CHOICES

A Call for State Action: Identifying Potential Imbalances in Risk Adjustment Transfers

June 15, 2016

Background

At the mid-point of the third year for the ACA Individual and Small Group markets, stakeholders in the market are still seeking to gain a better understanding of the substantial effect the Risk Adjustment (RA) program has on the market. The Centers for Medicaid and Medicare Services' (CMS) stated goals for the program were to "mitigate the impacts of potential adverse selection" and "stabilize premiums in the individual and small group markets."[1] For plan year 2014, thus far the only year there is information available, the program required the transfer of over $4.7 billion that was either paid or received by health plans, resulting in significant swings in net revenue for carriers. The substantial impact the RA program has had on the market has been widely studied.[2] However, with only a single year as a data point, understanding the full impact of the program remains elusive. Given the accepted inaccuracies of the program, it is likely that the end result of the transfers unintentionally disadvantaged some issuers while providing excess gains to others.

In an attempt to address these concerns, the Department of Health and Human Services (HHS) and the Centers for Medicaid and Medicare Services (CMS) have engaged with issuers and state regulators to discuss the current risk adjustment program in an effort to identify ways to improve its implementation. As evidenced by the "Amendments to Special Enrollment Periods and the Consumer Operated and Oriented Plan Program" rule, issued by CMS on May 6, 2016, it appears CMS is listening. In this rule, CMS acknowledged that some issuers were negatively impacted by the current risk adjustment methodology, noting that "certain issuers, including some new, rapidly growing, and smaller issuers, owed substantial risk adjustment charges that they did not anticipate." Moreover, CMS is actively looking for ways to address the specific concerns with risk adjustment that were listed in the CHOICES white paper published in December 2015.[3] CMS has proposed several promising steps for implementation in plan years 2017 and 2018 and is continuing to develop others.

While the need to improve the accuracy of the RA program is an effort that CMS has widely acknowledged and continues to develop, its recent guidance was a clear signal that it is encouraging state regulators to explore the need to identify market-destabilizing imbalances and prescribe adjustments when deemed necessary. Specifically, CMS stated "we are sympathetic to these concerns and recognize that States are the primary regulators of their insurance markets. We encourage states to examine whether any local approaches, under State legal authority, are warranted to help ease this

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[1] CMS Presentation "Risk Adjustment Methodology Overview", May 21-23, 2012

[2] Sample of studies: American Academy of Actuaries. *Insights on the ACA Risk Adjustment Program*, April 2016 (link) / Milliman. Financial analysis of ACA health plan issuers, February 19, 2016 (link) / Avalere Health. Evolving the Risk-Adjustment Model to Improve Payment Accuracy in the Individual & Small Group Market, March 2016

[3] CHOICES White Paper. *Technical Issues with ACA Risk Adjustment and Risk Corridor Programs, and Financial Impact on New, Fast-Growing, and Efficient Health Plans*, Dec. 4, 2015 (link)

transition to new health insurance markets."[4] States have repeatedly proven that they should be the incubators of innovation, and allowing states to develop their own solutions would be fitting given the diverse market dynamics among state insurance markets. The recent conversations CMS had with issuers and state regulators are very encouraging. The ruling provides a window of opportunity for states to take pragmatic actions to ensure carriers in their respective market are not unfairly affected by the program before CMS can introduce improvements to the RA methodology. In the absence of such state actions, additional insurers could decide to exit the ACA marketplaces, leading to reduced competition, fewer insurance choices, and higher premiums for consumers in the long run.

On June 30, CMS will release just the second year of risk adjustment transfer results for the plan year 2015. Given the need to file products for the 2017 plan year in May, many carriers have invested significant resources developing models to estimate the potential impacts of risk adjustment. Despite this investment, the estimates for RA transfers vary widely, and given the zero-sum nature of the program there will certainly be carriers that will have over- or under-estimated their transfer payments. Once again, there are concerns that RA transfer payments will require much higher payments than carriers anticipated, which can have damaging effects on carriers' financial position.

Methods for Determining Destabilizing Risk Adjustment Transfers

To mitigate the current negative impacts of the RA program, state regulators will first need to develop processes that identify if there is a problem in their respective markets, and second create a solution to mitigate the negative effects. The remainder of this paper will focus on states' need to develop the first step in the process, the ability to identify if the transfers within a state are potentially inequitable and excessive. How to structure a solution to the problem will be released in a subsequent paper.

While there are several methods that could be employed to identify if a carrier's RA transfer is likely to be deemed inequitable and excessive, CHOICES has worked with actuarial consultants and health plans across the country to develop three potential approaches, outlined below. It is important to note that these processes are meant to identify if there is a likelihood of inequitable and excessive transfers, but further investigation may be required to evaluate the negative result with greater certainty:

1. Identify carriers with excessive changes in medical cost ratio (MCR)[5] attributable to RA
2. Identify carriers with aggregate risk scores that are outliers in the market
3. Identify "high growth" carriers

[4] HHS (May 11, 2016). Patient Protection and Affordable Care Act; Amendments to Special Enrollment Periods and the Consumer Operated and Oriented Plan Program; Interim final rule (link)

[5] Defined as *Incurred Claims,* divided by *Direct Premium Revenue* plus *Reinsurance Revenue plus Risk Adjustment Transfer* (positive or negative).

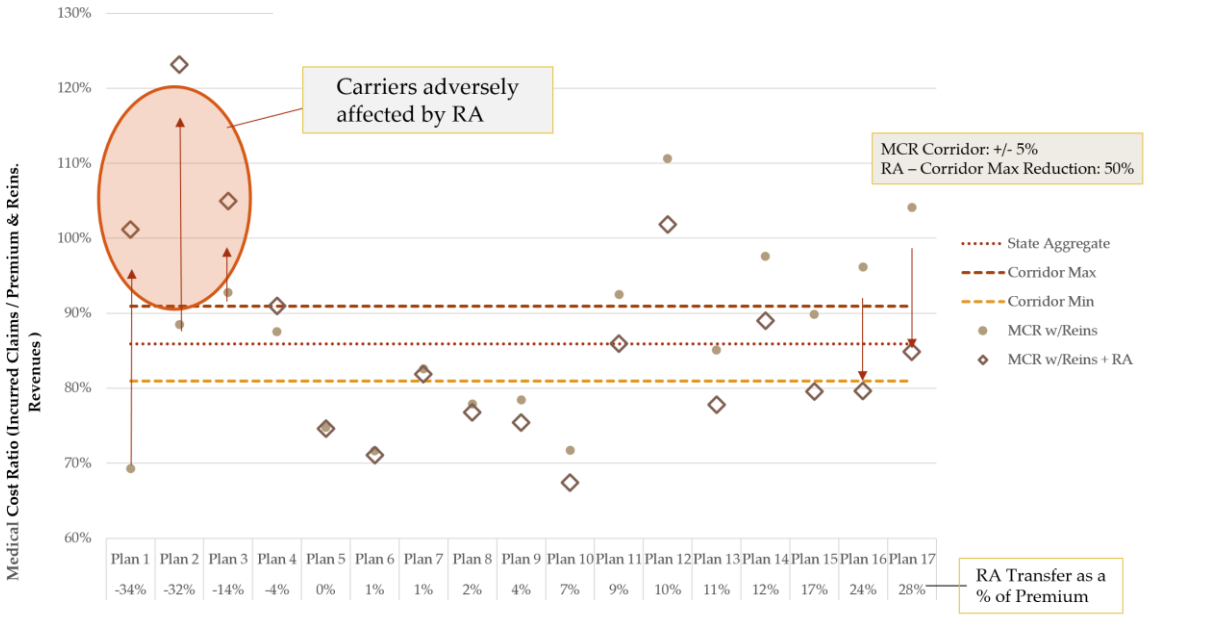
1. **Identify carriers with excessive changes in medical cost ratios due to RA transfers:**

   This approach evaluates all carriers based on a consistent and simple methodology that addresses a core function of health plans, specifically ensuring that premium dollars cover medical expenses, shown as a Medical Cost Ratio (MCR).[6]

   Given the differences in every state's individual and small group markets, this methodology is based on developing a state aggregate mean for both the small group and individual lines of business to establish a norm for the market, which will likely be different for every state. To determine if transfers are excessive, a state would create a corridor of expected minimum and maximum MCR results, then compare carriers' MCRs with these corridors before and after the RA transfers. Given the zero-sum aspect of risk adjustment, the state's aggregate MCR will be constant; what fluctuates is each carrier's MCR score based on either positive or negative RA transfers, which impacts its net revenue.

   The chart below *(Chart 1)* is based on actual results in the individual market for a large state in 2014. Carriers are arranged from left to right based on the amount by which the RA transfer impacted their revenue. The state aggregate MCR is shown to be near 85% in this illustration, with expected minimum and maximum bars at five percentage points above and below. As shown in the chart, three carriers would be flagged for likely inequitable and excessive RA payments, since their net MCRs after RA rose substantially above the state's expected maximum MCR. Note, carriers on the far right, that experienced MCRs well above the state mean before RA transfers, achieved net results well within the corridor and even below the state average after RA payments were accrued. This is a sign the RA transfers are working directionally as intended but may be excessive.

Chart 1



[6] Note the Medical Cost Ratio (MCR) differs from the more traditional Medical Loss Ratio defined under the ACA as it is explicitly meant to be a more simple and comparative approach - see footnote #4 for definition. A state may also look at net impact on MLR which should result in relatively similar outcomes.

Process: To execute a similar process to the one above, a state would need to have access to certain data elements that should be available to state regulators. These data points, based only on QHP-eligible populations, would be: Member months, direct premiums written, incurred claims, reinsurance receipts, and risk adjustment transfers.

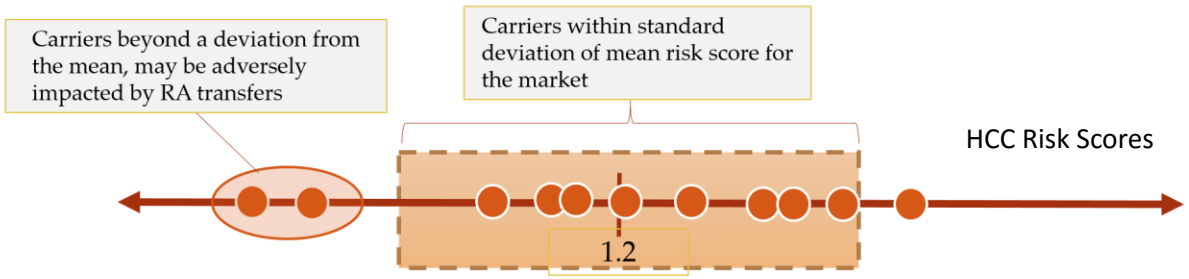
2. **Identify carriers with aggregate risk scores that are outliers in the market:**
   This approach compares the plan liability risk scores of all carriers within each state's respective small group and individual markets, using the scores calculated by CMS with the HHS-HCC risk-scoring methodology. This model is known to understate the calculated risk scores for lower-cost individuals and to overstate them for higher-cost individuals. As a result, plans with relatively young and healthy membership will have a plan liability risk score that is significantly understated due to the bias in the HHS-HCC model. Conversely, risk scores for carriers with sicker-than-average populations will be somewhat overstated.

   States that have results that are within a relatively narrow range, around the mean risk score in the market, are unlikely to have a problem as a result of the RA model's bias. The concern comes into play when there are carriers whose aggregate risk scores represent a significant deviation from the state mean—either well below average or well above. Carriers that show significant deviations from the mean are also more likely to be smaller carriers, given the likelihood that larger carriers are more representative of the mean score due to their higher market share.

   The graphic below *(Chart 2)* shows how most carriers in a market would be expected to cluster around the market mean. Smaller carriers, through no fault of their own, are more likely to deviate from the mean, simply due to the smaller share their membership represents as a total of the market. Also, Catastrophic, Bronze, or Platinum, or special-needs plans that tend to attract a disproportionately low- or high-cost enrollment may end up with an unusually low or high plan liability risk score that deviates significantly from the state mean. Such carriers are likely to be affected by the HHS-HCC risk adjustment model's bias—either unfavorably in the case of plans with low risk scores, or favorably for those with high risk scores.

   It should be noted that an unusually low risk score can result from either of two causes. The first being that the plan truly acquired a much lower risk population, which as previously discussed would create an excessive negative RA transfer amount. The second problem could be that the low risk score is an indication that the health plan did not fully report its members' health conditions. This under-reporting has been a likely cause of lower risk scores in the market due to the significant number of new members in the market and the difficulty of carriers, particularly those that are fast growing, to properly code everyone's diagnoses.

Chart #2



Process: For a state to execute a similar process to the one above, a state would need to have access to the HCC scores submitted to CMS to execute the RA program. Given CMS will have these score to run the RA program, CMS should be able to easily provide all states with carriers' plan liability risk scores.

3. **Flag fast growing companies:**
   A third (and relatively simple) approach highlights an issue that has been referenced in this paper in addition to being acknowledged as a problem by CMS and other studies of RA: fast growing health plans are more likely to be charged inequitable and excessive RA transfers than other carriers. New and fast growing carriers are likely to have a high proportion of new members for whom the carrier must acquire accurate and complete health diagnoses. The effort to ensure accurate data for risk score purposes may be unduly burdensome or prohibitively expensive for plans with new provider networks and a majority of enrollees for whom there are no prior-year records. Missing diagnoses can result in a substantial understatement of a carrier's true risk profile and a correspondingly overstated RA charge.

   Simply identifying these new and fast growing health plans, to flag them for further review when RA transfer payments are made public, would provide an indication to the market that these potential problems are known and will be reviewed as needed.

In summary, a state could implement any or all of the approaches highlighted in this paper to support a review process that ensures a more balanced regulatory environment. As CMS continues to make modifications to risk adjustment and other programs to achieve stability in the long-run, it is important for states to implement needed adjustments to support a competitive market in the near term that will result in better choices and lower premiums for consumers.

*Consumers for Health Options, Insurance Coverage in Exchanges in States, or **CHOICES**, is a coalition dedicated to preserving and promoting consumer choice through strengthening the stability and viability of individual and small group insurance markets. Through its member organizations, CHOICES works with regulators to ensure equity in premium stabilization programs, endeavors to lower barriers to entry for prospective insurance participants, and works to secure a healthy regulatory and policy environment in which health plans can compete fairly.*