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CMS Reinstates ACA Risk Adjustment Payments

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On Tuesday, July 24, the Centers for Medicare and Medicaid Services (CMS) issued a final rule intended to clarify the program methodology and reinstate payments under the Affordable Care Act's (ACA) permanent risk adjustment program for the individual and small group markets. Earlier this month, CMS suspended the risk adjustment program, citing a February 28 federal court order from New Mexico that vacated the agency's payment formula as a reason for the suspension. CMS believes that the final rule provides a fuller explanation supporting the 2017 risk adjustment methodology, consistent with the court's request, to allow the agency to resume the risk adjustment program. The final rule is available here and the CMS press release accompanying the rule is available here.

The ACA's risk adjustment program transfers money from insurers with relatively healthier risk pools to insurers with relatively sicker risk pools to help compensate for potential adverse selection when requiring coverage for people with preexisting conditions. The risk adjustment payments to insurers totaled $10.4 billion for the 2017 plan year. These payments have significant financial implications for insurers and the overall stability of the insurance markets. The Department of Health and Human Services (HHS) establishes the risk adjustment methodology in advance of each plan year through the notice-and-comment rulemaking process.

In February 2018, the New Mexico federal district court raised issue with the methodology that HHS has used to calculate insurers' obligations under the risk adjustment program in plan years 2014 – 2018 (*New Mexico Health Connections v. United States Department of Health and Human Services et al*). Specifically, the court vacated the use of a statewide average premium as a basis for the risk adjustment methodology, citing that HHS did not adequately explain its decision to adopt a budget-neutral framework that requires amounts collected to equal payments made between insurers each year. In response, CMS abruptly halted the risk adjustment program in early July, raising insurers' concerns about higher premiums and greater instability of the individual and small group markets.

In the final rule, CMS maintains the budget-neutral framework for the risk adjustment program. CMS stated that the ACA does not authorize additional funding for risk adjustment payments in excess of charges collected. Therefore, absent relying on Congress to provide additional appropriations, HHS could not implement a program that was not budget-neutral. The agency also maintained the statewide average premium as a basis for the payment transfer formula. CMS stated that risk adjustment collections and payments may be more volatile from year to year and sensitive to outlier premium changes if scaled to a plan's individual premium instead of the statewide average premium.

Of note, CMS decided the final rule would take effect immediately to address concerns that insurers may exit the market or be forced to increase premiums for 2019 in response to market uncertainty. CMS also indicated that it intends to issue a notice of proposed rulemaking seeking comments on a new risk adjustment methodology for the 2018 plan year.

For more information on this or other matters, please contact Sheila Burke, chair of Baker Donelson's Government Relations and Public Policy Group.