

Attachment 1

The HCA exchange comments

Washington State Health Care Authority

October 4, 2010

Response to comments requested by the Department of Health and Human Services on the Exchange-Related Provisions of the Patient Protection and Affordable Care Act

The Washington State Health Care Authority is pleased to submit comments to the Department of Health and Human Services, Office of Consumer Information and Insurance Oversight on health insurance exchanges.

Planning for a State Exchange

State-based exchange

Washington State has decided to examine a state-governed, state-operated (“state-based”) exchange for potential implementation by January 1, 2014, as a “straw option”. At some point, should our examination demonstrate that a state-based exchange is too risky, or not feasible for some other reason, then the federal exchange will be considered. It would be helpful to have the specifications of a federally operated exchange outlined in the regulations to allow states to make an informed decision about the tradeoffs. We know our opportunity to examine the feasibility of a state-based exchange, before considering the option of a federal exchange, is time-limited. Consequently, analysis of the information technology needed to support an exchange was a top priority in our state’s reply to the federal planning grants issued in August 2010.

Key stakeholders

Washington State began outreach activities as the Patient Protection and Affordable Care Act (ACA) was signed into law. Much of that stakeholdering has focused on the initial insurance reforms and the exchange. The Washington State Legislature established a Joint Legislative Select Committee on Health Reform Implementation (JSC). The JSC is comprised of Legislators and they established a JSC Advisory Group on the Exchange and Insurance Reforms. Chaired by Legislators, the Advisory Group is a cross-section of knowledgeable stakeholders from the state’s health insurance market.

The Washington State Insurance Commissioner has also formed a Health Care Reform Realization Committee that focuses on the Exchange and Insurance Reforms. The Realization Committee is also a cross-section of knowledgeable stakeholders from the state’s health insurance market with strong representation from community leaders that provide or promote access to care. The

Realization Committee has two co-chairs; one being a Board member of the Washington State Health Insurance Partnership (HIP), a program that will subsidize low-income employees of low-wage small employers.

Governor Gregoire formed a Health Care Cabinet charged to provide leadership and accountability for how the state implements health care reform.

All of these groups will provide input and guidance to the grant activities submitted by Washington State. To successfully complete the grant activities, stakeholdering will also reach out to additional members of the public and policy-makers.

Governance options

Washington State would like to retain the broadest set of options for the governance of an exchange. For example, the State might find it advantageous to establish a governance structure soon prior to designing a state-based exchange. In that case, an operational organization would be preliminarily designated and partnered with at least a general description of a Board or governing entity. In contrast, the state might determine that it is better to design a state-based exchange and then select the governance structure that best fits that exchange. Therefore, Washington State requests that any federal requirements directing governance of a state-based exchange allow us to continue to consider either path toward establishing a governance structure.

Washington State is beginning a process to identify factors that will likely determine the structure of a state-based exchange. Washington State finds the flexibility of a nonprofit entity appealing and yet also recognizes the value of the potential administrative support that can be provided from existing state agencies. The tight timeframe for implementing an exchange necessitates carefully weighing both options and balancing the flexibility provided by a nonprofit entity with the value of maximizing existing administrative infrastructure. Washington State has successful experience with both models. Our Basic Health Plan and Health Insurance Partnership (HIP) programs are housed in state agencies, while our high risk pool and Washington Vaccine Association are administered by private nonprofit entities. Washington State requests that states are allowed this flexibility to determine the best governance structure for an exchange.

Federal planning grant activities

Washington State's initial examination of ACA exchange provisions lead to the development of technical questions about the direction provided in the law, concerns about adverse selection among insurers (within and outside the exchange), and has demonstrated the importance of extensive planning activities. The purpose of our planning grant is to identify and document the high-level requirements

and business operations of a state-based exchange. The activities of the planning grant conclude by September 2011, with the development of a high-level implementation plan, which establishes a basis for designing options and making recommendations for further development.

Washington State welcomes and needs federal guidance and encourages the Department of Health and Human Services (HHS) to issue regulations that specify outcomes for states to achieve in partnership with insurers, health care providers, and consumers in the market. The ACA provides some guidance on the goals and functions of an exchange. We would appreciate additional guidance that elaborates on the specific outcomes HHS would like to see, but does not prescribe the means by which the states achieve those outcomes.

Resources for an exchange and the Health Insurance Partnership

Washington State also needs to identify the resource capacity that can be provided by insurers, producers, health care providers, and community organizations. The implementation of an exchange can be enhanced through the broad utilization of Washington's existing infrastructure for private and public coverage. With the determination to avoid administrative duplication, services performed by an exchange can possibly be simplified and expenses minimized. Washington State has relied upon private-public partnership in the coverage of Medicaid enrollees, Apple Health for Kids (coverage for low-income children), the Basic Health Plan, and most recently, the Health Insurance Partnership (HIP), a program that will subsidize low-income employees of low-wage small employers.

Through the support of a State Health Access Program (SHAP) grant, HIP will directly subsidize the premium contribution of low-income individuals within small groups beginning January 1, 2011. Small employers may also receive a boost through the ACA's small business tax credit which can be used to subsidize a small employer's premium contribution to HIP. Since federal SHAP subsidies are provided through August 2014, Washington requests that any regulations support, not impede, the application of those complementary subsidies for small-employer group plans in Washington State. When designing an exchange, Washington State will most likely apply the lessons learned through the implementation of HIP. Guidance on how the HIP can either co-exist with the exchange, transition to the exchange, or become a part of the exchange will help Washington State's small employers.

Preliminary market analysis

A discussion of the preliminary analysis needed to 1) merge the individual and small group markets and, 2) consider the federal basic health option will comprise the initial analytic activities of the planning grant. In our discussions, we will need to explore the difference between establishing an

exchange that could offer plans to individuals and small groups and an exchange that merges the risk pools of individual and small group plans.

Issues needing further clarification

Through the advice of experts, Washington State has identified a number of technical questions about the exchange in the attached document, “Exchange questions Sep 2010.” Other issues that need clarification are highlighted below.

Clarify eligibility issues: Washington State will likely be asked to clarify whether people eligible for Medicaid, the Children’s Health Insurance Program (CHIP), the federal basic health option, or any other locally-offered subsidized coverage can choose to enroll in the exchange. Washington State’s reading of the ACA suggests that people eligible for Medicaid or the federal basic health option are not eligible to receive subsidies through the exchange. However, might persons with income at the Medicaid coverage level (0% to 133% of the federal poverty level) elect to obtain nonsubsidized coverage in the exchange, or would enrollment within Medicaid be their only alternative among public programs that offer coverage? Verification of these interpretations will guide us to consider ways to establish distinct income eligibility standards for each program and research processes to seamlessly administer eligibility and enrollment for Medicaid, the exchange, and possibly, the federal basic health option. Further clarification of Medicaid and CHIP screening, eligibility, and enrollment requirements for the exchange directed in subsection 1311(d) will greatly assist planning, and hopefully expand options for streamlining administration. Similarly, subsidies in the exchange will be based upon the most recent tax return (subsection 1401) whereas eligibility for Medicaid and CHIP will be based upon a point in time (subsection 2002) in the eligibility process. Implementation of eligibility and screening for the “no wrong door concept” could be streamlined if based upon the same measure of income.

Transitions between public programs are a necessity as family’s experience changes in their eligibility. However, to avoid undue movement between Medicaid and an exchange due to frequent changes in income, we would like to know if the ACA’s direction is broad enough to allow persons to remain enrolled in their existing Medicaid or exchange health plan for a 12-month annualized period?

Role of the exchange in implementing the individual mandate: Further clarification of the role of the exchange in implementing the individual mandate will be most useful, especially in clarifying the expectations of the exchange, or the state, in working with the Department of Treasury. Similarly, any expectations of the exchange in supporting employer reporting of group health information to the Department of Treasury in subsection 1502 or in assisting, applying, or collecting the shared

responsibility penalty for large employers in subsection 1513 will help clarify the scope of our information technology support.

Risk of adverse selection: Washington State is concerned about adverse selection and will continue to monitor any rating or health insurance regulations that would establish a perceived difference between the exchange and the non-exchange market. Applying streamlined eligibility and regulations across Medicaid and the exchange can assist with the management of adverse selection. In that vein, it may be critical to apply more insurance-type standards to all programs (e.g., annual open enrollment periods vs. monthly enrollment switching allowed in Medicaid today, etc.). Similarly, if the state chooses to implement a federal basic health option it would be helpful to have clarification on whether those enrollees can be pooled (for risk purposes) with Medicaid or exchange enrollees. Language in the ACA leads us to believe that Medicaid enrollees likely cannot be pooled with the exchange, but we need clarification.

Health services coverage across programs: Washington State believes that the Medicaid benefit benchmarks for existing Medicaid client groups that are not elderly or disabled and new ACA Medicaid eligibles should be aligned with the essential health benefits and that sensible, specific policy goals need to accompany any differences in benefit designs. This flexibility is essential to promote a seamless interface and continuity of care for low-income persons moving between Medicaid, the federal basic health option, and the exchange. Although the essential benefits themselves and the levels for qualified health plans are important policy questions to resolve, they are not critical to the initial functional design of an exchange. However, the timeline for establishing the essential health benefits is important because Washington State would like to have a full dialogue about retaining, eliminating, or modifying different state benefit mandates before implementation of an exchange in 2014 with sufficient time to revise our statutory requirements and allow the insurance carriers to prepare new or revised products. It would be ideal to have the essential health benefits defined by January 2012, to allow states time to respond during the 2012 legislative cycle. Pushing the benefit definitions beyond this cycle jeopardizes the development of programs during 2013.

Incentives to improve health plan performance: Washington State would like the opportunity to consider how additional enrollee premium subsidies to promote enrollment in the highest performing health plans might be used to incentivize performance improvement by health plans participating in the exchange, Medicaid, CHIP, and the federal basic health option. At this time, we cannot specify how performance might be measured or rewarded. However, retaining the latitude to study higher premium

incentives to people enrolled in top-performing qualified health plans is an option our state would like to retain.

Exchange as an aggregator: Washington State would also like to further examine and understand the role an exchange might play in aggregating premium contributions from varied sources and distributing the necessary enrollment data and aggregated premium dollars to the selected plan. The Health Insurance Partnership (HIP) will aggregate the federal subsidy and the employer and employee contributions and send premium payment and associated data to the insurer. It is possible that some individuals would receive contributions towards their coverage from multiple employers. Clarification on how this could be accommodated will be essential for Washington State.

Health plan selection across programs: Washington State promotes coordinating the selection of Medicaid plans, standard basic health option plans, or qualified health plans for an exchange. The coordination could apply to the price and quality metrics established for health plans or possibly designating a single process to select plans across multiple programs. It would be desirable for states to have the opportunity to deem health plans for the exchange that may have been previously approved by a more rigorous selection process for a different program such as Medicaid or even through the State's Insurance Commissioner. To the extent permitted under federal law, HHS should consider amending Medicaid plan requirements to be consistent with the exchange requirements. This would allow states the potential to deem qualified health plans in an exchange for the purpose of Medicaid participation. The selection process needs to recognize and likely coordinate with the essential task of reviewing plans and rates performed by the Insurance Commissioner. The certification and selection process for qualified health plans offered in the exchange should ensure that the existing regulatory process for private health plans is preserved. Washington State promotes rules for the selection of qualified health plans that do not impede the ability to work closely with the Office of Insurance Commissioner. It is critical that insurers continue to meet the state's insurance code for private plans offered inside and outside of the exchange.

Implementation Timeframes and Considerations

The planning grant submitted by Washington State focused on the key business functions and information technology support necessary to implement an exchange by January 1, 2014. The tasks that will challenge our state's implementation of an exchange by 2014 are highlighted below.

Eligibility for Medicaid, CHIP, the federal basic health option, and the exchange

Guidance is needed not only to implement initial eligibility and enrollment processes, but also to clarify how changes in eligibility are triggered and how enrollees can seamlessly transfer from one program to another. Our initial discussions on this topic have focused on the themes of simplifying the accurate verification of eligibility, assuring continuity of care for enrollees that transition between programs, and keeping a lid on overall administrative costs. We are cognizant of the emphasis the ACA puts on coordinating eligibility determination and enrollment across Medicaid, CHIP, the federal basic health option, and the exchange. However, we are equally concerned about continuity of care for subsidized families who may experience relatively frequent changes in income. In that light, Washington State would like to study different methods of retaining or transferring enrollees between programs as their income changes in a manner seamless to enrollees and with minimal disruption to care. It is worth exploring whether a family whose changed income, which results in a change in program eligibility, can remain enrolled in their current health plan. For example, if a family's income decreases due to job loss and they transition to Medicaid, but their health plan is not participating in Medicaid, could Medicaid funds be used to pay their premium in their current plan to enhance health outcomes through the continuity of care?

Washington State also is interested in considering demonstration options where modified adjusted gross income (MAGI) could be used as the basis for determining the Federal Medical Assistance Percent (FMAP) claiming rates for both existing and new eligibility groups. Such an option would greatly simplify the coordination and administrative burden between the exchange, Medicaid, and federal basic health option, and hopefully avoid the confusion and complexities that will arise if the complex eligibility determination processes currently in place continue alongside MAGI. For example, this could resolve the potential problem caused by timing differences in income documentation to be used in determining eligibility; last year's tax return for exchange eligibility and point-in-time income for Medicaid eligibility.

Administrative simplification can also be achieved by successfully coordinating with other low-income assistance programs such as Food Assistance, which offers the potential to deem income measured for one program as acceptable for determining eligibility in another. Also, guidance is needed for the information technology structure that will support an exchange. In particular, Washington State will need specifications for the data matching and security described in subsection 1413 to support eligibility and enrollment processes. Finally, we are seeking guidance on how citizenship status will need to be determined for the exchange. Best practices of state Medicaid programs could be quite helpful in

developing these requirements and should be considered as an option for determining a common standard across subsidized coverage options.

Certifying and offering qualified health plans

An effective certification process has the potential to build buy-in for an exchange and contribute to successfully offering coverage in the first year. As stated earlier, we believe states need to retain their options to coordinate plan certification with the approval processes now in place with our state's Insurance Commissioner and to coordinate the process with our state Medicaid program and the federal basic health option. This could involve deeming certification of qualified health plans that have met, for example, the provider network, price, quality, and administrative requirements of the state Medicaid program. Even with retaining that latitude to coordinate, the governing entities of exchanges will need clarification about their ability to certify and select qualified health plans as directed by subsection 1311(d) and "such other requirements as an applicable exchange may establish" as stated in subsection 1301(a). Must an exchange select and offer every qualified health plan? Could an exchange specify requirements that apply to insurer-wide practices when evaluating potential qualified health plans for certification or selection? Can an exchange specify that an insurer must offer plans in more than just the silver and gold levels as specified by subsection 1301(a)(C)(ii)? Can an exchange specify that an insurer must offer plans in the exchange, federal basic health option, Medicaid, and CHIP programs?

Payment of health insurers and the exchange as an aggregator of funds

Subsection 1412 (c) specifies that the Department of Treasury will pay subsidies to the insurer and inform the exchange of those payments. One interpretation of subsection 1412 could place insurers in the role of collecting private premium contributions from individual enrollees, employers and employees, and matching them to the correct subsidies (possibly federal and state-funded) and accounts. Washington State's Basic Health Plan and Health Insurance Partnership (when implemented) aggregate the public and private contributions that form the total premium paid to insurers, and thus, eases the administrative complexity and cost for insurers. Our state envisions a similar role for exchanges and would suggest that rules clarify the ability of an exchange to aggregate public and private premium contributions. The alternative could be very costly to our health care system.

Risk management

Washington State recognizes the important role risk management can play in stemming adverse selection within the exchange and between the exchange and the private health insurance market outside of the exchange. Successful implementation of three risk management mechanisms – two of

them being temporary – necessitates ensuring their success over a brief time period and minimizing their administrative burden. Each mechanism – reinsurance, risk corridors, and risk adjustment – are highly dependent upon correct data. Washington State will attempt to build upon existing data sources, possibly leveraging recent data and reporting activities of the Puget Sound Health Alliance, to capture the correct data for each mechanism. States will need flexibility in operating risk management programs because we need to be prepared for the possibility of significant enrollment churn in the initial years of the exchange. Consequently, regulations should guide and promote the outcomes that should be achieved through risk management and attempt to avoid specifications that necessitate the collection of different data elements for similar goals. Reinsurance or other risk management mechanisms necessitate establishing new administrative functions. The challenge will be to minimize the administrative burden, especially for the temporary reinsurance and risk corridor programs, while ensuring that each program provides effective service. It might also be worth considering extending risk adjustment options in the exchange to the Medicaid program where actuarially appropriate. Please see the attached Milliman document on risk adjustment for the coverage of public employees in Washington State.

Administrative support for the individual mandate and large employer penalties

Successful implementation of key administrative business functions is as essential to operating an exchange on January 1, 2014, as offering qualified health plans to individuals and small groups. For example, an exchange will support the implementation of the individual mandate by determining which individuals can be exempt from purchasing essential minimum coverage. Guidance is needed to specify the expectations of exchanges in support of the individual mandate. The ACA does not directly specify an administrative role by an exchange in assisting the implementation of large employer penalties, and consequently, any expectations of states to administratively support the federal implementation of large employer responsibilities needs to be clarified.

Assessing progress toward a state-based exchange

Washington State is pleased to comment on the potential criteria that should be considered in determining whether a state has made sufficient progress in establishing an exchange. In general, HHS should rely upon setting minimum thresholds each state can reasonably be expected to meet. We offer governance and information technology as two examples.

Governance: A state should be able to identify the entity that will administer the exchange and the general membership of the governing body. Washington State suggests that readiness should not rest solely upon the topic of governance. Washington State could establish a governance structure, set

the membership of a Board, or designate a state agency, nonprofit entity or other operational organization early in the design of an exchange. The state, however, would also like to retain the flexibility to design a state-based exchange and then select the governance structure that best fits that exchange. A demonstration of readiness should include governance as well as key operational functions and contracts needed for successful implementation and administration.

Information technology: In general, a state should be able to demonstrate sufficient readiness of a technology environment that supports the major business functions of an exchange, e.g., determining eligibility for programs or subsidies, at the time of implementation. Given the timeframe for implementation, our information technology assessment will identify a core set of required initial functionality, with planning for future enhancements that can expand on those initial capabilities.

Operational considerations for a state-based exchange

The pace of implementation necessitates establishing strong working relationships with private and public organizations that will play major roles in the success of an exchange. HHS has established itself as an active partner in promoting effective communication and stakeholdering. Washington State, however, recognizes the gap that exists in the public's knowledge of an exchange. That gap needs to close: we encourage HHS to continue to be a strong partner with the states by using the regulatory process to incrementally enhance public awareness of the exchange and other changes to coverage.

Value for small employers

Washington State is entering the planning phase of an exchange with some concern about the added value of an exchange for small employers. Opportunities to develop reasonable portability and suitable individual choice of health plans for employees are possible for our state-based exchange. However, we believe more clarification is needed to ensure that small employers can purchase coverage using a defined-contribution or ensure that a low-income employee can receive a subsidy when an employer is making a defined contribution toward a health plan.

Cost containment strategies

To receive long-term value for public subsidies, states will likely need to explore cost containment strategies that can be implemented through an exchange and their Medicaid programs. Federal support or partnership of our cost containment strategies will enhance our ability to achieve positive, stable, and efficient changes in coverage and the delivery of care. For example, we have noted above our concerns related to health plan participation across public programs. We have heard repeatedly from physicians that different cost containment and quality improvement strategies across

multiple payers are a burden and do not result in systemic quality improvement or cost containment. The opportunity to include consistent cost containment and quality improvement strategies in contract or certification standards for health plans participating in the exchange, Medicaid, CHIP, and the federal basic health option and to coordinate with other private purchasers in defining these standards could greatly promote our ability to improve the delivery and quality of health care services in Washington State.

Uniformity and flexibility

A combination of uniformity and flexibility, and the judgment to apply them, will be critical to implementing an exchange. Washington State has experienced successes and setbacks in our use of standards and flexibility. We are glad to provide our best input on when to use both within an exchange:

Uniformity

Income eligibility: Administrative simplification will be enhanced if modified adjusted gross income (MAGI) is used as a standard for income eligibility or screening across the exchange, Medicaid, CHIP, and the federal basic health option. Over the last two decades, the Washington State Basic Health Plan and Apple Health for Kids have often adjusted their definitions of income to accommodate the variety of ways people earn a living. There is no question that many of those adjustments have created equity for certain families. However, taken together, these adjustments have added complexity to the program. As outlined above, Washington State is interested in exploring demonstration options where MAGI could be used as the basis for determining the Federal Medical Assistance Percent (FMAP) claiming rates for both existing and new eligibility groups. Such an option could greatly simplify the coordination and administrative burden between the exchange, federal basic health option, and the Medicaid program, and reduce confusion for individual program enrollees.

Financial reports and auditing: Expectations for financial reporting, integrity, and cooperation with audits and investigations are set forth in subsection 1313 without specifying the reporting that will be required. Until further clarification is received, Washington State will proceed by evaluating our state standards for audits, budgeting, and finance -- the best available proxy for federal standards. HHS should make every attempt to use existing data and figures commonly found in the public and private health insurance markets when detailed reporting is specified. We also encourage HHS to set and maintain reporting standards with minimal changes. Finally, we are mindful of the ACA goals related to simplifying and streamlining eligibility determination processes. Realization of these goals could be jeopardized if eligibility auditing standards are not modified to acknowledge that simplification of

eligibility determination processes could yield a greater incidence of persons receiving subsidies who at some point in time during the year may appear to have income in excess of defined eligibility levels.

Health plan performance ratings: We encourage HHS to select from reports commonly adopted by the public and private sectors when establishing standards for relative price and quality ratings in subsection 1311(c). Through extensive involvement of private and public organizations, Washington State's Puget Sound Health Alliance now produces a meaningful version of the eValu8 report based upon local data.

Information technology: Like all states, Washington needs to develop an information technology structure that supports the eligibility and payment requirements and the extensive interfaces with state and federal agencies and private-sector insurers and participants. Any technology specifications for Medicaid eligibility, implementation of the individual mandate, or administrative support for employer reporting or penalties will need to be considered in our assessment of Washington State's information technology enterprise architecture. The information technology assessment will consider a full range of potential technical solutions including creative public-private partnerships. It is worth noting that the creation of a central information technology hub with the capacity to interface eligibility calculations among all states has been mentioned since national health care reform was enacted. Washington State remains open to studying certain vast technology solutions that offer the possibility of monumental achievements in efficiency but also contain enormous risk. For Washington State to participate in such a project, our technology experts would first need an opportunity to extensively study the feasibility of a specific option and its technology architecture.

Health plan rating: As mentioned earlier, Washington State believes that certification or selection processes for qualified health plans should be compatible with the review applied by our Insurance Commissioner. Due to our rural areas and insurers that serve niche markets, Washington State will continue to need the ability to use geographic rating areas. To date, insurers that provide statewide or near-statewide coverage in the individual market have used very broad geographic rating areas (West, Central, and Eastern counties).

Washington State received a health insurance premium review grant. The anticipated transparency and uniformity, and the prospective capacity to translate data into consumer information, should also assist the certification process for qualified health plans.

Flexibility

Plan certification and selection: Broad certification and selection regulations should allow states the flexibility to set standards or expectations that enhance competition. The certification criteria

must allow insurers to innovate with wellness programs, consumer engagement, reimbursement methods, and medical homes or accountable care organizations. The certification and selection processes need to allow the governing entity of an exchange to promote competition on value, possibly by using the relative price and quality rating systems described in subsection 1311(c). While it is possible that a state may choose to mandate a governing entity to select and offer every certified plan in an exchange, it is desirable for the rules to allow broad state flexibility in determining the selection process. For example, the Health Insurance Partnership (HIP) currently selects and offers specific small group plans -- please see the attached document that describes the plan selection process used by the HIP.

Premium subsidy scale: Washington State would like the opportunity to consider ways to modify the premium subsidy scale to reward those plans that perform best.

Benefits: The specification of the essential health benefits should not require constant adjustments as medical technologies advance. A clear definition of which benefits are essential, and which are not, also needs to provide states with the opportunity to consider alternative benefit mandates. As outlined above, states should be given the flexibility to consider the same essential health benefits design for the benchmark benefits under the Medicaid and CHIP programs.

Waiver process: Subsection 1332 allows states to waive all or parts of a health insurance exchange (includes essential health benefits/qualified health plans) beginning with plan years after January 2017. The waiver process should provide states with the flexibility to implement improvements in cost containment or coverage. For example, Washington State will begin subsidizing coverage for small employer groups on January 1, 2011, through the Health Insurance Partnership (HIP). It is not clear whether HIP's three-share method of subsidizing low-income employees of a small employer group can be offered through an exchange. If HIP is successful, but its operational mechanisms are not allowed by the ACA, then Washington State would want the option to consider requesting a waiver that targets advancements in coverage based upon empirical evidence.

Qualified Health Plans

Washington State would like to offer these considerations as HHS develops the essential health benefits and qualified health plans:

The range of qualified health plans will need to provide adequate options for enrollees of both individual and small group plans. The range of plans also needs to offer options that attract uninsured individuals in an environment where enforcement of the individual mandate is initially weak.

The floor, or bronze plan, will be an important definition for applying the individual mandate (“maintain minimum essential coverage”), the shared responsibility of employers to offer minimum essential coverage, and the calculation of the voucher applied in subsection 1513. The bronze plan will also impact the value of the silver plan; cost-sharing subsidies for out-of-pocket expenses are available only to silver plan enrollees.

The development of the essential health benefits will need to align with the development of the Medicaid benchmark benefits and basic health standard plans to ensure coordination of coverage and effective cost-sharing across public programs.

Washington State would like to study and consider whether plans offering subsidized coverage in the exchange might also be required to participate in the Medicaid and federal basic health option programs.

Outreach

Washington State programs have a successful history of actively collaborating with strong community organizations that help provide access to care for low-income people. The provision of electronic access to eligibility and enrollment systems has enhanced the customer service they provide. Apple Health for Kids was implemented with assistance from community-based organizations, local health jurisdictions, and tribes to achieve near-universal coverage of children. The Basic Health Plan has a long history of support from community organizations. Regulations should set standards for responsible participation of community organizations, and Navigators, without restricting the variety of organizations that can potentially participate or restricting the broad set of services these community partners can provide.

The Health Insurance Partnership has received similar support from the producer community. Washington State recognizes that continual participation from community support organizations, and the interest created by Navigators, will likely necessitate some regulations that clarify the activities and services that must be performed by licensed professionals.

Attachment 2

Exchange questions

Exchange -- questions to consider

These questions consider operational and policy issues pertaining to exchanges in the Act.

Primary questions – what do we need to know to get started?

1. Should Washington State have a federal or state governed exchange?

- a. We know that by January 1, 2013, states must have elected to make the required exchange operational and taken the actions necessary by this date to implement an exchange on January 1, 2014, as determined by HHS. § 1321(c)(1)
- b. We know that a state law or regulation can be used by HHS to determine that the Secretary's exchange standards will be implemented. This means legislative sessions in 2011 and 2012 are available for legislative policy development on an exchange. § 1321(b)(2)
- c. We do not think that HHS will be required to approve that a state's exchange complies with the Secretary's standards (general reading of § 1321), but HHS may investigate an exchange and will conduct annual audits of an exchange. (§ 1313)
- d. We do not know how HHS might choose to design an exchange for non-electing states. E.g.,
 - i. HHS might establish a model framework of standard policies to be implemented, with some latitude, state by state.
 - ii. HHS might choose to set certain policies such as how the exchange will be governed, one exchange for the entire state, no regional exchanges with other states, separate exchanges for individuals and small groups, certification of plans, and determine if a Basic Health Option could be administered by the same operational structure as the exchange; and provide options for other policies such as quality rating of plans, how quality delivery of health care services can be rewarded, or collecting and combining premium contributions from multiple sources.
- e. We do not know how HHS might choose -- or whether there will be flexibility -- to administer an exchange for non-electing states. E.g.,
 - i. HHS might administer these exchanges from a central office.
 - ii. We think it might be possible for HHS to direct the "State Medicaid agency under title XIX of the Social Security Act" to administer the exchange. If implementation of an exchange is

left to the federal government, we are unsure if the federal government can then delegate implementation tasks to the state such as directing the State Medicaid agency to administer all or key portions of an exchange. § 1311(f)(3)(B)(ii)

- iii. HHS might select one or more contracted entities to administer these exchanges. § 1311(f)(3)
- f. We do not know if a federal exchange opens Washington State up to additional federal direction about how state laws should be amended to accommodate a federal exchange or direction on how Washington implement insurance reforms. § 1321(a) and (b) and (c).
- g. Open enrollment periods will be established by HHS. We do not know how much discretion states might receive to design open enrollment periods that address their potential concerns about adverse selection or other issues. § 1311(c)(6).
- h. We think it's possible that HHS will implement – or direct Washington State to implement – risk adjustment and transitional reinsurance in a standard federal format for all states. § 1343 and § 1341. The federal government will establish and administer a temporary risk corridors program. § 1342.

2. Should the service area of the exchange be regional (multi-state or interstate) or subsidiary (geographically distinct area within a state) or statewide?

- a. We know that each exchange must cover a geographically distinct area. § 1311(f)(1)(B)
- b. We know HHS must approve a “regional or interstate” exchange. § 1311(f)(2)
- c. We think an area of a state could potentially join in another state's exchange. For example, southwest Washington, with the approval of Washington State, could make an exchange with Oregon. § 1311(f)(1) and § 1311(f)(2)
- d. A regional exchange might be a feasible option to transition to sometime in the future.

3. How will Washington State choose to administer an exchange?

- a. If at the state level, we know the exchange could be administered by the state Medicaid agency, a state agency, a public-private partnership, or some variation of these. § 1311(b)(1)
- b. We know that states are provided with flexibility to determine which functions of the exchange should be handled in-house and which by contract with a non-carrier private entity or the state Medicaid agency. § 1311(f)(3).

- 4. Will Washington State apply for a “health care choice compact” which allows qualified health plans to be offered in individual markets in more than one state?**
- a. We know that a health care choice compact cannot be effective until January 1, 2016. Consequently, any consideration of a choice compact will not likely impact how to implement an exchange in 2014. § 1333(a)(4)
 - b. Under a compact, we think this means that individual plans from another state would have to be offered in all Washington State exchanges. General reading of § 1333, § 1311(b), and § 1304(a)
- 5. Should there be separate exchanges for individuals and small groups?**
- a. Should one administrative structure be used to operate separate exchanges for individuals and small groups? Then, one exchange would administer two risk pools.
 - b. Should one exchange serve a merged risk pool offering the same qualified health plans to individuals and small groups? Then, one exchange would administer one risk pool that merges individuals and small groups.
 - i. Even in a merged risk pool, catastrophic plans can only be offered to individuals. § 1302(e)
 - ii. Will the private market for grandfathered plans and plans offered outside the exchange also need to merge individual and small group risk pools if those risk pools are merged in the exchange?
 - c. Should the small group exchange serve employers with 1-50 or 1-100 employees before January 1, 2016 when the national definition of 1-100 applies?
 - d. How will reinsurance, risk corridors, and risk adjustment be developed and applied to the exchange and current private markets?
 - i. Transitional reinsurance program: each state will establish and administer, under the guidance of federal standards, a transitional reinsurance program from 2014-16 in the individual market for both qualified health plans and new plans (excludes grandfather plans) offered in the exchange and the current private market. § 1341
 - ii. Transitional risk corridors for the individual and small group qualified health plans: HHS, not the state, will establish and administer a “payment adjustment system” based on “risk corridors” for qualified health plans from 2014 through 2016. The subsection does not specify that the payment adjustment system must apply to a merged market or separately to each market. § 1342
 - iii. Risk adjustment for individual and small group markets: Each state will establish and administer, under the guidance of federal

standards, a mandatory risk adjustment program for health plans (excludes grandfather plans) offered in the individual and small group markets, which includes plans offered in the private insurance markets and through the exchange. Self-funded plans are specifically excluded. This program is not transitional and the subsection does not specify whether the risk adjustment program must apply to a merged market or separately to each market. § 1343

6. What should be the purpose of an exchange and what does it need to achieve?

- a. The answer could depend on multiple perspectives forming a purpose for an exchange and clarifying what it should achieve, especially in terms of access to coverage and any potential impact on the efficient delivery of high-quality health care services. How an exchange tackles these two questions could help clarify its purpose:
 - i. When and how will the exchange implement market-based incentives that reward quality? § 1311(g)
 - ii. How will the exchange assign a rating based on relative quality and price to each qualified health benefits plan? § 1311(c)(3)
- b. We know that, in general, exchanges are established to “facilitate the purchase of qualified health plans.” § 1311(b)(1)(A)
- c. Does an exchange become the new private market for individual and small group plans by leaving little incentive to purchase grandfathered plans and plans offered outside the exchange in the current private markets for individuals or small groups?
- d. We know that SHOP exchanges for small employers are established to assist small employers by “facilitating” the enrollment of their employees in qualified health plans “offered in the small group market in the State.” § 1311(b)(1)(B)
- e. We know that the Basic Health Option directs states to “establish a competitive process for entering into contracts with standard health plans.” § 1331(c)(1)
- f. We know that in offering multi-state plans, the Office of Personnel Management is relieved of the responsibility to perform competitive bidding under the format prescribed for federal employees health coverage (OPM is not precluded from using competitive bidding, however). § 1334(a)(1)
- g. An exchange can set distinct rating areas within the area it serves. Who will set those rating areas, and if it’s the exchange, might it need to coordinate with other agencies? § 1301(a)(4) and § 1311(f)(2)
- h. Issues such as the type of relative quality ranking of the plans, the potential health insurance issuers, and the type of standardized benefit

designs will all impact what the exchange can achieve and what will be its purpose.

7. Are direct premium tax credits and cost-sharing reductions only made available to publicly subsidize qualified low-income individuals enrolled only in individual (“nongroup”) qualified health plans in the exchange?

- a. We know that the Act provides an exchange with the authority to request advance premium credits for individuals enrolled in qualified health plans in the individual market through the exchange for premium subsidies and cost-sharing reductions. § 1412(a)(1)
- b. In the procedures for determining eligibility for the exchange and premium assistance, the discussion of subsidies is not linked with enrollment in the individual market. § 1411(a)(1)
- c. We know that the definition of a “qualified individual” is someone enrolling in a qualified health plan in the *individual market* through the exchange. At this time, we are not sure why this subsection focuses on enrollment in the individual market. § 1312(f)(1)(A)
- d. We know that the individual market is specifically referred to when the premium assistance amounts are discussed under refundable tax credits. § 1401(b)(2)(A)
- e. We know that the individual market is referred to when the reference premium is discussed (second lowest cost silver plan). § 1401(b)(3)(B)
- f. We know that an employer *may* specify the level of a plan and then the employees may choose a plan within that level. § 1312(a)(2)
- g. We think regulations need to clarify how premium assistance and cost-sharing reductions for eligible, low-income individuals enrolled in small group SHOP plans can be implemented under the Act. Regulations on SHOP coverage will need to clarify considerable details about subsidies and the role of employers and employees if the Act is to allow for the administration of a three-share (employer, employee, and public premium contributions) program or employer defined contribution program for small employers. A defined contribution program that allows employees to choose any plan in the exchange has the potential to be more administratively complex than a three-share program. This is because premium assistance and cost-sharing reductions would likely be coordinated over more plans for each employer.

8. Can qualified low-income individuals receive tax credits when enrolled outside an exchange?

- a. We know that a qualified health plan cannot be offered outside of an exchange. § 1311. Directions on premiums for qualified health plans are in § 1401 and people can only receive premium tax credits when enrolled in a qualified health plan, i.e., enrolled in an exchange. Also, see

definition of "qualified individual" and "qualified employer" in § 1312(f)(1).

- b. Also, we know that the Act states that qualified individuals and qualified employers can purchase "health plans" (the term qualified health plan is not used) outside of an exchange. § 1312(d)

9. Should Washington State align its benefit requirements with the essential health services, or to say differently, will this state opt to require additional benefits in its qualified health plans?

- a. We know that the state must bear the full cost of low-income subsidies for mandated benefits that exceed the essential service coverage requirements. § 1311(d)(3)(B)
- b. We do not know if a federally administered exchange will inhibit or limit a state's ability to add benefits that exceed the essential health services. § 1321
- c. How involved might the state want to become in providing input on the development of essential health benefits in § 1302?
- d. Will the state want to align the development of qualified health plans with the Medicaid benchmark plan in § 2001?
- e. Will the Governor or Legislature elect to prohibit coverage of abortion services in qualified health plans consistent with state laws?
 - i. "Nothing in this act shall be construed to preempt or otherwise have any effect on State laws regarding the prohibition of (or requirement of) coverage, funding, or procedural requirements on abortions..." § 1303(c)(1)
 - ii. Chapter 9.02 RCW contains the state's current public policy on abortion but does not resolve the public policy issue about funding the coverage of abortion services in qualified health plans.

10. How will an exchange certify qualified health plans?

- a. We do not know if § 1311(b)(1)(B) means that all qualified health plans in the small group market must be offer through a SHOP exchange.
- b. We know that HHS will establish in regulation the criteria for the certification of qualified health plans. § 1311(c)
- c. We know that an exchange will implement the procedures for certifying a qualified health plan. § 1311(d)(4)
- d. In certifying qualified health plans in an exchange, an exchange is directed to make plans available that are in the "interest" of qualified individuals and employers. We believe regulations or the eventual governing entity of the exchange could clarify how an exchange should interpret that "interest." § 1311(e)(1)(B).

- e. We know that the exchange will take information on the justification of premium increases before implementation of the increase, “excessive or unjustified premium increases,” and “excess premium growth outside the exchange” into “consideration when determining whether to make such health plan available through the exchange.” We think this implies that the exchange can establish certification procedures that allow for excluding individual and small group plans, i.e., will not be obligated to offer all individual and small group plans in their respective markets. So, we believe exchanges can selectively certify plans but cannot negotiate or set premiums. § 1311(e)(1) and § 1311(e)(2)
- f. Will the exchange have the latitude to direct health insurance issuers to offer qualified health plans in more levels than silver and gold (as required by the Act), and if so, should Washington’s exchange have any need to require health insurance issuers to offer plans in more than those levels? § 1301(a)(1)(C)(ii)
- g. How will HHS, health insurance issuers, and the exchange operationally reduce the cost-sharing of silver plan individuals with household income that exceeds 100% but does not exceed 400% FPL? HHS can make “capitated payments” to carry out cost-sharing reductions and will those be made through the exchange, directly to the issuers? § 1402
- h. What would be the impact on an exchange’s ability to pool risk if Washington adopts the Basic Health Option to cover low-income persons between 133% and 200% of FPL? § 1331

11. Will an exchange cover and serve distinct markets and programs?

- a. We know that an exchange is directed to inform applicants of the eligibility requirements for Medicaid, CHIP, and applicable state and local programs (we presume this to include state and local programs that cover low-income individuals), and by screening an application, the exchange “enrolls” such individuals in any of those programs. This subsection does not state that individuals eligible for Medicaid/CHIP cannot enroll in a qualified health plan in an exchange. § 1311(d)(4)(F) and § 1413(a), § 1413(c).
 - i. We did not find direction in the definitions of qualified health plan (§ 1301(a)), qualified individuals or qualified employer (§ 1312(f)) that excludes the enrollment of people eligible for Medicaid/CHIP.
- b. We do know that multi-state plans and CO-OP plans will be qualified health plans offered through an exchange. § 1301(a)(2)
 - i. We know the act allows issuers to offer CO-OP plans in the individual and small group markets. We think this means that CO-OP plans can be certified and selected to be offered in an exchange. Since they are qualified health plans, we think CO-OP

plans will be rated in the same risk pool as other individual and small group plans. § 1322(a)(2)

- ii. Although we think CO-OP qualified health plans can be offered in the exchange, the subsection does not specify (as is done for multi-state qualified health plans) that tax credits can be used in CO-OP plans and we did not find any direction that these enrollees cannot be eligible for, or enrolled in, Medicaid/CHIP. § 1322
- iii. We know that each exchange will offer at least two multi-state qualified health plans for individual coverage, or in the case of small employers, group coverage. We know that multi-state qualified health plans will be deemed as certified for an exchange. § 1334(a)(1) and § 1334(d)
- iv. We know that multi-state qualified health plans “shall be treated as a separate risk pool” apart from FEHBP enrollees. Until regulations provide further clarification, we do not know if multi-state qualified health plans will be pooled in an exchange risk pool or some other risk pool representing the nation, a state, or multi-state risk pool. § 1334(e)(5)
- v. Individuals enrolled in multi-state qualified health plans can be eligible for public credits. However, we did not find any direction that these enrollees cannot be eligible for, or enrolled in, Medicaid/CHIP. § 1334(c)(3)
- c. We know that an eligible individual for the Basic Health Option has household income that exceeds 133% and does not exceed 200% of the poverty line and “is not eligible to enroll in the state’s Medicaid program under title XIX of the Social Security Act.” § 1331(e)(1)(A)

12. Does Washington State want to ensure that associations have an opportunity to facilitate the purchase of qualified health plans for individuals or small employers through an exchange?

- a. We do not know: we have not found direction in the Act on how an exchange should treat health plans that cover associations or member-governed groups. Some help might be provided by the definitions of individual and group markets in § 1304 or by regulations.
- b. This could depend heavily on how long association health plans retain their grandfathered status. E.g., if associations lose their grandfather status relatively quickly, then they might have more interest in purchasing through an exchange. § 1251.
- c. Associations are cited in § 1311(i)(2)(B) as an entity that could perform navigator services under a grant from an exchange.

13. How will the Washington State exchange interface and coordinate programs and markets?

- a. Basic Health Option is “in lieu” of coverage through an exchange, but can Basic Health be administered by the same operational structure, and if not, how will Basic Health and the Exchange coordinate? § 1331
- b. We know that eligibility of low-income subsidies can be performed by the state’s Medicaid agency. § 1413(d)(2)(A) Along with the coordination suggested in § 1311(d)(4)(F), we think this could be interpreted that a state could form a single agency for eligibility or eligibility and enrollment for low-income coverage programs.
- c. How will an exchange operationally provide information to individuals and Dept of Treasury on the amount of premium credits for tax returns? § 1311(d)(4)(G)
- d. The exchange grants certification to individuals that the individual mandate does not apply to them, i.e., they are exempt from the penalty imposed on those who are determined to be able to purchase coverage. § 1311(d)(4)(H)
- e. The exchange must report to the Treasury the name and taxpayer identification of those individuals exempt from the individual mandate and communicate whether an employer did not provide minimum essential coverage or coverage of minimum actuarial value. § 1311(d)(4)(I)
- f. Will the state need to pay the subsidies for any additional benefits that might be added to the essential health benefits?
- g. How will the exchange coordinate with the private individual and small group markets? If premiums must be the same inside and outside of the exchange and if rating and pooling regulations are also identical, will consumers see any benefit from being able to purchase health plans outside of the exchange? Does the exchange become the new market for small group and individual policies? § 1301(a)(1)(C)(iii)
- h. Free choice vouchers: the exchange will need to receive payments from applicable employers and credit those amounts against the employee’s premium in the exchange. § 10108 following § 1515
- i. Although not specified in the Act, exchanges will likely need to coordinate with other exchanges. § 1311

14. What are some of the key operational issues that remain?

- a. Undocumented individuals cannot be enrolled in an exchange and how will the exchange verify legal presence in the state and can this task be part of the income calculation/documentation process? § 1413
- b. How will the operations be self-sustaining beginning January 1, 2015? § 1311(d)(5)

- c. Who will establish and operate the “navigator” that carries out many of the education and information processes for enrollment? § 1311(i)
- d. How will the navigator coordinate with private producers? § 1311(i)
- e. How will the exchange verify that qualified health plans have only contracted with hospitals (with more than 50 beds) that meet safety and effectiveness standards as of January 1, 2015?
- f. How will the exchange operationally provide toll-free consumer assistance services and a website to provide standardized comparative information on qualified health plans? § 1311(d)(4)(B)
- g. How will the exchange provide information to employers on employees who cease coverage in a qualified health plan? § 1311(d)(4)(I)(ii)
- h. American Indian/Native Americans cannot pay cost-sharing when enrolled in a qualified health plan in an exchange. It’s possible that an exchange will need to assure that no cost-sharing is paid by American Indian/Native Americans.

Insurance Market Analysis

What do we need to know in order to answer the policy questions related to the insurance market and establishment of the exchange(s)?

1. What is the current status of our insurance market?
Individual, small group, large group, Association Health Plan, uninsured
Analyze: Market concentration, enrollees in each, average premiums, range of benefit plans, market share by carrier in each.
2. What trends are we seeing over the past 5 years, 3 years, 2 years?
3. What are the potential causes of any significant changes in status or standing?
For example, what incentives might cause employers to self-fund?
4. What are the potential impacts of our small group definition changing in advance of the 2014 date?
 - Who decides to go to the small group market instead of the individual market?
 - What market impact will that have?
5. What kinds of policies do we anticipate seeing in each of these markets between now and 2014? How will PPACA immediate insurance reforms impact that scenario? What will be the cost impact of offering qualified health plans?
6. What is the trend for AHP between now and 2014, and what will the definition of “grandfathered plan” mean to AHPs and subsequently the small group market?
7. What impact on the individual market will the Washington Health Plan make?
Will it draw out a considerable number of lower risk enrollees, leaving the individual market with more expensive folks?
8. What does the risk pool currently look like in the individual, small group and large group markets, and among the uninsured in our state? What benefit could

be gleaned if the individual and small groups were combined pools? What would the impact be in the near future, what would it be as time goes on?

Do we need to understand the status of our self insured market to make these decisions?

Relevant Dates

By January 1, 2014: Established exchange(s) in the state serving individuals and small groups.

- By March 23, 2011: Grants will be available to assist states with establishing exchanges. This grant program will end January 1, 2015.
- By July 1, 2012: HHS will determine the scope and guidelines of an initial open enrollment period for the exchange.
- By January 1, 2013: HHS will determine whether the State can/may implement the exchange.
- By July 1, 2013: HHS will issue regulations for the creation of health care choice compacts (limited purchase across state lines).
- By January 1, 2014: States must have in effect State law(s) that enable the operation of exchanges as described by HHS.
- By January 1, 2014: States must have in effect, according to Federal regulations, a reinsurance program for the individual market.
- By January 1, 2015, the exchange(s) must be self-sustaining.
- After January 1, 2016: A state may choose to enter into a health care choice compact if the state enacts a law authorizing such action.
- Beginning in 2017, states may allow large groups the ability to purchase qualified health plans through the exchange.

Attachment 3

Role of risk adjustment at HCA



The Role of Risk Adjustment

Recommendations to the Washington State
Health Care Authority

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EXECUTIVE SUMMARY

The Health Care Authority (HCA) has been performing some version of risk adjustment for over 20 years to address the issue of risk selection amongst health plans. The method currently operational was first implemented in 1998 after extensive research and has only undergone minor changes since. This paper presents a review of the methodology currently in practice.

Today, risk selection remains a concern in HCA plans and will likely continue so long as employees are offered multiple plans with different premium rates, benefit designs and cost sharing maximums. Thus, our recommendation is that the HCA continue to implement some form of risk adjustment as part of their competitive bidding procurement process. Nevertheless, risk adjustment industry practice has evolved past the HCA's model and there are opportunities for HCA to better meet its original policy goals, among which include providing a level playing field amongst all bidders.

“Our recommendation is that the HCA continue to implement some form of risk adjustment as part of their competitive bidding procurement process.”

HCA'S CURRENT ENVIRONMENT

The Health Care Authority (HCA) currently risk adjusts the payment rates paid to carriers offering health plans to Washington State employees. The need for risk adjustment arises due to the presence of risk selection. This is a common scenario in an environment where members choose between multiple benefit options. To understand this key distinction between risk selection and risk adjustment and how one leads to the other, consider the following vignette.

A Vignette

It is mid-November 2008, you are a healthy Washington State employee with no dependents, living in King County. You haven't been seriously ill in years and you don't foresee using any health care services in the upcoming year. Now it's time to choose your health plan for 2009, so you sit down and compare your options, displayed in Table 1.

Medical Plan	Monthly Contribution	Deductible	Out of Pocket Maximum	Cost Sharing
Group Health Value	\$25.00	100	\$1,500	More than average
Uniform Medical Plan	26.00	200	1,500	More than average
Group Health Classic	107.00	None	750	Less than average
Aetna Pub. Employees Plan	112.00	None	750	Less than average

Supposing that your own health assessment is reasonably accurate and that you look at choosing a health plan from a purely economic perspective, your optimal choice is clear: You will choose the plan with the lower premium and greater exposure to point-of-service

cost sharing. In this example, the Group Health plan or the Uniform Medical Plan will be chosen because they will cost you the least, with the choice between the two largely dependent on your biases regarding HMO or PPO coverage. Your decision to enroll in the Group Health Value plan or the Uniform Medical Plan as opposed to the other plans based on your anticipated future cost is known as risk selection.

Risk Selection - Observations from Industry

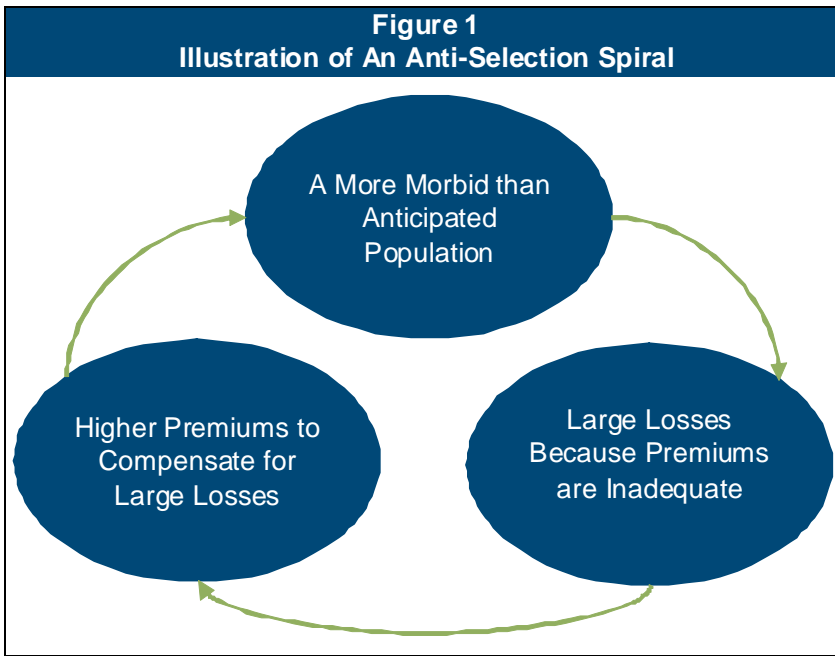
The principle underlying the hypothetical example presented above (risk selection) is a real business problem and not unique to the HCA. Not surprisingly, the correlation between a member's chosen health plan and his/her health status is observed throughout the health insurance industry. In one example from 2004, the Mayo Clinic health plan offered a new set of benefit plans to Clinic employees to better contain costs. Prior to the transition, 82% of the 20,379 clinic employees were enrolled in a plan with first dollar coverage, while the remaining 18% had a plan with copays and deductibles. Of the two new plans offered, there was one low premium plan with high out-of-pocket costs and one high premium plan with lower coinsurance and out-of-pocket-maximums. Research has shown that the health status of the employees and their dependents was a significant predictor in the choice of the employees' health plan.¹ Employees or dependents with more serious health problems were more likely to enroll in the high premium, low out-of-pocket-maximum plan. This is risk selection.

“Employees or dependents with more serious health problems were more likely to enroll in the high premium, low out-of-pocket-maximum plan. This is risk selection.”

Risk Selection vs. Risk Adjustment

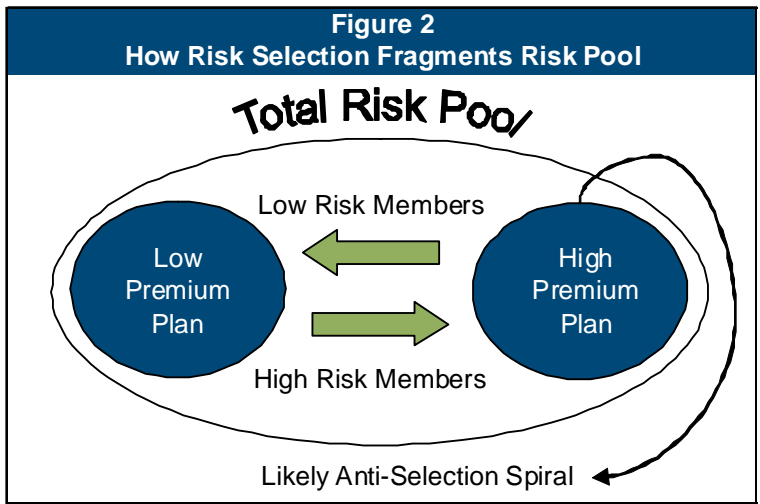
Risk selection occurs when members enroll in a health plan with a higher (or lower) chance of loss than assumed by the carrier when developing the rate. Risk selection can have either positive or negative financial consequences for an individual carrier. If a carrier enrolls members with lower costs than assumed in the rate, then the health plan will experience positive selection because medical claims will be less than expected, thus leading to a larger gain for the carrier.

But, just like any game with two players, wherever there's a winner you will also find a loser, and risk selection is no different. While some health plans will attract a healthier than average population, other plans may attract members that are more morbid than average. Plans that do can incur large losses, which can then lead to large premium increases. As was seen at the Mayo Clinic, high premium plans attract and retain a more morbid group as the healthier members switch out and the more morbid members remain. Additionally, members whose health has worsened over the year may also switch in. The final result of this risk selection yields an even more morbid population enrolled in the plan the next year, which results in bigger losses and yet higher premiums likely for the year after next. This positive feedback loop is referred to as an anti-selection spiral and is illustrated in Figure 1 on the next page.



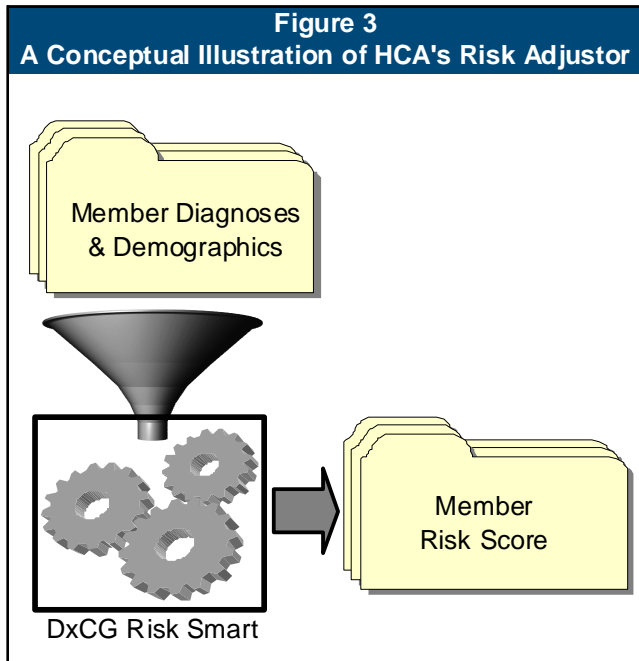
It is because an anti-selection spiral is so difficult to break that it is best to avoid the predicament altogether. This is done by managing and mitigating the impacts of risk selection. In a single carrier environment, this is easily accomplished by the pooling of risk. Pooling simply refers to the process of grouping people in such a way that the low costs of the healthier people balance out the high costs incurred by the more morbid people, such that a financially feasible cost can be charged for coverage to all members of the pool.ⁱⁱ

However, risk pooling as a method to combat risk selection begins to fall apart when multiple carriers and funding arrangements increase the likelihood that the grouping of risks changes after rating assumptions are set. This is exactly what happens to carriers in the HCA now by virtue of the fact that they must submit a bid for anticipated medical costs before they know who has enrolled in the plan. The result is a fragmentation of the risk pool – bid a high premium plan with lower out-of-pocket costs and the carrier will likely enroll members who anticipate higher than average health care costs. Bid a low premium plan and the carrier will enroll members who anticipate lower than average health care costs. It is in this manner that risk selection fragments the risk pool into sub-pools of high cost and low cost members. An anti-selection spiral then begins in the sub-pool of high cost members. This dynamic is illustrated in Figure 2, displayed on the next page.



Risk selection is a well known phenomenon to those pricing health plans and managing employee benefit programs. There are several techniques for mitigating risk selection. The simplest solution is where one carrier offers all of the available plan designs and the employee contributions for each plan are based on the actuarial value with a loading for selection. However, mechanisms exist for situations like the HCA's where multiple carriers offer the available plans, all at different premiums. The means by which one measures and adjusts for anticipated risk selection is referred to as risk adjustment. The risk adjustment mechanism can take various forms, however, one method currently very popular in the health insurance industry and the one implemented by HCA takes the form of a prospective payment rate adjustment based on risk scores from a health status regression model. Figure 3 below provides a conceptual illustration of HCA's health status risk adjustment model.

“The means by which one measures and adjusts for anticipated risk selection is referred to as risk adjustment.”



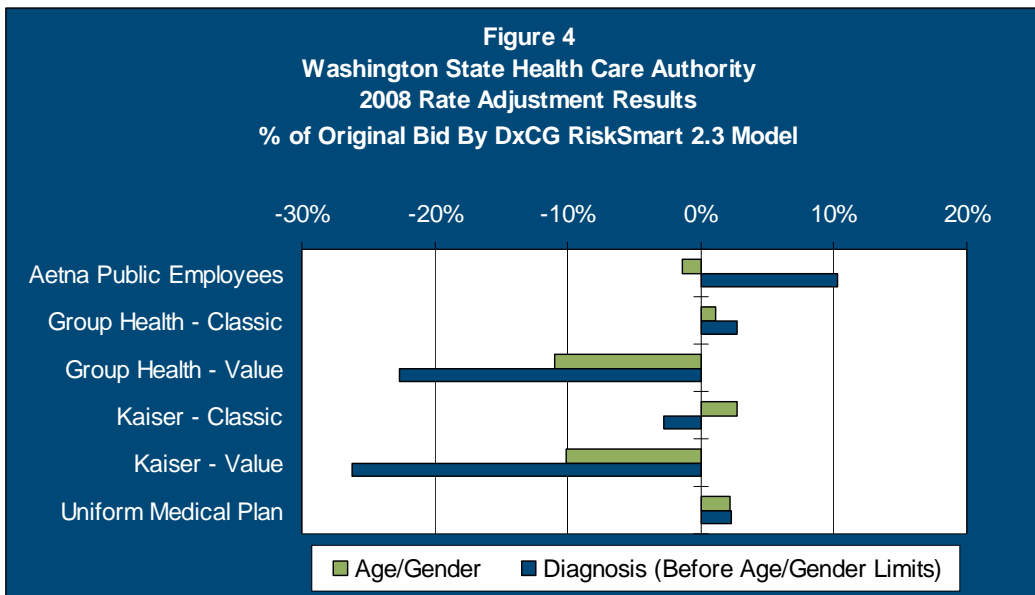
Member diagnoses and demographic information (age and gender) are input into a regression model developed by vendor DxCG (now known as Verisk HealthCare). The output of that regression model is a risk score for each member. A risk score is simply a number that represents the expected healthcare demands of that member relative to the total population average. So a member with a risk score of 1.05 is expected to require 5% more services than the population average given what is known about that member's age, gender and health status (where diagnoses are used as a proxy for health status).

The final step in HCA's current risk adjustment process is to group members' risk scores by health plan after open enrollment to calculate the differences in expected health status of each sub-population. Each carrier's original bid rates are then adjusted based on these differences so as to fairly compensate plans that enroll more morbid members and not to overpay plans that enroll healthier members.

Thus, it is by this diagnosis based regression model that the HCA adjusts payment rates to account for the risk selection amongst plans at open enrollment.

Is There Evidence of Risk Selection at HCA?

In one short word: yes. There is evidence that risk selection exists amongst plans. As was seen in the 2008 risk adjusted bid rates, both risk adjuster models indicated that the Kaiser - Value and Group Health - Value plans enroll a relatively healthier population. Figure 4 below displays results from the 2008 risk adjustment analysis. The figure displays the percentage by which original bid rates were increased (or decreased), by plan. These changes were made to bid rates in anticipation of differences in the health status of the enrolled populations.



The risk adjustment model increases a plan's bid rate when the enrolled population is estimated to be more costly than average (bars to the right of center) and decreases a plan's bid rate when the enrolled population is estimated to be less costly than average (bars to the left of center). Distances from the 0% vertical bar just to the right of center in Figure 4 correspond to differences from the HCA population average. Here, the lighter shaded green bars represent the change to premiums that would have been made based on differences in the age and gender mix of the enrolled populations alone. Based on just this age/gender metric, one observes that the Group Health - Value and Kaiser - Value plans enrolled a population that was younger than the Kaiser - Classic or Uniform Medical Plan enrolled populations. The darker shaded blue bars illustrate how much premiums would have been adjusted based on differences in age, gender and health status of the enrolled populations. Thus, because the diagnosis based adjustment is greater than the age/gender adjustment for Group Health - Value and Kaiser - Value, one can infer that these plans enrolled younger and healthier members on average than the other three plans.

This suggests that if the risk adjuster is properly calibrated and the data and execution are sound, the low premium, high deductible plans are enrolling a significantly healthier than average population – just as intuition would suggest and one would expect given the experience at the Mayo Clinic.

“The low premium, high deductible plans are enrolling a significantly healthier than average population.”

THE PATH FORWARD

The HCA has expressed that risk adjustment was originally implemented in support of the following four policy objectives:

1. Providing a level playing field via equitable reimbursement.
2. Encouraging the management of care, not the management of risk.
3. Increasing the accuracy of health plan bids.
4. Enhancing the HCA's opportunity to understand the unique health care needs of its population and use that information in designing appropriate benefit coverage.ⁱⁱⁱ

We assume these remain the HCA's guiding policy objectives as we address the following questions.

Should Risk Adjustment Be Continued?

So long as employees have a choice in health plans with markedly different premiums and cost sharing maximums, there will be risk selection. In this choice based environment, the HCA must make adjustments to health plan capitation rates in some manner to account for the almost certain differences in health status of the sub-populations. Not doing so will overpay certain carriers while underpaying others. Thus, guided by the HCA's first and second policy objective, we conclude that some form of risk adjustment must continue to be conducted.

“Guided by the HCA's first and second policy objective, we conclude that some form of risk adjustment must continue to be conducted.”

Is There A Scenario Where Risk Adjustment Isn't Necessary?

If risk selection were not a factor in the HCA's health benefits program, then no risk adjustment would be necessary. This scenario would involve no choice for the member

amongst health plans. Not only is this scenario unlikely, moving to such a benefit plan would also likely negatively impact the overall value of the HCA's health benefits program by eliminating a member's ability to enroll in a health plan that the member feels best meets his/her particular needs.

Explicit risk adjustment also wouldn't be necessary in an environment with one self-funded carrier. In this scenario, all gains or losses would accrue to the same entity and so the only consideration would be the level at which to set employee contributions. Selection amongst the plans would ideally be accounted for in the pricing, but because total profitability would remain constant, the accuracy of this adjustment affects only the optics of each plan's individual financial performance, not the total. Other large employer plans don't conduct risk adjustment for this very reason.

There is also another very unlikely scenario in which risk adjustment wouldn't be necessary. That scenario would be where the health status of the enrolled membership in each available plan on average matches the average of all the HCA's members' health statuses. Because average morbidity would be equal amongst all plans, no adjustment to the payment rates would be needed. The trouble is, without a risk adjuster, the HCA would never know if it approached such a scenario. One useful result of the risk adjuster is that each year, risk adjustment estimates how far away from this scenario actual enrollment is. As risk adjustment results approach a 1.0 adjustment factors to every carrier's bid, then the HCA will know they are approaching this most unlikely outcome.

Can Risk Adjustment Results Be Improved?

Risk adjustment results could likely be improved by implementing any and/or all of the following four changes to the HCA's risk adjustment methodology. They are:

- Use more recent diagnosis data for input into the model
- Select a model that more accurately matches the HCA's application
- Use additional data such as National Drug Codes and costs
- Increase carrier understanding and confidence in the methodology by increasing the frequency of data collection periods and increasing the level of reporting on risk scores.

First, the accuracy of the risk adjuster would likely improve if it used more recent data for inputs. One reason the magnitude of the risk adjustment results is so vulnerable to debate is because of the long lag period between the diagnoses used to develop risk scores and the period for which the risk scores apply. Currently risk scores for members in 2008 are based off diagnoses from 2006. That means there is a one-year gap in information on the health status of members. The exact magnitude of this impact is difficult to assess but could be significant, particularly for plans with low membership.

Second, the coefficients used to calculate risk scores in the DxCG model currently used by HCA were not developed with a gap between the data period and the predictive period. There are other models available that are developed accounting for this gap. Not building this gap between diagnosis collection and predicted period could overstate the importance of certain conditions, such as maternity, that have high costs in the first month but taper significantly in the following months. Ideally, the development of the risk adjuster used by HCA would more closely match its application and there are risk adjustment models that

do. Using one of these models could yield improved accuracy, as studies have shown they outperform the HCA's existing model.^{iv}

Third, additional data such as prescription drug codes used in combination with diagnoses can yield improved accuracy in risk adjustment models. Also, because pharmacy claims are typically paid faster than medical, more complete and recent data is available to fill in the gaps left by incomplete diagnosis coding and more immediate changes in health status. It may even be possible to transition to simple a Pharmacy-based risk adjuster with gains in both accuracy (due to more recent and complete data as well as neutralizing for differences in coding patterns) and simplicity of administration (due to the relative ease of submitting NDC codes as opposed to diagnoses).

Fourth, carrier understanding and acceptance of the risk adjustment methodology could be improved by increasing the frequency of data collection to a semi-annual or even quarterly basis. This would allow for the more frequent and timely calculation of member risk scores, which could then be reported back to carriers on a member level. This increased flow of data between carriers and the HCA could improve transparency of the methodology and create the opportunity for more substantial dialogue regarding specific concerns with the risk adjustment methodology. One important consideration, however, before embarking on this approach, would be to better understand the terms of the HCA's risk adjuster license. Semi-annual reporting could potentially double the licensing fees. Additional investigation would be needed to clarify these important details.

How Does Number, Size or Type of Carriers Affect Risk Adjustment?

As was discussed at length in the previous section on risk selection versus risk adjustment, the number, size or type of carrier alone isn't the impetus for risk adjustment. Risk adjustment is necessary because of the fragmenting effects of risk selection. It is interesting to note that of the approximately 20 carriers that were participating in 1993 when the HCA's health status risk adjuster was first being developed, only six plans covered approximately 80% of the entire population.^v Currently, there are now two plans with approximately 80% of the population. Nevertheless, what was true 15 years ago is still true today – risk selection causes significant differences in the relative morbidity between plans and risk adjustment is needed to address it.

Similarly, the type of carrier (self-funded versus fully-insured) has no direct impact on the underlying risk selection. Simply changing the carrier's funding arrangement doesn't impact the costs of providing medical benefits to the HCA population – it simply affects who captures the gains and who is stuck with the losses.

How Does Benefit Design Impact Risk Adjustment?

The difference in benefit designs leads to differences in plan premiums. These differences in design and premium drive risk selection. Thus, as long as the HCA offers multiple plans of different design and premiums, risk adjustment will be necessary.

If the HCA were to standardize the benefit plan offering and premiums, risk selection could be reduced. There would still remain the outstanding concern that the provider networks or other features of a particular plan would appeal to healthier enrollees on average than other plans.

If, on the other hand, the HCA were to go the route chosen increasingly by employers and offer employees yet another plan option that involved a low monthly premium and a high annual deductible, then the need for risk adjustment would very likely increase. This type of plan goes by several names: High Deductible, Catastrophic, Consumer Driven, Consumer Directed or Consumer Defined (CDHP). By any name, this type of health plan has been shown to attract young, healthy people, which causes additional risk selection.^{vi} For example, beginning in July 1, 2000, Humana offered the option to enroll in a CDHP to approximately 10,000 people (employees and dependents) enrolled as members of Humana's employee health benefit program. Research has shown that offering the CDHP plan alongside more traditional options caused risk segmentation within the employer group.^{vii} Those who enrolled in the CDHP plan were found to be less likely to have a chronic health problem and more likely to have no recent medical visits.^{viii} If the HCA were to implement a similar program in the coming years, risk adjustment would become even more critical in achieving the HCA's policy objectives.

Does Risk Adjustment Negatively Impact Performance Purchasing?

Risk adjustment does not alleviate a carrier from the responsibility of operating a cost-effective, high quality plan. In fact, risk adjustment successfully reorients incentives so that carriers are held to a higher standard. Without health status risk adjustment, payment rates would likely be the same within a given age/gender category. In this case, there is incentive for carriers to compete on the basis of risk selection – enroll the healthier than average members within a category yet receive a more than adequate payment rate. With health status risk adjustment, plans that enroll members with lower than average risk will be paid less and thus will have to manage costs on a margin that is equivalent to plans that enroll high risk members. Taken to the extreme, risk adjustment can result in cases where carriers would design plans to court members with certain high cost diseases. Carriers do this because the payment rate reflects the unique costs of the population and thus enrolling and managing these members is financially feasible.

OTHER IMPORTANT CONSIDERATIONS

Are Risk Adjustment Results Valid?

The HCA uses an ICD-9 diagnosis based DxCG model to measure relative risk between each plan's enrolled population. The most recent and comprehensive study of commercially available risk adjusters, published by the Society of Actuaries in April 2007, indicates that the "off the shelf" diagnosis based DxCG model had the highest predictive power of the diagnosis based risk adjusters tested.^{ix} A few other models performed slightly better but they included additional inputs and/or customization. Thus, while the accuracy of the output will always depend upon the quality of the input, HCA's risk adjuster model is well regarded as one of the best off the shelf diagnosis based risk adjusters currently available. This, in combination with all the other evidence on risk selection, is strong reason to believe that the differences in health status are real.

How Good Is the Data Submitted For Risk Adjustment?

One point that cannot be stressed enough is that the output of the DxCG model is inextricably tied to the quality of the diagnosis data submitted by each plan. One of

several potential concerns in data quality relates to the treatment of diagnostic claims. Currently, the DxCG model excludes diagnoses that are associated with diagnostic type procedures. Put simply, this means that the model excludes claims associated with imaging to assess if a person has a tumor, but would include a cancer diagnosis if one were in fact found. The HCA relies on each carrier individually to identify these claims and flag or exclude them appropriately. If carriers inconsistently identify these diagnostic claims, then the relative risk scores would be biased. It is difficult to assess the magnitude of this impact precisely because it is relatively unknown how accurate carriers are at identifying these claims. Improvements could be made in the future by providing more specific guidance from the HCA on exactly how carriers should identify these claims.

Risk score output is also subject to differences in diagnosis coding between different carriers. To the extent that some providers code diagnoses more thoroughly than others, relative risk score could be impacted. This contingency was anticipated by those who originally implemented the current risk adjustment model at the HCA and the results from the DxCG model in use at the time were believed to be less susceptible to these variations.

Is There Sufficient Breadth to the Risk Adjuster?

Some carriers might argue that the risk adjuster understates their population's illness burden. Implicit in such a claim is the assumption that the average illness burden between plans is different – the very scenario that health status risk adjustment was originally developed to address.

What is known for certain is that of the methods available to quantify and adjust for differences in illness burden currently available, the diagnosis based DxCG model is widely regarded as one of the best. That is not to say that improvements cannot, nor should not, be made. There are other models that warrant additional investigation to see if they might more precisely capture the variability in the HCA's members' risk.

How Do Employee Contributions Fit In With Risk Adjustment?

As has been discussed at length, risk adjustment is typically implemented to mitigate risk selection. In cases where the employer pays the entire cost of coverage, plans with different benefit designs would have different premiums and risk selection is a concern. In cases where the employer shares the cost of coverage with employees, the difference in premiums between plans can further exacerbate or mitigate risk selection depending on how the employer chooses to set the employee contribution.

At the HCA, employer contributions are set at 12% of the index rate, which is a weighted average of each carrier's normalized bid rate. The employee contribution for each individual plan is then simply the difference between the plan's normalized bid rate and the standard employer contribution for all plans. To determine their "normalized" bid rate, carriers are instructed to use the prior year's risk adjustment result to modify their rate to reflect an average population. Thus, because employee contributions are a function of the index rate and the index rate is a function of the normalized bid rate and the normalized bid rate is a function of the risk adjustment result from the prior year, risk adjustment and employee contributions are inextricably tied together. A change in either one impacts the change in the other the following year. Because the higher cost plans have higher risk

“In cases where the employer shares the cost of coverage with employees, the difference in premiums between plans can further exacerbate or mitigate risk selection depending on how the employer chooses to set the employee contribution.”

scores, the risk adjustment process reduces member premium differentials and helps to mitigate adverse selection.

Could An Error in Risk Adjustment Compound Over Time?

Suppose for a moment that for whatever reason (poor quality data, inadequate risk model, etc.), the risk adjustment result for a particular plan in year “zero” was significantly understated. When that carrier develops a normalized bid for the following year, if they do as currently instructed and divide their rates by the year “zero” risk adjustment result, their resulting “normalized bid rate” will be a rate that isn’t actually based on the average population. Because the denominator was too close to 1.0, the normalized bid would be too high.

This situation is analogous to a 100-meter dash where a different tape measure is used to determine the starting line for each runner. If the tape measure works as it should, each runner starts at the same point – 100 meters from the finish. But, if the tape measure for one runner is biased long, then that runner will actually start the race 5 meters behind their competitors, a significant disadvantage.

Thus, if your normalized bid is biased high because of a poor year zero risk adjustment result, your plan could have a higher than otherwise employee contribution because employee contribution is a function of the relationship of your bid to the index rate. Bids that are higher than the index will have higher employee contributions. Because risk selection is driven by differences in employee premiums, higher premiums intensify the impact of risk selection against your plan. Ideally, the risk adjuster will account for this in year one so that when you develop rates for year two you can move back up the 5 meters to the same starting line as all of your competitors.

The real danger is if the error in the risk adjuster is systemic. Put simply, if in year two, instead of moving up 5 meters to the start, you are pushed back another 5, now you compete in a 110-meter dash while everyone else runs 100 meters.

It is important to note, however, that this same bias could work in a plan’s favor as well – those who get a 10 meter head start. This takes the form of a risk adjuster that doesn’t adjust premiums down enough. In year zero, the plan enjoys even more favorable than expected loss ratios and when they go to develop a rate for year one, their normalized bid will be biased down. This results in a lower employee premium because their normalized bid is likely less than the index rate and thus a higher employer contribution relative to normalized bid. Lower employee premiums attract healthier enrollees and if the bias in the risk adjuster is systemic, this could result in yet even more favorable results for the following year.

The examples above should be interpreted as basic generalizations of the competitive bidding dynamic to elucidate key relationships. They are not suppositions as to how the HCA’s bidding currently performs. While the precise outcome of the HCA’s competitive bidding is obviously tied to many variables not explicitly accounted for in the examples above, they should make clear that there are three critical controls to successfully orchestrating the HCA’s current risk adjustment process over the long term. The three critical controls are:

1. Implementing the most precise risk adjuster feasible given administrative constraints. Like any model, risk adjusters will never be perfect, but they are

developing rapidly. Moreover, there have been significant improvements made to these models in recent years. While with risk adjusters, more data almost always results in better precision, the HCA must balance precision of the risk adjuster with the administrative burden of collecting and processing the data to run it.

2. Recognizing that risk selection, risk adjustment and employee contributions are inextricably connected in the HCA's current process. Certain collective bargaining agreements or policy objectives may limit the HCA's available options with regard to setting employee contributions. Nevertheless, if the current competitive bidding process is to be viable long term, it is critical to recognize that a change in any one of these three spaces will reverberate into the other two.
3. Understanding the importance of accurate and timely information to the bidders. Currently, bidding carriers are using dated information to develop future rates. While some lag in data is inevitable, it is critical for bidders to thoroughly understand the population they have enrolled in prior periods and to have access to reasonably current and detailed data with which to estimate and anticipate important future changes in next year's enrollees.

HISTORY OF RISK ADJUSTMENT AT HCA

The following history of risk adjustment at the HCA lends important context to how the HCA arrived at its current policy.

Genesis

Risk adjustment as a carrier payment policy at the Washington State Health Care Authority was born over 20 years ago. Beginning in 1988, the Washington State Health Care Authority risk adjusted payment rates made to carriers based on the demographics of their enrolled population.^x This method was used for several years; however, in the early to mid 90s as employees continued their migration to managed care plans, evidence emerged that this model was broken. Critics claimed that carriers were gaming the payment system by competing based on risk selection – trying to enroll the healthiest members, instead of based on risk management – how well they could manage the medical costs of the members who enrolled.^{xi}

To better understand the criticism, consider the following example. Suppose you're a purchaser with a population that consisted of only two women aged 35, one of whom is diabetic and the other has no known illness or disease. Under a demographic-based payment policy, the payments to carriers will be the same for both women while common sense indicates that they have very different expected costs. But because the payment rate to a carrier would be set to the average expected cost for the two women, carriers have significant incentive to try to enroll the healthy woman and not the diabetic. There is no reward for enrolling the diabetic, just a penalty – an inadequate payment rate – no matter how well the carrier may be able to manage diabetes.

Health Status Risk Adjustment

Demographic-based payment rates were common industry practice in the early 90s and the problem of risk selection was not unique to the HCA. Indeed, throughout the mid 90s,

many purchasers including Medicare and state Medicaid programs recognized that competition amongst carriers had devolved into what was essentially the health insurance equivalent of the children's card game Old Maid. In response, these organizations engaged University scholars to conduct significant research into new health-status payment methodologies that would neutralize the effect of risk selection and reward carriers for efficient risk management.

Simultaneously, the HCA embarked on its own project in 1993. Funded largely by the Robert Wood Johnson Foundation program Changes in Health Care Financing Organization (HCFO), key stakeholders including representatives from the HCA and the University of Washington School of Public Health worked to develop a diagnosis based risk adjustment payment system. These two groups worked in collaboration with an advisory board that included members from Group Health Cooperative, Kaiser Foundation Health Plan and multiple actuarial consulting firms. The team published 32 issue papers,^{xii} two peer-reviewed journal articles,^{xiii,xiv} presented at various conferences and even hosted a conference attended by representatives from 14 states and the District of Columbia.^{xv}

In 1997, after four years of research and over \$1.6 million in grants, the team reached consensus and the HCA began transitioning to a diagnosis based risk adjusted payment system for enrollment beginning January 1, 1998. During the development of the methodology, 20 plans originally agreed to submit data in support of the new payment policy and 17 actually did. Later, 20 plans bid on contracts for the 1998 contract year and 17 plans were awarded contracts. To help carriers transition to the new system, initial payment rates were agreed to be based on a blend of the new and old methods. Increasing weight on the new diagnosis based method was to be phased in over three years so that by the 2000 contract year payments would be fully based on the new diagnosis based risk adjusted payment system.

Today

The risk adjusted payment system in effect at the HCA currently begins with health plan procurement in the spring/summer. For the 2008 calendar year, carriers bid rates in the spring/summer of 2007 for their proposed health plan that are "normalized" to costs assuming they were to enroll a population equivalent to the overall HCA average.

Using the normalized bid rates from each of the carriers, a weighted average "index" rate is then calculated. The HCA employer contribution is then set at 88% of this "index" rate. The difference between the total cost and the employer contribution then determines the employee cost sharing by plan. For example, if there were two plans with normalized rate of \$300 and \$320 per employee per month and the weighted average index was \$315, then the HCA employer contribution would be set at \$277.20 ($\$315 \times 88\%$). The employee cost for each plan would then be \$22.80 ($300 - 277.20$) and \$42.80 ($320 - 277.20$), respectively.

To determine the risk adjusted bid rate, diagnoses from calendar year 2006 are fed into a diagnosis based explanatory model developed by DxCG. Interestingly, a previous version of this same model was used back in 1997 as the HCA transitioned to a diagnosis based payment methodology. There are two key outputs from the current risk adjustment model:

- 1) Member's risk score based just on their age and gender (the age/gender model) and

- 2) Member's risk score based on their diagnoses from 2006, age and gender (the diagnosis model)

Two sets of risk relativities are then calculated for each plan based on their enrollment as of February 2008; age/gender and health status. Using the age/gender relativities, risk corridors are calculated that limit the maximum impact of the health status adjustment to each carrier's rate. A floor for the final rate adjustment is set at -15% of the outcome from the age/gender model. Similarly, a ceiling is set at +15%. For example, if the results from the age/gender model resulted in a rate decrease of 5% and the results from the diagnosis model resulted in a decrease of 25%, the final rate adjustment would be capped at a decrease of 20% (the 5% age/gender decrease minus the 15% risk adjustment corridor). Thus, while the HCA originally intended to transition to a full health status based payment methodology, a blend of the demographic and health status methods is still in effect.

Risk scores from each of these two models are used to calculate the implied adjustment to each carrier's bid rate. This adjustment to the carrier's initial "normalized" bid (either up or down) becomes the final 2008 payment rate to the carrier for that plan. The HCA's employer contribution is determined as the risk adjusted bid minus the employee contribution (calculated previously from the index rate, as described above).

Finally, once bid rates are risk adjusted in the spring of 2008, a settlement takes place between an interim payment rate that had been made since the beginning of 2008 and the final rate as calculated approximately four months later.

Similarities to Other Purchasers

The HCA's current competitive bidding procurement program, where final payment rates to the plan are risk adjusted, is strikingly similar to how The Centers for Medicare and Medicaid administers its Medicare Advantage program. Both organizations require plans to submit competitive bids and both organizations base payments to health plans on diagnosis based risk adjustment models. One difference, however, between the two plans lies in the actual rate paid to the plan per person enrolled. For the HCA, every enrolled member generates the same payment to the carrier, whereas Medicare pays carriers a rate that is specific to that member's risk score.

Other Users of Risk Adjustment

Various methods of risk adjustment have been in use within the health insurance industry since the 1960s. Health status based risk adjusters were first developed in the mid-90s with the HCA playing a role in developing one of the first health status based risk adjusters. Notable contemporary users of risk adjusters include Medicare, state Medicaid agencies, large employer purchasing coalitions, insurance companies and even Canadian and European governmental entities. Medicare and some Medicaid state agencies are two examples where risk adjusters have been implemented successfully as a corrective tool to reorient the incentive structure of the health care market.

“Medicare and some Medicaid state agencies have successfully used risk adjusters as a corrective tool to reorient the incentive structure of the health care market.”

CONCLUSION

The HCA currently operates a unique and innovative program to procure health benefits on behalf of Washington State employees. While this program offers exciting opportunities to promote and capture additional value from health plans, the current process could likely be improved.

Specifically, the method of calculating risk scores should be reexamined with an eye towards balancing accuracy of prediction with the complexity of administration. One potential approach would be to move to a Pharmacy-only based risk adjuster because of the relatively quick payment of these claims and ease in summarization. However, additional investigation would be needed to assess the impact of this change.

Additionally, participating carriers and the HCA's members would likely benefit from improved transparency of the risk adjustment method. One way to lift the existing veil could take the form of additional detailed risk score reporting back to the carriers on their enrolled population. Also, publishing information on average risk scores by county may help carriers improve the accuracy of their bids and potentially draw bids from new carriers.

Finally, the current process weds risk selection, risk adjustment and the employee contribution so obtusely that the marriage of the three itself creates yet another level of financial risk and uncertainty. The resultant risk transcends the HCA's original policy objective of providing a level playing field. Thus, it would likely benefit all parties involved to rethink a more comprehensible and less uncertain approach to setting employee contributions.

CAVEATS AND LIMITATIONS

This report on risk adjustment was prepared for the internal use of the Washington State Health Care Authority (HCA). It is our understanding that the report is for the sole use of the HCA staff and is only to be relied upon by HCA.

No portion of this document may be provided to any other party without Milliman, Inc.'s prior written consent. In the event such consent is provided, the report must be provided in its entirety.

This document is subject to the terms and conditions of the Consulting Services agreement between the HCA and Milliman, Inc.

ENDNOTES

- ⁱ Naessens JM, Khan M, Shah ND, Wagie A, Pautz RA, Campbell CR. "Effect of premium, copayments, and health status on the choice of health plans." *Medical Care*, October 2008; 46(10):1033-40.
- ⁱⁱ Bender, K., Bachman, R., et al., "Wading Through Medical Insurance Pools: A Primer" Issue Brief, American Academy of Actuaries. September, 2006.
http://www.actuary.org/pdf/health/pools_sep06.pdf
- ⁱⁱⁱ Wilson VM, Smith CA, Hamilton JM, Madden CW, Skillman SM, Mackay B, Matthisen JS and Frazzini DA. "Case Study: The Washington State Health Care Authority." *Inquiry*, 35(2): 178–192, 1998.
- ^{iv} Winkelman, R., Mehmund, S., "A Comparative Analysis of Claims-Based Tools for Health Risk Assessment" Society of Actuaries. April, 2007.
- ^v Wilson VM, Smith CA, Hamilton JM, Madden CW, Skillman SM, Mackay B, Matthisen JS and Frazzini DA. "Case Study: The Washington State Health Care Authority." *Inquiry*, 35(2): 178–192, 1998.
- ^{vi} Burke, J., Pipich, R., "Consumer Driven Impact Study." Milliman Research Report, April 2008.
<http://www.milliman.com/expertise/healthcare/publications/rr/pdfs/consumer-driven-impact-studyRR-04-01-08.pdf>
- ^{vii} Laura A. Tollen, Murray N. Ross, and Stephen Poor, "Evidence about Utilization and Expenditures. Risk Segmentation Related to the Offering of a Consumer-Directed Health Plan: A Case Study of Humana Inc." *HSR: Health Services Research* 39:4, Part II (August 2004)
- ^{viii} Jinnat Briggs Fowles, Elizabeth A. Kind, Barbara L. Braun, and John Bertko, "Early Experience with Employee Choice of Consumer-Directed Health Plans and Satisfaction with Enrollment" *HSR: Health Services Research* 39:4, Part II (August 2004)
- ^{ix} Winkelman, R., Mehmund, S., "A Comparative Analysis of Claims-Based Tools for Health Risk Assessment" Society of Actuaries. April, 2007.
- ^x Robert Wood Johnson Foundation Grant Reports. Grant IDs #023111 and #023352.
<http://www.rwjf.org/reports/grr/023352.htm>
- ^{xi} Gruenberg, L., Kaganova, E., "Improving the AAPCC with health-status measures from the MCBS." *Health Care Financing Review*, Spring 1996, pp. 59-76.
- ^{xii} *Medical Risk Distribution Among Competing Health Plans: Options for Modeling Risk Assessment*. Seattle: University of Washington, 1995.
- ^{xiii} Wilson VM, Smith CA, Hamilton JM, Madden CW, Skillman SM, Mackay B, Matthisen JS and Frazzini DA. "Case Study: The Washington State Health Care Authority." *Inquiry*, 35(2): 178–192, 1998.
- ^{xiv} Blough DK, Madden CW and Hornbrook MC. "Modeling Risk Using Generalized Linear Models." *Journal of Health Economics*, 18(2): 153–171, 1999.
- ^{xv} "Risk Adjustment for Capitation Payment: Lessons for Purchasers," November 20–21, 1997, Seattle. Attended by nearly 100 public and private purchasers from 14 states and the District of Columbia. Four presentations and three panels:
- Presentations
- Gary Christenson, Washington Health Care Authority, "Why We did It: Washington Health Care Authority's Purchasing Vision."
- Ann Robinson, Buyers Health Care Action Group, Minnesota, "Purchasing Technologies for the Evolving Health Care Market."
- James Lubitz, Division of Health Systems Research, Health Care Financing Administration, "Medicare Moves toward Risk Adjustment."

Richard Dixon, National IPA Coalition, "A longer Term Look at Risk Adjustment — Will it Change Managed Care?"

Panels

"Risk Adjusted Capitation for Washington State Employees." Vicki Wilson, Health Care Authority; Cindy Madden, University of Washington; and James Matthiesen, William M. Mercer, Inc.

"Washington Stakeholders' Perspectives on Risk Adjustment." James Matthiesen, William M. Mercer (facilitator).

"State Updates: California, Colorado, Oregon, Illinois, Kentucky, New York, Massachusetts, Missouri, and Washington." Tom Bedell, Washington Medical Assistance Administration; Sandra Hunt, Coopers and Lybrand; and Laura Tollen, Colorado Risk Adjustment Project."

Attachment 4

HIP plan designation process

**Washington State Health Care Authority
Health Insurance Partnership (HIP) Health Plan Designation Process
October, 2010**

HIP – Background

HIP was created by the Washington State Legislature in 2007 for the following purpose:

[T]o remove economic barriers to health insurance coverage for low-wage employees of small employers by building on the private sector health benefit plan system and encouraging employer and employee participation in employer-sponsored health benefit plan coverage.

RCW 70.47A.010. HIP provides small employers in Washington State access to the same health insurance coverage available in the small group health insurance market, but at a lower employer contribution rate. To help employees pay for their share of the coverage, HIP also offers a premium subsidy to eligible low-income employees. The subsidy is based on family income and is anywhere from 60 to 90% of the employee contribution.

HIP offers quality health benefit plans selected from those already available in the small group market. Participating employers can choose from a variety of plans from different health insurance carriers that range from low-cost, high-deductible plans to comprehensive coverage. Employers select a plan and all participating employees enroll in the same plan. Both the employers and employees must agree to the terms of the selected health insurance plan as provided by the carrier.

HIP Board – Plan Designation Mandate

RCW 70.47A.110(1)(b) sets forth the mandate for the HIP Board regarding plan designation and states that the HIP Board shall:

Designate health benefit plans that are currently offered in the small group market that will be offered to participating small employers through the health insurance partnership and those plans that will qualify for premium subsidy payments. Up to five health benefit plans shall be chosen, with multiple deductible and point-of-service cost-sharing options. The health benefit plans shall range from catastrophic to comprehensive coverage, and one health benefit plan shall be a high deductible health plan accompanied by a health savings account. Every effort shall be made to include health benefit plans that include components to maximize the quality of care provided and result in improved health outcomes, such as preventive care, wellness incentives, chronic care management services, and provider network development and payment policies related to quality of care.

In addition, RCW 70.47A.110(1)(c) states that the HIP Board shall:

Approve a mid-range benefit plan from those selected to be used as a benchmark plan for calculating premium subsidies.

The Process - How Health Insurance Plans Are Evaluated for Designation

The program's goal was to establish a very collaborative and transparent process for designating health plans. HIP staff coordinated with carriers, brokers and the Technical Advisory Committee (TAC) during each step of the process and presented updates to the Board on a regular basis, with Board discussion following. HIP staff also had to balance making the process transparent while protecting confidential information about the health plans. Guarding competitive, confidential information about health plans was important to maintain the trust of participant carriers.

To begin the discussion, each participating carrier independently presented an initial set of recommendations to the Board during an open public meeting. Carriers were asked to provide information about the plan designs, and any additional value-added features. The Board asked questions of the carriers concerning their presence in Washington's small group market, demographics of their small group pool, and the attractiveness of the plans to small employers. The Board then began a discussion of whether the presented plans were appropriate for HIP's target population, and if they were appropriate to be eligible for subsidies.

These plans then became the starting point for plan designation. HIP's contracted actuarial firm, Milliman, calculated actuarial values for each plan, measuring the relative cost-sharing against an independent benchmark. For 2010, we are using Washington State's self-funded medical plan as the "benchmark" or 1.0 value plan (e.g. a plan with an actuarial value greater than 1.0 would have less cost sharing by the enrollees than under the state's self funded plan). The plans were then ordered into a grid, ranging from the categories of comprehensive to catastrophic, based on the actuarial value of each plan.

The second step in the process was for each carrier to provide plans from its line of products that were comparable to the grid of independent recommendations from the other carriers. The goal was to establish groups or "tiers" of plans in each category (comprehensive to catastrophic). With the variety of plans under consideration the carriers' primary concern was to minimize the amount of variation in the actuarial value within each designated plan category.

Throughout the process, the plan grid was distributed to the entire TAC and interested brokers with a request for comments and feedback concerning the popularity of the selected plans in the current small group market, and the ability of the plans to attract small employers who were currently not offering insurance. The considerations of the group covered premium levels, quality of plans, and the long-term stability.

Third, HIP staff selected a recommended 'benchmark' plan after more discussions with the TAC, brokers and carriers. The Board selected 'benchmark' plan is used to calculate the subsidy of the low-income employee's premium contribution, and is statutorily mandated to be the maximum subsidy payment an individual can receive. The central challenge in choosing a benchmark was to balance affordability with relative richness of the benefit plans. The goal was to have one benchmark plan for each participating carrier and that the actuarial value of the carrier benchmark plans have very minimal variation within the tier level.

Fourth, each Board member was individually briefed on the plans for consideration and provided additional proprietary and confidential information regarding the premium rates each carrier would charge for two hypothetical small employer groups enrolled in each of the plans. This discussion

provided the opportunity for each Board member to consider the relative premium cost and member cost sharing. It also provided an opportunity to explain the process used in the formulation of the recommendations and demonstrate the involvement of all the constituents.

Once that process was complete, HIP staff compiled the information in collaboration with the TAC, carriers and brokers and presented the Board with a recommended set of plans, corresponding tier levels, and the suggested benchmark plans. This information was briefly presented to the Board in an open, public meeting followed by an in-depth Board review and discussion by the HIP Board in Executive Session (closed to public). The Board also received a final briefing in the Executive Session from the carrier representatives. In Executive Session, Board members were able to ask specific questions about each carrier's plans, and the carrier representatives were able to provide detailed responses about their product line without revealing information to their competitors. This was the final discussion the Board had prior to convening back to the public meeting and approving the plans that were offered through HIP.