October 31, 2011

Donald M. Berwick, MD, MPP
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-9975-P
P.O. Box 8010
Baltimore, Maryland 21244-8010

RE: Standards Related to Reinsurance, Risk Corridors and Risk Adjustment
Response to Notice of Proposed Rulemaking
RIN 0938-AR07
File Code CMS-9975-P

Dear Dr. Berwick:

The undersigned members of the Consortium for Citizens with Disabilities (CCD) Health Task Force appreciate the opportunity to comment on the Proposed Rule for the Standards Related to Reinsurance, Risk Corridors and Risk Adjustment, published in the Federal Register on July 15, 2011. CCD is a coalition of approximately 100 national disability-related organizations working together to advocate for national public policy that ensures the self determination, independence, employment, integration and inclusion of children and adults with disabilities in all aspects of society. The CCD Health Task Force focuses on health policy from a disability perspective.

The Affordable Care Act was passed with the goal of providing access to affordable health care for all Americans. The new private insurance market rules that prohibit discrimination based on health status can only be achieved by broadening the insurance pool and covering as many Americans as possible. However, in a private market with such dramatic changes in the rules of participation, there are bound to be inequities and distortions until such a market matures. Private health plans that operate in good faith must be able to limit their exposure in instances where disproportionate costs are incurred by unexpected swings in the mix of enrollees in any given plan, or these plans will simply not survive.

From a consumer perspective, such unexpected swings in enrollee mix, often referred to as "adverse selection," is the key feature that leads to health plans continuing to find ways to discriminate based on health status. Without mechanisms to moderate the effects of adverse selection, people with disabilities, chronic conditions and high health care costs will continue to be on the receiving end of discriminatory practices in the insurance market in 2014 and beyond.

If is for this reason the Affordable Care Act included a series of protections against adverse selection including reinsurance, risk corridors, and risk adjustment. The CCD Health Task Force applauds the Centers for Medicare and Medicaid Services ("CMS") for issuing this proposed rule and for seeking ways to mitigate adverse selection and stabilize premiums. Among other things, these provisions are designed to removes financial disincentives for private health plans to cover people with disabilities and chronic conditions starting in 2014.

The proposed rule establishes three major programs, reinsurance, risk corridors, and risk adjustment, all of which are intended to spread risk appropriately. These provisions will guard against adverse selection in the individual and small group markets as insurance reforms and the state-based "Exchanges" are implemented.

- *Reinsurance:* The transitional State-based reinsurance program serves to reduce the uncertainty of insurance risk in the individual market by making payments for high-cost cases.

- *Risk Corridors:* The temporary Federally-administered risk corridor program serves to protect against uncertainty in the Exchange by limiting the extent of insurer losses (and gains).

- *Risk Adjustment:* On an ongoing basis, the state-based risk adjustment program is intended to provide adequate payment to health insurance plans that attract high-risk populations such as individuals with disabilities and chronic conditions. While the first two programs are only temporary, risk adjustment will be an ongoing policy for all non-grandfathered plans inside and outside of the Exchanges.

These are complicated programs that are very complex to design and implement appropriately. Consumer, disability, and provider organizations are not particularly well equipped to meaningfully comment on the intricacies of these risk spreading mechanisms. *But one thing is clear: These three programs are among the most important in the entire Affordable Care Act to truly reformulate the private insurance market and eliminate incentives to discriminate against individuals and small groups based on health status, claims experience, and disability status.*

Below we address more specific aspects of the proposed rule but our overall message is unwavering and well established. CMS should move forward with issuance of a final rule on reinsurance, risk corridors, and risk adjustment that affords the strongest protections possible to enrollees with disabilities, chronic conditions, and individuals with high health care costs to ensure that the prohibition against discrimination based on health status in the private insurance market is fully and effectively implemented in 2014 and beyond.

CCD's Specific Comments:

1. ***Standards for the State Notice § 153.110:*** Although the specific Federally-proposed reinsurance and risk adjustment parameters discussed in the proposed rule have not yet been set, we strongly support basing those parameters on actual high-claims cost and not

on a defined set of conditions or disabilities that are perceived to be costly. Different conditions and disabilities manifest themselves in various ways and with varying levels of severity. Blanket reinsurance and risk adjustment parameters based on a specified list of conditions or disabilities would not accurately predict cost and could perpetuate discriminatory practices. Indeed, there is no laundry list of health conditions long enough to account for every patient who might become an outlier in terms of health care costs in a given year.

Instead, high claims costs should be the primary factor considered in the reinsurance and risk adjustment parameters, particularly since payments are calculated at the end of the benefit year and outliers can be identified based on sound data. To the extent that States design their own parameters rather than relying on federal parameters, we recommend that CMS hold states to cost-based parameters and not allow condition or disability-specific parameters. We also support a requirement that States which choose not to adopt the federal parameters provide adequate public notice and a rationale for changing a federally-set risk adjustment parameter so that HHS can approve the change. Finally, we recommend including a process in which States can audit health plans to ensure accurate claim submission, in order to prevent "gaming" of the system.

2. ***Definitions of State Standards for the Transitional Reinsurance Program § 153.200 and Calculation of Reinsurance Payments § 153.230:*** CMS seeks public comment regarding alternatives to using the essential health benefits (EHB) package as the "attachment point" for application of reinsurance payments to plans that experience outlier patients. The "attachment point" is the threshold dollar amount of costs incurred by a health insurer for payment of benefits after which threshold, the costs for covered benefits are eligible for reinsurance payments. We oppose the linking of the reinsurance attachment point to health plan payments for essential benefit only. Nothing in the Affordable Care Act requires a link between reinsurance and payment for essential benefits. In fact, the essential benefits package has yet to be defined, although the Institute of Medicine recently recommended to the HHS Secretary that the EHB package be based on the typical *small* employer plan. The typical small employer plan is generally regarded as a fairly modest benefit package and, if the HHS Secretary adopts this point of view in the final rule on essential benefits, there will be a large number of benefits that are either uncovered entirely or that states will have to cover with state funds.

   In this light, limiting reinsurance payments only to those situations where insurers are covering essential benefits has the potential to significantly reduce the effectiveness of the reinsurance program. This is particularly true if high-cost, medically necessary benefits are left out of the essential benefit package. This will encourage plans to not cover such high-cost benefits and will ultimately lead to limitations in access to care. Instead, there should be flexibility in the reinsurance program to allow plans to submit all claims paid for medically necessary benefits regardless of their inclusion in the essential health benefit package.

3. ***Collection of Reinsurance Contribution Funds § 153.220:*** In terms of the collection of reinsurance funds from health plans and health insurance issuers, we support the fact that the reinsurance contribution level should be set at the federal level. Given the fact that the reinsurance program under the Affordable Care Act is temporary (i.e., from 2014 through 2016), we believe a federally-set contribution rate will be easier to administer, cause minimal inefficiency at the state level, and increase the likelihood that reinsurance programs will be fully operational at the state level by 2014. A federally-defined contribution rate will help equalize the reinsurance program across states and also ensure that some States do not underfund the reinsurance program.

   We also support allowing the States to collect more than the federally-defined rate if they feel as though the federally-defined rate is not sufficient for their population. Finally, we strongly support the view that nothing in the Affordable Care Act precludes a state from choosing to continue its reinsurance program after 2016 on a voluntary basis and the final rule should make an explicit statement to this effect.

4. ***Federally-certified Risk Adjustment Methodology § 153.320:*** We recommend that HHS establish a Federally-set risk adjustment methodology that States may modify with approval from the HHS Secretary, as opposed to allowing States to design their own methodology that would then subject to approval by HHS. This approach would create a more uniform methodology across states that would protect all beneficiaries from unequal practices in different areas of the country depending on the State in which the beneficiary resides.

5. ***Risk Corridor Standards for QHP Issuers § 153.520:*** Once again, we recommend implementing an audit process for the validation of claims for the risk corridor program. An audit will ensure correct claim submission, which will ensure that people with disabilities and chronic conditions with high-cost claims are truly protected by the risk corridor methodology.

We look forward to commenting on future proposed rulemaking, specifically the rule regarding the Federal notice of benefit and payment parameters and the rule regarding the essential health benefit package. We thank you for the opportunity to comment on this important proposed rule and encourage you to contact us to further discuss any of these issues.

For more information, please do not hesitate to contact any of the co-chairs below.

Sincerely,

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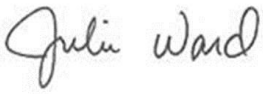

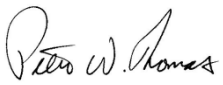

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