October 21, 2011

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201
Attention: CMS-9975-P

RE: File Code CMS-9975-P (Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors and Risk Adjustment)

Dear Sir or Madam:

As organizations and individuals that advocate on behalf of people with chronic illnesses, people with low-incomes, children and families, and consumers, we are strongly committed to ensuring the many benefits of health reform are fully realized for not only these populations but all Americans.

We therefore welcome this opportunity to comment on the proposed rules related to Reinsurance, Risk Corridors and Risk Adjustment. These are critical mechanisms that can limit the risk of adverse selection in the individual and small-group markets and help ensure the long-term success of the new Exchanges and the health insurance market reforms taking effect in 2014. The effective implementation of Reinsurance, Risk Corridors and Risk Adjustment is thus essential to the Affordable Care Act’s goal of providing affordable, high-quality health insurance options to millions of individuals, employees of small businesses, and small employers.

Please find attached our comments and we look forward to further working with you on these issues in coming months.

Sincerely,

Organizations:

American Cancer Society Cancer Action Network
American Heart Association
Center on Budget and Policy Priorities
Georgetown University Center for Children and Families

Individuals:

Timothy Jost, Washington and Lee University School of Law*

* for identification purposes only
Part 153 – Standards Related to Reinsurance, Risk Corridors, and Risk Adjustment under the Affordable Care Act

Subpart B – State Notice of Insurance Benefits and Payment Parameters

§153.100 Establishment of State insurance benefits and payment parameters

§153.100(a) General requirement

We strongly support the requirement that a State operating an Exchange publish an annual notice to disseminate information to health insurers and other stakeholders including consumers about the specific parameters the State will use in its reinsurance and risk adjustment programs. The State, however, should indicate in its notice an explanation of why it is using these specific parameters instead of using those specified for reinsurance and risk adjustment programs included in the annual Federal notice of benefit and payment parameters.

As we note in our comments to §153.210(c), however, we recommend that HHS must operate the reinsurance program in a State when the State does not opt to establish its own Exchange. As a result, proposed §153.100(a) should be amended accordingly.

Specific Recommendation: Amend §153.210(a) as follows.

“(a) General requirement. A State operating an Exchange, as well as a State establishing a reinsurance program, must issue an annual notice of benefits and payment parameters…”

§153.100(b) State notice deadlines

We support the requirement that States that plan to modify Federal parameters issue their notice by no later than early March in the calendar year before the relevant benefit year, after HHS publishes its annual Federal notice in mid-January. While States will have limited time in deciding to use different parameters relative to the Federal parameters, it is necessary to ensure timely implementation for the following year and to provide sufficient time for insurers and consumers to appropriately take into account the parameters (including any changes from the previous year).

§153.100(c) State failure to publish notice

We support the requirement that if a State operating an Exchange does not provide public notice of its intent to have State-specific parameters, the Federal notice of benefits and payment parameters shall apply. This would help ensure that States meet the required notice deadline under §153.100 and on a timely basis provide the necessary reinsurance and risk adjustment system information to stakeholders, if they are going to vary from the Federal parameters.
As we note in our comments to §153.210(c), however, we recommend that HHS must operate the reinsurance program in a State when the State does not opt to establish its own Exchange. As a result, proposed §153.100(c) should be amended accordingly.

Specific Recommendation: Amend §153.210(c) as follows.
“(a) State failure to publish notice. If a State operating an Exchange, or establishing a reinsurance program that fails to publish a notice…”

§153.110 Standards for the State Notice
§153.110(a) Reinsurance content

As with State notice related to risk adjustment, the State notice for reinsurance should also indicate the rationale for why the State is modifying a Federal reinsurance payment parameter, so that stakeholders (and HHS) can assess whether such modified parameters are warranted.

In addition, as we note in our comments to §153.210(c), however, we recommend that HHS must operate the reinsurance program in a State when the State does not opt to establish its own Exchange. As a result, proposed §153.110(a) should be amended accordingly.

Specific Recommendation: Amend §153.110(a) as follows.
“(a) Reinsurance content. If a State operating an Exchange or establishing a reinsurance program intends to modify a Federal reinsurance payment parameter, the State notice must specify at least the following information and the rationale for such modifications:”

§153.110(b) Risk adjustment content

We support the requirement that the State notice indicates the rationale for why the State is modifying a Federal risk adjustment parameter, so that stakeholders (and HHS) can determine whether such modified parameters are warranted.

The proposed rules in §153.110(b), however, appear to confuse a number of different terms and requirements. For example, as noted in the preamble to §153.310 and in our comments, section 1343(a) of the Affordable Care Act clearly requires that for purposes of risk adjustment, risk pools are required to be aggregated at the State level. States do not have any discretion in this matter and cannot opt to establish risk pools for purposes of risk adjustment that are not statewide. As a result, the proposed rules should strike any reference to “establishment of risk pools.” Moreover, proposed §153.320 clearly distinguishes between a Federally-certified risk adjustment methodology and the risk adjustment model used in conjunction with that methodology. The proposed rules should be amended accordingly. Finally, there is no federal methodology for risk adjustment data validation, though as we note in our comments to §153.350, we recommend that HHS determine the manner in which States shall conduct such audits. The proposed rules should be modified accordingly.
Specific Recommendation: Amend §153.110(b) as follows.

“(b) **Risk adjustment content.** If a State operating an Exchange intends to modify a Federal risk adjustment parameter, the State notice must provide a detailed description of and rationale for any modifications including:

1. The methodology for determining average actuarial risk, including the establishment of risk pools and the Federally certified risk adjustment model specified in §153.320; and
2. The Risk adjustment data validation methodology set forth in §153.350.”

Subpart C – State Standards for the Transitional Reinsurance Program for the Individual Market

§153.200 Definitions

As we note in our comments to proposed §153.230, we disagree that reinsurance should only apply to expenses for items and services within the essential health benefits. Nothing in the Affordable Care Act requires that such a limitation be applied, and depending on how the essential health benefits are defined by the Secretary, it could result in insurers being ineligible for reinsurance payments for costs related to certain benefits furnished to high-cost individuals and thus encourage such insurers to no longer cover such benefits in the individual market. As a result, we recommend that any reference to the essential health benefits be struck from the proposed definitions.

Specific Recommendation: Amend §153.200 as follows.

“**Attachment point** means the threshold dollar amount of costs incurred by a health insurance issuer for payment of essential health benefits, as defined in section 1302(b) of the Affordable Care Act, provided for an enrolled individual, after which threshold, the costs for covered essential health benefits, as defined in section 1302(b) of the Affordable Care Act, are eligible for reinsurance payments.

**Coinsurance rate** means the rate at which the applicable reinsurance entity will reimburse the health insurance issuer for costs incurred to cover essential health benefits, as defined in section 1302(b) of the Affordable Care Act, after the attachment point and before the reinsurance cap.

... **Reinsurance cap** means the threshold dollar amount for costs incurred by a health insurance issuer for payment of essential health benefits, as defined in section 1302(b) of the Affordable Care Act, provided for an enrolled individual, after which threshold, the costs for covered essential health benefits, as defined in section 1302(b) of the Affordable Care act, are no longer eligible for reinsurance payments....”

§153.210 State establishment of a reinsurance program

§153.210(a) General requirement
While we agree that States have flexibility in selecting a reinsurance entity, we strongly disagree with the preamble that there should be no specific standards or requirements at all for what entities can contract with States to administer their reinsurance programs. For example, there should be requirements preventing conflicts of interest; how the program is administered will affect the reinsurance payments received by plans in the individual market inside and outside the Exchanges so it is critical that officers of the reinsurance entity do not have conflicts that could lead to decisions that inappropriately advantage certain insurers over others in the State.

While section 1341(a)(2) of the Affordable Care Act permits States to set up more than one reinsurance entity, even though this is likely to increase administrative costs, we agree that the geographic service areas for each reinsurance entity should be distinct and together, cover the entire individual market in the State. We also agree that the State should publish information related to such geographic divisions in the State notice required under §153.110(a). The proposed rule, however, does not require the State to set such geographic areas in a reasonable manner. For example, States should demonstrate that such geographic divisions align with the premium rating areas determined by the State as required under section 2701(a)(2) of the Public Health Service Act, as added by section 1201 of the Affordable Care Act, as is required for the geographic areas served by subsidiary Exchanges under proposed rules in §155.160(b), which require that subsidy Exchange service areas be at least as large as premium rating areas in the State. The proposed rules should be amended accordingly.

Specific Recommendation: Amend §153.210(a) as follows.

“(2) If a State establishes or contracts with more than one applicable reinsurance entity, the State must:
(i) Ensure that each applicable reinsurance entity operates in a distinct geographic area with no overlap of jurisdiction with any other applicable reinsurance entity and is consistent with premium rating areas determined by the State; and…”

§153.210(c) Special State circumstances for establishing a reinsurance program

We disagree with the proposed rules in §153.210(c) that permit a State that does not elect to establish an Exchange to operate its own reinsurance program. Nothing in section 1321 or 1341 of the Affordable Care Act requires this interpretation. We believe that the proposed §153.310(a) related to risk adjustment strikes a better balance. Under those proposed rules, HHS will operate the risk adjustment program in the State if the State opts not to set up its own Exchange. Reinsurance is a critical temporary risk mitigation tool that would help ensure that the individual market, including the Exchange, functions well when the major insurance market reforms first take effect and the Exchanges become operational. It is critical that reinsurance is administered on a timely and accurate basis and as a result, Exchange QHPs can charge affordable premiums that help ensure sufficient participation in the Exchanges. Requiring HHS to administer reinsurance in a State that does not elect to establish an Exchange would help ensure that reinsurance is working in the individual market both inside the Exchange operated by HHS, and in the outside market. The proposed rules should be amended accordingly.
Specific Recommendation: Strike §153.210(c).

§153.210(d) Non-electing States

Consistent with our recommendation to not permit States to operate their own reinsurance program if they do not establish an Exchange and thus strike proposed §153.210(c), proposed §153.210(d) should be renumbered accordingly and amended to make needed conforming changes.

Specific Recommendation: Amend §153.210(d) as follows.

“(dc) Non-electing States. For each State that does not elect to establish an Exchange and does not determine to operate its own reinsurance program, HHS will carry out all of the provisions of this subpart on behalf of the State and establish the reinsurance program to perform all the reinsurance functions for that State.”

§153.220 Collection of reinsurance contribution funds

§153.220(b) Contribution rate

Because the reinsurance program is temporary (effective only for the period 2014-2016), we agree that use of a national contribution rate is an approach that is likely to be easier to administer and to provide more certainty (considering the lack of data on state-by-state differences in likely Exchange enrollment and the health status and costs of the newly enrolled population) than a state allocation approach. As a result, we agree that a national contribution approach will help facilitate reinsurance being fully operational by 2014.

We also agree that the percent of premium method is preferable to a flat per capita amount for calculating the required contributions using a national contribution rate. State premiums and health care costs tend to vary significantly, and state variation is likely to continue to some degree in 2014 and beyond, despite more uniformity in premium rating rules and other key market factors. A percent of premium method would take these differences into account; a flat per capita amount would leave certain States with higher premiums and health care costs with relatively fewer reinsurance funds. We also note that the methodology for calculating the required contributions of individual issuers and third-party administrators of self-insured plans should add in administrative costs to self-insured plans’ total medical expenses to ensure equitable application of the contribution requirements on issuers and third-party administrators. (This could be achieved, for example, by using a standard administrative cost adjustment to self-insured plans’ total medical expenses.)

We agree with the preamble that nothing precludes a State from supplementing the program and collecting additional contributions to make the reinsurance program more generous (and more effective in lowering premium costs). We also believe that nothing should preclude a State from continuing its reinsurance program after 2016 on a voluntary basis and the final rule should
make that clear. We also note that in discussing the ability of a State to collect additional reinsurance contributions to cover the administrative costs of the reinsurance entity, the preamble does not state that this option is specifically permitted in section 1341(b)(3)(B)(iii) of the Affordable Care Act and that the proposed rules in §153.220(b)(3)(ii) are merely codifying a provision of the Affordable Care Act.

The preamble seeks comment on the frequency by which applicable reinsurance entities should collect contribution funds from contributing entities. It offers one possible timeframe of monthly contributions starting in January 2014. Since payments have to be reduced on a pro-rata basis under §153.240(b)(2) to ensure payments to match the amount of contributions in a given reinsurance year, we believe the higher priority should be to set the frequency that produces a staggered approach. For example, contributions could be collected every quarter, with payments under §153.240 being disbursed in the subsequent quarter, to always ensure that reinsurance payments do not exceed contributions. Contributions could first be collected at the end of calendar year quarter 2013, to allow for reinsurance payments at the end of the first quarter of 2014.

§153.230 Calculation of reinsurance payments

General comments

The preamble solicits comments on a suitable method for ensuring that issuer costs are appropriate and accurate. The proposed rule is entirely inadequate on how reinsurance claims and reinsurance data submitted by insurers should be verified. For example, under proposed §153.240(c), States are required to maintain reinsurance records for each benefit year for at least 10 years but no similar requirement applies to insurers. Under proposed §153.340(d)(3), reinsurance entities can receive risk adjustment data for reinsurance payment verification purposes and to support audits but there is no requirement that the State and/or reinsurance entity actually audit insurers. As a result, we recommend that States be required to annually audit a sample of reinsurance claims and reinsurance data submitted by insurers to ensure that they are appropriate and accurate. This requirement could be incorporated into §153.210(e). Similarly, as a condition of eligibility for reinsurance payments, any insurer must agree to comply with such audits. This would produce confidence in the reinsurance system to ensure that contributions are actually going to valid reinsurance claims and thus helping lower premiums in the individual market. Such a requirement could be included in §153.230 related to reinsurance eligibility and in §153.240 related to data collection.

§153.230(a) Calculation of reinsurance payments

We agree that given the short-term nature of the reinsurance program, the objective should be to select an implementation approach that is administratively and operationally simple, but satisfies the goals of the program. We strongly disagree, however, with the proposed rules in §153.230 that tie eligibility for reinsurance payments to costs related to the essential health benefits (as defined under section 1302(b) of the Affordable Care Act) that exceed an attachment point. There is nothing in section 1341 of the Affordable Care Act, which establishes the
reinsurance program, that ties eligibility to the essential health benefits and there is no cross-reference to section 1302(b) in that section. Depending on how the essential health benefits are ultimately defined by the Secretary, tying reinsurance eligibility to the essential health benefits could result in insurers being ineligible for reinsurance payments for costs related to certain medically necessary benefits furnished to high-cost individuals. That, in turn, could encourage such insurers to no longer cover such benefits in the individual market. In addition, the preamble indicates that the goal in determining how to disburse reinsurance payments under §153.240 was to align with how commercial reinsurance (and, we note, public reinsurance programs operated by some States including New York) works today. Such existing reinsurance, however, does not distinguish among covered benefits but applies when costs for all covered plan benefits exceed an attachment point.

Specific Recommendation: Amend §153.230(a) as follows.

“(a) General requirement. A health insurance issuer of a non-grandfathered individual market plan becomes eligible for reinsurance payments when its expenses for covered items and services within the essential health benefits, as defined in section 1302(b) of the Affordable Care Act, of an individual enrollee exceed an attachment point.”

§153.230(b) Reinsurance payment

We believe it is reasonable that HHS has opted to base reinsurance payments on medical costs to the health insurer for covered benefits that exceed an attachment point, as that is how commercial (and public reinsurance programs like those in New York) tend to work. We also agree that reinsurance can potentially reduce incentives for health insurers to control costs, and the use of a reinsurance cap may address that concern. As in our comments on health insurer eligibility for reinsurance note, however, we strongly disagree with tying payments to costs solely related to the essential health benefits. The proposed rules in this section should be amended to strike any reference to the essential health benefits.

Specific Recommendation: Amend §153.230(b) as follows.

“…
(1) States must ensure that the reinsurance payment represents the product of the coinsurance rate times all health insurance issuer costs for an individual’s covered benefits, as defined in section 1302(b) of the Affordable Care Act, between the attachment point and the reinsurance cap.”

§153.230(c) State modification of reinsurance payment formula

In providing States flexibility in modifying the attachment point, reinsurance cap (including elimination of the cap) and coinsurance rate under this provision, the preamble notes that States may have unique situations and thus should be provided such flexibility. Moreover, according to the preamble, States may have many reasons to make adjustments to the HHS reinsurance payment formula. Yet the proposed rules do not require the State to actually provide a justification for such modifications. For example, a State altering its reinsurance cap from the Federal cap should be required to demonstrate that it better aligns with the typical reattachment
points used by commercial reinsurance in the State’s individual and small-group markets, or that a higher cap is necessary to take into account higher health care utilization and spending in the State. As we recommend in our comments to §153.110, any State notice about modifications to the Federal parameters should also include a rationale for such modifications.

Specific Recommendation: Amend §153.230(c) as follows.

“…
(2) States must publish any modification to the reinsurance payment formula and parameters and the rationale for such modifications in a State notice as described in §153.110.”

§153.240 Disbursement of reinsurance payments

General comments

We agree that it is reasonable to establish a standard method of collecting reinsurance data from insurers. Such a method would ensure uniformity and reduce burdens for insurers, while also making it easier to verify and audit reinsurance claims from insurers. We also support standard deadlines that ensure timely claim submission by insurers. As the preamble notes, standard deadlines would also facilitate calculations related to other requirements under the Affordable Care Act, including medical loss ratio reporting and risk corridors. We believe that such deadlines should immediately follow the end of the coverage year, if possible. Finally, we agree that States should maintain all reinsurance records for up to 10 years but note that such a requirement should also apply to insurers submitting reinsurance claims.

Subpart D – State Standards for the Risk Adjustment Program

§153.300 Definitions

As our comments to §153.310 note, we agree that section 1343(a) of the Affordable Care Act clearly requires that for purposes of risk adjustment, risk pools are required to be aggregated at the State level, including those enrolled in catastrophic plans offered in the individual market under section 1302(e) of the Affordable Care Act. The definition of risk pool included in §153.300, however, does not specifically require that risk is to be aggregated across the State. The regulations should be amended accordingly.

Specific Recommendation: Amend §153.300 as follows:

“…Risk pool means the State population across which risk is distributed in risk adjustment.”

§153.310 Risk adjustment administration
We agree that section 1343(a) of the Affordable Care Act clearly requires that for purposes of risk adjustment, risk pools subject to risk adjustment are required to be aggregated at the State level, even if a State decides to utilize regional Exchanges.

Moreover, the Statewide risk pools should include any catastrophic plans offered in the individual market under section 1302(e) of the Affordable Care Act. The draft HHS white paper entitled “Risk Adjustment Implementation Issues” issued on September 12, 2011 discusses an option under which catastrophic plans could be excluded from the risk pool subject to risk adjustment in the State (and placed in a separate risk adjustment pool). That would be contrary to the intent of the catastrophic plan provision which is to encourage younger, healthier individuals to participate in the individual market inside and outside the Exchange by allowing insurers to offer significantly less comprehensive coverage, and thus better ensure a balanced risk pool in the overall individual market. Taking catastrophic plan enrollees out of the rest of the risk adjustment system would entirely defeat that purpose. As a result, we oppose exclusion of catastrophic plan enrollees from the State risk pool subject to risk adjustment. Catastrophic plans will continue to be more affordable to young adults because they will have actuarial values that could be well below the minimum Bronze level required of all other plans.

We agree that it is a reasonable requirement for HHS to set June 30 of the year following the benefit year as the deadline for States to finalize risk adjustment data collection, as that approach is generally consistent with Medicare Advantage (under which final risk adjustment data must be submitted 2 months after the end of the plan year, but may at CMS’s discretion, include up to a 6-month lag time). We note, however, that Medicare Advantage uses a prospective risk adjustment system that provides interim risk-adjusted payments over the course of the year, which are subject to a final reconciliation process that is completed in the following year. Such a deadline should be used for the final reconciliation process, but should not be designed in a way to preclude a prospective system being adopted, as noted in our comments to §153.320.

As noted in our comments to §153.320, the proposed rules appear to envision the use of a retrospective risk adjustment system at least temporarily, with charges collected and payments disbursed only once well after the end of the benefit year. The preamble seeks comment on an appropriate timeframe for State commencement of payments. We believe that the system of charges and payments should be structured to allow for interim charges and payments over the course of the year, even in the first year of administration (2014). For example, an interim determination of charges and payments could be made at the six-month point in 2014 (or every quarter). We believe that it is critical that interim risk adjustment payments be available to plans in case they experience severe adverse selection, including smaller insurers or new insurers to the individual and small-group markets especially in the Exchanges. Such insurers (as opposed to large established insurers in the State) may not be able to wait until sometime in 2015 for risk adjustment payments if they experience higher-than-average actuarial risk, even with the potential availability of reinsurance payments over the course of the year. (Risk corridor payments would also not be provided until 2015 for the 2014 benefit year.) Otherwise, the lack of interim payments could reduce competition (and discourage new market entrants) in the
individual and small-group markets in the State, which is a critical goal of the Affordable Care Act.

The availability of interim payments, however, would require that the risk adjustment entity in the State (or HHS, on behalf of the State) have sufficient funding to provide risk adjustment payments. In the first year, that would likely require all insurers offering risk adjustment covered plans to pay a preliminary charge into the system (i.e., a percentage of each insurer’s premiums for its individual and small-group lines of business), even though charges may be immediately returned as interim payments (or ultimately provided as final payments in the following year). Interim charges over the course of the year could also include additional assessments to finance risk adjustment operations during the year and could build up a sufficient reserve for the State and HHS to ensure adequate funding on-hand to make necessary payments, per our comments to §153.320 below. Moreover, as we note in our comments to §153.320, we recommend that any retrospective system be transitioned to a prospective system as soon as possible, once sufficient data to use a prospective system is available. The interim system we recommend here could then be adopted to collect charges and provide payments to plans during the year on a periodic basis (e.g., quarterly).

We agree that States should provide HHS with a summary report of risk adjustment activities for each benefit year in the year following the calendar year in the report, and support that such report includes the average actuarial risk score for each plan, corresponding charges or payments, and any additional information HHS deems necessary to support risk adjustment methodology determinations. The report, however, should also include information on risk score and cost trends, including evidence of upcoding, as discussed in our comments to §153.350, as well as error rates determined under the most recently completed risk adjustment data validation audits under §153.350. The report should also permit States to make recommendations on how HHS could refine or recalibrate the system to address these trends. (In a State that is using an alternative methodology, it should report how it is refining its model to address upcoding and errors.) The report should also note when charges did not equal payments, and how charges or payments were adjusted to ensure risk adjustment budget neutrality.

§153.310(a) Risk adjustment administration

We agree with the proposed rule that any State electing to establish an Exchange is eligible to establish a risk adjustment program but that HHS would operate risk adjustment if the State does not establish an Exchange or does not elect to administer risk adjustment even if it elects to establish an Exchange.

If HHS operates an Exchange in a State, it is critical that risk adjustment is administered on a timely and accurate basis and that Exchange QHPs are not subjected to adverse selection relative to plans offered in the outside market. Requiring HHS to administer risk adjustment in a State that does not elect to establish an Exchange would help ensure that risk adjustment is appropriately mitigating the risk of adverse selection against the Exchange operated by HHS. As we note in our comments to §153.210(c), we believe that similar rules should apply to reinsurance programs. If a state does not elect to establish an Exchange, HHS should not only be required to operate the Exchange but also the reinsurance program in the State. Reinsurance is a
critical temporary risk mitigation tool that would help ensure that the individual market including within the Exchange functions adequately when the major insurance market reforms take effect

§153.310(b) Entities eligible to carry out risk adjustment activities

We agree that a State may elect to have an entity other than the Exchange perform the risk adjustment functions in the State. But we believe that the requirement that any risk adjustment entity comply with the various standards included in the proposed rules in §155.110 for entities operating Exchanges is wholly inadequate. For example, such rules would only require that an Exchange (or an entity other than an Exchange) ensure that a majority of the membership of a governing board do not have conflicts of interest, including representatives of health insurers (even if the rest of the board does have such conflicts of interest). Any decisions related to risk adjustment would produce inherent conflicts of interest, because such decisions would directly affect whether insurers are eligible for risk adjustment payments or are required to pay risk adjustment charges (and the amount of such payments or charges). Moreover, there is no specific requirement in the proposed rules in §155.110 that require consumer representation. Because of the technical nature of risk adjustment, decisions are likely to be dominated by insurers and actuaries about how to administer risk adjustment. Consumer representation on the governing board of any entity (including the Exchange) administering risk adjustment is essential to provide for a fair balance of interests. This is particularly important because the relative success of risk adjustment will have a direct effect on the affordability of coverage in the form of premiums in the individual and small-group markets and whether the Exchanges are viable over the long-term.

There is also no requirement in the proposed rules in §155.110 that the highly complex and detailed policy decision-making associated with the administration of risk adjustment is fully transparent. All decisions should be made in the open — the proposed rules in §155.110 only require that public governing board meetings be held regularly — and all major risk adjustment decisions by a State including rules, guidance, and technical specifications should be subject to public notice and comment to ensure adequate consumer input.

Finally, by referencing the proposed Exchange rules in §155.110, which include the requirements for entities contracting with the Exchange to perform Exchange functions, the proposed rules in §153.310(b) seem to inadvertently preclude a State from designating another State agency (other than the Exchange or the Medicaid agency) as the risk adjustment entity in the State. For example, a State may consider using its insurance department to administer risk adjustment. The final rule should clarify that other State agencies could serve as the risk adjustment entity in the State, in addition to the Exchange and the Medicaid agency. That could be accomplished by instead referencing in this section the proposed Exchange rules in §155.100(b), which incorporate by reference the requirements in §155.110.

§153.310(c) Timeframes

We agree that risk adjustment should commence with the 2014 benefit year. While section 1343 of the Affordable Care Act does not explicitly require risk adjustment to start in 2014, it was the clear intent of Congress that risk adjustment, like the reinsurance and risk corridor
programs, begin in 2014, when the major insurance market reforms and the Exchanges first take effect, in order to mitigate the risk of adverse selection in the individual and small-group markets inside and outside the Exchanges and among plans within the Exchanges.

§153.320 Federally-certified risk adjustment methodology

General comments

We strongly recommend that instead of allowing States to establish their own risk adjustment methodology, subject to federal approval, as the proposed rule would do, HHS should establish a standard risk adjustment methodology that every state would be required to use. This would provide national uniformity and produce comparable results that do not vary based on a specific plan or where the plan’s enrollees reside. A uniform methodology also means that States would not have to dedicate scarce resources to what is effectively reinventing the wheel — they would not have to develop their own risk assessment tools or purchase a proprietary system, and data collection elements would be standardized. In addition, a uniform methodology would provide for economies of scale and reduce the administrative burden for insurers in planning for the new system and in collecting and transmitting the data needed to do risk adjustment across states. This would be particularly important since the models will likely need to be modified as more data become available; a single uniform methodology would be easier to refine over time. States, however, should be given the flexibility to tailor that standard methodology (and related standards) for their state markets, subject to federal approval.

The proposed rule and the preamble appear to imply that risk adjustment will be done initially on a retrospective basis and that a retrospective system may be used indefinitely. (The preamble related to proposed rules in §153.310 only discusses risk adjustment charges and payments likely being made six months after the end of the plan year.) While it may be appropriate to temporarily use retrospective adjustment because of the lack of information about the newly insured population and the more generalized uncertainty about how risks will be initially distributed, the final rule should require a transition as soon as possible to a prospective system like the one used in the Medicare Advantage risk adjustment system. A prospective system means that the adjustment for a plan year will be based on past cost data (claims and encounter data) used in tandem with past or current health status data (demographics, diagnoses and potentially prescription drug data). Prospective adjustment has the advantage of placing insurers on a level playing field to the extent that they are all setting premiums based on prior data. In addition, it facilitates competition among insurers by reducing the barriers to market entry for a new insurer because new insurers would be assured, in advance, higher, predictable payments of specified amounts if they attract higher-risk populations. A prospective system is also more likely to encourage cost-efficiency by plans; in contrast, a retrospective system can potentially result in higher overall health care costs since it bases adjustments on actual costs in the plan year, whatever those costs are, incurred by insurers during the just completed benefit year.

We acknowledge, however, that the transition to a prospective system will largely depend on the speed with which data for risk adjustment reported by insurers during the 2014 plan year can be analyzed by HHS to design an effective and accurate prospective system and have it tested.
(For example, while a prospective system can be based in large part on the prospective system used in Medicare Advantage, the Medicare Advantage system, by definition, is not designed to accurately predict costs related to maternity or pediatric care, which will need to be carefully addressed. HHS could also consider transitioning to a prospective system but continuing a retrospective or concurrent approach for certain conditions like pregnancy and newborn care for some period of time, as discussed in the HHS draft white paper.) We note that some states with all payer claims databases may be able to proceed to a prospective system on a more expedited basis (or serve as a proving ground for such an approach).

The preamble seeks comments on how risk adjustment methodologies should adjust for differences in premium rating rules across States. We agree that it is critical to account for premium rating variation in some fashion to ensure that risk adjustment does not inappropriately adjust for the actuarial risk that insurers have already incorporated into their premium rates (for example, by charging older individuals three times as much as younger individuals). Without accounting for these differences, risk adjustment could result in some “double counting” under which certain insurers would be receive larger payments (or be required to pay lower charges) than they otherwise would. The methodology developed by HHS (and any alternative State methodology) should clearly explain how the methodology will account for those differences (and how States can adopt the HHS methodology to their specific premium rating rules). One possible approach would be to entirely remove rating variation from the risk adjustment methodology, but as noted in the draft HHS white paper, one potential consequence of “double counting” would be to effectively lower premiums for older individuals, which would make such coverage more affordable and older enrollees more attractive to insurers despite their higher risks (though it is unclear if that would actually happen in practice). HHS should continue to study the options in this area.

As the draft white paper notes, the risk adjustment methodology will also have to take into account premium variation based on family composition. (We note that we oppose the proposed Exchange rules in §156.255 that permits insurers to determine family premium categories; instead, the federal government and/or the States should decide the family premium categories that are to be used uniformly inside and outside the Exchange under section 1252 of the Affordable Care Act.) Calculating separate risk scores for plan enrollees even if they are part of the same family seems like one reasonable approach. In addition, the risk adjustment methodology may have to address premium differences between geographic premium rating areas determined under section 2701(a)(2) of the Public Health Service Act, as added by section 1201 of the Affordable Care Act. The draft HHS white paper outlines several possible approaches. Because it is unclear what standards States will have to meet in establishing their premium rating areas (and whether such requirements will be sufficiently robust), we recommend that the final rule not address that issue at this time, until it can be determined how State flexibility with regard to premium rating areas would interact with effective risk adjustment.

The methodology should also address how it will interact with section 1312(c) of the Affordable Care Act, which requires that all insurers in the individual market (and separately all insurers in the small group market) use a single risk pool across all plans offered by the insurer in that market. This requirement could help simplify risk adjustment administration, as risk
adjustment would be effectively applied across insurers (at least within the same market) rather than on each plan offered by each insurer. (We note that both the preamble and the proposed rules do not discuss the risk pooling requirement. The HHS draft white paper also ignores the risk pooling requirement, as its illustrative examples do not assume risk is being pooled across individual plans offered by the same insurer.)

The preamble also seeks comment on whether risk adjustment should be based on average state premiums (after adjusting for actuarial value) or actual plan premiums. While basing the adjustment on average state premiums rather than actual plan premiums can lower accuracy because premiums are based on a number of factors (e.g., provider networks, utilization review, administrative costs, profit, and provider payment rates) other than the relative risk of enrollees, using actual plan premiums could also allow for “double counting” depending on how insurers set their premiums. For example, if an insurer already builds an additional risk premium into its plan premium because it expects to enroll a sicker-than-average population and the insurer then receives a risk adjustment payment based on that higher-risk enrollment, the insurer could end up being overcompensated. Using actual plan premiums would require that the adjustment be instead made to a base plan premium that assumes enrollment of average risk (and excludes the premium effects of other factors, like those noted above, including actuarial value and provider networks). That may be too complex or uncertain a calculation to make in practice, at least in the early years of risk adjustment implementation.

On balance, we recommend that risk adjustment initially be based on average state premiums. We agree with the draft white paper that there should be an adjustment for differences in actuarial value; otherwise risk adjustment could end up compensating insurers for expenses their plans may not actually be incurring (for example, if the expenses are below a Bronze plan’s deductible). HHS should revisit this issue once it has collected and analyzed sufficient risk adjustment data and has a better sense of how insurers are calculating their plan premiums in the individual and small-group markets (and of whether HHS can identify a methodology to accurately adjust actual plan premiums to produce a base premium that could be used to calculate appropriate risk adjustment charges and payments).

The proposed rule does not address how States (or HHS, on behalf of a State) can finance the administrative costs of operating the risk adjustment system on an ongoing basis. (The Exchange Planning and Establishment Grants can be used by States to set up risk adjustment and for financing its operating costs through the end of 2014.) The final rule should make clear that States can finance operating costs by increasing the charges to insurers with lower-than-average risk, just as States can collect additional reinsurance contributions to provide funding for reinsurance administrative costs under §153.220(b)(3)(ii). Financing risk adjustment operating costs in this manner would also encourage insurers to report data on a timely basis and otherwise cooperate so that the process works as efficiently as possible. (States could also be permitted to finance risk adjustment operating costs by requiring all insurers subject to risk adjustment to contribute, as part of the risk adjustment system.) Another alternative approach that the final rule could permit would be for States to fund risk adjustment administrative costs out of assessments on insurers — operating inside and outside the Exchanges — on top of those that could be levied by States to finance Exchange operations. Such an approach would help to spread the costs for the risk adjustment authority more widely across all insurers that operate in
the State. States could also finance risk adjustment through assessments on Exchange QHPs. That approach, however, would place the burden of risk adjustment administrative costs solely on Exchange plans, even though risk adjustment applies to the entire individual and small-group markets and protects insurers offering plans inside and outside the Exchanges that experience adverse selection.

The proposed rules and the preamble mention the need for HHS to periodically refine and recalibrate the Federally-certified risk adjustment methodology it will develop but do not specifically address how it will make such improvements. As with the Medicare Advantage and Medicare Part D risk adjustment systems, HHS should establish clear procedures for making timely, periodic refinements to the risk adjustment methodology it is developing, for updating its constituent parts, and for correcting for upcoding and other risk score and cost trends. Such modifications would improve risk adjustment’s accuracy and its ability to limit adverse selection in the individual and small-group markets inside and outside the exchanges. These modifications will be especially important in the first few years, as more risk adjustment data become available for incorporation into the models and weights that need to be recalibrated. For example, over time, greater information about health status and spending in the individual and small-group markets will allow the model to become more and more predictive. (Such data should also allow the transition to a prospective risk adjustment system.)

The preamble seeks comment on how to address the situation when charges to finance risk adjustment payments do not equal the payments (either charges exceed payments, or payments exceed charges). We believe that in the situation when charges exceed payments, excess plan charges should be placed in a reserve account that would provide a margin of error to ensure that all necessary risk adjustment payments can be covered by the charges in a given year. This would be particularly important in the early years of the risk adjustment program. Over time, a portion of the excess charges could be returned to insurers (with that percentage growing over time, as the system becomes more predictable and it is less likely that charges will significantly exceed payments). In the situation where payments exceed charges, the best approach would likely be to split the shortfall between high-risk and low-risk plans and pro-rate in both directions. As the illustrative examples in the draft white paper make clear, that would produce the most reasonable outcome, by ensuring that low-risk plans pay somewhat higher charges on a pro-rata basis, while at the same time high-risk plans would receive somewhat lower payments, in order to ensure budget neutrality.

§153.320(a) General requirement

In developing its Federally-certified risk adjustment methodology, HHS should use standardized computer software. Ideally, it should be public and not proprietary and should be made available through an HHS website so that it is readily accessible to insurers and State entities using the system to administer risk adjustment in the State. Insurers need to be able to calculate their own plan scores and expected charges and payments for purposes of developing premiums for their plan offerings, as they do with Medicare Advantage today. (This requirement should also apply to any alternative State methodology.)
§153.320(b) Publication of methodology in notices

The Federal or State notice should also indicate how risk scores will be calculated for each individual plan enrollee. Once that score is calculated, though, the methodology would have to lay out how to calculate a composite health plan score across all of a plan’s enrollees. We recommend that the composite risk score used to calculate a plan’s average actuarial risk be based on the actual risk scores of the members enrolled on a periodic (e.g., monthly) basis during the relevant year, in part because of the expected turnover of enrollees in the individual and small-group markets.

Another issue the notice should address is how the methodology will incorporate mid-year enrollees. The risk score for such new enrollees could be based on: (a) the plan’s average risk score adjusted by age; (b) the risk score for the average population for the pool as a whole (i.e., the entire market in a state); (c) the enrollee’s demographic characteristics only; or (d) some combination of the above or another readily administered approach. This will be important because a significant number of people are likely to move in and out of plans during the year due to changes in personal circumstances. Another option, which would be easier to administer and avoid inaccurate results due to this churning, is to only include enrollees who are in the plan for a certain minimum period of time (e.g., six months), though plans experiencing significant churning could end up being over- or undercompensated by risk adjustment if new enrollees have risk scores that substantially differ from the risk scores of people enrolled for at least the minimum period of time.

It will be important to test whether the methodology should include the enrollee’s eligibility for premium subsidies among the factors to be employed in the model, which may help to capture variation that other factors in the model cannot explain, as was the case in Medicare Part D with Low Income Subsidy enrollees. Whether this requires more than a simple yes-no variable or a more nuanced measure to account for the wide income range captured by the premium subsidy will need to be determined. In addition, as the draft white paper notes, it will also be necessary to test whether the methodology should include the enrollee’s eligibility for cost-sharing reductions, which could capture not only potential utilization differences but other unexplained variation.

§153.320(c) Use of methodology for States that do not elect an Exchange

The proposed rules do not specifically state that HHS will specify in the annual Federal notice of benefits and payment parameters the methodology that will be used in States that elect to operate an Exchange but not to administer risk adjustment. The proposed rules should be amended to make clear that such a methodology will be the same one used in States that do not elect to operate an Exchange.

Specific Recommendation: Amend §153.320(c) as follows:

“(c) Use of methodology for States that do not elect an Exchange. HHS will specify in the forthcoming annual Federal notice of benefits and payment parameters the Federally-certified
risk adjustment methodology that will apply in States that do not elect to operate an Exchange or to administer risk adjustment."

§153.330 State alternative risk adjustment methodology

General comments

The preamble seeks comments on a timeline for States to submit requests to HHS to use an alternative methodology, rather than the methodology developed by HHS. The preamble raises one possible timeline where States would be required to submit requests no later than early November 2012, with HHS making a determination on the request within 60 days. While the timeline is tight, it appears reasonable considering the time it will take to fully implement risk adjustment as well as to give adequate time for insurers to reflect risk adjustment in setting their premium rates. States, however, could be given an additional 30 days to submit a request after the Federal notice of benefits and payment parameters is issued, which would provide stakeholders, including consumers, more time to comment on the State alternative. In addition, HHS could be given an additional 30 days to assess the State methodology, particularly if it differs substantially from the methodology developed by HHS. It is critical that HHS have sufficient time to determine if the State alternative does in fact produce results similar to or better than the HHS methodology, as discussed further below in our comments to §153.330(a).

§153.330(a) State request for alternative risk adjustment methodology

The preamble indicates that the standard of review for HHS in assessing State requests to substitute an alternative risk adjustment methodology is whether the methodology would offer “similar or better performance in that State than the Federally-certified risk adjustment methodology” developed by HHS or another State methodology that has already received federal approval. Yet the proposed rule does not include this rigorous standard or explain how the State is to demonstrate that it meets this standard through the information it is required to submit under proposed §153.330(a). We agree that no State methodology should be certified unless a State can demonstrate that it will do as well or better than the system developed by HHS. The proposed rules, however, should be modified to specifically require that the State do so.

We strongly support the requirement that States may substitute their own alternative risk adjustment methodology only by submitting a detailed application to HHS and then receiving approval from HHS for the State methodology to be certified as a Federally-certified risk adjustment methodology. We agree that the State should provide specific information about the methodology and demonstrate, among other things, that the methodology can meet performance metrics designated by HHS, accurately explain variation in costs across the population, link risk factors to daily clinical practice, encourage favorable behavior among providers and health plans and discourage unfavorable behavior, use data that are complete, high in quality and available in a timely fashion, be easy for stakeholders to understand and implement, provide stable risk scores over time and across plans, and minimize administrative costs. As noted in the preamble, these criteria are consistent with the principles that guided the creation of the Medicare Advantage risk adjustment system. As part of its application, the State, however, should also be
required to indicate how, among other things, it will transition to a prospective system (if it plans to use a retrospective system initially), address mid-year enrollees, identify and remedy upcoding problems, data reporting errors and other non-compliance issues among insurers, how its methodology could produce data that would be helpful to HHS in recalibrating or refining its methodology, and other factors determined by HHS. The State should also specify how it will finance ongoing risk adjustment operations after 2014.

The proposed rule also does not specify that applications by States should be standardized to streamline the HHS evaluation process and allow stakeholders to more easily assess the merits of a State application.

In addition, the State should be required to make any applications to use an alternative methodology publicly available for notice and comment before submission. Such state applications should be made available to the public on a website administered by HHS, along with the HHS decision related to the application.

Specific Recommendation: Amend §153.330(a) as follows and renumber accordingly:

“(a) State request for alternative methodology certification.
(1) The State request to HHS for the certification of an alternative adjustment model must be submitted in a manner determined by HHS and must include:
(i) A description of how the request incorporated stakeholder input through a public notice and comment process prior to submission;
…
(E) Calibration methodology and frequency of calibration; and
(F) Statistical performance metrics, as specified by HHS; and
(G) Funding for administrative expenses related to the risk adjustment program; and
(H) Other information required by HHS.
…
(2) The request must demonstrate how the methodology will produce similar or better results than the methodology developed by HHS under §153.320(a)(1) including the extent to which the methodology:…”

§153.330(b) State renewal of alternative methodology

We strongly support the requirement that States that operate an alternative methodology must renew HHS certification whenever changes are made, including at the time of recalibration. Changes could reduce the effectiveness and accuracy of the risk adjustment system, which would violate the requirement that the alternative methodology produce similar or better performance than the methodology developed by HHS.

§153.340 Data collection under risk adjustment

§153.340(a) Data collection requirements
We support the “intermediate” data collection approach required under the proposed rule under which issuers submit raw claims and encounter data to the State (or HHS, in States where it is operating the risk adjustment system). That will ensure accuracy, transparency and credibility for the system among insurers. (We note that if HHS accepts the recommendation in our comments to §153.320 that it should require all states to adopt a uniform federal risk adjustment methodology, we would recommend a data collection approach under which issuers submit claims and encounter data to HHS.)

Conversely, we vigorously oppose a “distributed” approach under which issuers would calculate their own risk scores and submit them to the State (or HHS) without providing the underlying raw claims and encounter data. This would make the risk adjustment system excessively vulnerable to errors committed by issuers, particularly those that are not already experienced with risk adjustment in Medicare Advantage and Medicare Part D. A distributed approach would also make it far more difficult for States (and HHS) to identify errors in risk score calculations (or upcoding trends) on a timely basis and would instead require reliance on the use of retrospective audits, which under §153.350 would not be completed for as much as three years after the end of the applicable plan year. It would also make the system more easily subject to outright fraud and abuse if some issuers deliberately skewed their risk scores in order to lower the contributions they would be charged or to increase the payments they would receive. That would undermine the system’s credibility among insurers, especially in its early years, and could lead to higher premiums in the individual and small group markets inside and outside the Exchanges and discourage insurer participation as Exchange QHPs, both of which could threaten the long-term viability of the Exchanges.

While some insurers may argue that a fully distributed system is necessary to protect enrollees’ privacy, we strongly disagree. The proposed rules under §153.340(b) require that States only use identifiable information for certain purposes, implement security standards that provide administrative, physical and technical safeguards for the individually identifiable information, and establish privacy standards. Moreover, risk adjustment data for millions of Medicare beneficiaries is already being used (and protected) in Medicare Advantage and Medicare Part D. (We note, however, that the proposed rules should make clear that risk adjustment data must be encrypted when the data are submitted and when they are stored. In addition, HHS should make clear that State costs related to instituting encryption and other security features into the risk adjustment system would be eligible expenses under the Exchange Planning and Establishment grants, as is risk adjustment implementation generally.) Having a credible and effective risk adjustment system is essential to ensuring that individuals and small businesses have access to affordable, comprehensive health insurance coverage options both inside and outside the Exchanges. In our view, the benefits of the intermediate approach far outweigh the privacy concerns, so long as privacy is appropriately protected with States and HHS by fully complying with the privacy requirements of §153.340(b).

We also support requiring federal standards for the risk adjustment data (and the formatting of such data) that insurers will be required to report. That will make it easier to calculate risk scores on a timely basis, identify reporting errors, and verify such data within a State, as well as to compare the effectiveness and accuracy of risk adjustment across States (including across States with different risk adjustment methodologies). In addition, as with States adopting the
Federally-certified methodology, standard data reporting and formatting requirements would provide for economies of scale and reduce the administrative burden for insurers in planning for the new system and in collecting and transmitting the data needed to do risk adjustment across States (if they are offering individual or small group coverage in multiple States).

§ 153.340(c) Exception for States with all payer claims databases

We believe that HHS should encourage all States to establish all payers claim databases (so long as they meet patient privacy protection standards). Such databases would be invaluable for a variety of purposes, including facilitating initiatives to improve patient safety and the quality of health care furnished in the individual and small group markets. Nevertheless, the proposed rule does not appear to clearly ensure that States with all payer claims databases seeking an exemption to the federal data collection standards actually demonstrate that such databases could be effectively used (with or without modifications) in conjunction with a Federally-certified risk adjustment methodology (and/or a State alternative risk adjustment methodology that qualifies for certification). Nor does the proposed rule appear to require that States demonstrate how such data could meet a variety of required purposes including helping HHS refine its risk adjustment methodology or support a variety of other critical functions including those related to Exchanges. The proposed rule should be modified to require that a State with an all payers claim database can only qualify for an exemption if it can demonstrate that such a database can meet all relevant data requirements.

Moreover, States could be required to make available the data in their all payers claim databases to HHS to test potential refinements or other modifications to the Federally-certified risk adjustment system (and potentially to create sample data files that could be used to assess whether proposed State alternative methodologies meet federal standards for certification). These data also could be used to test prospective risk adjustment systems that HHS would develop, as noted in our comments to §153.320. Such a requirement could come under “other purposes” identified by HHS, as added by the recommended revisions to §153.340(d) outlined below.

Specific Recommendation: Amend §153.340(c) as follows:

“(c) Exception for States with all payer claims databases. Any State with an all payer claims database that is operational on or before January 1, 2013 may request an exception from the data collection minimum standards in paragraph (b) of this section by submitting: (1) Technical specifications for the all payers claims database including data formats; (2) and demonstrating how it will make proposed system modifications to meet the data collection requirements of a Federally-certified risk adjustment methodology and support all necessary risk adjustment activities; (3) Proposed system modifications to and meet requirements set forth in paragraph (d) of this section and other Exchange-related activities.

§ 153.340(d) Uses of risk adjustment data

We support requiring that States (and HHS, in States where it is operating the risk adjustment system) make certain claims and encounter data collected under risk adjustment available to
support other activities including recalibrating Federally-certified risk adjustment models, verifying risk corridor submissions by insurers and verifying and auditing reinsurance claims. As noted, such data will be critical in making timely, periodic refinements to the Federally-certified risk adjustment model, for updating its constituent parts, and for correcting for likely upcoding of diagnoses. Such refinements, based on these data, would improve risk adjustment’s accuracy and its ability to limit adverse selection in the individual and small-group markets inside and outside the Exchanges. These modifications will be especially important in the first few years, as new information becomes available for incorporation into the models and as weights need to be recalibrated. States (and HHS) should also be required to report certain risk adjustment data to HHS for other relevant purposes, as determined by HHS. This will provide important flexibility to HHS to ensure that it has access to risk adjustment data if it identifies other critical activities related to Exchanges or insurance market reforms that would benefit from the availability of such data.

The proposed rules should also clarify that States (and HHS, in states where it is operating an Exchange and/or a risk adjustment system) have the authority to use, at their option, data collected under risk adjustment to enforce other critical Exchange requirements and insurance market reforms. For example, the data could be used to compare the demographic and diagnostic information submitted by insurers for purposes of risk adjustment to the data submitted by insurers for purposes of rate reviews under 45 CFR Part 154, or to help determine whether insurers are complying with the single risk pool requirement across all of their plans offered inside and outside the exchange under section 1312(c) of the Affordable Care Act. The data could also be used in Exchange consideration of QHP premium rate increase justifications under §155.1020. Insurers may argue that their premium rate increases were necessary because of past (and anticipated) changes in their risk pool (for which they were not being fully compensated under risk adjustment or risk corridors). Risk adjustment data could be used to evaluate such claims.

In addition, under section 1311(c)(1)(A) of the Affordable Care Act, in order to be certified as a Exchange QHP, insurers must demonstrate that they are not employing marketing practices or benefit designs that have the effect of discouraging the enrollment of individuals with significant health needs. Risk adjustment data can help ensure more effective enforcement of this requirement. States can carefully monitor changes in the relative health of enrollees in a plan over time using risk adjustment data to see if a plan’s marketing practices or benefit design changes have produced favorable selection over time (by deterring enrollment by those in poorer health).

Specific Recommendation: Amend §153.340(d) as follows:

“(d) Uses of risk adjustment data.
(1) The State, or HHS on behalf of the State, must make relevant claims and encounter data collected under risk adjustment activities available to support claims-related activities as follows:
   (4a) Provide HHS with de-identified claims and encounter data for use in recalibrating Federally-certified risk adjustment models;
   (2b) Provide HHS with summarized claims cost for use in verifying risk corridor submissions; and
(3c) Provide the reinsurance entity with summarized claims and encounter data from reinsurance-eligible plans for payment verification purposes and individual-level from reinsurance-eligible plans for audit purposes, and

(d) Provide HHS with de-identified claims and encounter data for use for any other purposes as determined by HHS.

(2) The State, or HHS on behalf of the State, may use relevant claims and encounter data collected under risk adjustment activities for other enforcement and verification purposes, as permitted by HHS.”

§153.350 Risk adjustment data validation standards

§ 153.350(a) General requirement

We strongly support the requirement that insurers be subject to risk adjustment data validation audits on an annual basis. We agree that such a process is essential to the establishment of a credible risk adjustment system for insurers and thus would make it more likely that risk adjustment has a positive effect on premium reduction. Such audits will allow the States and HHS to identify reporting errors by insurers and coding trends among insurers that together could skew risk score calculations, and therefore undermine the accuracy of the risk adjustment methodology.

The experience with “upcoding” in the Medicare Advantage program demonstrates how important a role data validation can play in ensuring that plans submit accurate data and that risk scores are accurately calculated. Upcoding refers to an observed increase in a plan’s average risk score over time that does not reflect actual changes in enrollees’ risk. While the phenomenon may be due, in part, to one-time improvements to data collection systems that allow insurers to more accurately report enrollee diagnoses, it is a significant problem if a plan’s diagnosis data consistently make their enrollees appear less healthy than they actually are.

Under Medicare Advantage, upcoding has been a persistent issue. Risk scores have increased over time even though Medicare Advantage enrollees continue to be healthier than those in traditional Medicare, on average, and there appears to be no corresponding change in their health status. That has resulted in overpayments to plans at the expense of the Medicare program. Congress, however, first tried to address the issue by including, in the Deficit Reduction Act (DRA) of 2006, a requirement that CMS take upcoding into account in setting Medicare payments to private plans for the 2008-2010 period. The Bush Administration failed to implement this provision, despite CMS and Congressional Budget Office (CBO) findings of growing evidence of upcoding. However, the Obama Administration used its administrative authority to provide for coding intensity adjustments beginning for the 2010 plan year. The ACA then extended and expanded the adjustment for coding intensity. In addition, plans are also subject to Risk Adjustment Data Validation (RADV) audits, which identify errors and whose results are used to correct risk adjusted payments accordingly.

In the individual and small-group insurance markets, in which risk adjustment affects the redistribution of funds among private plans, upcoding and coding errors would undermine the
effectiveness of the risk adjustment system by skewing payments so some plans are overcompensated for their risks while others are significantly undercompensated. As a result, risk adjustment validation is a necessary component of the ACA’s risk adjustment system.

The proposed rules, however, do not specify how a State would validate a statistically valid sample of risk adjustment data. HHS should establish a standard risk adjustment data validation approach for States to use. For example, HHS could adapt the RADV audits now used in Medicare Advantage for the use by States. That is a system with which many insurers are already familiar, and a standard system would make it easier for insurers operating in multiple states to comply with the audits. In addition, while the preamble notes that these audits will be required of every insurer offering a risk adjustment covered plan every year, the proposed rules do not clearly require annual audits. The final rule should specify that States must audit plans every year. It also would be helpful, especially in the first few years, for HHS to directly audit a sample of plans in States operating a risk adjustment system or conduct random audits of issuers across States on a periodic basis. Such a “look behind” audit function would help ensure that the annual audits are working as intended, and would identify ongoing patterns of upcoding or coding errors across States and among insurers. Moreover, as noted above, as part of the periodic recalibration and refinement of the risk adjustment methodology developed by HHS under §153.320(a)(1), HHS should also make any needed coding intensity adjustments in response to patterns of upcoding.

We note that neither the proposed rule nor the preamble proposes a specific deadline for completion of each year’s risk adjustment data validation audits. The preamble raises the possibility of a three-year deadline for completing data validation. Because risk adjustment is likely to experience the most errors during its initial years, it is critical that these audits be done on a more expedited basis. This likely requires interim validation results and adjustments to be made as soon as possible, which can be modified as necessary, when the process is finally completed.

The proposed rule also does not address the need for penalties for plans with error rates consistently exceeding those found for other plans in a State. While such plans would be subject to revised actuarial risk calculations and charge/payment adjustments, as discussed further below, HHS should consider whether such plans would be subject to interim prospective adjustments (prior to a validation being finalized) where there is an ongoing pattern of excessive error rates. Such plans also could be required to institute a corrective action plan to bring their error rates into line with other comparable plans in the State.

Specific Recommendation: Amend §153.350(a) as follows:

“(a) General requirement. The State, or HHS on behalf of the State, must validate a statistically valid sample of risk adjustment data from each issuer that offers at least one risk adjustment covered plan in that State in a given year, in a manner determined by HHS.”

§ 153.350(b) Use of data validation to adjust risk
As noted, risk adjustment data validation audits are a key tool to ensure the accuracy of the risk adjustment system. It is therefore essential that States (or HHS on behalf of the State) appropriately act on the results of the data validation audits by adjusting the average actuarial risk for each plan based on the error rate found in the validation audits. The proposed rule merely authorizes a State (or HHS) to adjust the calculation of the average actuarial risk but does not require the State (or HHS) to actually do so. Such an adjustment should be mandatory and we recommend that the proposed rules be amended accordingly.

Specific Recommendation: Amend §153.350(b) as follows:

“(b) Use of data validation to adjust risk. The State, or HHS on behalf of the State, may shall adjust the average actuarial risk calculated in §153.310 for all risk adjustment covered plans offered by an issuer based on the risk score error determined in the data validation conducted pursuant to paragraph (a) of this section.”

§ 153.350(c) Adjustment to charges and payments

Similarly, the proposed rule only authorizes a State (or HHS) to take the adjusted risk scores into account but does not require the State (or HHS) to make the appropriate adjustment to the risk adjustment charges or payments to an insurer based on those adjusted risk scores resulting from the error rates determined in the data validation audits. Such an adjustment should be mandatory and we recommend that the proposed rules be amended accordingly.

Specific Recommendation: Amend §153.350(c) as follows:

(c) Adjustment to charges and payments. The State, or HHS on behalf of the State, may shall adjust charges and payments to all risk adjustment covered plan issuers based on the adjustments calculated in paragraph (b) of this section.

§ 153.350(d) Appeals

The proposed rule appropriately requires the State to provide an administrative process for insurers to appeal data validation findings but does not specify the process to be used, including the timing of appeals and their resolution, the scope of the appeal, and the criteria to be used in assessing the merits of appeals. To provide uniformity and reduce burdens on insurers, HHS should specify the appeals process that is to be used by states.

HHS, however, should ensure that the scope of such appeals is limited; for example, insurers should not be able to challenge the error rate calculation methodology itself but could challenge alleged calculation errors using such methodology made by the State or HHS. Insurers also should not be permitted to substitute data used in the sample — for example, producing entirely new medical record information for the sample of enrollees — but could be permitted to argue that some inadvertent errors were made, such as a two-page medical record being split into two medical records, or to allow plans to get physician attestation for medical records where physician signatures were illegible or missing. Because the results of the audits are critical in ensuring the accuracy of the risk adjustment system (and allowing HHS or States to make needed
refinements and recalibrations of their risk adjustment methodologies), it is critical that the appeals process be designed to limit the ability of some insurers to game the appeals process and therefore unduly delay any required adjustments to their actuarial risk or charges/payments based on the data validation findings. HHS could adapt, as appropriate, aspects of the appeals process used for RADV audits in the Medicare Advantage program.

Specific Recommendation: Amend §153.350(d) as follows:

(d) Appeals. The State, or HHS on behalf of the State, must provide an administrative process to appeal data validation findings in a manner determined by HHS.”

Subpart E – Health Insurance Issuer Standards Related to the Transitional Reinsurance Program

§153.400 Reinsurance contribution funds

General comments

As we note in our comments to §153.220, we recommend that the frequency of reinsurance contributions should be set to allow for a staggered approach. For example, contributions could be collected every quarter, with payments under §153.240 being disbursed in the subsequent quarter, to always ensure that payments do not exceed contributions. Contributions could first be collected at the end of calendar year quarter 2013, to allow for reinsurance payments at the end of the first quarter of 2014.

We support the requirement that each contributing entity must submit to each applicable reinsurance entity the data required to substantiate the contribution amounts for the contributing entity. Such contributing entities should also be required to cooperate with any audits or other verification efforts conducted by the state or the reinsurance entity.

The proposed rule is silent on what penalties would be applied to contributing entities if they fail to make the required contributions on a timely basis. States could be permitted to require greater contributions from those entities, or bar those entities from receiving reinsurance payments (or receiving less payments than they are otherwise eligible to receive).

§153.410 Requests for reinsurance payment

General comments

As we note in our comments to §153.230, it is critical to ensure that reinsurance claims and data are appropriate and accurate. Yet there is no requirement that insurers be subject to audits or other data verification measures. We recommend that the proposed rules in §153.410 be amended to require any reinsurance-eligible plan making a request for payment to submit any
relevant data needed in the course of audits conducted by the State or applicable reinsurance entity, similar to the requirements under risk adjustment in §153.620(a). Similarly, insurers should be required to maintain reinsurance records for at least 10 years after the date of claim submission, similar to the requirement under risk adjustment in §153.620(b).

The preamble invites comment on how to manage late claims from reinsurance eligible plan issuers. Because other provisions rely on reinsurance payments being determined first, including the medical loss ratio and the risk corridors, the ability to submit late claims should be restricted to ensure that late claims do not delay medical loss ratio rebates to consumers or risk corridor payments to insurers offering QHPs in the Exchange.

Subpart F – Health Insurance Issuer Standards Related to the Temporary Risk Corridors Program

§153.500 Definitions

General comments

The preamble invites comment on whether allowable administrative costs for purposes of risk corridors should be aligned with those under the medical loss ratio (MLR) requirement in the Affordable Care Act and whether it should similarly limit administrative costs to 20 percent consistent with the MLR. We strongly support full alignment. We agree with the preamble that if allowable administrative costs are not aligned with the MLR, this would encourage insurers to use risk corridor payments to subsidize their MLR rebates. Moreover, full alignment would allow a number of the MLR reporting forms developed by the NAIC for HHS to be used for multiple purposes, which would promote administrative simplicity and transparency while reducing administrative burdens on insurers.

§153.510 Risk corridor establishment and payment methodology

General comments

Unlike the risk corridors in Medicare Part D which are not budget neutral (and actually produced net savings for Medicare Part D in the drug benefit’s initial years), we presume that the risk corridor program will be budget neutral. But the proposed rule is silent on how to address the situation when payments to plans whose costs exceed the target amount are greater than the contributory payments from plans whose costs are less than the target amount. We recommend that HHS consider something along the lines of our recommendations for the risk adjustment program under proposed §153.320. Where payments exceed contributions, the shortfall could be split between plans with higher-than-expected costs and plans with lower-than-expected cost by pro-rating in both directions. That would produce the most reasonable outcome in our view, by ensuring that lower-than-expected costs pay somewhat higher contributions on a pro-rata basis, while at the same time plans with higher-than-expected costs would receive somewhat lower
payments, in order to ensure budget neutrality. In the case of contributions exceeding payments, the surplus contributions could be held in a reserve fund to ensure budget neutrality in a subsequent year.

The preamble also invites comment on the timeframe for plans to make contributory payments or receive risk corridor payments. The preamble suggests 30 days from notice from HHS. That seems reasonable but the proposed regulations are silent on the penalties for failure to make necessary contributory payments. Such penalties could include increases to the contributory payments or limiting risk corridor payments in the subsequent year.

§153.520 Risk corridor standards for QHP issuers

General comments

We strongly support standard requirements for how QHP insurers should submit to HHS data for purposes of the risk corridors and agree that risk adjustment and reinsurance must be taken into account in the premium data for purposes of target amounts. This may require the insurer to also estimate the likely risk adjustment charges or payments, considering that final reconciliation for risk adjustment in any given year (whether in a prospective or retrospective system, and whether the system allows for interim payments) will occur after or at the same time that risk corridor contributory payments and payments will be determined.

The proposed rule, however, is silent in how HHS will ensure that the adjusted premium data and allowable costs data are valid and accurate. The proposed rule should be amended to require QHP insurers to submit any additional data needed to support an audit or other verification method conducted by HHS. In addition, they should be subject to penalties if they are found to be submitting invalid or erroneous data, including reductions in their risk corridor payments or increases in their risk corridor contributions.

Subpart G – Health Insurance Issuer Standards Related to the Risk Adjustment Program

§153.600 Definitions

The proposed rules in this section include what appears to be a typographical error, as a risk adjustment model involves more than just payments. Moreover, risk adjustment data includes data used in a risk adjustment methodology as well as in a risk adjustment model as they are defined under §153.300. The proposed rules should be amended accordingly.

Specific Recommendation: Amend §153.600 as follows:

“Risk adjustment data means all data that are used in the application of a risk adjustment methodology and a risk adjustment payment model.”
§153.610 Risk adjustment issuer requirements

§ 153.610(a) Data submission

We strongly support the requirement that all issuers that offer risk adjustment covered plans must submit all required risk adjustment data. Such data are necessary for the success of the risk adjustment system to mitigate the risk of adverse selection. We also support the required submission of other data, including methods for setting rates, which can be used, for example, to assess whether the risk adjustment methodology is appropriately accounting for a State’s premium rating rules, whether risk adjustment should be based on average state premiums (as we recommend, at least for now) or actual plan premiums, and to help enforce other Exchange requirements and insurance market reforms, including the requirements that insurers pool risk across all plans inside and outside the Exchange.

While the proposed rules do not specify specific timelines for data submission, the preamble indicates that HHS considered proposing the following timelines for risk adjustment data submission: claims and encounter data every 30 days and no later than 180 days following the date of service, enrollment and demographic information must be submitted by the end of the month following enrollment, rate setting rules must be submitted by the end of the month they become effective, and prescription drug utilization every 30 days and no later than 90 days following date of service. Such timelines would, as noted in the preamble, be generally consistent with Medicare Advantage (which requires encounter data to be submitted monthly) and would ensure timely availability of the data and help address anticipated issuer difficulty in transmitting large volumes of data at the end of the data collection period.

We finally note that the Affordable Care Act is clear that insurer participation in the risk adjustment program is mandatory. Section 1343 of the Affordable Care Act requires each State to assess a charge on non-grandfathered health plans and health insurance issuers providing coverage in the individual or small group market within the State with less than average actuarial risk and to provide a payment to such health plans and issuers with greater than average actuarial risk. Nothing in section 1343 can be reasonably interpreted to allow insurer participation to be voluntary. Moreover, mandatory participation is essential for the success of risk adjustment across the States.

§ 153.610(b) Issuer contracts

It is reasonable to permit insurers to require that contracting providers provide them complete and accurate risk adjustment data and subject providers to financial penalties for failure to submit complete, timely or accurate data. Such contractual obligations would help ensure that the data that insurers submit to the State or HHS is as accurate as possible. As noted in our comments to §153.620, however, it is critical that insurers be also subject to an array of penalties for failure to comply with various risk adjustment standards.

§ 153.610(c) Assessment of charges
As noted in our comments to §153.320, we believe that while a retrospective risk adjustment methodology may be appropriate in the first several years of implementation, a prospective system should be adopted once there is sufficient risk adjustment data to facilitate an accurate prospective risk adjustment methodology. As written, the proposed rules in §153.610(c) appear to envision only a retrospective risk adjustment system being used. The proposed rules should be amended to provide flexibility for the use of a prospective system. In addition, as noted in our comments to §153.320, there is likely to be the need for interim risk adjustment charges/payments over the course of the year even under a retrospective system, particularly for smaller insurers and those who experience significant adverse selection. As a result, the proposed rules should be amended to make clear that such a critical feature would be permitted.

In addition, as noted in our comments to §153.320, to ensure that the risk adjustment system has sufficient cash flow in its early years to make all required payments, including interim payments, all insurers in a State could be subject to a minimum charge, even if they are ultimately determined to be a plan with a net balance of payments, rather than a plan with a net balance of charges. The proposed rules should make clear that a State or HHS could do so.

As noted in our comments to §153.320, States (or HHS on behalf of the State) should be permitted to increase the charges that must be remitted by insurers with a net balance of charges to finance risk adjustment operating costs. This would have the benefit of encouraging insurers to report data accurately and on a timely basis and otherwise cooperate so that the process works as efficiently as possible. The proposed rules should be modified accordingly. (Alternatively, risk adjustment operating costs could be financed through an assessment on all insurers offering coverage in the individual and small-group markets inside and outside the Exchange, or as part of assessments just on Exchange QHPs used to finance Exchange operations, though that would place the burden solely on insurers offering Exchange QHPs even though risk adjustment potentially affects all insurers.)

Finally, the proposed rules do not specify a timeframe for when insurers with a net balance of charges must remit payments to the State or HHS. The preamble indicates that insurers will be given 30 days to make the required payments. That seems reasonable. The proposed rules should be amended to indicate that payments must be made within a timeframe to be determined by HHS. As noted in our comments to §153.620, it is also likely necessary to establish penalties for insurers who fail to make the required payments on a timely basis.

Specific Recommendation: Amend §153.610(c) as follows:

“(c) Assessment of charges. After charges and payments for all risk adjustment covered plans have been calculated, Issuers that offer risk adjustment covered plans determined to have a net balance of risk adjustment charges payable will be notified by the State, or by HHS on behalf of the State, for those net charges and must remit those risk adjustment charges to the State, or to HHS on behalf of the State, within a required timeframe determined by HHS. Such issuers may also be required to provide additional payments to provide funding for administrative expenses related to risk adjustment in the State. For a limited initial period, all issuers that offer risk adjustment covered plans may be required to remit risk adjustment charges to the State, or to HHS on behalf of the State, within a required timeframe determined by HHS, to ensure the
availability of sufficient funds for payments to issuers that offer risk adjustment covered plans with a net balance of risk adjustment payments.”

§153.620 Compliance with risk adjustment standards

General comments

The proposed rule does not address what penalties would be applied by a State or HHS acting on behalf of a State in the event of an insurer failing to submit the required risk adjustment data, provide the requested data to support risk adjustment data validation audits, or comply with other requirements related to risk adjustment operations. HHS should establish an array of sanctions that can be imposed by a State or HHS on insurers that do not comply with risk adjustment standards. For example, insurers consistently failing to comply with risk adjustment data requirements or failing to make required payments when they incur a net balance of charges could no longer constitute a QHP and would be thus barred from offering coverage through the Exchange. Insurers could also be charged additional penalty risk adjustment charges (or have their risk adjustment payments reduced) for patterns of non-compliance.

§ 153.620(a) Issuer support of data validation

We support the requirement that all issuers that offer risk adjustment covered plans must make available all data requested to support the risk adjustment data validation audits required under §153.350. Mandatory participation is essential to ensure that the data validation is effective and can be used to make the needed risk score calculation and charge/payment adjustments to ensure an accurate risk adjustment system in a State.

§ 153.620(b) Issuer records maintenance requirements

A 10-year record retention requirement is reasonable and is consistent, for example, with Medicare Advantage requirements and those related to the Medicaid drug rebate program.