

January 27, 2022

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-9911-P  
P.O. Box 8016  
Baltimore, MD 21244-8016

Via Regulations.gov

To Whom It May Concern:

The following comments on the proposed Notice of Benefit and Payment Parameters for 2023 (Notice), as published in the Federal Register on January 5, 2022, are submitted on behalf of the members of the National Association of Insurance Commissioners (NAIC), which represents the chief insurance regulators in the 50 states, the District of Columbia, and the United States territories.

First, we appreciate the Department's effort to publish the proposed Notice somewhat earlier than in some prior years. As NAIC has noted in past comments, publishing and finalizing the Notice earlier gives health insurance issuers and state regulators more time to develop and review plans and rates for the relevant year. We continue to request a longer comment period—allowing more than 30 days would give NAIC, individual state regulators, and other organizations a greater opportunity to offer meaningful comments.

### **State Requests to Reduce Risk Adjustment Transfers**

The proposed Notice would repeal the ability of states to request a reduction in risk adjustment state transfers, with an exception for states that previously requested a reduction. State regulators object to this change. State regulators recognize the importance of risk adjustment in maintaining predictable premiums and attracting issuers to markets. But unique dynamics in an individual state's insurance market can result in undesired outcomes when applying the federal risk adjustment methodology, which must be developed and applied nationwide. State regulators have the detailed understanding of their state markets necessary to recognize the rare instances when the federal risk adjustment methodology is inappropriate for a state's market.

Under current policy, states must apply for and receive approval from HHS to reduce risk adjustment transfers. This approval process leaves the final determination up to HHS and allows for states to provide justification for reducing risk transfers when conditions warrant. Foreclosing the opportunity for states to apply for reductions in transfers pre-judges all future market conditions. State regulators believe it is preferable to retain the current approach and keep open the possibility for states to make

applications. Because HHS has the authority to disapprove an application if a state fails to provide adequate justification, it is not necessary to disallow requests.

If the change in policy is finalized as proposed, state regulators support an ongoing exemption for the single state that has previously requested and been approved for reduced risk adjustment transfers. We also support Alabama's request to reduce its transfers for the upcoming year.

### **Annual Reporting of State Benefit Mandates**

The Notice proposes to remove the previously delayed requirement for states to report annually on their state-required benefits. State regulators strongly support removing this requirement. We found the requirement to be unjustified, since states already make their own determinations of what benefits are in addition to the essential health benefits and some have made defrayal payments. We appreciate HHS's attention to the concerns of state regulators and other stakeholders in reconsidering this policy. Regulators appreciate the technical assistance HHS has provided on essential health benefits and we look forward to continued collaboration in this area.

### **Refinement of EHB Nondiscrimination Policy for Health Plan Designs**

The proposal would provide additional clarification on protections against discrimination in offering essential health benefits (EHB). It clarifies that discriminatory provisions must be removed from plan designs, even if the discriminatory provision was present in the benchmark plan on which a state's EHBs are based, and it also provides examples of presumptively discriminatory plan provisions. State regulators have long sought more guidance on how to apply EHB requirements and how to align such requirements with plan designs that pre-existed the ACA but become part of a state's current EHB through the benchmark process. Thus, we appreciate the inclusion of additional clarifications in the proposed rule. Codifying these refinements in regulation rather than expressing them through individual consultations with states offers stakeholders more clarity and gives regulators a more solid basis in enforcing the requirements.

### **Network Adequacy – Federal Standards**

In the Notice, HHS proposes to resume assessing compliance with network adequacy standards as part of the QHP certification process, except in certain states that choose to perform their own assessments using standards as stringent as those applied by HHS. State regulators support efforts to assure QHP enrollees have access to a sufficient network of providers and recognize the potential for effective network adequacy review to advance health equity. We also recognize the potential benefit in aligning network adequacy standards to widely accepted, more comprehensive federal specifications, as it may protect consumers better without commensurate overburdening of issuers.

We are concerned, though, that the application of a uniform set of federal standards also has the potential to complicate enforcement, increase burden, and raise the possibility for plan withdrawal in certain areas if such standards conflict with state enforcement and ignore the complexities of provider practice and local conditions. We urge HHS to continue to refine its methodology for network adequacy reviews and give weight to state assessments, whether or not a state performs network adequacy reviews. State regulators generally have a better understanding than federal regulators of

the availability of providers in different areas of their states and of the market dynamics that influence provider-issuer contracting.

We support the option for states performing plan management functions to conduct their own reviews for network adequacy. Because network adequacy is not measured on a single dimension and no generally accepted approach exists for measuring it or measuring the stringency of different standards, we believe it may be difficult to clearly determine whether a state's network adequacy standards are as stringent as the federal standards. We suggest that HHS defer to a state's network adequacy review when the state's quantitative standards are "comparable to" the federal standard, rather than "as stringent as" the federal standard. Further, we urge HHS to make a determination of whether a plan management state's network adequacy standard is acceptable as soon as possible after the rule is finalized and soon after any updates to the state standard. Once the determination is made that a state will perform reviews, HHS should accept state network adequacy assessments without further review of its own to avoid delays and complications in plan certification.

State regulators ask HHS to provide more details on how it will perform network adequacy reviews. While time and distance standards are clearly defined in draft guidance, HHS has not made clear what data issuers would be expected to submit or in what format; how travel time would be computed; or what group of enrollees would be considered. Further details are also needed on the classification of provider types. Providers' academic qualifications or past practice, both of which may be correct on their own, may not help in useful classification if those taxonomies are not related to the providers' current practice. For example, when it comes to Primary Care Providers, it may be reasonable to classify many internal medicine physicians as primary care physicians. But what if an internal medicine physician only works in an emergency department? Alternatively, physicians trained in obstetrics may not provide obstetric services because associated hospitals do not provide childbirth services. Though academically qualified, these physicians' practices are more limited than their training. Provider-type definitions should be from a consumer's point-of-view, not an academic's point of view. If HHS, using its resources, could undertake centralized control over classification of providers and facilities that issuers could agree to, it would significantly aid state regulators in assessing and enforcing network adequacy. On the wait time standard, it is unclear on what basis issuers will make an attestation of compliance. State regulators suggest developing a standard for the collection and processing of wait-time data, perhaps drawing from issuer best practices if available.

These details may have a significant effect on measurement outcomes and whether plans must use the justification process, so further details on the standards are needed before they are enforced. With a changing process for network adequacy review, a proposed rule that may not be finalized until spring, and these remaining uncertainties about the details of federal network adequacy reviews, state regulators anticipate challenges for issuers to both comply with the standard and document their compliance to the appropriate state and federal authorities in time for certification of 2023 plans. We recommend delaying implementation of the proposed federal standards until plan year 2024.

State regulators appreciate the aspects of the network adequacy standards intended to tailor the standards to local provider and insurer market conditions. Basing measurements on counties is preferable to larger geographies and classifying counties by size and the presence of extreme access considerations is helpful. Nonetheless, issuers will likely be unable to meet the quantitative standards in some areas, requiring them to file justifications. Justifications are an important way to build flexibility

into the standards but developing and filing them can be burdensome for issuers and can delay the QHP certification process. We recommend that HHS continue to refine the quantitative standards with the aim of maintaining sufficient access to providers while minimizing the need for justifications. HHS should consider adjusting the standards year by year and specialty by specialty as it learns more about consumers' experiences in accessing care, provider availability, and issuers' efforts to secure provider contracts.

As for the question about the role telehealth should have in the assessment of network adequacy, state regulators appreciate the important role telehealth has had in expanding access to care, especially in rural areas. The use of telehealth should be one factor in determining sufficient network coverage, but its value should be carefully considered and balanced with making in-person care sufficiently available. Telehealth is clinically different than in-person care and may not provide the same level of care in some situations. Several states are currently wrestling with this issue, and we recommend that any federal standards be informed by those state discussions and not preempt state standards.

### **Telehealth Data Collection**

HHS has proposed that issuers submit information as part of the QHP certification process about whether network providers offer telehealth services. State regulators support the collection of this data and we note that several states already collect it. In addition to being an important tool in addressing the pandemic, telehealth services have the potential to improve care delivery, increase efficiency, and possibly reduce costs. Their adoption could also affect health equity goals, either for the better or for worse depending on how telehealth is deployed. Data on the availability of telehealth services and which providers offer them is currently lacking, so collecting this data will be a step toward better understanding and give regulators at both the state and federal level more information in enforcing network adequacy standards and other policies. If HHS collects telehealth data, we urge HHS to take into account the fact that some states already collect such data and request that the federal data be shared with state regulators.

### **Essential Community Provider Threshold**

The Notice proposes that for 2023 and beyond, the required Essential Community Provider (ECP) participation standard would rise from 20 percent to 35 percent of available ECPs, including approved ECP write-ins. State regulators recognize the importance of access to ECPs and the need for a specified standard in the QHP certification process. We urge HHS to apply the increased standard with attention to the variation in availability of ECPs in diverse geographies across the country. In some areas, meeting the standard in a county by contracting with several providers in one locality will do little to improve access to ECPs in remote areas of the same county. In other places, provider scarcity may challenge issuers' ability to build adequate networks at all. We encourage HHS to build enough flexibility into the standard to allow for reasonable deviations where necessary. Further, we invite HHS to consult with state insurance regulators to help assure that ECP and other network standards facilitate access to care rather than limit plan availability by keeping issuers from offering plans in certain areas.

## **Limiting “Plan Choice Overload”**

HHS seeks comment on the utility of limiting the number of plans that FFE and SBE-FP issuers can offer through the Exchanges in order to avoid plan choice overload. Some state regulators have concerns about the high number of plan variations offered through their federally-facilitated exchanges and would support regulatory changes to limit the number of plan choices. When consumers are faced with dozens of plan choices, it is more difficult for them to identify the plan that best meets their needs. Common plan search and display designs can hide plans from some issuers when other issuers market a high number of plans with only slightly different features. Thus, assuring plan offerings are meaningfully different from each other can improve consumer outcomes and promote competition among issuers.

While applying a meaningful difference standard can be appropriate in some circumstances, state regulators urge HHS to take a cautious approach in disallowing plan choices. Issuers should have the ability to market plans that offer features some consumers desire, even when relatively few consumers choose a certain plan. HHS should clearly establish its criteria for determining meaningful difference through a public process. It should also consult with state regulators during the QHP certification process and collaborate with them in determining whether a particular issuer or market has an excessive number of plan choices for a given year.

## **Agent/Broker Standards**

HHS proposes to codify additional details regarding the requirement that agents, brokers, and web-brokers provide correct information to FFEs and SBE-FPs regarding consumers’ contact information and household income projections. HHS states that these changes are to address instances when consumers are enrolled in QHPs without their knowledge or with inaccurate APTC amounts. We strongly support ongoing efforts on the part of HHS to address misleading and fraudulent marketing and sales practices in health insurance. We urge HHS to take additional steps beyond the proposed rule changes to secure consumer accounts on the federal platform from access by bad actors. Account access should require more than a consumer’s name and date of birth. Because date of birth is not confidential information, unscrupulous agents, brokers, or others are able to access consumer accounts and make changes that consumers may not be aware of. We recommend that access to consumer accounts require a consumer’s partial Social Security Number or other secure information.

State regulators look forward to continued collaboration with HHS on identifying and taking remedial action against licensed agents and brokers who engage in inappropriate practices. We recognize, though, that the proposed rule changes only impact agents and brokers who enroll consumers in QHPs. State regulators have noted improper marketing from agents and brokers as well as unlicensed individuals and entities. In addition to QHPs, this activity is often related to non-QHP health insurance and a variety of other products that are not major medical coverage. Because this activity does not fit cleanly within the jurisdiction of any one agency, we encourage greater collaboration and coordination among HHS, the Department of Labor, the Federal Trade Commission, the Federal Communications Commission, state insurance regulators, state attorneys general, and other appropriate agencies to better protect consumers from improper marketing practices that are constantly evolving.

## Health Equity

In 2020, state regulators created a Special (EX) Committee on Race & Insurance within the NAIC and a Workstream (#5) to look specifically at the issue of equity in health care. Workstream #5 was charged to:

1. Consider enhanced data reporting and record-keeping requirements across product lines to identify race and other sociodemographic factors of insureds, including consideration of legal and privacy concerns. Consider a data call to identify insurance producer resources available and products sold in specific ZIP codes to identify barriers to access.
2. Continue research and analysis related to insurance access and affordability issues, including:
  - a) Measures to advance equity through lowering the cost of health care and promoting access to care and coverage, with a specific focus on measures to remedy impacts on people of color, low income and rural populations, and historically marginalized groups, such as the LGBTQ+ community, individuals with disabilities, and Alaska Native and other Native and Indigenous people.
  - b) Examination of the use of network adequacy and provider directory measures (e.g., provider diversity, language, and cultural competence) to promote equitable access to culturally competent care.
3. Conduct additional outreach to educate consumers and collect information on health and health care complaints related to discrimination and inequities in accessing care.

During 2020 and 2021, Workstream #5 held several open calls and received input from state regulators and a variety of key stakeholders on the issues of data collection and access. At the end of 2021, the Workstream forwarded to the Special (EX) Committee a draft paper on “Principles of Data Collection” and also developed an outline for a paper on “Provider Network, Provider Directories and Cultural Competency.”

As the Workstream and the Special (EX) Committee continue their work in 2022, we will share our findings with federal agencies, and we look forward to working cooperatively with you on this important issue.

Turning to the requests for input from HHS in the proposed 2023 Notice of Benefit and Payment Parameters, the NAIC offers the following responses:

- HHS seeks input on:
  - a) Requiring QHP issuers to obtain the National Committee for Quality Assurance (NCQA) Health Equity Accreditation in addition to their existing accreditation requirements

**Response:** Insurers should achieve an equity accreditation recognized by their state insurance regulator, if such exists, rather than a federal endorsement of a specific accreditation entity. Some states have found the NCQA accreditation to be a bit broad at this point and have sought to develop more specific areas of measurement.

- b) The challenges QHP issuers could face implementing a new accreditation product on health equity.

**Response:** As states have attempted to develop and implement accreditation requirements they have found that: 1) the terms must be clearly defined so all carriers are providing accurate and comparable information; and 2) carriers must have sufficient time to comply with any new requirements to avoid market disruptions.

- Should QHP issuers be required to collect demographic and other SDOH data to help issuers gain a better understanding of the populations they serve, and thereby develop more equity focused QHPs? Which data elements should be considered to advance health equity within QHPs? What are some of the challenges and barriers to collect this data?

**Response:** Health insurance companies should be expected to systematically collect, maintain, protect, and report on, at minimum, voluntarily-reported enrollee data on race, ethnicity, preferred language, sex assigned at birth, gender identity, sexual orientation, and disability.

When collecting, maintaining, and reporting this data, health insurers should aim to align their practices with established national standards that are, where possible, aligned across the health care ecosystem consistent with any requirements of the state insurance regulator, if applicable. This would include alignment with any Medicaid requirements.

Health insurance companies should utilize industry-wide best practices in terms of data collection strategies and survey language that has been consumer-tested and is widely recognized for increased accuracy and responsiveness. Nationally, and within the states, work is currently underway to develop evidence-based, stakeholder driven demographic data standards and that future work should be informed by this ongoing work.

As a basic principle, the disclosure of demographic data by prospective insureds and enrollees must always be voluntary and based on self-identification or disclosure and be accompanied by a detailed explanation of why this data is being requested and that it will support efforts to provide equitable care. To ensure that the disclosure of demographic data does not result in the unintended consequence of compelling consumers to report this sensitive information, a “prefer to not answer” option should be included if insureds and enrollees are asked to answer demographic questions, and an “other” option should be considered to help identify additional future data collection categories. This Principle recognizes that self-reporting may lead to potential discrepancies and underreporting, which will impact stakeholders’ ability to utilize, evaluate, and rely upon this information. Entities should not be required to follow-up with individuals who select “prefer to not answer.”

To the extent that insurers use staff to collect and/or analyze demographic data, insurers should develop and implement trainings (either in-house or through partnership) on how to ask questions about race, ethnicity, and language (REL), sexual orientation and gender identity (SOGI), and disability, including training on how to maintain privacy of this sensitive information.

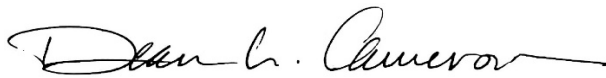
- What are the challenges QHP issuers face in promoting and advancing health equity? What are some strategies that could overcome those challenges?

**Response:** Disclosure of demographic data should be voluntary and based on self-identification. Self-reporting may lead to potential discrepancies and underreporting, which will impact utilization, evaluation, and reliance upon this information.

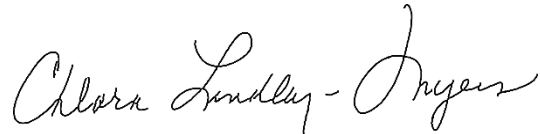
The time and resources needed to comply with any requirements must be taken into consideration. Creating clear instructions, aligning the data collecting and reporting requirements, and ensuring any data collected is focused on improving health equity will help reduce any unnecessary burdens on health insurers.

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

Sincerely,



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