Massachusetts Risk Adjustment Program: Executive Summary

Introduction

Wakely Consulting Group, Inc. has been retained by issuers in the Massachusetts market to review the methodology of the Massachusetts Risk Adjustment Program (the "Program"") and comment on its appropriateness and whether is meets the intended goals of the program. This document summarizes the salient results from that analysis.

Key Findings

The overarching goals of the Affordable Care Act are to increase the number of Americans covered by health insurance, and decrease the cost of health care. Wakely's review of the Program shows that the current structure of the Program will limit choice and increase the cost of care in Massachusetts by raising premiums and decreasing competition.

According to the HHS Notice of Benefit and Payment Parameters for 2014, "The goal of the Affordable Care Act risk adjustment program is to [i] mitigate the impact of possible adverse selection and [ii] stabilize the premiums in the individual and small group markets as and after insurance market reforms are implemented."[1] The present Massachusetts Risk Adjustment program fails to satisfy these two express purposes of risk adjustment.

1. **The Massachusetts Risk Adjustment Program Will Not Protect Against the Risks of Insuring Less Healthy Populations**
   - Because of near universal coverage under prior Massachusetts reforms, there has been no flood of newly insured persons. Massachusetts has successfully dealt with the risks of insuring less healthy populations without imposing risk adjustment payments through its previously implemented requirements including guarantee issue, community rating by class, and income based subsidies.

2. **The Massachusetts Risk Adjustment Program Will Destabilize Premiums**
   - It does not compare risks within a region, but compares issuer risks to a state average, creating unfair and anti-competitive biases between regions.
   - It systematically underestimates the cost of managing healthier members.
   - It puts an increased burden on limited network plans.
   - It does not take into consideration the transitional rating factors currently still being used in the merged market.
   - It not only results in transfers of medical costs, but also administrative cost components of premiums.
   - It requires lower cost issuers with lower risk scores to subsidize higher cost issuers for amounts unrelated to relative health status.
   - It will discourage new entrants to the market, which could further increase premiums.
   - Data concerns reduce validity of risk adjustment calculations.
   - The negative impact of the identified concerns will be amplified for any small issuer.
   - A review of 2014 year-end NAIC financial statements indicates that risk adjustment payables (expected risk adjustment payments for 2014) reduced the Risk-Based Capital

[1] 78 Fed. Reg. 15410, 15412 (March 11, 2013).

surplus for seven of nine companies reviewed. Reduced RBC levels will force companies to raise premiums.

Summary of Results

A. Risk Adjustment is an Attempted Cure of a Problem That Does Not Exist in Massachusetts

The acknowledged intent of risk adjustment is to mitigate adverse selection and to stabilize premium rates. In other jurisdictions there is an expectation that a significant number of newly insured persons will flood the market due to the mandated coverage provided by the ACA. In Massachusetts, however, as a result of previous reforms, there is nearly universal coverage. As a result, the Program attempts to solve a problem that does not exist in Massachusetts.

B. The Risk Adjustment Methodology Will Destabilize Premiums by Creating Regional Biases

The Massachusetts Program does not compare risk scores within a specific market region. The risk score for Western Massachusetts (.90) is much lower than the state average score (1.00). Issuers based solely in Western Massachusetts will therefore be paying into the risk adjustment pool. This would be an acceptable result if the Western Massachusetts population was in fact healthier than the rest of the Commonwealth. However, publicly available data indicates that the Western Massachusetts population presents higher actual risk than the population statewide. In particular:

- Western Massachusetts' population center, Hampden County, has historically had the lowest health status scores in the Commonwealth[2]
- Western Massachusetts includes three of the poorest counties in Massachusetts[3]
- Western Massachusetts has more towns designated as Medically Underserved areas than any other part of the Commonwealth[4]

There is evidence that regional differences in coding practices by practitioners affect risk scoring. Academic research suggests that providers in regions, such as the Boston area, with a higher intensity of medical practice are more aggressive in diagnosing and assigning HCCs than providers in lower intensity regions such as Western Massachusetts. This would contribute to the lower risk score in Western Massachusetts. Because there is a only a small component of the risk scores attributed to the demographic component (outside of infants) in the Massachusetts risk score calculation, HCCs comprise the majority the risk score and any under-coding will significantly impact the calculations.

This leads to unexpected results. One Massachusetts issuer, which draws nearly its entire membership from Western Massachusetts, has a higher risk score (.96) than the regional average (.90), indicating

[2] http://www.countyhealthrankings.org/app/massachusetts/2015/rankings/outcomes/overall

[3] Western Massachusetts includes four of the five counties with the highest percentage of poverty and the lowest per capita income in Massachusetts, based on US Census Bureau data. The largest county by population in Western Massachusetts, Hampden County, is the poorest county in Massachusetts measured by per capita income and the second poorest measured by people living in poverty. In 2011, the four Western Massachusetts counties comprised 12.5% of the State's population but accounted for 20.9% of its Medicaid enrollees.

[4] A large number of towns in Western Massachusetts have been designated as health professional shortage areas for primary care physicians and as medically underserved by the Health Resource and Services Administration of the U.S. Department of Health and Human Services ("HRSA"). Of the 102 Massachusetts towns designated as medically underserved by HRSA, 78 are in Western Massachusetts.

that it covers a higher risk population than some of its regional competitors, and should receive a risk adjustment payment from those regional competitors. Because the risk adjustment scores are compared to a state-wide average, however, instead of receiving a payment, the affected issuer will be required to make a sizeable payment to other issuers based on data from regions the affected carrier does not serve, and likely be forced to raise its premiums as a result.

Although the funds transfer formula includes a Geographic Cost Factor Adjustment ("GCF"), that adjustment does not address the problem identified above. The GCF "is intended to reflect the geographic variation in input prices or utilization rates that are likely to affect plan premiums."[5] In other words, the GCF accounts for higher provider prices, not differences in diagnosing and assignment of HCCs.

C. The Massachusetts Model is Biased Against Issuers with More Zero Condition Members

The Massachusetts Program assigns a very low risk score to individuals with no HCCs. Our analysis indicates that, for every one dollar of revenue remaining after risk adjustment transfer payments are taken into consideration for a member with no HCCs, over two dollars are spent in medical expenses. As a result, after risk adjustment, issuers are *losing* money on those members who are not assigned any HCCs. Therefore any issuer that has a larger proportion of zero HCC members than the market as a whole is penalized by the Massachusetts risk adjustment formula. If a plan has a significantly higher share of members with no HCCs (for example - a new entrant without significant member persistency), that plan would be unfairly harmed by the methodology.

For the same reason, the Program penalizes any issuer that implements a successful wellness program. In the event that an issuer is able to reduce its member HCC's to zero, the issuer will be penalized by then losing money on those members. This removes incentives for issuers to invest in programs that will make their members and communities healthy, which is contrary to public policy, and inconsistent with legislation that promotes health and wellness.

D. The Risk Methodology Penalizes Limited Network Plans

Chapter 224 requires most issuers in the merged market to offer limited and tiered network plans. Where required, these plans must be discounted 14% below the cost of comparable broad network plans. According to Division of Insurance Small Group Regulations, 211 CMR 66.00, the goal is "for these plans to be available throughout the Commonwealth." However, these plans attract younger, lower risk individuals. The analysis confirmed that one Massachusetts issuer with multiple limited network plans has 3-4% apparently healthier members (members with zero Hierarchical Condition Categories ("HCCs")) than the statewide average. Premiums for all limited network products will need to be increased to offset the risk adjustment transfer payment that will result from attracting the healthier population, potentially making these types of plans unsustainable. Further exacerbating the problem is that the carrier's average premium in these plans is lower than the average market premium due to the required discount, so the risk adjustment transfer will need to be a greater proportion of the premium than there would be for issuers with average overall premium levels. The Program's methodology penalizes issuers that have invested in providing discounted limited networks and calls into question the ability to comply with the state law with financially viable plans.

E. The Risk Adjustment Methodology Ignores Transitional Rating Factors

The Connector's decision not to take into consideration the transitional rating factors currently still being used in the merged market is inconsistent with CMS's guidance that indicates a need to normalize

[5] Commonwealth of Massachusetts Notice of Benefit and Payment Parameters 2014, p. 23.

for all rating variables.[6] For example, by not taking into account Massachusetts' continuing use of the industry factor, plans where the industry factor is less than one are penalized in the Massachusetts methodology because they receive smaller premiums for certain industries and then (assuming these groups have lower risk) also have to make a risk adjustment payment from revenues received from these industries. Federal regulators recently granted Massachusetts an extension to continue using transitional rating factors through 2017, which will result in an ongoing penalty to issuers utilizing this rating factor that cover groups in industries resulting in an average industry factor under one.

F. The Risk Adjustment Formula is Inappropriately Applied to Administrative Costs

Another concern is that the methodology calls for risk adjustment to be applied to premium amounts, not just the claim component of the premium. To the extent that administrative expenses do not vary with the level of claims, this methodology is inappropriate. Applying the formula to claims or a portion of the premiums is more appropriate. The current methodology results in plans paying into the pool at an inflated amount because premium dollars not used to pay claims are included in the payment transfer calculation. In addition, this results in excess amounts to plans receiving payments from the pool.

G. Low Cost Issuers Have More Volatile Payment Transfers than High Cost Issuers

The further a carrier's average premium drops below the statewide average premium, the lower the proportion of its risk transfer that is related to health status differences. As a result, low cost issuers with lower risk scores (achieved by negotiating lower rates with providers, excluding high cost providers, directing care to more efficient sites of service, or other methods) are penalized by the Program. For example, issuers that have embraced the strategy of providing limited network products at a discounted premium rate so that small employers and individuals can have access to quality care at an affordable premium price point are now being penalized for doing so. At the same time, issuers with more expensive provider networks are provided with an incentive to maintain those high cost networks.

H. Risk Adjustment Will Decrease Competition and Likely Increase Premiums by Unfairly Burdening New Entrants to the Market

The problems described above have special relevance to plans newly entering the market. Compared to older more established competitors:

- new issuers will not have member persistency, resulting in fewer accumulated HCCs with respect to its members and more members with zero HCCs;
- new issuers are likely to offer a more limited network;
- to assist their entry into a crowded market, new issuers are likely to offer lower premiums; and,
- new issuers have less complete claims experience and lower membership resulting in risk scores that are less predictable.

As a result, the risk adjustment program may create a number of burdens on new entrants to the market, ultimately inhibiting competition and likely resulting in increased premiums.

I. Risk Adjustment Results Have Been Unreliable Due to Data Issues

Uncertainty in risk scores does not depend entirely on the quality of the risk adjustment model being used. It also depends on the quality of the data being entered into the model. Data issues in the All Payor Claims Database, which are a result of the Connector website difficulties, have produced unreliable risk adjustment results. In addition, the existing data screening checks and error flagging capabilities are not adequate.

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[6] CMS-Risk Adjustment Payment Transfer Methodology presentation-page 7-May 7, 2012

J. Risk Adjustment Is Less Predictable for Smaller Issuers

The smaller the population analyzed for the risk score comparison, the greater the uncertainty about the ability of the score to predict actual claims costs. Smaller plans, which have smaller enrollments subject to risk adjustment, face greater uncertainty, and resulting risk adjustment payment transfers that may not be appropriate. This puts them at a disadvantage relative to larger competitors. If the smaller plan is new to the market, region specific, or has a large percentage of enrollment in limited network products, the anti-competitive effects discussed above are compounded.

Conclusion: The Massachusetts Risk Adjustment Program Destabilizes the Market

Ultimately, the risk adjustment program is de-stabilizing, rather than stabilizing, the Massachusetts marketplace. It will have the result of forcing small issuers with lower premiums and lower risk to increase those premiums to cover risk adjustment payments to large issuers. The overall result will be an increase in insurance costs in the individual and small group market.

A review of 2014 year-end NAIC financial statements for Massachusetts issuers indicates that the risk adjustment payables reduced the Risk-Based Capital levels for seven of nine companies we reviewed. The issuers with the lowest RBC levels are two of the hardest hit by risk adjustment transfer payments. The two issuers that expect a risk adjustment receivable from the pool are two of the issuers with the highest RBC percentages. From a financial solvency perspective, the Program is exposing the issuers that are most vulnerable to further insolvency risk.

When these financial impacts are considered along with the issues created by the methodology itself, it seems clear that implementing the Program will run counter to the stated purposes of risk adjustment: it will destabilize rather than stabilize the market. The Program is inappropriate for the Massachusetts market and disproportionately penalizes smaller, newer and regional health plans to the benefit of larger, better funded health plans. At a minimum, this inhibits competition, and at worst, it has the potential to drive smaller health plans out of the merged market, creating less competition and higher short- and long-term prices.

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