ACA COMPLIANCE BULLETIN

CMS RESUMES ACA RISK ADJUSTMENT PAYMENTS

HIGHLIGHTS

- CMS issued a final rule adjusting the risk adjustment methodology.
- This final rule allows collections and payments under the risk adjustment program to resume, despite ongoing litigation.
- A final ruling in the ongoing litigation is not expected until early September 2018.

IMPORTANT DATES

July 7, 2018
CMS halted collections or payments under the risk adjustment program until the litigation is resolved.

July 24, 2018
CMS issued a final rule adjusting the risk adjustment methodology, allowing the program to continue.

Provided By:
Buckman-Mitchell, Inc. - Financial & Insurance Services

OVERVIEW

On July 24, 2018, the Department of Health and Human Services (HHS) Centers for Medicare & Medicaid Services (CMS) issued a final rule adjusting the risk adjustment methodology, **allowing payments to resume under the risk adjustment program**.

Risk adjustment is a permanent program under the Affordable Care Act (ACA) that provides payments to insurers that attract higher risk populations by transferring funds from plans that enroll the lowest risk individuals to those plans that enroll the highest risk individuals. Previously, on July 7, 2018, CMS halted payments to insurers under the risk adjustment program as a result of ongoing litigation. According to CMS, conflicting federal court rulings prevented the federal government from collecting or disbursing funds under the risk adjustment program.

ACTION STEPS

This final rule allows CMS to continue operation of the risk adjustment program—including making collections and payments for the 2017 benefit year—despite the ongoing litigation. Despite CMS' motion for reconsideration, a final ruling resolving this ongoing litigation is not expected until early September 2018.

Since 1916 BMi Buckman-Mitchell, Inc. Financial & Insurance Services

Overview

Risk adjustment is a permanent program under the ACA that applies to all non-grandfathered plans in the individual and small group markets both inside and outside of the Exchanges. According to HHS, the primary goal of the risk adjustment program is to better spread the financial risk carried by health insurance issuers to make sure premiums remain stable. The program is intended to provide payments to issuers that attract higher risk populations by transferring funds from plans that enroll the lowest risk individuals to those plans that enroll the highest risk individuals.

The ACA requires each state to have a risk adjustment program. States that operate their own Exchanges could establish their own risk adjustment program, but were not required to do so. States that operate a SHOP-only Exchange could establish their own risk adjustment program for 2015 and later years if they use a methodology that addresses risk selection in both the individual and small group markets.

If a state did not establish its own risk adjustment program, HHS performs the risk adjustment functions for that state. Currently, HHS operates risk adjustment on behalf of all states, as no states operate their own risk adjustment program. HHS collects a user fee to support the administration of HHS-operated risk adjustment. This fee applies to issuers in states in which HHS is operating the risk adjustment program.

Ongoing Litigation

On July 29, 2016, a New Mexico health insurance co-op sued the federal government over the formula used to determine collections and payments under the risk adjustment program. On the same day, a health insurance issuer in Massachusetts filed a similar lawsuit. The primary focus of these lawsuits is whether CMS acted within its authority in using the statewide average premium to determine its risk adjustment formula.

On Jan. 30, 2018, the U.S. District Court for the District of Massachusetts ruled in favor of the federal government, finding that CMS acted within its authority in using the statewide average premium. However, on Feb. 28, 2018, the U.S. District Court for the District of New Mexico invalidated CMS' use of the statewide average premium in the risk adjustment transfer formula for the 2014-2018 benefit years, pending further explanation of CMS' reasons for operating the risk adjustment program in a budget neutral manner in those years.

According to CMS, the U.S. District Court for the District of New Mexico's ruling prevented the agency from making further collections or payments under the risk adjustment program until the litigation is resolved. **As a result, CMS announced that no collections or payments would be made under the program, including amounts for the 2017 benefit year or any amounts remaining for the 2014-2016 benefit years (including overpayments).**

Following the decision, CMS filed a motion for reconsideration with the U.S. District Court for the District of New Mexico. A hearing on the motion for reconsideration was held on June 21, 2018, but the federal judge in the case indicated that a final ruling may not come until Labor Day. On July 12, 2018, CMS issued a bulletin on the implications of the court's decision. This bulletin provided additional guidance on how CMS will handle

other issues relating to risk adjustment payments, including EDGE server data collection operations, appeals of 2017 risk adjustment amounts and how issuers should treat risk adjustment amounts in the calculation of medical loss ratios.

Final Rule

This final rule reissues, with additional explanation, the risk adjustment methodology that CMS previously established for transfers related to the 2017 benefit year. Because the court took issue with the methodology previously used by CMS, the adjusted methodology in this final rule resolves this conflict and enables CMS to resume the risk adjustment program in the individual and small group markets.

As a result, CMS can continue making collections and payments under the risk adjustment program, despite the ongoing litigation. This final rule provides a fuller explanation supporting the 2017 risk adjustment methodology, consistent with the federal judge's request. In addition, in the final rule, CMS announced its intention to issue a proposed rule to propose and solicit comment on the CMS risk adjustment methodology that will apply to the 2018 benefit year.