

December 22, 2023

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-9895-P  
P.O. Box 8016  
Baltimore, MD 21244-8016

Via Regulations.gov

To Whom It May Concern:

The following comments on the proposed Notice of Benefit and Payment Parameters for 2025 (Notice), as published in the Federal Register on November 24, 2023, 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 five United States territories.

### **Additional Required Benefits (Defrayal of State-Mandated Benefits)**

The Notice would change Department of Health and Human Services (HHS) policy regarding the requirement for states to defray the cost of state-mandated benefits. Rather than requiring defrayal for state mandates enacted after 2011, it would clarify that no defrayal is necessary for benefits that are included in a state's Essential Health Benefits (EHB)-benchmark plan, regardless of when the mandate was enacted or added to the benchmark. State regulators strongly support this change. While state policymakers must be cognizant of the impact any new mandates could have on premiums and federal tax credits, to arbitrarily limit EHB-benchmark benefits to those enacted before 2011 limits the ability of states to ensure plans meet the current needs of consumers.

In addition to the proposed change, state regulators request written guidance from CMS/CCIIO - in the Payment Notice or other method - on whether a state mandate that refines the definition of an existing EHB benefit is a "new mandate" that must be defrayed by the state.

For example, if a state EHB benchmark covers diagnostic imaging, would a new mandate that requires coverage of breast MRI or ultrasound, in addition to mammograms, be considered a benefit in addition to the EHB? Or, if the EHB

benchmark covers lab/diagnostic testing would a new mandate requiring coverage of biomarker testing be considered in addition to the EHB? States submitted comments to the EHB Request for Information noting that the current defrayal rules were an impediment to updating coverage to reflect new developments in health care delivery and state regulators and legislators need greater clarity on the potential impact of their decisions.

While the changes proposed in this draft Notice would provide a way to amend the EHB-benchmark and add new mandates without defrayal, this can be a lengthy process. We urge CMS to adopt language clarifying that a mandate that is a logical outgrowth of a covered EHB benefit, such as the examples stated above, would not constitute a new mandate for defrayal purposes. This would provide states with the flexibility they need to meet the needs of their consumers.

### **State Selection of EHB-Benchmark Plans**

State regulators strongly support the simplifications to the EHB selection process proposed in the Notice. The recommended updates would simplify state options, streamline the typicality test, eliminate a separate generosity test, and require prescription drug information only when relevant.

States appreciate the ability to update EHBs that was added to the EHB selection process in the 2019 Notice. As health insurance markets evolve over time and new health care treatments and services are developed, the set of benefits considered essential can change. A process for updating the EHBs was needed, and it was beneficial to keep it state-driven, like the initial EHB selection. Nonetheless, the current update process requires extensive actuarial evaluation for states to demonstrate that their choices comply not only with the law, but with a variety of requirements established in regulation. While the law requires EHBs to reflect the typical employer plan, regulation is the basis for the generosity test.

State regulators welcome the adjustment to the typicality test under which it will no longer be necessary to identify an exact match with an existing employer plan—this will add needed flexibility. However, we note that the reduction in the state burden may not be as broad as the proposal indicates. In order to establish the allowable range of generosity, states will need to determine which plans fit the definitions in 156.111(b)(2)(ii)(A) and (B) and arrange for an actuarial assessment of each to identify which is the most and least generous. Under the proposal, it will be easier for a state to fit its selected benchmark into the range of options, but it will still require significant analysis to establish that range. We encourage CMS to provide clear guidance on what will be required of states and to continue to work with states to streamline the process.

Eliminating the generosity test as a separate requirement makes sense as it is not grounded in the statute and the generosity of a state's benchmark is limited by the typicality test. Removing this test allows more flexibility for states to respond to identified needs and helps streamline EHB updates. We further support the proposed change that would require states to submit prescription drug formularies only when the state is making a change to the EHB drug formulary.

### **Provision of EHB (Routine Non-Pediatric Dental Services)**

We support the addition of a state option to add some adult dental services to the EHB. Oral health is essential to overall health. Nonetheless, for many years commercial coverage for dental services has developed separately from health insurance. Due to this separation, integrating dental coverage with health coverage can be challenging. Thus, we appreciate HHS's flexible, optional approach for adding adult dental services as EHB. In some states, health insurance issuers may be ready to collaborate with dental plans or directly with dental providers to offer services and to comply with EHB regulations on cost-sharing and in other areas. In other states, markets may not be ready to deliver services in this way.

Determining exactly which dental benefits should come with EHB protections should also be based on state needs and preferences. We recommend that, in the final rule, HHS maintain a flexible approach that relies on state choices to implement this option.

To implement adult dental EHBs, states will need to update their benchmark plans under the process HHS proposes to revise in the Notice. The benchmark selection process should accommodate dental benefits. Specifically, the typical employer plans that help define the benchmark should be ones that include dental benefits. If a health insurance plan does not include dental benefits, states should be permitted to add a typical dental benefit to the generosity of the employer health plans before testing typicality.

### **Non-Standardized Plan Option Limits**

The Notice would allow the previously finalized limit on non-standardized plans to go into effect for plan year 2025. Issuers would be permitted no more than two non-standardized plans per network type, metal level, and inclusion of dental/vision coverage, down from four in 2024. A newly proposed exceptions process would be available in 2025, under which issuers could offer more non-standardized plans if the plans provide lower cost-sharing for chronic and high-cost conditions. As we have expressed in previous comments, state insurance regulators support a flexible approach to non-standardized plans that allows for variation based on market conditions in each state.

Some state regulators share HHS' concerns about the high number of plan options offered through their Federally-Facilitated Marketplaces (FFM) and support regulatory limits on the number of plan choices. Other states, however, wish to promote competition by allowing issuers to innovate and offer the number of plans that best suits their markets, their customers, and their competitive strategies.

State regulators agree that changes in the allowable number of plan options should not be disruptive to markets and that there is room for an exceptions process to allow issuers to market more non-standardized plans in some circumstances.

We encourage HHS to study the state-by-state effects of the 2024 non-standardized plan option limit before it enforces a lower limit. There is significant variation by state and by service area in the number of Marketplace issuers and plans. The numbers HHS cites in discussing its policy to limit offerings are averages across all FFMs. However, Alaska, West Virginia, and Wyoming (as well as some State-Based Marketplaces (SBMs)) have only two Marketplace issuers in 2024 and many areas have fewer than the average number of plans. Before moving forward with a reduced limit, HHS should demonstrate that the policy is not having unintended effects on premiums, consumer choice, or market stability in states with the fewest issuers or plan options. State regulators would welcome consultation on the impacts of the non-standardized plan option limit in their states.

State consultation could also benefit the exceptions process proposed for non-standardized plans. State regulators are best situated to understand the dynamics of their state markets and assess when limits on the number of plan options should be applied. Thus, state regulators request opportunities for input on the exceptions process—we ask that state regulators be consulted before HHS approves or disapproves an issuer's request for exception.

State regulators support the availability of exceptions for plans that benefit consumers with chronic and high-cost conditions. Additional exceptions may be appropriate, as well. State regulators may wish to request a blanket exception for issuers in their state when the two-plan limit is not appropriate for a state's market.

### **State-Based Marketplace Open Enrollment Periods**

The proposed Notice would require all Marketplaces to begin their Annual Open Enrollment period on November 1<sup>st</sup> and have it continue through at least through January 15 of the following year. Some SBMs have adopted, with great success, an earlier starting date for their Open Enrollment period and some have established an earlier ending date, thus avoiding the issue of consumers enrolling in a plan that does not begin on January 1<sup>st</sup>.

There are valid operational and consumer protection reasons for states choosing an Open Enrollment period that varies from the Federal dates. While we understand the benefits of having a consistent starting date and a minimum time period, we are not sure these outweigh the benefits of the state-based dates. State regulators encourage CMS to reconsider this proposal and continue to allow SBMs to set the appropriate Open Enrollment dates that best meet the needs of their consumers and markets.

### **Additional SBM and SBM-Federal Platform (SBM-FP) Requirements**

The draft Notice proposes many new minimum standards for SBMs and SBM-FPs. These include: Network Adequacy; new SBMs; centralized eligibility and enrollment platforms; call centers; enrollment entity websites; failure-to-reconcile checks; special enrollment period effective dates (and Open Enrollment dates, as discussed above); incarceration verifications; re-enrollment hierarchies; and data hub fees.

While the proposed Notice discusses the benefits of these standards, it does not provide evidence of why these additional requirements are needed. SBMs are doing an excellent job enrolling and protecting consumers using standards and processes that best meet the needs of their residents. Before adding additional requirements, CMS should provide a clear explanation of why they think current SBM standards and practices are insufficient. State flexibility is the hallmark of the SBM and SBM-FP option and if it is the goal of Federal officials to have more states implement these Marketplaces the implementation of unnecessary requirements should be avoided.

The network adequacy standards, in particular, may be challenging for SBMs and SBM-FPs to develop in time for the proposed effective date of January 1, 2025. Plans for 2025 will be submitted to state and federal regulators for review soon after the 2025 Notice is finalized. States that do not already have them will have little time to promulgate regulations to establish enforceable quantitative network adequacy standards. If this proposal is finalized, we recommend a later effective date.

We support the exceptions process for SBMs and SBM-FPs proposed in the Notice. States should have the opportunity to demonstrate that their network adequacy standards are effective, even if they differ from the existing federal standards. We also appreciate HHS' commitment to providing technical assistance to states in this area.

### **Risk Adjustment and State Requests to Reduce Risk Adjustment Transfers**

Many state regulators have raised concerns about the effect the current Risk Adjustment (RA) process can have on small or new health carriers entering a market. Rates that prove to be inaccurate have, at times, been driven by lack of expertise and resources and the desire to gain market share. And these can be exacerbated by the federal RA process. Recently, this has been a factor in plan failures that not only harm

consumers but negatively impact other carriers in the state who are owed RA payments.

The NAIC and state regulators continue to discuss the variety of obstacles facing plans entering a market, including the RA program. We acknowledge that the problem is complicated, as are the possible solutions. We request that CMS/CCIIO remain our partner in this effort to foster insurance markets that promote innovation and competition.

On a related note, state regulators still object to the 2024 Payment Notice provision that repealed the ability of states to request a reduction in RA state transfers, including for the state that has previously requested and been approved for a reduction. As we have seen, the unique dynamics in an individual state's insurance market can result in undesired outcomes when applying the federal RA methodology, which must be developed and applied nationwide. State regulators have the detailed understanding of their state markets necessary to recognize the rare instances when the federal RA methodology is inappropriate for a state's market. We ask that this flexibility be reinstated for all states.

### **Compliance With Appointment Wait Time Standards**

The proposed 2025 Notice leaves unchanged the policy set by the 2024 Notice related to appointment wait times as a network adequacy measure. The 2024 Notice delayed implementation of wait time standards and moved enforcement to plan year 2025. State insurance regulators supported the delay in this aspect of network adequacy reviews, and we believe further delay may be warranted. We remain concerned with the availability and reliability of data to demonstrate compliance with this standard. HHS expects to rely on issuers' attestations of compliance with the standard. It remains unclear what data or measures on which issuers are expected to base their attestations. Neither state nor federal regulators have appropriate tools to assess whether attestations are accurate. While the waiting time until an appointment is a key aspect of access to care and an important indicator of network adequacy, state regulators urge more detailed development of related measures before robust enforcement of this network adequacy standard.

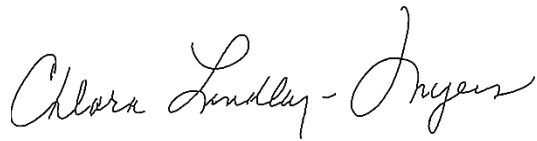
### **FFM and SBM-FP User Fee Rates**

State insurance regulators appreciate HHS' continued efforts to keep user fees low. Maintaining the 2025 fees at their 2024 levels will benefit consumers and issuers. We offer the assistance of state regulators as HHS finds additional operational efficiencies that will keep fees low even as the level of service remains high.

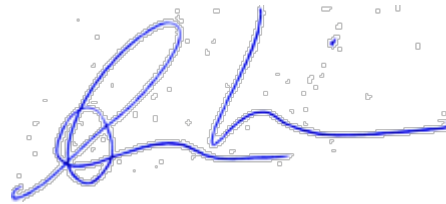
Thank you for the opportunity to comment on HHS' proposed updates to regulations in these areas. We appreciate your consideration of state regulators' perspective on

the proposals and their potential impact on consumer protection and market competition. We are available to discuss these or other issues as HHS continues its work and the Notice is finalized.

Sincerely,



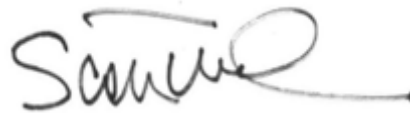
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