

Tribal Technical Advisory Group

To the Centers for Medicare & Medicaid Services

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September 27, 2011

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9975-P
P.O. Box 8010
Baltimore, MD 21244-8010

RE: Comments on CMS-9975-P: Standards Related to Reinsurance, Risk Corridors and Risk Adjustment

I am submitting the following analysis and comments on behalf of the Tribal Technical Advisory Group (TTAG) to the Centers for Medicare and Medicaid Services (CMS). The TTAG advises CMS on Indian health policy issues involving Medicare, Medicaid, the Children's Health Insurance Program, and any other health care program funded (in whole or part) by CMS, such as the Affordable Care Act.^{1,2} In particular, the TTAG focuses on providing policy advice to CMS regarding improving the availability of health care services to American Indians and Alaska Natives under these Federal health care programs, including through providers operating under the health programs of the Indian Health Service, Indian Tribes, tribal organizations and urban Indian organizations.

The TTAG is submitting these comments to the Centers for Medicare and Medicaid Services, Department of Health and Human Services (HHS) in response to the request for comments published July 15, 2011 in the *Federal Register* involving "Standards Related to Reinsurance, Risk Corridors and Risk Adjustment" (CMS-9975-P or Proposed Rule). We appreciate the opportunity to comment on this Proposed Rule. The analysis and comments offered here are presented in the general order of the sections in the Proposed Rule.

¹ Sec. 5006(e) of the American Recovery and Reinvestment Act codifies in statute, at sections 1902(a)(73) and 2107(e)(1)(C) of the Social Security Act, the requirement for the Secretary of Health and Human Services to maintain a Tribal Technical Advisory Group within CMS and the requirement that States seek advice from Tribes on a regular and ongoing basis where one or more Indian health program or urban Indian organization furnishes health care services.

² The "Affordable Care Act" refers collectively to the Patient Protection and Affordable Care Act (Pub. L. 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152) and is used interchangeably with "ACA."

SUMMARY OF COMMENTS ON PROPOSED RULE (CMS-9975-P)

In summary, the TTAG concurs in large measure with the Proposed Rule. Nonetheless, we believe the risk management approaches in these regulations are helpful, but not sufficient, to “mitigate the impact of potential adverse selection” and ensure access for American Indians and Alaska Natives to comprehensive and timely health care services, including access to the “I/T/U”³ health care providers and programs that traditionally have served American Indians and Alaska Natives (AI/AN). As a means of mitigating potential adverse selection, through these comments as well as in the to-be-filed TTAG comments on the proposed rule on Exchange Establishment (CMS-9989-P), we are recommending that health plans offered through a health insurance exchange (“Exchanges”) be required to offer to contract with I/T/U providers in their service area.

In addition, the TTAG is recommending that the claims and encounter data that are provided to a State or HHS be made available for legitimate research purposes. These data from private health insurance plans are needed to supplement Medicare, Medicaid and HIS data that are already available in order to create a complete and valid picture of the services and expenditures being made on behalf of AI/AN, including services rendered by I/T/U providers.

Finally, we are recommending that HHS include discussion and rulemaking in this Proposed Rule on an additional risk management mechanism that is specific to AI/AN. As do the three risk mitigation mechanisms in the Proposed Rule, this additional mechanism is also designed to mitigate the potential impact of adverse selection (by making payments to Exchange plans to account for higher cost enrollees) and to stabilize premiums in the individual and small group markets. We refer to this payment mechanism found in ACA section 1402(d)(3) as the “HHS Indian Offset”.

Under “Special Rules for Indians” in section 1402(d) of the Affordable Care Act, AI/AN with family income at or below 300 percent of the federal poverty level who are enrolled in the individual market in an Exchange are protected from cost-sharing requirements. In addition, any AI/AN (regardless of income) enrolled in a qualified health plan in an Exchange shall not have cost-sharing requirements for any item or service provided by an Indian health provider.⁴ The HHS Secretary is directed to make payments (*i.e.*, the HHS Indian Offset) to health plans offered through an Exchange in an amount that is sufficient to offset the additional actuarial value of the plan as a result of these special protections for AI/AN. Again, we recommend that HHS add a discussion and the necessary rulemaking in this Proposed Rule in order to ensure that timely and adequate payments are made under this provision of the Affordable Care Act.

³ “I/T/U”, or “Indian health provider”, means the Indian Health Service (IHS), an Indian Tribe, tribal organization or urban Indian organization provider.

⁴ “Indian health provider”, or “I/T/U”, means the Indian Health Service (IHS), an Indian Tribe, tribal organization or urban Indian organization provider.

DISCUSSION

Subpart C – State Standards for the Transitional Reinsurance Program for the Individual Market

The reinsurance program will make payments to health plans for high-cost cases.

§ 153.220. Collection of Reinsurance Contribution Funds

HHS included a discussion of two methods for determining contributions to a State's reinsurance pool. Each health insurance issuer and third party administrator, on behalf of a self-insured group health plan, is to contribute to a State reinsurance program. The first method (and the one selected in the Proposed Rule) would establish "a percent of premium amount applied to all contributing entities". The second method (which was rejected in the Proposed Rule) would impose "a flat per capita amount applied to all covered enrollees of contributing entities." All contribution funds collected by a State will stay in that State and be used to make reinsurance payments on valid claims submitted by reinsurance-eligible plans in that State.

- The TTAG concurs with the selection of the "percent of premium" approach. This approach will more likely generate revenues in each State commensurate with the costs and needs in a particular State. The alternative approach could result in excessive revenues being generated in some States and inadequate revenues being generated in other, likely higher cost States.

§ 153.230. Calculation of Reinsurance Payments

The Proposed Rule identifies two potential approaches to calculating payments to health plans: (1) payment for costs incurred or (2) fixed payment schedule for specific conditions.

- The TTAG concurs with the method selected in the Proposed Rule which would use the funds in the reinsurance pool for "payments for costs incurred above an attachment point in order to guard against under serving hard-to-reach high-cost populations in the initial years. By tying payment to actual treatment of the condition, this reinsurance method creates an incentive for plans to provide needed treatments.
- The TTAG believes the alternative "fixed payment schedule" method would create an incentive for health plans to enroll AI/AN that have high-cost medical conditions, but would not provide incentives for those plans to actually render timely, quality and comprehensive services to those AI/AN enrollees.

In summary, option 2 (which was rejected under the Proposed Rule) could have created an incentive for enrolling, but not serving, high need, hard-to-reach populations. Option 1, the selected option, in contrast, aligns incentives in a way so that enrollees with high-cost medical conditions and the plan will have the resources and inclinations to seek needed health services

(in the case of the enrollee) or provide needed health care (in the case of the providers and health plan).

§ 153.240. (Timely) Disbursement of Reinsurance Payments

As indicated in the Proposed Rule, the transitional reinsurance program should provide early and prompt payment of reinsurance funds *during* the benefit year. This is particularly important given that the payments under the risk adjustment mechanism and the risk corridors are likely to be calculated *after* the end of the benefit year.

For health plans serving a high percentage of AI/AN, and particularly for smaller plans that may be operated by Tribes, timely payments that counter adverse selection will be critical not only to the plan's survival but also to ensure that resources for health care services are available when they are needed.

- The TTAG concurs with the intention described in the Proposed Rule to provide reinsurance payments during the course of a benefit year and as close as feasible to the submission of verifiable data on the actual claims experience.

Subpart D – State Standards for the Risk Adjustment Program

The risk adjustment program is intended to provide adequate payments to health insurance issuers that attract high-risk populations by transferring funds from insurers with lower risk enrollees to insurers with higher risk enrollees. The risk adjustment program is intended to reduce or eliminate premium differences between plans based solely on expectations of favorable or unfavorable risk selection or choices by higher risk enrollees in the individual and small group market. The risk adjustment program also serves to level the playing field inside and outside of the Exchange, reducing the potential for excessive premium growth or instability within the Exchange.

§ 153.310 Risk Adjustment Administration: Single Insurance Market

To avoid and protect against adverse selection, issuers may set premiums higher than necessary in order to offset the potential (but uncertain) expense of high-cost enrollees. Under the Proposed Rule, the evaluation and adjustment for adverse selection is conducted across all plans in the individual and small group markets within a State that are offered inside and outside an Exchanges. In effect, one risk adjustment pool is operated for an entire State in order to make risk adjustment payments based on a comparison of costs to a State average.

- The TTAG concurs with conducting one risk adjustment process in a State that includes all plans in the individual and small group markets that are operating inside or outside one or more Exchanges operating in a State. This approach will reduce gaming by insurers and small businesses that may opt to steer certain (higher cost) enrollees inside an Exchange and other (lower cost) enrollees to non-Exchange plans.

§ 153.310 Risk Adjustment Administration: Statewide Risk Adjustment Pool

The Proposed Rule aggregates risk pools at the State level, even if a State decides to utilize regional Exchanges. An alternative approach was to aggregate risk pools on a regional basis.

- The TTAG concurs with the program design in the Proposed Rule whereby risk is aggregated at the State level, and payments are made from the statewide revenue pool. This approach will reduce an incentive for establishing multiple Exchanges in a State for the purpose of risk avoidance (i.e., segmentation of the market or “redlining”.) This approach provides for a broader spreading of risk, is anticipated to mitigate a potential effect of market segmentation by region, and allows for the broadest distribution of risk adjustment payments based on actual resource needs. This approach is more likely to result in resources being available in all corners of a State based upon need rather than reliance on arbitrary geographic boundaries being established that may or may not correlate with need.

§ 153.310 Risk Adjustment Administration: Timing of Risk Adjustment Payments

In the Proposed Rule, comments are requested on the deadline by which risk adjustment payments must be completed.

- The TTAG stresses the importance of timely risk adjustment payments. Prompt payment will be particularly critical after the expiration of the reinsurance and risk corridor mechanisms (after year 3). The TTAG recognizes that, in the initial years, it will be necessary to develop a baseline data set to calculate risk adjustment payments. For subsequent years, though, the TTAG recommends that HHS consider making interim risk adjustment payments to plans based on their prior year plan enrollee demographics.

For health plans serving a higher percentage of high-cost enrollees (some of whom may be AI/AN enrollees) and particularly for smaller plans (some of which may be operated by Tribes), timely payments that compensate for potentially higher cost enrollees will be critical not only to ensure that resources for health care services are available when they are needed but also to ensure that such plans will be able to sustain themselves and survive over time. Again, for plans with a significantly higher risk enrollee population and/or for small plans, the carrying costs of waiting for risk adjustment payments post-benefit year may be substantial.

§ 153.340 Data Collection under Risk Adjustment

The State, or HHS on behalf of the State, must collect risk-related data to determine individual, plan-specific risk scores that form the basis for risk adjustment. Insurers are to submit raw claims and encounter data sets to the State government consistent with to-be-developed national standards for data submission and use. HHS has requested comments on potential alternative uses of the risk adjustment data to support other Exchange-related functions.

- The TTAG strongly recommends that the claims and encounter data that are provided to a State or HHS be made available and used to support other Exchange-related functions and broader purposes of the Affordable Care Act. Specifically, The TTAG recommends that claims and encounter data be made available to determine the extent to which the plans can accurately classify claims and encounter data of 1) AI/AN served in fulfillment of the Federal trust responsibilities and legal obligations to Indians including those who self- identify as AI/AN regardless of any other race or ethnicity they indicate; and 2) the diagnoses, procedures and payments made for any item or service furnished directly by I/T/U or through referral under contract health services.

For AI/AN, the claims and encounter data currently made available from the Indian Health Service (IHS), and from the Medicaid program's State Information System (MSIS) and from the Medicare program's enrollment and claims-based data provide a valuable picture of the type, quantity and cost of services rendered to AI/AN. From these data, improvement efforts can be targeted to expand access to health care services, to improve provider billing and plan payment practices, and to identify practices that may be retarding improvements in health status among AI/AN.

These currently available data need to be supplemented by encounter and claims data from private health insurance plans serving AI/AN in order to create a complete and valid picture of the services and expenditures being made on behalf of AI/AN. Providing such data will enable research to determine the adequacy of health services to AI/AN and, at the same time, address a main goal articulated in the Affordable Care Act.

Under section 10221 of the ACA,⁵ the law states, "A major national goal of the United States is to provide the resources, processes, and structure that will enable Indian tribes and tribal members to obtain the quantity and quality of health care services and opportunities that will eradicate the health disparities between Indians and the general population of the United States."

This section of the law continues with a "Declaration of National Indian Health Policy," stating that "Congress declares that it is the policy of the Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians—(1) to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy" ...⁶

Again, the provision of the encounter and claims data from plans subject to the risk adjustment mechanism will greatly contribute to understanding and addressing the health care needs of AI/AN. Particularly as the data pertain to AI/AN, it is critical that the Federal government establish guidelines for consistent methods and systems to gather and report the data. For instance, how information is gathered on who is an AI/AN can greatly influence the number of

⁵ § 102(2) of the Indian Health Care Improvement Reauthorization and Extension Act of 2009 (IHCIREA), as reported by the Committee on Indian Affairs of the Senate in December 2009, and included by reference in the ACA at section 10221.

⁶ § 103 of the IHCIREA.

individuals ultimately identified in the data systems as being AI/AN. There is also a need to indicate which agency and at what level of government will be responsible for reporting and/or providing access to data on AI/AN persons and I/T/U providers.

The TTAG supports maintaining the privacy of individual enrollees. Valid concerns over privacy can be adequately addressed, however, as long as the data are made available in a manner consistent with the to-be-developed standards for medical data submission and use.

- The TTAG does not support the contention that claims and encounter data are “proprietary” and should not be made available for legitimate analytical purposes.
- The TTAG urges the adoption of appropriate data use policies that would allow for accurate assessments of the Affordable Care Act, the Indian Health Service, Medicaid and Medicare and their ability to carry out the “special trust responsibilities and legal obligations [of the Federal government] to Indians.”

Subpart F – Health Insurance Issuer Standards Related to the Temporary Risk Corridor Program

The risk corridor program is designed to lessen the extent of significant gains or losses experienced by a health plan as a result of the level of intensity of services to enrollees during the initial years of Exchange establishment. We concur that this program will serve to reduce risk to the Exchange plans, but we believe that this and the two other risk mitigating programs discussed in this Proposed Rule are not sufficient to remove potential financial incentives for health plans to avoid enrollment of AI/AN.⁷

- The TTAG is recommending that Exchange plans be required *to offer* to include I/T/U as in-network providers. A primary means of depressing enrollment of AI/AN in a health plan is the lack of inclusion of I/T/U providers in the plan’s network. The offering of in-network contracts to all I/T/U providers in a plan’s service area will serve to (1) broaden the range of health plans selected by AI/AN, thereby spreading any heightened financial exposure more evenly across a broader number of plans, and (2) for AI/AN who enroll in a particular plan they will be able, at a minimum, to access their traditional providers of health care services.

Combined with the three ACA-established risk mitigating programs, along with the HHS Indian Offset discussed below, the mandatory offer of contracts to I/T/U providers will strengthen the financial health of plans who wish to proactively serve AI/AN. Conversely, a requirement on all Exchange plans to offer in-network contracts to I/T/U providers, together with these other risk

⁷ On average, AI/AN communities suffer from some of the most intense health care conditions when compared to other populations. For specific AI/AN individuals and communities who may or may not have higher-than-average health care costs, this perception has led to a lack of interest by health plans to seek to enroll or proactively serve AI/AN individuals and communities. In addition, during the initial phase-in of the health insurance coverage expansions, there is likely to be a greater frequency of pent up demand for health services from uninsured AI/AN as AI/AN, on average, currently have a significantly higher rate of uninsured.

mitigating measures, will minimize the likelihood a health plan that determines it may be in their interest to (1) avoid enrollment of AI/AN or (2) poorly serve AI/AN who do enroll by excluding the traditional providers to Indian people will reap a financial benefit from doing so. At a minimum, the AI/AN enrollees in the health plan would be able to access their I/T/U providers as a result of the requirement to offer to contract with I/T/U providers.

Additional Mechanism to Protect Plans and Enrollees from Adverse Selection: “HHS Indian Offset”

The TTAG encourages HHS to include an additional risk management mechanism in the Proposed Rule that would, like risk adjustment, risk corridor and reinsurance, “mitigate the impact of potential adverse selection and stabilize premiums in the individual and small group markets as insurance reforms and the Exchanges are implemented.”⁸

- The TTAG suggests that this payment by the Secretary to health plans serving AI/AN enrollees may be referred to as the “HHS Indian Offset.”
- The TTAG recommends placing the discussion and rulemaking for Section 1402(d) in this Proposed Rule because the HHS Indian Offset payment mechanism is similar in design and function to the risk adjustment, risk corridors and reinsurance mechanisms.

Under “Special Rules for Indians” in section 1402(d) of the Affordable Care Act,⁹ AI/AN with family income at or below 300 percent of the federal poverty line who are enrolled in the individual market in an Exchange are protected from any cost-sharing requirements. In addition, any AI/AN (regardless of income) enrolled in a qualified health plan in an Exchange shall not have cost-sharing requirements for any item or service provided by an Indian health provider.¹⁰

Because sections 1402 (d)(1) and (d)(2) in this special rule have the potential to disadvantage a health plan operating in an Exchange or a health care provider that serves AI/AN, and could

⁸ Contained in the “Summary” statement of the Proposed Rule, Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors and Risk Adjustment, *Federal Register*, Vol. 76, No. 136, Friday, July 15, 2011, page 41930.

⁹ ACA section 1402(d) reads as follows: (d) SPECIAL RULES FOR INDIANS.— (1) INDIANS UNDER 300 PERCENT OF POVERTY.—If an individual enrolled in any qualified health plan in the individual market through an Exchange is an Indian (as defined in section 4(d) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(d))) whose household income is not more than 300 percent of the poverty line for a family of the size involved, then, for purposes of this section—(A) such individual shall be treated as an eligible insured; and (B) the issuer of the plan shall eliminate any cost sharing under the plan. (2) ITEMS OR SERVICES FURNISHED THROUGH INDIAN HEALTH PROVIDERS.—If an Indian (as so defined) enrolled in a qualified health plan is furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services— (A) no cost-sharing under the plan shall be imposed under the plan for such item or service; and (B) the issuer of the plan shall not reduce the payment to any such entity for such item or service by the amount of any cost-sharing that would be due from the Indian but for subparagraph (A). (3) PAYMENT.—The Secretary shall pay to the issuer of a qualified health plan the amount necessary to reflect the increase in actuarial value of the plan required by reason of this subsection.

¹⁰ For purposes here, the cost-sharing protections apply to any item or service furnished directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services.

create disincentives for Exchange plans to enrollee AI/AN persons and providers to serve AI/AN patients, the ACA drafters added section 1402(d)(3). Section 1402(d)(3) states, “[t]he Secretary shall pay to the issuer of a qualified health plan the amount necessary to reflect the increase in actuarial value of the plan required by reason of this subsection” [*i.e.*, provisions (d)(1) and (d)(2) of § 1402]. As such, HHS is directed to make a payment to health plans *that enrollee AI/AN* in the individual market in an Exchange in an amount that offsets the additional costs associated with implementation of the waiver of cost-sharing requirements completely for AI/AN enrollees with family income at or below 300 percent of the poverty level (under section 1402(d)(1)) or waive cost-sharing for AI/AN enrollees with family income over 300% of the poverty level when they are served by I/T/U providers (under section 1402 (d)(2)).

- The TTAG recommends that the amounts calculated under the HHS Indian Offset be sufficient to cover a) the loss of cost-sharing by AI/AN enrollees as well as b) the likely increase in utilization as a result of the elimination of cost-sharing.

Taken together, the cost-sharing waiver (1402(d)(1) &(2)) and the HHS Indian Offset payment authorization (1402(d)(3)) have the potential to greatly improve access to health care services for AI/AN. However, this favorable outcome depends on the strict enforcement of the cost-sharing protections. In addition, as is the case for risk management mechanisms in general, timely payment is key to maximizing the benefit of the HHS Indian Offset mechanism. For health plans serving a significant percentage of AI/AN, and particularly for smaller plans (some of which may be operated by Tribes), timely payment of the HHS Indian Offset will be critical not only to ensure that resources for health care services are available when they are needed but also to ensure that such plans will be able to sustain themselves and survive over time.

Alternatively, if the HHS Indian Offset payments are not made or are not made in a timely fashion, the health plans may view AI/AN enrollees as posing an excessive risk, and the health plans may avoid enrolling AI/AN. For health plans that do serve a significant number of AI/AN, if not made in a timely manner the carrying costs of waiting for the HHS Indian Offset may be substantial. For smaller plans, the carrying costs may be prohibitive. For these reasons, we recommend that HHS pay the HHS Indian Offset on a monthly basis along with the base premium payments.

Interaction of HHS Indian Offset with ACA Section 1001 / Section 2718 of the Public Health Service Act

As modified by ACA section 1001, under section 2718(b)(1)(B) of the Public Health Service Act titled “Ensuring That Consumers Receive Value for Their Premium Payments,” insurers must rebate payments to plan enrollees, if plan revenues exceed plan medical expenditures by more than an allowable amount. Referred to as the medical loss ratio, plans are required to expend at least 85 percent of plan revenues (for large plans) or 80 percent of revenues (for insurers offering coverage in the small group market). Health plan revenues include “payments or

receipts for risk adjustment, risk corridors, and reinsurance under sections 1341, 1342, and 1343 of the [ACA] for such year”.¹¹ This provision is codified at 45 CFR Part 158, § 158.130.

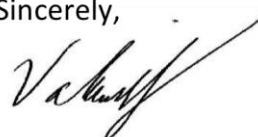
The interim final rule (issued by HHS on December 1, 2010 titled “Health Insurance Issuers Implementing Medical Loss Ratio Requirements under the Patient Protection and Affordable Care Act”) briefly discusses including “the collections or receipts for risk adjustment and risk corridors and payments of reinsurance”¹² in the calculation of health plan premium revenue. The interim final rule indicates that “HHS anticipates providing guidance on these provisions at a later time.”¹³

The medical loss provision is designed to create incentives for plans to provide needed services to plan enrollees or to reduce plan premiums, either upfront when setting plan premium rates or through a subsequent rebate.

- The TTAG recommends including the HHS Indian Offset payment provided for under ACA section 1402(d)(3) in the PHSA section 2718(b)(1)(B)(i) calculation for the total amount of plan premium revenue, along with the payments provided pursuant to the general risk adjustment mechanisms established under ACA section 1343.

Thank you in advance for consideration of these recommendations as we jointly work to advance the health status of American Indian and Alaska Native individuals and communities across the United States.

Sincerely,



Valerie Davidson, Chair

C: Dr. Yvette Roubideaux, Director, Indian Health Service
Kitty Marx, Director, CMS Tribal Affairs Group

¹¹ ACA section 1001 modifying section 2718(b)(1)(B) of the Public Health Service Act titled “Ensuring That Consumers Receive Value for Their Premium Payments.”

¹² Federal Register, Vol. 75, No. 230, Wednesday, December 1, 2010, Interim Final Rule, Health Insurance Issuers Implementing Medical Loss Ratio Requirements under the Patient Protection and Affordable Care Act, page 74873.

¹³ Federal Register, Vol. 75, No. 230, Wednesday, December 1, 2010, Interim Final Rule, Health Insurance Issuers Implementing Medical Loss Ratio Requirements under the Patient Protection and Affordable Care Act, page 74873.