ACAP
Association for Community Affiliated Plans

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Bob Thompson, Chairman | Margaret A. Murray, Chief Executive Officer

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Dr. Donald M. Berwick
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Baltimore, MD 21244
File code: CMS–9975–P

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

Dear Dr. Berwick:

The Association for Community Affiliated Plans (ACAP) appreciates this opportunity to provide comments to the Center for Consumer Information and Insurance Oversight (CCIIO) related to the proposed rule called *Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors and Risk Adjustment* of the Patient Protection and Affordable Care Act, enacted on March 23, 2010.[1]

ACAP is an association of 59 not-for-profit and community-based Safety Net Health Plans (SNHPs) located in 28 states.[2] Our member plans provide coverage to 9 million individuals enrolled in Medicaid, Children's Health Insurance Program (CHIP) and Medicare Special Needs Plans for dual eligibles. Nationally, ACAP plans serve approximately one-third of all Medicaid managed care enrollees. 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; such plans must be viewed as a full partner in meeting the coverage needs of our nation's low-income health care consumers – whether they are eligible for Medicaid, CHIP, coverage in health state-based health insurance Exchanges, or other health care programs.

Our comments regarding this proposed rule are summarized below:

1. ACAP seeks clarification as to whether Medicaid plans will be considered "contributing entities" for the purpose of making contributions toward the reinsurance pool.

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[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.

[2] ACAP represents safety net health plans that are exempt from federal income tax, or that are owned by an entity or entities exempt from federal income tax, and which serve primarily or exclusively individuals receiving benefits under a Federal health care program as defined in section 1128B(f)(1) (42 USC 1320a-7b(f)(1)) or a health care plan or program which is funded, in whole or in part, by a State or locality (other than a program for government employees).

2. ACAP urges HHS to require contributions of reinsurance funds only from those health insurance issuers that would be eligible to receive reinsurance payments because of service to the Exchange or individual market.
3. ACAP asks HHS to require that risk adjustment systems include risk factors that are highly prevalent in higher-risk populations that will be served by the Exchange, such as mental health and substance abuse disorders, and we also ask that income, language barriers, and other barriers to health care be included in approved risk adjustment methodologies.
4. ACAP recommends that the federally-certified risk adjustment methodology take into consideration the make-up of the plan's provider network.
5. ACAP believes that HHS must strive to improve the R2 so that a health plan's risk is adequately accounted for during the risk adjustment process.
6. ACAP requests HHS to explore using other data sources to augment data gleaned from qualified health plans from the coverage year, including Medicaid data for those individuals who have been previously covered in that program.
7. ACAP urges HHS to develop a process by which both the federally-certified and state risk adjustment processes are overseen by an objective entity.
8. ACAP requests that the Department conduct research and development on risk adjustment for the purpose of improving risk adjustment methodologies.
9. ACAP recommends that HHS establish a risk adjustment program that builds on the successful elements of existing risk adjustment models used by some states for Medicaid, and that HHS look to the successful elements of the Medicare risk adjustment process, to ensure simplification for those health plans serving both Medicaid and the Exchange.
10. ACAP requests HHS to determine which models have resulted in fair payment to plans, and to employ a robust R2 value for risk adjustment for the newly covered expansion populations.

Please find below ACAP's expanded responses to selected parts of the proposed risk mitigation rule.

Subpart A — General Provisions

§ 153.20 Definitions.

Reinsurance contributions will total, nationally, $10 billion in 2014, $6 billion in 2015, and $4 billion in 2016. Each contributing entity must make payments in a frequency and manner determined by the state or HHS to the reinsurance entity; the contribution rate will be set by HHS as a percent of premium. Contributing entities must also submit enrollment and premium data and data on covered lives and total expenses.

The definitions section of the proposed rule indicates that "*Contributing entity* means any health insurance issuer and, in the case of a self-insured group health plan, the third party administrator of the group health plan." ACAP notes that many Medicaid health plans are not considered "health insurance issuers" because state Medicaid programs do not require these plans to be licensed as such.

> **ACAP respectfully requests clarification** as to whether Medicaid plans will be considered "contributing entities" for the purpose of making contributions toward the reinsurance pool.

Furthermore, although some Medicaid plans are required to be licensed as health insurance issuers, they may not opt to serve the Exchanges or any market other than those covered by government programs, and therefore should not be required to contribution to the reinsurance pool.

> **ACAP urges HHS to require contributions of reinsurance funds only from those health insurance issuers that would be eligible to receive reinsurance payments** because of service to the Exchange or individual market.

Subpart D—State Standards for the Risk Adjustment Program

§ 153.320 Federally-certified risk adjustment methodology.

And

§ 153.330 State alternate risk adjustment methodology.

In sections 153.320 and 153.330 related to Federally-Certified Risk Adjustment Methodology and State Alternate Risk Adjustment Methodologies, respectively, HHS requests recommendations for developing a risk adjustment methodology that accounts for variation in risk among qualified health plans. In section 153.320, HHS requests comments on the extent of state flexibility that should be allowed in adopting an approach to determine average actuarial risk.

> **ACAP feels strongly that risk adjustment systems should include risk factors that are highly prevalent in lower-income populations.** Risk adjustment must take into account **diagnoses, including for mental health and substance abuse disorders,** as well as **income, language barriers, and other barriers** for the populations that will be covered through the Exchange.
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> Furthermore, such systems must also account for the proportion of a plan's network that comprises providers that serve higher risk populations, such as community health centers, hospital based clinics, and others. As ACAP has noted in our comments on the proposed rule called Establishment of Exchanges and Qualified Health Plans, many Safety Net Health Plans anticipate serving a high proportion of enrollees receiving health care services from federally qualified health centers (FQHCs). Because the Affordable Care Act will likely require that FQHCs be reimbursed using the prospective payment system (PPS) methodology for Exchange products, the upfront cost for these services may well be higher than the cost of comparable services delivered by non-clinic providers. Because they will play a valuable role in providing coverage to low-income consumers in the Exchange, it is critical that Safety Net Health Plans not be competitively disadvantaged by these critical relationships with safety net providers.
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> **ACAP recommends that the federally-certified risk adjustment methodology take into consideration the make-up of the plan's provider network.** We also recommend that states devising alternate risk adjustment methodologies be required to account for the make-up of the qualified health plans' provider network.

ACAP believes that HHS must strive to improve the R2 so that a health plan's risk is adequately accounted for during the risk adjustment process. ACAP urges HHS to ensure that federally-approved state risk adjustment methodologies similarly utilize an appropriate R2 value.

The risk adjustment system as articulated in the law occurs retroactively, theoretically utilizing a year's worth of actual patient data. It is ACAP's feeling that these data may not be sufficiently complete nor precise so as to provide for adequate risk adjustment. For this reason, **ACAP requests HHS to explore using other data sources to augment data gleaned from qualified health plans from the coverage year, including Medicaid data for those individuals who have been previously covered in that program.** Research suggests that 40 percent of the new subsidized population in the Exchange will have had some experience with Medicaid, CHIP or another subsidized program. ACAP recommends that this experience be used to improve the new risk adjustment programs.

In addition, **ACAP urges HHS to develop a process by which both the federally-certified and state risk adjustment processes are overseen by an objective entity** that will provide health plans with an opportunity to appeal risk adjustment decisions, when necessary.

ACAP also recognizes an opportunity at this juncture for the Department to conduct research and development on risk adjustment for the purpose of improving risk adjustment methodologies to ensure fair payment to health plans and advance the goal of section 1343 of mitigating the "impact of potential adverse selection and stabilize premiums in the individual and small group markets.

ACAP recommends that HHS establish a risk adjustment program that builds on the successful elements of existing risk adjustment models used by some states for Medicaid, and that HHS look to the successful elements of the Medicare risk adjustment process, to ensure simplification for those health plans serving both Medicaid and the Exchange. For those issuers offering health plans in multiple settings, including the Exchange, Medicare and Medicaid, it will be important that standardized, streamlined policies are utilized as much as is feasible.

ACAP urges HHS to recognize that not all Medicaid risk adjustment models have worked effectively. For example, some states currently employ an R2 value that does not sufficiently predict the risk of the covered Medicaid population. **ACAP requests HHS to determine which models have resulted in fair payment to plans, and to employ a robust R2 value for risk adjustment for the newly covered expansion populations**.

We appreciate your consideration of our comments regarding the *Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors and Risk Adjustment* proposed rule. ACAP is prepared to assist the agency with additional information as needed. If you have any additional questions please do not hesitate to contact Jennifer Babcock (202) 204-7518 or jbabcock@communityplans.net.

Sincerely,

Margaret A. Murray
Chief Executive Officer