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administration meets challenge to risk-adjustment payments, counter to critics' assumptions

An announcement issued by the Centers for Medicare & Medicaid Services (CMS) in July that the agency had stopped, or at least put on hold, collections and payments under the risk-adjustment program established by the Affordable Care Act (ACA)—along with the announcement that payments to navigators would be substantially reduced—led to a chorus of comments that the move was just one more attempt by the Trump to undermine the ACA.

CMS's announcement was a response to a February ruling against the risk adjustment program by the U.S. Court for the District of New Mexico, in a case brought by a New Mexico consumer operated and oriented plan (CO-OP) challenging the program.

Although there is little question that the president and his administration are opposed to the ACA, and they welcomed last year's efforts to repeal it, the administration has never sought to stop risk adjustment collections and payments. In fact, its recent actions indicate the reality is quite the opposite—CMS not only asked the U.S. Court for the District of New Mexico to reconsider its ruling but also followed up by issuing on July 24 a final rule that would enable it to restore the operation of the program. In its announcement of the final rule, CMS notes that its aim in issuing the rule is to provide "a fuller explanation supporting the 2017 risk adjustment methodology, consistent with the judge's request, and allows us to resume the risk adjustment program without delay."

The Legal Challenges to the Program

The case in New Mexico was not the first legal challenge to the risk adjustment program. In January, the U.S. District Court of Massachusetts ruled against a legal challenge to the program brought by Minuteman Health, a Massachusetts CO-OP whose attempt to provide coverage in Massachusetts and New Hampshire through the insurance marketplace ultimately met with failure. Minuteman Health claimed it failed in large part because HHS had not properly designed the risk adjustment program.

Just one month later, however, the district court in New Mexico ruled that the regulations implementing the program were invalid because the U.S. Department of Health and Human Services (HHS) had not undertaken the correct process in justifying the development of portions of the risk adjustment formula. This ruling effectively struck down the program. More specifically, the court concluded that the statute hadn't directed HHS to implement the program in a budget-neutral manner and that the program could be implemented in a non-neutral way. Because HHS regulations implementing the program directed that it be budget-neutral without explaining why it should be so, the judge concluded the regulations were invalid.

The Purpose of Risk Adjustment

The purpose of the risk adjustment program is clear enough. It was intended to compensate plans having an unusual number of sick enrollees by shifting a percentage of payments from plans having primarily younger and/or healthier enrollees.

The rationale for the program was as follows: Under the ACA rules, insurers selling plans in the exchanges cannot charge more for individuals expected to have high medical expenses and are allowed to vary premiums only by a ratio of 3:1 for different age groups (i.e., premiums for the pre-Medicare population can be no more than three times the premium cost for young adults). Yet, under such circumstances, plans would have incentives to shun individuals whose use was expected to be high; although they would not be permitted to directly exclude such individuals, they could establish networks that limit the number or availability of providers who treat various high-cost diseases. A well-functioning risk adjustment program was seen as a way to eliminate such incentives for plans to avoid high-cost individuals.

The Need for Quick Action

After the New Mexico district court decision, the worry was that a failure to quickly resolve the issue might lead insurers to increase their rates for the 2019 premium to protect themselves should the risk adjustment program be discontinued or changed in unexpected ways. Premium rates needed to be finalized soon because the next enrollment period begins on Nov. 1. The Trump administration understood the time constraints and, by issuing the interim final rule (through a type of rule that can become effective immediately), has allayed those concerns.

Implications of the CO-OP Challenges

The Massachusetts and New Mexico cases challenging the ACA risk-adjustment program provide an interesting sidelight regarding questions about the program's purpose and effectiveness. It may seem counterintuitive that the challenges in both cases were made by CO-OPs that believed the program was harmful to their existence. The program's intent, after all, was to prevent harm to companies that might end up with a disproportionate number of sick enrollees. In fact, at the program's inception, it was reasonable to regard the CO-OPs as being among the most likely beneficiaries of risk adjustment—more so than established companies that have better data for pricing and presumably could withstand an unbalanced mix of enrollees more easily than the newer, smaller start-ups.

The CO-OPs and newly established insurance companies claimed, however, that the way the formula was structured caused companies that were insuring healthier lives to pay disproportionately more into the program than other payers. The start-ups also argued that because they didn't have extensive claims history for their enrollees showing whether their members were more or less healthy, the companies were unable to get paid the amounts due to them.

The larger insurance companies in the exchanges—mostly Blues plans with broad experience—didn't challenge the claim that they benefited from being able to draw on more extensive histories. But they did refute the claim that the broader experience gave them an advantage, and they correctly claimed they were only responding to the rules established by the exchanges.

The not-for-profit CO-OPs had been touted as a preferred alternative to the for-profit insurance companies participating in the marketplace (ignoring the high participation rate of the not-for-profit Blues plans). However, the newer start-up companies, and especially the CO-OPs, failed at least in part because they had insufficient capitalization and faced to a difficult challenge in correctly estimating their enrollees' future use of health care. Their experience is a clear reminder that setting up an insurance company requires size, capital, and insurance experience. Whether an inadequate risk adjustment program was a major contributor to their failure is less clear.

One other thing has become clear, though: Not every action by the administration involving the ACA is an attempt to undermine the law. ■

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