
MEMORANDUM

TO:

FROM: TOMI OSSANA

SUBJECT:

DATE: 12/17/2012

CC:

This memo is a response to the Proposed Rule by the Health and Human Services Department on 12/07/2012: Patient Protection and Affordable Care Act, HHS Notice of Benefit and Payment Parameters for 2014. These comments are specific to *Section III, Provisions of the Proposed HHS Notice of Benefit and Payment Parameters for 2014, Subsection C., Provisions and Parameters for the Transitional Reinsurance Program.*

The Patient Protection and Affordable Care Act (PPACA) was enacted by Congress with numerous provisions for involvement from the states. It was never intended to be a "one-size fits all" Federal program, but included mechanisms for each state to implement the law in a manner that works most effectively for each state, given their own unique characteristics and the tremendous variation that occurs across states in terms of health costs, demographics, rate setting, institutional characteristics, and more. **It seems clearly defined in PPACA that the Reinsurance program was to be a collaborative effort between State and Federal see SEC. 1341. TRANSITIONAL REINSURANCE PROGRAM FOR INDIVIDUAL AND SMALL GROUP MARKETS IN EACH STATE.**

This reduced role for the states is contrary to that which was described on March 23, 2012, when HHS published a final rule to implement policy parameters governing the transitional reinsurance program (see Standards Related to Reinsurance, Risk Corridors and Risk Adjustment Final Rule (45 CFR Part 153), published at <http://www.gpo.gov/fdsys/pkg/FR-2012-03-23/pdf/2012-6594.pdf>). This document outlined and clarified direction for states seeking to administer reinsurance programs under the Affordable Care Act. Specifically:

"States must either enter into a contract with an existing applicable reinsurance entity or establish an applicable reinsurance entity to carry out the provisions for the reinsurance program. We believe the statute allows State flexibility in selecting an applicable reinsurance entity and did not propose more specific guidelines."

- This document continues in describing many parameters within the control of the states in establishing and implementing a reinsurance program. For example:
 - The selection of the reinsurance entity for performance of administrative functions, including payment of reinsurance funds to specific carriers,
 - The selection of payment parameters (thresholds, coinsurance, caps) for the reinsurance program in the state,

- The selection of benefit parameters appropriate for the particular market characteristics in a given state, and
- The timing of payments to carriers to ensure fair and adequate support to the individual market carriers in a state.

Our first comment **regarding the proposed rules issued 12/07/2012 is that the collaboration between the Federal Government and the States outlined in the PPACA**, and subsequently confirmed by the Rules published on March 23, 2012 - and then again confirmed in the Bulletin on the Transitional Reinsurance Program: Proposed Payment Operations by the Department of Health and Human Services, May 31, 2012, **has been ignored and overridden** in these newly Proposed Rules. The newly Proposed Rules have been created without input and dialogue from the states.

This change in philosophy removes any state flexibility or variations that could be implemented to meet the needs of our state. We describe areas where Utah would propose state specific variations and the disadvantages of the proposed rule further below.

Secondly, the Proposed Rules we are addressing greatly diminish the role of the states in managing their specific insurance markets, as well as creating disincentives for some carriers to manage care and contain health costs.

State insurance market characteristics vary greatly. Implementation of the ACA is subject to tremendous uncertainty, a fact demonstrated while operating the Pre-existing Condition Insurance Program (PCIP). Original cost projections estimated that PCIP costs and population behaviors would mirror that of state-run high risk pools, this turned out not to be the case. In Utah, most features of both programs are identical; plan administration, benefit design, the contracted provider network and reimbursement mechanisms, as well as care management functions. However, vast differences in utilization and costs between the plans have been observed. The PCIP program is experiencing costs associated with the provision of intense, acute medical services. Nearly half of the claims dollars associated with the PCIP are for inpatient hospitalization (IP). Also significant is the fact that Rx Costs are only 2% of the total cost of the PCIP Plan. Also, Utah's PCIP population is significantly lower income, and has approximately twice the proportion of females between 20-40 years of age.

The purpose of the PPACA's reinsurance program is to **stabilize premiums in the individual market**. The individual market in each state differs by:

- Demographics - Utah has a younger population than most states.
- Rate setting: Some markets currently have insurance premiums based on risk rating, while other states have markets that use community rating,
- Cost Management: States vary considerably in the degree of care coordination and efforts to reduce unnecessary utilization.
- Administrative cost per member.
- Cost relativity of inpatient, outpatient, physician and pharmacy expense

Particularly in Utah, where we have a younger, healthier population than most states, as well as the 49th lowest cost of care in the nation, the collection and distribution of reinsurance payments as proposed would create a tax shift where taxes on our citizens would be shifted to states with more cost and unnecessary care. The Proposed Rules create disincentives for insurance carriers and providers to manage care as efficiently as possible, in effect, penalizing them for better care and health plan management.

In order for the reinsurance program to achieve the goal of premium stabilization, the reinsurance reimbursements should be targeted towards the newly destabilizing events. This matching would take the form of ensuring that the reinsurance directly addresses:

- Claims cost from current risk pools and group conversion policies
- Newly insured participants with pent-up demand for services
- Premium age variation by reinsuring more claims from older enrollees
- Reduce outmigration by decreasing cost of adverse selection under guaranteed issue
- Together with risk adjustment, help protect individual carriers from more risk than market average

What progress comes from implementing the Proposed Rules at the expense of a state and its businesses that have made so much progress in lowering health care costs and improving outcomes?

Utah has spent a considerable amount of time and resource towards implementing the reinsurance provisions of the PPACA as defined by communication from HHS in March and May of 2012. In particular:

- Achieving support from the State Legislature and Governor's Office for running a state based reinsurance program.
- Defining benefit and payment parameters, including thresholds, coinsurance amounts, benefit caps, and fee schedules for diagnostic or procedure specific reimbursements. Reimbursements made in this way would appropriately incentivize carriers and providers to improve care management, rather than simply paying for service volume. In addition, these parameters, when subject to the discretion of the state, can be altered when needed.
- Determining the best way to collect data, and use it as effectively and efficiently as possible to provide reinsurance payments, on a schedule that would have been more frequent than that proposed in the new rules. Utah's data collection and analysis has been designed to be more detailed and comprehensive than the distributed data approach defined by the rules. This state based analysis, along with flexibility in setting benefit and payment parameters, would provide reinsurance that was fair and consistent, as well as enabling the state to appropriately manage incentives to provide health care at a lower cost with better outcomes. The distributed data approach proposed by HHS is limited, untested, and would not provide any credible information that can be used for care management.

- Framing an organizational structure and defining functions for the non-profit, state based reinsurance entity that would carry out this part of the PPACA. Legislation was being drafted at the time the newly Proposed Rules were released on 12/07/2012. In addition, it is reasonable to suggest that administrations costs for the reinsurance program defined in the newly Proposed Rules would be more costly to the citizens of Utah. Again, using the PCIP as an example, Utah's administrative costs are approximately 2% for the program, vs. the 10% allowed by PCIP guidelines
- Creating a state-based reinsurance program that would decrease uncertainty in the insurance market (facilitating lower costs), provide greater responsiveness than the newly proposed model, and increase cost management and improving outcomes. The program defined in the newly Proposed Rules would increase uncertainty in Utah's individual insurance market, along with decreasing incentives to contain costs.

As a result of the newly proposed rules, all progress pertaining to a state based reinsurance is subject to great revision.

In addition, the Proposed Rules do not provide enough information for the states to use to adequately design a feasible reinsurance program. For instance, while the Rules do state that there is room for state based High Risk Pools to "complement" Exchanges, it provides no detail in terms of how this is to be done. In fact, from our reading of the Proposed Rules, it is to a state's benefit, if it has characteristics like Utah, not to continue operating a high risk pool.

In conclusion Utah stands behind the belief that a total Federal administration of the reinsurance program will not provide flexibility in plan design, collection of assessments, the amounts to be assessed (which may be crucial in order to sustain the market), or plan duration.

If Utah had the ability to administer the Reinsurance program under past rules it would have allowed flexibility in many aspects of the administration. For example:

- Utah can design the parameters to meet our needs. Federal rules do not always fit perfectly.
- The data approach used by Utah could be modified from a distributed data model defined by HHS. The HHS model may limit the state's choices about what type of risk is being paid for and how it is being paid (for example: are claims paid on allowed or billed charges). By developing a state-specific model, data collection could be more detailed; we could conduct data claim reviews, pull diagnosis codes, etc. (Utah's All Payer Claims Database (APCD) may be utilized for these functions).
- The timing and processing of payments could be adjusted to meet the issuers needs - monthly vs. quarterly (HHS).
- Administrative costs would likely be lower if the state ran the program.

Cathy Dupont

From: Christensen, Isaac <imchristense@cvty.com>
Sent: Saturday, December 15, 2012 10:24 PM
To: Cathy Dupont
Cc: Kyle, Frank; Trettin, Todd
Subject: Comments for CCIIO on Reinsurance and Risk Adjustment

Cathy,

Here are the comments I have for CCIIO regarding reinsurance and risk adjustment. I would love to voice these to CCIIO verbally if that phone calls ends up happening.

Reinsurance

1. If the main goal of the reinsurance program is to stabilize premium, given how widely healthcare costs vary from state to state, it would make sense to have varying parameters by state. As a hypothetical example, a \$50,000 attachment point may make sense for a low-cost state, whereas a \$100,000 attachment point could make more sense for a high-cost state. If there is already a large volume of >\$50,000 claimants in a high-cost state, the premiums would already reflect that fact, and thus the reinsurance level needed to “stabilize” the premium for that state would be higher.
2. Nationalizing the reinsurance program (same parameters across the country, same fee across the country, and all payments come from the same pool regardless of state) ultimately means that lower-cost states are subsidizing higher-cost states.
3. Premiums in low-cost states will receive more of a “shock” than those in high-cost states for two reasons:
 - a. The flat \$5.25 PMPM represents a larger percentage of the premium for a low-cost state than for a high-cost state, and thus the needed premium increase for a low-cost state is higher as a percentage than the increase for a high-cost state.
 - b. Since the attachment point is the same for all states and since the reinsurance payments are distributed from one national pool, ultimately high-cost states will receive more payments in general, thereby receiving more relief to premium rates.
4. As an example to illustrate #3, assume that costs start out at \$262 PMPM in State A and at \$525 PMPM in State B. Further, assume costs go up by 20% in each state as a result of the newly-insured population, AV mandates, EHB coverage, healthy people dropping coverage, etc (it likely won’t be the exact same percentage increase from state to state, but since we don’t know, it isn’t an unreasonable assumption to make). First, the \$5.25 PMPM reinsurance fee would increase premiums in State A by 2%, but only by 1% in State B. Second, since State B is high-cost and has a larger volume of high-cost claimants, it will receive more reinsurance payments, and thus carriers will be able to decrease their premium by -10%. Since State A has fewer high-cost claimants, they will only be able to decrease their premium by -5%. As a result, State A’s premiums increase by 17%, while State B’s premiums increase by 11%. State A has received more of a shock.
5. Ultimately, due to the above comments, states that are managing their costs well and keeping them low are being penalized as a result of the nationalization of the reinsurance program.
6. While it is recognized that nationalizing the program can save on administrative costs, the improved premium stabilization across states may be worth the additional costs, depending on what the additional costs are. In other words, states would likely be willing to pay the additional costs if they were given more flexibility in return.

7. Giving states the flexibility to choose their own parameters, and then charging them reinsurance fees that correspond to their utilization levels and parameters, would ensure that the reinsurance program would best meet the premium stabilization needs of that state.

Risk Adjustment

1. It would be ideal for carriers to get periodic risk score updates, both for the carrier's own population within a state as well as for the entire state. While it probably doesn't make sense to give a March 2014 or June 2014 update due to credibility, a September 2014, December 2014, and March 2015 update for the calendar year of 2014. This way carriers can get a better picture of financial performance, accrue for anticipated risk adjustment payouts/receipts, and better price for 2016.
2. It makes sense to adjust for partial membership, especially in the small group market that does not have an open enrollment period. A member with only 1 month in the calendar year with the carrier should not be treated the same as an equivalent-risk member with 12 months in the calendar year.
3. The Actuarial Value Calculator adjusts for induced demand in calculating the AVs used for the metal tiers. Since a carrier's risk score is adjusted for metal tier, isn't it double-counting to also adjust for induced demand?

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