Minuteman Health™

July 31, 2015

Louis Gutierrez
Executive Director
Commonwealth Health Insurance Connector Authority
100 City Hall Plaza, 6th Floor
Boston, MA 02108

RE: Minuteman Health, Inc. Request for Reconsideration of 2014 Risk Adjustment Payment

Dear Executive Director Gutierrez:

Minuteman Health respectfully requests reconsideration of its risk adjustment settlement for 2014. The calculation results in Minuteman paying a total transfer of $3,064,679.45 which represents 71% of Minuteman's gross premium. We believe this amount is excessive, reflects neither policy intent nor statute, and is the result of data flaws in the risk transfer formula as well as data calculation errors.[1]

EXECUTIVE SUMMARY

The issues with the Risk Adjustment Calculation fall into three categories:

1. Data Quality is Inadequate. Unaudited CHIA data has led to wildly fluctuating results, final premium numbers used to calculate the critical market average premiums had to be estimated and not calculated by the Connector, and rating regions were assigned incorrectly. **Even a perfect risk scoring calculation could not work with such faulty data inputs**.

2. Calculation of Risk Scores Itself is Flawed. The demographic calculation yields arithmetically impossible results, the lack of appropriate adjustment for immaturity of HCC assignments structurally penalizes high-growth plans, and access to relevant data is not shared with all healthplans. **This means that even if the data inputs had been perfect that a faulty risk score would still be generated.**

3. Market Average Premium Calculation Incorrectly Penalizes Consumers and Efficient Providers. The Market Average Premium Calculation (MAPC) used by the Connector works against the intent of existing law. Using unaudited and reportedly estimated data from the all payor claims database, the MAPC forces consumers who are trying to save money to instead subsidize those purchasing richer plans. Further, this flawed result then penalizes the most efficient hospitals and providers. Lastly, the data issues are then compounded by timing delays that introduce further unpredictable market volatility. **If both data quality and risk score calculations had been perfect – and both were not – then the use of the 2014 Market Average Premium Calculation would still have arbitrarily harmed Minuteman, our members, and our highly-efficient providers.**

[1] Minuteman has attempted to quantify the monetary impact of each of the addressed areas. However, the total of the estimated impact for each of the elements exceed the total payment because many elements interact with each other. In addition, there are certain data issues that Minuteman cannot quantify because it does not have access to the underlying data that would be necessary.

We believe that the magnitude of this impact could not have been anticipated and was not the desired outcome of the drafters of the risk adjustment program. In fact, we were told by the actuary appointed to the Massachusetts Connector Board, John Bertko, in October of 2014 that it was impossible that any plan could experience a risk transfer payment greater than 10% of gross premium. Clearly that was incorrect. Instead, $2,168.92 of each of our members' money that we had reserved for their use has been forced to be paid out due to a fundamentally flawed data set, process, and calculation.

It is clear is that a review of 2014 results alone is insufficient. The unanticipated flaws in the program indicate that there are systemic and structural problems in how the data is used that will continue unless addressed. We recognize and agree that risk adjustment was intended to be a critical element of the ACA and health reform and that other risk adjustment programs in both the private and government sector can and do work. In looking to those more established risk adjustment methodologies, Minuteman views it possible and even potentially likely that a payout of some kind would have been generated based upon 2014 experience. We know of no successful risk adjustment process, however, that would have generated the extreme results we see here now.

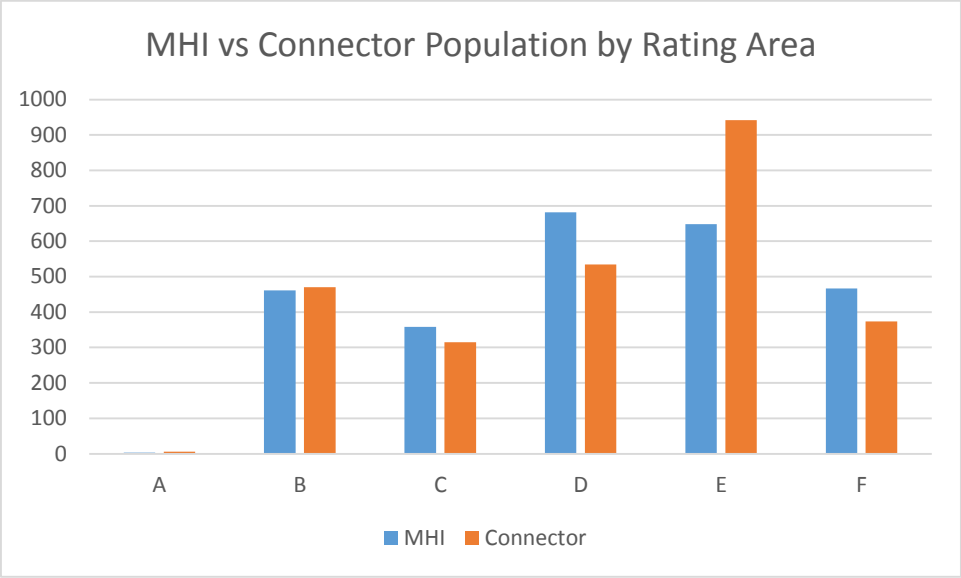
This particular version of risk adjustment, Version 1.0, simply does not work as intended. As with all risk adjustment programs that have become successful over time, the data must be analyzed, the calculations checked, and the reality of the outcomes held up against the theory of the intended design. This program needs to be significantly improved in order to avoid the current unintended market consequences that work against the objectives of health reform and the statutory mandate.

DATA QUALITY ISSUES

1. **Unaudited CHIA data is unreliable**. As the Connector has itself said, data reporting by the carriers has been erratic and uneven over the last year. The accumulation and dissemination of this data has also shown uneven and erratic results. As far as MHI is aware, neither carrier data feeds nor CHIA's processes or results have ever been audited. Given the critical importance of *all* carrier data and the consistent aggregation of that data by CHIA, such a gap undermines the credibility of all calculations. Minuteman cannot score the value of the impact this may have because of the very nature of the problem.

2. **Premium was inappropriately estimated**. Market premium numbers are similarly critical in calculating the final payment under this program. As far as MHI is aware, data were not only not audited but also in the end estimated in order to arrive at final market average premiums. Minuteman cannot estimate the value of the impact to such an estimate since we do not know what a correct average of all carrier premiums would be. We do know that 40% of our total payment – over $1.2M – was due solely to the impact of market average premium. As estimate on something with an impact that large is simply inappropriate.

3. **Example of data problems: Incorrect rating regions were assigned**. MHI has determined that approximately 20% of our membership has not been coded in the correct rating region by the Connector. MHI can provide member-specific information regarding each members' correct rating region as compared to the incorrect rating region assigned to the member by the Connector at the Connector's request. The graph below summarizes that data, showing how the distributions vary between MHI and Connector data.



The impact of this error is $29,000. More important than these estimated dollars is that this serves as an indicator of the level of concern we should all have regarding this data. This relatively small, discrete element is one of the few things we could measure because we had all of the data. We cannot measure the impact for elements about which we do not have all of the data.

Minuteman believes that a wholesale review of the data integrity, collection process, aggregation, and calculation needs to be performed. In short, an audit is needed. Forcing the transfer of millions of dollars of members' money based upon unaudited and fluctuating data – some of which was then further estimated – is inappropriate in our view.

CALCULATION OF RISK SCORES

1. **The default demographic factor in the Massachusetts risk adjustment formula is too low.** This does not enable health plans to cover preventative health services and health care needs not accounted for in the Hierarchical Clinical Conditions (HCC's) or even administrative costs.

   The demographic amount in the Massachusetts formula is .1087 for platinum and gold plans and .0546 for silver, bronze and catastrophic plans. This means that if a member has no HCC's (and the risk transfer formula only considered the risk factor), the plan would keep only 5% of its premium for most these members. This is too low to cover administrative costs, the costs of preventative screening services that represent good evidence based clinical practice as well as to cover the myriad of costs related to medical conditions not accounted for in the HCC definitions. It goes beyond the regulatory objective of eliminating the benefit of positive risk selection or covering only healthy populations, and instead punishes plans for covering members who have no health issues. In other words, the methodology overshoots its objectives and takes too much away from plans covering healthy persons, ensuring that any plan with an abundance of zero HCC members will be unable to cover basic medical costs and administrative expenses.

   Minuteman estimates the financial impact of this at $766,000.

2. **The lack of low enrollment factors.** As the only new market entrant in 2014, Minuteman was particularly harmed by the failure of the Connector that year. Minuteman had an average monthly enrollment of 1413. Our average enrollment months per member was approximately 6 months. We had only 200 members who were enrolled with Minuteman for the full 12 months of 2014.

   The risk adjustment methodology is a statistical methodology that estimates the burden of illness for a particular member. Like all statistical methods, it can both underestimate and overestimate the true burden of illness. It is a basic statistical principal that with greater number of observations, the underestimations and overestimations cancel out and there is a greater confidence that the mean and produces a reliable estimate of the actual result. The lower number of observations or members, the less confidence in the result. It would be appropriate to protect small enrollment plans by limiting the impact of extreme results that could easily be attributable to statistical anomalies rather than data driven results.

   If one were to simplistically use the credibility factors in place for the MLR calculation, then the financial impact of not applying such a factor could have an impact of $1.6 million. Other formula would of course generate different results.

3. **The short term enrollment factors are inadequate.** This adjustment does not adequately recognize the mechanics of the collection of risk adjustment information. Risk adjustment data is collected only for selected qualified, usually face to face, encounters. These encounters do not occur continuously. Indeed the qualified encounters could occur just once per year. The shorter period a member is enrolled during the year the more likely the encounter occurred outside of their enrollment in a plan. However, this does not mean the member is not receiving medical services. They could be receiving prescription drugs, diagnostic or therapeutic imaging procedures, lab tests, or medical supplies for their conditions. None of these services would result in the condition being documented during a short enrollment period. Indeed, plans with longer term enrollment have the added benefit of knowing about conditions documented in prior years and can make outreach efforts to ensure the condition is documented during the measurement year. As a new plan, Minuteman has no information regarding its members prior conditions and less time to do anything about it. Therefore, new entrants are penalized not only for the small size of their member populations, but also for the lack of persistency within those populations.

   This shortcoming could be remedied if the Connector were to be able to share HCC-related data in the APCD with any carrier with a new member. This would allow the new carrier to mine historical data just like an incumbent and pursue the information sufficient to generate an HCC score. Alternatively, the Connector could create a formulaic adjustment to reflect the immaturity of the data with which a carrier could appropriately code an HCC for a particular new member.

   It is impossible to score the impact that this has since one cannot score data one does not have. It is instructive to note, however, how many high-growth plans nationally have been impacted by this same element in the federal risk adjustment calculation. Dozens and dozens of smaller plans have both received enormous federal reinsurance payouts as a percentage of their total claims and also been forced to pay out significant sums in risk adjustment. At the surface, this seems to imply that each high-growth plan seem to have the same two very different populations – one very sick one that generates reinsurance payouts, and another very healthy one that requires risk adjustment payouts. Other factors – such as the relative strength of a high-growth carrier's network, medical management, etc., may come into play. Such a glaring and unexpected outcome that in turn drives significant payment swings does require us to step back and evaluate the critical issue regarding new member growth.

4. **There are no short term enrollment factors for bronze or catastrophic plans.** The risk adjustment short term enrollment adjustment factors referenced above are not applied to the bronze and catastrophic plans. There is no logical reason why there are no factors for bronze and catastrophic. *These plans represent the majority of Minuteman members*. Minuteman expects that the impact of this item could be in excess of $1 million.

USE OF MARKET AVERAGE PREMIUM

1. **The use of Market Average Premium has no basis in law**. For the first year of the risk adjustment program, any state which created its own risk adjustment methodology was supposedly required to use the federal payment and charges methodology, including the use of a state-wide average premium for calculating the risk transfer payments and charges.[2] Regardless of whether CMS ever solidified this "requirement" as a rule, all parties can agree that if that requirement ever did exist, it has now lapsed, and the Connector is free to propose its own methodology for payments and charges.[3]

   Minuteman urges the Connector to pursue a risk payment methodology that does not counteract other policy initiatives in the Commonwealth. In particular, the current methodology works in opposition to the Commonwealth's efforts to promote low cost tiered, regional, and narrow network products.

2. **The use of the statewide average premium produces the illogical result where the transfer payment can exceed the gross premium collected**, excessively penalizes low cost plans, and creates a substantial uncertainty in rate setting. Again, none of this has anything to do with the intended purpose of risk adjustment – to adjust for the relative health status of populations.

   Federal rules and guidance require that the risk adjustment program "reduce or eliminate premium differences between plans *based solely on expectations of favorable or unfavorable risk selection or choices by higher risk enrollees* in the individual and small group markets." (emphasis added).[4] The Commonwealth's program does not adjust solely based on differences in expectations of risk; instead, it adjusts for and unfairly penalizes plans that are low cost, have more enrollment in the lower metallic tiers, and/or have low administrative expenses.

   The formula compares the risk adjustment results to the allowable rating factors. These two factors might suggest that the plan member's actual burden of illness (as measured by the risk score) was 70% of what the plan was compensated

[2] This requirement was first suggested in March 2012 in the commentary to the final rule related to risk adjustment, and reiterated in various CMS presentations (see, e.g., https://www.cms.gov/CCIIO/Resources/Files/Downloads/fm-1e-state-flex.pdf); however, MHI has been unable to find such a requirement anywhere in federal statue or regulations, and therefore it is unclear that this "requirement" even existed in year one of the risk adjustment program.

[3] See Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors and Risk Adjustment, Final Rule, March 23, 2012, pg 17233, at http://www.gpo.gov/fdsys/pkg/FR-2012-03-23/pdf/2012-6594.pdf ("...requiring a national methodology for calculating payments and charges initially, and leaving open the possibility of permitting State variation in later years, relieves States from the burden of developing such a methodology *in the first year*…") (emphasis added).

[4] Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors and Risk Adjustment, Final Rule, March 23, 2012, pg 17230, found at http://www.gpo.gov/fdsys/pkg/FR-2012-03-23/pdf/2012-6594.pdf

for. But that 70% is not multiplied by the member's actual premium but by the average statewide premium, which could easily be double or possibly three times the actual premium paid by the member to the plan. Simple arithmetic results in a transfer payment greater than premium collected. This is not an extreme or uncommon result. *The risk transfer payment exceeded premium collected for approximately 50% of Minuteman members*. Minuteman understands that an early simulation conducted by the Connector showed that its risk transfer payment would exceed all of the premium for Minuteman as a whole. While Minuteman is thankful that it does not have to pay a risk transfer payment greater than the total premium collected, the actual result is only slightly better. If the risk transfer formula used Minuteman's average premium in the calculation, its risk transfer payment would have been reduced by 40% or requiring approximately $1.8 million instead of $3 million.

3. **This methodology disproportionality penalizes low cost plans, efficient providers, and the consumers who purchase them**. All Minuteman plans are lower cost relative to the established commercial plans. Our rates are closer to the Medicaid Managed Care Plans (NHP, Boston Healthnet and Network Health). Minuteman is able to offer a competitively priced product to price-sensitive consumers because it has created a select network of high quality, low cost providers. In essence, Minuteman has achieved what Massachusetts policy makers have long encouraged: a low cost product built on a narrow network. However, the lower a plan's premium is as compared to the statewide average premium, the higher percent of its risk transfer payment will be unrelated to the risk profile of the plan's members, and the higher percent of its risk transfer payment will be solely based on the fact that it is offering health plans that are less expensive.

   The Connector and all policymakers on Beacon Hill and in Washington need to focus closely on this dynamic. *As currently configured, risk adjustment will directly harm the intent to shift towards provider risk-bearing*. Efficient providers will be grievously harmed if they can indeed lower prices – an element they control – but end up with a healthier population – an element outside their control. A typical profitable hospital system will make 2-3% of revenue per year. As illustrated in Minuteman's example, having a lower-cost network and delivering the lower prices consumers deserve to pay could generate a payout of nearly 30% of total revenue. Unchecked, this component of risk adjustment will torpedo ACOs and any other risk-bearing provider construct.

   Again, if the risk transfer formula used Minuteman's average premium in the calculation, its risk transfer payment would have been reduced by 40% or requiring approximately $1.8 million instead of $3 million.

4. **This calculation penalizes all Minuteman members simply because more of them chose bronze plans.** While the item above shows how Minuteman is penalized merely because the prices for our products are lower than the average in the market, Minuteman is then further harmed because we were then additionally penalized because of the plans consumers chose to purchase. Again, none of this has anything to do with the intended purpose of risk adjustment – to adjust for the relative health status of populations.

   Minuteman's goal is to create affordable products for price-sensitive consumers. As a result, Minuteman has a high number of bronze plan members as compared to other carriers in the market. This means that Minuteman pays risk transfer payments based on a much higher metal level than the plans we provide.

5. **The process and timing of the Market Average Premium calculation introduces additional pricing instability into the market.** Important data elements were simply unknown by all carriers going into the 2014 rating process, and limitations are still present today. Therefore it introduces an unknown into the rating process. The first published statewide average premium was June 30th, well after all plans filed 2014 and 2015 rates and a few days before 2016rates were due. All prior risk adjustment simulations excluded publishing the statewide average premium. Minuteman understands that this is because the Connector was having difficulty making this calculation. If the Connector could not calculate the statewide average premium, how could individual carriers have been expected to incorporate the statewide average premium into their rate development? Minuteman estimated the statewide average premium with the assistance of Milliman. Our estimate was over $60 less than the rate published by the Connector on June 30. Even going forward, the statewide average premium is unknown to plans at the time of rate setting. The most recent published amount does not reflect the 2015 average, let alone the 2016 average. Therefore, the notice of benefit and payment parameters, published by the Connector in order to enable carriers to incorporate risk adjustment payments and charges into their rates, is wholly insufficient. It is impossible for carriers to accurately predict risk adjustment transfer, and therefore, impossible to build those transfers into their rates, based on the information in those notices.[5]

SUMMARY AND CONCLUSION

Each of these flaws separately have a profound effect on Minuteman, but in combination create a "perfect storm". The risk adjustment program was put in place in order to "mitigate the potential impact of adverse selection and provide stability for health insurance issuers in the individual and small group markets."[6] As implemented by the Connector, the risk adjustment program goes beyond simply ensuring that plans are protected against adverse selection to punishing plans that are small, new, low cost, and/or cater to individuals and small groups looking to purchase the most affordable products. Not only does the program punish these plans, it does so to such a punitive extent as to be massively destabilizing, having the opposite impact as that required by the authorizing legislation. Whether evaluated as a percent of premium, a percent of risk based capital, or any other measure, it is easy to see that low cost health plans in Massachusetts will be forced de-emphasize the very lower-cost/higher-value products that they offer the market today.

This is not only a problem for Minuteman. It will adversely impact the competitiveness of the market place because it excessively punishes new low cost plans. What that really means is punishing those providers who have been putting in the hard work to put the 'Affordable' in the Affordable Care Act. New plans will inevitably look like Minuteman Health in being low cost and having a lower than average risk score. New plans need to be low cost or they will not attract new members. Additionally new plans will almost inevitably have a lower than average risk score. Persons with current illness are less likely to choose a new innovative plan and will instead choose the established plans. So new plans almost always initially attract

[5] The Commonwealth must publish its notice of benefit and payment parameters by the later of March 1 of the calendar year prior to the applicable benefit year, or by the 30th day following the publication of the final HHS notice of benefit and payment parameters for that benefit year (see 45 CFR 153.100(c). This is required because "HHS recognizes that health insurance issuers must have detailed information about risk adjustment prior to setting rates for any benefit year because the risk adjustment methodology will affect both the total value of premiums received after accounting for payments and charges, as well as administrative costs." (Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors and Risk Adjustment, Proposed Rule, July 15, 2011, pg 41940, available at http://www.gpo.gov/fdsys/pkg/FR-2011-07-15/pdf/2011-17609.pdf)

[6] Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors and Risk Adjustment, Final Rule, March 23, 2012, pg 17220, at http://www.gpo.gov/fdsys/pkg/FR-2012-03-23/pdf/2012-6594.pdf

healthier patients more willing to try something different until it develops a reputation for good service in the marketplace. But if the new plans are excessively punished by the risk transfer methodology, they will be forced to offer higher cost products.

In short, the current methodology creates a barrier to entry for new health carriers and a disincentive to create innovative, low cost products. If the health market is less competitive, it will inevitably result in higher premium rates to consumers which will undermine the objectives for health reform. It appears that the unintended consequences of the Commonwealth's risk adjustment program are working in direct opposition to the Commonwealth's efforts to contain healthcare costs through increased competition and innovative product design.

We believe the risk transfer payment required of Minuteman is excessive and sincerely hope that the Commonwealth will continue to work to correct these obvious problems. We do realize that any improvements must be approved by CMS. Many of the issues above are shared by the federal risk adjustment methodology, however, and CMS could benefit from allowing the unique and until now largely successful Massachusetts healthcare reform to continue. We can continue to be one of the 'laboratories of democracy' and assist the federal government as they continue to iterate their own methods and processes for the rest of the county. Simply put, risk adjustment methodology must be reformed to achieve the objectives of health reform and the ACA and for the good of the citizens of the Commonwealth.

Sincerely yours,

Thomas Policelli
CEO, Minuteman Health, Inc.

CC: Michael Norton, via electronic mail
Ed DeAngelo, via electronic mail