

MEMORANDUM

To: Health Connector Board of Directors
Cc: Louis Gutierrez, Executive Director
From: Edward DeAngelo, General Counsel
Michael Norton, Senior Manager of External Affairs & Carrier Relations
Date: April 3, 2015
Re: Adoption of Final Risk Adjustment Regulations

BACKGROUND

Health Connector staff recommends that the Board adopt final regulations to implement a risk adjustment program for the Massachusetts small group and non-group health insurance merged market. A copy of these proposed final regulations is attached with redlines to reflect the changes made since this Board approved the issuance of these regulations in draft form for public comment at the December 11, 2014 Board of Directors meeting. The public comments received and the changes made in response to those comments will be discussed in more detail below.

Risk adjustment is a federally required program under which carriers are comparatively assessed on the amount of actuarial risk that is represented by their population of insureds. A financial adjustment is then made via transfer payments from carriers with lower than average actuarial risk to compensate carriers with higher than average actuarial risk. The Affordable Care Act (ACA), passed in 2010, requires that there be a risk adjustment program in every state. See 42 U.S.C. § 18063. States had the option of establishing their own risk adjustment program or defaulting to a risk adjustment program run by the federal government. In 2012, the Massachusetts Legislature authorized the Health Connector Board to define and establish by regulation a risk adjustment program as required by the ACA. See Mass. Gen. Laws ch. 176Q, § 3(v). Subsequently, the Health Connector applied for and received approval from the Centers for Medicare and Medicaid Services (CMS) to run its own risk adjustment program. The regulations now being presented to the Board are designed to implement that program for the 2014 plan year going forward.

SUMMARY OF THE RISK ADJUSTMENT PROCESS

The regulations set out the process under which risk adjustment will be conducted. Risk adjustment is a multi-phase process. In the memorandum submitted to the Board prior to the December 11, 2014 meeting, we outlined in detail the phases of the process, and will only recap that briefly here.

The phases include the collection of data, resolution of data discrepancies, a final settlement calculation and dispute resolution. First, data is collected from carriers through the Commonwealth's existing All Payers Claims Database. The Health Connector uses this data to prepare monthly reports and quarterly simulations for carriers that will forecast their relative risk scores. The Commonwealth's ability to provide these regular reports has been beneficial to carriers in helping to both predict the final risk

adjustment outcomes and to identify issues with the data early on so they can be remedied. The regulations provide for a process to resolve such data discrepancies throughout the year. Then, under the regulations, the Health Connector makes a final calculation based on the data as of April 30 of each year. The Health Connector will issue a report by July 1, in which it states the charges to carriers with higher actuarial risk populations and the payments to carriers with lower actuarial risk populations. The regulations provide carriers with a procedure to seek reconsideration of that final charge through a two stage appeals process, involving, first, a paper review and then a more formal hearing.

PUBLIC NOTICE AND COMMENT PERIOD AND RECOMMENDED CHANGES

This Board voted on December 11, 2014 to issue draft regulations. Notice of these draft regulations was provided in accordance with state law. The public was given an opportunity to comment on the draft regulations. A public hearing was held on Friday, March 6, at 10 a.m. at the Health Connector offices. A public hearing had originally been scheduled for January 28, 2015, but was cancelled because of snow.

Testimony and/or comments were received from the following entities: Blue Cross Blue Shield of Massachusetts (BCBS); Community Catalyst; Fallon Health; Health New England (HNE); Health Care For All (HCFA); the Massachusetts Association of Health Plans (MAHP); and Minuteman Health. A summary of their testimony and comments and the Health Connector's response follows.

Timing of Risk Adjustment Implementation

Four commenters (Fallon, HNE, MAHP and Minuteman) commented that the implementation of risk adjustment should be delayed. Alternatively, HNE asked for a phase in or limitation of the risk adjustment payments, while Minuteman asked the Commonwealth to seek a waiver of the ACA requirement.

As grounds for this request, these entities made policy arguments that risk adjustment would have a disruptive effect on the market. They predicted that risk adjustment will lead to premium increases by carriers that are required to make risk adjustment payments, which will reduce competitiveness in the market. They claimed that the risk adjustment payments will create a burden for carriers that have limited networks, which tend to draw lower-risk enrollees. They also argued that, by requiring payments from carriers with a large population of low risk members, risk adjustment removes incentives for carriers to administer wellness programs. They claimed that, unlike other states, Massachusetts does not need risk adjustment in order to compensate for ACA-imposed market reforms, such as guaranteed access, because these reforms have been in place in the Commonwealth for a number of years already.

Several commenters also raised the concern that the risk adjustment payments could impose a financial burden on smaller or relatively low-cost carriers. They argued that low-cost carriers are likely to attract a lower-actuarial-risk population, and thus those carriers are likely to have to make risk adjustment payments. For smaller carriers, they argue, this could endanger their profitability or even solvency, with

the potential result of a decrease in the number of carriers operating in the Commonwealth and a consequent decrease in choice for consumers.

These carriers also claimed that a delay was justified because, in 2014, a number of individuals were enrolled in Commonwealth Care and temporary Medicaid coverage as opposed to in plans sold in the merged market. Additionally, these carriers pointed out that certain small group rating factors, including industry, which were not permitted under the ACA, remained in place in Massachusetts in 2014 due to a transition permitted by CMS at the Commonwealth's request, but these rating factors were not taken into account in developing the risk adjustment methodology.

Finally, these carriers expressed concern about the reliability of the data being used as the basis of risk adjustment calculations.

By contrast, one carrier, BCBS, commented that implementation of risk adjustment this year is legally required under both the ACA, and the federal regulations implementing the ACA. Further, the Health Connector has applied for and received federal approval to do risk adjustment for the 2014 benefit year. Additionally, the Division of Insurance (DOI) advised carriers to take risk adjustment into account in filing proposed rates for 2014, and a delay at this point would upset the expectations of carriers who relied on that advice.

HCFA also commented that risk adjustment was beneficial because it provided reimbursement to carriers with high actuarial risk, which in turn would result in those carriers developing lower premiums than they would charge without that reimbursement. This ultimately would benefit sicker individuals by providing them with lower premiums for the plans they choose. Community Catalyst commented that risk adjustment should not be delayed because it is a legal requirement.

The comments summarized above address the merits of conducting a risk adjustment process at all. However, as stated above, risk adjustment is created under the ACA. The purpose of these regulations is to implement that federal statute. Thus, policy considerations about whether to implement risk adjustment are outside the scope of the regulations themselves. Further, the Health Connector believes that it should not delay adoption of these regulations. The Health Connector has received federal approval to perform risk adjustment in Massachusetts for the 2014 plan year. Carriers took risk adjustment into consideration when developing their 2014 plan year rates. Further, CMS will be performing risk adjustment for carriers in the rest of the nation for that year.

As far as the unique circumstances of 2014, the Health Connector has been providing regular reporting to carriers in order to identify data discrepancies; this process has led to significant improvements in the reliability of the data, so that this data can serve as the basis for the 2014 risk adjustment calculation. The fact that there were transitional rating factors used in the small group market in 2014 was known and acknowledged at the time that the Health Connector developed its methodology for the 2014 plan year risk adjustment calculation, and carriers had an opportunity to comment on that methodology at the time. Finally, although the continuation of Commonwealth Care and the use of temporary Medicaid were not anticipated prior to 2014, there was still significant activity in the merged market in 2014, and it would upset carrier expectations to completely defer risk adjustment for this year.

Changes to Data Submission and Discrepancy Resolution Process

As drafted, the regulations provide that the Health Connector will produce monthly member month reports and quarterly risk adjustment simulation reports. The regulations state that a carrier has 30 days to either confirm the accuracy of these reports or to report that there are discrepancies. If a discrepancy is reported, the Health Connector and the carrier will work together to resolve the matter. If the carrier does not respond within 30 days, the reports are deemed to be accurate.

BCBS's comments were supportive of the reporting process and of the presence of a "safety valve" to report and resolve discrepancies.

Fallon commented that the deeming process should be eliminated and that a carrier should be required to attest affirmatively to the accuracy of the reports. Fallon further commented that the process should not go forward unless the carrier attests that the reports are accurate to a high degree. Fallon also requested that the regulations include a provision requiring the Health Connector to audit the data submitted by carriers.

Minuteman requested that the risk adjustment methodology should be adjusted or contain an outright exemption for small issuers. The Health Connector believes that this is an issue that properly concerns the methodology, which has already been approved by CMS for this year. Further, the Health Connector's actuarial consultants believe that there is sufficient data and claims experience at this point to be credible for all carriers subject to risk adjustment.

The Health Connector staff believes that no change should be made in the deeming provision. It is certainly optimal if the carrier attests to the accuracy of the report or, if it cannot attest, identifies the discrepancies so they can be resolved. But the deeming process was added so that a carrier cannot simply refuse to either agree with the data reports or identify the discrepancies, and thereby prevent any discrepancies from being resolved. The goal of the discrepancy resolution process is to increase accuracy of the data so that the final risk adjustment calculation will be reliable. As to auditing, the regulations do state that there will be a RADV process and the Health Connector is now undertaking to implement that process going forward.

BCBS commented that the discrepancy resolution process should involve CHIA. The regulations currently provide that if a carrier identifies a discrepancy in the monthly or quarterly reports, the Health Connector and the carrier will work together to resolve that discrepancy. It is the intention to involve CHIA in that resolution as necessary, and so we are proposing an amendment to the draft regulations stating that the Health Connector will work with CHIA as appropriate as part of that process.

BCBS also stated that there should be greater clarity in the regulations about the default charge, which is a charge that the Health Connector will impose on a carrier that fails to submit complete data to CHIA. The default charge is specified in the risk adjustment methodology that CMS approves annually. As such, the specifics of the charge may change, and it would be inappropriate to provide specificity in regulations. The regulations, as written, do state that the default charge will be calculated in accordance with the methodology, which is defined as the federally-certified methodology approved

each year. However, we are proposing a clarification stating that the default charge will be imposed when incomplete data is provided, as well as when no data is provided.

Changes to Reconsideration Procedures

Under the regulations, a carrier may seek reconsideration after the risk adjustment charge is calculated and imposed. As currently written, grounds for reconsideration include an incorrect application of the risk adjustment methodology, including issues related to unresolved data discrepancies, or mathematical error.

HNE commented that the grounds for reconsideration should be expanded to include an appeal of the methodology itself. The Health Connector does not believe that this is feasible as the methodology must be approved in advance by CMS. The Health Connector does publish its methodology every year in advance of federal certification in order to obtain comments. Thus the methodology is known to carriers before they develop their rate filings for the plan year affected by that methodology, allowing them to predict the impact of risk adjustment in calculating their rates.

Minuteman proposed that the regulations add another ground for reconsideration if the risk adjustment charges might cause a carrier's risk-based capital, as defined by DOI regulations, to fall below certain levels that would trigger DOI supervision, or where DOI or the Health Connector believes that the risk adjustment would cause financial instability of an issuer or impact the competitiveness of the market. Fallon similarly requested that grounds for reconsideration include the claim that risk adjustment payments would destabilize an individual carrier, reduce competitiveness in the market, or undermine merged market reforms. The Health Connector is not recommending this ground of reconsideration. The reconsideration process is designed to correct errors that affect the accuracy of the calculation, not to give powers to a hearing officer to make ad hoc changes to the calculation results.

BCBS commented that the regulations should provide for civil monetary penalties for carriers that do not make risk adjustment payments that they have been charged with. The regulations, as written, impose a 12 percent interest charge on late payments. The Health Connector does not have statutory authority to impose civil monetary penalties.

FINAL REGULATIONS AND VOTE

Based on the foregoing, the Health Connector staff is recommending that the Board adopt the regulations as final with the revisions reflected in the copy attached. If the Board does so vote, the regulations will be officially promulgated and become effective later in April.