



*The Commonwealth of Massachusetts  
Commonwealth Health Insurance Connector Authority  
100 City Hall Plaza  
Boston, MA 02108*

CHARLES BAKER  
Governor

MARYLOU SUDDERS  
Board Chair

KARYN POLITO  
Lieutenant Governor

LOUIS GUTIERREZ  
Executive Director

**Board of the Commonwealth Health Insurance Connector Authority**

**Minutes**

Thursday, December 10, 2015  
9:00 AM to 11:00 AM

One Ashburton Place  
Boston, MA 02108  
21<sup>st</sup> Floor Conference Room

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**Attendees:** Louis Gutierrez, Dolores Mitchell, Nancy Turnbull, Rina Vertes, Daniel Judson, Marylou Sudders, Mark Gaunya, Dimitry Petion, Michael Chernew, Celia Wcislo, Louis Malzone. Lauren Peters attended as the delegate of Kristen Lepore.

The meeting was called to order at 9:04 AM.

- I. Minutes:** The minutes of the November 12, 2015 meeting were unanimously approved.
- II. Executive Director's Report:** Mr. Gutierrez began the meeting by reviewing recent Health Connector activities. He stated that with Open Enrollment nearly halfway complete, processes remain stable for members. He noted that the Health Connector continues to review Section 1332 waiver opportunities with regular meetings with stakeholders and stated that the Health Connector is proposing to move forward with a draft waiver application as early as next month, with a final application filed with the federal government in early spring. He summarized topics to be included in the first phase of the application, including a request to keep small group rate filings on a quarterly basis, rather than transitioning to annual filing. He added that stakeholder engagement on larger and more complex possibilities will continue in the longer term. Ms. Wcislo commended Health Connector staff on their work around Section 1332 waiver consideration.

**III. 2016 Open Enrollment Update:** The PowerPoint presentation “2016 Open Enrollment Update” was presented by Vicki Coates and Ashley Hague. Ms. Hague began the presentation by stating that auto enrollment, which was the next major milestone at the last meeting of the Board, was successfully completed. She explained that auto enrollment is the process that enrolls individuals into their renewal plan automatically if they did not actively switch to a different 2016 plan. She noted that individuals are still able to shop for and switch plans. She added that approximately 16,000 new members are enrolled in Qualified Health Plans (QHPs) for 2016 coverage who were not previously enrolled in QHPs or MassHealth in 2015. In response to a question from Ms. Wcislo, Ms. Hague replied that the Health Connector does not yet know the demographic characteristics of the new 16,000 members but did note that the majority are enrolled in the ConnectorCare program. Ms. Hague then provided further detail on the auto enrollment process, stating that approximately 129,000 applications, representing about 160,000 members, were auto enrolled into a 2016 plan. She noted that those numbers do not include people who actively shopped for a new plan prior to auto enrollment. She added that invoices were sent in early December for January 1, 2016 coverage.

Next, Ms. Hague reviewed recent enrollment statistics. She stated that currently, approximately 180,000 people are in an enrolled status for January 1, 2016 coverage. She reviewed a graphic showing the numbers of individuals who were re-determined eligible for 2016 QHP coverage; individuals who renewed into and paid for 2016 coverage; renewing individuals who are currently shopping for a new 2016 plan but have not yet paid; and new individuals for 2016 coverage who were not enrolled in 2015. She noted that the payment deadline for January 1 coverage is December 23, so enrollment numbers will climb as the deadline approaches. In response to a question from Mr. Gaunya, Ms. Hague stated that all individuals enrolled in 2015 coverage who remained eligible for 2016 coverage were placed into a 2016 plan. Ms. Hague then reviewed renewing member movement among metallic tiers from 2015 to 2016 and commented that most members remain in their same metallic tier. She noted that most of these members are probably in a passive status. She stated that 76% of 2015 Catastrophic plan members remain in 2016 Catastrophic plans. She added that the Health Connector added messaging to encourage shopping, making sure that individuals are aware of rate changes. A shopping outreach series was launched last week, she said, with helpful information about limited networks, cost sharing and metallic tiers. In response to a question from Mr. Chernew, Ms. Hague stated that individuals eligible for cost sharing subsidies are determined into ConnectorCare and are not at risk of forgoing subsidies. In response to a question from Secretary Sudders, Ms. Hague said the Health Connector will get more information regarding whether new individuals who shop for a QHP but do not enroll default into Health Safety Net coverage.

Ms. Coates then presented the “Customer Experience Update” portion of the presentation. She stated that the call center received approximately 74,000 calls in November and is projecting about 127,000 calls in December. She stated that in the first month of Open Enrollment, the call center’s abandonment rate was 0.2%, equating to 128 abandoned calls during the month. The average speed to answer in November, she said,

was eight seconds. She then reviewed the top call drivers, with application and eligibility questions and questions about enrollment accounting for more than half of calls received. Next, Ms. Coates discussed performance of the Health Connector's walk-in centers. She stated that the walk-in centers received about 3,800 visits in November, averaging 129 per day. She stated that the Health Connector recently wrote press releases to encourage more individuals to utilize the walk-in centers if they need help. Ms. Coates then summarized recent work on urgent services cases. She stated that an Ombudsman program was established in October but that a lot of questions submitted via the Ombudsman form can be handled routinely through the service centers. Ms. Coates then reviewed customer satisfaction results for the month of November. She stated that overall customer satisfaction increased from the previous month and that customers are finding Customer Service Representatives (CSRs) knowledgeable and helpful. She then compared call center statistics for the first 30 days of Open Enrollment in 2014 and 2015 but noted that last year was very different because all members had to be re-enrolled. Secretary Sudders commented on the significant increase in the percentage of customers completely satisfied between October and November. Ms. Coates noted that training has focused on helping CSRs answer customers' questions while the customer is still on the phone, even if the CSR needs to transfer the customer to a supervisor. In closing, Ms. Coates stated that invoices were sent, and a second bill run was done for the first time to catch additional people who enrolled late in November. She reiterated that December 23 is the payment deadline. Ms. Turnbull expressed concern regarding the confusion consumers are experiencing with the new name for Tufts Network Health. She stated that individuals think they are joining the same network as Tufts and that providers also participated in the plan without knowing its network. In response to a question from Ms. Wcislo, Ms. Hague confirmed that the number of individuals in ConnectorCare Plan Type I is low because people moved to Medicaid.

- IV. Risk Adjustment Update:** The PowerPoint presentation "Risk Adjustment Update" was presented by Edward DeAngelo and Michael Norton. Mr. DeAngelo began the presentation by explaining that today's discussion pertains to the risk adjustment program for 2017 and after. He stated that Massachusetts received approval from the Centers for Medicare & Medicaid Services (CMS) to conduct a risk adjustment program for Benefit Years (BY) 2014, 2015 and 2016. He stated that BY2014 risk adjustment is nearly complete and that data analysis for BY2015 is in process. Secretary Sudders asked why Massachusetts requested to run its own risk adjustment program. In response, Mr. DeAngelo stated that at the time, it was believed that Massachusetts could perform risk adjustment in a way that better reflected the unique characteristics of the Massachusetts market. He added that since Massachusetts conducted a smaller risk adjustment program for Commonwealth Care, it had some expertise and experience in running a program. Mr. Gaunya added that Massachusetts's unique position as the only state with a merged market also contributed to the decision to run a state-based risk adjustment program. In response to a question from Ms. Mitchell, Ms. Turnbull stated that in addition to Massachusetts, Minnesota and Wisconsin have strong regional carriers and a relative absence of national carriers. Ms. Wcislo added that Massachusetts thought that with the the All Payer Claims Database (APCD), the Commonwealth had more accurate data than the federal government. Mr. DeAngelo provided more detail on the APCD, stating that

the Center for Health Information and Analysis (CHIA) runs the database, obtaining all claims data from payers. He noted that carriers also have to report their data to the federal government and that risk adjustment is a permanent program under federal law. He then discussed the Massachusetts risk adjustment methodology, stating that it is fixed through BY2016. He stated that the Massachusetts methodology is very similar to the federal one and that to change the methodology would require a significant amount of lead time. He noted that the development of the Massachusetts methodology lasted about a year. Mr. DeAngelo provided further background on the risk adjustment program, stating that it is a permanent program that can not be waived under Section 1332 of the Affordable Care Act (ACA). He stated that Massachusetts is the only state operating its own program, with all other states running their risk adjustment programs through CMS. He described the basic features of risk adjustment, explaining that it transfers money from carriers with a lower risk profile to carriers with higher risk scores. In response to a question from Mr. Chernew, Rong Yi, an advisor from Milliman who has been working with the Health Connector to conduct risk adjustment, stated that the federal government does not use the Verisk model to calculate risk scores because it is proprietary. She added that the variables used in the Massachusetts calculations are unique to Massachusetts and coefficients are created using the APCD. She stated that age and gender alone explain less than 5% of variability at the member level and when diagnoses are added, the federal model explains 25-35% while the state model's explanatory power is between 45-55% at the member level. In response to a question from Ms. Mitchell, Ms. Yi stated that the Massachusetts market is considered large, as the entire merged market covers approximately 1.1 million lives.

Mr. DeAngelo continued to explain the Massachusetts methodology. He stated that when it was approved by CMS, it was approved for use anywhere in the country. He discussed the differences between the state and federal methodology, noting that the two are very similar. He stated that the Massachusetts methodology contains several additional diagnostic codes but otherwise is not radically alternative. In response to a query from Mr. Chernew, Mr. DeAngelo stated that Massachusetts has tried to model the two methodologies at the plan level and that the results are the same directionally, such that the carriers that pay and receive funds are the same under either model. He added that there are some slight differences in the volume of transfers between the models, with the federal methodology resulting in a smaller transfer using 2014 data but led to a higher aggregate transfer with 2015 data. Mr. Gutierrez emphasized that directionality is the same under the two methodologies, with volume varying by scenario. He added that more recent scenarios show that the ConnectorCare population could be healthier than anticipated. Ms. Mitchell stated that the Verisk model used by the Group Insurance Commission (GIC) comes to the same conclusions – that smaller plans tend to have younger, healthier members. Ms. Mitchell then asked if any of the models include a variable representing the relative size of the entities in the analysis. Mr. DeAngelo replied that such a variable is not included in either the federal or state model. He added that the variables considered were the ones tied into the setting of rates. In response to a question from Ms. Mitchell, Mr. DeAngelo stated that state average premium is used for calculating risk adjustment transfers under both the federal and state models.

Mr. DeAngelo then discussed the cost of state-based administration of the risk adjustment program. He stated that the cost to run the program will be passed on to carriers if the state retains the program beyond 2017. He stated that the state's cost Per Member Per Month (PMPM) is about \$0.30, which is twice as high as the federal PMPM. He noted that Risk Adjustment Data Validation (RADV) is not included in the PMPM because the federal government does not factor RADV into its PMPM. He stated that the state's costs to run the program are higher in part because the state does not have the same economy of scale as the federal government. Mr. Gaunya commented that if health plans are assessed the charge to run RADV beyond 2017, the cost will ultimately be passed on to consumers through higher premiums. In response to a question from Ms. Vertes, Mr. Norton confirmed that health plans are not currently being assessed that charge. In response to a question from Mr. Chernew, Mr. Norton answered that both the state and federal risk adjustment programs use concurrent data in their models. Next, Mr. DeAngelo reviewed responses to the Health Connector's Request for Information (RFI) seeking comment from the market regarding whether the state should retain the risk adjustment program. He stated that all but one carrier preferred that the state continue to administer the program, but carriers wanted significant changes to the methodology that could not be made quickly. He added that at least one issuer wanted the state to administer the program but use the federal methodology. Mr. DeAngelo noted that Massachusetts cannot create a methodology that could not be used in the rest of the country. Secretary Sudders commented that a methodology is much less unique if it has to be able to be used in any other state. She expressed concern regarding cost considerations and difficulties of administration should the state continue to administer the program and wondered if the state could operate with the same efficiency as the federal government. Mr. DeAngelo then reviewed policy considerations and stated that the Health Connector is not planning to pursue continued authorization to operate a state-based risk adjustment program. He stated that the state does not have the economies of scale to efficiently run the program; the state does not want to pass the cost of program administration on to consumers; there is not a solution the market would agree upon; and the state methodology would not make a big difference to the market. Mr. DeAngelo summarized next steps and stated that if the state wanted to operate the risk adjustment program in 2017, it would need to apply to CMS this December, which the state does not plan to do. He stated that the state has discussed the transition with CMS and the transition will occur seamlessly. He added that the state will continue to administer the risk adjustment program in the remaining years for which it is authorized.

Mr. Gaunya stated that the theory behind the risk adjustment program was to protect states with high populations of uninsured individuals. That works in states with high rates of uninsurance, he said, but the Massachusetts market has an insurance rate of approximately 96%. He stated that an unintended consequence of the risk adjustment program is that it discourages plan design innovation, and small plans tend to innovate. He commented that he is reluctant to give up states' rights but that having the responsibility to administer the risk adjustment program without having the power to change the methodology is not a right. He added that in this context, it makes sense to transition the program to the federal government. In response to a query from Mr. Chernew, Mr. DeAngelo stated that Massachusetts is constrained by the data available in

the APCD and we are unable to change to using prospective data. Ms. Mitchell stated that she is a long-time supporter of risk adjustment but that the program is an example of unintended consequences that cannot be ignored. She agreed with Mr. Gaunya's remarks regarding the innovation and uniqueness of smaller plans. She stated that smaller plans add to the richness of the marketplace in a way that market consolidation does not. She added that she would be distressed to see smaller plans struggling financially under large transfer payments and that we have an obligation to discuss what we can do to help smaller plans survive. Mr. Petion commented that he would like to see parity between larger and smaller carriers. He stated that he would be concerned if Massachusetts retained the risk adjustment program, particularly with respect to the implied cost passed on to the consumer. He expressed his support for Mr. Gaunya's views and stated that he would like to see Massachusetts move forward with transitioning to the federal model. Mr. Chernew remarked that risk adjustment provides incentives for health plans to insure sicker, higher-cost individuals and expressed concern that when risk adjustment moves to federal administration, it will be out of Massachusetts's control. Ms. Vertes noted that the unintended consequences Massachusetts experienced were felt in every state across the country. She added that the federal government is aware of that and that the difference between the Massachusetts and federal methodologies is not materially different enough to justify passing \$0.15 PMPM onto consumers via premiums. She supports the recommendation to transition the program to the federal government, she said, but added that we should remain vigilant, so that if there are changes at the federal level that are not beneficial to Massachusetts, we should revisit the decision. Secretary Sudders stated that this decision may be revisited and that Massachusetts will monitor developments in the federal risk adjustment program. She added that insurance carriers have been in conversation with the federal government. She stated that Massachusetts has a strong delegation and that Massachusetts will not be quiet on this issue. Mr. Gutierrez stated that Massachusetts still has two settlement years for which to conduct risk adjustment and that the Health Connector is committed to working with CHIA and health insurance carriers to successfully administer the 2015 and 2016 settlements. Secretary Sudders stated that the transition to the federal risk adjustment program does not require a Board vote. In closing, Secretary Sudders requested that the January Board meeting include information regarding how marketing efforts have moved uninsured individuals to enroll in insurance.

The meeting was adjourned at 10:20 AM.

Respectfully submitted,  
Maria H. Joy