October 6, 2016

Andy Slavitt
Acting Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Submitted electronically via www.regulations.gov

Dear Mr. Slavitt:

I am writing on behalf of the National Association of Health Underwriters (NAHU), a professional association representing more than 100,000 licensed health insurance agents, brokers, general agents, consultants and employee benefits specialists nationally. We are pleased to have the opportunity to provide comments in response to the proposed rule titled "Patient Protection and Affordable Care Act: Notice of Benefit and Payment Parameters for 2018." NAHU greatly appreciates the willingness of the Department of Health and Human Services (HHS) and the Centers for Medicare and Medicaid Services (CMS) to hear from stakeholders on this important regulation, which covers such a wide array of health-policy issues.

The members of NAHU work on a daily basis to help millions of individuals and employers purchase, administer and utilize health insurance coverage. Over the past six years since the passage of the Patient Protection and Affordable Care Act (ACA), our members have worked directly and tirelessly with millions of individuals and employers of all sizes to help them obtain new coverage, including coverage through both the individual and Small Business Health Options Program (SHOP) marketplaces. NAHU members also work directly with individuals and employers to help them implement health-plan changes related to the ACA. Ensuring market stability and competition, as well as improving health coverage affordability, are amongst our top goals. A representative group of health insurance agents and brokers helped to develop these comments, which have been organized by topic as the topics appear in the proposed rule. Please note that the following comments reflect the views of experts who fully understand the needs and interests of today's individual and group health insurance consumers.

Age Rating for Children
NAHU has concerns about the proposal outlined in §147.102 to create multiple age bands for children covered through either individual or small-group market fully insured coverage. Our members recognize that children incur, on average, higher medical care costs during the early parts of their childhood and that the current structure of imposing one band for all children ages 0-20 results in a significant premium increase when children attain age 21 and are still covered on the same plan. However, NAHU members who work with employers every day in designing and administering group benefit plans know the detrimental impact that age rating of adults has had on employer benefit plans. The combination of the strict 3:1 age bands for individual and small-group policies and the graduation of the bands for each year of life between ages 21 and65 has effectively eliminated the use of composite rates for small employers. Although current federal regulation allows for issuers to provide employers with

composite rates for adults on the plan under specified conditions, in practice few issuers still offer composite rates that, up until implementation of the age bands in 2014, were the norm. The effective elimination of composite rates has affected employer plan contributions to employees and has presented small employers with a number of new and undesirable human resource concerns. As such, NAHU has significant concerns about the proposed change to stagger age band rate increases annually for children ages 15 and older. Under the current age-rating rules, at least employers may use a single rate for dependent non-adult children on group plans. This proposal would extend the current composite rate dilemma for employers down to the children covered through the group benefit plan. Furthermore, this proposal would have a detrimental cost impact on families with older children, even though older children consume less medical care services than their younger counterparts on average. NAHU recommends no change to the existing age-rating structure for children.

Guaranteed Availability of Coverage

In the preamble to the proposed rule, HHS solicited comments as to whether a final rule or future rulemaking should prohibit a common practice of PPO network plans limiting coverage through shared networks of affiliated issuers. Under these arrangements, the carrier requires the employer to be sited in the primary issuer's service area. The supporting issuers will not offer their network plans to the employer that is sited outside of their primary issue area, even if employees who live there access their networks through the shared network system. NAHU members report that this is a well-established system, particularly in certain areas of the country, that impacts both PPO and HMO plan offerings. Given that individual employees are not impacted by the current system as they are able to utilize providers located outside of their plan's primary service area through the use of shared networks, and given that employers are already used to coverage options being offered in this way, NAHU members see no need to disrupt this current system. There is little to no evidence that requiring all of the carriers in the state offering coverage to accept any employer applying for coverage if they could accommodate them via the use of shared network would reduce prices. Provider reimbursement costs and other medical care costs that drive premiums will remain the same. However, a change could be confusing to consumers or, perhaps more important, to providers regarding claims submission and processing. Therefore, NAHU does not recommend that HHS move forward with any changes in this regard.

Guaranteed Availability of Coverage Issues Not Raised in the Proposed Rule

NAHU members routinely work with business owners of all sizes to design and implement health-coverage options for employees. Accordingly, our members have had the opportunity to observe how the intricacies of ACA requirements can impact business owners and human resource professionals on a day-to-day basis as they work to ensure that their employees have access to affordable and high-quality coverage options. Over the past year of helping employers implement the employer shared responsibility requirements outlined in IRC §4980H, NAHU members have noticed several market concerns relative to guaranteed availability of coverage and we would welcome additional regulatory action or guidance from CMS to help employers and issuers address these issues. First, CMS has already established via existing regulation that large employers purchasing fully insured coverage in the large-group market do not have to meet participation thresholds when coverage is issued, to ensure that such employers can also meet their IRC §4980H obligations. However, the existing rules allow for carriers to impose participation standards on renewal in certain instances, which has been forcing carrier switches and causing coverage instability. NAHU members have reported cases of carriers imposing participation audits on large-group cases, and they report that some issuers have imposed large-group renewal-participation requirements unevenly and arbitrarily, choosing to rate-up certain groups that cannot meet participation standards, refusing to continue

coverage for other groups or allowing groups to continue coverage without any type of penalty. NAHU would appreciate clarification that the carriers may only impose renewal-participation requirements on employer groups subject to IRC §4980H if state law requires a minimum participation standard for such employers.

Also, given that the majority of states have elected to keep the size of their small-group markets as 2-50 employees, and there are many small businesses that are subject to IRC §4980H because they employ many part-time employees or could be part of a controlled group, many American businesses that are subject to the IRC §4980H requirements are also required to buy health insurance coverage through their state's small-group marketplace. These groups can also struggle both with the imposition of participation requirements on renewal and participation requirements when they purchase coverage. As such, NAHU recommends that HHS, at minimum, amend §147.104 to exempt any employer that can document that it is subject to IRC §4980H regardless of employee count from having to meet small-group participation requirements at any time during the year.

A related issue concerns large groups with variable-hour employees. This issue impacts both large employers that are purchasing fully insured coverage and those operating self-funded plans and purchasing stop-loss coverage. IRC §4980H requirements are quite clear that employers must treat employees who are determined to be full-time employees for the purposes of the health coverage offer requirements during a measurement period as full-time employees for the purposes of health coverage for the entire duration of the subsequent stability period, regardless of the number of hours worked. However, there is no related requirement for the issuers that provide such employers with either fully insured health coverage or stop-loss coverage for a self-funded plan. NAHU members are reporting cases of issuers imposing participation/hours worked audits on large employer plans and then denying claims and coverage, particularly following the review of high-cost claims. The employer can be left with absolutely no recourse relative to its coverage offer requirements and can be forced to absorb quite high costs and difficulties to ensure that coverage may be offered to such employees. As IRC §4980H implementation has moved forward, this is becoming an increasingly common issue, one that NAHU believes is an unintended consequence of the way the law has been implemented that runs afoul of statutory intent. As such, we are requesting that the final rule that all issuers, including stop-loss plans providing coverage to employer-sponsored health benefit plans, treat all individuals offered coverage based on their hours worked/full-time status in the employer's measurement period as full-time for coverage-participation requirements in the subsequent stability period, regardless of their actual hours worked in the stability period.

Finally, guidance is needed to ensure that carriers accommodate individual enrollments of newly eligible employees based on satisfaction of either the monthly measurement or look-back measurement method. Many carrier systems cannot accommodate these new rules, resulting in individuals being classified as late enrollees and denied coverage until the next open enrollment. Employers have no means of preventing these issues and have no recourse against IRC §4980H excise penalties in all of these cases. Furthermore, individual employee coverage is disrupted or not provided, in conflict with the intention of the ACA statute. It is imperative that these consumer- and employer-protection issues be addressed by CMS as soon as possible.

Guaranteed Renewability

NAHU supports the proposed changes outlined in §147.106 to modify the five-year reentry rule to make it easier for carriers undergoing mergers or transitions to not inadvertently violate the rule and thereby shut themselves out of offering coverage in a state for an extended period of time. However, we have concerns about applying the

five-year rule on carriers when they realign and substantially change their product offerings in a particular market. NAHU believes that applying the market-withdrawal standard and five-year reentry rule in this way would significantly limit the ability of issuers to respond to changing market needs and ultimately harm overall health insurance market stability in states. Issuers often need to make such shifts for financial reasons, and they may make significant product-offering shifts to respond to market trends, changing demographics and consumer needs. Forcing insurers out of state markets rather than allowing them to realign their product offerings would only hurt competition and consumers. NAHU believes that Administration policy should encourage such issuer course corrections rather than punishing them for responding to market trends and solvency risks.

Guaranteed Renewability/Auto-Reenrollment for Individuals Transitioning to Medicare

NAHU has longstanding concerns about the practice of passive reenrollment, and these concerns extend to newly eligible Medicare beneficiaries. While NAHU recognizes the need to keep people continuously enrolled in coverage to prevent adverse selection, our members do not think that reenrollment in coverage should be at the complete expense of an individual's choice in coverage options. This viewpoint is especially relevant for individuals who are newly Medicare-eligible, as it could result in wholly inappropriate enrollments for seniors and individuals who are eligible for Medicare for other reasons, such as sufferers from end-stage renal disease. We strongly believe that all consumers, particularly those transitioning to Medicare eligibility, should deliberately review their coverage choices each year and make informed decisions utilizing their personal needs and budgets. Medicare-eligible individuals who are passively reenrolled into individual-market coverage could face lifetime late-enrollment penalties from Medicare, as well as claims issues with their individual-market coverage. NAHU would strongly support disallowing passive reenrollment for individuals whose birthdate indicates that they are likely Medicare-eligible.

Risk Adjustment

In the proposed rule, HHS outlines a number of changes to its existing risk-adjustment model and methodology, including an adjustment for partial-year enrollees, the inclusion of select prescription drug utilization data in the risk-adjustment model and modifications to establish transfers for costs associated with high-cost enrollees so a portion of any individual claims costs exceeding $2 million would be shared among all issuers. Given that NAHU represents independent health insurance agents, brokers and consultants, we have elected not to comment on the details of the proposed formula adjustments. We feel that detailed comments in this area are far more appropriate from state regulators, actuaries and issuers, as they can provide far more accurate assessments of how the specific proposed changes could impact state regulation and issuer operations and financial solvency. However, NAHU does want to point out that the adequacy of risk adjustment in a guaranteed-issue marketplace cannot be compromised without the risk of grave insurance market instability, including higher costs and fewer choices for individual health coverage consumers, small-business owners and the self-employed.

The risk-adjustment program as it exists currently has already created much market instability. By assessing charges against plans with lower-risk beneficiaries and claims costs to make payments to plans with higher-risk individuals, CMS has unfairly penalized many smaller and more innovative plans. Risk-adjustment failures are one of the key reasons so many CO-OP plans have failed, causing coverage instability for consumers in many states. Furthermore, the inadequacy of the existing adjustment formula is a reason many issuers, including national plans and smaller entities, have cited as to why they can no longer serve the individual and small-group exchange marketplaces. NAHU also notes that the preservation of state regulatory authority to ensure financial solvency of

issuers is crucial and that pooling of risk across all states may not be the most appropriate means. Accordingly, NAHU urges CMS to evaluate the views of all issuers, regulators and actuaries that provide commentary on the proposed risk-adjustment formula changes carefully, and to heed advice that will improve the adequacy of the methodology, issuer solvency and competition without impeding state regulatory authority.

Consumer-Assistance Services

NAHU appreciates the language requirement specificity provided in §155.205 permitting the aggregation of the top 15 languages spoken across multiple states for multistate issuers and web brokers with regard to translation and tag-line requirements. With regard to the translation requirements for summaries of benefits and coverage (SBCs), NAHU requests that this requirement be scaled for employers that must develop SBCs for self-funded employee benefit coverage options, including Health Reimbursement Arrangements (HRAs) given that these employers, which can be smaller businesses, do not have the resources that larger entities and health plans have for translation services.

Post-Enrollment Support by Brokers

In section 155.220, HHS requires that brokers provide service to exchange enrollees they have helped enroll in coverage to provide post-enrollment services necessary to effectuate enrollment or resolve enrollment issues, such as data-matching issues related to eligibility. NAHU member brokers routinely provide their customers with year-round coverage-needs assistance. However, the proposal as currently drafted by HHS does raise some concerns, especially considering the current broker-compensation environment. Health insurance issuers are increasingly ceasing to pay commissions on individual market health insurance coverage or changing or eliminating commissions mid-plan year. This has resulted in many marketplace-certified brokers charging fees for assessment and placement of coverage with an additional fee for service after the sale, or certified brokers offering consumers a package of services. NAHU has concerns that this assignment-of-duties requirement will raise significant financial concerns for what are largely independent small-business owners. For example, does this requirement still apply if a carrier ceases to pay a commission mid-plan-year? What if a broker sells his or her book of business or an agency merges with another? While NAHU feels very strongly that year-round consumer support is necessary for exchange market purchasers and that brokers are uniquely positioned to provide such support, they cannot do so with out recompense. NAHU believes additional discussion is warranted before the imposition of any such requirement for support and service is made upon certified agents and brokers. Otherwise, broker participation in the exchange could be compromised.

Additionally, NAHU has concerns about the proposed standards of conduct outlined in §155.220 that would extend to businesses and agents that use the words “exchange” and “marketplace” in their names and websites. NAHU does not in any way support websites operated by brokers or others that are intentionally misleading to consumers and attempt to confuse them relative to the federal marketplace. In addition, we support the required disclaimer to note that the entity or website is not the federal exchange and requirement to include a link to HealthCare.gov. However, we also note that the words “exchange” and “marketplace” are common and have been part of the names (and web addresses) of many long-standing insurance-related businesses established well before the federal marketplace was envisioned. For example, a NAHU-member company, The Insurance Exchange, has been operating as one of the largest general insurance agencies in Texas for decades. Businesses like this should be able to continue to operate and market online as they have for years without fear of federal reprisal. We request that the final rule acknowledge that there are entities that have used these words in their name for years prior to

the creation of the FFM, that these entities are in no way trying to confuse consumers by maintaining their longstanding corporate identities and that HHS does not expect these businesses to change names, websites, trademarks, etc. that have long been part of their business identity.

Web Brokers/Direct Enrollment
In §155.220, HHS has proposed a new "enhanced direct enrollment" process that would allow consumers who choose to enroll in federal marketplace individual health insurance using a direct issuer enrollment platform or through a web broker to remain on the web broker or insurer website for the entire enrollment and subsidy-determination process. The exchange would verify eligibility information using government-agency data that would not be shared with the direct-enrollment partner.

NAHU enthusiastically embraces the concept of a single streamlined application that would enable a consumer to complete the eligibility portion without leaving the web broker's or issuer's website, and believe it can be achieved without sacrificing critical consumer protections. Furthermore, NAHU would support extending the accessibility of enhanced enrollment to state-based exchanges, both for direct issuer enrollment and web brokers.

NAHU also agrees that any modifications designed to streamline the process must not come at the expense of overall program integrity, specifically consumer privacy and security. The HHS proposal to require brokers and issuers to strictly adhere to existing eligibility exchange language and scope of required information is a prudent safeguard. We support provisions for conspicuous notice to consumers to assure they are aware they are applying for exchange coverage even though they will no longer be directed to the exchange website at any point in the application process. In addition, we encourage HHS to minimally require the submission of each web broker's and issuer's MARS-E Compliance Manual that details how they manage their compliance process, with particular attention to the implementation and maintenance of a MARS-E compliance level. Web brokers and issuers that fail to materially meet MARS-E standards should not have access to the proposed streamlined application process until such time as they can demonstrate compliance.

With regard to downstream entities that may access a web broker's or issuer's technology to assist consumers, we note that licensed health insurance agents and brokers are already required to abide by extensive state and federal privacy requirements and that the federal marketplace already has the authority to suspend the activities of certified agents and brokers that do not meet their privacy responsibilities. We believe it is appropriate to require issuers and web brokers to refuse to imbed its enrollment technology in a downstream producer's website without the appropriate indemnification and HIPAA privacy agreements, and to take responsibility for stopping access to enrollment technology to individual producers in case of a downstream entity breach. However, ultimately individually licensed consumers are responsible for their own actions and the ability of a web broker or issuer to fully operate enhanced enrollment capabilities should not be compromised by the actions or mistakes of a downstream entity, provided that access to that entity is halted in the case of a breach.

EFT Withdrawals for Consumers Losing Premium Tax Credit Eligibility
In the preamble to the proposed rule, HHS solicited comments regarding consumers who utilize electronic fund transfer (EFT) withdrawals from their bank accounts to cover their share of marketplace policy individual health insurance premium payments. HHS expressed concern about consumers who utilize EFT for premium payments then lose their tax credit eligibility. Once the tax credit is no longer advanced on their behalf, their premium

payments will increase exponentially. Subsequent EFT payments could be overwhelming, as the full premium cost without subsidy will be withdrawn from consumer's bank account by the issuer. HHS requested comments on whether this could be a problem for consumers, as well as potential solutions. NAHU members who routinely work with subsidy-eligible individual-market consumers to meet their health coverage needs report that this could easily be a problem for both consumers and issuers alike. NAHU recommends that issuers be required to obtain written authorization from a consumer in order to change or increase the designated monthly EFT amount for the consumer.

Eligibility Determinations
NAHU supports the provisions noted in §155.330 that would allow for increased examination of data sources for eligibility determinations for government health programs such as the Children's Health Insurance Program. Similarly, NAHU strongly recommends that HHS look at data sources for verifying offers of employer coverage for exchange subsidy-eligibility purposes, as this is also a problem. Inadequate eligibility verification for government programs and advance premium tax credit subsidies is particularly an issue with redeterminations and reenrollment, as the preamble notes, and the development of alternative procedures to help prevent costly mistakes by taxpayers is certainly warranted. NAHU would welcome more guidance in this area for the scenarios described and with regard to individuals who may have been offered employer-sponsored coverage.

QHP Enrollment
NAHU supports the provision outlined in §155.400 to provide flexibility for issuers to extend deadlines to require binder payments within a reasonable timeframe during times of high volume. Our members believe that allowing for such flexibility will benefit consumers and prevent cancellations of coverage and retroactive reinstatements. As for the proposed change to not require binder payments if an individual is passively reenrolled in the same product, NAHU members do have some concern. Not only could this new practice pose operational concerns for issuers, but NAHU members also note that the submission of a binder payment requires consumer action. NAHU has expressed longstanding concerns about the practice of completely passive reenrollment in coverage since it takes consumer choice and decision-making out of the annual health insurance equation, often to the consumer's own detriment. Requiring the binder payment reengages the consumer, which is needed in the exchange enrollment process.

Special Enrollment Periods
NAHU supports the clear codification of special enrollment period (SEP) qualifications outlined in §155.420. These include SEPs for Native American dependents enrolling at the same time as a parent, for victims of spousal abuse and their dependents who are seeking separation from the perpetrator, for those who apply for coverage but are later determined ineligible for CHIP or Medicaid, for those at the resolution of a data-matching error or for those who experienced a material plan or benefit error from the exchange website and it is resolved/uncovered post-open enrollment. Additionally, we would support verification of an individual and/or dependents qualification for these SEPs, as appropriate at the time of enrollment.

HHS requested comments in the preamble on the SEP-verification process, including if verification of SEP qualification is needed and if the enhanced SEP-verification process initiated this past spring is sound policy and if it should be continued or expanded. NAHU believes that the goal of requiring greater verification of SEP eligibility for the most common enrollment situations is a sound policy and we commend CMS for expanding the eligibility-

verification process for the federally facilitated marketplace. The individual health insurance market is naturally more prone to adverse selection than perhaps any other insurance market because individuals typically bear the price of coverage themselves and because people have unique knowledge of their health status and can seek coverage only when they feel they truly need to use medical care services. However, for this market to function properly and maintain both price and risk stability, as many participants as possible need to enter the market because they want the financial protection health insurance coverage provides – not because they are in ill health. Furthermore, to provide both national health security and market stability, as many people as possible need to maintain their coverage year-round and from year to year. Given that the ACA mandates an open-enrollment period/special enrollment period for the entire individual insurance marketplace, it is critical that individuals who are seeking coverage outside of the annual open-enrollment period have a legitimate reason for doing so.

NAHU believes that the best practice for ensuring SEP eligibility would be to require appropriate documentation of SEP-qualifying status by the consumer to the marketplace prior to the effectuation of coverage. The use of this process would protect both the issuers and the consumers far better than retroactive terminations, and we believe issuers would be able to easily implement it. As such, NAHU supports the recently proposed pilot program to test pre-enrollment eligibility verification during 2017 outlined in the "Frequently Asked Questions Regarding Verification of Special Enrollment Periods" document issued by CMS on September 6, 2016.

Terminations/Rescissions
HHS inquired about the impact of a potential §155.430 requirement on individual-market issuers to notify the exchanges in the cases of legitimate rescissions done under existing ACA rules due to their enrollment role. NAHU believes that this would be a reasonable requirement of issuers.

Appeal Processes for Eligibility Determinations and Employers
Section 155.505 proposes allowing for an alternative paper-based subsidy-eligibility determination appeals process for appellants who can't complete the online process. While NAHU understands the desire to strive for a paper-free appeals process, an alternative paper-based system would seem to clearly benefit certain types of individual-market consumers, many of whom have limited Internet access. Similarly, in §155.555, CMS proposes an alternative paper-based appeals process for employers that have received marketplace notices about an employee to allow them to establish that either (a) the employer provides minimum-value and affordable coverage to the employee or (b) the employee has actually enrolled in employer-sponsored coverage. Again, NAHU believes that an alternative paper-based appeals process is appropriate. NAHU members have assisted many employers with the employer marketplace notice appeals process over the past six months and can attest to the difficulty some employers have had with the online appeals system.

SHOP Exchange
It is proposed that electronic distribution would be the default methodology utilized by the federal SHOP exchange to provide notices to employers. NAHU supports this proposal, provided the SHOP exchange follows federal electronic-distribution requirements. Additionally, we recommend that copies of electronically distributed notices to employers also be provided to any certified health insurance agent or broker assisting an employer with its SHOP coverage.

HHS also proposes a number of changes to SHOP enrollment procedures that NAHU supports, including starting the 30-day clock for new employees to make plan determinations on the day the employer tells the SHOP about the new employee rather than when the employee actually became eligible through the employer due to past notification delays. We also support the proposal to smooth out the SHOP enrollment process and coverage eligibility dates to benefit the employee when a SHOP employer imposes a legal waiting period for coverage. Previously, individuals could have up to a 15-day gap in coverage. By making the consumer's start date the first day of the month post-plan selection or the end of the legal waiting period, this issue will be smoothed out.

However, NAHU has significant concerns with the related proposal to limit variable-hour measurement periods for SHOP-participating employers to 10 months rather than the maximum of 12 allowable for all other employers. While right now most SHOP participating employers are not subject to the IRC §4980H employer responsibility requirements, given the possibility of SHOP expansion by states in 2017 and later, NAHU believes this new requirement would be a substantial barrier to entry and compliance issue for any large employer considering purchasing coverage through a SHOP exchange. Similarly, we oppose the proposed reductions and restrictions in the legal waiting periods for SHOP-participating employers. By creating both variable and more restrictive requirements on participating employers, the SHOP exchange is only discouraging employer participation and inviting compliance errors. If SHOP would like to attract new employer entrants, its focus should be on making the coverage and compliance process simpler and more advantageous for employers and employees alike.

QHP Certification

Section 155.1090 would create an appeals process for issuers that have been rejected for QHP certification by the marketplace. NAHU supports this proposal to create a formal process for issuers to request reconsideration of a QHP certification denial.

NAHU also supports a related proposed provision that if an issuer is not recertified as a QHP, then the issuer has to notify enrollees within 30 days that it will not be offering marketplace coverage in the year ahead, just as if the issuer had decided to voluntarily withdraw from the exchange. However, if the issuer elects to appeal the QHP certification denial, then NAHU believes this notification requirement should not take effect until the appeals process is complete.

Actuarial Value of Bronze Plans

NAHU appreciates HHS's recognition in §156.140 of the market reality that current actuarial value and other federal requirements for Bronze plans (which are required to have a 60 percent actuarial value with de minimis variations of plus or minus two percentage points) make it largely impossible for Bronze plan designs to provide coverage for virtually any services other than preventive care before the application of the plan's deductible, thereby rendering most Bronze plans less generous than catastrophic coverage options. To provide more flexibility for insurers to design plans meeting Bronze plan requirements, the proposed rule would redefine de minimis variation by plus five percentage points (and minus two) for Bronze plans that agree to cover at least one "major service" before the application of a deductible. While NAHU generally supports the provision of increased flexibility for Bronze plans, we have concerns about the lack of specificity in the "major service" coverage requirements and request much more detail about the application of this requirement in a final rule.

QHP Certification Standards
In §156.220, HHS proposes requiring that certified QHP issuers offer both Silver and Gold plans in every exchange service area they cover in the state, not just one, noting that HHS believes this reflects statutory intent. While NAHU does not have concerns with this recommendation, we do have comments about a related requirement that requires such individual-market QHP issuers to also offer Silver and Gold small-group products through the state SHOP exchanges under specified circumstances. NAHU urges HHS to consider removing this requirement to preserve consumer choice in the individual-market exchanges. Before the enactment and implementation of the ACA, a state-level requirement linking individual and small-group market participation in the highly regulated New Jersey market caused higher rates, a lack of competition and ultimately a death spiral in the less-preferred market. Issuers showed that they didn't want to be forced to participate in both markets by either leaving the state entirely or filing very high premium rates and extremely limited product offerings in the less-preferred market (in New Jersey, this was the individual market) to merely demonstrate that they were participating. Given the current problems attracting carrier participation in the individual marketplace, particularly in certain areas of the country, NAHU does not believe it would be in anyone's best interest to continue to make the individual marketplace participation bar higher for issuers at this time.

Standardized Options
HHS proposes to expand the standardized federal marketplace options created through the 2017 Notice of Benefit and Payment Parameters, including the creation of a new standardized, HSA-qualified, Bronze High-Deductible Health Plan (HDHP) option. While NAHU supports the concept of greater availability of HDHP/HSA qualified plans through the marketplace generally, we do have broader concerns about the creation of standardized options for FFM individual-market consumers. NAHU members who work with individual consumers routinely on their purchase decisions report that standardized plans are not needed in the marketplace. In fact, consumers should not be limited in their choices but instead should have transparency in the marketplace and access to licensed professional brokers to help them best pick the coverage that suits their specific need. Given that the standardized options will debut on the federal marketplace this coming plan year of 2017 and have not been fully tested yet, NAHU believes that it would be prudent to wait until there is evidence of consumer response and data on how well the standardized plan options work in 2017 before proposing an expansion of the options. NAHU is also concerned about the plan-structure limitations proposed in this rule, in particular the proposal to limit FFM options to plans with no more than one in-network provider tier, since this could reduce health plan quality. Experience in the group marketplace tells us that this plan-design framework is a common one that consumers often prefer. Furthermore, networks that are designed using tiers based on not only cost but also specific quality measures can help hold down the bottom line and improve coverage and medical care for recipients significantly.

Network Adequacy
In the preamble to the proposed rule, HHS seeks comment on whether to expand the network adequacy display requirements for the federal marketplace. The current federal marketplace network adequacy display features will be tested on Healthcare.Gov via a pilot program that will occur during the upcoming 2017 open-enrollment season. Given that the pilot program has yet to occur, NAHU recommends that HHS spend the 2017 plan year deliberately gathering data about the pilot and release data on the results prior to the start of the 2018 open-enrollment season rather than just jumping to expanded display options in 2018 without the benefit of supporting data. Based on the results of the 2017 pilot, HHS could still expand the display options for 2018 if necessary, via the 2019 Notice of

Payment Parameters or other regulatory guidance, and then any expansions of the display options will be evidence-based.

Full-Year Participation by QHPs

Section 156.272 of the proposed rule also would require QHPs to commit to the marketplace for a full year in order to preserve network adequacy for consumers. Similarly, NAHU requests that CMS stipulate that issuers who file premium rates with the state that include broker compensation and are ultimately certified as a QHP may not alter the general compensation rate for brokers proposed and approved for the duration of that plan year as a condition of their QHP certification. Such a requirement should not preclude an issuer from suspending broker compensation in the case of individual broker proved misconduct, but should prevent an issuer from altering a commission structure included in filed and approved rates for all brokers or a set grouping of brokers (such as appointed brokers) in the midst of the plan year.

During the past year, issuers in multiple states implemented mid-year commission changes for the individual market even though rates filed for these products included commissions and the premiums for such policies were not being correspondingly reduced. NAHU is very concerned about the impact this practice will have on consumers and believes that it is within CMS's authority to address it with issuers on several fronts. While CMS has been clear that it does not require or regulate broker compensation for marketplace products, CMS does stipulate that if an issuer provides broker compensation, then the issuer must provide the same level of compensation for all substantially similar QHP products, regardless if they are sold via the exchange marketplace or in the off-exchange marketplace. The reasoning for this requirement is CMS's direct authority to both enforce the ACA's guaranteed-issue requirement and to ensure stability in the exchange marketplace. If the compensation environment is not kept level for substantially similar products both on- or off-exchange, then the guaranteed-issue provisions of the law are undermined as individuals might not have access to all products through their brokers and people may be unknowingly directed to one market or another, creating an unlevel market playing field and consumer harm.

The same threats to the ACA's guaranteed-issue requirements and market-stability protections apply to a mid-year commission policy change by an issuer. If an issuer provides brokers with one commission rate during open enrollment then reduces rates for the remainder of the plan year during the special enrollment period, an individual's access to coverage and exposure to all channels of consumer assistance will be diminished. This is especially true of a commission change that impacts the SEP since consumers with SEP rights often need the most help taking advantage of their special status. Furthermore, by reducing their rate to a noncompetitive level midway through the plan year, an issuer may be able to inappropriately shift risk to other issuers in the marketplace, causing instability for all. If an issuer reduces its commission rate to zero after the open-enrollment process ends, then the issuer can unfairly shift almost all of its potential SEP risk, and certainly all broker-driven risk, to other issuers.

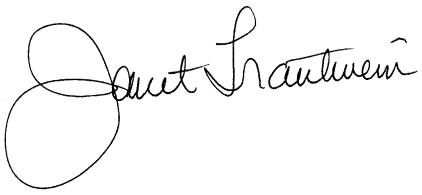
NAHU believes that CMS has the responsibility and authority through the QHP-certification processes to ensure that issuers maintain the services that they promise via filed and approved rates throughout the plan year. Much like CMS plans to stipulate in the new §156.272 that issuers may not leave the marketplace mid-plan year, we believe it would be appropriate to stipulate that the services promised as part of approved rates, including access to the purchasing services and plan year and renewal consumer support offered by a licensed health Finsurance agent or broker, not be eliminated partway through a given plan year. Otherwise, consumer services that are

promised as part of the approved rates of the policy may be reduced, and the consumer would see no corresponding premium reduction.

Medical Loss Ratio Calculation
NAHU supports the provision in §158.121 to allow issuers who are newly entering health insurance markets greater MLR calculation flexibility by allowing them to exclude new 12-month policies from the calculation until they have more than one year of claims experience to evaluate and report on, provided that such new policies represent at least 50 percent of the issuer's total earned premiums for the year. NAHU also supports the plan described in §158.232 and §158.240 to mitigate the detrimental impact the three-year claims averaging rule for MLR rebates can have on newer and small plans. We agree that providing flexibility to HHS to put a cap on rebate liability for no more than the last year of experience when that amount is less, provided that the issuer agrees and meets specified reporting conditions would be helpful to the fully-insured marketplace. NAHU has long expressed concern that strict MLR rules could inhibit the number of insurers willing to write health insurance in the individual and small-group markets, or both, which will leave consumers underserved, reduce competition and cause countless insured individuals to lose coverage. By providing greater rule flexibility for new market entrants and smaller plans, hopefully HHS's action will encourage greater small-group and individual-market competition, positively impacting consumers, issuers and the marketplaces.

NAHU is grateful for the opportunity to provide comments on the proposed rule. If you have any questions or need additional information, please do not hesitate to contact me at either (202) 595-0787 or jtrautwein@nahu.org.

Sincerely,



Janet Stokes Trautwein
Executive Vice President and CEO
National Association of Health Underwriters