



October 31, 2011

Department of Health and Human Services
Center for Medicare and Medicaid Services
Attention CMS-9975-P
P.O. Box 8010
Baltimore, MD 21244-8010

Re: Proposed Rule – Standards Related to Reinsurance, Risk Corridors and Risk Adjustment (CMS -9975-P) – AHIP Comments

Submitted electronically: www.regulations.gov

Dear Sir or Madam:

We write to offer comments in response to the Department of Health and Human Services' ("HHS") proposed rule on Standards Related to Reinsurance, Risk Corridors and Risk Adjustment ("3Rs") ("the proposed rule") published July 15, 2011 in the Federal Register.

We appreciate the opportunity to comment on the proposed rules, recognizing their importance to the overall functioning of health insurance markets beginning in 2014 and the creation of a stable and predictable environment for offering health insurance coverage. The creation of a predictable and stable environment, that adequately recognizes differences in risk among enrollees and seeks to maintain affordable coverage options in order to encourage the development and maintenance of well balanced risk pools in the first instance, is critical to health plans, consumers, employers of all sizes, states and all others with an interest in the availability of health insurance coverage.

Overall Structural Comments

Design Challenges with the 3Rs

The challenge and complexity associated with developing and implementing the 3Rs is well recognized at least among technical experts. While there is experience with risk adjustment in the Medicare and Medicaid programs, implementing risk adjustment in health care reform under the Affordable Care Act (ACA) presents many special challenges that should be given careful consideration as part of the implementation process. These special challenges include:

- the diversity of the under age 65 population affected by health care reform across a range of dimensions, and the significant unknowns associated with this population;

- the need to integrate the various risk mitigation mechanisms described in the proposed rule with each other and with other ACA provisions under highly compressed timeframes;
- the need to tightly integrate all three risk mitigation mechanisms with the premium development process, recognizing that beginning in 2014 premiums will no longer be able to be fully adjusted to reflect actuarially based differences in the cost of providing coverage; and
- the potential for volatility in the post 2014 environment (particularly in the first few years) with respect to the entry and exit of individuals and entities sponsoring coverage, and general uncertainty over the cumulative effect of health care reform provisions on risk pools and underlying medical cost trend.

Encouraging the Right Incentives & Protecting Privacy & Market Competition

Moreover, the 3Rs must accomplish these tasks in a way that supports appropriate incentives with respect to provider behavior and care management, while at the same time seeking to remain as administratively simple as possible.

Data issues are also particularly important, including consideration of alternative, distributed data architectures that simplify burden and at the same time protect sensitive information from the perspectives of consumer privacy and market competition. In particular, our concern for the issues and risks associated with traditional data collection approaches leads us to strongly recommend development of a distributed data architecture to support 3R implementation.

Integrating Across the 3Rs and with Other ACA Provisions

Timing issues are likewise of paramount concern, both in operation and in planning. Operationally, the various 3R mechanisms must be integrated with each other and with other provisions in the ACA such as the Medical Loss Ratio provision, recognizing that the 3Rs will impact a range of ACA provisions that are dependent on calculations of aggregate or earned premiums. Given tight timelines and complexity, flexibility will be important. From a planning perspective, the race against the clock has already begun recognizing the need for any risk adjustment model and associated methodology to be made publicly available and reflective of public input and tested in the context of the special challenges outlined above. All this must be accomplished in the context of the premium development process, a complex and time staking process in its own right, where health plans must develop premiums and work with states to file rates across the country in time for coverage offerings to be available for consumers and employers in the reform environment on January 1, 2014.

Taking Account of Adverse Selection Risks – Implementation Outside of the 3Rs

Finally, as discussed in greater detail below, it is important to recognize that while the various 3R mechanisms seek to mitigate the negative effects of adverse selection they do not generally prevent adverse selection from occurring in the first instance. Moreover, risk adjustment (the only permanent mechanism among the 3Rs) aims to normalize or equalize risk between health plans. It does not, however, address adverse selection against the entire market, which has the potential to push up premiums, while covering fewer and fewer people. This underscores the importance of other factors and policies relating to implementation of the 2014 market reforms in ways that encourage the development of well balanced risk pools. Some of these mechanisms – such as the use of open enrollment periods – are addressed to some extent in the exchange proposed rule, but pertain only to exchange coverage. Thus a broader consideration of these issues – both as to their substance and their applicability inside and outside exchanges is critical.

Importance of Transparency & Engagement

Recognizing these challenges, we appreciate that HHS will on a parallel track be pursuing a consultative process to inform at a more technical and specific level the development of the federally-certified risk adjustment methodology, which is to be announced in a Federal Payment Notice to appear in the Federal Register. We appreciate that the recently released “Risk Adjustment White Paper” is part of the process.

More specific and technical comments on the proposed rule follow.

Subpart B – State Notice of Insurance Benefits and Payment Parameters

Establishment of State insurance benefits and payment parameters (§ 153.100)

The proposed rule and preamble lay out a timeline for the issue of the Annual Federal Notice of Benefit and Payment Parameters. They also provide guidance for states concerning the timing of any state notice to the extent a state plans to modify federal parameters for reinsurance or risk adjustment.

The preamble specifically requests comments on whether the proposed timing allows issuers sufficient time to reflect these state requirements in setting rates, and whether the schedule should be adjusted in the initial year to provide additional time for setting rates in 2014.

In general, we believe that more time is necessary. As we understand the schedule, HHS is proposing to publish its final notice in Mid-January (presumably of 2013 following the chart at 41933), with states required to issue their notice by March that year. This would give issuers a

very short space of time with which to react to any proposed state changes – and could be especially challenging to issuers that offer coverage on a multi-state basis depending on the extent of state-level changes. Given that the premium rate development process for commercial coverage generally begins 6 to 8 months prior to the issue of rates, and the additional timing that is likely to be required to complete the rate filing process given the special complexity and challenges for 2014, it is difficult to see how the proposed schedule could be accommodated.

We recommend an approach that ensures details are provided on at least the transitional reinsurance and risk adjustment by late spring/early summer 2012. This recognizes both the complexity issuers will face in determining how to develop premiums for 2014, and the need for the various risk mitigation mechanisms to be taken into account in the development of 2013 rates from a standpoint of encouraging premium stability.

Application of 3Rs to Policies Issued in 2013

One question that does not appear to be addressed in the proposed rule relates to the potential application of the 3Rs to policies that are issued in 2013 and lapse into and come up for renewal in 2014. Underlying this issue is a related question concerning the application of the 2014 adjusted community rating rules to such policies.

Consider, for example, a non-grandfathered policy that is issued on July 1 of 2013 and which would ordinarily not be renewed until July 1 of 2014. The question is whether the new adjusted community rating rules would first be applied to such a policy on July 1 of 2014, or on January 1 of 2014.

We believe this question reflects a complex inter-related set of issues with potential implications for the filing of rates (both substance and timing), premium stability, and time frames for the operation of structured, open enrollment periods both inside and outside an exchange.

Given the inter-related set of questions, complexity and potential implications, we urge HHS to address the issue in a way that allows for appropriate public input as part of any proposal.

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

Definitions & Calculation of Reinsurance Payments (§ 153.200, § 153.230): Tying the Attachment Point and Reinsurance Payments to Costs Incurred for an Individual's Essential Health Benefits

The proposed rule defines the “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. Likewise, § 153.230 (Calculation of reinsurance payments) provides that “States must ensure that the reinsurance payment represents the product of the coinsurance rate times all health insurance issuer costs for an individual’s essential health benefits . . . which the health insurance issuer incurs between the attachment point and reinsurance cap.”

We recommend that the definition for the attachment point and language related to reinsurance payments be broadened to include, in addition to covered essential health benefits, any covered state required benefit mandates. Broadening the definition and terms in this way recognizes that these mandates will add costs such that not including them as eligible for reinsurance payments would serve to undercut the effect of the reinsurance program. It is also equitable in the sense that it would apply equally to all coverage subject to the state benefit mandates.

To encourage states to properly take into account the costs associated with imposing such mandates, HHS should also make clear that the requirement that states “defray” the cost of any additional benefits required of a qualified health plan (QHP) should be applied to QHPs inside and outside an exchange. The additional costs that states are required to defray should include the increase in reinsurance payments resulting from including state required benefit mandates in the calculation of the attachment point (along with an appropriate allocation of administrative expenses required for an applicable reinsurance entity to operate the program).

Steps should also be taken to limit any additional burden associated with having to maintain a subset of experience relating to costs for essential health benefits and state benefit mandates. While there are ACA provisions suggesting that these type of breakouts may be necessary for other purposes (for example, the ACA states that actuarial value is based on essential health benefits and states, as noted, are required to defray QHP costs for additional benefits), the importance of limiting unnecessary complexity cannot be over-emphasized from an overall systems integrity perspective. Examples for limiting complexity in this area highlight the interconnected nature of various ACA provisions – in this case between the transitional reinsurance and essential benefits provisions.

Clarification on a Basic Point with Respect to Reinsurance Payments

Finally, we encourage clarification on a basic point with respect to any reinsurance payments. Our assumption is that eligibility for reinsurance payments is based on the issuer’s total costs for an individual, as opposed to an approach that would evaluate on a “claim by claim” (or encounter by encounter) basis whether costs for that particular claim or encounter exceeded the attachment point. Such a claim by claim type approach would have significant unintended consequences, particularly as it concerns individuals who may suffer from multiple chronic conditions, but where the costs of any one claim or encounter may not exceed the attachment point.

Thus, a claim by claim type approach would direct relatively more reinsurance dollars to otherwise healthy individuals with a single acute event, while directing relatively fewer reinsurance dollars to individuals with chronic conditions and predictably high costs. It would also make the definition of what constitutes a single “claim” or encounter critical. Given the wide variety of contracting methods and provider billing practices, it is likely that the amount of the reinsurance payment for any particular individual would be significantly affected by the extent to which provider charges were or were not bundled into a single bill.

Because of the complications associated with a claim by claim type approach, and the need for certainty on this point, we believe that a clarification making clear that the relevant measure is total cost for an individual would be helpful.

Calculation of Reinsurance Payments (§ 153.230): Method for Determining Eligibility and Payment Amounts

The proposed rule recommends that the identification of reinsurance-eligible individuals be based on the medical cost to the health insurance issuer for covered benefits, rather than a condition-based approach. The rationale provided for recommending this approach includes operational simplicity and the limited data on this population at the outset.

We understand the rationale for the proposed eligibility-determination and payment structure of the transitional reinsurance program -- recognizing the transitional nature of the reinsurance program and the limited data on this population initially, combined with recommendations outlined in the rule regarding incentives to encourage continued appropriate care management. However, given this cost-based approach, it is important that HHS adopt accommodations for delivery systems that do not use claims as the basis of provider payment to ensure that all health insurance issuers are treated equally as it concerns the operation of the reinsurance program. Disadvantaging plans that contract with providers on a capitated basis (relative to fee-for-service reimbursement) would seem inconsistent with the purpose of the transitional reinsurance program, and broader efforts with respect to payment and delivery system reform.

Collection of Reinsurance Contribution Funds (§ 153.220)

The proposed rule provides that CMS will establish a national contribution rate and requires that states, at a minimum, ensure that all applicable reinsurance entities operating in a state collect the amount set forth by the national rate, and that amounts collected reflect a “percentage of premium” approach.

In general, we agree with the goals of simplicity and clarity articulated for establishing a national contribution rate, and the desire to avoid penalizing lower premium plans in proposing a percentage of premium (as opposed to flat per capita amount approach). However, there are a

number of issues raised that either have not been addressed by the proposed rule or could benefit from further clarification or elaboration.

Need for a Clear Premium Allocation Rule: There is a need for a clear rule or methodology for how premium dollars will be allocated to a particular state. In this regard, while a large employer may be incorporated or domiciled in a particular state, or may issue all contracts for coverage from a single situs, its employees may be spread across the country. For reinsurance purposes, then, a rule that allocates premium dollars based on the residence (or if necessary worksite) for employees might be most appropriate in order to ensure equity across states in the availability of reinsurance dollars and to avoid conflicting collection efforts among states vis-à-vis the same health insurance issuers or TPAs on behalf of self-insured health plans.

Taking Account of the Relative Size of a State's Individual Market: HHS may also wish to consider that some states may have smaller individual markets relative to the size of their group markets; in those states, a national contribution rate will produce proportionately more revenue per individual market enrollee. Other states may have a more balanced risk mix in their individual market, resulting in a lower frequency of enrollees with catastrophic costs. In either case, a national contribution rate will result in either unused funds or attachment points that are significantly lower than those in other states. It will also place more pressure on group coverage costs than would be necessary to provide the level of reinsurance protection provided in other states. While the advent of the coverage reforms, establishment of exchanges and premium tax credits makes the size of the individual market difficult to predict for 2014 and beyond, there are a range of estimates that HHS could look to in considering this factor.

HHS could develop a target for the reinsurance subsidy per individual market enrollee, or similarly based on each state's share of the individual market, at the same time it develops the national contribution rate (although we recognize that HHS might consider such an approach to have features akin to what it described as a "state-level" allocation option). This target could be used to adjust the contribution rate in those states where less reinsurance funding is likely to be necessary. The result would be to lessen the burden in those states where fewer reinsurance dollars are likely to be necessary, while increasing the availability of reinsurance dollars in states with larger individual markets. Alternatively, any excess funds could be rolled forward to provide transitional reinsurance in the fourth and fifth year of implementation. A final approach would be to have a national contribution rate, but to re-allocate dollars based on the estimated size of the individual market at full reform implementation.

Premium Base for the Contribution: The premium base for collecting contributions for issuers and TPAs on behalf of self-insured plans should reflect the ACA statutory language. In this regard, the ACA provides "the contribution amount for any plan year may be based on the percentage of revenue of each issuer and the *total* costs of providing benefits to enrollees in self-insured plans or on a specified amount per enrollee." (*emphasis added*). We appreciate in this regard the proposed rule discussion indicating that a per enrollee amount might reflect an

excessively high percent of premium for products intended to have low premiums targeted toward certain populations like young adults and children. As indicated, we support the proposed approach of basing contributions on a percentage of premium, although we note that determining the relevant “premium” amounts in the context of self-funded coverage is likely to be complex – but we do not see how this could be done on a per enrollee basis from a technical or equitable perspective.

Additional Funding for Reinsurance Payments (§ 153.230) & Reduction of Payments on a Pro Rata Basis (§ 153.240)

We appreciate that, as discussed in the proposed rule, the intent of the transitional reinsurance program is that the presence of the reinsurance funds (reflecting the formula and parameters proposed and identified funding) will be taken into account in the development of premiums. The fact that the dollars available for reinsurance are finite gives rise to two related issues: a) the possibility that states will seek to collect additional funding for reinsurance payments; or b) that payments will need to be reduced.

Given that collecting additional funding places upward pressure on the costs of coverage in other markets, we are significantly concerned about the prospect of assessments being increased. Rather, we believe that the most appropriate course would be for states to do the best job possible of estimating reinsurance needs and available funds based on the established contribution rates, and to adjust the reinsurance payment parameters in order to balance them on a projected basis. In performing these projections, states should rely on the reinsurance payment parameters (attachment point, coinsurance, cap) established by the federal government, in order to avoid creating situations where a change in these parameters creates additional demand for reinsurance dollars. Having performed these estimates, if during the course of the year reinsurance needs are estimated to be outrunning available funds, the state could increase the coinsurance required of health plans as a means of reducing reinsurance payments on a pro rata basis. Even this approach, however, may not fully address concerns related to the potential advantaging or disadvantaging of certain types of plans that might qualify for reinsurance reimbursement more quickly than others based on e.g., benefit plan design. For this reason, we offer an additional suggestion concerning the potential creation of a “global withhold” as articulated below.

With respect to the raising of additional funds, we recommend a revision of the proposed rule. As the preamble indicates, the relevant statutory provision in the ACA is best understood as a constraint on federal authority, such that “[n]othing in the Affordable Care Act precludes a State from supplementing this program.” (Fed. Reg. at 41935). That said, the statute does limit the collection of additional amounts in that it explicitly states that nothing precludes a state from collecting additional amounts from issuers on a “voluntary basis” – strongly suggesting that affected issuers would have to voluntarily agree to such action. (See Sec 1341(b)(3)(B)).

Consequently, we recommend that the proposed rule be revised to reflect the “voluntary” nature of the statutory language and to require that a state undertake an appropriate formal process in order to collect additional amounts. The formal process should be one that ensures fair consideration of the costs of such measures, ensures transparency in decision making, and involves issuers recognizing the voluntary nature of the ACA statutory language. To the extent a state did take action to increase funding, the rule should make clear that additional contributions would be raised in the same manner as the base contributions (i.e., reflecting on an equitable basis contributions from both fully-insured and self-insured sources).

Tension Between Trying to Provide Reinsurance Reimbursement During the Course of the Year Without Creating a “First-Come, First-Serve System”

The preamble indicates support for the idea of ensuring that reinsurance reimbursement is available during the course of the year from a cash flow perspective, recognizing that the risk adjustment and risk corridor processes are likely to be executed after the end of the year. The tension here is balancing this desire against the reality of a finite resource of reinsurance dollars in order to avoid creating a first-come, first serve system which the preamble also notes HHS wishes to avoid.

As indicated above, one way to address this concern is for states to do the best job possible of estimating reinsurance needs and available funds based on the established contribution rates. If during the course of the year reinsurance needs are estimated to be outrunning available funds, the state could increase the coinsurance required of health plans as a means of reducing reinsurance payments on a pro rata basis. However, also as discussed above, because this approach may not fully address concerns related to the potential advantaging or disadvantaging of certain types of plans that might qualify for reinsurance reimbursement more quickly than others we suggest a further protection. This further protection could ensure states have the flexibility to essentially create a “global withhold” – paying out some portion of the reinsurance during the course of the year and the remainder at the end of the year – with a pro rata reduction in payments made if needs outstrip costs.

Finally, if a health insurance issuer was not made whole in one year, contributions for future years could be used to make such issuers whole. Such an approach would appear consistent with the language of the ACA which expressly allows amounts collected to be used in any of the three calendar years based on the needs of a particular period or reflect experience in a prior period.” We would suggest that consideration be given to rolling forward both unreimbursed reinsurance claims and unused reinsurance funds (as discussed above).

Coordination with high-risk pools (§ 153.25)

Reflecting the ACA, the proposed rule addresses coordination with high risk pools, and provides that a state shall eliminate or modify a state high risk pool to the extent necessary to carry out the

reinsurance program, and provides that states may coordinate the state high risk pool with the reinsurance program.

We support the goal of coordinating with state high risk pools. In this regard, we support an implementation goal focused on encouraging coordination in a way that maximizes the effectiveness of all funds in the system and leverages existing mechanisms and risk pools in order to try and provide as smooth a transition to the 2014 market reforms as is possible.

Building on this goal, we would encourage an effort to coordinate the Pre-Existing Condition Insurance Plan (PCIP) program with the transitional reinsurance program, especially in light of the fact that many PCIPs were integrated into state high risk pools. While that program formally ends in 2014, it is likely based on current projections that funding for that program will not be fully utilized (and the accounting for those funds is already built into the federal budget baseline). Thus, an important aspect of coordination would be to make use of any remaining PCIP funds to help support the transitional reinsurance program and provide for a more stable transition.

Subpart D – State Standards Related to the Risk Adjustment Program

Overview

By design the proposed rule provides few specific technical details concerning the exact operation of the risk adjustment program, expressly leaving these details to other processes such as through development of the forthcoming federal payment notice. We view the recent release of the “Risk Adjustment White Paper” as part of this process.

Recognizing that key information and details on risk adjustment will be coming outside of the proposed rule, we generally limit our comments in this Subpart to key principles with some exceptions.

At its core, the risk adjustment process – in conjunction with the other risk mitigation methods – should strive to provide a predictable system that gives health plans the confidence they need to participate in markets across the country. At the same time, the system should provide for appropriate incentives that align with the goals of payment and delivery system reform.

While there is experience in the Medicare and Medicaid programs in implementing risk adjustment, health care reform under the ACA presents many special challenges that should be given careful consideration as part of the implementation process. In particular, the under age 65 population affected by health care reform is highly diverse across a range of dimensions, and there are significant unknowns associated with this population. The unknowns include: (1) questions regarding the health status of those without coverage today, and their potential needs once covered – with due regard to issues such as “pent up” demand for services; and (2) the

potential for the population of newly covered individuals to reflect “adverse selection” -- meaning that those newly obtaining coverage will disproportionately reflect those with immediate health needs, while others with future, expected needs will delay obtaining coverage. Likewise, there is significant concern that the post 2014 environment (particularly in the first few years) will be volatile with respect to the entry and exit of individuals and entities sponsoring coverage. Such “churning” in coverage as it sometimes called adds additional concern with respect to adverse selection, and the ability of different risk adjustment models and methodologies to accurately reflect risk scores under these conditions given the complex interaction of timing lags with respect to diagnoses and encounter information, and enrollment volatility.

Another important difference from the experience of Medicare and Medicaid, and reflected in the White Paper and to some extent the proposed rule, is the need for the risk adjustment process to be tightly integrated with the process for developing premiums. In other words, the risk adjustment process should address factors that are actuarially significant in terms of actual underlying cost differences between enrollees, but for which premiums will no longer be able to be fully adjusted to reflect these differences. In practice, this will prove complex given that the ACA’s rules on the pricing of coverage (effectively adjusted community rating) will itself require careful, complex implementation and an eye for emerging policy issues.

As reflected in the proposed rule, the incentives any risk adjustment system provides with respect to provider behavior and care management incentives is also an important consideration.

Finally, as discussed above, it is important to keep in mind that while the various 3R mechanisms seek to mitigate the negative effects of adverse selection, they do not generally prevent adverse selection from occurring in the first instance. Moreover, risk adjustment (the only permanent mechanism among the 3Rs) aims to normalize or equalize risk between health plans. It does not, however, address adverse selection against the entire market, which has the potential to push up premiums, while covering fewer and fewer people. This underscores the importance of other factors and policies relating to implementation of the 2014 market reforms in ways that encourage the development of well balanced risk pools. Some of these mechanisms – such as the use of open enrollment periods – are addressed to some extent in the exchange proposed rule, but pertain only to exchange coverage. Thus a broader consideration of these issues – both to the type of possible mechanisms that might be developed particularly at the state level – and their applicability inside and outside exchanges is critical.

Risk Adjustment Administration (§ 153.310)

Interaction Among the 3 Risk Mitigation Methods and Other ACA Provisions

The preamble (*See* 41938) acknowledges the important interaction among the three risk mitigation mechanisms and the Medical Loss Ratio provisions in particular under Section 2718

of the Public Health Services Act. In this regard, the preamble provides “[t]imely completion of the risk adjustment process is important because risk adjustments affect calculations of both risk corridors and rebates specified under section 2718 of the PHS Act.” Building on this point, the preamble asks for comment on the appropriate deadline by which risk adjustment must be completed, and suggests illustratively a date of June 30 of the year following the benefit year.

It is difficult to see how such a timeline, especially during the period 2014 to 2016 where the transitional reinsurance and risk corridor calculations must also be completed, can be well coordinated with the MLR timeframe. The current MLR IFR, effective through 2013, requires the payment of rebates no later than August 1 following the end of the MLR reporting year and submission of a MLR report in most cases to the HHS Secretary by June 1 of the year following the end of the MLR reporting year. Given the complexity associated with completing and integrating the various risk mitigation mechanisms – which has never been done before on this scale and with such variation – we recommend that the timeline for MLR reporting and administration be extended during the 2014 to 2016 period when all three of the risk mitigation mechanisms will be operating.

Federally-Certified Risk Adjustment Methodology: Plan Premiums for Valuing Payments and Charges (§ 153.320)

The preamble discusses two methods for determining the value of payments and charges – multiplying plan average actuarial risk by the state average normalized premiums vs. the specific premiums collected for each plan (*see Preamble* at 41939).

Given that HHS is developing the federally-certified risk adjustment methodology largely on a separate track from the proposed rule, we suggest that HHS not attempt to decide this issue of premium cost basis under the proposed rule. Our concern is that the need for tight integration among decisions is paramount, and we are concerned that locking in on this point through regulation creates risk and the possibility of misalignment given that many other technical details have yet to be established.

As an example of such integration considerations, we highlight the important issue of variation in the pricing of coverage between different benefit levels (i.e., “metal level” tiers). In order to provide for a market that supports coverage across different tiers, it will be important that premiums across tiers be allowed to vary by more than difference in benefit values. Were such variation not allowed then, for example, bronze level coverage would likely become prohibitively expensive, creating even greater challenges with respect to the public policy goal of creating balanced risk pools in the post 2014 reformed market environment. In this regard, premiums should reflect a reasonable assumption of cost differences due to plan selection – not to reflect the relative risks of enrollees in these plans – but to account for other factors such as “induced utilization” that occur when individuals face very low levels of cost sharing with respect to the use of health care services.

The focus of our comment here is both to highlight the importance of this issue in its own right, and at the same time to suggest illustratively that a decision on the issue of actual vs. average premiums is likely to interact with a number of other considerations that have yet to be determined. Thus, it strikes us as premature to decide this issue under the proposed rule.

Similarly, while we agree with the discussion in the preamble that adjustments may be necessary to ensure that payments and charges balance under risk adjustment (i.e., that the system is “budget neutral”), we believe the precise methodology chosen for accomplishing this must be considered in the context of other policy choices. For example, the choice of premium cost basis (as discussed above) and other considerations, such as levels of permitted variation, are likely to have an impact on the expected magnitude of any adjustment in a given year – and the interaction of all these and other factors is likely to be important in choosing an exact methodology.

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

See comments above concerning Subpart C – State Standards for the Transitional Reinsurance Program for the Individual Market.

Subpart F -- Standards Related to the Temporary Risk Corridors Program

Definitions (§ 153.500)

Allowable Administrative Costs

The risk corridor mechanism operates through a ratio reflecting Allowable Costs/Target Amount where the Target Amount means an amount equal to the “total premiums incurred by a QHP, including any premium tax credit under a governmental program, *reduced by the allowable administrative costs of the plan*” (*emphasis added*). In turn, the proposed rule defines *allowable administrative costs* to mean “the total non-medical costs as defined in § 158.160(b) [of the Medical Loss Ratio IFR], including costs for the administration and operation incurred by the plan as set forth in § 158.160(b)(2).”

We recommend that the proposed rule definition of “allowable administrative costs of the plan” be revised to clarify that the concept of return on investment or gain/loss margin is included within this definition. The root of this confusion is with the reference to the MLR IFR definition at § 158.160(b) which addresses “other non-claim costs.” The technical issue is that this section does not address the concept of net gain or loss, but the MLR is generally understood to define “administrative cost” as the residual or proportion of earned premium that is not attributable to incurred claims or activities that improve health care quality, as defined under the IFR. This

understanding is supported by a reading of various CMS “Insurance Standards Bulletins/CCIIO Technical Guidance” documents which reference “profits” as part of “overall administrative expenses.”¹ Moreover, the statutory language of the ACA provides that the risk corridor program “shall be based on the program for regional participating provider organizations under Part D of title XVIII of the Social Security Act” (which we interpret as a reference the Medicare Prescription Drug Part D program). Under the Part D program, the “target amount” under the risk corridor equals the “total amount of payments . . . less the administrative expenses (including return on investment) assumed in the standardized bids.” Return on investment in this context is understood as gain/loss margin.

We also recommend that the proposed rule clarify that the reference to the Medical Loss Ratio IFR is defining the types of expenses included as “Allowable Administrative Costs.” The MLR rule is concerned with a retrospective review of actual plan experience, while the Target Amount reflects a plan’s prospective expectation for benefit costs as reflected in the premiums it sets. We believe this clarification is appropriate, because we understand that the intent of the risk corridor mechanism is to test actual benefit costs against expected benefit costs. The target for expected claim payments should not be adjusted retrospectively because non-benefit expenses were higher or lower than anticipated.

Finally, related to the discussion of allowable administrative costs, the definition of “Target” should properly account for federal and state taxes and licensing and regulatory fees, as well as community benefit expenditures paid by not-for-profit health plans. These amounts are deducted from an issuer’s premiums for MLR purposes and should likewise be deducted from premiums as part of the risk corridor calculation, or equivalently these amounts should be included as part of allowable administrative costs. Not adjusting the Target to reflect these amounts would create inconsistencies between the MLR and risk corridor calculations – which the proposed rule indicates it seeks to avoid.

Allowable Costs

The proposed rule defines “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 recommend that the proposed rule clarify what is intended with respect to the exclusion of allowable administrative costs in the numerator, since the term “total medical” costs would seem to exclude them by definition.

In addition, the preamble invites comment on how *activities that improve health care quality* as described in § 158.150 and § 158.151 of the MLR IFR should be treated.

¹ See *Insurance Standards Bulletin Series (CCIIO Technical Guidance – 2011-002), Questions and Answers Regarding the Medical Loss Ratio Interim Final Rule* (May 13, 2011) Q&A #11; *CCIIO Technical Guidance 2011-004* (July 18, 2011) Q&A #19.

Here, to the extent CMS proceeds to tie the definition of allowable administrative costs to the MLR IFR categories than the term “allowable costs” *should likewise include quality improvement activities (on a projected basis)*.

Operational Order of the Risk Mitigation Mechanisms & Actual vs. Projected Amounts

The proposed rule implies that the various 3R mechanisms need to be completed (with the risk corridor calculation coming last) before MLR calculations can be completed (recognizing the interplay between the 3Rs and earned premium for MLR purposes). At the same time, as indicated, the definition of allowable administrative costs refers back to the MLR IFR. We recommend addressing this point more directly. For example, if (as we believe) the intent is that allowable administrative cost should reflect a projected amount (or actuaries call it “a priced for amount”) that should be specified.

Additionally, as noted above, the rule proposes to link the definition of allowable administrative costs to the § 158.160 of the MLR IFR. (“Other non-claims costs”). To the extent HHS proceeds with this approach, we recommend it clarify that the reference applies with respect to the various *categories* described (subject to our comments above concerning the definition of allowable administrative costs), not as it concerns the actual amounts reported. If the reported amounts are required, it would create a circular definition where amounts reported under the MLR are required for the risk corridor calculations, and where the MLR calculation is dependent on the outcome of the risk corridor calculations.

Building on this point, it should be clarified with respect to each of the *risk corridor* elements whether the definition refers to actual or projected amounts. In this regard, it is very important that there be clarity in exactly what figures are to be used given the importance of these calculations and their submission to the government. Importantly, in this regard, we would expect that allowable claims would reflect actual results, total premium is a projection, and allowable administrative costs is projected.²

Relationship of the Risk Corridor Target to the MLR Thresholds

The preamble to the proposed rule also asks whether it should limit administrative costs under the risk corridor Target to 20 percent consistent with the MLR. The preamble states in this regard, “If the allowable administrative costs differ from the calculations for the MLR rebate, issuers may be incentivized to use risk corridors payments to pay for their MLR rebates.”

² One approach to addressing this might be to make clear that the Target Amount should reflect an expected loss ratio developed on a prospective, projected basis. In other words, the expected loss ratio implied by the filed premiums is equal to the projected benefit payments and quality improvement expenses divided by projected premiums (or, equivalently, premiums less projected non-benefit expenses other than quality improvement costs). This expected loss ratio would be developed prospectively; the target amount would then be equal to total premiums times the expected loss ratio.

We note here that the issue is not whether issuers would be incentivized, but rather whether risk corridor policy on the margins leads to more risk corridor payments to the federal government or rebates under the MLR. Equally, it is important that, whatever the policy, it not result in issuers effectively paying twice – both making a payment under the risk corridors and then potentially paying a rebate under the MLR.

The dynamic seems to be the opposite of what is outlined in the proposed rule. If allowable administrative costs are capped at 20 percent (and if an issuer's pricing because of e.g., natural volatility in year-to-year claims experience required that they price below the 80 percent MLR target on a projected basis), the effect would be to reduce the issuer's ratio of allowable costs to the risk corridor target, potentially increasing payments to the government under the risk corridors. However, these risk corridor payments would then need to be deducted from earned premium under the MLR (in the denominator), to avoid creating a double payment scenario. In this regard, the preamble to the MLR anticipates as much – i.e., that risk corridor payments, similar to risk adjustment and reinsurance payments serve to adjust earned premium in the MLR (upward or downward depending on the direction of the payment). The 3Rs proposed rule likewise needs to reflect this point, and at the appropriate time the MLR rule should be revised to reflect this point in the rule to match the preamble. In the same vein, if the risk corridor rule does not cap allowable administrative costs at 20 percent and if this were to contribute to a higher risk corridor payment made to the issuer, then the amounts of this risk corridor payment would serve to increase earned premium under the MLR IFR.

Level of Aggregation Under the Risk Corridor

The proposed rule does not specify at what level of aggregation calculations are to be made under the risk corridors. We recommend that this should occur at the issuer level, as opposed to the “plan level.” The reason relates to the concept of statistical credibility where, especially given the discontinuous or “cliff like” nature of risk corridor thresholds, it would not be desirable from a standpoint of public policy or actuarial integrity that risk corridor payments (whether made to or from the government) reflect natural and random variations in year-to-year experience. Calculating the risk corridors at a higher level of aggregation increases the number of experience points and in so doing reduces the likelihood that the outcome under the risk corridor in any given year for a particular issuer is due to random statistical variation. Moreover, aggregation at the QHP Issuer level would help to address other issues such as concerns over the treatment of QHPs with partial year experience or where a benefit year cuts across different calendar years. Aggregating at the QHP Issuer level would help to smooth out these complexities.

QHP Issuer Clarification

Under the proposed rule, the risk corridors apply to QHP issuers. This is different from the application of risk adjustment (which applies to all plans offered in the individual and small group markets except for grandfathered plans), or the reinsurance programs which apply to all health insurance issuers of a non-grandfathered individual market plan.

There are two levels of comment here. First, is to suggest a revision to clarify whether the risk corridor applies to all of a QHP Issuer's QHPs or just those offered in an exchange. In this regard, the 3R's preamble provides: "We interpret the risk corridor provision to apply to all QHPs offered in the Exchange" (*Preamble at 41943*). At the same time, the Exchange proposed rule (to which the 3R's proposed rule refers for the definition of "QHP" and "QHP Issuer") provides that the term "qualified health plan only refers to those QHPs that are certified by and offered through an Exchange; however, a QHP issuer is not precluded from offering the certified QHP outside an Exchange."³ From a standpoint of administrative simplicity and because the pricing of QHPs is supposed to be the same whether offered on or off an exchange, it would seem that the risk corridors should apply to all of a QHP Issuer's QHPs (regardless of where offered). To help clear up any ambiguity we recommend that HHS provide illustrative examples with respect to the treatment of a QHP Issuer's QHPs whether offered on or off an exchange.

Second, is to highlight that even if the risk corridors apply to all of a QHP Issuer's QHPs, the fact they do not apply to all issuers (unlike risk adjustment and transitional reinsurance) has the potential to create disparate treatment among different types of health plans, especially taking into account the linkages between the various 3R programs. Our view is that implementation needs to occur in a way that is neutral to whether a plan or issuer is subject to the risk corridor program. In this regard it would be helpful if CMS were to address this issue including an expression of its view of the potential dynamics. However, given that the matter has not been raised in the proposed rule, we would strongly recommend creating a clear comment opportunity before deciding on any proposed policy response to the extent one is considered.

Data Related Issues: Collection, Submission, Alternative Models & Validation (§§ 153.110, 153.340, 153.350, 153.610

Numerous sections and provisions of the proposed rule address issues associated with data and the 3Rs. These sections include:

§ 153.110: State notices and data requirements and data collection frequency for health insurance issuers to receive reinsurance payment.

³ Consistent with this point, the preamble to the exchange proposed rule at 41869, provides that the term "'qualified health plan' denotes a health plan that is certified to be offered through an Exchange as a QHP, while a 'qualified health plan issuer' is an issuer that is subject to the requirements in this proposed rule related to the offering of QHPs through an Exchange."

§ 153.340: Data collection under risk adjustment – laying out a state level approach in which issuers submit raw data sets to state governments, or the entity responsible for administering the risk adjustment process at the state level. The proposed rule specifically recommends this approach over a distributed approach, which the proposed rule characterizes as a model “in which each issuer must reformat its own data to map correctly to the risk adjustment database and then pass self-determined individual risk scores and plan averages to the entity responsible for assessing risk adjustment charges and payments.”

§ 153.350: Risk adjustment data validation standards – establishing that the state or HHS on behalf of the state must validate a statistically valid sample of risk adjustment data from each issuer that offers at least one risk adjustment covered plan in the state.

§ 153.610: Risk adjustment issuer requirements and data submission providing that all issuers that offer risk adjustment covered plans must submit all required risk adjustment data for those risk adjustment covered plans, and states that these data may include but are not limited to:

- Claims and encounter data for items and services rendered;
- Enrollment and demographic information; and
- Prescription drug utilization data.

General Concerns with the Proposed Approach & Recommendation on a Distributed Model

In light of these and other provisions, we are concerned that the proposed rule raises significant issues that could adversely impact market competition and privacy. As such, we strongly urge a reconsideration of the proposal to pursue the “intermediate state-level approach” in which an issuer “submits raw claims data sets to the state government.” Rather, we would recommend further consideration of a distributed model. There are important and successful precedents with such an approach as distributed data models have been used by other agencies, such as the FDA. Moreover, a distributed model could take advantage of developments with respect to “cloud based” computing providing a scalable solution to address many of the privacy and other confidentiality concerns associated with a centralized data warehouse approach.

Thus, while we appreciate the complexity of the task at hand, we have concerns that the approach outlined in the proposed rule does not adequately consider the potential of relying on an alternative, distributed data model vs. the creation of centralized databases (whether at the federal or state level) that would minimize burden and ensure data from numerous issuers can be compared uniformly. In this regard, from a standpoint of public policy, a distributed data architecture alleviates many of the privacy and market competition concerns related to the inadvertent release or improper use of sensitive data, and by its nature would be more resilient to cyber-attack and hacking. We expand on these points below.

Proposed Model for Data Collection Raises Concerns

As alluded to above, the preamble includes a discussion of three possible models for data collection: 1) a centralized approach where raw data is submitted to HHS; 2) an “intermediate state-level approach” where an issuer submits raw data sets to the state government; and 3) a distributed data model where each insurer would maintain its data and respond to queries to the entities responsible for risk adjustment. In the preamble discussion, the first and second models are favored while the distributed data model was eliminated from consideration. For the reasons listed below, we urge HHS to reconsider its approach and to support a distributed data model.

A critical concern is that the rule as proposed raises significant issues that could adversely impact market competition and privacy. The preamble supposes that centralized data bases are justified because of other requirements that states submit claims and encounter data to the federal government to support “Exchange-related functions” that are related to “cost sharing requirements and quality reporting.” The justification offered in the proposed rule, relying in material part on vague references to other ACA provisions, does not adequately consider the ability of a distributed model to better support the 3Rs, and provide an architecture through which broader data needs may be met.

Nor does the justification offered in the proposed rule address or alleviate risks the rule as proposed creates relevant to other laws, such as with respect to the confidentiality and competitively sensitive nature of the information and consumer privacy. Instead, the proposed rule simply suggests that the approach proposed “may raise concerns related to consumer privacy standards.”

Relevant to our concerns here are considerations for the potential inadvertent or improper release under the HIPAA Privacy Rule, Trade Secrets Act, and Freedom of Information Act, as well as additional risks associated with information in the public domain being combined with agency public use files or other disclosures in a way that creates market competition and privacy concerns. Consideration of how a proposal interacts with these laws, and growing attention to concerns related to data collection, is consistent with existing Office of Management and Budget requirements concerning implementation of the Paperwork Reduction Act and recent Executive Orders (such as Executive Order 13563). As such, a distributed model advances a number of key principles, including:

- (a) Treating data carefully and ensuring they are not unnecessarily collected;
- (b) Ensuring Government’s use of data is identified and narrowly tailored to achieve a specifically identified Congressional purpose;

- (c) Avoiding approaches that unnecessarily increase risks relevant to other laws, such as from the standpoint of the confidentiality and competitively sensitive nature of the information, and consumer privacy; and
- (d) Limiting burden associated with data collection requirements and potentially duplicative agency demands.

For these reasons, we recommend that HHS reconsider the distributed data model. We recommend that HHS work with issuers to provide aggregated information in response to specific queries developed by the entity responsible for assessing risk adjustment charges and payments – rather than exposing identifiable raw data on individuals. As noted, such models alleviate many of the concerns related to the inadvertent release or improper use of sensitive data from a standpoint of consumer privacy or market competitiveness and may be more resilient to cyber-attack and hacking given the distributed nature of the architecture. And, there are important and successful precedents with such an approach.

Other State Data Collection Efforts

Our recommendation to support a distributed data model builds on health plan experiences with the development and implementation of all payer claims databases or APCDs. Given the implementation challenges faced to date with APCDs, we strongly recommend eliminating the proposal to permit states with existing APCDs as of January 1, 2013 to request an exception from the minimum standards for data collection.⁴ While we support the goal of leveraging existing state efforts to help mitigate burden for multi-state issuers and an emphasis on data standards (i.e., HIPAA administrative transaction standards), we do not believe APCDs have a role to play in risk adjustment. In this regard, health plans have encountered numerous data challenges in their work with APCDs, relating for example to problems associated with the standardization of data fields (even when HIPAA standards are used), inconsistent data collection methodologies across APDC efforts, inherent limits on integrating data sources through an APCD platform, and instability related to prohibitive and rising vendor costs. Our recommendation to support a distributed data model reflects and is consistent with this experience.

Data Validation

We also urge as part of the development of any *data validation standards*, that consideration be given to how programming in the risk adjustment model could help address known data problems such as where conditions and diagnoses remain but are often not reflected in the current medical record on a consistent basis. Moreover, any approach for assessing whether a

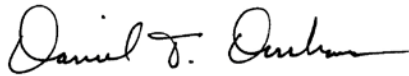
⁴ We also note that this is yet another issue that is addressed and subsumed in our recommendation to proceed with a distributed data model architecture.

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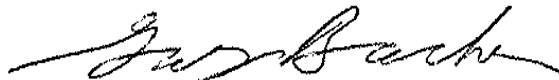
sample of risk adjustment data is statistically valid (whether employed at the federal or state level) should be made transparent, with an opportunity for expert comment. We stand ready to work with you in this regard on an approach for recognizing or developing acceptable methods of data validation that are efficient, practical, statistically reliable, and cost-effective.

We appreciate the opportunity to submit these comments and are available to discuss them and other implementation issues at your request.

Sincerely,



Daniel T. Durham
Executive Vice President
Policy and Regulatory Affairs



Gary Bacher
Senior Vice President