

Comments on the Draft Annual Letter to Issuers January 12, 2015

Key Comments

State regulators are very concerned about the short timeframes for form and rate review included in this draft letter to issuers. The requirement that health insurance carriers submit initial forms and rates by April 15, 2015 does not allow them sufficient time to collect the claims information necessary to develop rates for 2016. Also, reinsurance and risk adjustment numbers from 2014 will not be available until June 30, 2015. If a state desires to review the forms and rates before they are submitted carriers could be squeezed even further.

We would also like to reiterate our objection to the proposal in the draft Notice of Benefit and Payment Parameters which would require all plans – inside and outside the Marketplace – to submit their initial rates at the same time. If this is finalized, and the April 15th deadline is retained, carriers and state regulators would be faced with an almost impossible task.

We strongly recommend that the initial submission date be moved back to give carriers more time and information to develop their products and rates for 2016. In addition, for states that perform the plan management functions for the Federally-Facilitate Marketplace (FFM) we urge you to allow the state insurance regulator to set the deadlines for submissions and revisions, as long as the final deadline is met. This would give state regulators needed flexibility to work with carriers to establish a reasonable review process based on available data and resources.

State regulators also note that the final date set for signing Qualified Health Plan agreements – September 15, 2015 – may once again conflict with some state notification requirements. This was a problem in 2014 and should not be repeated in 2015.

State regulators are also concerned about the oversight activities of federal agencies and their contractors. In particular, there must be better communication between state and federal officials when an audit or outlier analysis is done and carriers and state officials must be provided detailed information on the standards being used to perform any audits or outlier analysis. Too often carriers were given insufficiency notices on their networks or prescription drug formularies, but not provided an explanation on what standards were used to make that determination.

Finally, we are concerned about the requirement in the law that “small group” be defined as employers with 1-100 employees beginning January 1, 2016. This could be very disruptive to employers with 51-100 employees and some states may seek a waiver from this requirement for 2017. We ask that you consider ways to give states more flexibility for 2016. Of course, any action would need to be taken quickly, before small group forms and rates are filed for 2016.

Following are more specific comments from state regulators, by section:

Chapter 1

Section 1: QHP Application and Certification Process

- When will the Notice of Benefit and Payment Parameters (NBPP) and CCIIO’s plan management templates be finalized? Given the shortened timeframes, carriers and state regulators need these as soon as possible.
- Additional CMS training materials and review tools would be helpful to have for state reviewer staff and consultants to prepare in advance of the filings being submitted. Comprehensive training documents containing lists of all things that CCIIO deems important to consider with links to original sources and go at your pace

webinars could help. Having more checklists or lists in bullet form that have links with more complete info may be useful to our staff and might help with meeting deadlines.

- The table on pages 8-9 talks about risk pools with QHPs. There's a footnote on pg. 9 that talks about risk pools with no QHPs. The draft NBPP says all rates are expected to be filed at the same time. How can pools with no QHPs be separate from the rate filings that are all due at once?
- Regarding the table on pages 8-9 and the "Deadline for All Risk Pools with QHPs to be in 'FINAL' Status in the URR system" (due date of 7/24/15), based on the experience with the 2015 Plan Year health plans and the lack of clear guidance or delineation of expectations from CMS, please explain what "FINAL" status means and what are a State's (who has an effective rate review designation) obligations relating to that status, i.e. what must a State do, when must they do it by, etc. This being a state issue, it does not seem right to have those obligations in the Issuer Letter, but some written, clear guidance for States that is given well in advance of the review season would be welcomed.
- In footnote 5 on page 9, the statement "All risk pools with no QHPs must be in 'final' status in the URR system by September 15, 2015" is not clear here or in the proposed HHS Notice of Benefit and Payment Parameters for 2016 regulation). Does this apply to the individual market single risk pool filings or to all (individual and small group) single risk pool filings? Presumably the proposed amendments to 45 CFR 155.410(e) relating to open enrollment begin date of October 1, 2015, apply only to the individual market given that 45 CFR 147.104(b)(1)(i)(B) – where the small group market open enrollment period is defined – was not proposed for revision. If small group open enrollment is later, we fail to understand why reviews must be completed in September for the small group market that does not have any QHPs in the risk pool.
- Related to issuers withdrawing from the exchange for 2016, this letter should make it clear that withdrawal from the application for 2016 QHPs is not the same as a HIPAA product discontinuation or market withdrawal. Withdrawal from the exchange does not constitute grounds for failure to comply with HIPAA guaranteed renewal. The letter should make this clear.
- The last row of the table at the top of page 12 talks about data submissions necessary to align QHPs with the products and plans approved by the state. Could they provide an example of this kind of change? The QHP should be a plan approved by the state already. The QHP should not need any aligning with what the state has approved, but the data template might. Can you clarify this?

Section 2: QHP Certification Process in a State Performing Plan Management functions in the FFM

- It appears that the term "states that are performing plan management functions" includes "partnership" states—silent and otherwise. Can you confirm what states are included in this category?
- The first SERFF data transfer deadline—even if only for draft documents--does not work for some states. One of the main reasons some states chose to do plan management was to give them flexibility as the state regulator to set deadlines, within the parameters of the "final deadline" that the FFM needs.
- It appears that "substantive changes" may not be considered after the SERFF data transfer deadline—such as changing from PPO to HMO or changing service areas. Is this true? If so, states can think of specific examples where there could be a dispute with a company over those very issues that would need to be resolved after that deadline.
- The correction windows appear to leave out the state regulator altogether. The table is replete with "FFM notifies states of needed corrections" --as early as 5/27/15. States don't utilize correction windows during their review process— it is much more fluid. Getting corrections from two different regulators in the same time frame will create confusion for regulators and the insurers.

- If CMS is going to be reviewing plans and rates and networks before state reviews are finished, the purpose of avoiding dual regulations appears to be lost. In addition, the information being reviewed by CMS could be as much as 5 weeks old and be obsolete.

Chapter 2

Section 2: Service Area

- The network adequacy process mentioned on pg. 22 was not explained last year but it was evidently used and many states and companies were sort of blind-sided when told they had network access problems. The draft letter doesn't say anything about what CMS would find to be reasonable or not reasonable. It would be helpful if this letter provided a better explanation of exactly what CMS is reviewing.
- Also on pg. 22, 2016 certification/recertification instructions are mentioned. What are those?
- The letter currently states that no changes will be allowed after initial data submission without a petition approval. Please clarify the date of initial data submission? Would this be June 9th for SPM's since the data transferred on April 15th is considered draft only?

Section 3: Network Adequacy

- Under subsection ii, the draft letter says that CMS proposed requiring issuers to make the provider directories available in machine readable format. However, this was not actually proposed in the NBPP. The NBPP mentions that CMS is thinking about requiring it but did not actually propose a change yet. Is this being proposed for 2016?
- As state regulators said throughout 2014, when it comes to network adequacy "one size does not fit all", e.g. every state has differing demographics relating to the network adequacy issue. State regulators are more familiar with their respective state and thus better suited to determine adequacy of the network...not the feds. Some states have robust network adequacy programs in place which are more comprehensive than the federal requirements. Consideration should be given to an "effective network adequacy state" designation like is done on the rate side. However, if the feds will not change the process, it is imperative that they reveal to state regulators the standard on which they are basing their guidance so we may have a more consistent network adequacy standard throughout the state.
- States would like more certainty and direction on CMS's priorities and requirements in the areas of network adequacy and prescription drug plans. Does CCIIO want states to review for adequacy of certain specialties? Which ones? Only the list here? Does CCIIO want states to review for specific drugs? How will the tool help states do that?

Section 6: Patient Safety Standards for QHP Issuers

- Will compliance attestation be in the Issuer attestations form or will there be a separate attestation form?

Section 9: Discriminatory Benefit Design

- With regard to the following statement from the second paragraph, "CMS cautions both issuers and states that age limits are discriminatory when applied to services that have been found clinically effective at all ages", please provide guidance on what legal grounds under the ACA or regulations adopted thereunder that a state can rely upon when arguing that a state statutorily adopted age limit associated with a mandated benefit is illegal and that the issuer must provide the coverage without regard to the age of the individual.

- With regard to the statement in the second paragraph relating to a single-tablet regimen or extended-release product that is just as effective as a multi-table regimen, please explain what CMS considers to be “an appropriate reason” for refusing to cover the extended release product? Will the Prescription Drug/Formulary tool perform these type of checks or will CMS provide access to some tool that does?

Section 10: Prescription Drugs

- Subsection ii mentions CMS is reviewing the drug coverage for coverage of 4 specified medical conditions. How did CMS pick these four conditions?

Chapter 3: Stand-Alone Dental Plans: 2016 Approach

- What is the state regulator role in recommending certification for SADPs in 2016?

Chapter 5: FF-SHOPs

- The first paragraph on pg. 50 mentions that no dependent can be covered in a SHOP plan unless the employee is also covered in that plan. Under certain situations governed by COBRA for employers with more than 20 FTEs, federal law requires plans to extend coverage to dependents when the employee is no longer covered. Some states have state laws mirroring COBRA for groups under 20 FTEs. The final letter should make it clear that the SHOP plans must comply with state and federal COBRA.
- The draft letter says employers can choose only plans that make premiums available on an averaged basis, and other plans will not be displayed to an employer that picks this option. How do the deselected plans comply with HIPAA guaranteed issue requirements in the small group market if the employer can't even see these plans? This would be easy to address, but the letter should make it clear that issuers' HIPAA obligations are not waived at this point.
- With regard to the description of how average enrollee premiums will be calculated by the FF-SHOPs, please confirm that this only applies when the state has not received CMS' approval of an alternate methodology under 45 CFR 147.102(c)(3)(iii)(B).
- As for guaranteed renewability in the SHOP, condition #2 describes employers that were small when coverage was issued, but became large (over 100) at some point during the plan year and are large groups at the renewal date. These groups are guaranteed the right to keep their SHOP plan. This aligns with HIPAA, but what rate applies to these groups?
- The draft letter mentions CMS guidance issued March 5, 2014. Is there a link for that guidance?