

October 6, 2016

Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-9934-P
P.O. Box 8016
Baltimore, MD 21244-8016

To Whom It May Concern:

The following comments on the proposed Notice of Benefit and Payment Parameters for 2018 (the Notice), as published in the *Federal Register* on September 6, 2016, 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 5 United States territories.

General Comments

Just as we did last year, state regulators strongly object to the brief comment period provided for this draft Notice. On September 7, 2016, we sent a letter to Secretary Burwell requesting that stakeholders be given sufficient time to review and comment on the many policy and process changes included in this draft Notice. We noted, once again, that Executive Order 12866, which was reiterated in President Obama's Executive Order 13563, states that "each agency should afford the public a meaningful opportunity to comment on any proposed regulation, which in most cases should include a comment period of not less than 60 days". Given the importance of this Notice and its impact on health insurance premiums and markets we believe at least a 60-day comment period is warranted.

On September 19, 2016, the Director of the Center for Consumer Information & Insurance Oversight (CCIIO) – notably, not the Secretary – responded that stakeholders are given more time this year because the clock did not start until the draft was posted in the *Federal Register*, whereas last year the clock started eleven days earlier when the draft was displayed on the website. The fact that the egregious errors of last year have been fixed does not mean that all errors have been fixed. We need more stability in the markets and any significant changes need to be thoroughly considered. Unfortunately, the federal government still does not agree.

State regulators also remain concerned about the number of changes being made from year-to-year through the Notice. This is now the fourth such Notice and the Department of Health and Human Services (HHS) is asking state regulators and carriers to once again make hundreds of changes, some of which have no relation to benefits or payments. The goal should be to foster competition, encourage participation in the Exchanges, and stabilize rates, while still protecting consumers. As we have said repeatedly, constant changes in the regulatory requirements will discourage participation in the Exchanges and destabilize rates and not, ultimately, benefit consumers.

Specific Comments

Age Bands (Sec. 147.102) & Age Curve (Sec. 147.102)

State regulators support updating the child rating structure for a more gradual transition. We agree that the current age curve factor for under-21 is low and believe it should be higher. We would be fine with the new factors and the new age banding as long as those states that currently have their own state based age curve can maintain the factors that they currently have (or supply new factors) and not have the under-21 factors automatically substituted for the state's under-21 age factors.

Further, state regulators support implementing the proposed changes to the new factors all at once rather than over a 3 year period. Even if the new age banding and factors are not adopted, we recommend increasing the under-21 age curve factor above the current level of 0.635 to better reflect the cost of these enrollees.

Discontinuing All Products, but Remaining in the Market (Sec. 147.106)

State regulators agree with allowing flexibility to discontinue all products or transfer them within a controlled group of issuers without incurring the 5 year ban on market re-entry. However, clarification as to whether a company would be required to transfer to all of its products in a single risk pool to an issuer in its controlled group would be helpful.

We also agree that in these situations the products should be considered the same products for purposes of the Federal rate review requirements, to the extent applicable. However, we don't feel this is consistent with the treatment when the majority of plans within a product are discontinued and the membership is crosswalked to a new product. Because some plans remain in the old product there is no indication that the Federal rate review would apply for the members moved to the new plans within the new product.

For example, a carrier in year 201X has product 001 with 10 plans with a product type of PPO and for 201X+1 discontinues 9 of those plans, but maps them to new plans within a product 002 with product type EPO. The new product is outside of uniform modification because of the product type change and is not subject to rate review. This seems inconsistent with the treatment proposed had the issuer discontinued the whole product.

Requiring rate review only when all products are replaced adds another layer of complication from a rate review standpoint. It would be more streamlined if the same rules applied when a company replaces all products and when they replace only a few.

Definition of Large Employer for the Risk Adjustment and Risk Corridors Programs (Sec. 153.20)

State regulators agree with the proposed change in the definition of "large employer." This would allow companies participating in the SHOP to participate in Risk Adjustment and Risk Corridors programs if they started out as a small employer but grow beyond the definition of small employer while maintaining SHOP coverage.

Risk Adjustment and Merged Markets (Sec. 153.20)

State regulators support the proposal to merge the risk adjustment pool between individual and small group, but only if the applicable state agrees.

In addition, it is our understanding that states that elected to require the Market Adjusted Index Rate to be based on both the individual and small group market experience might have chosen to merge markets if not for the inability to have quarterly rate increases in the small group market. Perhaps a different solution would be to allow merged market states to have quarterly increases in their small group market.

Risk Adjustment Changes (Sec. 153.320)

First, state regulators agree with the use of partial year enrollment duration factors to improve the accuracy of the risk adjustment model. We further recommend that HHS explore ways to track enrollees across carriers so that full risk adjustment factors can be applied for individuals that switch plans mid-year. We also agree with adding Rx to the risk adjustment model. However, we urge you to implement the proposed changes before 2018.

Second, state regulators agree with the proposal to consider two separate sets of age-sex coefficients for enrollees with and without hierarchical condition categories (HCCs), but caution that there may be some interplay between these and the enrollment duration factors. While some partial year enrollees may have high claims because of anti-selection, others may not have any HCCs simply because they moved to an individual plan from a small employer plan in November.

We are concerned about the approach described for adjusting plan liability risk scores outside of the model to adjust for under or over prediction. As presented in the draft Notice, this sounds very arbitrary. We hope that this would be done with some scientific rigor and we request additional information prior to implementing this approach.

While we agree that it would reduce the magnitude of the risk adjustment transfers and potentially better reflect the risk related charges to use a premium net of administrative expenses for risk adjustment transfers, we also agree with the statement in the draft Notice: “We also note that administrative costs are affected by claims costs and that correctly measuring the portion of administrative costs unaffected by claims costs may be difficult.” We do not see an easy way to adjust out the administrative expenses correctly and believe that using a constant percentage may favor some issuers or promote gaming of the administrative expenses.

Finally, state regulators agree with the proposal to use EDGE data instead of MarketScan data for risk adjustment and AV calculator models.

Special Enrollment Periods (Sec. 155.420)

The proposed rule seeks to codify several Special Enrollment Periods (SEPs) and verification processes in order to ensure clear rules and limit abuses. The abuse of SEPs continues to be a factor in the instability of the individual market risk pool and we urge HHS to move quickly to implement post- and pre- application verification processes to identify and stop the abuse. Accomplishing this is a substantive change that is critical to the sustainability of the health insurance markets under the Affordable Care Act (ACA).

Network Adequacy Pilot Program (Sec. 156.230)

This section of the proposed Notice is very confusing. First, the Notice does not define what it means by “integrated delivery system” as used in this context. Second, the proposal to use the alternate essential community provider (ECP) methodology as set forth in 45 CFR 156.235(b) to define which plans utilize an

integrated delivery system seems inconsistent with the 2017 ECP calculation methodology otherwise proposed for continued use in 2018 as set forth in 45 CFR 156.235(a)(2)(i).

Compliance Reviews – Penalties (Sec. 156.715)


Before these proposed changes are implemented, state regulators strongly encourage HHS to clearly define what “non-responsive” means and clearly outline how federal compliance activities will be coordinated with the state regulators, who remain the primary regulators.

Thank you for this opportunity to comment. As state regulators continue to review the draft 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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