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Association**

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December 18, 2013

Marilyn Tavenner  
Administrator  
Centers for Medicare & Medicaid Services  
Hubert H. Humphrey Building  
200 Independence Avenue, S.W., Room 445-G  
Washington, DC 20201

***RE: CMS-9954-P Patient Protection and Affordable Care Act; Notice of Benefit and Payment Parameters for 2015; Proposed Rule (Vol. 78, No. 231, December 2, 2013)***

Dear Ms. Tavenner:

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed rule setting out the benefit and payment parameters for 2015 and revisions to other provisions implementing the *Patient Protection and Affordable Care Act* (ACA).

For decades, the AHA has supported efforts to expand the availability of affordable health care coverage for all Americans, including the current rollout of the ACA. We recognize that many of the provisions included in the above referenced proposed rule are essential to maintaining the financial viability of affordable coverage, including the three risk mitigation programs designed to stabilize the new individual health insurance marketplaces in the early years. The AHA will comment in a separate letter on the requirement for qualified health plans to ensure that the hospitals in their networks have contractual relationships with local patient safety organizations.

**The AHA takes issue with three of the proposed revisions to the three-year temporary reinsurance program – specifically the proposals to: (1) exempt certain self-funded, self-administered plans from the requirement to contribute to the reinsurance pool; (2) distribute all excess annual reinsurance pool monies to health plans at the end of each year on a pro rata basis, even if those distributions are above and beyond current attachment point and cost-sharing rules; and (3) enrich the already significant level of payout on reinsurance claims for 2014.** Our member hospitals and health systems are among the many large group health plans that must contribute to the cost of the temporary reinsurance program but receive no reinsurance benefit as a result of those contributions.



## **TEMPORARY REINSURANCE PROGRAM**

The ACA establishes three federal risk mitigation programs to help stabilize the individual QHP market beginning in 2014: the permanent risk adjustment program, the three-year temporary risk corridor program, and the three-year temporary reinsurance program. Our comments are limited to the temporary federal reinsurance program that shares financial risk beyond a claims threshold, or attachment point, with issuers in the individual marketplaces for 2014, 2015, and 2016. The temporary reinsurance program requires all group health insurance issuers or third party administrators on behalf of self-insured plans (contributing entities) to make per capita contributions to fund the program. The program is designed to reduce the degree of reinsurance protection across the three years as health plan issuers become more accustomed to setting rates under the new health insurance reforms. Under the ACA, only the issuers of qualified health plans in the individual health insurance marketplaces are eligible to receive the benefit of the reinsurance fund.

**Definition of “Contributing Entities” (Sec. 153.20).** For the last two years of the program, 2015 and 2016, CMS proposes to change the definition of “contributing entities” to exclude self-funded health plans that are self-administered, while continuing to include those self-funded plans that use third party administrators (TPAs). **The AHA strongly recommends against the adoption of the proposed exemption of self-administered, self-funded health plans.** The ACA clearly intended that all group health plans, whether fully insured or self-funded, contribute to the temporary reinsurance fund. This policy is to spread the cost of stabilizing the individual marketplace during the early years of implementing major insurance reforms where it is difficult to accurately predict claims expenses for purposes of setting premiums. There is no appreciable difference in terms of enrollee coverage or claims risk between self-funded employer plans that use TPAs to administer their benefit plans, and those that do not, and therefore, there is no sound basis for singling out one type of self-funded plan from another. To do so is inequitable to all the other self-funded health plans that will have to bear not only their own share of the cost, but potentially that of the exempted plans as well.

**Distribution of Each Year’s Fund (Sec. 153.230).** CMS proposes to revise its rules regarding the disposition of any excess monies remaining in each year’s fund. The current rules call for excess monies to be carried over to the next year’s fund. Instead, CMS now proposes to distribute excess funds each year to the issuers that file successful reinsurance claims that year through uniform payment adjustments. **The AHA recommends that CMS not adopt this revision; rather, CMS should retain the current policy that rolls excess funds over to the next year. Furthermore, any funds left over at the end of the temporary three-year reinsurance program should be redistributed back to the contributing entities that provided the funds.** These funds should not be used to provide payments to health plans beyond what is needed to ensure short term stabilization of the new marketplaces.

**Modification to the 2014 Rates and Proposed 2015 Rates.** For 2014, the per capita fee paid by contributing entities was set at \$63; in terms of reinsurance payouts, the attachment point (the point at which reinsurance begins to cover a portion of the claim) was set at \$60,000, with a reinsurance payment rate of 80 percent of claims expenses that exceed the attachment point, up to a \$250,000 payment cap per claim. The preamble discussion in the proposed rule indicates that CMS now believes its earlier estimates of covered claims costs

for 2014 is overstated and proposes to lower the 2014 attachment point to \$45,000. **Given the current enrollment uncertainty in the marketplaces, the AHA does not believe that CMS should lower the 2014 attachment point, thus ensuring that enough funding is available to pay eligible high cost claims and stabilize the markets.** If excess funding were available after all 2014 claims are paid, CMS should carry that over to 2015, as described above, and further reduce the 2015 reinsurance fee for contributing entities. The AHA believes these same rules should apply to 2015 funding for the reinsurance program.

For 2015, CMS proposes to set the per capita contribution rate at \$44 per capita; reinsurance payouts would be based on an attachment point of \$70,000, and a reinsurance payment rate of 50 percent of claims expenses beyond the attachment point up to the same payment cap of \$250,000. **The AHA and its members appreciate and support the reduction in the per capita rate that will be required of contributing entities in 2015.** Many of our members have found the 2014 contribution rate difficult to shoulder in the current payment and economic environment.

Thank you for consideration of our comments. The AHA looks forward to working with you and your staff on the further implementation of the ACA. If you have any questions, please feel free to contact me or Ellen Pryga, policy director, at (202) 626-2267 or [epryga@aha.org](mailto:epryga@aha.org).

Sincerely,

/s/

Rick Pollack  
Executive Vice President