ACAP
Association for Community Affiliated Plans

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

May 31, 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 this opportunity to comment on the above proposed rule related to implementation of the health insurance providers fee established by the Affordable Care Act (ACA)[1].

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.

ACAP will limit its comments on the notice of proposed rulemaking to 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

[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).

efforts to enroll all eligible individuals in the appropriate health insurance option. Our comments are summarized below:

- **Definition of Governmental Entity:** ACAP believes that the definition of "governmental entity" outlined in the draft regulations should be more broadly structured to be consistent with the overall intent of the exclusion provisions of the statute.
- **Certain Nonprofit Corporations:** ACAP recommends that the criteria for being considered a "certain nonprofit corporation" should be modified to:
    - recognize revenues received from affordable health insurance programs similar to Medicaid, Medicare and CHIP, and
    - reflect gross *premium* revenues, so as to ensure that small changes in non-premium related revenues do not result in insurer failure to meet the 80 percent threshold.

We appreciate your solicitation of comments regarding these draft regulations, and offer the following, in greater detail, for your consideration:

26 CFR Part 57 – Health Insurance Providers Fee
Section 57.2 (b): Explanation of Terms; Exclusions

This section of the regulations defines those entities which are excluded from being covered entities, and therefore are not subject to the health insurance provider fee. We believe that the definitions outlined in these draft regulations are inappropriately restrictive in a number of areas and should be broadened to be more consistent with the overall intent of the exclusion provisions. Our comments on the definitions of these excluded entities are as follows:

- §57.2(b)(2)(ii): Governmental entity

  This section of the draft regulations defines four types of entities which will be considered "governmental entities," and, therefore, will be exempt from the health insurance providers fee. Subparagraph (D) specifically focuses on the type of governmental entity which is created by a State or a political subdivision and outlines the three requirements which such an entity must meet:

  - Be a public agency created by a State or a political subdivision;
  - Be organized as a nonprofit under State law; and
  - Contract with the State to administer State Medicaid benefits through local providers or HMOs

The above definition appears to arise from the language contained in the Joint Taxation Committee Report which states the following:

> "A covered entity does not include any governmental entity. For this purpose, it is intended that a governmental entity **includes** [emphasis added] a county organized health system entity that is an independent public agency organized as a nonprofit under State law and that contracts with a State to administer State Medicaid benefits through local care providers or HMOs." [2]

This language clearly outlines that a specific type of entity -- the County Organized Health System, or COHS -- is to be included in the definition of a governmental entity, but it does not, nor was it intended to, limit the definition of a governmental entity to such a constrained set of organizations. The construction of the commentary in the Joint Committee report makes this clear, by beginning with the sentence "A covered entity does not include any governmental entity" and only then continuing with the language specifically noting one particular type of entity – the COHS – which the Committee wanted to clarify be included within the overall definition.

Health insurance plans have been established which are owned by public hospital systems or public authorities. As such, their owners are public agencies created by a state or a political subdivision (such as a county or a city), but it is unclear from the draft regulations whether such plans would be considered by the IRS to be governmental entities. We believe that such plans, as long as they meet the other criteria (as modified by our recommendations), should meet the qualifications of a governmental entity.

Health insurance plans may also be public agencies created by their State or a related political subdivision. These plans may not be formally or legally "organized" or delineated as nonprofit organizations under their respective state laws, such as nonprofit corporations, but they are clearly not operating as for-profit organizations. Overall, a requirement of being a public agency and a nonprofit under state law is redundant.

Finally, while the entities intended to be specifically identified as being excluded in the legislation may all have contracts with their states to administer state Medicaid benefits, governmental entities can currently have contracts with states (including through an intermediary such as a public hospital, and therefore, not directly with a state) for Medicaid, the Children's Health Insurance Program (CHIP) and/or with CMS under the Medicare program. In addition, when the Affordable Care Act's Exchanges become operational and the Basic Health Program is established by some states, these health insurers may also have contracts with states and/or CMS to operate those programs. [3]

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[2] Joint Committee on Taxation, Technical Explanation of the Revenue Provision of the "Reconciliation Act of 2010," as amended, in combination with the "Patient Protection and Affordable Care Act", March 21, 2010, JCX-18-10, page 90

[3] In a letter to Senator Cantwell (D-WA) concerning the Basic Health Program, Secretary Sibelius commented on the agency's commitment to implementing the program in 2015 http://www.cantwell.senate.gov/public/_cache/files/43cebb4b-424a-4960-b88b-d0d9e0bf3692/Senator%20Cantwell%20final%20response%20on%20the%20Basic%20Health%20Plan.pdf

Participation in these types of affordability health insurance programs is as valid a purpose for a governmental entity as participating solely in the Medicaid program.

We therefore respectfully recommend that the definition of a governmental entity in subdivision (D) be modified to:

- Clarify that organizations which are owned by public hospital systems or public authorities, which are themselves public agencies, are also considered to be "public agencies."
- Reflect that use of the term "organized" includes the defacto operation of an organization as a nonprofit, even if the organization is not formally designated as a nonprofit under a state's laws.
- Ensure that references to health insurance contracts reflect that the contracts can be:
    - with a state, including through an intermediary organization,
    - for any of the several insurance affordability programs in which a state might participate (i.e., Medicaid, CHIP, the Basic Health Program or subsidized Exchange coverage), and
    - also with the federal government under the Medicare program.

- §57.2(b)(2)(iii): Certain nonprofit corporations

This section of the draft regulations defines the characteristics which a nonprofit organization must meet to be an excluded entity. Subparagraph (E) of this section speaks to the gross revenue criteria, to wit: "More than 80 percent of the gross revenues of which is received from government programs that target low-income, elderly, or disabled populations under titles XVIII [added: Medicare], XIX [added: Medicaid] and XXI [added: CHIP] of the Social Security Act." While we did not believe that this was ever in question, we were pleased to read in the preamble to the draft regulations that your office specifically noted that health insurance revenues for those who are dually-eligible for Medicaid and Medicare would count towards the 80 percent gross revenue criteria.

As we have noted in earlier correspondence with the IRS (see attached letter dated April 10, 2012), we believe that this revenue criteria should also include revenues derived from the soon-to-be-established Basic Health Program. This program, when operational, will provide affordable health insurance coverage to many of the same individuals who are currently, or who could currently be, provided Medicaid coverage under Section 1115 waiver authority and related expansion programs. In fact, the first year of the fee will recognize 2013 revenues received by health insurance plans for these expansion and waivered populations as Medicaid revenues. Given that this population is so similar in nature to that served by the Medicaid and CHIP programs, and, in fact, data analysis demonstrates that when this program becomes operational, there will be a significant

amount of movement among the Basic Health Program and Medicaid and CHIP due to short-term changes in income[4], we again request that your office consider that premium revenues from the Basic Health Program be used to meet the 80 percent threshold needed for exemption from the health insurance providers fee.

Similarly, we recommend that the regulations also identify premium revenues from subsidized Exchange health insurance coverage as meeting the 80 percent threshold. The Affordable Care Act clearly recognizes that individuals with incomes up to 400 percent of the federal poverty level will have difficulty purchasing health insurance coverage without some level of financial assistance. Moreover, the ACA further recognizes that individuals with incomes below 250 percent of the poverty level will also need assistance in meeting the cost sharing requirements which arise when they access health services. In addition, in states which do not establish a Basic Health Program, the "churning" among health insurance programs which we noted above will occur with subsidized Exchange coverage programs.

Including revenues from subsidized health coverage purchased through the Exchange and under the Basic Health Program will appropriately recognize the similarities of the populations served by these various programs with those served by the Medicaid, CHIP and Medicare programs. We firmly believe that health insurers who are participating in these markets are focused on meeting the health care needs of a very similar population and, as such, the premium revenues from these programs should be incorporated into the determination of the exemption from the provider fee.

In addition, since the development of these regulations, new approaches to the structure of Medicaid expansion programs have come under discussion as states consider how to tailor the Medicaid expansion concept to their specific environments. Two major types of innovations are being discussed. The first is the concept of using Medicaid funds to purchase health insurance coverage for Medicaid-eligible individuals through state or federal Exchanges (otherwise known as "premium assistance" programs). While the health insurance coverage would be accessed through the Exchanges, rather than directly through the Medicaid program, the revenues received by the participating plans will clearly be Medicaid dollars. In a similar approach, at least one state is planning to use Medicaid waiver funding to provide a wrap-around subsidy to individuals in its state exchange to enhance program affordability. In both these cases, we believe that the statute clearly intends for these revenues to be considered Medicaid revenues and would request that regulations be clarified or that commentary be provided to so state. Given the evolutionary nature of state approaches to addressing the Medicaid expansion opportunity, we believe that a general statement concerning the appropriateness of "following" the Medicaid, CHIP or Medicare funding as it is used to purchase health insurance coverage would assist in keeping these regulations up-to-date.

[4] Sommers, Benjamin and Rosenbaum. Sara, "Issues In Health Reform: How Changes in Eligibility May Move Millions Back and Forth Between Medicaid and Insurance Exchanges." *Health Affairs,*2011.

Finally, we also recommend that the final regulations modify the term "gross revenues" to be consistent with what we believe is the intent of Congress in establishing the exemption. The purpose of establishing this criterion was to ensure that nonprofit entities which are excluded from the health insurance providers fee are those which focus their programs and activities on those individuals who most need assistance in obtaining health care coverage. To that end, activities which support the efficient operation of the Medicaid program – such as providing third party administrative services for another health plan's Medicaid, Medicare and CHIP programs, or operating a nurse advice line for another insurer -- should not result in a health insurer finding that they no longer meet the 80 percent criterion. However, unless specific modifications to address these types of situation are incorporated in the final regulations, a health plan which is assisting another plan which does not have the requisite claims processing or nurse call line capabilities could find itself in just such a situation.

Similarly, a health plan should not find itself in the position of losing its exemption from the health insurance providers fee exemption due to, for example, a successful return on its investment portfolio. This kind of situation could easily occur in the next few years if interest rates increase from their historic low levels. The following is an example of a health insurer which, as a result of a relatively small change in the overall return on its investment portfolio, would find that it is no longer exempt from the provider fee:

Year	Gross Premium Revenues Which Count Toward 80% (Public Programs)	Gross Premium Revenues Which Do Not Count Toward 80%	Investment Revenue	% of Gross *Premium* Revenues from Public Programs	% of Gross Revenues from Public Programs
Year 1	$1.150 B	$275M	$8 M	80.7%	80.25%
Year 2	$1.150 B	$275M	$16M	80.7%	***79.8%***

As a result, we strongly recommend that the final regulations apply the 80 percent criterion to gross premium revenues to avoid inadvertent inequities. This modification would also be consistent with the overall basis of the fee, which is "net premiums written."

- §57.3: Reporting requirements and associated penalties

  This section of the draft regulations notes that all covered entities are required to report their net premiums written on Form 8963. It is our understanding that this form is currently under development and is not available for review. We would appreciate an update on the status of this form, and an indication of whether there will be an opportunity to review the form prior to its finalization.

- §57.4(b)(1): Determination of net premiums written

  This section of the draft regulations addresses the process which the IRS will take to determine the total amount of net premiums written in the United States. One of the major sources of information which the IRS states that it will use in this process is the Supplemental Health Care Exhibit (SHCE) filed with the NAIC pursuant to state law. Several ACAP plans are not required by state law to file reports with the NAIC and, therefore, would also not be required to file the SHCE, although they do file financial and other reports with their state regulators. ACAP respectfully requests confirmation that nothing in these draft or final regulations will modify the requirements concerning health plan filings with the NAIC and that there will be no financial or other penalties imposed on health plans which are not required to file reports with NAIC for "failure" to file reports which the IRS would prefer to use in its calculations and analyses.

- §57.5(a): Notification of preliminary fee calculation and §57.6: Error correction process

  These sections of the draft regulations outline how and when the IRS will notify a covered entity of its preliminary fee calculation and note that a process for identifying errors will be established. Since many ACAP plans will not be covered entities, most ACAP plans do not expect to receive such notifications. If, however, a notification is received and the plan believes that the basis for the notification itself is in error, it is unclear whether the error correction process in §57.6 will apply. Given that there are significant penalties associated with failing to accurately report, ACAP requests that the final regulations clarify that the process in §57.6 would apply or outline what the process will be.

Conclusion

ACAP appreciates the opportunity to review 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: April 10, 2012 ACAP letter to the IRS