



RICARDO LARA
CALIFORNIA INSURANCE COMMISSIONER

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Submitted via regulations.gov

Alex M. Azar II, Secretary
Department of Health and Human Services

Seema Verma, Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-9916-P
P.O. Box 8016
Baltimore, MD 21244-8016

SUBJECT: *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2021; Notice Requirement for Non-Federal Governmental Plans*
File Code: CMS-9916-P

Dear Secretary Azar and Administrator Verma:

As California's Insurance Commissioner, it is my privilege and responsibility to regulate the nation's largest insurance market and lead the largest consumer protection agency in the state. The California Department of Insurance (CDI) implements and enforces the consumer protections provided by the Affordable Care Act (ACA), such as essential health benefit requirements, anti-discrimination protections, and laws pertaining to access to health care as codified in California law. The health and economic security of millions of Californians have improved through access to adequate, affordable, and accessible health insurance as a result of the ACA. With the goal of maintaining access, affordability, and quality of coverage in mind, I provide comments on certain provisions of the *Notice of Benefit and Payment Parameters for 2021* proposed rule.

1) *Timing*

The proposed *Notice of Benefit and Payment Parameters for 2021* was not published for comment until February 6 and comments are due a mere 25 days later, on March 2. Even with the abbreviated comment period, this rule will not be finalized until sometime in the spring or summer, allowing insurers and regulators little time to implement any new requirements imposed by the final rule. In addition, only providing a 25-day comment period (from the date of publication in the Federal Register) provides insufficient time to review and comment upon these important rules. Please consider

publishing the proposed Notice for 2022 late in 2020 and include a full 60-day comment period.

2) *Auto re-enrollment process, 85 FR 7119*

CDI opposes any changes to the auto re-enrollment process. CMS admits that “[a]utomatic re-enrollment significantly reduces issuer administrative expenses, makes enrolling in health insurance more convenient for the consumer, and is consistent with general health insurance industry practice.” (85 FR 7119.) Yet, CMS is soliciting comments on suspending advance premium tax credits (APTC) at re-enrollment for those consumers whose APTC covers their full premium.

Suspending APTC at re-enrollment will cause confusion for those relying on automatic re-enrollment, and will lead to individuals losing their health insurance coverage, with resultant market disruption. Consumers are accustomed to the current auto re-enrollment process. From a consumer’s perspective, their premiums will appear to skyrocket as a result of suspension of APTC; some of these consumers will cancel their coverage under the mistaken belief that they can no longer afford their premiums. Other consumers may believe that, since their income has not changed, they will automatically receive the same APTC, unaware that their APTC has been suspended and their premiums are not being paid. Suspending APTC will lead to cancellation of coverage for individuals and families that are eligible for APTC. CDI is concerned that any action to change the auto re-enrollment process could depress enrollment, cause loss of vital coverage, and create ripples of uncertainty among consumers and in the insurance market.

3) *State Selection of EHB-Benchmark Plan for Plan Years Beginning on or after January 1, 2020, (§ 156.111) 85 FR 7128*

CMS proposes to amend § 156.111 to require states to submit an annual report identifying state-mandated benefits applicable to qualified health plans (QHPs). As a part of that report, when a state determines that mandated benefits are not subject to defrayal because they are not in addition to Essential Health Benefits (EHBs), the state must provide a basis for that determination. In the initial report, states would also be required to identify all state-mandated benefits, including those that are EHBs because they were required by a state action that occurred prior to January 1, 2012.

CDI shares the concerns of the National Association of Insurance Commissioners (NAIC) and other states that CMS has not adequately explained how it will use the reported information to conduct increased oversight of state compliance with section 1311(d)(3)(B) of the Patient Protection and Affordable Care Act (PPACA). CMS has not codified a standard that it would use to determine whether a state law applicable to QHPs is a benefit mandate subject to defrayal, nor has it proposed to do so. The only standard CMS ever proffered for identifying a state-mandated benefit in

excess of EHBs (that the law must require coverage of specific care, treatment, or services) was described in the preamble to the 2013 final EHB rule.¹ States have relied on this standard to evaluate benefit laws since then, and it would be unjust and disruptive for CMS to use state-reported information on benefits mandated under the 2013 guidance to change its approach to identifying state-mandated benefits subject to defrayal, especially in a retrospective fashion. For past benefit mandates adopted by states in reliance on the standard in the 2013 final EHB rule's preamble, CMS should not require states to make defrayal payments or change their laws if it disagrees with a state's good faith determination that a benefit mandate does not exceed EHBs.

Moreover, before finalizing any reporting requirement, CMS should fully explain how it intends to enforce section 1311(d)(3)(B), and properly adopt a standard for identifying a benefit mandate pursuant to notice-and-comment rulemaking procedure. If CMS does not properly adopt a workable standard, it should not "second-guess" a state's good faith determination of compliance with section 1311(d)(3)(B). To implement this proposal, CMS must also establish a neutral and fair process for evaluating state-mandated benefit laws and resolving disputes between it and the states concerning whether mandated benefits exceed EHBs, and apply the new policy only prospectively once it has been properly vetted through the rulemaking process.

In addition, the proposed reporting requirement is unnecessarily burdensome. States submitted this information to CMS years ago during implementation of EHBs, and a list of each state's benefit mandates that was taken from this information is available on CCIIO's webpage entitled "Information on Essential Health Benefits (EHB) Benchmark Plans." Therefore, it is unclear why CMS believes it is necessary to require states to submit the same information yet again. The rationale for these state-mandated benefits qualifying as EHBs is straightforward based on the date of state action, and not in dispute. Therefore, CMS should not require states to expend resources creating unnecessary reports containing information that it already possesses.

Finally, CDI opposes charging the Exchanges with responsibility for identifying state-mandated benefits that exceed EHBs. Because state regulators enforce benefit mandates, including EHBs, they are in the best position to make this determination, and not the Exchanges. CDI also opposes CMS taking this role, given it does not have expertise in evaluating state-mandated benefit laws and enforcing their requirements, and that CMS has not proposed a fair process for resolving disagreements with the states regarding characterizing state-required benefits as being within the scope of EHBs. As long as EHBs are defined by state-regulated benchmark plans, state

¹ "As we explained in the preamble of the proposed rule, we interpret 'state-required benefits' to include the care, treatment and services that an issuer must provide to its enrollees. Other state laws that do not relate to specific benefits, including those relating to providers and benefit delivery method, are not addressed in § 155.170." 78 FR 12833, 12838 (Feb. 25, 2013).

regulators should determine whether a state benefit law would be subject to defrayal under section 1311(d)(3)(B).

4) *Promoting Value-Based Insurance Design*, 85 FR 7137

While value-based insurance design bears the promise of potential consumer benefit, it can also penalize consumers with rare, chronic, or catastrophic health conditions who are monitored and treated with what are characterized as “low-value services.” The preamble to the proposed rule states that “low value services are those services in which the majority of consumers would not derive a clinical benefit.” Designing benefits based on this ill-defined, subjective principle without considering the consequences for consumers who have significant health conditions could shift additional out-of-pocket cost burden to these consumers without demonstrably reducing use of “low-value services” by people for whom the services are ineffective or unnecessary.

If improperly implemented, value-based insurance design could be exploited to reduce the value of benefits for consumers who utilize them, and to select for relatively healthy consumers in contravention of benefit design nondiscrimination laws. The benefits on the list of “commonly overused service categories” that could be subject to increased cost sharing under the definition of “low-value services” are all benefits that are more heavily utilized by consumers with significant health needs. Consequently, any policy that promotes value-based insurance design should not unduly harm consumers who utilize “commonly overused” services due to medical necessity, and should be balanced by the principle that insurance is intended to spread the cost burden of health care utilization across a broader population of covered persons.

Lastly, CDI agrees that if this policy is pursued, it should be permitted only to the extent consistent with state law, and that CMS should establish benchmarks that must be satisfied for a plan to be labeled “value-based.” Leaving this determination entirely to the issuers could render such a label misleading or even meaningless.

5) *Medical Loss Ratio*, 45 CFR §§ 158.110 & 158.140

CMS’s proposal clarifies the medical loss ratio (MLR) treatment of payments to third party vendors and other entities. It requires that expenses for such functions be reported consistently with how other expenses must be reported. Furthermore, the notice clarifies that issuers must deduct from incurred claims prescription drug rebates received by the issuer. CDI supports the proposed changes here and recommends that CMS modify the MLR reporting form to accommodate the changes for accuracy of reporting and to permit verification that the issuers have complied with the rules.

Alex M. Azar II, Secretary
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March 2, 2020
Page 5

Thank you for the opportunity to comment on these proposals.

A handwritten signature in black ink, appearing to read 'Ricardo Lara', with a large, stylized initial 'R' and a long horizontal stroke.

RICARDO LARA
Insurance Commissioner