CMS' EXCHANGE RULE – WHAT YOU NEED TO KNOW

On Monday, **the Obama Administration announced new regulations intended to strengthen the health of the Affordable Care Act's (ACA) marketplaces** and improve the experience for insurers (our previous note attached). The slate of technical tweaks announced by the Centers for Medicare and Medicaid Services (CMS) — known as the draft 2018 Notice of Benefit and Payment Parameters — is the latest step in a range of actions the administration has taken this year to address complaints by insurers, and follows recent exits from the ACA's marketplaces by some of the industry's largest players, including United, Humana, and Aetna (our note on that is also attached). The 300-page proposed rule is technical in nature – so here's a **brief overview of what you need to know.**

The proposed regulations released by CMS would make several changes to the ACA marketplaces and refine the law's risk adjustment, addressing a primary concern raised among insurers who have announced major retrenchments for the 2017 plan year. Risk adjustment is the only permanent program that the ACA maintains to help mitigate risk in the new insurance market, and results in the transfer of funds from plans with healthier patients to those with a sicker population. Under CMS' proposal, starting in 2018 risk adjustment will factor in prescription drug data for disease such as hepatitis C, HIV/AIDS, end-stage renal disease and diabetes.

While incorporating drug use information and other proposed changes to CMS' risk adjustment methodology could make the system more accurate, legitimate questions remain as to whether further steps must be taken to restore insurer's confidence in the marketplaces. While some have suggested that CMS' proposal "should be enough to stop the bleeding," it's also worth noting that risk adjustment only moves money around between insurers – it doesn't add more money into the system. Assuming these policy changes impacts all issuers roughly equally, updates to the risk adjustment will not necessarily change funds transfers between insurers.

The balance of this update provides an **overview of the key tenants of CMS' proposed changes to the risk adjustment methodology**, and examines their implications for the future of the ACA's exchanges.

Prescription Drug Information

- **Starting in 2018, risk adjustment would factor in prescription drug data** in addition to all the normal conditions and illnesses that are factored into an individual's risk score. This is consistent with arguments made by health insurers who have suggested that their enrollees look healthier than they actually are because the program fails to account for the medicines people are taking.
- CMS had been considering four prescription drug use models (as detailed in a March 2016 White Paper) that would either account for a medical condition's severity or predict the costs

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of a specific condition based on what drugs someone takes. AHIP encouraged CMS to adopt an "imputation" model that uses prescription drug data to identify conditions that would not have otherwise been recorded because an enrollee did not visit a provider during the enrollment period. PhRMA has gone one step further, encouraging CMS to also use prescription drug data to pick up on the "severity" of a patients illness. In the proposal, **CMS is suggesting using prescription drug data for both imputation and severity** in what some are deeming a "hybrid" approach.

- The proposed rule lays out the 11 drug-diagnosis pairs that would indicate a sicker patient in the risk adjustment model. All told, the proposal includes 127 illness categories known as hierarchical condition categories (HCCs). In choosing the final pairs, CMS selected those it believes are least likely to be overprescribed for the sake of getting more money out of risk adjustment. CMS will look at whether to add or remove other drug-diagnosis pairs after analyzing how the new methodology affects drug use patterns.
    - The 11 drug categories include: Hep C Antivirals, HIV/AIDS Antivirals, Antiarrhythmics, ESRC Phosphate Binders, Anti-Diabetic Agents, Insulin, Multiple Sclerosis Agents, Immune Suppressants, Cystic Fibrosis Agents, Ammonia Detoxicants, and Diuretics.
- Including this data could improve the risk adjustments because people with the same condition often have vastly different drug costs. For example, a person with early stage or rheumatoid arthritis typically takes a relatively inexpensive drug, but as their disease progresses, they eventually take far more expensive biologics. Estimating payments based just on diagnostic codes does not take this into account. Also, using prescription data could create more complete records. A diagnosis code may be missed, but if a person is receiving medication treatment, it could be included.
    - The inclusion of prescription drug data could particularly benefit small plans, who have argued their membership bases look healthier than they are because they do not have as much claims data. Smaller regional plans also have far less capital than more established insurers, making it challenging to comfortably make large risk-adjustment payments.
        - Some experts believe allowing state regulators to cap how much can be transferred between plans would further limit financial damage to small plans.
- Some risk-adjustment experts have suggested **using drug data could create perverse incentives for doctors to change their prescribing behavior**. Specifically, plans could encourage enrollees to be shifted to drugs for more serious stages of their condition in an effort to increase risk adjustment payments. Other stakeholders questioned whether that worry is realistic, since insurers do not prescribe drugs and they assume doctors would act ethically instead of cheating the system.
    - Drug makers have supported the approach taken by CMS. PhRMA has said that by incorporating drug data "plans would... be more willing to design formularies and utilization management protocol to channel clinically appropriate patient populations to treatment, with the assurance that the plan will be appropriately compensated whether or not the patient is treated with medicines."

Other Risk Adjustment Changes

- CMS is also proposing changes to the risk adjustment model that will: (1) allow for adjustments based on the number of full months a member was enrolled in a plan, and (2) create a pool of high-cost enrollees.
    - ***Partial-Year Enrollees.*** Risk adjustment will also begin accounting for people who enroll outside of the open enrollment period. Insurers have said people are gaming the system by waiting until after they are sick to sign up for insurance.
        - The Obama administration had already responded to some industry concerns by tightening the restrictions for signing up outside of open enrollment. For example, earlier this year, CMS announced for first time that it would start making enrollees provide documentation to prove that they actually qualified for the extra sign-up periods by proving that they recently moved residences.
    - ***High-Risk Pools.*** The proposal includes new protections for insurers with extremely high-cost enrollees. Costs above $2 million for any one individual would be shared among insurers.
        - Insurers who qualify will be reinsured through the risk adjustment program, but would continue to bear enough of the claims to incentivize managing cost.

Young and Healthy Enrollees

- CMS also makes changes in their proposed rule focused on encouraging more young and healthy people to enroll by giving them more options for less costly plans that offer less coverage. CMS is proposing a standardized option, or Simple Choice plan, at the bronze level of coverage that qualifies as a high-deductible health plan that can be used with a health savings account. The rule states that high deductible plans are "an option valued by many consumers."
    - Bronze plans will have to pay for only one major service before the deductible, such as primary-care visits, generic drugs or emergency room services. Preventive services will still be required to have zero cost sharing.
    - HSA owners or their employers can add a limited amount of pre-tax income to the accounts annually, and deductions made for qualified health care are also tax-free. Money in the accounts can be used tax free for any purpose once an account holder turns 65.

What it Means for the Future of the Exchanges

- This group of proposed changes is largely in response to requests from the insurance industry, and is intended to be helpful in spurring insurer confidence in the exchanges. Nonetheless, there are myriad factors that determine an insurer's decision to participate in a given market, and **it's too early to predict whether plans will expand their exchange participation in plan year 2018** assuming these proposed changes to the risk adjustment program go into effect.
    - CMS held off on proposing several other ideas that were included in the aforementioned White Paper, such as modifying the payment transfer formula and moving to a concurrent system instead of the current retrospective payments. America's Health Insurance Plans (AHIP) urged the administration in a letter not to pursue those proposals and focus on simple changes to more accurately adjust for risk.
    - Some insurance industry stakeholders have expressed concern that the changes will not be adopted quickly enough to address the systematic issues in the exchanges.

- "The big issue is that this is for 2018 – and not addressing many of the challenges that plans are facing for 2017, which is the more immediate need," according to a spokesman from AHIP.
- Consumers for Health Options, Insurance Coverage in Exchanges in States (CHOICES) has said that "the longer it takes for changes to be made, the greater likelihood we will see more carrier exits, higher premiums, and more consumers left without health insurance options."

- While the political pitfalls over any changes to the ACA are abundant, the politics of the law have been shifting – albeit at a glacial pace.
  - Some of the major changes sought by insurers would require action from Congress, such as repealing the Health Insurance Tax or allowing for charging older people higher premiums.
  - Republicans' relentless focus on opposing the ACA has waned over the last year or so. While some campaign rhetoric has remained laser focused on "repealing and replacing Obamacare," other high profile issues – such as trade, immigration, national security, and race relations – have been the focal point of the 2016 campaign season.
  - Senate Majority Leader Mitch McConnell (R-KY) indicated recently that Congress will likely address the ACA in 2017 "no matter who wins the election, no matter who's in control of Congress." While the GOP will likely continue to mount a rhetorical offensive on the ACA, legislation intended to ameliorate the "failures" of the law (i.e. shoring up the exchanges) could be politically achievable in 2017.
- Despite the widely reported concerns about the viability of the exchanges and consumers' access to affordable options, the Obama administration has been sanguine in their public statements. In the midst of pending double-digit premium increases in some states, HHS recently released an analysis stating that coverage would still be affordable for most consumers who receive premium subsidies. And yesterday (Thursday), HHS Secretary Sylvia Burwell said that the exchanges can be made sustainable even if Congress does not act.