

New York appreciates the opportunity to comment on the proposed regulations for 45 CFR Parts 144, 146, 147, 148, 153, 154, 155, 156, 157, and 158; HHS Notice of Benefit and Payment Parameters for 2018 [CMS-9934-P].

Part 147- Health Insurance Requirements for the Group and Individual Markets

- **147.104 Guaranteed Availability of Coverage**

- *The proposed rule seeks comments on how restricting an employer's ability to purchase coverage from an issuer, when the offering of such coverage would not exceed the scope of the issuer's license, may limit employers' options.*

Allowing insurers to refuse to issue coverage to an employer to cover employees who live, work or reside in its service area simply because the employer does not have a presence in their service area will limit an employer's options to cover its employees and, in some cases, eliminate all coverage options. If an employer outside an insurer's service area has employees who live or reside in the insurer's service area, that employer should have the ability to purchase coverage for the employees who live or reside in the insurer's service area. If an insurer is allowed to refuse to issue coverage to an employer in that scenario, the employer may not be able to purchase any coverage for those employees.

- *The proposed rule seeks comment on how insurer affiliation agreement may be structured to satisfy the guaranteed availability rights of employers and be consistent with state licensure requirements.*

If HHS opts to allow affiliation agreements to satisfy the guaranteed availability rights of employers, then HHS should require insurers to guarantee all consumer protections are provided under each of the affiliated health insurance policies. For example, HHS should require that insurers afford consumers access to an adequate network of providers under each of the affiliated health insurance policies.

- **147.106 Guaranteed Renewability of Coverage**

- *HHS proposes to amend § 147.106(e)(3)(i) to provide that, for purposes of guaranteed renewability, a product will be considered to be the same product when offered by a different issuer within an issuer's controlled group, provided it otherwise meets the standards for uniform modification of coverage. HHS also proposes to permit issuers to replace their entire portfolio of products without triggering the 5-year ban under the market withdrawal provision when an issuer replaces its entire portfolio of products in a market with products that are different in ways that are not within the scope of uniform modifications, provided the issuer reasonably identifies which newly offered product (or products) replace which discontinued product (or products) and subjects the new product (or products) to the Federal rate review process under part 154 (to the extent otherwise applicable to coverage of the same type and in the same market (for example, the Federal rate review process does not apply in the U.S. territories)) as if it were the same product as the discontinued product it replaces.*

New York supports the proposed amendments to 45 CFR 147.106(e)(3)(i), as they are consistent with New York law with respect to marketplace withdrawals. HHS issued guidance dated June 26, 2014 with respect to the discontinuance of a particular product. The guidance interpreted the

Federal guaranteed renewability statute and regulations as providing that an issuer does not satisfy the requirement to offer other health insurance coverage currently being offered “by the issuer” if the issuer automatically enrolls consumers into a product of another issuer that is separately licensed to engage in the business of insurance in a state (including an affiliated company). In light of the proposed rule, HHS should make clear if its position from the guidance remains unchanged.

As each state has its own definitions of related business entities, New York recommends that HHS defer to the states as to which entities are included instead of using “controlled group” as defined by the Internal Revenue Code.

- **§147.106 Guaranteed Renewability in the Individual Market and Medicare Eligibility**
 - *The proposed rule seeks comments on whether the guaranteed renewability and anti-duplication should together be interpreted to require or prohibit renewal of a Medicare beneficiary’s individual market coverage, if the issuer has knowledge that the renewed coverage would duplicate the Medicare beneficiary’s benefits; and the effects of such provisions on consumers, premiums, and out-of-pocket costs, how these provisions could affect individuals’ decisions to enroll in the Medicare program or individual market coverage, and the effects these provisions and those decisions could have on the Medicare and individual market risk pools, as well as whether this is a permissible coordination of benefits provision with respect to the individuals who could but do not have Medicare coverage.*

NY supports consumer choice in the renewal of individual market coverage even if the individual becomes Medicare eligible. However, NY suggests that insurers of individual market coverage be required to assist Medicare eligible consumers upon renewal by providing information regarding the benefits that the individual market coverage actually provides once an individual becomes eligible for Medicare Part B benefits, especially if the insurer carves the Medicare benefits out of the individual market coverage it offers. Consumers would benefit from a requirement on insurers to provide more transparency regarding benefits and premiums. For example, a side-by-side comparison chart of the individual market coverage benefits and the benefits under Medicare, along with the premium to be charged for the individual market coverage would be useful for consumers in making an informed choice about whether or not to renew the individual market coverage once eligible for Medicare. Insurers should also inform Medicare eligible consumers that they may wish to consider Medicare supplement insurance, Medicare Advantage Plans, and/or Medicare Part D prescription drug plans as an alternative to renewing individual market coverage and provide links to the CMS website and the state insurance department website for more information.

Part 153 – Standards Related to Reinsurance, Risk Corridors, and Risk Adjustment under the Affordable Care Act

- **§153.320 – Risk Adjustment Changes**
 - *The proposed rule seeks comments on the addition of a “High-Cost Risk Pooling” provision.*

“Therefore, beginning for the 2018 benefit year, we are proposing a threshold of \$2 million and a coinsurance rate of 60 percent (where the issuer would be liable for 40 percent of costs above \$2 million). Beginning with the 2018 benefit year recalibration, we would also incorporate these parameters in our recalibration of the model by truncating at 40 percent of costs above \$2 million in our dataset used to simulate plan liability.”

Insofar as the risk adjustment formula may not properly account for high cost individuals, New York recognizes the goals of the program. However, we also do not wish to stifle innovation in plan design or cause market uncertainty for new entrants to the market. Therefore, it is important that the risk adjustment model be designed to strike a balance that would allow for the existence of plan designs that attract high-cost enrollees as well as plan designs that are intended to control costs. Currently, that balance has not yet been achieved. The current federal methodology does not appear to account fully for insurers’ efforts to innovate plan designs intended to control health care costs by improving health care quality. Such plan designs may include narrower networks of high performing providers who are incented to deliver quality care. New York welcomes the opportunity to engage in further discussions with CMS on how best to achieve that balance.

- **§153.320 - Other Considerations**

- *The proposed rule seeks comments on how to appropriately define billable member months in states with family rate tiering structures.*

“We have received feedback that there may be alternative methodologies for calculating billable member months in family tiering States, such as by adjusting for the expected actual number of members on the policy, not the number of members that implicitly count towards the premium. We seek comment on whether our methodology for calculating billable member months in family tiering States should be altered, and how.”

The modification to the definition of billable member months that CMS makes for New York to account for our unique rating tier structure results in distorted payments. By only including a maximum of one child in the billable member month count for our “adult plus child” and “family” rating tiers, insurers with more than the statewide average number of children on such policies may end up being overcompensated by the model. Likewise, insurers with fewer than the statewide average number of children on such policies may end up being disadvantaged by the model. Therefore, we believe it would be more appropriate to define billable member months in New York for such policies as the actual number of children on a given policy up to a maximum of the statewide average number of children enrolled in all such policies. New York would welcome further discussion with CMS on this issue.

- *The proposed rule seeks comments on CMS’ plan to update the risk adjustment model coefficients for the 2018 plan year as well as subsequent plan years. Additionally, the proposed rule seeks comments on various other tweaks to the risk adjustment model.*

“We are considering using 2015, 2016, and 2017 MarketScan® data for 2018 risk adjustment, publishing the final, blended coefficients in the early spring of 2019, prior to final 2018 benefit year risk adjustment calculations. We have previously finalized the risk adjustment methodology, including the final coefficients prior to rate setting and benefits being provided to members. We seek comment on this proposal, specifically the timing of

the release of final coefficients and whether such a practice would affect issuer expectations with respect to the methodology to be applied. “

New York supports the use of the updated coefficients for the 2018 plan year as long as the preliminary results associated with that plan year, which would be released in the spring of 2019, are determined using those same coefficients so that insurers have accurate risk adjustment data for pricing purposes.

- *“We also seek comment on the timing of the publication of the final coefficients, providing a few options to reduce the data lag as much as possible. As the first option, we could release final coefficients for the 2018 benefit year risk adjustment model in the spring of 2017 that would reflect the incorporation of 2015 MarketScan® data, after it becomes available, blended with 2013 and 2014 MarketScan®. On the other hand, we could release final coefficients for the 2018 benefit year risk adjustment model in the spring of 2019, prior to the April 30, 2019, data submission deadline for the 2018 benefit year that would reflect 2015, 2016, and 2017 blended MarketScan® data. We could also provide interim coefficients in the spring of 2018 using 2014, 2015 and 2016 blended MarketScan® data, in addition to the interim coefficients that would be published in the 2018 Payment Notice final rule using 2013 and 2014 data. As noted above, we would continue to finalize the risk adjustment methodology for the corresponding year through notice and comment in the applicable annual Payment Notice.”*

New York supports the use of coefficients that reflect the most current experience as well as initiatives that serve to reduce the data lag as long as the final version of the model used to calculate actual results is the same as that used to calculate preliminary results for a given plan year to allow for accurate pricing. While we are supportive of the use of MarketScan data to update the coefficients for the 2018 plan year, it would be our preference for state specific enrollee-level Edge server data to be used for this purpose in states where such data is sufficiently credible.

- *“For the 2018 benefit year, in addition to the RXCs we are proposing to include in the adult risk adjustment model, we are also proposing to separate the Chronic Hepatitis HCC into two new HCCs for Hepatitis C and Hepatitis A and B, in the adult, child, and infant models. This would increase the total HCCs in the HHS risk adjustment methodology from 127 to 128.”*

New York supports the stratification of Chronic Hepatitis HCCs as costs associated with Hepatitis diagnoses can vary significantly.

- *“We are continuing to evaluate the impact of administrative expenses on risk adjustment transfers, and seek comment on removing a portion of administrative expenses from the statewide average premium for the 2018 benefit year or for future benefit years.”*

New York strongly supports the removal of administrative expense and profit components of the statewide average premium for purposes of calculating payments and charges as we are of the opinion that such transfers should be made solely on the basis of the underlying claim costs.

- *“Beginning for the 2019 benefit year, while maintaining the underlying goals of the distributed data approach, including information privacy and security, we propose to recalibrate the risk adjustment model using masked, enrollee-level EDGE server data from the 2016 benefit year. A separate report would be run on issuers’ EDGE servers to*

access select data elements in the enrollee, medical claim, pharmacy claim and supplemental diagnosis files, with masked enrollee ID, plan/issuer ID, rating area, and State. This approach would allow for the creation of a masked, enrollee level dataset and would not permit HHS to know the identity of the enrollee, the plan ID, the issuer ID, rating area, State or the EDGE server from which the data was extracted. HHS would provide additional information regarding the data elements it would collect and the related process considerations in future guidance.”

New York supports the use of enrollee-level Edge server data to recalibrate the risk adjustment model going forward. New York also proposes that such recalibration be performed separately using state specific data in states that have data sufficient to be considered fully credible. This will ensure that transfer payments are as accurate as possible in such states.

While many of the New York comments on risk adjustment are aimed at specific sections of the regulation as requested by CMS, New York welcomes the opportunity to engage with CMS in a more broad dialogue on how to improve the federal risk adjustment program more generally.

Part 155—Exchange Establishment Standards and Other Related Standards Under the Affordable Care Act

- **§ 155.205 - Consumer Assistance Tools and Programs of an Exchange**

- *The proposed rule permits entities that serve more than one state to aggregate limited English proficient populations across states to determine the top 15 languages in which taglines must be provided.*

The proposed rule should not preclude a state-based Marketplace from setting standards for identifying the top languages based on the population that the QHP issuer serves in that state.

- **§155.330 - Eligibility redetermination during a benefit year**

- *The proposed rule allows Marketplaces to use alternative methods of calculating advance premium tax credits in the middle of the benefit year through 2023.*

New York supports using an alternative method to recalculate advance payments of the premium tax credit.

- **§ 155.400 - Enrollment of Qualified Individuals into QHPs**

- *The proposed rule allows flexibility on binder payment deadlines in the event of high volume or technical errors.*

New York supports flexibility on binder payment deadlines and suggests that this not be limited to high volume or technical errors, but also apply to other circumstances at the discretion of the state-based Marketplace.

- **§ 155.430 - Termination of Exchange Enrollment or Coverage**

- *The proposed rule provides that QHPs can rescind coverage from an enrollee if they have demonstrated, to the Marketplace’s satisfaction, that the rescission is appropriate.*

New York supports the requirement that QHP issuers demonstrate to the Marketplace's satisfaction that the rescission is appropriate.

- **§155.725 - Enrollment Periods Under SHOP**

- *The proposed rule provides highly prescriptive timelines for enrollment periods on SHOP for qualified employees.*

In order for the SHOP to be competitive, states should have the ability to align rules with the practices of the small group market outside the SHOP. New York requests that the new requirements be made optional for state-based SHOPS.

Part 156 – Health Insurance Issuer Standards under the Affordable Care Act, Including Standards Related to Exchanges

- **§156.80 - Index Rating Methodology for Single Risk Pool**

- *The proposed rule seeks comments on proper calibration of the starting index rate.*

“To more explicitly reflect how the rating factors under 45 CFR 147.102 and the index rating methodology under 45 CFR 156.80 work together, we propose to restructure paragraph (d)(1) as paragraphs (d)(1)(i) through (iv), adding new paragraph (d)(1)(iii) to provide that the index rate must be calibrated on a market-wide basis to correspond to an age rating factor of 1.0, a geographic rating factor of 1.0, and a tobacco rating factor of 1.0, in a manner specified by the Secretary in guidance. Because it is essentially an adjustment to the index rate, the calibration from the single risk pool index rate to the allowable rating factors may not vary by plan; it must be made uniformly for all plans in a State and market. We would provide detailed technical guidance through Unified Rate Review Instructions to ensure accurate and uniform application of the calibration methodology proposed here. We seek comment on this proposed codification.”

New York is of the opinion that CMS should continue to allow for state flexibility. State regulators, particularly those with effective rate review designations such as New York, are in the best position to assess and work through these types of details.

- **§ 156.140 Levels of Coverage: Bronze Plans**

- *The proposed rule allows flexibility to design plans meeting bronze level requirements, specifically to allow variation in the 60% AV of -2% to +5% to allow insurers to cover additional services before the deductible or to be HDHP-eligible.*

New York supports additional flexibility for Bronze Plan actuarial value variation to promote plan design that would allow additional services for consumers before they reach their deductible.

- **§156.230 Network Adequacy Standards**

- *The proposed rule seeks comments on policy changes that could limit “surprise bills.”*

New York recommends consumer protections for surprise bills and encourages HHS to consider requiring health plans and non-participating physicians to hold insureds harmless for surprise bills, meaning that the insured is only responsible for any applicable copayment, coinsurance or deductible that would be owed if the insured utilized a participating physician. HHS may also wish to consider establishing an independent dispute resolution process for the resolution of disputes regarding surprise bills. These protections are currently codified in New York laws and regulation in Article 6 of the New York Financial Services Law and 23 NYCRR Part 400. New York welcomes further discussion with CMS to continue to identify areas where consumer protections can be improved.

New York appreciates HHS' consideration of these comments and looks forward to continuing to work with our federal partners to refine the proposed regulations.