



October 4, 2010

Office of Consumer Information and Insurance Oversight  
Department of Health and Human Services  
Hubert H. Humphrey Building, Room 445-G  
200 Independence Avenue, SW  
Washington, DC 20201

Submitted via [www.regulations.gov](http://www.regulations.gov)

**Re: OCIIO-9989-NC - Request for Comments Regarding Exchange-Related Provisions  
in Title I of the Patient Protection and Affordable Care Act**

Dear Director Angoff:

The Alliance of Community Health Plans (ACHP) is pleased to respond to the Office of Consumer Information and Insurance Oversight (OCIIO) Request for Comment on planning and establishment of exchanges published in the *Federal Register* on August 3, 2010 (75 FR 45584).

ACHP is a national leadership organization representing community-based and regional health plans and provider organizations that collectively provide health care and coverage for approximately 18 million Americans. Our members are delivery system-aligned health plans that are not-for-profit or subsidiaries of not-for-profit health systems. Member plans share longstanding commitments to their communities, close partnerships with providers, and substantial investments in the innovative approaches and infrastructure necessary to provide health care that is coordinated, affordable and high quality.

ACHP greatly appreciates the work of OCIIO and DHHS, as well as the Departments of Treasury and Labor, as they implement the Affordable Care Act (ACA). ACHP recognizes that exchanges are a central element for providing coverage for millions of uninsured Americans. Exchanges also have the potential to significantly change how health plans operate and compete in the market. For these reasons, we applaud that the Department has sought information and recommendations through this RFC prior to rulemaking.

ACHP and its members are committed to successful implementation of exchanges, and believe that policy development must focus on the practical realities of the task confronting us. The federal government, states, and the employer, health plan and health care delivery communities must implement an enormously complicated set of changes in a limited time, impacting almost every American. Exchanges do not exist today in most of the nation and must be operational in every state as a centerpiece of reform in 2013 for full implementation of coverage improvements in 2014.

**MAKING HEALTH CARE BETTER**

## Guidelines

The overarching principle with which we have approached our response to the RFC is that exchanges should provide consumers a broad choice of high-quality health plans and delivery systems. Consumers value such choices, and we also believe that choice encourages competition, innovation and improvement. An exchange that offers few choices and then shifts offerings from year to year is likely to deprive consumers of choice and create periodic disruptions in consumer relationships with providers and health plans. In the context of this principle of broad choice, we would set out several guidelines as a framework for policy development:

- Exchanges should not only facilitate the offering of more and better coverage options to individuals and small businesses, but they should promote continuous improvements in quality and value in order to move toward more affordable care and make health care reform sustainable.
- The administrative imperative to establish exchanges in every state in the near future must be accorded deference in any policy discussions. There will be opportunities for further improvements once the system is operational and there is more experience with it.
- As a starting point, policy should be grounded wherever possible in existing federal, state and private standards.
- State exchanges must be structured to accommodate local and regional plans and delivery systems as well as the larger statewide and national carriers. They should promote a variety of models of health plans and delivery systems.
- Exchanges should not duplicate existing regulatory structures.
- Decision-making at the federal and state levels should be transparent and inclusive.

Using these guidelines, ACHP has developed comments and recommendations in a number of areas raised by the RFC.

### A. State Exchange Planning and Establishment Grants

Item A in the RFC focuses on the considerations states will make in designing and establishing their exchanges, with guidance and funding provided by DHHS. The design work done by states under the exchange planning and establishment grants will go a long way in determining the success of health reform in bringing higher quality care to millions more Americans and reducing the unsustainable growth of health care expenditures. Several issues must be carefully considered in this process.

#### Individual and Small Group Markets

We believe that states should be very cautious when they make decisions on merging the individual and small group markets and that, perhaps with exceptions in some states, those markets should remain separate. The decision on whether to merge small group and individual *markets* is distinct from the choice of operating either separate or combined *exchanges* for individuals and small businesses. States must address the question of whether and when to merge the individual and small group *markets* as an analytical question that requires significant data on both the uninsured and currently insured populations. For example, in order to predict purchasing behaviors and market impacts accurately, data on the uninsured should include current employer-sponsored and/or family

insurance availability, government-sponsored health plan eligibility, tobacco usage, geographical location, age, income, family status, and other factors that will drive the likely purchasing behavior of the individual. Similarly, data must be collected to determine the likely changes in employer-sponsored insurance in the small group market, the impact of expanded Medicaid eligibility on the currently insured population, and other potential effects on the currently insured population. It will take states a good deal of time to collect and analyze detailed, accurate data in these areas. We believe that, in general, successful ACA implementation depends on taking a sequential approach to the myriad changes called for under the law, thereby limiting market upheaval as much as possible. While we recognize there may be exceptions in some states, in most cases we believe this is a strong argument for leaving current *market* structures in place at least in the near-term.

## AHBE and SHOP Exchange Structures

### *Sustainability*

Exchanges will have to be self-sustaining by 2015. States may wish to consider a range of financing options to sustain exchanges in the long-term; however, any financing option should be mindful of creating a level playing field between plans inside and outside the exchange and not create additional incentives for self-insured coverage. A scenario under which the mechanism for exchange financing makes policies offered through the exchange uncompetitive with those outside could lead to “death spirals” similar to those which caused the failure of previous exchange-like experiments.

In assessing who should pay the cost of a function required under the ACA, traditional government functions should be paid for by public entities (primarily state or federal government) using public funds, while functions related to operation of the exchanges should be paid for by the exchanges, via whatever financing mechanisms are utilized. For example, while the costs associated with eligibility determination and enrollment in exchange plans are legitimate expenses for exchanges to bear, the cost of the Medicaid data interface required under the ACA, and of the actual enrollment process for those deemed to be eligible for Medicaid, should be the Medicaid program’s responsibility. Not only will this ensure an equitable distribution of costs, it will also reduce overhead for the exchanges, making them more competitive and sustainable in the long-term.

Operating procedures and business rules should be formulated to encourage the highest level of participation by both plans and eligible individuals and small businesses. Recognizing that exchanges will possess, to some degree, a captive base population because of the subsidies they facilitate, the additional non-subsidized lives required to achieve sustainability may vary from state to state. However, this calculation of “sustainability” is critical as states review the decision on how to structure their exchanges. States should ensure that their decisions maximize the number of plans and number of lives in an exchange, while keeping the operational overhead costs as low as possible.

### *Governance*

It is our belief that a single governance entity outside the immediate direction of elected officials should be empowered to operate both the AHBE and SHOP exchanges. In addition, Section 1311 (f)(3) of the ACA provides that this entity should not be owned or operated by a health plan or its

subsidiaries. A single exchange would reduce costs in the areas of information technology, outreach and marketing, while providing a true “one stop shop” for those purchasing coverage through the exchange. It will also be more attractive to plan offerers, since a single exchange will allow for consistency in the presentation of policy information, IT interface and other factors that impact the attractiveness of an exchange to plan officers. As the ACA requires, specific attention should be paid to the unique needs of small businesses providing coverage through the exchange and the appropriate resources dedicated to this sector.

Under the ACA, exchanges are not intended to have a regulatory function, serving instead as a marketplace for the purchase of high-quality coverage. ACHP feels that state departments of insurance, whose roles involve the regulation of plans that will be offered by the exchange, should therefore be precluded from consideration as potential administrators of an exchange.

### *Multi-State Exchanges*

ACHP feels that the challenges posed in establishing state exchanges will be sufficiently large as to make the creation of multi-state exchanges inadvisable at least in the short term. States should focus, instead, on establishing their own viable exchanges before attempting to tackle the complexities of interstate operations.

## **B. Implementation Timeframes and Considerations**

Item B in the RFC concerns the considerations states must weigh and deadlines they must meet in order for exchanges to make a full range of plan choices and services available on January 1, 2014. There are several key policy and procedural implementation tasks that states and the exchanges must complete well in advance of 2014. The completion of these tasks will give insurers, businesses and individuals the information they need in order to determine if and how they will conduct business with the exchange. In addition, if individuals and small businesses are to be able to enroll in plans beginning January 1, 2014, there are a number of essential business functions that must be operational in 2013.

### Implementation Tasks

Among the policy and procedural implementation tasks that states and/or exchanges must complete in order to provide the information necessary for health plans to develop their exchange plans and processes are:

- Providing a premium aggregation function, possibly through the use of a third party administrator.

One of the features most likely to attract participation by health plans and consumers in an exchange would be its capacity to ease the administrative burdens associated with shopping for, selecting, paying for and using health insurance. A payment or premium aggregation function through which premium contributions are collected from a number of sources, matched or allocated to an insured party and routed to plans in a single, lump sum payment (with associated payment data) would promote utilization of the exchange, not only by health plans, but also by purchasers. The Secretary should require that the SHOP exchanges

perform premium aggregation as one of its minimum functions. This would be our preference for the AHBE exchange as well; however, if this is precluded under the statutory language, the Secretary should require AHBE exchanges to act as a “virtual aggregator.” Under this scenario, the exchange would establish essentially a "notional account" for each individual, collect premium payments from the individual, and aggregate them with the value of applicable tax credits. The exchange would then make the premium payment to the insurer, while simultaneously notifying IRS and triggering the real-time release of funds as well as providing the appropriate notional account balance to the insurer. This would facilitate the insurer’s ability to match IRS subsidies with the insured individual via an automated process.

- Clarifying procedures for enrollment of individuals and employees of eligible small businesses in plans, including the locus of the enrollment process and the timing and duration of open enrollment periods.

The process of selecting and purchasing an insurance product is distinct from the verification of eligibility for premium tax credits and cost-sharing subsidies. ACHP believes that states and health plans together should determine which entity should perform those functions. In some cases it will be efficient to conduct enrollment on the exchange website; in other cases enrollment might better be done on the health plan website.

- Sharing with plans the standards and processes for a plan to be certified as a qualified health plan (QHP) as well as additional plan and design requirements.
- Establishing what information will be expected from plans, when and in what form.
- Developing the management structure necessary to operate the three risk-sharing programs, including risk adjustment, risk corridors and reinsurance.
- Establishing the process and timing for health plans to receive payments.

### Business Functions

Several business functions must be tested and made operational in 2013 to ensure individuals can enroll in policies through the exchange. Unless these functions are “live” well before the exchanges plan to accept enrollees, there will not be a fully operational exchange on January 1, 2014. The business functions that must be operational before 2014 include, but are not limited to, the establishment of:

- The exchange web portal
- A standard format for the display of plan information
- The process for certifying and rating QHPs
- The data interface between Medicaid and CHIP
- Eligibility and enrollment processes and procedures
- Contracts with necessary vendors and plans offering through the exchange
- Marketing and outreach operations
- The aggregator function
- The three risk sharing programs

## **C. State Exchange Operations**

Item C in the RFC raises issues about how an exchange should perform its assigned functions and utilizing which systems. ACHP believes that the standards and operations of the exchange should maximize choice and quality. We recommend several policies be standardized nationally to ensure that consumers have access to the greatest possible number of high-quality plans.

### Maximum Choice

Specifically, the Secretary should make clear that all plans that meet QHP and relevant state solvency and licensure standards should be allowed to participate in the exchange. We strongly recommend limiting the discretion of exchanges, under Section 1311(e)(1) of the ACA, to exclude a plan from participation even if the plans meets all requirements for QHPs. The Secretary should also affirmatively establish the right of sub-state plans to participate in every exchange, allowing qualified local plans without statewide or national networks to continue to add value in the communities they serve.

While ACHP believes that maximum choice is an essential element of successful exchanges, we also believe that the exchanges should implement mechanisms designed to demonstrate the quality of different plans. These tools should help consumers identify and choose those plans that perform at the highest quality and offer the best overall value.

### Quality Standards and Open Enrollment Periods

ACHP believes that every plan participating in an exchange should be held to the same quality standards nationwide. For these purposes, we suggest turning to existing measures of quality (see below). Finally, we believe the Secretary should consider standardizing policies governing the open enrollment process, while granting states flexibility in the timing of such periods.

### Information Systems

When considering the health information system requirements for various exchange functions, including plan qualification, data reporting and payment flows, we suggest following the models provided by existing HIPAA and state processes that function effectively today. In short, we do not believe that the system requirements for exchange functions should be proprietary to the exchange process.

There are many IT solutions, including a federal solution modeled off of the technology used for the Medicare Part D interface, as well as the existing MMIS structures in place under state Medicaid programs, that could be used to make exchanges operational. In terms of data sharing, plans should take responsibility for providing, but not formatting, the information requested by exchanges. The data sharing process should not be overly manual in nature. Specifically, we recommend states provide a standardized, web-based application programming interface (API) through which plans can input information required by the exchange. Considering some of the challenges posed by the recent national web portal launch, and understanding the time pressure that DHHS faced in starting up that site, we urge that exchanges be required to provide significantly longer lead time in their requests for data than was the case for the national portal.

## Rate Review

ACHP feels that exchanges should play a limited role in the rate review process, and should defer to existing state processes where possible. The state's criteria for determining whether a premium increase is "reasonable" should be the same for the plans offered inside and outside of the exchange. The rate review process should also include consideration of the base from which a percentage increase is calculated. For example, plans that had been offering premiums far below those of their competitors may have legitimate justification for increases that bring their premiums closer to those of their competitors. Finally, ACHP believes that any plan meeting the Medical Loss Ratios set under PPACA is, by definition, charging "reasonable" rates and should be qualified to offer coverage on the exchange short of a compelling reason to the contrary.

The process for reviewing premium increases should be mindful of several additional factors including: the quality and type of services provided, the outcomes of those services, the risk of enrollees and the length of the plan's relationship with particular high-risk customers; the cost of contracting with providers and the trends associated with health care costs overall, including geographically-specific cost-drivers; and the health plans' need to meet state solvency requirements.

## **D. Qualified Health Plans**

Item D in the RFC concerns the certification criteria to be set by the Secretary for Qualified Health Plans (QHPs), as well as exchange processes that will facilitate participation by an appropriate mix of QHPs that compete on the basis of price, quality, and value.

## Certification

The certification criteria in the ACA defer where possible to existing state regulatory structures and rules for the individual and small group markets. We believe it very important to rely on that overall structure of state licensure to avoid overlapping requirements and delays in implementation.

The exchange should be open to all plans that (1) meet state licensure and solvency standards and (2) meet quality standards as determined by the Secretary to preserve a broad range of options and encourage consumer selection of high-quality health plans and delivery systems. We note that the statute does not require that QHPs must offer coverage throughout a state, and we strongly recommend that the Secretary reflect in certification criteria that exchanges must recognize and include qualified local plans that may not have a statewide or national network but are leaders offering high quality and value in the areas that they serve.

In several areas noted in the RFC, the statute does set certain additional requirements for the Secretary to establish. The RFC specifically asks in question D2 about issues to consider in developing criteria under Sec. 1311(c) related to marketing requirements and ensuring a sufficient choice of providers and network adequacy.

## Marketing requirements

State insurance and/or managed care departments have implemented health plan marketing requirements for many years. With the increased funding made available to those departments under the ACA, state agencies are best equipped to meet the statutory standard that marketing practices and benefit design not have the effect of discouraging enrollment by individuals with significant health care needs. Relying on such standards will also assure that standards and enforcement are the same for plans in the exchange and any plans that opt to sell products only outside the exchange.

## Network adequacy and sufficient choice of providers

In this area also, state insurance and/or managed care departments have implemented requirements which should serve as the standards for provider networks. Two recommendations are particularly important for health plans such as ACHP members, which are organized delivery systems or work very closely with provider networks on coordination of care, care management, and quality improvement:

- Plans must have the ability to define networks to assure value for the consumer through access to high quality providers. An "any willing provider" approach does not yield the high-value result envisioned in the ACA.
- The essential community provider provisions of the ACA should be implemented in a manner that accommodates consumers who opt for organized health plans and coordinated delivery systems. Plans must be able to evaluate quality and cost in making decisions about providers that are part of the network.

## Encouraging competition

As envisioned by the ACA, exchanges will foster competition among health plans. There is no need for a formal "bidding" process given the structural incentives of the exchanges. Plans need to submit their premiums for the QHPs on a timely basis for consumers to choose. QHPs will compete for customers in the small group and individual markets by offering a competitively priced essential benefit package at the bronze, silver, gold and platinum levels. We believe that the key for a competitive model like this to work, and to drive to the value desired, is an intense focus on, and clarity for, the consumer. This question directly relates to item E in the RFC (Quality), which is also discussed below.

The exchanges must adopt plan selection tools that allow consumers to *accurately* compare plans on price and quality. It is particularly important that the consumer be able to drill down below the surface level of premium, coverage and co-payments to learn the real and *total cost of their care under various scenarios* that reflect the likely care needs of their families. For example, individuals with a chronic condition such as diabetes should be able to see realistic estimates of their total cost of care under different plans, so they can make an informed choice.

As a starting point, consumer tools such as the eHealthInsurance web-portal provide attractive plan selection features, recognizing that they need to be adapted to help consumers understand their total cost of care as noted above.

More health plans are likely to participate in the exchange if adverse selection risks are reduced and the process for offering through the exchange is perceived to be transparent and fair. Open enrollment should be limited to a 30-day window, with strict enforcement of this period and clear guidelines on exceptions for “qualifying events.” There will need to be strong enforcement of the non-participation penalties individuals and businesses.

## **E. Quality**

Item E in the RFC poses questions related to the ACA requirement that the Secretary develop a plan rating system on the basis of quality and price that would be used by the exchanges, and to establish quality improvement criteria that health plans must meet to be QHPs. As national leaders in delivery system improvement, ACHP member plans appreciate the breadth of the ACA’s approaches in the area of quality measurement and improvement. For QHPs, the RFC hones in on several important issues: the basic plan rating approach, quality improvement, and consumer information.

### Plan Rating System

Question E1 raises the question of standards for the plan rating system. This is an area where there is a long history of quality measurement of health plans in the governmental and commercial markets.

We believe that the Secretary should set a standard plan rating system to be used by all exchanges so that quality is measured uniformly across the country. This is not the time to introduce another and different rating system for plans. The drive for quality and value requires aligned ratings and incentives across payers; there are already tested and effective models that could be adopted, with appropriate modifications, such as the Medicare Advantage star rating system (as revised for the quality incentive payment program) or the National Committee for Quality Assurance (NCQA) plan ratings.

### Quality Improvement Strategies

Question E2 asks about the ACA requirements for implementing quality improvement strategies, as called for in Sec. 1311(g) and (h). This again is an area in which health plans have long experience in working with both private accrediting bodies such as the NCQA and others, as well as with public programs like the Medicare Advantage program and state Medicaid plans.

The Secretary should expect that QHPs provide or arrange for high quality care and promote movement in this direction from the start by setting a limited number of delivery and performance improvement objectives. For example, QHPs could be encouraged to demonstrate team care capabilities and to establish performance goals at the provider group level for specified outcome measures, such as a reduction in health care acquired infection rates.

With multiple plans available and a quality rating system in place, exchanges should encourage choice of the highest quality plans. Those QHPs meeting high quality standards should receive some preferential notice or listing on the exchange. In addition, high quality plans should be given preference for enrollment when the exchange implements a default enrollment protocol.

The Department and state exchanges should also plan to continually upgrade policy in driving toward delivery system improvement, quality and value for the consumer. That can include:

- phasing in thresholds for quality improvement based on the rating system;
- further development of the initial set of priority delivery improvements noted earlier;
- performance reward pools that would further encourage and reward high quality plans; such an approach could start with pilot demonstrations, potentially aligned with comparable performance incentives for quality improvement and value undertaken by the Center for Medicare and Medicaid Innovation.

## **G. Enrollment and Eligibility**

Item G in the RFC concerns management of the eligibility determination and enrollment processes, particularly where the state and federal government, and public assistance programs and the exchange, overlap in performing these functions.

ACHP believes that the principle of “shared responsibility” is central to the long-term success of health care reform, and we offer several recommendations below. Developing open enrollment policies that will ensure people purchase and maintain quality insurance coverage will mean a greater likelihood that treatment is provided in the appropriate setting at the appropriate time, eliminating wasteful spending. Conversely, the churning of members on and off of commercial and government-subsidized care can lead to delays in treatment, higher costs and an unfair “gaming” of the system by certain individuals.

Massachusetts’ experience is illustrative. There, a pattern emerged in which a significant number of people were found to have enrolled, utilized services at a much higher rate than the average member, and then dropped their plans within a matter of months. The state legislature responded to this trend by passing a law in August that limited open enrollment in the individual and small group markets to twice a year in 2011 and once a year thereafter, with exceptions for certain qualifying events.

### Open Enrollment Period

ACHP supports an annual, 30-day open enrollment period for individual coverage in the exchange, along with special enrollment periods for changes in marital status, children, and other life events. This open enrollment period should be aligned with tax filing deadlines to establish a link in consumers’ minds between the credits available for coverage and the requirement that they obtain it to avoid tax penalties. The policy should be widely publicized as part of the exchange’s overall outreach efforts. States should also explore whether instituting certain additional penalties, along the lines of those applied to Medicare premiums for individuals that fail to enroll in a timely fashion, would increase participation. Similar penalties might be considered for those who voluntarily disenroll from plans outside the prescribed window. In either case, the penalties should be limited in duration (unlike the Medicare surcharge) and should be capped on a sliding scale based on the individual’s income. Any such penalties should apply to consumers both inside and outside the exchange. This will bolster the enforcement of the ACA’s individual responsibility provision and reduce any incentive for late enrollees to enroll outside the exchange.

## Cost-Sharing Subsidies

Our members also have an interest in ensuring that the system for determining and delivering cost-sharing subsidy payments from the Department of Health and Human Services to plans on behalf of lower-income individuals be seamless and as “real-time” as possible. Ideally, information regarding the appropriate adjustment to the individuals’ cost-sharing limits would be included when the plan is notified of their enrollment by the exchange. ACHP supports the concept of making capitated subsidy payments to plans and encourages the Secretary to exercise the discretion granted in the law to do so in consultation with health plans and the National Association of Insurance Commissioners.

### **I. Rating Areas**

Item I in the RFC focuses on implementation of the ACA requirement that each state establish rating areas, subject to review by the Secretary. It poses questions about existing practices and criteria that might be used to set rating areas.

Our experience is that there is extraordinary diversity in premium rating areas among and within states, carriers and lines of business. It would be difficult and counterproductive for the Department to set standards in this area. Especially in the initial years, the Secretary should defer to state judgments in this area.

In developing criteria by which the Secretary conducts a review of those state decisions about rating areas, we would point to the need to assure that the state uses an open and transparent process including all stakeholders in making its decisions, and that the resulting rating areas are not in some fashion discriminatory. But until there is a great deal more federal experience in oversight of the implementation of the rating areas in the exchanges, we would urge that any Departmental intervention be limited to exceptional circumstances.

### **J. Consumer Experience**

In general, plans and exchanges have a mutual responsibility to ensure that the right expert is answering the right questions at the right time for consumers. This includes, wherever possible, taking advantage of existing information and resources already available on plan sites. Individuals, however, will also need the opportunity to interact on a personal level with the exchange. The quality of the exchange’s customer service programs should be monitored and evaluated, as is the case with private plans today.

Consumers must be offered clear, concise information that includes factors beyond simply premium costs to make an educated decision. For example, customers may be offered the opportunity to calculate their expected cost under different health scenarios; shown their projected out-of-pocket cost for care under different plan options; or provided information on health outcomes and customer satisfaction with plans or providers. However, exchanges should be mindful of the potential to overwhelm customers with too much data when considering how best to present information. Often the order in which plans are displayed impacts the decision-making process for customers. Therefore, ACHP suggests displaying plan choices in an order that reflects their scores on various quality measures.

## **K. Employer Participation**

Item K in the RFC poses questions regarding how to maximize participation in and satisfaction with the Small Business Health Options Program (SHOP) exchange. Clearly, these will be driven by a number of factors, including the ease with which small business owners and their employees can access the SHOP (both at enrollment and on an ongoing basis), the administrative resources they provide, and the participation of a broad range of carriers in the marketplace.

### Services Offered Through a SHOP Exchange

SHOP exchanges that offer services that relieve the regulatory burden of small businesses are more likely to attract a broader customer base. Among the services that should be included are: third-party administration of Human Resource functions such as payroll deductions for premium payments, Section 125b cafeteria plan tax assistance, counseling of employees in selecting insurance, and assisting employees with insurance-related issues that arise.

### Aggregation Function

To attract the broadest choice of plans to the SHOP exchange, policymakers at the state and federal levels should authorize and facilitate premium aggregation within the SHOP exchange, as well as the AHBE. Aggregated payments would simplify the payment collection process for plans and assure the pre-tax treatment of premiums paid by employers and employees. It would also allow for contributions from multiple sources to be credited to the account of a single participant--meaning that part-time employees might draw premium assistance from multiple employers and eligible individuals could continue to draw down subsidies from existing state, county and local health assistance programs.

### Defined Contribution

While encouraging entry into the SHOP exchange by a wide variety of carriers and plan models, exchange operators should be mindful of the effect that different plan designs might have on certain populations. For example, allowing defined contribution plans to be offered through the exchange could yield significantly higher net premiums for older workers, a factor that should be considered before authorizing these types of plans to be offered through the SHOP exchange. The Massachusetts experience with their pilot for small business is instructive.

## **L. Risk Adjustment**

Item L in the RFC asks for comments about the ACA requirements for a permanent risk adjustment program in the small group and individual market, as well as the transitional three year programs for reinsurance across all markets and risk corridors in the small group and individual markets. Questions L1-L4 focus on the risk adjustment program called for by the ACA for the small group and individual health insurance market, both inside and outside the exchanges.

### Risk adjustments should meet the following principles:

- Adjustments should improve markets and promote competition based on quality, service and price.
- If rules result in a difference between expected cost for a population and the ability of carriers to match rate with cost, adjustments should seek to bridge that gap.
- Information informing adjustments should be verifiable and adjustments should not be subject to manipulation.
- Adjustments should strike a balance between accuracy and ease of administration and explanation. They should be based on information expected to be readily available on a timely basis.
- Funding should be guaranteed and timely.

We do have concerns as to how risk corridors can be appropriately applied in connection with the other two elements. It will be important to manage the interaction among risk adjustment, reinsurance and risk corridors

### Key Risk Adjustment Criteria

Risk adjustment should be condition based, rather than claims based, to the extent feasible, to ensure that health plans effectively manage care. However, policymakers will need to modify current risk adjustment approaches to consider unique features of the individual and small group markets:

- There will be more turnover in the individual and small group markets than occurs in large group markets or Medicare;
- A significant portion of cost in the individual and small group markets relates to maternity, newborn care, injuries and other costs that are difficult to predict in advance.
- There will be less consistency in benefit values and age-related premiums than in most markets where risk adjustment is widely used.

### Risk Adjustment and Market Data

Rates quoted by health plans will need to be based on the impact of the various financial adjustments. Health plans will need to have an understanding of their relative membership risk in advance of quoting 2014 rates. The development of market data in advance of 2014 should assist in this understanding. Risk score development should be accomplished using a standardized federal approach.

### Risk Adjustment Methods

The methods of assessing the risk of enrollees may be similar to Medicare with the need for modifications noted above. However, the method of adjusting payment to and among health plans will need to be different. This is because in Medicare the government pays the cost of covering Medicare basic benefits and the base capitation is adjusted based on the assessed risk factor. In the commercial market, funding comes from premiums collected from groups or individuals, tax credits and other subsidies, and risk adjustment transfers funds from one health plan to another. Premiums

collected already will reflect some adjustment for risk (e.g. family size, and age based premiums). Risk adjustment must avoid double counting these cost drivers.

The individual and small group markets in 2014 will be different from those today. However, there will be a need to collect and analyze data from existing markets in advance of 2014. There should be national standardization for: a) the data and record layouts to be provided by health plans to facilitate risk adjustment, b) the software- e.g. the same application that is used to develop Part C risk scores) and (c) the scoring (the score that comes out of the model would be independent of state of residence, or submitting health plan.) States should have latitude on how to apply the risk scores in order to improve the state market. Other issues include: protecting proprietary information from competitors and legal authority to compel the submission of data.

Finally, risk adjustment should follow the Medicaid model of not recalculating the risk score of enrollees who have chronic or life-long conditions – for example, under Medicaid a diabetic person will remain scored as a diabetic without annual recalibration. There is substantial administrative expense and waste when a health plan is required, as in the Medicare program, to get enrollees to see a physician in order to certify that his/her disease status has not changed.

#### Risk Adjustment Issues to be Considered by States

- The level that risk adjustment takes place (market wide or by benefit plan).
- Timing: We believe risk adjustment and other settlements should be performed in time to affect MLR calculations.
- How to treat partial year members.
- How to modify a condition based approach to reflect differences in benefit design, churning, population and the predictability of high cost cases.
- Whether to include other plan factors such as geographic region or tobacco use in the formula.

#### Entities that conduct risk adjustment

In private markets, risk adjustment is generally undertaken by a third party entity. Funds move between health plans or through the group sponsor. In Medicare, CMS performs the adjustment and distributes funds. Under health reform, a state or federal government entity would be responsible for administration or oversight of risk adjustment and might contract with a qualified third party.

#### Timing of Payments

Commercial risk adjustment arrangements usually have reconciliation after the coverage period to reflect actual enrollment and actual premium.

#### Key Reinsurance Criteria

Reinsurance is an important mechanism to protect health plans from adverse risk in a reformed market. In the commercial market, reinsurance payments are typically calculated as a percentage of

high cost claims. Challenges that states are likely to face in implementing reinsurance include:

- Identifying and verifying qualifying conditions;
- Equitably managing available funds;
- Timeliness;
- Effective interaction with other adjustment mechanisms;
- Systems issues for data collection;
- Resources to analyze data and administer the program; and
- Funding

### Risk Corridors

Risk corridors were used successfully in implementation of Medicare Part D. However, it will be difficult to apply risk corridors in connection with risk adjustment and reinsurance in the individual and small group markets. It will be difficult to determine whether a health plan's higher or lower than expected costs justify application of a corridor. And it will be difficult to design an adjustment program that appropriately incorporates all three elements- risk adjustment, re-insurance and risk corridors. We believe that risk adjustment and reinsurance should be undertaken before deciding how to implement risk corridors.

### **N. Additional Comments Regarding Exchange Operations**

ACHP would like to offer the following additional comments on issues not addressed above:

- When purchasing through an exchange, the subsidized and unsubsidized populations should have access to the same plan choices. ACHP believes that the segregation of the two categories of purchasers is unnecessary and anti-competitive and could lead to an unacceptable divergence in choice and quality of care based primarily on income levels.
- In states where Association Health Plans (AHPs) are authorized, these plans could reduce the viability of the SHOP exchange if they are allowed to operate under rules that provide them a competitive advantage vis-à-vis plans in the SHOP. Policymakers should ensure a level playing field that allows the SHOP exchange to compete for small business participation, while being mindful not to unnecessarily disrupt existing arrangements that are in the best interest of enrollees.

Thank you for consideration of our recommendations. We would be happy to answer any questions or provide additional information.

Sincerely,



Patricia P. Smith  
President and CEO