

Risk Adjustment Methods, Applications, and Considerations

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Agenda

- Big picture – risk mitigation considerations in healthcare reform
- Risk adjustment as of now
 - Special issues and challenges posed by healthcare reform
 - Are current risk adjustment tools adequate?
- Risk adjustment options for going forward
 - High-level principles of risk adjustment
 - Key decision points and design questions
- Open discussions

Summary of Key Issues

- Risk adjustment is one of several risk mitigation programs that need to interact and be coordinated
- The current Medicare risk adjustment model (and other models) does not adequately address the complexity of risk issues inherent in the non-Medicare commercial markets
- Development of an appropriate risk adjustment model requires a number of key decisions to be made in terms of structure, data, methodology, timing, and administration
- Consumers will be best served by thoughtful attention to comprehensive, equitable, and practical approaches to risk mitigation built upon specific guiding principles

THE BIG PICTURE

Risk Adjusters

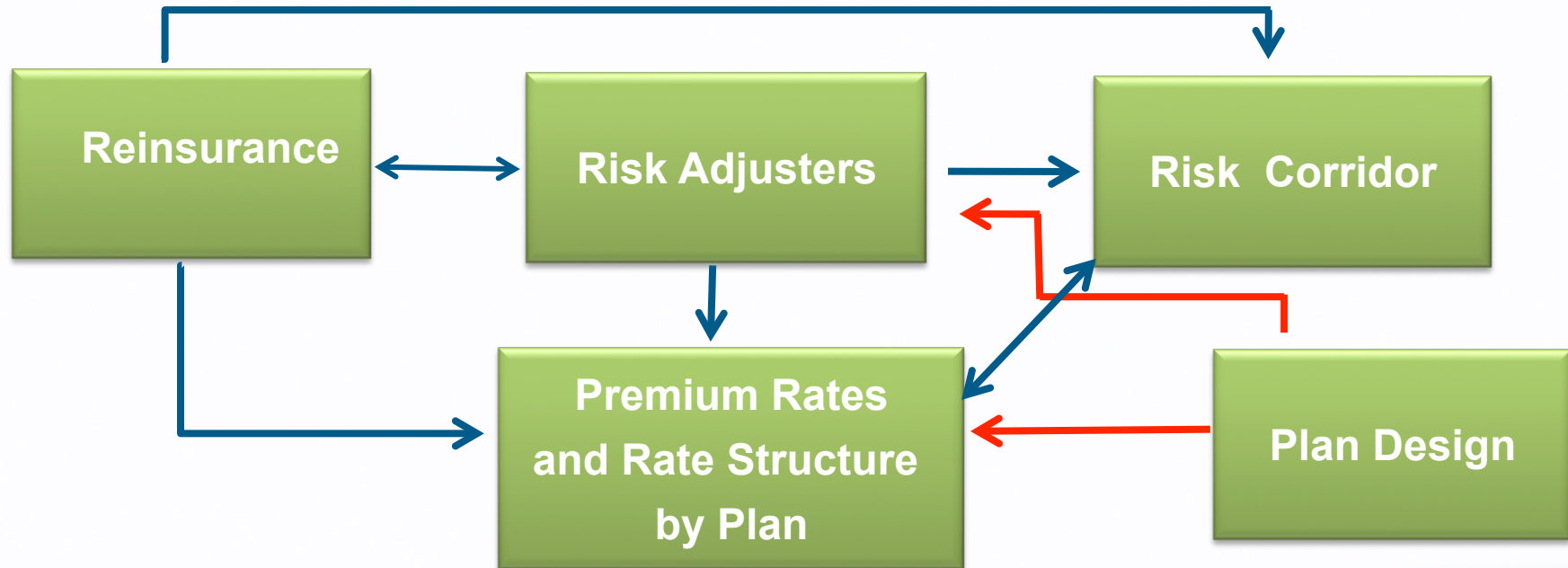
BIG PICTURE

Interaction of Risk Mitigation Programs

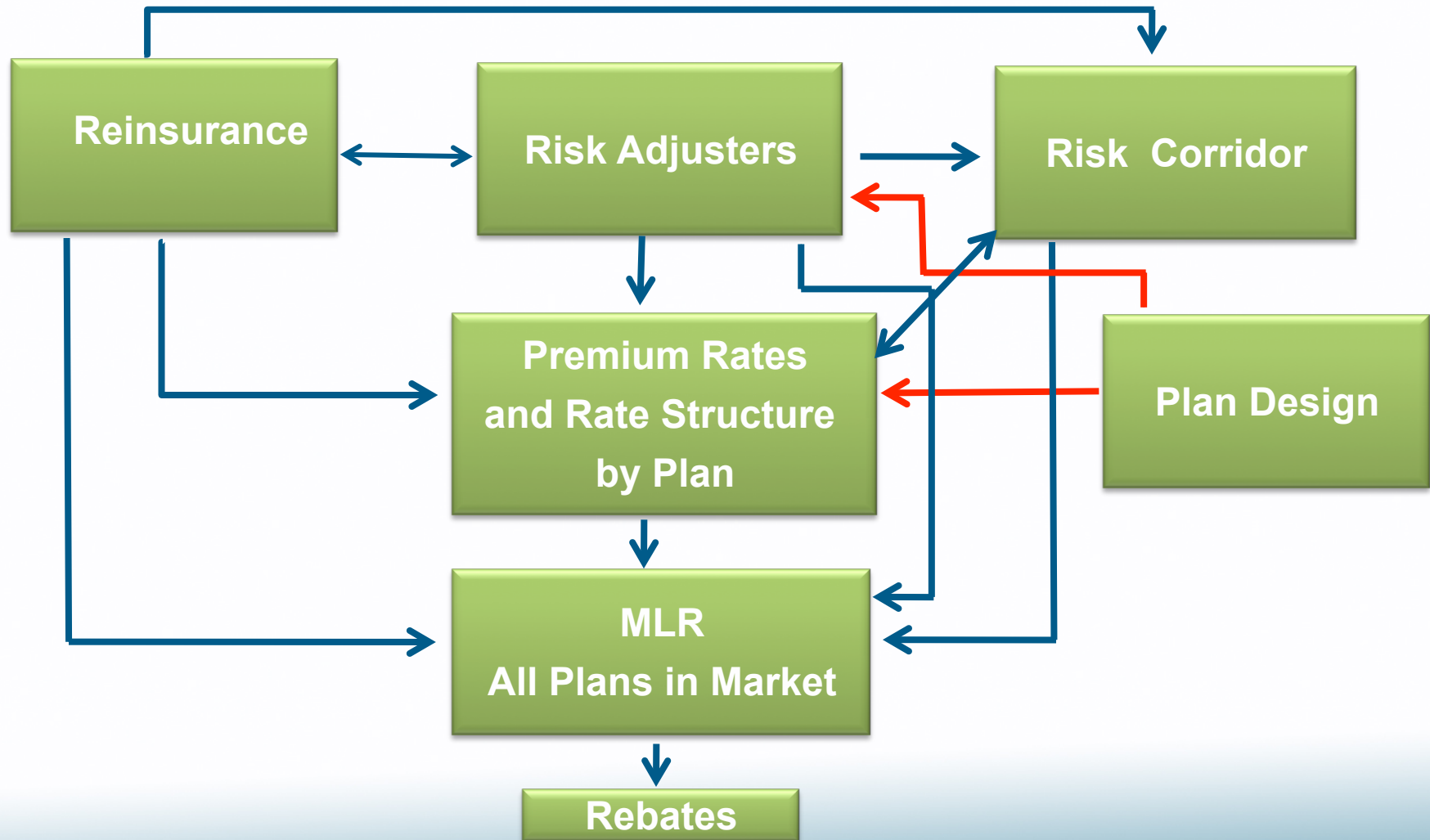


BIG PICTURE

Interaction of Risk Mitigation Programs and Premium Rate Setting



BIG PICTURE: Interaction of Risk Mitigation Programs, Premium Rate Setting, and MLR Rebate Calculations



The Purpose of Risk Mitigation

- ACA introduces fundamental changes to healthcare financing and health insurance that need to be addressed through risk mitigation programs
- Risk mitigation is intended to protect the availability of health plan choice for consumers by normalizing among insurers those risk classes that insurers are not allowed to reflect in setting premium rates.
- While it is not practical to include all risk characteristics through risk adjustment programs, it is important to decide which of them are most appropriately addressed.

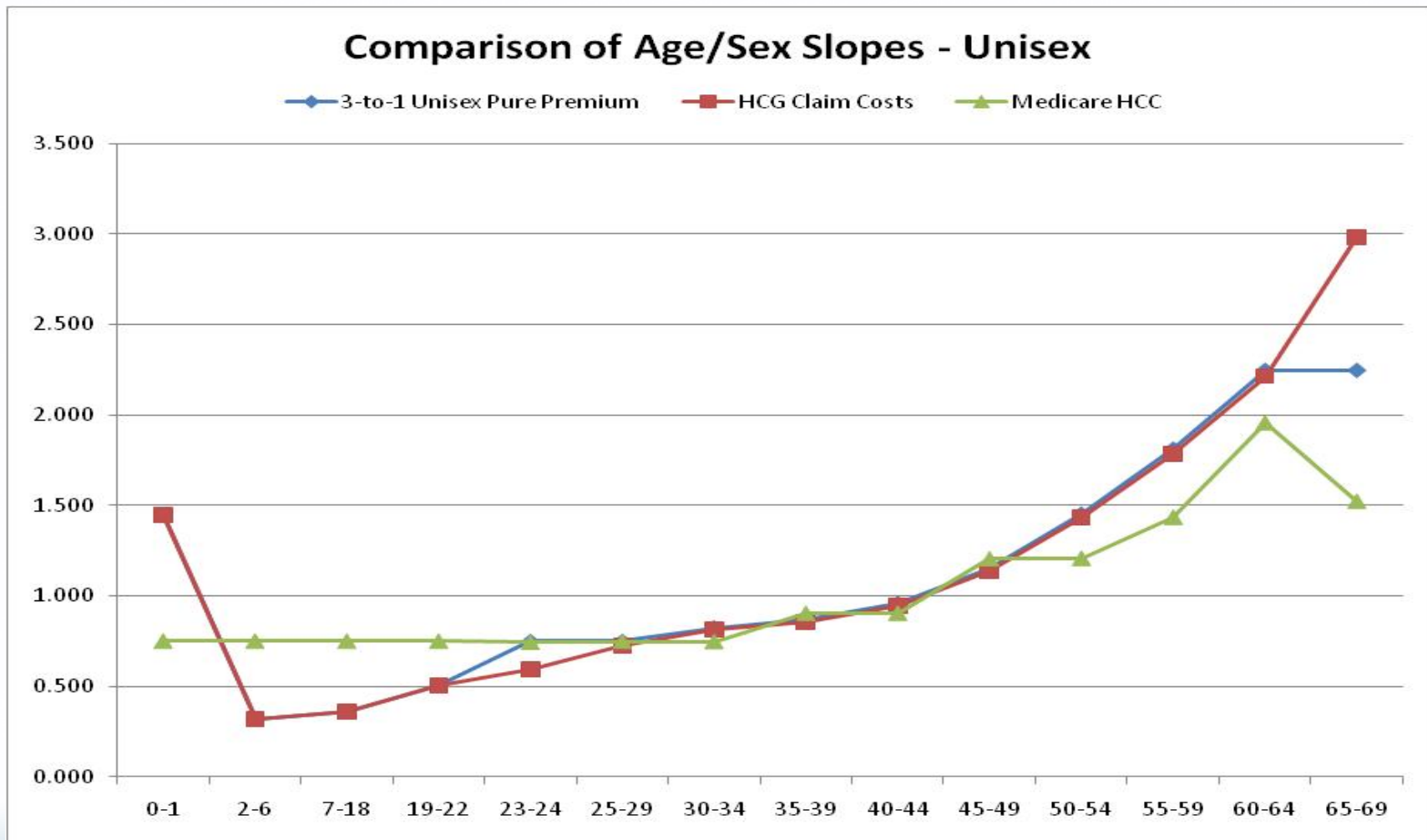
Rating Characteristics under ACA

- Individual plan or family plan (limitations unknown at this time)
- Geographic rating area (unknown at this time)
- Age (limited by ACA to 3-to-1 variation for adult rates)
- Tobacco use (limited by ACA to 1.5-to-1.0)
- Benefit design (including recognition of provider network and degree of managed care?)
- Limitations are often determined for social or political reasons and are not reflective of the true risks involved

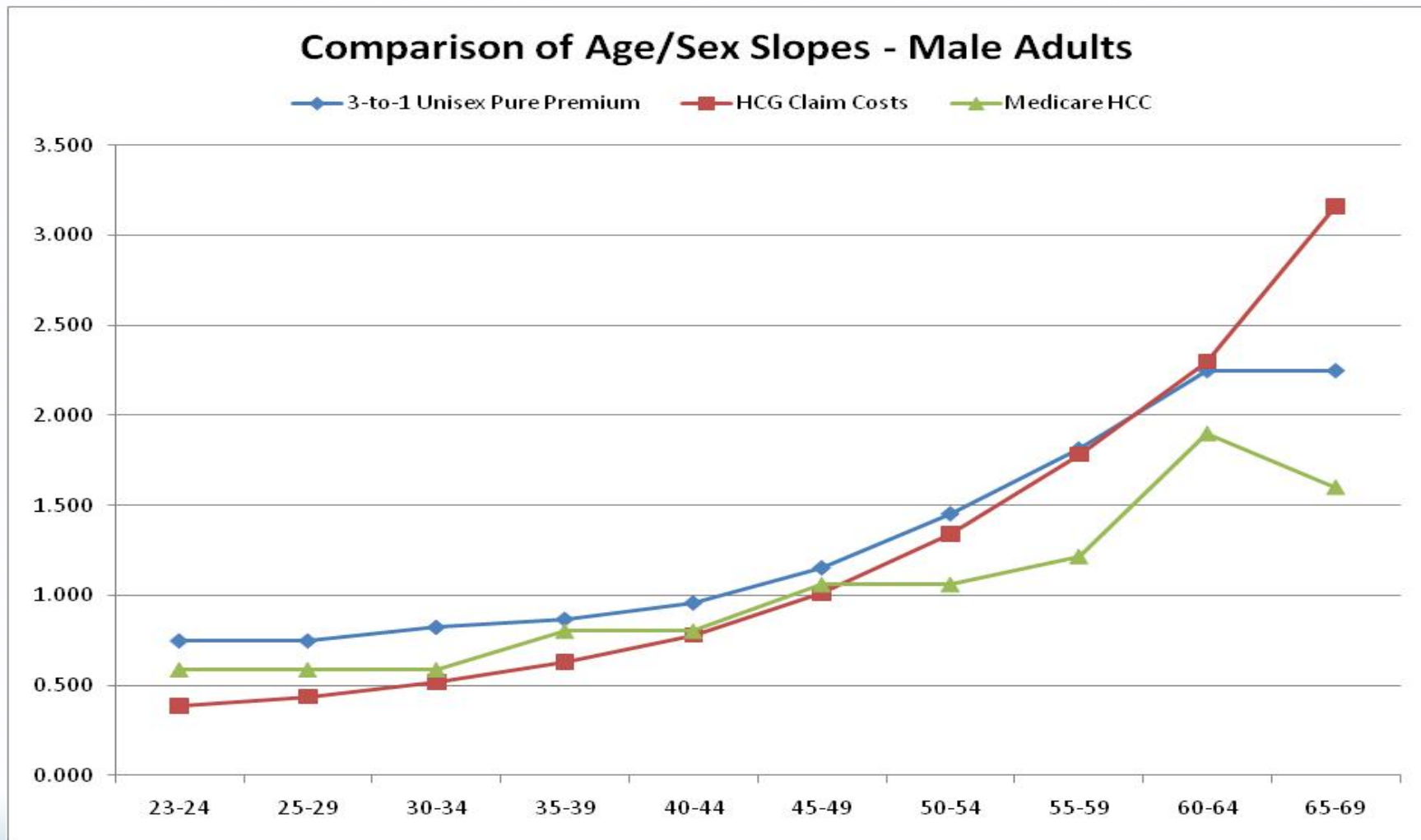
Other Risk Classes

- Health status
- Gender
- Group size
- Industry (Group) / Occupation (Individual)
- Income
- Make up of enrollees – full-time, part-time, retiree, COBRA
- Persistency (variation in movement between plans and markets)
- Duration of coverage
- Pent up demand / prior coverage
- Distribution source
- Financial viability of a group

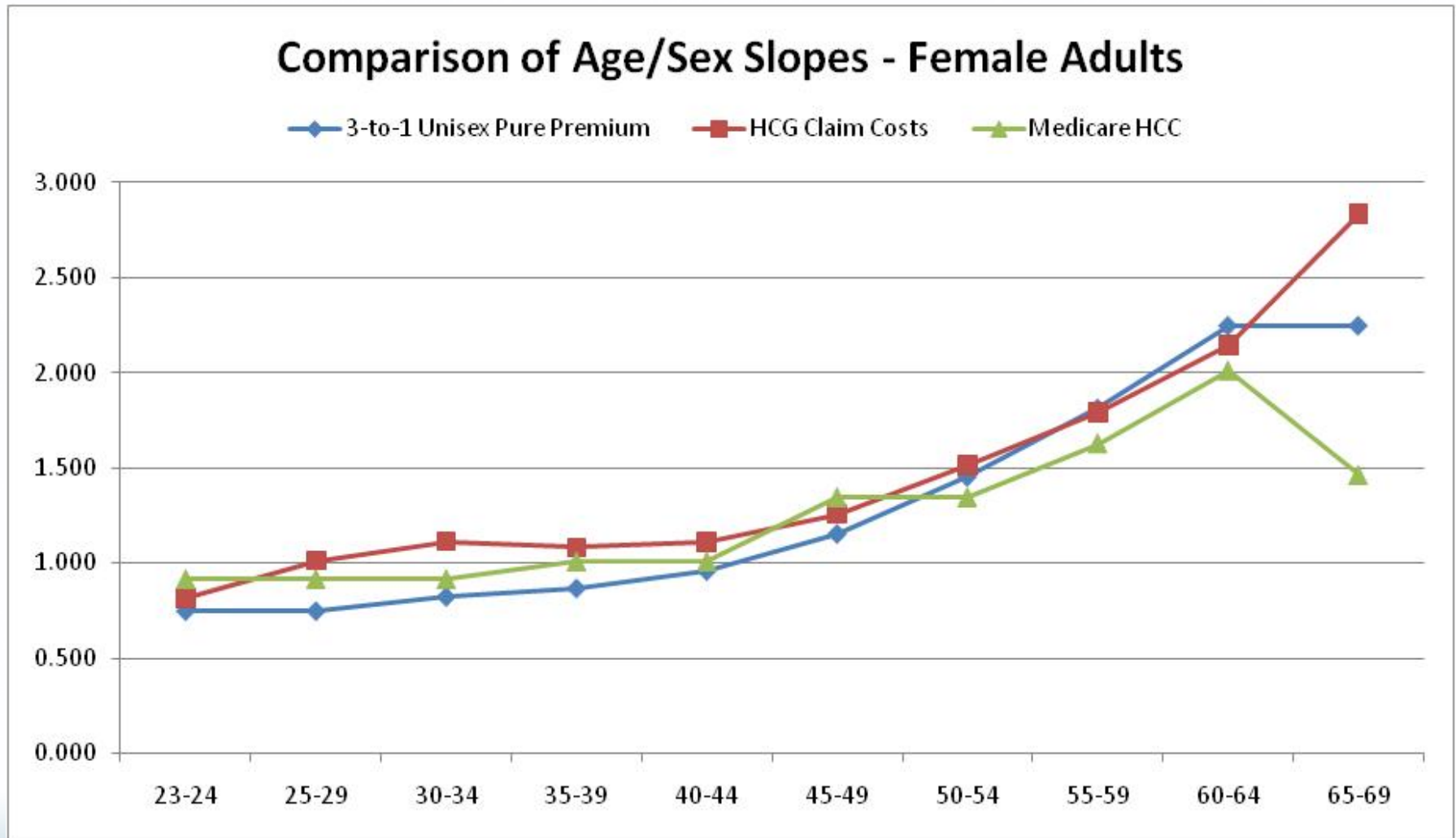
Medicare HCC Age/Gender Factors May Not Be Appropriate for Commercial Markets



Even though premiums are unisex and limited to a 3-to-1 ratio, claims are not



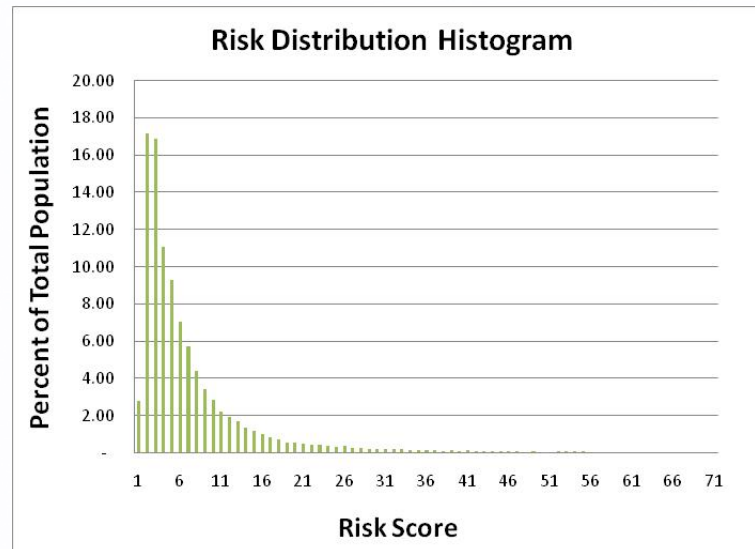
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Risk Adjustment: Issues and Special Challenges Posed by Healthcare Reform

Risk Adjustment Process

Step 1 – Risk Assessment



Step 2 – Funds Transfer



Current Risk Adjustment Payment Systems in the U.S

- Government programs:
 - Medicare Advantage and Part D risk adjustment
 - State Medicaid managed care contracting
 - Massachusetts Health Connector
- Commercial market:
 - Variety of uses in provider reimbursement normalization
 - Emerging uses for ACOs and Patient-Centered Medical Home
- Risk adjustment models have been calibrated to specific population types, no “All-Population” risk adjustment

Issues in Current Risk Adjustment Systems

- Context - current risk adjustment systems are designed and maintained to fit current healthcare systems
- Models are not perfect
 - Overall predictive accuracy: only about 12% R^2 for Medicare HCC, <30% R^2 for prospective models, <60% R^2 for concurrent models
 - Payments may not track well with actual claims experience
 - Under and over-prediction for certain subpopulations
 - Health plans offering richer benefits may be both adversely selected and underpaid
 - May never be perfect but always better than just age/sex adjustment
 - Can be improved with richer & better quality data, better designs, more practical considerations

Issues in Current Risk Adjustment Systems (Cont.)

- Data issues – Importance of understanding the coding process
 - Coding persistency
 - Coding precision and specificity
 - Number of diagnosis fields captured
 - Need more transparency of risk drivers
- Operational issues
 - Communication and education about the risk adjustment model
 - Transparency – what's driving risk?
 - Coding creep
 - Uncertainty and credibility in risk scores – is there a substantial difference between this year's score vs. last year's?

Special Challenges RA Needs to Address in Healthcare Reform

- Lack of data on the uninsured
 - Demographic profile
 - Medical conditions and healthcare needs
- Mixed population types, high turnover, and partial year enrollment
- Pent-up demand from the uninsured and from individuals who will be getting more services covered under healthcare reform
- Risk scores in the first year
- National model vs. state specific RA
- Inside and outside the exchange
- Data exchange and risk score portability

Special Challenges RA Needs to Address in Healthcare Reform

- Transparency in RA model and process
- Claim Lag, Update Frequency, and Finalized Risk Scores
- Risk Adjustment Data Audits
- ICD-10-CM conversion in Q3 2013
- Integration with other risk mitigation programs in the ACA
- Integration with other provisions in the ACA

Options for Going Forward and Key Decision Points

What Do We Mean by “Implementing an RA System”?

Operational Issues

Model Coefficients

Representative Population

Clinical Classification

Input Data

Guiding Principles

Guiding Principles of RA

- Key guiding principles for RA model development
 - On the clinical classification system
 - On statistical rigor
 - On the balancing predictive accuracy and gameability
- Guiding principles for RA implementation and operation
 - Data availability and reliability
 - Transparency
 - Reflective of most recent system design, medical practice and population characteristics

Key Decision Points

- Input data – Dx or Rx or other?
- Which condition categories and how many?
- Prospective or Concurrent?
- Additional factors (e.g., benefit levels, age/gender)?
- How to treat the newly enrolled in the RA process?
- Calibrate model on what population types and which geography?
- Phase-in?
- Frequency of funds transfer?
- Individual risk score or plan-level risk score?
- Frequency of recalibration and model updates?

Key Decision Points (cont.)

- Same RA inside and outside the exchange?
- What other risk classes should be included in the risk adjuster program?
 - Age – recognition of 3-to-1 limitation?
 - Gender?
 - Benefit design?
 - Geography?
 - Income?
 - Occupation?
- Should the risk adjuster program have a small employer component?
 - Group size risk differentials?
 - Industry?
- Is a multilayered risk mitigation methodology needed?