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EHB, MLR, and risk adjustment: Stakeholder considerations on the 2019 proposed Notice of Benefit and Payment Parameters

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On October 27, 2017, the U.S. Department of Health and Human Services (HHS) released its annual proposed Notice of Benefit and Payment Parameters (NBPP) for 2019. The proposed 2019 NBPP covers a myriad of topics, including proposed changes related to essential health benefits (EHBs), the Small Business Health Options Program (SHOP), Qualified Health Plan (QHP) certification standards, the risk adjustment program, medical loss ratio (MLR) reporting, and rate review, among others. There is a repeated theme in the notice, per the Centers for Medicare and Medicaid Services (CMS), to increase state flexibility and reduce regulatory burden[1], consistent with President Trump's executive order released at the start of last year to "minimize the economic burden of the ACA.

Many of these proposed changes would expand the role of states in how the markets operate. They may also affect premiums in the market. This paper focuses on three proposed changes in the notice that would likely affect premiums in the individual and small group markets, including changes to:

1. Essential health benefits
2. Medical loss ratio standards
3. The risk adjustment program

Essential Health Benefits

Section 1302(b) of the Patient Protection and Affordable Care Act (ACA) requires that EHB plans include services covered in 10 broad categories. To implement this section of the law, HHS defined EHB based on a benchmark approach, with a choice of 10 base-benchmark plans (three largest small group, three largest employee state options, three national federal plans, and one large health maintenance organization [HMO]). The 2019 NBPP proposes additional flexibility with respect to a state's annual selection of an EHB benchmark plan for 2019 and beyond, with the goal of increased affordability in the health insurance markets.

Section 156.111 of the 2019 NBPP proposes to give states flexibility to:

- Select an EHB benchmark plan used by another state for the 2017 plan year.
- Replace one or more EHB categories of benefits with another state's EHB categories of benefits used for 2017.
- Select any other set of benefits that are not more generous than the richest small group base-benchmark plans supplemented to cover state and federal mandates and the state EHB package in place for 2017.

Independent of which option a state decides to use for selecting its benchmark plan, it must be equal in scope of benefits to what is included in a typical employer plan. The NBPP suggests a typical employer plan would be a fully or self-insured employer group plan with at least 5,000 enrollees, but is open to alternate suggestions. HHS is also considering establishing a federal default for EHB "further in the future" but with continued flexibility for states to choose their own benchmark plans.

This proposed rule does not intend to change policies related to state-mandated benefits. That is, any benefits mandated by the state prior to December 31, 2011, could still be considered EHB, but any benefit mandates required after that date would require the state to defray[3] the cost of the additional benefits, per the policy under 45 CFR §155.170, even if the mandated benefits are part of another state's selected EHB package prior to this date. That is, states cannot avoid defraying costs for their own state mandates by selecting a plan from another state that covers these benefits as EHB.

[1] The full notice is available at: https://www.federalregister.gov/documents/2017/11/02/2017-23599/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2019.

[2] CNN (January 20, 2017). Full text: Trump's executive order on Obamacare. Retrieved December 29, 2017, from http://www.cnn.com/2017/01/20/politics/trump-obamacare-executive-order/index.html.

[3] Section 1311(d)(3)(B) of the ACA directs states that require state-mandated benefits above and beyond those in the EHB plan to "assume the cost" and make payments on behalf of individuals for premium tax credits and cost-sharing reductions for such benefits. CMS later determined in regulation that benefits required by state action on or before December 31, 2011, would still be EHB. Additionally, certain classes of benefits (including adult vision and dental) are prohibited from being EHB, even if required by state action prior to the cutoff.

A state's selection of another state's benchmark plan that omits particular mandates enacted prior to December 31, 2011, in the selecting state must still be supplemented by the state and would continue to be considered EHB and not subject to the state defrayal policies. In this situation, the state would have to follow the documentation rules and requirements associated with the third EHB selection option above, which are more resource-intensive and onerous.

STATE IMPLICATIONS

This proposed flexibility may result in states choosing leaner or richer EHB plans. The table in Figure 1 provides an example of a comparison under these more flexible proposed rules evaluating benefits in two states: State A, as the selecting state, using option 1 to replace its richer EHB plan with State B's leaner EHB plan. Figure 1 highlights only differences in the selecting state's benefit categories among those that are covered differently between the two states' EHB plans.

FIGURE 1: COMPARISON OF COVERED AND NON-COVERED BENEFITS IN TWO STATES' 2017 STATE-SPECIFIC EHB PLANS[4]

BENEFIT	(SELECTING STATE) STATE A (RICHER EHB PLAN)	STATE B (LEANER EHB PLAN)	STATE MANDATE IN SELECTING STATE?
PRIVATE-DUTY NURSING	COVERED	NOT COVERED	NO
ROUTINE EYE EXAM (ADULT)	COVERED	NOT COVERED	NO
BARIATRIC SURGERY	COVERED	NOT COVERED	NO
CHIROPRACTIC CARE	COVERED	NOT COVERED	NO
HEARING AIDS	COVERED	NOT COVERED	YES
BASIC DENTAL CARE - CHILD	COVERED	NOT COVERED	NO
ORTHODONTIA - CHILD	COVERED	NOT COVERED	NO
MAJOR DENTAL CARE - CHILD	COVERED	NOT COVERED	NO
ACCIDENTAL DENTAL	COVERED	NOT COVERED	NO
PROSTHETIC DEVICES	COVERED	NOT COVERED	NO
NUTRITIONAL COUNSELING	COVERED	NOT COVERED	NO
DIABETES EDUCATION	NOT COVERED	COVERED	NO

For purposes of this discussion, we assume that all other benefits are identical in the two states.

As summarized above, if State A chose to replace its entire richer EHB plan with State B's leaner 2017 EHB plan, several existing benefits that are currently covered for individual or small group consumers would no longer be part of State A's EHB plan. However, as seen in Figure 1, because hearing aids are a state-mandated benefit in State A, hearing aid coverage would have to be supplemented in that state's EHB plan, and would not be subject to state defrayal policy if it had been mandated before 2012. Alternatively, diabetes education would become covered as an EHB for consumers in State A where this benefit was potentially previously not covered. Lastly, if State A had added certain state-mandated benefits after 2012 (e.g., autism treatment), it would be required to continue offering these benefits but would have to defray the cost under current defrayal policy (regardless of coverage of these benefits in State B's benchmark plan).

To the extent that a state chooses a leaner EHB plan, it may lower member premiums for all ACA-compliant plans offered in the market. To the extent that a state chooses a richer EHB plan, it may increase member premiums for all ACA-compliant plans. However, the net financial impact would be different for consumers who are subsidized and those who are not subsidized.

For consumers who are eligible for subsidies on the exchanges, the amount of the premium tax credit (PTC) is determined using the second-lowest-cost silver plan in an individual's rating area and the premium cap accompanying that person's household income, determined using the percentage of the federal poverty level (FPL). While the premium caps by FPL remain constant for consumers, if the premium rates in the market decrease, for example, so too may the PTC, which is the difference between the second-lowest-cost silver plan premium in the region and the consumer's premium cap. This would leave a subsidy-eligible consumer with fewer PTC dollars to purchase coverage on the exchange. In this situation, other plan premiums would also decrease, and the net impact to consumers would vary based on the premium level of their plan selections as compared to the second-lowest-cost silver plan.

[4] The actual comparison of EHB for two states is based on data from https://www.cms.gov/cciio/resources/data-resources/ehb.html.

The table in Figure 2 provides a simplified example of how changes in a state's selected EHB plan could affect both subsidized and unsubsidized consumers' net premiums for an individual consumer aged 40 residing in State A.

FIGURE 2: IMPACT TO NET PREMIUMS FOR SUBSIDIZED AND UNSUBSIDIZED CONSUMERS (USING LEANER EHB PLAN)

	SILVER	BRONZE	GOLD
ASSUMES EXISTING STATE A EHB PLAN			
2018 STATE A ANNUAL PREMIUM[1]	$7,089	$5,678	$8,473
MEMBER ANNUAL PREMIUM CAP (SUBSIDY-ELIGIBLE)[2]	$2,418	$2,418	$2,418
PREMIUM TAX CREDIT	$4,671	$4,671	$4,671
NET MEMBER PREMIUM (SUBSIDIZED)	$2,418	$1,007	$3,802
NET MEMBER PREMIUM (UNSUBSIDIZED)	$7,089	$5,678	$8,473
STATE A SELECTS NEW EHB PLAN (USING STATE B'S LEANER EHB PLAN)			
REVISED 2018 STATE A ANNUAL PREMIUM[3]	$6,735	$5,394	$8,050
MEMBER ANNUAL PREMIUM CAP (SUBSIDY-ELIGIBLE)[2]	$2,418	$2,418	$2,418
REVISED PREMIUM TAX CREDIT	$4,317	$4,317	$4,317
REVISED NET MEMBER PREMIUM (SUBSIDIZED)	$2,418	$1,077	$3,733
REVISED NET MEMBER PREMIUM (UNSUBSIDIZED)	$6,735	$5,394	$8,050
IMPACT TO NET MEMBER PREMIUMS			
NET MEMBER PREMIUM IMPACT (SUBSIDIZED)	0%	7%	-2%
NET MEMBER PREMIUM IMPACT (UNSUBSIDIZED)	-5%	-5%	-5%

[1] 2018 premiums accessed from healthcare.gov.

[2] Assuming annual modified adjusted gross income of $30,000.

[3] Assumes that, for illustrative purposes, the removal of certain EHBs summarized in Figure 1 above is equivalent to a 5% reduction in premiums.

The impact of removing EHBs equates to an illustrative 5% premium reduction across all individual market ACA plans and translates directly into 5% lower net premiums for unsubsidized members. On the other hand, most subsidized members would not see similar proportional reductions in the net premium they pay.[5] In this example, a member purchasing the revised silver plan (using the new EHB package) would be paying the same net premium as that person had under the old silver plan, 7% more for a revised bronze plan, and 2% less for a revised gold plan, with all of the revised plans reflecting a leaner set of benefits.

As such, plans would become more affordable (in terms of the net premium paid by the member) for the unsubsidized population in the event that a state chooses a leaner EHB plan; however, the net premiums would not become as proportionally affordable for the subsidized population, who may wind up paying the same, slightly lower, or even higher net premiums, depending on the plan selected, for fewer benefits. Alternatively, if a state chooses a richer EHB plan, the opposite would be true for subsidized and unsubsidized members (i.e., the increase in a subsidized member's net premiums would be dampened due to an increase in PTC, and subsidized members selecting leaner plans would see net premium reductions while those selecting richer plans would see net premium increases).

In addition, for members eligible for cost-sharing reductions (CSRs), in addition to PTC, any reduction in the EHB plan would also eliminate any federal subsidies for reduced cost sharing that the member previously received for these benefits. Alternatively, reduced cost sharing may become available for new benefits to the extent that additional benefits are added to a state's EHB plan.

Lastly, it is possible that carriers may include the "lost" EHBs in their plans as benefits above and beyond EHB. However, because these benefits are no longer part of EHB, they are not eligible for PTC nor would federal subsidies for cost-sharing reductions be available and, as such, subsidized consumers would have to pay for them out of pocket, likely with higher cost sharing.

Other implications to a state in deciding whether to use one of the new EHB plan selection approaches include the resources involved in developing a new EHB plan. While the first two options (selecting a state's entire EHB plan or a state's EHB category) may not require substantial data collection on a state's part, the third option of developing a state's own benchmark plan may be more resource-intensive, given that it does not rely on any existing

[5] Certain consumers eligible for PTC, but for whom the premium cap exceeds the plan premium, would receive the same proportional reductions to premiums as their unsubsidized counterparts (given that they receive zero PTC).

benchmark plan already available, along with the additional certifications it would be required to submit to certify that the plan is no more generous than the most generous of the current EHB plans or the three largest small group plans in the state.

CARRIER IMPLICATIONS

Carriers would have to understand and internalize the various EHB changes in a potentially very short timeframe if a state chooses to take advantage of one of the new options for 2019 pricing, given that the proposed deadline for states to submit the new 2019 EHB plan, is in March 2018. This allows very little time for carriers to translate all of the changes into the pricing of their plans for 2019, with the earliest rate submission deadlines potentially beginning in May 2018,[6] particularly if new benefit categories are entirely added or removed.

Specifically, carriers would have to estimate the associated utilization and cost impact of new or removed benefits, consider any induced demand associated with the new services, consider cost shifting to the extent members may shift utilization to other services from those that are no longer covered, and assess what impact the new EHB plan has on their risk adjustment transfer payments and receipts (given that all premiums in the market and potentially service utilization that feeds EDGE diagnoses would likely be affected by the changes). Complicating matters, HHS indicated that any state changes for 2019 would not be available in the federal plan and benefits template, potentially leading to additional confusion regarding which benefits are EHB.

Medical Loss Ratio Standards

HHS is proposing two changes to medical loss ratio (MLR) standards for the purposes of MLR reporting and rebating, and premium rate setting:

1. Allow issuers to report expenses associated with quality improvement activities (QIA) at a fixed percentage of premium (0.8%).
2. Relax the standards used by states to request adjustments below the 80% MLR threshold in the individual market.

HHS is also considering permitting issuers to exclude employment taxes from the premium (i.e., denominator) of the MLR formula, though this is not a formal proposal in the 2019 NBPP.

STATE IMPLICATIONS

The additional flexibility related to MLR proposed in the notice is aimed at encouraging additional market participation and improving market stability, particularly in the individual market, but may have predictable consequences to premiums in these markets that impact consumers.

Currently, states must submit certain information to request adjustments to the 80% MLR, including information on how a state assesses compliance with the MLR formula, market withdrawal requirements, and options available to the state to provide consumers with more options for alternative coverage, as well as market enrollment at the issuer and product levels. The 2019 NBPP proposes eliminating or relaxing such standards, where applicable, for states to request MLR thresholds below 80%. This could result in higher premiums in the individual market given that issuers would have more room for administrative expenses and profit before violating MLR thresholds. Many carriers in the individual market have been losing money, as evident by deteriorating MLRs[7,8] in the individual market, and subsequently exiting the market. It is possible that this proposed policy could improve market stability if existing carriers could add in additional profit margin, without violating MLR thresholds, to rebuild their capital positions. It may be likely that carriers would need express permission from the state to do so. In addition, it may also improve market participation if it entices startups, which typically exhibit higher administrative expenses in their initial years, to enter markets if their higher administrative expenses could be covered under lower MLR thresholds.

If issuers are permitted to exclude employment taxes from premium or to report flat expenses for QIA that exceed their current expenses for these activities, it is possible that premiums would increase, given that issuers would now be permitted to include additional administrative expenses and profits into their premium development before violating MLR thresholds. We expect the impact from the QIA change to have a minor impact on premiums given the magnitude of this proposed adjustment.

ISSUER IMPLICATIONS

The additional flexibility in the proposed notice related to MLR would relinquish some carriers from the burden of identifying, tracking, allocating, and reporting QIA expenses separately if they wish to exercise this option. However, given that HHS is proposing a flat 0.8% of premium to account for these expenses (based on a review of historical issuer MLR filings), carriers that have QIA expenses beyond this threshold may still wish to perform their due diligence in identifying and allocating these expenses instead of using the flat 0.8% amount. Indeed, it may remain a necessary accounting function for these carriers if they

[6] Based on previous years' state deadlines in several states.

[7] Gray, C.R. et al. (March 21, 2016). 2014 Commercial Health Insurance: Overview of Financial Results. Milliman Research Report. Retrieved December 29, 2017, from http://www.milliman.com/insight/2016/2014-commercial-health-insurance-Overview-of-financial-results/.

[8] Houchens, P.R. et al. (March 21, 2017). 2015 Commercial Health Insurance: Overview of Financial Results. Milliman Research Report. Retrieved December 29, 2017, from http://www.milliman.com/insight/2017/2015-commercial-health-insurance-Overview-of-financial-results/.

have Medicaid and Medicare Advantage lines of business, where such a safe harbor has not yet been introduced. Carriers that have QIA expenses below this point are advantaged by the proposal, both in premium setting and MLR reporting, given that it would allow for additional administrative expenses and profit to be incorporated into the premiums and/or reduce the likelihood of paying out rebates, though the impact to premium is minimal given the magnitude of the proposed flat value and the fact that most issuers incur some QIA expenses regardless of accounting procedures.

Similarly, the additional flexibility in allowing issuers to deduct additional expenses related to employment taxes would advantage most carriers because it would allow for additional administrative expenses and profit to be incorporated into premium rate setting before violating MLR thresholds (or alternatively, reduce rebates paid to consumers). This policy may particularly advantage start-up or smaller issuers that have not gained economies of scale in certain markets to more broadly allocate their fixed administrative expenses over larger volumes of enrollees.

Risk adjustment program

Under the current market rules, commercial non-grandfathered individual and small group premium rates are allowed to vary by family structure (individual versus family), age (federal 3:1 age curve or state-specific age curves), geography, and tobacco use (up to 50% rate-up). Carriers enrolling sicker-than-average members may not charge higher premium rates due to member health status. Risk adjustment addresses this by transferring funds from health plans with lower actuarial risks to those with higher actuarial risks, such that carriers could be made agnostic with respect to the health status of the members they actually enroll. In theory, risk adjustment is an important policy tool and works together with the market rules toward the goal of achieving market stability.

The risk score calculations, basis for risk adjustment funds transfers, rules, standards, and operational requirements for the risk adjustment program are published in the NBPP annually. Over the years, HHS has been modifying and improving the risk adjustment methodology continuously while engaging stakeholders. This is done through standard NBPP rulemaking processes that include the proposed rule and an open commentary period prior to finalization in the first quarter of the year prior to the program year. HHS has also held public meetings and released white papers on various aspects of the risk adjustment programs. For instance, in the spring of 2016, HHS released a white paper on potential methodological improvements for the risk adjustment model to facilitate a discussion with carriers, and finalized many of the proposed changes in the 2018 final NBPP.

Comparing the 2019 proposed NBPP to the 2018 final NBPP, it appears that there is a good amount of continuity in a number of areas and relatively few changes related to the risk adjustment program:

- Risk adjustment model for calculating member risk scores: Using a combination of medical and pharmacy claims data for risk scoring, and accounting for partial year eligibility, with relatively minor changes in the scope of condition categories between the 2018 and 2019 models.
- High-cost risk pool: Continuing to use the 2018 attachment point and coinsurance levels.
- Adjusting for administrative expenses: Credit for the administrative cost portion remaining at 14% of the premiums in the risk adjustment funds transfer formula.
- Data for risk adjustment model development: Incorporating emerging EDGE data to calibrate the risk adjustment model along with two years of Truven MarketScan data. For background, HHS has been using the Truven MarketScan commercial database to calibrate the risk adjustment models, and the MarketScan data is primarily from the large group market, which may not be a good representation of the individual and small group markets.
- Preventive services:[9] In the 2019 proposed NBPP, HHS continues to include preventive services in the risk adjustment methodology.

An additional proposal was added to the 2019 NBPP that provides states with flexibility to reduce risk adjustment funds transfers (referred to as “risk transfers” here on) in the small group market by up to 50% of the transfer amounts after the 14% reduction attributed to administrative costs implemented in 2018 and continued in 2019. Compared to risk transfer calculations for 2017, the proposed flexibility would result in up to a 57% reduction in transfer magnitude in the small group market. CMS is seeking comments on whether or not a similar approach should be applied to the individual market. This is likely to have a material impact on carrier premiums in the small group market, if states exercise this proposal to the maximum available adjustment or a significant percentage within the range.

In the Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2016 Benefit Year (CMS, June 30, 2017),[10] CMS provided the magnitude of

[9] In the past, concerns have been raised with regard to the model’s prediction for very low risk members. In particular, members who receive preventive services but otherwise have no significant health conditions that are recognized by the HHS-HCC model may be under-predicted.

[10] Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2016 Benefit Year, https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Summary-Reinsurance-Payments-Risk-2016.pdf

funds transfers as a percentage of total premium. Risk transfers in 2016, as a percentage of premium, averaged 11% in the individual market and 6% in the small group market, similar to the 2014 and 2015 risk transfer percentages, at the national level. However, there is substantial variance at the market and carrier levels. For example, CMS summarized risk transfers as a percentage of claims in this report and indicated that, in the individual market, carriers with the lowest claims (bottom 25 percentile of claims) pay, on average, 18% into the risk adjustment program, whereas carriers with the highest claims (top 25 percentile of claims) receive, on average, 17% from the risk adjustment program. Such statistics were not available for the small group market in this report, but variance in risk transfers has also been observed in the small group market (albeit at lower magnitude).[11]

The magnitude of risk transfers can be material for certain carriers, as noted above, and could cause concerns with respect to premium stability, particularly for carriers who did not build an accurate estimate of risk adjustment into their premiums. Ideally, under perfect information, premiums should include estimated risk adjustment transfer amounts such that carriers expecting to pay into the risk adjustment pool would increase premiums accordingly, and carriers expecting to receive a risk transfer payment from the risk adjustment pool would be able to lower their premiums accordingly.

In practice, however, risk adjustment funds settlement calculations are conducted six months after the closure of the calendar year, whereas premium rates are typically filed six to eight months before the start of the calendar year. This creates a two-year or longer gap between rate filings and funds settlement, leaving potential changes during the gap unaccounted for. Advancements in medicine (such as the introduction of new and expensive drugs), carrier entries and exits, Medicaid eligibility rule changes, non-funding of cost-sharing reduction subsidies, and reductions in risk corridor payments have taken place unexpectedly during the gap periods, just to name a few items. These events can have significant implications for the risk pool, and affect the direction and magnitude of risk transfers in ways that cannot be anticipated by carriers during rate development. In other words, unexpected events can lead to a misalignment between premiums that were based on expectations from two years ago and the actual risk transfer distribution. The degree of misalignment can vary by carrier and by market. While the risk adjustment methodology remains the same, if market conditions change unexpectedly, the outcome of risk adjustment that is based on what actually happens in the market may change and could create differential impact on different carriers. Imperfect information at the time of pricing and the challenges in projecting statewide average parameters only compound the volatility of risk adjustment. The combined results could unexpectedly make carriers that were expected to be risk adjustment payers pay more and carriers that expected to be recipients receive less, or it could do the opposite, or even change the payers to recipients and vice versa.

STATE IMPLICATIONS

States should consider whether the federal risk adjustment methodology is appropriately calibrated for their markets and whether or not additional adjustments are needed. For example, New York issued emergency regulations for the 2017 program year to reduce risk adjustment transfers by up to 30% of what was calculated by CMS,[12] citing concerns that the federal methodology, as it was applied to New York, has certain inadequacies, including not giving appropriate consideration to the New York's family tier rating structure, not adequately addressing the impact of carriers' administrative costs and profit, and not accounting for network differences, plan efficiencies, effective care coordination, and disease management.[13] New York estimated that the inadequacies in the federal methodology result in excess funds transfers and has plans to reduce the risk transfer to mitigate this impact.

In the case of New York, a state attempted to modify the outcome of the federal risk adjustment program to better suit its own market conditions using its own insurance market regulatory authority. Through the 2019 proposed NBPP, HHS is proposing to provide all states with the same flexibility to adjust the magnitude of transfer payments in their small group markets without having to operate fully independent risk adjustment programs.

States considering reducing risk adjustment transfers should first determine whether the federal risk adjustment methodology provides adequate predictability in the relative health status of members in the small group market for carriers in their state. This may require additional state resources to collect and compile necessary market data from different sources, such as carriers' rate filings, financial reports, interim risk adjustment simulation results, past funds settlement results, and potentially data on Medicaid and the individual and group markets. These data collectively could help the state quantify the presence and magnitude of the issues or inequalities, and thereby determine

[11] http://www.milliman.com/insight/2017/2015-commercial-health-insurance-Overview-of-financial-results/

[12] New York State Department of Financial Services. Guidance Regarding Emergency Risk Adjustment Regulation for the 2017 Plan Year for the Small Group Market (11 NYCRR 361.9). Retrieved December 29, 2017, from http://www.dfs.ny.gov/insurance/health/exchanges/2017_Guidance_Risk_Adjustment.pdf.

[13] New York State Department of Financial Services (September 9, 2016). DFS issues emergency regulation to address New York factors necessary to remedy adverse impact of federal risk adjustment program on New York health insurers. Press release. Retrieved December 29, 2017, from http://www.dfs.ny.gov/about/press/pr1609091.htm.

whether a reduction in risk transfers may be needed for the state, and, if so, how much of one.

States should also consider the implications that reducing risk transfers would have on premiums in the state and how it may affect carriers and consumers. Carriers that were expected to pay into the risk adjustment program would be paying less after reductions to the risk transfers, and may decrease their premiums or increase margins. Carriers that expected to receive payments from the risk adjustment program would receive less after reductions to risk transfers, and may have to increase premiums or reduce their margins. Consumers enrolled with carriers that have to make such unexpected premium changes, who themselves may have different health statuses, healthcare needs, and financial constraints, may be affected differently as well. Each state may need to seek to strike a balance between affordability and market stability.

From the past three years of national risk adjustment funds transfer settlement results, we see that the impact of risk adjustment, before reductions, has been about 6% of average premium across all plans in the small group market at the national level. Reducing risk transfers could change the status quo for the small group market and reduce the 6% potentially down to 3.4% (6% x 43%) if all states elected to use the maximum range of reduction as proposed in the 2019 NBPP, everything else being equal. However, this percentage may vary substantially at the state and carrier levels.

As it may impact rates and profit, reducing risk transfers may have implications for carriers' market participation. Prior Milliman research found that new market entrants could face special challenges with respect to risk transfers that are due to reasons such as the lack of prior year data, new provider and administrative relationships, and low relative market share.[14] Reducing risk transfers could help with mitigating some of these issues unique to new market entrants that are also payers in risk adjustment and encourage their participation in the small group market. On the other hand, carriers that received less in risk transfer payments due to this reduction may need to increase premiums, become less competitive in the market, or may be less incentivized to remain in the market. States may need to strike a balance between premium stability and market competition when deciding on whether a reduction would be desirable for their small group markets, and, if so, how much.

States can elect to assume regulatory authority over the risk adjustment program in its entirety, beyond making small adjustments to scale the risk transfers. Alternatively, a state can elect to administer its own risk adjustment program using a state-based risk adjustment methodology with federal approval and certification. Administering a state-based risk adjustment program could be a substantial undertaking for the state, given the complexity of data collection for all the calculations, developing rules, and allocating resources required at the state level, as well as evaluating effects on the carriers. An important benefit is that the risk adjustment methodology, including how risk scores are calculated, which factors are used to calculate risk transfers (e.g., family tier rating could be better reflected, as well as network efficiencies, and other factors), and the basis for risk transfers, could be tailored to the state's specific market conditions and policy objectives.

Whichever direction a state may choose to go, it should consider announcing the decision with respect to reducing risk transfers before carriers finalize their premium rates, such that carriers may be able to adequately reflect the reduced funds transfers into their pricing.[15]

Lastly, as it relates to EHB benchmark plans, the current risk adjustment methodology assumes that the commercial individual and small group plans will cover the 10 categories of essential health benefits, and that the plan's actuarial values will fall within the de minimis ranges defined by the ACA. If any of these market rules change materially, the risk adjustment methodology may need to be reevaluated to ensure that it is appropriately supporting the new rules of the market. For instance, the current HHS-Hierarchical Condition Categories (HCC) model risk weights vary by metallic tier for the same HCCs, reflecting the different plan liabilities under different levels of benefit coverage. The actuarial value (AV) factors and the induced demand factors (IDF) used in the funds transfer formula were derived from the current metallic tier definitions.

Starting in 2018, the de minimis ranges for the metallic tiers expanded to -4/+2% (other than certain bronze plans, which expanded to -4%/+5%), creating a potential six-point difference in AV for two plans on both extremes of the de minimis range within the same metallic tier.[16] Plans from adjacent metallic tiers could also have smaller differences in actuarial value, such as a gold plan with a 76% actuarial value versus a silver plan with a 72% actuarial value. The federal model risk weights are still calibrated to the average AV for the metallic tier, and the AV and IDF factors in funds transfer are still pegged at the average for the metallic tier. In this example, risk adjustment will treat the 76% gold plan using the gold model HCC risk weights, and gold IDF

[14] Siegel, J. & Liner, D.M. (July 2, 2015). ACA Risk Adjustment: Special Considerations for Health Plans. Milliman Healthcare Reform Briefing Paper. Retrieved December 29, 2017, from http://www.milliman.com/insight/2015/ACA-risk-adjustment-Special-considerations-for-new-health-plans/.

[15] In the 2019 proposed NBPP, HHS proposes that states intending to reduce risk transfers be required to submit the proposal to HHS within 30 days after the publication of the proposed NBPP for the applicable year.

[16] Practical limitations of the federal AV calculator make the minimum possible bronze AV 58.5%.

and AV factors. The program will also treat the 72% silver plan using the silver HCC risk model and silver IDF and AV factors. The projected plan liability by the risk adjustment model on average could be a 14% difference (0.8 versus 0.7) between the two plans, whereas the actual difference in plan liability is only 5.5% (0.76 versus 0.72).

The 2019 NBPP does not address recalibration of the methodology related to this issue, but the misalignment between predicted plan liability and actual plan liability could leave room for gaming of the system. Similarly, to the extent that there are significant changes in EHB, an evaluation of whether the risk weights associated with the HCCs appropriately reflects plan liability should be considered.

CARRIER IMPLICATIONS

As discussed above, any changes in the magnitude of risk transfers will have potentially material impacts to carriers in the market, particularly as it relates to profitability, cash flow, projected premiums, and market position. As such, carriers should be prepared to determine the implications of risk transfer reductions on their small group books of business. Such analysis could involve analyzing publicly available risk adjustment transfer information along with available premium data to ascertain what the changes may mean for their market position and their competition, in addition to how market share may shift (given that price is usually a key purchasing decision for both employers and consumers). Subsequent adjustments to benefit offerings and cost-sharing levels may be necessary to remain competitive as a result of expected increases in premiums (for issuers that expect their premiums to increase). Alternatively, carriers that become more competitive (if premiums are expected to decrease) should understand whether they can withstand additional membership growth and the increased capital requirements that come with it.

CAVEATS AND LIMITATIONS

The estimates presented in this report are based on publicly available data and certain assumptions. Actual experience is certain to vary from these estimates.

The conclusions presented in this paper are based on proposed federal regulations issued on October 27, 2017. Our interpretations of these proposed regulations should not be relied on as legal interpretations. In addition, readers of this paper should not interpret this paper as an endorsement of any particularly legislation by Milliman or the authors. To the extent future regulations materially modify these proposed regulations, the statements and conclusions reached in this paper may require modification. The views expressed in this paper are made by the authors and do not represent the collective opinions of Milliman, Inc.

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