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Bulletin on the Risk Adjustment Program: Proposed Operations by the Department of Health and Human Services

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Background

The Affordable Care Act established a number of programs to stabilize premiums in the individual insurance market and minimize the effects of adverse selection that may occur in the initial years of operation of Affordable Insurance Exchanges (Exchanges) as coverage is expanded and market-wide insurance reforms are implemented. These programs include transitional reinsurance, temporary risk corridors programs, and a permanent risk adjustment program. This bulletin sets forth and seeks comment on HHS's broad-based intended approach to implement risk adjustment when the Department of Health and Human Services (HHS) is operating the risk adjustment function on behalf of a State. This bulletin is not comprehensive and does not include specific risk adjustment parameters that will be proposed in the draft annual notice of benefit and payment parameters. Comments received on this bulletin will inform future guidance.

Purpose and Scope

Section 1343 of the Affordable Care Act directs States, or HHS on behalf of a State, to operate a risk adjustment program that includes all non-grandfathered plans in the individual and small group market both inside and outside of the Exchange market. The primary goal of the risk adjustment program is to spread the financial risk borne by issuers more evenly in order to stabilize premiums and provide issuers the ability to offer a variety of plans to meet the needs of a diverse population. More specifically, the risk adjustment program is intended to reduce or eliminate premium differences between plans based solely on expectations of favorable or unfavorable risk selection, or choices by higher risk enrollees in the individual and small group market. The risk adjustment program also serves to level the playing field inside and outside of the Exchange, reducing the potential for excessive premium growth or instability in markets inside or outside the Exchange.

The Affordable Care Act directs the Secretary, in consultation with the States, to establish criteria and methods to be used in determining the actuarial risk for plans within a State. Under the risk adjustment program, payments will be transferred from issuers with relatively lower-risk populations to issuers with relatively higher-risk populations. Because the risk adjustment program will need to balance payments within a State and within a market, HHS will not remit payments to issuers until after receipt of charges owed by issuers in a given State. Policy parameters governing risk adjustment programs for States and health insurance issuers are available for review in the recently published final rule, the Standards Related to Reinsurance, Risk Corridors and Risk Adjustment Final Rule (45 CFR Part 153), published at http://www.gpo.gov/fdsys/pkg/FR-2012-03-23/pdf/2012-6594.pdf on March 23, 2012.This rule is herein referred to as the Premium Stabilization final rule.

The Affordable Care Act allows HHS to operate risk adjustment on behalf of a State where the State does not operate the program. Under the final rule, a State electing to establish an Exchange is eligible to establish a risk adjustment program. Given the flexibility afforded to States in the final rule, it might be helpful to States, issuers, consumers, and other stakeholders to understand how HHS might operate risk adjustment when HHS operates it on behalf of a State. The purpose of this bulletin is to provide an initial

view into how the Federal government will implement risk adjustment when operating the risk adjustment function on behalf of a State.

In keeping with our commitment to a transparent policy-making process and to providing information as soon as possible, we are outlining our initial thinking around the policy and operational choices that must be made in implementing risk adjustment. We acknowledge the importance of consulting with various stakeholders and providing technical assistance to States and issuers to ensure that risk adjustment is appropriately and efficiently implemented. We also recognize that regular consultation with and assistance to States and health insurance issuers are important to a smooth risk adjustment implementation process. We are planning a number of venues for consultation, including the opportunity for written comment and a public meeting outlining our proposed methodological and operational approach.

In this bulletin, we outline our operational approach to implementing risk adjustment when HHS implements the program on behalf of a non-electing State. More detailed information on the risk adjustment methodology that HHS will adopt will be published in the first draft HHS Notice of Benefit and Payment Parameters in the fall of 2012. The final notice is slated to be published in January 2013.

The bulletin contains the following sections:

- Section I: Risk Adjustment Methodology.
- Section II: Operating Risk Adjustment.
- Section III: Data Collection Approach and General Data Requirements.
- Section IV: Assessing Existing State Data Resources and Market Characteristics.
- Section V: Timeline and Stakeholder Communication.

Section I: Risk Adjustment Methodology

The Premium Stabilization final rule defines five parts of a risk adjustment methodology

1. The risk adjustment model.
2. The calculation of plan average actuarial risk.
3. The calculation of payments and charges.
4. The data collection approach.
5. The schedule for implementation.

The risk adjustment model calculates individual risk scores. These individual risk scores are used to develop the plan average actuarial risk, which in turn is used for the calculation of payments and charges for risk adjustment covered plans.

HHS recognizes the importance of selecting a robust risk adjustment methodology to address the concerns of risk selection and to maintain stability in the individual and small group markets in 2014 and beyond. We also recognize the importance of providing as much information as soon as possible about

the risk adjustment methodology to develop the associated policies using a transparent process. As such, we have proposed and finalized a rule that provides broad policy parameters for the risk adjustment methodology. In addition, on September 12, 2011, HHS released a White Paper titled, "Risk Adjustment Implementation Issues" (http://cciio.cms.gov/resources/files/riskadjustment_whitepaper_web.pdf) that outlined a number of methodological decisions that need to be made in developing the Federal risk adjustment methodology. We sought and received comments on these methodological choices. These comments have been useful in informing model development and the approach to data collection.

In particular, the White Paper outlined a number of issues including how to account for other elements of the Affordable Care Act in the risk adjustment methodology including the insurance market reforms to rating and the use of metal levels for differentiating plans. We have been considering all comments received as we develop the risk adjustment methodology.

Section II: Operating Risk Adjustment

A. Determining who operates risk adjustment

The Premium Stabilization final rule allows States that are approved to operate an Exchange the option to operate risk adjustment. If a State is not approved to operate an Exchange, it may not operate a risk adjustment program and HHS will do so on its behalf. While the final rule does not specify a date by which a State that has received certification as an Exchange must notify HHS of its intention to implement risk adjustment, we encourage States to communicate their intentions to HHS as soon as possible.

HHS intends to make its Federal risk adjustment methodology available for use by States, in its entirety or to help a State develop its own methodology. Only States approved to operate an Exchange and that choose to operate their own risk adjustment program can elect an alternate methodology. The final rule specifies that States operating risk adjustment in 2014 and wishing to submit an alternate risk adjustment methodology for HHS approval must do so within 30 days after issuance of the draft HHS Notice of Benefit and Payment Parameters which is slated to be released in fall 2012. HHS will be providing more detail about the process and criteria for HHS approval of State alternate methodologies in the draft HHS Payment Notice.

B. Payment and Charge Transfer Timing and Process

Under the risk adjustment program, payments will be transferred from issuers with relatively lower-risk populations to issuers with relatively higher-risk populations. Where HHS is running the risk adjustment program on behalf of a State, HHS will develop a payment transfer methodology that will compensate issuers for liability incurred due to the health status of their enrollee populations. The payment methodology will be based on a plan's average risk score across all enrollees. The Risk Adjustment Methodology White Paper discussed many of the factors that must be taken into account in the payment methodology. Plan level differences in factors such as metal level or actuarial value, permissible rating variation, and induced demand have an impact on plan liability. These factors can be

controlled for in the methodology so that payment transfers compensate for liability differences due to health status. Additionally, the payment methodology needs to be balanced: the payments to plans with higher risk selection must equal the charges to plans with favorable selection. This condition has significant implications for the equation that is used for calculating payments. The White Paper discussed several options for achieving neutral transfers. HHS will specify the payment methodology including all the applicable calculations and adjustments in the draft HHS Notice of Benefit and Payment Parameters, which will be open for public comment before finalization.

To ensure proper balancing between payments and charges, all of the payments made to issuers must be completely funded through the charges assessed to other issuers within the same market in the same State. Consequently charges will be invoiced prior to processing issuer payments. The final rule stipulates that the calculation must be complete and issuers invoiced no later than June 30 of the year following the risk adjustment year (June 30, 2015 for plan year 2014). Once the calculations of payments and charges are complete, the next step in the process is to notify the issuer of the results, including the amount owed by the issuer or payable by HHS and the details of the underlying basis of all risk adjustment calculations. Following the notification of results, HHS will send an invoice to issuers that owe charges within any State. An issuer must remit net charges payable to HHS on behalf of the State, within 30 days of notification. To ensure equity within any State's risk adjustment program, HHS will treat each State's risk adjustment charges and payments as separate accounts. HHS will not offset charges for an issuer for one State based on payments due to that same issuer in another State. HHS will only be able to pay issuers in a State the amount they are owed after receipt of funds owed by issuers in that State. If full charges are not received from issuers in that State, HHS could determine to issue interim payments that are pro-rated across issuers in a State based on the total charges remitted to date. After the remaining charges have been collected, HHS will remit the remainder of outstanding payment balances.

Section III: Data Collection Approach and General Data Requirements

In order to operate the risk adjustment model and calculate individual risk scores, information is needed about the demographic and health status of enrollees in each plan. In many risk adjustment programs, data to determine the health status of enrollees is based on medical diagnoses (in the form of ICD-9-CM codes or with eventual ICD-10 code adoption) contained on medical claims or medical encounter records. HHS has stipulated that it will not collect medical claims or medical encounter records from issuers for the calculation of individual risk scores. HHS is firmly committed to protecting individuals' private health information as it develops and operates a robust risk adjustment program that will help stabilize premiums and the marketplace in 2014 and beyond.

While the Premium Stabilization final rule gives States flexibility when they operate risk adjustment to choose the data collection approach that best suits their program needs, HHS will use a distributed approach when we operate risk adjustment on behalf of a State. This approach was adopted in the final rule to address concerns that were expressed in response to the NPRM.

In a distributed approach, the data required to operate risk adjustment is collected and stored by issuers; no data is transmitted to HHS. The policy objectives for the federal risk adjustment distributed data approach are to ensure that issuer proprietary data remains within the issuer environment to minimize transfers of protected health information in order to lower privacy and data security risks. A major advantage of the distributed model in general is that it allows HHS to leverage existing issuer data to the extent possible.

HHS is considering various approaches to implement a distributed data approach. The overall distributed data concept requires issuers to map claims data into a common HHS defined data format.

HHS laid out two potential distributed data approaches for consideration in the preamble to the Premium Stabilization final rule

1. HHS runs software: HHS would run risk adjustment software on enrollee data that reside on an issuer's server, calculate enrollee-level risk scores and plan average risk, and provide enrollee-level risk scores back to the issuer.
2. Issuer runs software provided by HHS: Issuer would run HHS risk adjustment software using enrollee data on the issuer's own server and report back enrollee risk scores to HHS in order to calculate plan average risk scores.

In weighing operational considerations for either option, the policy objective would be to standardize software processes, timing, and rules to apply risk adjustment uniformly across issuers and finally, to ensure an audit sample is controlled and maintained. HHS recognizes that this will require detailed instructions to issuers on technology associated with both approaches. HHS recognizes issuers could have to purchase server capacity and install software for both approaches. In addition, we understand that issuers store different kinds and amounts of information in a variety of ways. These differences mean that the impact of implementing a distributed model on health insurance issuers may vary. HHS notes that the majority of issuer commenters on the proposed rule recommended the use of the distributed approach. HHS will continue to engage with issuers on various technology platforms to implement a distributed approach. We intend to hold telephone calls with issuers to discuss these issues beginning in summer 2012.

HHS also will continue to consult with States and issuers about their current data collection tools and capacity.

We welcome input on potential ways to address the following issues with regard to the distributed model including

- What is the issuer's ability to ensure data is accurately formatted and mapped?
- What issuer support will be necessary to ensure validity and accuracy of data?
- To the extent possible, how can HHS leverage any existing issuer data?

A. Minimum Data Needed for Risk Adjustment and Data Validation

Regardless of the specific mechanism for data collection, HHS plans to leverage commonly-used data elements from existing claims data standards, including those currently used in the Medicare Advantage and Prescription Drug programs, for risk adjustment in order to minimize burden on issuers. For

example, the data elements and parameters that could be required to operate risk adjustment under the Federally-operated risk adjustment program are primarily those which are required to run risk adjustment under the Medicare Advantage and Prescription Drug programs. The data gathered for risk adjustment is used for a variety of calculations informing the risk adjustment model, including model selection for risk selection, risk score calculation, variable rating calculation, and calculating the premium basis for payments/charges. To that end, HHS intends to outline a minimum data set needed to perform risk adjustment model calculations and validate data submissions early in the process to ensure high quality data is available.

As a first step to assist issuers, HHS plans to define each of the data sets needed in detail to assist issuers in their efforts to understand all underlying elements needed to make these data available in order to perform risk adjustment model calculations. Below is a sample data set that HHS could utilize to produce plan average risk scores.

Possible Potential Data Elements for Risk Adjustment. Not for Final Requirement Purposes.

Sample Data Parameter	Sample Data Elements	Sample Purposes for Data
Enrollee-level data	• Enrollment effective dates • Enrollment plan type • Premium amount • Date of birth • Cost-sharing reductions • Sex • Tobacco use* • Pharmacy data • Medical claims data for cost and diagnosis selection • Location (e.g. zip code, geographic rating area or both)	• Model selection for risk calculation • Risk score calculation • Variable rating calculation • Premium basis for payments/charges • Weighting for state and plan average • Actuarial risk • Data validation
Plan level data	• Metal level* • Actuarial value* • Benefit year • Individual versus small-group*	• Model selection for risk score calculation • Payments and charges calculation • State average actuarial risk • Data validation
Market level data	• State average actuarial risk (HHS-sourced)* • State rating curve*	• Risk score normalization • Rating variation

**The asterisk denotes all data elements not currently collected under Medicare Advantage but are unique features of the individual and small group market rating practices. All other data elements are those which are currently being collected under the Medicare Advantage and Prescription Drug programs.*

B. Ongoing Coordination Efforts

In addition to regular consultation and ongoing technical assistance that HHS will offer, we hope to minimize burden on health insurance issuers by closely coordinating with other HHS' data collection efforts to the extent possible. HHS will schedule monthly or quarterly user groups to provide technical

assistance and feedback. HHS plans to establish an issuer instruction website or support system as well that will help provide technical assistance and an interactional platform for guidance.

HHS also seeks comment on and plans to consult with health insurance issuers and States in the development of common data format that takes into account current data formats already used by States. This format will need to specify coding systems, data-layout, file structuring, and uniform definitions to data requirements. At the conclusion of this process, in January 2013, HHS will release detailed common data format requirements for use in the Federally-operated risk adjustment program or for States to use if they are operating their own risk adjustment program. In order to lower implementation risk, HHS will require issuers to run test files with common data formats well in advance of the implementation of risk adjustment.

C. Privacy and Security Standards for Data

HHS is committed to protecting the personal health information of all enrollees and is working to establish privacy and security standards at a high standard while ensuring that risk adjustment functions properly. In order to address privacy standards, States operating their own risk adjustment program must utilize specific privacy standards for their data collection and risk adjustment procedures. The standards in the final rule are meant to represent a minimum standard to be used in the risk adjustment program. We expect risk adjustment programs will build on these minimum privacy and security standards. As specified in §153.340 of the Premium Stabilization final rule, to ensure adequate data privacy standards, the State, or any official, employee, agent, or representative of the State must not collect or store individual identifiers unless those identifiers are encrypted by the issuer, with the key to that encryption withheld from the State except for purposes of audit. The rule also requires that states operating a risk adjustment program implement security standards that provide administrative, physical, and technical safeguards for the individually identifiable health information consistent with Health Insurance Portability and Accountability Act of 1996 (HIPAA) security standards. HHS also plans to provide further direction in the form of user group calls, guidance or technical assistance detailing specifications for encryption of data and security standards for risk adjustment programs and databases stored by the issuer.

D. Proposed Data Validation Approach

The Premium Stabilization final rule directs States, or HHS on behalf of States, to validate a statistically valid sample of data for all issuers that submit data for risk adjustment every year, and provide for an appeals process. The rule also allows States, or HHS on behalf of States, to make adjustments to payments based on data validation sample error rates.

HHS will provide additional guidance on its development of the data validation methodology as we address oversight and financial integrity in future rulemaking, under sub-regulatory technical guidance or other communication engaging stakeholders, especially in the first year of the program.

The overall objectives of data validation are to promote confidence in the risk adjustment data that will be used for application of a Federally-certified risk adjustment methodology across the market, and to account for accurate health status of both healthy and sick enrollees. HHS seeks to promote consistency

and a level playing field by establishing uniform audit requirements, and to protect privacy information by limiting data transfers through the data validation process. We also recognize the need to promote flexibility and minimize burden by allowing issuers to set their own internal deadlines for completing the initial audits, and to leverage existing resources to conduct data validation.

HHS considered several current data validation standards familiar to health insurers including those used in Medicare Advantage and the Healthcare Effectiveness Data and Information Set (HEDIS) Compliance Audits. Under an approach similar to Medicare Advantage, issuers would first submit full medical records for HHS review in a specified timeframe. In an effort to reduce burden on insurers, HHS is instead considering for its data validation approach incorporating concepts from the best practices of industry audit standards such as HEDIS compliance audits. The HEDIS audit allows issuers to audit their own data based on specific methodologies, samples and standards set forth by NCQA. For example, building on standards such as HEDIS compliance audits, HHS would select a representative enrollee audit sample from across the full distribution of enrollees for each issuer. This distribution could include enrollees with and without risk adjustment diagnoses. HHS is also considering covering verification of enrollee demographics through review of source plan enrollment information, and enrollee health status through review of medical record documentation.

In addition, similar to the HEDIS compliance audits, HHS is considering having issuers or their companies to hire independent audit entities to validate their risk adjustment data. This would allow issuers to more effectively leverage existing resources to conduct their own data validation activities. In order to establish uniform audit requirements and a level-playing field across issuers, HHS would also establish baseline audit requirements to be used by the independent audit entities for validation of issuer risk adjustment data. Finally, HHS proposes to conduct second level validation and oversight audits to confirm the data validation findings from each independent audit entity. These various data validation approaches are not intended to be alternatives to each other, but rather HHS intends to implement each of these concurrently.

HHS looks forward to receiving input from a variety of stakeholders to inform development of the data validation approach. HHS understands the complex nature of data validation for risk adjustment. The proposed approach is expected to ensure HHS is able to verify the accuracy of the plan’s risk score while minimizing operational burden on issuers. Additionally, the proposed data validation approach for the federally-operated risk adjustment program could offer a less burdensome process and differ substantially from the more traditional data validation models that have been developed under the Medicare Advantage program. This is primarily due to the unique nature of how risk adjustment is administered with respect to assessment and flow of payments and charges.

Furthermore, HHS plans to carefully evaluate the data validation findings in the first year of the risk adjustment program. HHS does not intend to make retroactive adjustments to prior years’ payments and charges based on data validation error results. More specifically, the risk score error results based on the data validation for benefit year 2014 would apply prospectively during the risk score and payments and charges calculation processes for benefit year 2015. Therefore, the initial application of

risk score error adjustments based on data validation would not occur until calendar year 2016, as part of the process for assessing payments and charges for benefit year 2015.

Finally, HHS needs to assure balancing the flow of payments and charges since payments cannot be made until charges are collected. Therefore, HHS is considering application of a data validation error rate adjustment, based on prior year's data validation results, during the process for determining enrollee and plan average actuarial risk. Consequently, risk score accuracy based on data validation results would be taken into account when HHS assesses payments and charges. Again, HHS looks forward to input on this type of approach.

Section IV: Proposed Assessment of Existing State Data Resources and Market Characteristics

As discussed above, HHS will use a distributed approach when operating risk adjustment on behalf of a State. In some of the States where HHS operates risk adjustment, there may be an All Payer Claims Database (APCD) or other database already in place. HHS understands that many States have invested significant resources into building these databases and therefore will work with States to assess whether we could incorporate their existing data sources into our data collection approach at a future date. It is important to note that States operating their own risk adjustment program can use their APCD, but in cases where HHS runs the risk adjustment program, HHS will utilize the distributed approach to accessing data at least in the initial years.

As set forth in the final rule, States that elect to operate risk adjustment may submit alternate methodologies, which include data collection approaches such as APCDs or other existing databases, within 30 days of the release of the draft HHS payment notice. If the data collection approach is approved through the payment notice process, then the existing database can be used for risk adjustment. HHS will announce criteria which will be used to evaluate alternate data collection approaches in the draft HHS payment notice. HHS proposes to continue studying these databases as a potential data collection approach and we welcome feedback during this process. As part of these efforts to assess State's current data collection and storage capacities, we propose to explore with States the following questions:

- What issuers are included in existing data collection?
- What claims types are included?
- Are all data elements required for risk adjustment collected? If not, are there mechanisms to collect the remaining data?
- What privacy and security standards are in place to protect sensitive data?
- Does the State have the legal authority to use data from the existing database to operate risk adjustment?
- Are there any validity or quality checks when collecting data? If so, what data elements are checked and what (if any) processes are in place to allow issuers to make corrections?
- What is the timing of the data collection?

In addition, HHS is committed to working with States to help assess market characteristics that might have an impact on the risk adjustment program. For example, under 1312 (c) of the Affordable Care Act, States have the option to merge individual and small group markets for purposes of rating. Since this is a state insurance market reform decision that will interact with the risk adjustment program, HHS will work with States to understand the impact of separate or combined individual and small group risk pools if HHS is operating risk adjustment on behalf of a State.

Section V: Timeline and Stakeholder Communication

As outlined above, HHS is committed to assisting health insurance issuers understand and implement operational requirements associated with risk adjustment. To this end, HHS will communicate through a series of regular public meetings, technical user group calls and instruction bulletins. HHS will also post instructions and other communication via a dedicated website at http://cms.cciio.gov.

The chart below details key dates related to the establishment and operation of the risk adjustment program.

Item	Date
HHS issues Premium Stabilization Rule.	March 23, 2012
Public risk adjustment meeting held to discuss: • Risk Adjustment Model. • Calculation of Plan Average Actuarial Risk. • Calculation of Payments and Charges. • Process and Timing for Data Collection Methodology and Options. • State Flexibility and Considerations.	May 7th & 8th, 2012
User group calls continue to be conducted with stakeholders	Spring/Summer 2012
Proposed date for HHS to engage issuers to test data processing concept.	Fall 2012
HHS publishes the draft annual HHS notice of benefit and payment parameters, which includes Federal risk adjustment parameters. This will include requirements for data validation.	Fall 2012
States Submit Alternative Methodology if Approved State Based-Exchange elects to operate risk adjustment.	Within 30 days after issuance of the draft final annual Federal notice of benefit and payment parameters.
HHS publishes the final annual HHS notice of benefit and payment parameters.	January 2013
HHS releases requirements for data storage to issuers and continues to work with issuers to implement.	Early 2013
Final deadline for States to publicly select Alternative Methodology for Approved State-Based Exchange.	No later than March 1st 2013
Payments and Charges implementation	Completed by June 30, 2015

HHS will solicit feedback on other technical concerns and potential topics for future discussions during our public meeting outlining our progress to date on developing the methodology. The public meeting will be held in Arlington, VA on May 7th and 8th, 2012. Please visit the CCIIO website for details on the meeting including how to register at http://cciio.cms.gov/resources/other/index.html#fm. We look forward to a wide ranging discussion at that meeting to hear from a variety of stakeholders on our intended methodology.