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Comments of
The California Health Benefit Exchange,
The California Health & Human Services Agency
The Managed Risk Medical Insurance Board
The California Department of Insurance &
The California Department of Managed Health Care

CA SUMMARY OF PROPOSED RULES FOR REINSURANCE, RISK CORRIDORS AND RISK ADJUSTMENT (RRR)

45 CFR PART 153
CMS-9975-P
Summary & Comment

Reg Page	Proposed Regulatory Requirement **Note: Page numbers in this column refer to Preamble. Page numbers in column to the left are those of the actual regulations.**	Federal Preamble Comments	California Observations/Comments
			Per our comments on the NPRM for Establishment of Exchanges and

			Qualified Health plans, California believes that premiums charged in the small group and individual market should reflect the value of the benefits and not the just the risk of the consumers enrolled in the product. States should have flexibility to limit the ability of QHP issuers to establish rates for each benefit tier that exceed the difference in the actuarial value of the benefits between each tier. Additionally, per our comments on the NPRM for Establishment of Exchanges and Qualified Health Plans, we stress the importance of having the same market rules apply both inside and outside the Exchange.
41951	**Pg 41932 1)S. 153.10 Basis & scope**		California seeks clarification on whether multi-state and CO-OP plans are subject to the reinsurance requirements. If so, the regulations should articulate this (Board principle 4).
41951	**Pg 41932 2)S. 153.20 Definitions**		

	[Note: Not a comprehensive list] a. "Applicable reinsurance entity"- a not-for- profit organization that carries out the reinsurance program b. "Contributing entity" – any health insurance issuer and, in the case of a self-insured group health plan, the 3rd party administrator of the plan c. "Reinsurance eligible plan" - any health plan offered in the individual market, other than a grandfathered plans d. "Risk adjustment covered plan" - any plan offered in individual or small group markets, other than a grandfathered plan	a. Pg 41934 of the preamble states that DHHS believes state should have discretion to make a number of decisions with in the proposed standards, including the appropriateness of any specific entity as administrator of the reinsurance program	a. CA would have to create such a non-profit entity and is concerned about its ability to do so timely given the many other responsibilities in implementing HCR (Board principle 7)
41951	**Pg 41934 1) S. 153.200 Definitions** [Note: Not a comprehensive list] a. "Attachment point" – the threshold for payment eligibility. It is the cost incurred by an issuer for essential health benefits. When issuer costs for an individual exceed the threshold those costs are eligible for reinsurance payment b. "Reinsurance cap" – A threshold that ends payment eligibility c. "Co-insurance rate" – rate paid to issuer for costs between the two above thresholds. d. "Contribution rate" is the mathematical formulation that constitutes the amount an issuer or TPA (for a self-insured group) will pay	"Essential benefits" will be defined in a future rule. DHHS believes that costs should be tied to those of the essential benefits package to ensure payments are made on a comparable set of benefits. *DHHS solicits comment on alternatives to use of essential benefits package*	a. California supports using essential benefits for determining reinsurance costs, not alternative benefit packages. The Exchange may very well elect the provision of a standardized benefit package that would consist of essential benefits. It would be very difficult to separate out benefit design issues from risk issues if a broader definition were used. (Board principles 3 & 4) d. Self-insured groups should pay

	into the reinsurance program. Of note: issuers pay a percentage of earned premium while self-insured groups pay a percent of medical expenses.		for administrative costs if charges are to be equitable and consistent across all types of coverage. (Board principles 3 & 4)
41952	**Pg 41934 2) S. 153.210 State establishment of a reinsurance program** a. A state operating an exchange MUST establish a reinsurance program from 2014 through 2016 1. It must contract with an existing "applicable reinsurance entity" or establish one 2. If it contracts with more than one, several specified requirements apply 3. The entity may subcontract specific administrative functions 4. States must approve subcontracting arrangements	DHHS will have to create a reinsurance program for fall back states, ii) DHHS will establish the amounts that a state must collect and iii) risk adjustment is discretionary for states.	California would like the federal government to assist in the establishment of a multi-state entity that could operate the reinsurance program. (Board principle 7) California seeks better understanding of the enforcement remedies that will be available when issuers, TPA's or self-insured groups fail to provide required data or fail to pay amounts owed. Will this be a state and/or federal responsibility? Is it possible for the final regulations to specify penalties for non-compliance? California believes that the federal government needs to articulate a regulatory structure and enforcement mechanism to ensure that self-insured employers participate in the temporary reinsurance program and the other risk adjustment mechanisms contained in the Affordable Care Act

	5. The contract with the entity must be of sufficient duration to complete reinsurance activities through 2016 and any activities that must be taken in subsequent periods b. A state can fulfill the requirement via an entity serving multiple states, but its contract must be for its individual purposes c. A state that does not establish an exchange MAY establish a reinsurance program d. For a state that does not operate an exchange and does not elect to administer its own reinsurance program, DHHS will perform the function for the state e. State must ensure that its contracting entity complies with the law and regulations	5) DHHS wants to assure that the contract will cover the period after 2016 when payments for the reinsurance period still have to be made. The time period cannot last beyond 12/31/18 per the ACA.	(Board principle 4) California agrees that it is advisable to use the same contractor for the length of the program, but administering entities should have the option to terminate for cause. (Board principle 2)

41952	**Pg 41935 4) S. 153.230 Calculation of reinsurance payments** a. General requirement**.** Issuer is eligible for payments when an enrollee's expenses for items and services with the essential benefit package exceed the attachment point.	DHHS consulted with the American Academy of Actuaries (AAA) in developing the payment policies. AAA issued an issue paper on the topic that can be found on its website www.actuary.org. The paper identifies four possible approaches to determining who will be covered: 1) enrollees with specific conditions based on claims data; 2) enrollees with specific conditions based on survey data; 3) high risk enrollees using risk adjustment data and a condition based risk adjustment model and 4) enrollees based on medical cost to issuer for covered benefits and two possible approaches on how to calculate payments: a) payments for costs incurred above the attachment point and b) a fixed payment schedule for specific conditions. DHHS chose to use 4) medical cost experience to identify enrollees for who issuers can receive payment with use of an attachment point approach for determining payment.	California supports the NPRM's proposed use of medical cost experience in identifying enrollees for whom payment would be made. (Board principles 3 & 4)

		Itdiscusses its rationale in the preamble. *DHHS invites comment on the best method of determining payments including the most suitable method for ensuring issuer costs are appropriate and accurate.*	
	b. Reinsurance payment. States may use the formula and values promulgated in Federal notice 1) State must ensure that funding collected is adequate to cover costs 2) State must submit funds to the Department of Treasury with the frequency determined by DHSS	b. The program is not intended to replace commercial reinsurance. Therefore DHHS intends to set the attachment point at that of commercial reinsurance. *DHHS seeks comment on this approach. It also seeks comment on the frequency and method for payments to the Department of Treasury.*	
	c. State may modify the formula. Can change attachment point, co-insurance rate, and reinsurance cap. If it does so, must ensure that funding is sufficient for payments and amounts owed to the Department of the Treasury	c. State may choose to modify formula for a variety of reasons including: to increase the benefit level from that established by DHSS; to make adjustments associated with carryovers from prior years; to make payments earlier or later in the medical cost experience; or to vary the annual amounts (without varying the 3 year total).	
41952	**Pg 41936 5) S. 153.240 Disbursement of**		

	reinsurance payments a. State must ensure entity collects data from issuers at the frequency established by the state or federal government b. State must ensure that entity makes payments without exceeding contributions. Payments must be based on the reinsurance payment formula. Payments may be reduced on a pro-rata basis to match contributions received for a given year. State must ensure that payments are made pursuant to requirements and after receipt of a valid claim. State must maintain records for each benefit year for10 years. c. For each benefit year, the State must maintains all records related to the reinsurance program for 10 years, consistent with requirements for record retention under the False Claims Act	b. *DHHS invites comments on 1) the most appropriate time frame for an entity to make payments (noting that claims make exceed contributions in a given month, but not contributions for the year) 2)whether the deadline for issuers to submit claims should be the same as it is under Medicare Part D (6 months after end of coverage year) 3) whether there should be a standard deadline and what it should be given the interaction of this program with the MLR and risk corridor processes, and 4) the record retention requirement.*	(b)California requests that states have as much flexibility as possible in setting timeframes for reinsurance entities to pay claims to address particular market conditions. (Board principle 2) (c) California suggests that the records retention period be no longer than 5 years. California also suggests that the final regulations allow flexibility for states to designate will retain the records. (Board principle 2)
41954	Pg 41942 **S153.400 Reinsurance Contribution Funds.** Issuer or TPA must make payments as required to the applicable reinsurance entity for each state in which it issues health insurance. If a state has more than one reinsurance entity, the issuer/TPA must pay each such entity that covers the area where they issue health insurance. Issuers must provide data on enrollment and premiums. TPA's must provide data on covered lives and total medical expenses. An issuer /TPA must submit to	*DHHS invites comments on* *1) the frequency and manner in which issuers/TPAs' payments should be made* *2) the appropriate timing to collect data , and* *3) whether there are existing sources of data that can be drawn upon.*	California suggests that when a self-funded plan registers with or reports to the federal government, it should designate the entity responsible for calculating and paying its contributions. This will simplify program operations. (Board principles 3 & 4)

	each entity data required to substantiate its contribution amounts		
41953	**Pg 41938 2) S. 153.310 Risk adjustment administration** a) A state that operates an exchange is eligible to establish a risk adjustment program. DHHS will operate a program for a state that does not elect to establish one or for one without its own Exchange. Such states forgo implementation of all state functions described. b) A state operating an Exchange can elect an entity other than the Exchange to perform risk adjustment if it meets the requirements to serve as an Exchange under S.155.110 of the Exchange regulations. These are : 1) an entity incorporated under and subject to the laws of one or more states with experience on a state or regional basis in the individual and small group markets and in benefits coverage that is not an issuer or treated as such as a member of the same controlled group of corporations (under Section 52 (a) or (b) of the Code of 1986, or 2) a state Medicaid agency		(b)(1) It is unclear what entities besides Medi-Cal and the Exchange could operate the risk adjustment program. California suggests that the final regulations specifically authorize the Exchange to contract with other public agencies in addition to the Medicaid department, including state health coverage regulators. (Board principles 2 & 5) California seeks better understanding of the enforcement remedies that will be available when issuers (particularly those not participating in the Exchange) fail to provide required data or fail to pay amounts owed. Will this be a state and/or federal responsibility? Is it

	c) A state (or DHHS) must begin calculating payment and charges with the 2014 benefit year.	c) Risk adjustment must be coordinated with reinsurance and risk corridors. Timely administration is important because risk adjustment affects calculations of both risk corridors and rebates under 2718 of the PHS Act. DHHS is considering a requirement that the deadline for completion be June 30th of the year following the benefit year-an approach similar to that used in Medicare Advantage Part C *DHHS seeks comment on the appropriate deadline by which risk adjustment must be completed*. Risk adjustment must be	possible for the final regulations to include penalties for such non-compliance? (Board principles 3 & 4) California supports an option that would allow a state to rely on federal administration of the risk adjustment program initially but to have the option to assume administration of the program later. By what date would a state be required to inform the federal agencies of such a choice? (Board principles 2 & 7) If the federal government operates the risk adjustment program, who will bear the program's administrative costs? Will the federal government pay those costs? Will health issuers pay the costs through an assessment, and if so, who will collect the assessment from the plans? (Board principle 5) (c) California seeks federal input on how this coordination can best occur given the different entities administering the three programs (Board principles 5 & 7)

		budget neutral. Thus a state would need to receive payments from low risk plans before making payments to high risk plans. *DHHS seeks comment on an appropriate timeframe for commencement of payments*. To ensure that state risk adjustment programs are working properly, DHHS is proposing that states provide DHHS with a summary report of specified elements on risk adjustment activities for each benefit year in the year following the calendar year covered in the report. *DHHS seeks comment on the requirements for the reports including data elements and timing*.	.
41953	**Pg 41937 3) S.153.320 Federally-certified risk adjustment methodology** a) Any risk adjustment methodology must be Federally-certified. One can become certified by one of the following: a method developed by DHHS and promulgated in a federal notice or a method submitted by a state that is certified by DHSS which	DHHS considered a requirement that all states use a methodology developed be DHHS, but elected not to do so because states may have other methods that would achieve the same results. The Federally certified method will	

	the state promulgates in a notice. b) Each methodology must include information specified in this section and promulgated in a notice c) DHHS will promulgate a notice detailing the method it will use in states that do not operate exchanges.	be a comparative standard *b) DHHS seeks comment on* *1) other information that should be included in the notice,* *2) how to account for allowed variation in rating (region, family size, tobacco use) so that the method does not adjust for risk that issuers have been allowed to incorporate in their premium rates.* *DHHS also seeks comment on* *1) possible approaches to achieving the policy goals for risk adjustment, including the implications of approaches for market efficiency, potential incentives created for how issuers set rates and how approaches address allowed rating variation* *2) other approaches to determining average actuarial risk and whether links exist between the actuarial risk methodology and the payments and charges methodology and* *3) the extent of State flexibility*	

		that it should allow in adopting an approach to determine average actuarial risk. The preamble notes that the ACA does not specify a method for states to use to determine the precise value of payments and charges. DHHS has identified two options: 1) multiplying plan average actuarial risk by the state average normalized premiums, and 2) multiplying plan average actuarial risk by the specific premiums collected for each plan. The preamble discusses the additional steps necessary to complete the process. It also cautions that there will likely be inequalities between payments and charges due to premium variance. It details 3 adjustment methods to address this issue. *DHHS requests comment on the methodologies and any alternatives.*	California supports Option 1: multiplication by the state average normalized premiums, an adjustment that is essential. (Board principle 4)
41954	**Pg 14940 5) S. 153.340 Data collection under risk adjustment**	DHHS considered 3 approaches to data collection: a centralized	(a) If state elects not to operate a risk adjustment program, can it

	a) State (or DHHS) must collect risk-related data to determine individual risk scores that form the basis of risk adjustment b) State (or DHHS) must meet minimum standards for data collection, as specified. Individually identifiable permitted only as specifically set forth c) A state with an all payer claims database operational on or before 1/1/13 may request an exception from the minimum standards by submitting specified information d) State (or DHHS) must make data available as follows: 1) Provide DHHS with de-identified claims & encounter data for use in re-calibrating federally certified risk adjustment models 2) Provide DHHS with summarized claims cost for use in verifying risk corridor submissions 3) Provide the reinsurance entity with summarized claims &encounter data from reinsurance eligible plans for payment verification purposes and individual level data from such plans for audit purposes	one under which issuers would submit raw data to DHHS; one in which issuers submit data to the state (or DHHS as appropriate; and) a distributed approach under which an issuer reformats its own data and passes on its self-determined individual risk scores to the entity assessing charges and payments. <u>It chose the second</u> for reasons explained in the preamble. *DHHS seeks comment on* *1) The proposed approach as well as comments on the advantages and disadvantages of alternative approaches;* *2) Its proposed use of risk adjustment data for the purposes set forth in d;* *3) Its proposal to establish national standards for consumer privacy standards & standard submission formats;* *4) The use of data under the selected option (the "intermediate approach")for auditing purposes;* *5) Whether it should rely on existing HIPAA& NCPDP standards for transaction*	nevertheless elect to collect risk-related data and report it to DHHS? (Board principles 2 & 7)

		standards or develop new ones (consulting with stakeholders); *6) Whether to include submission of issuers' rate setting rules in (privacy standards?);* *7) Timelines for notifying states with all payer claims databases of exemption approval.*	
41955	**Pg 41944 2) S. 153.610 Risk adjustment issuer requirements** a) Issuers must submit all required data as directed by state (or DHHS). Data may include claims & encounter, enrollment & demographic and prescription drug utilization**.** b) Issuers may include in their contracts with providers and suppliers requirements for submission of such data. The contracts can also include financial penalties for failure to provide compete, timely, accurate data.	a) *DHHS seeks comment on whether other categories of data should be required, such as rate setting methods, and* *2) Data submission timelines. DHHS is considering proposing the following:* *Claims & encounter data – every 30 days and no later than 180 days following date of service* *Enrollment and demographic information – end of the month following enrollment* *Issuer rate setting rules – end of the month in which they become effective* *Prescription drug utilization data – every 30 days and no later than the end of 90 days following date*	a) California suggests not expanding on the data categories required, at least until the system is up and operation for several years (Board principles 2 & 7)

	c) Issuers that have a net balance after risk adjustment has occurred must remit it to the state (or federal government) after notice of the amount owed.	*of service.* *c. DHHS solicits comment on the timeframe in which issuers must pay balance owed. It considered a 30 day timeframe from date of billing.*	

Table 2
High Level Overview

Program	Reinsurance	Risk Adjustment	Risk Corridors
Purpose	Gives issuers with greater payment stability as ACA reforms take effect. Reduces concern of issuers (and thus rates) in individual market due to enrollment of persons with uncertain risk. Does so by providing funding to plans in individual market that enroll highest cost individuals. Offsets high cost outliers.	Transfers funds from issuers with lowest risk to those with high risk in individual and small group markets. Provides funds to issuers that attract high risk populations thus protecting them from (and mitigating rates associated with) adverse selection	Gives issuers of Exchange QHPs greater payment stability as ACA reforms take effect. Limits issuer losses and gains within an exchange. Protects against inaccurate rate-setting.
Who is responsible?	Proposed: If state has exchange, state. If it does not, state option.	Proposed: If state has exchange, state MAY assume responsibility or may leave it to the federal government (DHHS). In a state that	Federal government (DHHS)

		assumes the responsibility, **Exchange is the administrator unless the state designates another entity, eligible to serve as an exchange, to do so.**	
Length of program	Temporary: 3 years, 2014-2016	Permanent. Begins at the end of benefit year 2014.	Temporary: 3 years,2014-2016 (after reinsurance and risk adjustment)
What issuers make payments?	All issuers (large group, small group, individual) and TPAs	Individual and small group plans in and outside the Exchange (but not grandfathered plans)	QHPs (e.g. only plans in Exchange)
What issuers receive funding?	Individual market plans (but not grandfathered plans)	Individual and small group plans in and outside the Exchange (but not grandfathered plans)	QHPs