Technical Issues with ACA Risk Adjustment and Risk Corridor Programs, and Financial Impact on New, Fast-Growing, and Efficient Health Plans

Prepared by CHOICES: Consumers for Health Options, Insurance Coverage in Exchanges in States[1]

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The Affordable Care Act makes sweeping changes to public and private health insurance in the United States. Among the legislation's many goals and priorities is the establishment of new marketplaces for individual and small group insurance products, where health plans compete for customers by offering high-quality health care and affordable premiums. Due to the financial risks inherent in these new markets, where individuals, families, and small employers can obtain health insurance regardless of health status, the ACA wisely includes the "3 Rs" programs for permanent risk adjustment, transitional reinsurance, and temporary risk sharing with the federal government through the risk corridor program.

Unfortunately, certain limitations in the current risk adjustment and risk corridor programs have an unintended and extremely adverse financial effect on new health insurance plans, those experiencing rapid growth in enrollment, and any insurer that focuses on efficient, innovative, and value-driven care. These limitations have already contributed to the withdrawal or outright failure of a number of marketplace plans, including 12 of the new Consumer Operated and Oriented Plans (CO-OPs). Unless the risk adjustment and risk corridor problems are addressed, more withdrawals by plans of all kinds are certain, and the benefits of innovation and robust marketplace competition will be greatly reduced.

New, fast-growing, and/or efficient health insurers are particularly affected by the technical problems with the risk adjustment and risk corridor programs. All CO-OPs, for example, are nonprofit, consumer-driven health plans that focus, first and foremost, on the well-being of their members. To serve the growing insured market and help achieve the "Triple Aim," plans need to negotiate effective provider contracts and to specialize in the coordination of care at every level for all of their patients. Top priorities are keeping people healthy, lowering premium costs, and delivering appropriate levels of care at the right time to keep members home and out of unnecessary hospital stays. In view of competitive pressures and the ACA's requirements such as the Medical Loss Ratio standards, any experience gains must be reinvested into expanded benefits and/or lower premiums for plan members.

Although these health plans are enthusiastic partners in the Affordable Care Act's individual and small-group marketplaces, unless technical corrections are made to the risk adjustment and risk corridor programs, their viability as efficient, public-focused health insurance plans will be severely jeopardized.

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[1] CHOICES is a multi-state coalition of health care plans concerned that the current formulation and administration of the 3Rs (reinsurance, risk adjustment, and risk corridors) are driving up premiums for consumers and small businesses while reducing competition and harming a shift to efficient, risk-bearing provider networks. CHOICES members are non-profit and investor-owned, health system-sponsored and independent, and startups as well as companies with decades of experience as members of their local communities.

The risk adjustment and risk corridor programs have been designed with considerable thought and care. Nonetheless, the technical problems described below are serious and warrant immediate attention. The purpose of this paper is threefold:

- To describe the technical problems affecting the ACA risk adjustment and risk corridor programs;
- To illustrate their impact on new, innovative, rapidly growing, and low-cost health insurance options; and
- To strongly recommend that corrections be implemented both prospectively and retrospectively to prevent the unintended and anomalous results caused by the risk programs' operations in their current form.

Technical Issue #1: Time lag until risk adjustment determination is available

Plan year 2014 receipts and charges, for health insurance carriers in the individual and small group markets, were not determined and announced until June 30, 2015.[2] Despite extensive modeling, the actual results were nothing short of startling for many plans of all sizes. Moreover, the announcement came well after the deadline for plans' 2016 premium submissions had already passed.

The time lag until the final determination is probably unavoidable, given the necessity of complete claims data for risk score calculations. However, an "advance look" for 2014, based on preliminary data, would have helped plans adjust and update their expectations regarding their risk profile relative to other plans in the area. The benefits of earlier availability of this information are twofold: First, plans could have incorporated improved estimates of their risk sharing liabilities into their premium submissions for 2016. And second, awareness of the sometimes-anomalous results produced by the current risk adjustment program could have accelerated the process of identifying causes and implementing corrections.

The preliminary "advance look" notification would also be helpful on an ongoing basis, even after the risk adjustment and transfer formulas are refined. In addition to improving premium calculations, any future data problems or other difficulties could be recognized and addressed prior to the final determination.

Technical Issue #2: Time lag between enrollment of new members and identification of their conditions (and HCC diagnoses) for new and fast-growing plans

This issue has a major adverse financial effect on the truly new health insurance plans participating in the ACA marketplaces, as well as any plans with rapid growth in their membership (including several large existing companies that expanded into the new marketplaces). First, such plans have very limited information on the health status of their

[2] Centers for Medicare & Medicaid Services. *Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2014 Benefit Year*. June 30, 2015. Available at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RI-RA-Report-Draft-6-30-15.pdf.

enrollees, compared to established insurers with a substantial portion of known members from pre-ACA lines of business. New members start off with risk scores that reflect only their demographic information and exclude any HCC diagnoses, even though some of the individuals in question have acute or chronic conditions.[3] All of a new plan's members will initially be in the no-HCC category, with the appearance of being very low-cost individuals. In contrast, a significant majority of members in a marketplace plan offered by an established insurer will have previously been in a health insurance plan operated by the same company. Their risk profiles will be known, and the insurer can act immediately to ensure current-year diagnoses for these high-cost members.

The identification and recording of relevant risk factors normally occurs over time, as the members of a new plan have provider visits and other health care services that result in formal diagnoses. In the interim, however, these plan members have risk scores that in many cases do not reflect their true health status. A plan that experiences rapid growth in its membership will also have an above-average proportion of new members, even several years into its operations.[4] Significant "churning" between marketplace plans, employer-sponsored health coverage, and Medicaid enrollment has been fairly common to date and can also result in new members with unknown medical histories.

In an under-65 population that has an average risk profile overall, a relatively small proportion of members will have HHS-HCC diagnoses. In an article in the *Medicare & Medicaid Research Review*, the developers of the HHS-HCC risk adjustment model indicate that only 19.2% of the adult population in their database had at least one HCC diagnosis. However, the authors also note that these individuals account for 63% to 76% of total plan expenditures for the population, depending on the "metal level" of the health plan.[5] In other words, the presence of HHS-HCC diagnoses has a very pronounced effect on a population's overall risk score—and any missing diagnoses will cause a disproportionately large reduction in a plan's measured risk score.

Identifying and understanding members' health issues is an extremely high priority for high-performing health plans—both for the purpose of appropriately meeting their health care needs and to ensure appropriate recognition of members' health status for risk-adjustment and other

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[3] This problem and others affecting new marketplace plans are documented in Liner, David and Siegel, Jason. "ACA risk adjustment: Special considerations for new health plans." *Milliman Insight*, July 2, 2015. Available at http://www.milliman.com/insight/2015/ACA-risk-adjustment-Special-considerations-for-new-health-plans/.

[4] A notable illustration of this effect is available in the June 30, 2015 CMS summary report (cited in footnote 2). Table 6 shows issuer-specific information on transitional reinsurance payments and risk adjustment transfer amounts. Several dozen plans received both large reinsurance payments for 2014 (indicating that a significant number of their members had very high health care costs) but also had large risk adjustment "charges" (suggesting a below-average-cost risk profile). For example, the Humana Medical Plan, Inc. of Florida received over $125 million in transitional reinsurance proceeds but was also charged $81 million in risk adjustment transfers as a result of the plan's low measured risk score. **While there is not necessarily a close correspondence between the operations of the reinsurance and risk adjustment programs, it nonetheless appears unusual for plans to have such a combination of "high cost" and "low cost" indications. Among the plans with this combination, the most prevalent factor that they have in common is rapid enrollment growth.**

[5] John Kautter, Gregory C. Pope, Melvin Ingber, Sara Freeman, Lindsey Patterson, Michael Cohen, and Patricia Keenan "The HHS-HCC Risk Adjustment Model for Individual and Small Group Markets under the Affordable Care Act." *Medicare & Medicaid Research Review*, 28, no. 3 (2014): E11. Available at https://www.cms.gov/mmrr/Downloads/MMRR2014_004_03_a03.pdf.

functions under the ACA. But it takes time to reach out to members, assess their health status, arrange treatments, and establish accurate diagnosis coding by providers. Until a precise baseline can be established for the great majority of members, the risk adjustment program will seriously understate plan liability risk scores for new and rapidly growing insurers.

Technical Issue #3: Risk adjustment formula coefficients that are too low for non-HCC enrollees and too high for those with one or more HCC diagnoses

The adverse financial effect on new plans from incomplete diagnosis records is compounded by the nature of the HHS-HCC risk classification model. Specifically, the risk scores for individuals with no HCC diagnoses tend to *understate* the true relative cost for this category of members, while the scores for those with one or more HCC diagnoses tend to *overstate* actual relative costs. For plans with an artificially high proportion of members with no HCC diagnoses, the impact on calculated risk scores is thus further magnified by understatement from the risk adjustment formula.

This pattern of estimation error for the HHS-HCC formula is well documented[6] and, counter-intuitively, is the opposite of what normally occurs in risk adjustment models developed in the private sector and the CMS-HCC model for Medicare Advantage enrollees. As a general rule, risk adjustment models can only explain a portion—often a fairly low one—of the total statistical variation that exists across individuals' or groups' health care costs. Cost variation that is not attributed to the model's demographic, diagnosis, and other explanatory variables is normally reflected in the model's baseline cost level, causing it to be higher than would be the case with greater explanatory power among the variables. Correspondingly, the demographic and non-demographic coefficients in most models tend to understate the actual cost variation attributable to these factors.

It is not clear why the HHS-HCC risk adjustment model understates costs for individuals without HCC diagnoses and overstates costs for those who have diagnoses, in contrast to virtually all other risk adjustment models. One speculative explanation for this pattern would be that it results from an intentional policy goal of encouraging plans to enroll members with existing health conditions, rather than continuing to use recruitment efforts designed to avoid such individuals. In fact, high-performing health plans should be entirely sympathetic to this public policy goal, since their intention is to provide the best health care possible for all members of society, regardless of their health issues, and to do so in a way that actively reduces the likelihood of further disease progression. As noted in the discussion of Technical Issue #5 below, such plans also strive to provide the most appropriate level and setting for care, manage members' health situations closely, apply value-based insurance design principles, establish effective provider networks, and take other steps to ensure that high-quality care is also cost efficient.

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[6] See, for example, Siegel, Jason and Petroske, Jason "When adverse selection isn't: Which members are likely to be profitable (or not) in markets regulated by the ACA." *Milliman Healthcare Reform Briefing Paper*, December 2013. Available at http://us.milliman.com/insight/2013/When-adverse-selection-isnt-Which-members-are-likely-to-be-profitable-or-not-in-markets-regulated-by-the-ACA/.

However, with the current HHS-HCC model, the risk adjustment calculation for new and fast-growing plans not only excludes many relevant diagnoses, it understates relative costs for the artificially high proportion of members recorded as having zero HCC diagnoses. Moreover, the magnitude of the understatement is significant: Exhibit 7 of the article cited in footnote 5 shows that the HHS-HCC risk adjustment model predicts relative cost levels for low-cost adults that average only 65% to 90% of their actual costs (depending on the "metal level" of the plan). Together, these two technical issues result in a significant adverse financial impact on new and fast-growing plans (including all CO-OPs) that have a high proportion of new members and for whom detailed health records are not readily available.

Technical Issue #4: Exclusion of prescription drug utilization data from the HHS-HCC risk adjustment model

Implementing risk adjustment for the new ACA marketplace plans required use of a "concurrent" model, where a plan's risk score for a given year would be determined by health care conditions diagnosed by means of claims incurred during that year. Unfortunately, one of the simplest, most effective, and most reliable indicators of health status was purposely excluded from the HHS-HCC model: prescription drug utilization.

As noted in Issue #2, establishing diagnoses from claims data on health care encounters requires considerable time before a person's complete profile is known. In contrast, many chronic conditions can be identified much more quickly and economically by a patient's use of specific prescription drugs. Since prescriptions are generally refilled every month, such drug-based diagnoses can be timely and reliable indicators of health status (and inexpensive to monitor). Many other commercial and government risk adjustment systems include prescription drug use as an input, and at least one successful private health insurance exchange uses a concurrent risk adjustment model based *solely* on prescription drug utilization.

Drug use was excluded from the HHS-HCC model largely because of limitations in the database used to calibrate the model. Given the potential improvement in explanatory power, and the ability to help address the lack of member diagnostic information for new and fast-growing health plans, incorporating readily available and timely data on prescription drug utilization into the risk adjustment model should be a very high priority.

Technical Issue #5: Lack of a "Care Coordination Factor" in the risk transfer formula

In keeping with the Affordable Care Act's mandate, the mission of high-performing health plans is to improve the health of all enrollees while ensuring access to high-quality health care and affordable insurance premiums. To fulfill this mission, a number of plans have undertaken a broad portfolio of successful member- and provider-engaging activities, including cutting-edge use of value-based insurance design. Unfortunately, because of technical limitations in the risk adjustment and risk transfer formulas, these plans are actually penalized for the favorable outcomes and results of their innovative programs.

The fundamental issue is that successful efforts to coordinate care and manage chronic conditions can help prevent further disease progression, reduce inpatient hospitalizations, and

avoid other more intensive health care services. The improved health outcomes are highly beneficial for patients, but they also translate into lower risk scores than would otherwise be the case. If the risk scores accurately reflected the plan's lower cost of care, then the risk adjustment and transfer programs would appropriately account for the relative risk profile of the enrollees. As noted in Technical Issue #3, however, the risk adjustment formula is "tilted" in the direction of understating relative costs for lower-cost individuals and those without HCC diagnoses.

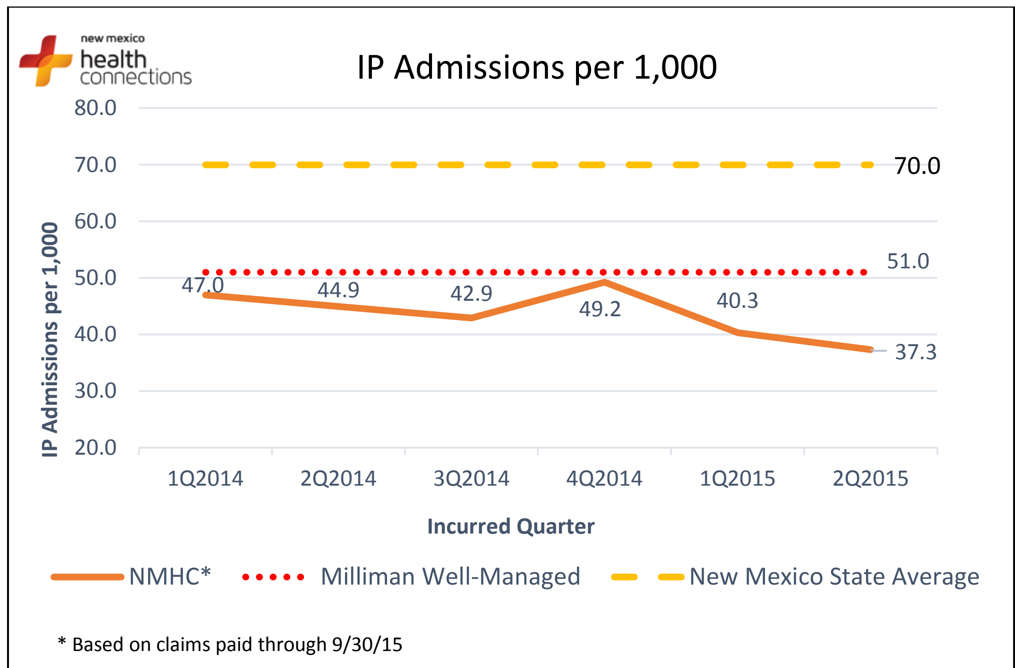
Consequently, the lower plan expenditures resulting from care coordination and management tend to be exaggerated in the risk score calculations, and the risk transfer amounts are biased against effective plans (and in favor of less effective ones). The situation is compounded by the higher care-management expenditures of effective plans on behalf of their members, compared to lower amounts expended by other plans. Neither the HHS-HCC risk adjustment formula nor the risk transfer formula directly takes such costs into account.

The net effect is an unintended cross-subsidization from plans that carefully manage care to ones that do not. This situation prompted one health plan CEO to comment, "As the formulas are structured now, it would be simply easier and more financially rewarding to 'manage to the formulas' in lieu of actually managing the health of our members." In fact, many large, established insurers have substantial resources invested in predictive modeling and other techniques to identify and market to the most profitable categories of enrollees, given the specifics of the risk adjustment and risk transfer formulas. This approach makes good business sense under the circumstances, but it is not consistent with the goals and priorities of the Affordable Care Act, especially those relating to provider-based plans and other innovative insurers working to deliver new efficiency into the market.

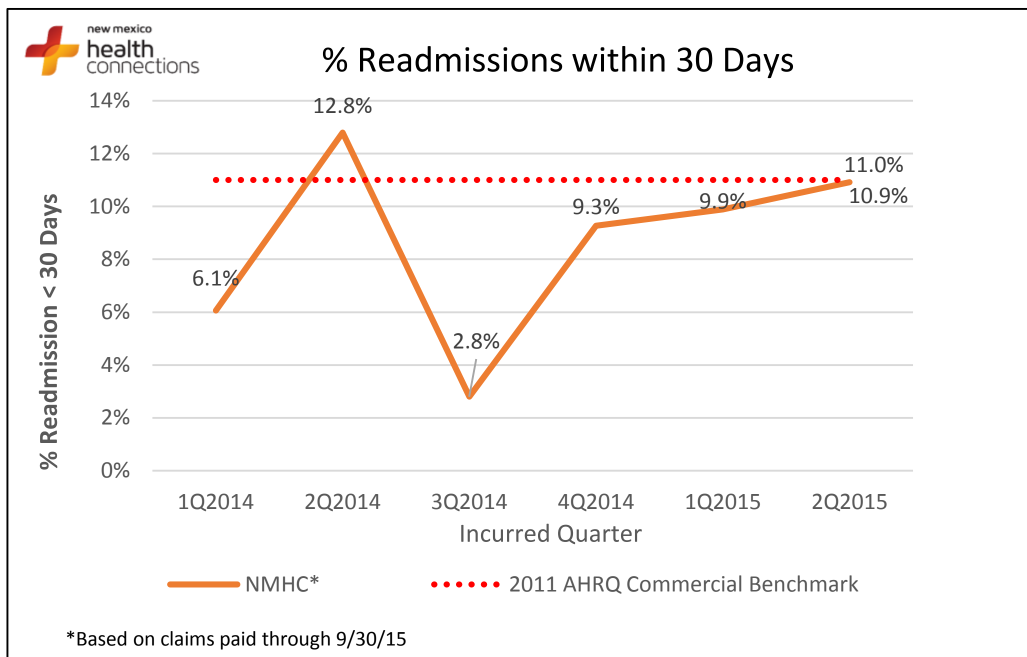
The following examples of medical management activities and results are drawn from New Mexico Health Connections (NMHC):

- NMHC operates a "Late to Refill" member outreach program and uses a value-based plan design featuring $0 copayments for generic medications for 9 chronic conditions (e.g., asthma, diabetes, depression). These programs are designed to (i) maximize compliance with prescription drug regimens for all patients, (ii) help ensure that members with known chronic conditions can afford medications that are critical to their treatment, and (iii) help prevent worsening (and more expensive) disease progression. These value-driven insurance design elements have resulted in:
    - Generic Dispensing Rate of 87.3% for NMHC compared to an average of 85% for the OptumRx pharmacy benefit manager's 283 commercial clients.
    - PMPM prescription drug spending of $53.57 for NMHC versus $67.14 for the OptumRx commercial average (with a comparable risk profile).
    - With lower member cost-sharing, medication adherence is higher, with the resultant well-proven improved health and reduction in avoidable cost—yet also reducing associated risk scores.
- From 8/1/15 through 10/15/15, there were 267 outreach attempts for NMHC members who were late to fill their retail prescriptions by at least 10 days and also had been late to

refill prior prescriptions at least twice within the previous 6 months. These include high-priority prescription drugs for behavioral health disorders, asthma, seizures, congestive heart failure, atrial fibrillation, coronary artery disease, and diabetes. A value-driven insurance design, with $0 copayments for Primary Care Physician and Behavioral Health office visits, has resulted in higher outpatient utilization and avoidance of higher risk-score-associated events (i.e., inpatient hospitalization). The following chart compares NMHC's low and declining rate of inpatient hospitalizations per 1,000 members to corresponding average rates from the Milliman Well-Managed Benchmark and for the State of New Mexico overall. As indicated, NMHC has been successful in avoiding unnecessary hospitalizations, thereby reducing plan costs and improving patient safety and satisfaction while also effectively treating their conditions. At the same time, this success translates into many fewer high-cost HCC diagnoses, thereby reducing NMHC's risk score to a greater extent than its costs for care (and not recognizing costs for care management).



- NMHC's "Multidisciplinary Member Care Rounding Meetings" address hospitalized members with highly proactive and merged Case Management and Utilization Review activities, resulting in optimal care coordination and reduced readmission rates—but fewer high HCC diagnoses associated with readmissions. As shown in the following chart, NMHC's readmission rate has generally been well below the commercial benchmark established by the HHS Agency for Healthcare Research and Quality. Again, by providing higher-quality and more-efficient care, NMHC has reduced healthcare costs but experienced an even greater reduction in its HHS-HCC risk score.



- NMHC's "Embedded Community Health Worker Program," as part of FQHC-associated Shared Savings contracting, addresses social determinants of health at the member local level. It has resulted in avoidance of high-cost inpatient admissions—but has also led to fewer high-HCC diagnoses that would typically accompany those admissions.

    - Highly specialized Behavioral-Health-focused Care Management and Disease Management staffs, and a Behavioral Health screening tool, have helped address Behavioral Health issues that historically underlie higher utilization for the chronically ill. These initiatives have resulted in lower admission and readmission events but are also associated with disproportionately lower risk scores for NMHC's members.

- NMHC identified over 7,500 new members in the Albuquerque area who had no provider visits and no claims, and thus were unassessed and unmanaged from a health status standpoint. NMHC partnered with the ABQ Health Partners physician medical group to develop outreach and scheduling processes that resulted in nearly 30% of those who were reachable being scheduled for a comprehensive assessment visit within 3 months.

In practice, designing and implementing a care coordination factor for the risk adjustment program would be challenging. As illustrated by the NMHC initiatives, care management activities can take many different forms, and quantifying their financial effects can be difficult. As described in the next section, use of plan-specific premium amounts in the risk transfer formula could serve as a workable alternative that would appropriately reflect the impact of care coordination and management efforts, value-based insurance design, network effectiveness, and all other factors affecting overall plan efficiency.

Technical Issue #6: Use of the Statewide market average premium in the risk transfer formula for all plans

The risk transfer formula for calculating risk adjustment charges and payments is based on the difference between an approximation of a plan's relative premium including any risk selection impact and an approximation of that plan's relative premium including only allowed risk factors (primarily age). This difference is then multiplied by the Statewide market average premium to estimate the average monthly amount by which a plan's actual premium reflects above-average or below-average health risk among its members. That difference, multiplied by the plan's total number of member months, constitutes the payment that the plan will receive from the risk adjustment pool or the "charge" it will have to pay to the pool (depending on whether the amount is positive or negative, respectively).

The estimate produced by this formula is affected by its use of the Statewide market average premium. To the extent that a plan's actual premiums are significantly lower (or higher) than the market average, then its estimated premium difference will be significantly exaggerated. In particular, for efficient, high-performing plans focusing on thorough care management, cost-efficient care, effective provider networks, low administrative costs, and, in some cases, low nonprofit margins, member premiums will generally be well below average in an area, for a given mix of enrollees. If such a plan's premium is, say, 20% below the market average, then the risk transfer formula's estimate of the plan's premium related to unallowed health factors will be 20% greater than the reality.[7]

The risk transfer formula uses the Statewide market average premium in significant part because it simplifies the calculations and automatically results in plan payments and charges that sum to zero.[8] Use of a plan's *actual* average premium in the risk transfer formula, rather than the Statewide market average premium, would eliminate this significant source of estimation error and result in much fairer transfers among plans.[9]

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[7] "Reality" in this example is a relative term. The risk transfer payment also depends critically on the plan's measured risk score, which, as noted previously, may be substantially understated by incomplete HCC diagnosis data for its members. In addition, use of *average claims costs* would be more appropriate than average premiums.

[8] See Gregory C. Pope, Henry Bachofer, Andrew Pearlman, John Kautter, Elizabeth Hunter, Daniel Miller, and Patricia Keenan. "Risk Transfer Formula for Individual and Small Group Markets Under the Affordable Care Act." *Medicare & Medicaid Research Review*, 4, no. 3 (2014): E5-E6. Available at https://www.cms.gov/mmrr/Downloads/MMRR2014_004_03_a04.pdf.

[9] This approach would be equivalent to using a "plan efficiency factor" in both terms of the risk transfer formula, much like the existing use of a geographic cost factor in both terms. The plan efficiency factor would be the ratio of the plan's actual average premium to the Statewide market average premium. The recommendation above, to directly use each plan's actual average premium, is just a simpler mechanism for achieving the same result. In either approach, it would be necessary to adjust the aggregate "payments" to receiving plans and/or "charges" to other plans to achieve overall balance among the transfers. Limiting aggregate payments to the amount provided by aggregate charges would serve as an effective incentive for lower-efficiency plans to improve their cost effectiveness.

<u>Technical Issue #7</u>: Statutory requirement for the risk corridors program to be self-funded

In developing the Affordable Care Act, Congress recognized the much greater uncertainty associated with the new individual and small group insurance markets formed by the legislation, with guaranteed issue requirements, minimal allowed premium variation for underwriting factors, and relatively modest penalties for individuals opting not to obtain qualified health insurance. Because many of the new marketplace enrollees would be gaining health insurance coverage for the first time, the health status of a plan's membership was much harder than usual to predict.

In addition, legislators knew that the risk adjustment process would not be perfect. A particular concern was the possibility that marketplace enrollment in the early years might be highly select; that is, individuals with serious health care needs would be more inclined to purchase insurance than others in better health. Such adverse selection—which has, in fact, occurred—would result in an enrolled risk pool with above-average costs. The risk adjustment transfers would help protect plans with risk profiles in excess of the market-wide average, but it was not designed to mitigate the situation where the market-wide average itself was significantly more expensive than the population of all eligible members.

In recognition of the uncertainties and risks facing insurers in a new market, Congress designed the risk corridor program for 2014-2016, which would share the risk of adverse financial performance between the marketplace insurers and the federal government. Similarly, plans that performed better than expected would be required to share the gains with the government. In addition to sharing the financial risk with individual plans, the risk corridor program would address the possibility that the overall risk profile within a marketplace would be significantly greater than that of a "standard" or population-wide average. A similar risk-sharing approach has been successfully employed for the Medicare Part D prescription drug benefit, which is provided through private insurance plans.

Most insurers correctly anticipated a significant degree of change in overall morbidity among participants in the new insurance marketplaces and factored that likelihood into their premium determinations. Long after premiums had been established for 2014, however, the Administration altered the rules governing the transition of existing individual and small group health insurance plans to the ACA rules, and many States used the new flexibility to allow such plans to continue in operation under pre-ACA rules—and outside of the risk adjustment process. Because these plans used conventional underwriting standards, their insured populations had better-than-average risk profiles, and their continuation outside of the new ACA marketplaces resulted in worse-than-expected risk levels within the new marketplaces.

The new transition rules for these "grandmothered" plans increased the likelihood of higher-than-expected costs for the majority of marketplace plans, reducing anticipated gains and worsening any losses. In many cases, however, the higher losses would be shared with the federal government through the risk corridors program, which was not required by the Affordable Care Act to be "budget neutral." Then, during 2014, federal budget pressures led to consideration of requiring the risk corridors program to be budget neutral—that is, the federal sharing of plan losses could only occur to the extent permitted by revenues from federal sharing of other plans' gains. This possibility was enacted in December 2014 by Public Law 113-235,

the "Consolidated and Further Continuing Appropriations Act, 2015." This so-called "CRomnibus" budget legislation prohibited use of any other revenues in fiscal year 2015 for the purpose of sharing plan losses through the risk corridor program.

The "CRomnibus" limitation resulted in federal loss-sharing payments to marketplace plans that totaled only 12.6% of the full amount due under the original, unrestricted risk corridor program. While losses can occur for many reasons, major factors in 2014 included (i) the after-the-fact change in transition policy for "grandmothered" plans (which affected all plans in States adopting the new policy) and (ii) the technical limitations with the risk adjustment program, described above (which predominantly affected new plans, fast-growing plans, and high-efficiency plans). Many health plans experienced serious financial losses for the 2014 plan year. Moreover, the primary causes of the situation were largely or entirely out of the control of otherwise high-performing insurers, who chose in good faith to participate in the new ACA marketplaces.

Conclusion

As a result of these technical problems with the risk adjustment and risk transfer formulas, new, fast-growing, and highly efficient health care plans have experienced very adverse financial adjustments. In addition, the after-the-fact transition policy changes for "grandmothered" health plans have significantly worsened the overall risk pool for marketplace insurers. Finally, the CRomnibus limitation on funding the risk corridor program vitiates the ACA's intended sharing of insurance risks in the new marketplaces.

Collectively, these technical issues and policy changes have led to the outright failure of several new, fast-growing, and efficient health plans, as well as jeopardizing the ongoing viability of many others. Although designed to add stability and equity to the operation of the new marketplaces, in too many instances the actual implementation of the risk adjustment and risk corridor programs have caused instability and inequitable results, while also contributing to higher premiums. In the process, the ACA's goals of fostering competition among plans and promoting rapid innovation have been hindered, thereby countering improvements in quality of care and cost-effectiveness.

Examples abound of the unintended adverse effects on new plans and existing ones that expanded into the ACA marketplaces:

- Minuteman Health of Massachusetts was able to set low premiums by focusing on a narrow plan network and negotiating very economical provider payment rates. Already struggling with low 2014 enrollment (caused by the Massachusetts Health Connector's systems problems), Minuteman discovered in June 2015 that it owed risk adjustment transfer charges for 2014 equal to *71%* of its gross premium revenues.[10] This wholly implausible result is due to

[10] Massachusetts opted to develop its own risk adjustment and risk transfer programs, rather than using the HHS-HCC model. The Massachusetts model is fundamentally similar to the HHS-HCC system used by all other States and is subject to the same distortions described in this report.

- A very low plan liability risk score (reflecting new enrollees with no recorded HCC diagnoses, together with a concurrent risk adjustment model lacking prescription drug inputs and using understated coefficients for individuals without HCC diagnoses); and
- Use of a Statewide market average premium in the risk transfer formula that fails to account for Minuteman's much lower premium rate. (Fully 40% of the risk adjustment charge paid by Minuteman was simply due to the fact that its premiums were so much lower than those of the broad-market products that drove the Statewide average.)

The company's dramatically high risk transfer charge resulted in a large operating loss in 2014—which was only minimally shared with the federal government as a result of the CRomnibus limitations on risk corridor funding.

- The start-up insurance company Oscar has been hailed for bringing an innovative, member-friendly, and high-tech approach to health care, including an easy-to-use website and mobile app, understandable benefit statements, zero-cost telemedicine services, and value-based insurance designs such as free generic prescription drugs. Oscar's features tend to attract younger and healthier enrollees, resulting in a better-than-average plan liability risk score. The low risk score would not be a problem by itself, but it is compounded by the significant understatement of relative costs in the HHS-HCC risk adjustment model for individuals with below-average health expenditures.

  Moreover, use of the New York market average premium in the risk transfer formula, rather than Oscar's actual low premium level, greatly exaggerates the risk transfer charge assessed against the company. While Oscar had transitional reinsurance receipts of $17.5 million in 2014, indicating a significant number of members with high-level health care costs, its exaggerated charge for risk adjustment amounted to $8.1 million. As with the majority of marketplace health plans, the CRomnibus requirement for budget neutrality in the risk corridor program means that Oscar's financial losses will be only minimally shared with the federal government.

- Preferred Medical Group, Inc. of southern Florida found itself in a similar situation as Oscar. This long-established health insurer focused on cost-efficient health care, with premiums that were among the lowest in the area. As a result of its competitive position, Preferred Medical signed up twice its expected number of enrollees in 2014—only to discover that its low premium level, compared to the Statewide market average premium, contributed to a risk adjustment charge of more than $97 million—or roughly $89 per member per month. The expectation of an unreasonably high risk transfer charge, and the likelihood of minimal risk sharing through the risk corridor program, led the company to suspend further enrollment in May 2015.

- New Mexico Health Connections implemented a CO-OP plan built upon cutting-edge care coordination and management programs together with strong value-based insurance design elements. Their success in maximizing drug regimen adherence, reducing unnecessary hospitalizations, and achieving other medical management savings allowed

NMHC to submit a 10% premium reduction for 2015—before they learned of their $6.6 million charge to the risk adjustment pool (for reasons similar to Minuteman Health).

- An analysis of the 35 health insurance companies that could be identified as being new to the commercial market in 2014 showed that three-fourths of them faced charges to the risk adjustment transfer pool, with an average per-plan charge amount of $7.4 million. These charges represented approximately $37 per member per month (among the plans for which enrollment figures are available). The very high proportion of new plans with risk adjustment charges reflects the limited time available for obtaining HCC diagnoses, and the PMPM charge of $37 would be financially devastating to any health plan, let alone efficient plans with low premiums.

- To date, 12 of the original 23 CO-OP plans will have had to cease operations by the end of 2015. Although these plan terminations reflect a variety of financial and operational factors, the biggest reasons were (i) exaggerated risk transfer charges, caused by the limitations with the risk adjustment model and risk transfer formula, and (ii) the failure of the risk corridor program to share insurers' financial risks.

In many respects, new, member-focused health insurance plan choices have been very successful at achieving the goals of the Affordable Care Act regarding coordinated, efficient, and high-quality health care, as well as offering marketplace competition and affordable premiums. Moreover, such plans have the potential to continue and build upon their initial strong showing in future years. Their ability to do so, however, is severely jeopardized by adverse financial adjustments resulting from the technical shortcomings of the current risk adjustment and risk corridor programs. These problems can and must be corrected through refinements to the methodology, improved data handling, and adequate funding for the risk corridor program.

Such changes will take time, and more immediate action is needed to address the chaotic financial situation in which new, fast-growing, and highly efficient plans in the ACA marketplaces find themselves. Given the circumstances, it would be appropriate to put in place one or more emergency measures to address the problems with the 2014 risk adjustment program, such as the following:

- Exempt new and fast-growing plans from risk adjustment for the first 3 to 5 plan years, in recognition of their difficulty in obtaining complete HCC diagnoses for their enrollees. A gradual phasing-in of risk adjustment for such plans would also address this problem.

- Alternatively, apply a "credibility-based" approach to participation in risk adjustment, accounting for both overall plan size and the proportion of members who have not previously been enrolled with their current insurer. Plans with very low credibility would be excluded from risk adjustment altogether, and others would participate proportionally until fully credible.

- Place an upper bound (e.g., 10%) on the amount of a plan's risk adjustment transfer charge, to avoid financial harm to insurers and undue premium increases for members resulting from limitations in the risk adjustment program.

- Recalculate 2014 and later risk transfer payments and charges for all plans with below-average premiums in a State, using the plans' own average premium amount or average claims cost, to avoid the unjustified leveraging of these transfers for efficient plans when based on the Statewide market average premium. (The same approach could be used for all plans, including those with above-average premiums; applying it to efficient plans only would provide an incentive for high-premium plans to become more efficient.)

The member organizations in the CHOICES coalition are more than willing to assist our partnership with CMS and Congressional lawmakers by helping to develop technical corrections, designed to ensure that these important risk programs work as intended for the overall benefit of marketplace enrollees across the country.