December 21, 2015

Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Attention: CMS-9937–P
P.O. Box 8016
Baltimore, MD 21244–8016

To Whom It MayConcern:

The following comments on the proposed Notice of Benefit and Payment Parameters for 2017 (the Notice), as

EXECUTIVE OFFICE • 444 North Capitol Street NW, Suite 700 • Washington, DC 20001-1509 p | 202 471 3990 f | 816 460 7493
CENTRAL OFFICE • 1100 Walnut Street, Suite 1500 • Kansas City, MO 64106-2197 p | 816 842 3600 f | 816 783 8175
CAPITAL MARKETS & INVESTMENT ANALYSIS OFFICE • One New York Plaza, Suite 4210 • New York, NY 10004 p | 212 398 9000 f | 212 382 4207
www.naic.org

The consequence of setting the child factor too low is that older adults are subsidizing children and young adults; the age curve is off balance and nearly every factor is inappropriate, but especially at older ages.

Minnesota is one of a handful of states that adopted a unique age curve, where the only difference in Minnesota's curve versus the standard HHS age curve is the child factor (the child factor is set at 0.890 instead of 0.635). Feedback from Minnesota carriers was used to set the new child factor and, generally, the carriers agreed that the

should fit within the existing index rate format. CMS should consider removing any

Default Risk Adjustment Charge III.D.5.e

We believe moving the default risk adjustment percentile factor from the 75th percentile to the 90th percentile is overly punitive. The calculation already takes the absolute value of the plan risk transfer amounts, which includes some penalty for not participating. And while it is calculated based on enrollment, the percentile choice isn't. You could have a situation where 99% of the people are on a plan with a very low risk transfer amount and the other 1% is spread out over 100 plans that have high absolute risk transfer amounts. We feel the 75th percentile is adequately punitive and that changing to the 90th would add additional barriers to entry for new and smaller insurance companies.

We disagree with using a threshold of 500 billable member months, as this translates into approximately only 42 members. We would agree with the proposal if it were 500 members. We also recommend a graded approach to the default risk charge that would adjust the percentile factor from 50th to 75th for those issuers with 500 to 2,000 billable members (using a linear graduation) to allow the company more flexibility as they transition into participation on the EDGE server.

Reinsurance Program

The proposal to change reinsurance parameters at the end of the program, instead of identifying and updating the parameters as information is available, is disruptive. The proposal ignores the impact on states that exercised the option to create a supplemental reinsurance program. These states depend on knowing the federal parameters to set their own. States cannot begin their reinsurance payment work while the federal program remains undefined.

Rate Increases Subject to Review (§154.200)

We agree with the move away fr

additional benefits because this was the responsibility of the federal exchange. On the flip side, many states have not granted any state official the authority to make that determination. How would this requirement be enforced in such states? How would it be enforced in direct enforcement states?

Overall, the whole issue of defraying benefits in excess of the EHB is an area that still needs clarification and we

Standardized Options (§156.20)

State regulators have some concerns with this proposal to allow carriers the option to sell plans that include nationally-standardized cost-sharing. Would this option be available to carriers in states that have established their own standardized plans? How would this be coordinated with states such as Arkansas, which have utilized standardized Marketplace plans as a way to further Medicaid Expansion? Would there be two standardized plans in such situations? This could lead to unnecessary confusion and additional administrative burdens.

States that have established standardized plans have found that considerable time is necessary to find packages that consumers will purchase and that will meet additional Medicaid requirements. Could there be flexibility for states to modify the standardized plans for their state, or to vary them for different areas of their state?

Prescription Drug Benefits (§156.122)

The draft Notice requests comments regarding the scope and application of fast-track appeals when appealing for coverage of non-formulary drugs. Several states adopted an earlier NAIC managed care model law that requires managed care plan utilization review procedures to be available for any person seeking coverage of a non-formulary drug. If these procedures result in an adverse determination, both standard and expedited appeal processes are available. The proposed change in this draft Notice is something we support.

AV Calculation for Determining Level of Coverage (§156.135)

The AV Calculator is a crucial tool and any updates can have material, and sometimes unintended, consequences. We applaud your efforts in introducing more flexibility in the timing of future updates, but we cannot support this proposal without more information on the timeline.

Termination of Coverage or Enrollment for Qualified Individuals (§156.270)

State regulators support the grace period change to ensure consumers do not lose protection if they lose their Advanced Premium Tax Credit (APTC). This is an issue regulators have identified as a growing issue and have sought relief for consumers caught in this situation.

Essential Community Providers (§156.235)

State regulators do not agree that Essential Community Provider facilities with multiple providers should be counted as just one provider. In many communities the local facility can have many providers that cover many areas of need. Carriers should receive credit for contracting with these facilities and covering care provided by all of their providers. This change should be made as soon as possible.

Enforcement Remedies in Federally-Facilitated Exchanges (§156.810)

How does HHS "reasonably" determine the financial solvency of a carrier on the FFM? The financial solvency of issuers is a serious matter regulated by the Department of Insurance in each state. Creating a dual regulatory

how hospitals that meet the standard can be prospectively identified by plans, consumers and regulators: Does CMS collect and publish data on the patient safety evaluation system as defined in 42 CFR 3.20? What is the regulatory reference for “a comprehensive perso