

December 19, 2012

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9972-P
P.O. Box 8012
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 Act: Health Insurance Market Rules, and Rate Reviews 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 market reforms will have on premiums, especially for those who are younger and healthier. While subsidies and higher cost-sharing options may be of some assistance, in most states, these populations could have their individual market rates rise considerably in 2014. This potential “rate shock” could, in turn, result in their 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 work with issuers to address this problem. States must be able to develop appropriate geographic areas, age bands and curves, rate caps and other tools to benefit all consumers. While we understand the desire to have consistency for purposes of risk adjustment and enforcement, this needs to be weighed against the need for innovation to preserve healthy pools and competitive markets.

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 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 insurance regulators to ensure that they do not result in unnecessary costs.

Rating Areas

We recommend § 147.102 (b)(2), (3) and (4) be deleted. However, if they are retained, we propose that, for the reasons outlined below, states be given additional flexibility in defining the number of geographic rating

areas to allow for considerations related to service area, competition, and access issues, as well as disruption to consumers.

The designation within a state of no more than seven geographic rating areas, and the definition of rating area by zip code or county – but not both – are potentially detrimental to insurance markets in some states. The following are some potential complications that may arise from the proposed requirements for geographic rating areas:

1. Setting geographic rating areas that are larger than service areas, may result in reduced competition or consumer access issues in cases where issuers choose to write business only in the lower cost counties within a geographic rating area. States should have the flexibility to align rating areas with service areas to avoid issuer cherry-picking of service areas.
2. Geographic differences in cost structures and provider contracting may not be consistent from issuer to issuer, making consolidation of geographic rating areas difficult for states and creating winners and losers among issuers, potentially reducing competition.
3. Requiring consolidation of current geographic rating areas will likely result in additional disruption to consumers, who will already be facing considerable rate changes in 2014.
4. Requiring consolidation of geographic rating areas reduces cost transparency and could impede issuer initiatives to lower costs, especially in areas with high-cost, dominant provider and hospital groups.
5. In some states, issuers currently break some counties up into two or more areas by 3-digit zip code to better reflect price variation within the county.

We also recommend, for the reasons articulated above, that in cases where states do not define geographic rating areas, CCIIO consider using counties and/or 3-digit zip codes (based on the predominant model used by issuers in that state) rather than defining either a single rating area for the state or multiple areas based on MSAs.

We also have concerns regarding the following passage from the Rule (pg. 32): “If the state’s rating areas are inadequate (for example, they do not cover a sufficient number of individuals) . . . CMS may establish such rating areas.” We are concerned about basing this analysis on a “sufficient number of individuals.” Issuers should be setting geographic rating factors using unit costs based on provider contracts in the area, in which case it is unimportant whether the area’s population is large enough to generate credible claims experience.

Age Rating and Age Bands

We recommend that CMS provide states with the flexibility to phase in the 3:1 age factor ratio over a specific period of time to mitigate the rate shock for this key demographic of the market. With a transition to the required 3:1 age ratio, younger, healthier individuals will experience more gradual rate increases rather than large one-time rate shocks and will be less likely to drop coverage and further destabilize the market. The phase-in of the 3:1 ratio would be uniformly applied within each state’s markets to ensure consistency across issuers. We recommend that states have the option to transition to the 3:1 ratio over a three-year period.

We agree that using single-year age bands and determining age at renewal makes sense. However, we want to ensure that states can institute different policies if they so desire.

Family Rates

A concern has been raised regarding the development of rates for a family. The proposed rule suggests that each member of the family age 21 or over will be added to the rate based on their age and tobacco use, then children under age 21 (up to a maximum of the three) would be added to the rate. Under this proposal, a family with four or more children could face a significant increase in premiums when one of those children turns 21 – adding another adult at a much higher rate than the flat, under-21 rate. Some states suggest extending the cap on three oldest children to age 26, the age at which children can remain on the parents' plan under the ACA. The total family premium would still rise as the older children turn 21, but the family would not be required to, in effect, add another person to their policy.

In addition to this year-to-year instability, we are concerned about the potentially significant rate increases some families may face as the new rules become effective. We recommend that states have the latitude to transition to the new family rating methodology in the first couple of years to help limit these increases.

In response to the question as to whether “the final rule should specify the minimum categories of family members that health insurance issuers must include in setting rates for family policies, or whether we should defer to the states and health insurance issuers to make this determination”, we believe the definition of such categories should be left to the discretion of the states, and to the issuers if permitted by the state.

Closed Blocks

The proposed regulation would require all non-grandfathered plans that have been closed to be reopened and made available to new enrollees. Some states have raised concerns that this requirement could prompt carriers to terminate closed plans that provide more generous benefits to their enrollees. This seems to be an unnecessary disruption to the market. The real issue is that sicker people are stuck in closed plans – and that issue goes away in 2014. We recommend that states be given the flexibility to determine the best policy for addressing “closed blocks.”

Open Enrollment Periods

In the preamble, HHS has solicited comments on “whether this proposal sufficiently addresses the open enrollment needs of individual market customers whose coverage renews on dates other than January 1 and whether aligning open enrollment periods with policy years (based on a calendar year) in the individual market is more desirable.” Aligning open enrollment periods with policy years based on a calendar year in the individual market would address some problems, but might create others.

We believe each state should have the flexibility to choose the approach that will work best in its market. Advantages to the calendar year approach include:

- Except for those enrolling during a special enrollment period, it would eliminate the situation where an enrollee has less than 12 months to reach the deductible.
- Having everyone, or nearly everyone, in the market shopping at the same time each year would be consistent with the concept of an Exchange and would allow issuer marketing to be focused on a single period of time, similar to the Medicare Advantage market today.

Disadvantages include:

- The transition could be problematic. Those who purchase or renew a policy in a month other than January in 2013 would have their coverage cut short when the policy year “resets” on January 1, 2014. Someone who renewed late in 2013 and had a rate increase would likely have another rate increase January 1. Alternatively, policies issued or renewed in 2013 could be allowed to run their course and then renew for a partial year ending December 31, 2014.
- Under the rule as proposed, policyholders would still have the option of buying a new policy on January 1, 2014. Forcing everyone to restart on January 1 would reduce consumer choice.

We further believe that states choosing the calendar year approach should have the option of requiring a rating adjustment for policies covering less than a full year. This would include policies issued or renewed in 2013 (or in 2014 if the reset to a calendar year basis is implemented on January 1, 2015) and policies issued during a special enrollment period. The rating adjustment would reflect the fact that the enrollees will have less than 12 months to reach the deductible.

Bona Fide Associations

In the proposed regulation, the question is raised as to “whether and how a transition or exception process for bona fide association coverage could be structured to minimize disruption while maintaining consumer protections.” Some regulators suggest that these policies be allowed to be renewed, at the discretion of the state, but not open for new enrollment. This proposal could be implemented for a limited time as a transitional measure to minimize disruption.

Adverse Selection Due to Guaranteed Issue

Adverse selection is of great concern to state regulators. In a guaranteed issue, no pre-existing condition environment, the reward for waiting to obtain coverage until it is needed, or switching coverage to minimize cost and maximize benefits will always exist, even with the tax penalties in federal law. In the proposed regulation, HHS solicits comments on “possible ways to discourage consumers from abusing guaranteed availability rights (for example, by ensuring enrollees cannot use open and special enrollment periods to facilitate such abuses) while ensuring consumers are guaranteed the protections afforded to them under the law.” There are many tools states use to limit adverse selections, such as, open enrollment periods (which are included in the regulations), waiting periods, penalties for late enrollment, and others. In the small group market, states are also looking at ways to address adverse selection between self-insurance and full insurance. States need flexibility to develop a regulatory environment that will discourage adverse selection while preserving consumer protections, rather than having the federal government prescribe open enrollment as the tool that states must use.

High Risk Pools

Some individuals currently covered in the individual market will experience large increases as markets transition to the new rules required by the ACA. One of the largest sources of premium pressure comes from the individual markets absorbing individuals previously covered by the state and federal high risk pools.

Allowing state high risk pools to stay open to maintain coverage for current enrollees is being considered as an option. In many instances, high risk pools are a mechanism for spreading the costs of high risk

individuals over a broader market, at least broader than the individual market. State high risk pools may be funded by the State's general fund, or by broad-based assessments on issuers in the state.

Under the proposed rule, high risk pools would not be open to new enrollees once the ACA market rules become effective. Allowing continued access to high risk pools simply would not make sense in a guaranteed issue environment.

States need flexibility to modify market rules relative to high risk pools, recognizing their unique role and minimizing the impact on rates during this transition.

Plan Termination

Under §155.430(b), an Exchange may terminate an enrollee's coverage, and permit a QHP issuer to terminate such coverage, if: (1) the enrollee is no longer eligible for coverage in a QHP; (2) payments of premiums for coverage of the enrollee cease and any grace period(s) have been exhausted; (3) the enrollee's coverage is rescinded due to fraud or misrepresentation; (4) a QHP terminates or is decertified; or (5) the enrollee changes from one QHP to another during an annual open enrollment period or special enrollment period. There is a question as to whether an issuer should be required to renew that coverage on a non-QHP basis, outside the Exchange. We recommend that renewal only be required in situation #4, when a QHP voluntarily terminates participation in the Exchange, or is decertified.

We also note that, in such situations, consumers must be notified about the change in the status of their plan, since their eligibility for subsidies would be impacted. Such notification should include the reason a plan is decertified and is no longer sold on the Exchange.

Plan Changes for Non-Grandfathered Plans

The proposed regulation notes that "issuers may need to make some cost-sharing adjustments at renewal to ensure that policyholders' plans remain at the same actuarial value level from year to year." It is then suggested that issuers can make these types of policy changes "consistent with the uniform modification of coverage requirements under PHS Act sections 2703 and 2742." We agree with this interpretation and agree that it should be explicitly incorporated into the text of the final rule. We also suggest that current enrollees be notified of the change in cost-sharing.

Index Rate – Single Risk Pool

With respect to term "actuarial value" in §156.80, please clarify whether this has the same meaning as in the Essential Health Benefits rule or if it has a different meaning, such as the pricing actuarial value. If the latter, the term needs to be more clearly defined. All four factors allowed for price variance need to be more clearly defined so company actuaries can clearly demonstrate, and regulatory actuaries can effectively evaluate, the reasonableness of the four factors. Also, it should be made clear whether the adjustments to the index rate may reflect differences in health status between the populations that choose different plans.

Rate Reporting and Review Threshold

Section 154.215 requires issuers to file all rate increases, regardless of size, with both the state and CMS. State Departments of Insurance will continue to utilize their own data collection templates and formats in order to maintain effective rate review. Therefore, the proposed rule would require issuers to file rates using different templates and formats. This would be an unfair and unnecessary burden, especially to small issuers

and new entrants. In states deemed to have an effective rate review program, filing only with the state will provide the necessary degree of regulatory oversight that is the objective of this section.

Several states have noted that they do not find the proposed CMS template useful or adequate for their own rate review, and that they are developing or plan to develop their own rate review templates. In states with effective rate review programs, if CMS needs further information to monitor rate increase patterns, it should seek it from the states and not directly from the issuers. If CMS must require use of a template in all states, we urge CMS to strip from its proposed template all fields intended for rate review, and collect only information essential for non-rate review purposes such as QHP certification and verification of premium tax credits and cost-sharing reductions. For states without effective rate review programs, a separate rate review-only version of the template could be made available to assist CMS in monitoring issuer rates in those states.

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,



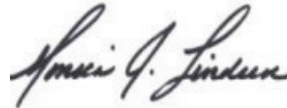
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