Oct. 28, 2011

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9975-P
Room 445-G
Hubert H. Humphrey Building
200 Independence Ave., SW
Washington, DC 20201

Re: Proposed rule on standards related to reinsurance, risk corridors, and risk adjustment

To Whom It May Concern:

The American Academy of Actuaries'[1] Risk Sharing Work Group appreciates the opportunity to provide comments to the Centers for Medicare & Medicaid Services (CMS) on the proposed rule implementing the risk-spreading mechanisms included in the Affordable Care Act (ACA). The work group that developed this letter includes health actuaries with a broad spectrum of actuarial experience who have particular expertise in risk-spreading mechanisms. Our objective in submitting these comments is to provide CMS with a balanced perspective and to assist you in the development of a technically sound rule. We have attempted to do this by exploring different alternatives and providing input on the advantages and disadvantages of those alternatives as the rule on these risk-spreading mechanisms is finalized.

This letter includes general comments, requests for clarification on aspects of the proposed rule, and responses to the solicitation of comments on specific provisions. Before outlining our specific comments, we highlight some of the overarching concerns that arose during our work group discussions. We recommend CMS take these concerns into consideration while finalizing the rule:

- **Timing of risk-spreading programs' results**. There is a significant trade-off between allowing sufficient time for reinsurance, risk adjustment, and risk corridor data to emerge versus expediting the timeframe for calculating all three risk-spreading programs' results. The former allows for provider claims to be submitted and paid (claims data runout) and relies on relatively more robust data. The latter allows the medical loss ratio (MLR) calculation and rebates to occur early enough to make meaningful the connection between rebates and the premiums paid by consumers. The latter also offers consumers more time to review issuer rankings and rate changes to assist them in making future purchasing decisions, and enables issuers to finalize their financial position for the preceding year.

[1] The American Academy of Actuaries ("Academy") is a 17,000-member professional association whose mission is to serve the public on behalf of the U.S. actuarial profession. The Academy assists public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

- **Plan year and benefit year as calendar year**. For purposes of reinsurance assessment, reinsurance payment, and risk corridors, CMS should clarify whether "plan year" and "benefit year" are the same as "calendar year." This is especially critical given potential complexities when they are not aligned in that manner and the fact that MLR calculations will be on a calendar-year basis.

- **Information in advance of 2014**. Issuers' pricing actuaries need to know the risk-spreading methodologies and parameters sufficiently in advance of deciding in which markets to recommend participating in and how to price their products. To the extent that some products will commence coverage in 2013 and end in 2014 and that 2014 experience will be part of the plan year subject to risk-spreading (e.g., reinsurance), information will be needed in early 2012. Separate from methodological and parametric information, issuers also are looking to CMS and/or states for state-level demographic, risk, and cost information to help with product pricing. Lack of such advance information in sufficient detail to assist health plan issuers in their business and pricing decisions would contribute to unnecessary market uncertainty.

- **Interim information during initial years**. During 2014 and 2015 (and to some extent 2016), issuers' valuation actuaries will be faced with a significant level of uncertainty compared to that of previous years. As a result, interim reports—such as projected sufficiency or shortfall in a state's reinsurance funds or issuers' estimated risk adjustment funds transfer amounts as of the interim date—could be valuable. This interim information will be needed to establish reasonable accruals and to issue actuarial opinions. In addition, without interim results, year-end risk funds transfer amounts could be unexpectedly large or small enough to cause financial instability for issuers. It also could make subsequent years harder to forecast and difficult to price.

- **Additional safeguards against risk selection.** Although the ACA requires issuers to accept all applicants and prevents issuers from varying premiums among purchasers by health status, risk selection still could occur if issuers are able to use non-health status information (such as consumer data) to estimate individual health spending and to target marketing materials to those with low expected health spending relative to others in their premium rating category and/or risk adjustment cell. Consumer information like credit card transactions and spending patterns that indicate lifestyle choices, for instance, is becoming increasingly available to market researchers. Because risk adjustment will not be able to fully reflect the underlying risk of enrollees, CMS may wish to consider appropriate marketing restrictions or network adequacy requirements.

The rest of this letter is organized by subpart and section of the proposed rule.

In addition, we have included an Appendix at the end of this letter that provides more detail on many of the issues discussed below. It specifically highlights certain technical, policy, and practical implications associated with many of these issues.

Subpart B—State Notice of Insurance Benefits and Payment Parameters

153.100 Establishment of State Insurance Benefits and Payment Parameters

Initial year schedule
The proposed regulations indicate that CMS will publish advance notice regarding reinsurance and risk-adjustment parameters by mid-October 2012, allowing a one-month comment period. States' alternate risk-adjustment methodologies will need to be submitted by November 2012, and it appears to us that certification will run concurrently with CMS finalizing its notice in January 2013. If the state methodologies differ from the federal parameters, states will be allowed to issue their final reinsurance and risk-adjustment parameters by March 2013.

We suggest that the time frame be moved up by three months to allow a state using an alternate reinsurance or risk-adjustment methodology sufficient time after the federal final notice to evaluate what changes it might need to develop its alternate methodology. It is difficult to envision how the concurrence of certification of states' alternate risk-adjustment methodologies and the CMS final notice issuance would work. Advancing the federal final notice timeline not only will help states make their choices but also will afford issuers adequate time to conduct reviews and assessments, make any required revisions to their market and pricing strategies, design and implement systems and operational changes, and amend provider contracts to incorporate needed modifications. Consideration should be given to the fact that at approximately the same time, many other ACA provisions will require approval, including exchange participation. This work, in addition to risk adjustment, reinsurance, and risk corridors, will involve extensive analyses and development, including plan design and rate filing work. States will be required to design and set up all administrative and related functions (including reinsurance and risk adjustment) for exchange certification.

On another note, the open-enrollment period for state exchanges begins in October 2013. Working backwards, a March 2013 start date appears to be too late for all state-level methodological decisions and operations implementation followed by issuers' plan design development, rate filing work and establishment of administrative and operational processes.

For these reasons, we recommend that CMS:
- Publish its advance notice by June 30, 2012, rather than in October 2012;
- Schedule the issuance of the federal final notice for Sept. 30, 2012; and
- Allow sufficient time for each state to evaluate the federal notice and submit its alternate methodology to CMS, obtain approval, and publish the state final notice by Dec. 31, 2012.

Note that this timeline still will be challenging for policies with plan years that begin in 2013 and end in 2014 and get included in risk calculations.

The Appendix outlines some options for the timeline along with the implications of each option.

153.110 Standards for the State Notice

We recommend, in addition to the items included in the list provided in Section 153.110, that a state planning to modify the federal parameters be required to include in its annual notice whether and when it intends to collect reinsurance contribution rates that are higher than

federally specified standards, as well as the amount of that higher rate. This would be a key input to issuers in their product pricing efforts.

Subpart C—State rule for the Transitional Reinsurance Program for the Individual Market

Our comments regarding the transitional reinsurance program are based on an understanding that its main objective is to make the cost of individual insurance more affordable at the outset by mitigating some of the initial adverse selection. Three critical policy goals identified by CMS include: 1) protection against medical cost overruns for high-cost individual enrollees; 2) early and prompt payment of reinsurance funds; and 3) minimal administrative burden since it is a temporary program.

As indicated in the proposed rule, this work group submitted comments to HHS in September 2010, outlining options for structuring the reinsurance program.[2] The letter did not recommend any particular option but instead discussed the implications of various options for identifying individuals eligible for reinsurance and for structuring payments. The approach proposed by HHS is consistent with the options offered in that letter.

153.200 Definitions

Alternatives to using essential health benefits package
We observe that "risk-spreading" (i.e., reinsurance, risk adjustment, and risk corridors) and "premium subsidy" are defined in terms of essential benefits. CMS should rely on an actuarial certification for purposes of premium subsidy determination. This certification should include the allocation of premiums between the essential and supplemental benefits as well as the adequacy of both components. Note that the supplemental benefits could include state-mandated benefits on which state-specific regulations may require additional reporting.

Maintaining claims experience separately for essential and supplemental benefits (potentially further separated by state-mandated benefits versus non-state-mandated benefits) would be difficult, however, because of the way in which deductibles, co-payments, coinsurance, and out-of-pocket (OOP) limits would apply across both categories of benefits. In addition, the order in which benefits (essential or supplemental) are utilized and applied is unknowable and uncontrollable. This could alter the timing of when an OOP maximum is reached or a reinsurance attachment point is achieved for the same claims with different dates of occurrences.

If the added cost of the supplemental benefits is nominal or less than a small percentage (e.g., 3 percent of the cost of the essential benefits), CMS might consider their OOP cost impact to be insignificant, given the temporary nature of reinsurance and risk corridors. It also would be important to ensure that the supplemental benefits that interact with the OOP maximum are adequately priced and do not contain any element of potential catastrophic claims expense.

If the added cost of supplemental benefits exceeds that small percentage (e.g., 3 percent), then CMS for administrative simplicity might consider subtracting the total of supplemental claims

[2] American Academy of Actuaries letter to HHS on potential approaches for identifying high-risk individuals and determining payments under the temporary reinsurance program (September 2010): http://www.actuary.org/pdf/health/Reinsurance%20Options%209%2022%202010.pdf

incurred from the total claims incurred for temporary reinsurance and risk corridor purposes. In such a case, issuers would be required to differentiate essential benefits from supplemental benefits in the claims data submitted for reinsurance reimbursement, which is not required of issuers today. We expect that this generally would be an additional administrative cost for issuers.

A list of options regarding what benefits may enter into the reinsurance calculation and how they would be incorporated can be found in the Appendix at the end of this comment letter.

153.210 State Establishment of a Reinsurance Program

Unexpended reinsurance funds

Section 153.210 in the proposed rule provides that states must ensure the establishment of a reinsurance entity to cover completion of all reinsurance activities in 2014 through 2016. We believe clarification is needed on the provision in the law that states "amounts remaining unexpended as of December, 2016, may be used to make payments under any reinsurance program of a State in the individual market in effect in the 2-year period beginning on January 1, 2017." There are multiple ways in which this language can be interpreted, as described below.

One interpretation could be that any reinsurance funds remaining from 2014 could be carried into 2015 and additional carried-over amounts accumulated into 2016. A further interpretation could be that funds remaining from the assessments from 2014 to 2016 could be used to continue a reinsurance program until Dec. 31, 2018. Any remaining funds after Dec. 31, 2018, would be transferred to the Treasury. Under these interpretations, the state reinsurance entity must contain continuation provisions.

As an alternative, the proposed rule could be interpreted to limit the reinsurance program to costs incurred during the three years (i.e., 2014–2016), with runout for two years after Dec. 31, 2016, allowing issuers to submit non-reimbursed reinsurance claims incurred during 2014–2016, provided reinsurance funds remain. This may be the intended interpretation, but it would result in reinsurance payments to issuers not entering into the risk corridor and MLR rebate calculations on a timely basis. This should be clarified in the final rule. Another option is that CMS consider returning the excess funds to contributing entities on a pro-rata basis and we have included this as an option in the Appendix.

153.220 Collection of Reinsurance Contribution Funds

Diminishing reinsurance funds effect on 2015 and 2016 rate changes

The work group notes that the subsidy aspect of the reinsurance assessment ($10 billion in 2014, $6 billion in 2015, and $4 billion in 2016), when applied to anticipated premiums in the individual non-grandfathered market, is material and is proportionately beyond what typical reinsurance covers. The proportionality depends on the number of non-grandfathered individuals covered in 2014 and the change in the size of the individual non-grandfathered population each year thereafter. If that population is 20 million in 2014, for example, the 2014 assessment amounts nationally to $500 per covered member per year (PMPY). This would represent a material portion of total expected claims and would have a material impact on expected premiums. (Note that this proportionality may vary by state depending on local per covered person costs and the amounts available for reinsurance in each state as discussed below.)

Since an objective of the reinsurance program is for issuers to reflect this subsidy prospectively in consumer premiums, the decreasing amount of total reinsurance dollars and an increasing enrollment in eligible plans, all other things being equal, could result in significant premium increases of an additional 6 percent to 10 percent or more in 2015 above any real medical trend. This is the result of the reduction in the available reinsurance subsidy per year (from $10 billion in 2014 to $6 billion in 2015 to $4 billion in 2016) and expected increases in the size of the (reinsured) individual non-grandfathered insured population.

Given the unpredictability of the size of the covered market and the potential fallout of premium increases, CMS may want to consider spreading the payment of the reinsurance assessments from 2014 to 2016 (or to 2018 depending on CMS' interpretation of the continuation of reinsurance programs through 2018) to assist carriers in a growing market and consider the impact on consumers. In the rate review process, CMS also may want to consider separating adjustments to premium rates that reflect anticipated reinsurance subsidies from adjustments to premium that account for all other items. This would isolate the effect of premium increases resulting from the diminishing reinsurance subsidy and, therefore, not result in an unreasonable premium increase determination.

To illustrate the above points, we have provided some examples below. Table 1 assumes that in 2014 there will be a total of 20 million lives in the individual non-grandfathered market, which grows over the years, with Scenario 2 growing faster than Scenario 1. The remaining assumptions on premium pricing (like loss ratio and resulting retention component) are as shown in the table below (note that claims trend is assumed to be zero). The important result is the bolded/shaded row, which shows the effect of the reducing reinsurance subsidies and growing market on premium changes not driven by claims trend.

Table 1: Reinsurance Subsidy Impact Model (assumes zero claims trend)

	Scenario 1				**Scenario 2**			
	2014	**2015**	**2016**	**2017**	**2014**	**2015**	**2016**	**2017**
Size of individual non-grandfathered market (millions)	20	25	30	35	20	30	40	50
Annual premium w/o reinsurance	$5,000	$5,000	$5,000	$5,000	$5,000	$5,000	$5,000	$5,000
Loss ratio	80%	80%	80%	80%	80%	80%	80%	80%
Retention w/o reinsurance	$1,000	$1,000	$1,000	$1,000	$1,000	$1,000	$1,000	$1,000
Subsidy (billions)	$ 10	$ 6	$ 4	$ -	$ 10	$ 6	$ 4	$ -
Subsidy PMPY	$ 500	$ 240	$ 133	$ -	$ 500	$ 200	$ 100	$ -
Expected claim cost PMPY	$4,000	$4,000	$4,000	$4,000	$4,000	$4,000	$4,000	$4,000
Claim trend over prior year		0.0%	0.0%	0.0%		0.0%	0.0%	0.0%
Subsidy as % of expected claims	12.5%	6.0%	3.3%	0.0%	12.5%	5.0%	2.5%	0.0%
Claim cost less reinsurance subsidy	$3,500	$3,760	$3,867	$4,000	$3,500	$3,800	$3,900	$4,000
Premium priced net of subsidy	$4,375	$4,700	$4,833	$5,000	$4,375	$4,750	$4,875	$5,000
Change in above premium		7.43%	2.84%	3.45%		8.57%	2.63%	2.56%
Retention under subsidy	$ 875	$ 940	$ 967	$1,000	$ 875	$ 950	$ 975	$1,000
Premium increase excess over claim trend		**7.43%**	**2.84%**	**3.45%**		**8.57%**	**2.63%**	**2.56%**
Retention impact due to subsidy	$ 125	$ 60	$ 33	$ -	$ 125	$ 50	$ 25	$ -

Table 2 shows Scenarios 3 and 4 which are similar to the ones above, except that claims trend is assumed to be 8 percent. We see that a non-zero claims trend impacts the premium increase component attributable to the reduction in reinsurance subsidy across the years.

Table 2: Reinsurance Subsidy Impact Model (assumes 8 percent claims trend)

	Scenario 3				**Scenario 4**			
	2014	**2015**	**2016**	**2017**	**2014**	**2015**	**2016**	**2017**
Size of individual non-grandfathered market (millions)	20	25	30	35	20	30	40	50
Annual premium w/o reinsurance	$5,000	$5,000	$5,000	$5,000	$5,000	$5,000	$5,000	$5,000
Loss ratio	80%	80%	80%	80%	80%	80%	80%	80%
Retention w/o reinsurance	$1,000	$1,080	$1,166	$1,260	$1,000	$1,080	$1,166	$1,260
Subsidy (billions)	$ 10	$ 6	$ 4	$ -	$ 10	$ 6	$ 4	$ -
Subsidy PMPY	$ 500	$ 240	$ 133	$ -	$ 500	$ 200	$ 100	$ -
Expected claim cost PMPY	$4,000	$4,320	$4,666	$5,039	$4,000	$4,320	$4,666	$5,039
Claim trend over prior year		8.0%	8.0%	8.0%		8.0%	8.0%	8.0%
Subsidy as % of expected claims	12.5%	5.6%	2.9%	0.0%	12.5%	4.6%	2.1%	0.0%
Claim cost less reinsurance subsidy	$3,500	$4,080	$4,532	$5,039	$3,500	$4,120	$4,566	$5,039
Premium priced net of subsidy	$4,375	$5,100	$5,665	$6,299	$4,375	$5,150	$5,707	$6,299
Change in above premium		16.57%	11.08%	11.18%		17.71%	10.82%	10.37%
Retention under subsidy	$ 875	$ 1,020	$ 1,133	$1,260	$ 875	$ 1,030	$ 1,141	$1,260
Premium increase excess over claim trend		**8.57%**	**3.08%**	**3.18%**		**9.71%**	**2.82%**	**2.37%**
Retention impact due to subsidy	$ 125	$ 60	$ 33	$ -	$ 125	$ 50	$ 25	$ -

Table 3 illustrates two additional Scenarios 5 and 6 that assume 2014 will begin with a smaller number of enrollees (18 million) than in the previous scenarios. We see that this increases the premium increase component attributable to the reduction in reinsurance subsidy.

Table 3: Reinsurance Subsidy Impact Model (assumes fewer initial enrollees, and assumes 8 percent claims trend)

	Scenario 5				Scenario 6			
	2014	**2015**	**2016**	**2017**	**2014**	**2015**	**2016**	**2017**
Size of individual non-grandfathered market (millions)	18	25	30	35	18	30	45	50
Annual premium w/o reinsurance	$5,000	$5,400	$5,832	$6,299	$5,000	$5,400	$5,832	$6,299
Loss ratio	80%	80%	80%	80%	80%	80%	80%	80%
Retention w/o reinsurance	$1,000	$1,080	$1,166	$1,260	$1,000	$1,080	$1,166	$1,260
Subsidy (billions)	$ 10	$ 6	$ 4	$ -	$ 10	$ 6	$ 4	$ -
Subsidy PMPY	$ 556	$ 240	$ 133	$ -	$ 556	$ 200	$ 89	$ -
Expected claim cost PMPY	$4,000	$4,320	$4,666	$5,039	$4,000	$4,320	$4,666	$5,039
Claim trend over prior year		8.0%	8.0%	8.0%		8.0%	8.0%	8.0%
Subsidy as % of expected claims	13.9%	5.6%	2.9%	0.0%	13.9%	4.6%	1.9%	0.0%
Claim cost less reinsurance subsidy	$3,444	$4,080	$4,532	$5,039	$3,444	$4,120	$4,577	$5,039
Premium priced net of subsidy	$4,306	$5,100	$5,665	$6,299	$4,306	$5,150	$5,721	$6,299
Change in above premium		18.45%	11.08%	11.18%		19.61%	11.09%	10.10%
Retention under subsidy	$ 861	$ 1,020	$ 1,133	$1,260	$ 861	$ 1,030	$ 1,144	$1,260
Premium increase excess over claim trend		**10.45%**	**3.08%**	**3.18%**		**11.61%**	**3.09%**	**2.10%**
Retention impact due to subsidy	$ 139	$ 60	$ 33	$ -	$ 139	$ 50	$ 22	$ -

National contribution rate or state-level allocation

A consistent national formula allows for easier determination and adjustment for meeting annual funds of $10 billion/$6 billion/$4 billion over 2014–2016 (plus the $2 billion/$2 billion/$1 billion to Treasury). Under a state-level allocation method, it may be more difficult to make these determinations and adjustments.

National contribution rate: percent of premium or flat per capita amount

- One approach would be the flat percentage of premium assessment.
  - Reinsurance-assessable insured premiums can be viewed as the sum of prospectively anticipated incurred claims in the coverage period plus administrative expenses, taxes, and other fees assessed. In contrast, self-insured employers might not have comparable projected costs on an incurred-claims basis that also include a loading for expected non-benefit costs. This appears to create issues as to whether the same percentage should be applied to insured and self-insured plans.
  - Use of self-insured claims for reinsurance assessment would require an adjustment for lack of claim runout or another mechanism to lengthen the process timeline.
  - Since there is no definition of "situs" for self-insured groups as exists for insured groups, clarification is needed on how this approach will work in terms of determining the state to which the claims base belongs.
  - For multi-state employers, detailed guidelines are needed on the process of disaggregating assessments across states.
- Another approach would be a fixed-dollar assessment on a per covered member per year basis across the country.

- This approach would be combined with the distribution of reinsurance funds to each state on the basis of a level amount per individual insured (limiting the distribution calculation to non-grandfathered insureds). This would provide a degree of equity for low-cost areas by providing them with a higher allocation per non-grandfathered insured individual in return for a level per member assessment.
- Administrative simplification could be achieved by CMS and the IRS by consolidating the pre-2014 known allocation of the pre-2014 average per-member assessment of the patient centered outcomes/comparative effectiveness fee base per average member per year, if the assessment bases can be reconciled (issuer and self-insured employer assessment bases are worded differently). This assessment could be converted easily to a per-member (or per-employee) per-month fee to account for shifting populations over a year.
- Due consideration should be afforded to the type of enrollees that are in the individual market versus the self-insured market. The individual market will be weighted toward the adult population, since children below 200 percent of the federal poverty limit (FPL) will continue to be eligible for the Children's Health Insurance Program (CHIP). The self-insured markets will be a broader mix of adults and children, since these populations are insured through the employer base. This may create some inequity while using a per-member per-month calculation method uniformly across the two markets.

The preamble to the proposed rule mentions that funds collected in a state will stay in that state, so that states with a larger (headquartered) employer market will collect more funds. This can result in disproportionate funding relative to the individual market. The ratio of group business to individual business within a state, multi-state group attribution, and self-insured group situs issues becomes material in determining the proportion of subsidies and funds available for reinsurance across states. A state with a high group-to-individual ratio, for example, may see subsidies much greater than the $500 example presented earlier. In contrast, a state with a vibrant individual market and a lower group-to-individual market size ratio would see lower subsidies.

Regardless of the assessment/allocation methodology, there is always the possibility that reinsurance funds might fall short in a given state. Each state would have to create a contingency plan.

Collecting contributions by "plan year":
Clarification is needed on the application of "plan year" with respect to collecting funds for reinsurance funding. The ACA states: "*make payments … for any plan year beginning in the 3-year period*"[3] and "*for each plan year beginning in the 36-month period beginning January 1, 2014.*"[4]

If CMS opts for a pure "plan year" collection for reinsurance assessment, the collection period for funding each year (starting with 2014) would extend beyond the calendar year cutoff dates for reinsurance, risk adjustment, and risk corridors. This affects both the estimation of the required contribution amount to hit targets as well as resulting cash flows to the reinsurance entities. If contributions from pure plan years beginning in 2014 are used to fund calendar year 2014 reinsurance, then there would be a lag in assessment collection to the end of that plan year and into 2015. If funds collected in 2014 could be used in 2014, then a portion of the original

[3] Section 1341(b)(1)(A) of the Affordable Care Act
[4] Section 1341(b)(3)(A) of the Affordable Care Act

$10 billion (2014) target that is not collected until 2015 would not be available for 2014 reinsurance. Under both scenarios, the process would be more straightforward administratively if "plan year" could be defined as "calendar year."

Additional reinsurance contributions collected by states
The option to collect additional reinsurance contributions offers flexibility to states. A state will have to consider its variation in the magnitude of reinsurance funds available per member or as a percentage of overall expected claims reflecting the method for allocating reinsurance funds to a state. A state also will have to consider variations in expected reinsured claims payout and the possibility of an annual shortfall to ensure that the reinsurance program is fully funded.

The implications of using this option versus a national level rate of contribution are included in the Appendix.

Frequency of collecting issuer contributions
To facilitate making funds available for reinsurance and transmission to the Treasury, there would need to be a balance between when the first reinsurance payments can be made, associated administrative costs, and the method of assessment (percent of premium or per member fixed amount), such as a quarterly upload of assessment payments with true-ups at appropriate intervals. The availability of funds for reinsured claims both early in the calendar year and throughout the year need to be considered to avoid overall shortfall in a given state.

CMS should consider making the assessment base subject to certification for insured business, with state regulatory oversight and auditor attestation for self-insured business as an appropriate agency oversight (e.g., Departments of Labor or Treasury). If the per-member basis is used, then CMS should consider utilizing the mechanisms for collecting and verifying the collections of the comparative effectiveness fees, beginning with plan years ending in 2013, to the extent that the assessment bases are equivalent. CMS should clarify whether the "business to be assessed" is the same assessment base for the comparative effectiveness fee and the reinsurance assessment, both for insured and self-insured.

See the Appendix for a brief summary of considerations for monthly versus quarterly collection of issuer contributions.

153.230 Calculation of Reinsurance Payments

Payments based only on essential benefits
This discussion has been covered earlier under Section 153.200.

Coordination of benefits
Confirmation is needed that coordination of benefits will apply across individual and small-group markets, such that should an individual be covered by more than one health insurance issuer then the total amount of benefits paid may not exceed what the primary and secondary issuers would have paid in aggregate, and the total payment may not exceed 100 percent of allowed charges. This would be consistent with current practices and determination of primary versus secondary responsibility.

Subrogation of medical benefits paid by auto insurance, workers compensation insurance, and other liability coverages (e.g., homeowners insurance)
Clarification is requested on how subrogation of medical benefits paid by auto, workers' compensation, and other liability insurance will be handled. The court decisions regarding subrogation of auto and workers' compensation medical with medical coverages are beyond this work group's area of expertise. Properly incorporating subrogation recoveries under other liability insurance will be reflected in lower costs of individual insurance and reinsurance.

Paid or incurred basis
Clarification is needed on whether reinsurance payments are made on a paid or incurred basis.

- A paid basis reflects claim accumulations that result from claims paid during a specified period. This would not appear to be the natural choice for the temporary reinsurance program because "reinsured" individual non-grandfathered insured premiums are established on an incurred-claims basis, while a paid-claims basis reinsurance program initiated in 2014 would use paid claims in 2014 (and incurred in 2014), resulting in a short reinsured year. In addition, a paid basis would create a potential incentive for issuers to attempt to game the system by accelerating or delaying claim payments to maximize the amount of reinsurance received by maximizing the claims paid during a single reinsurance year, notwithstanding prompt pay rules. Due to these and other issues, reinsurance is seldom on a paid basis in current health insurance markets. Under ACA, this also would affect the reinsurance amounts recognized in or deferred from risk-corridor and MLR rebate calculations.
- The alternative to a paid basis is an incurred basis, which reflects claim accumulations that result from claims incurred during a specified period. Payments for those claims may run out over several months following the end of the incurred period.
    - This is the most common form of reinsurance in current health insurance markets.
    - It appears that the reinsurance in 2014 might apply to reinsurance accumulated on a calendar year incurred basis for all incurred claims on an individual.
    - A decision will need to be made on the length of the claim runout period. This should be coordinated with the risk corridor, MLR determinations, and the use of estimates of claims incurred but unpaid in the calculation. It is not unusual for existing reinsurance on issuers to be on the basis of a 12-month incurred period with a 15- or 18-month paid period, after which any further claim payments would be cut off and excluded from the reinsurance calculation. Carryover provisions typically are not used in traditional reinsurance, so there is a tail risk with any cutoff that may be considered part of the normal risks issuers take. It is recognized that there are runout risks and sometimes delays in large claim incidents that come to the attention of health insurance issuers. These tails of large claimants, however, would be difficult to estimate if reserves for such liabilities were to be attempted. The risk obviously is diminished with each additional month of runout.

Ensuring suitability of claim payments for reinsurance coverage
CMS should consider the possibility that an issuer that is also a provider, and therefore able to contract provider reimbursement rates for itself, may have an opportunity to establish reimbursement rates that are outside the normal range for procedures or lengths of stay that would attract reinsurance. This could position the issuer to receive higher levels of reinsurance reimbursements. This situation is unlikely to exist when the issuer is not the provider and the market forces arms-length reimbursement contracting. One approach to address this is to require the reinsuring entity to re-price all of the medical claims submitted for reinsurance using a rule-

pricing model, such as a fixed multiple of Medicare reimbursements, in which that multiplier yields an approximate market value rate.

The Appendix summarizes the implications of reinsurance payment methodologies as they relate to issuers who also are providers.

153.240 Disbursement of Reinsurance Payments

Timeline for issuers to submit reinsurance claims
The work group suggests that CMS clarify the definition of "benefit year" (see discussion above on plan year). If the benefit year is the calendar year, and reinsurance payments are determined on claims incurred within the calendar year, then timely incorporation into rate corridor and MLR calculations requires a short timeline. Shorter deadlines result in using less complete data and may require using more uncertain and larger accruals. Longer deadlines result in the opposite effect.

Traditional reinsurance programs generally allow for three months of runout with two or three additional months to submit claims data.

Frequency of reinsurance payments to issuers while avoiding funds shortfall or excess
Health insurance issuers will have insured individuals reaching the reinsurance attachment point at different times throughout the year. We presume that issuers will report claims that become eligible for reinsurance as they occur throughout the year. Monthly or quarterly reimbursement for reinsurance claims later in the year could be limited by funds availability if higher-than-anticipated claims occurring earlier in the year deplete most of the available funding for the program. As a result, for the initial months, payments may be made on a percentage of covered amount basis (e.g., 80 percent) or adjusted depending on fund projections, subject to true-up.

See the Appendix for a discussion of the options and implications.

153.250 Coordination with High-Risk Pools

High-risk pools
With the advent of guaranteed issue requirements and both premium and benefit subsidies in 2014, it would appear that pre-reform state and post-reform state and federal fallback high-risk pools (HRPs) will sunset and today's enrollees in the HRPs will enter the individual insurance market.

But if HRPs were to continue, then clarification from CMS would be necessary on the following:

- Will post-reform (non-grandfathered) HRPs be eligible for individual reinsurance?
- Eligibility for HRP coverage is restricted to ineligibility for individual coverage in the previously underwritten markets and, therefore, the HRPs by definition would not be open to the general population. This would seem to imply that HRPs would be ineligible to be qualified health plans (QHPs) in the exchanges. Would HRPs therefore be ineligible for federal premium or benefit subsidies or risk corridors?
- HRP premiums typically are not self-supporting and require subsidies from health issuers in the respective states.

- Would HRPs be open to the general public? If yes, would the reinsurance payments reduce the above subsidies from health issuers? Or would the anticipated reinsurance payments be used to draw down the premium rates further?
- If the carrier subsidization is continued, will such subsidization be allowed as an adjustment to risk-corridor calculations and MLR rebate as a state fee or tax?
- Is the expectation that the carrier subsidization indirectly will increase the federal government's premium and benefit subsidy costs by affecting QHP premiums in the exchanges? Or is the expectation that QHP premiums in the exchange will be lower because they will not be covering the higher-cost HRP individuals, resulting in a lowering of the federal subsidies in the exchanges?

Subpart D—State Standards for the Risk Adjustment Program

Legislative intent assumptions
Of the three risk-spreading mechanisms under ACA, risk adjustment is unique because it is permanent. In contrast, reinsurance and risk corridors are temporary (i.e., for three years). Risk adjustment, therefore, is particularly important for the long-term stability of the individual and small-group health insurance markets.

Our understanding of the legislative intent of ACA for risk adjustment in the individual and small-group markets is as follows:

- The central policy goals of risk adjustment are to:
  - Appropriately compensate issuers based on the health status of their enrollees so that they will be indifferent as to who they enroll, eliminating any potential incentive to game the enrollment process.
  - Transfer money between issuers in the individual and small-group markets so that no plan/issuer is significantly advantaged or disadvantaged by selection.
  - Support the overall health reform goals of providing Americans with quality, cost-effective health care. Risk adjustment, therefore, must operate in such a way that issuers continue to have incentives to reduce health care risk by providing quality, cost-effective care.
  - Enhance market stability.

- In pursuit of the central policy goals, risk adjustment should:
  - Be budget neutral—the money collected by the risk-adjustment administrator is intended to equal the money disbursed by the administrator.
  - Be applied on a consistent and equitable basis between issuers.
  - Be structured to work well under evolving market conditions.

Our comments on risk adjustment are based upon the assumptions above.

General comments on risk adjustment
Several themes emerged during the work group's discussion on specific portions of the proposed rule, including:

- **The need for revised and new definitions.** Some revisions to proposed definitions and some new definitions would enhance the clarity of the rule. We have proposed definitions that may be appropriate. We are less concerned, however, with the specifics of the definitions than

with the need for a common vocabulary and understanding of the definitions and, hence, the rule.

- **The importance of the choice between prospective and concurrent risk adjustmen**t. The rule appears to leave flexibility for the risk-adjustment methodology to be concurrent (i.e., risk adjustment for a given year is based on the health status of insureds during the same year) or prospective (i.e., the health status for one year affects the subsequent year's risk adjustment, such as Medicare Advantage). Medicare Advantage risk adjustment is used for payments from CMS to issuers and Medicaid managed care risk adjustment is used for payments from states to issuers for relatively stable populations using capitation rates established by the government agencies. Risk adjustment under ACA, however, is an unprecedented transfer *between issuers* in a *relatively unknown market* in which significant transfers are anticipated in an unprecedented guaranteed issue environment with *different premiums* expected to be set by each issuer. The choice between prospective and concurrent risk adjustment affects data timing, risk adjustment transfer predictability, the degree to which an issuer's risks in that year are recognized, issuers' pricing and financial forecasting, and issuers' approaches to developing care-management monitoring targets. We discuss the implications of each of the two approaches in this letter.
- **The necessary role of premiums and rating factors in risk-adjustment methodologies**. Because different issuers will set different premiums for different health plans (benefit levels or "metal" product tiers within a market), for benefits beyond the essential health benefits, and for certain insured demographic factors (e.g., age, family tier, smoking status, and geographic area), premium variations and rating factors must be accounted for in the risk-adjustment methodology. The preamble to the proposed rule asks for guidance on how premiums and rating factors may be built into risk-adjustment methodologies. We have provided a high-level discussion on pages 21-24 of the conceptual trade-offs between the various options.
- **The necessary links between methodology, data, and timing.** The risk-adjustment methodology determines what data must be collected. The available data, particularly in the first year of risk adjustment, similarly constrains the choices with respect to risk-adjustment methodology. Appropriate timeframes for risk-adjustment settlement are, in turn, a function of risk-adjustment methodology and data collection. As a result, methodology, data collection, and time frames must be synchronized.
- **The complexity of modeling risk-adjustment methodologies**. In this letter, the work group has provided a high-level perspective of risk-adjustment methodologies. A detailed analysis of risk-adjustment methodologies, inclusive of accounting for premium variations and rating factors, requires modeling that is beyond the scope of this discussion. If requested, we could pursue a joint project with the Society of Actuaries (SOA) and actuaries with expertise in this area to identify and assemble resources to assist with such modeling.
- **State alternate methodology evaluation with consideration for local markets, policy goals, and data availability.** The work group suggests that, in the interests of clarity, the rule should provide guidance on the criteria CMS will use to evaluate states' deviations from the federal standard. The work group also suggests that the rule not require a similar or better statistical fit[5] for an alternate state methodology to be acceptable. Statistical fit should be included as only one consideration by which an alternate state methodology can be evaluated.

[5] Statistical fit primarily refers to the R-squared statistic of the risk-adjustment regression model. It also is used sometimes to refer to the mean absolute percentage error between the regression data and the regression model's estimated values. It sometimes is used loosely to describe the general performance of a model in its application via predictive ratios, that is, the ratios of the model's predictions and the actual values.

As an example, a state for policy reasons (risk-adjustment predictability and financial forecasting) may prefer a prospective methodology to concurrent risk adjustment—even though prospective risk adjustment produces less statistical fit than concurrent risk adjustment.

- **The potential impact of risk adjustment on issuer financials and the need for issuers to have advance information for rating and planning purposes**. The work group is concerned about the effect that large, unplanned risk-adjustment payments, due within a short period, could have on issuer financial stability (and in some cases, solvency). Issuers waiting for a year-end settlement payment also may have financial stability issues, particularly if the payment is delayed until after the state collects payments. While solvency is a concern in the early years of risk adjustment when the health insurance market is likely to be most volatile, unexpected financial fluctuations could be detrimental to individual issuers even within a stable insurance market. The work group suggests that the federal government and states should cooperate to provide as much information as possible to issuers before and during 2014 so that issuers can make the best possible estimates of the effect of risk adjustment on their book of business. This would include finalizing the risk-adjustment methodology sooner than the time frame outlined in the proposed rule, thereby providing a means for issuers to evaluate the risk profile of their existing business and a state's uninsured population before 2014, and providing interim calculations as 2014 progresses.
- **Small-group market.** We did not find much reference to risk adjustment in the proposed rule as applicable to the small-group market, either with the in-exchange market being separate or merged with the individual in-exchange market. More guidance is required with respect to small-group markets.

The following are more detailed comments regarding the proposed rule.

153.300 Definitions

The rule would be clearer if the definitions of "risk adjustment model" and "risk adjustment methodology" are enhanced and several new definitions are added. Although we have proposed specific definitions, we are somewhat less concerned with the specific definitions than with the need for a common vocabulary and understanding of the definitions and, hence, facilitate a common understanding of the rule. At a minimum, the definitions should distinguish clearly between:

1. The method or process used to *assign a risk score* or other measure of relative actuarial risk to a specific enrollee;
2. The method or process used to determine the *transfer of funds* between health plans/issuers based on the risk score or other measure of relative actuarial risk; and
3. The combined system comprising 1 and 2 above.

We believe the definitions also should provide a clear, common terminology to describe the periodic processes necessary to update the system, distinguish between individual enrollee risk and plan or issuer risk, and clearly distinguish between prospective and concurrent approaches.

We propose these revisions to two definitions:

- *Risk-assessment*[6] *model*: a statistical tool used to assess the relative risk of an individual based on predicted costs or expected health care resource use.

[6] Note that we suggest 'assessment' and not 'adjustment' for the scoring tool.

- *Risk-adjustment methodology*: a specific set of actuarial procedures, inclusive of a risk-assessment model, used to assess the aggregate relative risk of issuer enrollees to determine risk-adjustment fund transfers between issuers in an insurance market.

We propose these additional definitions:

- *Enrollee actuarial risk*: a measurement of an enrollee's predicted costs compared to the predicted costs for the average enrollee in the risk pool under consideration. The output of a risk-assessment model directly captures relative enrollee actuarial risk within a risk pool that has a uniform benefit design or is in relatively similar geographical areas. But to compare risk relativities across benefit plans or geographies in an insurance market, adjustments to the model output may be needed for benefit levels and geographic area[7] depending on whether such health care resource predictors are part of the risk-assessment model.
- *Issuer actuarial risk*: a measurement of the predicted costs of an issuer's average enrollee compared to the predicted average cost for all enrollees in the insurance market. Issuer actuarial risk is an output of a risk-adjustment methodology and the precursor to the calculation of risk-adjustment fund transfers.
- *Recalibration*: the process of modifying the risk-assessment model, usually by modifying the risk weights within the model. Recalibration often is used to make the risk-assessment model more specific to the population, data,[8] and other characteristics of the program for which it is being used. Normalization often is embedded within recalibration.
- *Normalization*: the process of modifying the risk-assessment model results and/or methodology for a defined population so that the overall average results in a 1.000 risk factor. Normalization enables budget neutrality (or balancing) in the sense that it leads to a zero sum across all risk-adjustment fund transfers. Budget-neutrality normalization factors can be applied without recalibration or in addition to the normalization embedded within recalibration.
- *Prospective risk-adjustment methodology*: Estimation of the relative actuarial risk of an enrollee for a contract period based on the enrollee's health status prior to the beginning of that contract period. Thus, for a risk-assessment model[9] to be prospective, all claims-based data used must be incurred during a period prior to the beginning of the contract period (i.e., would use 2012/2013 data to estimate relative actuarial risk in 2014).[10]

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[7] This point can be extended to other rating variables such as smoking status as well as to other risk factors such as income.

[8] This refers to data content, data time period as well as to ensuring that these calibration data have been validated consistent with the issuers' contract period data validation methodology that will be included in the state notice and is described in Section 153.350. In the initial year, the timing of the calibration process and the issuance of the state notice will be relevant for ensuring that the consistency is achieved. It will ensure that extrapolations of error rates measured in issuers' data validation processes will result in risk scores that are calibrated using similarly adjusted data. See the Academy's Health Practice Council January 2011 comment letter on RADV sampling and error calculation methodology at www.actuary.org/pdf/health/RADV_comment_letter_012111_final.pdf. An alternative would be to at least measure the baseline error rate in the calibration data for use as reference before issuers' error rates are extrapolated.

[9] Note that while the risk-assessment model is prospective, the risk-adjustment methodology can be structured to absorb concurrent features like recognizing the incidence and relative complexity of pregnancies in the contract period.

[10] In some programs, risk-assessment models *calibrated* with concurrent data (risk weights developed by regressing costs from a historical year on health-status indicators from the same historical year) are used for a prospective risk-adjustment methodology. This assumes a stable market with relative risk scores for issuers that are stable from year to year and may not be appropriate for the newly-reformed market. It also may be viewed as an application of the concurrent approach in a lagged manner.

- *Concurrent risk-adjustment methodology*: Estimation of the relative actuarial risk of an enrollee for a contract period based on the enrollee's health status during that same contract period. Thus, a risk-assessment model is concurrent if it uses any[11] claims-based data incurred during the contract period to determine the enrollee's actuarial risk for that period (i.e., uses 2014 data to measure relative actuarial risk in 2014). The relative risk therefore emerges during the year (concurrently) and can be assessed fully only after the end of the year. Because relative risk cannot be measured until after the end of the year, concurrent risk adjustment also sometimes is referred to as retrospective risk adjustment.

153.310 Risk Adjustment Administration

Appropriate deadline by which risk adjustment must be completed

As with all the three risk-spreading programs, the trade-off regarding timelines is between (a) allowing sufficient time for claims data to complete and have robust data on which to base the risk calculations and (b) expediting the calculations to provide closure for the year. Closure of the risk-adjustment process is necessary for closure of the MLR process. Early closure provides enrollees with timely MLR rebates and issuers with information that they can incorporate into the next year's plan designs and rates.

For completion of risk-adjustment calculations, the achievable timeline is dependent on whether the risk-adjustment methodology is prospective or concurrent.

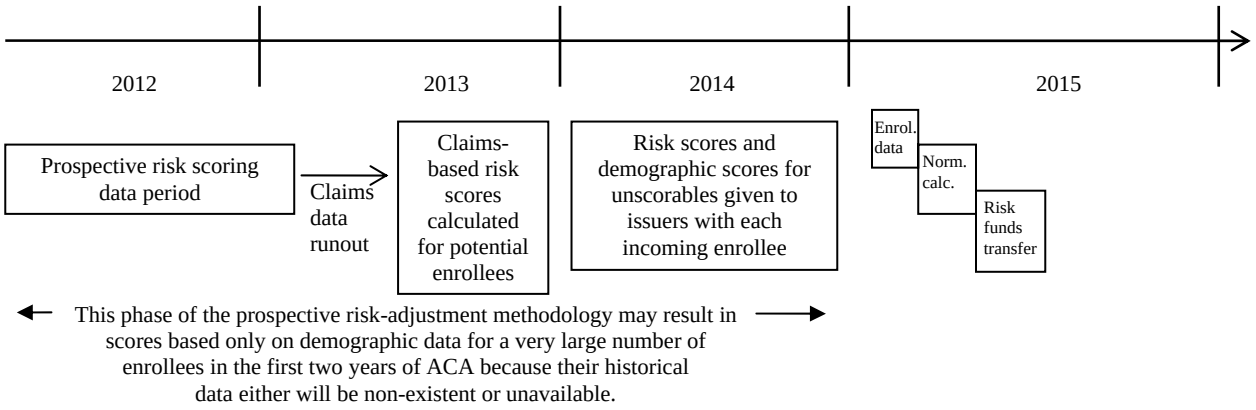
- If the risk-adjustment methodology is prospective, the achievable timeline for completing risk adjustment will be relatively quicker—since only enrollment and premium data will need to be compiled and there will be no need to wait for claims data to run out. Enrollment and premium data should be available within a couple of months after the end of the calendar year. Two more months may be required for the risk-adjustment calculation (including the normalization step), with a resulting completion date of early May. One consideration, however, may be for the enrollment data compilation period to exceed the 90-day grace period required for subsidized coverage within an exchange, which could take this process until June to complete.[12]

  The time chart below attempts to capture the milestones for steps within the prospective approach for the first year of ACA. The year axis would move forward by exactly a year for each subsequent year under ACA.

[11] Note that some types of claims usually are not included in risk-assessment models, for example, laboratory or radiology tests ordered by physicians to rule out certain diagnoses so that the associated suspected diagnoses do not influence the risk score. Other types of claims like those associated with accidents may be included depending on the payer's policy goal of using risk adjustment to spread only health status risk or also insurance risk.

[12] It is expected that in 2014 and 2015 there will be a significant percentage of enrollees who might receive only a demographics-based risk score under the prospective methodology since data for their health status-based risk score may not exist or may not be available.

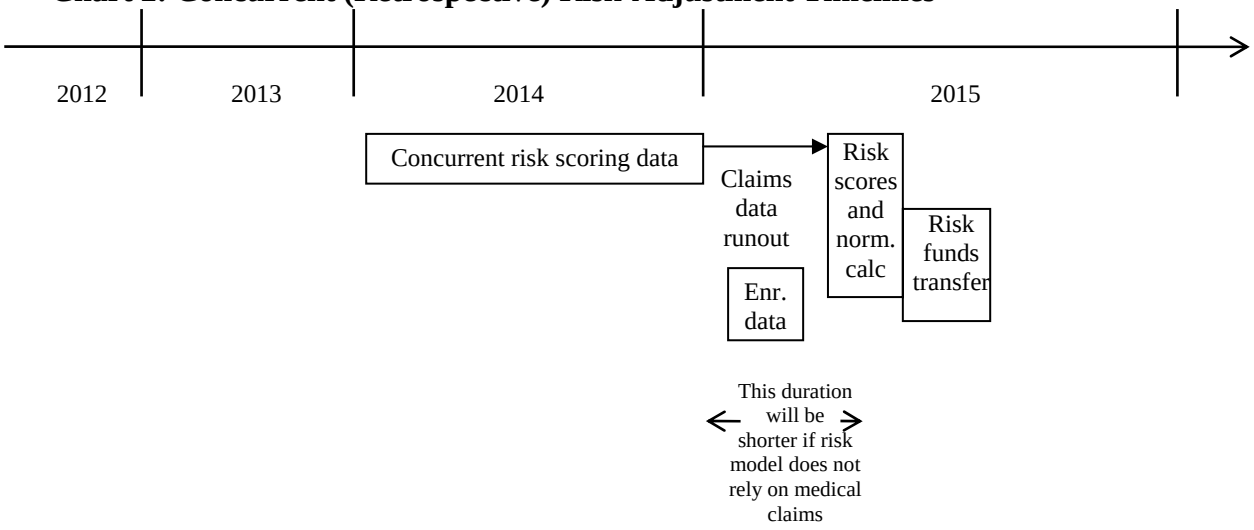
Chart 1: Prospective Risk-Adjustment Timelines



- If the risk adjustment methodology is concurrent (also characterized as retrospective), the achievable timeline for finalizing risk-adjustment calculations will depend on whether the risk-assessment model uses medical claims in addition to pharmacy claims data. Enrollment data can be compiled quickly relative to pharmacy or medical claims and, therefore, does not really influence achievable timelines.
  - If the risk-assessment model does not rely on diagnoses in medical claims, it may be possible to rely on one or two months of pharmacy claims runout and complete the risk-adjustment process in the same time frame as outlined above. Note that use of pharmacy data is a step towards recognition of actual 2014 issuer experience, but it is only a partial proxy for inclusion of medical diagnosis.
  - If the risk-assessment model does rely on diagnoses in medical claims, approximately six months of claims runout may suffice, so that risk adjustment is complete by September. In Section 153.610(b), the proposed rule mentions including penalties in provider contracts to achieve quicker data completion. Even if such contractual changes do not significantly improve data runout periods, one viewpoint is that if claims runout is limited (e.g., to four months), the loss of accuracy in measuring relative risks may be far outweighed by the advantage of completing risk adjustment earlier. This is because the runout beyond a specified minimum period may not affect significantly the amount of funds transferred unless provider claims reporting and issuers' claims payment speeds vary significantly across organizations. A study could be conducted for analyzing the impact of gathering, for example, six versus four months of runout. Using fewer than three months of runout would require rigorous study and stakeholder engagement for support, since issuers might be skeptical of the robustness of the methodology if shorter runout periods are used.

The time chart below attempts to capture the milestones for steps within the concurrent (retrospective) approach.

Chart 2: Concurrent (Retrospective) Risk-Adjustment Timelines



Some work group members hold the viewpoint that the initial years may be implemented with a concurrent approach, and that a state thereafter can transition into a prospective approach in the outer years as more enrollees' diagnoses data become available and the market becomes less uncertain. Other work group members hold the view that, even if the prospective approach relies on only demographic risk scores for a large number of enrollees in the initial years, the relative financial predictability gained by issuers outweighs the loss in risk score accuracy by not having medical or pharmacy data to score the morbidity risk component for those enrollees. Yet other work group members believe that only the concurrent approach would best match payment to risk.

Note that if the federally certified and state alternate risk-adjustment methodologies differ in terms of being prospective versus concurrent, or reliant on medical claims data versus not reliant, a uniform deadline across all states would need to accommodate the methodology that has the longest timeline. Methodological flexibility afforded to states therefore will help each state meet its specific goals, but the trade-offs include administrative burdens for multi-state issuers as well as potentially different timelines across states.

Appropriate timeframe for state commencement of payments

The timing of risk-adjustment transfers largely will be dependent on the timing of the completion of the risk-adjustment calculations, which will be dependent on timeframes for necessary data collection as described above.

Regulators should consider the timing of risk-fund transfers in the context of issuer financial stability. Large, unplanned risk-adjustment charges, due within a short period, may affect issuer cash flow. Issuers waiting for a year-end settlement payments also may experience cash flow issues, particularly if the payment is delayed while the state collects payments. This is of particular concern in the early years of this new risk-adjustment mechanism when the market is likely to be most volatile.

While the exact timing of payments, or a decision to make payments after collecting remittances from lower-risk issuers, may affect market stability and issuer financials, our work group is more concerned about the timing of *communication and reporting* to issuers. If the risk-adjustment administrator assesses relative actuarial risk for issuers mid-year in the early years of the risk-

adjustment program and provides these interim information-only reports to issuers, such communication could help mitigate some of the risk-adjustment-associated financial uncertainty for issuers. Such mid-year reports also may be able to communicate the implications of mid-year issuer insolvencies and market exits, as well as mid-year market (issuer) entrants. The disadvantages of mid-year reports are that mid-year calculations create additional administrative burden and the results could be misleading if significant data issues exist at the beginning of the program in early 2014 or if the enrolled population in the first part of the year is not representative of the entire year.

Requirements for risk adjustment reports from states to CMS

In the interests of transparency, states should have an obligation to not just report to CMS but also make useful information available to issuers. The state's report to CMS should document the full risk-adjustment methodology, including average enrollee actuarial risk in the state, issuers' relative actuarial risks, and the fund transfers. The information that the state makes available to the issuers also should allow issuers to compare themselves in detail to the statewide aggregate.

Each state's report to CMS specifically should include the following:

1) Data metrics for each carrier and the entire market, including number of diagnoses per claim by type of claim (e.g., inpatient hospital and outpatient hospital), and results of the data validation process.
2) Demographic and disease prevalence report for each issuer and the entire market, including a short description of the condition, risk weight, frequency, and risk contribution.
3) Rating factors (e.g., age, family tier, smoking status, and geographic area) used in the risk adjustment methodology, whether specific to each issuer or a standardized set of factors.
4) Premium rate information used in the risk-adjustment methodology.
5) A calculation trail showing how items 2 and 3 are used to determine the actuarial risk for each issuer.
6) A report showing the funds receivable or payable for each plan.

Each state's information to issuers should include the above, but it should show only each respective issuer's information and the market total. Existing state Medicaid risk-adjustment programs offer excellent examples of such information shared with issuers.

See the Appendix for practical implications of options that allow state latitude to deviate from a fixed federal reporting format.

153.320 Federally-Certified Risk Adjustment Methodology

Methodology elements for publication in notices

The enumerated list in this section describes the elements of the risk assessment model. Details should be added under Section 153.320(b)(2) to cover all the elements of the risk-adjustment methodology so that a qualified person who had access to appropriate data would be able to run the risk-assessment model, apply the risk-adjustment methodology, and produce the same results as the risk-adjustment administrator. Examples of such details are: clarification on the factors applied to enrollees outside of the risk-assessment model if they do not meet the minimum enrollment duration requirement for the risk-assessment model; how premiums and rating factors will be incorporated into the methodology; how benefits in excess of the essential health benefit

package will be incorporated into the methodology; and the timing of announcements of assessments, collections, and payments.

Our work group recognizes that the reinsurance program is only temporary. Since the reinsurance coverage apparently will be in the mid-range of claims rather than in the outlier range, a significant overlap is expected, however, in payments to issuers from risk adjustment and reinsurance for unhealthy enrollees. We suggest that CMS clarify whether a separate risk-assessment model will be calibrated for the individual market net of reinsurance, potentially changing with each year's decrease in reinsurance funds and likely increase in covered individuals. Another approach, which is not typical, would be to account for individual level risk-adjustment results to determine reinsurance payments net of risk adjustment.

Predictors in risk model

The work group suggests model factors could be expanded to include enrollee income (or even just a subsidy eligibility indicator) and more refined area adjustments. Since the goal of risk adjustment is to compensate health plans appropriately based on the health status of their enrollees so that they will be indifferent as to whom they enroll, it is desirable to minimize any potential incentive to game the enrollment process. Research[13] indicates that low-income and disadvantaged populations have higher disease incidence and less favorable prognoses once a disease is diagnosed. Poverty, race, ethnicity, and area are highly correlated, so an adjustment to one of these factors could reduce adequately the advantage or disadvantage a plan may experience due to differences in any of these factors. If geographic area is used, it may be appropriate to define areas smaller than county in some states/instances, particularly with respect to large, economically diverse urban counties. Cook County, Illinois, for example, includes wide tracts of poor and wealthy areas within both urban and suburban areas; different areas of Cook County, therefore, justifiably could have different area factors for risk-adjustment purposes.

Note that by using income, subsidy eligibility, or neighborhood as a predictor variable, not only can the associated relative health status risk be captured by the risk-assessment model, but it also will be possible to model the risk associated with the increased service utilization induced by the cost-sharing subsidies available to those with low income.

The Appendix discusses the implications of including these factors at the federal level and of allowing states discretion to incorporate the factors.

Adjustments to model weights to determine average actuarial risk under the risk-adjustment methodology

Integrating risk adjustment with premium rating factors that differ across issuers to calculate average and relative actuarial risk is complex. Premium rating factors fully or partially adjust for differences in relative risk. Risk adjustment should not make the same adjustment again. The relative risk associated with an enrollee's age, for example, is reflected in both rates and risk adjustment. As a result, it is necessary to develop a thoughtful approach to combining risk-

[13] Cutler, D. M., Lleras-Muney, A., & Vogl, T. (2008). *Socioeconomic Status and Health: Dimensions and Mechanisms, NBER Working Paper No. W14333.* Cambridge, MA: National Bureau of Economic Research.
Mechanic, D. (2007). Population Health: challenges for Science and Society. *Milbank Quarterly, 85*(3), 533-559.
Adler, N. E., & Newman, K. (2002). Socioeconomic Disparities In Health: Pathways And Policies. *Health Affairs, 21*(2), 60-76.
Adler, N., & Ostrove, J. M. (1999). Socioeconomic Status and Health: What We Know and What We Don't Know. *Annals of the New York Academy of Science, 896*, 3-15.

assessment model scores and rating factors.[14] The approach would account for risk measurement gaps and overlaps between risk-assessment model scores and rating factors to determine average actuarial risk and subsequent risk-adjustment-based funds transfers between issuers.

In concept, the risk-adjustment mechanism should adjust for differences in expected cost[15] that are not reflected in premiums due to rating restrictions.[16] In contrast, to the extent that differences in cost are reflected in premium rating factors, the risk-adjustment mechanism should not "double count" by providing a second, duplicative adjustment for the same cost difference. In cases in which a risk factor may be partially—but not fully—reflected in premiums, the risk-adjustment mechanism should adjust only for that portion that cannot be reflected in premiums. For example:

- If costs varied by 5:1 based on age, and premiums can vary by 3:1 (the maximum permitted by ACA), then the risk-adjustment mechanism should adjust only for the residual difference between the 5:1 costs and the 3:1 premiums.
- If geographic areas varied by 2:1 based on morbidity and non-morbidity cost differences, resulting in the use of 2:1 geographic rating factors by issuers, while the risk model picks up only the morbidity component of 1.5:1, then the risk-adjustment methodology should ensure that the 1.5:1 is not double counted.[17]
- If a family tier rating factor is 2.3 while the risk-assessment model calculates the total score across all (e.g., three) family members to be 6.3 for an average of 2.1, then the risk-adjustment methodology would need to lay out clearly whether the 2.1 would be used instead of the 2.3 in aggregating the issuer's overall relative risk score.[18]
- If the smoking rating factor is 1.5 while the risk score picks up 1.1 via the lung disease weights in the risk-assessment model for the unhealthy individuals or 0.0 for individuals who have not yet been diagnosed with diseases caused by smoking, then the risk-adjustment methodology would need to clarify whether the risk score would be adjusted up to the full rating factor of 1.5.

As a result, a key decision in integrating risk adjustment with ratings is which premium relativities (rating factors) will be used in determining issuers' risk relativities. This is separate from over-pricing or under-pricing the *market average risk* that may be used by issuers either as

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[14] These rating factors may be combined explicitly with risk-model scores, or the combination may occur implicitly within risk-model scores.

[15] It should recognize differences in expected cost only due to differences in enrollee risk profiles. It should not recognize differences in expected cost due to issuer-specific efficiencies or inefficiencies in securing competitive provider contracts and operating appropriate utilization and care-management programs.

[16] Note that this refers to premium relativities across rating cells and not to over-pricing or under-pricing the *market average risk* that may be used by issuers as deliberate market strategies. These issuer-specific strategies can be prevented from being recognized in the risk-adjustment methodology if the market average premium is used for multiplying with the issuer relative risk score.

Rating factors will vary across issuers, and while the implication of such variation is typically of less magnitude than the overpricing or underpricing issue, it is possible instead to use uniform rating factors in the risk-adjustment methodology across all issuers. Issuers still would use their own unique rating factors for pricing and only the risk-adjustment methodology would use uniform rating factors for calculating average and relative risk scores.

[17] Note that only the portion of geographic factors due to differences in morbidity typically is included in risk-adjustment models. CMS or states may want to prescribe the use of geographic factors that measure non-morbidity variation by area, or allow/prescribe geographic factors that capture both morbidity and other variation. In the case of the latter, this approach would require setting or reporting separate non-morbidity based area factors for use in combination with the risk-adjustment model morbidity-based scores.

[18] Family tier factors typically are inferior in matching risk compared to the total risk of all family members as measured by the risk-assessment model.

deliberate produce and market volume strategies; to cover their revenue needs due to their estimated costs (the latter being driven by their provider contracting, utilization and care management program efficiencies); or more generally, because of the uncertainties about the new market and covered populations. As suggested in the proposed rule, a key consideration should be avoiding unintended consequences and inappropriate incentives.

Similar to the issue of overlaps and gaps between risk-model scores and rating factors described above, is the issue of gaps between risk-model scores and the relative value of different benefit packages for which an issuer's enrollees have coverage. These can be addressed once there are fewer unknowns about benefit plan premium rating rules and policies on risk-adjustment goals. It is not yet clear, for example:

- Whether under ACA a state can allow issuers to let their benefit plan premiums differ by relativities that recognize costs of induced utilization and adverse selection and different percentages of administrative expense in addition to the difference in actuarial value.
- Whether and how nonessential benefits will be accommodated within the risk-adjustment process.
- Whether outside the exchange, in which benefit levels will vary more than in the exchange(s), plans will be grouped into tiers of actuarial value for purposes of risk adjustment (e.g., 0 percent to 15 percent, 15 percent to 25 percent, 25 percent to 35 percent, etc.).
- Whether an issuer that provides secondary coverage to an individual will get no risk score, full risk score, or a risk score adjusted for secondary coverage benefit value net of the primary coverage benefit value.

Regardless of the risk-adjustment methodology, it should mirror the decisions made on the above topics so that the adjustments to the risk-assessment model scores result in risk-fund transfers that make issuers whole for risk related to benefit plan design that is not allowed to be reflected in premiums but is allowed to be recognized under risk-adjustment goals.

Coordinating the risk-adjustment methodology with premiums will require either a) that the weights in the *risk-assessment model* be adjusted during the risk-model calibration explicitly to exclude or include[19] those variations in risk that are reflected in premium relativities, or b) that the *risk-adjustment methodology* remove the premium variations (only the portion captured by the risk assessment model) that otherwise would be double-counted after the model risk scores are calculated and before determining the amounts to be transferred between plans. The work group believes that the first approach (adjusting the weights in the risk model to synchronize with premium rating factors and benefit plan design that affects different diseases differently) is likely to require considerable development time and be quite complex and difficult to communicate and audit.

A full understanding of the points discussed above and potential approaches to resolving specific issues and their implications can be gained only from complex modeling and simulations, which is beyond the scope of the analyses that the work group undertook for this comment letter. If requested, in conjunction with the Society of Actuaries, we may be able to identify and assemble resources necessary to assist with such modeling. We have, however, used the Appendix to

[19] This would be synchronized with complementary steps in the risk-adjustment methodology—using rating factors and benefit plan relativities in addition to the risk-model scores versus not using rating factors and plan relativities.

provide a summary of 1) the implications of three possible approaches for handling the premium relativities for such rating factors as age, family status, and tobacco use; 2) the implications of two approaches for incorporating benefit and utilization relativities; and 3) the implications of incorporating relativities directly into the risk-assessment model versus adjusting for relativities as part of the risk-adjustment methodology subsequent to calculating the enrollee level risk model scores (as it is done today).

Extent of state flexibility that should be allowed in adopting an approach to determine average actuarial risk

Per the proposed rule, state flexibility may be permitted with respect to the risk-adjustment methodology for determining average actuarial risk that is exclusive of the risk-assessment model, such as the incorporation of rating factors and benefit plan values, the appropriate average premium, the handling of members with limited data, balancing, and renormalization.

CMS should provide in advance as much information as possible on acceptable variations from the federal methodology so that states understand what may be allowed before developing alternative models and methodologies.

The Appendix discusses the implications of CMS allowing less or more state-level deviation.

Multiplying plan average actuarial risk by the state average normalized premiums or by the specific premiums collected for each plan

The decision regarding what premium multiplier to use can be expanded beyond the choice between issuer average premium and state average premium. We have provided an expanded list of options in the Appendix.

In general, while it is likely that the new risk-adjustment system will not balance automatically to budget neutrality due to data and timing issues, methods that reduce the need for large retrospective reconciliations are preferable (as discussed in more detail below). Using state average premium or a reference premium makes the risk-adjustment methodology inherently more self-balancing. Using a state average or reference premium also eliminates the concern that if issuer-specific premiums are used, an issuer that overprices its premiums will experience relatively larger risk-fund transfer amounts, whether charges or payments. An issuer that under-prices its premiums will experience relatively smaller risk-fund transfers.

The self-balancing, or lack thereof, is best demonstrated via modeling. Our work group has developed preliminary modeling and, if requested, we can provide a copy.

The Appendix contains a discussion of the implications of the following premium[20] approaches: state average market premium, state average premium normalized for a benefit plan's actuarial value, a reference premium instead of an average premium, and issuer-specific actual premiums. The Appendix also provides a discussion of the exclusion of the premiums associated with non-essential health benefits.

[20] Relevant to all the premium multiplier options is a discussion of the non-medical component of premium. In general, the administrative costs and target underwriting gain do not change significantly based on the overall morbidity profile of an issuer's enrollees. As such, instead of premium, the average actuarial risk may be multiplied by the premium amount lowered by allowed administrative costs and target underwriting gain. Under the risk corridor discussion, we label this as the *target amount* or *projected medical cost*.

Methodologies for balancing the system when there is an imbalance between charges and payments
CMS proposes one-sided and two-sided balancing methodologies and also the possibility that excess charges simply will be reserved. Assigning an extra financial burden or benefit to issuers on one side or the other of '1.00' could create inequities. Reserving excess money will deviate from the policy intent of risk adjustment being a zero-sum mechanism. The work group, therefore, believes the approach of splitting shortfalls *and excesses* in both directions between high-risk and low-risk issuers is preferred.

The Appendix includes the implications of one-sided, two-sided, self-balancing, and renormalization methodologies.

153.330 State Alternate Risk Adjustment Methodology

Criteria for federal certification of state alternate methodologies
Section 153.330 provides assorted criteria for evaluating a state's alternate risk-adjustment methodology. Section 153.320 states that a state's alternate risk-adjustment methodology must offer similar or better performance than the federally certified methodology. If Section 153.320 is a reference to statistical performance, we suggest that CMS relax this requirement in consideration of the other criteria enumerated in Section 153.330 and expand the criteria enumerated in Section 153.330 to include additional policy criteria. While statistical fit is a valid consideration in adopting a particular model, policy and data considerations may justify a decrease in statistical fit. An example that was cited previously is the better statistical fit of concurrent models which, for practical reasons of relatively more financial certainty for issuers under a prospective model, may be foregone.

It is worth reiterating that the choice between prospective and concurrent risk adjustment is associated with technical, practical, and policy issues that we have incorporated into many of the comments in this letter. The choice between prospective and concurrent risk-adjustment methodologies, for example, affects data timing, risk adjustment funds transfer predictability, and the degree for which each issuer's experience is accounted. Concurrent versus prospective is a fundamental risk-adjustment methodology decision. The rule should clearly indicate which approach will be used under the federal methodology and provide guidance as to when it may be appropriate for states to deviate from the federal approach. Considerations include administrative burdens for multi-state issuers as well as the uniform coordination of timing for the risk corridor and MLR-rebates processes across states that might have different risk-adjustment timelines if allowed to deviate significantly with respect to concurrent versus prospective approaches.

Allowing states flexibility is desirable for customizing the risk-adjustment process to the states' market and policy goals. Some areas in which flexibility in risk-assessment models could be extended include:
- prospective instead of retrospective models,
- the inclusion of income or more refined area adjustments than at the county level,
- claim grouping algorithms,
- weight calibration algorithms, and
- weight calibration datasets and timing.

Some areas in which flexibility in risk-adjustment methodology could be allowed include:

- adjustments to risk-assessment model scores for determining average actuarial risk,
- premiums for multiplying with the relative risk scores,
- risk-fund transfers being determined across all benefit tiers or by each benefit tier,[21]
- approaches for handling risk funds excesses or shortfalls, and
- timelines for completing the risk-adjustment process each year.

Regardless of areas in which flexibility is allowed, to make the federal certification process more efficient, the final rule should clarify what options will not be approved.

Deadlines for submission of requests for state alternate risk-adjustment methodologies
Requiring requests by November, two years before the affected calendar year, is reasonable for years subsequent to 2014, especially since the state presumably has the option of submitting a request earlier.

This timeline, however, could be challenging for 2014. As noted in the proposed rule, CMS will not issue draft methodology notices until mid-October 2012. It appears that CMS will finalize its notice and review state alternative methodologies at the same time. This will require states to develop their methodologies independent of federal methodology. The variations among states' submissions may provide valuable input to CMS as it finalizes the federal notice. But states that don't receive certification will have little time after January 2013 to evaluate CMS' final notice, make appropriate adjustments to the submission that was denied certification, obtain consensus from state stakeholders, resubmit to CMS, and obtain certification. Even if states meet the deadlines, issuers then will have little time to appropriately develop, file, and implement rates based on the system. We recognize that the CMS process also is effort-intensive, but to the extent states can be afforded sufficient time after the later of certification denial or federal final notice, they will not be rushed into adopting a less-than-optimal methodology for the state.

153.340 Data Collection Under Risk Adjustment

Centralized, intermediate, and distributed approaches
Because the risk-adjustment mechanism will be administered at the state level, perhaps often by the states themselves, it could be argued that the data collection decision should be left to the states. A centralized approach can be viewed as vulnerable to data privacy issues; however, the advantage of a centralized national approach is that it facilitates uniformity across states, economies of scale for the administering agency/agencies, and a lowering of administrative expenses for multi-state issuers. Similar considerations exist for choosing between an intermediate state-level approach and a distributed approach—balancing efficiency, transparency, maintaining confidentiality of personal health data, and ensuring the ability to audit the system.

The Appendix contains information on the implications of the three approaches.

[21] Our assumption is that the federal methodology risk transfers will be across all benefit plans (metal tiers). The possibility of adjusting by each benefit plan (metal tier) is associated with significant implications for pricing and selection discussed earlier.

Using risk adjustment data for other purposes
A single data submission, used for multiple purposes, would create the least administrative burden for issuers. It requires more coordination, however, on the part of the various stakeholders who will use the data, which, in turn, potentially could raise more privacy, proprietary, and anti-trust concerns.

The Appendix contains information on the implications of a consolidated data call in which common data support both risk adjustment and other purposes versus multiple routine and ad hoc data calls.

Reliance on HIPAA and NCPDP standards
Reliance on existing national standards with respect to enrollment and claims data would be effective and appropriate for providing consistent and reliable data—the foundation for quality risk adjustment. There are no current national standards, however, for the reporting of plan or enrollee specific premiums or rating factors that may be required to support the risk-adjustment methodology.

Should submission of issuers' rate setting rules be required?
Data requirements are driven by the risk-adjustment methodology. If the methodology uses issuer or enrollee specific rating factors, then the issuer must report on these rate setting rules.

Exemption for states with all-payer databases (APDs)
The proposal that states with APDs must submit proposed system modifications to meet risk adjustment and other exchange-related activities is appropriate. APDs, for example, may be adequate with respect to enrollment and claims data but likely will not contain the premium and rating factors data. A potential shortcoming is that some APD states have exemptions or limitations for small carriers, which will create problems that need to be addressed for risk adjustment.

We suggest that the language of this section be enhanced to emphasize the necessary relationship between methodology and data. Because the methodology and data are so intricately linked, synchronizing the time of the exemption request and the filing of state alternative risk-adjustment methodologies seems appropriate. The language also may need to address the possibility of new APD states.

153.350 Risk Adjustment Data Validation Standards

Possibility of a three-year deadline for validation with possible redistribution of risk-adjustment funds
There is clearly a balance between having a robust audit program that discourages submission of inappropriate codes and one that provides issuers with some financial certainty. The best validation is validation before the data are used in risk adjustment. The data submission and acceptance process should include automatic validation checks. Plans should be given sufficient time to correct their data errors (an argument in favor of monthly or quarterly collection of data instead of bulking data collection at the end of the year when data corrections will run up against the deadlines for the risk-adjustment settlement process).

After-the-fact validation, however, likely still will be required. In the Appendix the implications of two alternatives for possible audit programs are presented.

We have already noted that the data validation process should be applied to the risk-assessment model calibration data to ensure robust applicability of the model's risk scores.

Subpart E—Health Insurance Issuer Standards Related to the Transitional Reinsurance Program

153.400 Reinsurance Contribution Funds

Type of issuer data required to substantiate reinsurance contributions
See discussion in Subpart C related to the reinsurance contribution method (percent of premium versus fixed per capita).

Frequency of data submissions
Issuers may prefer quarterly over monthly, as they can build on existing quarterly reporting processes and not add administrative burden for a temporary program.

153.410 Requests for Reinsurance Payment

Timing for submission of requests for payment
This may be monthly or quarterly, each having advantages and disadvantages as summarized in the Appendix. The trade-off is between frequent cash flow for issuers in need versus reducing administrative burden.

Deadline for submission of claims
The Appendix lists the implications of requiring claims submission within three months versus six months after the end of the year. The main trade-off is between having relatively more complete data versus expediting the process to reach final conclusion on MLR rebates based on accrual estimates.

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

Our work group generally regarded some unintended oversights or needed clarifications in the proposed rule, and that as written with respect to taxes, fees, and underwriting gains[22] in the target, the proposed rule would operate contrary to the goal of encouraging competition. More details are provided in the paragraphs below.

153.500 Definitions

Allowable costs
Our work group discussed both options regarding the consideration of costs for activities that improve health care quality as described in Section 158.150 and Section 158.151. The first option is to include costs for activities that improve health care quality, which would be consistent with the federal MLR definition. The second option is not to include costs for activities that improve health care quality. If quality improvement expenses are not included as

[22] Underwriting gain refers to contributions to surplus for the risk being assumed, profit for for-profit issuers, and covers cost of capital, including risk margin.

an allowable cost, however, they should be deducted along with non-medical costs in determining the target amount.

Another concern is about provider-owned issuers—much like the discussion under reinsurance. In the absence of some uniform pricing of all claims, by charging high hospital reimbursement rates, an issuer owned by a hospital could create losses on the issuer's financial reports and have extra profits on the hospital, with the risk-corridor program partially covering some of the issuer's reported losses.

Limiting allowable administrative costs
If administrative costs are assumed to be limited to 20 percent in a manner consistent with MLR calculations, such costs would have the advantage of a uniform allowed limit but could create a non-level playing field for issuers in- and off-exchange if the plans outside the exchange are not similarly limited. Issuers also may face a pricing challenge since the actual distribution of plans may differ from the projected distribution, resulting in a mismatch between actual administrative expense and projected expense.

If administrative costs are not limited, there is the potential for an issuer to use risk-corridor payments to pay for MLR rebates, which may be limited under the unreasonable rate increase review process by the state departments of insurance (DOI) or by the federal Center for Consumer Information and Insurance Oversight (CCIIO).

Target amount—taxes and assessments
The work group has concerns with how "target amount" is defined, specifically regarding premium tax and state assessments not being included in the determination of target amount. The proposed rule cites Section 158.160(b) to define the allowable administrative costs. Section 158.160(b) is "non-claims costs other than taxes and regulatory fees" from the MLR interim final rule. In that environment, taxes and regulatory fees are treated as a reduction to the premium. We present three options of how to treat premium tax and state assessments.

One option would be to not recognize the premium tax and state assessments as an allowable reduction from the premium in determining the target amount. Issuers could face a risk-corridor charge even when actual claims experience turns out to be the same as or worse than expected. Issuers would not receive risk-corridor payments until actual claims well exceed the expected amount. Not addressing this oversight could lead to unintended consequences. Considering premium collected to pay for taxes and state assessments to be issuer profits that are subject to risk spreading via risk corridors likely would discourage carriers from entering the market. A further consequence may be an impetus for current carriers to exit the market.

A second option would be to include taxes and regulatory fees as an allowable administrative cost. A third option would be to include taxes and regulatory fees as a separate offset to premiums. The second and third options may be mathematically equivalent. Categorizing taxes as an offset to premiums might enable more meaningful administrative cost comparisons from downstream risk corridor reporting and comparison-to-MLR reporting.

Target amount—underwriting gain
The work group has concerns with how "target amount" is defined, specifically including or excluding underwriting gain in the determination of the target amount. We offer two options.

One option would be to allow for underwriting gain in the determination of the target amount, subtracting it along with the allowable administrative cost from the premium. This would be consistent with the Medicare Part D approach in which issuers include a target margin in their bid submissions (under Medicare Part D, actual allowable cost is compared to the projected allowable cost amount). One alternative would be to establish a guideline of permissible margin in the determination of the target amount. A second alternative would be to consider the MLR rebate threshold as a safe harbor.

Another option would be that underwriting gain is not recognized in determination of target amount. We are not sure if CMS intends to implement this option and request clarification on the definition of the target amount. Issuers with margin expectations greater than 3 percent of target (2.4 percent of premium) would be subject to risk-corridor payments to CMS even if actual costs were equal to projected costs. Issuers would not receive risk-corridor payments until actual claims exceed their projected claims by their entire projected margin and the 3 percent threshold (103 percent of target).

Target amount—projected costs

In the preamble to the proposed rule, the risk corridor is determined by comparing a QHP's actual costs with the cost projections. Projected costs, however, are not mentioned in the proposed rule. A slight clarification in the rule would help confirm the intent to use *projected* costs as the target amount. This may become moot after the clarification on allowable administrative costs and reductions to premium (discussed above) that is used in the definition of the target amount.

We have illustrated some of the points above via an example below. Table 4 provides a hypothetical scenario of a fictitious issuer's pricing methodology with the various components that build up to the total gross premium.

Table 4: An Issuer's Pricing Summary—Hypothetical Scenario

Hypothetical Scenario	
An issuer prices an individual to achieve the rebate threshold	
The issuer manages its administrative costs exactly as projected in pricing	
Experience is net of risk adjustment and reinsurance	
Ignore activities to improve quality and other taxes for this illustration	
Pricing Summary	
Expected medical expense	**$ 76**
Expected administrative cost	$ 13
Target loss ratio set at rebate threshold	80%
Target underwriting gain	$ 6
Premium less tax	**$ 95**
Premium tax	$ 4
State assessment	$ 2
Premium tax credit (50% of assessment)	$ (1)
Gross premium	**$ 100**

Tables 5–7 below illustrate how the risk-corridor calculations and MLR rebate would work based on different methods of determining the target amount. For the MLR rebate, we have incorporated the risk-corridor amount as an adjustment to the denominator, as indicated in Section 2718.

In Table 5, we provide an illustration of how the risk-corridor calculation and MLR rebate will work based on the proposed rule (allowable administrative costs as defined in Section 158.160(b), which includes neither taxes and regulatory fees nor underwriting gain). The most important point to note is that in the first scenario, even though actual claims equal what was projected at the pricing stage with a loss ratio of 80 percent (administrative cost also the same as projected), there will be a risk-corridor charge by CMS. It therefore appears that the definition of the target amount may have been an oversight in the proposed rule.

Table 5: Risk-Corridor Calculation—Per Proposed Rule

Actual	**Risk-Corridor Calculation (per proposed rule)**		
Premium	$ 100		
Premium tax credit	$ (1)		
	$ 101		
Administrative cost	$ 13		
Target amount	$ 88		
92% of target amount	$ 80.96		
97% of target amount	$ 85.36		
103% of target amount	$ 90.64		
108% of target amount	$ 95.04		
		Scenarios	
	Medical expense exactly as predicted	**Less medical expense than predicted**	**More medical expense than predicted**
Actual medical expense	$ 76.00	$ 71.00	$ 92.00
Risk-corridor payment (receipt)	$ 6.17	$ 10.17	$ (0.68)
MLR Rebate Summary			
Numerator for MLR	$ 76.00	$ 71.00	$ 92.00
Denominator for MLR	$ 88.83	$ 84.83	$ 95.68
MLR calculation for rebate purposes	85.55%	83.69%	96.15%

The above table shows that when an issuer performs exactly as expected, with a 6 percent target margin, the risk corridor charge would equal 6.17 percent of premium, which would more than eliminate all of the issuer's underwriting gain. In addition, another scenario could be developed illustrating that an issuer would not pay any rebate until medical expense falls below $63.

Table 6 presents an alternative approach in which taxes and assessments are deducted from the premium when calculating the target amount. This approach still does not address the problem of a scenario in which actual claims match projected claims costs because the underwriting gain is not deducted from the premium.

Table 6: Risk-Corridor Calculation—Premium Tax/Assessments Permitted as Expense

Actual	Alternate Approach (premium tax/assessments are permitted as expense)
Premium	$ 100
Premium tax credit	$ (1)
	$ 101
Administrative cost and tax assessments	$ 19
Target amount	$ 82
92% of target amount	$ 75.44
97% of target amount	$ 79.54
103% of target amount	$ 84.46
108% of target amount	$ 88.56

	Scenarios		
	Medical expense exactly as predicted	**Less medical expense than predicted**	**More medical expense than predicted**
Actual medical expense	$ 76.00	$ 71.00	$ 92.00
Risk-corridor payment (receipt)	$ 1.77	$ 5.60	$ (4.80)
MLR Rebate Summary			
Numerator for MLR	$ 76.00	$ 71.00	$ 92.00
Denominator for MLR	$ 93.23	$ 89.40	$ 99.80
MLR calculation for rebate purposes	81.52%	79.42%	92.18%

The above table illustrates that, to a lesser degree, the same concerns exist as in Table 5. When an issuer performs exactly as expected, it still would not attain its target underwriting gain. Instead, 30 percent ($1.77/$6.00) of the target underwriting gain would become a risk-corridor charge. An issuer would not pay any rebate until medical expense falls below $73.

Table 7 presents another approach that also recognizes target underwriting gain as an allowable reduction from premium and thus uses projected costs for the target amount. This approach resolves the problem of requiring risk-corridor payments even when actual costs equal projected costs.

Table 7: Risk-Corridor Calculation—Target Amount is Projected Medical Expense

	Hypothetical Risk-Corridor Calculation (target amount is projected medical expense)		
Projected target amount	$ 76		
92% of target amount	$ 69.92		
97% of target amount	$ 73.72		
103% of target amount	$ 78.28		
108% of target amount	$ 82.08		
	Scenarios		
	Medical expense exactly as predicted	**Less medical expense than predicted**	**More medical expense than predicted**
Actual medical expense	$ 76.00	$ 71.00	$ 92.00
Risk-corridor payment (receipt)	$ -	$ 1.36	$ (9.84)
MLR Rebate Summary			
Numerator for MLR	$ 76.00	$ 71.00	$ 92.00
Denominator for MLR	$ 95.00	$ 93.64	$ 104.84
MLR calculation for rebate purposes	80.00%	75.82%	87.76%

The above table shows that when the target amount is based on projected claims, an issuer performing exactly as expected pays no risk corridor amount or rebate. We therefore recommend adopting a similar risk-corridor methodology as utilized in the Medicare Part D, program in which the target amount equals projected claims and actual claims are compared to projected claims when determining the risk-corridor amount.

The work group would like to make an observation about the treatment of the risk-corridor amount as an adjustment to the denominator for MLR rebate calculation. In the course of modeling the above illustrations, we noted that in all scenarios in which issuers were paying both rebate and risk-corridor amounts, the combined payout would be more than 100 percent of the favorable claims experience. In Table 7, for example, when actual claims experience was $5 lower, $5.27 would be paid as risk corridor ($1.36) and rebate ($3.91=4.2%x$93.64) amount. The payout amount was 5.4 percent (=$5.27/$5) higher than the claims improvement.

As the issuer's experience became more favorable, the ratio of the sum of risk corridor and rebate amount over the claims-improvement amount increased. In a scenario in which actual claims experience is $15 lower than expected, $16.81 would be paid as risk corridor ($9.04) and rebate ($7.77) amount. The payout amount was 12 percent (=$16.81/$15) higher than the claims improvement amount.

We also note that when the risk corridor was treated as an adjustment to the numerator, the combined risk corridor and rebate amount would be the same as the amount in claims improvement. This would raise the question whether it is appropriate to treat the risk corridor

calculation as an adjustment to the numerator for MLR rebate calculation. We suggest consideration be given to this issue to ensure the programs work together in a reasonable manner.

153.510 Risk Corridor Establishment and Payment Methodology

Timeline for remittance of charges to HHS
Regarding assessments of charges, we suggest that notifications be provided at the same time to issuers with a net receivable or net payment due. Cash flow and timing should be considered for both the issuers and states.

Thirty days appears to be a reasonable time period to expect remittance after notice delivery. We are more concerned, however, with the timing between plan-year close and determination of risk-corridor payments in relation to MLR rebate determination and reinsurance payments.

Another option would be to allow more than 30 days. A question arises as to whether the time allowed for submission of payment would be consistent with CMS payments owed to issuers.

The timing and coordinating of additional reporting responsibilities for states' and issuers' staff already performing monthly, quarterly, and annual financial reporting may need to be considered.

Risk corridor by benefit year
We interpret "benefit year" to be the same as "calendar year." We recommend all risk-spreading programs be based on a calendar-year period for individual and small group so that it is consistent with the MLR calculations.

Risk-corridor calculations performed at QHP level
It is important to consider the alternative methods of determining risk-corridor payments at the issuer level.

- One option would be to determine target amounts and allowable costs for each QHP, apply risk-corridor calculations at the QHP level, and then total the results for each issuer. This appears to us to be the approach adopted in the proposed rule.
- A second option would be to determine the target amounts and allowable costs for each QHP, aggregate the results for an issuer, and then apply risk-corridor calculations to the aggregated results at the issuer level.
- A third option would be to determine the target amounts and allowable costs for each QHP, aggregate the results by line of business (small group and individual) for an issuer, and then apply risk-corridor calculations at the line-of-business level.

Issuers usually do not report or track administrative expenses at the QHP level. As a result, the option included in the proposed rule would impose an additional reporting burden on issuers for a temporary program. With respect to the third option, aggregating by line of business (small group and individual separately) is consistent with the federal MLR calculation from the point of view of the issuer.

But since there is not an underlying normal distribution, applying risk-corridor calculations at the QHP level and then aggregating by issuer will arrive at a different result than first aggregating experience to the line-of-business or issuer level and then applying the risk-corridor calculations.

To illustrate, assume an issuer has two plans, with one accounting for 90 percent of its volume. Further assume that the higher-volume plan, with actual allowable cost at 97 percent of the target amount, results in no risk corridor amount. The 10 percent volume plan, with actual allowable cost at 108 percent of the target amount, owes a risk-corridor payment. The issuer with an overall favorable experience when compared to the target would receive a risk-corridor payment (Table 8).

Table 8: Single Issuer with 2 QHPs with Overall Favorable Experience

Plan Level	Volume	Actual vs. Target Amount	Risk Corridor Payment (Charge)
QHP A	90%	-3.0%	0.00%
QHP B	10%	8.0%	2.50%
Combined payment (charge)		-1.9%	0.25%
Issuer level			
Combined plans		-1.9%	0.00%

In this example, an issuer with an overall experience 1.9 percent lower than the target receives a risk-corridor payment of 0.25 percent of the target amount when the calculation is done at the plan level. But there is no risk-corridor payment when the calculation is done at an aggregated line-of-business or issuer level.

If we switch the favorable/unfavorable experience by QHPs in the example (Table 9), the issuer with an overall unfavorable experience compared to the target similarly would owe a risk-corridor amount.

Table 9: Single Issuer with 2 QHPs with Overall Unfavorable Experience

Plan Level	Volume	Actual vs. Target Amount	Risk Corridor Payment (Charge)
QHP A	90%	3.0%	0.00%
QHP B	10%	-8.0%	(2.50%)
Combined payment (charge)		1.9%	(0.25%)
Issuer level			
Combined plans		1.9%	0.00%

In this example, an issuer with an overall experience 1.9 percent higher than the target is charged a risk-corridor amount of 0.25 percent of the target amount when the calculation is done at the plan level. But there is no risk-corridor charge when the calculation is done at the aggregated line-of-business or issuer level.

153.520 Risk Corridor Standards for QHP Issuers

Risk adjustment and reinsurance as adjustments to premium

The proposed rule states that QHP premium amounts must be increased by the amount of any payments received for risk adjustment and reinsurance and reduced for any risk-adjustment charges assessed, reinsurance contributions made, and user fees paid. Under Section 158.140, it

appears that risk corridor and reinsurance amounts are treated as adjustments to incurred claims, which is different from how they are defined in the proposed rule.

It would be reasonable to treat risk-adjustment fund transfers as adjustments to premiums. If there is a corresponding increase or decrease in risk as reflected by the risk-adjustment factor, projected claims will increase/decrease correspondingly. Reinsurance payments would be treated more appropriately as adjustments to claims.

Inclusion in the premium (i.e., adjusting the target amount) would tend to increase/decrease an issuer's profit potential if the net risk-adjustment and reinsurance payments are positive/negative.

Until the risk-adjustment and reinsurance methodologies are finalized, it is not clear whether the transfer payments will be more consistent with adjusting premiums or claims.

We request clarification on the meaning of "received." We assume CMS means payments of which issuers have been notified but which they have not received, and that this is based on an "accrual" basis and not a "cash" basis.

After-the-fact adjustments

We interpret "after-the-fact adjustments" in the preamble to mean the final reinsurance and risk-adjustment amounts would be used in risk-corridor calculations after all the required data is collected in determining final risk-adjustment and reinsurance amounts. We support using final reinsurance and risk-adjustment amounts for risk-corridor calculations. As previously noted, we also request clarification of the meaning of "received."

Interaction with MLR

The rule states that in attributing reinsurance payments to risk corridors, payments are to be based on the claim submission date. This approach is not consistent with issuers' pricing, the federal MLR calculation, or financial reporting. In addition, issuers potentially can delay claims submissions to the following year to maximize risk-spreading opportunities. Since the risk corridor is a temporary program, claims not submitted in time for the 2016 risk calculation may not be used in risk-corridor calculations.

Another option is to base reinsurance payments on the claim incurred date. This approach would be consistent with issuers' pricing, federal MLR calculations, and financial reporting, and would not be subject to the type of manipulation described above.

Regardless of whether reinsurance payments used in risk-corridor calculations are based on the date of claims submission or claims incurred, there is a tradeoff between an earlier cutoff date and a later cutoff date. If an earlier cutoff date is used, risk-corridor calculations may not include all of the final reinsurance claim amounts but would have a known amount for pricing and financial reporting. While having a later cutoff date would yield more accurate results, issuers would not have the final amount until later in the year and would have more uncertainty for pricing and financial reporting in the interim.

Timelines and compliance for QHP data submission

Since the MLR calculation will depend not only on risk-corridor calculations but also on reinsurance and risk adjustment, the timeline will depend heavily on what methodologies are adopted for reinsurance (e.g., data runout, submission or incurred date, interim or final amount)

and risk adjustment (e.g., prospective or concurrent, data runout). The tradeoff is between allowing sufficient time for results to be more complete and expediting the process so that issuers would have a known amount to conduct their business and consumers would receive MLR rebates sooner.

Limiting reporting requirements
The work group notes that it may not be feasible to use data from Section 2718 for the risk-corridor program for the following reasons: 1) MLR reporting is based on plans aggregated under a legal entity and the risk-corridor program might be based on a more granular level by QHPs, and 2) risk-corridor calculations need to be completed earlier and fed into MLR calculations, which creates a timing issue.

Subpart G—Health Insurance Issuer Standards Related to the Risk Adjustment Program

153.610 Risk Adjustment Issuer Requirements

Other categories of data required in support of risk adjustment
This section explicitly discusses claims and encounter data, enrollment and demographic data, and prescription drug data. The work group suggests that additional premium and rating data likely will need to be collected as necessary to support the risk-adjustment methodology that each state implements. Depending on the methodology used for adjusting model risk scores and calculating market average risk, the issuer may need to submit the rating factors used to calculate the enrollees' premium. In general, data must be collected to support the approved risk-adjustment methodology.

The work group suggests that it may not be necessary to obtain all data directly from issuers. If rate factor information is available from the state DOIs, for example, issuers only may need to submit indicators as to what rate factors were applied to an enrollee rather than the actual rate factors. It is ultimately the quality and timeliness of the data, not the source, that matters.

Finally, the work group suggests that there may be value in collecting relevant data beyond the minimum required to support the risk-adjustment methodology. It would allow the risk-adjustment administrator to monitor the health insurance market for signs of issuers being advantaged or disadvantaged significantly by selection. It also would allow the administrator to test future risk-adjustment methodologies to mitigate the advantages and disadvantages without the need for a special data call.

The Appendix contains information on the implications of collecting and not collecting additional data.

Data collection monthly
While monthly data collection would support more frequent dry runs for assessing and correcting data quality and interim risk-adjustment estimates, the work group suggests that quarterly data collection to coincide with the quarterly close of books may be sufficient. We are less concerned with the size of the files to be transmitted than allowing sufficient time for data validation and correction of data quality issues. Both monthly and quarterly submissions could be used to prepare interim risk-adjustment estimates. The work group encourages such estimates so that

issuers are not surprised with the outcome of year-end settlement calculations and so that states can pro-actively manage potential solvency issues.

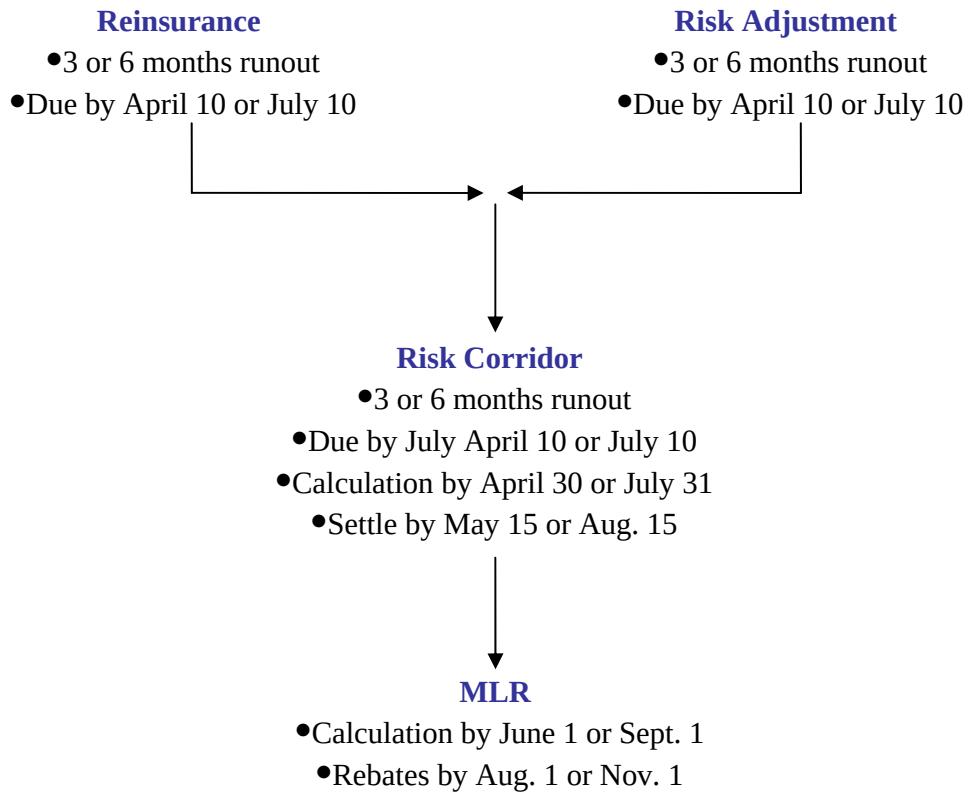
Issuers given a 30-day timeframe in which to pay net charges
While recognizing the need to collect and pay the risk-adjustment transfers and complete the process for the year as rapidly as possible, the work group is concerned about the effect that large, unplanned risk-adjustment charges, due within a short period, could have on issuers' cash flow. Issuers waiting for a year-end settlement payment similarly could have cash flow issues, particularly if the payment is delayed while the state collects charges. Financial instability is of concern in the early years of risk adjustment, when the market is likely to be most volatile.

We suggest that federal and state risk-adjustment administrators need to provide interim mid-year risk-adjustment estimates as indications of relative risk and likely risk-adjustment settlement costs. They also need to share the results of the final risk-adjustment calculation as soon as they are complete (to both issuers with net charges and issuers with net payments) to allow issuers to plan adequately for the effect of risk adjustment on their financial position while timeframes allow for the risk fund transfer process. Early estimation and notice of risk adjustment, along with early reinsurance and risk corridor results, will help issuers prepare as soon as possible for predicting the MLR rebate results.

The Appendix includes implications of some specific suggestions.

Risk-spreading mechanisms time chart
As mentioned at the beginning of this letter, one of the prominent concerns in our work group discussions was the interdependence of timelines of the three risk-spreading programs and the MLR calculation. We discussed multiple scenarios and have tried to reflect some of them (for illustrative purposes only) in Chart 3 below.

Chart 3: Illustration of Timelines—Dependence of MLR and Risk Corridor Calculations on Reinsurance and Risk Adjustment Methodologies



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We welcome the opportunity to discuss any of the comments presented in this letter with you at your convenience. If you have any questions or would like to discuss these items further, please contact Heather Jerbi, the Academy's senior health policy analyst (202.785.7869; Jerbi@actuary.org).

Sincerely,

Mita Lodh, FSA, MAAA, PhD
Chair, Risk Sharing Work Group
American Academy of Actuaries

APPENDIX: Summary of Work Group Comments on Proposed Rule

Decision Point	Options	Implications		
		Technical	Practical	Policy
Subpart B—State Notice of Insurance Benefits and Payment Parameters				
153.100 Establishment of State Insurance Benefits and Payment Parameters				
Initial year schedule	Timeline as in proposed rule		A state may have to issue its notice in March 2013 without sufficient time to react to the federal notice in January 2013.	
	Advance the federal notice		States will have more time to review the federal notice, evaluate areas needing state-specific customization, obtain all stakeholders' consensus, and adopt parameters that will provide a strong start to its risk-spreading programs.	
	Advance the federal notice and also advance the state notice timeline		In addition to the above, a state will have more time to implement its methodology, and issuers will have more time to prepare and plan their market and pricing strategies.	

Decision Point	Options	Implications		
		Technical	Practical	Policy
Subpart C—State Standards for the Transitional Reinsurance Program for the Individual Market				
153.200 Definitions				
Alternatives to using the essential health benefits package	Limit application of reinsurance to essential benefits only	This would create a level playing field. It would be difficult to untangle application of plan deductible and coinsurance and OOP maximums from non-essential benefits.	It may be unnecessary to carve out state-mandated benefits as these would apply to all issuers in the state.	
	Use essential benefits plus state-mandated supplemental benefits	This would create a level playing field It may be difficult to untangle application of plan deductible and coinsurance and OOP maximums from non-essential and non-state-mandated benefits.		
	Use essential benefits plus state-mandated supplemental benefits plus other supplemental benefits included in plan, and just subtract the total of other supplemental claims		This could result in inequity issues.	It would be a policy decision to use this approach if the supplemental benefits are not minimal in relative cost (e.g., more than 3 percent of the cost of essential benefits), are adequately priced, and do not contain any element of catastrophic claims expense.
	Use essential benefits plus state-mandated supplemental benefits plus other supplemental benefits included in plan	This would be simpler to administer and issuers would be less likely to have to make IT changes to submit data.	This could result in inequity issues.	It would be a policy decision to use this approach if the other supplemental benefits are minimal in relative cost (e.g., no more than 3 percent of the cost of essential benefits), are adequately priced, and do not contain any element of potential catastrophic claims expense.

Decision Point	Options	Implications		
		Technical	Practical	Policy
153.210 State Establishment of a Reinsurance Program				
Unexpended reinsurance funds	Use excess funds to pay additional reinsurance claims incurred in benefit years 2014–2016 but submitted too late	Would not enter into risk-corridor or MLR calculations, as those years would be settled.	Amounts should be immaterial.	
	Excess reinsurance assessment funds may be carried over year-to-year, including into 2017 and 2018. Any remaining funds after Dec. 31, 2018, would be transferred to the Treasury.	Requires clarification of intent of statute.	The size of the reinsured market will be unknown prospectively. If carry-over amounts are significant, extension into 2017 and 2018 could lessen the effect on premium increases across the years.	The consumer is affected via the effect on premium increases over the years.
	Return excess funds to contributing entities on pro-rata basis	This would be calculable off of contributions made.	Excess amounts returned are expected to be immaterial to any contributing entity's income statement.	

Decision Point	Options	Implications		
		Technical	Practical	Policy
153.220 Collection of Reinsurance Contribution Funds				
Diminishing reinsurance funds' effect on 2015 and 2016 rate changes	While not supported by statute, an option would be to distribute the annual funds collected slower over more years	The effect on rate increases reflects the drop off in reinsurance funds amplified by anticipation of a larger covered pool in 2015, 2016, etc. Spreading funds across the years will mitigate these premium increases.	Difficult to anticipate pool size in 2014. In addition, depending on attribution of reinsurance funds to states, the proportionalities of the reinsurance funds available per member per year will vary considerably.	The consumer is affected via the effect on premium increases over the years.
National contribution rate or state-level allocation	National contribution rate	Consistent national formula allows easier determination and adjustment for meeting annual funds of $10b/$6b/$4b over 2014–2016 (plus the $2b/$2b/$1b to Treasury).		
	State-level allocation	It may be more difficult to make these determinations and adjustments; also more difficult to determine each state's portion of the annual reinsurance fund.		
National contribution rate: percent of premium or flat per capita amount	Percent of premium for insured and a percent of medical expenses for self-insured	The percentage applied to insured premiums applies to prospectively anticipated, fully-incurred claims grossed up for administrative expenses, fees, taxes and assessments or to paid medical claims only for self-insured. This creates equity issues if the percentages applied are the same. To which state does premium or medical expense base belong? State of issuance for individual insured business is well-defined; state of "situs" may present problems among states for group (employer-sponsored) insured business; "situs" not defined for	For self-insured business, could use COBRA-defined premium equivalents. May need to consider disaggregation of employer-group employees into state of residence or state of employment for multi-state employers. May be more practical for self-insured group sponsors to self-report due to using multiple benefit administrators.	Leveling of application of contribution rates among insured and self-insured programs. Whether multi-state employer assessments should be disaggregated for purposes of determining whether collected in a state and therefore to be used in that state.

Decision Point	Options	Implications		
		Technical	Practical	Policy
		self-insured markets.		
	Per capita amount (per employee or per member) applied to both insured and self-insured markets	This would be fairly simple to apply. Would need to ensure counting of employee or member happens only once. It would be easier for issuers and self-insured groups to forecast contributions they will make each year once rate is determined. This approach could apply to Treasury contributions, as well. This approach may not necessarily yield an equitable application of contributions for high-cost areas versus lower-cost areas.	To ease cash flow, and ensure early transfer of contributions, could be applied per month from monthly enrollment data, estimated from prior periods with true-up to current period. May need to consider disaggregation of employer group employees into state of residence and state of employment. May be more practical for self-insured groups to self-report due to using multiple benefit administrators. Could use the same mechanism as for comparative effectiveness fee.	If groups are to be disaggregated by state, realizing that employer/employee costs do not reflect any experience in a given state and typically are level among states may be a consideration towards a per-member assessment methodology.
Collecting contributions by "plan year"	Define "plan year" as "calendar year"	ACA refers to collecting reinsurance assessments on plan years beginning in 2014.	Strict adherence to "plan year" significantly defers collection of funds available for reinsurance and expands assessments across calendar years.	
Additional reinsurance contributions collected by states	Allow states to require a higher level of contribution	States could fund projected shortfall of reinsurance funds using the national reinsurance parameters for attachment point, cap, and coinsurance percent.	Shortfalls or excess funds may be difficult to forecast sufficiently in advance, given the uncertainties of the reinsurance program (e.g., number of individual participants, level of additional selection risk, and interaction of selected reinsurance parameters).	
	Nationally determined level rate of contribution	Less complex to administer, and one less uncertainty, given the difficulty for issuers to price effect of reinsurance.	Shortfalls or excess funds no harder to manage.	
Frequency of collecting issuer contributions	Monthly	This would allow faster initial fund accumulation. This would require additional		

Decision Point	Options	Implications		
		Technical	Practical	Policy
		reporting on bases that may not be well defined.		
	Quarterly	Quarterly reporting sources should exist to calculate or reasonably estimate. More likely to be able to build off existing processes. Could require earlier in-the-year contribution with true-up in subsequent quarter.	It would minimize the administrative cost burden.	

Decision Point	Options	Implications		
		Technical	Practical	Policy
153.230 Calculation of Reinsurance Payments				
Payments based only on essential benefits.	See Section 153.200 earlier in this Appendix.			
Paid or incurred basis	Paid basis	Claims payments may be accelerated or decelerated across paid accumulation periods.	Seldom used with issuers in current markets.	
	Incurred basis	Need to make decision on runout cut-off.	Most common form of reinsurance in current markets.	
Ensuring suitability of claim payments for reinsurance coverage	Accept net paid claims from issuers	Claims would be adjudicated according to issuer contracts with providers. Issuers that also are providers could have outlier provisions that are favorable to them that generally are not available to issuers that are at arm's-length-contracting with providers.	Could rely on independent audits of data. Could result in unfair and unintended reimbursement levels for issuers that are providers.	
	Reinsuring entity to reprice all claims submitted for reinsurance using standard schedule, such as a multiple of Medicare reimbursement rates	This could ensure a level playing field. Issuers could determine expected reinsurance payments subject to reinsuring entity re-calculation.	Number of expected reinsurance claims will be a subset of all claims, so repricing using consistent formula should not be too complex. If a multiple of Medicare pricing is used, fee schedule gaps will need to be filled for components without a Medicare allowable amount such as pharmacy. Multiplier could be determined to approximate state's average net reimbursements, and published in advance for issuer pricing and planning.	Desire to promote fair competition and distribution of reinsurance funds.

Decision Point	Options	Implications		
		Technical	Practical	Policy
153.240 Disbursement of Reinsurance Payments				
Timeline for issuers to submit reinsurance claims	Short deadline	Allows timely incorporation into risk-corridor and MLR calculations. Results in using less complete data, and may require considering more uncertain and larger accruals for balance of payments in the absence of timely payment of reinsurance to issuers.	Presence of reinsurance should act as further stimulus beyond prompt payment for large claims submissions and payment.	
	Longer deadline	Opposite of the above		
Frequency of reinsurance payments to issuers while avoiding funds shortfall or excess	Pay reinsurance quarterly at full rate until funds are exhausted	Claims submitted later in the year are subject to not getting paid or at reduced amounts.	Reinsurance is catastrophic in nature and, hence, not distributed evenly and often takes longer to surface. This first-come-first-served approach is not likely to be viewed as equitable. Easy to administer; not perceived as equitable if funds exhausted or if it requires retrospective reductions.	
	Pay reinsurance quarterly at a fractional rate (75 percent or 80 percent) with final settlement for all reinsurance claims submitted by deadline (e.g., 180 days following the end of the calendar year).	Slows cash flow to issuers that may be hurt by unusual volume of catastrophic claims. Pays significant partial funds to all issuers. Ensures final determination of reinsurance so that remaining funds may be paid out proportionately if funds are insufficient.	Temporary reinsurance is not a substitute for normal risk and cash management. Additional administration, but with small number of expected reinsurance claims, should be manageable. Perceived as more equitable. May lengthen timelines to incorporate into risk-corridor and MLR calculations.	

Decision Point	Options	Implications		
		Technical	Practical	Policy
Subpart D—State Standards Related to the Risk Adjustment Program				
153.310 Risk Adjustment Administration				
Appropriate deadline by which risk adjustment must be completed (Note: dependent on prospective versus concurrent methodology and pharmacy versus medical claims usage)	Less claims run-out (e.g., 3 months for medical claims)	The measurement of relative risk may be less accurate, although the difference may not be significant. The largest concern is bias across health plans for which there is significant variation in diagnosis / NDC reporting with shorter run-out periods.	The timing for risk-adjustment completion is accelerated which is important for health plan pricing and valuation purposes.	A uniform deadline across all states would need to accommodate the state's methodology that has the longest timeline.
	More claims runout (e.g., 6 months for medical claims)	The measurement of relative risk is expected to be more accurate.	The timing for completion of risk adjustment is pushed out, creating additional financial uncertainty for health plans.	A uniform deadline across all states would need to accommodate the state's methodology that has the longest timeline.
Appropriate timeframe for state commencement of payments (Note: options listed here are about communication rather than actual payment)	Risk-adjustment administrator provides interim risk assessments and risk-adjustment elements	Dependent on early data.	More work and more cost for risk-adjustment administrator.	Helps issuers and regulators to manage issuers' financial health. Promotes market stability.
	First communication is when risk-adjustment calculations are finalized		Less work and less cost.	Potential financial instability for issuers.
Requirements for risk-adjustment reports from states to CMS	Standardized report across all states		Only practical if there is limited range of state-to-state variation in risk-adjustment methodology.	
	Standardized report with approved customization to accommodate state deviation from the default federally certified risk-adjustment methodology		Accommodates state deviations while preserving some degree of consistency.	

Decision Point	Options	Implications		
		Technical	Practical	Policy
	Each state designs its own report under guidelines established by the regulation		More tailored to specific states, but difficult to compare across states.	

Decision Point	Options	Implications		
		Technical	Practical	Policy
153.320 Federally-Certified Risk Adjustment Methodology				
Methodology elements for federal notices	Include methodology details in notice so that a qualified individual who has access to the appropriate data can develop same results as CMS/state	Improved confidence in results and understanding of methodology.	Will require additional communication.	
Predictors in risk model	Use existing models that do not incorporate income, race, or neighborhood-level ZIP codes into risk adjustment at federal or state level	The industry already has such risk assessment models developed, so no additional technical development will be needed.	Research indicates that population segments with low income or in disadvantaged geographical areas are associated with higher health care resource consumption, so that the exclusion of income/ neighborhood factors from risk adjustment may create disincentives for health plans to serve such populations. Since a disproportionate share of enrollees in the exchange will be low income, issuers accordingly may be less inclined to participate in the exchange.	Target marketing and market segmentation strategies (sometimes based on only income/ethnicity/ neighborhood, but at times also based on consumer/credit card transactions data) by issuers for selection will continue or even escalate if not prohibited. Inconsistent with the policy goal of making issuers indifferent to the demographic profile of their insureds.
	Incorporate income or small-area adjustments into the default federal methodology and all federally certified risk-adjustment methodologies to ensure appropriate payment for underserved populations and areas	Once reliable data are acquired, there are no technical implementation issues. The expected R-squared gain is small. But since the exchange will have a disproportionate share of low-income enrollees, the impact may be important to encourage issuers to participate in the exchange.	Income (up to 400% of FPL) and area will be readily available without any special collection efforts and will be relatively unambiguous. Of the two, income is the more practical variable for federal risk adjustment as it potentially can be applied uniformly across the country. In contrast small-area factors would need to be crafted for areas within each state. In addition, geographic areas small enough to target effectively disadvantaged populations may be too small to easily produce credible data for establishing area	Would result in state-to-state consistency, but not necessarily inter-program consistency. Medicare Advantage makes an adjustment for income by way of a Medicaid dual-eligibility adjustment—but Medicare does not adjust for areas smaller than county.

Decision Point	Options	Implications		
		Technical	Practical	Policy
			adjustments.	
	Allow states the opportunity to incorporate income or small-area adjustments into their risk adjustment as a deviation from the default federal methodology	Same as above.	States have the greatest interest in developing and managing small-area adjustments.	Responsive to individual state health care market management strategies.
Adjustments to model weights to determine average actuarial risk under the risk-adjustment methodology—*rating factors (or premium relativities)*	Use the issuers' actual rating factors	This approach has the potential to create some gaming incentives, and it compromises the goal of risk adjustment as based on uniform calibration of risk variables. It is possible that over time all issuers in a state will start using similar rating factors. This would not address, however, the initial few years' problem.	Will need to collect rating factors from every issuer in the state, on and off the exchange. Overestimation of risk factors by an issuer would lead to larger sums being transferred (whether paid or charged) under risk adjustment, while underestimation would lead to smaller sums being transferred (paid or charged).	The adjustment is for the gap and overlap between enrollees' model risk scores and risk captured by issuers' actual rating factors.
	Use market average rating factors	Need an appropriate way to weight all issuers' actual factors to calculate market average.	Would need to collect rating factors for every plan in the state, on and off the exchange.	The adjustment is for the gap and overlap between enrollees' model risk scores and risk captured by market average rating factors.
	Use standardized rating factors promulgated by CMS or by the state authority administering the risk-adjustment mechanism	If risk-adjustment payments are based on a set of standard pricing factors, competitive pressures may drive carriers also to price using those factors (or ones very close to them), in which case the factors would become a de facto pricing standard for the market.	Using standard factors for all plans in a state would simplify the risk-adjustment calculations. On the other hand, the promulgating authority would require access to the data necessary to establish standard factors appropriate for the market. The appropriateness of the factors would need to be monitored, with periodic updates as necessary.	The adjustment is for the gap and overlap between enrollees' model risk scores and risk captured by the standardized rating factors that the issuer could have charged. The potential policy implications of this result should be explored (e.g., does it increase competition, or decrease it? Is it consistent with the intent of anti-trust rules?)

Decision Point	Options	Implications		
		Technical	Practical	Policy
Adjustments to model weights to determine average actuarial risk under the risk-adjustment methodology—*benefit and utilization relativities* .	Use 90%, 80%, 70%, 60% actuarial value factors for the metal plans	Such factors used as external multipliers to risk model scores will keep the risk-adjustment methodology isolated from issuers' pricing strategies. Catastrophic plans and plans not sold on exchanges are not confined to the 4 percentage levels. Plans, therefore, would have to submit the actuarial value or the state/DOI would have to calculate it.	Actual cost differences between metal tiers are likely to be different due to selection and induced utilization, each of which will also differ by disease condition. As a result, this likely would create an implicit subsidy between the lower tiers to the higher benefit tiers and across diseases. The size of the subsidy would depend on the level of selection and induced utilization by disease attributable to the higher benefits provided by the tiers with higher actuarial values. Actuarial studies may be able to quantify this subsidy and make the results available for consideration in future risk-adjustment methodology enhancements.	
	Use factors for the metallic plans that reflect the cost impact of selection and induced utilization as well as differences in actuarial value. These factors could be based on any of the three options discussed for rating factors above (actual plan rating factors, market average rating factors, or standardized rating factors promulgated by CMS)	Issuers likely will charge higher premiums in metallic plans in which they anticipate adverse selection and induced utilization, and vice-versa. The resulting actual premium relativities therefore are not just reflective of benefit package differences, but also are confounded with relative risk. As a result, use of actual premium relativities will double-count risk embedded in the risk-model scores. Plans not sold on exchanges are not confined to the four metallic plan levels. The development of market average factors or administratively mandated standardized factors, therefore, might be technically unfeasible.	Similar to those discussed previously for rating factor options.	

Decision Point	Options	Implications		
		Technical	Practical	Policy
Adjustments to model weights to determine average actuarial risk under the risk-adjustment methodology—*synchronizing premium relativities directly at the risk assessment model calibration stage, versus incorporating them later in the risk adjustment methodology*	Incorporate the variables represented by rating factors and plan design directly into the risk-assessment model, eliminating the need for a separate adjustment	Not done this way today and would require technical innovation. This would be the most sophisticated approach that also captures the various interaction effects between rating variables, plan design and the standard risk model predictor variables. A disease such as asthma, for example, may have a greater reduction in relative weight under the bronze plan versus the platinum plan as compared to a high-cost disease like congestive heart failure.	The necessary innovations would take time. The resulting model would be technically complex and probably difficult to communicate and audit. The risk-adjustment methodology steps outside of the risk-assessment model would become greatly simplified.	Potential lack of transparency as a result of the difficulty in communicating and auditing a technically complex model. The risk model scores reflect the relativity of an issuer's average risk profile to the market's average risk profile.
	Use currently available risk models' weights followed by subsequently adjusting for risk gaps/overlaps with rating factors and benefit plan values, depending on what variations in premiums will be considered as allowable when calculating the risk-funds transfer amounts	Does not require any changes to today's generation of risk assessment models. Would require adjustments outside of the model at the time risk fund transfers are calculated.	This approach likely would be simpler and easier to explain, and would not require recalibration of the risk-assessment model coefficients when rating relativities change. It likely will not capture the interaction between benefit design and diseases. It would complicate the calculation of risk-adjustment transfer amounts.	The risk model scores coupled with the subsequent external adjustments reflect the relativity of an issuer's average risk profile to the market's average risk profile.
Extent of state flexibility that should be allowed in adopting an approach to determine average actuarial risk.	Less allowable deviation	Potentially less specific to each state's market. Less innovation.	Easier to review and for multi-state carriers to understand and administer across states.	
	More allowable deviation	Potentially more specific to each state's market. More innovation. Annual modifications will allow	More difficult to review and, for multi-state carriers, to understand and administer across states.	ACA encourages state ownership of health care reform management.

Decision Point	Options	Implications		
		Technical	Practical	Policy
		states to adopt best practices from other federally certified methodologies.		
Multiplying plan average actuarial risk by the state average normalized premiums or by the specific premiums collected for each plan	State average market premium. This would reflect the average product choice of all participants in the market	Premium and enrollment data from all participating plans would be needed to calculate the average. One decision would be whether to weight the average based on premiums or on enrollment (using premiums would be inherently more self-balancing).	Timing of the data collection would be important. The closer the actual average is to the estimate, the more likely the system is to be budget-neutral without additional adjustments. Risk adjustment may offset partially the effect of pricing below or above the market.	Risk-adjustment payments would be based on the average benefit level actually purchased by market participants. If this approach is contemplated, consideration should be given to the effect if most market participants were to gravitate to either the highest or lowest product offered– would the risk-adjustment mechanism reinforce that trend?
	State average premium, normalized for benefit plans' actuarial values	The same premium and enrollment data, as for a straight market average, would be needed, with an additional adjustment to normalize the benefit level. This would require access to an actuarial value (or equivalent benefit adjustment) for all non-exchange plans.	Because the actual premiums are unlikely to average to the specified benefit level, this approach likely would increase the size of the final adjustment necessary to make the system budget neutral. Risk adjustment partially may offset the effect of pricing below or above the market.	Risk-adjustment payments would be based on a benefit level chosen for policy reasons (e.g., a determination of the level of coverage to be encouraged or subsidized). May have the effect of encouraging enrollment to gravitate to the chosen benefit level. Does not recognize issuer-specific differentials in premium needs driven by non-risk driven cost differentials (e.g., downstream provider reimbursement and utilization management strategies). Encourages lower premiums since risk adjustment shifts focus from pricing strategies to competitive cost containment.
	Exclude nonessential benefits from risk-adjustment calculations	Would require that premiums to be reliably and consistently allocated between essential and nonessential benefits.	Not all plans have claims systems that separately can identify non-essential benefits. If the expansion is not a new type of service, but rather a frequency or application (e.g., colonoscopies every year), it may be impossible to track in claims experience.	Avoids the use of risk-adjustment funds assessed on plans providing only essential benefits to subsidize the purchase of nonessential benefits by other enrollees. Likely would tend to discourage the offering and purchase of nonessential benefits. Raises the question of how to handle state-mandated nonessential benefits.

Decision Point	Options	Implications		
		Technical	Practical	Policy
	Issuer-specific actual premiums	Relies on readily available numbers. Preserves pricing differentials across issuers that are not attributable to risk, but rather to provider contracting, utilization management, and market penetration strategies. Risk adjustment does not mitigate pricing strategies.	There could be significant amounts of overall market excess or shortfall of risk-adjustment funds transfer amounts. Normalization for budget-neutral risk funds transfer will be influenced by pricing differences across issuers.	Inefficient actual premiums would exaggerate an issuer's risk funds transfer; efficient actual premiums will dampen the issuer's risk funds transfer.
	A reference premium instead of average premium	An appropriate reference premium would have to be defined. This could be something like the average premium for the five plans with the highest enrollment, the median premium in the market, or a national premium based on an external measure, such as a state employee benefits plan. Reference premiums can be set prospectively or retrospectively, the former affording some financial predictability to issuers.	It would avoid the need for calculating a market average. The further the reference premium is from the average market premium, the larger the adjustments that will be necessary to make the system budget neutral.	If a back-end calibration adjustment is applied to ensure that the transfers balance so that the system is budget neutral, then the premium used serves primarily as an index value. Having a simple reference that is easily calculated and administered, therefore, may be seen as more important than the specific value that is used. Shifts focus from pricing strategies to competitive cost containment. Reference premiums also can be used as a tool to dampen or magnify the overall amounts of funds transfer.
Methodologies for balancing the system when there is an imbalance between charges and payments	One-sided adjustment methodology	Technically feasible.	Issuers' uncertainties uneven between those paying and those being charged.	Collecting additional payments from issuers with favorable risk without reducing payments to issuers with unfavorable risk, or vice-versa, could put a large additional payment burden on a potentially small portion of the market.
	If there's an excess, hold it in reserve	Technically feasible.		This introduces inter-year subsidy for reasons not directly attributable to inter-year risk differentials and defeats the goal of a neutral transfer within a year.

Decision Point	Options	Implications		
		Technical	Practical	Policy
	Two-sided methodologies that don't redefine the cutoff point between favorable and unfavorable risk	Technically feasible.		Two-sided methods are more consistent with the intent of risk adjustment than one-sided methods.
	Use a risk-adjustment methodology that is inherently self-balancing	Technically feasible.	By definition, certain elements of the risk-adjustment methodology parameters will not be prescribed fully in advance to permit the balancing. This creates an element of uncertainty for issuers. If the system is inherently self-balancing it is likely to reduce the amount of imbalance created by administrative considerations—such as uncertainty in projecting market averages—thus reducing the size of the final reconciliations necessary to maintain budget neutrality.	Two-sided methods are more consistent with the intent of risk adjustment than one-sided methods.
	Introduce a renormalization as the last step of the risk-adjustment methodology that forces balance	Essentially divide the system by a factor that brings payments and charges into balance.	Redefines the cutoff between favorable and unfavorable risk and adjusts payments and charges. This will force some issuers to switch between net payment and net charge positions.	

Decision Point	Options	Implications		
		Technical	Practical	Policy
153.330 State Alternate Risk Adjustment Methodologies				
Criteria for federal certification of state alternate methodologies	Include statistical fit as only one among other criteria for evaluating state risk-assessment models and methodologies	Less of an emphasis on statistical fit with more flexibility in approach.	Additional emphasis on practical considerations in developing risk-assessment model and risk-adjustment methodology.	Methodologies with less statistical fit may be more suitable overall with respect to policy goals.
	CMS should provide information in advance on acceptable variations from the federal model		May save some states significant time and effort but will require more advance federal planning. Waiting for states to submit methodologies and rationale might allow otherwise disapproved methodologies to be approved.	May limit flexibility/innovation.

Decision Point	Options	Implications		
		Technical	Practical	Policy
153.340 Data Collection Under Risk Adjustment				
Centralized, intermediate, and distributed approaches	Centralized approach in which issuers submit raw claims data sets to CMS		CMS will need to receive individual claims data from all plans. States likely will want similar data from plans, resulting in duplicate submissions. While the Medicare program may be seen as a potential precedent for this approach, the situation is very different. In the case of Medicare, the program is centrally administered by CMS.	Since risk adjustment is administered at the state level, this approach could be pursued for national level analyses, research, and methodological innovation.
	An intermediate state-level approach in which issuers submit raw claims data to the entity administering the risk-adjustment mechanism at the state level		States routinely will be collecting data in the process of administering the risk-adjustment mechanism and exchange. Collecting these data at the state level likely will be more efficient and provide more opportunities for testing against other data submissions. Because the risk-adjustment mechanism and exchanges will be administered at the state level, this approach is the closest analogy to the Medicare program, in which the data are collected by the same entity that administers the risk-adjustment mechanism (as well as the rest of the program). Would require significant data transfers on a routine basis and significant data processing by the states.	Collection by the entity administering the risk-adjustment mechanism provides greater opportunity for audit controls and quality review as well as allowing for other uses of the data in analyzing the effectiveness of the risk-adjustment mechanism and updating the risk-assessment model. National level studies always could be pursued by ad hoc data calls from CMS to all states.
	A distributed approach in which issuers store data at their own sites using a standardized protocol; enrollee risk scores, and issuer averages are calculated by each	The risk-assessment model would have to be made available to plans on a timely basis in a format that would allow them to run it against their data in a consistent and auditable manner.	Data and processes at the plan level would need to be subject to periodic audit and review processes. Fewer data submissions would be required, reducing the administrative burden for plans. Would minimize the data processing requirements placed on states. Relatively more efficient and cost-effective than a centralized	A distributed approach better preserves the confidentiality of plan data and lessens the likelihood that personal health information will be disclosed inadvertently.

Decision Point	Options	Implications		
		Technical	Practical	Policy
	issuer and passed on to the administrator of the risk-adjustment mechanism		approach.	
Using risk adjustment for other purposes	Consolidated data call in which common data support risk adjustment and other purposes	Coordinates the diverse technical needs of various stakeholders.	Administratively efficient, but less flexible. Careful deliberation needs to be given to the data elements and format necessary to meet the diverse needs of CMS, the states, and the exchanges, both current and future.	Health care administrative efficiency is a policy goal. There could be concerns relating to privacy, proprietary nature of data, and anti-trust issues.
	Multiple routine and ad hoc data calls	Maximum flexibility in specifying the exact data required for a given technical need.	Logistically difficult for issuers. Data quality will take longer to stabilize and will be a particular concern for ad hoc calls.	
Reliance on HIPAA and NCPDP standards	Leverage standards wherever possible, such as using HIPAA and NCPDP. Develop standards as necessary for new data such as premiums and rating factors	Consistent and reliable data are essential for risk adjustment.	Administratively efficient, but less flexible. The proposed standards are the standards issuers already are using and with which they are familiar. Well-defined, consistent data are the foundation of quality risk adjustment.	

Decision Point	Options	Implications		
		Technical	Practical	Policy
153.350 Risk Adjustment Data Validation Standards				
Possibility of a three-year deadline for validation with possible redistribution of risk-adjustment funds	Audit program with time period limitation (e.g. three years), with redistribution of funds	Most complete, actuarial solution in terms of following risk adjustment principles.	Very difficult for health plans to operate with significant financial uncertainty.	
	Audit program with penalties only for those issuers who have higher-than-average error rate	One sided, so risk-adjustment budget neutrality is not inherently maintained.	There is still significant uncertainty since an issuer will not know average error rate until after audits are complete.	Only issuers with higher-than-average error rates are subject to uncertainty after the initial risk-adjustment process is completed. The recoupment-only approach detracts from the risk-adjustment principle of transferring funds between issuers in a zero-sum approach.

Decision Point	Options	Implications		
		Technical	Practical	Policy
Subpart E—Health Insurance Issuer Standards Related to the Transitional Reinsurance Program				
153.400 Reinsurance Contribution Funds				
Frequency of data submissions	Monthly	More timely but more administratively burdensome, as many issuers may not have auditable processes in place.		
	Quarterly	Less timely, but issuers likely can build on existing processes used for quarterly reporting and annual independent audits.	Reinsurance program is temporary and should not require extensive new reporting or systems development.	
153.410 Requests for Reinsurance Payment				
Timing for submission of requests for payment	Monthly starting after a date (e.g., March 31) at which time sufficient reinsurance funds are expected to have been collected	Data may not be sufficiently complete, and may require multiple submissions. Would allow cash flow relief for issuers having significant volume of reinsurance eligible claims.	Expect interim payments at a reduced rate (75 percent or 80 percent) to ensure funds not exceeded.	
	Quarterly starting after a date (i.e., March 31) at which time sufficient reinsurance funds are expected to have been collected	Data more complete and fewer submissions may be required. Less administrative handling. Possible reduced cash flow to issuers in need.	Expect interim payments at a reduced rate (75 percent or 80 percent) to ensure funds not exceeded.	
Deadline for submission of claims	Three months following the end of the calendar year	Assumes incurred calendar year basis reinsurance. Claims less complete and many may not be submitted due to lack of available data.	Shortens timelines; but, many reinsurance claims may not get submitted. May require larger reserves and accruals for risk corridors and MLR calculations.	
	Six months following the end of the calendar year	Assumes incurred calendar-year basis reinsurance. Claims more complete and more likely to be known. Closer to traditional reinsurance requirements.	Longer timelines, but most reinsurance claims should be known and submitted. Smaller reserves and accruals needed for risk corridors and MLR calculations.	

Decision Point	Options	Implications		
		Technical	Practical	Policy
	Submission of additional claims beyond the cutoff	Claims submitted beyond the deadline still might be eligible for reinsurance payment if sufficient funds remain, and if the lack of submission of data is due to contracts with providers that are beyond the issuers control, but before some ultimate deadline of 60 additional days.	These additional payments would not be reflected in the risk corridor and MLR calculations, which could unintentionally advantage an issuer.	

Decision Point	Options	Implications		
		Technical	Practical	Policy
Subpart F—Health Insurance Issuer Standards Related to the Temporary Risk Corridors Program				
153.500 Definitions				
Allowable costs	Include costs for activities that improve health care quality		It would be consistent with the federal MLR definition.	
	Do not include costs for activities that improve health care quality	If quality improvement expenses are not included as an allowable cost, they should be included as a reduction along with nonmedical costs in determining the target amount.		
Limiting allowable administrative costs	Limit administrative costs to 20 percent, consistent with MLR	Since issuers have to project an additional variable distribution by plan, it would create additional pricing uncertainty. If actual plan distribution is different from projection, there will be a mismatch between actual administrative expense and projected expense.	It would be consistent with the federal MLR definition. It would limit the potential for issuers to use risk corridor payments to pay for MLR rebates.	If only QHPs in the exchange have the 20 percent limit and plans outside the exchange are not restricted, it would create a non-level playing field.
	Allow justification of company allowable costs, as written		Under the unreasonable rate increase review process, rates would be reviewed by the state or CCIIO, which would limit an issuers' attempts to use risk-corridor payments to pay for MLR rebates. As an alternative, if risk corridors were to be performed on an aggregate level instead of a QHP level, it would limit issuers' ability to use risk-corridor payments to pay for MLR rebates.	
Target amount—*projected costs*	Target amount is premium less allowable	Issuers with margin expectations greater than 3 percent of target would be subject to risk-corridor		

Decision Point	Options	Implications		
		Technical	Practical	Policy
	administrative costs, and allowable cost has the same definition as in Section 158.160(b)	payments to CMS even if actual costs were equal to projected costs. Issuers would not receive risk-corridor payments until actual claims exceed their projected claims by their entire projected margin and the 3 percent threshold (103 percent of target).		
	Targets reflect projected incurred claims only	Risk corridor would work as expected, resulting in a charge when actual claims are lower than expected by the threshold amount and vice versa.		ACA stated that the risk-corridor program would be based on the program under Medicare Part D. If the target amount means projected incurred claims, then it would be similar to Medicare Part D.
Target amount—*taxes and assessments*	Not recognize premium taxes and state assessments in determining allowable administrative costs	Issuers likely would be charged a risk-corridor amount even when actual claims experience turns out to be the same as expected. Issuers would not receive risk-corridor payments until actual claims well exceed the expected amount.	Considering premium collected to pay for taxes and state assessments to be issuer profits subject to risk-spreading via risk corridors likely would discourage issuers from entering the market and may encourage current issuers to exit.	
	Either include taxes and assessments as allowable administrative costs or, alternatively, include them as an offset to premiums	Recognizing taxes and assessments as an offset to premiums may enable more meaningful administrative cost comparisons from downstream risk-corridor reporting and comparison to MLR reporting.		
Target amount—*underwriting gain*	Underwriting gain is not recognized in determination of target amount	Issuers with margin expectations greater than 3 percent of target would be subject to risk-corridor payments to CMS even if actual costs were equal to projected costs. Issuers would not receive risk-corridor payments until actual claims exceed their projected claims by their entire projected margin and the 3		

Decision Point	Options	Implications		
		Technical	Practical	Policy
		percent threshold (103 percent of target).		
	Underwriting gain is recognized in determination of target amount	This would be consistent with Medicare Part D approach, in which issuers include target margin in their bid submissions. (And, under Medicare Part D, actual allowable cost is compared to projected allowable cost amount).	Alternatives include: --Establish guideline of permissible margin in the determination of the target amount. --Consider the MLR rebate threshold as a safe harbor, in which target amounts less than the MLR rebate threshold would need further justification.	

Decision Point	Options	Implications		
		Technical	Practical	Policy
153.510 Risk Corridor Establishment and Payment Methodology				
Timeline for remittance of charges to CMS	30 days		30 days is an appropriate amount of time	
	More than 30 days		Will the time allowed for submission of payment be consistent with CMS payments owed to issuers?	
Risk-corridor calculations at the QHP level.	Determine target amounts and allowable costs for each QHP, apply risk-corridor calculations at the QHP level, then add up the results for an issuer, as in the proposed rule	Experience less credible than if aggregating at the issuer level.	Issuers usually do not report or track administrative expenses at the QHP level. This would impose an additional reporting burden on issuers for a temporary program.	By applying the risk-corridor formula at the plan level (not issuer), unintended consequences may result. An issuer operating at a gain could receive a risk-corridor payment. An issuer operating at a loss similarly could be charged a risk-corridor amount.
	Determine target amounts and allowable costs for each QHP, aggregate the results for an issuer, then apply risk-corridor calculations at the issuer level	Experience more credible.		
	Determine target amounts and allowable costs for each QHP, aggregate the results by line of business (small group and individual) for an issuer, then apply risk-corridor calculations at the line-of-business level	Experience more credible.	Aggregating by line of business (small group and individual separately) for an issuer is consistent with the federal MLR calculation.	

Decision Point	Options	Implications		
		Technical	Practical	Policy
153.520 Risk Corridor Standards for QHP Issuers				
Risk adjustment and reinsurance as adjustments to premiums	Adjustments to premium, as in the proposed rule		It would be reasonable to treat risk adjustment as adjustments to premiums. If there is a corresponding increase or decrease in risk as reflected by the risk-adjustment factor, projected claims will increase/decrease correspondingly.	
	Adjustments to claims		Reinsurance payments would be treated more appropriately as adjustments to claims.	Under Section 158.140, it appears that risk-corridor and reinsurance amounts are treated as adjustments to incurred claims.
Interaction with MLR	Reinsurance for risk corridor cutoff by claim submission date	Reporting by submission dates is not consistent with pricing, federal MLR calculation or financial reporting.	Issuers can delay claims submission to the following year to maximize risk share opportunities. Risk corridor is a temporary program; claims not submitted in 2016 would not be used in risk corridor calculations at all.	If an earlier incurred cutoff date is used, risk-corridor calculations may not include all the final reinsurance claim amounts. For the issuers, there is a tradeoff between accuracy and uncertainty.
	Reinsurance for risk corridor cutoff by claim incurred date	Consistent with pricing, federal MLR calculations, and financial reporting.	Would not be subject to the manipulation described above.	While having a longer claims lag time would yield more accurate results, issuers would not have the final amount till later in the year and have more uncertainty for pricing and financial reporting in the interim.

Decision Point	Options	Implications		
		Technical	Practical	Policy
Subpart G—Health Insurance Issuer Standards Related to the Risk Adjustment Program				
153.610 Risk Adjustment Issuer Requirements				
Other categories of data required in support of risk adjustment	Collect only the data necessary to support the approved risk-adjustment methodology. All foreseeable methodologies require the allowable rating variables, with tables indicating rate factors applied to each enrollee or family		This would be the easiest approach.	Meets immediate goals of supporting risk-adjustment.
	Collect the data necessary to support the approved risk-adjustment methodology, as well as other potential future methodologies		It may be difficult to predict comprehensively which data may be valuable in the future.	Regulators should monitor actively for non-adjusted risk selection and adjust methodologies accordingly. They cannot do so without data.
Data collection every 30 days	Quarterly data collection as an alternative to monthly	It is not clear that monthly data collection adds sufficient value as opposed to quarterly.	Monthly collection potentially is more work but allows for a more rapid response to data quality issues.	Meets immediate policy goals.
Issuers given a 30-day time frame in which to pay net charges	Interim and mid-year risk-adjustment estimates so that issuers are prepared for net settlement costs (or receipts)		Interim informational reports can be costly to produce.	Better financial management and enhanced market stability.