

April 23, 2014

Centers for Medicare & Medicaid Services,  
Department of Health and Human Services,  
Attention: CMS-9949-P  
P.O. Box 8016  
Baltimore, MD 21244-8016

To Whom It May Concern:

Thank you for the opportunity to comment on the proposed regulations, *Patient Protection and Affordable Care Act: Exchange and Insurance Market Standards for 2015 and Beyond*, published in the *Federal Register* on March 21, 2014. 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.

States are the primary regulators of private insurance. States license the carriers, approve the plans, oversee rates and market conduct, and ensure solvency. State regulators take seriously their responsibility to protect consumers and preserve a competitive health insurance marketplace. Federal regulation must not infringe on the ability of state regulators to accomplish these goals.

#### **45 CFR 146.152; 147.106; 148.122 – Product Withdrawal/Standard Consumer Notices**

In the provision regarding the “Exception for uniform modification of coverage” in 146.152 and 147.106, we are concerned about the use of the word “product” in reference to discontinuations and renewals. Discontinuations and renewals often occur at the plan, not at the product, level. Therefore, use of the word “product” in this context causes unnecessary confusion and ambiguity. In addition, we are concerned with the wording of the following criteria outlined in (f)(2): (iii) the product covers a majority of the same counties in its service area, and (iv) the product has the same cost-sharing structure. With respect to (iii), in many states product service areas are not filed with the state insurance department. Regardless of whether a state requires product service areas to be filed, it is generally allowable for health insurance products to include plans with service areas that are a subset of the product service area. For this reason, the proposed rule’s service area condition would be very difficult for states to administer. With respect to (iv), it should also be noted that cost-sharing and actuarial value (AV) levels are set at the plan, rather than at the product, level.

We ask that HHS clarify that the removal or addition of an Essential Health Benefit from a product, such as the pediatric dental or vision benefits, would not be allowed under the proposed product modification standards and would constitute a plan discontinuation and replacement. For example, a product with all 10 EHBs could not remove the pediatric dental benefit and be considered the same product, even though the pediatric dental EHB would be available through a stand-alone dental plan.

We also note that the proposed regulation uses the term “discontinuation” while the notices use the term “discontinuance.” Using uniform terminology is recommended.

As for the draft discontinuance and renewal notices published by CCIIO on March 14, and referenced in the proposed regulation, state regulators have the following comments:

- a) We suggest that the a statement relating to being charged more because of a pre-existing condition be added to the second bulleted point under the “How Do I Choose A New Policy?” and “What If I Want To Choose A Different Policy?” provisions in all four notices. Such a statement should also reflect its applicability to the purchase of individual and small group coverage only. Otherwise, in reading the entire notice an individual, small group enrollee or small group employer may presume that he/she can be rated differently due to a pre-existing condition when purchasing coverage outside the Marketplace, which is specifically prohibited for all plans under Section 2701 of the PHSA.
- b) In Section III of the bulletin, we suggest that the statement indicating that an insurer can include a cover letter with the notices providing additional information, such as insurer contact information, be amended to specifically permit the insurer to include information on premium changes, since renewal notices traditionally include the new premium for the new term.
- c) In Attachments 1 through 4, we are concerned that the phrase “guarantee health care security” in the first bulleted paragraph may be misleading. We suggest changing “guarantee” to “promote” or some other term. There are well-publicized accounts of consumers whose health care security is not “guaranteed” by a policy with high premiums and/or cost-sharing.
- d) In Attachments 1 through 4 we believe the two paragraphs for “How to Choose a New Policy” are also misleading and may be considered improper steering. The ACA amendments to the PHSA apply to all policies, not only those on the Exchanges. Therefore, everything in the first paragraph is true both inside and outside the marketplace except for the last sentence about financial assistance: policies on and off the Exchange “meet certain standards”, policies on and off the Exchange have no pre-existing condition exclusion, and one may “choose a private plan that fits your budget and health care needs” either on or off the Exchange. Suggest that these paragraphs be revised to contain parallel language for all except the last sentence in each.
- e) In Attachments 1 through 4, under “How Can I Learn More”, space should be provided to insert a reference to the state website that HHS shows on healthcare.gov. States with State-Based Exchanges note that reference to a federal website and toll-free number are confusing to consumers – only the state website and consumer assistance numbers should be included.
- f) In Attachments 1 through 4, since the last sentence says “Please contact us”, carriers should be permitted to put their contact information at the end of that sentence.
- g) In Attachments 3 and 4, we suggest that the “What Do I Need to Do?” sections in both attachments be amended as follows: “There is nothing you are required to do. At the end of your current policy year, we will automatically enroll you in the same coverage, presuming you have paid the premium necessary to renew your policy.”
- h) In Attachment 3 the third bullet seems inaccurate and inconsistent with the lead-in paragraph of the “What If I Want to Choose a Different Policy” section, perhaps due to the reference to learning “the dates of the next open enrollment period.” At least for 2014, when there will be a “limited open enrollment period” for persons on a non-calendar year policy, it is confusing and potentially inaccurate to say that someone cannot enroll in a new plan instead of renewing a policy except during the standard open enrollment period. See 45 C.F.R. §147.104(b)(2). See also 42 U.S.C. 300gg-1(b)(1) (issue “may” restrict enrollment).
- i) In Attachment 3, in the paragraph immediately following the bullets, it may appear misleading to say that one must “maintain health insurance coverage in order to comply with applicable State and Federal law.” The mandate to maintain coverage is found only in federal law and one or two states.
- j) The proposed regulations suggest using the same notice for both small and large groups. Since the rules can vary greatly for the two markets, we recommend a separate notice for small groups and large groups.

- k) The proposed notices are addressed to “Dear Member.” This could be confusing to group policyholders, which are not necessarily members of the plan. We recommend that the notices be addressed to “Dear Policyholder.”
- l) In the renewal notice, it should be made clear that if a renewal is offered, the policyholder is not required to renew the plan.
- m) The discontinuance notice to employees should note that the employer may be switching to another plan. As currently drafted, the notice to the employee may lead them to believe they will be without any coverage, which may not be the case.

#### **Section 148.124 – Certification of Creditable Coverage**

It is possible that in a limited number of scenarios that a certificate of creditable coverage might still be needed after 12/31/2014. For example, if an adult dependent (a spouse) were to be added to an individual grandfathered plan, there would be no prohibition against pre-existing condition exclusions. Therefore, it is suggested that the requirement to provide a certificate of coverage upon individual request – currently paragraph 148.124(b)(ii) – be retained, while the requirement to issue automatic certificates be eliminated.

#### **Section 148.220 – Fixed Indemnity**

While state regulators share the goal of protecting consumers, many states are concerned about the impact of the new definition of “fixed indemnity plans” will have on consumers and the marketplace. In particular, they are concerned about the requirement that these plans be supplemental and how this new regulation will impact current policies and how it would be enforced:

1. First, carriers have for years been selling fixed indemnity plans to consumers in compliance with federal and state regulations. Many of these previously issued fixed indemnity policies continue to be in force. Under the proposed regulation, if they are not supplemental, they would no longer be excepted benefits. These plans would become health benefit plans subject to all the requirements of the ACA and HIPAA, including metal levels, rating requirements, essential health benefits, guaranteed renewability, no pre-existing condition limitations, etc. However, they have not been reviewed for compliance with these laws. This raises two transitional questions:
  - a. Would the carrier be required to contact their policyholders upon renewal to determine whether they have minimum essential coverage in order for the plan to remain an excepted benefit?
  - b. Would the carrier be required to non-renew a previously sold fixed indemnity contract if enrollees fail to provide assurance that they have other minimum essential coverage?
2. Second, how would this requirement be enforced going forward? Would fixed indemnity plans lose their excepted benefit status if enrollees fail to maintain minimum essential coverage? If so, this is very different from all other types of excepted benefits, which are always excepted benefits (i.e. long-term care, Medicare supplements, specified disease, disability, etc.) regardless of any actions or inactions by the plans’ enrollees. How are carriers and regulators expected to monitor compliance?
3. Finally, while fixed indemnity insurance is not comprehensive health insurance, this type of coverage may fill a need for certain consumers. It can provide a bridge for those individuals who did not purchase coverage during the open enrollment period and are not eligible for a special enrollment period, or a bridge between coverage’s when changing jobs. Under the proposed rule, these options would be eliminated.

State regulators agree that consumers need to be protected and well-informed of what this sort of coverage is (limited benefits) and what it is not (comprehensive coverage that satisfies the requirements of the individual mandate). However, we are concerned that the proposed change in the definition raises many questions and concerns that need to be addressed before these options are taken away from consumers.

The NAIC recommends that the requirement that fixed indemnity plans be supplemental be removed from the regulation and that federal and state regulators, along with consumer and carrier representatives, should work together to develop a definition that will protect consumers and also retain coverage options. In the meantime, we agree that all fixed indemnity plans must include a clear notice that the coverage is not minimum essential coverage and does not satisfy the individual mandate.

Regarding that notice, the proposed regulation includes a requirement that a fixed indemnity plan must include a prominently displayed notice in all “plan materials”. However, the definition of “plan materials” is not provided. There are a number of places where notices could be given to ensure consumers have clear notice and we believe a definition will provide clarity to the industry and ensure a level playing field. They include:

- The face page of the policy form;
- The application form, including electronic application formats;
- The face page of the certificate or plan booklet if provided in addition to or in lieu of the policy;
- All print advertisements and all other advertisements including but not limited to TV, radio and social media;
- The member ID card; and
- All other print materials or electronically distributed materials that are distributed to insured’s.

### **Section 153.500 – Risk Corridors**

The proposed rule states that the federal government intends to operate the risk corridor program in a budget-neutral fashion. This is not a requirement of the federal law and state regulators question the Department’s authority to implement and enforce such a requirement. We have also expressed our concerns about changes to the formula that may be required to meet budget neutrality and their potential impact on the certainty of plan pricing from year-to-year. We ask that you reconsider this goal.

### **Section 155.210 – Navigators**

State regulators are greatly concerned about the broad language in the proposed regulation that would preempt state oversight of Navigators and other assisters. As you know, states have the primary responsibility to protect consumers from fraud and misleading marketing tactics and we take this responsibility very seriously. Consumer protection is the reason why for years state regulators have made a distinction between the duties of an enroller as opposed to the duties of a licensed producer. State regulators have witnessed the harm done to consumers by misinformation provided by individuals that lack the depth of knowledge to fully articulate the benefits of a particular product.

For the federal government to tie the hands of state governors, legislators and regulators is very troubling. The wording in the proposed regulation blurs the line between Navigator and producer activities. Of particular concern is the preemption of the following state standards:

- Except as otherwise provided under subsection 155.705(d), requirements that navigators refer consumers to other entities not required to provide fair, accurate, and impartial information;
- Requirements that would prevent navigators from providing advice regarding substantive benefits or comparative benefits of different health plans; and
- Requirements that would prevent certified application counselors from providing advice regarding substantive benefits or comparative benefits of different health plans.

Regarding the first standard, the proposed regulation states that, “regulations which require navigators, non-navigator assistance personnel subject to section 155.215, and certified application counselors to refer consumers to agents or brokers, or to any other sources not required to provide them with impartial advice, would prevent the application of the provisions of title I of the ACA.” This standard fails to recognize that there are consumers who begin the application process with a navigator or CAC but get to a point in which they want a recommendation about which plan they should ultimately choose. In most states, it is a violation of long-standing state law for anyone but a licensed health insurance agent to recommend one plan over another. If a consumer is asking for advice or a recommendation,

the navigator or CAC has, at a minimum, a legal obligation to indicate that they cannot help them with that request. States, as a consumer assistance measure, should be able to require navigators and CACs to make consumers aware of that fact that there are licensed health insurance agents available who can help them determine which specific plan is in their best interest. We therefore oppose the prohibition on states requiring navigators and CACs to refer consumers to entities not required to provide impartial information.

With regard to the last two standards, we object to HHS's characterization that state laws preventing navigators from providing advice regarding substantive benefits or comparative benefits is in conflict with or prevents the application of the ACA. The rationale offered in the proposed regulation is that such a standard would prevent navigators from performing their duty to provide fair and impartial enrollment information. However, the term "advice," according to Merriam-Webster, "is an *opinion* suggesting a wise or proper course of action." Providing an opinion is not giving impartial information and, as referenced above, in most states it is a violation of state law for anyone but a licensed health insurance agent to advise consumers on the best plan for them. If navigators and CACs are currently making specific plan recommendations, i.e. advising the consumer that one plan is better for them than another, they are, in most, if not all states, violating long-standing, pre-ACA state insurance laws. Any navigator or CAC wishing to give plan recommendations will be subject to insurance producer licensing laws and requirements. In the interest of consumers, the proposed regulation should not limit a state's ability to prohibit navigators and CACs from offering advice they are not trained to provide.

If it is not the intent of HHS to prohibit states from preventing navigators or CACs from offering an opinion/providing advice on specific plan options but rather to prevent states from limiting the ability of navigators and CACs to impartially explain the difference between plan features, it is recommended that the word, "advice" be replaced with "information." There is a distinct difference between ensuring a consumer understands the product features of the plans they are considering and providing *advice* specific to those plan options. We also recommend that a new subparagraph 155.210(c)(1)(G) be added to state: "*Nothing in this section shall prevent a State or Exchange from directing Navigators or non-Navigator assistance personnel to refer consumers to licensed agents or brokers when advice on enrollment in a specific health plan is requested, or when a consumer's questions regarding a health plan exceeds the bounds of Navigator or other assistance personnel expertise.*"

It is important to remember that state navigator/assister licensure and certification requirements are a consumer protection measure intended to:

- Ensure consumers are working with individuals who are knowledgeable about their state insurance market and public assistance programs;
- Trigger state regulatory authority to stop individuals from holding themselves out as navigators or assisters who are not legally serving in that role; and
- Allow state insurance departments to serve as a resource when there are concerns over navigator or assister conduct.

While navigators, non-navigator assistance personnel and CACs may have certain rights under federal law, states continue to be the primary regulator of insurance. It is important that states have the authority to identify and regulate navigators and other assisters—not only to ensure they understand particular state requirements and the state's insurance market, but also so that states have the ability to stop individuals who are posing as navigators and non-navigator assistance personnel in order to scam the general public.

We also note that the success of many State-Based and Federally Facilitated Exchanges in enrolling consumers during the 2014 enrollment period was due in no small part to the many insurance agents and brokers who provided invaluable assistance to consumers. The NAIC opposes any rule changes that would tend to undermine the successful engagement by, and assistance from, the agent and broker community in supporting the Exchanges.

### **Section 155.410 – Open Enrollment Period**

State regulators request the addition of language in the final regulation clarifying that states may set an open enrollment period for the exchange that is broader than the federal period. This flexibility is referenced in the preamble of the final exchange regulation, but states have been told that they will not be allowed to set a different open enrollment period for their Exchange (even a State-Based Exchange) because the law requires the Secretary to set the open enrollment period and, therefore, no state can set a different open enrollment period. Not only does this interpretation ignore the preamble language, but also ignores the general rule on preemption – a state can have rules that differ from the federal rules as long as they do not “prevent the application” of the federal rule. Broader open enrollment periods do not prevent consumers from purchasing coverage during the federal open enrollment period and therefore should be allowed. This should be clarified in this final regulation.

Also, concerning the timing of the notice on the annual enrollment and redetermination period, requiring the notice to be sent between October 1, 2014 and November 15, 2014, would create the greatest amount of state flexibility.

### **Section 155.420 – Special Enrollment Period**

Please specify under (d)(1) that a 60-day special enrollment period will be available for non-calendar year policies in 2015 and 2016, even if the qualified individual or dependent has the opportunity to renew the transitional policy. Otherwise, only those whose transitional policies’ renewal dates happen to coincide with the annual open enrollment period will have the choice of enrolling in the new marketplace on or off Exchange. All others will be forced to renew their non-ACA compliant plan or to be uninsured until the following January.

The intent behind the creation of these transitional plans, and their extension, was to increase consumer choice, allowing people to either keep their current plan, or to enroll in new ACA-compliant plans. Limiting the choice to enroll in the new Exchange (and to receive tax credits or cost-sharing subsidies, if eligible) to the minority of insured’s whose renewal happens to coincide with the annual open enrollment period removes choice and locks consumers into noncompliant plans.

Also, 147.104(b)(2) specifies that the special enrollment period for this event is 30 days, whereas the proposed 155.420(c)(1) states that, unless otherwise specified, the special enrollment period is 60 days. Discussion of this proposed new paragraph (on page 118 of the pdf version) indicates that this 60 day period is to apply to the special enrollment period described at the proposed paragraph 155.420(d)(1). We suggest a conforming amendment to paragraph 147.104(b)(2) to reflect that the special enrollment period is 60 days.

### **Section 155.705 – SHOP Exchange**

States are concerned about the ability of the federal government to implement “employee choice” functionality in the federal SHOP Exchange, when it was unable to operate a simple employer choice model in 2014. The introduction of employee choice raises considerable challenges for the Exchange and the carriers, as well as employers and employees.

The proposed regulation affords states the opportunity to request a delay in the employee choice option in 2015 if certain criteria are met. We ask that the details of this process be published as soon as possible so states can make their case before carriers make their decisions whether to participate in the SHOP Exchange in 2015 or not. In addition, we recommend that the federal government defer to the state decision whenever possible, as state regulators are best informed regarding the potential impact this decision could have on consumers and the market.

We are in support of the proposed rule that, in states with a State-Based Exchange, the state regulatory authority will recommend a policy on whether to allow employee choice within the SHOP, and the Exchange will then make the final determination. We also support allowing this flexibility for years after 2015.

### **Section 156.122 - Essential Health Benefits-Prescription Drug Benefits**

The preamble to the proposed regulations indicates that HHS is considering amending 45 C.F.R. 156.122(c). This section currently reads:

*A health plan providing essential health benefits must have procedures in place that allow an enrollee to request and gain access to clinically appropriate drugs not covered by the health plan.*

HHS is considering amending the formulary exceptions standards to require that these processes can be expedited when necessary based on exigent circumstances, such as when an enrollee is suffering from a serious health condition or an enrollee is in a current course of treatment using a non-formulary drug.

While the proposed rule does not amend the regulations themselves, it does request comments on what standards would be appropriate for defining this expedited exceptions process and on a suggested provision requiring decisions on formulary exceptions requests within 24 hours following the issuers' receipt of the exceptions requests.

State regulators suggest that HHS consider an "emergency case" standard for this expedited exceptions process which would allow for a 24-hour decision process, but only in true emergencies. The lack of all non-formulary prescriptions may not be an emergency in every case. For example, if the individual still had a sufficient supply of the prescription remaining, a decision may not be needed in 24 hours. Providing an "emergency case" standard for 24-hour decisions would ensure consumer protection without overwhelming carrier resources unless necessary.

We thank you for your consideration of our comments; we are available to discuss them in detail and would be happy to answer any questions.

Sincerely,



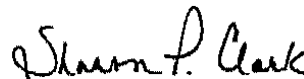
Adam Hamm  
NAIC President  
North Dakota Insurance Commissioner



Monica J. Lindeen  
NAIC President-Elect  
Montana Commissioner of Securities & Insurance



Michael F. Consedine  
NAIC Vice President  
Pennsylvania Insurance Commissioner



Sharon P. Clark  
NAIC Secretary-Treasurer  
Kentucky Insurance Commissioner