

January 8, 2019

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9922-P
P.O. Box 8016
Baltimore, MD 21244-8010

Via Regulations.gov

To Whom It May Concern:

The National Association of Insurance Commissioners (NAIC), on behalf of its members, submits the following comments on the proposed regulation “Patient Protection and Affordable Care Act; Exchange Program Integrity,” published November 9, 2018. NAIC represents the chief insurance regulators in the 50 states, the District of Columbia, and the 5 United States territories. Our comments will focus on distinct issues within the proposal and should not be misconstrued as support or opposition for any other provisions, or for the rule in its entirety, by the NAIC or any of its members.

As state regulators have noted in comments on previous regulations, the establishment of clear rules for insurers participating on the exchanges, and avoiding last-minute or mid-plan year changes, are important to maintaining stable, competitive health insurance markets. Unanticipated changes can lead to disruptions to the markets and consumer confusion. We urge the Centers for Medicare and Medicaid Services (CMS) to avoid the disruption for consumers, insurers, exchanges, and state regulators that would stem from requiring changes to billing practices in the middle of a plan year. We also suggest that the final rule more clearly identify the exchanges to which audit requirements apply.

State regulators do not have a consensus viewpoint on the proposed requirement that certain enrollees in plans with abortion coverage pay for that coverage separately. However, NAIC members do agree that instituting this requirement in the middle of a plan year would create undue burdens on many stakeholders.

The preamble to the proposed rule indicates that new billing procedures for abortion services would be required “as of the effective date of the final rule.” If adopted and implemented as proposed, consumers would be adversely affected when they unexpectedly receive two separate bills for their health coverage. Requiring the new procedures as soon as the final rule becomes effective allows no time for issuers, exchanges, or regulators to educate consumers on the new billing process. Many consumers that are accustomed to the payment arrangements they had been following during the plan year would unexpectedly need to make changes when the rule becomes effective. Some consumers will be confused by the mid-year changes and some will likely fail to make changes to their payment arrangements. Consumers can more easily adapt to new payment arrangements at the beginning of a plan year, when they expect premiums to be different and other changes to their plan to occur.

In addition, we expect that issuers would face a substantial burden in complying with a new requirement if it goes into effect immediately upon finalization as they will have no time to alter their practices and systems to comply with the rule. State regulators expect that prudent issuers will take steps to educate their enrollees

before changing billing practices; immediate effectiveness would not give them time to plan or execute such education. Due to the small amounts issuers would bill for abortion services, many issuers may choose to revise their premium payment threshold policies permitted under 45 CFR 155.400, but again would not have time to do so if the rule were made effective immediately.

State regulators, too, would face additional burden with an immediate and mid-year effective date for this rule change. While state regulators are ready to accept the responsibility of primary enforcement of this rule given appropriate lead time, they will be ill-equipped to enforce it if it is made immediately effective—regulators will need time to develop enforcement policies in consultation with state stakeholders. Further, regulators will be burdened by the need to respond to consumer and insurer confusion over the new requirements.

We recommend that any changes to insurer requirements under § 156.280, as with nearly any change applicable individual market issuers, be made effective to coincide with the beginning of a plan year.

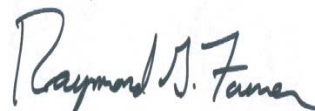
Further, we urge CMS to make a clarification in § 155.1200. Proposed paragraph (d) would require “the State Exchange” to ensure that audits address several named factors, including a number tied to eligibility and enrollment functions. State-based exchanges that use the federal platform (SBE-FP) rely on the federal platform for eligibility and enrollment activities, so these factors are not relevant for SBE-FP audits. We recommend that CMS finalize a rule that more clearly specifies that eligibility and enrollment activities need not be included in audits of SBE-FPs.

Thank you for this opportunity to comment. As state regulators continue to review the Departments’ regulations and policies and their impact on exchanges, market competition, premiums, and consumer protections, we will continue to provide comments. We are available to discuss these or other issues as the regulation is finalized.

Sincerely,



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