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Stephen W. Robertson, Commissioner

October 31, 2011

Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-9975-P
PO Box 8010
Baltimore, MD 21244-8010

Dear Secretary Sebelius,

The following is Indiana's response to the proposed regulation entitled, "Standards Related to Reinsurance, Risk Corridors and Risk Adjustment" [Federal Register Vol. 76, No. 136], which was published in the *Federal Register* on July 15, 2011. We appreciate the opportunity to provide comment on this proposed rule. As noted in our comment on the proposed regulation for the Establishment of Exchanges and Qualified Health Plans, [45 CFR 155 and 156], Indiana has not yet committed to a state-based Exchange, and the final regulations released by CMS will weigh heavily on our decision.

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

Section 153.200 Definitions

HHS currently defines "contribution rate" as "the rate, based on a percent of premium, used to determine the dollar amounts each health insurance issuer and third party administrator, on behalf of a self-insured group health plan, must contribute to a State reinsurance program." It would be much easier for carriers to implement a premium-based assessment than an enrollment-based assessment, as this is similar to what carriers currently do. In either case, the assessment formula will be an approximation and will not generate exactly the projected amount of revenue. In many cases, a per-member assessment would add a disproportionate cost burden on low premium plans and is not advisable. Further, reinsurance payments should be based on total claims payments, without regard to whether the claim is included as part of the essential benefits package.

Also in this section, the term benefit year generally refers to the 12 month period that follows the initial date of the policy being issued. However, we believe that CMS has intended that the benefit year would be defined as a calendar year. If this is the case, Indiana provides comment that the reinsurance program would be the easiest to operate on the calendar year definition, and should be defined as such in the final rules.

Finally, the definition of "percent of premium" is currently stated as "percent of total revenue, based on earned premiums...in a fully insured market or the percent of total medical expenses in a self-insured market." In an effort to be consistent with Medical Loss Ratio (MLR) regulations, a better term than "total medical expenses" would be "earned premium equivalents."

Section 153.220 Collection of reinsurance contribution funds

Section153.220 requires that the reinsurance entity "collect specified additional contribution funds for deposit into the general fund of the U.S. Treasury." These payments are set at $2 billion in calendar years 2014 and 2015 and $1 billion in 2016. Comments were requested regarding the method and frequency for these collections. In order to reduce burdensome efforts, reinsurance contributions should be collected no more frequently than quarterly and only for the funds that have been actually received from contributing entities. Further, Indiana does not have enforcement authority over self-insured employers or their third party administrators; these plans are governed by the U.S. Department of Labor. Therefore, the regulations should include a provision for effective enforcement by federal or state authorities for payments to be made by or on behalf of self-insured employers.

Additionally, while several methodologies were given for collecting these payments, Indiana requests clarification as to what sort of refunding mechanism will be created if the federal government receives over $2 billion in 2014-15 and $1 billion in 2016. There is no specific reason for these payments beyond funding the federal government's administration of the program, though much of the work may actually reside with the States, and it is important that a mechanism exist for refunding these payments.

Section 153.220 also sets forth the use of a national uniform contribution rate. The commentary accompanying the proposed rule discusses a second option that was considered where HHS would use a State-level allocation, ensuring that the sum of all contribution funds equals the national amounts set forth in the ACA. In response to HHS' request for comment on this provision, Indiana recommends that HHS allow flexibility for the contribution rate to be determined on a national level. State-specific contribution rates will require all health insurance issuers, including administrators of self-insured plans, to allocate the assessment base (premiums or enrollment, for example). This is not something that needs to be done on an issuer-by-issuer basis. Making and verifying the calculation at a state level for each issuer would be expensive to both the issuers and the states and likely would not guarantee either its accuracy or fairness.

By using total premium, premium equivalents, or enrollment statistics, the total contribution, which is fixed in the law, can be allocated to issuers. Similarly, the total contribution can be allocated to states based on state-level premium, premium equivalent, or enrollment statistics that would be reported on a consistent basis state-by-state and sum to the national total. Then, each issuer would be directed to pay a calculated share to each state in which it does business.

Section 153.250 Coordination with high-risk pools

The regulation specifically states that funds will be collected from all markets and distributed to the individual market. With respect to existing high risk pools, states should be allowed the flexibility to modify their programs and should be allowed to participate in the ACA Reinsurance program. This level of flexibility proposed should also include the funding mechanisms states use for the distribution of payments to the high risk pool and the qualified recipients as identified by the State.

Subpart D – State Standards for the Risk Adjustment Program

Section 153.310 Risk adjustment administration

The timelines for all risk adjustment activities should be no longer than when MLR and risk corridor needs to be reported.

Section 153.320 Federally-certified risk adjustment methodology

Section 153.320 proposes a method by which states are expected to determine the precise value of payments and charges as part of the risk adjustment methodology. Indiana requests the flexibility from HHS to determine risk sharing based on the net premium costs, which allows for the medical cost, but not the administrative cost, to be distributed among the carriers. However, it could be prudent to include some administrative costs associated with serving a higher risk population: increased claims processing costs and disease and case management. To the extent that the federal government defines the methodology, Indiana requests the flexibility to use net premium cost as a basis instead of gross premium costs.

Additionally, several items remain unclear in regards to the risk adjustment methodology, including: 1) relative weights; 2) concurrent risk scores v. prospective risk scores; 3) integration with reinsurance; 4) primary vs. secondary insurance; 5) cost sharing reductions; 6) new individuals and unscored individuals; and 7) prescription drugs and laboratory tests. However, further comments and decisions from Indiana are pending upon the NAIC's Risk and Reinsurance subgroup's comments on CMS's white paper entitled, "Risk Adjustment Implementation Issues."

Section 153.340 Data collection under risk adjustment

In Section 153.340, HHS outlines three possibilities for data collection under risk adjustment. Indiana requests that instead of defining one specific means of data collection, that states are given flexibility.

Subpart F – Health Insurance Issuer Standards Related to the Temporary Risk Corridors Program

Section 153.500 Definitions

HHS requested comments on potential limitations on the definition of "allowable administrative costs." Indiana requests that "allowable administrative costs" be limited to 15 to 20 percent consistent with the amount allowed for MLR. This will reduce the incentive for an insurer to use risk corridor payments to pay their MLR rebates. In addition, quality improvement expenses, as described in sections 158.150 and 158.151, should be an allowable cost. It is important to keep the definitions closely aligned between the two programs.

Section 153.510 Risk corridor establishment and payment methodology

Indiana requests that the risk corridor payment methodology, proposed in 153.510, be adjusted for risk adjustment payments and receipts of reinsurance payments to ensure that carrier reimbursement remains equitable.

Section 153.520 Risk corridor standards for QHP issuers

According to the proposed rule, QHP issuers must submit data related to actual premium amounts collected by QHP issuers. Indiana offers the comment that risk corridors may be established based on targeted medical costs (net premiums) in addition to the premium rates.

In conclusion of these comments, this document parallels and supports the NAIC comments as submitted to HHS regarding the programs detailed in the regulation: risk adjustment; reinsurance and risk corridors. Some sections in the regulation need more details or time in order to develop an effective response. If you have any questions, please contact Logan P. Harrison, Chief Deputy Commissioner for Health, Legislative and Public Affairs at (317) 234-7734 or lharrison@idoi.in.gov.

Sincerely,

Stephen W. Robertson

Stephen W. Robertson
Indiana Commissioner of Insurance