October 31, 2011

Donald Berwick, MD
Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC  20201

Submitted via the Federal Regulations Web Portal http://www.regulations.gov and to OMB via mailto: OIRA_submission@omb.eop.gov

Re:  Proposed Rule for Standards Related to Reinsurance, Risk Corridors and Risk Adjustment (CMS-9975-P)

Dear Dr. Berwick:

The Blue Cross and Blue Shield Association (“BCBSA”) appreciates the opportunity to provide comments on the proposed rule for Standards Related to Reinsurance, Risk Corridors and Risk Adjustment as issued in the Federal Register on July 15, 2011.

BCBSA is a national federation of 39 independent, community-based, and locally operated Blue Cross and Blue Shield companies (“Plans”) that collectively provide healthcare coverage to more than 99 million – one in three – Americans. We believe that developing an effective risk mitigation system that is efficient and accurate is critical for mitigating adverse selection and protecting consumers from premium increases in 2014 and beyond.

BCBSA appreciates the issuance of the proposed rule for Standards Related to Reinsurance, Risk Corridors and Risk Adjustment. However, we are concerned the rule does not provide adequate detail on how HHS proposes to implement these critical programs, leaving many important components still to be determined, which will have far-reaching implications for health plans and their customers.

BCBSA believes all federal regulations underlying these programs – including those addressing essential benefits, insurance reforms, subsidies, exchanges and risk mitigation – must be issued in final form, following a proposed rulemaking process, during the first quarter of 2012 to permit adequate time for States and health plans to implement the ACA. We are now within two years of the proposed initial open enrollment period for exchanges, and major aspects of these interwoven rules have not been set out by HHS and other federal agencies. The proposed risk mitigation regulation, is missing some of the most important details – such as what methodology HHS plans to use for risk adjustment -- which makes it difficult to fully analyze. As a result, and contrary to the Administrative Procedure Act, the public will not be able to provide intelligent comments to ensure the most successful final product if all proposed rules are not released soon.
BCBSA believes that two issues are of utmost importance in designing a risk adjustment program: 1) how to collect data to implement the risk adjustment program; and 2) what methodology to use to calculate risk scores.

On the first issue, BCBSA urges HHS to adopt a distributed approach similar to the third option for data collection in the NPRM, but with a number of enhancements to prevent gaming by issuers. Our comments below detail how a distributed approach can work more easily and efficiently than a centralized approach. BCBSA strongly opposes the creation of a centralized database – at either the state or federal level – as it raises serious consumer privacy concerns, will be extremely expensive and time consuming to build and maintain, and could impede market competition by revealing sensitive and proprietary information. In addition, we believe the complexity – and associated cost – of building centralized claims repositories would be enormous. In fact, preliminary estimates from a study BCBSA commissioned to analyze the costs of creating a centralized database indicate the costs would be well over $400 million for the initial build and $150 million annually to maintain.

On the second issue, which was not addressed in the proposed rule, BCBSA urges HHS to adopt a concurrent methodology (calculating current year risk scores based on current year claims) for the risk adjustment program.

As described in the detailed recommendations that follow, BCBSA's additional priority comments on the proposed rule are as follows:

- As noted above, we strongly recommend that HHS use a distributed model for accessing risk adjustment data. BCBSA's preferred model is detailed in Attachment B (White Paper on Distributed Data Model). Our recommended model: 1) alleviates members’ privacy concerns since States will not be collecting confidential, individually identifiable health information; 2) retains issuers’ control of proprietary data that has strategic importance; and 3) allows States/HHS to maintain the same control over the process while alleviating the burden of creating, securing, maintaining and updating a large costly centralized multi-payer database.

- We urge HHS to issue the risk adjustment methodology, data collection methodology, and other critical issues as soon as possible so there is adequate opportunity for public comment. While we appreciate the recent issuance of the risk adjustment white paper on HHS options, the paper does not include HHS’ proposed methodology. We urge HHS to ensure it provides adequate time for the public to comment knowledgeably once HHS indicates how it proposes to address many of these open issues.

- BCBSA strongly recommends a robust risk adjustment methodology that is not phased-in. As noted above, we favor a concurrent methodology (calculating current year risk scores based on current year claims) using both medical and pharmacy data over a prospective methodology using only medical data as used in Medicare Parts C and D. Concurrent methodology improves risk assessment of new enrollees (and those who change carriers) whose data are not available, and recognizes that the under-65 commercial population experiences more variation in medical conditions than the Medicare population, which tends to have more chronic conditions.

- We recommend that HHS adopt a federal risk adjustment methodology based on standard premium rather than carrier-specific premium. The use of standard premium derived from market incurred claims provides equity to carriers and reduces the opportunities for carrier gaming since pricing actions will not influence risk adjustment transfers.

- For the transitional reinsurance program to provide adequate protection to carriers against medical cost overruns for individual market enrollees, each State’s pool of reinsurance funds needs to be proportionate to its market size. BCBSA recommends using a simplified flat per-enrollee reinsurance contribution fee rather than a percent of premium method and distributing fees to the States based on the size of their individual markets.
• All three risk mitigation programs interact with each other as well as with medical loss ratio reporting and rate setting (see Attachment C -- Estimated Timeline for Risk Mitigation Programs and MLR). Therefore, all programs should be considered together in the development of the settlement process timeline. We recommend that the claims data used as the basis for these programs also be consistent with one another. We suggest that incurred claims be determined as claims with service dates in the calendar year which are paid by March 31 of the following year plus any remaining claims liability.

• BCBSA recommends having a “trial run” period for the three risk mitigation programs prior to implementation. This would allow for testing of systems and processes so both issuers and the government can prepare for actual implementation.

Attached are our detailed comments and recommendations on this proposed rule to ensure the risk mitigation programs work effectively and efficiently (see Attachment A – Detailed BCBSA Comments on Risk Mitigation NPRM).

We appreciate your consideration of our comments and recommendations on the proposed rule. We look forward to continuing to work with the HHS on risk mitigation issues related to the ACA. If you have any questions, please contact Kris Haltmeyer at (202) 626-4814 or at kris.haltmeyer@bcbsa.com.

Sincerely,

Justine Handelman
Vice President, Legislative and Regulatory Policy
Blue Cross Blue Shield Association

Cc: Steve Larsen, Deputy Administrator and Director of the Center for Consumer Information and Insurance Oversight, CMS, HHS

Attachments:

Attachment A: Detailed BCBSA Comments on Risk Mitigation NPRM
Attachment B: White Paper on Distributed Data Model for Risk Adjustment
Attachment C: Estimated Timeline for Risk Mitigation Programs and MLR
ATTACHMENT A -- Detailed BCBSA Comments on NPRM on Standards Related to Reinsurance, Risk Corridors and Risk Adjustment

The Blue Cross and Blue Shield Association (BCBSA) offers the following detailed recommendations to ensure that the risk mitigation programs can effectively meet the objectives of the ACA while assuring that they are efficient and not administratively burdensome.

GENERAL COMMENTS ON THE NEED FOR FULL NOTICE-AND-COMMENT RULEMAKING

On several important questions discussed below, major aspects of the rules, and the details of how they are expected to operate, have not been set out by the agency. Instead, the Notice of Proposed Rulemaking states that crucial details and regulations will be proposed later, e.g., 76 Fed. Reg 41930, 41933 (July 15, 2011) (“the public will have an opportunity to comment” upon “forthcoming annual Federal notice of benefit and payment parameters”). This segregation of rulemakings on highly interrelated subjects prevents us, as well as other stakeholders, from being able to comment fully and intelligently on the current proposal. We are concerned that this will keep us and others from providing the Administration with all the feedback needed for the informed decision making most likely to result in good outcomes as the process is finalized.

While HHS recently issued a draft white paper on “Risk Adjustment Implementation Issues” to provide some additional details, the white paper merely “describes potential approaches to calculate payments and charges, and explores permissible rating variation” rather than stating what approach the Administration will take and seeking comment on that approach.

Given the interwoven nature of the reforms, the public must be given the opportunity to comment intelligently and fully on the entire range of interrelated policies and on how they interrelate before they become final and effective. Otherwise, the public will have been deprived of the notice and opportunity to participate in the rulemaking process that is guaranteed by the rulemaking provision of the Administrative Procedure Act, 5 U.S.C. § 553.

NOTICE OF INSURANCE BENEFITS AND PAYMENT PARAMETERS

State Annual Notice of Benefits and Payment Parameters – 45 C.F.R. § 153.100

Issue:
The proposed rule requires that a State operating an exchange or establishing a reinsurance program issue an annual notice to disseminate information to stakeholders describing specific parameters that the State will employ that differ from parameters specified in annual Federal notice of benefit and payment. The rule provides a schedule for the forthcoming annual Federal notice of benefit and payment parameters for 2014 and subsequent years.

Recommendation:
HHS’ process for issuing rules through an annual notice procedure should comply with the notice-and-comment requirements of the Administrative Procedure Act. This process should ensure that all information necessary to prepare estimated health plan risk scores be available in time to submit rate filings to States for approval, a process that can take more than a year in some states today. Therefore, the annual notices should be issued in the summer of 2012 (at the latest) to have products and rates approved and on exchanges for the October 2013 open enrollment.

Rationale:
Please see our “General Comments On The Need For Full Notice-And-Comment Rulemaking” in the section above. (For the sake of brevity, we will no longer repeat this point throughout these
comments but state that they should be deemed implicit in all our comments below.) Also, the timeline specified does not appear to provide sufficient time for the industry to prepare for 2014. The timeline is unlikely to be sufficient for subsequent years, as changes to the risk adjustment program would be provided after some plans have filed rates.

**TRANSITIONAL REINSURANCE**

**Use of Essential Benefits to Calculate Reinsurance Payments – 45 C.F.R. § 153.200**

**Issue:**
The proposed rule indicates that reinsurance payments will be calculated based on claims cost to cover the essential health benefits package only, in order to ensure payments are made on a comparable set of benefits.

**Recommendation:**
Reinsurance payments should be calculated based on essential health benefits package only.

**Rationale:**
BCBSA acknowledges that there will likely be some administrative complexity to limiting the reinsurance payments to claims for only essential health benefits, but believes that it is the most equitable method. If reinsurance payments are calculated based on any benefit design above those required by federal law, payments would be skewed toward very rich product designs. Moreover, claims for experimental procedures should be excluded, as these procedures have not been proven to be safe or effective and can be expensive.

**State Establishment of a Reinsurance Program – 45 C.F.R. § 153.210**

**Issue:**
The proposed rule requires that each State electing to operate an exchange establish a reinsurance program for years 2014 – 2016. States must either enter into a contract with an existing reinsurance entity or establish an entity to carry out the provision of the reinsurance program. If there is more than one entity, the State must ensure that each operates in a distinct geographic area and publish the boundaries in a State notice. If the reinsurance entity operates programs for more than one State, that entity must maintain separate risk pools for each State’s reinsurance program.

**Recommendation:**
BCBSA supports the establishment of reinsurance programs by the states and if a State opts-out, the establishment of a reinsurance program for that State by HHS. We support State-based reinsurance pools with the recommendation that state be defined, for individual and employer business, as the state in which the policy is issued. We suggest the rule clarify the treatment of association and trust business as follows: For association policies, the State should be defined as the state in which the certificate is issued to the member. For group trust or multiple employers’ welfare association, it would be the State where the employer or association has its principal place of business.

**Rationale:**
Since reinsurance provides protection to issuers that cover high-cost individuals and stabilizes market premiums, it is important that a reinsurance program is in place when a State elects not to implement a reinsurance program. The above definition of State, including association and trust businesses, is consistent with the definition in the medical loss ratio regulation.
Collection of Reinsurance Contribution Funds – 45 C.F.R. § 153.220

**Issue:**
The proposed rule requires that contribution funds be collected by the reinsurance entity from all health insurance issuers and from third party administrators on behalf of self-insured plans. The aggregate contribution funds would be returned to issuers that qualify for the transitional reinsurance program. The proposed rule recommends the use of a national contribution rate set by HHS (instead of a state-level allocation method) and a percent of premium method (instead of a flat per capita amount) to collect contributions.

**Recommendation:**
Since the objective of the reinsurance program is to ensure each state has a viable individual market, and in order for the reinsurance funds to be made available to each state on the same basis and be equitable across states, we recommend redistributing collected contribution funds to each state and making the redistribution proportional to the size of the State's individual market.

Following the above recommendation, BCBSA recommends that HHS use a flat per-enrollee fee as the basis for reinsurance contributions rather than a percent of premium method. We recommend building the system for collecting reinsurance funds off the comparative effectiveness fee reporting process to make the flat-fee approach even more efficient. The U.S. Treasury will already be collecting enrollee counts across the country under the comparative effectiveness program. A national flat-fee could be determined from the total enrollment included in these reports. States could collect the fees from the health insurance issuers and self-insured plans and remit to the U.S. Treasury.

If a percent of premium is ultimately the favored approach for collecting reinsurance fees, then the definition for the self-insured market should be a percentage of the sum of medical claims (net of specific stop-loss recoveries), stop-loss premium, and administration expenses to be on the same basis as fully insured coverage. Otherwise, the different bases for fees collected could incent smaller employers to self-insure without recognizing all the risks involved.

The ACA directs TPAs on behalf of group health plans to make payments to applicable reinsurance entities. BCBSA recommends that the final rule clarify that self-funded groups, and not their TPAs, are ultimately responsible for the required reinsurance contribution. It should be explicitly expressed in the rule that the TPA is merely the conduit for collection of such payments.

Throughout this document, our recommendations regarding the state definition assume funds will be reallocated across states for the reinsurance program.

**Rationale:**
A flat per-enrollee approach is simpler to administer and is not influenced by all the factors in premium calculations, such as breadth of benefits, cost-sharing provisions, provider arrangements (HMO/PPO/POS), regional medical cost variations, or ages of enrollees. In order for the transitional reinsurance program to offer adequate protection to health insurance issuers against medical cost overruns for high-cost enrollees in the individual market, each State's pool of reinsurance funds needs to be proportionate to its projected market size. A national flat per-enrollee approach will allow the allocation of funds to be proportionate to each state's individual market. The use of a percent of premium approach collected only within each State separately can result in disproportionate funding with states that have a bigger employer market (based on companies headquartered in the State) collecting more funds to distribute to a smaller individual market base and likewise, states with a less robust employer market collecting fewer funds to support a larger individual market.
Calculation of Reinsurance Payments – 45 C.F.R. § 153.230

**Issue:**
The proposed rule recommends using medical cost experience only to identify eligible enrollees for whom health insurance issuers would receive reinsurance reimbursement. Payment will only be made for coverage of items and services within the essential health benefits for an individual enrollee that exceeds an attachment point. The reinsurance payment amount is to be a percentage of costs above an attachment point and below a reinsurance cap. The proposed rule recommends allowing states that run a reinsurance program to establish their own formula by varying the attachment point, coinsurance rate, and reinsurance cap.

**Recommendation:**
BCBSA understands the rationale for basing reinsurance eligibility on medical cost experience only, given that this is a temporary program. We support a uniform eligibility basis for this program across the states; however, we recommend that HHS provide flexibility for states to use supplemental reinsurance programs that are condition-based. For cost-based programs, we support the recommended approach for calculating reinsurance payments, using a percentage of medical costs above an attachment point and below a reinsurance cap. A method for determining medical cost amounts is needed for staff model HMOs, as providers may not bill for all services. Modeling may be needed to determine how best to set the attachment points each year to recognize that reinsurance funds will decrease each year and the likely growing individual market. We also support allowing states the flexibility to establish its own payment formula.

**Rationale:**
The purpose of the reinsurance program is to mitigate the risk attributed to individuals with pre-existing conditions entering the individual market on a guaranteed issue basis, with few benefit limitations, and no health-status rating adjustments. Mitigating this risk should help to stabilize the individual market during the initial transition to these reforms.

We believe these types of programs are most effective when targeted to those with pre-existing conditions. Given that this is a three-year program, we understand the appeal of the administrative simplicity gained from basing eligibility only on medical costs. However, states should also be permitted to create additional targeted, condition-based reinsurance programs. A longer reinsurance program may be needed to stabilize states’ individual markets beyond the program included in the ACA.

BCBSA supports payment for costs incurred above an attachment point rather than a fixed payment schedule for specific conditions. The fixed payment approach tends to over-compensate for enrollees with low claims and under-compensate for those with high claims, similar to risk adjustment scoring. The reinsurance program should not exacerbate the weakness of the related risk adjustment program, but instead offset it. The flexibility for each State to establish its own payment formula enables it to better target the total pool of reinsurance funds available.

Disbursement of Reinsurance Payments – 45 C.F.R. § 153.240

**Issue:**
The proposed rule recommends that states ensure that the reinsurance entity collects data required to calculate reinsurance payments from health insurers using a standard collection method. Reinsurance payments must not exceed reinsurance contributions and states may reduce payments on a pro-rata basis to match the amount of contributions received that year. The reinsurance entity is to make payment only after receiving valid claims. The proposed rule requires that states maintain records related to the reinsurance program for 10 years, consistent with requirements for record retention under the False Claims Act.
**Recommendation:**
Since reinsurance payments are for claims accumulated throughout a calendar year, the data needs to coincide with an accumulated (year to date) claim. Claims should include allowed and paid charges for each service date and provider. Eligible claims should be incurred (i.e., have service dates) within the calendar year and paid by March 31 of the following year. This run-out period is consistent with the medical loss ratio run-out period. Issuers should submit claims by April 30 with payments by June 1.

There may be a conflict between the second reinsurance policy goal identified in the proposed rule (early and prompt payment of reinsurance funds during the benefit year) and a limited pool of funds to distribute. If reinsurance payments are paid as claims are submitted, reinsurance funds could be exhausted before year-end. Therefore, we recommend that health insurance issuers submit claims as they reach the attachment point throughout the year. The reinsurance entity would pay health insurance issuers at 75% of the eligible amount. When all claims are processed, if the full amount of funds is not available, the remaining 25% of the claims would be prorated and paid to the insurers.

**Rationale:**
Having the reinsurance entity pay 75% of eligible claims when received and prorating the remaining 25% after all claims are processed allows for prompt payment of reinsurance funds during the benefit year while managing the overall distribution of a limited pool of funds.

**Coordination with High-Risk Pools – 45 C.F.R. § 153.250**

**Issue:**
The State shall eliminate or modify any State high-risk pool to the extent necessary to carry out the reinsurance program. The State may coordinate the State high-risk pool with the reinsurance program to the extent it conforms to the provisions of the reinsurance program.

**Recommendation:**
We recommend that if a state high-risk pool continues after January 1, 2014, it should be considered a reinsurance eligible health insurance issuer for the purpose of receiving payments under this program.

HHS should also consider the implications of the phase-out of state high-risk pools in addition to the Pre-existing Condition Insurance Program (PCIP). Procedures for transferring high-risk pool enrollees to exchanges should allow PCIP and state high-risk pools to continue until 2016, providing participants with an option to shop for coverage on individual exchanges until 2016. HHS should evaluate mechanisms to ensure that a distribution of enrollees is balanced among health plans on exchanges, e.g., by requiring participants to purchase through the shopping portal or looking at random assignment if people do not transition voluntarily.

**Rationale:**
Since the goal of reinsurance is to provide protection to issuers covering high-cost individuals and to stabilize market premiums, and since high-cost individuals would most likely enter the individual market in the absence of a state high-risk pool, it seems reasonable that the state high-risk pool be considered a reinsurance eligible health insurance issuer.

If a State high-risk pool is considered a reinsurance eligible health insurance issuer and therefore eligible for reinsurance payments, then the high-risk pool must also make required contributions to reinsurance funding. Additionally, the high-risk pool must offer coverage that meets the requirements applicable to traditional health insurance (e.g. guaranteed issue, 3:1 age band, 1:1.5 tobacco, etc.).
In 2014, many high-risk pool enrollees will be eligible for expanded coverage and subsidies by purchasing coverage on health insurance exchanges. However, there is also a need to ensure a balanced risk pool on exchanges at initial implementation to help ensure their success. Experience with earlier state purchasing cooperatives indicates that health plans with comprehensive benefits and broad networks are likely to suffer from adverse selection. This is a particular risk when exchanges are first established because, in addition to the transition of PCIP enrollees to an exchange, states are required to modify or eliminate high-risk pools. To balance these competing priorities, states and PCIP should be allowed to transition people to the reformed individual health insurance marketplace in exchanges on a gradual basis by making this an option.

According to the data posted September 16th on CCIIO’s website, 30,395 people are enrolled and have coverage in effect in the PCIP program as of July 31, 2011 and the enrollment varies by state, ranging from 1 in Massachusetts to 3,762 in Pennsylvania [http://www.healthcare.gov/news/factsheets/2011/09/pcip09162011a.html](http://www.healthcare.gov/news/factsheets/2011/09/pcip09162011a.html). Steps should be taken to ensure that there is a balanced distribution of risk among issuers on exchanges given that risk mitigation programs may not completely adjust for the risk of these participants in 2014. These steps might include passing people through the shopping portal of an exchange and then randomly assigning those who do not enroll voluntarily.

Moreover, the transition from risk pool coverage should be synchronized with the ACA’s risk mitigation programs. The initial influx of high-risk members into exchange and non-exchange pools will cause highly volatile, unpredictable large loss scenarios for some, if not all, health plans and therefore should be included in the risk adjustment modeling. While BCBSA strongly recommends a concurrent approach to risk adjustment which will address many of the concerns with this transition in 2014, if a prospective system is created, then it is critical that information be transferred to ensure that high risk enrollees can be tracked in 2014.

**Reinsurance Contribution Funds – 45 C.F.R. § 153.400**

**Issue:**
The proposed rule requires that all contributing entities make contributions, in a manner and frequency to be determined by HHS, to the applicable state reinsurance entity. If a State has more than one applicable reinsurance entity, the contributing entity must contribute an appropriate payment to each applicable reinsurance entity according to the formula established by the State. Each contributing entity will be required to provide data necessary for the applicable reinsurance entity to calculate the amounts due from the contributing entity.

**Recommendation:**
BCBSA recommends quarterly data reporting from contributing entities. The reinsurance program should build off the comparative effectiveness fee structure. The reinsurance fees should be collected from both carriers and sponsors of self-funded plans via the state reinsurance entities to the U.S. Treasury, which should allocate the funds back to the states based on the projected size of each State’s individual market.

**Rationale:**
In order for the transitional reinsurance program to offer adequate protection to health insurance issuers against medical cost overruns for high-cost enrollees in the individual market, each State’s pool of reinsurance funds needs to be proportionate to its market size. A national flat per-enrollee approach is simpler to administer and will allow the allocation of funds to be proportionate to the State’s projected individual market. Building off the comparative effectiveness program will be efficient, as the U.S. Treasury will already be collecting enrollee counts across the country for the comparative effectiveness fees reporting.
Request for Reinsurance Payment– 45 C.F.R. § 153.410

**Issue:**
Health insurance issuers must submit a request for reinsurance payments to the reinsurance entity according to the method to be specified by the State or in the annual federal notice.

**Recommendation:**
BCBSA recommends that health insurance issuers be allowed to submit a request for reinsurance payment whenever an individual claim causes a beneficiary’s accumulated claims costs for the plan year to exceed the attachment point and that health insurance issuers be permitted to submit subsequent adjustments as the claim fully develops.

**Rationale:**
High-cost claims can occur throughout a calendar year. It can take many months for all the medical services to be provided, to receive all the medical bills, and to adjudicate the claim. By permitting an issuer to submit a request for reinsurance payment whenever the accumulated claim exceeds an attachment point, reinsurance payments will be better synchronized with the underlying claims payments.

RISK ADJUSTMENT

Risk Pool Aggregation at the State Level – 45 C.F.R. § 153.300

**Issue:**
The proposed rule interprets the ACA’s requirement for states to assess risk adjustment charges and provide risk adjustment payments based on plans’ actuarial risk compared to a state average, to mean risk pools must be aggregated at the State level, even if the State decides to utilize a regional exchange.

**Recommendation:**
BCBSA agrees that risk adjustment pools should be within states (defined as the state in which the policy is issued for employer business, the state in which the certificate is issued to the member for association business or the state where the employer or association has its principal places of business for group trust or multiple employers welfare association business), and should be split into individual and small group pools unless the State has combined the individual and small group for risk pooling. Results will be needed separately for the individual and small group markets to coordinate with risk corridors and MLR reporting.

**Rationale:**
Limiting the risk pool aggregation to the state level ensures that residents of a State are not subsidizing another State’s costs. Thus, a State’s premium levels will reflect the actual costs within the State. Similarly, individual and small group business will not subsidize each other if the risk adjustment pools are kept separate.

Risk Adjustment Program Eligibility – 45 C.F.R. § 153.310

**Issue:**
The proposed rule ties eligibility to establish a risk adjustment program to a States’ decision to establish an exchange. States that establish exchanges are eligible to establish a risk adjustment program, but states that do not establish an exchange are not. States may select an entity other than the exchange to administer its risk adjustment program, so long as it meets the requirements for eligibility to serve as an exchange.
**Recommendation:**
BCBSA recommends that an entity with expertise in risk adjustment (e.g., a risk adjustment vendor) should be eligible to administer state risk adjustment programs, regardless of whether a State has implemented an exchange. Eligibility to carry out risk adjustment activities should be based on an entities’ expertise and not on whether it meets the requirement to serve as an exchange.

**Rationale:**
Risk adjustment requires specific technical knowledge and expertise which may not necessarily be present in exchange entities. Moreover, risk adjustment applies across the individual and small employer markets, not just within an exchange. A State may have capacity to implement risk adjustment even if it decides that it cannot implement an exchange in time for open enrollment for 2014. HHS has not provided sufficient justification for the linkage between establishing exchanges and establishing risk adjustment programs in the proposed rule.

**Federally Certified Risk Adjustment Methodology – 45 C.F.R. § 153.320**

**Issue:**
The proposed rule requires that HHS develop and authorize a Federally certified risk adjustment methodology that may utilize criteria and methods similar to those used under Medicare Part C or D. However, the rule does not specify what methodology HHS will use. The rule allows a State to submit an alternative risk adjustment methodology that may become a Federally certified risk adjustment methodology through HHS certification.

**Recommendation:**
BCBSA recommends a national risk adjustment model with standardized characteristics and some state flexibility to account for unique market factors. This national model should use a concurrent risk adjustment approach that uses both medical (diagnosis codes) and pharmacy data for enrollees with data above a threshold number of months. For enrollees with data below a threshold number of months, standard risk factors should be assigned based on demographics, metal plans and geographic areas.

Data elements used for the development of risk scores should be standardized nationally, using medical and pharmacy data that includes diagnoses, demographics, eligibility for cost-sharing subsidies and geographic area. As detailed in subsequent comments on the issuer data submission requirements in 45 C.F.R. § 153.610, BCBSA recommends that HHS specify three months of run-out for claims. States should be allowed to develop and use risk score methodologies that meet the national standards and consider all required variables. BCBSA recommends a robust risk adjustment methodology that is not phased-in. BCBSA also strongly encourages HHS to provide a full and useful opportunity to comment on the proposed federal risk adjustment methodology.

**Rationale:**
While the proposed rule does not specify the federal risk adjustment methodology, we strongly favor a concurrent method (calculating current year risk scores based on current year claims) over the prospective methodology used in Medicare Part C and D. BCBSA recommends a concurrent risk adjustment method over a prospective method for the following reasons:

1) Large numbers of previously uninsured new entrants coming into the insurance market in 2014 will not have prior year claims data from which to calculate a risk score.

2) People who were insured in 2013 may not have the essential benefit package in 2013, so risk scores based on 2013 data will not reflect the anticipated 2014 experience under essential benefits.
3) Lack of accurate risk score on new entrants may lead to selection by insurers.

4) Data concerns: getting accurate risk scores on people who have been covered by another carrier in the previous year, possibly from different rating areas/states where risk scores are not directly comparable to new health plan rating area.

5) Expected high turnover (migration between carriers) from year-to-year and migration between Medicaid, individual and group markets.

6) Concerns about prospective model accuracy for younger age populations since prospective models (e.g. CMS-HCC) focus on chronic health problems (of an older population) vs. acute.

BCBSA is concerned about a phase-in of risk adjustment due to the expected impact of all the insurance market reforms and new entrants occurring in 2014. If a robust risk adjustment methodology is not in place for 2014, carriers may structure plans to only attract the better risks, circumventing the intent of the ACA. In addition, carriers will not be willing to absorb the participants of the high-risk pools if adequate risk adjustment is not in place. We believe that a concurrent approach with a three-month run out for claims will be more accurate than a prospective approach with a 6 month run out.

BCBSA strongly urges HHS to adopt a concurrent approach as noted above. However, if prospective is a favored approach from the administration’s viewpoint, a phase-in to prospective using concurrent for the first several years and then moving to prospective may alleviate the concern of large numbers of members without risk scores in 2014. However, significant concerns would remain about the scoring of members who were with other carriers the previous year, especially for those moving between areas.

Allowing state flexibility, provided the basic federal risk adjustment standards are met, will maintain consistency across states, while accounting for unique market factors.

Interaction with Medicaid and CHIP under Federally Certified Risk Adjustment Methodology – 45 C.F.R. § 153.320

Issue:
The proposed rule is silent with regard to the potential treatment of Medicaid and CHIP eligible-individuals who are allowed to purchase coverage on exchanges. We are concerned that states are being advised to combine their Medicaid and CHIP populations into a single exchange and risk adjustment system, even though the ACA applies risk adjustment to the individual and small group markets only.

Recommendation:
HHS should require states to comply with the ACA which establishes a risk adjustment system for the individual and small group markets. Implementing regulations should ensure there is a firewall between Medicaid and CHIP populations and risk mitigation systems for private coverage in order to avoid transfers of private premium to state programs and assure affordability for consumers.

Rationale:
The ACA clearly specifies the scope of the risk adjustment program only applies to policies purchased in the individual and small group markets. We are concerned that if Medicaid and CHIP populations are included, risk adjustment payments to issuers under those programs would amount to a subsidy of public programs by private purchasers. Some have also suggested that state Medicaid and CHIP programs wrap around coverage offered on exchanges to ensure the same benefits and cost-sharing available under these state programs, which could create induced utilization and increase the potential for such transfers.
Medicaid and CHIP programs operate very differently than QHPs will and serve a separate set of enrollees who tend to be higher risk due to the ability to “spend down” to become eligible for those public programs. Adding these individuals to the risk adjustment program may be a deterrent to health plan participation on an exchange and could result in higher premiums for private plans.

It is unclear how risk adjustment payments to Medicaid managed care plans would be treated for determining the federal match. States would be incentivized to game the Medicaid and CHIP federal partnership by seeking CMS matching funds for payments made to a Medicaid plan from charges on low-risk QHPs rather than state funding sources.

Additionally, inherent differences between these two programs need to be addressed. For example, there are benefits differences between Medicaid and ACA essential benefits, risk profile differences between Medicaid and commercial enrollees, and rating rules between Medicaid and the individual and small group markets. We are also concerned that efforts devoted to resolving these fundamental differences would diminish the limited resources available for implementing the program for commercial population.

**Allowed Variation in Rating – 45 C.F.R. § 153.320**

**Issue:**
The proposed rule recommends that the risk adjustment methodology describe any adjustment made to the risk adjustment model weights when calculating average actuarial risk, including premium rating variation. The Preamble clarifies that variation in rating needs to be accounted for so that risk adjustment does not adjust for the actuarial risk that issuers have already incorporated into their premium rates.

**Recommendation:**
Risk adjustment should account for factors that could contribute to selection risk between carriers. BCBSA agrees that the risk adjustment methodology needs to recognize the extent of the allowed rating variation for age, area, tobacco use and family status. To accomplish this, the following variables should be included in risk adjustment:

- **Age/Gender/Health condition** – Risk scores should duplicate the claim cost slope expected by age and gender with variances by individual to account for health conditions. Age can be included as a rating variable but is limited at most to a 3:1 spread. The risk adjustment methodology needs to account for the restricted ability to rate age. Since gender and health condition are not allowed rating variables, they should be reflected in the risk score.

- **Family Size** – If limitations are imposed on insurers’ ability to rate for family size, then risk adjustment needs to account for the risk of larger families selecting a particular insurer. This can become a complex technical algorithm due to the need for a risk score for each family member and then adjustments needed for family rating limits. Also, insurers may have different family rating structures, which can make the calculation more complex. HHS appears to be considering inclusion of tax dependents (which could include individuals not traditionally covered under family contracts) on family policies, which could complicate these adjustments further. BCBSA has recommended a member level build-up of rates in the NPRM on establishment of exchanges that was also issued in the Federal Register on July 15th, which we believe would be more consistent with the rating requirements of the ACA and rules for risk adjustment. If member level build-up of rates on the exchange is allowed, then family size will not be a factor that needs to be accounted for in risk adjustment.

- **Low-Income status** – Risk scores also should reflect low-income status, because it captures higher utilization due to cost-sharing limits and other differences, such as medication adherence, that diagnosis alone will not pick up. BCBSA recommends using the level of cost-
sharing subsidies as a proxy for income in the small group market. Individual and small group risk adjustment methodologies should be consistent. Although the individual market will be collecting income information, the small group market will not have this information readily available.

- **Area** – If States impose rating restrictions by area or define area as being larger than counties, then the risk adjustment methodology needs to reflect that premium rates may not align with underlying expected costs.

- **Tobacco** – With diagnosis-based risk scores, tobacco users with tobacco-related conditions will have higher risk scores. Tobacco use data should be collected, in states that allow tobacco usage in rating, on a standardized enrollment form. Since this is a self-reported rating variable, tobacco use will likely be under-reported. Methods should be developed to verify the smoking status to ensure appropriate premiums are collected and the data is available for risk adjustment. The addition of the tobacco indicator for the development of risk scores may also be reviewed to determine if the accuracy of the scoring is improved. The risk adjustment methodology should reflect the rate-up allowed by the ACA (1.5:1) for tobacco. This may vary by state since states may not allow tobacco use as a rating factor or may mandate a lower premium spread than 1.5:1.

- **Employee Choice** – Exchanges and small groups using an employee choice approach for selecting coverage will have more selection impact than small groups where the employer chooses the insurer and benefit package. This should be reviewed as a possible risk score adjustment factor. Two options may be considered: 1) insurers can incorporate risk selection from employee choice into their small group rates, and therefore not include it in risk adjustment; or 2) a selection factor can be applied to these small groups within the risk adjustment methodology.

- **Other Relevant Variables** – Other variables that may be important for risk adjustment but not allowed as a rating variable should be included.

The following variables should **not** be included in risk adjustment:

- **Acute Conditions/Accidents** – Risk scores generally should not reflect the impact of acute conditions and accidents that are not subject to selection risk. However, conditions such as high-risk pregnancy/neonatal and other acute conditions where selection risk is present should be accounted for in risk adjustment. The definition of “acute conditions to be excluded” needs to be carefully considered.

- **Medical Management** - Claims cost and utilization data should not be used in the development of risk scores. Risk scores should be based on diagnoses and other factors outlined above. Thus, to the extent carriers can reduce utilization for a given diagnosis they will not be penalized.

**Rationale:**

In order to ensure that carriers compete on quality and efficiency rather than by selecting the best risk, the risk adjustment system needs to reflect all components that affect the cost of members and also contribute to selection risk. The risk adjustment methodology needs to recognize the extent of the allowed rating variation for age, area, tobacco use and family status so that the allowed rating variation is preserved after risk adjustment.

**Valuing Risk Adjustment Payments and Charges – 45 C.F.R. § 153.320**

**Issue:**
The ACA does not specify the method by which states are expected to determine the precise value of risk adjustment payments and charges. HHS identifies two methods that may achieve the goals of
mitigating financial impact of adverse selection on risk adjustment covered plans while also limiting overall issuer uncertainty:

1) A plan’s average actuarial risk would be multiplied by the State’s average normalized premium. (To get the normalized premium, a plan’s premium would be divided by its actuarial value, a necessary step because plan premiums reflect differences in benefits and administration, including actuarial value.) States then would use these normalized average premiums as the basis for the state normalized average premiums, weighted by enrollee months, for all plans in a specific risk pool. The state normalized average premium represents the premium that would be used in the risk adjustment charges and payments calculation. The next step would be to calculate the amount by which a plan’s average actuarial risk deviates from the state average actuarial risk. This deviation in actuarial risk would be multiplied by the state normalized average premium, the plan’s enrollee months, and the plan’s actuarial value.

2) Under an alternative methodology, the plan’s average actuarial risk would be multiplied by the plan-specific premium, which then would be used as the basis for calculating the gross plan charges and gross plan payments. To determine the gross plan charges and total plan payments that would be collected from or disbursed to health plans through risk adjustment, the deviation in actuarial risk would be multiplied by the aggregated plan premiums.

Recommendation:
Our preferred risk adjustment method includes standard premium relativity factors, concurrent risk scores and risk score adjustment factors. The standard premium relativity factors represent the allowed rating variables with any limits set by the State or the ACA. The risk score adjustment factors are applied to the risk scores for the variation in expected claims cost due to benefit level (including induced utilization) and area.

Our preferred risk adjustment method divides a carrier’s adjusted risk scores by the standard premium relativity factors to determine the residual risk (i.e., the remaining risk that cannot be accounted for in the premium rates). The residual risk is multiplied by a standard premium (determined based on the standard premium relativity factors and market average incurred claims loaded for claims adjudication expense).

The standard premium is based on actual market average incurred claims per member per month (PMPM) for each risk pool. Incurred medical cost would be defined as the sum of claims incurred during the risk adjustment experience year and paid through March 31 of the following year, and unpaid claims reserves associated with claims incurred during the risk adjustment experience year. This is consistent with the definition used in the MLR calculation. The incurred claims for each risk pool would be divided by the enrollee months to determine the market average incurred claims PMPM. An average administrative load would be applied to add provision for claim expenses.

In the calculation by plan, the plan’s residual risk is multiplied by enrollee months, the loaded market average incurred claim PMPM and the plan’s standard premium relativity which reflects the plan’s actuarial value, induced utilization (if allowed in pricing), age distribution, tobacco use, family composition, and area distribution. This is similar to the state average normalized premium method described in the Preamble with the exception of the use of market average incurred claims instead of state average normalized premium and reflecting induced utilization (if allowed in pricing), age, family composition, and area in the standard premium relativity in addition to actuarial value.

The use of market average incurred claims instead of state average normalized premium interacts with the results of the temporary risk corridor program. For example, the use of actual market incurred claims may increase risk corridor payments to issuers who under-price and are risk
adjustment payers, but may reduce risk corridor payments to issuers who under-price and are risk adjustment receivers.

**Illustrative Method to Calculate Factors and Risk Scores**

1) Calculate a risk score for each member in the experience year based on demographic data and reported diagnoses. For members without enough claims experience to calculate a risk score, a default age/gender factor would be assigned. The carriers would be responsible for formatting their data and running the data through the risk score calculation software.

2) Risk scores and exposure months are reported by rating cell (age, tobacco, metal level, area, and family tiers if mandated).

3) Risk adjustment entity calculates standard premium relativity factors by age from aggregate risk scores reported for the risk pool statewide. The factors need to be adjusted to meet the 3:1 age-ratio requirement using total market data.

4) The standard premium calculation needs to reflect limitations on rating dependents based on family tiers. Risk scores should be calculated for each member, but the residual risk calculation will compare the risk scores to the standard premium that can be charged under the allowed family tiers.

5) Risk adjustment entity calculates standard premium relativity factors and risk score adjustment factors for metal level, which are based on the cost difference between the value of benefits and the value of induced utilization. If pricing is not allowed to reflect induced utilization, the standard premium relativity factors should be based on the cost difference between benefit values only, but the risk score adjustment factors will include both the benefit value cost difference and induced utilization. The value of induced utilization may be available from consulting firms or estimated using an average of carrier-submitted induced utilization assumptions.

6) If rating limitations are imposed on carriers for area, the standard premium relativity factors and risk score adjustment factors for area will vary reflecting the difference between expected claims cost and the allowable rating amount. Standard area adjustments could be developed by consultants. The use of average carrier area factors may not be appropriate due to differing discounts by area among carriers.

7) The standard premium relativity factor for tobacco could be set at the maximum 50% load (or state-mandated load if less) or could be based on the expected cost differential for smokers and non-smokers as determined by a consulting group.

8) Carriers report an aggregate incurred claim PMPM for use in calculating the transfer payments. The incurred claim PMPM should include only essential benefits and state mandates (if included by the State in risk adjustment) and should exclude cost-share subsidies. A load for carriers’ claims adjudication expenses is needed, which may be a flat percentage determined by the risk adjustment entity.

9) Risk adjustment entity normalizes standard premium relativity factors for all variables (age, metal, area, tobacco) based on aggregate carrier-reported exposure by rating cell so that the standard premium relativity factors weight to 1.0.

10) Risk adjustment entity normalizes risk scores based on aggregate carrier-reported exposure by rating cell so carriers know their population risk score compared to the market. Risk adjustment entity normalizes risk score adjustment factors (i.e. metal level, area) so that the product of the risk score and the risk score adjustment factors weighted by aggregate carrier-reported exposure by rating cell equals 1.0.

11) Risk adjustment entity calculates residual risk for each carrier at the metal/area level by multiplying the carrier’s average risk score for the metal/area by the appropriate
metal/area risk score adjustment factor, dividing by the carrier’s standard premium factor for this metal/area and subtracting 1.

12) Risk adjustment entity calculates transfer payment for each carrier at the metal/area level by multiplying the residual risk by the standard premium and enrollee months, which is the aggregate incurred claim PMPM multiplied by the carrier’s standard premium relativity factor at the metal/area level.

13) Risk adjustment entity adds the transfer payments by metal/area for each carrier to determine total transfer by carrier.

**Rationale:**
Use of a standard premium based on market incurred claims reduces uncertainty for health plans with higher than average risk since they will be compensated at a level consistent with incurred claims. The value of the transfers will not be influenced by intentional or unintentional mispricing by carriers in the market. Carriers will have additional incentive to price accurately since the risk transfer amounts will be based on actual claim levels and opportunities for gaming are reduced since carriers cannot influence risk adjustment payments with pricing changes. A properly normalized risk adjustment methodology based on a standard premium curve developed from actual risk scores by rating cell and total aggregate claims should have no mismatch between payments and credits, thus alleviating concerns about handling risk assessment shortfalls or excess funds.

**Data Collection Method – 45 C.F.R. § 153.340**

**Issue:**
A State, or HHS on behalf of the State, is responsible for collecting the data for use in determining individual risk scores needed for the risk adjustment process. HHS considered the following three possibilities for data collection.

1) A centralized approach in which issuers submit raw claims data to HHS;

2) An intermediate state-level approach in which issuers submit raw claims data sets of individually identifiable information to the state government, or the entity responsible for administering the risk adjustment process at the state level; and

3) A distributed approach in which each issuer must reformat its own data to map correctly to the risk assessment database and then pass on self-determined individual risk scores and plan averages to the entity responsible for assessing risk adjustment charges and payments.

The proposed rule recommends the “intermediate” approach above as the most complete, and actuarially sound methodology that supports other functions requiring encounter-level data, while maintaining state flexibility.

**Recommendation:**
As mentioned earlier, BCBS strongly opposes a centralized approach – whether at the state or federal level – for collecting data. Instead, BCBSA recommends a “distributed” model for risk adjustment data collection that is different from the distributed approach described in the proposed rule. Importantly, risk scores would not be self-determined by the issuers themselves. We are concerned that CMS’ description of the distributed model – which suggests that insurers will calculate their own risk scores and pass them on to the risk adjustment entity – will bias comments on this section of the proposed rule. Thus, we recommend that HHS discount concerns it receives in comments on the proposed rule that suggest that this is not a viable model because health plans could “game the results.”
Under BCBSA’s recommended distributed model, data would remain at each issuer’s own site and the risk adjustment model would be executed remotely by the State (or HHS on its behalf). Using a web-based interface, the State would access the issuers’ data and calculate risk scores using the program developed, controlled and maintained by the State (or HHS in cases where it administers the risk adjustment program).

Under our proposed distributed model, the risk score calculation process and risk score validity would be exactly the SAME as the state-level approach, except issuers would store their specified member data at their own site instead of transmitting it to a State’s central database. Issuers would prepare data in a standardized format according to specifications, the same as if they were to submit data to the State/HHS. State/HHS would run the edit programs remotely to verify data format, data validity and members’ eligibility, and then run the risk adjustment model remotely to calculate the risk scores. Risk score results and reports would be available to both the State and each issuer.

**Rationale:**
The ACA’s risk adjustment program is designed to transfer dollars among issuers – not between the government and issuers. As such, it is important that HHS develop a system that protects the privacy and security of sensitive consumer information while also balancing the interests of health insurance issuers by ensuring health plans ultimately control their data assets.

BCBSA strongly believes that a distributed model can be implemented in a manner that assures all parties that the risk adjustment system is robust, fair and reliable. Under BSBCA’s recommended “distributed” data collection approach, the advantages described in the proposed rule would remain while the concerns are mitigated. The advantages are:

1. Alleviate public/members’ privacy concerns since sensitive and confidential health information is retained by issuers without additional exposure of transmitting and storing massive amounts of individually-identifiable data in a central database. This approach would minimize the opportunity of potential data security breaches.

2. Retain issuers’ control of proprietary data that has strategic importance. This is particularly important for private sector business (versus government business such as Medicare or Medicaid). Allowing issuers to retain control of risk adjustment data acknowledges and protects their property interest in the confidentiality of their proprietary information. See, e.g., *Carpenter v. U.S.*, 484 U.S. 19, 26 (1987); *Ruckelshaus v. Monsanto*, 467 U.S. 968, 1001-04 (1984).

3. State/HHS would maintain the same control over the process while alleviating the burden of creating, securitizing, maintaining and frequently updating a large costly centralized multi-payer database.

BCBSA’s recommended distributed model would address the concerns identified with HHS in the proposed rule by taking a number of steps to ensure the integrity of the system for determining health plan risk scores. The listed concerns are addressed as follows:

1. Issuers would prepare the data to pass data edits and work to resolve problems with risk adjustment program manager; which would be the same amount of work for the State or the issuer as under the state-level approach.

2. Since issuers are not calculating or self-determining their own risk scores, they would not generate the type of errors as described. In any event, if there were concerns with the approach, the proposed data validation process should further alleviate the concerns.
3) The “distributed” data collection approach can be applied to other on-going data needs such as to recalibrate the risk adjustment model. Specified data can be accessed remotely and summarized from issuers’ standardized database via routine or ad-hoc queries. This would be more efficient than expanding the size of the central database to accommodate these additional data needs, particularly data needs for transitional programs such as reinsurance and risk corridor programs.

The distributed model approach has been piloted successfully in quality/performance measurement, comparative effectiveness research and medical product safety evaluation where data from multiple organizations are required. Each organization follows a standard protocol, creates data with standard definitions and data formats that are housed within each organization. Aggregated data is then accessed from each organization by external users to perform analysis and studies.

The process of implementing the risk adjustment program for all individual and small group issuers is new to states and issuers. We can take this opportunity to create an improved process that is efficient and addresses the major concerns of stakeholders. However, like any new programs, there will be additional work involved.

As already mentioned, BCBSA strongly opposes a centralized data collection approach, but we do recognize some information will be sent to state and/or federal governments. To the extent information is exchanged between issuers and HHS, the proposed rule is silent regarding the interest issuers have in keeping their proprietary information confidential. The proposed rule does not indicate whether HHS would keep such proprietary information confidential or protected, nor does it acknowledge that such confidentiality concerns exist. The final rule should expressly recognize that issuers have a protected property interest in keeping their proprietary information confidential, since the public disclosure of such information by HHS or the states could constitute a taking under the 5th amendment of the Constitution. **Ruckelshaus v. Monsanto**, 467 U.S. 986 (1984). To this end, HHS should incorporate into the text of the regulation itself a statement that confidential proprietary information will be protected from public disclosure under the Freedom of Information Act. 5 U.S.C. § 552(b)(4). Such language would be consistent with recent agency rulemakings where similar concerns existed regarding the potential disclosure of confidential commercial information. 45 C.F.R. § 154.215(i)(2) (acknowledging that public disclosure of sensitive rate review information is subject to FOIA protections). A key advantage of the distributed model is that it would decrease the risk that confidential proprietary information would be disclosed.

We further respectfully question whether the Agency can meet the following criteria in the Paperwork Reduction Act, 44 U.S.C. § 3506(c)(2)(A)(i)-(iv) – “whether the proposed collection of information is necessary for the proper performance of the functions of the agency,” “the accuracy of the agency’s estimate of the burden of the proposed collection of information” and whether the proposal “minimize[s] the burden of the collection of information on those who are to respond.” As discussed above, the proposed collection of information is not necessary to accomplish the agency’s goals since the distributed model greatly reduces the burden of information collection on issuers while meeting the agency’s goals. Finally, the burden estimate of 12 hours on issuers seems to us to be understated. The burden of submission will be many multiples of that. In addition, as mentioned earlier, we believe HHS has grossly underestimated the complexity and associated cost to build centralized claims repositories. In fact, preliminary estimates from a study BCBSA commissioned to analyze the costs of creating a centralized database indicate the costs would be well over $400 million.

Lastly, we recommend that states and HHS provide technical assistance and operational training to issuers to ensure successful initial implementation and on-going operation. Issuers that do not have

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3 See 76 Fed. Reg. at 41946 col. 1 (“We estimate that it will take an issuer approximately 12 hours to collect this data electronically on an annual basis. We estimate that it will take an operations analyst 12 hours (at $55 per hour) to collect this data annually.”).
prior experience with risk adjustment processes may want to contract with accredited third party vendors to provide turn-key operations and ensure a smooth implementation.

**Minimum Standards – 45 C.F.R. § 153.340**

**Issue:**
The proposed rule requires that states, or HHS on behalf of a State, use standard HIPAA transaction standards for data collection. Specifically, states must use two specific HIPAA transaction standards for risk adjustment data collection: the ASC X12N 837 Health Care Claim transaction standard for any claims related data including encounters and the ASC X12N 834 Enrollment and Maintenance transaction standard for any enrollment or demographic data. However, neither standard is ready for use without further work by X12N (the responsible Standards Development Organization). X12N will need to develop new implementation guides (the business and operating rules for 837 and 834), and it may also need to make data content modifications for the 5010 version of the 834 standard.

**Recommendation:**
BCBSA supports using the 837/834 HIPAA transaction standards as the basis for preparing input data in a standardized format and does not support the unnecessary time and costs to develop a different transaction standard. However, because neither standard is ready for use without further work by X12N (the responsible Standards Development Organization), and because plans will need time to implement the new standards, a transitional period is essential.

In addition, BCBSA urges HHS to align the standards required for preparing risk adjustment input data with standards required for other data collection purposes, such as the health insurance exchange eligibility and enrollment functions. This means, for example, that HHS should ensure that X12N develops one new version of the 834 standard to support all of the new ACA-related functions.

**Rationale:**
A transitional period is essential because it will not be possible for many issuers to be ready by January 1, 2014. X12N will need to develop new implementation guides (the business and operating rules for 837 and 834), and it may also need to make data content modifications for the 5010 version of the 834 standard. It is likely that X12N will take at least one year from start to final approval to make the needed modifications in the 837 and 834 transactions. It is imperative that this additional work is completed expeditiously because once X12N approves the modified 837/834 transactions, issuers will then need several months to make the necessary system and coding changes to prepare input data conforming to the 837/834 standards.

However, during the same timeframe, IT workloads will already be stretched to the breaking point with ICD-10 implementation to meet the October 1, 2013, compliance date, and with implementation of other administrative simplification requirements such as new operating rules and a health plan identifier (plus the extensive information systems changes needed to meet other ACA-related requirements). Thus, issuers will have neither the time nor the resources to implement new 837 and 834 data reporting standards in 2013. During a transition period, plans should be permitted to use either the 837/834 standard or to prepare input data using standard spreadsheets or flat files (with data elements, definitions, and formatting that align with the 837/834 standard).

In a centralized model of data collection, since HHS anticipates using claims and enrollment data collected for risk adjustment to support other exchange-related functions, the costs of complying with the 837/834 standard would be in addition to the enormous costs associated with standardizing, cleansing, and storing extensive claims, enrollment, and prescription drug data in centralized databases. This is one more reason to use a distributed approach.
State All Payer Claims Databases – 45 C.F.R. § 153.340

**Issue:**
States with all payer claims databases (APCDs) can request an exception from the minimum standards for data collection. The timing of the request submission would likely be synced with requirements for alternate risk adjustment models. HHS would notify states as to exception status concurrently with the publication of the forthcoming annual Federal notice. Requests for an exception from minimum data collection standards would have to include technical specifications, as well as proposed modifications to support risk adjustment and other claims related activities.

**Recommendation:**
BCBSA strongly supports a distributed model for risk adjustment data collection, which would remove the need for and the harmful effects of exceptions for states with APCDs. In the context of centralized data collection, permitting exceptions would degrade the efficiency and effectiveness of the health care system. Moreover, current state APCDs do not include the data needed to support a robust risk adjustment process. These problematic issues would be moot if HHS uses a distributed model of claims and encounter data collection for the purpose of risk adjustment. The use of a distributed model allows individually identifiable information to remain protected health information (PHI) under HIPAA Privacy and Security Rule requirements, it avoids the creation of another entity with costly administrative, technical safeguards and privacy policies and procedures, and best reflects the privacy and security expectations of consumers.

**Rationale:**
State APDCs vary a great deal in the types of data collected, data definitions, data formats, etc: “While the rules and regulations governing the collection and release of data across the states have many common characteristics, no two states have exactly the same requirements. There are as many models for doing this as there are states.”

1 Therefore, permitting exceptions would degrade the efficiency and effectiveness of the health care system by leading to a proliferation of different standards, adding greatly to plans’ administrative costs.

In addition, most current state APCDs are not capable of supporting accurate and comprehensive risk adjustment because they only collect data for members residing in-state. If a health insurance issuer insures a small group that has employees who live outside the state (as is likely, for example, in metropolitan areas that cross state boundaries), then the state APCD would be missing data for some portion of the issuer’s enrollees. Therefore, state APCDs do not have the data necessary to ensure an accurate assessment of a health plan’s average risk score. And states could not easily change their laws to require that payers report claims for members residing out of the state because of extra-territoriality issues.

The problems associated with permitting exceptions for State APCDs underscore the advantages of a distributed model for risk adjustment data collection. Indeed, adopting a distributed approach may help states with APCDs transition away from the antiquated model of centralized data collection, which mistakenly assumes that all data need to be copied and aggregated under one roof before they can be examined to a more efficient and effective data collection model.

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Data Validation Standards – 45 C.F.R. § 153.350

**Issue:**
The proposed rule requires that states, or HHS on their behalf, will perform risk adjustment data validation each year on a statistically valid sample of all issuers. The State, or HHS on its behalf, will adjust the average actuarial risk calculated for all risk adjustment covered plans offered by an issuer based on the risk score determined in the data validation. The State would be permitted to adjust charges and payments to all risk adjustment for covered plan issuers based on the above calculated adjustments. The State would be required to provide an administrative process to appeal data validation findings.

**Recommendation:**
BCBSA supports the need for data validation. However, we prefer a method that ensures settlements are accurate and timely. We recommend that each participating health insurance issuer obtain an independent audit (from an auditor pre-approved and pre-selected by HHS) of its data and submit a certification of the data’s accuracy.

In the data submission section, we recommend year-to-date data updates on a quarterly basis with final paid claims data through March 31 of the following year. Given this timing, data validation audits can begin prior to the final data update and be completed within a month after the final year-end data update. Certifications could be submitted to the State shortly thereafter and prior to final calculation of risk adjustment transfer amounts.

**Rationale:**
We are concerned that the time needed for the State to perform validations on each health insurance issuer within that State will either: 1) delay the risk adjustment settlement process and subsequently the risk corridors and medical loss ratio (MLR) processes; or 2) result in retroactive adjustments to all health insurance issuers’ risk adjustment transfer amounts, risk corridor payments/charges, MLR rebate calculations, and financial statements. These delays and adjustments also lead to higher pricing uncertainty and, could lead to higher premium rates. Our recommended approach allows for final settlements in a more timely manner without the risk of subsequent adjustments that may have significant financial implications.

Issuer Data Submission Requirements – 45 C.F.R. § 153.610

**Issue:**
The proposed rule requires all issuers of risk adjustment covered plans to submit data according to the timetable and format prescribed by the State, or HHS on behalf of the State. Data will include demographic, encounter and prescription drug utilization.

**Recommendation:**
BCBSA recommends that risk adjustment be based on medical and pharmacy data, using diagnosis codes (instead of expenditure data) for the medical portion.

**Rationale:**
When implementing a risk adjustment system, it is important to strike a balance between using data that are readily available, maximizing predictive accuracy, minimizing the opportunity for gaming, and ensuring the model can be implemented at a reasonable cost. Risk assessment methods that rely solely on demographic data are easy to administer but have lower predictive value. It is preferable to use a combination of diagnostic health and pharmacy data to improve the system’s predictive power and lower the chances for gaming.
Data Submission Timeline – 45 C.F.R. § 153.610

Issue:
The Preamble to the proposed rule solicits comments on the following proposed timeline for risk adjustment data submission:

- Claims and encounter data: every 30 days and no later than 180 days after the date of service
- Enrollment and demographic information: by the end of the following month
- Issuer rate-setting rules: by the end of the month in which effective
- Prescription drug utilization data: every 30 days, and no later than 90 days following date of service.

Recommendation:
BCBSA recommends that medical claims, pharmacy claims, and enrollment data be updated quarterly, with three months of run-out. Each quarterly submission would include incurred dates of service from January 1, through the end of the submitted quarter, using claims processed from January 1, through the end of the following quarter. For example, first quarter data would be prepared for incurred dates of service from January 1 through March 31 using claims data processed from January 1 through June 30, allowing ample time for claims incurred in that period to be submitted, adjudicated and paid. Similarly, fourth quarter data would be prepared for incurred dates of service from January 1 through December 31 using claims data processed from January 1 through March 31 of the following year. Use of the three-month run out is also consistent with the definition of claims for MLR purposes. We also recommend using that same definition for the reinsurance and risk corridor programs to keep them all on the same basis.

Rationale:
Preparing data monthly may be burdensome given the marginal benefit to be gained in risk score accuracy. We believe that quarterly data balances the need for interim risk score information with minimizing administrative burden. Each quarterly dataset would have updated year-to-date claims to ensure the most complete data available are used, which would eliminate the need for the proposed time limits of 180 days for medical claims and 90 for pharmacy claims. Given our preferred methodology, submission of issuer rate-setting rules is not needed either.

TEMPORARY RISK CORRIDORS PROGRAM

Definitions – 45 C.F.R. § 153.500

Issue:
The following definitions are proposed for the purpose of administering risk corridors.

Allowable Costs – An amount equal to the total medical costs (no administrative costs) paid by the QHP in providing benefits covered by the QHP.

Allowable Administrative Costs – The total non-medical costs defined in §158.160(b) (administrative costs other than taxes and regulatory fees). HHS suggests that if allowable administrative costs differ from calculations for the MLR rebate, issuers may be incentivized to use risk corridor payments to pay MLR rebates.

Target amount – An amount equal to the total premiums incurred by a QHP, including any premium tax credit under any governmental program, reduced by the allowable administrative costs of the plan.
**Recommendation:**

*Allowable Costs* - We recommend allowable costs be defined as an amount equal to total incurred medical costs (no administrative costs) incurred by the QHP. Incurred medical cost would be defined as the sum of claims incurred during the risk corridor reporting year and paid through March 31 of the following year, and unpaid claims liabilities associated with claims incurred during the risk corridor reporting year. This is consistent with the definition used in the MLR calculation.

*Allowable Administrative Costs* - We recommend the definition of allowable administrative costs include return on investment (or gain/loss margin), to be consistent with the definition used for Medicare Part D risk corridors, and include user fees, taxes and regulatory fees. In the case where the expected gain/loss margin is negative (<0%), we recommend that a zero margin be assumed in place of the negative gain/loss margin. We also recommend that HHS not limit a QHP’s administrative costs to 20%.

*Target amount* – We recommend that “assumed” allowable administrative costs, which are determined at the beginning of the year, rather than actual allowable administrative costs be used in target amount calculation.

**Rationale:**

Risk corridors should be used to limit issuers’ losses in the early years of the ACA due to the many new risks, such as the lack of data and experience on the previously uninsured, the elimination of medical underwriting and pre-existing condition clauses, new benefit designs, new rating rules, and other changes that are effective in 2014 with no phase-in period.

*Allowable Costs* – Our recommendation of allowable costs is measured based on claims incurred during the risk corridor reporting year. It would align benefits with premiums in the same reporting period, and it is consistent with the definition used in MLR regulation.

*Allowable Administrative Costs and Target Amount* – In the Proposed Rule, allowable administrative costs exclude gain/loss margin and taxes and regulatory fees and the Target Amount is defined as total premiums incurred by a QHP reduced by the allowable administrative costs of the plan. There are several implication and issues with the proposed definitions:

1) The proposed definition implies administrative expense would need to be reported at the QHP level. It is not common for issuers to track and report administrative expense at a QHP level. It would be administratively burdensome if administrative expense has to be reported at that level.

2) The Preamble describes the Risk Corridor program as comparing actual to projected costs. However, under the proposed definition of allowable administrative expense, where gain/loss margin, user fees, taxes and regulatory fees are excluded, the Target Amount would not equal projected claims amount.

3) In the Target Amount definition, if the intention is to use “assumed” allowable administrative expense, then actual administrative expense by QHP is not needed. This would be consistent with the reporting requirements under §153.520 where allowable administrative expense is not a reporting item. Also, using “assumed” allowable administrative costs would be consistent with Medicare Part D risk corridor program.

QHP issuers should have the flexibility to price each product with different levels of cost assumptions (including gain/loss margin) and should not be limited to 20%. Administrative costs do not all vary in proportion to the total dollar amount of claims or premiums; some administrative costs are more or less fixed, while others vary by the complexity of the benefit design, and others vary more closely to size. Therefore, depending on the product, 20% may be too little, while in other cases it may be too much. Additionally, some QHPs may not be large enough to be credible, and suffer from variations
that may offset other QHP variations. At the QHP level, the 20% requirement is too restrictive, and is inconsistent with the MLR requirement, which is on an aggregated basis.

Establishment and Payment Methodologies – 45 C.F.R. § 153.510

Issue:
HHS will establish risk corridors by specifying risk percentages above and below the target amount. A QHP issuer is to adhere to the requirements set by HHS for the establishment and administration of a risk corridor program for 2014 - 2016. Risk corridors guidance will be plan specific and not issuer specific and will apply to all QHPs offered in the exchange.

Recommendation:
The proposed rule states that the risk corridor guidance will be plan specific and not issuer specific. We interpret this to mean that each QHP will be evaluated separately for risk corridors. We recommend risk corridor calculations be applied to QHPs aggregated under a single issuer separately for individual and small group business, so the sum of allowable costs of all QHPs is compared to the sum of target amounts of all QHPs under the same issuer by individual and small group business.

Rationale:
Aggregated experience would produce more credible and stable results and would be much less administratively burdensome. Experience at the plan level should be expected to be more volatile, especially with newer and smaller blocks of business. Further, it should be expected that aggregating that experience would result in offsetting the poorer extremes from one plan against more favorable results of another plan. This concept is also consistent with the MLR requirement, which uses aggregate experience.

Standards for QHP Issuer – 45 C.F.R. § 153.510

Issue:
The proposed rule states that in arriving at the adjusted premium, payments received for risk adjustment and reinsurance are to be added. In accounting for reinsurance payments, QHP issuers must attribute reinsurance payments to risk corridors based on the date on which the valid reinsurance claim was submitted.

In the Preamble, HHS requested comments on:
- Deadline for issuers to complete submission of risk corridor data.
- Interaction between risk corridor and MLR process.
- How to utilize MLR reporting data for risk corridors to limit reporting requirements on issuers.
- Treatment of reinsurance and risk adjustment for purposes of determining risk corridor amounts.

Recommendation:
We request clarification of the term received in using payments received for risk adjustment and reinsurance payments to arrive at adjustment premium. We recommend using expected risk adjustment and reinsurance payments to be made instead of payment received, since there may be a lag in actual payment, but the amounts should be reported in advance. In accounting for reinsurance payments, we strongly recommend reinsurance claims be attributed based on date incurred for both risk corridors and medical loss ratios and not based on submission date.

Deadline for QHP issuers to complete submission of all risk corridor data – Final risk adjustment and reinsurance figures are needed to properly calculate the risk corridor payments and charges. Therefore, we suggest that all risk mitigation programs are considered together in the development
of the settlement process timeline. We recommend the following timeline for settlement of all risk mitigation programs:

- All incurred claims amounts should be determined as claims with service dates in the calendar year which are paid by March 31 of the following year plus any remaining claims liability.

- The risk adjustment program should employ quarterly interim risk score calculations based on year-to-date claims data with three months of run-out. Final risk adjustment scores should be based on full-year claims data as of March 31 of the following year. Health insurance issuers should have until April 30 to prepare the year-end data. Risk scores should be calculated and reports produced by May 31 with the actual transfer of funds by June 30.

- Reinsurance-eligible claims should be incurred within the calendar year and paid by March 31 of the following year. Health insurance issuers should have until April 30 to submit claims to the reinsurance entity. All reinsurance claims should be processed by June 30.

- Risk corridor calculations, using final risk adjustment and reinsurance amounts, should be completed and submitted to HHS by July 31.

**Interaction between risk corridor and MLR process.** Given that the risk corridor program is two-way risk sharing between the federal government and health insurance issuers and that the MLR process is a one-way value test from health insurance issuers to enrollees, final results of the risk corridor calculations will need to feed into the MLR calculations. Based on the timelines proposed above for the risk mitigation programs, MLR reports should be completed by August 31 of the following year or later.

**Utilize MLR reporting data for risk corridors.** It may not be feasible to directly use MLR reporting data for risk corridor calculation, particularly if risk corridor is plan specific and not issuer specific. It would be desirable to have consistent definitions to the extent feasible, such as basing unpaid claim reserves on 3 months claims run-out period, including unearned premium in premium amount, and reporting by calendar year, while allowing for differences, such as defining allowable administrative costs to include non-claims costs, taxes and regulatory fees, user fees and gain/loss margin.

We request clarification of the meaning/treatment of reinsurance and risk adjustment as “after-the-fact adjustments” to premium for purposes of determining risk corridor amounts.

**Rationale:**
Payment received date is more a cash flow concept. If risk corridor payment were based on payment received date, it would unnecessarily delay risk corridor calculations. There is a tight turnaround time for risk adjustment, reinsurance, risk corridor and MLR calculations.

Reinsurance claims should be attributed by incurred date rather than submission date, to be consistent with risk adjustment and MLR calculations.

The above timeline is consistent with our proposal for using final risk adjustment and reinsurance amounts for risk corridor and MLR calculations.

MLR reporting data may not be used directly in risk corridor calculation because MLR reporting is at a higher level (including QHPs and non QHPs), and due to timing difference (risk corridor amount needs to be completed before MLR so the result can be incorporated into MLR and rebate calculation). Having consistent definitions to the extent possible would be administratively less burdensome and would minimize reporting errors.
ATTACHMENT B

A DISTRIBUTED DATA MODEL SHOULD BE USED TO DETERMINE HEALTH PLANS’ RISK SCORES

I. BACKGROUND

Under health care reform, health plans’ premiums for Individual and Small Group business are to be re-distributed among plans to reflect their members’ risks via a risk adjustment program. While there are many open questions related to the operational system of risk adjustment, BCBSA and its member Plans support a system based on a “distributed” data model. Under BCBSA's recommended distributed data model, the risk score calculation and data validation processes are exactly the same as the state-level centralized data model suggested in HHS's proposed rule. The only difference between the models is that under the distributed data model, data remains with each health plan, while under the centralized data model, each health plan transmits its data to be stored in a central database maintained by the state or HHS on its behalf. The state, or HHS on its behalf, calculates the risk scores by running its risk assessment model using a web-based interface that accesses each health plan’s data remotely. Risk scores would not be self-determined by the health plans.

This paper demonstrates how the process would work to calculate risk scores using a centrally controlled risk assessment program, without sending detailed claims data to a central state repository. Successful pilot programs demonstrate that it is possible to design a distributed model that provides valid and reliable results across health plans, addresses privacy concerns that may arise with a centralized model, and encourages a streamlined and efficient process for both health plans and government agencies.

II. DISTRIBUTED DATA MODEL VERSUS CENTRALIZED DATA MODEL

Under a centralized data model, health plans submit specified member diagnostic data in a standardized format to the state entities on a periodic basis. Member data from all health plans reside in centralized repositories at the state level, which poses significant privacy and security issues. The state/HHS entities execute their standard risk assessment model programs to accept or reject the data, to assign risk scores to each member, and to determine health plan risk adjustment transfers. Summarized risk scores are produced for the state/HHS entities, which also need to be shared with the health plans. The state/HHS entities must also maintain data privacy and security of the central data repository.

The process is the same under a distributed data model, except health plans store the specified member data at their own sites. Health plans follow standardized data protocols to ensure data integrity. Using web-based interfaces to access the health plans’ data remotely, the state/HHS entities execute their standard risk assessment model programs to accept or reject the data, to assign risk scores to each member, and to determine health plan risk adjustment transfers. No maintenance or protection of the data by state/HHS entities is needed. Summarized risk scores are produced for the health plans and state/HHS entities simultaneously. The distributed model is similar to those used in quality measurement, comparative effectiveness research and medical product safety evaluation.

III. EXAMPLES OF DISTRIBUTED DATA MODEL

Distributed data models were piloted successfully in quality/performance measurement, comparative effectiveness research and medical product safety evaluation where data from multiple organizations are required. Instead of creating a central data repository, control of the data remained with the data owners. Each organization followed standard protocol, created data sets with standard definitions and formats, and housed them internally. Aggregated data set were accessed from each organization by external users to perform analysis and studies. The following four examples describe the distributed data model:
The first program is a large-scale pilot program called Mini-Sentinel that lays the groundwork for the Food and Drug Administration’s (FDA) Sentinel System. Based on a distributed data network, the Sentinel System is used to query diverse automated healthcare data holders – including electronic health record systems, administrative and insurance claims databases, and registries – to evaluate possible medical product safety issues quickly and securely. Under the Mini-Sentinel’s distributed data model, health plans store the standard data in their own systems, perform analyses by running computing programs distributed by a coordinating center, and send the summarized results to the FDA. This model provides the FDA the capability to monitor the safety of approved medical products by running queries against the electronic health information of more than 60 million people. Health information consisted of claims data, inpatient and outpatient medical records and patient registries. Future data will include laboratory-test results and vital signs from electronic health records and clinical laboratory records. Concerns with data privacy and security were the key drivers in the decision to build Mini-Sentinel using a distributed data model.

The second example is a study that successfully demonstrates the capability of a distributed health data model in supporting research needs without the creation of a centralized data repository, and at the same time, addresses the data owners’ key concerns. The study was performed by Harvard Medical School and Harvard Pilgrim Health Care Institute; University of Pennsylvania School of Medicine; Lincoln Peak Partners; and Deloitte, NCPHI/OD. Similar to the last example, data owners maintain control over their protected data and its use. Data was transformed to a common data model with uniform definitions and storage formats. A web-based portal system enables external users to submit queries against summary-level data-sets held by data owners. Data owners review the query details and decide whether to execute, reject or hold the query. The query runs against a local database and the result is reviewed by the data owner prior to uploading to the portal for aggregation. The aggregated result is reviewed by the external users. The driver behind the distributed data model is noted in the report - “In practice, a centralized approach raises several serious security, proprietary, operational, legal and patient privacy concerns for data owners, patients and funders. As one example, even if a centralized database omits explicit identifying information like names and address, it is effectively impossible to prevent re-identification of individual level longitudinal data that contains enough detail to serve multiple purposes.”

The third example is the Vaccine Safety Datalink (VSD) project run by the Centers for Disease Control and Prevention. It monitors the use of new vaccines using a distributed data model to combine information from electronic medical records and administrative databases from eight health plans covering nine million members.

The fourth example is the Data Aggregation Project sponsored by the Robert Wood Johnson Foundation with support from the Engelberg Center for Health Care Reform at the Brookings Institution. A key goal of the project is to test a standard method for collecting and aggregating data across multiple health plans that are valid and reliable for provider performance measurement. Similar to the above examples, health plans prepare the data in accordance with specifications, use common software tools run at each site to produce measurement results, and summarized results are matched by physicians across plans to create a unique physician file. This project demonstrates that performance measurements requiring data from multiple plans can be effectively accomplished using a distributed data model where detailed claims information, including diagnosis and procedure codes, do not need to leave the health plan.

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IV. DESCRIPTION OF A DISTRIBUTED DATA MODEL

A. The goals of a distributed data model are to ensure:
   1. Valid, consistent and reliable data from each health plan;
   2. Valid and reliable results across health plans;
   3. Streamlined and efficient process for health plans and state and federal government agencies; and
   4. Privacy and security of member health information.

B. Overall process:

There are many steps involved in calculating a risk score based on an individual’s membership and health records. The steps are the same whether the data resides in a central repository or at each health plan’s site. The only difference is that under the centralized model, the data resides in a central repository, and the state/HHS entity executes the programs for editing and risk score calculations, while under the distributed model, the data resides with the health plan, and the state/HHS entity executes the programs for editing and risk score calculations remotely. Under both models, the state/HHS entity controls and maintains the computer programs, runs the edit programs to validate data integrity and members’ eligibility, and runs the risk assessment program to determine the risk scores. The key point is that under either model, the same degree of controls and validation would be in place to ensure data/program integrity and validity of results.

An overview of the steps for risk score calculation is described below:

1. Prepare input data in a standardized format according to specifications. Example of a minimum set of medical data for capturing diagnosis codes or groupings includes member identification, age/sex, ICD diagnosis codes, service dates and provider type (inpatient, outpatient or physician).  
   
2. Run input data through edit programs to verify input format, data validity and member’s eligibility. Input data that does not pass edit checks is rejected.

3. Correct and re-check data until data passes the edits or incorrect records are deleted.

4. Run verified data through a risk assessment model to calculate a risk score for each member.

5. Produce risk scores results and reports (routine and ad-hoc). Reports should demonstrate validity of the summarized risk scores. Specified transaction records, files and reports are retained by health plans for future audits.

6. The state/HHS entities calculate the transfer amounts (either as payable amount or receivable amount) and ensure payments are distributed according to regulations and policies.

The above steps are the same under the centralized data model and the distributed data model. The difference is the location of the data. The table below describes the steps and delineates the key differences between the two models.

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5 Additional data/files would be required for example to verify membership eligibility, or if drug data is used.
Similarly, for input/output data validation and monitoring purposes, the process is the same under the centralized model and the distributed model, except the data is accessed remotely under the distributed model.

C. Keys to a successful process:

In order for the risk adjustment program to be successful, it is important that the requirements of the various stakeholders are met. For example, a major objective is that health plans and the state/HHS entities have assurances that risk adjustment results are valid, and the process is transparent, reliable, auditable and not prone to gaming. Following are some key elements to achieve that objective (presumably same as those under the centralized model):

1. Employ a common data model with uniform definitions, data layout, file structure and coding systems. This allows easy data checking, data correction, monitoring, auditing and communication to resolve data issues.

2. Establish a stringent audit process where health plans’ data and output are audited periodically to ensure results are valid and reliable.

3. Implement robust data verification and monitoring process to validate input and output data regularly, for example, by comparing output results to normative data to detect and flag unusual frequencies of diagnosis codes. Alert health plans when data anomalies are detected so corrections can be made in a timely basis and not wait until final year end reconciliation.

4. Institute a governance structure to oversee the process, set the rules, monitor adherence to the rules, and co-ordinate interactions and communications among plans and the state entities.

5. Require health plans to certify to data accuracy.
6. Institute penalties on health plans and providers that intentionally falsify data or commit fraud.

7. Provide technical assistance and educational/operational training to health plans to ensure successful initial implementation and continual operations. (Smaller health plans may contract with accredited third party vendors that can provide turn-key operations.) Recommend health plans to set up internal cross functional teams including business units, information system, operations, actuarial, finance, audit, medical management and provider contracting areas, to perform tests, dry runs and monitor ongoing processes and results.

8. Provide technical assistance and educational training to providers to ensure proper coding procedures. Health plans should also incorporate any coding requirements into their provider contracts.

9. Form a workgroup to develop the detailed process. Workgroup members would include representatives from health plans, government agencies, and the state entities. Items to be determined would include: standardized data (input specification), data testing and verification standards, data aggregation for risk adjustment calibration (if needed), and a process to ascertain health plans’ risk scores are accurate.

10. Allow sufficient lead time for health plans to perform dry runs, and test their programs and processes.

V. WHY GO WITH A DISTRIBUTED DATA MODEL?

A. Health plans’ perspective:

Under a distributed data model, health plans are better able to maintain the privacy and security of sensitive health information, retain control of proprietary data and reduce administrative cost.

Privacy/Security: Health plans put a high priority on retaining members’ trust by ensuring the privacy and security of their sensitive health information. Under a distributed data model, detailed membership and claims data such as claims amount, diagnosis codes, procedure codes, member identification, member birthday, etc. would not suffer a potential loss of privacy and security – as explained further below – by leaving the health plan.

Proprietary data: Health plans also put a high priority on retaining control over proprietary data which has strategic importance. This is of particular importance with private sector business, versus government business such as Medicare or Medicaid plans.

Reduce administrative cost: Health plans have to create the input data file under either approach. By storing the data at its own site, it would keep down administrative costs by avoiding creation of a new central data repository.

B. Members’ perspective:

A distributed model, where protected health information (PHI) is retained by the health plans without massive data being sent and stored in a central data repository, alleviates members’ privacy concerns. Personal health information may be accessed and breached when data is moved from one entity to another, with additional exposure under a central data repository. With the proliferation and increased use of electronic health records, consumers are caught between the belief that electronic health records would improve health care co-ordination and quality of care, and the fear of unauthorized use of their

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6 State could set up different penalty levels, varying from minor, moderate or major violations.
health information. For example, in a 2006 survey for the Markle Foundation, 80 percent of respondents were “very concerned” about theft or fraud of their health records. In choosing between centralized and distributed models, privacy and security of member health information should be placed in the forefront of decision making. Minimizing the opportunity of potential data breaches will keep the program credible and trusted.

C. Government’s perspective:

A distributed model alleviates the government’s burden of creating, securitizing, maintaining and frequently updating a large, costly centralized multi-payer database. It would minimize the opportunity of potential data breaches and demonstrate government’s support of maintaining the privacy and security of member PHI.

VI. CALIBRATION OF THE RISK ADJUSTMENT MODEL

Calibration refers to the process of modifying the risk scores to be more specific to the population the model is applied to. The key here is to assign appropriate weights to the diagnosis groupings or medical conditions, so health plans will not be penalized or awarded unintentionally as they attract a disproportionate percent of members with conditions that are over- or underweighted. Population here refers to those who will be in the individual and small group markets after 2014, including those currently insured, those in the high-risk pools, those currently uninsured, and those moving from other markets (such as large group or Medicaid). A database covering this new population mix does not exist today.

If a current commercial risk adjustment model is selected, the model would already be calibrated for medical conditions that are prevalent in the commercially-insured population. After several years, if additional precision in the calibration is desired, external data from various sources, such as existing commercial population used by risk adjustment vendors today, state Medicaid population, and high-risk pools, can be obtained. Re-calibration to reflect more recent coding and expenditure patterns may also be desirable. Re-calibration can be performed using the distributed model described above. Each health plan creates a standardized database with uniform definitions; the risk adjustment entity submits queries to run against each health plan’s standardized data base to obtain the summarized results; and health plans review the queries prior to data being accessed as well as review the summarized results prior to releasing.

VII. OTHER RISK ADJUSTMENT CHALLENGES NOT RELATED TO DATA MODEL

There are many challenges and details to work through on the design and implementation of the risk adjustment program, and many of them are unrelated to whether the program is operated under a distributed or centralized model.

One of the challenges is the transition to ICD-10, effective October 1, 2013. Three likely issues are pertinent to risk adjustment:

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7 President’s Council of Advisors on Science and Technology. December 2010. Report to the President realizing the full potential of health information technology to improve healthcare for Americans: The Path Forward.

8 For this discussion, we are focused on assigning appropriate weights to the medical conditions versus normalizing risk scores of each health plan relative to the market average.

9 Examples of additional calibration may include adjustments to reflect state specific characteristics, low income member risks, variation by metal plans and interaction with reinsurance mechanism.
First, it is widely believed that for at least the first year after the ICD-10 implementation, the quality of the diagnosis codes will deteriorate as providers and coders become familiar with the new system. Providers will need some time to adjust to the new coding system. Since risk adjustment is highly dependent on the accuracy and consistency of the diagnosis codes, accuracy of risk adjustment model will also suffer.

Second, since the selection of the model is likely to be based on the ICD-9 codes, it is uncertain if the model would work as expected when actual ICD-10 codes kick in. Although it is expected the model will be tested based on translation of ICD-9 codes to ICD-10 codes, it is uncertain how well the translation is given the mappings are not one to one. Also, calibration of the model will be based on historical ICD-9 codes and the real life risk adjustment would be based on newly implemented ICD-10 codes.

Third, for some period after October 1, 2013, a considerable number of claims will continue to include ICD-9, not ICD-10 diagnoses. This is because many payers permit providers to submit claims up to two years after the date of service, and claims submitted for services rendered before the ICD-10 deadline are likely to be submitted using ICD-9 coding. Indeed, CMS currently requires that national code sets be compliant with the regulations in effect on the date of service, not on the date of receipt. (The volume of continued ICD-9 claims may be even greater if some covered entities are not ready by the deadline.) Since the greater granularity of ICD-10 support more precise risk adjustment, it is uncertain what effect differences in prevalence of 9 or 10 may have on risk scores for different populations.

Another issue is risk score transferability. Today’s risk adjustment models are mostly designed with members having at least six to twelve months eligibility. Under the new environment, we expect many members would have a shorter eligibility period, as they move from one health plan to another plan, from Medicaid or uninsured status to private health plans, from one market to another market (individual/small group/large group), or from one state to another state. One way to address this is to link up the individual’s experience regardless of where the individual is. However, there is practical complexity as well as privacy concerns with this approach. Another approach is to adjust the risk adjustment model to better assess risk profiles of individuals with a short eligibility period; for example, by either shortening the required eligibility periods or utilizing drug claim data to identify chronic conditions in addition to demographic factors.

Given the complex issues related to risk adjustment, and the long timeline involved, it would be advisable to start addressing and finalizing some of the key decisions, so all the stakeholders can start working together on modeling, testing, and putting the process in place. Health plans would also require substantial training to implement the risk assessment process.

VIII. DISTRIBUTED DATA MODEL CAN ALSO BE APPLIED TO OTHER HEALTH CARE REFORM PROGRAMS

In addition to the risk adjustment program, a distributed data model can also be applied to other programs that require health plans’ claims data, such as reinsurance, risk corridors and low income cost sharing subsidies programs. Brief descriptions of each of the programs are shown below (details of the programs have yet to be finalized):

Reinsurance: This is a transitional risk mitigation program effective for the years 2014 – 2016, where states are required to establish a nonprofit reinsurance entity that collects payments (from all health plans), and makes payments to health plans in the individual market that cover high risk individuals.

Risk corridors: This is another transitional risk mitigation program effective for the years 2014-2016, where HHS will share in profits and losses with Qualified Health Plans (QHPs) participating in Exchanges. If a QHP’s costs exceed 103% of its target claims amount, HHS will make payments to the
plan, and if a QHP’s costs are less than 97% of the target claims amount, the plan will make payments to HHS.

Low income cost sharing subsides: For individuals enrolled via Exchanges with household income between 100 and 400 percent of the Federal Poverty Level (FPL), their cost sharing are reduced. HHS will either make periodic and timely payments to health plans equal to the value of the reductions or establish a capitated payment system. Under the first approach, health plans need to report the amount of cost sharing reductions to the Exchange and HHS to ensure proper reimbursements.

A distributed model can be applied to the above programs following the same process as described for risk adjustment program (see Description of a Distributed model under section IV). Instead of health plans submitting detailed claims data to the various regulating entities, health plans will house specified data sets internally under standardized definitions, record layout, file structure and coding systems, and provide the necessary output to regulating entities for interim payments and financial settlements. Regulating entities will maintain control of the system programs, establish rules, require audits and impose penalties for fraud and intentional false reporting. Applying a distributed model to these programs will further alleviate the need of a giant centralized data repository.

**IX. CONCLUSIONS**

The process of implementing the risk adjustment mechanism for the Individual and Small Group markets is new to the state entities as well as to the health plans. There is no set procedure in place today to conduct risk adjustment for this new population; both the state entities and the health plans need to implement a new process.

There are many reasons why a distributed data model should be used for the private health insurance market, in brief, they are:

A) Public/Members' privacy concerns would be alleviated;

B) State would maintain the same control over the process while alleviating the burden of creating, securitizing, maintaining and frequently updating a large centralized multi-payer database.

C) Health plans would retain control of proprietary data that has strategic importance.

Regardless of which data model is adopted, there may be initial concerns regarding health plans’ ability to report risk scores accurately or the possibility of gaming. These can be overcome with the implementation of proper controls, audits or certifications, non-compliance penalties, and by providing technical assistance and working collaboratively together to make it work. Health plans have vested interests in ensuring the successful implementation of risk adjustment program (and other financial related programs), since it has major pricing and financial impact on their core businesses.
Attachment C

Estimated Timeline for Risk Mitigation Programs and MLR (based on a 3-month runout period)

- July 31: Prepare 6/30 data for Q1 risk scores
- Aug 31: Receive Q1 risk score reports
- Oct 31: Prepare 9/30 data for Q2 risk scores
- Nov 30: Receive Q2 risk score reports
- Jan 31: Prepare 12/31 data for Q3 risk scores
- Feb 28: Receive Q3 risk score reports
- Mar 31: Runout date for all 2014 claims
- Apr 30: Prepare 3/31 data for 2014 risk scores
- May 31: Last date to submit reinsurance claims
- Jun 30: Receive final 2014 risk score reports
- Jul 31: Actual transfer of 2014 RA funds
- Aug 31: Final settlement of 2014 reinsurance
- Sep 30: Risk corridor calcs submitted
- Oct 31: Prepare 6/30 data for Q1 risk scores
- Nov 30: MLR reports submitted
- Dec 31: Receive final Q1 risk score reports