Minuteman Health

Minuteman Health, Inc.
P.O. Box 120025
Boston, MA 02112-0025

September 11, 2015

Mr. David Seltz
Executive Director
Health Policy Commission
50 Milk Street, 8th Floor
Boston, MA 02109

Dear Mr. Seltz,

Enclosed please find Minuteman's written testimony in response to the Health Policy Commission's letter of August 6, 2015. If you have any questions, please do not hesitate to contact Susan Brown, General Counsel, at susanbrown@minutemanhealth.org or 857-265-3322.

As Chief Executive Officer of Minuteman, I am legally authorized and empowered to represent Minuteman for the purposes of this testimony. The enclosed responses are accurate to the best of my knowledge. I have relied on others in the company for information on certain matters not within my personal knowledge and believe that the facts stated with respect to such matters are true. I sign under the pains and penalties of perjury.

Sincerely,

Tom Policelli

Exhibit A: Notice of Public Hearing

Pursuant to M.G.L. c. 6D, § 8, the Health Policy Commission (HPC), in collaboration with the Office of the Attorney General (AGO) and the Center for Health Information and Analysis (CHIA), will hold a public hearing on health care cost trends. The hearing will examine health care provider, provider organization and private and public health care payer costs, prices and cost trends, with particular attention to factors that contribute to cost growth within the Commonwealth's health care system.

Scheduled hearing dates and location:

Monday, October 5, 2015, 9:00 AM
Tuesday, October 6, 2015, 9:00 AM
Suffolk University Law School
First Floor Function Room
120 Tremont Street, Boston, MA 02108

Time-permitting, the HPC will accept oral testimony from members of the public beginning at 4:00 PM on both days. Any person who wishes to testify may sign up to offer brief comments on a first-come, first-served basis when the hearing commences on October 5 and 6.

Members of the public may also submit written testimony. Written comments will be accepted until October 9, 2015 and should be submitted electronically to HPC-Testimony@state.ma.us, or, if comments cannot be submitted electronically, sent by mail, post-marked no later than October 9, 2015, to the Health Policy Commission, 50 Milk Street, 8th floor, Boston, MA 02109, attention Lois H. Johnson.

Please note that all written and oral testimony provided by witnesses or the public may be posted on the HPC's website: www.mass.gov/hpc.

The HPC encourages all interested parties to attend the hearing. For driving and public transportation directions, please visit: http://www.suffolk.edu/law/explore/6629.php. Suffolk University Law School is located diagonally across from the Park Street MBTA station (Red and Green lines). Parking is not available at the law school but information about nearby garages is listed at the link provided.

If you require disability-related accommodations for this hearing, please contact Kelly Mercer at (617) 979-1420 or by email at Kelly.A.Mercer@state.ma.us a minimum of two (2) weeks prior to the hearing so that we can accommodate your request.

For more information, including details about the agenda, expert and market participant panelists, testimony and presentations, please check the Annual Cost Trends Hearing section of the HPC's website, www.mass.gov/hpc. Materials will be posted regularly as the hearing dates approach.

Exhibit B: Instructions and HPC Questions for Written Testimony

On or before the close of business on September 11, 2015, please electronically submit written testimony signed under the pains and penalties of perjury to: HPC-Testimony@state.ma.us. **You may expect to receive the questions and exhibits as an attachment received from HPC-Testimony@state.ma.us.** If you have any difficulty with the template or did not receive it, please contact Kelly Mercer at Kelly.A.Mercer@state.ma.us or (617) 979-1420.

Please complete your responses in the provided **Microsoft Word** template. If necessary, you may include additional supporting testimony or documentation in an Appendix. Please submit any data tables included in your response in **Microsoft Excel or Access format**.

We encourage you to refer to and build upon your organization's 2013 or 2014 Pre-Filed Testimony responses, if applicable. Additionally, if there is a point that is relevant to more than one question, please state it only once and make an internal reference. If a question is not applicable to your organization, please indicate so in your response.

The testimony must contain a statement that the signatory is legally authorized and empowered to represent the named organization for the purposes of this testimony, and that the testimony is signed under the pains and penalties of perjury. An electronic signature will be sufficient for this submission.

If you have any other questions regarding this process or regarding the following questions, please contact Lois Johnson at Lois.Johnson@state.ma.us or (617) 979-1405.

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Exhibit B: HPC Questions for Written Testimony

1. Chapter 224 of the Acts of 2012 (Chapter 224) requires health plans to reduce the use of fee-for-service payment mechanisms to the maximum extent feasible in order to promote high-quality, efficient care delivery.
    a. Please describe your organization's efforts in the last 12 months to meet this expectation. Attach any analyses your organization has conducted on the effects of alternative payment methods (APMs) on (i) total medical expenses, (ii) premiums, and (iii) provider quality. Please specifically describe efforts and analyses related to bundled payment and similar payment methods.
    Minuteman Health is a new entrant in the marketplace. In 2014, due largely to the failure of the Connector, Minuteman had only 1400 members. In 2015, Minuteman has grown to 15,000 members (distributed between Massachusetts and New Hampshire). As a result, Minuteman does not currently have sufficient volumes of members (and importantly, sufficient volumes of members with certain provider organizations) to undertake risk based contracting initiatives.

    Minuteman supports alternative payment methodologies and looks forward to working with its provider partners to implement those methodologies in the future. However, Minuteman does not believe that the current Risk Adjustment model in use would allow efficient providers to successfully bear full risk-*adjusted* payments for new products. Because risk adjustment transfer payments are both unpredictable and material, payers will need to transfer risk to providers in a way that takes into account risk-adjustment payments on a retrospective basis. Providers that are most efficient and lowest cost are at the most risk under the current rules. As a result, there would be significant risk outside of providers' control that could materially and negatively impact their performance under an alternative payment design. Therefore while Minuteman shares the goal of alternative and risk-based contracts in theory, Minuteman believes that the current Risk Adjustment program is an impediment to risk based contracting.

    b. Please describe specific efforts your organization plans to undertake between now and October 1, 2016 to increase the use of APMs, including any efforts to expand APMs to other primary care providers, hospitals, specialists (including behavioral health providers), and other provider and product types. Please specifically describe efforts related to bundled payment and similar payment methods.
    See 1a.

    c. In its 2014 Cost Trends Report, the HPC stated that major payers and providers should begin introducing APMs for preferred provider organization (PPO) covered lives in 2016, with the goal of reaching at least one-third of their PPO lives that year. Please describe your plans to achieve this goal. Additionally, please describe any specific barriers for moving self-insured business into APM arrangements.
    See 1a.

2. Describe your organization's efforts to develop insurance products or plan designs that encourage members to use high-value (high-quality, low-cost) services, settings, and providers, and detail progress made over the past year. Example of such efforts include: phone triage or telehealth services; targeted information about and incentives to reduce avoidable emergency department (ED) use; and reference pricing, or cash-back reward programs for using low-cost providers. Please describe the result of these efforts and attach any quantitative analyses your organization has conducted on these products, including take-up, characteristics of members (e.g., regional, demographic, health status risk scores), members' utilization of care, members' choice of providers, and total medical spending. Please describe efforts your organization plans between now and October 1, 2016 to continue progress in encouraging members to use high-value services, settings and providers. What barriers have you identified to introducing insurance products or plan designs that encourage members to use high-value services, settings and providers in Massachusetts?

   Minuteman is proud to offer a select network of high quality, low cost providers. Minuteman has steadfastly refused to contract with providers whose high unit costs would drive up Minuteman's premium. The major barrier to offering low-cost products in Massachusetts is the risk adjustment program. Because the program penalizes low-cost payors, it creates a significant disincentive to offering value-based products. For example, in 2014, Minuteman members saw 71% of every premium dollar paid out through the risk adjustment program. Minuteman is penalized by the risk adjustment program because (1) Minuteman's provider network is significantly less expensive that the state-wide average premium, and (2) because Minuteman focuses on delivering low cost products to price-sensitive consumers and, as a result, Minuteman has a higher number of members in Bronze products than other payors. As a result of these two factors, 40% of Minuteman's risk adjustment payment was *completely unrelated* to the risk profile of its members, and instead was purely a penalty for being a low cost payor with a large number of Bronze members. The Commonwealth has long prided itself for being in the vanguard of health care reform. Most recently, the Commonwealth has focused on promoting high quality, low cost products, including tiered, limited, and geographic network products. The current risk adjustment program, without reform, will penalize payors who offer those innovative products and force low cost payors to increase premiums. For more information regarding Minuteman's concerns regarding the risk adjustment program and the impact it has on cost containment, please see Minuteman's Request for Reconsideration of the risk adjustment payment, attached hereto.

3. Chapter 224 requires payers to provide members with requested estimated or maximum allowed amount or charge price for proposed admissions, procedures and services through a readily available "price transparency tool." Please describe your organization's progress in meeting this requirement. If you had a tool in place prior to November, 2012, please describe your organization's prior experience, including how long your tool has been in use and any changes you have made to the tool over time.
   a. Using **HPC Payer Exhibit 1** attached**,** please provide available data regarding the number of individuals that seek this information and identify the top ten admissions, procedures and services about which individuals have requested price information for each quarter listed below and the number of inquiries associated with each.

b. Do consumers have the ability to access cost data for the following types of services (yes/no)? If no, please explain.

Inpatient	Yes	☒	No	☐
Outpatient	Yes	☒	No	☐
Diagnostic	Yes	☒	No	☐
Office Visits (medical)	Yes	☒	No	☐
Office Visits (behavioral)	Yes	☐	No	☒

Minuteman Health does not contract directly with its behavioral health (BH) providers at this time, but rather through its relationship with First Health. Each claim for these BH providers is transmitted to and "repriced" by First Health nightly in order to derive the allowed amount for claim adjudication. As such, Minuteman does not have reimbursement rates loaded in its database, and thus cannot provide ad hoc cost-of-care (COC) estimates.

c. Does consumer-accessible cost data reflect actual provider contracted rates? If no, please explain.

Yes ☒ No ☐

d. Do you provide actual out-of-pocket estimates that reflect a member's specific benefits and deductible status? If no, please explain.

Yes ☒ No ☐

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e. Do you provide provider quality and/or patient experience data with your cost data? If no, please explain.

Yes ☐ No ☒

Minuteman Health does not score, capture or publish provider quality data or patient experience data at this time.

f. Please describe any information you have collected regarding how your members use this information and the value of this information to members. Please describe any analyses you have conducted to assess the accuracy of estimates provided and the impact of increased price transparency for members as well as any limitations in the tools you have identified and ways your organization plans to address them.

Minuteman Health captures and records every member's COC-online-tool interaction in its COC-online-tool database tables. Additionally, every phone interaction related to COC is captured, categorized and recorded in its call center database. Minuteman tests its COC calculations regularly to ensure that the latest and most accurate COC estimation data is made available to its members. The limitation related to behavioral health COC is an issue that will continue to be explored as part of Minuteman Health's behavioral network strategy.

4. The Massachusetts health care environment has recently undergone significant changes, including multiple hospital and physician group acquisitions and affiliations. Please describe your views on

recent market changes, including any impacts these changes have had on costs (e.g., prices and total medical expenses), referral patterns, quality and access to care.
Expansion of tertiary medical facilities into the community raises costs without improving quality. Minuteman has observed, in particular, that community-based oncologists are increasingly affiliated with a tertiary provider which has resulted in an increase in the price of oncology services. In addition to increasing the cost of community-based care, we anticipate that these affiliations may impact referral patterns, driving patients to higher cost centers of care.

5. As documented by the Office of the Attorney General in 2010, 2011, and 2013; by the Division of Health Care Finance and Policy in 2011; by the Special Commission on Provider Price Reform in 2011; by the Health Policy Commission in 2014; and by the Center for Health Information and Analysis in 2012, 2013, and 2015, prices paid to different Massachusetts providers for the same services as well as global budgets vary significantly across different provider types, and such variation is not necessarily tied to quality or other indicia of value.
    a. In your view, what are acceptable and unacceptable reasons for prices for the same services, or global budgets, to vary across providers?
    Minuteman's philosophy is to identify low cost, high quality providers and to aggressively seek to include them in the Minuteman provider network in order to avoid unnecessarily high variation in pricing.

    b. What steps are you taking to address this variation in prices and budgets? Please include any approaches you have considered implementing to reduce the role that past or current fee-for-service price disparities play in global budgets.
    As explained previously, Minuteman only contracts with providers that can help Minuteman's maintain its low premium price point in the market.

6. Please describe your policies and procedures, including notice policies and protections from out-of-network charges, for members referred to out-of-network providers and cases in which services at in-network facilities are provided by out-of- network providers. Please describe any policies you have in place to ensure that a referring provider informs a patient if a provider to whom they are referring the patient is not in the patient's insurance network.
As a select network payor, Minuteman prioritizes member and provider education regarding the importance of staying within the Minuteman network. This includes member-friendly descriptions of in and out of network cost implications, outbound educational calls, and administrative exception policies designed to support the educational process. Minuteman also seeks to require providers to make best efforts to refer members to in-network providers.

7. The Medicare Payment Advisory Commission and others have noted that patient visits to outpatient-based practices, which can bill a "facility fee," are increasing faster than visits to freestanding practices. Please describe any shift you have observed toward increased use of outpatient-based practices and the impact of facility fees and any such shift toward the use of outpatient-based practices on health care costs, quality and access.
In our experience, the market has been trending away from in-patient to out-patient services. Facility fees are charged by a number of providers in the out-patient services market. We find that our members are very confused by these fees, and because many of

our products have deductibles, our members are significantly and directly impacted by those fees. These fees increase the cost of out-patient services in a way that is not easily understandable or explainable to members.

8. The Commission has identified that spending for patients with co-morbid behavioral health and chronic medical conditions is 2 to 2.5 times as high as spending for patients with a chronic medical condition but no behavioral health conditions. As reported in the July 2014 Cost Trends Report, higher spending for patients with behavioral health conditions is concentrated in emergency departments and inpatient care.
    a. Please describe your efforts in the past 12 months to effectively address the needs of these patients in an integrated manner, clearly identifying areas of progress, attaching any attaching analyses you have conducted.
    Minuteman had only 1,400 members in 2014. As a result, Minuteman has insufficient data to track the relationship of expenses and co-morbid behavioral health and chronic medical conditions.

    b. Please describe your specific plans for the next 12 months to ensure that integrated treatment is provided for these patients, including specific goals and metrics you will use to measure performance whether you use a behavioral health managed care organization ("a carve-out") or manage behavioral health care within your organization.
    At this time, Minuteman still has insufficient data to measure outcomes for this population. Minuteman will continue to identify opportunities for meeting the needs of patients with co-morbid conditions as Minuteman grows.

9. Please submit a summary table showing actual observed allowed medical expenditure trends in Massachusetts for CY2012 to CY2014 according to the format and parameters provided and attached as **HPC Payer Exhibit 2** with all applicable fields completed. Please explain for each year 2012 to 2014, the portion of actual observed allowed claims trends that is due to (a) demographics of your population; (b) benefit buy down; (c) and/or change in health status of your population. Please note where any such trends would be reflected (e.g., utilization trend, payer mix trend).
Because Minuteman has only had one full year of operations, Minuteman has no trend information regarding TME.

HPC Pre-Filed Testimony - Payer Questions
HPC Payer Exhibit 1

Health Care Service Price Inquiries CY2014-2015				
Year		**Aggregate Number of Inquiries via Website**	**Aggregate Number of Inquiries via Telephone or In Person**	**Aggregate Average Time to Resolve Inquiries***
CY2014	**Q1**	0		
	Q2	0		
	Q3	2	1	Immediately**
	Q4	35		Immediately
CY2015	**Q1**	184		Immediately
	Q2	94		Immediately
	TOTAL:	315	1	

** Please indicate the unit of time reported.*

***Note: The single Telephonic Price Inquiry was delivered immediately, but due to the caller's confusion a*

******In addition, payers MUST identify the Top 10 admissions, procedures and services in the next two (2) tabs ("Top 10 CY2014" and "Top 10 CY2015")******
All 3 tabs must be completed.

bout patient, provider, service type. etc., additional days and actions were required for full resolution

Identify the Top 10 Admissions, Procedures and Services for CY2014 by Quarter:

CY2014 Q1	**1**	
	2	
	3	
	4	
	5	
	6	
	7	
	8	
	9	
	10	
CY2014 Q2	**1**	
	2	
	3	
	4	
	5	
	6	
	7	
	8	
	9	
	10	
CY2014 Q3	**1**	Acne Surgery
	2	Allergy/Sensitivity Test
	3	
	4	
	5	
	6	
	7	
	8	
	9	
	10	
CY2014 Q4	**1**	MRI
	2	Abortion - Inpatient Hospital Stay
	3	Biopsy of skin Lesion
	4	Echocardiogram with Contrast
	5	Follow-up Evaluation
	6	Testicular Imaging
	7	Access Vein/Artery/Aorta
	8	Cesarean Section
	9	CT Scan
	10	CT Scan with Contrast

Identify the Top 10 Admissions, Procedures and Services for CY2015 by Quarter:

CY2015 Q1	**1**	Bone Density Scan
	2	Physician Office Visit
	3	Ultrasound- Physician's Office
	4	MRI
	5	Physical Therapy
	6	Eye Exam
	7	Abortion - Physician's Office
	8	Colonoscopy
	9	Mammography
	10	Acid Perfusion of Esophagus
CY2015 Q2	**1**	Laparoscopy - Hospital Outpatient
	2	Laparoscopy
	3	X-Ray
	4	Physician Office Visit
	5	Appendectomy - Hospital Inpatient Stay
	6	Carpal Tunnel Surgery
	7	Hysteroscopy
	8	Laparoscopy - Preventative/Screening
	9	Adrenal Imaging
	10	Appendectomy - Physician's Office

HPC Payer Exhibit 2

All cells shaded in BLUE should be completed by carrier*

Actual Observed Total Allowed Medical Expenditure Trend by Year
Fully-insured and self-insured product lines

	Unit Cost	Utilization	Provider Mix	Service Mix	Total
CY 2012	NA	NA	NA	NA	NA
CY 2013	NA	NA	NA	NA	NA
CY 2014	NA	NA	NA	NA	NA

Please note that MHI started issuing business in 2014, and therefore has no TME trend to report at this time.

Notes:

1. ACTUAL OBSERVED TOTAL ALLOWED MEDICAL EXPENDITURE TREND should reflect the best estimate of historical actual allowed trend for each year divided into components of unit cost, utilization, , service mix, and provider mix. These trends should not be adjusted for any changes in product, provider or demographic mix. In other words, these allowed trends should be actual observed trend. These trends should reflect total medical expenditures which will include claims based and non claims based expenditures.

2. PROVIDER MIX is defined as the impact on trend due to the changes in the mix of providers used. This item should not be included in utilization or cost trends.

3. SERVICE MIX is defined as the impact on trend due to the change in the types of services. This item should not be included in utilization or cost trends.

4. Trend in non-fee for service claims (actual or estimated) paid by the carrier to providers (including, but not limited to, items such as capitation, incentive pools, withholds, bonuses, management fees, infrastructure payments) should be reflected in Unit Cost trend as well as Total trend.

Minuteman Health™

July 31, 2015

Louis Gutierrez
Executive Director
Commonwealth Health Insurance Connector Authority
100 City Hall Plaza, 6th Floor
Boston, MA 02108

RE: Minuteman Health, Inc. Request for Reconsideration of 2014 Risk Adjustment Payment

Dear Executive Director Gutierrez:

Minuteman Health respectfully requests reconsideration of its risk adjustment settlement for 2014. The calculation results in Minuteman paying a total transfer of $3,064,679.45 which represents 71% of Minuteman's gross premium. We believe this amount is excessive, reflects neither policy intent nor statute, and is the result of data flaws in the risk transfer formula as well as data calculation errors.[1]

EXECUTIVE SUMMARY

The issues with the Risk Adjustment Calculation fall into three categories:

1. Data Quality is Inadequate. Unaudited CHIA data has led to wildly fluctuating results, final premium numbers used to calculate the critical market average premiums had to be estimated and not calculated by the Connector, and rating regions were assigned incorrectly. **Even a perfect risk scoring calculation could not work with such faulty data inputs**.

2. Calculation of Risk Scores Itself is Flawed. The demographic calculation yields arithmetically impossible results, the lack of appropriate adjustment for immaturity of HCC assignments structurally penalizes high-growth plans, and access to relevant data is not shared with all healthplans. **This means that even if the data inputs had been perfect that a faulty risk score would still be generated.**

3. Market Average Premium Calculation Incorrectly Penalizes Consumers and Efficient Providers. The Market Average Premium Calculation (MAPC) used by the Connector works against the intent of existing law. Using unaudited and reportedly estimated data from the all payor claims database, the MAPC forces consumers who are trying to save money to instead subsidize those purchasing richer plans. Further, this flawed result then penalizes the most efficient hospitals and providers. Lastly, the data issues are then compounded by timing delays that introduce further unpredictable market volatility. **If both data quality and risk score calculations had been perfect – and both were not – then the use of the 2014 Market Average Premium Calculation would still have arbitrarily harmed Minuteman, our members, and our highly-efficient providers.**

[1] Minuteman has attempted to quantify the monetary impact of each of the addressed areas. However, the total of the estimated impact for each of the elements exceed the total payment because many elements interact with each other. In addition, there are certain data issues that Minuteman cannot quantify because it does not have access to the underlying data that would be necessary.

We believe that the magnitude of this impact could not have been anticipated and was not the desired outcome of the drafters of the risk adjustment program. In fact, we were told by the actuary appointed to the Massachusetts Connector Board, John Bertko, in October of 2014 that it was impossible that any plan could experience a risk transfer payment greater than 10% of gross premium. Clearly that was incorrect. Instead, $2,168.92 of each of our members' money that we had reserved for their use has been forced to be paid out due to a fundamentally flawed data set, process, and calculation.

It is clear is that a review of 2014 results alone is insufficient. The unanticipated flaws in the program indicate that there are systemic and structural problems in how the data is used that will continue unless addressed. We recognize and agree that risk adjustment was intended to be a critical element of the ACA and health reform and that other risk adjustment programs in both the private and government sector can and do work. In looking to those more established risk adjustment methodologies, Minuteman views it possible and even potentially likely that a payout of some kind would have been generated based upon 2014 experience. We know of no successful risk adjustment process, however, that would have generated the extreme results we see here now.

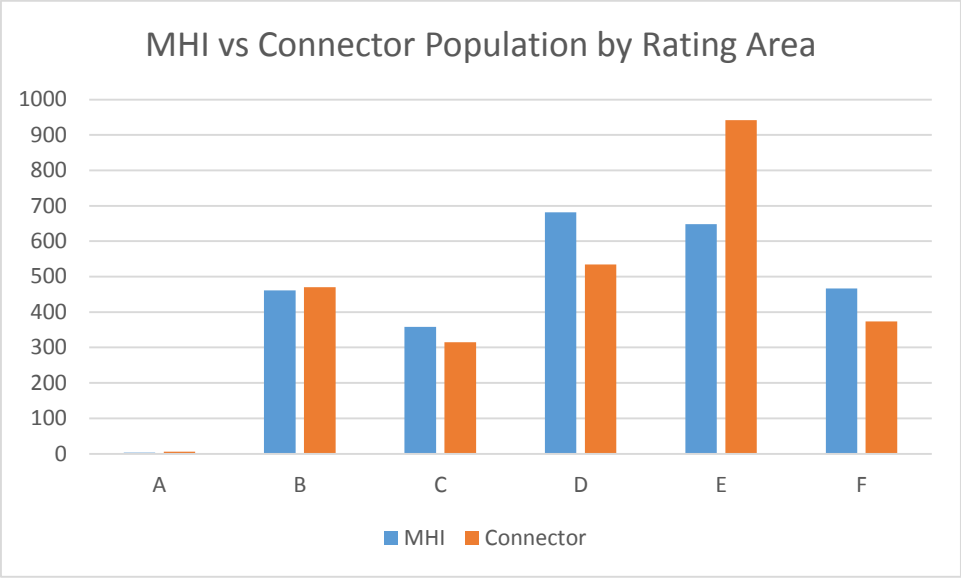
This particular version of risk adjustment, Version 1.0, simply does not work as intended. As with all risk adjustment programs that have become successful over time, the data must be analyzed, the calculations checked, and the reality of the outcomes held up against the theory of the intended design. This program needs to be significantly improved in order to avoid the current unintended market consequences that work against the objectives of health reform and the statutory mandate.

DATA QUALITY ISSUES

1. **Unaudited CHIA data is unreliable**. As the Connector has itself said, data reporting by the carriers has been erratic and uneven over the last year. The accumulation and dissemination of this data has also shown uneven and erratic results. As far as MHI is aware, neither carrier data feeds nor CHIA's processes or results have ever been audited. Given the critical importance of *all* carrier data and the consistent aggregation of that data by CHIA, such a gap undermines the credibility of all calculations. Minuteman cannot score the value of the impact this may have because of the very nature of the problem.

2. **Premium was inappropriately estimated**. Market premium numbers are similarly critical in calculating the final payment under this program. As far as MHI is aware, data were not only not audited but also in the end estimated in order to arrive at final market average premiums. Minuteman cannot estimate the value of the impact to such an estimate since we do not know what a correct average of all carrier premiums would be. We do know that 40% of our total payment – over $1.2M – was due solely to the impact of market average premium. As estimate on something with an impact that large is simply inappropriate.

3. **Example of data problems: Incorrect rating regions were assigned**. MHI has determined that approximately 20% of our membership has not been coded in the correct rating region by the Connector. MHI can provide member-specific information regarding each members' correct rating region as compared to the incorrect rating region assigned to the member by the Connector at the Connector's request. The graph below summarizes that data, showing how the distributions vary between MHI and Connector data.



The impact of this error is $29,000. More important than these estimated dollars is that this serves as an indicator of the level of concern we should all have regarding this data. This relatively small, discrete element is one of the few things we could measure because we had all of the data. We cannot measure the impact for elements about which we do not have all of the data.

Minuteman believes that a wholesale review of the data integrity, collection process, aggregation, and calculation needs to be performed. In short, an audit is needed. Forcing the transfer of millions of dollars of members' money based upon unaudited and fluctuating data – some of which was then further estimated – is inappropriate in our view.

CALCULATION OF RISK SCORES

1. **The default demographic factor in the Massachusetts risk adjustment formula is too low.** This does not enable health plans to cover preventative health services and health care needs not accounted for in the Hierarchical Clinical Conditions (HCC's) or even administrative costs.

   The demographic amount in the Massachusetts formula is .1087 for platinum and gold plans and .0546 for silver, bronze and catastrophic plans. This means that if a member has no HCC's (and the risk transfer formula only considered the risk factor), the plan would keep only 5% of its premium for most these members. This is too low to cover administrative costs, the costs of preventative screening services that represent good evidence based clinical practice as well as to cover the myriad of costs related to medical conditions not accounted for in the HCC definitions. It goes beyond the regulatory objective of eliminating the benefit of positive risk selection or covering only healthy populations, and instead punishes plans for covering members who have no health issues. In other words, the methodology overshoots its objectives and takes too much away from plans covering healthy persons, ensuring that any plan with an abundance of zero HCC members will be unable to cover basic medical costs and administrative expenses.

   Minuteman estimates the financial impact of this at $766,000.

2. **The lack of low enrollment factors.** As the only new market entrant in 2014, Minuteman was particularly harmed by the failure of the Connector that year. Minuteman had an average monthly enrollment of 1413. Our average enrollment months per member was approximately 6 months. We had only 200 members who were enrolled with Minuteman for the full 12 months of 2014.

   The risk adjustment methodology is a statistical methodology that estimates the burden of illness for a particular member. Like all statistical methods, it can both underestimate and overestimate the true burden of illness. It is a basic statistical principal that with greater number of observations, the underestimations and overestimations cancel out and there is a greater confidence that the mean and produces a reliable estimate of the actual result. The lower number of observations or members, the less confidence in the result. It would be appropriate to protect small enrollment plans by limiting the impact of extreme results that could easily be attributable to statistical anomalies rather than data driven results.

   If one were to simplistically use the credibility factors in place for the MLR calculation, then the financial impact of not applying such a factor could have an impact of $1.6 million. Other formula would of course generate different results.

3. **The short term enrollment factors are inadequate.** This adjustment does not adequately recognize the mechanics of the collection of risk adjustment information. Risk adjustment data is collected only for selected qualified, usually face to face, encounters. These encounters do not occur continuously. Indeed the qualified encounters could occur just once per year. The shorter period a member is enrolled during the year the more likely the encounter occurred outside of their enrollment in a plan. However, this does not mean the member is not receiving medical services. They could be receiving prescription drugs, diagnostic or therapeutic imaging procedures, lab tests, or medical supplies for their conditions. None of these services would result in the condition being documented during a short enrollment period. Indeed, plans with longer term enrollment have the added benefit of knowing about conditions documented in prior years and can make outreach efforts to ensure the condition is documented during the measurement year. As a new plan, Minuteman has no information regarding its members prior conditions and less time to do anything about it. Therefore, new entrants are penalized not only for the small size of their member populations, but also for the lack of persistency within those populations.

   This shortcoming could be remedied if the Connector were to be able to share HCC-related data in the APCD with any carrier with a new member. This would allow the new carrier to mine historical data just like an incumbent and pursue the information sufficient to generate an HCC score. Alternatively, the Connector could create a formulaic adjustment to reflect the immaturity of the data with which a carrier could appropriately code an HCC for a particular new member.

   It is impossible to score the impact that this has since one cannot score data one does not have. It is instructive to note, however, how many high-growth plans nationally have been impacted by this same element in the federal risk adjustment calculation. Dozens and dozens of smaller plans have both received enormous federal reinsurance payouts as a percentage of their total claims and also been forced to pay out significant sums in risk adjustment. At the surface, this seems to imply that each high-growth plan seem to have the same two very different populations – one very sick one that generates reinsurance payouts, and another very healthy one that requires risk adjustment payouts. Other factors – such as the relative strength of a high-growth carrier's network, medical management, etc., may come into play. Such a glaring and unexpected outcome that in turn drives significant payment swings does require us to step back and evaluate the critical issue regarding new member growth.

4. **There are no short term enrollment factors for bronze or catastrophic plans.** The risk adjustment short term enrollment adjustment factors referenced above are not applied to the bronze and catastrophic plans. There is no logical reason why there are no factors for bronze and catastrophic. *These plans represent the majority of Minuteman members*. Minuteman expects that the impact of this item could be in excess of $1 million.

USE OF MARKET AVERAGE PREMIUM

1. **The use of Market Average Premium has no basis in law**. For the first year of the risk adjustment program, any state which created its own risk adjustment methodology was supposedly required to use the federal payment and charges methodology, including the use of a state-wide average premium for calculating the risk transfer payments and charges.[2] Regardless of whether CMS ever solidified this "requirement" as a rule, all parties can agree that if that requirement ever did exist, it has now lapsed, and the Connector is free to propose its own methodology for payments and charges.[3]

   Minuteman urges the Connector to pursue a risk payment methodology that does not counteract other policy initiatives in the Commonwealth. In particular, the current methodology works in opposition to the Commonwealth's efforts to promote low cost tiered, regional, and narrow network products.

2. **The use of the statewide average premium produces the illogical result where the transfer payment can exceed the gross premium collected**, excessively penalizes low cost plans, and creates a substantial uncertainty in rate setting. Again, none of this has anything to do with the intended purpose of risk adjustment – to adjust for the relative health status of populations.

   Federal rules and guidance require that the risk adjustment program "reduce or eliminate premium differences between plans *based solely on expectations of favorable or unfavorable risk selection or choices by higher risk enrollees* in the individual and small group markets." (emphasis added).[4] The Commonwealth's program does not adjust solely based on differences in expectations of risk; instead, it adjusts for and unfairly penalizes plans that are low cost, have more enrollment in the lower metallic tiers, and/or have low administrative expenses.

   The formula compares the risk adjustment results to the allowable rating factors. These two factors might suggest that the plan member's actual burden of illness (as measured by the risk score) was 70% of what the plan was compensated

[2] This requirement was first suggested in March 2012 in the commentary to the final rule related to risk adjustment, and reiterated in various CMS presentations (see, e.g., https://www.cms.gov/CCIIO/Resources/Files/Downloads/fm-1e-state-flex.pdf); however, MHI has been unable to find such a requirement anywhere in federal statue or regulations, and therefore it is unclear that this "requirement" even existed in year one of the risk adjustment program.

[3] See Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors and Risk Adjustment, Final Rule, March 23, 2012, pg 17233, at http://www.gpo.gov/fdsys/pkg/FR-2012-03-23/pdf/2012-6594.pdf ("...requiring a national methodology for calculating payments and charges initially, and leaving open the possibility of permitting State variation in later years, relieves States from the burden of developing such a methodology *in the first year*…") (emphasis added).

[4] Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors and Risk Adjustment, Final Rule, March 23, 2012, pg 17230, found at http://www.gpo.gov/fdsys/pkg/FR-2012-03-23/pdf/2012-6594.pdf

for. But that 70% is not multiplied by the member's actual premium but by the average statewide premium, which could easily be double or possibly three times the actual premium paid by the member to the plan. Simple arithmetic results in a transfer payment greater than premium collected. This is not an extreme or uncommon result. *The risk transfer payment exceeded premium collected for approximately 50% of Minuteman members*. Minuteman understands that an early simulation conducted by the Connector showed that its risk transfer payment would exceed all of the premium for Minuteman as a whole. While Minuteman is thankful that it does not have to pay a risk transfer payment greater than the total premium collected, the actual result is only slightly better. If the risk transfer formula used Minuteman's average premium in the calculation, its risk transfer payment would have been reduced by 40% or requiring approximately $1.8 million instead of $3 million.

3. **This methodology disproportionality penalizes low cost plans, efficient providers, and the consumers who purchase them**. All Minuteman plans are lower cost relative to the established commercial plans. Our rates are closer to the Medicaid Managed Care Plans (NHP, Boston Healthnet and Network Health). Minuteman is able to offer a competitively priced product to price-sensitive consumers because it has created a select network of high quality, low cost providers. In essence, Minuteman has achieved what Massachusetts policy makers have long encouraged: a low cost product built on a narrow network. However, the lower a plan's premium is as compared to the statewide average premium, the higher percent of its risk transfer payment will be unrelated to the risk profile of the plan's members, and the higher percent of its risk transfer payment will be solely based on the fact that it is offering health plans that are less expensive.

   The Connector and all policymakers on Beacon Hill and in Washington need to focus closely on this dynamic. *As currently configured, risk adjustment will directly harm the intent to shift towards provider risk-bearing*. Efficient providers will be grievously harmed if they can indeed lower prices – an element they control – but end up with a healthier population – an element outside their control. A typical profitable hospital system will make 2-3% of revenue per year. As illustrated in Minuteman's example, having a lower-cost network and delivering the lower prices consumers deserve to pay could generate a payout of nearly 30% of total revenue. Unchecked, this component of risk adjustment will torpedo ACOs and any other risk-bearing provider construct.

   Again, if the risk transfer formula used Minuteman's average premium in the calculation, its risk transfer payment would have been reduced by 40% or requiring approximately $1.8 million instead of $3 million.

4. **This calculation penalizes all Minuteman members simply because more of them chose bronze plans.** While the item above shows how Minuteman is penalized merely because the prices for our products are lower than the average in the market, Minuteman is then further harmed because we were then additionally penalized because of the plans consumers chose to purchase. Again, none of this has anything to do with the intended purpose of risk adjustment – to adjust for the relative health status of populations.

   Minuteman's goal is to create affordable products for price-sensitive consumers. As a result, Minuteman has a high number of bronze plan members as compared to other carriers in the market. This means that Minuteman pays risk transfer payments based on a much higher metal level than the plans we provide.

5. **The process and timing of the Market Average Premium calculation introduces additional pricing instability into the market.** Important data elements were simply unknown by all carriers going into the 2014 rating process, and limitations are still present today. Therefore it introduces an unknown into the rating process. The first published statewide average premium was June 30th, well after all plans filed 2014 and 2015 rates and a few days before 2016rates were due. All prior risk adjustment simulations excluded publishing the statewide average premium. Minuteman understands that this is because the Connector was having difficulty making this calculation. If the Connector could not calculate the statewide average premium, how could individual carriers have been expected to incorporate the statewide average premium into their rate development? Minuteman estimated the statewide average premium with the assistance of Milliman. Our estimate was over $60 less than the rate published by the Connector on June 30. Even going forward, the statewide average premium is unknown to plans at the time of rate setting. The most recent published amount does not reflect the 2015 average, let alone the 2016 average. Therefore, the notice of benefit and payment parameters, published by the Connector in order to enable carriers to incorporate risk adjustment payments and charges into their rates, is wholly insufficient. It is impossible for carriers to accurately predict risk adjustment transfer, and therefore, impossible to build those transfers into their rates, based on the information in those notices.[5]

SUMMARY AND CONCLUSION

Each of these flaws separately have a profound effect on Minuteman, but in combination create a "perfect storm". The risk adjustment program was put in place in order to "mitigate the potential impact of adverse selection and provide stability for health insurance issuers in the individual and small group markets."[6] As implemented by the Connector, the risk adjustment program goes beyond simply ensuring that plans are protected against adverse selection to punishing plans that are small, new, low cost, and/or cater to individuals and small groups looking to purchase the most affordable products. Not only does the program punish these plans, it does so to such a punitive extent as to be massively destabilizing, having the opposite impact as that required by the authorizing legislation. Whether evaluated as a percent of premium, a percent of risk based capital, or any other measure, it is easy to see that low cost health plans in Massachusetts will be forced de-emphasize the very lower-cost/higher-value products that they offer the market today.

This is not only a problem for Minuteman. It will adversely impact the competitiveness of the market place because it excessively punishes new low cost plans. What that really means is punishing those providers who have been putting in the hard work to put the 'Affordable' in the Affordable Care Act. New plans will inevitably look like Minuteman Health in being low cost and having a lower than average risk score. New plans need to be low cost or they will not attract new members. Additionally new plans will almost inevitably have a lower than average risk score. Persons with current illness are less likely to choose a new innovative plan and will instead choose the established plans. So new plans almost always initially attract

[5] The Commonwealth must publish its notice of benefit and payment parameters by the later of March 1 of the calendar year prior to the applicable benefit year, or by the 30th day following the publication of the final HHS notice of benefit and payment parameters for that benefit year (see 45 CFR 153.100(c). This is required because "HHS recognizes that health insurance issuers must have detailed information about risk adjustment prior to setting rates for any benefit year because the risk adjustment methodology will affect both the total value of premiums received after accounting for payments and charges, as well as administrative costs." (Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors and Risk Adjustment, Proposed Rule, July 15, 2011, pg 41940, available at http://www.gpo.gov/fdsys/pkg/FR-2011-07-15/pdf/2011-17609.pdf)

[6] Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors and Risk Adjustment, Final Rule, March 23, 2012, pg 17220, at http://www.gpo.gov/fdsys/pkg/FR-2012-03-23/pdf/2012-6594.pdf

healthier patients more willing to try something different until it develops a reputation for good service in the marketplace. But if the new plans are excessively punished by the risk transfer methodology, they will be forced to offer higher cost products.

In short, the current methodology creates a barrier to entry for new health carriers and a disincentive to create innovative, low cost products. If the health market is less competitive, it will inevitably result in higher premium rates to consumers which will undermine the objectives for health reform. It appears that the unintended consequences of the Commonwealth's risk adjustment program are working in direct opposition to the Commonwealth's efforts to contain healthcare costs through increased competition and innovative product design.

We believe the risk transfer payment required of Minuteman is excessive and sincerely hope that the Commonwealth will continue to work to correct these obvious problems. We do realize that any improvements must be approved by CMS. Many of the issues above are shared by the federal risk adjustment methodology, however, and CMS could benefit from allowing the unique and until now largely successful Massachusetts healthcare reform to continue. We can continue to be one of the 'laboratories of democracy' and assist the federal government as they continue to iterate their own methods and processes for the rest of the county. Simply put, risk adjustment methodology must be reformed to achieve the objectives of health reform and the ACA and for the good of the citizens of the Commonwealth.

Sincerely yours,

Thomas Policelli
CEO, Minuteman Health, Inc.

CC: Michael Norton, via electronic mail
Ed DeAngelo, via electronic mail

Minuteman Health™