CHOICES

For Immediate Release

Contact: David Lee, Advisor to CHOICES. Office: (202) 774-1408

Proposal for State Authority to Address Estimation Bias in the HHS-HCC Risk Adjustment Model

For the second year in a row, the results of the federal risk adjustment program have been highly volatile for the individual and small group markets. While often directionally correct, the magnitude of the results is significantly greater than would normally be expected. The result is that many health plans are pulling back from the exchanges specifically or the insured market entirely. This serves to drive-up prices and harm consumers and small employers.

The Consumers for Health Options and Insurance Coverage in Exchanges and States (CHOICES) coalition has long advocated for certain structural changes in the Affordable Care Act's (ACA) risk adjustment program, as codified and established by the Centers for Medicare and Medicaid Services (CMS). While we recognize the importance of a well-functioning risk adjustment program in this marketplace, the current model contains clear biases and limitations. As CMS itself identified at its March 31, 2016 conference on risk adjustment, the model and its inputs require revisions. It's proposed timeline to address these concerns is gradual, anticipating up to four or more years for changes to take effect. To the extent CMS is not able to develop and implement improvements in the near-term, we believe states should consider using their own authority, as encouraged by CMS, to address immediate concerns.

One of the core challenges with the current formula is the understatement of risk scores for relatively healthy individuals and a corresponding overstatement for those with significant health conditions. This shortcoming has been well documented by CMS and outside reviewers. CHOICES has collaborated with stakeholders in the market and former Chief Actuary for CMS, Rick Foster, to identify solutions to this estimation bias. The attached memo introduces an important interim solution that significantly mitigates the bias through a simple adjustment to each plan's risk score in a state. The adjusted risk scores would substituted for the original HHS-HCC values in the CMS formula with all other factors remaining unchanged. The resulting transfer amounts would be significantly more accurate, consistent with correction of this estimation bias.

We recognize that risk adjustment transfer amounts for 2015 have been posted by CMS with the intention to force fund transfers on August 15, 2016. Over the coming 30 days, we believe this estimation bias correction method could be applied by state regulators to help improve accuracy and mitigate the transfer variance that poses risk to their market. This straightforward correction could be run by CMS or performed by state regulators by simply applying a new calculation on the chassis of the existing HHS-HCC risk adjustment model. For the latter, we propose that states exercise this authority by leveraging the existing HHS-HCC risk adjustment model while instituting the methodology for the estimation bias correction, applying these changes to the transfer amounts for 2014 and 2015.

To accomplish this, state regulators will require the plan risk scores and other risk adjustment data and the transfer formula factors from CMS. CMS should also be afforded the ability to work with states on the re-calculation. States would assume the authority of working with the issuers under their stewardship in sharing the estimation bias correction methodology and recalculating final transfers.

This correction to the formula does not resolve other issues, but takes a solid step forward in improving accuracy and mitigating the variability in transfers that exist in the market today. It is actuarially sound and simply corrects a known bias that has distorted the risk adjustment results published on June 30, 2016, while maintaining CMS' objective of a 'zero-sum' solution and harming no market participant.

We strongly encourage CMS to work with the NAIC or other state regulators to quickly validate the methodology in the attached memo and promulgate any guidance needed to adopt these changes. No funds should be forced to be paid under a methodology that is currently biased and can be easily corrected.

About CHOICES

Consumers for Health Options, Insurance Coverage in Exchanges in States (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.