

New York appreciates the opportunity to comment on the proposed regulations for 45 CFR Parts 153, 155, 156, 157 and 158; Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014; Proposed Rule [CMS-9964-P]

These comments build upon comments previously submitted by New York regarding the Patient Protection and Affordable Care Act: Standards Related to Reinsurance, Risk Corridors and Risk Adjustment Rule (77 CFR 17220); Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers (77 CFR 18310).

General Comment:

Reports. New York requests that in instances where any reports related to the implementation of the rate stabilization programs are required to be provided to HHS from health insurance issuers or from health insurance issuers to HHS that the states are also provided with such reports. At the very least, states with effective rate review programs should receive copies of such reports on the same time-line. This will ensure that such states have access to the same information that that is available to HHS when reviewing premium rates.

- Preamble, III, Subpart B, section 3, subsection (b), (3) Prescription Drugs (page 73128)
New York believes it is appropriate to incorporate Rx data in the near future. There are many high-cost conditions where costly drugs are prescribed to treat conditions which are not captured by inpatient/outpatient records alone. Rx data can also be used to enhance the risk adjustment model's ability to assess the severity of a particular condition. Additionally, including Rx data provides an opportunity to highlight instances where prescription drugs are being prescribed by particular provider in an inappropriate manner. Having the ability to highlight such instances provides an opportunity to better manage costs in the future.
- Preamble, III, Subpart B, section 3, subsection (c), (2), (vi) (H) - Calculation of the Plan Transfer Payments (page 73145)

The PMPM transfer payment calculated from the proposed payment transfer formula would be multiplied by the total number of plan member months for billable members to calculate the total plan level payment. Transfers would be calculated at the plan level within rating areas. New York State believes that it makes sense for transfers occurring on the back end to be made at the plan level within rating areas in order to be consistent with the pricing adjustments that are allowed on the front end. However, this concept seems to suggest that each rating area would in effect be a separate risk adjustment pool. Because this sounds contradictory to the single risk adjustment pool concept referenced in various areas of this draft Notice, it may be helpful to include some clarifying language in order to avoid confusion as to what is actually intended.

- Preamble, III, Subpart B, section 1, subsection (c), (5), (b) (2) – Initial Validation Audit (page 73148)

Issuers of risk adjustment covered plans would provide enrollment and medical record documentation to validate the demographic and health status data of each enrollee. Issuers would have considerable autonomy in selecting their initial validation auditors and audits in accordance with audit standards established by HHS according to one of three methods:

- HHS or a designated entity could prospectively certify auditors for these audits;
- HHS could develop standards that issuers and initial validation auditors would follow, without any requirement of prior HHS certification or approval of auditors; or
- HHS could issue non-binding, “best practice” guidelines for issuers and auditors.

New York supports the first option whereby HHS or its designee would prospectively certify auditors for such audits. This would provide states with at least some level of comfort with regard to the quality of the auditors being utilized.

- Preamble, III, Subpart B, section 1, subsection (c), (5), (d) – Payment Adjustments (page 73148)

HHS proposes in paragraph §153.630(e) that HHS may adjust payments and charges for issuers that do not comply with the initial or second validation audit standards set forth in §153.630(b) and (c). In such instances, New York believes that non-compliant companies should be treated as if they were determined to be net payers into the system; paying an amount at least as great as what net paying companies of similar size and risk profile are paying.

- Preamble, III, Subpart B, section 1, subsection (c), (5), (e) – Proposed HHS-Operated Data Validation Process for Benefit Years 2014 and 2015 (page 73149)

As with Medicare Part C risk adjustment, HHS plans to observe and work with issuers on data validation during the first two years of this program. HHS seeks comment on improvements to data validation, alternatives to forgoing changes to payments and charges that should be adopted, and methods to ensure data integrity in the first two years of the program. New York does not support forgoing adjustment to payments and charges as a result of audit findings in any year. Because of the high level of interdependency among companies required to implement a successful risk adjustment system, New York urges that adjustments to payments and charges should be made as appropriate, based on audit results, in all years including the first year. Adjustments will provide an incentive for companies to iron out as many data issues as possible. New York also believes that it makes sense to provide at least some level of additional flexibility in the early years; therefore, we would be in favor of striking an appropriate balance between adjustments and some leniency in the early years of the program.

- Preamble, III, Subpart C, section 5 – Eligibility for Reinsurance Payments Under Health Insurance Market Rules (page 73159)

New York is of the opinion that administering the reinsurance program on a calendar year basis is appropriate. The proposed Regulation also indicates that the deadline for submitting reinsurance claims is April 30. This time-line makes it possible for up to 3 months of claims run-out to be utilized. Given the level of interdependency that is needed to ensure the success of these programs, New York recommends using the maximum number of months of claims run-out in order to increase accuracy.

- Preamble, III, Subpart C, section 9 – Allocation and Distribution of Reinsurance Contributions (page 73162)

New York is of the opinion that reinsurance contributions collected within a particular state should remain in that state. If such contributions are allowed to cross state lines, there will be less incentive for plans to maintain grandfathered status as competition for the funds that are available for this program increases; making it more difficult for enrollees to keep their current plan.

- Preamble, III, Subpart D, section 1 – Definitions (page 73163)

New York recommends that any explicit provision for profits is capped at 2.0%.

- Preamble, III, Subpart D, section 2 –Risk Corridors Establishment and Payment Methodology (page 73164)

New York agrees that it makes sense to revise the MLR reporting deadline as proposed by HHS. Doing such allows for all of the relevant items to be accurately reflected in the MLR calculation which eliminates the need to use accruals. While this will result in delayed payment of rebates, we believe that it is more important that the rebates be accurate. Using accruals is less desirable because it adds another variable to the calculation which could be used as a cushion to reduce overall rebate amounts over time.

- Preamble, III, Subpart H, section 6 – Determining Employer Size for Purposes of SHOP Participation (page 73186)

While the Exchange Establishment Rule did not finalize a method for determining employer size, we note that part-time employees must be taken into account in some reasonable way to be consistent with the Affordable Care Act standards for determining employer size. We propose to amend the definitions of “small employer” and “large employer” in §155.20 to specify the method for determining employer size and to add the definition of large employer to §157.20. In determining whether an employer is a small employer for purposes related to the SHOP, we propose that the full-time equivalent method used in section 4980H(c)(2)(e) of the Code, as added by section 1513 of the Affordable Care Act, be used. We seek comment on the proposed definition.

- Preamble, III, Subpart H, section 8 – Transitional Policies (page 73186-87)

Currently, section 4235(c) of the New York Insurance Law permits employers to offer group health insurance coverage to classes of employees based upon their conditions of employment. These conditions can include geographic situs of employment, earnings, method of compensation, hours and occupational duties. The ability to classify employees for health insurance purposes gives employers a great deal of flexibility. Removing this as an option may also require regulatory or legislative action in New York. Therefore, we seek clarification on whether the proposed counting methods and definition of full time employee will apply outside the Exchange or the SHOP after 2016 or are limited to products sold within the Exchanges.

- Preamble, III, Subpart H, section 9 –Web Site Disclosures Relating to Agents and Brokers (page 73187)

New York has stringent requirements for broker licensing and training and the state is in the process of developing a mandated training and testing curriculum for brokers and agents who will sell products on the Exchange and SHOP. New York supports this proposal to permit states to limit website disclosure to for those brokers and agents who are registered and who have completed training.

- Preamble, III, Subpart I, section 1 – Treatment of Premium Stabilization Payments, and Timing of Annual MLR Reports and Distributions of Rebates (page 73187)

New York agrees that it makes sense to revise the MLR reporting deadline as proposed by HHS. Doing such allows for all of the relevant items to be accurately reflected in the MLR calculation which eliminates the need to use accruals. While this will result in delayed payment of rebates, we believe that it is more important that the rebates be accurate. Using accruals is less desirable because it adds another variable to the calculation which could be used as a cushion to reduce overall rebate amounts over time.

- Preamble, VI, Subpart D – Regulatory Flexibility Act (page 73202)

New York does not have estimates on the number of self insured groups are classified as “small entities.” Given that there is now a greater incentive to self-insure in order to avoid the requirements of the ACA, it is possible that the number of self-insured “small entities” may increase. A level playing-field in terms of assessment of reinsurance contributions is therefore desirable, so as not to provided additional incentives for “small entities” to self-insured and thereby deny their employees the consumer protections applicable to insured products under State and federal laws.