

RISK ADJUSTMENT

Risk adjustment is an important opportunity to ensure the sustainability of the exchanges and coverage for patients with chronic conditions.

If risk adjustment is not implemented correctly, many people could lose access to their coverage. The environment is open for improvements to the risk-adjustment program, and advocates must seize this opportunity. The National Health Council (NHC) believes that there are numerous improvements that could be made to the current risk adjustment program and urges stakeholders to advocate that the program reflect the needs and interests of patients.



What is Risk Adjustment?	2
Background	3
How Does the Affordable Care Act Adjust Risk in the Individual and Small Group Market?	3
Overview of Risk Adjustment	4
Is Risk Adjustment Used in Other Insurance Markets?	4
Why is Risk Adjustment Important?	4
The Current Risk Adjustment Model for Exchanges	5
How is Risk Adjusted?	5
How Does the Current System Fall Short for Patients?	6–7
CMC Proposes to Strengthen Risk Adjustment	8
What Changes Were Proposed to Risk Adjustment?	9
The NHC Recommendations to Improve Risk Adjustment	10
NHC Propose Changes to Benefit the Patient Community	10
What Other Analyses Would Support Additional Modifications to Risk Adjustment?	11

What Is Risk Adjustment?

Risk adjustment is a program designed to stabilize insurance markets by compensating plans based on the expected health-care costs of their members, taking into account the level of illness in that population. A properly designed risk adjustment system provides the necessary incentives for insurance plans to enroll people across a wide spectrum of health statuses— from the generally healthy to those with multiple chronic conditions.

In general, risk adjustment provides increased payments to plans with sicker patients from a pool funded by plans with healthier individuals. This system is designed to appropriately compensate plans for the relative health status of their enrollees. Risk adjustment protects insurers and patients against the negative effects of adverse risk selection. Adverse selection is a phenomenon where patients who are most in need of healthcare are more likely to purchase insurance. Risk selection occurs when insurers have an incentive to avoid covering patients in poor health who are likely to require more costly medical care.

Background

How Does the Affordable Care Act Adjust Risk in the Individual and Small Group Market?

The Affordable Care Act (ACA) lays out a vision of providing accessible and affordable coverage, and risk adjustment plays an instrumental role in achieving this goal. The ACA improved access to coverage for many people, including patients with chronic conditions, by providing new options for coverage and by changing insurance market rules to make choices available to patients. In addition to establishing health insurance exchanges and providing subsidies for qualifying individuals to purchase insurance, the law requires individual and small group plans to cover all eligible individuals,

regardless of health status. The ACA also established rating rules that would not allow premiums to vary based on health status.

Prior to 2014, it was unknown which types of patients would seek coverage on exchanges or if there would be a mix of healthy and sick individuals in the market. As a result, the ACA created risk stabilization programs to help plans establish themselves in this new market. The three premium stabilization programs, known as the 3Rs, were intended to balance some of the uncertainty around the scope and health of the population enrolled in this new market:

1. Reinsurance

(Temporary: 2014–2016)

Provides payments to plans that enroll higher-cost individuals.

2. Risk Corridors

(Temporary: 2014–2016)

Limits losses and gains beyond an allowable range.

3. Risk Adjustment

(Permanent)

Redistributes funds from plans with lower-risk enrollees to plans with higher-risk enrollees.

Overview of Risk Adjustment

In the risk adjustment program, which is the only permanent risk stabilization program, funds are paid by plans with low-risk enrollees into a pool, which is then distributed to plans with high-risk enrollees, as calculated by risk scores based on diagnosis codes. In the reinsurance program, which runs from 2014 to 2016, plans and third party administrators contributed to a fund that distributes payments to plans when their costs reach a certain threshold. In the risk corridor program, which runs from 2014 to 2016, funds are reallocated from plans that have higher-than-projected gains to plans with lower-than-expected gains. Reinsurance and risk corridors expire at the end of 2016, leaving

risk adjustment as the only permanent mechanism that spreads risk across the population.

Risk adjustment is used to ensure plans are compensated appropriately for all individuals, since they are no longer permitted to vary premiums or benefits based on a patient's health status. Plans that enroll sicker-than-average patients depend on accurate risk adjustment payments to keep benefits robust and premiums affordable. Thus, if risk adjustment is inaccurate, plans will not receive appropriate compensation for enrollees and may design benefits that discourage enrollment for high cost enrollees to protect against financial risk.

Is Risk Adjustment Used in Other Insurance Markets?

The federal government has long used risk adjustment in public health coverage programs. The government first began using risk adjustment in 1997 in the Medicaid program, where states with Medicaid managed care may use one of three main risk-adjustment models. In 2000, the government began using risk adjustment in the Medicare Advantage program to increase or decrease per-member payments to each

plan. In fact, the Medicare Advantage model is the basis for the risk-adjustment model developed for the individual and small group markets, though there are key distinctions between the programs used for these two markets.

Most notably, risk adjustment transfer payments are budget neutral in the exchanges, while Medicare Advantage can incorporate additional funds.

Why Is Risk Adjustment Important?

An accurate risk-adjustment system is critical to the stability and sustainability of the insurance exchanges. Patients, payers, physicians, and policymakers all have a vested interest in proper risk-adjustment models. Inaccurate risk adjustment can lead to insufficient

funding for plans that enroll sicker populations with higher-than-average health care needs. Insufficient funding may make providing care to some enrollees unaffordable for plans and may cause insurance companies to drop out of the exchange entirely.

The Current Risk Adjustment Program for Exchanges

How Is Risk Adjusted?

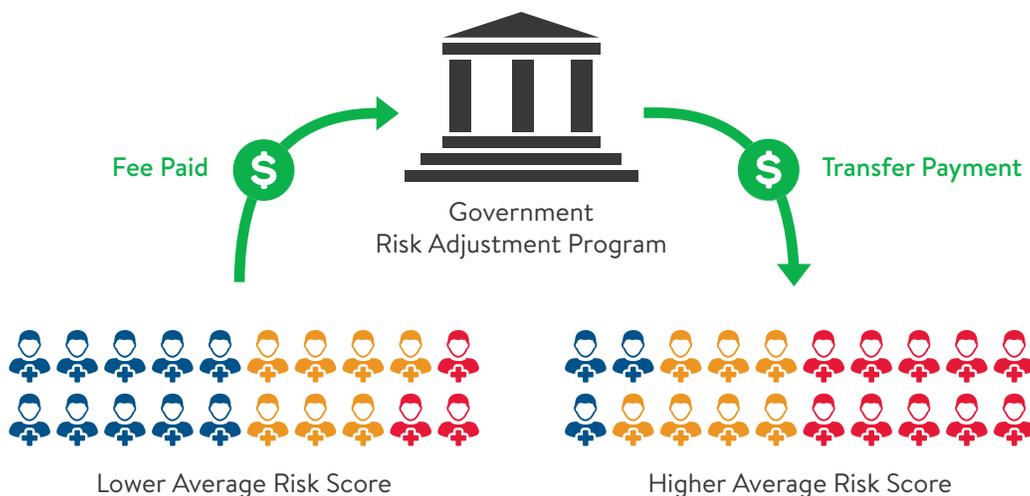
The risk-adjustment program used in the individual and small group market is based on methods originally established for the Medicare Advantage program. In general, the model calculates risk scores for a select set of conditions for each enrollee in each plan. The

model assigns risk scores based on demographics and diagnosis code(s) assigned during medical visits and procedures. The risk scores for each enrollee estimate the expected costs of the enrollee compared to the expected costs for the “average” enrollee.

	<p>Patient 1 21-Year-Old Female No Diagnoses Low Risk Score</p>		<p>Patient 2 41-Year-Old Male Diabetic Mid Risk Score</p>		<p>Patient 3 61-Year-Old Female Multiple Sclerosis Smoker High Risk Score</p>
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Next, the risk scores for each enrollee are aggregated as an average for each plan. In order to determine which plans will pay and which will receive payment, CMS uses a formula to compare each plan’s average risk score to the average across all issuers. In general,

if a plan’s aggregate risk score is greater than the average risk score across all issuers within their state, the plan receives a “transfer payment.” If the plan’s aggregate risk score is less than the average risk score, then the plan pays a fee.



The Current Risk Adjustment Program for Exchanges

How Does the Current System Fall Short for Patients?

CMS and plans have both cited risk adjustment as a key area for improvement in the individual and small group market. The risk pool in this market seems to have higher health needs, on average, than predicted. Further, the model does not seem to adequately compensate for patients with very high health needs. And, finally, enrollees in this market do not always maintain membership for an entire plan year, adding unexpected challenge to a system requiring diagnosis codes for input. In recent months, several carriers have announced reduced participation in the exchange market, citing the lack of appropriate risk adjustment as a contributing factor to this action. As evidenced by plan departures from the

exchange market, inaccurate risk adjustment can lead to fewer plan choices for patients. With fewer plans available, plans that continue to participate will have increased pressure to succeed. In order to limit their financial liability, some plans may structure benefits to avoid certain high cost enrollees. All in all, inaccurate risk adjustment can lead to an individual and small group market that does not fulfill the vision of the ACA—to offer comprehensive, affordable coverage to people who have otherwise not had access to health insurance coverage.

The current risk-adjustment model used in the individual and small group markets has several limitations with regard to its accuracy:

1. The exchange population is different than the population used to estimate the model.

The current risk-adjustment model is based on data from self-funded, large employer commercial claims. The large employer market is generally different (both at the demographic and health status level) from the exchange market. The exchange population also is more likely to

have enrollment for less than entire calendar year. These differences mean the utilization and cost metrics for enrollees in the individual and small group markets will vary from the model's predictions, leading to inaccurate transfer payments between plans.

The Current Risk Adjustment Program for Exchanges

2. There has not been sufficient examination of how patients with specific diseases or disabilities are affected by the model.

To date, CMS has not released data comparing predicted spending based on risk scores to actual spending in exchange plans. More information is needed to assess the efficacy of the current model, which would allow stakeholders to determine changes that are needed and the priority of such changes.

The model is not comprehensive and only includes a select set of diseases and disabilities, which limits the breadth of conditions experienced by enrollees in the market that influence plan scores. The risk model excludes certain conditions from the risk-adjustment model. If the health status of the enrolled population is not accurately captured in the model, the model will

fail to compensate plans based on the actual health care costs of the individuals enrolled.

The model uses only diagnosis codes to develop risk scores, rather than additional health care utilization data, such as prescription drug fills, to identify diseases or to adjust for the severity of diseases. Specific medication use may provide greater insight into a person's health status. The use of a prescription drug could also serve as a proxy for diagnosis in cases where diagnosis data are incomplete. And, in some cases, the model could use drug data to determine disease severity. CMS has begun to address this in the 2018 Notice of Benefit and Payment Parameters (NBPP) draft rule.

3. The program underpays for partial-year enrollees

Further, many individuals are enrolled in individual and small group plans for a limited amount of time and often cost plans more than what their risk scores indicate.

Increasing the opportunities for such enrollees to trigger one or more risk scores could allow for more accurate payments to plans in these markets.

CMS Proposes to Strengthen Risk Adjustment

With two of the three premium stabilization programs expiring (i.e., reinsurance and risk corridor), 2017 marks the first year of heightened attention on risk adjustment, as it will be the only remaining risk-stabilization program. As the exchange markets continue to face significant challenges, risk adjustment will become even more important for their sustainability.

Given the numerous concerns regarding the current risk adjustment methodology, CMS has recently shown a willingness to engage with stakeholders and a commitment to improving the program. CMS has taken several

initial steps aimed at improving risk adjustment. In March 2016, CMS published a white paper that summarizes the risk-adjustment methodology, but more importantly, outlined options for improving the risk-adjustment model. Later that month, CMS hosted a conference to present the options laid out in the white paper and solicit feedback from stakeholders. On August 29, CMS released a draft of the 2018 Notice of Benefit Payment Parameters (NBPP), which proposed several changes to the risk adjustment methodology in based on the concepts introduced in the white paper.

Summary of Risk and Market Stabilization Programs in the Affordable Care Act

	Risk Adjustment	Reinsurance	Risk Corridors
DATES IN EFFECT	2014, onward (Permanent)	2014–2016 (Temporary—3 years)	2014–2016 (Temporary—3 years)

Source: Sections 1341, 1342 and 1343 of The Patient Protection and Affordable Care Act

CMS Proposes to Strengthen Risk Adjustment

What Changes Were Proposed to Risk Adjustment?

CMS addresses risk adjustment each year in the NBPP. The draft NBPP for 2018 offers the largest set of changes to risk adjustment since the program's inception and, thus, creates an opportunity for patient advocacy groups to comment, both on the changes CMS has suggested it will make, as well as on any other modifications that might improve the risk adjustment program.

Specifically, CMS proposes to include in the 2017 risk model partial year enrollment duration factors to incrementally increase the risk score of an enrollee who is covered for less than one year. Additionally, CMS proposes to include prescription drug data as an indicator of in the 2018 risk adjustment model. Generally, this change will increase the risk scores of enrollees who take certain types of medicines. In this model, prescription drug use would provide an additional source to indicate a disease and would indicate the relative severity of an enrollee's condition.

Other proposed changes for 2018 include reintroducing an element of reinsurance by covering 60 percent of claims above \$2 million for any enrollee from a separate

pool of funds as well as several other possible approaches to recalibrate the risk models so that they can better predict risk for healthier subpopulations.

CMS's current proposals may not fully address all of the limitations of the current risk adjustment program, and it is critical that further advocacy efforts are utilized to ensure changes that will enhance the accuracy of risk adjustment.

While it is important that CMS proposed a set of changes to risk adjustment, the relative impact of these proposals remains unclear. Moving forward in this process, advocates need to be informed about how proposed changes could potentially impact the patient community, as well as given the opportunity to provide additional improvement suggestions. Advocates have an opportunity to push for more information on how changes will impact the risk-adjustment methodology. All stakeholders must work together to improve the risk-adjustment program to ensure the sustainability of the exchanges and patient access to affordable and robust coverage.

The NHC Recommendations to Improve Risk Adjustment

Improving the accuracy of the risk-adjustment program is critical to ensuring the viability and sustainability of the insurance exchanges for patients. An accurately designed and implemented risk model will result in a system that scores and captures each enrollee's expected

expenditures so that payments across plans are equitable. If the risk model is inaccurate, plans may reduce benefit designs and increase premiums to protect against financial risk. As a result, patients may face significant challenges obtaining adequate, affordable coverage.

NHC Proposed Changes to Benefit the Patient Community

The NHC has identified several reforms that would improve the current risk-adjustment program and benefit patients in the exchanges. Among the policies that CMS has indicated that they will explore, the NHC has particular considerations that can further enhance the ability of the risk-adjustment program to appropriately spread risk across plans. These include:

1. Leveraging new data sources to construct the risk-adjustment model

Relying on data that more accurately reflects the breadth of individuals and families who are enrolled in the exchange will produce a more stable marketplace for patients.

2. Examining the impact of partial-year enrollments on plans' risk profiles

A comprehensive analysis of this trend will help determine whether an enrollee's risk score accurately reflect their costs under the current model and the need for solutions that might be required.

3. Including prescription drug information to determine diseases and assign severity

Using prescription drug fills data to inform risk scores will produce a more accurate model that will offer more detailed information on patients than previously possible and allow for adjustments based on the severity of the disease.

The NHC Recommendations to Improve Risk Adjustment

What Other Analyses Would Support Additional Modifications to Risk Adjustment?

In addition to the policies already under consideration, the NHC believes that additional data and analysis could help resolve underlying issues within the current system and any future changes. Specifically, CMS should consider:



1. Publishing data on specific conditions among patients in the exchanges

Data on the prevalence of chronic conditions in the exchanges would permit stakeholders to gain a better understanding of the differences between the model’s projected cost versus

actual cost for patients with specific conditions. Understanding the differences could identify potential priority areas for resolution.



2. Promoting greater transparency and soliciting feedback on the coverage criteria for conditions included in the model.

To date, no data have been released on the process used to determine which conditions are included or excluded from the model or how these conditions are grouped. This data could allow stakeholders to

understand the gaps in the model and propose methods to fill those gaps in order to ensure that more enrollees with specified diagnoses are acknowledged and scored by the model.



3. Performing a comprehensive study to determine if current risk adjustment in the exchanges is sufficient

A comparison of risk-adjustment programs across exchanges, Medicare Advantage, and Medicaid would permit CMS to develop a better understanding of the limitations and successes of each program and to consider solutions that could improve risk adjustment for all programs.

Enrollment of younger enrollees is lower than expected. Since the risk model was designed with certain assumptions in mind, the impact of

fewer younger enrollees than originally projected should be considered.

Unlike Medicare Advantage and Medicaid, risk adjustment in exchanges is required to be budget neutral. Though new funding sources are always a challenge, performing assessments that test whether a budget neutral program can appropriately spread risk in the exchanges could lead to innovative solutions.

Risk adjustment is an important opportunity to ensure the sustainability of the exchanges and coverage for patients with chronic conditions. If risk adjustment is not implemented correctly, many people could lose access to their coverage. The environment is open for improvements to the risk-adjustment program, and advocates must seize this opportunity. The NHC believes that there are numerous improvements that could be made to the current risk adjustment program and urges stakeholders to advocate that the program reflect the needs and interests of patients.

Mission Statement

The mission of the National Health Council (NHC) is to provide a united voice for people with chronic diseases and disabilities and their family caregivers.



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