Tribal Technical Advisory Group
To the Centers for Medicare & Medicaid Services
c/o National Indian Health Board 910 Pennsylvania Avenue, SE Washington, DC 20003 (202) 507-4070 (202) 507-4071 fax

Submitted via: www.regulations.gov

March 9, 2018

Centers for Medicare & Medicaid Services (CMS)
Office of Strategic Operations and Regulatory Affairs Division of Regulations Development
Room C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: Comments on Standards Related to Reinsurance, Risk Corridors, and Risk Adjustment (CMS-10401/OMB control number 0938-1155)

Dear CMS Official:

On behalf of the Centers for Medicare and Medicaid Services (CMS) Tribal Technical Advisory Group (TTAG)[1], I write to submit comments on the notice of proposed revisions to the information collection request (ICR) titled "Standards Related to Reinsurance, Risk Corridors, and Risk Adjustment" (Notice). The ICR addresses requirements for states and health plans associated with the reinsurance, risk corridors, and risk adjustment programs established under the Affordable Care Act (ACA). In the Notice, CMS proposes to revise the currently approved ICR to eliminate programs and update data collections to conform to Federal statute and regulations.

In response to the Notice, the TTAG wishes to comment on two issues related to the Indian-specific cost-sharing protections available to certain American Indians and Alaska Natives (AI/ANs) enrolled through a Marketplace.[2]

First, the TTAG wishes to comment on health insurance issuer reporting of enrollee-level data related to the permanent risk adjustment program, specifically data that CMS uses in determining the adjustment for the receipt of cost-sharing reductions (CSRs) in the Federal risk adjustment model (referred to as the "induced utilization factor"). The TTAG believes that continued collection of individual, enrollee-level data on the usage of CSRs and overall health care service utilization—for the purposes of determining the induced utilization factor—is justified and essential to ensuring a precise accounting of utilization among AI/ANs and the accurate reimbursement to issuers for induced utilization resulting from the provision of comprehensive, Indian-specific CSRs for certain AI/AN enrollees. Without the data needed to calculate an accurate induced utilization factor, a situation that could result in underpayments to certain health plans, plans might have a disincentive to enrolling AI/ANs and/or applying fully the comprehensive, Indian-specific CSRs.

---

[1] The TTAG advises CMS on Indian health policy issues involving Medicare, Medicaid, the Children's Health Insurance Program, and any other health care programs funded (in whole or part) by CMS. In particular, TTAG focuses on providing policy advice to CMS regarding improving the availability of health care services to American Indians and Alaska Natives (AI/AN) under these federal health care programs, including through providers operating under the health programs of the Indian Health Service (IHS), Tribes, Tribal organizations, and Urban Indian organizations (I/T/Us or Indian health care providers).

[2] The comprehensive Indian-specific cost-sharing protections are available to individuals enrolled in a Federally-recognized Tribe or shareholders in an Alaska Native village or corporation.

Second, the TTAG wishes to highlight the potential for the costs of the Indian-specific cost-sharing protections to be shifted to Marketplace enrollees—including eligible AI/ANs themselves—due to the elimination of direct Federal funding of the CSRs and proposes modifying the Federal risk adjustment model to help address this concern.

Discussion

Background on Indian-Specific CSRs

Section 1402(d) of the ACA provides critically important CSRs for AI/ANs who enroll in qualified health plans (QHPs) through a Marketplace. These Indian-specific cost-sharing protections—under which AI/ANs who meet the ACA definition of Indian pay no deductibles, coinsurance, or copayments when receiving essential health benefits—serve as one means of upholding the Federal trust responsibility to AI/ANs. Under sections 1402(d) (1) and (d) (2), eligible AI/ANs can enroll in either a zero or limited cost-sharing plan, depending on their income level and eligibility for premium tax credits (PTCs). Enrollees in zero cost-sharing plans have no cost-sharing, regardless of where and how they receive health care services. Enrollees in limited cost-sharing plans have no cost-sharing when they receive health care services through an IHS, Tribe or Tribal organization, or urban Indian organization (I/T/U) facility, as well as through an I/T/U referral to a non-I/T/U provider. The ACA also provides general cost-sharing protections for individuals who have a household income of up to 250% of the Federal poverty level (FPL) and enroll in a silver-level QHP.[3]

Issue 1: Continued Use of Accurate Induced Utilization Factor in Federal Risk Adjustment Model

QHP issuers for 2018 will continue to receive an adjustment for the provision of CSRs as part of the Federal risk adjustment model.[4] The risk adjustment program—which generally applies to non-grandfathered individual and small group market health plans, both inside and outside the Marketplace—redistributes funds from plans with lower-risk enrollees to plans with higher-risk enrollees. Under the program, health plans determine their average actuarial risk based on the individual risk scores of enrollees, and plans with lower actuarial risk make payments to plans with higher risk. As previously noted by CMS, the "goal of the Affordable Care Act risk adjustment program is to mitigate the impacts of possible adverse selection and stabilize the premiums in the individual and small group markets as and after insurance market reforms are implemented."[5]

For 2018, the Federal risk adjustment model will provide issuers with an upward payment adjustment of 15% for zero or limited cost-sharing plan enrollees in bronze-level coverage, 12% for those in silver-level coverage, and 7% for those in gold-level coverage. In the most recent Notice of Benefit and Payment Parameters, CMS proposed to retain these adjustment factors for 2019, with the expectation of "adjusting

---

[3] These general protections require QHP issuers to reduce cost-sharing in their standard silver plans, which have an AV of 70%, to meet a higher AV: 94% for individuals up to 150% FPL, 87% for those from 151-200% FPL, and 73% for those from 201-250% FPL.

[4] States that operate a Marketplace can either establish their own risk adjustment program or allow HHS to administer one for the state; states that rely on a Federally-Facilitated Marketplace (FFM) must have HHS administer their program. HHS has developed a risk adjustment methodology for use by states or by the department on behalf of states; states electing to use an alternative model must seek Federal approval and submit annual reports to the department. See 45 CFR 153.320.

[5] See 77 FR 73120, "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014" (CMS-9964-P).

these factors ... for the 2020 benefit year as enrollee-level data from the individual market will be available in time for proposal in that rulemaking.[6]
The TTAG would like to encourage CMS to make future adjustments to the induced utilization factor based on individual, enrollee-level data and, to the extent possible, take into account in any adjustments the apparent significant variations in the degree to which some AI/ANs access the cost-sharing protections afforded under section 1402(d) of the ACA.[7] One factor contributing to the variance in utilization of the CSR protections is the concentration of I/T/Us facilities in certain regions and the absence of I/T/U facilities in other regions. Without continued enrollee-level data, the induced utilization factor might greatly overstate or understate the CSR-related additional utilization costs for QHP issuers operating in and enrolling AI/ANs in a state or region of a state. In particular, insufficient compensation to issuers for Indian-specific CSR-related induced utilization costs could dissuade issuers from offering health plans in areas with greater concentrations of AI/AN enrollees (such as remote rural areas).

It is also important to note that the need for maintaining an accurate induced utilization factor in the Federal risk adjustment model is likely to become more pressing over time, as two factors work to increase issuer costs associated with the Indian-specific CSRs.

- First, AI/ANs are increasing their enrollment in health insurance secured through a Marketplace, a trend leading to a greater concentration of AI/AN CSR recipients in a Marketplace. In part, this is a result of AI/ANs gaining an increased understanding of the availability of the Indian-specific CSRs. CMS data show that the number of Tribal members (who meet the ACA definition of Indian and thus qualify for the Indian-specific CSRs) enrolled in Marketplace coverage rose from about 23,000 in 2015 to almost 33,000 in 2017 in states using the HealthCare.gov platform; from 2016 to 2017 alone, there was a 20.7% increase in enrollment of Tribal members in Marketplace coverage.[8]

- Second, although there continues to be deficiencies in issuer understanding and compliance with the Indian-specific CSRs, compliance is improving. For example, a recent [INSERT TRIBE] review of two Indian-specific Summary of Benefits and Coverage (SBC) documents for eight QHPs offered across four states found that, in general, the zero cost-sharing plan SBCs were comprehensive and accurate, while the limited cost-sharing plan SBCs contained several inaccuracies (see more in Attachment A). And while instances of improper application of the Indian-specific CSRs continue for some AI/AN Marketplace enrollees, these cases are becoming less frequent and less systemic.

Fully compensating issuers that are applying the Indian-specific CSRs correctly is warranted and will (continue to) act as an incentive for issuers to serve AI/ANs better. Further, minimizing instances of rewarding non-compliance will help in aligning financial incentives with increased access to care for AI/ANs.

Issue 2: Funding Indian-Specific CSRs Without Shifting Costs to Marketplace Enrollees

Section 1402(d)(3) of the ACA directs the Department of Health and Human Services (HHS) to pay QHP issuers the amount necessary to offset any increase in the actuarial value (AV) of their plans as a result of the Indian-specific CSRs.[9] However, the Trump administration on October 12, 2017, announced that HHS will

---

[6] See 82 FR 51071, "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019" (CMS-9930-P).
[7] See TSGAC comments on CMS-9964-IFC, dated April 30, 2013, at https://www.regulations.gov/document?D=CMS-2012-0152-0490.
[8] See CMS, "Table 1: American Indian and Alaska Native Applicants and Enrollees in the Federally-Facilitated Marketplace," for coverage years 2015, 2016, and 2017.
[9] Section 1402(c)(3) includes a similar provision regarding the general CSRs.

no longer make CSR payments to issuers, effective immediately, based on the legal opinion that Congress, through the passage of the ACA, authorized but never appropriated funding for the CSR payments.[10] Despite the termination of these payments, the ACA requires issuers to continue to provide CSRs to eligible enrollees. To compensate for the loss of the CSR payments, issuers for 2018 typically have responded by funding these CSR protections through increased premiums (in some cases significantly), either on all of their ACA-compliant individual market plans (both inside and outside the Marketplace), only their silver-level plans inside and outside the Marketplace, or only their silver-level plans inside the Marketplace.

The TTAG asks CMS to consider modifying the Federal risk adjustment model for 2019 and beyond to account for the loss of CSR payments to QHP issuers for the Indian-specific CSRs.

As noted above, in an effort to offset the loss of direct CSR payments from the Federal government, an approach has been taken in many states under which CSR-related increases in health plan premiums are largely focused on silver-level plans, as Marketplace enrollees eligible for the general cost-sharing protections must enroll in these plans to receive CSRs. It is important to note, however, that AI/AN Marketplace enrollees eligible for Indian-specific cost-sharing protections can enroll in bronze-level plans and still receive those protections; AI/ANs also are not required to be PTC-eligible in order to qualify for one version of the Indian-specific CSRs.

The alternative funding approach discussed above in many cases has increased the value of PTCs, which are determined in part by the amount of the premium for the second-lowest-cost silver plan in a Marketplace. As such, AI/ANs who qualify for PTCs and enroll in a bronze plan in many cases are protected from CSR-related increases in health plan premiums. But to the extent the premium (and resulting PTC) increases are not adequate to cover the cost of the more comprehensive Indian-specific cost-sharing protections, there is a risk that some of the CSR-related costs could be (and have been) shifted to AI/AN enrollees themselves, through increased bronze plan premiums. In addition, AI/ANs who do not qualify for PTCs but do qualify for Indian-specific CSRs must bear the full cost of any CSR-related increases in bronze plan premiums.

The above scenarios—whereby AI/AN Marketplace enrollees cover some or all of the costs/funding of the Indian-specific CSRs—do not seem to uphold congressional intent. And to the extent that AI/AN enrollment grows as a percentage of total Marketplace enrollment, the dynamic of AI/ANs "self-funding" their own cost-sharing protections also increases. Likewise, if the concentration of AI/AN enrollees in a Marketplace rises over time, it will become increasingly important that a more functional funding mechanism be found for the CSR-related costs, rather than continue to have issuers shift these costs to enrollees in the form of higher premiums or absorb the losses themselves.

The TTAG suggests that CMS consider making further adjustments to the induced utilization factor, or other components of the risk adjustment mechanism, to address these concerns. Doing so would have the combined effects of helping stabilize premiums in the Marketplace—the stated goal of the risk adjustment program—protecting AI/AN enrollees from self-funding the Indian-specific CSR protections, and minimizing financial incentives for issuers to avoid enrolling AI/ANs who are eligible for the comprehensive CSR protections.

[10] See letter from then-Acting HHS Secretary Eric Hargan to CMS Administrator Seema Verma, dated October 12, 2017, at https://www.hhs.gov/sites/default/files/csr-payment-memo.pdf.

<u>Recommendations</u>
In response to the concerns outlined above, the Tribal Technical Advisory Group requests that CMS continue to require QHP issuers to submit individual, enrollee-level data on the usage of CSRs. The TTAG further asks that CMS make any future adjustments to the induced utilization factor based on enrollee-level data to capture the great variation in the degree to which some AI/ANs access the Indian-specific CSRs. In addition, the TTAG urges CMS to consider modifying the Federal risk adjustment model, either through the induced utilization factor or through some other mechanism, to account for the loss of CSR payments to issuers for the Indian-specific CSRs for AI/AN enrollees.

<u>Conclusion</u>
Thank you for the opportunity to provide these comments on the Notice.

Sincerely,

Chairman, National Technical Advisory Group

cc: Kitty Marx, Director, Division of Tribal Affairs/IEAG/CMCS