

Commercial risk adjustment and transfer payments: Are you ready?

Key items to consider as you prepare for 2014



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Healthcare reform is moving full speed ahead after the Supreme Court decision in June 2012 and the November 2012 elections. As a result, we will see changes (and challenges) in the individual and small group markets starting in 2014, including the introduction of risk adjustment and transfer payments for non-grandfathered plans. Part of the healthcare reform legislation mandated that the U.S. Department of Health and Human Services (HHS) establish a transfer payment methodology between plans in these markets to help mitigate differences in the risk characteristics of members. The transfer payment methodology results in transfers between carriers on a *zero-sum* basis—if a plan is receiving a payment, that payment must come from another carrier.

To be successful in this new environment, carriers will have to submit accurate diagnosis codes to HHS to ensure their risk scores reflect the actual risk of their population. If plans cannot do that, then they are likely to end up subsidizing other carriers. Hence, a proactive approach to understanding the proposed risk adjustment model and transfer payment methodology could be crucial for success. Failing to have accurate and complete submission of diagnoses could have a material impact on an insurer's loss ratio, potentially 2% or more depending on what other carriers in the market do.

This is a similar challenge (and opportunity) to what Medicare Advantage (MA) plans faced when risk adjustment was introduced in 2004. Hence, there are a number of lessons that can be learned from what MA plans are currently doing. In addition, understanding the transfer payment mechanism and what will impact whether a carrier *owes* or *collects* will help in planning for 2014 and later.

This paper addresses both the operational challenges of submitting diagnoses and how the transfer payment will work. There are also key questions all insurers need to be asking in order to ensure they can be successful in the new environment.

BACKGROUND

A recent Society of Actuaries (SOA) research study, in draft form at the time of this publication, concludes that there will be a large influx of new members into the insurance market in 2014 (primarily through the exchanges) due to the individual insurance mandate and the availability of subsidies for low-income individuals. The SOA estimate is that 10.4 million members will join through individual exchanges and another 2.2 million will join through the small business exchange. Current

members in non-grandfathered plans in the individual and small group markets and newly participating individuals will be subject to the risk mitigation components of the Patient Protection and Affordable Care Act (PPACA): risk adjustment, risk corridors, and reinsurance (the 3 Rs). (Note that reinsurance will only apply in the individual market.)

While the temporary risk corridors and reinsurance will help protect against significant deviation between the pricing assumptions and actual results, commercial insurers can evaluate the potential impact of these items through scenario testing and reflect that impact in their pricing for 2014. However, insurers may not be able to address these items prospectively. The risk adjustment model applicable to these members, on the other hand, could result in winners and losers due to the required transfers between plans, and carriers can start now to prepare.

HHS indicates in its proposed regulations that the Medicare risk adjustment model implemented by the Centers for Medicare and Medicaid Services (CMS) starting in 2004 guided the development of the commercial risk adjustment model, in terms of both methodology and operation. Both models rely on grouping of diseases into condition categories and then assigning hierarchical condition categories (HCCs) to designate different level of risks. HHS has distinguished the models by identifying the Medicare model as CMS HCCs and the commercial model as HHS HCCs. Because the Medicare model started almost 10 years ago, reviewing the Medicare model and what actions MA plans have taken to be successful in a risk adjustment environment can be illustrative for commercial carriers in order to ensure success for them in that environment.

The risk adjustment, reinsurance, and risk corridor programs interact with each other, and collectively they have deep implications for an insurer's business strategies, operations, and financial success. This paper focuses strictly on the risk adjustment program and its impact on financials absent risk corridors and reinsurance. Hence, any illustrative results presented might not reflect the actual financial results after the risk corridor and reinsurance programs are included.

IT'S ALL ABOUT THE DATA

As with the Medicare risk adjustment model, the key driver of the risk score attributed to each commercial insurer will be diagnosis data submitted by the insurer for its members. HHS released the coefficients for the HHS HCC risk adjustment model in late November 2012 and the ICD-9 diagnosis codes that map to each HCC on January 16, 2013.¹ Under both risk adjustment models, a carrier must submit an ICD-9 code listed in the model in order to have an HCC assigned to a member. For example, while ICD-9 code 249 is *secondary diabetes mellitus*, neither the Medicare nor commercial risk adjustment model recognizes this ICD-9 code as sufficiently specific to assign a diabetes HCC to a member. Instead, both models require the diagnosis to include two digits after the 249 (e.g., 249.00) in order to have the diabetes HCC assigned to the member.

The HHS-proposed rule indicates that HHS intends to follow a similar level of specificity in assigning diagnoses to HHS HCCs to *provide incentives for more specific diagnostic coding*. This is consistent with the current direction of the official ICD-9 coding guidelines where less specific codes are becoming invalid in favor of more definitive specificity. Commercial insurers may want to review their 2012 and emerging 2013 claims to determine the level of specificity currently included by their providers. In many cases, provider reimbursement is based on procedure codes and not diagnosis codes, which results in providers having little incentive to provide *specific* coding as part of their claims submission.

MA plans have spent a significant amount of time and resources educating providers about the importance of specific coding in order to impact both their risk scores and revenue. If all MA plans increased their risk scores in a given year, the total revenue paid by CMS would increase for that year because the pool of dollars is not fixed. On the other hand, the commercial risk adjustment model with transfer payments is zero sum because the pool of dollars is fixed (see Transfer Payments section). Commercial insurers that either have experience with MA coding requirements or that are proactive in educating their providers about the requirements will be more likely to have higher risk scores, which could increase their payments from other carriers (or reduce payments to other carriers).

HHS has indicated that only certain claims and claim types are eligible for determining a member's actual diagnoses. HHS published a list of CPT/HCPCS codes on January 16, 2013, that they consider acceptable for submitting diagnoses and indicated

that non-facility claims without one of those codes should not have any diagnoses submitted. It also provided similar guidance about what inpatient and outpatient claims are valid sources for diagnoses. This is actually a change from the Medicare model, where CMS has previously provided general guidance about what types of claims are valid for submitting diagnoses but has never published a specific list.

HHS currently anticipates using the claim data submitted by carriers as part of the reinsurance program to determine risk scores since this data should have the necessary information to calculate the risk scores based on the HHS criteria. However, insurers will likely still want to filter their data to understand which diagnoses are from valid claims and whether there are other diagnoses for which the claims will not provide valid support. As discussed in the next section, a claim record is not sufficient to ensure that a member has a diagnosis. A claim record is considered a financial transaction and not a medical record, so while it may be an appropriate starting point for determining diagnoses, it would not be sufficient to support the diagnosis as part of the data validation process.

One additional item that could have an impact on the risk score for an insurer is the availability of separate medical claims and enrollment records for newborn infants versus mothers. HHS specifically addresses this potential data issue in the proposed rule and asked for comments on the operational feasibility of matching claims to the newborn versus the mother or splitting claims that are bundled. Because the coefficients assigned to newborns with any of the severity HCCs can be significant, especially for premature newborns, ensuring that HHS has the ability to assign these HCCs to members could have a significant impact on an insurer's risk score.

DATA VALIDATION: THE PROOF IS IN THE MEDICAL RECORD

HHS also indicated in the proposed rule that the diagnosis data submitted by insurers will be subject to a data validation process. While the final process is still in development by HHS, there may be lessons to be learned from the Medicare Risk Adjustment Data Validation (RADV) audits currently performed by CMS. There will be several steps to the HHS data validation process, as follows:

- The initial validation audit will be performed by outside vendors retained by the commercial insurer on a sample provided by HHS. The proposed rule indicates that HHS will provide a list of approximately 300 members to the insurer within each state and that the auditor will be responsible for validating that the diagnoses submitted are accurate and substantiated by the medical records.
- The second validation audit will be performed by HHS (or its designees) to review and confirm the findings of the initial audit on a sample of the approximately 300 members.
- As a final step, HHS will calculate an error rate based on both of the audits and apply that error rate to the final calculated risk score. For the first couple of years of the program, HHS has

¹ U.S. Dept. of Health and Human Services (November 2012). HHS Risk Adjustment Model Algorithm Instructions. Retrieved January 24, 2013, from http://ccio.cms.gov/resources/files/ra_instructions_proposed_1_2013.pdf.

indicated the error rate will not impact the risk scores or payment transfers. However, in future years, the error rate could be used to adjust the risk score and the transfer payments. If HHS finds that the diagnoses are not supported by the medical records, then a plan could have its calculated risk score reduced to reflect the error rate due to unsubstantiated diagnoses.

One potential concern about these validation audits is finding appropriate staff to perform them. CMS currently performs a limited number (fewer than 50) of targeted RADV audits per year, and a number of MA plans have internal staff that they can dedicate to that effort. As part of these audits, MA plans must obtain copies of inpatient, outpatient, and physician medical records for the audited members. They must then determine the *one best medical record* for each submitted diagnosis and provide that medical record to CMS. Assuming an average of 10 commercial insurers participate in each state and are subject to the data validation requirements, 500 audits will need to be conducted. The potential tenfold expansion in the number of these audits being performed across the country could lead to a significant strain on the current available and *certifiable* staff to perform these audits.

TRANSFER PAYMENTS: WINNERS AND LOSERS?

While the risk adjustment methodology and philosophy for the new commercial and existing Medicare models are similar, the payment formula is not. As mentioned previously, the federal government pays MA plans directly because the MA plans are replacing the federal government as the insurer. Hence, if all MA plans increase their risk scores for a given year, all plans would receive a higher payment to reflect those risk scores from CMS. There is no fixed pool of funds. In its CY2010 Announcement, CMS recognized the efforts of the MA plans to do a better job of identifying and submitting appropriate diagnoses and that this was *having a notable impact on payment* and included the adjustment factor to offset that difference. However, that factor does not change based on the actual risk scores calculated for a given year and is published annually before the payment year, so there is no *adjustment* to the total payment if the factor underestimates any actual change in risk scores.

Unlike for MA plans, however, individuals who enroll through the exchanges (and non-grandfathered members who enroll outside the exchanges) or those members' employers will be the primary parties responsible for paying premiums to the insurers. The government will also provide subsidies to low-income individuals, but that subsidy will be based on the premium charged by the insurer and not the risk score of the member. Because the *pool* of premium dollars is fixed once premiums are set and members enroll, the commercial risk adjustment model will result in transfers of that fixed pool of premium dollars between insurers as opposed to a change in total payments to carriers. Since the pool of dollars is fixed, carriers that do not focus on submitting valid and specific diagnoses will likely be disadvantaged financially when compared to those who do.

There are a number of factors that will go into the calculation of the transfer payments, such as:

- State average premium (essentially the average billed premium for all members in the risk adjustment pool)
- Plan average risk score (average risk score of all members in the plan)
- Actuarial value of the different level of plans offered
- Permissible rating variation (allowable age rating factors because the model does not include adjustments for family size or tobacco usage/wellness discounts)
- Geographical cost differences within a state (based on relative premiums charged for the silver plan in different rating areas)
- Induced demand (which is due to advanced payment of cost sharing for low-income individuals)

The transfer formula is the difference between the *plan premium with risk selection* and the *plan premium without risk selection*. These components are calculated as the following:

Plan premium with risk selection

- State average premium (SAP)
- Plan average risk score
- Induced demand factor
- Geographical cost factor

Plan premium without risk selection

- State average premium (SAP)
- Actuarial value
- Allowable rating factor
- Induced demand factor
- Geographical cost factor

The key component in determining whether a carrier will receive or make a transfer payment is how the carrier's calculated risk score (after normalizing across all carriers) compares to the product of the actuarial value and allowable rating factors (after normalizing across all carriers). In general, if the normalized risk score is higher than the normalized product of the actuarial value and the allowable rating factor, then the plan will receive a payment, and vice versa. The induced demand and geographical cost factors have a residual impact on the actual transfer payment but are not a key driver of the amount.

The following figures provide a sample illustration of how the transfer payments are expected to work. For this example, we have assumed only two plans, each of which has only one member enrolled.

FIGURE 1: STATE AVERAGE PREMIUM

	PLAN A	PLAN B	STATE AVERAGE PREMIUM
FILED PREMIUM PMPM	\$137.50	\$142.50	
AGE FACTOR	1.78	1.78	
BILLED PREMIUM	\$244.75	\$253.65	\$249.20

The table in Figure 1 illustrates the calculation of the state average premium. In this case, we have assumed that both plans have enrolled a 50-year-old member who would have an age factor of approximately 1.78 based on the CMS proposed standard age curve.² The difference in the billed premium between the two plans is due to the filed premium, not the allowable adjustment factors of age, family size, tobacco use, and wellness discounts. The state average premium reflects the actual billed premium and the number of members enrolled, not the filed premiums for each plan. We have assumed that Plan B has a higher filed premium due to additional administrative costs for ensuring accurate coding of diagnoses, not higher medical costs. Plan B also has a lower filed loss ratio.

FIGURE 2: PLAN PREMIUM WITH RISK SELECTION

ADJUSTMENTS W/RISK SELECTION	PLAN A	PLAN B
RISK SCORE	0.90	0.95
INDUCED DEMAND FACTOR	1.00	1.00
GEOGRAPHICAL COST FACTOR	1.00	1.00
ADJUSTMENT FACTOR	0.90	0.95
NORMALIZED ADJUSTMENT FACTOR	0.97	1.03
STATE AVERAGE PREMIUM	\$249.20	\$249.20
PLAN PREMIUM WITH RISK SELECTION	\$242.46	\$255.94

The table in Figure 2 illustrates the calculation of the plan premium with risk selection. Again, we have assumed that neither member has an induced demand factor that is due to subsidies, nor do they reside in different geographical locations. The only difference is that the member in Plan B has a 0.95 risk score, which is due to additional diagnoses being submitted by Plan B and not due to any actual difference in medical costs (i.e., both members have the same underlying morbidity). The adjustment factors for each plan are then *normalized* across the entire population as part of the transfer payment formula. The normalized adjustment factors are calculated by dividing the actual adjustment factor for each plan by the weighted average of the actual adjustment factors for all plans, which is 0.925 in the example.

FIGURE 3: PLAN PREMIUM WITHOUT RISK SELECTION

ADJUSTMENTS W/O RISK SELECTION	PLAN A	PLAN B
BENEFIT TIER LEVEL ACTUARIAL VALUE	0.70	0.70
ALLOWABLE RATING FACTOR	1.78	1.78
INDUCED DEMAND FACTOR	1.00	1.00
GEOGRAPHICAL COST FACTOR	1.00	1.00
ADJUSTMENT FACTOR	1.25	1.25
NORMALIZED ADJUSTMENT FACTOR	1.00	1.00
STATE AVERAGE PREMIUM	\$249.20	\$249.20
PLAN PREMIUM WITHOUT RISK SELECTION	\$249.20	\$249.20

The table in Figure 3 illustrates the calculation of the plan premium *without* risk selection. As with the plan premium with risk selection, we have assumed that neither member has an induced demand factor that is due to subsidies, nor do they reside in different geographical locations. We have also assumed that both members are enrolled in the same benefit tier *metal* plan, with a factor of 0.70 (i.e., a silver plan).

Similar to the calculations in Figure 2, the adjustment factors for each plan are then *normalized* across the entire risk adjusted population within each state as part of the transfer payment formula. The normalized adjustment factors are calculated by dividing the actual adjustment factor for each plan by the weighted average of the actual adjustment factors for all plans, which is 1.25 in this example.

FIGURE 4: TRANSFER PAYMENT

	PLAN A	PLAN B
PLAN PREMIUM WITH RISK SELECTION	\$242.46	\$255.94
PLAN PREMIUM W/OUT RISK SELECTION	\$249.20	\$249.20
TRANSFER PAYMENT PMPM	(\$6.74)	\$6.74

The table in Figure 4 illustrates the calculation of the final transfer payment. The calculation is the plan premium with risk selection minus the plan premium without risk selection. Because there are only two plans and the sum of the transfer payments must be zero, the plan with the lower risk score has a negative amount, which indicates that it pays money to the plan with the higher risk score.

² U.S. Dept. of Health and Human Services (November 26, 2012). Proposed Rules, Part III. Federal Register. Retrieved January 24, 2013, from <http://www.gpo.gov/fdsys/pkg/FR-2012-11-26/pdf/2012-28428.pdf>.

FIGURE 5: FINANCIAL IMPACT

	PLAN A	PLAN B
BILLED PREMIUM	\$244.75	\$253.65
TRANSFER PAYMENT PMPM	(\$6.74)	\$6.74
RECEIVED PREMIUM PMPM	\$238.01	\$260.39
CLAIMS PMPM	(\$210.38)	(\$210.38)
GROSS MARGIN	\$27.64	\$50.01
LOSS RATIO	88.4%	80.8%

Finally, the table in Figure 5 illustrates the actual financial impact of both plans. In this example, we have assumed that both plans projected (and achieved) the same costs for their member and that the difference in the filed premium was due to an increased administrative cost for Plan B and a lower target loss ratio. In this example, we assume that Plan A filed a loss ratio of 86% (\$210/\$245) and Plan B filed a loss ratio of 83% (\$210/\$254) to reflect the additional \$9 per member per month (PMPM) in administrative costs. The results indicate that Plan B ends up with a gross margin more than \$22 PMPM higher than Plan A because Plan B receives almost \$7 PMPM from Plan A. Hence, the additional \$9 PMPM in administrative costs associated with ensuring accurate diagnosis submission have a return on investment of almost 2:1 because the higher administrative costs result in a net increase of \$7 in margin. However, because of the price-competitive nature of the exchanges, insurers may need to factor in some assumption regarding *better than average coding* and expected transfer payments as a substitute for margin in their pricing in order to be attractive to members.

While this example is illustrative and the actual experience will likely vary significantly from it, a Milliman study indicated wide variation in the average number of HCCs per member submitted by MA plans, some of which could be attributed to coding efforts by those plans. Hence, a similar variance in the commercial market could also be due to differences in coding efforts and not morbidity. In this example, a variance of only 0.05 results in a difference between the actual and expected loss ratio of 2% for both plans.

PREPARING FOR 2014

While the transfer payments and application of the HHS risk adjustment model do not start until 2014, insurers may want to start preparing for them in 2013. Several actions that insurers currently in the small group or individual markets may want to consider are:

- Are providers coding at the required level of specificity? Are certain providers coding at a significantly lower level of specificity than others?

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- Do information technology/system changes need to be made in order to comply with the HHS data submission requirements?
- Do the treatment patterns and resulting cost for certain diseases vary by state versus the nationally representative data on which the model was developed? Are there certain conditions that have a higher risk score coefficient than claims for a carrier's existing population would indicate and would that be a population worth pursuing for a carrier?
- If current diagnosis submission patterns appear to indicate missing diagnoses when compared to benchmarks, how can carriers identify members with *missing* diagnoses? Can prescription drug claims be used to identify members without medical records who have diseases included in the HHS HCC model? If so, then how does a carrier capture those diagnoses?
- What will be the impact of the transition to ICD-10, expected to occur on October 1, 2014? Will HHS release a new model to reflect that transition during the data collection period? Will it result in significant issues for diagnoses submitted after October 1, 2014?

CONCLUSIONS

For insurance carriers in the individual and small group markets, the introduction of risk adjustment could materially impact the market. Focusing on accurate pricing and controlling claims may no longer be sufficient to be successful. Submitting accurate, complete, and valid diagnoses could be as important for financial success. Even if a carrier's population closely resembles the average population in the state, a carrier could be required to make a transfer payment to other carriers. If a carrier does not ensure that it is at least *average* in its efforts to submit diagnosis codes it will likely end up owing money to those plans that do invest in the technology and staff to measure, validate, and submit the data to HHS.

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Key sources

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