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
Howard A. Kahn, Chairman | Margaret A. Murray, Chief Executive Officer

August 16, 2013

Daniel Werfel
Acting Commissioner
Department of the Treasury
Internal Revenue Service
P.O. Box 7604
Ben Franklin Station
Washington, DC 20044

Re: Health Insurance Providers Fee, REG-118315-12; Notice of Proposed Rulemaking and Notice of Public Hearing (March 4, 2013)

Submitted electronically via: http://www.regulations.gov

Dear Mr. Werfel:

The Association for Community Affiliated Plans (ACAP) appreciates the opportunity to submit comments, supplementary to those which we submitted on May 31, 2013 (see attachment), on the above proposed rule related to implementation of the health insurance providers fee established by the Affordable Care Act (ACA)[1]. Although we are submitting these comments after the official comment period, we believe that the issues which we address in this letter are of substantial significance, and we respectfully request that you take them into consideration as you finalize the draft regulations.

ACAP is an association of 58 not-for-profit and community-based Safety Net Health Plans (SNHPs) located in 24 states. ACAP member plans provide coverage to over 10 million individuals enrolled in Medicaid, the Children's Health Insurance Program (CHIP) and Medicare Special Needs Plans for dual eligibles. Nationwide, ACAP members serve approximately one in three individuals enrolled in Medicaid managed care plans. ACAP's mission is to represent and strengthen its member plans as they work with providers and caregivers in their communities to improve the health and well-being of vulnerable populations in a cost-effective manner. Our plans are full partners with the federal government and the states in meeting the coverage needs of our nation's low-income health care consumers – whether they are eligible for Medicaid, CHIP, the soon-to-be-developed Basic Health Program, coverage in state- or federal-based health insurance Exchanges, or other health care programs – and we are pleased to comment on these draft regulations.

[1] The Patient Protection and Affordable Care Act (P.L. 111-148) and the Healthcare and Education Reconciliation Act (P.L. 111-152) together are referred to in this letter as the Affordable Care Act (ACA).

As noted in the initial paragraph of this letter, on May 31, 2013, ACAP submitted initial comments on the notice of proposed rulemaking. Our comments focused on issues of particular importance to Safety Net Health Plans as they strive to support the implementation of the ACA, provide coordinated, continuous health care coverage to their enrollees, and support efforts to enroll all eligible individuals in the appropriate health insurance option.

Our comments at that time focused on the definition of a governmental entity as well as the criteria which would be used to identify certain nonprofit corporations, both of which are groups excluded from being covered entities. Since our submission of these comments, it has come to our attention that the intent of the provisions of the underlying statute with respect to these excluded entities may be thwarted as a result of certain subcontracting, or "subcapitation," arrangements into which these health plans enter. It is this issue which is the focus of this letter.

Background on Relevant Health Insurer Operations

Many health insurers delegate some portion of the risk that they assume under a contract to provide health insurance to other entities. This delegation can also be termed "subcapitation" because the health insurer passes some or all of its risk and its capitation rate down to another entity.

Health insurers do this for a number of reasons. A primary reason for such arrangements is that another more specialized organization may be able to better meet specific health care needs of its members (e.g., in the case of a health plan which delegates its risk for dental care to a separate dental insurance provider or for behavioral health services to a behavioral health provider).

In other cases, plans may fully delegate the health insurance risk for a portion of their population to another organization, resulting in that organization being responsible (with the originating plan's oversight) for all care provided. In California, for example, governmental entity health plans, which are considered excluded entities, nearly all subcontract with Kaiser Permanente Health Plan to provide care for a subset of their Medicaid members. In fact, these plans were mandated to establish and/or expand their contracts with Kaiser as a result of the State's decision to eliminate its CHIP program and move children into the Medicaid program.

In addition to delegating or "subcapitating" to another health insurer, plans also delegate/subcapitate to providers (e.g., hospitals, physician groups) who are not insurers. This can be done, for example, in support of the federal government's encouragement of Accountable Care Organizations .

Health insurers can also achieve their goals (e.g., to enable them to meet the specialized needs of their insured populations) in other ways which are similar, but not identical, to delegation or subcapitation. For example, a health insurer could decide to contract with a dental insurance company to provide dental care for its members, but reimburse the dental insurance company on an actual expenses, rather than capitation, basis.

26 CFR Part 57 – Health Insurance Providers Fee
Section 57.2 (b)(1): Explanation of Terms; Covered Entities, 57.2 (b)(2) Exclusions and 57.2(h)(2) Health Insurance; Exclusions

These sections of the regulations define those entities which are subject to the health insurance providers fee (covered entities), those which are excluded from being covered entities, and therefore are not subject to the health insurance provider fee, and define what health insurance is and is not.

In general, those organizations which are covered entities are health insurance providers which receive premiums for health insurance risks in the United States and which are licensed by their respective states as being health insurance providers. Among those health insurers who are not considered covered entities are those which are governmental entities (57.2(b)(2)(ii)) and those which are certain nonprofit corporations (57.2(b)(2)(iii)).

The intent of the above-noted exclusions was to address three issues by ensuring that these plans would not have to pay the health insurance provider fee or otherwise reflect the costs of this fee:

- Applying the tax to health plans which disproportionately contract with government to provide services to Medicaid, CHIP and dual eligible Medicare beneficiaries would only serve to increase the costs for these programs;
- Applying the taxes to these "safety net" or governmental health plans would undermine the capacity of these plans to serve these programs; and,
- The added costs of the tax could disadvantage these plans in the eyes of state and federal governments because their premium costs would be higher because they could not cost shift the burden of the tax to other product lines.

As noted earlier in this letter, it has come to our attention that implementation of the draft regulations as currently written could frustrate the intent of these exclusions if those health insurers with whom excluded entities contract with on a premium/risk basis are required to pay the health insurance provider fee on the portion of their business which is generated from excluded entities. In such cases, we would expect that these health insurers would pass on the cost of the fee to the excluded entities in the form of higher premiums.

As a result, while the excluded entities would not themselves be subject to the fee, their costs would increase as a result of the fee. Given that capitation rates received by these excluded entities are required to be actuarially sound, rates paid by the health programs to the health insurance plans would need to increase, thereby increasing costs to the states and the federal

government – in clear contravention to the intent of the underlying legislation. As a result, **ACAP respectfully requests that the final regulations at §57.2 (h)(2) be modified to clarify that premiums paid by excluded entities to health insurers who are subject to the health insurance provider fee are not considered health insurance in the context of this regulation.**

Without in any way moderating the request above, ACAP also requests that several related issues be addressed in the final regulations:

1. As noted in the background discussion earlier in this letter, health insurers can contract with other health insurers on a premium risk basis as well as via other arrangements (such as paying actual expenses). ACAP requests that the commentary in the final regulations clarify that non risk-based payments to an insurance company are not considered premiums and/or insurance and, therefore, are not be subject to the health insurance provider fee.
2. Similarly, ACAP also requests that commentary in the final regulations clarify that risk-based payments to non-insurance entities (such as hospitals, physician groups, Accountable Care Organizations or pharmacy benefit corporations) are also not considered premiums and/or insurance for the purposes of the health insurance provider fee.

Conclusion

ACAP appreciates the opportunity to provide additional comments on these draft regulations and to provide its input into the final regulatory underpinnings of the health insurance providers fee. We believe that incorporation of the modifications which we have recommended in these comments will strengthen the appropriate imposition of the fee and meet the intent of Congress as it established the fee and identified those organizations which would be exempt from its payment.

Please do not hesitate to contact me (202-204-7509 or mmurray@communityplans.net) or Kathy Kuhmerker (202-204-7510 or kkuhmerker@communityplans.net) if you have any questions concerning our comments.

Sincerely,

Margaret A. Murray
Chief Executive Officer

Attachment: May 31, 2013 ACAP letter to Acting Commissioner Werfel