



# AMERICAN ACADEMY *of* ACTUARIES

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Oct. 4, 2010

Department of Health and Human Services  
Attention: OCIO-9989-NC  
Hubert H. Humphrey Building, Room 445-G  
200 Independence Avenue, SW  
Washington, DC 20201

## **Re: Request for Comments – Exchange-Related Provisions in ACA**

Dear Sir/Madam:

On behalf of the American Academy of Actuaries'<sup>1</sup> Health Practice Council Exchanges Work Group, I appreciate this opportunity to provide comments to the Department of Health and Human Services in response to the recent request for comments on exchange-related provisions in the *Affordable Care Act* (ACA). Our responses only address those questions for which the actuarial perspective is important for successful implementation of the exchanges.

### **Summary**

The comments provided address fiscal responsibility, risk management, and equitable treatment. There is a significant amount of complexity to each of these as applied to the operations of an exchange, and we have attempted to address some of these complexities as well.

The items that relate to fiscal responsibility include efficient exchange-related operations that leverage existing processes, such as state-based Department of Insurance (DOI) rate reviews to minimize stakeholder administrative expenses. Other points of leverage could include use of a bidding process similar to Medicare Part D or the Federal Employees Health Benefit Program (FEHBP). The exchanges, similarly, could satisfy the quality and access requirements stipulated by ACA by leveraging existing criteria and processes such as Healthcare Effectiveness Data and Information Set (HEDIS) and National Committee for Quality Assurance (NCQA) standards.

We also provide suggestions to help HHS determine an operating model for the exchanges that is balanced and fair. For example, among the various service capabilities and policies that the exchanges will need are to attract a wider participation of employers to maintain the risk pool, insurers to maintain a viable market for consumers, and individuals to ensure a robust and meaningful market. In a similar way, exchange policies related to equitable treatment of health plans, regardless of size and markets served, are also discussed. Successfully addressing these challenges will lead to greater choice and a competitive marketplace for consumers.

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<sup>1</sup> The American Academy of Actuaries is a 17,000-member professional association whose mission is to serve the public on behalf of the U.S. actuarial profession. The Academy assists public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

There also is a need for clear communication. This is a significant factor for individuals who will need to understand the benefit plans offered and how to evaluate the differences between plans, as well as for health plans that will need to understand how the exchange defines and uses risk adjustment and risk-sharing mechanisms. Benefit plan availability and pricing transparency for both individuals and small groups are considered critical objectives of the exchanges. Employers also are expected to need a level of transparency and information to make the appropriate decisions about whether to participate in the exchanges.

Our work group, reflecting a broad cross section of the health insurance market, considered many of the questions in the request for comments. We found instances in which a question was too broad to be addressed adequately in this forum. We believe the dialogue initiated with this request for comment is an important one, and we encourage HHS to include the Academy in its ongoing evaluation of operating model issues. We look forward to further assisting with actuarial analysis, especially for those areas of particular complexity noted in this letter.

### **Other Considerations**

As we answered the questions posed in the request for comments, the work group also identified several topics or concerns on which comments were not specifically requested. We believe these topics are important, however, and need to be addressed.

As actuaries, we are concerned with how the exchanges will operate and how that operating model will affect risk selection within them. Requirements such as limited-enrollment periods, defined rules for small group versus individual enrollment, and benefit plan selection will have a material impact on the makeup of the risk pool in the exchanges. There are many complexities to be considered if the exchange rules and procedures were to allow for a situation such as when an individual, his or her spouse, and their children all have different plans.

The transition of the marketplace to one involving an exchange also should be considered. Risk selection will be materially affected if there are different rules inside and outside the exchange. Special consideration similarly may be needed for the various ERISA-enabled programs, such as MEWAs and self-funded large employer groups. The transition of the market also should account for prior rating rules that had, for example, wider rating age bands (e.g., 5:1 age bands) compared to the new rating rules (3:1 age bands).

The financial stability of the market is also a major concern for the Academy's work group. Risk-based capital standards must be maintained and not compromised by any potential revision to the rating reviews that a DOI or exchange would perform. Improper application of risk-adjustment factors may compromise financial security. It currently is unclear what, if any, fiduciary standards will be established for exchanges.

In conclusion, the determination and communication of the actuarial value of benefit plans is a particularly complex issue, involving a wide array of adjustments and judgment. The derivation of actuarial value must be clearly communicated, illustrated, and supported with defined standard documentation and calculation methods. The entity responsible for setting or enforcing these financial reporting standards is another complexity of the intended exchanges operating model.

The Academy is prepared to assist HHS with developing rules related to actuarial value in the exchanges.

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### C. State Exchange Operations

#### **C.6. What factors should Exchanges consider in reviewing justifications for premium increases from insurers seeking certification as QHPs? How will States leverage/coordinate the work funded by the rate review grants to inform the decisions about which plans will be certified by QHPs?**

Exchanges should work in cooperation with other regulatory entities, such as the departments of insurance (DOI) in each state, to ensure certain factors are included, at a minimum, as part of the review process. These may include:

1. Historical pattern of rate increases compared to the market and/or provider charges and service utilization results.
2. Reasonableness of rates compared to national and local conditions based on factors, such as:
  - a. Anticipated health status of the population using risk scores;
  - b. Adjustments for demographic shifts (e.g., age or gender);
  - c. Projected changes in provider contracts or financial incentives to providers;
  - d. Projected change in the rate of utilization of medical services;
  - e. Cost impact of changes in benefits;
  - f. Legal and regulatory compliance requirements such as mandated benefits;
  - g. Historical loss ratio experience;
  - h. Unusual or catastrophic events (i.e., shock claims, flu, etc.) are not inappropriately inflating projected claims;
  - i. Changes as a result of new technologies, drugs, etc;
  - j. Plan design leverage—if copays, deductibles, out-of-pocket (OOP) limits do not rise with underlying medical cost trend, then paid claims trend higher than overall medical cost trend.
3. Actuarial certification that premium rates comply with QHP standards of actuarial value.
4. Insurer solvency.
5. Rating formula and supplementary rating tables.

We recommend exchanges leverage the actuarial certification process required under DOI rate reviews to determine qualified health plan (QHP) status and set the actuarial standards for being a QHP.

In a case in which a given state DOI has a rate review and approval process, it would be more efficient for an exchange to leverage the existing state DOI rate review. As a result, the exchange would validate only that the rates charged within the exchange are on the same basis as those outside the exchange. For states in which there is no current DOI approval, the exchange then could use the factors listed above as guidelines for creating or justifying their rate review

process. To allow separate rate approval processes within an exchange and a DOI likely would create confusion as well as complexity (and expense). From an actuarial perspective, it is important for premiums to be reviewed by the regulatory entity responsible for monitoring the solvency of health plans.

#### **D. Qualified Health Plans (QHPs)**

##### **D.1. What are some of the major considerations involved in certifying QHPs under the Exchanges, and how do those considerations differ in the context of individual and SHOP State Exchanges, subsidiary Exchanges, regional or interstate Exchanges, or an Exchange operated by the Federal government on behalf of States that do not elect to establish an Exchange?**

Certifying a QHP implies that a plan meets the minimum criteria described in the legislation. The various types of exchanges listed are expected to result in risk pools with different risk characteristics that will drive different benefit plan designs when determining actuarial value. Certifying QHPs that cross DOI jurisdictions, such as regional or federal plans, could create significant complications. As such, a simple option may be to leverage the DOI review of the state with the greatest concentration of enrollees.

A QHP must be designed to take into account the needs and characteristics of the covered individuals or groups within an exchange service area. Current state-licensed issuers have an advantage, given their familiarity with their local markets and established reputations. The process of certifying QHPs should include consideration for local insurers, given their experience in the given exchange-purposed market. For example, local market plans have certain experience, and the regional exchange should not be structured in a way that disadvantages local plans by requiring them to offer coverage in all areas.

HHS should consider having QHPs certified based on the exchange-specific market and the actuarial value of products delivered to that market (e.g., state, regional, national).

Overlapping exchange territories would create confusion. As such, we encourage HHS to identify the appropriate level of exchanges so that all markets have coverage without overlap (e.g., there would not be a Small Business Health Options Program (SHOP) exchange at the state level and another one at the regional level).

##### **D.3. What factors are needed to facilitate participation of a sufficient mix of QHPs in the Exchanges to meet the needs of consumers?**

- a. What timeframes and key milestones will be most important in assessing plans' participation in Exchanges?**
- b. What kinds of factors are likely to encourage or discourage competition among plans in the Exchanges based on price, quality, value, and other factors?**

Several factors will influence the number and mix of QHPs in an exchange, including how difficult or cumbersome the administrative requirements to comply with regulatory standards are, the scope and complexity of the minimum actuarial and quality-based standards, and the volume

of enrollees in the exchange. Enrollment volume in the exchange can be increased to the extent access is adequate, quality standards are clearly understood, and choice in the form of variation in benefits and services is available. Allowing for benefit design variation within the levels of coverage (i.e., bronze, silver, gold, and platinum) would allow QHPs to differentiate beyond price alone. For example, a QHP could have more than one silver benefit plan that meets all the QHP-specific criteria and minimum standards, and different QHPs may have a different mix of deductibles, copays, and supplemental benefits to achieve the specified silver actuarial value.

#### **D.4. What health plan standards and bidding processes would help to facilitate getting the best value for consumers and taxpayers?**

To address the minimum standards and bidding processes that likely would increase “value,” it is important to consider how value is defined. ACA section 1311(c) specifies certain standards and measurements for qualified health plans, including cost, quality, network, and customer satisfaction. From an employer and employee perspective, “value” may be assessed based on these four elements.

Certain standards will be required to maintain or improve the value perceived. In addition to the established minimum qualifying standards, participation standards should exclude consistently low-performing plans. The QHP standards initially should be set to include as many health insurers as possible, as long as the actuarial value of benefit plans meets the proper associated exchange threshold. The additional factors that determine value, as noted above, can be phased in over time to provide health plans with an opportunity to address potential shortfalls that may lead to adverse selection. Standards intended to limit the number of plans to a select few could reduce the number of interested plans below a level at which the exchange does not appeal to consumers due to lack of choice.

One example for evaluating the quality of a health plan is the Medicare Advantage five-star quality rating system, which uses four sources:<sup>2</sup>

- CMS administrative data on plan quality and member satisfaction;
- The Consumer Assessment of Healthcare Providers and Systems (CAHPS®);
- The Healthcare Effectiveness Data and Information Set (HEDIS®);
- The Health Outcomes Survey (HOS).

Any system ultimately adopted should be calibrated/adjusted to reflect the exchange population.

The bidding process should reinforce the value perceived. To participate in the bidding process, plans should be required to meet the minimum standards. Creating clear communication materials that facilitate purchase decision-making and clarify the intended rate-effective periods also should be considered as minimum requirements to bid.

Clarity of communications is a significant driver of value for individuals. HHS should consider structuring communication content and other educational materials to direct low-income enrollees who receive subsidies to the appropriate lower-cost plans that have certain ratings

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<sup>2</sup> Kaiser Family Foundation, *What’s in the Stars? Quality Ratings of Medicare Advantage Plans, 2010*. (December 2009) <http://www.kff.org/medicare/upload/8025.pdf>

under the quality and price rating system. By identifying all plans with premiums below the second-lowest-cost silver plan that is used to determine the premium assistance amount, HHS would make the selection process easier and more understandable. This would create incentives for health plans to compete for low-income enrollees. This is similar to the Part D low-income enrollees concept.

Another bidding process that HHS could consider is the auction model patterned after the Part D process. Silver-level benefit plans would be the benchmark and have a common effective date for purposes of the bidding process. Adjustments for alternative effective dates and different benefit levels would be allowed once the exchange-specific benchmark silver rate was established. This bidding process is expected to result in the most value for consumers.

#### **D.5. What factors are important in establishing minimum requirements for actuarial value/level of coverage?**

Actuarial value is affected by a significant number of factors. As such, it is not simply a matter of comparing a number assigned to a benefit design. Some of the relevant factors include geography, the definition of a standard population, and the benefits that would be included in the calculation.

A health insurance plan's actuarial value indicates the average share of medical spending that is paid for by the plan, as opposed to being paid out of pocket by the consumer. The calculation takes into account various plan features, including the range of services covered by the plan and the plan's cost-sharing elements, such as deductibles, coinsurance, copayments, and out-of-pocket limits. When two or more plans have the same actuarial value, they are said to be "actuarially equivalent."<sup>3</sup>

Actuarial value comparisons will not incorporate several other factors, however. Plans will vary in terms of their provider networks, negotiated provider payments, and utilization review techniques. Although these factors are incorporated into premium calculations, they are not incorporated into actuarial value calculations. As a result, even among plans with the same actuarial value, premiums will differ.

When evaluating the actuarial value of benefit plans, it also will be important to recognize the underlying cost levels and the how they affect the value of any cost sharing. Costs will vary geographically reflecting the cost of services in different areas, as well as variations in practice patterns for delivering medical services.

ACA specifies four benefit tiers. Plans within the same benefit tier are roughly actuarially equivalent. The benefit tiers provide consumers a gauge of the relative generosity of different plans. For instance, platinum level plans provide more insurer-paid coverage, on average, than bronze level plans.

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<sup>3</sup> Please refer to the Academy publication [Critical Issues in Health Reform; Actuarial Equivalence](#) for more information on issues related to actuarial equivalence.

Because actuarial value calculations are done on an average basis for a given population, however, different plans may be more or less valuable to any particular individual, even among plans in the same benefit tier. For instance, given an actuarial value, benefits can be structured to provide a high value to a small share of members or to provide a moderate value to a larger share of members. As a result, consumers should not choose a plan based solely on actuarial value.

Given the complexity associated with defining actuarial value and implementing it as part of the exchanges, this work group is developing a subsequent comment letter that addresses these issues in more detail.

**D.6. What factors, bidding requirements, and review/selection practices are likely to facilitate the participation of multiple plans in Exchanges? To what extent should the Exchanges accept all plans that meet minimum standards or select and negotiate with plans?**

There are three primary factors that would affect wider participation of health plans—administrative costs, governance, and risk selection. While these factors also are discussed in conjunction with other questions posed by HHS in this request for comments, they are addressed in more detail in this section. The balance between these factors and the potential for increased enrollment due to the availability of low-income subsidies through the exchanges is likely to determine the willingness of health plans to participate.

- *Exchange-related administrative costs:* Insurers will be more likely to participate in an exchange if it does not significantly increase the cost of doing business. Certain administrative functions of an exchange will add cost. For example, while an exchange will enroll participants, an insurer still will need to enroll each participant in its own system so that identification cards can be issued and claims can be paid appropriately. The exchange also may require insurers to maintain an exchange-specific means for quoting premium rates to prospective insureds. To the extent additional costs are added by the exchange, coupled with MLR restrictions, insurer participation may decrease. Since the MLR requirements limit the amount of administrative costs that can be included in the premiums, higher exchange-related costs are expected to result in fewer health plans participating in the exchange. Some suggestions that may help reduce administrative costs to participants include:
  - Develop an effective marketing campaign to publicize the exchange and bring traffic to its website to make it attractive to a plan to be listed there;
  - Allow health plans to have service areas smaller than a state;
  - Provide sufficient information so that users of an exchange may compare plans offered in regions of the state and do so without substantial customer service support;
  - Limit accounting of subsidies to low-income individuals inside the exchange.
- *Governance of the exchange:* Insurers will be more likely to participate if the exchange acts more as a distribution system and less like an additional regulatory entity. For example, if a state DOI requires the filing of rates and the exchange incorporates its own separate rate increase filing requirement to maintain certification as a QHP, then plan

participation might be lower, in part, because of the duplication of regulatory functions. On the other hand, if the exchange serves as a distribution system, adding little cost to insurers and attracting many individuals and small employers, then it could be a competitive marketplace in which many insurers would want to participate. In addition, the new minimum loss ratio standards could reduce the premium margin available for commissions and other distribution costs, making it difficult for some insurers to maintain their existing agent/broker arrangements. If the exchanges serve as effective distribution channels, plan participation would increase as a way to solve the distribution question. If, however, the exchanges were to prove relatively ineffective as distribution systems, or added more cost than direct distribution outside the exchanges, then they would be less attractive to plans. To increase participation, in terms of governance, the following factors should be considered:

- Ensure consistent regulation inside and outside of the exchange;
  - Define minimum standards, and accept all plans that meet those minimum standards;
  - Clearly document a health plan's level of compliance for consumers making choices (e.g., the quality scores of the plan).
- *Risk adjusters*: The effectiveness of risk adjusters likely will affect participation in the exchange. An exchange will make it easier for consumers to compare multiple insurers' plans. It is anticipated that individuals will choose different plans for many different reasons, including their perceived health status. For example, individuals who perceive themselves as less healthy may choose a plan with a broader network of providers, lower cost sharing, or a reputation for customer service and generous claims-paying practices. They may choose such plans even if they are more expensive. If insurers perceive that they are being selected against by less healthy individuals, and the risk adjuster is not adequately compensating the insurer, then the insurer may choose not to participate in the exchange. To increase participation through risk adjustment, HHS should:
- Define clearly how the risk adjustment and other risk-sharing mechanisms will work so health plan professionals can make an informed decision;
  - Lower adverse selection by not allowing enrollment outside of the annual open-enrollment period and establishing non-financial incentives to increase participation (e.g., allowing people to move up only one coverage level from one year to next);
  - Require plans in the exchange, with affiliates outside of the exchange, to pool experience.

**D.7. What are some important considerations related to establishing the program to offer loans or grants to foster the promotion of qualified nonprofit health plans under CO-OP plans? How prevalent are these organizations today? What is the likely demand for these loans and grants? What kinds of guidance are they likely to need from HHS and what legislative or regulatory changes are they likely to need from States?**

A number of issues must be considered when establishing the program to offer loans/grants to promote co-ops. One approach would be to offer grants and loans via a two-step process. The



first step would be a feasibility study and resulting operational plan for obtaining state licensing. The second step, after a license is obtained, would be to provide additional funds to meet start-up and initial solvency requirements, based on the detailed operational plan.

1. Co-op feasibility study applicants would submit an abbreviated business plan for their co-op to the appropriate federal authority that includes their proposed:
  - a. Names of board members;
  - b. Disclosure of start-up capital and its source(s);
  - c. Target market, including any unique aspects of the individuals or groups to be targeted;
  - d. Target geographic regions;
  - e. Provider network;
  - f. Statement of intent to participate in the local exchange;
  - g. Disclosure of outsourced activities and potential partners, including a “flow of funds” diagram;
  - h. Identification of any unique aspects of the plan offerings that will benefit members and serve to make the market more competitive;
  - i. Estimated total cost of the feasibility study along with the share funded by the co-op founders/investors.
2. The appropriate federal authority would decide which co-ops have been successful or suggest value in further study and award an initial loan.
3. Co-ops selected for additional investment or loans then would develop and file an in-depth business plan with their state of domicile with significantly more detail, including but not necessarily limited to:
  - a. All the items listed under point No. 1 above.
  - b. Pro forma financial statements, including sufficient detail to confirm that the financial plans are viable while funding adequate surplus and meeting all requirements with respect to medical loss ratio and still repaying any federal monies as required. To the extent that the plan relies on federal loans or grants, such reliance should be fully described.
  - c. A brief statement from each board member discussing his or her historical background and reason for being a board member, including any actual, perceived, or potential conflicts of interest.
  - d. All other information required by the state of domicile for licensing a health plan/health insurer.
4. The state then would determine whether the co-op should be awarded a license and be allowed to sell health insurance in its state and others. As the law states, we envision co-ops having to abide by substantially all of the regulations insurers will have to abide by in any state, unless there is a good reason for exempting them from certain regulations. These regulations include a sufficient provider network, offering of qualified health plans, filing of rates and formulas (with the associated actuarial certifications), minimum loss ratio requirements, risk-based capital requirements, statutory financial reporting, etc.

5. We envision the federal government providing additional loan and grant monies (up to a predetermined limit) as a co-op works with the state and becomes fully operational.
6. From the time loan or grant funds are initially paid out, until the time all loans have been repaid as required, regular status reporting would be in place to keep both the state of domicile and HHS informed of the co-op's progress. The items that would be reported include expenditures versus budget, as well as progress on such milestones as network contracting, development of policy forms and rates, and development of administrative capabilities.
7. Contingency plans should be in place to address situations in which a co-op is failing to meet expectations or becomes insolvent, and the role of state guaranty funds with respect to insolvent co-ops needs to be clear, on a state-by-state basis.

### **E. Quality**

#### **E.1. What factors are most important for consideration in establishing standards for a plan rating system?**

##### **a. How best can Exchanges help consumers understand the quality and cost implications of their plan choices?**

Quality can be measured in many ways—for example, it may include considerations related to quality of care and access to physicians. Quality of care determination is discussed in question D4 in more detail, but communicating what quality means may require using specific examples rather than quoting HEDIS scores or the Medicare Advantage five-star quality rating system-based measure that may be too abstract. These types of examples could include measures of outcomes, such as reductions in cholesterol or blood pressure, or number of mammograms provided to the appropriate population.

Cost implications can be reflected in the premium paid by individuals. For example, the Minnesota Advantage program (for state employees) classifies primary care clinic-based networks into four cost levels and evaluates the performance of the clinics at year-end. The evaluation uses risk adjustment to make the comparison valid. The most efficient clinics are offered at lower cost-sharing levels than the least efficient. For example, cost level 1 clinics have a \$50 deductible, while cost level 4 clinics have a \$600 deductible.<sup>4</sup> The communication to employees then explains why certain clinics are level 1 and reinforces that message with cost differentials.

##### **b. Are the measures and standards that are being used to establish ratings for health plans in the Medicare Advantage program appropriate for rating QHPs in the Exchanges? Are there other State Medicaid or commercial models that could be considered?**

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<sup>4</sup> Minnesota Advantage Health Plan Benefits Schedule 2010, <http://www.mmb.state.mn.us/doc/ins/adv-ee/highlights.pdf>.

The Medicare Advantage star-based system would have the advantage of already being nationally implemented (and familiar to health care plans); however, it may need to be modified to reflect the different service mix of care provided to children and non-senior adults. Other models that may be considered include HEDIS, as well as other publicly available published sources that are also commonly used and include measurements that are geared toward the general population (e.g., HEDIS includes preventive care and immunizations for children).

**c. How much flexibility is desirable with respect to establishing State-specific thresholds or quality requirements above the minimum Federal thresholds or quality requirements?**

With the wide variation of health care markets in the states due to differences in practice patterns of medicine, access to providers, and demographics of populations, establishing one national threshold may not be practical. States may decide that they want to set higher thresholds than national minimums. The advantage of allowing states to set a higher standard could be an increase of quality beyond just that state. The disadvantage, however, could be an increase in cost to consumers and loss of competition in the marketplace. Federal thresholds would have to accommodate underserved health care markets, since access to care cannot be improved without additional physicians and facilities and the local markets may not support increases in these resources. Whatever process is chosen, the goal should look to create a continuous cycle of incremental improvements in the quality of care delivered.

**E.2. What are some minimum standards or other factors that could be considered with respect to establishing quality measurement and improvement thresholds or quality requirements that should be met by QHPs? What other strategies, including payment structures, could be used by plans to improve the practices of plan providers?**

Quality parameters were discussed in question D4. One option for quality standards would be to base them on HEDIS measurements and the change in measurements over time. This would give plans financial incentives to improve quality. Some consideration should be given to modifying HEDIS-type scores with risk adjustment information and to reflect relative acuity (and improve equitable treatment/evaluation).

The Medicare Advantage five-star quality rating measure was discussed in question D4. Certain of these cost-saving and outcome measures include HEDIS measures as well, such as blood pressure control, diabetes control, glaucoma screening, cholesterol management, and osteoporosis management. When possible, measures used in the determination of quality should be based on claims data and not member surveys. This applies to such measures as flu and pneumonia vaccine compliance.

Quality metrics commonly refer to evidence-based standards that should be met with rare exceptions. These are the measures developed by groups such as the American Medical Association's Physician Consortium for Performance Improvement (AMA-PCPI), the NCQA and the Agency for Healthcare Research and Quality (AHRQ). Such measures are vetted through the National Quality Forum (NQF), which uses physicians, payers, consumers, and other groups

to ascertain the relative importance of such measures. They are then distributed through the Ambulatory Care Quality Alliance (ACA Alliance). NQF measures are endorsed by certain state attorneys general in their efforts to provide consumer protections. On the other hand, HEDIS/NCQA measures are important for accreditation of commercial plans and to determine potential bonuses for Medicare Advantage plans.

The quality benchmarks for QHPs should reflect some combination of these measures.

HHS should consider that measures such as those established by AHRQ, NQF, and ACA are due for another revision as well. Such a revision would apply quality measurement development of individual specialty measures that are largely process measures to a more global measure of patient outcomes (e.g., 30-day readmission rates). The current system isolates each disease or organ system looking for evidence-based measures. The revision would consider the wider recognition of multiple co-morbidities, especially for Medicare beneficiaries. Revisions to quality metric evaluation would create a commensurate change in reimbursement methods that reinforce concepts such as 30-day all-cause readmission rate controls, care coordination, and population management by cohorts other than disease.

The required quality parameters for QHPs should translate into the provider community as well. While ACA promotes the use of medical homes and accountable care organizations, HHS may consider offering additional incentives or higher quality scores for those plans that move more quickly from pilot to implementation for these or similar reformations of physician reimbursement that reinforce quality.

An opinion article by Mark Chassin and Jerod Loeb from the Joint Commission describes greater consistency in achievement of quality standards in hospitals based on the transparency and incentives given to hospitals over the past decade.<sup>5</sup> The implications are the same for physicians, but hospitals have been doing this for a longer period of time than doctors. Due to their numbers and less organized nature, physician-based quality improvements may take longer to achieve. HHS guidelines or quality benchmark parameters should phase in over a time period that reflects these different patterns of adoption.

In the long term, HHS should consider advanced quality measures that encourage measures that promote accountability. The characteristics of quality measures they recommend are those that have a strong evidence base showing that the revised care process leads to improved outcomes, that the measure accurately captures whether the evidence-based care process has been provided, and that the measure addresses a process that has few if any intervening care processes that must occur before the improved outcome is realized. In addition, the Joint Commission also notes that implementing the process change should have little or no chance of inducing unintended adverse consequences.

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<sup>5</sup> Chassin, Mark and Jerod Loeb. "Accountability Measures—Using Measurement to Promote Quality Improvement," *New England Journal of Medicine* (Aug. 12, 2010), <http://www.nejm.org/doi/full/10.1056/NEJMs1002320>

## **G. Enrollment and Eligibility**

### **G.1. What are the advantages and issues associated with various options for setting the duration of the open enrollment period for Exchanges for the first year and subsequent years? What factors are important for developing criteria for special enrollment periods?**

Open enrollment will be a critical contributing factor in determining the success of the exchanges. If an insurance plan attracts only those with higher than average expected health care spending, otherwise known as adverse selection, then premiums will be higher than average to reflect this higher risk. Attracting healthier individuals ultimately will help keep premiums more affordable and stable. Imposing an annual open enrollment period will help reduce adverse selection by limiting an individual's ability to forgo purchasing coverage until health care needs arise. As a result, healthy individuals will have an incentive to purchase coverage. Premium subsidies and nonenrollment penalties also provide incentives for healthy individuals to purchase coverage. If these incentives are not strong enough to mitigate adverse selection concerns, however, the required premiums will increase rapidly. This would result in an unsustainable option for both the typical consumer and health plan.

Initial and ongoing open enrollment periods should have strict limitations to help minimize potential adverse selection.

Items that will need to be addressed are:

#### *Number of open enrollment periods offered each year*

There should be only one open-enrollment period offered each year. This will allow for a balance of choice for the consumer and provide a means to manage the adverse selection issues. In addition, open enrollment is a time- and administrative-costly process. Restricting the number of open-enrollment periods to one per year supports the objective of sustainable, affordable coverage for members.

#### *Length of the open enrollment period*

The initial open-enrollment period may require a longer time period (up to four months) to adequately communicate the program and enroll individuals and groups. Subsequent open-enrollment periods, however, could be limited to four weeks. Periods shorter than four weeks could slightly improve the adverse selection within the program. Periods longer than four weeks, however, could have a dramatic impact on selection issues—the longer the period, the greater the potential for adverse selection.

Plans in the exchange presumably will be administered on a calendar-year basis in terms of deductibles and out-of-pocket limits, which would be consistent with a calendar-year effective date. There also should be a time period during which rates, product information, and quality and cost comparison data are available to consumers prior to the enrollment period, similar to what exists today for Medicare Advantage products. Having the open-enrollment period close at least a few weeks prior to the calendar effective date would allow time for information on enrollees to be passed from the exchange to the carriers and for production of contract materials and

membership cards. This also would help to avoid the situations that were problematic when Medicare Advantage first started (i.e., when there was poor communication on enrollment and members presented at pharmacies claiming coverage when the insurer had no record of enrollment). This would suggest an annual open-enrollment period of perhaps Oct. 15 to Dec. 1.

A longer period (e.g., one month) between the close of the open-enrollment period and the associated contract-effective date would increase the likelihood of success from an administrative perspective. This is important given the potential for a large volume of enrollment through the exchange.

#### *Allowed coverage changes due to qualifying life events*

Limited open-enrollment periods in other parts of the year would be appropriate for *Health Insurance Portability and Accountability Act* (HIPAA) qualifying types of events. Coverage changes due to qualifying life events should be administered similar to the methods and restrictions used currently in group insurance. These should be limited to specific events such as births, deaths, marriage, relocation to a new exchange jurisdiction, loss of prior coverage, and involuntary loss of group coverage. In addition, the enrollment opportunity afforded for these cases should be limited in duration from the event trigger.

#### *Consistency of rules for the open enrollment period*

As a final note, the rules for the open-enrollment period should be the same for all carriers in the market and for products inside and outside the exchange, for both the initial open-enrollment period, subsequent annual open-enrollment periods, and for any qualifying events. In particular, the open-enrollment periods need to be uniform for all carriers; otherwise, individuals will have, in effect, several open-enrollment periods throughout the year. Having non-uniform open-enrollment periods would limit the extent to which this provision can reduce adverse selection.

### **G.2. What are some of the key considerations associated with conducting online enrollment?**

A key consideration relating to online enrollment is how the enrollment information will be coordinated between the employer/individual, the exchange, and the carrier. Typical considerations for web form/portal development include multiple language support, clarity of content, visual ease of recognition, and error checking against fields required to be filled.

Related to this, how will premium dollars flow to the carrier? Will the carrier collect from multiple sources, or will the exchange become the clearing house for all funds—from the employer, the individual and the subsidy, and back out again to the carriers? Or perhaps multiple carriers for different members of a family?

### **G.3 How can eligibility and enrollment be effectively coordinated between Medicaid, CHIP, and Exchanges? How could eligibility systems be designed or adapted to accomplish this? What steps can be taken to ease consumer navigation between the programs and ease administrative burden? What are the key considerations related to States using Exchange or Medicaid/CHIP application information to determine eligibility for all three programs?**

It is important that a single tool/process be used to screen individuals to determine income and asset eligibility for Medicaid and CHIP and, at the same time, collect information to determine eligibility for a subsidy through the exchange. Once program eligibility is determined, the applicant needs to be directed to a variety of choices—for example, an array of managed Medicaid plans for a Medicaid-eligible person or plans for individuals qualifying for the subsidy for exchange enrollees. One concern is that many Medicaid recipients gain and lose eligibility more than once throughout a year, causing them to lose continuous enrollment status, which typically creates a revenue loss for the carrier with no comparable loss in claims (i.e., claims are "timed" to occur during coverage periods whenever possible). Allowing for longer periods of Medicaid eligibility could reduce the potential for individuals moving frequently between Medicaid and subsidized exchange coverage.

**G.6. What are the verification and data sharing functions that States are capable of performing to facilitate the determination of Exchange eligibility and enrollment?**

Exchange efforts to determine eligibility and enrollment status is expected to require certain data to which various state agencies should have access. Consistent with other comments in this paper, HHS should try to leverage the information, and the information collection processes of these various state agencies, as much as possible in the discharge of these eligibility and enrollment responsibilities. Eligibility criteria, such as income limits, can be validated with state tax filings, as well as from current enrollment data associated with state Medicaid plans. Age and residence validation could be augmented to the extent income tax returns are not available or are incomplete, with information such as that obtained for drivers' license records.

The ability, however, of state-based agencies to complete additional data sharing and validation functions may be limited. Age and zip code information may not be complete or accurate within the motor vehicle records, and this information may not be available if no driver's license is held. Additional reconciliations, such as with payroll taxes and Social Security data, may be required to systematically verify or audit reported information pertinent to eligibility and enrollment.

**G.7. What considerations should be taken into account in establishing procedures for payment of the cost-sharing reductions to health plans?**

The current bidding process for Medicare Part D provides a reasonable approach to this question. A plan's bid includes an estimate of the amount of cost-sharing subsidy it will need. This is included in the monthly premium paid, with an annual reconciliation for actual low-income enrollment. We believe this provides the best method for addressing the amount of subsidy and for properly adjusting the actuarial value of the silver plan pricing such that the value is not inflated once subsidies are included.

**I. Rating Areas**

**I.1. To what extent do States currently utilize established premium rating areas? What are the typical geographical boundaries of these premium rating areas (e.g.,**

**Statewide, regional, county, etc.)? What are the pros and cons associated with interstate, statewide, and sub-State premium rating areas? What insurance markets are typically required to utilize these premium rating areas?**

States vary in their approach to defining rating areas, ranging from no regulation to well-defined geographies typically made up of multiple counties. In addition, states may have different rating area definitions based on products.

In terms of the typical geographic boundaries, these premium rating areas either are large metropolitan areas in which strong provider networks can be established and maintained, or regional or county boundaries for the remainder of the state.

The goal of premium rating areas should be to define geographies that are similar in costs, and thus premiums, to avoid cross subsidization across geographies. Larger rating areas require lower-cost areas to subsidize higher-costs areas, which could result in individuals/groups in those lower-cost areas to look for other alternatives, such as self funding. Smaller areas allow a more area-specific view of the cost of medical care there. If a rating area becomes too small, however, analyzing the relative cost of medical care within that area becomes difficult due to insufficiently credible data.

Interstate or regional exchanges should reflect localized rating areas. Some of the issues that affect relative costs between areas include:

- General cost of living;
- Medical practice patterns;
- Type of facilities available (i.e., teaching hospitals);
- Negotiated contracts;
- Number of available facilities/providers (competition).

States vary in their approach to implementing premium rating areas. Some states do not regulate them, so this is not applicable by market. Other states, however, regulate the areas and will subject all markets to the geographical definitions.

**I.2. To the extent that States utilize premium rating areas, how are they established? What kinds of criteria do States and other entities typically consider when determining the adequacy of premium rating areas? What other criteria could be considered?**

Some states, such as Kentucky, use the same criteria as Medicare rating areas; others define rating areas based on metropolitan and rural definitions.

The criteria may include ease of comparison, such as Medicare counties, metropolitan and rural definitions, and/or like-county characteristics.

The criteria should consider cost and utilization differences due to provider contracts, adequacy of provider networks, administrative expense, and medical cost patterns.



## **K. Employer Participation**

### **K.1. What Exchange design features are likely to be most important for employer participation, including the participation of large employers in the future? What are some relevant best practices?**

There are a number of design features that will determine employer participation in the Exchange. The most important employer-focused capabilities/design features include:

- *Premium support and subsidies*—For example, how would eligibility of FPL subsidies be determined? The employer may not have the complete family income of its employees to determine appropriate FPL subsidies.
- *Provider coverage and area coverage*—access and networks are considered above.
- *Multi-state capabilities* (i.e., employees in multiple locations)—This primarily would affect larger companies that may be in multiple states or multiple exchange areas.
- *Simplified enrollment and member change capability*—How easy is it to enroll members, add/remove family members, and change coverage within the exchange? The exchange would need to develop consistent standards for participating carriers regarding the acceptance of late payments and conditions for reinstatement after lapses for late payment. This is particularly true if employees are eligible to choose from multiple carriers in the exchange
- *On-line provider directories and provider rating*—Can employees determine which doctors are in the network, and can employers research completeness of provider and hospital coverage based on their employee locations?

Some additional capabilities that the exchange may want to consider that typically are offered by insurers include:

- *Reasonable selection*—Are there sufficient insurer options?
- *Care management/disease management programs*—Are these programs available?
- *Experience reporting*—Information for employers regarding their group's claims experience.
- *Coverage information*—A true marketplace would need to have an easy method to display coverage and rates (presumably on-line) to employers and employees, which would allow for easy premium comparisons between carriers.
- *Data warehouse that collects pharmacy interactions at point of sale*—This currently is performed by prescription benefit managers (PBMs) today. Would this continue?
- *Consolidated billing*—The employer would need a single bill for health care costs rather than separate bills from each carrier that employees have selected (assuming individual selection is available). This probably would be the responsibility of the exchange to issue bills, collect premium, and allocate amounts appropriately to the various carriers.
- *Type of service cost analyzer on-line*—Would members be able to obtain an estimate of cost before having a particular treatment/service performed?
- *Clarity of benefit options.*
- *Administrative costs*—Will administrative costs increase for tasks that are duplicated between the exchange and the carrier (e.g., enrollment)?

**K.2. What factors are important for consideration in determining the employer size limit (e.g., 50 versus 100) for participation in a given State’s Exchange?**

Allowing larger firms to participate in an exchange could result in firms selecting against the exchange. When firms are large enough that their premiums can reflect their own experience, their choice will be to use their own experience and insure outside the pool or purchase through the exchange. Firms with higher-cost employees, either because of age, health status, or other characteristics, may be able to find lower premiums in the exchange because exchange plans would be limited in how much they can vary premiums. If firms with lower-cost employees continue to insure outside the exchange, and firms with higher-cost employees insure through the exchange, this will put upward pressure on premiums in the exchange.

HHS should look to the state-level limits on small group community-rated requirements as a guideline for setting participation limits for groups. Limiting the exchange to 50 or 100 would require additional study, but the concept of capping the group size may improve the likelihood of a more equitable spread of risk among carriers in the exchange.

**K.3. What considerations are important in facilitating coordination between employers and Exchanges? What key issues will require collaboration?**

To encourage their participation, an exchange would need to provide employers, at a minimum, with services they currently receive from insurance carriers. To provide greater flexibility, the exchange could allow employees to select from any carrier participating in the exchange. With this flexibility comes issues that need to be addressed such as consolidated billing, premium allocation to the appropriate carrier, experience reporting by carrier, and the ability to handle special situations (e.g., coordination of benefits/subrogation, COBRA, and Medicare primary for groups with fewer than 20 employees). Consolidated billing allows the employer to make a single payment through an exchange for all employees regardless of which carrier an employee may choose. The exchange would need to allocate the billings to the appropriate carriers and develop consistent rules if payments are late or insufficient. The exchange also would need to inform insurance carriers of each group size—with member selection, they may not know actual group size through the enrollment process. This affects whether Medicare is primary for older employees.

**L. Risk Adjustment, Reinsurance and Risk Corridors**

**L.1. To what extent do States and other entities currently risk-adjust payments for health insurance coverage in order to counter adverse selection? In what markets (e.g., Medicaid, CHIP, government employee plans, etc.) are these risk adjustment activities currently performed? To the extent that risk adjustment is or has been used, what methods have been utilized and what are the pros and cons of such methods?**

### *Demographic risk adjusters*

State employee health plans have traditionally used demographic risk adjusters. Washington, a few years ago, also made use of a pre-65 retiree risk adjuster. For the states that use a simplified demographic risk adjuster (e.g., age, gender and sometimes retiree status), the method is simple, the data are readily available from membership files, and it can be applied easily. The major disadvantage is that demographic risk adjusters only explain a small part of the variance in an individual's use of health care services, typically in the 1 percent to 3 percent range.

### *High-cost condition risk adjuster*

Some states use variations of high-cost condition risk adjusters. For example, a simplified high-cost-condition risk adjuster was used in the original California HIPC if triggered by risk scores outside a corridor. A high-cost condition reinsurance program is used in New York as a risk adjuster, but there are few such conditions reported and the method has been difficult to implement in connection with the pricing cycle (i.e., reimbursement for reported conditions was late, beyond the time needed to submit premiums).

### *State employee plans network evaluation*

The Minnesota Advantage program (state employees) classifies primary care clinic-based networks into four cost levels and evaluates the performance of the clinics at year-end. The evaluation uses risk adjustment (ACGs) to make the comparison valid. The most efficient clinics are offered at lower cost sharing levels than the least efficient. For example, cost level 1 clinics have a \$50 deductible, while cost level 4 clinics have a \$600 deductible.<sup>6</sup> This plan gives health plans an incentive to be efficient without punishing or rewarding them for having a disease burden that is different from the average, and it gives the employees a financial incentive to choose efficiency while still having options.

### *Medicaid*

States are using risk adjustment to pay their Medicare managed care plans. The models currently in use are Chronic Disability Payment System (CDPS), Adjusted Clinical Groups (ACGs), Episode Risk Groups (ERGs), Medicaid Drug (MDrug), Clinical Risk Groups (CRGs) and Diagnostic Cost Groups (DxCGs). With the exception of California, most of the large Medicaid states have implemented a risk-adjusted payment system.

Encounter-based diagnosis systems, like those mentioned above, have higher predictive power than those using demographic data alone, and incorporating pharmacy data can further increase predictive power.<sup>7</sup> In some states there may be retrospective risk adjustment for certain conditions/populations, such as high cost neonatal cases for the temporary assistance for needy families (TANF) population.

The statistical performance of the major models is comparable. The major challenge that states have faced when implementing a risk-adjusted payment system is collecting accurate and complete encounter data. This may be a major issue for the Exchanges since many of the

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<sup>6</sup> Minnesota Advantage Health Plan Benefits Schedule 2010, <http://www.mmb.state.mn.us/doc/ins/adv-ee/highlights.pdf>.

<sup>7</sup> Ross Winkelmann and Syed Mehmud. 2007. *A Comparative Analysis of Claims-Based Tools for Health Risk Assessment*. Schaumburg, Ill.: Society of Actuaries.

commercial plans may not have sophisticated systems in place to submit encounter data and evaluate the quality of the data that they receive from their provider network.

<b>State Medicaid Programs</b>			
<b>State</b>	<b>Risk Adj. System</b>	<b>Individual or Aggregate</b>	<b>Prospective or Concurrent</b>
<b>Colorado</b>	<b>CDPS</b>	<b>Aggregate</b>	<b>Prospective</b>
<b>Florida</b>	<b>CDPS/MedicaidDrug</b>	<b>Aggregate</b>	<b>Prospective</b>
<b>Maryland</b>	<b>ACG</b>	<b>Individual</b>	<b>Prospective</b>
<b>Massachusetts</b>	<b>DxCG</b>		
<b>Michigan</b>	<b>CDPS</b>	<b>Aggregate</b>	<b>Prospective</b>
<b>Minnesota</b>	<b>ACG</b>	<b>Aggregate</b>	<b>Concurrent</b>
<b>New Jersey</b>	<b>CDPS</b>	<b>Individual</b>	<b>Prospective</b>
<b>New York</b>	<b>CDrugG</b>		
<b>Ohio</b>	<b>CDPS</b>	<b>Aggregate</b>	<b>Prospective</b>
<b>Oregon</b>	<b>CDPS</b>	<b>Aggregate</b>	<b>Concurrent</b>
<b>Pennsylvania</b>	<b>CDPS</b>		
<b>Tennessee</b>	<b>CDPS</b>	<b>Aggregate</b>	<b>Concurrent</b>
<b>Utah</b>	<b>CDPS</b>	<b>Aggregate</b>	<b>Concurrent</b>
<b>Washington</b>	<b>CDPS</b>		
<b>Wisconsin</b>	<b>CDPS</b>	<b>Aggregate</b>	<b>Both</b>

*A Guide to Implementing a Health-Based Risk-Adjusted Payment System for Medicaid Managed Care Programs,* Center for Health Program Development and Management, University of Maryland, Baltimore County, and Actuarial Research Corporation, Annandale, Va, 2003.

*Health-Based Risk Assessment: Risk-Adjusted Payments and Beyond,* Martin et. al., January 2004

*Predictive nature of risk adjustment*

Risk adjustment is a poor predictor at the tails (i.e., the lowest- and highest-risk individuals). These models are better at predicting health status than predicting claims cost. This is because only diagnosis information typically is examined; utilization, claim dollars, types of treatment, benefit design, patient compliance with treatment plans, etc., are not considered—although each would increase the predictability of claims cost. With that said, a model that includes treatment information is susceptible to gaming.

Resulting predictive ratios are better when using an aggregate approach (i.e., average risk score for a group of enrollees is used) rather than an individual approach (i.e., each individual is assigned a risk score that follows them through the system).

The following table illustrates a comparison of risk-score models.

Comparison of Models		
Models	Advantages	Disadvantages
<b>Demographic only</b>	<ul style="list-style-type: none"> <li>Simple to use.</li> <li>Most current data are used (e.g., gender information as of the current month).</li> </ul>	<ul style="list-style-type: none"> <li>Low predictive ratios as average differences between age/gender cells are used and differences in morbidity within age/gender cells are not considered.</li> </ul>
<b>Diagnosis data based</b>	<ul style="list-style-type: none"> <li>Better predictive ratios than demographic only models.</li> </ul>	<ul style="list-style-type: none"> <li>Variance in coding practices among providers can lead to inequities.</li> <li>Gaming can occur if upcoding practices are employed.</li> <li>Complex models/methodologies and normalization processes are required.</li> <li>Detailed diagnosis information is required.</li> </ul>
<b>Pharmacy data based</b>	<ul style="list-style-type: none"> <li>Found to have good predictive ratios.</li> <li>Data complete quickly, so most recent data can be used in modeling.</li> <li>Pharmacy data files are fairly uniform, making it easier to combine data of various carriers</li> <li>Drugs are typically treatment-based rather than diagnosis-based.</li> </ul>	<ul style="list-style-type: none"> <li>High potential for gaming, so controls would be needed.</li> <li>Hard to determine severity since people with varying levels of the same condition may take the same drugs.</li> </ul>

In addition to the various risk-adjustment models illustrated above, each model can be modified to be either prospective or concurrent in nature.

Concurrent vs. Prospective Diagnosis Based Models	
Prospective	Concurrent
<ul style="list-style-type: none"> <li>Uses data from prior year to estimate costs for future year (e.g., Medicare Advantage model).</li> <li>Estimates costs during the rating period.</li> <li>Requires two systems of setting risk scores as new entrants would not have prior diagnosis information upon which to base their risk scores.</li> </ul>	<ul style="list-style-type: none"> <li>Uses member data from current year to explain expenses in the same period, which leads to higher predictive power.</li> <li>Estimates costs during the experience period.</li> <li>Less resistant to gaming than prospective models.</li> <li>Requires retrospective reconciliation after sufficient run-out has occurred.</li> <li>Requires only one system for setting risk scores.</li> </ul>

**L.2. To what extent do States currently collect demographic and other information, such as health status, claims history, or medical conditions under treatment on enrollees in the individual and small group markets that could be used for risk adjustment? What kinds of resources and authorities would States need in order to collect information for risk adjustment of plans offered inside and outside of the Exchanges?**

There currently is little systematic collection of demographic information in the individual and small-group markets and no collection of health condition/status information in these markets. Many states have implemented health information exchanges (HIEs), however, and those data eventually could be used to risk-adjust members in the health benefit exchanges. HIE data may include clinical information, such as lab values and diagnostic information (e.g., ejection fraction for CHF patients or diabetes observations). The challenge will be to use the master patient ID number used by the HIEs to identify a member in an Exchange.

**L.3. What issues are States likely to consider in carrying out risk adjustment for health plans inside and outside of the Exchanges? What kinds of technical assistance might be useful to States and QHPs?**

Assuming that this question addresses all of the plans offered inside the exchange, and only those nongrandfathered plans outside of the exchange that are subject to risk adjustment, the following issues should be considered:

- What is the predictive power of the risk adjuster?
- Is the data collection process practical and not burdensome from either a time or cost perspective?
- Are risk differences big enough to warrant the work needed for risk adjustment?
- Can insurers have sufficient time to price products assuming risk adjustment takes place?
- How will the exchange enforce data collection on plans and premiums outside of the exchange?
- Will the risk adjuster be applied in a zero-sum manner?
- What data source will be used to risk-adjust members at start-up?
- Can states transition between models as improved data becomes available?
- Will the same risk adjustment methodology be adopted across the states? If not, multistate carriers will have additional administrative burden and challenges to overcome.
- Will the adjustments be calibrated separately for plans in the individual and small group markets? What are the various issues that need to be considered (e.g., if they are combined or treated separately for MLR purpose; the temporary reinsurance is in place for the individual market but not small group market)?
- Will a member's risk score or diagnosis information follow him or her from carrier to carrier, state to state, or will the member receive a "new enrollee" risk score when changing carriers/states? If so, a central repository, perhaps at a national level, will be needed.

- How will the data be validated/audited to ensure gaming/fraud/upcoding does not occur?

**L.4. What are some of the major administrative options for carrying out risk adjustment? What kinds of entities could potentially conduct risk adjustment or collect and distribute funds for risk adjustment? What are some of the options relating to the timing of payments, and what are the pros and cons of these options?**

Administration of risk adjustment consists of two parts: (a) risk assessment through the collection of data and determination of risk scores and (b) making the assessments and payments to plans. These tasks can be done by one organization or separate organizations.

For risk assessment, the exchange may do the work itself or contract out to another organization that has significant experience in computing plan risk scores. With the data collection power of the exchange, plans would submit a limited dataset to this organization. This dataset could include, but not be limited to, encounter data for certain conditions, prescription drug data, and membership information, including demographic data (most risk-adjustment systems use both age/gender and condition data). Plans would have a strong incentive to submit complete data because submitting little or no data would result in a lower risk score and the likelihood of paying a risk assessment. Risk scores then could be calculated and normalized to reflect the state's population, so that relative risk scores (averaging 1.00 for the whole population) would be supplied to the exchange.

Assuming the exchange was granted the necessary power to make assessments and payments to plans both inside and outside the exchange (i.e., similar to departments of insurance that make solvency pool assessments), then the exchange would likely:

- Determine if risk selection was large enough to warrant using the assessment/ payment process;
- Calculate and inform each plan of its assessment or payment;
- Collect and distribute the funds.

Any of these functions could be performed administratively by either exchange staff or by contracting out to some local, regional, or even national organization.

A separate question would be the choice of risk adjuster. The secretary presumably could decide if the preference is to use one risk-adjustment system for all states (similar to Medicare Advantage) or certify several risk-adjustment systems from vendors and allow state exchanges to have their choice of which system to use. If the exchange is operated by a Medicaid agency, the state may prefer to use the system already in place in its Medicaid program.

As a final note, HHS also should consider how the risk-adjustment baseline is determined, and over what time period this will be recalibrated. The analysis would be expected to take substantial effort in the initial years to ensure the method is sound. Risk-adjustment audits also would be needed to cross check the reported diagnosis codes (whether diagnosis, Rx, or other treatment) with medical records.

**L.7. What methods are typically used to determine which individuals are deemed high-risk or high cost for the purposes of reinsurance?**

**L.8. What challenges are States likely to face in implementing the temporary reinsurance program?**

In response to questions L7 and L8, the Academy's Risk Sharing Work Group has submitted an initial assessment related to the reinsurance provisions in ACA.<sup>8</sup>

**L.9. How do other programs (i.e., Medicaid) use risk corridors to share profits and losses with health plans or other entities?**

#### *Medicaid*

Risk corridors have been implemented in Medicaid programs in cases in which there is uncertainty about the underlying risk of the population to be capitated to protect both the health plan and the state against undue risk. The risk corridors are defined in the contract. They typically are developed based on the surplus or deficit on an incurred basis when comparing revenues paid to the health plan versus expenses incurred by the health plan.

The state sets a target medical expense loss ratio (MLR or loss ratio) when developing the fully insured rates for the health plans. Some programs will set a second MLR and require plans to return to the state all or a portion of the revenue a health plan may receive if the plan's loss ratio is below that MLR. For example, the state may set a MLR of 85 percent and require plans to share in the savings 50/50 of anything below this MLR. If a plan receives \$10 million in revenue and has \$8.1 million in claims, it is at an 81 percent loss ratio. The plan should have spent \$8.5 million in claims to meet the 85 percent MLR. Under this scenario, the plan would return to the state \$0.2 million [(\$8.5 million - \$8.1 million) x 50 percent].

Other states set a minimum and maximum loss ratio in which the latter would help protect plans in bad years or years when the rate development may not be as accurate (such as in start-up years). In these situations, the state usually will cap the maximum amount of its risk at a fixed dollar amount (e.g., \$5 million). One variation of this top-side risk protection is to determine whether the plans meet the maximum loss ratio by combining the results of all the participating plans. If in aggregate the plans' loss ratio is above the maximum loss ratio, the state then pays to the health plan(s) a percentage of the loss (e.g., 50 percent) up to a set dollar limit that exceeds the maximum loss ratio. If all plans are above the maximum loss ratio and 50 percent of their losses exceed the maximum dollar amount, the payment would be prorated to each plan based on its membership.

#### *Commercial Reinsurance*

Quota-share reinsurance agreements (as opposed to excess-of-loss reinsurance) are structured according to the risk tolerances and the capital position of the health plan. Risk corridors, often based on loss ratios, may be included, which effectively allows the health plan to retain a different percentage of the risk/results outside of a specified corridor of results. For example, if the annual loss ratio for the reinsured business is below a certain minimum, the health plan may

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<sup>8</sup> American Academy of Actuaries letter to HHS regarding the reinsurance provision in the Affordable Care Act, <http://www.actuary.org/pdf/health/Reinsurance%20Options%209%2022%202010.pdf>.



retain a greater percentage of the risks (or excess profits) under the program. If the losses are above a specified loss ratio, the reinsurer may be responsible for a greater percentage of the losses. It protects the health plan's capital from depletion due to an unexpectedly high loss ratio. Note that this is different from some of the government health programs, in which corridors often are used to return a portion of any excess profits to the governmental entity.

### ***Part D***

Part D utilizes reinsurance, risk corridors, and risk adjustment together. Prior to the passage of the Medicare Modernization Act, there was concern with providing standalone drug coverage to all seniors, primarily because of the potential for adverse selection. To mitigate the financial risks and the experience volatility, CMS incorporated reinsurance, risk corridor, and risk-adjustment mechanisms into the Part D program. The combination of these three mechanisms helped mitigate the risks for plans entering the new program and helped stabilize the market.

#### *Reinsurance*

Claims in excess of \$6,440 (in 2010) are 80 percent reinsured by CMS—plans are responsible for approximately 15 percent of the allowable costs and seniors are responsible for approximately 5 percent of the allowable costs through cost sharing. During 2006-2010, plans also could opt to reinsure themselves via a demonstration program. The reinsurance threshold is increased annually.

#### *Risk corridor*

The risk sharing is graded down by years. Actual claims (excluding reinsurance) are compared to a target amount. For 2006 and 2007, CMS covered 75 percent of the excess of actual-versus-expected claims if the actual-to-expected claims fell between 102.5 percent and 105 percent, and 80 percent of the excess if the actual-to-expected claims exceeded 105 percent. In addition, if a sufficient number of plans serving a substantial majority of enrollees received risk corridor payments in a year, CMS would cover 90 percent of costs instead of the 75 percent. The risk corridors are structured symmetrically. As such, if actual claims are below expected claims, CMS would share in the favorable experience.

For 2008 through 2011, the risk corridor thresholds are doubled. The assumption was that by then plans would have sufficient experience in bidding and projecting costs. CMS covers 50 percent of the excess of actual versus expected claims if the actual-to-expected claims falls between 105 percent and 110 percent, and 80 percent of the excess if the actual-to-expected claims exceeds 110 percent. For 2012 and beyond, CMS has the authority to further increase the risk corridor thresholds provided they are structured symmetrically.

#### *Risk adjustment*

Risk adjustment helped mitigate the risk of adverse selection. CMS uses the Drug HCC risk-adjustment model. CMS recalibrates the model annually to ensure the average member risk score remains at 1.0.

## **How are corridors defined and monitored under these programs?**

### *Medicaid*

Corridors are defined in the health plan contracts. Although the definitions of what should be included as revenue and expenses historically have been fairly open and not well defined, they are becoming more well defined. The contracts vary as to whether they include administration costs in the revenue and expense figures as part of the profit/loss calculation, as well as how they handle reinsurance premiums and payouts. In addition, revenue may or may not exclude taxes and other pass-through items. Revenue may or may not be risk-adjusted, depending on the level of data available and the uncertainty in the underlying population. Provider bonus and incentives may or may not be included as claims. Pharmacy rebate and recoveries from coordination of benefits or third-party liability usually are netted from the claims. The contract between the health plan and the program explicitly details what can be included within the health plan expenses—e.g., care management as a medical expense or as an administrative expense and actual administrative expenses versus a fixed allocation determined by the program.

The contract requires either that the plan provide a calculation to the state each year at a specified time after the end of each plan year, or that the state will hire someone to perform the calculation using in-house data or data requested from the health plan. If the plan performs the calculation, the state usually will hire an actuary to review the calculation. The actuary sometimes requests additional details and backup documentation for the calculation. The incurred but not reported (IBNR) reserve estimate often is examined in detail as it can be a significant component of the calculation, depending on the timing of the due date of the calculation after the end of a plan year. Due dates range from one month following the end of the plan year to 18 months.

Monitoring may be performed indirectly by reviewing the quarterly financial reports submitted by the health plan as part of program participation. But the quarterly financials may not be representative of the data that are required in the risk-corridor calculations. For example, reported incurred claims are based on the change in reserves, whereas, incurred claims used in the risk-corridor calculation usually are based on claims runout for incurrals only in the contract period.

The CMS rate-setting checklist for Medicaid managed care programs also provides guidance on risk adjustment, risk corridor, and reinsurance arrangements.

### *Commercial Reinsurance*

Corridors are defined in reinsurance contracts. The definitions of what should be included as revenue and expense are explicit. Settlement provisions typically are defined within the contract along with the timeframe of settlement. Monitoring may be performed by reviewing the financial reporting, but such monitoring is subject to the same issues mentioned above.

## **What mechanisms are used to collect and disburse payments?**

### *Medicaid*

The state usually asks for a check payment, or revenue payments are withheld. The payment could be in the form of a lump sum amount or spread over a period of months. Some states also allow a carry-forward of amounts owed, which potentially can be offset in a future year

(essentially an extension of the time period for the calculation—a state may extend the time from a two-year calculation to a three-year calculation, adding one additional year). The mechanism to collect and disburse payments is typically a year-end financial accounting done sufficiently in arrears that there will be little or no need for the application of completion factors—e.g., six to 18 months after the close of the fiscal year. For Medicaid, since federal law allows up to two years to submit claims, states have tended to wait 12 to 18 months for the final accounting. If the state allows only one or two months of claims runout, however, it could be problematic since the IBNR estimate may not be robust and may unduly affect the accuracy of the risk corridor results.

#### *Commercial Reinsurance*

For commercial plans, potential amounts due from a plan often are held in escrow or collateralized through a letter of credit. Settlements typically are calculated 12 months after the end of the period, with payments due within 30 days.

#### **L.10. Are there non-Federal instances in which reinsurance and/or risk corridors and/or risk adjustment were used together?**

Risk adjustment, reinsurance, and risk corridors structures each can be used to manage risk. In general, risk adjustment is used to address the risk associated with a group's average demographics and/or average health status deviating from the overall population risk score. Excess (or specific stop-loss) reinsurance is used to manage the risk of the severity of individual claims. Risk corridors (or aggregate stop-loss or quota-share reinsurance) are used to address the variability of the total claims for a population. These mechanisms can be used individually or on a combined basis, depending upon the objectives.

#### *Medicaid*

We are aware of one state using reinsurance and risk corridors together in Medicaid. Risk adjustment is being considered as an addition.

#### *Low-Income Programs*

The Massachusetts Commonwealth Care program for low-income individuals uses a combination of risk adjustment, reinsurance, and risk corridors.

#### *Commercial Insurance*

The combination of reinsurance and risk corridors commonly is used in commercial business. The arrangement may be between a health plan and a reinsurer, in which the reinsurer provides the risk protection to the health plan. Or the arrangement may be between an employer and a health plan, in which the health plan provides the risk protection to the employer. Risk adjustment also may be used by health plans in pricing employer group plans.

#### *Between health plans and reinsurers*

Excess-of-loss reinsurance and risk corridors in quota-share agreements both are used by health plans to manage their risk. It is common for plans to reinsure individual claims, above certain retention, to a commercial reinsurer. Smaller, or less well-capitalized, health plans also may enter into quota-share reinsurance agreements. These agreements cover the aggregate risk retained by the plan that is below the specific retention. Such agreements may contain risk

corridors in which the reinsurer participates at a different percentage of the risk outside of the corridor. The specific structure of such agreements is tailored based on the risk tolerance and capital position of the plan.

The commercial reinsurance of Medicare Advantage (MA) health plans is an example of the use of reinsurance and risk adjustment. The Medicare risk-adjustment mechanism is used to adjust premium levels for MA plans; such plans also purchase commercial reinsurance (both excess and quota share) to cover fluctuations in actual results.

#### *Between employers and health plans*

In group business, under minimum premium funding arrangements, it is common to include specific and aggregate stop-loss insurance in the contract. Aggregate stop loss is similar to the risk corridors concept; it protects the employer from broad fluctuations in the overall expenditure. Specific stop loss acts the same as the “reinsurance” provision—it protects the employer against large catastrophic claims. Specific stop-loss experience is netted out of the aggregate stop-loss expenditure to ensure those claim expenses are not double counted.

In group business, under refunding arrangements, it is common to use risk-stabilization funds for risk protection (for the benefit of both employers and carriers). At the end of a policy year, if experience is better than the target, the favorable experience is put aside in a stabilization fund. If experience is worse than the target at the end of a policy year, funds can be drawn from the stabilization fund to offset the loss the health plan would incur. The fund is held for the policyholder by the health plan. The concept of the stabilization fund is similar to risk corridor with multiyear risk sharing. This also can be combined with large claims pooling, which is similar to specific stop-loss reinsurance.

#### **What kinds of special considerations are important when implementing multiple risk selection mitigation strategies at once?**

First, the multiple mechanisms should have minimal overlap with each other. To accomplish that, it is important to recognize the purpose of each risk-sharing mechanism and its value added versus shortfall. For example, a risk-adjustment model does a reasonable job—but it is not perfect—in predicting costs. It also tends to understate the claims at the upper end of the claims distribution and overstates the claims at the lower end. Given the unknown risks due to guaranteed issue and other coverage requirements, reinsurance would help protect the risk associated with specific claims—whereas risk corridors would help protect the risk in aggregate. This is similar to the specific and aggregate stop loss reinsurance in group insurance. The thresholds and cost-share amount need to be balanced carefully so they offer sufficient protection without creating incentives for increased health spending. In addition, risk corridors and reinsurance may be more important for smaller plans and in the start-up years, when experience is lacking.

Second, there should be clear specifications on how the calculations are to be performed and what should be included in revenue and claims. For example, would claims above the reinsurance threshold be excluded in risk corridor calculations? Would there be interim and final

settlements? Final settlements should allow enough lag time for claims and reinsurance reimbursements to come through (at least six months, preferably 12 months or longer).

Third, the structure should allow for the least cumbersome administrative burden to the government and plans.

### **M. Economic Analysis**

#### **M.1. What policies, procedures, or practices of plans, employers and States may be impacted by the Exchange-related provisions in Title I of the Affordable Care Act?**

- a. What direct or indirect costs and benefits would result?**
- b. What stakeholders will be affected by such benefits and costs?**
- c. Are these impacts likely to vary by insurance market, plan type or geographic area?**

It is difficult to separate the effects of exchange-specific provisions from the other provisions in ACA that are effective within the exchange (e.g., rating rules), all of which may overlap to a certain extent. As such, the following comments may reflect thoughts on provisions that are not considered exchange-specific.

#### *Pricing*

Allowable rating methodologies currently vary from state to state. They range from very little restriction in some states to pure community rating in others. Under ACA, premiums for medical plans will be allowed to vary by age (with no more than a 3-to-1 ratio between the highest and lowest rates), geographic area, tobacco use (1.5-to-1 ratio), and family size. For states with little restriction today, the new rules could result in new or shifting cross-subsidies and potentially large increases or decreases in premiums for some groups with certain age and gender characteristics.

The role of the exchange in rate reviews was discussed at length in the beginning of this document in questions C.6 and D.1.

#### *Mandated benefits*

It is important that plans offered in the exchange have the same requirements for state-level mandated benefits across all plans to maintain a level playing field both within the exchange, as well as with plans offered outside the exchange. This could pose a challenge in multi-state exchanges if plans are offered across all states.

#### *Administrative functions of the exchange*

The exchange likely will perform and charge a fee for many of the basic administrative functions such as premium collection, premium distribution to the health plans, membership maintenance and reporting, and data analysis and reporting. Since health care plans will need to continue to perform some of these functions, this may result in a net cost to the system. Additional exchange costs, such as expanded member appeal rights and regulatory oversight, also are expected to result in additional expenses. Some of these additional costs, however, will be offset due to the

elimination of the underwriting function, as well as the exchange-facilitated marketing and enrollment functions.

**M.3. Are there unique benefits and costs affecting consumers? How will these consumer benefits be affected by States' Exchange design and flexibilities and the magnitude and substance of provisions mandated by the Act? Please discuss tangible and intangible benefits.**

*What will be the ease and availability of QHP plans?*

A critical element to the success of the exchanges will be the transparency and ease by which plan comparisons and purchases can be made by consumers with limited or no knowledge of the health care marketplace. Essential to the issue of transparency is the ability to compare rates across comparable benefit-plan offerings. Some consideration also should be given to communicating or illustrating the extent to which there is price or benefit parity with individual and small-group plans offered outside of the exchange.

*What will be the effect on costs to the consumer?*

Changes in premium rating and benefit coverage rules, along with MLR requirements and enhanced premium oversight, will have a direct financial effect on the consumer. The precise effect will vary from consumer to consumer.

In states that currently allow underwriting and/or have rating restrictions that are more liberal than the permissible rate bands under ACA, the exchange communication materials will need to address this transition more thoroughly than in geographies in which state-based provisions are already more restrictive. The exchange will need to address the concerns of consumers with existing less comprehensive and less expensive coverage than will be required in one of the standard benefit plans offered through the exchanges.

In addition to this direct financial impact, the perspective of the consumer utilizing the exchange should be considered when designing an exchange and determining the communication and educational content. Targeted consumers will have unique cost-benefit perspectives and biases.

**M.4. Are there paperwork burdens related to the Exchange-related provisions in Title I of the Affordable Care Act, and, if so, what estimated hours and costs are associated with those additional burdens?**

Plan sponsors will need to have the administrative capabilities to submit the appropriate information to the exchanges and account for any vouchers/penalties they may have to pay.

The exchanges may have more enrollment periods (initial, annual, and special) than the one typically in place for many plans. There will be, therefore, paperwork and cost burdens associated with arranging and promoting the additional enrollment periods and tracking the selections.

Costs associated with additional paperwork and reporting could include new or upgraded payroll/accounting systems or possible outsourcing of such functions if they become overly

complex; diversion of existing human resources staff to maintain compliance with new requirements; professional fees for legal and tax support required for compliance; expanded use of employee benefit consultants to understand and communicate new options. These costs are likely to be proportionally greater for smaller employers that might otherwise have less sophisticated payroll and reporting systems and fewer existing staff resources to devote to compliance and communication.

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Thank you again for allowing us to provide input into this critically important rulemaking initiative. We would welcome the opportunity to engage in further discussions about this topic. If you have any questions, please contact Heather Jerbi, the Academy's senior federal health policy analyst, at [jerbi@actuary.org](mailto:jerbi@actuary.org) or 202.785.7869.

Sincerely,

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