October 17, 2011

Submitted electronically via the Federal Rulemaking portal @ www.regulations.gov

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

Dear Sir or Madam,

Subject: Proposed Rule on Standards Related to Reinsurance, Risk Corridors, and Risk Adjustment (CMS–9975–P) (RIN 0938-AR07)

Aon Hewitt welcomes the opportunity to submit for consideration our comments relating to the proposed rule on Standards Related to Reinsurance, Risk Corridors, and Risk Adjustment that was published in the *Federal Register* on July 15, 2011.

Who We Are

Aon Hewitt is the global leader in human resource consulting and outsourcing solutions. The company partners with organizations to solve their most complex benefits, talent, and related financial challenges, and improve business performance. Aon Hewitt designs, implements, communicates, and administers a wide range of human capital, retirement, investment management, health care, compensation, and talent management strategies. With more than 29,000 professionals in 90 countries, Aon Hewitt makes the world a better place to work for clients and their employees.

Below are Aon Hewitt's comments on specific provisions of the proposed rule.

State Notice of Insurance Benefits and Payment Parameters

The preamble discussion of proposed section 153.100 describes a process under which states issue an annual notice to disseminate information to issuers and other stakeholders about specific requirements to support payment-related functions, including descriptions of any reinsurance or risk adjustment parameters that differ from those specified in the forthcoming annual federal notice of benefit and payment parameters. Under the process, the Department of Health and Human Services (HHS) states its view that information contained in the state notice should be provided one year in advance of the benefit year "so that issuers may account for any updates in their design and review of plan benefits and in establishing and reviewing rates." HHS then proposes that, from the date HHS publishes its final notice in mid-January of each year, states would have only until "early March" to issue their notice that contains modifications to the federal parameters.

Aon Hewitt believes that states, like issuers, should be given a reasonable amount of time to make well thought out decisions regarding Exchange support. When HHS publishes its final notice each mid-January, states will have to analyze the federal parameters on reinsurance or risk adjustment, and determine whether any modifications to those parameters should be employed by the state. A period of as short as six

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weeks might not be sufficient for states to perform their analysis and reach a determination on whether to modify. To make such a decision on reinsurance, for example, states may wish to review (in years following the initial year of the program) the purchase history of enrollees and their coverage selection, any trends in purchases of enrollees, demographics of enrollees, etc., and assess all those factors against the final federal parameters for the upcoming benefit year. Due to all the factors that states may have to review and assess against the final federal parameters, Aon Hewitt requests that states be given at least three months after the end of a benefit year and after publication of the HHS notice to publish its own state notice. We understand that such a time frame may reduce the amount of time that issuers would then have to reflect the state-specific requirements in setting rates. To minimize this impact, the final rule could require HHS to publish its final notice earlier than mid-January of each year. Issuers would then have nine months during which to review state-specific requirements and set rates. While Aon Hewitt believes that this nine-month duration is likely a sufficient amount of time, we understand that the issuers will have the best ideas regarding how the setting of rates during this timeframe can be facilitated.

Risk Corridor Establishment and Payment Methodology

The preamble discussion of proposed section 153.510 describes how the temporary risk corridor program would apply to health insurance issuers. The amount of “charges” to be remitted to HHS and “payments” to be made by HHS to qualified health plan (QHP) issuers would be based on a fixed formula, based solely on the QHP issuers’ actual costs compared to projected costs. The amount of “charges” is not adjusted to take into account the amount of “payments” and vice versa. Thus, the total amount of “charges” and “payments” for a given year could very likely differ, resulting in either a surplus of charges or a deficit.

Aon Hewitt requests clarification as to whether HHS agrees that such surpluses or deficits may occur under the proposed rule. And if so, how HHS will use any surpluses, how deficits will be funded, and whether full payments under the fixed formula will actually be paid to QHP issuers when such calculated total payments exceed total remitted charges. We note that regulatory impact analysis states that “CBO did not score the impact of risk corridors, but assumed collections would equal payments to plans in the aggregate. The payments and receipts in risk adjustment, reinsurance, and risk corridors are financial transfers between issuers.” This statement suggests that charges should equal payments and vice versa over the three-year period that the temporary risk corridor program is in place.

Closing

If you have any questions or comments, please contact the undersigned at the telephone number or email address provided below.

Sincerely,

Aon Hewitt

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