Atlantic Corporate Center
2317 Route 34, Suite 2B
Manasquan, NJ 08736
732-201-4133
CHIEF EXECUTIVE OFFICER: Thomas B. Considine

January 17, 2017

The Honorable Orrin Hatch
Chair
Senate Finance Committee
104 Hart Office Building
Washington, D.C., 20510

The Honorable Ron Wyden
Ranking Member
Senate Finance Committee
221 Dirksen Senate Office Bldg.
Washington, DC 20510

The Honorable Lamar Alexander
Chair
Senate Health, Education, Labor
& Pensions Committee
455 Dirksen Senate Office Building
Washington, D.C. 20510

The Honorable Patty Murray
Ranking Member
Senate Health, Education, Labor
& Pensions Committee
154 Russell Senate Office Building
Washington, DC 20510

Dear Chairman Hatch, Chairman Alexander, Ranking Member Wyden, and Ranking Member Murray:

On behalf of the National Conference of Insurance Legislators (NCOIL), I write to you expressing NCOIL's commitment to working with Congress in the months to come when considering changes to the Affordable Care Act (ACA).

NCOIL is a legislative organization comprised principally of legislators serving on State insurance and financial institutions committees around the nation. NCOIL writes Model Laws in insurance, works to both preserve the State jurisdiction over insurance as established by the McCarran-Ferguson Act seventy years ago and to serve as an educational forum for public policy makers and interested parties. Founded in 1969, NCOIL works to assert the prerogative of legislators in making state policy when it comes to insurance and educate state legislators on current and perennial insurance issues.

As you know, State legislators played a vital role in the development and implementation of the ACA. Since that time, State legislators have been in the unique and important position to have seen what aspects of the ACA worked, and what aspects did not. It is therefore critical that Congress communicate with NCOIL when considering any legislative actions surrounding the ACA in order to ensure that such actions recognize the

uniqueness of health insurance and healthcare from State-to-State. State legislators are willing and able to inform Congress of the specific needs of their States' individual markets – markets which vary in local and regional aspects. NCOIL is committed to working with Congress and all other interested parties to deliberately and thoughtfully take a bi-partisan approach towards improving the overall U.S. healthcare system.

Enclosed you will find two (2) letters I wrote to the U.S. Department of Health and Human Services (HHS) when I was Commissioner of the New Jersey Department of Banking and Insurance that dealt with certain issues surrounding the ACA. It is important to note that I wrote those letters in my individual capacity as a State Insurance Commissioner rather than as a member of the National Association of Insurance Commissioners (NAIC) because of the time it would have taken for the NAIC to coalesce around a position concerning those issues. NCOIL, on the other hand, can provide effective and important feedback in an efficient manner on critical issues such as the future of the ACA.

Accordingly, I invite Congress to have frequent and robust discussions with NCOIL as we are an accomplished group of bi-partisan, solutions-oriented legislators from around the country who are ready to help Congress face the difficult tasks before it.

With appreciation for your consideration and kind regards, I am,

Very truly yours,

Thomas B. Considine

CC:

The Honorable Mitch McConnell
Majority Leader
United States Senate
317 Russell Senate Office Building
Washington D.C. 20510

The Honorable Chuck Schumer
Minority Leader
United States Senate
322 Hart Senate Office Building
Washington D.C. 20510

The Honorable John Cornyn
Majority Whip
United States Senate
517 Hart Senate Office Building
Washington D.C. 20510

The Honorable Dick Durbin
Minority Whip
United States Senate
711 Hart Senate Office Building
Washington D.C. 20510

State of New Jersey
DEPARTMENT OF BANKING AND INSURANCE
OFFICE OF THE COMMISSIONER
PO BOX 325
TRENTON, NJ 08625-0325
TEL (609) 292-7272

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

THOMAS B. CONSIDINE
Commissioner

July 15, 2010

Office of Consumer Information and Insurance Oversight
Department of Health and Human Services
Attention: OCIIO-9991-IFC
PO Box 8016
Baltimore, MD 21244-1850

In re: Interim Final Rules for Group Health plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act (PPACA)

To Whom It May Concern:

Throughout the health care reform debate and to the present day, American citizens and businesses have been reassured that if they like their health insurance they can keep it. Choice has long been a cornerstone of America's insurance industry, with great diversity in levels of coverage and corresponding premiums available. Mandating specific coverage levels removes that choice, requiring the premium-payer to forego options desirable to them in favor of coverage levels selected by government.

The promise to Americans to be able to keep their coverage was substantially undercut by the statute, which already provided they could not keep their current waiting periods, lifetime and some annual limits, or dependent limiting age – they had to pay for the coverage elected by Congress. Rather than protecting employers' rights to keep their existing coverage, the subject rules put to final rest any hope of keeping it. Even with the expansions compelled by the law described above, the Interim Rules 'let' employers keep their current coverage only if they:

- Don't make any reductions of benefits or increases to cost-sharing to offset the added expenses required by the law;
- Don't shop for another insurer willing to write the same plan for a lower premium;
- Provide employees with a notice disparaging their coverage;
- Don't terminate a different, more expensive plan; and
- Jump through administrative hoops to prove plan terms in existence on March 23.

None of this is necessary, and none of this is consistent with the spirit of the promise. Employers have a right to expect maximum flexibility and administrative simplicity in keeping their current plans.

As the Department notes in the preamble, many plan sponsors make changes to the terms of their plans on an annual basis. Change can also occur organically. Some of the structural changes include shopping for new administrators or insurers, and adjustments to cost-sharing and contributions to maintain economic viability. Organic changes include changes in the medical delivery system that result in different formulary configurations and medical necessity determinations, and changes in networks as health care providers join and terminate. The ability for employers to keep their plans should include keeping that ability to continue to react to the changing market dynamics, rather than an obligation to cast in stone the detail that existed on the day the President signed the law. Instead, the Department's own analysis estimates that just continuing to make these changes would compel between 50 and 80 percent of small employers to lose grandfather status under these rules by 2013.

The Constitution guarantees all Americans the right to free speech, and this includes the right not to be compelled to broadcast positions with which they disagree[1]. Employers who want to maintain their existing coverage do not believe that "Being a grandfathered plan means that your [plan or policy] may not include certain consumer protections of the Affordable Care Act that apply to other plans" as the model notice would compel them to notify their employees. Being a grandfathered plan means no more or less than that their employer has decided to retain the level of coverage that has worked for them rather than the level selected by Congress.

In line with the foregoing general comments, the following are specific comments on the Interim Final Regulations. The citations are to the Treasury regulations, but the same comments apply to the corollary provisions in the DOL and HHS regulations:

54.9815-1251T (a)(1)(ii) – Entering into a new policy with substantially the same benefits as the existing policy should not cause a plan to cease to be grandfathered. Plans should continue to have the ability to shop for less expensive vendors.

54.9815-1251T (a)(2) – Plan sponsors should not be required to provide notice of the grandfathered status to employees in grandfathered plans. By defining grandfathered plans as excluding 'consumer protections that apply to other plans' and inviting questions and complaints, the model notice requirement appears designed to discourage grandfathering by disparaging the plan that the employer has been providing. This will have a chilling effect on employers, that by the estimates of the Departments will add at least $39.6 million in costs.

54.9815-1251T (a)(3) – Plans should not be required to perform recordkeeping above and beyond their existing obligations in order to maintain grandfathered status. Again, by the Departments' own estimates, this adds $32.2 million to the cost of grandfathered plans, further disincenting the exercise of their 'right' under PPACA.

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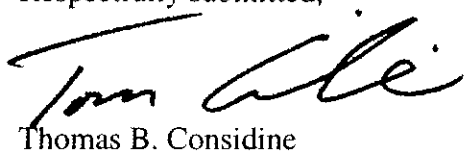
1. See International Dairy Foods Association v. Amestoy (2d Cir., 1996)(striking down Vermont law requiring milk producers to label milk from cows treated with synthetic growth hormones that had no effect on the safety of the milk); Wooley v. Maynard, 430 U.S. 705, 714, 51 L. Ed. 2d 752, 97 S. Ct. 1428 (1977) ("We begin with the proposition that the right of freedom of thought protected by the First Amendment against state action includes both the right to speak freely and the right to refrain from speaking at all.").

54.9815-1251T (b)(2)(ii) – Employers should be permitted to drop plans without causing remaining plans to lose grandfathered status, even if the basis of dropping the plan is cost of coverage. This is a direct denial of their right to keep their existing coverage.

54.9815-1251T (g) – Plan sponsors should be entitled to continue to make changes to cost-sharing amounts and contribution levels without losing grandfathered status.

In summary, the regulations should be recast to support, rather than deny, the rights of employers to keep their existing coverage.

Respectfully submitted,



Thomas B. Considine
Commissioner

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DEPARTMENT OF BANKING AND INSURANCE
OFFICE OF THE COMMISSIONER
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TRENTON, NJ 08625-0325

TEL (609) 292-7272

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

THOMAS B. CONSIDINE
Commissioner

January 31, 2012

The Honorable Kathleen Sebelius
Secretary
US Department of Health and Human Services
200 Independence Avenue, SW
Washington, D.C. 20201

Essential Health Benefits Bulletin

Dear Madam Secretary:

Thank you for the opportunity to comment on the Department's bulletin concerning the determination of Essential Health Benefits (EHBs).

First, we wish to express our support for the practical approach taken by the Department. Allowing states the latitude to select from several options presents a pragmatic approach that recognizes the importance of the local marketplace in shaping what is right for each state, provides a practical solution for handling state mandates, and facilitates a solution consistent with the recommendations of the Institutes of Medicine for beginning with plan designs conscious of cost structure.

The comments made in this letter are intended to further those aims by offering practical solutions to some of the potential adverse effects of the interplay between the approach described in the bulletin and the statutory requirements of the Affordable Care Act (ACA). We believe the ultimate goal must be attaining and maintaining health for all citizens covered under the plans by aligning incentives for patients and providers to seek and deliver high quality, cost-effective care at the right time. Uniformity is desirable when it provides a baseline against which consumers can meaningfully decide among options in their marketplace. Uniformity becomes an obstacle to progress when it forecloses choice and innovation within a market simply for its own sake, preventing states from being the laboratories in which evidence-based approaches to cost-effective care delivery are tested. States, rather than the federal government, should set Essential Health Benefits beyond 2016.

Re-balancing the Benchmarks

One result of the approach proposed in the bulletin is to expand the categories of EHBs

beyond the ten identified in the statute to include *all* services that happen to be covered in the selected benchmark plan. Since EHBs cannot have an annual or lifetime maximum, any such maxima in the benchmark plan must be disregarded even if the service is not included in the ten categories identified in the statute. Ancillary services when provided under a plan are frequently subject to cost-limitations such as annual maxima.

Another result of the proposed approach, as described in the bulletin, is to require that the benchmark plan be expanded to include all ten categories where not already addressed. Taken together, this creates at the outset a plan that is more expensive than the current benchmark plan in two ways, all other things being equal.

In New Jersey, for example, the legislature established a mandate requiring insured health benefits plans to provide coverage toward the purchase of hearing aids for children less than 16 years old. The law states that benefits provided are $1,000 per hearing aid for each hearing-impaired ear every 24 months. The legislature therefore struck a balance between the desirability of financial support for hearing aids and the need to control health insurance costs. The benchmark plans based on New Jersey HMO, small employer and State Health Benefits Plans accordingly include such a benefit.

Removal of such maxima and the addition of services included in the ten categories identified in statute should not be required to be mechanically additive to the benchmark plan, but should come with tools for maintaining the cost-benefit balance anticipated by the original design. Plans based on such a benchmark should have alternatives to annual limits that are no longer permissible. For example, such a plan could be permitted to have cost-sharing that steps up to 100% for services not included in the ten categories that are delivered within a time period. Alternatively, the plan should be able to constrain the reimbursable amount to some benchmark such as Medicare's level of reimbursement. Plans should have latitude to retain the original cost structure by trading changes in dollar caps, visit limits, or plan allowances not included in the benchmark, without regard to whether such design elements are ultimately deemed cost-sharing, as discussed further below.

Covered Services versus Cost-Sharing Features

The bulletin makes a distinction between 'covered services', which are ascertained by the selected benchmark plan, and 'cost-sharing features', to be the subject of future guidance. These terms, however, are not self-defining or exhaustive of all aspects of plan design affecting coverage and reimbursement. For example, 'covered services' could reasonably be defined as the catalog of health care services and supplies to which the plan provides access or reimbursement, and 'cost-sharing' as deductible, copayment or coinsurance. Other aspects of plan design also affect reimbursement. Plans will provide different reimbursement levels based on network status, for example using negotiated rates in network and some benchmark such as Medicare for out-of-network reimbursement, no out-of-network reimbursement for network-only plans, or plans with out-of-network services subject to dollar limits. Plans may also include other limitations such as frequency limits or number of visit limits. Plans may cover services differently when performed in a hospital, doctor's office or ambulatory surgery center, or when provided on an outpatient versus inpatient basis. Pharmaceuticals may be covered differently depending upon whether they are dispensed at a pharmacy, in a provider's office, or in a

facility. These are elements of plan design intended to incent the most cost-effective and/or highest quality access to care.

At the same time, innovations in the marketplace are re-engineering the financing and delivery systems to better align incentives for quality outcomes through things like patent-centered medical homes and accountable care organizations. We believe that for purposes of using a benchmark plan for defining the EHB, only the covered health care services and supplies in the benchmark are relevant, and plans should continue to have the ability to vary coverage levels and alter reimbursement and delivery models. This would include different reimbursement methodologies for out-of-network utilization or based on place of service, different methodologies for determining the plan's payment allowance, different frequency and visit limitations, pre-authorization requirements, and different dollar maxima, as long as the member has a venue for receiving EHBs that are not subject to an annual or lifetime dollar limit. Limitations leaving unreimbursed amounts would of course figure into the actuarial value calculation as appropriate.

Habilitation

As the bulletin notes, the concept of covering habilitative services including maintenance of function is virtually unknown in commercial insurance. A well-crafted plan would provide vital services and devices to people with developmental delays or disabilities or debilitating injuries or illnesses. An ill-defined plan could redirect scarce premium dollars to many services and supplies that do not add value commensurate with the cost.

While parity could provide some ability to control costs, it artificially constrains coverage within parameters really designed for recovering lost function. Habilitative devices, in particular, are not analogous to rehabilitative devices. We would prefer the transitional approach, under which habilitative services and devices would be decided at the plan level. In New Jersey, individual and small employer standard plans are promulgated by Program Boards for the market, and we would anticipate the definition here similarly being defined New Jersey-market wide. Since this is a largely new area for coverage, we believe it requires some level of study and experimentation first at the local level.

Pediatric Oral and Vision Care

The bulletin seeks comments on whether pediatric oral and vision services should be permitted to be set at the plan level. We believe this would be problematic. Families may elect to be covered under an EHB issued by a medical carrier that includes some level of pediatric dental coverage, and by a separate dental carrier that includes comprehensive coverage for the entire family. The required level of pediatric dental coverage should be standardized so that the two plans are seamless in their coverage, with no gaps or redundancies. This would require a level of standardization. The same is true of vision coverage. Unlike habilitative services, coverage of dental and vision care is relatively mature, so the clear demarcation of benefits provides under the medical versus dental or vision plan becomes the more important consideration.

We would also recommend that the rules make it clear that the medical plan need not cover pediatric dental or vision services if the child is covered under a separate dental or vision plan.

The Department proposes in the bulletin that the EHB definition would not include non-medically necessary orthodontic benefits. We would like to confirm that that would apply without regard to whether the benchmark plan includes orthodontia.

The concept of medical necessity with respect to a procedure such as orthodontia is problematic. Most considerations of medical necessity look to the current medical literature and clinical practice guidelines to determine whether a procedure is generally accepted as safe and efficacious for the treatment of the illness or injury complained of. To the extent malocclusion is accepted as an illness or injury, almost all orthodontia would be deemed medically necessary. We would suggest strictly defining the coverage parameters, such as orthodontia medically necessary due to accidental injury to natural teeth or malocclusion resulting in other physical dysfunctions such as temporandibular joint disorder.

Moving Forward

We believe it would be disruptive to the market to reset the benchmark entirely each year based on past year plan popularity. This also has the effect of requiring the number of covered services to continually increase, as all covered services in one year's plan become the minimum EHBs in next year's.

A state with a governing body responsible for establishing minimum standards should have the authority to review the EHBs each year and make changes based on the evolution of the health care delivery and financing marketplaces in that state.

Respectfully submitted,

Thomas B. Considine
Commissioner