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Rural Health Panel

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Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-1631-P

P.O. Box 8012

Baltimore, MD 21244-8016

By electronic submission at <http://www.regulations.gov>

RE: 42 CFR Parts 144, 146, 147, 148, et al. Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2018; Proposed Rule

To Whom It May Concern:

The Rural Policy Research Institute Health Panel (Panel) was established in 1993 to provide science-based, objective policy analysis to federal policy makers. The Panel is pleased offer comments in response to questions posed by CMS in the Proposed Rule regarding Benefit and Payment Parameters for 2018. Our comments are limited to rural-specific issues and are structured to parallel general questions posed, or issues stated, by CMS.

§ 153.20 Definition of Large Employer for Risk Adjustment and Risk Corridors

Allowing small employers to continue participating in a SHOP after an increase in the number of employees would otherwise make them ineligible is likely to be especially useful in rural communities. Opportunities to explore other options will be more restricted in rural areas because of smaller markets and therefore fewer competitive choices for employers seeking contracts with health plans on their own. Allowing them to remain in risk pools created through SHOPS will benefit rural employees and their families.

§ 153.320 Federally certified risk adjustment methodology

Prescription drug hybrid model

We support the careful approach suggested for adjustments based on prescription drug utilization and expenses. We encourage CMS to test the assumption made on page 61469 that beneficiaries in rural areas with low access to pharmacies will therefore be lower utilizers of prescription medications. Studies published by the RUPRI Center for Rural Health Policy Analysis Rural provide evidence of rural pharmacy closures resulting in less convenient access to pharmaceutical services, but not necessarily a change in fill rates of prescribed medications. Those findings are based on empirical analyses of closures where there are no other pharmacies in rural communities and none within at least 10 miles, and case studies of consequences of closure. CMS should conduct research using Medicare prescription drug data to examine patterns in medication use before and after pharmacy closure to test the hypothesis that access to the physical structure of a pharmacy has a measurable impact on utilization.

High-Cost Pooling

The Panel strongly endorses the notion that high-cost risk should be better incorporated into the risk adjustment model. The potential for high-cost outliers in small rural health insurance markets is almost certainly a factor that discourages firm participation in rural areas. Furthermore, the current methodology that transfers funds only within individual states does not adequately neutralize risk for an insurer considering offering plans in a state with a low total population or a state that has more concentrated rural poverty. We therefore favor the proposed change to encompass all states in the adjustment. We further note that while a uniform percentage is fair, this parameter may be viewed as a policy lever for encouraging firm participation in less active marketplaces. A percentage that is inversely related to the average number of firms in the state might be beneficial in this regard.

§ 156.140 Levels of coverage

The Panel agrees that changing the allowable variation for certain bronze plans, including those that qualify as HDHPs, to a range of -2 percentage points and +5 percentage points is likely to be beneficial to consumers, including those in rural areas. This section also discusses the draft 2018 AV Calculator, in reference to the proposed change, but we would like to take the opportunity to recommend some refinement of the AV Calculator in terms of geography. Currently, we understand that the actuarial value generated from the model is based upon a nationwide sample of utilization and claims. In places where costs of care are higher, the generated value will underrepresent the true expected cost of the firm of providing coverage, and we would expect premiums to rise accordingly in these places. While we assume that this is the reason geographical variation is allowed at the rating area level, we suggest that state-level adjustments within the AV Calculator might be useful in reducing the apparent geographic variation in premiums. Higher premiums (even when they are due to additional actuarial value provided) tend to discourage enrollment in HIMs.

§ 156.50 FFE User Fee for the 2018 Benefit Year

There are special challenges associated with education and outreach in rural areas due to population dispersion and limited access to broadband. Therefore as CMS considers allocating outreach investments we recommend that an increased share of those investments be made in rural areas.

§ 156.200 Qualified Health Plan Minimum Certification Standards

We support the requirement that firms offer the same levels of coverage throughout the Exchange in a state, specifically that silver and gold plans be offered throughout each rating area in which the insurer offers coverage through the Exchange, as we feel this issue described by CMS is of particular concern to consumers in rural areas. However, in conjunction with our earlier comments in this letter, we caution that this policy change, on its own, may discourage firms from offering coverage altogether in rating areas that are less populated or which have higher-than-average costs of care delivery. Adjustment to the risk calculation methodology and the AV calculations would, we believe, counteract the effect.

Furthermore, as the proposed rule mentions Multi-State plans as able to meet the new standard, we take the opportunity to ask CMS to consider additional incentives for firms that become MSPs. While originally the intent of MSPs seemed analogous to the “nationwide” plans available in the Federal Employees Health Benefits Program, their slow adoption in practice has prevented them from achieving the role of a fail-safe option in rural areas.

Essential Community Providers

The Panel supports counting multiple providers at a single location as a single ECP.

Sincerely,

The Rural Policy Research Institute Health Panel

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