

October 5, 2011

Donald M. Berwick, M.D., M.P.P.  
Administrator  
Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attention: CMS-9989-P  
Mail Stop: C4-26-05  
7500 Security Boulevard  
Baltimore, MD 21244-1850

Dear Administrator Berwick:

Please find attached comments from the National Association of Insurance Commissioners (NAIC) on the proposed regulation entitled, "Standards Related to Reinsurance, Risk Corridors and Risk Adjustment" [CMS-9975-P] which was published in the *Federal Register* on Friday, July 15, 2011. By providing these comments on the specifics of the proposed regulation, neither the NAIC nor its individual members are hereby expressing a position on the underlying law.

The NAIC is the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, the District of Columbia, and five U.S. territories. Through the NAIC, state insurance regulators establish standards and best practices, conduct peer review, and coordinate their regulatory oversight. NAIC staff supports these efforts and represents the collective views of state regulators domestically and internationally. NAIC members, together with the central resources of the NAIC, form the national system of state-based insurance regulation in the U.S.

The Affordable Care Act (ACA) requires guaranteed issue with no health underwriting. Carriers may only rate on a limited number of factors, consisting of tobacco use, individual versus family coverage, age, and geographic rating area. These new rules cause concern about the potential influx into the individual market of people with poor morbidity and the uncertain claims levels that might emerge in the early years of implementation of these provisions (2014 – 2016). As a result, many carriers may be tempted to estimate a high claim level in establishing their rates. To address this, the ACA establishes a transitional reinsurance program which assesses individual, small group and large group health plans, including both insured and self-insured plans, to temporarily reimburse a portion of the claims of the individual market, in order to help stabilize that market, allowing insurers to set premiums at levels that will hopefully result in more affordable coverage and adjust pricing over time as actual experience emerges. The federal law also requires the establishment of risk corridors and risk adjustment mechanisms to help stabilize rates and address concerns about adverse selection in the market.

While the ACA calls for HHS, in consultation with states, to establish criteria and methods to be used in carrying out the risk adjustment activities under the ACA, state insurance departments will remain the regulators of insurance company solvency. To the extent that the risk adjustment, risk corridor, and reinsurance processes interact with the solvency responsibilities of states, it is critical that states retain authority to modify these processes to maintain the effectiveness of their solvency oversight. The final rule should, within the constraints of the federal law, preserve the authority of states to address state-specific needs.

As this and other regulations are finalized, state regulators offer their expertise and experience to the Department and we are prepared to answer any questions you may have regarding our comments. We also note that there are some areas where additional information and discussion are necessary and we look forward to a continued dialogue as we work together to implement the provisions of the ACA.


Sincerely,



Susan E. Voss  
NAIC President  
Iowa Insurance Commissioner



Kevin M. McCarty  
NAIC President-Elect  
Florida Insurance Commissioner



James J. Donelon  
NAIC Vice-President  
Louisiana Insurance Commissioner



Adam Hamm  
NAIC Secretary-Treasurer  
North Dakota Insurance Commissioner

## **Subpart B – State Notice of Insurance Benefits and Payment Parameters**

### **Section 153.100 Establishment of State insurance benefits and payment parameters**

#### **From HHS Proposed Rule:**

“We propose that States that plan to modify Federal parameters issue their notice by early March in the calendar year before the effective date. We understand that States may have their own timelines for public notice; this proposed requirement sets an outer bound for the final notice to be issued by a State that intends to utilize any reinsurance or risk adjustment parameters that differ from those specified in the forthcoming annual Federal notice of benefit and payment parameters. We seek comment on whether the proposed timing allows issuers sufficient time to reflect these State requirements in setting rates. In particular, we seek comment as to whether the schedule should be adjusted in the initial year to provide issuers additional time for setting rates for 2014.”

#### **NAIC Response:**

For most individual and small group plans, the carrier generally begins rate work approximately 6 – 8 months before the rate effective date to allow enough lead time for management decisions regarding rate levels, any benefit changes or new product offerings, marketing emphasis, etc., in addition to preparing and submitting filings in states where rates are required to be filed for either review or approval. As such, an outer bound of March in the calendar year before the effective date for issue of notice should provide sufficient time for carriers to reflect reinsurance and risk adjustment parameters in pricing.

It is probably more important for notification of the reinsurance parameters, as those expected costs may be easier to predict than those generated by risk adjustment. Also, reinsurance involves a carrier’s own claims experience on a stand-alone basis, while risk adjustment requires that a carrier knows their enrollee risk relative to other carriers in the market.

Regardless, it will be vital as we move into uncharted insurance territory beginning in 2014 that carriers are operating with as much knowledge as possible with respect to the new market rules and parameters, so early notification of such is certainly preferable. March in the calendar year before the effective date seems to provide reasonable notice of reinsurance and risk adjustment parameters, even in the initial year. We assume that “outer bound” means such date is the latest date for carrier notification.

## **Subpart C – State Standards for the Transitional Reinsurance Program for the Individual Market**

### **Section 153.200 Definitions**

#### **From HHS Proposed Rule:**

“In §153.200, we propose several definitions that are critical to the establishment of a properly functioning transitional reinsurance program. We define an “attachment point” as the threshold dollar amount of costs incurred by a health insurance issuer for payment of essential health benefits provided for an enrolled individual, after which threshold, the costs for covered essential health benefits are eligible for reinsurance payments. The definition of “essential health benefits” will be proposed in future rulemaking. We define “coinsurance rate” as the rate at which the applicable reinsurance entity will reimburse the health insurance issuer for costs incurred to cover essential health benefits after the attachment point and before the reinsurance cap. We define the “reinsurance cap” as the threshold dollar amount for costs incurred by a health insurance issuer for payment of essential health benefits provided for an enrolled individual, after which threshold, the costs for covered essential health benefits are no longer eligible for reinsurance payments. In order to ensure reinsurance payments are made

on a comparable set of benefits, we propose that payments be calculated for costs to cover the essential health benefits package. We solicit comments on alternatives to the use of the essential health benefits package.”

**NAIC Response:**

Reinsurance payments should not be based solely on the essential benefits package because the added complexity to issuers of compiling the necessary data for reimbursement, in particular the coding of extraction queries that would sort out only those claims arising from selected (essential) benefits from each insured’s total paid claims, would be administratively burdensome and the net impact on the payment amounts would not justify the extra expense involved in making that calculation. Therefore, the NAIC proposes that the reinsurance payments be based on total claims payments, without regard to whether the claim is included as part of the essential benefits package.

**Section 153.220 Collection of reinsurance contribution funds.**

**From HHS Proposed Rule:**

“Although the transitional reinsurance program is State-based, §1341(b)(3) sets contribution levels for the program on a national basis. We considered two approaches by which to collect contribution funds: (1) use of a national uniform contribution rate, and (2) use of a State-level allocation, both set by HHS to ensure that the sum of all contribution funds equals the national amounts set forth in statute. In paragraph (b) we propose the first approach to collect contribution funds for amounts listed in paragraph (a)(1) and (a)(2). Use of a national contribution rate is a simpler approach. Further, since there is significant uncertainty about Exchange enrollment, the overall health of the enrolled population, and the cost of care for new enrollees, we believe that a national contribution rate would be the less ambiguous approach of the two. All contribution funds collected by a State establishing a reinsurance program, using the national contribution rate, will stay in that State and be used to make reinsurance payments on valid claims submitted by reinsurance-eligible plans in that State. A State-level allocation would be more complex to administer. We solicit comments regarding whether to use a State-level allocation or a national rate.”

**NAIC Response:**

The NAIC supports the use of a national contribution rate for the reinsurance program. State-specific contribution rates will require all health insurance issuers, including administrators of self-insured plans to allocate the assessment base (premiums or enrollment, for example). This is not something that needs to be done on an issuer-by-issuer basis. Making and verifying the calculation at a state level for each issuer would be expensive to both the issuers and the states and likely would not guarantee either its accuracy or fairness.

By using total premium, premium equivalents, or enrollment statistics, the total contribution, which is fixed in the law, can be allocated to issuers. Similarly, the total contribution can be allocated to states based on state-level premium, premium equivalent, or enrollment statistics that would be reported on a consistent basis state-by-state and sum to the national total. Then, each issuer would be directed to pay a calculated share to each state in which it does business.

The efficiency and equity of this is to remove the concern that the amount paid by issuer A to state N is absolutely accurate. As long as issuer A believes that the total amount paid nationally is a fair and accurate share of its business, it does not really care if the amount it pays to N is too high or too low based upon differing views of how premium or enrollment should be allocated by state. Also, as long as state N feels that the amount it receives is a fair and accurate share of the nationwide total assessment, it should similarly not be concerned with the amounts it is getting from each carrier.

Furthermore, under this system there is no reason why an affiliated group of carriers cannot bundle all payments due to a state, including those attributable to all of the self-funded plans it administers, and make a single payment.

**From HHS Proposed Rule:**

“There are two methods we considered for determining contributions using a national rate: (1) a percent of premium amount applied to all contributing entities, and (2) a flat per capita amount applied to all covered enrollees of contributing entities. In paragraph (b)(1), we propose the percent of premium method as the fairest method by which to collect these contributions, as it allows States that tend to have higher premium and health care costs, and thus reinsurance claims, to collect additional funds towards reinsurance. A flat, per capita amount could represent an excessively high percent of premium for products that are designed and intended to have low premiums targeted toward a population such as young adults and children. HHS will establish the percentage through a forthcoming annual Federal notice of benefit and payment parameters, based on its estimate of total premiums in the fully insured market and medical expenses in the self-insured market. We invite comments regarding the preferred method for calculating health insurance issuer contribution funds using a national rate.”

**NAIC Response:**

Either method of allocation (premium or enrollment) can work. A premium-based assessment is more familiar and fairer, and is not much more difficult to implement, explain, and monitor than an enrollment-based assessment. In either case, the assessment formula will be an approximation and will not generate exactly the projected amount of revenue.

Another consideration is that a per-member assessment would add a disproportionate cost burden on low premium plans.

Section 153.200 defines “percent of premium” as “percent of total revenue, based on earned premiums... in a fully insured market or the percent of total medical expenses in a self-insured market.” In our opinion, this proposed definition is inequitable to health insurers, because it includes administrative expenses in the revenue base for insured health plans but not for self-insured health plans. We suggest using “earned premium equivalents” in place of “total medical expenses” for the self-insured market. This is a familiar and relatively easy calculation for self-insured employers to make, because it is how they evaluate the cost of providing medical benefits to their employees.

**From HHS Proposed Rule:**

“We have also considered the frequency by which applicable reinsurance entities should collect contribution funds from contributing entities. For example, applicable reinsurance entities could collect contribution funds intended for reinsurance payments and payments to the U.S. Treasury on a monthly basis beginning in January 2014 so that reinsurance payments could begin in February 2014. We invite comments on the most appropriate method and frequency to collect reinsurance contribution funds.”

**NAIC Response:**

In general, reinsurance contributions should be collected quarterly, and as early as possible in order to provide cash flow to the reinsurance entity. For example, contributing entities such as insurers, TPAs, and self-insured employers could be required to calculate their anticipated contributions for each quarter of 2014 by October 31, 2013, and report them to the reinsurance entity. Then the payments could be made by January 1, 2014 for the first quarter of 2014. As of January 31, 2014, contributors could re-calculate their anticipated quarterly contributions,

and make their second quarter payment by April 1, 2014. This is an area where national uniformity is important, since many contributing entities operate in a number of different states.

**Section 153.230 Calculation of reinsurance payments.**

**From HHS Proposed Rule:**

“In paragraph (b), we propose to announce the reinsurance payment formula and State-specific values for the attachment point, reinsurance cap, and coinsurance rate in the forthcoming annual Federal notice of benefits and payment parameters. We believe that publishing this information in a Federal notice is the best approach for announcing the attachment point and reinsurance cap as these values may change in years 2015 and 2016. The ACA does not suggest that the three-year reinsurance program should replace commercial reinsurance or internal risk mitigation strategies. There will be a continued need for ongoing commercial reinsurance. Therefore, we propose establishing a reinsurance cap set at the attachment point of traditional reinsurance. We seek comment on this approach.”

“The last option, which we propose to adopt, focuses on all high-cost enrollees without respect to the conditions that caused the increased cost. This approach would be most familiar to health insurance issuers and administratively less burdensome than the first and second options. Data will be immediately available and dependent only on health insurance issuers filing proof of payment for claims. While the third option might mitigate some of the burden and cost concerns, it would not eliminate the timing issues that are critical to effective reinsurance implementation. In 2014, we will be able to collect reliable condition information only for those conditions that are diagnosed during that benefit year. In other words, condition-based reinsurance will not be a predictive model until at least 2015 due to lack of sufficient and timely data. As a result, we found all of the condition-based approaches to eligibility identification to be considerably more burdensome in comparison to the medical cost approach without significant improvement in outcomes from a determination standpoint. We solicit comments for a suitable method for ensuring that issuer costs are appropriate and accurate.”

“In sum, we propose using medical cost experience only to identify eligible enrollees for which health insurance issuers would receive reinsurance. Accordingly, we also propose to use the attachment point approach for determining payment. As described by AAA, an attachment method for calculating reinsurance payments considers costs only for high-risk individuals and may reduce incentives for health insurance issuers to control costs. However, use of a reinsurance cap, as well as the requirement for health insurance issuer coinsurance rate above the attachment point and below the cap, may incentivize health insurance issuers to control costs. We invite comment regarding the best method of determining payments for the reinsurance program, which can relate to either our criteria for selecting eligible enrollees for payment or the method for calculating the payment amounts.”

**NAIC Response:**

For administrative ease and clarity, the NAIC recommends that payments be based on claims paid during the relevant time period. The danger of manipulation of claims payments can be addressed by prompt-payment laws and the use of audits. Condition-based reinsurance, and other similar predictive modeling schemes, may theoretically provide more incentives for claims management and adjudication. However, the short term nature of this program and the quest for certainty among the paying facility and issuer claimants cause us to recommend using real payments.

There are many options that could reassure reinsurance programs that ceding carriers' claims are appropriate and accurate. At the low end of the intensity spectrum are attestations from officers. Programs might also consider insisting on the right to review and audit claim submissions. At the other end of the spectrum are mandatory audits. Intermediate steps might involve reasonability checks where the submission involves reconciliation to the carrier's Supplemental Health Care Exhibit. In this manner, programs could look at ratios of submitted

reinsurance claims as a function of market size and total claims versus the experience of other issuers. Outliers might warrant further review.

HHS proposes that the individual market be subsidized via payment of claims over an attachment point. New York (NY) has operated two mechanisms that use such a threshold/reinsurance corridor payment method for about ten years. The Healthy NY program, which provides basic coverage to lower income enrollees, uses a \$5,000 attachment point and a \$75,000 cap. NY's Direct Payment (individual) market mechanism uses a \$20,000 attachment point and a \$100,000 cap. In both cases, NY subsidizes 90% of calendar year cumulative paid claims within the respective corridors. If valid reimbursement requests exceed a year's appropriated funding, NY prorates payments down. For the individual direct payment fund, appropriated funding has never increased, so, with rising medical costs, payments have been prorated down to available funding for several years. NY attempts to provide carriers with an estimate by mid-year of the next year's proration based on claims to date and prior year trends.

A concern HHS notes with covering claims over an attachment point is that it could reduce incentives for insurance issuers to control costs. A way to address this would be by establishing a lower percentage reimbursement per claim from the transitional reinsurance fund (e.g. less than 90%), with a higher issuer coinsurance rate, giving issuers a greater stake in continued utilization review and cost control (e.g. a 70%/30% split might be considered). However, since HHS will establish the total that each State is to collect and pay out through the transitional reinsurance program, the threshold and cap must be established in consideration of the coinsurance rate so that together they generate approximately the State's prescribed share of the \$10 Billion fund. For example, if a State believed a coinsurance rate of 30% is necessary to promote cost control, the State might set its reinsurance attachment point and threshold at 70% of a \$5,000 - \$120,000 versus 90% of \$20,000 - \$100,000.

At the outset, it is unknown how many will purchase coverage despite the mandate and penalties, nor how quickly enrollment will increase. Thus, it is important to give states latitude to modify the reimbursement variables that were announced the previous March as needed, including allowing for retroactive changes so sufficient funding gets distributed to hold individual market rates down. For example, it might be determined that 80% of claims from \$5,000 - \$120,000 should actually be paid. The goal would be to make such a determination as quickly as possible so as to notify issuers who could reflect the impact in the most immediate next rating cycle.

Since adjustment of the corridor or coinsurance rate would be based on claims experience, it will be important to obtain claims paid data as early as possible. NY requires quarterly preliminary notification of paid claims reports, from which claims paid are projected through year end.

Traditional reinsurance and the transitional "reinsurance" funding mechanism established under ACA have different, separate purposes. The cap on the transitional funding mechanism will influence the choice of attachment point for traditional reinsurance. Traditional reinsurance does not reduce the ceding insurer's average costs over time, but is used to spread the cost of larger individual claims or spikes in aggregate claims in a given period among additional issuer(s) or over a longer period, with an attachment point based on each individual insurer's assessment of how much risk it can sustain. Traditional reinsurance actually adds to overall cost, since a reinsurer will charge sufficient premiums to cover its share of the ceding carrier's claims plus its own overhead and profit.

A further note on the use of the traditional reinsurance attachment point is that, due to the relatively short-tail claim reserves health insurance benefits generate and rating rules that generally allow regular periodic adjustment of rates, many insurers do not rely on traditional reinsurance at all.

Section 153.230 specifies that reinsurance-eligible individuals must be identified retrospectively based on covered medical costs of the individual. As discussed in the preamble, the American Academy of Actuaries identified four

approaches and this was the one selected. We recommend more state flexibility by allowing a state to opt for one of the other approaches if the state determines that a different approach is more appropriate for that state. As an example, the state of Maine recently enacted a reinsurance program that is in many ways similar to the federal transitional reinsurance program [Title 24-A M.R.S.A. Chapter 54-A as enacted by 2011 Public Law Chapter 90]. Maine's program begins July 1, 2012 and will be ongoing. For the three years the federal program is in effect, it would be desirable for the Maine program to serve both purposes rather than creating a separate, duplicative structure. However, under the Maine statute, reinsurance-eligible individuals are to be identified based on a health questionnaire designed by the board of the reinsurance entity. Under the proposed §153.230, some individuals would be eligible for the state program but not the federal program, while others would be eligible for the federal program but not the state program. Therefore we recommend allowing a state to elect an option for identifying reinsurance-eligible individuals other than the default option specified in proposed §153.230.

In §153.230(b)(1), the term "health insurance issuer costs" is ambiguous. We suggest using the term "total medical expenses" instead.

**From HHS Proposed Rule:**

"We propose in §153.230(b)(2) that all payments to the general fund of the U.S. Treasury be made in a manner specified in the forthcoming annual Federal notice of benefits and payment parameters. We have also considered the frequency for which payments should be made to the U.S. Treasury. For example, the applicable reinsurance entities could remit payment on a monthly or quarterly basis commencing February 28, 2014, continuing through January 31, 2017 or until States have remitted the full amount of all payments. We invite comment as to the most appropriate frequency and method for applicable reinsurance entities to remit payment to the U.S. Treasury."

**NAIC Response:**

Reinsurance entities should remit payment to the U.S. Treasury on a quarterly basis, and only for the funds that they have actually received from contributing entities. To the extent that contributing issuers have not contributed the full amount required, states have the authority to take enforcement actions. However, states do not currently have such authority over self-insured employers or the TPAs that are hired by them to administer their employee benefit plans. Therefore, the regulations should include a provision for effective enforcement by federal or state authorities for payments to be made by or on behalf of self-insured employers.

**Section 153.240 Disbursement of reinsurance payments.**

**From HHS Proposed Rule:**

"In paragraph (b)(3), we propose that the State must ensure that an applicable reinsurance entity makes payments as specified in §153.410(b) to the issuer of a reinsurance-eligible plan after receiving a valid claim for payment. We invite comments as to the most appropriate timeframe that an applicable reinsurance entity should make payments for reinsurance claims submitted, particularly, since reinsurance claims may exceed contributions for a given month, but not total projected contributions for the entire year."

"We have also considered deadlines by which a health insurance issuer could submit a claim for a given reinsurance benefit year. For example, Medicare Part D has a requirement for data submission within 6 months after the end of the coverage year, and we believe this is an appropriate standard. We seek comment as to whether the deadline for health insurance issuers for submitting reinsurance claims should be the same or different."

"A standard deadline would allow for an orderly completion of the payment processes that depend upon reinsurance, specifically the risk corridors program and the medical loss ratio (MLR) reporting to support the rebate calculations in §2718 of the PHS Act. Health insurance issuers must know the value of their reinsurance



payments and must report that value to HHS under the risk corridor and MLR reporting provisions. Failure to establish a standard deadline could result in excessive delays in the completion of the rebate calculations under §2718 of the PHS Act. Such delays would in turn delay receipt of rebate payments by the affected enrollees. We invite comment on the use of a standard deadline and the most appropriate deadline considering the interaction of the reinsurance program with risk corridor and the MLR process.”

**NAIC Response:**

Reinsurance facilities need to take care not to disburse available funds too rapidly, as that would reward carriers on a first-come, first-served basis. Instead, to the extent that valid claims for reinsurance payments exceed a State’s funds, all reinsurance claims shall be paid on uniform proportional basis.

The MLR rules allow carriers to establish unpaid claim reserves and consider the same for payment. Coordination with the MLR rule and risk corridor calculations is necessary.

The deadline for health insurance issuers for submitting reinsurance claims should not adversely impact MLR and risk corridor calculations. Timeframes should be no longer than when MLR and risk corridor need to be reported.

States should be given as much flexibility as possible in setting timeframes for reinsurance entities to pay claims due to the unique market circumstances in each state. For example, a state might have existing standards that can stay in place for these payments.

**From HHS Proposed Rule:**

“Finally, in paragraph (c), we propose that for each benefit year, the State maintains all records related to the reinsurance program for 10 years, consistent with requirements for record retention under the False Claims Act. We solicit comments on this record retention requirement.”

**NAIC Response:**

The requirement for a State to maintain records for 10 years for a reinsurance program that will be in existence for only 3 years is unduly burdensome. Health insurance claims are considered claims with relatively short tails. This means that they are paid relatively quickly after they are incurred and they do not typically have a long run off period. Therefore, the records maintained by a health reinsurer will show that reinsurance claims submitted by a health insurer will be final or closed significantly sooner than over a 10 year period. Most, if not all, states have record retention requirements for insurers and insurance agents codified in either state statute or administrative regulation. These typically require insurers and insurance agents to maintain records of their insurance business for a certain period of time substantially less than 10 years. We suggest that the 10 year requirement contained §153.240 (c) be reduced to 5 years.

In addition, the subsection states that it is the State’s responsibility to maintain such records. If the temporary reinsurance entity which is carrying out the reinsurance program dissolves after the program ends, it makes no sense to maintain the entity for a period of 10 years after the program terminates. This would be an undue and costly administrative burden to maintain the reinsurance entity just for the purpose of being the custodian for the records. To that end, in addition to reducing the 10 years to 5, we suggest that the regulation clarify that another State entity such as the State Insurance Department be allowed to maintain the records.

**Section 153.250 Coordination with high-risk pools.**

**From HHS Proposed Rule:**

“In §153.250, we codify the requirement under §1341(d) of the Affordable Care Act that States shall eliminate or modify high risk pools to the extent necessary to carry out the reinsurance program. As stated in the introduction to this subpart, the reinsurance program required under the Affordable Care Act is designed to help mitigate adverse selection risks in the first three years of Exchange operation. In paragraph (a), we codify the above-referenced section. In paragraph (b), we propose to allow a State that continues its high risk pool to coordinate its high risk pool with its reinsurance program to the extent it conforms to the provisions of this subpart. We seek comment regarding whether a high risk pool that continues operation after January 1, 2014 should be considered an individual market plan eligible for reinsurance under this provision.”

**NAIC Response:**

A state wishing to provide continuity of coverage for its high risk pool participants should have flexibility to do so, including the ability to modify its high risk pool funding mechanism to be part of the ACA reinsurance program. Since state high risk pool funding mechanisms vary widely from state to state, states electing to do this should be allowed as much flexibility as possible within the constraints of the federal law.

**Subpart D – State Standards for the Risk Adjustment Program**

**Section 153.310 Risk adjustment administration.**

**From HHS Proposed Rule:**

“In paragraph (c), we propose timeframes for completion of the risk adjustment process. We propose that all payment calculations must commence with the 2014 benefit year. The Affordable Care Act does not explicitly set forth a timeframe by which risk adjustment programs must start. However, we believe risk adjustment must be coordinated with reinsurance and risk corridors to help stabilize the individual and small group markets and ensure the viability of the Exchanges, which begin in 2014. Timely completion of the risk adjustment process is important because risk adjustments affect calculations of both risk corridors and the rebates specified under §2718 of the PHS Act. By law, HHS will be performing the risk corridors calculations for all qualified health plans (QHP) in all States. Therefore, we seek comment on the appropriate deadline by which risk adjustment must be completed. For example, HHS may require that States complete risk adjustment activities by June 30 of the year following the benefit year. This timing assumes at least a three-month lag from items and services furnished in a benefit year and the end of the data collection period. This approach is similar to the Medicare Advantage (Part C) risk adjustment data submission, in which the annual deadline for risk adjustment data submission is 2-months after the end of the 12-month benefit period, but may, at CMS’ discretion, include a 6-month lag time.”

“Since risk adjustment is designed as a budget neutral activity, States would likely need to receive remittances from issuers of low actuarial risk plans before making payments to issuers of high actuarial risk plans. We seek comment on an appropriate timeframe for State commencement of payments.”

**NAIC Response:**

The deadline by which risk adjustment activities must be completed should not adversely impact MLR and risk corridor calculations. Timeframes should be no longer than when MLR and risk corridor need to be reported. Other than that, states should be given as much flexibility as possible in setting timeframes due to the unique market circumstances in each state.

The following is an example of a satisfactory option for a state to set risk adjustment timeframes:

Risk adjustment should require submission of data within two months of the end of the year and completion of calculations and billing before the end of the 2<sup>nd</sup> Quarter. Under the NY Insurance Department's risk adjustment mechanisms, data (demographic, paid claims, and/or weighting factors) is generally due by February 28 of the year following the benefit year being adjusted. This timeframe allows desk audit and basic analytic review of data, along with some follow up with carriers, and billing calculations by May or June, with contributions and disbursements invoiced at that time. Billing by May or early June gives carriers a better estimate of their receivable or liability for use in filing NY's MLR reports required as of June 30. Federal MLR reports have a proposed June 1 filing date, so a slightly earlier billing would be more useful. Carriers could estimate these amounts, but an earlier billing or notices of estimated payments would be more useful.

Detailed audit of data should be done over the next six months, from about May to November. Adjustments resulting from audits of a year's risk adjustment submissions can be invoiced as additional charges or credits in the next year's billing. After the first year, when carriers become familiar with the reporting, adjustments should not be significant.

## **Subpart E – Health Insurance Issuer Standards Related to the Transitional Reinsurance Program**

### **Section 153.400 Reinsurance contribution funds.**

#### **From HHS Proposed Rule:**

“In paragraph (b), we propose that if any State establishes multiple applicable reinsurance entities, the contributing entities must contribute an appropriate payment to each applicable reinsurance entity according to the formula established by the State. We propose in paragraph (c) that contributing entities will be required to provide the data necessary for the applicable reinsurance entity to calculate the amounts due from each contributing entity. The type of data required will depend on the contributing entity. For contributing entities in the individual and fully insured market, we propose that data on enrollment and premiums be required. For contributing entities in the self-insured market, data on covered lives and total medical expenses would be required. This data, for example, could be collected on a monthly or quarterly basis beginning January 2014. We invite comments on the appropriate timing to collect data submissions from contributing entities. We also seek comment on whether there are existing sources of this data that can be drawn upon.”

#### **NAIC Response:**

A completely different set of rules should not be required for determining or collecting reinsurance contributions from self-funded plans. When the self-funded plan registers with or reports to the federal government, it should designate who is responsible for calculating and paying its contributions. Some very large plans may be administered internally and so the plan itself is the contact. In most cases, it will be a Third-Party Administrator (TPA), or an insurer acting as a TPA. The actual designations may vary from state to state. The TPA or insurer will calculate total national contributions for a self-funded plan and will remit to the various states according to whatever allocation formula is used.

If the contribution is premium based, the self-funded plan will need to calculate premium equivalents. If the plan is administered by a carrier, the carrier already calculates premium equivalents for its annual statement in total.

If the contribution is enrollment based, there is no need to calculate premium equivalents.

Section 153.400 (c)(2) requires self-insured plans to submit data to the reinsurance entity for their contributions concerning covered lives and total expenses. States do not have ready access to information from self-insured

plans. While most states regulate stop loss insurance, the extent to which they regulate stop loss insurance varies. In addition, not all self-funded employers purchase stop loss coverage.

It is also important to note that states do not have the authority to enforce requirements on employers that have self-insured health benefit plans for their employees. Consideration needs to be given to the issue of who will enforce the requirements on self-insured plans to participate in the assessment for the temporary reinsurance program. While state insurance departments may have some regulatory authority over insurers and third party administrators in this area, states are preempted by ERISA from asserting any regulatory authority over the employers. We urge HHS, IRS and DOL to determine the regulatory structure and enforcement mechanism, including states' authority, to ensure that self-insured employers participate in the temporary reinsurance program and the other risk adjustment mechanisms contained in the Affordable Care Act.

## **Subpart F – Health Insurance Issuer Standards Related to the Temporary Risk Corridors Program**

### **Section 153.500 Definitions**

#### **From HHS Proposed Rule:**

“In §153.500, we propose a number of definitions for the purpose of administering risk corridors. First, we define “allowable costs” as an amount equal to the total medical costs, which include clinical costs, excluding allowable administrative costs, paid by the QHP issuer in providing benefits covered by the QHP. We define “allowable administrative costs” as total non-medical costs defined in §158.160(b), including costs for the administration and operation of the health insurance issuer. We invite comment on whether we should consider costs for activities that improve health care quality as described in §158.150 and §158.151 for allowable costs to be consistent with the medical loss ratio (MLR) policy in the Affordable Care Act. We also invite comment on whether we should limit administrative costs to 20 percent consistent with MLR. If the allowable administrative costs differ from calculations for the MLR rebate, issuers may be incentivized to use risk corridors payments to pay for their MLR rebates.”

#### **NAIC Response:**

Activities that Improve Health Care Quality: Costs for activities that improve health care quality as described in § 158.150 and § 158.151 should be allowed in the risk corridor calculation, to be consistent with the medical loss ratio (MLR) policy in the Affordable Care Act.

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**NAIC NOTE:** For the following sections we have listed, we will need more program details or time in order to develop an effective response. We look forward to working closely with you in the future on these outstanding issues.

## **Subpart D – State Standards for the Risk Adjustment Program**

### **Section 153.320 Federally-certified risk adjustment methodology.**

### **Section 153.330 State alternate risk adjustment methodologies.**

### **Section 153.340 Data collection under risk adjustment.**

### **Section 153.350 Risk adjustment data validation standards.**

## **Subpart E – Health Insurance Issuer Standards Related to the Transitional Reinsurance Program**

**Section 153.410 Requests for reinsurance payment.**

**Subpart F – Health Insurance Issuer Standards Related to the Temporary Risk Corridors Program**

**Section 153.510 Risk corridor establishment and payment methodology.**

**Subpart G – Health Insurance Issuer Standards Related to the Risk Adjustment Program**

**Section 153.610 Risk adjustment issuer requirements.**

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**NAIC NOTE:** For the following sections we have listed, we will need more program details or time in order to develop an effective response. In light of our statutory directive, we intend to discuss and evaluate with regard to their interaction with and impact on MLR rebate calculations, and to provide a response in the future.

**Subpart F – Health Insurance Issuer Standards Related to the Temporary Risk Corridors Program**

**Section 153.500 Definitions**

**From HHS Proposed Rule:**

“In §153.500, we propose a number of definitions for the purpose of administering risk corridors. ... We also invite comment on whether we should limit administrative costs to 20 percent consistent with MLR. If the allowable administrative costs differ from calculations for the MLR rebate, issuers may be incentivized to use risk corridors payments to pay for their MLR rebates.”

**Section 153.520 Risk corridor standards for QHP issuers**

**From HHS Proposed Rule:**

“Therefore, in paragraph (a)(1), we propose that the reported premium amounts must be increased by the amounts paid to the QHP issuer for risk adjustment and reinsurance. Similarly, we propose in paragraph (a)(2) that the reported premium amounts be reduced for any risk adjustment charges the QHP issuer pays on behalf of the plan, reinsurance contributions that the QHP issuer makes on behalf of the plan, and Exchange user fees that the QHP issuer pays on behalf of the plan. We invite comment on the treatment of reinsurance and risk adjustment as after-the-fact adjustments to premium for purposes of determining risk corridor amounts.”

“In paragraph (a)(3), we propose rules for accounting for reinsurance claims submitted on a date to be determined by HHS for a given reinsurance benefit year. Specifically, we propose that QHP issuers attribute reinsurance payments to risk corridors based on the date on which the valid reinsurance claim was submitted. For example, if the QHP issuer submits a claim on or before the deadline for a benefit year, that QHP issuer would attribute the claim payment to risk corridor calculation for the benefit year in which the costs were accrued. Conversely, if the QHP issuer submits a claim after the deadline for a benefit year, that health QHP would attribute the claim payment to risk corridor calculation for the following benefit year. We invite comments on how the risk corridor calculations would interact with the MLR process.”