ACAP
Association for Community Affiliated Plans

1015 15th Street, N.W., Suite 950 | Washington, DC 20005

Tel. 202.204.7508 | Fax 202.204.7517 | www.communityplans.net

December 31, 2012

Gary Cohen, Director
Center for Consumer Information & Insurance Oversight
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS–9964–P
Room 445-G, Hubert Humphrey Building
200 Independence Avenue SW
Washington, DC 20201

Dear Mr. Cohen:

The Association for Community Affiliated Plans (ACAP) thanks you for providing us with an opportunity to comment on proposed rule *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014*, published December 7, 2012 in the Federal Register. We appreciate your willingness to consider these comments.

ACAP is an association of 59 not-for-profit and community-based Safety Net Health Plans (SNHPs) located in 25 states. Our member plans provide coverage to approximately 9 million individuals enrolled in Medicaid, the Children's Health Insurance Program (CHIP) and Medicare Special Needs Plans for dually-eligible people. Nationally, ACAP plans serve roughly one-third of all Medicaid managed care enrollees. Many Safety Net Health Plans currently are developing plans to serve those individuals that will gain new coverage due to insurance expansions enacted by the Affordable Care Act. Many of our members intend to build qualified health plans (QHPs) that will participate in the Exchanges operating in their states.

Our comments are summarized below.

1. **FFE User Fee for QHPs.** ACAP recommends that HHS reduce the percentage of the user fee for QHPs participating in the FFE. In addition, ACAP recommends that HHS conduct regular analysis of value of the functions paid for by the fee, and alter the fee percentage accordingly.
2. **Risk Adjustment.**
    a. **Timely Improvements to Risk Adjustment Model.** ACAP recommends that HHS (and states) respond as soon as possible with improvements to the risk adjustment system.
    b. **Analysis of Newly-Insured.** HHS should perform careful analysis of the newly-insured over the first few years of the Exchanges to see whether adjustment for them could be improved.
    c. **Evaluate Income-Related and Social Variables.** HHS should evaluate inclusion of income-related variables or additions to risk scores to improve accuracy for plans serving low-income populations.

d. **Gather Additional Data for High-Risk Groups.** ACAP recommends that HHS gather additional health data, including clinical measures, for defined high-risk groups with lower health status.
e. **Transfer Individual Diagnostic and Treatment Information.** HHS should develop systems for transferring individual diagnostic and treatment information between QHPs or QHPs and the Exchange to create a longer-term individual health history for enrollees who change plans or sources of coverage.
f. **Examine Need to Adjust for Socio-Economic Circumstances.** Similar to (c) above, ACAP asks HHS to examine the longer-term need to adjust payment methods for differences in socio-economic circumstances that increase needs for health care and care management.
g. **Consider Extending Reinsurance and Risk Corridor Programs Beyond 2016.** HHS should consider developing a legislative proposal to extend reinsurance and risk corridors beyond the first three years of the Exchanges if risk adjustment alone proves insufficient for payment accuracy.
h. **Three-Month Minimum Coverage Window.** ACAP recommends that HHS strive to ensure that as many individuals as possible can be assigned an individual risk score by shortening the window of required coverage to three months.
i. **Concurrent Risk Adjustment Model for Plans that Capitate Provider Payments.** ACAP recommends that HHS study problems related to concurrent risk adjustment for QHPs that capitate provider payments to ensure they are not penalized by the inability of capitated providers to submit accurate, complete, and timely data.

We explain these positions in greater detail below.

1. **FFE User Fee for QHPs.** Section 156.50 requires participating issuers to remit user fee payments and other payments required by a state Exchange. This section also requires issuers participating in the FFE to remit a monthly user fee. Section III. F. on page 73181 of the preamble to the Draft Notice explains that QHPs in the FFE will benefit from several Exchange operations, including
    - Provision of consumer assistance tools,
    - Consumer outreach and education,
    - Management of a Navigator program,
    - Regulation of agents and brokers,
    - Administration of advance payments of premium tax credits and cost-sharing reductions,
    - Enrollment processes,
    - Certification processes for QHPs, and
    - Administration of the SHOP exchange.

HHS further explains that only those benefits accruing to QHP issuers will be paid for by the user fee.

ACAP recognizes that the user fee serves a critical function – funding the FFE – and understands the need for health plans to contribute to this function. However, the percentage envisioned for the fee in 2014 – proposed at 3.5 percent – may exceed the value of the benefits, as analyzed by some issuers, and also may be very burdensome for some issuers. Furthermore, we feel as though HHS should engage in ongoing study of this cost because the cost of the functions described above may fluctuate. HHS proposes to align the FFE user fee with user fees imposed by state-based Exchanges; however, it may be that alignment of the fee with the actual value of the benefits is more useful. In any case, issuers will want to be reassured that their payments are reasonable and not excessive; HHS should make any study it conducts transparent for issuers and other stakeholders.

ACAP recommends that HHS consider reducing the percentage of the user fee in 2014. In addition, ACAP recommends that HHS conduct regular analysis of value of the functions paid for by the fee, and alter the fee percentage accordingly.

2. **Risk Adjustment.** Part 153 of the Draft Notice of Benefit and Payment Parameters describes standards related to reinsurance, risk corridors, and risk adjustment under the Affordable Care Act. ACAP will restrict our comments to the federal risk adjustment program at this time.

   In November 2012, ACAP published a report authored by researchers Tony Dreyfus and Ellen Breslin Davidson of the BD Group called *Improving Risk Adjustment in Health Insurance Exchanges to Ensure Fair Payment*. This paper draws on the expertise of both the authors and a wide array of other risk adjustment experts, explores the special circumstances of QHPs that serve a large proportion of high-risk and low-income individuals, and culminates in a series of recommendations that ACAP submits to HHS to provide focus to the special needs of health plans serving high-needs and low-income people.

   The risk adjustment program as conceived by Congress and interpreted by HHS strives to stabilize the insurance market by ensuring fair payment to all health plans. ACAP believes that establishment of a robust and effective risk adjustment program will be particularly important for Medicaid-focused health plans. The following excerpt from the report explains this concern:

   > "Medicaid-focused health plans have an established role in serving high-need people in low-income areas, and are more likely than other plans in the Exchanges to attract many newly-insured individuals. But newly insured individuals lack the diagnostic records needed for effective risk adjustment. As a result, Medicaid-focused health plans will not be compensated adequately if they disproportionately attract the more costly individuals among the newly insured population.

Plans that specialize in serving low-income populations may also enroll a disproportionate share of new enrollees who "churn," or move between sources of insurance coverage due to changes in eligibility. People with low incomes will experience much eligibility churn as a result of changes in income, employment status, family status or health. As many as 30 million people each year will shift between Medicaid, the Exchanges, employer-sponsored insurance and no insurance.

Similarly, churn will also limit the availability of diagnoses needed for risk adjustment. As a result, plans may receive payments that are unadjusted for risk for millions of individuals who are moving into the Exchanges. The movement of many individuals among sources of coverage will also pose challenges to plan administration and care management.

The challenges of the newly insured and churn will be mitigated by the temporary use of reinsurance and risk corridors. But in 2017 when these supports are discontinued, risk adjustment alone will bear more fully the burden of getting the rates right. As a result, plans and public officials should devote time and resources to improving the risk adjustment system to ensure accurate payments to plans with disproportionate shares of high-need enrollees.

If plans experience many newly insured enrollees and much churn, with a disproportionate share of high-cost members, they will face a higher level of uncompensated adverse selection than other plans. Medicaid-focused health plans may be hit harder than most plans, because of the special role that they have in serving low-income communities."

The full report is available here and is attached to these comments. The first seven of the following recommendations are pulled directly from the report; the final two were developed separately.

a. **Timely Improvements to Risk Adjustment Model.** In the short run – the first year or so of operating the risk adjustment model – there is substantial concern that some plans may receive many newly insured enrollees with high needs for whom risk adjustment based on age and gender alone will produce inadequate risk scores. These inadequate risk scores will lead to uncompensated adverse selection. The federal government could alleviate this problem for health plans with prompt action.

   Those administering the risk adjustment process should monitor plan experience closely to determine the effects of new entrants and increase (or decrease) payment rates promptly to reflect the new experience.

   In the short term, we advocate that the federal government and states implementing their own Exchanges should play the role of an active overseer of the payment

process. This means that Exchange managers should not wait for twelve months or more to judge developments but act immediately, collecting data on the experience of plans to see if there is uncompensated adverse selection. The large numbers of newly insured entering the Exchanges behooves the government to monitor and adjust systems as needed.

ACAP recommends that HHS (and states) respond as soon as possible with improvements to the risk adjustment system.

b. **Analysis of Newly-Insured.** Adverse selection uncompensated by risk adjustment among both newly insured and existing enrollees in plans appears likely, and the cost implications may be large enough to threaten the viability of plans with limited financial resources. The volume of the newly insured will be large even when the program has matured because of churn, so careful analysis of new enrollees will be needed in the medium term as well. One concrete question to settle will be whether the payment weights used for people with considerable length of eligibility in the Exchange are accurate in calculating risk scores for newly insured. HHS may find that alternate weights are needed. A second question is whether adjustment for new enrollees can be improved by using their prior insurance status as a variable. For example, prior eligibility for Medicaid might be a useful variable that could lead to an increase in an individual's risk score.

In the medium-term, HHS should perform careful analysis of the newly insured over the first few years of the Exchanges to see whether adjustment for them could be improved.

c. **Evaluate Income-Related and Social Variables.** Adding variables for income or geographical proxies for income could also improve risk adjustment particularly in the absence of diagnostic information on new eligibles. Economic variables and even social variables might become useful supplemental variables to diagnostic data as improved full-service data become available over time. Eligibility information for premium tax credits and cost-sharing reductions, zip code or census tract could be used as a proxy for income.

In the medium-term, HHS should evaluate inclusion of income-related variables or additions to risk scores to improve accuracy for plans serving low-income populations.

d. **Gather Additional Data for High-Risk Groups.** The gathering of additional health-related data for defined high-risk groups with lower health status could also be used to facilitate better care management and development of best care practices. For example, clinical measures of physical health and of cognitive function might contribute to improved risk adjustment and care management for some groups. Efforts to improve risk adjustment with diagnostic, functional and socio-economic

variables should yield greater result with greater efficiency when focused on the most expensive individuals.

In the medium-term, ACAP recommends that HHS gather additional health data, including clinical measures, for defined high-risk groups with lower health status.

e. **Transfer Individual Diagnostic and Treatment Information.** Risk adjustment can eventually be improved in the Exchanges by expanding the time period for which diagnoses are used to estimate risk. A longer period of time should yield more diagnoses and more accurate predictions, in part because many important diagnoses appear in the diagnostic record in much greater frequency with longer timeframes.

One way to accomplish these longer timeframes would be through the establishment of personal health histories that follow individuals as they move from one source of coverage to another. Such an extended personal health record could improve care management as well. While the extended record would introduce complicated administrative and confidentiality issues, it would also help address the challenge of estimating risk of future new enrollees, for whom only short periods of diagnostic collection are possible in the short term.

In the long-term, HHS should develop systems for transferring individual diagnostic and treatment information between QHPs or QHPs and the Exchange to create a longer-term individual health history for enrollees who change plans or sources of coverage.

f. **Examine Need to Adjust for Socio-Economic Circumstances.** As discussed previously in this letter, adding variables for income or geographical proxies for income could improve risk adjustment particularly in the absence of diagnostic information on new eligibles. Not just in the mid-term, but over the long-term, socio-economic variables might supplement diagnostic and demographic data.

ACAP asks HHS to examine the longer-term need to adjust payment methods for differences in socio-economic circumstances that increase needs for health care and care management.

g. **Consider Extending Reinsurance and Risk Corridor Programs Beyond 2016.** In addition, federal and state policymakers should study the extension of risk mitigation measures such as risk corridors and reinsurance beyond the three-year period envisioned in the ACA, if risk adjustment alone does not accomplish its goals. Such an extension would require federal legislative change or state action. If these measures are extended, they would relieve the risk adjustment system of the

full burden of matching payments closely to need and assure Safety Net Health Plans more reliable financing.

HHS should consider developing a legislative proposal to extend reinsurance and risk corridors beyond the first three years of the Exchanges if risk adjustment alone proves insufficient for payment accuracy.

h. **Three-Month Minimum Coverage Window.** Plans may experience some level of uncompensated adverse selection as a result of churn. Individuals who churn experience breaks in eligibility, which results in an incomplete risk profile for the individual. For individuals lacking diagnostic information, age and gender could be used to calculate risk scores. Age and gender, however, will serve as a poor substitute for diagnostic information, especially for those enrollees with the highest costs. Shortening the window of time required for diagnostic information to be used in risk adjustment for new members could alleviate this problem. Proponents of concurrent risk adjustment might suggest a window as short as three months.

ACAP recommends that HHS strive to ensure that as many individuals as possible can be assigned an individual risk score by shortening the window of required coverage to three months.

i. **Concurrent Risk Adjustment Model for Plans that Sub-Capitate Provider Payments.** The preamble to the Draft Notice explains that HHS selected a concurrent risk adjustment model because 2013 diagnostic data will not be available for use in the model in 2014. It further explains that HHS anticipates that enrollees may move between plans, or between programs because of the eligibility churn we describe earlier in this letter. HHS believes that "a concurrent risk adjustment model would be better able to handle changes in enrollment than a prospective model because individuals newly enrolling in health plans may not have prior data available that can be used in risk adjustment."

Although ACAP recognizes the value of a concurrent risk adjustment model and supports HHS's selection of such because of the potential for solving some of the issues related to churn, we know that some health plans that sub-capitate payments to providers may face difficulty in collecting comprehensive and accurate data on a timely basis. For certain Safety Net Health Plans, this may be a substantial problem preventing full participation in the risk adjustment program, and therefore leading to unfair payment.

ACAP recommends that HHS study problems related to concurrent risk adjustment for QHPs that sub-capitate provider payments to ensure they are not penalized by the inability of sub-capitated providers to submit accurate, complete, and timely data.

Conclusion

Again, ACAP would like to thank you and your colleagues for your willingness to discuss these issues with us. If you have any additional questions or comments, please do not hesitate to contact Jenny Babcock at (202) 204-7518 or jbabcock@communityplans.net.

Sincerely,

Margaret A. Murray
Chief Executive Officer