National Association of Insurance Commissioners & The Center for Insurance Policy and Research

January 8, 2014

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9954-P
P.O. Box 8016
Baltimore, MD 21244-8016

To Whom It May Concern:

The following comments on the proposed Notice of Benefit and Payment Parameters for 2015, as published on December 2, 2013, are submitted on behalf of the members of the National Association of Insurance Commissioners, which includes the chief insurance regulators in the 50 states, the District of Columbia, and the 5 United States Territories.

Health Insurance Reform Requirements for the Group and Individual Health Insurance Markets

Composite rating

- As a general comment, composite rating for small group plans should be allowed, but not required, subject to the discretion of each state. Moreover, it is not clear that there is a compelling need for uniformity in composite rating to be established at the federal level. This is a matter that can and should be left to state regulation.

- On page 27 of the HHS Notice of Benefit and Payment Parameters for 2015 (NBPP), it is unclear how the uniform tiered-composite rating would appropriately reflect rating factors that apply to individual members (e.g. tobacco use.) This seems inconsistent with the original rationale to sum each member's rates.

- In the two-tiered structure, we assume the composite premium for covered adults would be applied per adult. For example if the composite adult rate is $100, a single employee's rate would be $100, an employee and spouse would be $200, and an employee and spouse with two adult children (21-25) would be $400. Is that accurate? If so, would the composite premium for covered children then be applied per child? If so, this is different than how tier rating has generally been applied in the past. For most carriers, the premium does not vary with the number of covered children.

  We have similar questions regarding the three-tiered structure. Is the composite premium for covered adult dependents applied per adult dependent and is the composite premium for covered children applied per child?

- We would like CCIIO to consider the situation that occurs when a new small group is quoted a rate assuming an employee and dependent census taken at one point in time which changes upon final enrollment. The wording in the composite rating section says that the composite premium would be calculated based on applicable employee enrollment at the beginning of the plan year. It is common practice in the small group market to quote/renew using an assumed census at a point in time, but then there may be variation at final enrollment. There is usually a 1-2 month time lag between new or renewal quoting processing and final enrollment and it is common to have changes in census during that period. In addition, during the enrollment process, employees decide on coverage for themselves and dependents based on the net cost to them after employer contribution and coverage choices may be different than what was assumed when the employer communicated the employee rates during the enrollment process.

With composite premiums in the rule based on final enrollment, the quoted composite rate, which is used by an employer to determine the employee contribution and by employees in making enrollment decisions, could change based upon those final enrollment decisions. If the carrier is then required to change the composite premium after final enrollment, the small group premium would change and potentially impact both the employer's and employees' contributions.

We suggest CCIIO consider applying a threshold, as is common in today's small group market, allowing the composite premium to stay the same as quoted unless it increases or decreases by more than a specified percentage (e.g. 10%)of total premiums due to changes in final enrollment.

Permanent Risk Adjustment Program

Section 153.630 Data validation requirements when HHS operates risk adjustment

- On pages 47-48 of the NBPP, HHS proposes that medical record documentation must be generated in the course of a face-to-face or telehealth visit, which we think may be too restrictive. For example, in the case where a policyholder changes carriers but not their provider, this could potentially be a significant issue.

Transitional Reinsurance Program

Section 153.20 Definitions

- Proposed definition of "major medical coverage" for identifying plans subject to reinsurance contributions (pg. 69)

  We welcome the proposed rule's clarification that only major medical coverage providing a broad range of services and satisfying minimum value would be subject to reinsurance contributions. However, we would suggest that the rule clarify that, for the individual market, any coverage subject to actuarial value requirements be automatically considered major medical coverage. This would reduce the burden on issuers of calculating minimum value for these plans which would be presumed to meet minimum value by virtue of meeting actuarial value.

- De minimis offering of services to plans subject to reinsurance (pg. 72)

  While we understand and appreciate the use of a de minimis application to reduce the burden on smaller entities providing only limited services, we believe that any entity providing services to plans subject to reinsurance should be required to submit contributions for their benefits. Alternatively, CMS could require the primary provider of services to include in their contribution all benefits from the plan and have them seek reimbursement from secondary providers, to the extent service payments include reimbursement for their reinsurance liability.

- Requirement for reinsurance contributions for plan sponsors with blend of insured and self-insured without third party administrator (pg. 73)

  Any change in definition should include those self-funded plans that use any third-party services or have fully insured components of their plan.

Section 153.230 Calculation of reinsurance payments made under the national contribution rate

- National reinsurance rate set at $44 per enrollee for the 2015 plan year (pg. 74)

  The national reinsurance rate will decrease from $63 per covered life for 2014 to $44 per covered life in 2015, resulting in estimated collections of $12.02 billion for 2014 and $8.025 billion for 2015. These figures imply

an assumed population subject to the reinsurance contributions of 190.8 million for 2014 and 182.4 million for 2015. According to the CBO[1], the insured population was anticipated to increase by 5 million from 2014 to 2015, meaning the assumed population subject to the assessment would increase to 196 million. The difference between 182 million in 2014 and the estimated 196 million in 2015 would imply the self-administered, self-funded plans amount to 14 million covered lives. We are concerned that the removal of these health plans from the reinsurance contribution has an unfair impact on those remaining enrollees subject to the reinsurance fee. In fact, keeping this population subject to the reinsurance fee would be estimated to reduce the fee per covered life by $3, to $41.

- Timing of reinsurance payments (pg. 77)

  We have no concern with CMS' proposal to separate the contributions for reinsurance program payments and payments to the U.S. Treasury. We support the provision that allows the full reinsurance contribution to be included in the 2014 MLR despite the fact that the 2nd installment has not yet been paid.

- Use of excess reinsurance collections (pg. 79)

  We support the pro-rata adjustment on a national basis to reflect the difference between payments and contributions, to the extent payment requests exceed contributions. However, if contributions exceed payments, we recommend carrying forward the difference to the following plan year to offset any potential future year shortfall.

- Adjustment options (pg. 85)

  On page 85, second paragraph, HHS proposes to decrease the 2014 attachment point to $45,000 from $60,000. We suggest instead that HHS consider keeping the attachment point at $60,000 and increasing the reinsurance cap instead. The reasoning is the reinsurance program should be reimbursing carriers for large claims that may be incurred more frequently due to the inception of guaranteed issue requirements, and by lowering the attachment point the reinsurance program will be reimbursing claims that are moving closer to what we would not consider large claims. Moreover, increasing the reinsurance cap will result in fewer claims being paid (although in larger amounts) so that claims administration expenses will be somewhat less.

Section 153.270 HHS audits of State-operated reinsurance programs

- We have no comment on CMS' plans to audit state reinsurance entities, contributing entities, or reinsurance-eligible plans (pg. 90-92), other than to encourage CMS to work with state insurance departments to coordinate audits and to take advantage of their knowledge of their issuers and the health insurance market.

Section 153.400 Reinsurance contribution funds

- Identification of contributing entity (pg. 93)

  We agree with CMS' goal of collecting the reinsurance fee only once per covered life (pg. 93), regardless of the number of plans in which that covered life is enrolled. It seems appropriate that responsibility for remitting the fee rests with the contributing entity providing the primary major medical coverage and that secondary providers should not be responsible for the collections.

- Form 5500 counting method (pg. 95)

  On page 95, first paragraph, HHS states that a self-insured group health plan that offers both self-only coverage and coverage other than self-only coverage would calculate the number of lives covered by adding the numbers of total participants covered at the beginning and at the end of the most current plan year, as

[1] http://www.cbo.gov/sites/default/files/cbofiles/attachments/43900_ACAInsuranceCoverageEffects.pdf

reported on the Form 5500. It appears that HHS may have left out the wording "then dividing by two." Adding these words will avoid double counting enrollees.

Transitional Risk Corridor Program

Auditing risk corridor data

- We have no comment on CMS' plans to audit risk corridor data of issuers (pg. 97), other than to encourage CMS to work with state insurance departments to coordinate audits and to take advantage of their knowledge of their issuers and the health insurance market.

Section 153.510 Risk corridors establishment and payment methodology

- Health plans must be subject to market reform rules to qualify for risk corridors (pg. 101)

  We understand the difficulties the transitional policy presents to risk corridors but agree that it is difficult to combine them with the 2014 plans subject to market reforms to calculate the risk corridor payments.

- Using State employee counting method for risk corridors (pg. 101)

  We would support an approach whereby all risk mitigation programs and MLR calculations utilize the State employee counting method, not just risk corridors. The use of different counting methods creates inconsistencies between risk mitigation programs.

- Modifications to MLR and risk corridors formulas to reflect removal of transitional policies (pg.104)

  The MLR ratios have been widely publicized and any change will likely create more confusion as to how to interpret MLR ratios and rebates.

Reduced Maximum Annual Limitation on Cost Sharing for Benefit Year 2015

- On page 162 of the NBPP, it is proposed that for the 2015 benefit year an annual limit on cost sharing for the pediatric dental EHB when offered through an SADP be set at $300 for one covered child and $400 for more than one covered child. We comment that this limit will restrict the flexibility which is needed by each state for our unique markets. This reduction in flexibility will result in fewer options for consumers.

Sincerely,

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