



February 19, 2019

Secretary Alex Azar  
Department of Health and Human Services  
Hubert H. Humphrey Building  
200 Independence Avenue SW.  
Washington, D.C. 20201

Re: Covered California comments on Patient Protection and Affordable Care Act;  
HHS

Notice of Benefit and Payment Parameters for 2020; CMS-9926-P (RIN 0938-  
AT37)

- Risk Adjustment Validation
- Premium Adjustment Methodology
- Drug Coverage and Formulary Standards

Dear Secretary Azar,

Covered California is submitting comments in response to the proposed regulations CMS-9926-P. The comments in this letter refer to proposed policies on Risk Adjustment Validation, Premium Adjustment Methodology and Drug Coverage/Formulary Standards. Covered California has also submitted comments on the proposed [FFE user fee](#) and as well as joined with the Executive Directors of all 13 state-based marketplace in submitting comments regarding [automatic re-enrollment and stability in cost-sharing reduction funding](#).

### **Risk Adjustment Data Validation**

The Affordable Care Act established the risk adjustment program to mitigate the impact of possible adverse selection in the individual and small group market and seeks to accomplish this by transferring funds from plans with lower-risk enrollees to plans with higher-risk enrollees. Risk adjustment is vitally important to maintaining stable individual and small group markets and those adjustments should be – as much as possible – reflections of the actual differences in the risk population between carriers.

One element to ensure as much accuracy as possible is the Risk Adjustment Data Validation Audit (RADV). Regulations have clarified that the state, or

Health and Human Services (HHS) on behalf of a state, may validate a statistically valid sample of risk adjustment data for all issuers on a yearly basis. The current RADV program begins with an initial audit of 200 enrollees performed by an independent auditor on behalf of the issuer. A second audit is then performed by HHS to verify the findings of the initial validation audit.

HHS is proposing several changes to the initial validation audit requirements and seeking comments on the RADV process. First, HHS is proposing to vary the initial sample size based on issuer characteristics such as issuer size and prior year Hierarchical Condition Categories (HCCs) failure rates by using the 2017 RADV results as an initial basis for determining 2019 initial validation audit sample sizes. Under this approach, HHS would increase the precision of initial validation audit samples above 200 enrollees for issuers with lower or higher than average HCC failure rates that are not precisely measured. For issuers with average HCC failure rates, the initial validation audit sample size would remain at 200 enrollees. Alternatively, HHS proposes to vary the initial sample size based only on the size of the issuer while continuing to use the proxy Medicare Advantage risk score error data for conducting precision analysis.

Covered California makes these comments in the context of serving a state with eleven active carriers and with hundreds of millions of dollars being transferred between carriers based on the underlying risk adjustment process and the adjustments made by RADV. These transfers must be as accurate and predictable as possible since the transfers impact underlying premiums, relative position of issuers in the market and – most importantly – provide necessary resources for issuers to assure adequate care is provided to consumers they cover based on the risk mix of their covered lives.

### **Importance of Risk Adjustment and RADV Done Right**

Covered California strongly supports the need for RADV audits and risk adjustment transfers in order to have a fully functional risk adjustment process. An effective and accurate risk adjustment process is a vital component to ensuring that the individual market functions well, and that health plans are not discouraged from participating because: (1) the risk adjustment process does not accurately and fairly represent the actual relative risk and costs associated with that risk among plans; and (2) uncertainty in the extent and amount to which issuers pay into, or receive from, from the risk adjustment and RADV process.

### **Ensuring RADV is Done Accurately and Making Near Term Improvements**

While Covered California agrees that the RADV program is necessary and important, we believe that as designed, the process does not deliver the necessary checks and balances to ensure accuracy and predictability, and that

the current program – including for the 2017 plan year – needs to be adjusted to accomplish the intent of the RADV program.

Covered California is concerned that should HHS finalize the first proposal, which would vary initial sample size based on issuer characteristics and use 2017 RADV results, the methodology would not appropriately reflect 2019 enrollment data. For instance, the absence of the shared responsibility payment (i.e., the mandate penalty) would not be factored into the calculations when using data prior to 2019. While we acknowledge that ensuring accuracy of the RADV methodology will take time, we ask HHS to continue with its risk adjustment and RADV program but increase the sample size given that current error rates are relatively high.

Based on actuarial review, the initial and secondary audit should consider a larger maximum sample size than what is currently provided regardless of HCC failure rates. Similar to HHS's current explanation for not changing the sample size (200) for very small issuers (3000 or fewer enrollees), we believe that all sample sizes should be statistically significant, not capped at 200, or 400 for large issuers and that larger sample sizes would increase the accuracy of the RADV results. Projection of future year adjustments based on too small a sample size may be subject to errors and be inappropriate. Covered California notes that many of our issuers are very large (with over 100,000 enrollees) so a larger sample size would be important for determining any error rate used to make significant adjustments to risk adjustment transfers. In addition, the current "over-sampling" methodology may need to be re-examined to do a better job of evaluating error rates across the 50+ HCC conditions. HHS should also consider an adjustment to address the current "cliff" effect whereby the current methodology measures the magnitude of the risk adjustment failure rate.

Absent making adjustments to the existing program, issuers may be discouraged from participating in the individual market to the detriment of consumers.

### **Long Term Improvements to Risk Adjustment Accuracy**

Covered California is concerned that the current RADV process does not meet either of the core needs of assuring accuracy and minimizing health plan uncertainty. We encourage HHS to convene a joint industry, stakeholder, risk adjustment experts and HHS workgroup to discuss improvements to the risk adjustment, RADV or other methodologies to ensure the risk adjustment program operates as intended.

While HHS works to develop a more accurate methodology, the RADV program should move forward to prevent any market disruption. As HHS develops a more accurate methodology, it may be necessary to develop a retroactive adjustment for risk adjustment years that used 2017 benefit year data or perform the RADV but wait to finalize until a necessary evaluation of the methodology is completed.

## **Premium Adjustment Methodology**

Annually, the Secretary of HHS determines the annual premium adjustment, a measure of premium growth that is used to set the rate of increases for the 1) The maximum annual limitation on cost sharing (2) the required contribution percentage used to determine eligibility for certain exemptions; and (3) the employer shared responsibility payment amounts. HHS is proposing to use an alternate premium measure that captures increases in individual market premiums, in addition to increases in employer-sponsored insurance premiums, for purposes of calculating the premium adjustment percentage for the 2020 benefit year. Covered California recommends that CMS reconsider the proposal to include individual market premiums in the premium adjustment percentage methodology. As CMS notes, individual market premiums were not included in the premium adjustment percentage formula previously to allow time for volatility in the individual market during ACA implementation to settle. While some states, including California, have taken active steps to ensure individual market stability, federal actions such as zeroing-out the individual mandate penalty, cessation of federal CSR payments, and recent rulemaking (including the substantial delay of this year's proposed NBPP) have not contributed to stability in the individual market, recommending against methodological changes at this time.

The indexing methodology itself places the burden of rising health care costs and sluggish wage growth squarely on households, which CMS acknowledges will result in added cost burdens to consumers. As this federal Administration has noted, health coverage policy should support the hard-working Americans who struggle to pay premiums and out of pocket costs, rather than exacerbating them. For this reason, policymakers in California are actively exploring options to increase affordability of individual market coverage. We urge CMS to uphold this principle by maintaining the current methodology that does not include individual market premiums when indexing advance premium tax credits and cost sharing limits.

## **Changes to Prescription Drug Formularies**

HHS is proposing to allow issuers in the individual, small, and large group markets to update their prescription drug formularies by allowing certain mid-year formulary changes, if permitted by state law. Specifically, HHS is proposing to allow issuers to make formulary changes during the plan year when a generic equivalent of a prescription drug becomes available on the market, within a reasonable time after that drug becomes available.

Additionally, HHS is proposing that amounts paid toward cost sharing using any form of direct support offered by drug manufacturers to insured patients to reduce

or eliminate immediate out-of-pocket costs for specific prescription brand drugs that have a generic equivalent are not required to be counted toward the annual limitation on cost sharing.

Covered California strongly supports state flexibility when finalizing this proposed regulation. We maintain that health care and health insurance markets are local and as states are looking at tackling the high cost of prescription drugs, state flexibility will allow for innovative solutions to high and rising out-of-pocket costs for prescription drugs.

Sincerely,



Peter V. Lee  
Executive Director

cc: Covered California Board of Directors