July 7, 2014

Ms. Debbie Dombrowski
Technical Director, Medicaid Managed Care
Center for Medicaid and CHIP Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Mr. Christopher Truffer, MAAA, FSA
Actuary
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: Health Insurance Providers Fee and Medicaid Managed Care Organization Payments

Dear Ms. Dombrowski and Mr. Truffer:

On behalf of the American Academy of Actuaries'[1] Medicaid Work Group, I would like to request specific guidance on the Health Insurance Providers (HIP) fee (Section 9010) of the Affordable Care Act (ACA). The work group believes that formal guidance on this topic is needed rather than the current approach, which includes informal state-by-state discussions or a proposal submission process. With Medicaid, the unique aspect of each state program often presents challenges to uniformity for specific issues. However, the work group believes that the HIP fee is one issue that lends itself to development of uniform principles and practices, including what amounts should be federally matchable by the Centers for Medicare & Medicaid Services (CMS).

The HIP fee is due by the date specified by the Secretary of the Treasury, but no later than September 30 of each year and invoices (the actual amount each impacted entity will pay will not be known until the date the invoice is received) are sent to each entity no later than August 31 of the fee year.[2] As such, additional guidance on this issue is needed to allow time for completion of required information that is as accurate as possible. Furthermore, consultation and coordination between the Internal Revenue Service (IRS) and CMS may be desirable or required.

[1] The American Academy of Actuaries is an 18,000-member professional association whose mission is to serve the public and the U.S. actuarial profession. The Academy assists public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualifications, practice, and professionalism standards for actuaries in the United States.

[2] Internal Revenue Bulletin: REG-118315-12, Notice of Proposed Rulemaking and Notice of Public Hearing Health Insurance Providers Fee: http://www.irs.gov/Businesses/Corporations/Affordable-Care-Act-Provision-9010

The Code of Federal Regulations – 42 CFR 438.6(c) – requires that Medicaid managed care capitation rates be actuarially sound. Industry practice has determined that premium-based fees and taxes (CMS allows these fees and taxes to be included in the Medicaid managed care capitation rates, and the states receive federal matching funds as long as the taxes and fees meet certain criteria) are necessary components of actuarially sound rate development. Therefore, the HIP fee (and applicable "gross ups" or loads described below) needs to be included in Medicaid managed care capitation rates.

Some actuarial material[3] has already been developed on these topics. We request formal guidance from CMS regarding both the approval of and the federal payment matching of the following four items:

- The HIP fee;
- The gross-up component that accounts for the non-deductibility aspect of the fee for any federal (and state) income tax purposes;
- The impact of other state, county, or local taxes or assessments, such as those on revenue, which would have their amounts altered by the first two items listed above; and
- The intent of ACA Section 9010 with respect to the exclusion of long-term care, nursing home, home- and community-based services expenses for all types of Medicaid managed care programs (including, but not limited to, dual demonstrations and PACE programs), and whether CMS and the IRS have a defined and shared understanding of exactly which services may be excluded so that there is no ambiguity.

In addition, the Medicaid Work Group would like guidance on the following:

- Confirmation (and any limitations) around use of the data year or the fee year as the base for any retrospective capitation rate adjustment;
- Information on when a state will make the payment to the Managed Care Organizations (MCOs);
- Guidance on the process and criteria a state should use in paying the MCOs who had a contract in 2013, but not 2014 (this is in regards to how the HIP fee is allocated in 2014 based on revenues from 2013);
- Guidance on how the HIP fee and associated effects, such as those listed in the first two items above, should be accounted for in risk-sharing arrangements and minimum medical loss ratio calculations; and
- Information on the approaches to the HIP fee that various states may have already submitted to and received approval from CMS.

[3] One example is the recent Actuarial Standards Board exposure draft on Medicaid Managed Care Capitation Rate Development and Certification: http://www.actuarialstandardsboard.org/pdf/exposure/Medicaid_exposure%20draft_december%202013.pdf (See Section 3.2.11.d., on page 9).

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We appreciate the opportunity to provide these comments and would be happy to discuss them with you. If you have any questions or would like to discuss, please contact Tim Mahony, the Academy's state health policy analyst at 202.223.8196 or Mahony@actuary.org.

Sincerely,

Michael E. Nordstrom, MAAA, ASA
Chairperson, Medicaid Work Group
American Academy of Actuaries

Cc:/ Matt Salo, Executive Director, National Association of Medicaid Directors