

STATE OF MAINE  
Department of Professional and Financial Regulation

BUREAU OF INSURANCE

December 1, 2011

**To:** Board of Directors of the Maine Guaranteed Access Reinsurance Association

**From:** Eric A. Cioppa, Superintendent of Insurance

**Subject:** Compatibility between MGARA and Federal Transitional Reinsurance Program

The federal Affordable Care Act (ACA) provides for a three-year transitional reinsurance program to be established by each state to operate in the years 2014 – 2016. This program is in many ways similar to the program MGARA will administer. Like MGARA, the federal program will provide reinsurance for large claims in the individual market and will be subsidized by an assessment on the entire health insurance market. It may be possible that the MGARA program could serve both purposes. We believe such a combined reinsurance mechanism would be more beneficial to Maine citizens with less expense and administrative burden on Maine employers and insurers than would two separate programs.

The U.S. Department of Health and Human Services (HHS) recently issued draft rules spelling out the details of the federal program. Several of the details proposed in the draft federal rule differ from those in Maine law relating to MGARA. I submitted comments on the draft rule, asking for more state flexibility in designing its reinsurance program. A copy of those comments is attached. However, some of the inconsistencies between the state and federal programs result from the underlying federal law. Therefore, even if HHS follows our recommendations in finalizing its rules, there will likely be some remaining issues. Other issues could arise depending on how the MGARA Board implements the Maine law. The potential issues are detailed below. I recommend that the Board bear these issues in mind as it proceeds with its work. In some instances, the Board may need or want to seek legislative changes in order to coordinate with the federal rules. With that in mind, I want to highlight the following issues:

- **Eligibility:** Under the proposed HHS rule, eligibility for reinsurance benefits is determined retrospectively based on claims. Reinsurance benefits are payable for any individual insured whose claims reach the attachment point. Under the MGARA law, high-risk individuals must be identified prospectively based on a health questionnaire. Reinsurance benefits are payable only if claims for an identified individual reach the attachment point. This is an area where I have recommended to HHS that more state flexibility be allowed. However, if the final rules do not provide that flexibility, the Board may want to seek legislation allowing MGARA to determine eligibility consistent with the federal program. The preamble to the proposed federal rules includes a discussion of the reasons HHS chose the approach they did, and the some of the same considerations may be applicable to Maine. Excerpts are appended to this memorandum.

- Covered services: The proposed HHS rule provides that only claims related to “essential health benefits,” as defined in federal rules, are eligible for reinsurance. The Maine law does not restrict the types of claims that are eligible. I have recommended to HHS that they change this provision to allow all claims or at least allow state flexibility in this area. However, if the final rule retains this restriction, the Board may want to seek legislation allowing MGARA to follow the same procedure.
- Assessment base: Both the state and federal programs provide for assessment of third-party administrators (TPAs), but the proposed federal rule defines TPA to include an employer administering its own plan: “Finally, we define ‘third party administrator’ as the claims processing entity for a self-insured group health plan. As such, if a self-insured group health plan processes its own claims, the self-insured plan will be considered a third-party administrator for the purpose of the reinsurance program.” The Maine law does not include such employers. The federal rule would appear to give the state authority to do this for the years 2014 – 2016, but a change in the state law would be needed.
- Assessment amount: The proposed HHS rule allows states to assess more but not less than the federal percentage. The federal premium percentage has not yet been determined, but for 2014 has to raise \$10 billion nationally plus \$2 billion for Treasury. HHS previously estimated that \$10 billion is about 1%, so the specified percentage may be about 1.2%. It is possible that this would exceed the \$4 per member per month cap in the Maine law, although the law does allow up to an additional \$2 per member per month to cover losses. It is not clear whether the additional assessment could be required in the absence of losses in excess of \$4 per member per month. If not, a change to state law might be necessary. The national target under the ACA reduces to \$6 billion + \$2 billion in 2015 and \$4 billion + \$1 billion in 2016, so this is less likely to be an issue in those years.
- Form of assessment: The proposed HHS rule requires the “contribution” to be a percent of premium, while the Maine law states a \$4 maximum flat amount per member per month. Here again, I have recommended to HHS that state flexibility be allowed. If the final rule retains this restriction, the Maine law could perhaps be interpreted to allow a percent of premium assessment as long as the aggregate amount raised would not exceed \$4 per covered person.
- Reinsurance benefit structure: The Maine law provides for payment of 90% of claims between \$7,500 and \$32,500 and 100% of claims over \$32,500. The proposed HHS rule provides for payment of a to-be-determined percentage of claims between a to-be-determined attachment point and a to-be-determined reinsurance cap, and 0% of claims over the cap. It permits state variations of the percentage, attachment point, and cap, including eliminating the cap, but it is not clear that the percentage could differ for different ranges. I have recommended to HHS that it be clarified that this would be permitted.
- Premiums: Under the Maine law, the reinsurance is only partially subsidized, so insurers in the individual market are required to pay reinsurance premiums. The federal law and rule do not require this, although it is not clear whether it would be prohibited. I have recommended to HHS that it be clarified that this would be permitted.

- Subcontracting: The Maine law permits the association to contract with other entities to perform some of its functions and does not require approval of these contracts except in the case of “contracts with similar organizations of other states for the joint performance of common administrative functions or with persons or other organizations for the performance of administrative functions.” It may be that the Board has no interest in contracting out any functions that would not be considered “performance of administrative functions,” but if the Board did contract out any non-administrative functions, Maine law does not appear to require approval by the Superintendent. However, the proposed federal rule requires that “States must review and approve subcontracting arrangements to ensure efficient and appropriate expenditures of administrative funds.” It is not clear whether this is a conflict since arguably if the contracted function does not involve “performance of administrative functions,” then it would not involve “expenditures of administrative funds.” This does not appear to be a significant issue, but I did want to bring it to your attention

I hope this memorandum is helpful to the Board. I and/or my staff would be happy to further discuss these issues with you.

## Excerpts from Preamble to Proposed HHS Rule Relevant to Eligibility for Reinsurance

As a basis for reinsurance payments, the law directs the Secretary to develop a list of 50 to 100 medical conditions to identify high-cost individuals or to identify alternative methods for payment in consultation with the American Academy of Actuaries (AAA).

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We identified three critical policy goals of the transitional reinsurance program. First, the transitional reinsurance program should offer protection to health insurance issuers against medical cost overruns for high-cost enrollees in the individual market, particularly those that are newly insured or those with previously excluded conditions, thereby allowing issuers to set lower premiums.

Second, a transitional reinsurance program should permit early and prompt payment of reinsurance funds during the benefit year to help offset the potential high costs of health insurance issuers early in the benefit year. This objective is particularly important since the two other risk sharing protections against adverse selection—risk adjustment and risk corridors—are likely to be calculated after the end of the benefit year.

Third, the transitional reinsurance program should require minimal administrative burden since it is a temporary program. Given the short-term nature of the program, the costs of setting up and administering this program must be commensurate with its benefits over the three-year window.

We received a number of comments on the transitional reinsurance program in response to the RFC. Multiple respondents emphasized that, although underlying conditions are referenced in the Affordable Care Act with respect to the reinsurance provisions, reinsurance programs typically do not consider the health status of the individual. Health insurance issuers seek traditional reinsurance to protect against unusually high medical cost of enrollees during a coverage year. Generally, reinsurance is not tied to underlying conditions that lead to high enrollee medical costs but to high claims costs beyond a specific dollar threshold within a coverage period, regardless of health condition.

Several commenters asserted that coverage of specific conditions under a reinsurance program could lead to discriminatory practices toward certain individuals, with one commenter noting that identifying medical conditions as a basis for reinsurance payments requires a level of verification beyond that of traditional reinsurance. Another commenter contended that traditional reinsurance that makes payments based solely on incurred costs does not encourage efficient and effective care.

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In our consultation, AAA laid out a number of different ways to implement the reinsurance payment provisions. A letter outlining this issue can be found on their Web site at [https://www.actuary.org/pdf/health/Reinsurance\\_Options\\_9\\_22\\_2010.pdf](https://www.actuary.org/pdf/health/Reinsurance_Options_9_22_2010.pdf). With respect to the determination of who will be covered, AAA identified four possible approaches:

- (1) Identification of individuals with specific conditions based on claims data.
- (2) Identification of individuals with specific conditions based on survey data.
- (3) Identification of high-risk individuals using risk adjustment data and a condition-based risk adjustment model.
- (4) Identification of reinsurance-eligible individuals based on medical cost to the health insurance issuer for covered benefits.

The last option, which we propose to adopt, focuses on all high-cost enrollees without respect to the conditions that caused the increased cost. This approach would be most familiar to health insurance issuers and administratively less burdensome than the first and second options. Data will be immediately available and dependent only on health insurance issuers filing proof of payment for claims. While the third option might mitigate some of the burden and cost concerns, it would not eliminate the timing issues that are critical to effective reinsurance implementation.