National Association of Insurance Commissioners
& The Center for Insurance Policy and Research

October 5, 2011

Donald M. Berwick, M.D., M.P.P.
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9975-P
Mail Stop: C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Administrator Berwick:

On behalf of the National Association of Insurance Commissioners (NAIC), we write to comment on proposed rules regarding the Establishment of Exchanges and Qualified Health Plans published in the Federal Register on July 15. By providing these comments on the specifics of the proposed regulation, neither the NAIC nor its individual members are hereby expressing a position on the underlying law.

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 U.S.

We appreciate the opportunity to comment on these crucial regulations and were glad to see the flexibility that the proposed rule gives states to establish Health Insurance Exchanges that meet the different needs of their residents and insurance markets. This flexibility is a crucial component of implementation of the Exchange provisions of the ACA and of the statute generally, and we applaud the flexibility the proposed rule provides in many areas. The proposed framework for establishment of Exchanges (§155.105), including the conditional approval process and the ability of a state to receive approval after 2014 and assume responsibility for operation of the Exchange (§155.106), recognizes the fact that states are currently at different levels of readiness to establish Exchanges and demonstrates a commitment on the part of HHS to give states every opportunity to operate Exchanges themselves. We also appreciate the proposal for a state-federal partnership in operating Exchanges and look forward to learning more about it as additional details become available.

We were also glad to see that the proposed rule recognized the importance of close coordination between Exchanges and state insurance regulation. The proposed rule's network adequacy (§156.230) provision provides states the flexibility to craft standards that meet the very different requirements of urban and rural areas and that account for other differences in delivery systems between and within states. The proposed provision regarding marketing of Qualified Health Plans (§156.225) provide states with the ability to ensure that the same standards apply in the Exchange and the outside marketplace, eliminating a source of adverse selection that could have been detrimental to Exchanges and insurance markets. We also appreciated that the proposed rule provided states and employers with as much flexibility as possible under the statute with respect to employer and employee choice requirements (§155.705(b)(3)).

Though we were generally very pleased with the proposed rule, in the spirit of state-federal cooperation, we have several suggestions regarding ways in which we believe it could be improved to help ensure that Exchanges deliver on the statute's promise of a transformed marketplace that streamlines the purchase of health insurance and allows consumers to make better-informed decisions regarding their coverage.

Exchange Plan Amendment Process:

In section 155.105(e), the proposed regulation requires states to notify HHS before making any significant change to an approved Exchange Plan and that such changes must be approved by HHS in writing before they may be effective. The preamble describing this provision notes that you are considering utilizing the State Plan Amendment Process in place for Medicaid and CHIP in order to evaluate and approve or disapprove Exchange Plan Amendments and seeks comments on this approach. While we agree that establishing ongoing dialogue with each state is important and that HHS has a responsibility to ensure that Exchanges are operating in compliance with federal requirements, we believe that the timeframes in the State Plan Amendment Process are too cumbersome for the application to Exchange Plan Amendments. If they are to be successful, Exchanges must be nimble enough to respond to changes in the health insurance marketplace, particularly in the first several years after they become operational and the market reforms go into effect. The timeframe for approval of a State Plan Amendment could be in excess of 180 days from the date on which it is first submitted, which would severely limit the ability of Exchanges to adapt to changing market conditions. If an issue that required a change in the Exchange Plan arose in the last half of a calendar year, the Plan Amendment would likely not be approved in time to take effect for the next annual open enrollment period, resulting in an additional year's delay in implementation of the change. We would instead propose a 30-day advance notice requirement in lieu of a filing for approval, which would give HHS the opportunity to raise concerns if it believes a change is not consistent with Federal law.

Treatment of Sole Proprietors:

We were concerned with the preamble's statement that sole proprietors, certain owners of S corporations and their relatives would not be entitled to purchase coverage in the small group market in under Federal law. We are concerned that this method of counting employees in the small group market, which is at odds with the way group size has been determined in the states since the passage of HIPAA in 1996. We are particularly concerned that this provision would exclude sole proprietors from purchasing coverage through the SHOP in the eleven states that currently allow them to purchase coverage through the small group market today. At the very least, we would suggest a clarification that a state may expand SHOP eligibility to sole proprietors and certain S-corporations without preventing the application of the ACA or the Exchange regulations.

Special Enrollment Periods:

One of the challenges that state insurance regulators are most concerned about is the potential for adverse selection as guaranteed-issue and adjusted community rating requirements are implemented. Several features of the ACA attempt to mitigate this threat, including individual responsibility requirements, subsidies for low and moderate income Americans, and the risk adjustment, reinsurance and risk corridor programs. Another feature of the ACA that will help reduce adverse selection is the limitation of enrollment in Qualified Health Plans to specified annual open enrollment periods and special enrollment periods. In order to most effectively prevent adverse selection, special enrollment periods must be carefully tailored to allow changes in enrollment when special circumstances warrant without defeating the need to prevent adverse selection. With this in mind, we would suggest that during special enrollment periods triggered by changes in eligibility for cost-sharing subsidies enrollees should be limited to switching to or from a silver level plan without switching carriers. This will allow these individuals to these cost-sharing subsidies while minimize mid-year changes in risk pools and reduce administrative burdens on issuers and Exchanges. We provide additional responses below to specific requests for comment on this special enrollment periods.

In addition to these concerns, the preamble to the proposed rule seeks comment on various issues and proposals. We are providing responses to many of these requests below.

Definitions (§155.20)

Comments have been requested on how to reconcile a perceived inconsistency in the definition of "health plan" that references MEWAs "not subject to state insurance regulation." Section 1301(b)(1)(B) of the ACA states that "the term 'health plan' shall not include a group health plan or multiple employer welfare arrangement (MEWA) to the extent the plan or arrangement is not subject to State insurance regulation under section 514" of ERISA. However, section 514 of ERISA allows State regulation of MEWAs, provided that such regulation does not conflict with standards of ERISA.

We understand the phrase "not subject to state insurance regulation under section 514" to exclude only those MEWAs that section 514 of ERISA prohibits the states from regulating as health insurance issuers. Under this interpretation, the MEWAs that are excluded are fully-insured MEWAs. This interpretation makes the exclusion consistent with the intent of section 1301 of the ACA, to define the qualified "health plans" that may be offered on the Exchanges by state-regulated health insurance issuers. It is also consistent with how states currently regulate MEWAs. States do not regularly seek to regulate fully-insured MEWAs directly because they regulate the insurers providing the insurance to the fully-insured MEWAs. It is the insurer, in those cases, that is offering a "health plan" within the meaning of section 1301(b)(1), and if it meets the standards for a QHP, the issuer may offer that health plan on the SHOP Exchange as well as offering it through one or more fully-insured MEWAs.

Entities eligible to carry out Exchange functions (§155.110)

Section 155.110(a)(1) provides criteria for entities that are eligible to carry out Exchange functions. The proposed provision also specifically mentions in subsection (a)(2) that a State Medicaid agency is an eligible entity with which an Exchange may contract with to carry out one or more of the Exchange responsibilities. While we believe that state insurance regulators clearly meet the criteria of subsection (a)(1), we believe that it would be a helpful clarification to additionally specify that state insurance regulators are eligible to carry out Exchange functions. Given that many of the functions and duties of an Exchange, particularly with respect to rate review, fall directly within the regulatory purview of state insurance departments, it would help avoid duplication for state insurance commissioners continue this function.

Section 155.110(b) provides that an Exchange remains responsible for meeting all federal requirements related to the contracted function. HHS requests comments on whether it should place conflict of interest requirements on contracted entities. The NAIC supports the provisions of this section. However, we suggest that HHS permit states to develop and apply appropriate conflict of interest requirements on individuals and entities with which an Exchange may contract with to carry out some of its responsibilities. The states have a history of demonstrated experience in this area and we would not want any regulations in this area promulgated by HHS to supplant state requirements.

Sections 155.110(c)(3) and (4) propose standards on the membership of an Exchange governing board related to conflicts of interest and management qualifications. Specifically, section 155.110(c)(3) proposes that the voting members of an Exchange governing board represent consumer interests by ensuring that membership may not consist of a majority of representatives of health insurance issuers, agents or brokers or any other individual licensed to sell health insurance. HHS requests comments on the extent to which these categories of representatives should be further specified and on the types of representatives who have potential conflicts of interest. The NAIC does not believe it is necessary for HHS to further specify the categories of representatives or types of representatives who have potential conflicts of interest. States should have the flexibility to determine the

categories of individuals and the types of individuals that might have conflicts of interest. States have been involved in and experience with establishing governing boards for a variety of state committees, commissions, and similar quasi-governmental entities. States know best given the peculiarities of their state what categories and types of representatives to the state decides is appropriate for appointment to an Exchange governing board and what real and potential conflicts they may have. With respect to section 155.110(c)(4), the NAIC applauds HHS' decision to give states the flexibility to select and appoint members of their Exchange boards. Consistent with this, the NAIC suggests that HHS not include in any final regulations more specific requirements related to the composition on an Exchange board. As long as, any additional appointments to an Exchange board meet the minimum Federal requirements, the states should be free to select additional members as a state feels are appropriate to carry out the Exchange's required functions.

Section 155.110(d) proposes to set two requirements related to governance principles of an Exchange. With respect to the second requirement in section 155.110(d)(2), which would require an Exchange to have in place procedures for disclosure of financial interest by members of the governing body or governance structure of the Exchange, HHS requests comment on whether the regulations should include additional detail. The NAIC believes that additional detail is not needed related to this disclosure requirement. As we have previously stated, states have demonstrated experience in establishing governing boards. Along with this, they also have experience in establishing appropriate conflict of interest disclosure requirements for board members. As such, the NAIC would urge you to maintain state flexibility in this area.

Section 115.110(f) proposes that HHS periodically review the accountability structure and governance principles of an Exchange. While the NAIC does not have any comment on the frequency of such reviews, the NAIC would caution HHS to not make these reviews extremely prescriptive given all of the other audit, review and similar oversight requirements already required of an Exchange.

Navigator Program Standards (§155.210)

Section 155.210 addresses the role and regulation of Navigators, the entities that will help educate and assist consumers on their coverage options and the information available through the Exchanges. We are pleased that the draft regulation recognizes that states are best positioned to determine the duties, training and certification that are appropriate for these entities in order to protect consumers. As we stated in a Resolution adopted in August 2010, we must ensure that the "duties of Exchange Navigators appropriately reflect the important role of insurance producers who are skilled, knowledgeable, educated and licensed and regulated. "

In subsections (b) and (c) comments are requested on the conflict-of-interest standards that should be applied to the Navigators. State regulators agree that strong conflict-of-interest standards must be enforced and believe that they should not just address situations where the Navigator is receiving direct compensation for the sale of Qualified Health Plans (QHPs) in the Exchange. Monetary or non-monetary compensation or consideration made to the Navigator for sales of QHPs and non-QHPs should be taken into account.

In section 155.210 comments are also sought on the standardization of the information provided by the Navigators, the referral of questions to state agencies, and the types of entities with which the Exchanges must contract. In each of these areas we recommend that the participating states have wide latitude to develop the appropriate standards as they are best suited to do so given their understanding of consumer needs and the community organizations that are capable of fulfilling the Navigator role.

Agents and Brokers (§155.220)

Section 155.220 provides great flexibility to participating states in establishing the right role for agents and brokers in the reformed marketplace. Licensed health insurance producers provide a wide range of services for both individual consumers and the business community. Producers interface with insurers, acquire quotes, analyze plan options, and consult clients through the purchase of health insurance – and that is just the beginning. Agents and brokers continue to provide much-needed advice and assistance to consumers even after the coverage is purchased. States are considering how best to retain these critical services in the future and must have the flexibility to design Exchanges to reach this goal.

Payment of Premiums (§155.240)

Section 155.240 rightfully makes it clear that an Exchange is not required to collect and distribute premiums nor are they required to set up an upfront group payment system that would limit consumer choices. These are options, but the final decision is left to participating states. We strongly support this position.

Initial and annual open enrollment periods (§155.410)

In section 155.410(e), the proposed rule sets an annual open enrollment period from October 15 through December 7 of each year but also suggests an alternative annual open enrollment period from November 1 through December 15 of each year. You requested comments regarding these approaches. We believe that states should be given sufficient flexibility to structure open enrollment periods in ways that best mitigate adverse selection and administrative burdens, while ensuring that consumers have ample time to gather information about their health insurance choices, consider their options and enroll in coverage. While we recognize that there are many clear advantages to a uniform open enrollment period for all eligible individuals, this approach also concentrates the year's enrollment activity into a shorter period of time, creating administrative challenges and making it somewhat more difficult to monitor marketing activity. States should have the flexibility to work with HHS to opt for a rolling open enrollment period of a given duration that begins on a different date for each individual in order to spread enrollment activity across the entire year.

Special enrollment periods (§155.420)

Comment is requested on whether a special enrollment period should be granted to individuals who have lost coverage that did not meet the requirements for minimum essential coverage. We agree with the proposed rule, which does not provide for a special enrollment period when less than minimum essential coverage is lost. Providing such a special enrollment period would encourage individuals to wait until they experience a health crisis before enrolling in a Qualified Health Plan, creating a risk of adverse selection.

In section 155.420(d)(2), comment is requested on whether states might consider expanding the special enrollment period to include gaining dependents through life events other than those specified in the proposed rule. We believe that states should have the flexibility to grant this special enrollment period to individuals experiencing any event that creates or eliminates dependent status under state law or under the Exchange-approved terms of one or more Qualified Health Plans.

In section 155.420(d)(6), comment is requested on whether the start of the 60-day special enrollment period for individuals experiencing a change in eligibility for advance payments of the premium tax credit or cost-sharing reductions should start on the date on which the individual experiences a change in eligibility or based upon the date of the eligibility determination. In order to ensure seamless transitions in coverage, we would suggest that the special enrollment period end on the date that is 60 days after the later of the two, but that individuals be

allowed to begin seeking an eligibility determination prior to the occurrence of the actual change in change in eligibility for tax credits or cost-sharing reductions. This may result in special enrollment periods that are in excess 60 days for some individuals, but would help minimize any disruptions in coverage. We believe that this arrangement should also apply to cases in which an individual seeks a special enrollment period because their employer-sponsored health coverage no longer meets minimum value requirements and because of a permanent move under subsections (d)(6) and (d)(7), respectively.

In section 155.420(f), comment is requested on whether an exception should be added for pregnant enrollees in catastrophic plans that would allow them to switch to a different level of coverage. We do not believe such an exception is warranted. Those who enroll in catastrophic plans do so for the entire year and are making a fully informed decision that any health expenses that arise during the year below the plan's deductible will be their own responsibility. We do not see a compelling reason as to an exception would be made for pregnancy but not for other health-related expenses, such as a diagnosis of cancer or another serious condition. To the contrary, pregnancy is frequently, though not always, is a planned event and an exception in the case of pregnancy would encourage individuals to enroll in catastrophic coverage until they need more comprehensive coverage and then switch. For this reason, we would oppose such an exception.

Section 155.420(f) also seeks comments on whether Exchanges should be required to automatically enroll individuals who received advance payments of the premium tax credit, and then are disenrolled because the Qualified Health Plan is no longer offered on the Exchange and the individual has not selected another plan. We believe that states should be able to pursue this option if it believes it to be in the best interest of its residents. We do not believe, however, that this should be a mandatory function of Exchanges.

Effective Dates of Terminations for Rescission (§155.430)

Section 155.430(d)(4) provides that the effective date for termination of coverage for reasons other than at the request of the enrollee, enrollment in other minimum essential coverage, and change in plans is the 14th day of the month, if the termination was initiated by the 14th day of the previous month or the last day of the month if the termination was initiated by the last day of the previous month. Under the proposed rule, these effective dates would apply to cases where policies had been rescinded for reasons of fraud or intentional misrepresentation of material fact by the policyholder, in accordance with 45 CFR §147.128. Rescissions are, however, retroactive by definition and result in the return of all premiums, less any claims paid, as if the policy never existed. Because coverage issued inside and outside Exchanges in 2014 will be subject to guaranteed issue and adjusted community rating requirements and prohibitions on the imposition of preexisting condition exclusions, we expect the potential for the sorts of fraud and misstatements that would result in rescission to be dramatically reduced. For this reason, we believe that rescissions will be very rare after 2014, but there may still be occasions when rescission may be appropriate. Because rescissions are, by definition retroactive, we believe that the application of the proposed effective date for termination is not appropriate. Instead, rescissions of coverage under a Qualified Health Plans should simply be subject to the requirements of 45 CFR §147.128, implementing section 2712 of the PHS Act.

Functions of a SHOP (§155.705)

Section 155.705(b)(2) requires a SHOP to permit a qualified employer to select a level of coverage in which all qualified health plans (QHPs) within that level of coverage are made available to its qualified employees. This is consistent with section 1312(a)(2)(A). Given that, allowing a qualified employee to purchase any plan across levels raises a potential for risk selection, which may be mitigated through the risk adjustment program established under section 1343 of the ACA, it makes sense to not include a requirement that an Exchange permit its SHOP to permit qualified employees to select a QHP offered in the SHOP at any level, but to provide

flexibility, as provided in section 155.705(b)(3), for an Exchange to consider the advantages and disadvantages of permitting employees to use their own money to buy up or buy down for a lower employee contribution.

The NAIC applauds the flexibility provided in section 155.705(b)(3) to permit an Exchange and their SHOP to choose additional ways for qualified employers to offer one or more QHPs to their qualified employees. The NAIC agrees with your interpretation of section 1312(f)(2)(B) of the ACA to permit "employer choice" whereby an employer can select a single QHP for its employees. This has been a significant issue and clarifying it in the final regulation is welcome.

HHS has asked for comments on whether: 1) QHPs offered in the SHOP should be required to waive application of minimum participation rules at the level of the QHP or health insurance issuer; 2) a minimum participation rule applied at the SHOP level is desirable, and if so, how the rate should be calculated, what the rate should be; and 3) the minimum participation rate should be established in federal regulation. We believe minimum participation requirements at the QHP or issuer level should not be permitted for employee choice plans. Imposing such requirements defeats the purpose of employee choice. Whether such requirements should be applied at the SHOP-level raises different issues. Whether they should be permitted depends, in part, on the behavior of employers and employees in the SHOP. Given this, the NAIC suggests that whether to permit minimum participation requirements be left to the discretion of an Exchange and that the final regulations do not include this requirement. The same holds true for employer choice plans. However, if the final regulations were to include minimum participation requirements for SHOP-level participation for employee choice or QHP-level participation for employer choice, the NAIC suggests that the regulations be limited to making sure the requirements are not too onerous, perhaps, the limiting them to the traditional 75% along with safeguards to ensure safeguards to ensure that certain defined categories of employees are not counted because their failure to buy the SHOP plan has little or nothing to do with adverse selection.

Section 155.705(b)(6) proposes standards for rates and rate changes. With respect to this section, HHS asks for comments on whether the final rules should permit a more permissive or restrictive time frame for changing rates than monthly, quarterly or annually. HHS also asks for comment on what rates should be used to determine premiums during the plan year. Given the number of possible models the states may use to establish an Exchange, the requirement in the proposed regulations that a qualified employer's premium not change for a plan year may be unduly restrictive, and may lead to a level of conservatism in rate setting. A state should have the option of deciding whether to impose such a requirement based on the Exchange model it ultimately adopts. The rate schedule in force as of the effective date of coverage is the rate that should be used to determine premiums during the plan year. The rate schedule should be available sufficiently in advance in order for employers and employees make their coverage decisions. Rating factors should be locked in to the same extent as they are for individual plans.

Eligibility Standards for SHOP (§155.710)

We would also like to comment on the statement in the preamble to this section that "the PHS Act" – whose definitions of "employer" and "employee" establish the scope of the small group market under both HIPAA and the ACA – is "consistent with the definition of an employee in section 3(6) of ERISA. Because the PHS Act definition of employer and ERISA definition of group health plan refer to at least 1 employee, they exclude sole proprietors, certain owners of S corporations, and certain relatives of each of the above." In other words, the Proposed Regulation interprets the PHS Act definition of "employee" to exclude sole proprietors, "certain" other owners of small businesses, and "certain" relatives.

This interpretation is inconsistent with both the plain language and the purpose of the statute, and with 15 years of established interpretation under HIPAA. Section 2794(2)(5) of the PHS Act states that "the term 'employee' has the meaning given such term under section 3(6) of the Employee Retirement Income Security Act of 1974," and

section 3(6) of ERISA states (emphasis added) that "the term 'employee' means any individual employed by an employer." There is no exclusion for self-employed persons or their relatives.[1]

Under HIPAA, the definitions of both "small employer" and "employer" were limited to employers with at least 2 employees. States were permitted, however, to adopt broader definitions for state law purposes, and several states chose to allow "groups of one" to purchase coverage in their small group markets.[2] It was universally understood that "one" meant one self-employed person, either a sole proprietor or the owner of a corporation with no outside employees. This understanding was not limited to the states that chose to recognize groups of one. States that adhered to the HIPAA standard likewise understood that the purpose and effect of the "2 to 50" standard was to exclude self-employed individuals with no full-time outside employees. A business that employs the owner and one unrelated individual has consistently been counted as a 2-employee business in every state and has been eligible to purchase coverage in the small group market.

HHS is now asserting that this universal and long-standing interpretation is erroneous, and that sole proprietors and certain other working owners and relatives should not be included when counting the size of an employer. This undermines the intent of the ACA, which left the definition of "employee" unchanged but expanded the definition of small employer to include "employers with at least one employee." Based on our discussions with the drafters of this provision, this interpretation is contrary to their intent, which was to include the self-employed in the small group market. This intent is reinforced by section 1311(d)(6), which identifies "small businesses and self-employed individuals" as one of the key stakeholder constituencies for the Exchange. Why would they be mentioned together if the intent were to bar self-employed individuals from the SHOP Exchange and treat them as no different from any other purchasers in the individual market?

Including sole proprietors in the SHOP also furthers the goal of preventing disruptions in the continuity of care when very small employers gain and lose employees. If sole proprietors are excluded from the SHOP, they would move back and forth between the SHOP and the Individual Exchange as they gain and lose employees, which could require them to change networks and providers during an episode of care. Including sole proprietors in the SHOP would also allow a sole proprietor to add an employee mid-year and offer health benefits without changing plans. In addition, the small group market often offers different products and coverage options that may better suit the needs of the self-employed.

However, should HHS go forward with this interpretation of the meaning of "at least one employee" we request clarification that states are free to go beyond this definition of small employer, as they did with HIPAA, and expand the small group market to include the self-employed. It would be ironic if the result of the ACA's expansion of the definition of small employer to those with "at least 1" employee was to preempt those states that were already allowing the self-employed to purchase small group coverage. States, in implementing HIPAA's small market reforms, were free to expand those reforms as long as they didn't prevent the application of the federal law. The exact same savings language is used in the Affordable Care Act (ACA). Additionally, the ACA specifically allows states to merge their small group and individual markets, if they choose. There is no reason to prevent states, at their option, from continuing to allow sole proprietors, certain owners of S corporations, and their relatives the choice to purchase coverage in the small group market where they can participate in the SHOP, or in the individual market where they may be eligible for subsidies.

[1] The reference to "S" corporations, a status that has significance only for income tax purposes, suggests an interpretation based on section 401(c) of the Internal Revenue Code, which defines "self-employed individuals and owner-employees." That provision, however, states that such individuals are considered employees, although they are excluded from certain deductions and credits.

[2] Colorado, Connecticut, Delaware, Florida, Hawaii, Maine, Massachusetts, Mississippi, New Hampshire, North Carolina, Rhode Island, Vermont and Washington.

We ask that you reconsider your definition of "small employer" in light of current definitions and the intent of Congress. At the very least, we ask that you clarify in the regulation that states have the option under the ACA to allow the self-employed to purchase coverage through the SHOP Exchange.

Certification Standards for QHPs (§155.1000)

In paragraph (a) the proposed rule defines *Multi-State plans* to be health plans offered by an issuer under contract with the U.S. Office of Personnel Management, which among other things, must meet all requirements for QHPs. The NAIC strongly supports this requirement. Applying different standards to Multi-State plans risks creating a potential for adverse selection and giving some of the largest insurers regulatory advantages over their smaller competitors. For more detail on the problems associated with different standards for Multi-State Plans, please see the attached comments that the NAIC submitted in response to OPM's Request for Information on these plans. (Attachment A)

QHP Issuer Rate and Benefit Information (§155.1020)

The proposed rule requests comment on how best to align section 2794 of the PHSA, providing for review and disclosure of potentially unreasonable rate increases, with section 1311(e)(2) of the ACA, requiring Qualified Health Plans to submit justifications of all premium increases to the Exchange and publish them online. We strongly agree with the need to avoid duplication of effort between the Exchange and the state Department of Insurance, which typically already reviews premium increases. We do not believe that states should be free to implement this requirement in a way that works best with its existing rate review authority. Several states already make rate justifications public and should be free to use this existing process. Others may wish to utilize the disclosures for potentially unreasonable rate increases under section 2794 or another disclosure designed for use by Qualified Health Plans.

Establishment of Exchange Network Adequacy Standards (§155.1050)

Section 155.1050 requires an Exchange to ensure that the provider network of each QHP offers a sufficient choice of providers for enrollees. HHS asks for comments on additional minimum qualitative or quantitative standards for the Exchange to use in evaluating whether the QHP's provider networks provide sufficient access to care. The NAIC applauds the flexibility that this section offers to the states on the network adequacy requirements that an Exchange may impose on a QHP. The NAIC suggests that no additional requirements are necessary as to additional minimum qualitative or quantitative standards for an Exchange to use to evaluate the sufficiency of a QHP provider network. Section 155.1050, as written, already imposes an obligation on the Exchange to establish standards. The states differ in local health care delivery systems, market conditions and geographical characteristics (rural versus urban). A national standard might not be sufficiently broad or flexible to account for or address these differences. For the same reasons, the NAIC suggests that the final regulations not include specific network adequacy standards. Establishing such standards is best left to each state to determine when establishing its Exchange. For the same reason, the NAIC suggests that the final regulations not include an additional standard to ensure that QHP's provider networks providing sufficient access to care for all enrollees, including those in medically underserved areas.

Marketing of QHPs (§156.225)

Section 156.225(b) prohibits a QHP issuer and its officials, employees, agents and representatives from employing marketing practices that discourage the enrollment of individuals with significant health needs in QHPs. HHS asks for the best means for an Exchange to monitor QHP issuers' marketing practices to determine whether they have discouraged enrollment of these individuals. The NAIC suggests that the Exchange rely on

current state laws and regulations related to marketing, which is already a requirement in the proposed regulations in section 156.225(a). Such laws and regulations already include sufficient monitoring mechanisms related to preventing such marketing practices, including prohibitions against health insurance issuers misrepresenting the benefits, advantages, conditions, exclusions, limitations or terms of a health plan.

The same holds true for HHS' other requests for comment for this section. All states have adopted the NAIC's *Unfair Trade Practices Act* (#880) or related legislation, which defines, or provides for the determination of, all such practices in the state that constitute unfair methods of competition or unfair or deceptive acts or practices and prohibits the trade practices so defined or determined. This model applies to insurers and their representatives, such as officials and employees and insurance producers. It is not necessary that the final regulations include such a broad prohibition. If HHS determines that such a prohibition should be included in the final regulations, the final regulations should provide that current state laws and regulations would apply, which already, prohibit such practices. In addition, HHS does not need to add provisions for an Exchange to take action, which could duplicative at best or conflicting at worse with existing state law and regulations. The appropriate regulatory authority, which in most cases will be the state insurance department, already has the necessary authority and resources to take necessary and appropriate action.

Sincerely,

Susan E. Voss
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Iowa Insurance Commissioner

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