



November 27, 2017

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Attention: **CMS-9930-P**
Submitted via <https://www.regulations.gov>

RE: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019 – Proposed Rule

Dear Ms. Verma:

The Alliance of Community Health Plans (ACHP) is pleased to comment on the proposed rule, “Patient Protection and Affordable Care Act: HHS Notice of Benefit and Payment Parameters for 2019.”

ACHP is a national organization bringing together innovative health plans and provider groups leading the nation towards a value-based health care financing and delivery system. Members are non-profit organizations or subsidiaries of non-profit health systems. They provide coverage and care for more than 19 million Americans in the commercial market and ACA marketplaces and for Medicare, Medicaid, and federal, state, and local public employees.

Part 153 – Standards Related to Reinsurance, Risk Corridors, and Risk Adjustment under the ACA

ACHP supports many of CMS’ proposed provisions related to the risk adjustment program. We are especially pleased to see the planned continuation of the methodological modifications finalized in previous rulemaking. These include incorporating preventive services in the simulation of plan liability, using granular trend rates to reflect specialty and other drug expenditure increases as accurately as possible, accounting for partial year enrollment in the adult models and including some prescription drug utilization factors in those models. We also support CMS’ plans to incorporate EDGE enrollee-level data in updates to the risk adjustment models, a step that should improve their predictive accuracy. CMS’ proposed changes to reduce burden related to data validation are also welcome.

We support increased flexibility for states and recommend that CMS extend to states the ability to adjust the risk adjustment payment transfer percentage within the individual market as CMS proposes for the small group market. We also recommend that states should be allowed to modify the payment transfer

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formula so as to improve the fairness of the risk adjustment program. Our specific concerns and recommendations follow.

Proposed Changes to the Risk Adjustment Model (§153.320)

ACHP supports the proposal to remove two severity-only classes among the ten prescription drug classes (RXC) within the risk adjustment model. Because including the severity codes in the model may incentivize prescribers to over-prescribe certain costly drugs, we recommend that CMS remove all ten of the remaining RXCs for 2019. Our members are also concerned that the RXC data isn't adequately verifiable through the RADV process as a program integrity matter, given that there is not a "paper trail" for the relevant prescriptions.

We recommend that CMS provide in the final rule more timely and detailed information on the specific drugs included within the model. Also necessary is further information on what medication records are applicable – in-office or hospital administration, home health (non-pharmacy) administration, standard pharmacy claims, and additional records.

We appreciate and support the proposed streamlining of the Risk Adjustment Data Validation ("RADV") process. However, we do not believe that auditing pharmacy data is feasible through clinical records. While clinicians are able to document diagnoses accurately in the record, there is no similar clinical documentation in pharmacy data. CMS should not incorporate data in a risk adjustment model that cannot be audited through the clinical documentation.

Risk Adjustment Payment Transfer Percentage (§153.320)

Under CMS' proposal, the statewide average premium in the risk adjustment transfer formula would be adjusted by 14 percent to account for the proportion of administrative costs that do not vary with claims, beginning for the 2019 benefit year. CMS would allow state insurance regulators to request an adjustment to this administrative percentage by up to 50 percent, but would limit this new flexibility to states' small group markets.

ACHP supports this proposal as it applies to states' small group markets and requests that CMS expand the application of the proposed adjustment process to states' individual markets. We believe that allowing higher adjustments than the federally specified 14 percent, where a state can appropriately justify it, would help mitigate the adverse impact that ACHP plans and others have experienced under the current statewide average premium methodology. That impact is especially acute in smaller or rural areas covered by a health plan, such as Geisinger Health Plan in central Pennsylvania, that does not also serve large urban populations.

Under the current statewide average premium approach, a health plan that experiences adverse selection in its own market area may nevertheless be assessed risk adjustment charges which are sent to competitors that, on a statewide basis, have higher risk scores. In some areas, the statewide average premium methodology has the effect of transferring dollars from plans in poor and rural areas to those in large, more prosperous urban areas. To address this problem, ACHP urges CMS to further broaden state flexibility with respect to the payment transfer methodology by allowing a state to establish the geographic definition for a risk pool for both the individual and small group markets. This added state flexibility would better mitigate the adverse effects of the payment transfer model in those states that deviate significantly from the national dataset that CMS uses.

At a time when evidence of the adverse effects of health disparities on populations in more rural communities continues to mount (both in terms of availability of health care and worse health outcomes, including shorter life expectancies), the required statewide average premium aspect of the risk transfer methodology warrants modification. Because we appreciate that different markets may be affected differently, ACHP believes that our recommendation to allow states to establish the geographic definition for a risk pool for its individual and small group market would be consistent with, and well suited to, the process for the state administrative percentage adjustment that CMS is now proposing. Some states may find that a market-based definition would lead to a fairer risk adjustment system; others may find that the current statewide definition provides for the fairest outcome. CMS would continue to have the final approval of states' approaches.

Part 154 – Health Insurance Issuer Rate Increases: Disclosure and Review Requirements

ACHP supports CMS' proposed change to the current effective rate review requirement whereby it would modify the current 10 percent threshold triggering review of unreasonable rate increases to a threshold increase of 15 percent or more. Also under CMS' proposed change, only those insurers subject to review because their proposed "unreasonable" rate increase is 15 percent or more would be required to submit a *Consumer Justification Narrative* for those rate filings. We believe this change is amply justified by the array of market factors that have driven up average rate increases in the individual and small group markets.

We further urge CMS to return rate review to the product as opposed to current plan level because the product level would provide for a more appropriate level of review for unreasonable rate increases. We also support CMS' proposed modification to the current rules that would require states to seek approval from the Secretary only for a higher threshold than the federal default threshold of 15 percent instead of requiring them, as is the case under current rules, to request approval for both higher and lower thresholds than the federal default.

Qualified Health Plan Minimum Certification Standards

In its 2018 Market Stabilization rule, CMS finalized its proposed change to rely on states for Qualified Health Plan (QHP) certification related to network adequacy and Essential Community Providers (ECPs). ACHP supports CMS's proposal to continue this policy. We believe that this proposal would eliminate duplicative requirements that needlessly add to plan compliance costs while maintaining the integrity of important ACA consumer safeguards.

ACHP views this proposal as striking the appropriate balance to implement the ACA's QHP certification process and requirements. Under the proposal, CMS would defer the responsibility of QHP network adequacy and ECP certification only to those states that CMS has determined have both the authority and means to conduct sufficient network adequacy reviews. In the case of states that do not have such capabilities, CMS would rely on an issuer's accreditation from an HHS-recognized accrediting entity such as the National Committee for Quality Assurance.

CMS also proposes to rely on states for QHP certification reviews in a number of other areas where the agency believes its review is duplicative. These may include accreditation requirements, compliance reviews, definition of the minimum geographic area for plans' service areas and the quality improvement strategy. Although ACHP agrees with CMS about the need to reduce duplicative federal and state certification activities, we believe that it would be more appropriate for CMS to advance such

proposed changes through notice and comment rulemaking with a fuller discussion of the rationale for each rather than implementing these changes through guidance.

Part 156 – Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges

Essential Health Benefits (EHB) – Benchmark Plan (§§156.100 – 156.115)

Changes to EHB Base Benchmark Plans. ACHP supports reasonable flexibility and new options for states and issuers to develop products that best suit the needs of the local community. Such flexibility encourages innovation, greater value and customer-oriented benefits. Importantly, new options for the benchmark plan will help states with a history of rich employer benefits to address the need for affordable premiums.

We recommend that CMS strike a careful balance between EHB changes that would allow for more flexible benefit designs and those that might undermine the gains in coverage and important consumer protections that have been achieved in the market in recent years. The choices for EHB base benchmark Plans and the floor on the value of coverage represented by the “typical employer plan” have ensured that basic services are covered in individual and small group plans to an extent available to other people within the state. At the same time, states have had flexibility in the choice of 10 base benchmark plan options. Together, these rules have made comparison shopping in the individual and small group markets easier for consumers. They also have provided for a more level playing field for insurers, meeting a core ACHP principle: encouraging competition on the basis of price and quality rather than on benefit design. Those requirements also make possible the evaluation of the actuarial value of plans, facilitate risk adjustment among them, and mitigate segmentation of risk pools.

While ACHP believes that additional benchmark plan options will help states and issuers offer affordable choices, we believe that the breadth of proposed flexibility for EHB benchmark plans raises the possibility that EHB coverage will not meet the health care needs of the population and that some issuers will take advantage of more flexible benefit definitions to use benefit design to cherry pick healthier enrollees. Without maintaining and ensuring the integrity of the ten EHB categories, there is a risk that coverage for essential services such as maternity care or mental health care will not be part of benchmark plans or be so diluted as to be meaningless. Allowing substitution across EHB categories reintroduces in the market the risk that some issuers will attempt to avoid enrollees with costly health problems through selective benefit designs.

We are also concerned about the proposal to define a “typical employer plan” as an employer plan designated by the state that is sold either in the small group or large group market in one or more states and that has at least 5,000 enrollees. Under this proposal, states could choose any single plan in either the employer market from any state – however limited the benefits – and designate it as “typical.”

In the final rule addressing state options, ACHP suggests the need for criteria or guardrails to ensure that a “typical” plan is actually representative of plans in the state. These criteria should include:

- A typical employer plan must provide for minimum value (defined in Section 36B(c)(2)(c)(ii) of the Internal Revenue Code as having no less than 60 percent actuarial value) and cover all 10 EHB categories. The minimum value threshold is used (along with other criteria) to determine if an employee who is offered such a plan is eligible for a premium tax credit for coverage through the Marketplace.

- A typical employer plan must meet an enrollment threshold *within the state*, as compared to the proposed threshold which is within one *or more* states.

ACHP also suggests the need for guardrails on the opposite end of the EHB spectrum – that is, to serve as a check on potential increases in benefits that can make plans unaffordable for many consumers. Under the option of adopting the base benchmark plan of another state, we recommend that states be limited to plans that do not cost more than the current benchmark plan in the state. Adoption of a benchmark plan that increases costs beyond the state’s current benefits could lead to unaffordable premiums, particularly if the state does not defray the cost of benefits beyond the EHB benchmark. No state does so under current regulations.

We believe that CMS should eliminate the proposed option for states to develop a new base benchmark plan without reference to plans currently offered in the market. Also, as we have suggested, CMS should adopt reasonable criteria for defining a typical employer plan beyond the number of enrollees. We encourage CMS to engage in ongoing dialogue with health plans and other stakeholders about the EHB requirements.

Flexibility for Issuers. CMS proposes to extend additional flexibilities to issuers to make substitutions of benefits that are “substantially equivalent.” Under existing rules, issuers can substitute benefits within categories of EHB at a state’s option. Under the proposed rule, CMS would allow such substitution to occur across categories of EHB as well as within categories.

Consistent with our comments about EHBs and base benchmark plans generally, ACHP believes that this proposal, if finalized, should include clearly defined criteria and careful monitoring that the states and CMS would use to ensure that health plan substitutions continue to meet the requirement that they are “substantially similar” to the EHB benchmark. Guidelines and monitoring should be designed to ensure that substitution of benefits does not result in designs that discriminate against enrollees or applicants on the basis of their health conditions or on any other basis.

Thank you for your consideration of ACHP’s recommendations. If we can answer any questions or provide additional information, please contact Howard Shapiro, Director of Public Policy, at hshapiro@achp.org.

Sincerely,



President and CEO