BlueCross BlueShield Association

1310 G Street, N.W.
Washington, D.C. 20005
202.626.4800
www.BCBS.com

July 12, 2017

Seema Verma
Administrator
Centers for Medicare and Medicaid Services
7500 Security Blvd.
Baltimore, MD 21244

Submitted via the Federal Regulations Web Portal, www.regulations.gov

RE: RFI on Reducing Regulatory Burdens Imposed by the PPACA and Improving Healthcare Choices to Empower Patients

Dear Administrator Verma:

On behalf of the Blue Cross Blue Shield Association ("BCBSA") and the 36 independent, community-based Blue Cross and Blue Shield Plans across the country, we appreciate the opportunity to comment on the Request for Information (RFI), "Reducing Regulatory Burdens Imposed by the Patient Protection and Affordable Care Act & Improving Healthcare Choices to Empower Patients."

For more than 80 years, Blue Cross and Blue Shield (BCBS) companies have provided secure and stable healthcare coverage to people in communities across the country. Given our experience insuring one in three Americans and our commitment to the local communities we serve, we understand what it takes to make health insurance markets work for consumers.

We believe Americans are best served by a competitive private health insurance market that offers consumers the choices they want at a price they can afford. We appreciate steps that CMS has already taken to reduce burden, improve choice, and stabilize the market, including the finalization of the Market Stabilization Rule. We are encouraged that CMS is soliciting feedback on additional steps needed to stabilize the market and encourage participation.

In response to the four topics for which CMS is requesting information, BCBSA's priority administrative recommendations are as follows:

1. **Stabilizing the individual, small group, and non-traditional health insurance markets.**

   - **Cost-Sharing Reductions:** Provide a clear path forward on how CMS will handle cost-sharing reductions (CSRs) funding for the remainder of 2017 and 2018.

   - **Reinsurance:** Continue to make the entire scheduled $4 billion in reinsurance payments to issuers for 2016.

   - **Individual Mandate:** Continue to enforce the individual mandate until legislative fixes are in place (e.g., adequate funding for high risk individuals, rebalancing tax credits to

make coverage more affordable for younger consumers, and providing strong incentives for individuals to maintain continuous coverage).

- **Risk Adjustment:** Continue to implement planned improvements to risk adjustment without making any changes that would undermine the integrity and accuracy of the program. CMS should preserve the integrity of the risk adjustment program while protecting consumer data and continue to rely on the existing EDGE server for recalibrating the risk adjustment model, rather than creating a national data set. By taking these actions, CMS will help to ensure a sustained effective risk adjustment program with the right incentives to cover everyone, which is necessary for market certainty and stabilization.

- **Third Party Payments:** CMS should not expand the list of entities from which issuers are required to accept third party premium payments and should re-issue the December 2016 Interim Final Rule as a proposed rule and finalize it as soon as possible. The Rule should also be broadened to prevent health care providers, manufacturers or the interest groups and foundations that they support from steering individuals who are eligible for Medicare and Medicaid to private coverage. Such steering may cause harm to consumers if, for example, premiums are not paid all year. To protect consumers and the stability of the market, third party payments should only be permitted if they meet standards that ensure assistance is based on financial need and paid for a full year. While some claim that third party payment programs expand consumer choice when such programs are targeted to increase the profitability of certain providers, they have the opposite effect on the individual market, decreasing choice and affordability.

- **Short-term Limited Duration Coverage:** Maintain the rule that became effective April 1, 2017 that reduced the maximum coverage period of short-term limited duration (STLD) coverage to three months. This rule ensures a level playing field for individual market coverage. Allowing STLD coverage to be sold for up to 364 days would allow individuals to opt out of comprehensive major medical coverage when they are healthy and switch coverage if they have a significant medical need, resulting in adverse selection and higher prices for those in the pool for comprehensive coverage.

- **Medicare Program Integrity:** Ensure individuals that are entitled to or enrolled in Medicare and individuals that are Medicaid eligible do not enroll into QHPs or renew in existing QHP coverage.

2. Empowering patients and promoting consumer choice.

- **Out of Network Requirements:** Eliminate the requirement applying cost-sharing for services by out-of-network (OON) ancillary providers to in-network limits. CMS should act immediately to provide relief and clarity so issuers are not required to invest in complex systems to implement these changes that will later need to undergo costly modifications to align with policy changes.

- **Benefits and Formularies:** Streamline current rules and modify the current benchmark approach to reduce costs and provide more flexibility when designing products to meet the needs of the consumer. For example, pharmacy & therapeutics committees (P&T committees) should be provided more flexibility to set formularies. Additionally, CMS

should consider eliminating federal criteria beyond those required in the benchmark plan such as separate annual visit limits for both rehabilitative and habilitative services.

- **Maximum Out-of-Pocket (MOOP) Limit:** Give issuers more flexibility in designing benefits to guide patients to high-quality/low-cost providers, such as clarifying that in a two-tier or three-tier network design, only cost-sharing for benefits received through the first tier would accumulate to the MOOP. Additionally, CMS should provide flexibility to issuers on whether an individual MOOP applies to each person enrolled under a family plan (i.e., embedded MOOP).

- **Mental Health Parity:** Provide issuers with greater flexibility in implementing mental health parity requirements to improve the value and safety of behavioral health care. Current testing requirements for quantitative limits should be streamlined. Also, issuers should have more flexibility to improve behavioral healthcare than what the current mental health parity rules provide. In particular, the broad application of parity to "non-quantitative treatment limitations" restricts an issuer's ability to use care management tools that differ for mental health or substance abuse services.

3. Enhancing affordability.

- **Streamline reporting and notice requirements:** CMS should remove reporting and notice requirements if they duplicate existing practices or if it is unclear whether consumers benefit from the information. For example, CMS should remove duplicative data collection requirements for consumers that issuers already make available (i.e. requiring the submission of provider directory and formulary information for the development of Healthcare.gov and third party lookup tools). Also, CMS should provide a good faith compliance safe harbor for issuers that produce summary of benefits and coverage documents (SBCs) including non-enforcement on page limitations. In addition, the volume of notices and taglines issuers send to consumers under Section 1557 should be reduced. Finally, CMS should remove the new information displayed on healthcare.gov on network breadth and quality ratings as it is unclear whether such information assists consumer decisions.

4. Affirming the traditional regulatory authority of the states in regulating the business of health insurance.

- **State authority:** States should have authority for rate review, benefit review, provider network adequacy, and certification of health plans on exchanges.

- **Section 1332 waivers:** We appreciate CMS's guidance to states on waiver flexibility and strongly recommend immediate approval of state applications impacting 2018 coverage. Given the uncertainty for 2018 in certain areas, we support CMS working with issuers and state departments of insurance to ensure coverage is available. As CMS considers near and long-term waiver proposals, issuers need to know what the federal funding payments to the state will be for developing products and rates.

In addition to our priority recommendations, we strongly support the work CMS is doing to implement pre-enrollment verification of special enrollment periods (SEPs) and to develop enhanced direct enrollment for advanceable subsidies off-exchange. Also, we strongly support

CMS finalizing the requirements in regulation so small employers have the option to receive tax credits through QHPs and issuers are not required to pay user fees for the FF-SHOP website.

In the attached chart, we provide additional technical recommendations to help achieve CMS's goal to create a more streamlined, flexible, and less burdensome regulatory structure.

* * *

We appreciate your consideration of our comments. If you have any questions, please contact Kris Haltmeyer, Vice President of Legislative and Regulatory Policy, at 202.626.4814.

Sincerely,

Kris Haltmeyer
Vice President, Legislative and Regulatory Policy

BCBSA Detailed Responses to CMS RFI: Reducing Regulatory Burdens Imposed by the PPACA and Improving Healthcare Choices to Empower Patients

Issue	Recommendation
Preserve the private health insurance market and do no harm	
Individual Mandate	**Elimination of the mandate must be coupled with strong continuous coverage incentives and high risk pool funding** to mitigate premium increases. Recommend **deferring any action to eliminate the individual mandate to future legislation to** preserve savings to fund other stabilizers (given that non-enforcement of the mandate through executive order could cause CBO to update their baseline, eliminating funding that could be used for other improvements).
Cost-sharing reductions	**Allow cost-sharing reductions (CSRs) to continue until a replacement is in place and make contracted reimbursement to issuers to avoid disruptions in coverage for millions of Americans**. Because CSRs are built into the plans issuers sell, issuers need to know immediately how CSRs will be treated for the remainder of 2017 and 2018, so they can finalize their 2018 rates. **Permanently recall the December 16, 2016 guidance** on transferring accumulated cost-sharing when an enrollee switches CSR plans during a benefit year.
Reinsurance	**Continue to make the entire scheduled $4 billion** in reinsurance payments to issuers for 2016.
Transitional products	**Extend the policy allowing for non-grandfathered transitional ("grandmothered") products** in the individual and small group markets. During this time of uncertainty, transitional products provide continuity of care and stability for consumers.
Close coverage loopholes that lead to higher costs for consumers	
Special Enrollment Periods (SEPs)	**Require state-based exchanges to verify eligibility for an SEP prior to coverage becoming effective.** • Add language to 45 CFR § 155.420(d) to require both state and federal exchanges to verify SEP eligibility before enrollment. **Amend regulations to ensure birth allows only new dependents to gain coverage. Currently, for example, parents and siblings of a new baby are permitted to enroll during a birth SEP.** • Amend 45 CFR § 155.420(a)(4) and/or 155.420(d)(2) to limit new enrollments to only those dependents gained through birth, adoption, foster care, or court order. **Amend regulations** to reduce the length of SEPs from 60 to 30 days and limit the window for applicants to access SEPs prior to certain life events. • Amend 45 CFR § 155.420(c)(1) to reduce the length of SEPs from 60 to 30 days.

Issue	Recommendation
	• Amend 45 CFR § 155.420(c)(2) so certain individuals would have either 30 days before or 30 days after an SEP triggering event to enroll, at the option of the consumer. Current regulations allow a 120-day SEP for life events including loss of coverage, permanent move, and leaving incarceration. **Amend regulations** to so all consumers are assigned an effective date based on when they enroll to avoid consumers setting an effective date based on incurred medical expenses. • Remove 45 CFR § 155.420(b)(5). **Amend regulations** to reduce the number of SEPs. • Amend 45 CFR § 155.420(d) to reduce the number of triggering events. **Modify regulations** to required qualified individuals to demonstrate that they had minimum essential coverage (MEC) for one or more days during the 60 days preceding a qualifying event for all SEP life events (except for birth, adoption, placement for foster care, release from incarceration, an individual who previously lived outside of the U.S., domestic violence, or individuals wrongly determined ineligible for Medicaid or CHIP). **Modify regulations** to allow issuers the option to apply SEP metal level restrictions off-exchange. Our concern about the misuse of enrollment periods is just as strong off-exchange as it is on-exchange. Issuer verification of SEP eligibility does not prevent consumers from switching metal levels during an SEP. • Amend 45 CFR §147.104(b)(2)(iii) by removing the language, "§155.420(a)(4) of this subchapter does not apply" and replacing it with "issuers may apply §155.420(a)(4) of this subchapter".
Open enrollment	**Issue subregulatory guidance** allowing states to determine how issuers communicate with enrollees during the open enrollment period. Currently, CMS limits open enrollment communications between issuers and their members, adding unnecessary work for CMS and preventing an optimal renewal experience for consumers.
Casework	**Train CMS caseworkers and review HICS cases** to prevent cases from being unnecessarily directed to issuers, thereby reducing processing time and improving the consumer experience.
Third-party payments of premiums and cost sharing	**Expand the framework of the December 2016 interim final rule (IFR)** that prevents steering by dialysis clinics of Medicare and Medicaid beneficiaries to commercial coverage to the broader provider community and reissue as a Notice of Proposed Rulemaking (NPRM). Clarify that issuer acceptance of a payment does not constitute an assurance under the requirements of the IFR framework. Work with issuers to enforce and operationalize new criteria. • *Dialysis Patient Citizens, et al., v. Burwell*, 4:17-cv-16, E.D. Tex., Jan. 25, 2017. Judge issued a preliminary injunction preventing enforcement of the new rule at 89 Fed. Reg. 90211 (Dec. 14, 2016).

Issue	Recommendation
	Amend regulations to provide issuers with the authority to reject third party payments from any entity not listed at 45 CFR § 156.1250, including where premium and cost sharing payments are made directly or indirectly by a financially interested provider. • Do not expand the list at 45 CFR § 156.1250 of required entities from which issuers must accept third party payments. • Clarify that federal rules for rejecting third party payments supersede state guidance.
Ensure persons enrolled in or entitled to Medicare may not enroll in a QHP and also are not eligible for subsidies	**Amend regulations** at 45 CFR §§ 147.106 and 147.104 with respect to Medicare-eligible individuals to limit guaranteed renewability and guaranteed availability to only members who can demonstrate denied eligibility for Medicare under 42 CFR § 406.20, and those eligible for ESRD programs but in a waiting period. **Amend regulations** at 45 CFR § 155.305 to provide explicitly that non-eligibility for Medicare and non-enrollment in Medicare are eligibility requirements for enrollment in a QHP through an exchange.
Medical Tourism	**Amend regulations** to provide an exception to guaranteed issue to individuals that cannot provide proof of permanent residence (to address "medical tourism"). • Amend 45 CFR § 147.104(a) to define "in the state" to mean an individual or employer that provides proof of permanent residence.
Cut back regulations and fees that add costs without value.	
Federal exchange 3.5% user fee	**Amend regulations** to reduce the FFM user fee. • Modify the user fee amount of 3.5% for the federal exchange, as provided in the 2018 Notice of Benefit and Payment Parameters Final Rule. 81 Fed. Reg. 94058, 94138 (Dec. 22, 2016).
Section 1557	**Adopt a non-enforcement policy and modify subregulatory guidance** to reduce the volume of notices and taglines issuers send consumers under Section 1557. • Eliminate Section 1557 FAQs #22, 23, 24, 25, and 26. Release new FAQs indicating that OCR will not enforce regulatory requirements to include notice and taglines in all "significant communications" so long as the covered entity that uses a good faith interpretation in their approach to determining which communications are significant. Further clarify that covered entities that provide the notice and taglines at least two times per year will be deemed to have satisfied regulatory requirements.
	Issue new subregulatory guidance to clarify Section 1557 criteria do not apply to essential health benefits (EHBs), third-party premium payments, and HIPAA-excepted benefits • Issue a FAQ or bulletin clarifying that issuers that follow CMS's third-party premium payment regulations (45 CFR § 156.1250) are not violating

Issue	Recommendation
	Section 1557 and its implementing regulations. • Issue a FAQ or bulletin clarifying that issuers that follow CMS's requirements for offering EHBs (45 CFR §§ 156.115, 156.122, 156.125) are not violating Section 1557 and its implementing regulations. • Do not enforce the Preamble language in the Section 1557 final rule stating that HIPAA-excepted benefits are not exempt from the requirements of Section 1557 of the ACA. 81 Fed. Reg. 31375, 31383 and 31430 (May 18, 2016).
	If the Section 1557 final rule is reopened, amend it to allow issuers to post taglines in the lesser of: a) the top 15 languages spoken by individuals with limited English proficiency of the relevant state or states; or b) all languages spoken by at least 10,000 individuals with limited English proficiency of the relevant State or States. Amend FAQs 1-9 on OCR's website titled "Frequently Asked Questions to Accompany the Estimates of at Least the Top 15 Languages Spoken by Individuals with Limited English Proficiency under Section 1557 of the Affordable Care Act (ACA)."
	If the Section 1557 final rule is reopened, amend it to reduce the scope of requirements so they only apply to the activities of health programs that are minimal essential coverage and not to the entire operations of an entity. • Narrow the scope of the Section 1557 final rule, specifically the applicability section at 45 CFR § 92.2. • Revise the definition of a health program at 45 CFR § 92.4 to remove the following: "For an entity principally engaged in providing or administering health services or health insurance coverage or other health coverage, all of its operations are considered part of the health program or activity, except as specifically set forth otherwise in this part. Such entities include a hospital, health clinic, group health plan, health insurance issuer, physician's practice, community health center, nursing facility, residential or community-based treatment facility, or other similar entity. A health program or activity also includes all of the operations of a State Medicaid program, a Children's Health Insurance Program, and the Basic Health Program." 81 Fed. Reg. 31375 (May 18, 2016). • Maintain the definition of "on the basis of sex" and the provisions of 45 CFR § 92.206, but revise the Preamble of the final rule to indicate that an original denial of services, as the result of a gender-mismatch within a claims processing system, for transgender individuals is not discriminatory. This balances the requirement to avoid discrimination with the technical realities of claims processing systems.
	If the rule is reopened, amend to require administrative exhaustion for all discrimination claims raised under Section 1557 before a private right of action may be taken.
SHOP	**Amend regulations** to clarify that federal and state exchanges are not required to have a SHOP with an on-line enrollment website. Small employers could enroll directly with an issuer without receiving an eligibility determination. If an employer

Issue	Recommendation
	wanted to access the small employer tax credit, they could enroll in a QHP directly with an issuer, apply to the IRS to receive the tax credit like they do today, and document that they enrolled in a QHP. • *See* Flexibilities for State-based SHOP Direct Enrollment FAQs, *available at*: https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/SBM-SHOP-Transitional-Flexibility-FAQ-Rev-5-29-2015.pdf (June 1, 2015). • *See also* precedent for allowing access to the small employer tax credit if an employer enrolls in coverage but not through a SHOP at: ○ Section 45R – Transition Relief with Respect to the Tax Credit for Employee Health Insurance Expenses of Certain Small Employers (Notice 2014-6) https://www.irs.gov/pub/irs-drop/n-14-06.pdf ○ Section 45R – 2015 Guidance with Respect to the Tax Credit for Employee Health Insurance Expenses of Certain Small Employers Notice (2015-08) https://www.irs.gov/pub/irs-drop/n-15-08.pdf
	Preserve the removal of the SHOP tying provision in the final Notice of Benefits and Payment Parameters for 2018. • HHS Notice of Benefit and Payment Parameters for 2018 Final Rule. 81 Fed. Reg. 94058, 94144 (Dec. 22, 2016).
Summary of Benefits and Coverage (SBC)	**Amend regulations to provide a good faith compliance safe harbor** for issuers that produce summary of benefits and coverage documents (SBCs) including non-enforcement on page limitations.
Discontinuation and renewal notices	**Amend regulations and modify subregulatory guidance** to provide states and issuers flexibility in meeting notice requirements. • Amend 45 CFR § 147.106(f)(1) and (2) to remove the requirement that notice be provided "in a form and manner specified by the Secretary." • Modify the subregulatory guidance to remove specific language for notices. *Available at*: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-Updated-Federal-Standard-Renewal-and-Product-Discontinuation-Notices-508.pdf.
Record retention requirements	**Amend regulations** to allow for more reasonable record retention requirements. • Shorten the current requirement at 45 CFR § 156.705 for QHP issuers in the FFM to retain certain records from 10 years to 7 years.
Data display on CMS "Plan Finder Classic" under ACA Section 1103	**Modify subregulatory guidance** so issuers no longer have to submit data to CMS through the Health Insurance Oversight System (HIOS) for the "Plan Finder" website. Instead of using the RBIS templates to populate EDGE reference tables, CMS should utilize existing EDGE Server templates to support data collection

Issue	Recommendation
	necessary for risk adjustment. • Update Q&As for Plan Finder Data Entry, *available at*: https://www.cms.gov/CCIIO/Resources/Files/faq_plan_finder_data_entry.html; *see also* the RBIS User Manual, *available at*: https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/HIOS-RBIS-UserManual-020100.pdf (July 21, 2016).
HIPAA Transaction and Operating Rules Compliance Certification	**Do not finalize** the proposed rule on HIPAA administrative transactions and operating rules, "Certification of Compliance for Health Plans" which would establish a complex and costly process. • Withdraw 79 Fed. Reg. 298 (January 2, 2014).
Health Plan Identifier	**Rescind** September 5, 2012 health plan identifier (HPID) final rule which required issuers to obtain and use the HPID. This recommendation is consistent with the recommendations approved by the NCVHS on June 21, 2017.
Amend insurance market criteria	
Risk adjustment	**Continue to implement** the improvements to risk adjustment (i.e., adjustments for partial year enrollment, incorporating prescription drug data, pooling costs for high-cost enrollees) published in the final 2018 Notice of Benefit and Payment Parameters. These changes are integral to pricing coverage. • See Preamble to the 2018 Notice of Benefit and Payment Parameters Final Rule, 81 Fed. Reg. 94058, 94071-101 (Dec. 22, 2016). **Issue subregulatory guidance** that CMS will not implement the national data set of claims data for the purpose of recalibration of the risk adjustment methodology. • This can be done through subregulatory guidance and would correct the policy set in the Preamble of the 2018 Notice of Benefit and Payment Parameters Final Rule, 81 Fed. Reg. 94058, 94101 (Dec. 22, 2016) (announcing that in 2019, CMS intends to recalibrate the risk adjustment model using masked, enrollee-level EDGE server data from the 2016 benefit year.) **Align reporting dates** so that they are consistent from year to year and so that a comparison of equivalent data can be made. This would provide for a more efficient use of government and issuer resources. **Develop consistent timeframes with advanced notice** of at least 30 days for issuer archiving, testing, and updates that would provide issuers with adequate time to ensure data quality. This includes providing timelines for reference tables and data uploads. **Align CMS system upgrades with blackout periods** (i.e., periods in which data are not being processed) to prevent issuers from losing previously updated data during upgrades.

Issue	Recommendation
	Provide direct points of contact for issuer questions to reduce the burden associated with sending questions and issues to a general mailbox. The current process has resulted in issuers having to re-explain context of problems or errors with data submissions and system upgrades, thereby delaying resolution of questions and/or issues. **Provide needed clarity on business rules** in order to reduce the potential need for additional subregulatory guidance.
Benefit Requirements	**Evaluate the current EHB benchmark approach** and modify if appropriate to reduce the cost of the EHB package.
	Modify language in the Preamble of 80 FR 10749 and related subregulatory guidance to eliminate the requirement that an individual maximum out-of-pocket (MOOP) apply to persons enrolled under a family plan, (i.e., embedded MOOP). • Rescind FAQs about Affordable Care Act Implementation, Part XXVII, Qs 1 and 2, and discussion preceding those FAQs.
	Modify subregulatory guidance related to preventive services that inhibits flexible, cost-effective implementation of required coverage. • Modify FAQs related to preventive services recommended by the US Preventive Services Taskforce (USPSTF) that inhibit flexible, cost-effective implementation of required coverage. • Modify the definition of date of issuance of USPSTF recommendations to create a rational, predictable cycle for implementation (80 FR 41322: e.g., considered to be issued on the last day of the year in which the Task Force publishes the recommendation). • Modify new guidelines for women's preventive services supported by the Health Resources and Services Administration**.** • Modify or complement FAQ V, Q1 to clarify that wider use of value-based insurance designs (VBID) is permissible beyond steering patients to a particular high-value setting.
	Amend the Preamble of 78 FR 12833 and related guidance in order to require that States defray the cost of payment parity requirements in the same manner as benefit mandates.
	Amend regulations to allow combined limits for habilitative and rehabilitative services. (45 CFR 156.115(a)(5))
	Amend regulations and guidance related to formularies to allow more flexibility for issuers for 2018 to control costs. • Remove the requirements in 45 CFR § 156.122 for issuers to submit formulary drug lists.

Issue	Recommendation
	Amend regulations to require states to offset the costs of additional benefit mandates. • Amend 45 CFR §156.110(f) to prohibit states from adding mandates in the guise of defining habilitative benefits.
Marketwide Network Design	**Modify subregulatory guidance** to permit more flexibility in innovative reference-based pricing benefit designs and reduce administrative burden on issuers. • Modify FAQ about Affordable Care Act Implementation Part XIX, Q.4 (reference-based pricing) *available at:* https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-xix.pdf • Withdraw FAQ Part XXVII Q4-5 and reinstate FAQ Part XV, Q2, both *available at:* https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-xxvii.pdf and https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-xv.pdf
Mental Health Parity	**Eliminate FAQ Part 31, Q8, returning to the final regulation that** gives issuers flexibility to use "any reasonable method" in conducting parity testing for financial requirements and quantitative treatment limitations. *Available at:* https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-31.pdf **Amend regulations and guidance** to narrow the regulatory scope of non-quantitative treatment limitation so that issuers have more flexibility to improve the value and safety of behavioral health care. [45 CFR § 146.136(c)(4)]
Rate Review	**Amend regulatory and subregulatory requirements** to lessen the burden on issuers of reporting data on rate review requirements. • Remove requirements at 45 CFR §§ 154.215, 154.220, and 154.230; modify guidance requiring Issuer Posting of Rate Filing Information, *available at*: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Prominent-display-bulletin-final.pdf (Sept. 26, 2016). **Amend regulations and guidance** on disclosing 'unreasonable' rate increases to change threshold trigger to plan level (instead of product level), and relax requirements on states for effective review. • Remove the regulatory requirement that a rate increase is subject to review if any plan within the product meets the review threshold. 45 CFR § 154.200(c). • Remove the requirements for effective rate review states in 45 CFR § 154.310. • Increase the threshold for rate increases subject to review under 45 CFR § 154.200(a)(1) from 10 percent to 30 percent.

Issue	Recommendation
Medical Loss Ratio (MLR)	**Discontinue MLR audits by CMS** or reduce the number of audits and focus on issuers near the MLR threshold. **Amend regulation** to again include employment taxes in the definition of 'tax' for purposes of the MLR calculation. • Amend 45 CFR § 158.221(b) to include employment taxes in the numerator of the MLR calculation.
	Simplify requirements related to MLR. • **Amend regulations** 45 CFR § 158.240(e) to reset the rebate date from 9/30 to 10/31 to allow issuers time to provide premium credits, as opposed to issuing rebate checks. • **Amend regulations** 45 CFR §158.260 to simplify or eliminate the requirements in Part 4 of the MLR reporting form regarding historic rebates. • **Amend regulations** 45 CFR §158.120(d)(5) to allow issuers the option to report student business as part of the individual market to simplify reporting requirements. • **Amend regulations** 45 CFR §158.150 to include activities to include fraud/waste/abuse expenses as permissible quality improvement activities. • **Amend FAQs** to relax requirements to allow broker commissions to be excluded from premiums if the broker is a representative of an employer. For example, a form signed by the employer should be considered adequate documentation.
Geographic rating areas	**Allow issuers to address the specific costs of multiple networks within a geographic rating area.** The current rules require issuers that want to demonstrate the pricing variations specific to each network to either combine the costs within a plan, spreading them across all consumers who buy the plan, or to set up network-specific plans, which is administratively burdensome.
Return regulatory authority to states	
State innovation waivers (Section 1332)	**Amend regulations** to shorten federal review timeframes. Regulatory criteria should streamline the public comment process so there are not separate state and federal requirements. Regulations should also provide for expedited approval of waiver programs that have proven to provide market stability or remove administrative burdens under the ACA (e.g., Alaska's application for funding high-risk individuals). If a state is seeking to implement changes already proven to meet these standards in another state, federal approval should be expedited. • Amend 45 CFR §§ 155.1308 and 155.1316 to shorten the 180-day federal decision-making period to 90 days. • Amend 45 CFR §§ 155.1312 and 155.1316 to streamline processes.

Issue	Recommendation
	• Amend 45 CFR § 155.1308 to allow for expedited approval processes.
Federal requirements on states to establish an exchange	**Amend subregulatory guidance** in the state exchange Blueprint to decrease requirements on states and allow more efficient state exchanges. • Streamline criteria in the state exchange Blueprint. *See* https://www.cms.gov/CCIIO/Resources/Files/Downloads/hie-blueprint-11162012.pdf.
Direct enrollment processes for subsidy eligibility without going to an exchange website	**Accelerate operational design, development, testing and implementation** of the shared eligibility service or other solutions to provide for more flexibility to states, issuers, and web brokers for direct enrollment. • Continue the process of "enhanced direct enrollment," outlined in the 2018 Notice of Benefit and Payment Parameters Final Rule. 81 Fed. Reg. 94058, 94118 (Dec. 22, 2016).
Federal exchange's QHP certification requirements	**Ensure workable requirements for issuers** in the Issuer Agreement for Plan Year 2018 (QHP Agreement) by not expanding on or applying new requirements and standards on issuers. The Agreement should reflect existing criteria developed through a comment and feedback process with issuers with balanced obligations and responsibilities among issuers and CMS.
	Amend regulations to remove harmful effects on issuers' ability to build networks, and to lessen administrative burden • Amend 45 CFR § 156.230 to delete (e) [Out-of-network cost-sharing]
	Amend subregulatory guidance to eliminate the network breadth measure pilot and the display of network breadth data on Healthcare.gov. • Revise the 2018 Final Letter to Issuers in the FFM to remove Chapter 2, Section 3(iv). Note: The Preamble to the 2017 NBPP indicates CMS plans to provide classifications of network breadth, but the language was not codified.
	Issue subregulatory guidance returning authority to states for review of benefit designs and formularies and eliminate federal outlier review. • Amend the 2018 Final Letter to Issuers in the FFM, Chapter 2, Section 10 (benefit design outlier review) and Section 11 (formulary outlier review). • Amend FAQs to remove the use of the FFM drug count tool.
	Amend regulations to eliminate standardized option. • Delete the definition of "standardized option" in 45 CFR § 155.20, and eliminate standardized options and preferential display. Preamble to the 2018 Notice of Benefit and Payment Parameters Final Rule. 81 Fed. Reg. 94058, 94107 (Dec. 22, 2016).

Issue	Recommendation
	Amend regulations and subregulatory guidance to eliminate unnecessary and burdensome transparency in coverage data collections for Sec 2715A of the ACA. Do not implement requirements for issuers off exchange to submit such data. • Amend 45 CFR §§ 155.1040(a) and 156.220, to eliminate data collections. • Revise current subregulatory guidance to delay the requirement for issuers to submit data until a replacement is enacted. ○ ACA Implementation FAQs Set 15 *available at*: https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs15.html (April 29, 2013). ○ ACA Implementation FAQs Set 28, *available at*: https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/ACA-FAQ-Part-XXVIII-transparency-reporting-final-8-11-15.pdf (Aug. 11, 2015). • Continue to delay issuance of rules and guidance related to the requirement for issuers to submit data market wide under Sec. 2715A.
	Amend regulations and modify subregulatory guidance to no longer require issuers to make available to CMS and healthcare.gov display machine-readable data for provider directories and formularies. • Amend 45 CFR § 156.122 to delete (d)(2); amend 45 CFR § 156.230 to delete (c). • Revise the 2018 Final Letter to Issuers in the FFM (Dec. 16, 2016).
	Issue subregulatory guidance to not enforce submission of quality rating system (QRS) information for QHPs, including the enrollee satisfaction survey, as well as the Quality Improvement Strategy (QIS) plan or progress report forms and the patient safety/ hospital quality data. Continued submission is unnecessarily burdensome because the QRS is being piloted in only two states, and CMS has indicated it will be revising the QRS methodology. Further, CMS should not expand the pilot or the display of QRS scoring until it works with issuers to streamline QRS measurement and data submission requirements and make methodological improvements. • 45 CFR part 156, subpart L, and related provisions in the 2018 Final Letter to Issuers in the FFM (Dec. 16, 2016). • Quality Rating System and Qualified Health Plan Enrollee Experience Survey: Technical Guidance for 2017 (Sept. 2016).
	Amend regulations to return oversight and criteria of premium payments, including binder payments, and timing and criteria to issuers. Allow issuers to charge for use of credit card payments, consistent with off-exchange criteria. • Delete regulations at 45 CFR §§ 155.240 and 155.400(e).

Issue	Recommendation
	Amend regulations to no longer require issuers to demonstrate to the exchange that a rescission is appropriate in cases of fraud. Consumers already have termination recourse through appeals processes. • Amend 45 CFR § 155.430(b) to delete (2)(iii).
	Amend regulations to allow for more flexibility for system-specific and narrow network plans which provide affordability, value, and quality. • Amend 45 CFR § 156.235(a)(2)(ii)(B) that requires issuers to have one type of ECP in each county to one type at each service area level. • Amend 45 CFR § 156.235(b) to allow ACOs and other clinically integrated arrangements under the alternate ECP standard for integrated delivery systems, rather than limiting to providers employed by or "single contracting medical group."