Steve,

As you requested during the MLR Subgroup call on 1/11, please find excerpts below from the Blue Cross Blue Shield comment letter on risk mitigation proposed rule. These excerpts address some of the data and timing issues that may arise from the interaction of the three risk programs and the medical loss ratio process.

Please let me know if you have any questions.

Thank you,

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All three risk mitigation programs interact with each other as well as with medical loss ratio reporting and rate setting (See attached Estimated Timeline for Risk Mitigation Programs and MLR). Therefore, all programs should be considered together in the development of the settlement process timeline. We recommend that the claims data used as the basis for these programs also be consistent with one another. We suggest that incurred claims be determined as claims with service dates in the calendar year which are paid by March 31 of the following year plus any remaining claims liability.

**Disbursement of Reinsurance Payments – 45 C.F.R. § 153.240**

**Issue:**
The proposed rule recommends that states ensure that the reinsurance entity collects data required to calculate reinsurance payments from health insurers using a standard collection method. Reinsurance payments must not exceed reinsurance contributions and states may reduce payments on a pro-rata basis to match the amount of contributions received that year. The reinsurance entity is to make payment only after receiving valid claims. The proposed rule requires that states maintain records related to the reinsurance program for 10 years, consistent with requirements for record retention under the False Claims Act.

**Recommendation:**
Since reinsurance payments are for claims accumulated throughout a calendar year, the data needs to coincide with an accumulated (year to date) claim. Claims should include allowed and paid charges for each service date and provider. Eligible claims should be incurred (i.e., have service dates) within the calendar year and paid by March 31 of the following year. This run-out period is consistent with the medical loss ratio run-out period. Issuers should submit claims by April 30 with payments by June 1.

There may be a conflict between the second reinsurance policy goal identified in the proposed rule (early and prompt payment of reinsurance funds during the benefit year) and a limited pool of funds to distribute. If reinsurance payments are paid as claims are submitted, reinsurance funds could be exhausted before year-end. Therefore, we recommend that health insurance issuers submit claims as they reach the attachment point throughout the year. The reinsurance entity would pay health insurance issuers at 75% of the eligible amount. When all claims are processed, if the full amount of funds is not available, the remaining 25% of the claims would be prorated and paid to the insurers.

**Rationale:**
Having the reinsurance entity pay 75% of eligible claims when received and prorating the remaining 25% after all claims are processed allows for prompt payment of reinsurance funds during the benefit year while managing the overall distribution of a limited pool of funds.
Data Submission Timeline – 45 C.F.R. § 153.610

**Issue:**
The Preamble to the proposed rule solicits comments on the following proposed timeline for risk adjustment data submission:
- **Claims and encounter data:** every 30 days and no later than 180 days after the date of service
- **Enrollment and demographic information:** by the end of the following month
- **Issuer rate-setting rules:** by the end of the month in which effective
- **Prescription drug utilization data:** every 30 days, and no later than 90 days following date of service.

**Recommendation:**
BCBSA recommends that medical claims, pharmacy claims, and enrollment data be updated quarterly, with three months of run-out. Each quarterly submission would include incurred dates of service from January 1, through the end of the submitted quarter, using claims processed from January 1, through the end of the following quarter. For example, first quarter data would be prepared for incurred dates of service from January 1 through March 31 using claims data processed from January 1 through June 30, allowing ample time for claims incurred in that period to be submitted, adjudicated and paid. Similarly, fourth quarter data would be prepared for incurred dates of service from January 1 through December 31 using claims data processed from January 1 through March 31 of the following year. Use of the three-month run out is also consistent with the definition of claims for MLR purposes. We also recommend using that same definition for the reinsurance and risk corridor programs to keep them all on the same basis.

**Rationale:**
Preparing data monthly may be burdensome given the marginal benefit to be gained in risk score accuracy. We believe that quarterly data balances the need for interim risk score information with minimizing administrative burden. Each quarterly dataset would have updated year-to-date claims to ensure the most complete data available are used, which would eliminate the need for the proposed time limits of 180 days for medical claims and 90 for pharmacy claims. Given our preferred methodology, submission of issuer rate-setting rules is not needed either.

Standards for QHP Issuer – 45 C.F.R. § 153.510

**Issue:**
The proposed rule states that in arriving at the adjusted premium, payments received for risk adjustment and reinsurance are to be added. In accounting for reinsurance payments, QHP issuers must attribute reinsurance payments to risk corridors based on the date on which the valid reinsurance claim was submitted.

In the Preamble, HHS requested comments on:
- Deadline for issuers to complete submission of risk corridor data.
- Interaction between risk corridor and MLR process.
- How to utilize MLR reporting data for risk corridors to limit reporting requirements on issuers.
- Treatment of reinsurance and risk adjustment for purposes of determining risk corridor amounts.

**Recommendation:**
We request clarification of the term received in using payments received for risk adjustment and reinsurance payments to arrive at adjustment premium. We recommend using expected risk adjustment and reinsurance payments to be made instead of payment received, since there may be a lag in actual payment, but the amounts should be reported in advance. In accounting for reinsurance payments, we strongly recommend reinsurance claims be attributed based on date incurred for both risk corridors and medical loss ratios and not based on submission date.
Deadline for QHP issuers to complete submission of all risk corridor data – Final risk adjustment and reinsurance figures are needed to properly calculate the risk corridor payments and charges. Therefore, we suggest that all risk mitigation programs are considered together in the development of the settlement process timeline. We recommend the following timeline for settlement of all risk mitigation programs:

- All incurred claims amounts should be determined as claims with service dates in the calendar year which are paid by March 31 of the following year plus any remaining claims liability.
- The risk adjustment program should employ quarterly interim risk score calculations based on year-to-date claims data with three months of run-out. Final risk adjustment scores should be based on full-year claims data as of March 31 of the following year. Health insurance issuers should have until April 30 to prepare the year-end data. Risk scores should be calculated and reports produced by May 31 with the actual transfer of funds by June 30.
- Reinsurance-eligible claims should be incurred within the calendar year and paid by March 31 of the following year. Health insurance issuers should have until April 30 to submit claims to the reinsurance entity. All reinsurance claims should be processed by June 30.
- Risk corridor calculations, using final risk adjustment and reinsurance amounts, should be completed and submitted to HHS by July 31.

Interaction between risk corridor and MLR process. Given that the risk corridor program is two-way risk sharing between the federal government and health insurance issuers and that the MLR process is a one-way value test from health insurance issuers to enrollees, final results of the risk corridor calculations will need to feed into the MLR calculations. Based on the timelines proposed above for the risk mitigation programs, MLR reports should be completed by August 31 of the following year or later.

Utilize MLR reporting data for risk corridors. It may not be feasible to directly use MLR reporting data for risk corridor calculation, particularly if risk corridor is plan specific and not issuer specific. It would be desirable to have consistent definitions to the extent feasible, such as basing unpaid claim reserves on 3 months claims run-out period, including unearned premium in premium amount, and reporting by calendar year, while allowing for differences, such as defining allowable administrative costs to include non-claims costs, taxes and regulatory fees, user fees and gain/loss margin.

We request clarification of the meaning/treatment of reinsurance and risk adjustment as "after-the-fact adjustments" to premium for purposes of determining risk corridor amounts.

Rationale:
Payment received date is more a cash flow concept. If risk corridor payment were based on payment received date, it would unnecessarily delay risk corridor calculations. There is a tight turnaround time for risk adjustment, reinsurance, risk corridor and MLR calculations.

Reinsurance claims should be attributed by incurred date rather than submission date, to be consistent with risk adjustment and MLR calculations.

The above timeline is consistent with our proposal for using final risk adjustment and reinsurance amounts for risk corridor and MLR calculations.

MLR reporting data may not be used directly in risk corridor calculation because MLR reporting is at a higher level (including QHPs and non QHPs), and due to timing difference (risk corridor amount needs to be completed before MLR so the result can be incorporated into MLR and rebate calculation). Having consistent definitions to the extent possible would be administratively less burdensome and would minimize reporting errors.
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