Study of Risk Adjustment and Reinsurance: A Report to the Governor and Maryland General Assembly

Maryland Health Benefit Exchange
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Introduction

The Maryland Health Benefit Exchange (MHBE) Act of 2012 requires the MHBE to study and report on Maryland's risk adjustment and reinsurance programs. Specifically, the MHBE must report on the following:

- "Whether the State should develop a risk adjustment program as an alternative to the federal or Maryland-specific model selected under Title 31 of the Insurance Article that would provide more effective protection against adverse risk selection that could threaten the viability of the Maryland Health Benefit Exchange and the affordability of its plan offerings"[1]
- "Whether the State should develop a Maryland-specific reinsurance program to ensure the affordability of premiums in the individual market"[2]

In accordance with these requirements, the MHBE submits this report to the Governor and the Maryland General Assembly.

Risk Adjustment Program

Background

The Affordable Care Act (ACA)[3] created a permanent risk adjustment program to transfer funds from lower risk plans to higher risk plans in the individual and small group markets, inside and outside exchanges. Either state-based exchanges may establish their own risk adjustment program, or the U.S. Department of Health and Human Services (HHS) may operate a risk adjustment program on the state's behalf.[4] HHS operates the risk adjustment program for 49 states and the District of Columbia. Massachusetts is the only state that operates its own risk adjustment program.[5]

The risk adjustment program is designed to mitigate the potential impact of adverse selection, which can cause higher premiums, and stabilize the price of health insurance in the individual and small group markets.[6] Health insurance carriers that attract higher-risk populations, such as those with chronic conditions, are provided payments from carriers that attract lower-risk populations to reduce incentives for carriers to avoid higher-risk enrollees.[7] Carriers are compared based on the financial risk of their enrollees, which is calculated based on enrollee characteristics, such as age, sex, and medical diagnosis.[8] A plan is assigned an average risk

[1] Section 6, Chapter 152, 2012 Laws of Maryland.
[2] Id.
[3] Patient Protection and Affordable Care Act, 124 Stat. 119 (2010) (codified as amended at 42 U.S.C. § 18063 (Supp. 2010)).
[4] 45 CFR §153.310(a).
[5] Massachusetts began operating its own risk adjustment program for Commonwealth Care prior to the ACA.
[6] See 80 Fed. Reg. 10,751 (finalized February 27, 2015).
[7] See Id. at 754.
[8] Kaiser Family Foundation. (January 22, 2014). Explaining Health Care Reform: Risk Adjustment, Reinsurance, and Risk Corridors. Retrieved from http://kff.org/health-reform/issue-brief/explaining-health-care-reform-risk-adjustment-reinsurance-and-risk-corridors/.

score, which is the weighted average of all enrollees' individual risk scores. The average risk score represents the plan's predicted expenses. Plans with a relatively low average risk score will make payments that will be given to plans with relatively high average risk scores. Both payments and charges are calculated by comparing each plan's average risk score to the average premium in the state. Transfers are calculated at the geographic rating area, and transfers within a given state will net to zero. [9]

Risk Adjustment User Fees

The HHS-operated risk adjustment program is funded through a risk adjustment user fee.[10] In 2015, this user fee was $0.96 per enrollee per year.[11] As of October 2015, 115,000 individuals had effectuated coverage through qualified health plans (QHPs) offered through the MHBE, which resulted in total user fees of $110,400. In 2016, the user fee will increase to $1.75 per enrollee per year to offset the increase in contract costs to support the risk adjustment data validation process, which will be administered for the first time in 2016.[12]

Recommendation

The MHBE recommends that Maryland continue to use the HHS-operated risk adjustment program. This recommendation is in line with the practices of other states. Further, the cost of the HHS-operated program is low; the user fees are about $110,400 for 2015 and will be approximately $210,000 for 120,000 enrollees in 2016. Further, HHS bears the administrative burden of implementing changes and operating the risk adjustment program. If Maryland were to administer its own risk adjustment program, then the state would have to comply with various federal requirements regarding state-run risk adjustment programs. Maryland would have to receive federal approval to administer the applicable federally-certified risk adjustment methodology,[13] or receive federal approval to use an alternative methodology. HHS has requirements for approval, data collection, data security, data validation, record maintenance, annual reporting, public notice, and renewal of state-run risk adjustment programs. Thus, the MHBE believes that it would be costly and burdensome for Maryland to develop and implement its own risk adjustment program. Moreover, incurring this additional cost and operational burden would not bring any discernible benefits or value to this program.

Reinsurance Program

Background

The ACA created a three-year transitional reinsurance program for 2014 through 2016.[14] The reinsurance program was intended to help stabilize individual market premiums during the initial years of implementing health benefit exchanges by providing payments to insurance carriers that

[9] Id.
[10] 45 CFR §153.610(f).
[11] See 80 Fed. Reg. 10,759 (finalized February 27, 2015).
[12] Id.
[13] 45 CFR §153.310(c).
[14] Patient Protection and Affordable Care Act, 124 Stat. 119 (2010) (codified as amended at 42 U.S.C. § 18061 (Supp. 2010)).

incur high claims costs for certain enrollees. The goal was to reduce the incentive for insurers to charge higher premiums due to the uncertainty of the health status of the new enrollees in the market.[15] Under the reinsurance program, insurance carriers make reinsurance contributions to HHS and the Department of the Treasury.[16] These funds are then distributed to health insurance carriers for high-cost enrollees whose insurance claims exceed a certain threshold.

Under the ACA, each state must have a reinsurance program in place for 2014 through 2016. If a state does not create a reinsurance program, HHS will administer one on behalf of the state.[17] HHS allows states to supplement their reinsurance programs, regardless of whether the state administers it or HHS administers it on behalf of the state. Under regulations, HHS specifies three general methods by which a state may supplement the federal reinsurance program: 1) by decreasing the national attachment point; 2) by increasing the national reinsurance cap; and/or 3) by increasing the national coinsurance rate. [18] Maryland chose to supplement the federal reinsurance program in 2015 and 2016, using funds made available from the Maryland Health Insurance Plan (MHIP), the state's high-risk pool. Pursuant to statute, the MHIP and MHBE Boards of Directors approved use of the MHIP funds for the State reinsurance program. [19]

Reinsurance Program Parameters

The attachment point refers to the health care payment threshold for an individual, at which point HHS will begin providing reinsurance payments to carriers. The attachment point was $45,000 in 2014 and 2015; it will be $90,000 in 2016.[20] The reinsurance cap, which refers to the health care payment threshold for an individual at which HHS will stop providing reinsurance payments to carriers, will remain at $250,000 for 2014 through 2016.[21] The coinsurance rate refers to the percentage of health care costs for an individual, between the attachment point and the reinsurance cap, at which HHS will provide reinsurance payments to the carrier. The coinsurance rate for 2014 was originally set at 80 percent, but CMS announced in June 2015 that it would increase the 2014 coinsurance rate to 100 percent because the reinsurance funds it received from carriers exceeded the requests for reinsurance payments.[22] The federal coinsurance rate will decrease to 50 percent in 2015 and 2016.[23] The annual contribution rate for carriers was $63 per covered life in 2014, $44 in 2015, and $27 in 2016.[24] The contribution rate has decreased over

[15] Kaiser Family Foundation. (January 22, 2014). Explaining Health Care Reform: Risk Adjustment, Reinsurance, and Risk Corridors. Retrieved from http://kff.org/health-reform/issue-brief/explaining-health-care-reform-risk-adjustment-reinsurance-and-risk-corridors/.
[16] 45 C.F.R. §153.220.
[17] 45 C.F.R. §153.210(c).
[18] 45 C.F.R. §153.232(a).
[19] Insurance Article, § 31-117, Annotated Code of Maryland.
[20] See 80 Fed. Reg. 10,777 (finalized February 27, 2015).
[21] Id.
[22] CMS. (June 17, 2015). Transitional Reinsurance Program: Pro Rata Adjustment to the National Coinsurance Rate for the 2014 Benefit Year. Retrieved from https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/The-Transitional-Reinsurance-Program/Downloads/RI-Payments-National-Proration-Memo-With-Numbers-6-17-15.pdf.
[23] Id.
[24] See 80 Fed. Reg. 10,773 (finalized February 27, 2015).

time as the reinsurance program is being phased out. The federal reinsurance program will end after 2016.

Maryland did not supplement the federal reinsurance program in 2014. In 2015, Maryland supplemented the federal reinsurance program by increasing the coinsurance rate from 50 percent to 80 percent. For 2016, Maryland will continue to supplement the coinsurance rate, increasing it to 80 percent. Maryland did not supplement the attachment point in either 2015 or 2016. Table 1 shows the reinsurance parameters for the federal and Maryland programs for 2014 through 2016.

Table 1. Reinsurance Payment Parameters 2014-2016

Year	Federal Attachment Point	Federal Attachment Cap	Federal Coinsurance	Maryland Coinsurance	Annual Contribution Rate
2014	$45,000	$250,000	100%	0	$63
2015	$45,000	$250,000	50%	30%	$44
2016	$90,000	$250,000	50%	30%	$27

Impact of Reinsurance on Premium Prices

Table 2 shows the reduction in premium prices in the individual market by carrier as a result of the federal and the Maryland supplemental reinsurance programs for 2015 and 2016. For example, in 2015, the federal reinsurance program reduced BlueChoice's premiums by 3 percent, and the state reinsurance program reduced BlueChoice's premiums by 2.5 percent. In 2016, the federal program reduced BlueChoice's premiums by 1.3 percent, and the state program reduced BlueChoice's premiums by 1.2 percent. The reductions in 2016 are lower than in 2015 because the federal attachment point was increased to $90,000, and Maryland did not supplement it.

Table 2. Reduction in Premium Prices as a Result of Reinsurance, by Carrier

	2015		2016	
Carrier	Reduction in Premium from Federal Program	Reduction in Premium from Maryland Program	Reduction in Premium from Federal Program	Reduction in Premium by Maryland Program
All Savers	5.4%	3.7%	4.5%	3.0%
BlueChoice	3.0%	2.5%	1.3%	1.2%
CFMI/GHMSI	3.4%	2.6%	3.3%	2.3%
Cigna	7.0%	4.7%	7.0%	4.5%
Evergreen	6.1%	4.3%	4.7%	3.2%
Freedom	11.0%	7.1%	8.4%	5.4%
Kaiser	2.7%	2.3%	1.8%	1.5%
UHCMA	5.5%	3.9%	4.3%	3.0%

*Data Source: Maryland Insurance Administration

Conclusion

The MHBE is required to study and report on Maryland's risk adjustment and reinsurance programs. The permanent risk adjustment program transfers funds from lower risk plans to higher risk plans in the individual and small group markets, inside and outside exchanges. State-based exchanges may establish their own risk adjustment program, or HHS may operate a risk adjustment program on the state's behalf. The MHBE recommends that Maryland continue to use the HHS-operated risk adjustment program. This recommendation is in line with the practices of other states, and the low cost of the HHS-operated program—the user fees are about $110,400 for 2015. Further, HHS bears the administrative burden of implementing changes and operating the risk adjustment program.

The transitional reinsurance program was intended to help stabilize individual market premiums during the initial years of implementing health benefit exchanges by providing payments to insurance carriers that incur high claims costs for certain enrollees. Under the reinsurance program, insurance carriers make reinsurance contributions to the federal government, and these funds are then distributed to health insurance carriers for high-cost enrollees whose insurance claims exceed a certain threshold. Maryland chose to supplement the federal reinsurance program in 2015 and 2016 by increasing the coinsurance rate. Data from the Maryland Insurance Administration show that both the federal and Maryland supplemental reinsurance programs were effective in reducing insurance premiums across carriers in the state.

As the MHIP fund will cease to exist after July 1, 2016 and MHIP surplus funds have been repurposed, there is no continued funding for the transitional reinsurance program. The benefit of the program was demonstrated by the reduction in premiums which will continue for another year. Any continuation of a transitional reinsurance program will required dedicated funding to support.