

January 16, 2013

Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
Attention: CMS-9964-P  
P.O. Box 8016  
Baltimore, MD 21244-8016

To Whom It May Concern:

Thank you for the opportunity to comment on the proposed HHS Notice of Benefit and Payment Parameters for 2014, published in the *Federal Register* on December 7, 2012. We write as the chief insurance regulators of our respective states and members of the National Association of Insurance Commissioners. The National Association of Insurance Commissioners (NAIC) is the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, the District of Columbia, and five U.S. territories. Through the NAIC, state insurance regulators establish standards and best practices, conduct peer review, and coordinate their regulatory oversight. NAIC staff supports these efforts and represents the collective views of state regulators domestically and internationally. NAIC members, together with the central resources of the NAIC, form the national system of state-based insurance regulation in the United States.

### ***Temporary Reinsurance Program***

We strongly recommend that HHS abandon its plan to create a national pool for reinsurance collections and payments, as set forth in the revised Section 153.230 of the proposed rule, and replace it with a system of collections and payments calculated and maintained state by state. This modification would allow the transitional reinsurance program to stabilize individual insurance markets in each state, which differ significantly in size and other characteristics, rather than spreading contributions and payments across the nation as if there were one national market.

Section 1341 of the Affordable Care Act (ACA) directs states to set up reinsurance programs. Part 153 of the proposed rule provides various administrative and supervisory roles for HHS in connection with these state reinsurance programs, and also specifies operational details for reinsurance programs operated directly by HHS in states that choose not to set up programs. The NAIC is in general agreement with these roles as described in Part 153. However, some of the language in Part 153 is not consistent with the language of the ACA, in that it forces all state reinsurance programs to participate in one nationwide pool of contributions and payments.

The inconsistency between the Proposed Notice and the statute is revealed by the title of section 1341, which calls for the establishment of a reinsurance program "in each state." The text of the section then goes on to require that, "Each state shall...establish...reinsurance entities to carry out the reinsurance program under this section," while HHS is required to "include provisions that enable states to establish and maintain a program."

We note that the ACA was drafted to acknowledge and give deference to the state-based systems of health care financing and regulation. This deference is not present in the requirement in Part 153 that a state reinsurance program be part of a pooled national program. As the preamble notes, this nationally-pooled approach is justified only by administrative expediency because it “would be less complicated to administer.”) Furthermore, the uniform per capita national contribution rate specified in the Proposed Notice is inappropriate because health care costs vary widely between different states.

The per capita contribution rate should therefore also vary using some generally accepted index of health care costs by state. The payment parameters could then be adjusted in each state so that the projected payments equal the anticipated contributions in that state. This approach would avoid cross-subsidization of higher cost-states by lower-cost states, as intended by the statute.

In addition, we note that individually issued medical insurance policies are typically regulated by the state in which the policy was issued, regardless of the current residence of the insureds. However, group policies such as employer policies are typically regulated by the state in which the insureds work. We believe that self-insured employers or their contracted third-party administrators will easily be able to calculate either a percentage of premium or per-capita contribution separately for each state in which they have a work location.

### ***Risk Adjustment Program***

We also note that the risk adjustment program, which is designed to pool risk only within each state, should similarly allocate individual policies by the state of issue and group policies by the state in which the insureds work. Section 153.360 of the proposed rule indicates that small employer coverage participates “in the applicable risk pool in the state in which the enrollee’s policy was filed and approved.”

We recommend modifying this language for both the risk adjustment and reinsurance programs to “the state in which the small employer has its main work location.” While we agree that a small employer should not be split among states, it is not correct that an enrollee holds a “policy.” Rather, the employer has a policy, and each enrollee receives a “certificate of coverage” under the policy. For an association that sponsors coverage for small employers, the policy may be issued in the state where the association is organized, but the risk resides in the state where each small employer is located.

If HHS adopts our recommendation, it will need to clarify how collections from multi-state employers will be allocated by state. We suggest that allocation of collections be based on the employees’ work locations.

### ***Reinsurance Administrative Fee***

The proposal states that HHS would transfer \$0.055 of the per capita administrative fee to a state for purposes of administrative expenses incurred in making reinsurance payments in the case that a state operates its own reinsurance program. The proposal also states that administrative expenses for reinsurance payments will be distributed in proportion to the state-by-state total requests for reinsurance payments made under the national payment parameters. These appear to be two different approaches and we need clarification as to which approach HHS is advocating.

### ***Reinsurance Runout***

The Proposed Notice states that HHS intends to operate the reinsurance program on a calendar year basis, with an April 30<sup>th</sup> deadline to submit data to be considered for reinsurance payments from the previous calendar year. If that is the case, then it seems possible to include claims runout through March 31 for the calendar year claims. We advocate using runout so that claims that are incurred near the end of the year will be more fully represented, improving the accuracy of the program.

***Validation and Audit Requirement***

The proposal states that capitated plans should use their principal internal methodology for pricing encounters, which would be subject to validation and audit in the HHS-operated programs. We suggest that the validation/audit requirement be stated explicitly in paragraph 153.710 (c) of the Proposed Notice.

***Information Provided to States***

We are concerned that the Proposed Notice does not specify what information will be provided by HHS to states when HHS is administering the reinsurance and/or risk adjustment programs on behalf of a state. A state that administers its own premium stabilization programs will have access to information that will assist that state in the rate review process, as well as other regulatory areas in the individual and small group market. It is therefore important for states to have access to this same level of detailed information when HHS is administering these programs on a state's behalf. We suggest that HHS clarify the content and timing of the reports that States can expect to receive from HHS regarding these premium stabilization programs. The following list includes items that should, at a minimum, be included in reports to states for the risk adjustment and reinsurance programs.

Risk Adjustment Report

- Issuer Name
- Market (Individual / Small Group)
- Exchange Indicator
- Plan
- Metal Level AV
- Plan average risk score
- State average premium
- Allowable Rating Factor
- Induced Demand Factor
- Geographic Cost Factor
- Enrollment (member months)
- Payment Transfer Amount

Transitional Reinsurance Report - Contributions

- Issuer Name
- Market (individual/small group/self-insured)
- Plan
- Enrollment (member months)
- Counting Method
- National Contribution Amount

Transitional Reinsurance Report - Distributions

- Issuer Name
- Market (individual / small group)
- Exchange Indicator
- Plan
- Metal Level AV
- Reinsurance Distribution Amount

We recommend that HHS work with the NAIC in developing the final content and timing of the reports.

***Medical Loss Ratio (MLR)***

The Proposed Notice includes three proposals to adjust the MLR regulation. The NAIC has two comments on the introduction of premium stabilization parameters and a comment on community benefit expenses.

The proposal suggests the formula for the MLR be modified to incorporate elements of the premium stabilization programs established in Affordable Care Act: the Transitional Reinsurance Program, the Transitional Risk Corridor Program, and the Permanent Risk Adjustment Program. Specifically, while the proposal provides that reporting of these amounts will follow the approach dictated in the law, the regulation interprets the phrase "accounting for" to include deducting such amounts from the denominator and adding them to the numerator.

If such an approach is implemented, we recommend that the fees associated with these programs be returned to the denominator along with other fees and taxes. Specifically the \$5.25 per month associated with the

Reinsurance program, and the approximately \$1.00 per enrollee Risk Adjustment fee should be expenses/fees associated with running the programs, along with any additional fees a state might additionally impose, rather than be considered a payment or receipt stemming from the operation of these premium stabilization programs. These fees should not be considered the same as a risk corridor charge from an issuer with Allowable under Target, nor considered the same as a risk adjustment payment from an issuer with low risk scores.

Second, we recommend that the transfers associated with the risk adjustment program be returned to the denominator since they involve a transfer of claims and expenses, (i.e. a premium substitute), rather than just a transfer of claims. A simple example (attached) shows that to place such adjustments in the numerator disrupts the operation of the MLR ratio. The same reasons that the proposed rule uses to move risk corridor and reinsurance transfers to the numerator apply to suggest risk adjustment transfers should be kept in the denominator.

Third, while we are supportive of developing more equity relative to community benefit expenditures, we caution that the intent of the current regulation was that such expenditures be limited to the amount of legitimate deductions from premium they replace within the formula. It is unclear if the 3% cap represents an appropriate substitute for premium tax based upon the information provided in the proposal.

### ***Exchange User Fees***

To support the overhead of a Federally-Facilitated Exchange (FFE), we feel that using a percent of premium basis is an inappropriate way to assess the user fee. It does not cost the Exchange more to enroll and coordinate benefits for an enrollee paying a higher premium than an enrollee paying a lower premium. A per capita charge would be a more appropriate basis on which to assess the user fee.

In addition, we recommend that the FFE cost projections be broken down by jurisdiction, thus providing more transparency. This will greatly assist in ongoing feasibility analysis for states considering operating a State-Based Exchange (SBE) in the future. In addition, HHS should adhere to the same transparent process that has been required of SBEs in outlining financial sustainability plans for operations. Some states are concerned that HHS will not invest equally in jurisdictions on discretionary line items (navigators, marketing, etc.). A breakout of costs by jurisdiction will enhance transparency and accountability in this regard.

Finally, we are uncomfortable with the proposed linkage between FFE fees to and SBE fees. We see no inherent value to consumers in artificially linking the two. Independent of what happens in the SBE markets, HHS should do everything possible to keep fees in FFEs as low as possible. In no way should HHS inflate FFE fees to match those of SBEs. Furthermore, what funding source will HHS use to provide the balance of FFE operating expenses if the fees were felt to be too high in comparison to the SBE? Will HHS reduce FFE fees despite higher costs of operations?

### ***Definition of Small Business***

Under HCFA Bulletin 99-03, all employees, including part time employees, are to be counted consistent with the ERISA definition, which is cross-referenced in the law and which the NAIC used for reference in the small group model. In the Proposed Notice, employer size is determined by counting employees in a different manner. We seek guidance on how states and issuers should reconcile these different approaches.

***Participation Rules***

The participation rule in the Proposed Notice excludes from the denominator employees who have coverage through another employer plan or through a governmental plan, such as Medicare, Medicaid, or Tricare. Missing from the list are individual coverage and other creditable coverage. There does not appear to be any rational basis for not allowing for these other creditable coverage options in the calculation, or for penalizing an employer with employees who, for whatever reason, are covered by other creditable coverage. We recommend that the formula exclude anyone covered by any other creditable coverage from the denominator.

***Broker Compensation***

The Proposed Notice requires the same broker compensation for “similar plans” inside and outside the Exchange. However, “similar” is not defined. States have already received inquiries on this issue and we recommend a more objective standard, such as equal compensation for the same metal level or for plans with actuarial values within 5% of each other.

We thank you for your consideration of our comments; we are available to discuss them in detail and would be happy to answer any questions.

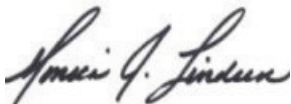
Sincerely,



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