State of California
DEPARTMENT OF INSURANCE
DEPARTMENT OF MANAGED HEALTH CARE
CALIFORNIA HEALTH BENEFIT EXCHANGE

December 31, 2012

Submitted electronically via www.regulations.gov

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

Re: CMS-9964-P; Comments to Notice of Proposed Rulemaking on Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014

Dear Secretary Sebelius:

On behalf of the State of California and many of the entities responsible for implementing the Patient Protection and Affordable Care Act in the state—the Department of Insurance, the Department of Managed Health Care, and the California Health Benefit Exchange — we submit the enclosed comments on the proposed rules for HHS Notice of Benefit and Payment Parameters for 2014. California appreciates the opportunity to comment on these important regulations.

California appreciates the significant effort involved in establishing the benefit and payment parameters for 2014 to ensure proper implementation of market stabilization programs outlined in the Affordable Care Act. California also appreciates the guidance that HHS has proposed with regard to all three premium stabilization programs and the medical loss ratio program of the Public Health Service Act. In these comments, which are presented in chart format, we offer suggestions for improvement of the proposed rules. As mentioned in the enclosed chart, California has concerns related to the proposed regulations to implement the Risk Adjustment and Temporary Reinsurance programs.

Although California intends to use federal services to perform the risk adjustment and reinsurance function, we strongly urge you to replace the proposal for a national

reinsurance pool with a system of collections and payment that are calculated state-by-state. Also, the proposed risk adjustment methodology, which uses claims data to determine risk adjustment payments, could significantly disadvantage California managed health care plans that pay for health care services through capitated arrangements rather than on a fee-for-service basis. Specifically, California strongly recommends using pharmacy data in addition to demographic and claims data when determining risk scores for health plans in states with a high proportion of capitated providers. Please see the attached chart for the details about specific issues and recommendations. We would welcome an opportunity to develop an approach to risk adjustment that works for California's health care delivery system and the managed care plans that operate in this state.

The enclosed comments reflect the consensus of all the signatories to this letter. Should you have questions concerning the comments, please direct them to all three agencies. Thank you for taking these comments into consideration as you finalize the rules and as California approaches the full debut of the Patient Protection and Affordable Care Act, which we have all worked diligently to successfully implement.

Sincerely,

Dave Jones, Insurance Commissioner

Brent Barnhart, Director, California Department of Managed Health Care

Peter V. Lee, Executive Director, California Health Benefit Exchange

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	III. Provisions of the Proposed HHS Notice of Benefit and Payment Parameters for 2014			
	B. Provisions and Parameters for the Permanent Risk Adjustment Program			
	3. Overview of the Risk Adjustment Methodology HHS Would Implement When Operating Risk Adjustment on Behalf of the State			
	b. Overview of the HHS Risk Adjustment Model			
1	73128	***Preamble only:*** *(3) Prescription Drugs* At this time, we have elected not to include prescription drug use as a predictor in each HHS risk adjustment model. While use of particular prescription drugs may be useful for predicting expenditures, we believe that inclusion of prescription drug information could create adverse incentives to modify discretionary prescribing.	We seek comments on possible approaches for future versions of the model to include prescription drug information while avoiding adverse incentives.	California strongly recommends using pharmacy data, in addition to demographic and claims data, when determining risk scores for health plans in States with a high proportion of capitated providers. California health plans regulated by the Department of Managed Health Care with capitated delivery systems have not traditionally reported encounter data as accurately as claims based data. The proposed risk adjustment model may lead to an unfairly low risk score for these health plans, and could unintentionally disadvantage the capitated delivery system relative to fee-for-service based provider networks.
	d. Overview of Data Collection Approach			
2	73145 73210*	**§ 153.20 Definitions.** * * * * * *Risk adjustment data collection approach* means the specific procedures by which risk adjustment data is to be stored, collected, accessed, transmitted, and validated and the applicable timeframes, data formats, and privacy and security standards. * * * * * **§ 153.340 Data collection under risk adjustment.** * * * * * **Subpart H—Distributed Data Collection for HHS-Operated Programs** **§ 153.710 Data requirements.** (a) *Enrollment, claims, and encounter data.* An	We welcome comment on this proposed data collection approach.	California health plans with a capitated delivery system have not traditionally received encounter data from these providers as accurately as data provided by claim-based providers. With the potential underreporting of encounter data, California recommends using pharmacy data, in addition to demographic and claims data, when determining risk scores for health plans in States with a high proportion of capitated providers. See comment in row #11. The proposed §153.710(c) would require a capitated health plan with a capitated delivery system to use a principal internal methodology to derive costs for applicable provider encounters. California recommends that the methodology used by capitated health plans be

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		issuer of a risk adjustment covered plan or a reinsurance-eligible plan in a State in which HHS is operating the risk adjustment or reinsurance program, as applicable, must provide to HHS, through the dedicated data environment, access to enrollee-level plan enrollment data, enrollee claims data, and enrollee encounter data as specified by HHS. (b) *Claims data.* All claims data submitted by an issuer of a risk adjustment covered plan or a reinsurance-eligible plan in a State in which HHS is operating the risk adjustment or reinsurance program, as applicable, must have resulted in payment by the issuer. (c) *Claims data from capitated plans.* An issuer of a risk adjustment covered plan or a reinsurance-eligible plan in a State in which HHS is operating the risk adjustment or reinsurance program, as applicable, that does not generate individual enrollee claims in the normal course of business must derive the costs of all applicable provider encounters using its principal internal methodology for pricing those encounters. If the issuer does not have such a methodology, or has an incomplete methodology, it must supplement the methodology in a manner that yields derived claims that are reasonable in light of the specific service and insurance market that the plan is serving.		subject to review and approval by the State and/or HHS.
	C. Provisions and Parameters for the Transitional Reinsurance Program			
	3. National Contribution Rate			
3	73155	***Preamble only:*** *Federal Administrative Fees* … we propose that HHS also collect reinsurance contributions from health insurance	We seek comment on this approach, and other reasonable, administratively simple approaches that may be used to calculate administrative	The paragraph states that HHS would transfer $0.055 of the per capita administrative fee to a State for purposes of administrative expenses

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		issuers, even if a State is operating its own reinsurance program. In this proposed rule, we estimate the Federal administrative expenses of operating the reinsurance program in 2014 to be approximately $20.3 million, or approximately 0.2 percent of the $10 billion in reinsurance funds to be distributed in 2014.	costs.	incurred in making reinsurance payments in the case that a State operates its own reinsurance program. The paragraph also states that administrative expenses for reinsurance payments will be distributed in proportion to the State-by-State total requests for reinsurance payments made under the national payment parameters. It appears that there are two different approaches and we request clarification as to which approach HHS expects to use.
	4. Calculation and Collection of Reinsurance Contributions			
4	73155 73206* 73207*	**§153.400 Reinsurance contribution funds.** (a) *General requirement.* Each contributing entity must make reinsurance contributions annually: at the national contribution for all reinsurance contribution enrollees, in a manner specified by HHS; and at the additional State supplemental contribution rate if the State has elected to collect additional contributions under §153.220(d), in a manner specified by the State. * * * * * **§153.240 Disbursement of reinsurance payments.** (b) *Notification of reinsurance payments.* For each applicable benefit year, (1) A State, or HHS on behalf of the State, must notify issuers annually of: (i) Reinsurance payments under the national payment parameters, and (ii) Reinsurance payments under the State supplemental payment parameters if applicable, to be made for the applicable benefit year no later than June 30 of the year following the applicable benefit year. (2) A State must provide to each reinsurance-	…we propose in §153.400(a) and §153.240(b)(1), respectively, to collect and pay out reinsurance funds annually to minimize the costs of administering the program and the burden on contributing entities…We note that this approach would delay the receipt of some reinsurance payments for individual market issuers, and solicit comment on the benefits and burdens for issuers, States, and other stakeholders of a more frequent collections and payment cycle.	We recommend the removal of §153.240(b)(2) because it is not clear why a requirement for the State to provide each reinsurance-eligible plan the expected requests for reinsurance payments is necessary. It is equally unclear how a State would do so, especially a state where HHS is operating the reinsurance program.

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		eligible plan the expected requests for reinsurance payments made under: (i) The national payment parameters, and (ii) State supplemental payments parameters if applicable, from such plan on a quarterly basis during the applicable benefit year in a timeframe and manner determined by HHS.		
	7. Uniform Adjustment to Reinsurance Payments			
5	73160 73205*	**153.230 Calculation of reinsurance payments made under the national contribution rate.** (d) *Uniform adjustment to national reinsurance payments.* If HHS determines that all reinsurance payments requested under the national payment parameters from all reinsurance-eligible plans in all States for a benefit year will exceed all reinsurance contributions collected under the national contribution rate in all States for an applicable benefit year, HHS will determine a uniform pro rata adjustment to be applied to all such requests for reinsurance payments for all States. Each applicable reinsurance entity, or HHS on behalf of a State, must reduce all requests for reinsurance payments for the applicable benefit year by any adjustment required under this paragraph (d).	This uniform pro rata adjustment would ensure that claims are paid at the same rate out of the national reinsurance fund, and promote equitable access to the national reinsurance fund across all States while furthering the goal of premium stabilization under the Affordable Care Act. We invite comment on this policy.	We believe it is essential that HHS modify its plan to create a national pool for reinsurance collections and payments, and replace it with a system of collections and payments calculated state by state. This method ensures that reinsurance operates to stabilize markets locally, rather than being spread across the nation as if there were one national market. If HHS adopts our suggestion, it will need to clarify how collections from multi-state employers will be allocated by state.
	10. Reinsurance and Data Collection Standards			
6	73163 73206*	**§153.240 (b)** *Notification of reinsurance payments.* For each applicable benefit year, (1) A State, or HHS on behalf of the State, must notify issuers annually of: (i) Reinsurance payments under the national payment parameters, and (ii) Reinsurance payments under the State supplemental payment parameters if applicable,	HHS intends to collaborate with issuers and States to develop these early notifications. We welcome comments on this proposal.	Please see comment in row #4.

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		to be made for the applicable benefit year no later than June 30 of the year following the applicable benefit year. *(2) A State must provide to each reinsurance-eligible plan the expected requests for reinsurance payments made under*: (i) The national payment parameters, and (ii) State supplemental payments parameters if applicable, from such plan on a quarterly basis during the applicable benefit year in a timeframe and manner determined by HHS.		
7	73163 73209*	**§153.420 Data collection** (a) *Data requirement.* To be eligible for reinsurance payments, an issuer of a reinsurance-eligible plan must submit or make accessible all required reinsurance data in accordance with the reinsurance data collection approach established by the State, or by HHS on behalf of the State. (b) *Deadline for submission of data.* An issuer of a reinsurance-eligible plan must submit or make accessible data to be considered for reinsurance payments for the applicable benefit year by April 30 of the year following the end of the applicable benefit year.	We propose to add new §153.420(a) to address data collection issues, including the distributed data collection approach that HHS intends to use when operating the reinsurance program on behalf of a State…In §153.420(b), we propose that an issuer of a reinsurance-eligible plan submit data to be considered for reinsurance payments for the applicable benefit year by April 30 of the following year. The April 30 deadline would apply to all issuers of reinsurance-eligible plans, regardless of whether HHS or the State is operating reinsurance. We welcome comments on this proposal.	HHS intends to operate the reinsurance program on a calendar year basis with an April 30th deadline to submit data to be considered for reinsurance payments from the previous calendar year (deadline is from page 159). We request that HHS clarify how much run out they intend to allow. We also suggest that HHS include at least 2 months of run out for the calendar year claims so that claims that are incurred near the end of the year will be more fully represented, as the claims that are incurred earlier in the year.
	E. Provisions for the Advance Payments of the Premium Tax Credit and Cost-Sharing Reduction Programs			
	2. Exchange Functions: Certification of Qualified Health Plans			
8	73167 73212*	**§ 155.1030 QHP certification standards related to advance payments of the premium tax credit and cost-sharing reductions.** (a) *Review of plan variations for cost-sharing reductions.* (1) The Exchange must ensure that	We welcome comment on this proposed standard and alternative approaches.	We do not agree that providing advanced payment to issuers for cost sharing reductions, as described, is necessary. We believe that the cumbersome process to develop quarterly estimates and then reconcile them annually is

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		each issuer that offers or seeks to offer a health plan at any level of coverage in the individual market on the Exchange submits the required plan variations for the health plan as described in § 156.420 of this subchapter. The Exchange must certify that the plan variations meet the requirements of § 156.420. (2) The Exchange must provide to HHS the actuarial values of each QHP and silver plan variation, calculated under § 156.135 of this subchapter, in the manner and timeframe established by HHS. (b) *Information for administering advance payments of the premium tax credit and advance payments of cost-sharing reductions.* (1) The Exchange must collect and review annually the rate allocation, the expected allowed claims cost allocation, and the actuarial memorandum that an issuer submits to the Exchange under § 156.470 of this subchapter, to ensure that such allocations meet the standards set forth in § 156.470(c) and (d). (2) The Exchange must submit, in the manner and timeframe established by HHS, to HHS the approved allocations and actuarial memorandum underlying the approved allocations for each health plan at any level of coverage or standalone dental plan offered, or proposed to be offered in the individual market on the Exchange. (3) The Exchange must collect annually any estimates and supporting documentation that a QHP issuer submits to receive advance payments of		unnecessary and issuers should be reimbursed for cost sharing reductions after submitting actual data to HHS. We suggest that HHS remove the requirements to estimate then reconcile payment.

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		certain cost-sharing reductions, under § 156.430(a) of this subchapter, and submit, in the manner and timeframe established by HHS, the estimates and supporting documentation to HHS for review. (4) HHS may use the information provided to HHS by the Exchange under this section for the approval of the estimates that an issuer submits for advance payments of cost-sharing reductions, as described in § 156.430 of this subchapter, and the oversight of the advance payments of cost-sharing reductions and premium tax credits programs.		
	4. Health Insurance Issuer Responsibilities with Respect to Advance Payments of the Premium Tax Credit and Cost-Sharing Reductions			
9	73176 73215*	**§156.430(d)** Reconciliation of amounts. HHS will perform periodic reconciliations of any advance payments of cost-sharing reductions provided to a QHP issuer under paragraph (b) of this section against – (1) The actual amount of cost-sharing reductions provided to enrollees and reimbursed to providers by the QHP issuer for benefits for which the QHP issuer compensates the applicable providers in whole or in part on a fee-for-service basis; and (2) The actual amount of cost-sharing reductions provided to enrollees for benefits for which the QHP issuer compensates the applicable providers in any other manner.	We welcome comment on this proposal.	We do not agree that providing advanced payment to issuers for cost sharing reductions, as described, is necessary. We believe that the cumbersome process to develop quarterly estimates and then reconcile them annually is unnecessary and issuers should be reimbursed for cost sharing reductions after submitting actual data to HHS. We suggest that HHS remove the requirements to estimate then reconcile payment.
	G. Distributed Data Collection for the HHS-operated Risk Adjustment and Reinsurance Programs			
	3. Risk Adjustment Data Requirements			
10	73183 73210*	**§ 153.710 Data requirements.** (a) *Enrollment, claims, and encounter data.* An	No comments requested.	California health plans with a capitated delivery system have not traditionally received

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		issuer of a risk adjustment covered plan or a reinsurance-eligible plan in a State in which HHS is operating the risk adjustment or reinsurance program, as applicable, must provide to HHS, through the dedicated data environment, access to enrollee-level plan enrollment data, enrollee claims data, and enrollee encounter data as specified by HHS. (b) *Claims data.* All claims data submitted by an issuer of a risk adjustment covered plan or a reinsurance-eligible plan in a State in which HHS is operating the risk adjustment or reinsurance program, as applicable, must have resulted in payment by the issuer. (c) *Claims data from capitated plans.* An issuer of a risk adjustment covered plan or a reinsurance-eligible plan in a State in which HHS is operating the risk adjustment or reinsurance program, as applicable, that does not generate individual enrollee claims in the normal course of business must derive the costs of all applicable provider encounters using its principal internal methodology for pricing those encounters. If the issuer does not have such a methodology, or has an incomplete methodology, it must supplement the methodology in a manner that yields derived claims that are reasonable in light of the specific service and insurance market that the plan is serving.		encounter data from these providers as accurately as data provided by claim-based providers. With the potential underreporting of encounter data, California recommends using pharmacy data, in addition to demographic and claims data, when determining risk scores for health plans in States with a high proportion of capitated providers. See comment in row#11.
	I. Medical Loss Ratio Requirements Under the Patient Protection and Affordable Care Act			
	2. Deduction of Community Benefit Expenditures			
11	73188	***Preamble only:*** Commenters have suggested that a 3 percent	Comments are solicited on the proposed community benefit expenditures deduction	California is concerned about potential market manipulation resulting from the inclusion of

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		limit on the deduction from premium for community benefit expenditures would be sufficient to allow a tax exempt issuer to maintain its current community benefit expenditure. … In light of the NAIC model rule and the comments received, we propose to limit the deduction from premium for community benefit expenditures for issuers that are exempt from Federal income tax to the higher of either 3 percent of premium or the highest premium tax rate charged in a State.	limit.	community benefit expenditures in MLR calculation, because the MLR by market segment could be manipulated by disproportionate allocations of such expenditures by market segment – even with the 3% limitation. We suggest that HHS clarify how such expenditures are to be allocated by market segment, included allocations to self-insured business as well as to insured business segments.