SNL RISK & REGULATION

Tuesday, March 29, 2016 9:59 AM ET Exclusive

State regulators, small health insurers unite in campaign to reform ACA's risk adjustment program

By Adam Cancryn

A loose coalition of small health insurers and state regulators is stepping up efforts to reform the Affordable Care Act's risk adjustment program, warning that without changes it could force a slew of companies off of state exchanges or perhaps even out of business.

The group has lobbied federal officials repeatedly on a pair of stopgap measures, including a so-called circuit breaker that would limit how much insurers might have to pay into the program. A second proposal would exempt new marketplace entrants from risk adjustment altogether, in response to concern that the program's formula disproportionately penalizes high-growth plans.

Now, it is considering forcing the Obama administration's hand through more direct action. Maryland Insurance Commissioner Alfred Redmer Jr. and New Mexico Insurance Superintendent John Franchini are circulating a plan to make unilateral changes to the risk adjustment program in a bid to limit its impact on their respective state marketplaces.

Several other states are considering taking similar action, Redmer said in an interview. The regulators are expected to hold more formal discussions at the NAIC's Spring National Meeting.

The plan, the specifics of which were first reported by *Inside Health Policy*, could put risk adjustment at the center of yet another debate over the federal government's power to implement the ACA. The program is one of three ACA-created mechanisms aimed at stabilizing the state health exchanges, and is federally administered in every state except Massachusetts, which runs its own similar risk adjustment. That means that to make changes, most states would need to challenge the Centers for Medicare and Medicaid Services' authority over the risk adjustment program, potentially angering the U.S. government and prompting a federal lawsuit.

Nevertheless, there is momentum among both small insurers and the regulatory community for imposing the state-level changes, following months of frustration with federal officials who they say are ignoring a growing threat to the exchanges' viability.

"CMS doesn't appear very interested in doing anything for today," Minuteman Health Inc. President and CEO Thomas Policelli said in an interview. "This is our members' money, and so we think this deserves a more timely response."

Private meetings

CMS said that it believes the program is fair and accurately redistributes funds across the exchanges, and on March 24 published a white paper backing up its assertions. The agency has told companies that it is willing to discuss alterations to the program that would take effect in 2018. It will hold a public forum on March 31 to hear suggestions and discuss a few of its own proposals.

But critics argue that CMS is ignoring the central problem, which is that the core formula underpinning the program is flawed and favors larger, more established companies at the expense of small or high-growth participants. There is no limit to the amount that an insurer can owe under risk adjustment, which small plans say adds to the difficulty of preparing each year for a potentially large financial obligation.

The risk adjustment program

The Affordable Care Act's permanent risk adjustment program was intended to stabilize the state health insurance exchanges by spreading financial risk across the market and protecting against adverse selection.

The Department of Health and Human Services collects money from insurers with member populations that it determines are healthier than average, and redistributes those funds to competing insurers with riskier-than-average populations.

Those objections grew louder in the wake of the 2015 collapse of 11 federally funded consumer operated and oriented plans. At least 17 of the 23 total co-ops owed money into the risk adjustment pool based on their 2014 membership, even though most had reported significant net losses during that year. The surprise charges stressed their thin capital reserves and played a central role in the wave of shutdowns toward the end of the year.

Amid those closures, three surviving co-ops joined with two private insurers and co-op trade group National Alliance of State Health CO-OPs to form the lobbying group Consumers for Health Options, Insurance Coverage in Exchanges in States, or CHOICES. Since then, CHOICES has led a single-minded charge to revamp risk adjustment. The group published a white paper outlining specific objections to the program's formula, and was the first to publicly propose installing a circuit breaker preventing insurers from paying more than 2% of annual premium revenue into the risk adjustment program. It also developed the concept of a three-to-five-year exemption from risk adjustment for new marketplace entrants.

The proposals have gained little traction with federal health officials. In a series of private meetings over the past few months, CMS Acting Administrator Andy Slavitt told Policelli, Evergreen Health Cooperative Inc. CEO Peter Beilenson and New Mexico Health Connections CEO Martin Hickey that the agency is constrained because it cannot "change the rules in the middle of the game." HHS Senior Counselor Aviva Aron-Dine similarly dismissed the trio's proposals during a January meeting.

CMS did not make Slavitt or any other individuals available for an interview, and did not comment on the meetings or their content.

No immediate changes

The rejections puzzled the co-op executives, who say that the Obama administration has yet to specify why it is so important that risk adjustment remain untouched.

"I said, 'With all due respect, sir, this is the only thing I can think of that you haven't changed in the middle of the game, literally,'" Beilenson said, describing one conversation with Slavitt. "Medicare risk adjustment, reinsurance, [special enrollment periods], open enrollment changes — every single year, meaningful use gets changed, network adequacy gets changed, as we're speaking things are changing, but you won't change risk adjustment with the circuit breaker. It doesn't make sense."

Indeed, CMS made a series of tweaks over the past year, most notably toughening the oversight of special enrollment periods and easing proposed network adequacy standards. The changes came after complaints from insurance giants including Aetna Inc. and UnitedHealth Group Inc., the latter of which threatened to leave the exchanges if participating did not become more profitable.

While large insurers have found success in throwing their weight around, they have steered clear of the risk adjustment debate. Companies with significant market share in the individual market paid less as a percentage of earned premium into the risk adjustment pool, a Milliman study found, and bigger insurers tend to have more diversified operations that can absorb the program's potential hit.

Trade group America's Health Insurance Plans did not respond to a request for comment.

CMS spokesman Aaron Albright did not respond to specific questions for this article, but said that the agency's official positions remain unchanged. He added that considering changes starting in 2018 makes sense because insurers are already in the process of setting their rates for 2017. As for the criticism that larger insurers tend to make out better under risk adjustment than small or high-growth companies, he pointed to a finding in the agency's white paper that the amount of an insurer's paid claims played a large role in its risk adjustment result, while size did not matter much at all. The paper also blamed outsized risk adjustment charges on insurers' own inexperience in compiling and submitting data.

"Some issuers who have stated they were overcharged had more difficulty than others in achieving quality data submissions, which could have affected risk adjustment transfer amounts, though CMS considers these difficulties to be preventable by the issuer itself," the white paper said.

'A huge amount of frustration'

At the state level, CHOICES and its allies are finding far more sympathy. Just days after CHOICES released its white paper, insurance commissioners grilled HealthCare.gov CEO Kevin Counihan on the risk adjustment program's impact, and later commissioned the American Academy of Actuaries to study its "perceived adverse effect on small issuers." The AAA will present its findings at the NAIC Spring National Meeting.

New Mexico's Franchini also launched his own campaign in favor of a 2% circuit breaker around the same time, warning that risk adjustment is so financially unpredictable it could prompt up to 100 small insurers nationwide to leave the exchanges, and others to drastically hike prices. In a January interview, he criticized CMS officials for their reluctance to listen to state regulators on the issue.

"There's a huge amount of frustration," Franchini said of insurance commissioners' work with their federal counterparts. "I just wish they would leave things alone that are working and let them flow, and the things that aren't working they should attack. It's amazing how they're always on the wrong foot."

Insurance commissioners found themselves at odds with CMS on a few occasions during the ACA's implementation, tapping into overarching fears of the federal government encroaching on the states' regulatory turf. CMS in November 2015 released proposed national network adequacy standards around the same time that the NAIC adopted its own network adequacy model law, riling insurance commissioners who had spent the last year-and-a-half crafting their standards. State regulators also clashed at times with CMS over how to handle the co-ops, most recently disagreeing on how to stabilize Maine's Community Health Options.

Most states have nevertheless remained reluctant to publicly side with Franchini on risk adjustment before a formal plan is in place. After Franchini said in a December 2015 interview that regulators in Massachusetts, Washington, Oregon, Iowa and Nebraska privately expressed support for his reform push, none of those state offices backed him up.

Spokesmen for the insurance offices in Washington, Oregon and Iowa all declined to comment, and Nebraska did not respond to a request for comment. A Massachusetts spokesman said that the state regulator is only considering the options surrounding risk adjustment and has not expressed any opinion one way or the other, but would welcome opportunities to participate in any dialogue with CMS.

Rising pressure

Franchini gained a strong ally in Maryland's Redmer, who took up the issue in part to defend Beilenson's Evergreen Health. In congressional testimony in February, Redmer said that risk adjustment "has proven to place newer carriers at a distinct disadvantage" and called for either a 2% circuit breaker or a full exemption for new and fast-growing plans.

Redmer in an interview said that he has had productive discussions with CMS on the potential for reforms, though he has not yet received a definitive answer on how the agency would react to state-level changes. State regulators would much rather find a compromise with the federal government on short-term measures than launch a direct challenge. But they face a time crunch ahead of the next round of risk adjustment calculations, as well as increasing pressure from CHOICES to make a move.

"We need to put pressure one way or another on the administration," Beilenson said, adding that state-level changes would force the government into a tough choice on whether to file a lawsuit. "The administration would look terrible coming in to attack the very new entrants that the ACA was trying to encourage to join the insurance market, so I think it would make sense. I would even concede that you might lose the [legal] case, but the political case would put a lot of pressure on CMS to just allow it."

Albright did not respond to a question about how the federal government would view such a challenge.

In the meantime, small health insurers are taking operational precautions ahead of the next round of risk adjustment. Insurers in Massachusetts' small group market requested rate hikes across the board, prompting the state insurance department to hold a January hearing on the filings. Harvard Pilgrim Health Care Inc. and CHOICES members Health New England Inc. and Minuteman Health singled out risk adjustment as a main driver of the rising prices during the hearing.

Policelli said that he is reserving more than 40% of his co-op's 2015 premium revenue for the risk adjustment program, a decision he said is part prudent accounting and part a protest of the program's unpredictability. Oscar Insurance Corp., the private startup backed by Google Inc., is setting aside nearly 24% of its premium revenue, or $28.3 million, according to its regulatory filing. The company paid $8.1 million into the pool in 2015. Oscar declined to comment.

At New Mexico Health Connections, Hickey said he has resorted to more traditional techniques. The co-op raised rates about 15% for 2016, he said, and is doing all it can to limit its claims costs. Its internal risk adjustment estimates for this coming round show it could be on the hook for about $4.3 million, but might have to pay as much as $8 million. Next year, its projections show it could make $10 million in a best case scenario, or lose $10 million in the worst case. Either way, Hickey is already planning to raise prices again in 2017.

"We're being a typical insurance company, which is what's making me want to throw up," he said.