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U.S. Department of Health and Human Services
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Submitted via e-mail hhshccraops@cms.hhs.gov

**Re: CMS HHS-Operated Risk Adjustment Methodology Discussion Paper—AHIP
Comments**

Dear Director Counihan—

We are writing on behalf of America's Health Insurance Plans (AHIP) to offer comments in response to the CMS HHS-Operated Risk-Adjustment Methodology Discussion Paper. AHIP and our member plans appreciate the significant thought and analysis by CMS in developing potential alternative approaches and changes to the risk adjustment program and the opportunity to provide input.

The Affordable Care Act's (ACA) risk adjustment program plays a critically important role in promoting market stability, assuring a level playing field among plans in the new marketplace and promoting affordability of coverage—particularly for patients with chronic health conditions. A robust and predictable risk adjustment model is one of the cornerstones of a competitive health insurance market—where plans innovate and compete on efficiency and value to the consumer. While we agree that the risk adjustment program has generally been successful and is largely working as intended, we also believe targeted changes are necessary to improve the model and more accurately reflect the risk of all enrollees. To that end, we appreciate CMS' consideration of potential changes to strengthen the risk adjustment program so that it can better fulfill its broad market-stabilizing role of promoting affordability and stability for consumers.

The discussion paper includes several detailed policy options and alternatives to strengthen the risk adjustment program. In assessing policy options to strengthen the program, we believe that any changes should be made well in advance of the applicable benefit year in which they would take effect and with sufficient opportunity for stakeholder input through the formal notice and comment process—consistent with the process contemplated under the discussion paper. Moreover, any changes to the risk-adjustment program should support a level playing field so that the rules of the program apply similarly across all health plans subject to the ACA risk-adjustment requirements. Assuring a level playing field is a critical element of ensuring vibrant,

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competitive markets based on fair competition—which benefits consumers through the value and quality of health plan choices.

The following summarizes AHIP’s major comments and recommendations to strengthen the risk-adjustment program.

- **Adopt a durational factor into the risk-adjustment model to better capture the risk of partial year enrollment.** This approach—which is less operationally complex than CMS’ proposal to create separate models for full year and partial year enrollees—holds promise in improving the accuracy of the model as it relates to the risk and costs associated with partial-year enrollees.
- **Support the inclusion of prescription drug data to improve payment accuracy under the risk adjustment model.** This can be best accomplished through an incremental approach—e.g., starting with a well-defined, targeted list of drugs under an imputation model—that would allow CMS and plans adequate time to assess and analyze the impact of these changes on the risk-adjustment model’s performance.
- **Support CMS’ decision to maintain the concurrent model for risk-adjustment.** This approach is more appropriate for the individual and small-group markets where movement between insurers and markets is commonplace.
- **Safeguard consumer privacy while preventing the disclosure of plan proprietary and confidential business information under any new data recalibration approaches to update the risk adjustment model—including the proposed re-calibration for the 2019 benefit year that would be based on edge server data submitted by plans.** While we agree that re-calibrating the risk-adjustment model to a more representative data set—such as utilizing plan edge server data that better reflects the claims experience of the individual and small group market—can improve the accuracy of the model, we have significant concerns about the approach described in the discussion paper and its potential implications for consumer privacy and protecting proprietary and confidential information.
- **Recommend that CMS should not go forward with the high-risk pooling approach described in the discussion paper.** While we appreciate the goal of improving the model’s accuracy in capturing very high-cost enrollees, we believe additional discussion and analysis are necessary to determine how this proposal could be implemented in a way that avoids unintended consequences—such as inappropriate risk payment transfers and other negative effects.

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- **Recommend that CMS should not adopt changes to the risk adjustment payment transfer formula that are considered in the discussion paper at this time—such as excluding fixed administrative costs in the statewide average premium.** Instead, CMS should focus on incremental policy solutions—including proposals detailed in the discussion paper such as addressing partial year enrollment and including prescription drug data—that hold promise in improving the accuracy and effectiveness of the risk adjustment model.

We look forward to working with you on policy options to strengthen the risk-adjustment program—which plays a critical role in promoting stability in the market and affordability for consumers.

Sincerely,



Matthew Eyles
Executive Vice President
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Greg Gierer
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AHIP Detailed Comments on CMS HHS-Operated Risk Adjustment Methodology
Discussion Paper

I. Partial Year Enrollment

The paper explores several ways to better account for the claims costs of partial year enrollees in the risk adjustment model. Issuers' experience to date suggests the current model significantly under-predicts the actual costs of these enrollees – since these individuals may not have a provider encounter that results in an HCC during their short enrollment period, but are still utilizing health care services (e.g. prescription drugs) or have non-HCC conditions that result in significant claims costs.

CMS outlines three possibilities to adjust for partial year enrollees: (1) the application of an additive duration factor that increases the relative risk of an enrollee based on the length of their enrollment, (2) creating separate risk adjustment models for partial year enrollees, and (3) a hybrid approach.

Although CMS appears to favor the second option – separate models by enrollment duration – we are concerned about the complexity this approach could add to the risk adjustment program. Developing additional risk adjustment models when CMS is also considering changes (such as the inclusion of prescription drug utilization and data recalibration) introduces additional uncertainty about the modified model's performance. It is possible – as even CMS argues – that these two changes could have an impact on how the model predicts costs for partial year enrollees. The incorporation of prescription drugs could identify HCCs that would not have been recorded because an enrollee did not visit a provider during a very short enrollment period, but for which there was still significant spending. Recalibrating the risk adjustment model to a different data set could also pick up trends in partial year enrollee claims costs that are unique to the individual and small group markets, and not currently reflected in MarketScan® data. But it is difficult to know in advance of their implementation how impactful these changes would be with respect to partial year enrollments.

Until we can better assess how the full set of changes contemplated for 2018 and beyond will interact with each other, we recommend CMS incorporate a duration factor to account for partial year enrollees. The application of a duration factor is a relatively straight forward approach that can help improve the predictive accuracy of the risk adjustment model. Although it may not have an effect as large as creating separate models for partial year enrollees, we believe this incremental approach is more consistent with the principle of implementing targeted changes to the risk adjustment program whose effects are (relatively) easier to predict. Once implemented in

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conjunction with other changes in 2018, CMS and issuers can evaluate its performance and decide then what additional modifications, if any, are needed to further address partial year enrollees.

II. Prescription Drugs

We continue to support CMS' efforts to investigate how prescription drug data could be incorporated into the risk adjustment model. As discussed elsewhere in this comment letter, we believe data on prescription drug utilization can help fill in gaps in the risk adjustment model and improve its accuracy in a variety of areas.

The myriad ways to include prescription drugs and the trade-offs involved, however, demonstrate how complicated an undertaking this could be. We applaud CMS' robust and thoughtful framing of the options around modeling the impact of prescription drugs, the criteria used to evaluate different proposals, and the discussion of potential adverse consequences outlined in the paper. This level of analysis is necessary to understand how the inclusion of prescription drug data will impact the risk adjustment program.

We look forward to further conversations with CMS about the most effective way to include prescription drug data, and offer the following comments on some of the specific options outlined in the paper:

- **All else being equal, simpler methodological approaches to incorporating prescription drug data should be favored over the more complex, at least in the short term.** The imputation only model meets this criterion in that its impacts can be modeled with relative ease and, we believe, is less susceptible to unanticipated results. This approach would allow issuers to become familiar with the impact of prescription drugs on enrollee and plan risk scores and work to address any shortcomings. A simpler model would also better facilitate auditing and verification of HCCs triggered or enhanced by prescription drug utilization. More complex options, such as the Rx Dominant or Flexible Hybrid models outlined in the paper, could be considered and adopted in future years.
- **Initial incorporation of prescription drug data should only involve a targeted, well-defined list of drug-condition pairs.** We support the list of drug-condition pairs that CMS has identified in table 4.4 of the paper. Focusing only on those pairs that result in more accurate identification of HCCs is an important stepping stone to better understanding how the addition of prescription drug utilization impacts the model.

- **We agree that prescription drug utilization should be included in the model in such a way that does not facilitate gaming or perverse prescribing incentives. We encourage CMS to adopt standards during the initial years of implementation to ensure that these data are actually improving the predictive accuracy of the model.** This reinforces the need for an incremental approach to incorporating prescription drugs into the model, so that appropriate investigation and analysis can take place to determine the model's performance.

III. High Risk Enrollee Pooling

The paper outlines a novel change to the risk adjustment model that would pool a portion of the costs for enrollees who had very high medical spending. The model would create a second risk adjustment transfer based on these pooled costs to reduce issuer's exposure to very high claims cost enrollees. CMS puts forth two arguments for why such an adjustment to the model would be beneficial: (1) the under-prediction of claims-costs for high risk enrollees could incentivize risk selection, and (2) the exposure to very high cost enrollees could disadvantage smaller issuers, leading to instability in the individual and small group markets.

We believe additional discussion and analysis is needed to determine how this proposal could be operationalized in such a way that avoids gaming and inappropriate transfers. Many of our members have identified contracting practices between plans and hospitals – specifically for very high cost enrollees – that could create an opportunity for gaming. Often times, issuers and hospitals will agree that once an enrollee passes a certain cost threshold, the reimbursement structure shifts from a fee schedule or durational payment structure to “outlier provisions,” such as a percentage discount on the billed amount. Through tactical negotiating, issuers and hospitals could reach contracted agreements that increase the frequency and magnitude of individuals above the high-risk pool payment threshold in return for reductions in the cost of lower-cost individuals. The net transfer from issuer to hospital would remain the same, but by increasing the frequency and magnitude of those individual above the payment threshold, it would result in the high risk pool compensating issuers inappropriately for claims costs that would otherwise have been borne by the issuer and hospital jointly. Because this contracting risk would be net neutral, reducing the high-risk pool reimbursement rate would not deter this form of gaming. We strongly encourage CMS to investigate ways this incentive could be reduced or guarded against if it ultimately moves forward with this proposal.

The paper also describes the costs above the threshold being placed into a uniform risk adjustment high cost pool. Absent some additional modification, a national high risk pool could result in cross-state subsidization of issuers based on medical costs, and not selection of high risk enrollees. Health care costs can differ substantially across state lines - an enrollee is more likely to hit the threshold for the high risk pool in Massachusetts than they are in Mississippi, even with

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the same condition. We are concerned that a national transfer pool would mirror these differences, resulting in transfers that subsidize more costly states at the expense of less-costly states.

We look forward to additional conversations with the agency to discuss how these hurdles could be overcome in such a way that leads to a more effective and accurate risk adjustment models.

IV. Prospective vs. Concurrent Model

Prior to the implementation of the ACA's risk adjustment program, there were significant discussions around whether the model should be prospective (as in Medicare Advantage and Part D) or concurrent. The concurrent model (applied retrospectively) was ultimately chosen for its ability to capture the costs of acute and high cost events, as well as provide a more straightforward approach for the initial year of the program, when usable data from past years was not available.

In response to some comments that CMS should move to a prospective model, the agency argues that a prospective model would not capture enrollee's movements across markets and issuers, and that the current model is promoting competition and guarding against adverse selection. We agree with this assessment, and support CMS' decision maintain the concurrent model for risk adjustment.

V. Data for 2018 Recalibration

As an additional step to better capture the expenditures for new and high-cost treatments, the paper explores the possibility of recalibrating the risk adjustment model for 2018 with data from only 2014, as opposed to three year blended coefficients from 2012, 2013, and 2014. CMS is exploring the tradeoffs between stability and newer data in such an approach.

Given the more substantial recalibration considered for 2019, we recommend CMS continue to utilize three year blended coefficients for the 2018 model. However, we propose bifurcating the publishing of the Notice of Benefit and Payment Parameters (the Notice) so that 2013, 2014, and 2015 data would be available for the 2018 model.

In past years, the annual Notice has been published as a proposed rule in late November and finalized in late February/early March. We recommend moving up the publication of those elements of the Notice that do not depend on updated MarketScan® data – the FFM user fee, the premium adjustment percentage, maximum out-of-pocket limits, cost-sharing parameters for CSR plans, and other associated policy and operational updates for the FFM. Publishing these

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proposed updates in late summer/early fall would provide issuers with much needed time to understand how they would impact product development and provide CMS with more substantive and thoughtful feedback prior to finalization. Updated risk adjustment model coefficients – which are less time-sensitive than other elements of the Notice – could be published through sub-regulatory guidance after 2015 MarketScan® data is made available and incorporated with data from 2014 and 2013.

We believe this approach balances the need for stability in the risk adjustment model while making all efforts to incorporate the most recent data. Moving up the publication of those other elements of the Notice will also help support market stability by giving issuers more time to understand and comment on critical updates for the 2018 benefit year.

VI. Data for 2019 Recalibration

For the 2019 benefit year, CMS is considering recalibrating the risk adjustment model using claims data from issuer's EDGE servers. This would be accomplished by creating a new EDGE server report that would extract and encrypt enrollee-level data elements that CMS believes are necessary for risk adjustment calibration, resulting in a de-identified, nationwide data set on the individual and small group markets. Because these data would represent the actual claims experience of the risk adjustment population, CMS argues, it would be a more representative and therefore accurate calibration tool for the risk adjustment program. CMS contemplates additional uses for such a data set – such as exploring other more sophisticated changes to the risk adjustment model (e.g. socioeconomic status) and use by other entities to understand the dynamics of health insurance markets.

We agree that calibrating risk adjustment model to a more representative data set could improve the accuracy of the model, but have significant concerns about the approach described in the paper.

One of the principles in adopting a distributed data approach was that detailed claims information would remain with issuers – CMS would only receive aggregated summary level information needed to run risk adjustment and reinsurance calculations. We continue to believe, as we did when the program was established, that this approach protects proprietary and confidential business information from entering the public sphere. Although we believe that calibrating the model to EDGE data would support a more effective risk adjustment program, CMS must take steps to protect against some of the potential negative policy consequences that could result from assembling and disseminating such a data set if it adopts this approach, including:

- **Limiting sensitive data fields unnecessary for model recalibration.** The list of proposed data elements that CMS would need to collect should be carefully evaluated and limited to only those that are absolutely necessary for model recalibration. It is unclear how some of the elements proposed by CMS (on pages 74-76 of the discussion paper) would be used in recalibration. Not only do we believe that some of the proposed data elements are unnecessary, but the inclusion of some could lead to the identification of specific issuers and their associated data. For example, there are publically-available databases that link issuer's HIOS IDs with a policy's premium. Including premium as a data element in this data set would allow outside parties to link detailed enrollee-level data with a particular issuer – presenting significant competitive and privacy concerns. If CMS ultimately adopts this approach, we recommend the agency complete and publish the results of an assessment detailing the need for each proposed data element – including a consideration of the steps taken to ensure that these elements cannot be used in conjunction with other data sets to identify specific issuers or populations.
- **Limiting use of the national data set.** We are also concerned with the seemingly open-ended uses of the national data set that CMS is considering – and how it will factor into future policy decisions regarding risk adjustment or the health insurance marketplace broadly. As CMS has acknowledged, such a data set does not currently exist, and could represent an opportunity for a range of stakeholders to analyze claims information and dynamics of the individual and small group markets in ways not previously possible. Given the sensitive nature of this information, we recommend that CMS restrict use of this data set only to recalibration of the risk adjustment model for the near future, and only consider an expansion of its use with substantive issuer input.

Given the uncertainty and proprietary information involved with such an effort, we also strongly encourage the agency to explore other statistical techniques that could leverage EDGE data for recalibration without compromising enrollee and issuer-specific information.

VII. Transfer Formula

The paper contemplates a change to the risk adjustment transfer formula that would remove administrative expenses from the transfer formula or by modifying the transfer formula equation by using a plan's own premium. Additional adjustments for plan characteristics – such as network differences, plan efficiency, or care coordination – are discussed at a high level.

Removing a portion of state average premium attributable to administrative costs is intended to assure that payment transfers are focused on the risk of the enrollee population and not unrelated costs—as recognized by the American Academy of Actuaries in their comments on the most

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recent Notice.¹ However as the paper notes, there are considerable operational hurdles to overcome before implementing such a proposal.

Given the other changes to risk adjustment contemplated for the near future, we do not recommend making any changes to the transfer formula at this time. CMS should instead focus on policy solutions that maintain a level playing field for all while improving the model's ability to accurately predict and normalize risk across health plans.

¹ Available at: http://www.actuary.org/files/Acad_comments_on_NBPP_122015_0.pdf