Health Insurers Support Proposal to Correct ACA Risk Payments

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• Proposed changes would include using prescription drug data, better accounting for partial-year enrollees

• Reinsurance changes would have biggest impact, health insurance attorney says

Oct. 12 (BNA) -- Health insurers support a proposal to correct a risk adjustment scheme that has played a role in driving insurers out of Obamacare exchanges.

Targeted changes to the Affordable Care Act risk adjustment program that include using prescription drug data and better accounting for the health risks of partial-year enrollees "hold promise in strengthening the program for the longer-term," America's Health Insurance Plans said in its Oct. 6 comment letter. The industry group commented on a Sept. 6 Department of Health and Human Services proposed rule (CMS-934-P) (24 HCPR 1245, 9/12/16).

"Going forward, we encourage HHS to continue evaluating updates to the model to more accurately reflect the actuarial risk of all populations—including the risk of the healthiest populations," AHIP said. The Pharmaceutical Research and Manufacturers of America (PhRMA) also supported including prescription drug claims data in the its risk adjustment model "in order to improve the model's accuracy and reduce incentives for plans to discriminate against individuals with severe or chronic conditions."

The risk adjustment program is crucial to making the ACA work because it would shift funds from plans that cover enrollees with lower than average health risks to plans with enrollees with higher than average risks. But many small, new plans that don't have data on their enrollees' health have had to make large payments to large, established health plans, which has made it more difficult for them to be profitable in the financially troubled ACA exchanges.

For example, 17 of the 23 Consumer Operated and Oriented Plans created under the ACA have failed, and several of them cite large risk adjustment payments as contributing to their failure.

Proposals Don't Do Much, ACA Critic Says

The changes to the risk adjustment in the 2018 Notice of Benefit and Payment Parameters (NBPP) proposed rule will not do enough to mitigate problems with the risk adjustment program, University of Houston Law Center professor Seth Chandler told Bloomberg BNA Oct. 12. "Way too much money is being transferred through that system," he said.

For 2014, $3.5 billion was transferred in the individual market and an additional $1.1 billion in the small group market for a total of $4.6 billion, about 10.3 percent of premiums, Chandler said, citing HHS data. For 2015, $5.6 billion was transferred in the individual market from low-risk insurers to high-risk insurers, and an additional $2.2 billion in the small group market for a total of $7.8 billion, representing about 6.6 percent of premiums, he said, citing data from the National Association of Insurance Commissioners.

“It is creating huge risks for small insurers, and it's at least partly responsible for the departure of many insurers from the market,” said Chandler, who is critical of the ACA.

Major insurers UnitedHealthcare, Aetna Inc. and Humana Inc., as well as some Blue Cross Blue Shield plans, have cut back on their offerings in the exchanges due to heavy losses on the plans.

According to an Aug. 19 report from health policy consulting firm Avalere Health, nearly 36 percent of exchange market rating regions may have only one participating insurance carrier offering plans for 2017 plan year, and there may be some counties where no plans are available.

The 2018 NBPP proposal calls for making adjustments based on the more expensive partial-year enrollees and including prescription drug costs in risk adjustment calculations but “probably won't move the needle very much” in terms of changing total payments, Morgan Tilleman, an associate in the Milwaukee office of law firm Foley & Lardner LLP, told Bloomberg BNA Oct. 12. “Those are things that all the carriers face,” he said. Tilleman represents health insurers who have made as well as received risk adjustment payments.

In some cases, partial-year enrollees sign up for coverage and let the coverage lapse after they receive treatment.

A provision in the proposed rule that is likely to have a greater impact for small carriers would provide reinsurance coverage for 60 percent of the costs of patients whose coverage was more than $2 million a year, Tilleman said. The costs would be spread broadly among individual and small group plans, he said.

For large carriers, very high-cost patients are “a small piece of the puzzle,” Tilleman said. But for small regional health maintenance organizations, $2 million could represent 2 percent of their annual revenue, he said. “Any relief they could get could help smooth out losses,” he said.

Tighten Special Enrollment Period Verifications

Insurers also called for the HHS's Centers for Medicare & Medicaid Services to tighten requirements to ensure that people signing up for ACA coverage outside of normal open enrollment periods are eligible to do so as a result of life-changing events such as marriage, the birth of a child or a job change. According to the CMS, about 25 percent of total ACA enrollment came through special enrollment periods (SEPs) in 2015, the Blue Cross Blue Shield Association (BCBSA) said in its Oct. 6 comment letter.

“While CMS has taken some steps to address inappropriate use of SEPs, issuers are continuing to see higher claims costs for enrollees who utilize SEPs in 2016,” the BCBSA said. Issuers are now required to enroll 40,000 individuals per week without proof of SEP eligibility, it said.

SEP enrollees for 2015 have 5 percent higher per-member, per-month costs, but risk scores that are 20 percent lower on average than those choosing a plan during the normal open enrollment period, Avalere reported Oct. 5. Under risk adjustment, plans with a relatively low average risk score make payments into the system, while plans with relatively high average risk scores receive payments.

“Consumers enrolling through special enrollment periods have higher healthcare spending than those picking a plan during open enrollment, and they are staying in the program for shorter periods of time,” Avalere President Dan Mendelson said in a release. “This is one of many technical problems that is presently destabilizing this program, and should be fixed by the Administration and the Congress to ensure continuity for patients.”

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For More Information

AHIP's letter is at http://src.bna.com/jiI.

The 2018 Notice of Benefit and Payment Parameters proposed rule is at http://src.bna.com/jjS.

Avalere's report, Experts Predict Sharp Decline in Competition Across the ACA Exchanges, is at http://src.bna.com/jll.

The BCBSA's letter is at http://src.bna.com/jiH.

Avalere's report, Consumers Enrolling in Exchanges through Special Enrollment Periods Have Higher Costs, Lower Risk Scores, than Open Enrollment Consumers, is at http://src.bna.com/jkT.

PhRMA's letter is at http://src.bna.com/jfR.

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