December 21, 2012

Gary Cohen
Deputy Administrator and Director
Center for Consumer Information and Insurance Oversight (CCIO)
US Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

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

Re: HHS Notice of Benefit and Payment Parameters for 2014 (CMS-9964-P)—AHIP Comments

Dear Mr. Cohen:

We are writing on behalf of America’s Health Insurance Plans (AHIP) to offer comments in response to the Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) Proposed Rule on the Notice of Benefit and Payment Parameters (CMS-9964-P). AHIP is the national association representing health insurance plans that provide coverage to more than 200 million Americans.

The Affordable Care Act (ACA) makes numerous and far-reaching changes to the nation's health care system that will be effective on January 1, 2014. As these changes take effect, health plans are focused on providing recommendations to the proposed regulations that address affordability issues as well as areas that could potentially disrupt coverage for the millions of individuals, families, and employers they serve.

We appreciate that the Department—in the proposed rules addressing insurance market reforms—is soliciting feedback on ways "to minimize disruption of rates in the current market and encourage timely enrollment in 2014.” In developing our comments, we solicited hundreds of health plan policy and operations leaders across the nation to develop specific recommendations to achieve this goal. Based on this feedback and the experience of health plans in the states, we believe specific steps are needed to make coverage more affordable, ensure broad participation in the system, and guard against adverse selection. This is especially important during the initial years of implementation when the penalties for not having insurance are at their lowest.

As the Department finalizes these regulations, we also ask that it carefully consider how the proposed regulations interact with statutory provisions that will add to the cost of coverage. For example, the new $100 billion health insurance tax will add $5,080 over ten years to the cost of
a family’s premium in the individual market. In addition, the requirement that all policies cover ten categories of coverage, many of which are not included in some policies today, will require millions of people to buy coverage that is more comprehensive – but also more costly – than the coverage they currently have. Another provision in the ACA would reduce costs for older individuals purchasing coverage by requiring younger individuals and families in 42 states to pay for higher rates than they do today.

Unless coverage is affordable, younger and healthier people may choose to forgo purchasing insurance until they are sick or injured. If that happens, costs will increase for everyone. This is why it is crucial that more flexibility be provided in the regulations to help ensure broad participation in the system and help mitigate disruption for consumers. While these recommendations will not eliminate cost increases, they will help stabilize the market and set the stage for a broader national conversation on addressing the soaring cost of medical care.

The comments submitted in this letter represent AHIP’s initial comments on this proposed rule. Given the limited duration of the comment period, the interactive effect of all of the proposed regulations, and the complexity of the federal/state allocation of responsibilities, we have endeavored to provide a timely reaction to this proposed regulation. We continue to analyze this proposed rule and its relationship to the *Insurance Market Reforms* proposed regulation and the *Essential Health Benefits and Actuarial Value* proposed regulation, as well as the collective impact of these rules. We are aware that the Department is operating within tight timeframes to finalize these regulations and as a result has established only a thirty (30) day comment period, which is shorter than the typical timeframe for proposed rules of this magnitude. As the Department proceeds to finalize these foundational rules and moves forward with implementation, we will continue to provide feedback from health plan operations leaders who are preparing for 2014 by designing benefits, developing products, and pricing offerings.

Sincerely,

Daniel T. Durham
Executive Vice President
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AHIP Detailed Comments on the HHS Notice of Benefit and Payment Parameters Proposed Rule (CMS-9964-P)

What follows are our detailed comments and recommendations on the HHS Notice of Benefit and Payment Parameters Proposed Rule. Recognizing that 2014 will be an extremely challenging transitional year, our comments identify different tools that could be employed to help minimize disruption for those with existing coverage and promote stability in the market. We appreciate the opportunity to share this feedback and stand ready to continue to work in partnership with the Department as health reform implementation moves forward.

We have organized our feedback into the following sections:

I. User Fees for the Federally-Facilitated Exchanges, Risk-Adjustment and Reinsurance;

II. Treatment for MLR Purposes of Compliance Costs Relating to Upload of Risk Adjustment and Reinsurance Data;

III. Risk-Adjustment, Reinsurance, and Risk Corridors (3Rs);

IV. Advanced Premium Tax Credit and Cost-Sharing Reductions;

V. Federally-Facilitated Exchanges and Small Business (SHOP) Exchanges; and

VI. Changes to the Medical Loss Ratio (MLR) Requirements.

We have also included a technical appendix with additional premium tax credit and cost sharing reduction recommendations.

I. User Fees for the Federally-Facilitated Exchanges, Risk Adjustment and Reinsurance (§ 156.50)

The notice proposes user fees to fund the administrative operations of the federally-facilitated exchange. Specifically, a participating issuer offering a plan through the federally-facilitated exchange would be required to remit a user fee to HHS. For 2014, HHS proposes a monthly user fee equal to 3.5 percent of the monthly premium charged by the issuer for a particular policy under the plan. For future years, HHS has proposed a per enrollee monthly fee to be established by HHS specified in the annual notice of benefit and payment parameters.

The preamble seeks to align this assessment rate with the fees charged by state-based exchanges and suggests that the assessment rate may be modified in the final notice for 2014. In accordance with the statutory guidelines and case law, in 2014 (and future years), a user fee must provide a specific benefit to an identifiable population. In addition, the user fee should be limited to the cost of providing the service or the value to the health plans participating in the Exchange, whichever is less. This limitation would prevent the fee from becoming an unauthorized tax.
In support of this principle, we ask that HHS provide greater transparency and detail about the assumptions that went into proposed user fees estimates. HHS should also ensure that it appropriately prorates its costs to account for any independent benefit to the public. By providing greater clarity and accounting, all stakeholders can have greater confidence in the important administrative and related functions of the federally-facilitated exchange.

In addition to the FFE user fee, the notice also proposes a risk adjustment user fee—set at a national per capita rate of $1 per enrollee per year (and estimated to cost $20 million in 2014). This fee is proposed based on HHS’ contract costs of operating the risk adjustment program including development of the model and methodology, collections, payments account management, data collection, program integrity and audit functions, operation and fraud analytics, stakeholder training, and operational support. The per capita user fee is intended to “spread the cost of the program across all issuers of risk adjustment covered plans based on enrollment.” The same principles stated above apply to the risk adjustment user fee.

Recommendations:

- **We recommend that HHS provide transparency and appropriate accounting of the FFE user fee in 2014 and future years—as the 3.5 percent user fee seems excessive.** We support the preamble language which describes HHS’ desire to seek an exception to the policy of recovering full cost of operating the FFE to maintain a competitive balance between plans inside and outside the Exchanges, to align with the administrative cost structure of State-based Exchanges, and because of future expectations of increased user fee receipts. This exception will promote affordability of FFE products, maintain a competitive balance inside and outside the FFE, and to approximate the value of state-based Exchanges. To be successful and facilitate access to affordable coverage, Exchanges—including state-based and Federally-facilitated Exchanges—must seek to operate as efficiently as possible by leveraging state expertise and not duplicating existing state regulatory functions. This can help keep exchange operating costs low which, in turn, alleviates the premium pressure of user fees and related insurer assessments. We recommend that HHS, to the greatest extent possible, seek to maximize efficiencies in the operation of Federally-facilitated Exchanges—including leveraging economies-of-scale—in order to minimize user fees and administrative costs that would otherwise place upward pressure on premiums for exchange plan coverage.

- **We also recommend that HHS provide for greater transparency and detail about the assumptions that went into proposed user fees estimates for the FFE and for the risk adjustment program.** By providing greater clarity about the assumptions, all stakeholders can have greater confidence in the important administrative and related functions of the federally-facilitated exchange and risk adjustment program. In addition, the fees should be appropriately prorated to account for any independent value to the public. To the degree that the fees collected overstate the costs (or value) attributable to the activities performed by HHS, there should be a process to credit the participating issuers for the next year.

- **We strongly support the proposal that would allow for additional adjustments to the index rate of the single risk pool for expected Exchange user fees and**
distribution costs for the set of health plans offered in a particular market, as well as administrative costs. The notice states that this approach is being considered to provide further protection against adverse selection for qualified health plans (QHP) coverage and to ensure that the costs of Exchange user fees are spread evenly across the market. We recommend that, in addition to Exchange user fees, distribution and administrative costs should also be included as part of the risk pooling to promote a level playing field inside and outside the Exchange.

II. Treatment for MLR Purposes of Compliance Costs Relating to Upload of Risk Adjustment and Reinsurance Data (Collection of Information Requirement, § 153.420)

Section 2718 of the Public Health Service Act (as added by ACA, § 1001) provides that the MLR standard for the individual and small group market is 80 percent (or a higher percentage set by a state). A rebate is required with respect to a plan year “if the ratio of the amount of premium revenue expended by the issuer on clinical services and quality improvement to the total amount of premium revenue (excluding Federal and State taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance under sections 1341, 1342, and 1343 of the Patient Protection and Affordable Care Act) for the plan year” (emphasis provided) is less than 80 percent.

HHS has defined “licensing or regulatory fees” to include “statutory assessments to defray operating expenses of any State or Federal department.” 45 C.F.R. § 158.161(a). Both the risk assessment and FFE user fees clearly fit within this definition. Similarly, new and costly regulatory Federal requirements for issuers to carry out the risk adjustment program in furtherance of the overall Risk Stabilization Programs should not have the effect of increasing the non-claims cost calculation of the MLR. According to the proposed rule, a total of $589,680,000 is estimated for 2014 for issuers’ costs associated with uploading risk adjustment and reinsurance data based on “the time and effort to ensure that information in the dedicated data environment complies with HHS requirements” as well as the cost of computer servers. An additional $81,000,000 in costs is estimated in 2014 for initial validation audits of risk adjustment.

Over the past two weeks, AHIP conducted a survey of member health plans about expected costs associated with the data submission and validation systems necessary to operate the risk adjustment and reinsurance programs. The results of our survey show an average per-plan cost of about $5.6 million in 2014, with some estimates as high as $25 million – far greater than the Department’s estimate of $327,600.²

² AHIP—Health Plans’ Estimated Cost of Compliance with Expanded Federal Rate Review and with Data Collection for Risk Adjustment and Reinsurance (December 2012): http://www.ahip.org/HPCostsCompliance2012/
Recommendation:

The MLR regulations should be amended to clarify that new regulatory costs relating to the Risk Stabilization Programs should be excluded from premium revenue as a regulatory fee for purposes of the MLR calculation or treated in accordance with the MLR treatment proposed for the risk adjustment, risk corridors, and reinsurance programs so that such costs will not be treated as non-claims costs. This policy should go into effect for calendar 2013 year to the degree that expenditures are incurred in 2013 (e.g., for capital costs, training, software development, etc.) for the 2014 calendar year.

Support for these approaches is found in the following:

- Section 2718 directs that premium revenue be calculated after payments or receipts for risk adjustment, risk corridors, and reinsurance. The costs borne by health insurance issuers associated with establishing and participating in the risk adjustment program can justifiably be considered as a portion of the payments and receipts under risk adjustment and may thus be treated in accordance with the MLR treatment proposed for the risk adjustment, risk corridors, and reinsurance programs.

- Another way of characterizing the costs would be to treat them as regulatory fees for risk adjustment excluded from premium revenue. The costs to be incurred by the health insurers for uploading risk adjustment information and conducting initial validation audits is indistinguishable from the $1.00 per enrollee risk adjustment user fee charged back to the issuers. All of these costs are integral to operating the risk adjustment program. This approach would treat all of these costs as regulatory fees in support of risk adjustment regardless of whether these costs are directly incurred by all issuers or incurred by HHS and charged back as user fees.

III. Risk Adjustment, Reinsurance, and Risk-Corridors (3Rs)

The Affordable Care Act’s risk mitigation programs (3Rs) are designed to mitigate the potential for adverse selection and help stabilize premiums in the individual and small-group markets—as comprehensive insurance market reforms are implemented beginning in 2014. The three risk-mitigation programs include—

- **Permanent risk adjustment program (2014 and subsequent years)** is intended to provide increased payments to health insurers that attract higher risk populations (such as individuals with chronic conditions) and assessments on insurers that attract lower risk populations. The risk adjustment program applies to non-grandfathered individual and small-group plans inside and outside the exchange.

- **Transitional reinsurance program (2014-2016)** aims to reduce the uncertainty of insurance risk in the individual market by making payments for high-cost claims. All health insurance issuers and third-party administrators on behalf of group health plans contribute funding to the reinsurance program. Non-grandfathered individual market plans (inside and outside the exchange) are eligible for payments under the reinsurance program.
- **Temporary federal risk corridor program (2014-2016)** seeks to protect against uncertainty in rates for qualified health plans (QHPs) by limiting insurer losses and gains. The risk corridor program applies to qualified health plans (QHPs).

Building on the regulatory framework in the proposed and final rules—as well as subsequent regulatory guidance on the operation of the 3Rs—the Notice of Benefit and Payment Parameters provides states, health plans, and other stakeholders with the critically important technical details and policy parameters necessary to implement and effectively operate these inter-connected programs. Our comments are aimed at assuring that the ACA’s risk-mitigation programs can function as efficiently and effectively as possible in order to assure a stable transition to the 2014 marketplace. Overall, we support the Administration’s broad approach to implementing risk adjustment—as well as the other 3Rs—and appreciate the open and transparent process for soliciting plan and other stakeholder feedback on the highly technical details that will impact the operation of these programs.

**Recommendations:**

A number of elements of the risk adjustment model and methodology—as well as the specific reinsurance contribution and payment parameters—provide much needed clarity about how these specific programs will be implemented and hold promise in promoting a workable and efficient risk-mitigation structure—as the insurance market reforms are implemented. However, there are a number of areas where technical clarifications are necessary—with respect to the risk-adjustment model and risk-adjustment operational policy. Below are our specific comments/recommendations.

**Risk Adjustment (§ 153.310-360, 153.630, 153.700-730)**

- **A mechanism for assessing relative risk scores should be provided under the risk adjustment model.** Under the notice of benefit and payment parameters, HHS will calculate risk scores with a concurrent model (with current year diagnoses being used to predict current year costs), result in balanced payment transfers within a market within a state, and adjust payment transfers for plan metal level, geographic rating area, induced demand, and age rating, so that transfers reflect health risk and not other cost differences. In implementing the risk adjustment program, we urge HHS (and states) to provide a mechanism for health insurance issuers to assess their relative risk scores and state average risk scores as part of the premium development process for 2014 and to monitor any changes on a periodic or interim basis (e.g. monthly or quarterly). Providing a snapshot of risk adjustment scores on a quarterly, interim basis is important in assuring that insurers are executing the intended risk adjustment methodology correctly as well as for premium and rate development purposes. Therefore, we recommend that HHS make provisions to make this information available when its running risk adjustment and reinsurance processes and require a similar reporting facility be made available by states running their own risk adjustment and reinsurance programs.
Linking the effective date for risk adjustment to plan years—consistent with the insurance market reforms proposed rule—can promote stability and avoid unnecessary market disruption. The notice states that plans providing benefits through policies that begin in 2013, with renewal dates in 2014, would not be subject to risk adjustment until renewal in 2014. To that end, the notice provides much needed clarity with respect to the effective date for the major ACA insurance market reforms (e.g. insurance reforms, 3Rs, and the Essential Health Benefits and Actuarial Value requirements) and—by linking the application of the 3Rs to the application of guaranteed issue, modified community rating, and related reforms—can help assure consistency in the application of these requirements, thereby promoting market stability and avoiding unintended disruptions in coverage.

The distributed data collection approach for the HHS-operated risk adjustment and reinsurance program is important to assuring effective administration of the program—while safeguarding the privacy and security of enrollees’ information and data. Consistent with the 3Rs final rules and subsequent regulatory guidance, the notice proposes that HHS will “use a distributed data collection approach to run software on enrollee-level and claims-level data that reside an on an insurer’s dedicated data environment.”

Adjustments for cost-sharing reductions can help improve greater accuracy in risk scores and promote a more effective risk-adjustment program. While this issue was initially addressed in the CCIIO Risk Adjustment White Paper, we appreciate that the notice includes additional details on how adjustments for cost-sharing reductions (including the impact of induced utilization) will be incorporated in the model. Accounting for cost-sharing reductions (and the impact of induced utilization) can improve the accuracy of risk scores and facilitate a more effective risk adjustment program. Moreover, we also support the requirement not to allow adjustment for reinsurance in the risk adjustment model—as it would likely reduce protections for insurers in the individual market that enroll high-cost individuals and undermine the effectiveness of the 3Rs in stabilizing premiums.

Treatment of catastrophic plans. The notice proposes to risk-adjust catastrophic plans as a separate risk pool from the general (metal level) pool. Under this approach, catastrophic plans with less than average actuarial risk (compared with other catastrophic plans) would be assessed charges while catastrophic plans with higher than average actuarial risk would receive payments. We support this approach as one way to promote affordability and assure adequate participation in the marketplace, particularly for younger individuals seeking more affordable coverage options. In addition, we appreciate the consistent approach taken for these plans with respect to the single risk pool in the proposed regulation on the 2014 market reforms. Specifically, we support the allowance for an adjustment factor to the index rate for the single risk pool to reflect the expected impact of the specific eligibility categories for catastrophic plans.
• **Treatment of student health plans.** Student health plans are treated as a separate group—under the draft notice—and would not be subject to risk adjustment charges and would not receive risk-adjustment payments. We support the notice’s provisions addressing the treatment of student health plans—as it will help assure that these plans remain available as an option to students in the marketplace. In addition, we appreciate the similar treatment provided for these plans with respect to the guaranteed issue and guaranteed renewability requirements in the proposed regulation on the 2014 market reforms. We further urge you to adopt the same approach with respect to the single risk pool and rating requirements. Specifically, this coverage should not be included as part of the issuer’s individual market single risk pool and it should not be subject to the individual market rating requirements. Adopting a consistent approach across all of the market reform requirements for student health plans is critical to ensuring the continued viability of this product and minimizing disruption for those with existing coverage.

• **Data validation.** The Proposed Rule addresses the topic of risk adjustment data validation. While the Proposed Rule outlines a potential approach it is also high level in a number of areas such that it does not lend itself to a detailed, technical response. As an example, we understand with respect to the Proposed Rule’s comment on “error estimation” that you are considering different methodologies for adjusting plan risk scores as part of the data validation process to include use of suitable confidence intervals for determining issuer error rates. As this is a significantly important area, and one in which many carriers have experience through Medicare Advantage – but for which some differences may be required here – we urge CMS to provide an opportunity for carriers to comment on the proposed statistical selection methodology in future guidance, recognizing that the level of detail provided in the Notice does not lend itself to such comments being offered here.

• **We also have a number of technical recommendations and comments with respect to the risk-adjustment program.** Specifically, we recommend that HHS—

  o Provide insurers with the mapping of the ICD-9 codes to the HCC categories and make the risk-adjustment model open-sourced for analysis and testing;
  o Provide insurers with the actual 15 risk adjustment models so that plans can better understand how they work and test how predictive they will be of their own claims data;
  o Consider adding demographic factors for people age 65 and older, since the model only captures up to age 64; and
  o Clarify the treatment of newborn enrollment in the first 30 days with respect to risk-adjustment (e.g. is the intent to treat the newborn as an enrollee and offer suggestions as to how claims would be unbundled).
Assuring a more streamlined reinsurance collection process can help reduce administrative burdens on employers and plans. The notice proposes that HHS collect all contributions under a national contribution rate from all health insurers and self-insured group health plans in a state. Use of a national contribution rate assures that the reinsurance payments—for the transitional reinsurance program as well as the Early Retirement Reinsurance Program—are subsidized through collections made broadly from all segments of insured and self-funded coverage. Insurers and plans will report the number of contribution enrollees no later than November 15th of each benefit year. HHS will notify covered entities of the reinsurance contribution amount that must be paid for the benefit year by the later of (a) 15 days after the report by the issuer or plan; or (b) December 15th—with payments due 30 days after the notice by HHS. The notice provides health insurers and self-funded group plan sponsors with several approaches to determining the number of contribution enrollees subject to the fee in a benefit year. We believe the streamlined collection approach—as outlined in the notice—can help ease administrative burdens on issuers and group plans sponsors while, at the same time, supporting adequate and consistent financing for the reinsurance program. In addition, we recommend payment to carriers 30 to 60 days following June 30th to assure the carrier has funds prior to the date the rebate checks are due.

Uniform contribution amount parameters and allowing for adjustments in reinsurance distributions based on a state’s need will enhance the reinsurance program’s effectiveness in promoting market stability. The notice proposes that the payment parameters for reinsurance will be used uniformly across all states, including those that operate their own reinsurance program. Furthermore, reinsurance payments will be disbursed based on a state’s need for reinsurance payments. In addition, as discussed in an earlier comment, we recommend contribution enrollees should be reported based on the situs of the insurance contract or location of the employer plan sponsor for self-funded group health plans. We support this approach as it will help assure that reinsurance payments are allocated more efficiently and fairly—so that the reinsurance program can better meet the goal of promoting greater individual market stability.

Quarterly notification of reinsurance payments approach can promote more accurate rate setting in 2014 and beyond. With the timing of reinsurance payments delayed until 2015, the quarterly notifications will provide important information to assist plans in the premium and rate development process which, in turn, can help promote

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3 As noted in the preamble to the proposed rule, the additional $5 billion that will be collected from insurers and self-funded group health plans and paid into the general fund of the U.S. Treasury, "is the same amount as that appropriated for the Early Retiree Reinsurance Program under section 1102 of the Affordable Care Act." 77 Fed/Reg. 73154.
more accurate rate setting and promote greater premium stability in the individual market.

- **Greater clarity with respect to certain plans and insurance products with respect to reinsurance contributions.** The notice clarifies that the reinsurance fee is applicable to health insurance issuers and self-insured group health plans except to the extent that—(1) the plan or coverage is not major medical coverage; (2) in the case of health insurance coverage, the coverage is not considered to be part of an issuer’s commercial book of business; or (3) in the case of health insurance coverage, the coverage is not issued on a form filed and approved by a state insurance department. The notice also explicitly excludes the following types of plans and coverage from reinsurance contributions:
  
  - Excepted benefits;
  - Private Medicare, Medicaid, CHIP, state and federal high-risk pools, and basic health plans;
  - HRAs integrated with a group health plan;
  - HSAs and health FSAs;
  - Employee assistance programs, disease management programs, and wellness programs;
  - Stop-loss and indemnity reinsurance policies;
  - Military health benefits; and
  - Indian Health Service and Indian Tribal coverage.

We support the provisions of the proposed rule clarifying the types of coverage that will be subject to or excluded from the fee. In addition, we agree that group health plan participants and beneficiaries should not be “double-counted” for purposes of the determining the number of contribution enrollees.

- **Recommend that an additional clarification be provided that certain types of expatriate coverage are excluded from the fee.** As noted, the counting methods adopted in the proposed rule are based on the procedures that will be used by health insurers and self-insured plans to report and pay the fee to fund the Patient-Centered Outcomes Research Institute (the “PCORI fee”). The PCORI fee final rule includes an exemption for expatriate coverage that should be adopted for purposes of the reinsurance fee.

- **Clarifying responsibilities for reporting the number of contribution enrollees and making payment of contribution amounts will streamline operational responsibilities for plan sponsors and administrators.** The preamble to the proposed rule indicates that in the case of a self-insured group health plan, “the plan is liable, although a third-party administrator or administrative-services-only contractor may be utilized to transfer reinsurance contributions on behalf of a self-insured group health plan, at that plan’s discretion.” (77 Fed. Reg. 73152, emphasis added). If the plan does not have a third-party administrator or contractor, the plan will make the reinsurance
contributions directly to HHS. The proposed rule, however, appears to contemplate that a self-funded plan administrator or contractor will continue to have primary responsibility for reporting the number of contribution enrollees and for making payments to HHS. Additionally, situations involving self-funded plans without a third-party administrator or contractor are not address by the proposed rule. We suggest that the rule clarify that a self-funded plan sponsor has responsibility for reporting the number of enrollees and paying the contribution amounts, although they may choose by contract to have such functions performed by a third-party administrator or an administrative-services-only contractor.

- **States should be required to notify HHS within 30 days after publication of the draft HHS notice of benefit and payment parameters of any additional contribution rate it is seeking to collect.**

**Risk Corridors (§ 153.500-530)**

- The risk corridor calculation should be applied in aggregate across all qualified health plans (QHPs) offered by a legal entity in a state by individual and small group market segment. Performing the risk corridor calculation at the QHP issuer level makes policy sense and in the context of the 3Rs provisions provides for a more consistent interpretation. It would also help to address concerns related to statistical credibility of results given the relatively small level of claims experience in any given QHP—which would help improve the predictability of pricing consistent with the 3Rs broad goals of premium stabilization.

**IV. Advance Premium Tax Credit and Cost-Sharing Reductions(§ 155.305-340, 155.1030, 156.215, 156.400-470)**

Cost-sharing reductions (under §1402 and §1412 of the Affordable Care Act) provide for reductions in out-of-pocket costs for low- and moderate-income individuals (with incomes up to 250% FPL) enrolled in subsidized exchange plan coverage. Specifically, cost-sharing reductions are available to those enrolled in qualified silver-level health plans in the individual market exchange.

The notice includes standards related to the design of silver plan variations of qualified health plans, provides the maximum out-of-pocket limit applicable to the various silver plan variations, and includes provisions for insurer submissions of estimates of cost-sharing reductions, which are paid in advance to insurers by the Federal Government.

Under the proposed rule, insurers are required to provide the cost-sharing reductions at the point of service. That is, an individual eligible for cost-sharing reductions would be required to pay only the amounts under the applicable silver plan variation. Insurers would be reimbursed directly by HHS for the cost-sharing reductions—which is broadly consistent with the HHS Actuarial Value and Cost-Sharing Reductions Bulletin released on February 24, 2012.
The notice implements a payment approach where HHS would make monthly payments to insurers to cover projected cost-sharing amounts along with a year-end reconciliation process at the end of the benefit year—which is similar to the approach used for the Medicare Part D low-income drug subsidy (LIS) program. The rule also establishes a methodology and formula for developing estimates of the value of cost-sharing reductions. As part of this formula, HHS proposes induced utilization factors for the purposes of calculating cost-sharing reduction advance payments.

Recommendations:

- **HHS’ intended approach for implementing the cost-sharing reductions and OOP limits provided for under the ACA raises several operational concerns.** The cost-sharing reduction methodology as well as the reconciliation approach as it is now constructed provides a disincentive for Exchange participation due to the operational complexity and cost. We look forward to working with you to ensure an operationally efficient process and reconciliation methodology. In addition, we note the overall approach to CSRs is based on a fee-for-service model. Today, health plans are transforming the payment and delivery system focusing on care coordination, care transitions and incenting providers for high-value comprehensive healthcare. A cost-sharing subsidy that relies on reductions in cost-sharing for fee-for-service healthcare does not make sense given the ongoing transformation.

- **We recommend that the cost-sharing reductions are limited to in-network benefits.** The preamble indicates that the definitions of cost-sharing and cost-sharing reductions only apply to essential health benefits (EHB) without regard to whether the EHB is provided inside or outside the QHP issuer’s network [77. Fed Reg. 73169]. This approach is inconsistent with the Department’s previous work related to implementation of the preventative services requirements as well as the EHB NPRM. The recent EHB NPRM at 45 CFR §156.130(c), clarifies that only in-network cost-sharing would count toward the annual limit on cost-sharing (e.g. OOP caps) and the annual limits on deductibles in the small-group market. Limiting to in-network allows for issuers to negotiate allowed charges with in-network providers as a way to promote effective, efficient health care, and allowing differences in cost sharing in- and out of-network enables plans to encourage use of in-network providers. Allowing zero cost sharing for out of network providers could reduce providers’ incentives to participate in insurer networks.

- **We recommend that HHS expand the de minimis requirement to that which was proposed in the AV/CSR Bulletin.** We are concerned that the reduced de minimis requirement of +/- 1% that is included in the Proposed Notice severely limits issuers’ ability to design reasonably simple benefit plans and recommend CMS expand the requirement to +/- 2% as proposed in the AV/CSR Bulletin. This would allow the most flexibility in designing QHPs and the plan variations the market demands, while maintaining stability in the market.
• **We support the recommendation that induced utilization is incorporated into the calculation for cost-sharing reduction advanced payments.** By incorporating induced utilization factors within the payment calculation, HHS can help ensure both the accuracy and operational efficiency of this important program.

• **We recommend that HHS consider an alternative approach to how cost-sharing reductions are displayed to consumers.** Under the proposed rule, if an individual is determined to be eligible to enroll in a QHP in the individual market, the QHP issuer must assign the individual to the appropriate plan variation using the enrollment and eligibility information provided by the Exchange. We are concerned that this approach may lead to consumer confusion due to the lack of education about the applicant’s specific plan variation given the exchange would not tailor plan selection to the specific plan variations for which an individual is eligible to enroll. We support an alternative approach where the exchange displays the specific cost sharing plan variation that for which the consumer is eligible for. This ensures consumers are aware of how their chosen QHP will implement the cost-sharing reductions.

• **Implementation of American Indian Cost-sharing reductions.** We do not support the requirement that for each individual market QHP at any level of coverage, an issuer must also submit zero and limited cost-sharing plan variations. This approach creates several operational challenges. Instead, we recommend that issuers file zero and limited cost-sharing variations only when there are differences in formularies, networks (e.g., HMO versus PPO) or benefits offered between metal tiers. Unless there are non-cost-sharing differences in QHPs such as network or benefit differences, issuers should have the option to offer plans for eligible AI/ANs with zero cost-sharing in one metal tier (e.g., bronze).

Please see a more detailed set of APTC and cost-sharing reduction recommendations in the Appendix.

V. **Federally-Facilitated Exchanges and Small Business (SHOP) Exchanges**

Regarding the implementation of the Federally-facilitated SHOP exchange (FF-SHOP), the compressed timelines along with the lack of detailed guidance and final rules presents significant challenges and risk. We are awaiting operational-level guidance for implementing the core functions of a SHOP exchange, including technical details on how the proposed contribution methodology will be operationalized within the SHOP and the impact of the proposed definition of full-time employee and how it would interact with other ACA provisions that use different definitions. In addition, details for the premium aggregation function will be critical, as well as the process for employer-group set up within the exchange.
Required SHOP Participation (§156.200(g))

The notice proposes to leverage issuers’ participation in an FFE to ensure participation in the FF-SHOP, provided that no issuer would be required to begin offering small group market products as a result of the provision. The FFE may certify a QHP in the individual market of an FFE only if the QHP issuer meets one of the following conditions: (1) the issuer offers through the FF-SHOP serving that State at least one small group market QHP at the silver level of coverage and one at the gold level of coverage; (2) the QHP issuer does not offer small group market plans in that State, but another issuer in the same issuer group offers through the FF-SHOP serving that State at least one small group market QHP at the silver level of coverage and one at the gold level of coverage; or (3) neither the issuer nor any issuer in the same issuer group offers a small group market product in the State.

We look forward to working with HHS to ensure the FF-SHOP is a robust and viable marketplace on October 1, 2013. However, we are concerned about the precedent that this certification requirement sets relative to the authority of the FFE. This requirement could have the unintended impact of discouraging issuers from entering the individual exchange marketplace due to their lack of experience or capacity in the small group marketplace. Therefore, we recommend that this certification requirement be removed. In the alternative, we recommend that prior to the 2016 plan year, HHS assess the SHOP exchange’s viability and, if there are concerns at that time consider establishing a certification requirement. By this time additional states will have also made the transition to a state-based exchange and each state could review its exchange-specific certification requirement. We note that this certification requirement was not included in the FFE Bulletin and we were unaware that this would be a certification requirement for the 2014 plan year. Participation in the FF-SHOP, along with the associated infrastructure to support the employee/employer choice requires a new operations infrastructure that many plans will not be able to immediately support.

Broker Compensation (§156.200(f))

The notice proposes in §156.200(f) that QHP certification by the FFE and a FF-SHOP is conditioned on the QHP issuer paying similar commissions inside as it would pay for “similar health plans” outside of the Exchange. HHS requests comments on whether “similar health plans” is a sufficient standard or not, which factors should be considered in identifying “similar health plans” and how this standard might apply when small group market commissions are calculated on a basis other than an amount per employee or covered life.

As we have previously mentioned, we support a level playing field between the inside Exchange market and the outside market including approaches to broker compensation that do not have the intent of favoring either the Exchange or the outside market. However, we are concerned that the proposed approach does not recognize the different role brokers will play in the new Exchange marketplace versus outside of the Exchange. The regulatory approach should recognize that the role of brokers in the FF-SHOP may be very different, in part due to the additional resources available within the Exchange and may evolve over time as the marketplace changes after 2014. Therefore, any requirements related to broker compensation need to allow for flexibility to adapt to these considerations, and accommodate the fixed costs already being required.
VI. Changes to Medical Loss Ratio (MLR) Requirements (§ 158.110-241)

The notice would change the medical loss ratio (MLR) reporting and rebate deadlines in order to “coordinate them with the reporting cycles of the premium stabilization programs [3Rs].” Specifically, the MLR reporting deadline has been moved back to July 31st (from June 1st) and the rebate due date back to September 30th (from August 1st)—beginning with the 2014 reporting year.

- We appreciate and support the notice’s provisions to resolve the conflict between the timing of Premium Stabilization Programs and the MLR reporting and rebate provisions. Addressing the timing issue—as proposed in the notice—will allow all of the 3R elements (including the risk corridors) to be completed before a carrier would be expected to calculate its MLR—thereby promoting a more workable regulatory and operational process for plans in their MLR reporting and rebate requirements.

The notice proposes to amend the MLR final rule, related to calculating the credibility adjustment in § 158.232. The original provision looked at just three years; there was no analysis of how it should be applied to successive periods exceeding three years. The revised language - newly added in § 158.232 (d) in stating only “beginning in 2013” with no further clarification - would have the unintended effect of making the test a one-year test, rather than a three-year test.

- We thus recommend that the language of § 158.232 (d) be revised as follows:

(d) No credibility adjustment. Beginning with the 2013 MLR reporting year, the credibility adjustment for an MLR based on partially credible experience is zero if both the following conditions are met:

1. This provision was not applied to either of the two previous reporting years;
2. The current MLR reporting year and each of the two previous MLR reporting years included experience of at least 1,000 life-years; and
3. Without applying any credibility adjustment, the issuer’s MLR for the current MLR reporting year and each of the two previous MLR reporting years (prior to any averaging) were below the applicable MLR standard for each year as established under § 158.210 in this subpart.

With this change we believe the original intent is preserved. Our understanding of that intent was that a company would lose the credibility adjustment in 2013 if all three years (2011, 2012 and 2013) were below the MLR standard prior to applying a credibility adjustment, based on the assumption that from a purely statistical point of view the probability of three consecutive years below the MLR standard was small at 12.5% (determined as 50% each year or .5^3). If this is true for three years, and the provision is applicable, then the statistical chance of it happening again the next year is 50% - not a continuation of the 12.5%. To avoid the improper effect, the provision should not apply if the provision applied in either of the two prior years.
Appendix: Additional APTC & Cost Sharing Reduction Recommendations

Eligibility Standards (§155.305)
CMS has revised the provision in the Exchange final rule pertaining to the eligibility for the cost-sharing reductions for multiple tax households to include a category of qualified individuals who are not eligible for any cost-sharing reductions and adds text to explicitly address situations in which Indians and non-Indians enroll in a family policy. We support this revision as it eliminates the potential for various members of a family to have different levels cost-sharing eligibility on a single policy, which that would be operationally challenging to implement. We discuss operational issues specific to the American Indian and Alaska Native (AI/AN) cost-sharing reductions later in our comments.

Eligibility Redeterminations during the Benefit Year (§155.330)
Subsection (g) addresses the recalculation of advance payments of the premium tax credit and cost-sharing reductions. The provision indicates that the Exchange should take into account any advance payments already made on behalf of the tax filer for which information is available to the Exchange such as not to result in an overpayment of the tax filer’s total projected APTC. In the preamble HHS describes an alternative approach in which the eligibility redetermination would result in an increase in APTC. HHS proposes to make retroactive payments to the QHP issuer to reflect the increased advanced payment amount, not to exceed the total premium for each month. We do not support this alternative approach, as it would create several operational challenges for QHP issuers who would have to track retroactive APTC payments and make corresponding premium adjustments. We recommend that HHS retain the approach described in the NPRM and that APTC payments remain generally prospective in that all changes to the APTC amount as a result of an eligibility redetermination are reflected on the first of the following month.

Cost Sharing Reconciliation Methodology
The operational implications of the cost-sharing reduction program are significant. We expect in some markets large numbers of applicants to be eligible for the CSRs and we expect that this population will likely experience changing eligibility levels throughout the course of the plan year. Because of the complexity of the CSR reconciliation process and the significant administrative impact that it will have on health plans, we have provided some preliminary comments on the reconciliation process and methodology but we request the opportunity to continue to work together to ensure an operationally efficient process for both HHS and QHP issuers that best meets the intent of this ACA provision.

The re-adjudication process required under the proposed reconciliation methodology requires an administrative process that does not exist today. Although health plans have established procedures for Part D reconciliation, the nature of the co-pay differential in pharmacy lends itself to a much simpler process. Health plans have a much longer lag times for medical claims than prescription drugs, which delays the reconciliation or requires the need to consider “incurred but not reported” claim adjustments. Any time there is a re-estimate due to delayed claims or changing eligibility levels that goes through a reconciliation process incurs additional administrative costs. – This essentially requires a double adjudication of claims that must take into account benefits as they were provided and as they would have been without cost-sharing
reductions, which would be highly complex and prone to errors. We recommend that the annual reconciliation process is optional and that in the long term, the reconciliation process rely on highly accurate monthly estimates so that an annual reconciliation becomes unnecessary.

Although a reconciliation can “accurately” price out the difference in cost share, it ignores the potential for induced utilization. No reconciliation method can explicitly identify utilization that was induced, which may contribute to their reluctance to engage in considering alternate methodologies. CCIIO argues that induced utilization is captured in the payment transfer formula. However, that is a separate process and involves a redistribution from different monies. We believe that the induced utilization should be directly reflected in the payment for the cost sharing reduction.

Applicability of CSR to Out of Network Benefits
In the preamble of the Notice of Benefit and Payment Parameters (77 Fed. Reg. 73169), CMS clarifies that the definitions of cost-sharing and cost-sharing reduction in 45 CFR 155.20 apply only with respect to essential health benefits (EHB). However, CMS notes that the cost-sharing and cost-sharing reductions apply without regard to whether the EHB is provided inside or outside of a QHP issuer network.

We recommend that these definitions are revised to limit cost-sharing reductions to in-network benefits only, for both enrollees in silver plan variations and the zero or limited cost-sharing plans for American Indians and Alaska Natives (AI/ANs). This approach is consistent with other HHS guidance and proposed rulemaking related to a QHP issuer allowing cost-sharing for services out-of-network. In the Essential Health Benefits, Actuarial Value, and Accreditation proposed rule at 45 CFR §156.130(c) the cost-sharing requirements for benefits provided outside of a plan’s network do not apply toward annual out-of-pocket maximums.4 Similarly the preventative services interim final regulation provides that the preventive care requirement be interpreted so that a plan is not required to provide coverage for recommended preventive services delivered by an out-of-network provider.5 In addition, a plan may also allow for cost-sharing for such services delivered out-of-network.6

As with cost-sharing reductions, the preventive care provision in ACA (§2713 of the Public Health Service Act) does not directly address the question of whether the provision applies to network providers. Here in the preamble to the IFR, the three Departments (HHS, DOL, and Treasury) considered the issue and determined that requiring coverage by out-of-network providers at no cost-sharing would result in higher premiums. The policy underpinnings for the three Departments’ decision-making are the same as that which would apply to the cost-sharing reductions for silver plan variations and zero and limited cost-sharing plan variations for AI/ANs. The agencies wrote:

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6 Here, the preamble of the IFR, 75 Fed. Reg. at 41728, provides. “With respect to a plan or health insurance coverage that has a network of providers, these interim final regulations make clear that a plan or issuer is not required to provide coverage for recommended preventive services delivered by an out-of-network provider. Such a plan or issuer may also impose cost-sharing requirements for recommended preventive services delivered by an out-of-network provider.”
Plans and issuers negotiate allowed charges with in-network providers as a way to promote effective, efficient health care, and allowing differences in cost sharing in- and out of-network enables plans to encourage use of in-network providers. Allowing zero cost sharing for out of network providers could reduce providers’ incentives to participate in insurer networks. The Departments decided that permitting cost sharing for recommended preventive services provided by out-of-network providers is the appropriate option to preserve choice of providers for individuals, while avoiding potentially larger increases in costs and transfers as well as potentially lower quality care.7

The regulatory approaches in both the EHB and preventative services rulemaking will allow QHP issuers to continue to design innovative plan benefit structures while encouraging the use of in-network providers. We recommend these same policy principles dictate a similar result for any rulemaking on cost sharing provisions for silver plan variations and zero and limited cost sharing plan variations for AI/ANs. Applying the cost-sharing reductions out-of-network has the potential to increase the utilization of out-of-network providers and would increase consumer’s out of pocket costs. As evidenced by the preventive services IFR, the agencies have authority to promulgate such a policy even in the absence of specific statutory language.

Assignment to applicable plan variation (§156.410(b))
Per §156.410(b) of the Notice, if an individual is determined to be eligible to enroll in a QHP in the individual market, the QHP issuer must assign the individual under enrollment and eligibility information submitted by the Exchange as follows:

- If the individual is determined eligible by the Exchange for cost sharing reductions in a silver health plan, and chooses to enroll in a silver plan, the QHP issuer must assign the individual to the appropriate silver plan variation (i.e., for individuals 100-150% FPL, 150-200% FPL, or 200-250% FPL) of the selected silver plan.
- If the individual is determined eligible by the Exchange for cost-sharing reductions for American Indians and Alaskan Natives (AI/ANs), the QHP issuer must assign the individual to the appropriate zero or limited cost-sharing plan variation of the selected QHP.

While we agree that the cost-sharing reduction plans should be presented as plan variations of the standard plan, we recommend the regulatory language at 156.410(b) is clarified to indicate that the enrollee selects the plan variation at the Exchange and that the QHP issuer simply enroll the individual into the appropriate plan variation as directed by the Exchange. From a consumer’s perspective this means that the Exchange would only display the plan variations for which the individual is eligible. We also expect there to be differences in how various QHPS implement the cost sharing reduction which would need to each be considered individually by the applicant. Following the Exchange eligibility determination, the website would display the plan variations for which the enrollee is eligible and the enrollee would directly select the silver plan variation, or zero or limited cost sharing variation, (or a non-silver metal level plan if the enrollee decides to forego the cost-sharing reductions) at the Exchange website. Following the

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7 75 Fed. Reg. at 41738.
selection, the QHP selected along with the applicable plan variation would be communicated to the issuer via the enrollment file. Given the number of options available to eligible AI/ANs, we discuss several other implications of this policy for the AI/AN cost sharing reductions later in our comments.

We are assessing several state regulatory issues that result from the cost-sharing plan variations. There is some uncertainty regarding whether state regulators will require separate rate and form filings for the various plan variations (silver and AI/AN zero and limited). In addition, if the Exchange website were not to display the applicant’s actual plan benefits and cost sharing we are concerned that all the various requirements regarding health plan contracts may not be met leading to consumer complaints that benefits and cost-sharing were not adequately explained to consumers prior to plan selection.

Changes in Eligibility for Cost Sharing Reductions (§156.425)

Effective date of CSR changes (§156.4254(a)) - The proposed regulations tie the effective date of cost-sharing eligibility changes to the effective date of eligibility required by the Exchange. However, we note that these regulations (45 CFR 155.420) do note that while in certain situations the coverage effective date is retroactive (e.g., in the case of a birth of a newborn coverage is retroactive to the date of birth) the cost-sharing reductions are not effective until the first day of the following month. It is critical that this approach is maintained, as any retroactive CSR eligibility would be challenging to implement. We ask similarly to the APTC, the CSR effective date is always prospective (the first of the following month) to eliminate the need for the re-adjudication of claims to determine the correct cost sharing reduction amount given that claims would need to be adjudicated based on the first plan variation and again for the new plan variation increasing administrative costs and complexity.

Continuity of deductible and out-of-pocket amounts (156.425(b)) - The rule describes that in a case of an assignment to a different plan variation (or a standard plan without the cost-sharing reductions) of the same QHP in the course of a benefit year, the issuer must ensure that any cost-sharing paid by the applicable individuals under the previous plan variation (or standard plan without cost-sharing reductions) is accounted for in the calculation of deductibles and annual limitations on cost-sharing in the individual’s new plan variation for the remainder of the benefit year.

We support the approach whereby the requirement to carry over previous cost-sharing only applies to changes within the same QHP. This will need to be clearly communicated during the eligibility redetermination process so that consumers are aware of the implications of switching QHPs during the plan year. Operational questions remain in certain situations wherein an individual decreases income and moves to a higher cost sharing reduction amount which may result in the individual has exceeded their out-of-pocket maximum. We are concerned about the complexity of accounting for excess out-of-pocket expenditures due to movement between plan variations and the impact on the reconciliation process. We ask the Department to consider some safe harbors in these situations for out of pocket expenditures already paid based on eligibility at that point in time and when due to data lags in claims filings where an enrollee may have met OOP limit but QHP issuer may not have been informed.

With regard to eligible AI/ANs eligible for cost-sharing reductions that who have the ability to
change QHPs no more than once per month, it is extremely important that any continuity of deductible amounts would only apply if the eligible AI/AN were to remain in the same QHP.

Payment for cost-sharing reductions (§156.430)
Cost sharing during special periods (156.430(f)) - The NPRM establishes rules on the advance payment and reimbursement of cost-sharing reductions during special transitional periods (i.e., inconsistency period, 90-day grace period, etc.). HHS proposes to continue to provide advance payments of the cost-sharing reductions during the grace period. HHS would reimburse the QHP for any reduction of cost-sharing for the 1st month of the grace period (where the Exchange final regulations require the QHP issuer to pay all claims received),; however, HHS proposes not to reimburse cost-sharing reductions provided during the 2nd and 3rd month of the grace period if retroactive termination occurs. We support this approach and support to consistency in how these issues are addressed across the APTC and CSR.

We also wanted to highlight a conflict between the ACA required 90 day grace period for enrollees receiving the APTC. In many states, health plans would be in violation of a state’s prompt pay law if they choose to “pend” claims following the first 30 days of the grace period. While some prompt pays would not apply during the 90- day grace period due to the definition of a “clean claim,” but this is not universal. A state’s definition of “clean claim” can help plans justify why a claim was paid or not. For example, some states include a specific “exception” for premium or eligibility, however, most states include language that could be interpreted as being such that “clean claim” means a claim with no defect or impropriety, or needs to include “all information necessary for an insurer to pay.” This would mean health plans would be liable for all claim payments during the grace period. We ask that you work with states to address this conflict.

QHP Certification Standards Related to the APTC and CSR (§155.1030)
Two new certification standards were added to address the review of plan variations for the CSRs and the review of the information for the administration of the APTC and the CSR. We recommend that HHS include a good faith compliance standard given the newness of the CSR monthly estimate process and the annual reconciliation process (especially in early years). This good-faith standard could be revisited prior to the 2016 plan year.

Cost Sharing Reduction Reporting
We are concerned that we do not yet have the technical details on how CSR estimates will be reported to HHS given the huge operational complexities surrounding the CSR program. We look forward to engaging in a series of technical discussions on the process, forms and templates that will be used to implement this program. We also would like additional information about the proposed approval process for the amount estimated by issuers on a monthly basis. We recommend that HHS consider a safe harbor if QHP issuers are using the formula and/or forms supplied by the HHS. We would also like to discuss how issuers will be allowed to make adjustments to the CSR amounts submitted due to enrollment fluctuations or changing demographics of their enrolled population as long as the adjustments are based upon one of the permissible rating factors.
Implementation of 1402(d) of the ACA – Cost Sharing for American Indians and Alaskan Natives

We agree with the interpretation of section 1402(d)(2) of the Affordable Care Act that the special cost sharing reduction provisions for American Indians and Alaskan Natives (AI/ANs) only apply to the individual market. These provisions should not apply to small group products inside or outside of the Exchange. Furthermore, we support the proposal that enrollment in catastrophic plans precludes eligibility for cost-sharing reductions, including for AI/ANs.

Eligibility Standards (§155.305(g)(3))

We support the proposed special rule for family policies, under which individuals who enrolled under a single policy who, if they were to enroll in separate individual policies would be eligible for different cost-sharing, would be collectively eligible for only the category of eligibility for which all individuals are eligible. It would be operationally infeasible for QHP issuers to have two family members with different cost-sharing levels enrolled in the same policy. For families in which some individuals are eligible for this cost-sharing reductions as members of a federally recognized tribe while others are not, those family members should be enrolled in different QHPs if they wish to secure the highest level of cost-sharing reduction for which they are individually eligible. However, we note that rules regarding dependents in these situations should be clearly stated to avoid any confusion for eligible AI/ANs, Exchanges, and QHP Issuers.

Submission of zero and limited cost sharing plan variations (§156.420(b))

The rule proposes that zero and limited plan variations be offered to accommodate the requirements in 1402(d) of the ACA for AI/ANs eligible under sections 155.350(a) and 155.350(b), respectively. However, the preamble of the proposed rule also notes that CMS considered an alternate approach by which QHPs would assign eligible AI/ANs to a standard plan and waive cost-sharing requirements at the point of service (77 Fed. Reg. 73179). We do not support this alternate approach and recommend that CMS adopt the proposal for zero and limited cost sharing plan variations.

As CMS notes in the preamble of this proposed rule, there are significant technical and operational constraints that would make the alternate approach extremely difficult for issuers to implement. Waiving cost-sharing for services provided to AI/ANs at or below 300% FPL at the point of service would be extremely difficult for issuers. In addition to the significant operational difficulty of member-based cost-sharing rules, many processes and services are tied directly to the plan type, including member services, member ID cards, member handbooks—all of the components that help enrollees understand copays, deductibles, etc. Attempting to differentiate members within a plan would negatively impact the overall member experience for AI/ANs. It would also be confusing to providers who would have to verify AI/AN status. Rather, we support the approach in the proposed rule whereby AI/ANs are enrolled in a plan variation of the standard QHP. This approach would make claim adjudication and member services, which are all tied directly to the type of plan, more feasible. The Exchange must be responsible for all eligibility determinations related to tribal membership and, under this model, would direct eligible AI/ANs at or below 300% FPL to equivalent no-cost sharing QHPs for plan selection.
Further, we do not support the proposed requirement the proposed rule requires that, for each health plan at any level of coverage for which an issuer seeks QHP certification for the individual market on an Exchange, an issuer must also submit zero and limited cost-sharing plan variations. We do not believe that it is necessary for issuers to produce zero and limited cost-sharing plan variations for every QHP offered through the Exchange at every coverage level and that to do so would be operationally burdensome for issuers. It is our understanding that, to ease the burden of submitting plans for certification, the benefit and cost-sharing templates described in the Initial Plan Data Collection to Support QHP Certification and other Financial Management and Exchange Operations (CMS-10433) would allow issuers to enter plan benefit information and use an Excel Macro to generate a pre-populated template for zero and limited cost-sharing plan variations. While such a feature would ease the upfront burden of submitting plan variations for certification, it does not address the greater backend administrative burden of operating zero and limited cost-sharing variations of every standard QHP.

Issuers are more concerned about the operational cost and administrative burden of operating so many plan variations for a number of reasons. First, we anticipate that AI/ANs will have little incentive to purchase a gold or platinum level plan when there are not significant non-cost-sharing differences between these plans and plans at the silver or bronze level. AI/ANs who do enroll in these higher metal level plans may decide that the added benefits of such a plan (e.g., broader network) do not equate to the higher premium payment and enroll in a new plan at the next month, causing unnecessary movement between plans. Second, by offering zero and limited cost-sharing plan variations for every standard QHP, issuers may be operating plans with very few or no enrollees. Some gold or platinum level plans may have few if any enrollees due to the higher premiums associated with those plans, and in states with very low AI/AN populations, there may be few enrollees in zero and limited cost-sharing plans at any metal level.

Instead, we recommend that issuers file zero and limited cost-sharing variations only when there are differences in formularies, networks (e.g., HMO versus PPO) or benefits offered between metal tiers. However, unless there are non-cost-sharing differences in QHPs such as network or benefit differences, issuers should have the option to offer plans for eligible AI/ANs with zero cost-sharing in one metal tier (e.g., bronze). We note that there will be differences beyond networks and benefits (e.g., out-of-network or non-EHB cost-sharing) that may need to be represented in plan variations but stress that the required number of alternate AI/AN QHP offerings should be limited. The operational cost of implementation increases with the additional numbers of plan variations, which and these additional plan variations may provide little added benefit for the enrollee given the expected similarities across QHPs.

Finally, we encourage CMS to consider the significant burden that submitting limited cost-sharing plan variations for every standard plan would have on issuers in states with very low AI/AN populations and few if any IHS or tribal facilities. We propose that in these states, states have the option to work with issuers on an alternative waiver approach to further limit the number of plan variations submitted for the AI/AN population. This would ease the administrative burden on QHP issuers where the cost-sharing reductions under the 1402(d)(2) provisions would be minimal and primarily composed of CHS referrals. For these states, it
makes little sense to require that QHP issuers develop and submit separate limited cost-sharing reduction plan variations for every standard QHP.

Payment for Cost-Sharing Reductions (§156.430)

The proposed rule sets forth the process by which QHP issuers will provide:

- An annual estimate of the dollar coverage of the CSR to be provided over the benefit year, and
- For the limited cost-sharing variations, an estimate of the per member per month dollar value of the cost sharing reductions.

The process for reconciling the AI/AN subsidies is consistent with that proposed for the silver plan CSRs, with the reporting of monthly estimates and the annual reconciliation process. However, issuers have the option to forgo estimates for limiting CSRs if the operational cost is not worth the value of the advanced payment. We support the consistent practice for reconciling AI/AN subsidies and those for silver plan CSRs, as well as the option for issuers to forgo monthly estimates at their discretion. A different approach for reconciling AI/AN subsidies would bring an unnecessary level of complexity to the process for issuers.

Additional Considerations for Limited Cost Sharing Plan Variations (§156.350(b))

Out of Pocket Accumulations - Services provided by IHS, Tribal Organizations, or through CHS referrals with zero cost-sharing should not count toward an enrollee’s out-of-pocket (OOP) maximum. Health plans do not have the operational capability to attribute what would have been the enrollee’s cost sharing amount (prior to the CSR) toward the OOP maximum. Accumulating OOP for services with zero cost sharing would require a manual process that would be resource intensive and would likely result in errors, which would create a frustrating experience for enrollees. Cost sharing amounts must be realized in order to trigger their attribution toward the OOP maximum.

Contract Health Service Referrals Program - For the AI/AN population above 300% FPL the greatest operational challenges appears to be the implementation of no cost-sharing for individuals who have referrals under the CHS program. Program eligibility is currently determined based on both medical necessity and availability of IHS appropriated funds and not made based on health insurance status. With the exception of balance billing, AI/ANs will receive services from these providers in or out of the QHP’s provider network at zero cost-sharing. In this program, for AI/ANs enrolled in a QHP through the Exchange, IHS would be a payer of last resort and thus would likely be paying out little for QHP enrollees, increasing the number of referrals that CHS would be able to make in 2014.

We would like to avoid manual processing of CHS referrals. We recommend that providers who have CHS referrals are required to include the IHS referral number on the existing HIPAA claim format under the existing referral field so health plans know upfront. Health plans would need to know the logic behind CHS referral numbers to track in their system to be able to identify such referrals as they come in and track them in their systems. If a CHS referral cannot be identified through the current structure of the referral number, we recommend a prefix or suffix (e.g., CHS) or other indicator that will allow payers plans to easily identify a CHS referral. If a health plan can determine that the referring provider is an IHS provider, the health plan will process the
claim with no member responsibility even if there is no CHS referral number. In the short term, CCIIO guidance should hold plans harmless during the CSR reconciliation process for all CHS referrals that are received for which health plans are not able to determine that the referring provider is an IHS provider with or without a CHS referral number. In the future, we ask that IHS develop an automated system for plans to use to verify referrals. Another option is for IHS to identify the insurer at the time of the referral request and alert plans in advance to expect claims when a referral has been granted.