



The ACA's Risk-Adjustment Program Needs Adjusting

By Brian Blase, Ph.D.

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Abstract

The Affordable Care Act (ACA) radically changed insurance regulation in the individual and small-group health insurance markets, leading to a separation of premiums from expected medical claims. The ACA included a risk-adjustment program designed to ensure the availability of plans for less-healthy people and discourage plans from prioritizing enrollment of healthier people. Risk adjustment was intended to make insurers indifferent to the health status and plan selection of their enrollees by transferring money from plans with healthier enrollees to plans with sicker enrollees. Risk adjustment is not working as intended, however, causing a myriad of problems that have reduced competition, increased average premiums and, perhaps most importantly, reduced the incentive for plans to enroll healthy people because of excessive transfers. Many reforms are needed to create a more robust individual and small-group health insurance market that offers greater competition and more affordable options. Fixing the problems with the ACA's flawed risk-adjustment program is an important start.



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Introduction

Oscar Health, in its insurance filing with New York State, proposed an average annual small-group premium of \$10,752 for a single person for its 2021 plan.¹ This amount is so high partly because 40 percent of the rate—or \$4,332—is a built-in factor to cover expected risk-adjustment outflows.

Risk adjustment is intended to address selection risks in which there are multiple competing insurers and products, but medical underwriting is prohibited. Risk adjustment does this by transferring money from plans with healthier enrollees to plans with sicker enrollees. Risk adjustment will always be an imperfect exercise and the ideal outcome—insurers' indifference to the health status and plan selection of enrollees and a purely unbiased distribution—is impossible to achieve. Unfortunately, six-plus years into its implementation, it is increasingly clear that the Affordable Care Act's (ACA) risk-adjustment program has reduced choices of plans, worsened the risk pools and produced higher average premiums for consumers in the individual and small-group markets, with the problems most pronounced in the individual market.

The risk-adjustment formula suffers from long-standing flaws and does not accurately measure enrollee risk. As a result, excessive transfers occur; in particular, too much money flows from plans attracting younger and healthier people to plans attracting older and sicker people. To compensate for risk-adjustment charges, insurers need to raise premiums on the plans—generally bronze plans—that better meet the needs of many healthy enrollees. The higher premiums for these plans discourage enrollment of the young and healthy people most needed for the ACA markets to work. The large transfers increase uncertainty, especially for smaller and more regionally based plans, and can impact how the insurers set premiums and even whether they continue to participate in the market. The formula also results in plans with lower administrative costs subsidizing plans with higher administrative costs. Some insurers, such as many Blue Cross Blue Shield plans, have reaped large benefits from the risk-adjustment program's flaws.

While improving the risk-adjustment formula will not fix all of the ACA's problems—including limited choices, high premiums and low enrollment—it will produce more plan competition and choice, lower average premiums and improve the risk pools. Fortunately, the Centers for Medicare & Medicaid Services (CMS) can take several commonsense actions to improve risk adjustment and thus the ACA markets. In particular, CMS should take four actions: 1) release more and better data, 2) recalibrate the values of the formula to avoid overpaying some conditions

¹ Bill Hammond, "Unsure of COVID Impact, NY Insurers Roll Dice on Rate Hikes," Empire Center, June 16, 2020. See: <https://www.empirecenter.org/publications/insurers-roll-dice-on-covid/>



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and discouraging healthy enrollees, 3) transfer less through risk adjustment and ensure that administrative expenses are not subsidized through the program, and 4) commit to better program administration and oversight.

The Need for Risk Adjustment

To sell ACA plans in the individual or small-group markets, insurers may only vary premiums within a rating region based on age (older adults can be charged no more than three times the amount of younger adults), family size and tobacco use (smokers can be charged up to 50 percent more than non-smokers). Every individual and business that applies for coverage must receive an offer without any exclusions—the “guaranteed issue” provision. The ACA provides subsidies for people in households with incomes below 400 percent of the federal poverty level (FPL) to purchase coverage on the individual-market exchanges;² included a tax penalty (the individual mandate) on individuals who did not obtain ACA-compliant coverage; and generally limits sign-ups to an annual open enrollment period.³ Congress eliminated the tax penalty in the *Tax Cuts and Jobs Act*, but the penalty proved ineffective at inducing healthier, higher-income people who are not eligible for large subsidies to enroll.⁴

The ACA’s core provisions cause lower-income individuals and those with expensive medical conditions to face premiums priced well below their medical risk, whereas individuals in middle-income and above categories and those who are healthy face premiums that are priced well above their medical risk. This actuarial incongruity produces incentives for the relatively sick and for lower-income people to over insure and for the relatively healthy and those with middle-incomes or higher to under insure.

By themselves, the ACA’s core provisions, which required insurers to charge healthy enrollees more than their expected claims cost and sicker enrollees less

² The Affordable Care Act (ACA) included premium tax credits, which limits the amount people have to contribute to a benchmark plan for households between 138 percent and 400 percent of the federal poverty level (FPL) in Medicaid expansion states and between 100 percent and 400 percent of the FPL in non-expansion states. In addition, the ACA required insurers to reduce out-of-pocket payments, such as deductibles and copayments, for individuals in households with income below 250 percent of the FPL who are enrolled in a silver plan.

³ People can enroll outside of the annual open enrollment period if they qualify for a special enrollment period, which includes the loss of employer coverage and change in household size, such as through marriage or divorce.

⁴ Rachel Fehr, Daniel McDermott, and Cynthia Cox, “Individual Insurance Market Performance in 2019,” Kaiser Family Foundation, May 13, 2020. See: <https://www.kff.org/private-insurance/issue-brief/individual-insurance-market-performance-in-2019/>



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than their expected claims cost, produced an incentive for insurers to design products to attract younger and healthier enrollees and avoid the less healthy. According to health insurance law expert Timothy Jost, it is “not that difficult for health insurers to avoid high-risk enrollees and attract low-risk enrollees through benefit design, networks and formularies, or marketing practices.”⁵ In an effort to counteract the incentives for insurers to design products that only attract healthy consumers, the ACA established a risk-adjustment program. In theory, risk adjustment prevents a so-called “race to the bottom” in coverage by transferring a portion of premium revenue from insurers that attract healthier enrollees to those that attract sicker enrollees.⁶

The ideal risk adjustment would make insurers indifferent to enrollees’ medical risk. The ACA’s risk-adjustment program operates on a budget-neutral basis—i.e., payments to insurers equal payments from insurers—within each state’s individual and small-group markets.

Under ideal risk adjustment, plans compete on services and value. On the other hand, if too little money is transferred through risk adjustment, plans compete on their ability to select the lowest-risk enrollees. If too much is transferred through the program, plans compete on the ability to select individuals with particular health conditions to gain excessive risk-adjustment receipts.

With properly functioning risk adjustment, insurers can be more confident that they can offer plans with features that may attract less healthy individuals, thus preserving more consumer options, such as plans offering extra services for those with chronic conditions. Robust competition is consistent with the aims laid out in the Trump administration’s *Reforming America’s Healthcare System Through Choice and Competition* report, which identified the need for reforming regulations that “reduce choice and competition in insurance markets and increase overall premiums.”⁷

The ACA’s risk-adjustment process assigns each enrollee a risk score. The methodology estimates financial risk based on an enrollee’s age and gender as well as on a set

⁵ Timothy Jost, “CMS White Paper Examines the ACA Risk Adjustment Methodology (Update),” *Health Affairs*, March 29, 2016. See: <https://www.healthaffairs.org/doi/10.1377/hblog20160329.054193/full/>

⁶ Section 1343 of the ACA established a risk-adjustment program for all ACA individual-market and small-group plans issued both on and off the ACA exchanges.

⁷ U.S. Department of Health and Human Services (HHS) Press Office, “Reforming America’s Healthcare System Through Choice and Competition,” HHS, U.S. Department of the Treasury, and U.S. Department of Labor, December 3, 2018. See: <https://www.hhs.gov/sites/default/files/Reforming-Americas-Healthcare-System-Through-Choice-and-Competition.pdf>



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of medical diagnostic codes called HHS Hierarchical Condition Categories (HHS-HCCs or HCCs). The risk-adjustment model includes 79 HCC diagnoses. Some of the most common are: pulmonary disease, congestive heart failure, vascular disease, cancer, ischemic heart disease, specified heart arrhythmia, diabetes, ischemic or unspecified stroke, angina, rheumatoid arthritis and inflammatory connective tissue disease.⁸ Each HCC is assigned a value for the average extra medical expenses a plan of a given metal tier (i.e., platinum, gold, silver, and bronze) would incur for a person with that condition. The formula accounts for multiple related conditions and includes an induced utilization factor for enrollees receiving benefit from the ACA's cost-sharing reduction program. The individual risk scores then are aggregated at the plan level. Finally, a transfer payment occurs from plans that enrolled lower-risk enrollees to plans that enrolled higher-risk enrollees.

Problems with the ACA's Risk-Adjustment Program

The ACA's risk-adjustment program has exacerbated adverse selection caused by the ACA's regulations, particularly in the individual market. The problems include unpredictable and excessive risk-adjustment transfers, which increase market instability and diminish competition and affordability. The risk-adjustment program considers factors other than actual risk and creates incentives to compete on factors other than services and value to beneficiaries. Further, the program creates incentives for insurers to avoid the healthy, thus undermining a balanced risk pool.

In 2016, I worked on a project that found HCCs were improperly valued, that excessive transfers occurred through risk adjustment, and that the program had a disproportionately negative effect on insurers with a small market share (such as co-ops), serving as a contributing factor to the demise or exit of many from the ACA markets.⁹ An updated analysis using data provided by the Initiative for Health Care Affordability¹⁰ shows that risk adjustment still suffers from several key problems. This largely produces an unfair gain for Blue Cross Blue Shield plans at the expense of smaller insurers and serves to weaken both the individual and small-group markets.

⁸ Formative Health, "Understanding Hierarchical Condition Categories (HCC)," 2018. See: www.formativhealth.com/wp-content/uploads/2018/06/HCC-White-Paper.pdf

⁹ This research was coauthored with Doug Badger, Ed Haislmaier, and Seth Chandler. It was ultimately not published because the author of this paper joined the National Economic Council when the paper was going through peer review.

¹⁰ The Initiative for Health Care Affordability is a coalition of five regional-based plans—Dean, Geisinger, Priority, Security and the University of Pittsburgh Medical Center.



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Longstanding Flaws with the Formula

The more poorly the risk-adjustment formula predicts actual expenses, the more arbitrary the transfers between insurers will be. The formula clearly failed in the earlier years of the ACA's implementation. As evidence, despite extremely high medical claims incurred by many co-ops in 2014 and 2015, they owed large risk-adjustment payments in both the individual and small-group markets. Several co-ops, as well as state insurance regulators, cited these large assessments as a reason for their collapse. Large risk-adjustment outflows decimated the co-ops' small-group business even though their medical claims were on par with larger insurers who received substantial risk-adjustment payments.¹¹

Initially, CMS's risk-adjustment formula relied on non-ACA large-group market data to set HCC valuations (MarketScan®).¹² This provided an advantage for bigger, more-established insurers that possessed more historical claims data. Smaller and newer health plans lack large volumes of claims data and confront more difficulty in predicting their risk-adjustment expenditures each year.

Table 1 shows that risk adjustment led to profound swings in plans' loss ratios in both 2014 and 2015.¹³ The effect was especially pronounced in the individual market in 2015. Insurers that experienced a "charge" under the risk-adjustment program had a loss ratio of 0.910, similar to the ratio of insurers that received a risk-adjustment payment. A sizeable amount was transferred through risk

¹¹ We stated that this data "support[ed] the view, expressed by some who have examined the issue, that the risk-adjustment program favored larger, more established insurers at the expense of the co-ops." Brian Blase, Doug Badger, Edmund F. Haislmaier, and Seth J. Chandler, "Affordable Care Act Turmoil: Large Losses in the Individual Market Portend an Uncertain Future," Mercatus Center, June 2016. See: <https://www.mercatus.org/system/files/blase-individual-market-upheaval-v2.pdf>

¹² "The 2019 benefit year was the first recalibration year in which enrollee-level EDGE data was used for recalibration. For 2020, CMS had proposed to blend enrollee-level data from its own EDGE servers (for plan years 2016 and 2017) with 2017 Truven MarketScan® data to calibrate the coefficients in the risk-adjustment model. The EDGE server data reflects actual use data from insurers' individual and small-group populations while the Truven data is designed to approximate those populations. CMS believed that these changes would make the risk-adjustment model more accurate and minimize volatility from 2019 to 2020. Beginning with the 2021 benefit year recalibration, CMS proposed to use only enrollee-level EDGE data (not MarketScan data) for its risk-adjustment model recalibration." See: Katie Keith, "The 2020 Final Payment Notice, Part 2: Risk Adjustment," *Health Affairs*, April 20, 2019. See: <https://www.healthaffairs.org/doi/10.1377/hblog20190420.666282/full/>. CMS finalized the transition EDGE data.

¹³ The loss ratio equals claims divided by the sum of premiums and reinsurance. The post risk-adjustment loss ratio shows the effect accounting for risk adjustment.



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adjustment—equal to 11.9 percent of premiums for payers—and led to large overall losses for insurers, generally smaller ones, that were assessed risk-adjustment charges. More than 26 percent of insurers with a state individual-market share of between two percent and 10 percent¹⁴ experienced a change in their loss ratio of at least 20 percent from risk adjustment.

TABLE 1: LOSS RATIOS OF RISK-ADJUSTMENT (RA) PAYERS AND RECIPIENTS

	2014		2015	
	<i>Before RA</i>	<i>After RA</i>	<i>Before RA</i>	<i>After RA</i>
Individual				
Payers	0.849	0.924	0.910	1.029
Recipients	0.924	0.860	0.929	0.864
Small Group				
Payers	0.794	0.801	0.800	0.809
Recipients	0.799	0.795	0.791	0.788

Source: Mark Farrah health insurance data, 2014 and 2015.

Note: The loss ratios include payments from the ACA reinsurance program.

A Maryland insurer, Evergreen Health Cooperative, filed a lawsuit against HHS claiming that risk adjustment caused arbitrary and unlawful transfers.¹⁵ Illinois’ insurance director ordered the Land of Lincoln Health Cooperative not to pay its 2015 risk-adjustment assessment because it would cause the insurer, which had 40,000 enrollees, to collapse.¹⁶ New Mexico Insurance Superintendent John Franchini called the implementation of the risk-adjustment program “completely

¹⁴ We selected these cutoffs because they represent insurers who are a non-trivial factor in the insurance market and yet are still small insurers within the state. If we included all insurers with market share less than 10 percent, the figure would be larger.

¹⁵ Bob Herman, “ACA’s Risk Adjustment Hammers Small Plans Again,” *Modern Healthcare*, June 30, 2016, <https://www.modernhealthcare.com/article/20160630/NEWS/160639997/aca-s-risk-adjustment-hammers-small-plans-again>

¹⁶ Ameet Sachdev, “Illinois regulators move to protect Land of Lincoln policyholders,” *Chicago Tribune*, June 5, 2016. See: <http://www.chicagotribune.com/business/ct-land-of-lincoln-insurance-0706-biz-20160705-story.html>



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backwards.”¹⁷ In June 2016, the New York State Department of Financial Services asked the Obama Administration for “immediate changes” to the program, and Connecticut shut down its co-op because of its risk-adjustment obligation.¹⁸ Richard Foster, CMS’s chief actuary from 1995 to 2013, authored a paper on behalf of the co-ops that argued risk adjustment was so flawed that CMS should immediately exempt new and fast-growing plans from risk adjustment for the first three to five years and place an upper bound on the amount of a plan’s charge.¹⁹

By 2016, the Obama Administration recognized the problems with the program as well. In March 2016, the CMS held an industry conference on risk adjustment and released a lengthy paper on the program.²⁰ According to actuary Greg Fann, who has closely tracked the implementation of the ACA:

The risk adjustment challenges were so widespread that one of the first two Strategic Initiatives of the Society of Actuaries (SOA) Health Section Council (charged to investigate ACA markets and challenges) devoted its focus exclusively to ACA risk adjustment complications while downplaying other pervasive concerns. A series of papers from a diverse group of actuaries had a common theme and mirrored comments submitted in response to the proposed annual ACA regulation; the papers focused on risk adjustment inequities, volatility and solvency anxiety, and disadvantages for low cost insurers who effectively manage care . . . The common theme expressed in the series of

¹⁷ Amy Goldstein, “Critics say ACA ‘risk’ strategies are having reverse Robin Hood effect,” *The Washington Post*, January 13, 2016. See: https://www.washingtonpost.com/national/health-science/critics-say-aca-risk-strategies-are-having-reverse-robinhood-effect/2016/01/13/e41cf574-b48f-11e5-a842-0feb51d1d124_story.html

¹⁸ Dan Goldberg, “Cuomo administration asks feds for ‘immediate changes’ to Risk Adjustment program,” *Politico*, July 5, 2016. See: <https://www.politico.com/states/new-york/albany/story/2016/07/cuomo-administration-asks-feds-for-immediate-changes-to-risk-adjustment-program-103529>; Mara Lee, “Nonprofit Obamacare Insurer in Connecticut Going Out of Business,” *Hartford Courant*, July 5, 2016. See: <https://www.courant.com/business/hc-obamacare-healthy-ct-20160705-story.html>

¹⁹ Gregory G. Fann, “Not Your Grandmother’s Risk Adjustment,” *The Actuary*, January 2019. See: <https://theactuarymagazine.org/not-your-grandmothers-risk-adjustment/#en-5046-13>

²⁰ Centers for Medicare and Medicaid Services (CMS), “March 31, 2016, HHS-Operated Adjustment Methodology Meeting: Discussion Paper,” HHS, March 24, 2016. See: <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/RA-March-31-White-Paper-032416.pdf>



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actuarial papers led to an unfortunate conclusion that “we all want young people to enroll in the market with only two exceptions: young people and the health plan that would likely enroll them.”²¹

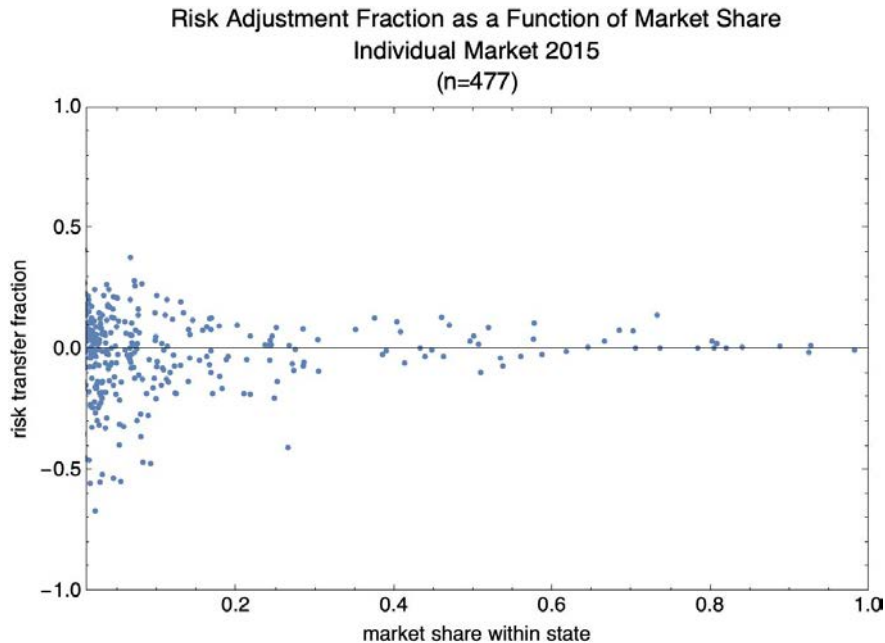
Increased Uncertainty, Particularly for Smaller Plans

Risk adjustment means that when insurers are setting premiums, they must try to project the health of their enrollees relative to those in the rest of the market. The smaller their market share, the greater the percentage by which insurers’ overall profitability may change because of unanticipated risk-adjustment transfers. This is compounded by the fact that CMS only releases reports²² on risk adjustment after the conclusion of the benefit year and because interim and final reports figures can vary. Figure 1 shows data for 477 insurers that sold individual-market plans subject to risk adjustment in 2015 and demonstrates how the magnitude of the risk-adjustment transfer as a percentage of premium (“risk-adjustment fraction”) decreases substantially as market share increases. Since businesses dislike uncertainty, larger risk-adjustment transfers are more likely to lead insurers with a smaller market share to cut back participation and price premiums higher as a precaution.

²¹ Gregory G. Fann, “Ten Years of the ACA,” Axene Health Partners, July 1, 2019. Retrieved on June 16, 2020 from <https://axenehp.com/ten-years-aca/>

²² Currently, CMS releases an interim report on the first three quarters of EDGE data, typically near the end of March following the benefit year, and a final report between the end of June and mid-July each year.

FIGURE 1



Credit: Seth Chandler, University of Houston, 2016

Large insurers heavily influence the average statewide premium and risk score, which reduces the volatility of their risk-adjustment payments. Moreover, the greater volume of covered lives helps them better understand which HCCs are overvalued and undervalued. According to Fann, “The ‘average’ nature of the formula severely exaggerates risk transfers for efficient insurers by mandating an inflated transfer amount relative to their cost structure. This particularly impacts small insurers who experience the most unpredictability and volatility with risk-adjustment results.”²³

One of the insurers in the Initiative for Health Care Affordability coalition experienced an influx of relatively healthy people in its bronze plan in 2018. This caused a substantial spread between the expected risk-adjustment payments and the actual risk-adjustment payments for its bronze plan in both the individual and small-group markets. Because of these losses and in order to fund future risk-adjustment payments, the insurer increased bronze plan premiums in 2019 and in 2020 (the extent of the 2018 experience would not be known until the spring of 2019 when it sets 2020 rates). Thus, the larger-than-expected risk-adjustment charge in 2018 means that its bronze plan offerings became less attractive in 2019 and 2020.

²³ Gregory G. Fann, “Annual ACA Check Up: Stabilizing the New Marketplaces,” Axene Health Partners, July 1, 2019. Retrieved on June 16, 2020 from <https://axenehp.com/ten-years-aca/>



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Sometimes the risk-adjustment projections will significantly differ from the actual transfer, but the market is more stable if the projections are as accurate as possible. For example, in 2016, one plan with the Initiative for Health Care Affordability overestimated individual market risk-adjustment transfers by 32 percent while another underestimated its individual market risk-adjustment transfer by nearly 140 percent in 2018. These substantial swings between projections and final transfers underscore the problems smaller plans face when attempting to anticipate the impact of risk-adjustment transfers.

Loss of Competition

Between 2015 through 2018, many insurers left the individual market, with the number of insurers in the exchanges declining from 308 to 181—a 41 percent drop.²⁴ This decline was driven by large losses from market-wide adverse selection, with risk adjustment making the situation unbearable for many insurers, particularly smaller ones. Blues' plans, on the other hand, have tended to increase their market share, and many of the remaining insurers are pricing their premiums higher to hedge against unpredictable risk-adjustment transfers.

In the aggregate, the ACA risk-adjustment program massively transfers funds from most insurers offering ACA plans in the individual and small-group markets to Blue Cross Blue Shield plans. Table 2 shows the net transfer to Blues' plans from 2014 through 2019 for the individual and small-group market. The transferred amount has generally grown over time. In 2018, the Blues reaped a windfall of \$3.09 billion through risk adjustment, with \$2.50 billion in individual-market transfers and \$0.60 billion in small-group market transfers. The amounts dipped slightly in 2019, with a total transfer to the Blues of \$2.94 billion—\$2.32 billion in individual-market transfers and \$0.62 billion in small-group market transfers. Some of this may be justified if sicker enrollees have become more attracted to Blues' plans over time, but it's also likely that the Blues' plans have advantages over other plans with respect to risk adjustment. These include: better historical data upon which to anticipate risk and set premiums, particularly with their plans heavily influencing the statewide average premium; a more sophisticated approach to coding health conditions of plan enrollees; and increased knowledge of which HCCs pay more than is justified so as to design coverage to attract individuals with those conditions.

²⁴ Edmund Haislamaier and Meridian Baldacci, "Premiums, Choices and Government Dependence Under the Affordable Care Act: A State-by-State Review," Heritage Foundation, March 12, 2020. See: <https://www.heritage.org/health-care-reform/report/premiums-choices-and-government-dependence-under-the-affordable-care-act>



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TABLE 2: NET TRANSFER TO THE BLUES (IN BILLIONS OF \$)

Year	Individual	Small Group	Total
2014	\$0.24	\$0.22	\$0.46
2015	\$1.20	\$0.42	\$1.61
2016	\$1.67	\$0.65	\$2.32
2017	\$2.57	\$0.54	\$3.12
2018	\$2.50	\$0.60	\$3.09
2019	\$2.32	\$0.62	\$2.94

Source: CCIIO's annual risk-adjustment reports.

Risk Formula Discourages Enrollment of the Healthy

If the HCC values are generally higher than appropriate, then too much is transferred through risk adjustment. HHS has acknowledged this is happening in proposed Notice of Benefit and Payment Parameters (NBPP) in both 2018 and 2021.²⁵ In the 2021 proposed NBPP, HHS wrote:

In the 2018 Payment Notice, we stated that based on the commercial MarketScan® data, the HHS risk adjustment models slightly under-predict risk for low-cost enrollees and slightly over-predict risk for high-cost enrollees. More precisely, the current HHS-HCC models under-predict for enrollees without HCCs, slightly over predict for enrollees with low HCC counts and under predict for enrollees with the highest HCC counts.²⁶

Overpredicting risk of people with HCCs relative to people without an HCC leads to two problems. First, it incents insurers to avoid enrolling relatively healthy people and to seek out those with health conditions that are coded the highest above the cost of care.²⁷ The overall risk pool, particularly in the individual market, has

²⁵ HHS, "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2018," 2016, p. 68. See: <https://s3.amazonaws.com/public-inspection.federalregister.gov/2016-20896.pdf>

²⁶ HHS, "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2021; Notice Requirement for Non-Federal Governmental Plans," 2020, p. 51-52. See: <https://s3.amazonaws.com/public-inspection.federalregister.gov/2020-02021.pdf>

²⁷ On the other hand, if too little is transferred through risk adjustment, insurers offering plans that attract high-risk people will no longer receive transfer payments adequate to cover their expenses. The inadequacy of payments will produce adverse selection pressures and a phase out of more generous plans.



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significantly deteriorated over the past few years. The percentage of enrollees with at least one HCC has increased from 19.4 percent to 22.9 percent between 2016 and 2019—a 3.5 percentage point increase and an 18 percent increase.²⁸ Second, plans that expect to enroll relatively healthy individuals, such as Oscar Health described earlier, will have to compensate for higher-than-appropriate risk-adjustment transfers by increasing premiums.

Three of the insurers in the Initiative for Health Care Affordability coalition were able to provide data for the years 2016, 2017 and 2018 for an empirical analysis.²⁹ The analysis was conducted for both the plans' individual and small-group lines of business, with the data broken down by age group and for enrollees without any HCCs and for enrollees with at least one HCC. The percentage of their individual market enrollees with at least one HCC was about 20 percent for each plan for each year, very similar to the national average, which suggests that this analysis is representative of the broader market dynamics.³⁰

All three insurers lost money across all age groups for people with no HCCs in 2016, 2017 and 2018. This was because of large risk-adjustment charges for these enrollees. In fact, insurers actually paid more in a risk-adjustment charge than the premiums they collected for some enrollees. In other words, the program required some insurers to pay a competitor more through a risk-adjustment transfer than the insurer earned in premiums for some members. This occurred for roughly 20 percent of two of the insurers' individual-market enrollees in 2016 and 2017. Because they imposed large premium increases in 2017 and 2018, this problem significantly diminished in 2018. As insurers' overall profitability substantially improved in 2018, again consistent with the overall market, the average losses they incurred on enrollees with no HCCs were only about half as large as those losses in 2016 and 2017.

While these insurers were losing money on healthy enrollees, they were making sizeable profits—because of large risk-adjustment transfers—on people with at

²⁸ CMS, “Summary Report on Permanent Risk Adjustment Transfers for the 2019 Benefit Year,” HHS, July 17, 2020. See: <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RA-Report-BY2019.pdf>

²⁹ The claims data represents claims as of late spring 2020. While most claims for 2016, 2017 and 2018 will have been paid by 2020, there likely will be some additional claims, particularly for the later years, that are still pending and thus will be paid in the future.

³⁰ The percentage of enrollees with at least one Hierarchical Condition Category (HCC) equaled 19.4 percent in 2016, 20.8 percent in 2017, and 21.7 percent in 2018. See: CMS, “Summary Report on Permanent Risk Adjustment Transfers for the 2018 Benefit Year,” HHS, June 28, 2019. See: <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Summary-Report-Risk-Adjustment-2018.pdf>



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least one HCC. Table 3 shows the average of the net annual payments received by insurers for individual-market enrollees in 2017 and 2018. Net payments equal premium revenue and the risk-adjustment transfer (which can be positive or negative) minus claims. These numbers are grouped by whether the enrollee has an HCC and by age category. They do not account for administrative expenses, which would amount to several hundred dollars per enrollee each year. They show that insurers lost money on enrollees without any HCCs but recouped those losses with money from enrollees with at least one HCC. Moreover, the most profitable set of enrollees for these insurers were people with at least one HCC who were age 35 and older.

TABLE 3: NET INDIVIDUAL-MARKET PAYMENTS, BY HCC STATUS AND AGE GROUPING IN 2017 AND 2018

	< 18	18-25	26-34	35-44	45-54	55+
0 HCC	-\$424	-\$248	-\$240	-\$157	-\$211	-\$328
1+ HCC	\$836	\$1,209	\$1,742	\$3,082	\$3,365	\$3,999

Source: Data from three health insurers in the Initiative for Health Care Affordability

Note: The net payments equal premium revenue combined with risk-adjustment payments, which can be positive or negative, minus claims. The values presented in the table were the average of the 2017 and 2018 weighted averages, with weights equal to the average annual members.

All three insurers made profits on all age groups for people with at least one HCC, with the overall profitability reaching excessive levels in 2018. One of the three insurers did incur losses on people with at least one HCC in 2016 and 2017, but that was reversed in 2018. The average profitability increased with enrollees' ages as well. The data did not allow an analysis of whether the increased profitability was independently related to age or if older people, who are more likely than younger people to have more than one HCC, are extra profitable because of multiple HCCs. Also, the data did not allow for an assessment of which HCCs may be the most overvalued, but that question is crucially important for recalibrating the risk-adjustment formula.

Table 4 contains the same information as Table 3 except for the small-group market. The general pattern in the small-group market is similar to the individual market. Since these numbers exclude administrative costs, which total in the hundreds of dollars per enrollee, insurers lost money, on average, for every age category of enrollees without HCCs. The loss these insurers incurred on people without any HCCs declined by more than half from 2016 to 2018. About 17 percent of



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small-group market enrollees have at least one HCC, which is about three percentage points below the percent in the individual market. On average, insurers made profits on their enrollees with HCCs because of risk-adjustment payments. Similar to the individual market, the largest profits were for enrollees aged 35 and older.

TABLE 4: NET SMALL-GROUP MARKET PAYMENTS, BY HCC STATUS AND AGE GROUPING IN 2017 AND 2018

	< 18	18-25	26-34	35-44	45-54	55+
0 HCC	-\$317	-\$257	\$51	\$151	\$103	\$99
1+ HCC	\$1,187	\$2,274	\$1,948	\$3,139	\$2,865	\$3,597

Source: Data from three health insurers in the Initiative for Health Care Affordability.

Note: The net payments equal premium revenue combined with risk-adjustment payments, which can be positive or negative, minus claims. The values presented in the table were the average of the 2017 and 2018 weighted averages, with weights equal to the average annual members.

Higher Premiums and Subsidies

Projected risk-adjustment charges or inflows represent a sizeable share of many insurers' overall premiums (meaning that they expect to enroll significantly healthier or sicker enrollees than other plans in the state). This was especially true in the individual market where risk-adjustment transfers equaled at least 10 percent of premium payments (inclusive of risk adjustment) for 44.3 percent of plans. Table 5 was derived from data from the Unified Rate Review Template for insurers' 2020 rate filings and shows the fraction that risk adjustment represented of total premiums. It shows that nearly 20 percent of individual-market plans had to price premiums significantly higher because of expected risk-adjustment charges.



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TABLE 5: EXPECTED RISK-ADJUSTMENT PAYMENT AS A PERCENTAGE OF PREMIUM

	<-40%	-40% to -25%	-25% to -10%	-10% to 10%	10% to 25%	25% to 40%	>40%
Individual	1.3%	7.0%	16.4%	55.7%	10.1%	3.7%	5.7%
Sm. Group	0.6%	1.4%	8.5%	85.3%	4.1%	0.0%	0.0%

Source: 2020 Unified Rate Review Template

Risk adjustment also has an important secondary effect on premiums. Plans expecting to attract more relatively healthy individuals will need to be priced higher to account for risk-adjustment charges. According to HHS, “plans facing a risk-adjustment charge will set higher premiums than they would in the absence of risk adjustment.”³¹ Since plans tend to lose money on people with no HCCs, there is upward pressure on premiums for plans expected to disproportionately enroll these individuals. This means that bronze plans and silver plans, particularly HMO plans, are priced higher because of risk adjustment, all else being equal. This also increases the cost of the program to the government by inflating the benchmark premium (the second-lowest cost silver plan premium), which is used to calculate the premium tax credit.

Conversely, since gold and platinum plans tend to enroll less healthy individuals, they receive risk-adjustment inflows and thus premiums are set lower. Hence, the presence of risk adjustment has an endogenous effect on creating a sicker risk pool.

Subsidization of Administrative Expenses

The purpose of the risk-adjustment program is to remove insurers’ incentives to compete on the relative health of enrollees and thus should only compensate plans for additional claims incurred from enrolling a less-healthy population. However, in practice, risk adjustment improperly distorts the formula with administrative costs, which include executive compensation. When an insurer enrolls a person with high medical risk, its claims expenses are likely to increase, but its fixed expenses will remain essentially unchanged. For example, the rent an insurer pays on its offices does not increase when one of its enrollees needs a lung transplant.

The final risk-transfer dollar amount relies on the average premium in the relevant market in a given state, which includes both claims and administrative expenses.

³¹ CMS, “March 31, 2016, HHS-Operated Adjustment Methodology Meeting: Discussion Paper.” See: <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/RA-March-31-White-Paper-032416.pdf>



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When, as is normally the case, premiums exceed claims, excessive amounts are thus transferred to other plans through risk adjustment. This excess transfer leads to plan uncertainty in premium setting, particularly for smaller insurers, and seemingly makes it more profitable to write policies for high-risk individuals, thereby worsening the overall market risk pool. Moreover, risk adjustment should not transfer money from insurers with lower administrative costs—effectively punishing insurers with lower administrative costs—to those whose premiums may be inflated by higher administrative costs.

Starting in the 2018 plan year, HHS took a step to mitigate the effects of this problem by reducing the statewide average premium amount by 14 percent and then applying the risk-adjustment formula to the reduced amount. However, this reduction is nevertheless insufficient, particularly in the individual market where the statutorily required medical loss ratio (MLR) is 80 percent. The MLR essentially requires insurers to spend at least a certain percentage of premium revenue on medical claims. The remaining 20 percent of premiums may go to administrative costs, overhead, marketing and profit—costs and features which should not be subject to risk-adjustment transfers among plans. Accordingly, setting the administrative cost reduction to 20 percent, not 14 percent, would further ensure that administrative costs do not continue to serve as vehicles for improper risk-transfer payments.

Administrative Solutions

CMS Should Release More and Better Data

CMS should provide timely, accurate data to enable health plans to better predict costs of certain enrollees and to more accurately set premiums. This data is particularly important for smaller and more regionally based plans. Unfortunately, interim reports released after the closing of the benefit year too frequently understate the actual amounts transferred through risk adjustment. The following information is needed by plans:

- The number of individuals covered in each market, broken down by both metal level, geographic level, and number of individuals accounted for under a policy
- The prevalence of each HCC at both the state and national levels for the past three years
- Age distribution of enrollees, and
- All the information contained in the interim report, including plan liability risk score, induced demand factor, and allowable rating factor.



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Recalibrating HCC to Avoid Overpaying Some Conditions and Discouraging Healthy Enrollees

CMS should carefully assess the overall impact that risk adjustment is having on premiums in both the individual and small-group markets and work to minimize uncertainty faced by smaller plans from excessive risk-adjustment transfers. Central to this is recalibrating HCCs to avoid overpaying some conditions (an analysis of specifically overvalued HCCs was beyond the scope of this paper) and to avoid excessive transfers from healthy individuals without any HCCs. CMS has stated in the past that it must improve the HCC coefficients. It's time for CMS to act and address this for the next benefit year. At a minimum, CMS should simply reduce the transfer from people without any HCCs.

Reduce Amount Subject to Risk Adjustment

Since too much is transferred through risk adjustment, it was a positive development that the absolute value of individual market risk-adjustment transfers as a percent of premiums declined from 11 percent in 2016 to nine percent in 2018 and from six percent of premiums in the small-group market in 2016 to four percent in 2018.³² Unfortunately, the percentage transferred increased to 10 percent in the individual market in 2019 although it remained flat in the small-group market.³³

The decline in the transferred amount from 2016 to 2018 occurred partly because of the 14 percent administrative cost reduction to the statewide average premium in the transfer formula, which would have led to a similar percent decrease in absolute transfers if all other things had remained constant. However, a greater adjustment is needed. Since the MLR requires insurers to rebate premiums if their loss ratio exceeds 20 percent, a simple heuristic method to reduce undue amplification would be to multiply premiums by 80 percent in the individual market (85 percent for the small-group market accounting for the higher MLR). An alternative, and perhaps more accurate, solution would be to replace the statewide average premium with statewide average claims costs as the cost-scaling factor in the risk-adjustment formula.

³² CMS, "Summary Report on Permanent Risk Adjustment Transfers for the 2018 Benefit Year," HHS, June 28, 2019. See: <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Summary-Report-Risk-Adjustment-2018.pdf>

³³ CMS, "Summary Report on Permanent Risk Adjustment Transfers for the 2019 Benefit Year," HHS, July 17, 2020. See: <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RA-Report-BY2019.pdf>



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Better CMS Administration and Oversight

As demonstrated in Medicare Advantage’s risk-adjustment program, many insurers aggressively code enrollees to ensure they appear as sick as possible. Risk adjustment cannot work properly if insurers can profit from negligently or intentionally recording incorrect diagnostic codes. In other words, to the extent that risk adjustment is measuring comparative degrees of aggressive coding, it does not fulfill its purpose. For the first few years of operation, a risk-adjustment program with integrity was not a top priority for HHS. In fact, the department did not meaningfully audit the ACA risk-adjustment program until benefit year 2017.³⁴

The failure to properly audit the program, particularly at the outset, is likely a substantial reason for excessive risk adjustment, certain HCCs valued higher than the medical risk those conditions represent, and risk being undercounted for the healthy. Audits and proper oversight are crucial, as evidenced by serious errors in insurer submissions with Medicare Advantage’s risk-adjustment program.³⁵ One audit of Medicare Advantage’s risk-adjustment program found, for example, that only 36 percent of the diagnoses were supported (i.e., had supporting evidence in the medical records) among high intensity contracts.³⁶ Only 10 of the 32 contracts that were selected for examination had supported diagnoses more than 40 percent of the time.³⁷ One audit found that CMS made \$14.1 billion in risk-adjustment payments with unsupported diagnosis in 2013.³⁸

³⁴ HHS did conduct two pilot audits of the risk-adjustment program for benefit year 2015 and 2016, but the results did not lead to any adjustments in risk scores or risk-adjustment transfers. According to HHS, “The 2017 benefit year HHS-RADV was the first non-pilot year that resulted in adjustments to issuers’ risk scores and the risk-adjustment transfers in the applicable state market risk pool(s) as a result of HHS-RADV (risk-adjustment data valuation) findings.” See: CMS and HHS, “Amendments to the HHS-Operated Risk Adjustment Data Validation Under the Patient Protection and Affordable Care Act’s HHS-Operated Risk Adjustment Program,” Federal Register, June 2, 2020. See: <https://www.federalregister.gov/documents/2020/06/02/2020-11703/amendments-to-the-hhs-operated-risk-adjustment-data-validation-under-the-patient-protection-and>

³⁵ U.S. General Accounting Office (GAO), “Medicare Advantage: Fundamental Improvements Needed in CMS’s Efforts to Recover Substantial Amounts of Improper Payments,” April 2016. See: <http://www.gao.gov/assets/680/676441.pdf>

³⁶ Ibid.

³⁷ Ibid.

³⁸ Ibid.



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Conclusion

The risk-adjustment program significantly added to the turbulence in the ACA markets—particularly in the individual market—in the first few years. The uncertainty and unpredictability brought by excessive risk-adjustment transfers reduced choices, increased premiums, and generally harmed the market. As a result of risk adjustment, smaller and more regionally based insurers have exited, leaving large insurers, principally Blues' plans that have generally reaped windfalls from the operation of risk adjustment, with greater control. Unfortunately, this has resulted in fewer choices of health plans and higher premiums for consumers.

The new data released in this paper indicates continued problems with risk-adjustment's operation as too much continues to be transferred through the program, and plans continue to lose money on healthy enrollees. Unless these problems are corrected, many smaller insurers will continue to stay on the sidelines and those that participate will be forced to price premiums higher than they would otherwise. Fortunately, CMS can take steps to rectify this situation and improve the regulatory climate for plans moving forward by releasing more and better data, recalibrating HCCs to avoid overpaying some conditions and discouraging healthy enrollees, reducing the amount subject to risk adjustment, and better administering and overseeing the program.



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