

New York State Comments on the Department of Health and Human Services (HHS) Notice of Proposed Rule Making (NPRM) on Reinsurance, Risk Corridors and Risk Adjustment.

Submitted by the New York State Department of Financial Services (DFS), formerly the New York State Insurance Department and the New York State Department of Banking.

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New York includes comments both where we (1) suggest a modification of a proposed rule; and (2) agree with the proposed rule but wish to offer information or suggestions based on New York's experience.

Subpart B—State Notice of Insurance Benefits and Payment Parameters

§ 153.100 -- §153.110 Establishment of state insurance benefits and payment parameters and standards for state notice.

These sections establish general requirements and deadlines for states to give notice of any modification of reinsurance or risk adjustment parameters from those specified in a forthcoming Federal rule and the standards for such notice.

New York comment regarding state flexibility. New York appreciates the flexibility that HHS proposes in allowing states to modify Federal parameters relative to the payments under the transitional reinsurance and risk adjustment mechanisms to ensure the needs of the states' populations are met.

HHS request for comments regarding timing. HHS seeks comment on whether providing insurers with notice of payment parameters by March 2013 allows them sufficient time to reflect the impact of the parameters in setting premium rates for 2014.

New York response. The timing of the proposed rule will work well under New York's review process for premium rates. In New York, insurers file premium rates to be effective on January 1 of a given calendar year in the 3rd quarter of the preceding year. Therefore, a March release of the payment parameters should allow insurers sufficient time to incorporate assumptions that reflect the impact of the revised parameters in their rate filings.

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

§ 153.200 Definitions.

HHS request for comments regarding essential health benefits. HHS solicits comments on alternatives to the use of the essential health benefits package as a basis for determining reimbursements.

New York response. New York supports allowing reinsurance reimbursement for coverage beyond essential health benefits to simplify administration while providing equivalent and equitable support to the individual market. See our comment below on §153.230 (p. 23) for a more detailed discussion.

§ 153.220 Collection of reinsurance contribution funds

This section requires states to ensure that the applicable reinsurance entity collects: (1) reinsurance contributions that will total, on a national basis, \$10 billion in 2014, \$6 billion in 2015, and \$4 billion in 2016; and (2) U.S. Treasury contributions that will total, on a national basis, \$2 billion in 2014, \$2 billion in 2015, and \$1 billion in 2016. The section provides that states must adhere to a uniform national contribution rate set by HHS which will be applied as a percent of premiums for insured plans and to claims for self insured plans.

HHS request for comments regarding calculating contributions. HHS requests comments regarding the calculation of contributions using a uniform contribution rate.

New York response. We agree that use of uniform national contribution rate is a simpler and less ambiguous approach than a state-level allocation.

HHS request for comments regarding premiums as the basis for contributions. HHS has requested comments regarding the use of premiums as the basis for determining contributions.

New York response. We agree with approach taken in the proposed rule. The objective in allocating the \$10 billion at the national level should be to ensure equitable distribution of reinsurance subsidies across all states. The two main options HHS has discussed as a basis for contributions are: (1) a per capita assessment per enrollee; or (2) a percentage of premium assessment. Premiums are the best measurement since premiums reflect actual costs, including regional differences. If HHS used a per-enrollee charge, states with relatively lower premiums would collect and distribute disproportionately more to each person than states with relatively higher premiums. Collections based upon premiums would correlate more directly with the relative cost of actual coverage by state.

New York comment regarding claims as a basis for self-insured contributions. We disagree with the proposed basis for determining the contributions of self-insured plans, which appears to create inequity between the insured and self-insured market. The proposed assessment base for insured business is premium, which includes a factor for administrative expenses. The proposed assessment base for self-insured business is medical expenses, or claims, which does not include an administrative expense component. HHS should define the basis for assessing self-insured business as “claims plus administrative costs” or “premium equivalents” to ensure parity between insured and self-insured business. If equity is not established, this rule could encourage employers to leave the state regulated insurance market in favor of self-insured options.

HHS request for comments regarding collections. HHS requests comments on the method and frequency of reinsurance contribution collections.

New York response.

Method and frequency. HHS should require insurers or self-insured plans to submit monthly or quarterly periodic reports, due within 30 days of the end of the reporting period. The reports should include premiums or claims plus administrative costs, as appropriate. The amount due (based upon the uniform national contribution rate) should be remitted with the report.

Self-insured data collection. States typically have the authority to require insurers who act as administrators of self-insured groups to report self-insured data needed to calculate and collect reinsurance contributions. However, few states have sufficient authority to gather this data for the self-insured market for plans administered directly by the employer or by a third party administrator (TPA). Additionally, few states have mechanisms in place to accomplish data collection from self-insured plans.

HHS should establish uniform reporting rules and procedures as well as enforcement authority. While HHS could confer authority to states to review and audit reports, to streamline the process, HHS should consider directly collecting, reviewing, and auditing the collection data.

Multi-state employers. HHS proposes to make allocations to states based on the enrollees’ state of residence. Multi-state corporations tend to purchase a single group health insurance policy covering employees that reside in multiple states. Similarly, some multi-state corporations establish self-insured plans covering employees residing in multiple states. Insurance products and self-insured plans covering employees residing in multiple states will need to separately report and pay amounts to each state in which they do business, based upon the employees’ states of residence. Thus, a large amount of contributions in a given state could arise out of premiums paid in another state. The accuracy of data reported regarding employees’ state of residence will significantly impact collections. A transparent process must therefore be

established with uniform reporting rules and procedures and appropriate enforcement authority. Data should be subject to regular, periodic audit (at least annually).

States do not currently have authority to review the data of other states' corporations and self insured plans. HHS should consider directly auditing data submissions. Alternatively, authority to audit could be conferred to the states. However, multi-state employers may find it unreasonable to be subjected to multiple audits by several states regarding the same data.

New York comment regarding defining situs for risk adjustment vs. reinsurance. New York recommends that risk adjustment funding should be based on the location in which the policy is issued (employer address) for all employees. Risk adjustment in the individual and small group market is directed at stabilizing the cost between carriers in the market in which a policy is sold. Some small business employees reside in adjacent states (e.g. New Jersey or Connecticut). Nevertheless, the target premium that risk adjustment is directed at is the total policy premium in the market where the pricing is done. To attempt to allocate a portion of the risk (enrollees) in such policies to another market would distort the relative risk values in both markets. Also, it would not be administratively feasible for an insurer to break out the claims data of selected enrollees based upon state of residence, nor would those states have the authority or jurisdiction to audit the records of such a foreign insurer. Thus, for risk adjustment, the basis for data assignment is necessarily the situs of the employer.

§ 153.230 Calculation of reinsurance payments

HHS request for comments on essential benefits package. HHS requests comments regarding distributions based on services for essential health benefits. HHS notes that, "Given the short-term nature of the program, our primary objective is to select an implementation approach that is administratively and operationally simple, but satisfies the goals of the program."

New York response. Limiting reinsurance reimbursement to claims for "essential health benefits" would require insurers to add coding of data extraction queries to isolate those claims. Whether reimbursements are based on all claims or only essential benefit claims will not impact the level of support the transitional reinsurance mechanism provides to the individual market. The added administrative cost to insurers is inconsistent with HHS's goal of administrative simplicity. For this reason, reimbursement should not be limited to claims for essential benefits.

HHS request for comments regarding interaction between transitional and traditional reinsurance. HHS proposes establishing the reinsurance cap at the attachment point of traditional reinsurance, noting the temporary transitional reinsurance program is not intended to replace commercial reinsurance.

New York response. New York believes it is unnecessary and inappropriate to tie the transitional reinsurance cap to the traditional reinsurance attachment point.

Traditional reinsurance and the transitional reinsurance funding mechanism established under the Patient Protection and Affordable Care Act (PPACA) have different purposes. The transitional reinsurance program is a premium assistance mechanism, intended to reduce overall costs in the individual market. The external financial support provided via the transitional reinsurance mechanism is for the purpose of encouraging insurers to set premiums at affordable levels when individual plans are initially introduced to the public through the Exchange. Addressing affordability at the onset of the Exchange should spur enrollment until a sufficient experience pool is developed to sustain reasonable premiums. By contrast, traditional reinsurance is not a premium assistance mechanism and it does not reduce overall cost. Rather, traditional reinsurance only spreads risk out via a premium insurers pay to a reinsurer to cover large individual claims or spikes in aggregate claims over a period. The cost of traditional reinsurance comes out of the premiums paid by enrollees. It therefore adds to overall cost of the underlying coverage because reinsurers must cover the claims plus overhead and profit.

The cap on the transitional program should not, therefore, be tied to the traditional reinsurance attachment point. The cap should be based only on an estimate of the size of the risk corridor needed to provide an adequate level of premium support to the individual market, giving due consideration to in the state's allocation of the \$10 billion of total nationwide funding. .

HHS request for comments regarding ensuring appropriate issuer costs. HHS invites comments on a suitable method for ensuring that issuer costs are appropriate and accurate.

New York response. New York agrees with HHS' proposed method to use actual medical costs paid by issuers as a basis for reimbursements. Paid claims are the most readily available and easily verifiable. HHS should establish paid claims as the basis for reimbursement for the transitional program. Issuers should provide summary reports of claims paid on coverage subject to the reinsurance program. The summary reports must be traceable to detailed claims records and should be audited annually.

HHS request for comments regarding incentives to control costs. HHS notes that an attachment point method could reduce incentives for health insurance issuers to control costs. A reinsurance cap and coinsurance rate can be used to provide an incentive for issuers to control cost.

New York response. New York agrees with HHS's concern that an attachment point method could reduce incentives for cost control. To maximize the premium impact of the reinsurance assistance, an appropriate cap and coinsurance rate must be used in conjunction with the attachment point to provide issuers with an ongoing incentive to control costs.

New York comment regarding the need for ongoing state flexibility in establishing attachment points, caps and reinsurance. There are many unknown factors that impact selection of an appropriate attachment point, cap and coinsurance rate for this program. For example, it remains uncertain how many will purchase coverage on an individual basis (despite the mandate and penalties), how quickly enrollment will increase, or what the risk profile of enrollees will be. Additionally, due to variations in demographics and average health care costs, we would expect significant national variation in claims. Thus, HHS should give states latitude to modify the reimbursement variables announced in March 2013. Additionally, if HHS intends to set the initial attachment point and cap, factoring in regional cost differences should be considered. However, if there is no regional variation set by HHS, states could each address their differences through modification at the state level. As long as some flexibility is left to the states in this area, either approach should work.

The latitude provided to states should also include allowing changes to permit sufficient funding to get distributed to hold individual market rates down. For example, a state that initially established a 75% reimbursement of claims from \$20,000 - \$100,000 might determine that 80% of claims from \$5,000 - \$120,000 should actually be paid in subsequent years. HHS should allow the state to make such a determination as quickly as possible so as to notify issuers who could then reflect the impact in the next rating cycle. Since adjustment of the corridor or coinsurance rate would be based on claims experience, it will be important for regulators to obtain claims paid data as early as possible. New York requires quarterly reports of paid claims including projections of claims paid through year end.

New York comment regarding carry-over of unused funds. We note that PPACA specifically provides that at the end of 2016 remaining reinsurance funds can be used over the next two years to continue to support individual rates. However, PPACA is silent regarding carry-over funds from 2014 to 2015 and 2015 to 2016. States should be provided the flexibility to apply the surplus funding to subsequent years if claims come in below expected levels.

HHS request for comment regarding method of determining payments. HHS invites comment regarding the best method of determining payments for the reinsurance program, which can relate to either the criteria for selecting eligible enrollees for payment or the method for calculating the payment amounts.

New York response. Section 1341 of PPACA provided for payments based on a list of from 50 to 100 high cost conditions, or other method recommended by the American Academy of Actuaries (AAA). The AAA provided a letter to HHS summarizing four possible options it would recommend. HHS chose the 4th method in AAA's list, which is a threshold method very similar to New York's stop loss method. A key reason HHS cited for selecting this method was administrative simplicity. HHS noted that insurers across the nation are generally familiar with reporting for commercial reinsurance under this method.

New York agrees with the proposed rule and recommends that aggregate paid claims on behalf of a given individual during a calendar year that exceed a stated threshold be the basis for calculating reimbursement. Reimbursement of such claims should also be subject to a cap and coinsurance.

HHS request for comments regarding remittance to the US treasury. HHS requests comments regarding the most appropriate frequency and method for applicable reinsurance entities to remit payment to the U.S. Treasury.

New York 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. The regulations should also include a provision for effective enforcement by federal or state authorities of payments to be made by, or on behalf of, self-insured employers.

§ 153.240 Disbursement of reinsurance payments

HHS request for comments regarding timing of payments. HHS invites comments as to the most appropriate timeframe for a reinsurance entity to make payments for claims submitted.

New York response. HHS should permit states to establish the timeframe for distribution of funds, with distributions flowing no less than annually. New York has had an effective system in place that provides distributions on an annual basis. For purposes of issuers' solvency-based reporting, it is not essential that issuers receive funds each month since insurers can typically carry a receivable for anticipated funds. New York's stop loss and market stabilization pools only pay annually and issuers have been able to work within that timeframe. However, in some states timely payment could be important to the cash flow of smaller issuers. Such states may want to implement a system that distributes funds on a monthly or quarterly basis. New York therefore recommends leaving the payment timing to each state's discretion.

HHS request for comments on cash flow. HHS expressed a concern that claims might exceed contributions in a given month and has requested input on this issue.

New York response. Contributions at the outset will likely exceed claims and there will be surplus funding until claims catch up. The reason is that contributions will be based on a percentage of premiums of existing enrollment in all classes (small group, large group, etc). Thus, contributions will begin to flow in at near 100% of the billing based on the state's allocation immediately. Claims, however, will be based on enrollment which will be low initially and grow through the first year. By mid-year, if collections are uniform monthly assessments based on premium, states should have built a significant cash reserve to cover claims reimbursement requests as they begin to grow.

HHS request for comments on claims submission deadline. HHS also seeks comment as to whether the deadline for health insurance issuers for submitting reinsurance claims should be the same or different from the Medicare Part D requirement, which has a data submission requirement of within 6 months of the end of the coverage year.

New York response. New York's stop loss programs require final submission by April 1 (i.e., three months from year-end) and our risk adjustment pools require submission by February 28. These submissions require paid claims data only, which carriers would need to file annual statements due even earlier than April 1. Three months would be a more appropriate deadline, to coincide with MLR reporting requirements and timing (see below). Preliminary notification even earlier would facilitate early audit and verification of reported amounts.

HHS request for comments regarding a standard deadline and coordination with MLR reporting. HHS invites comment on the use of a standard deadline and the most appropriate deadline considering the interaction of the reinsurance program with the risk corridor and the MLR process.

New York response. New York's MLR filings are due June 30, with rebates payable in September based on those reports. The MLR reports include offsets of claims for expected stop loss reinsurance recoveries. Preliminary notifications of each prior year's total requested stop loss reimbursement are due January 31 and a final reimbursement request is due by April 1. All reimbursements are based on cumulative calendar year paid claims. Paid claims are generally known, and summarized early in the first quarter for preparing statutory filings, so issuers have been able to submit these reports within this timeframe. If New York were to wait for accrued unpaid claims to emerge, it would make it difficult for issuers to report final numbers this early. New York's June 30 MLR date allows time for regulators to audit the reports and to determine if the total requests of all issuers exceed annual funding, in which case issuers are informed of pro rata reduction in reimbursement.

The federal MLR calculation is due June 1, so it would be desirable to have similar preliminary fourth quarter reports by January 31 and final reimbursement requests as early as possible thereafter. There are usually very few differences between the two and, inasmuch as the detail is from paid claim records, very few errors are found on audit.

HHS requests comments regarding record retention. HHS proposes a 10 year record retention policy and solicits comments.

New York response. New York has a six year record retention policy. Because this is a temporary transitional reinsurance program and we anticipate an annual audit of data submitted, our six year policy is sufficient.

Subpart D— State Standards Related to the Risk Adjustment Program

§ 153.310 Risk adjustment administration.

HHS requires creation of a risk adjustment mechanism with payments commencing in 2014. Timing will be coordinated with the reinsurance and risk corridors. HHS may require states to complete risk adjustment by June 30 of the year following the benefit year.

HHS request for comments regarding risk adjustment deadlines. HHS seeks comment on the appropriate deadline to complete risk adjustment.

New York response. To coincide with other statutory filing requirements, including 2nd Quarter MLR reporting, risk adjustment rules should require submission of data within two months of the end of the year. Calculations and billing should be completed before the end of the 2nd Quarter.

Under the New York DFS risk adjustment mechanisms, data (demographic, paid claims, and/or weighting factors) is generally due by February 28 of the year following the calendar year being adjusted. This timeframe allows DFS to conduct a desk audit and basic analytic review of data and to follow up with insurers, as appropriate. It also allows DFS to complete billing calculations and invoicing by May or June. Insurers must submit contributions within five days of receipt of invoice, with distributions scheduled to be made within thirty days of receipt of all contributions.

Invoicing contributions and distributions by May or early June gives insurers a reasonable estimate of their receivable or liability for use in filing New York's MLR reports, currently due June 30th. Federal MLR reports have a proposed June 1 filing date. Accordingly, regulators

should attempt to distribute invoices by the second week of May. Issuers could estimate these amounts for the purpose of their MLR filings, but timely billing (or notice of estimated payments) based on each year's new regional average relative cost data to ensure more accurate results.

Following billing, states should attempt to complete detailed audits of data over the remainder of the year to validate and finalize the year's calculations. Regulators can invoice as additional charges or credits in next year's billing any adjustments resulting from audits of a year's risk adjustment submissions. After the first year, when insurers become familiar with the reporting, adjustments should not be significant. Posting adjustments as charges or credits in the next year's billing allows closure of the current year on a timely basis.

The time frames described are those that we have used in New York's existing commercial market mechanisms. New York is in the process of examining the risk adjustment mechanisms to be put in place to satisfy the requirements of PPACA. These time frames do not provide for systematic monthly issuer reporting. Such periodic reporting throughout the year would facilitate earlier notification to issuers of estimated payments, thereby achieving more timely market stabilization and adjustment of premium rates. States should attempt to build systems to collect data systematically throughout the year and over time develop methodologies that will provide issuers the earliest possible estimates of risk adjustment payments.

HHS request for comments on timing of state payments. HHS seeks comment on the appropriate timeframe for state commencement of payments.

New York response. The timing of the billing and collection is contingent on the method of risk adjustment and reporting established in a state. Over the next several months, New York intends to study and compare methods we have used in the past as well as other models recently developed or under development across the country to determine what will work best for the commercial market in New York. The reporting timeframe will be contingent on the method selected, but whatever the chosen method is, invoicing should be done on a timeframe to provide results in sufficient time to facilitate insurers' MLR reporting deadlines. Any HHS rules in the short term should include provisions allowing states flexibility in constructing methods to ensure they are the best fit for the market in each state.

HHS request for comments regarding summary reports. HHS seeks comment on the requirements for reports regarding risk adjustment activities for each benefit year, including data elements and timing.

New York response. Annual reports to HHS should include a breakdown by issuer, by line of business, of premium and claims, average actuarial risk, contributions and receipts to or from the

risk adjustment pool. The data should give aggregate totals for the state plus totals for in and out of Exchange payments. Reports should be provided annually by September 30.

§ 153.320 Federally-certified risk adjustment methodology - notices

HHS notes the Secretary may adopt the risk adjustment criteria used under part C or D of title XVIII of the Social Security Act. But, HHS also recognizes that states may have alternative methods, such as risk adjustment for Medicaid or other methods. HHS interprets PPACA to allow certain levels of state variation. The PPACA provides that a state may submit a proposed alternate methodology for HHS review which will become a federally-certified methodology, if approved.

HHS sets out the content of notices of descriptions of risk adjustment models states may opt to use. The notices must include a full description of the model, including but not limited to demographic factors, utilization factors, qualifying criteria, weights assigned to each factor, data required to support the model and so forth, and seeks comments on other information that should be included in the notice.

New York response. New York agrees with the proposed rule and description of information that should be included by states in notices to issuers of the state's risk adjustment model, including demographic, diagnostic or utilization factors, and weights assigned to each factor. As states develop different models, HHS may want to add other items to the notice. HHS should remain open to possible revision.

§ 153.320 Federally-certified risk adjustment methodology – approaches to risk adjustment - state flexibility

HHS request for comments regarding facilitating the stated risk adjustment policy goals, as follows:

HHS requests comments on the implications of approaches for market efficiency, potential incentives created in how issuers set rates, and how approaches address allowed rating variation for age, family size, and tobacco use. HHS indicates that an approach is needed to account for these allowable variations in rating so that risk adjustment does not adjust for the actuarial risk that issuers have been allowed to incorporate into their premium rates.

HHS requests comments on other approaches to determining average actuarial risk and whether links exist between potential actuarial risk methodology and potential payments and charges

methodology as described in §153.345. HHS also requests comment on the extent of state flexibility that should be allowed in adopting an approach to determining average actuarial risk.

HHS requests comment on the validity of these assumptions, including the methods described, and any alternative methods that could be used to calculate payments and charges that would reduce uncertainty for plans. HHS requests comment on whether there are alternative methodologies that might be used, including their strengths, limitations, and any intentional or unintentional consequences from the use of either methodology.

New York response. Risk adjustment alternatives. Analysis of New York’s current methods and the HHS “Risk Adjustment Implementation Issues” White Paper.

The DFS and Department of Health (DOH) have operated risk adjustment mechanisms for several years. Over the next several months, New York seeks to make a comprehensive analysis of the mechanisms already used in this state to adjust risk in the community rated individual and small group markets and in the Medicaid managed care market. From this analysis, a “Best-for-New York” method may be developed, which may use appropriate features of both established mechanisms. New York therefore recommends that HHS allow continued flexibility in the study, construction, and definition of what qualifies as an alternative risk adjustment mechanism.

In addition, subsequent to New York’s initial review of the several requests for comment in the NPRM, HHS published a “Risk Adjustment Implementation Issues” White Paper, addressing numerous issues related to the development of risk adjustment methodologies. Since then, New York has been participating in a detailed analysis and discussion of those issues with several other states through the NAIC Healthcare Reform Actuarial Working Group’s (HCRAWG) Subgroup on Reinsurance, Risk Corridors and Risk Adjustment. As New York works through the White Paper questions with the several states’ officials and technical experts, we will provide a further response to HHS on the questions set forth above as well those contained in the White Paper. In the meantime, New York requests that HHS continue to allow flexibility in its proposed rules for risk adjustment. We hope to continue a dialogue with HHS officials as we work to examine a New York methodology.