significantly improve the underlying regulation and ensure a level playing field for all market participants while minimizing consumer confusion.

The NAIC and state regulators also urge you to reconsider the unnecessary change made in the March 2013 final regulations regarding the ability of states to ensure that rates for MSPs are sufficient to cover claims and reasonable in relation to the benefits provided under the plan. In the original proposed rule, you deferred to the important work that states do in this area, unless a state's denial of a rate was "arbitrary, capricious or an abuse of discretion."[4] The NAIC and state regulators supported this, but noted that remedies were already available to issuers whose rates may be denied by the state for these reasons. We were dismayed to see that you had expanded the scope of potential preemption in the final rule by reserving the right to ignore a state's rate review decision if "OPM determines, in its discretion, that the state's action would prevent OPM from administering the MSP program."[5] This new standard is unnecessary and amorphous. State regulators are greatly concerned that it could

[2] ACA 1334(c)(1)(A)
[3] 78 FR 15565
[4] 78 FR 15576
[5] 79 FR 69815

allow a MSP issuer to undercut the market by establishing rates that are not sufficient to support expected claims. State regulators—not OPM—are responsible for ensuring the solvency of health insurance companies, and such a scenario would impair our ability do so. In addition, at least one state uses its rate review process to advance health care delivery system reforms by aligning the incentives for health plans to address underlying cost drivers. We are concerned that the final rule's standard could interfere with innovative cost-reduction initiatives such as this. We urge you to amend the existing regulation to incorporate the language from the 2012 proposed rule.

We would be remiss, however, if we did not note our support for the addition of §800.603, clarifying OPM's ability to share information and data with state Departments of Insurance regulators and Exchanges. Effective market oversight depends upon a thorough understanding of all of the licensed entity's activities in the marketplace, whether they are related to MSPs, QHPs sold on the Exchange, or coverage sold on the outside market. We appreciated the work that OPM put into the joint development of a memorandum of understanding template that would allow states and OPM to exchange information while protecting the privacy and security of sensitive data. We believe that this proposed provision will enhance our ability to fulfill our roles as the primary regulators of all plans in our markets, including MSP issuers.

Again, thank you for the opportunity to comment on this proposed regulation.

Sincerely,

Adam Hamm
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