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October 31, 2011

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-9975-P
P.O. Box 8010
Baltimore, MD 21244-8010

Re: Notice of Proposed Rule Making Regarding Standards Related to Reinsurance, Risk Corridors and Risk Adjustment Consistent with the Patient Protection and Affordable Care Act (Published in Federal Register Volume 76, Number 136 on July 15, 2011)

To Whom It May Concern:

On behalf of the Massachusetts Health Connector (Health Connector), we appreciate the opportunity to provide comments on the Notice of Proposed Rule Making (NPRM) regarding Standards Related to Reinsurance, Risk Corridors and Risk Adjustment consistent with the Patient Protection and Affordable Care Act (ACA) published in the Federal Register on July 15, 2011. While the Department of Health and Human Services (HHS) offered guidance on a number of important areas for states and Exchanges to consider, our comments focus on areas in which the Health Connector has relevant past experience that has informed our thinking on these issues or on areas that may directly impact the policy or operations of the Health Connector in Massachusetts.

The Health Connector is an independent state authority created by Chapter 58 of the Acts of 2006 to implement key elements of Massachusetts' historic health reform law. The Health Connector serves as an Exchange that assists individuals, families and employers in acquiring health coverage either through the Commonwealth Care or Commonwealth Choice programs. Commonwealth Care is a subsidized insurance program available to adults in Massachusetts earning up to 300% of the Federal Poverty Level (FPL) who generally do not have access to Employer Sponsored Insurance (ESI) or other subsidized insurance and who meet certain eligibility guidelines. Commonwealth Choice is a commercial (non-subsidized) insurance program available to individuals and to small employers with

50 or fewer employees. Current enrollment in these programs is approximately 158,000 and 38,000 members, respectively[1].

The Health Connector strongly supports HHS's general approach to working with states on the implementation of premium stability programs. We believe that the combination of detailed federal guidelines and state-level flexibility within this federal oversight strikes the right balance between consistent enforcement of the ACA and reasonable accommodation of state-specific perspectives, needs, and challenges. For these relatively new and complex programs, an appropriate degree of state-to-state variation also provides an opportunity for comparison and improvement on an ongoing basis.

Flexibility permitted at the state level is particularly valued by a state like Massachusetts due to its history working with similar programs. The Health Connector, through the state-subsidized Commonwealth Care program, has had some experience working with concepts that are closely aligned with each of the three premium stabilization provisions under the ACA (reinsurance, risk corridor, and risk adjustment). While we see passage of the ACA and the inclusion of these concepts in the federal legislation as a critical opportunity to re-assess our approach, we also value the ability to leverage and build upon lessons learned from our experience to date.

In addition, sufficient state flexibility allows us to obtain maximum benefit from stakeholder inputs. As has been the state's long-standing model of health reform implementation, Massachusetts is committed to ensuring broad stakeholder participation throughout the ACA implementation process. We envision that state agencies will be working closely with health plans and other stakeholder groups to develop recommendations on state-based reinsurance and risk adjustment programs.

Below we have summarized our comments on a few specific issues raised in the NPRM, to a certain extent drawing upon our experience with Commonwealth Care. Although not elaborated here, the design and operational specifics of Commonwealth Care's risk adjustment and related processes have been described in depth by the Health Connector and others through separate efforts.

I. Transitional Reinsurance Program

Based on our study of the NPRM, for states that plan to operate Exchanges, a forthcoming Federal notice will publish detailed parameters of the reinsurance program, including contribution and payment formula, under the statutory reference of "model regulation". States are permitted to propose modifications to the methodology, which must be published in a State notice as described in Section §153.110 of the NPRM.

We value the level of state flexibility proposed by the NPRM as we believe this allows states to calibrate their reinsurance programs in accordance with market conditions that tend to be state-specific, including the size and characteristics of the individual market segment relative to the overall commercial market.

Below we comment on a number of areas in the program design where we highlight the considerations that will likely play a key role in state-level decisions, which typically strive to achieve an appropriate balance between methodological soundness and operational manageability.

[1]The Health Connector also administers a program referred to as Commonwealth Care Bridge. This program provides subsidized insurance coverage to approximately 14,500 legal immigrants who have been in the United States for less than five years.

Contribution methodology

Section §153.220 of the NPRM describes the method in which the reinsurance entity collects contribution funds that would cover payments of eligible reinsurance claims and administrative costs incurred by the reinsurance entity.

We are supportive of the use of a national contribution rate vs. a state allocation approach to determine the amount to be assessed from all health insurance issuers and third party administrators on behalf of self-insured plans. We agree that the state allocation methodology would be far more complex to develop given the uncertainty in the required size of the reinsurance pool for each state. Furthermore, a state allocation approach would not be particularly meaningful since a state would ultimately need flexibility to adjust the contribution based on its experience.

The NPRM further discusses two potential approaches to defining the contribution amount: 1) a percent of premium (or medical cost for self-insured plans); and 2) a flat per capita amount applied to all covered enrollees. The NPRM proposes that Option 1 (percent of premium) is the fairest method, as a flat per capita amount could disadvantage products that are designed to have low premium (e.g., children and young adults), and that HHS plans to establish the percentage through a forthcoming federal notice.

The Health Connector currently manages a reinsurance program for its Commonwealth Care program. The reinsurance pool is assessed from participating health plans of the Commonwealth Care program only, in the form of a uniform percentage of the capitation payments that the health plans receive to provide coverage for the population. Therefore, the Health Connector's approach is more closely aligned with Option 1.

However, we propose that HHS permit sufficient flexibility for states to choose between a premium-based option and a per-capita-based option, with an eye towards administrative feasibility. As a significant difference from what was implemented for the Commonwealth Care program, the transitional reinsurance program required by the ACA assesses contributions from *all* health insurance issuers and Administrative Services Only (ASO) administrators in the state. For self-insured products, if the assessment were to be based on medical cost as proposed by the NPRM, this raises the question as to whether this is sufficiently comparable to the percent-of-premium assessment on fully-insured products (which includes both medical costs and administrative costs); secondly, this approach will require significant lead time in collection of the contribution due to claims lag. In several places the NPRM stresses the importance of completing the reinsurance process within a defined deadline, especially due to its interactions with the risk corridor and MLR processes, and that health plans should receive payments on their reinsurance claims as early as possible. Depending on states' specific capacity to collect assessment from self-funded plans in a timely fashion, the per capita approach may better support this objective.

With regard to the concern about over/under-assessing health plans relative to their premiums, mitigation mechanisms can potentially be considered where the per capita amount is adjusted for certain types of products.

Please note that the Health Connector is not proposing that HHS choose the per capita based methodology over the percent of premium methodology. We are simply recommending state flexibility on this issue, which would allow for a more complete evaluation by each state.

Rate of contribution and Disbursement of Reinsurance Payments

Section §153.220 of the NPRM states that a State may collect more than its amount specified by the national contribution rate, if the State determines that this is needed to cover the payables under the defined reinsurance formula. In Section §153.240, the NPRM proposes that the State must ensure that the reinsurance entity makes payments that do not exceed contributions, and that States are allowed to reduce payments on a pro rata basis to match the amount of contributions received by the state in a given reinsurance year.

We interpret the NPRM to mean that a State has flexibility to determine its contribution amount, which allows the State to *avoid* having to reduce its reinsurance payment to eligible claimants (even though the state will have the option). We believe that this is an important flexibility for states to have.

The Health Connector's approach with its Commonwealth Care program is that the amount of assessment is adjusted so that it exactly matches the claims payment amount. In other words, if it is determined that the initial amount of contribution will not be sufficient to cover the reinsurance claims as calculated based on the pre-determined attachment point, reinsurance cap, and coinsurance amount, the Health Connector would increase the rate of assessment for the benefit year. Conversely, if the assessed reinsurance pool is in excess of what the reinsurance payments amount to in a benefit year, the surplus funds will be returned to the issuers on a pro rata basis.

We think the approach by the Health Connector should be an allowable option and states should be permitted to develop operational procedures to support such a mechanism. Reinsurance recoupment is a key input of issuer pricing, and the prospect of such recoupment being reduced due to assessment short-fall would introduce pricing uncertainty which could have inflationary impacts on premiums. In addition, while the NPRM emphasizes that any adjustment to the payout would need to impact all health plans in an equitable manner, this is difficult to achieve because health plans' attraction of high cost individuals could be drastically and systematically different.

We recognize the trade-off between uncertainties on the assessment side vs. the payout side. Our perspective is that given the assessment is on a much larger pool as compared to the payout which is on a more concentrated pool, the balance should be towards controlling issuer exposure in the individual market.

II. Risk Adjustment

We greatly appreciate HHS's openness to allowing states that elect to operate a state-based Exchange to define their own risk adjustment model and methodology, subject to federal certification. We believe this flexibility is important as it allows states to select models and methodologies that maximize the "goodness-of-fit" for their underlying populations, which could vary substantially across states given the wide range of existing insurance market rules and coverage penetration.

Risk adjustment model selection and calibration

The Health Connector introduced its first risk adjustment program in 2009 with a model calibrated for the Commercial population. At the time it was clear from our analysis that the Commonwealth Care population, with socioeconomic status between the Commercial and Medicaid populations, would have limited "fit" with the off-the-shelf model. In 2011, with more encounter data from the Commonwealth Care population at hand, the Health Connector recalibrated the model which led to a significant improvement in model predictive power (R-squared increasing from 12% to 17% for a prospective model). This was an important enhancement to the program that was very well received by participating health plans.

We look forward to detailed federal guidelines on the approaches that states can potentially adopt in order to maximize the effectiveness of premium stabilization post 2014. As an example, risk adjustment that applies across non-group and small-group products should take into account the effect of transitional reinsurance that applies to individual enrollees only, which introduces different actuarial risks for non-group and small-group members. This is particularly important for states with merged small and non-group markets, where rating differences between the two segments are not permitted. In order to adequately mitigate risk selection, we believe that to the extent there are quantifiable actuarial risk differences that cannot be sufficiently adjusted for with illness burden, additional parameters in the risk adjustment methodology may need to be explored.

In terms of calibrating the weights used in the model, we believe there should be clear guidelines on how the methodology would differentiate between true disease burden and costs driven by poor management. For example, health plans should not be financially rewarded for conditions that are avoidable, such as preventable readmissions and hospital-acquired conditions.

Payment and Charge calculation

In Section §153.320, the NPRM solicits comment on the method by which the dollar value of payments and charges is determined for each issuer. Specifically, two general concepts are discussed: 1) multiplying plan average actuarial risk by the State average normalized premiums; and 2) multiplying plan average actuarial risk by the specific premiums collected for each plan. The NPRM suggests that due to premium differences, Option 2 would lead to inequalities between payments and charges, which potentially increase administrative complexity.

Based on our understanding of the NPRM, states have the option to propose an approach relative to this particular methodology. The comment provided herein represents the Health Connector's perspective on this issue largely based on its experience with risk adjustment under the Commonwealth Care program.

The Health Connector determines risk-adjustment payments by multiplying issuers' risk scores to the plan-specific premium amounts (Option 2). As a result, the dollar amount that a plan is charged or paid is not only a function of its relative actuarial risk, but also tied to its normalized cost structure. To overcome the issue of payment and charge inequality, the Health Connector's model incorporates a step of "normalization" that forces the overall redistribution to be revenue neutral. The normalization factor, which is calculated for each risk adjustment cycle and relatively stable in the history of the Commonwealth Care program, is communicated to all issuers so that they can track how their risk adjustment payment/charge is derived. The benefit of this approach, we believe, is that it might make it easier for issuers to predict the dollar effect of risk adjustment, because the settlement amount is largely derived based on their own premium pricing and population risk, vs. a market average that may not be easy to estimate until later in the benefit year and certainly after pricing is complete.

Data collection

Section §153.340 of the NPRM discusses various approaches to the data collection method in support of risk adjustment, including 1) a centralized approach in which issuers submit raw claims data sets to HHS, 2) an intermediate State-level approach in which claims data is collected and aggregated at the state level, and 3) a distributed approach in which each issuer self-calculates its risk score and submits it for payment and charge determination.

The Health Connector strongly supports HHS's perspective that Option 2, the intermediate level is the most balanced option for states that elect to implement a state-based risk adjustment process. While we fully recognize the importance of ensuring data security, which states should address as a priority in their risk adjustment planning process, we have strong concerns about the distributive approach, for a number of reasons:

- It introduces complexities from the perspective of consistency and quality control;
- It would make it more cumbersome for the state or HHS to continuously evaluate and re-calibrate the risk adjustment model on an ongoing basis, which, in our view, is as important as the initial launch of risk adjustment
- A decentralized data infrastructure makes it more challenging to create risk profiles of individuals that are independent of their coverage history, as each issuer presumably would only have access to claims data of enrollees from their enrollment periods with the issuer only. In contrast, a centralized data set would allow for "cross-walk" of disease history of an individual across all insurers

To ensure that states maximize their capacity to pursue the intermediate approach to data collection, we believe the non-profit entity selected by the state to administer the risk adjustment process should be authorized to either collect from issuers the required data, or, to the extent the state has an All Payer Claims Database (APCD) that meets the risk adjustment needs, this entity should be authorized to access this data for the purpose of risk adjustment. Many states, including Massachusetts, New Hampshire, Vermont, and Maine, have had well-established claims data collection systems from insurers for many years. The Massachusetts APCD in particular proposes to serve as the central repository of claims data to meet various analytic needs for the Health Connector, Division of Insurance, the Group Insurance Commissioner, the Division of Health Care Finance and Policy and other government agencies. Therefore, a state-run APCD will monitor activities to ensure data completeness and accuracy which is critical for ensuring the reliability of risk-adjustment and analytic activities. We agree with section §153.610 in terms of requirement on issuers to submit data in accordance with the timeline and format prescribed by the state. We further agree with HHS that there should be a fixed deadline for the risk adjustment calculation to be completed, as it is the only way to achieve revenue neutrality as prescribed by the ACA.

III. Temporary Risk Corridor Program

Allowable costs for risk corridor calculation

Section §153.500 of the NPRM solicits comment on the type of medical costs that should be considered "allowable" for risk corridor calculation. A specific question raised is whether costs for activities that improve health care quality should be included. Our perspective is that such costs should not be included, and this is the approach adopted by the Health Connector for its

Commonwealth Care program. Although we agree that spending on quality improvement should be encouraged, our concern is the difficulty in managing the consistency among health plans in terms of defining such expenses. We are also wary of the room for "gaming" as health plans are likely to have discretion in their spending on quality management.

A related issue is how reinsurance payments should be attributed to the risk corridor calculation. A specific proposal put forth in §153.520 is that inclusion of the reinsurance payout would be a function of when the reinsurance claim is submitted by an issuer, in that if a qualified reinsurance claim misses the deadline for a given benefit year, the payment would be attributed to the following year's risk corridor calculation, if applicable. Again we are concerned about the opportunity for "gaming" as this could allow health plans to "optimize" the time period of reinsurance claim submission based on where they are profitability-wise in a given year relative to the corridor. We acknowledge that this puts pressure on the timeline of risk corridor calculation, which by design is the most downstream step of the premium stabilization process. The Health Connector encounters the same issue with its Commonwealth Care program, where we have maintained the policy of strict deadlines of all steps that precede the risk corridor settlement.

Temporary vs. Permanent Risk Corridor

With Commonwealth Care, risk corridors are incorporated as a *permanent* provision of the program, compared with the requirement of the ACA which defines the process as temporary. While we are developing our ACA implementation plan in accordance with the temporary timeline of risk corridors, we would like to take this opportunity to share with HHS that a key consideration of the Health Connector to maintain the risk corridor program to date is that it serves as an important mechanism to compensate for shortcomings of risk adjustment that are difficult to control.

In the early years of Commonwealth Care risk adjustment was not an option (due to lack of data), and risk selection, which was clearly observed as a barrier to effective competition, was to an extent mitigated by the risk corridor process. While risk adjustment was subsequently introduced to Commonwealth Care, pressure of risk selection was also on the rise as health plan differentiation was encouraged. As a result, we have continued to see the need for a risk corridor program because it maintained a critical level of competition based on true cost and utilization efficiency, allowing health plans that excelled in managing high-risk populations to sustain their competitiveness.

We thank you for consideration of our comments and look forward to continuing to work with the federal government in implementation of the ACA.

Sincerely,

Glen Shor, Executive Director
Health Connector

Jean Yang, Chief Financial Officer
Health Connector