

## Risk adjustment: Overview and opportunity

### Top 10 notable issues related to the federal risk adjuster

Mary van der Heijde, FSA, MAAA  
Jordan Paulus, FSA, MAAA



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#### INTRODUCTION

Healthcare reform brought about many changes in 2014, not the least of which is the introduction of commercial risk adjustment. The risk adjustment program has changed how insurers view and manage risk. Under this program, transfer payments are made between carriers based on the diagnosed medical conditions of members covered by individual and small group ACA-compliant plans.

On June 30, 2015, the Centers for Medicare and Medicaid Services (CMS) released a summary report including risk scores by state and risk adjustment payments by carrier for the 2014 plan year.<sup>1</sup> This report led many insurers to recognize the importance of a strong risk adjustment strategy.

Risk transfer payments are based on risk scores developed using claim data as determined by a risk adjuster provided by the U.S. Department of Health and Human Services (HHS). The risk adjuster is a concurrent model, meaning the risk score for a period is determined based on claims incurred in that period. Risk scores for both on-Exchange and off-Exchange business are then compared with the average risk score within that state and market (individual or small group). Transfer payments are made between insurers based on their relative risk scores. Insurers with a population that is sicker than average receive payments, while insurers covering populations healthier than average are required to pay into the pool. As we'll see, the transfer also depends on several other factors in addition to risk score.

Unlike the transitional reinsurance and risk corridor programs, which make up the other two parts of the "3 Rs," the federal risk adjustment program is a permanent provision.

In the remainder of this paper, we briefly discuss how the federal risk adjustment and transfer system works as well as our top 10 considerations when developing a risk adjustment strategy.

#### THE FEDERAL RISK ADJUSTMENT PROGRAM

The federal risk adjustment program is set up to transfer funds from payers with lower-risk individuals to those with higher-risk individuals. This was done in order to "level the playing field" between insurers by removing the incentive to only attract the healthiest individuals in order to drive down overall claim costs. In effect, the risk transfer program aims to normalize for the impact of differences in health status between carriers in a particular market. Differentiation in premium rates must be achieved through effective care management, discounts, efficient administration, and other factors not related to health status.

All but one state (Massachusetts) uses a federal risk adjuster developed by HHS to determine risk scores and resulting risk transfer payments. Risk scores are determined on a member-level basis and then aggregated by plan and area, to develop the total transfer amounts. The risk transfer formula accounts for differences in risk that are already accounted for by allowable premium rating characteristics, to reduce double-counting. To accomplish this, the risk adjustment formula includes two factors in determining the risk transfer payment. The first is a premium factor with risk adjustment (which represents the full risk profile of the group). The second is a premium factor that reflects allowable rating factors for the population and does not include risk adjustment (which represents what carriers were actually able to charge for). The difference between those two factors represents the portion that the transfer should cover.

<sup>1</sup> U.S. Department of Health and Human Services (June 30, 2015). Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2014 Benefit Year. Retrieved August 3, 2015, from <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RI-RA-Report-Draft-6-30-15.pdf>.

For each combination of plan, area, market, and state, the calculation for the risk transfer payment factor is as follows:

$$\frac{RS * IDF * GCF}{\text{Market Average of Above}} - \frac{AV * ARF * IDF * GCF}{\text{Market Average of Above}} = \text{Factor for Transfer Payment}$$

- ARF: Allowable Rating Factor  
*HHS factors for variation by age*
- AV: Actuarial Value  
*Benefit richness adjustment*
- IDF: Induced Demand Factor  
*HHS factor to adjust for increased utilization from richer benefits*
- GCF: Geographical Cost Factor  
*Factor to adjust for cost of area variations between regions within a market*
- RS: Risk Score  
*Includes age, gender, and health status*

The total risk transfer factor for an insurer is equal to the aggregated factor, multiplied by the market average premium. In addition, risk score coefficients vary by metallic tier levels. A member with diabetes enrolled in a gold plan contributes a different risk score coefficient than if that member were enrolled in a bronze plan.

Risk transfer receipts occur when members are less healthy than their various rating factors would suggest, and payments are made when members are healthier. As noted above, several of these rating factors have been prescribed by HHS.

While simple in premise, the actual administration of the risk adjuster is complicated. In studying the risk adjustment program, we have identified 10 things that we feel carriers should know about the risk adjustment program. These items vary from interesting aspects about the design and administration of the risk adjuster program to strategic considerations to make the most out of the program.

Without further ado, here are top 10 things you should know about the federal risk adjustment program.

## 10. THE HHS RISK ADJUSTER IS DIFFERENT FROM THE CMS RISK ADJUSTER

The federal government already uses a well-known risk adjuster as part of the Medicare program. The risk adjuster used by HHS in the commercial market is different from the CMS risk adjuster, although there are some similarities.

The commercial HHS risk adjuster employs Hierarchal Condition Categories (HCCs) much like the CMS-HCC risk adjuster. However, the HHS risk adjuster was calibrated to the commercial population instead of the Medicare population that is targeted with the CMS risk adjuster. The HHS risk adjuster identifies more conditions than the CMS risk adjuster, which is due to calibration differences and reflects the differing conditions that are most relevant for each population. However, relatively fewer members may be flagged in the HHS risk adjuster because it is used on a younger, healthier population.

## 9. ONLY A FRACTION OF MEMBERS TRIGGER CONDITIONS

The risk adjuster only identifies a subset of conditions. As estimated by HHS, only 19% of all adults, 9% of children, and 45% of infants are identified as having any of the flagged conditions.<sup>2</sup> This is quite a bit lower than in most commercially available risk adjusters. This approach reflects the intent of the creators to limit the opportunity for manipulating coding practices to artificially increase risk scores.

Because only a smaller portion of conditions are being flagged, it is critical that members with those conditions are identified. Issuers should ensure that providers are appropriately coding members who have these conditions, and that members who fall within the condition categories are tracked. One instance where coding concerns may present themselves is when the issuer capitates a large amount of services. Encounter information is often missing or is less detailed in this setting because the provider has less incentive to code all services.

Even if all services are coded correctly from the provider, issuers should pay close attention to the information technology aspects of coding and reporting claims for risk adjustment programs. To be accurately reflected in risk adjustment payments, diagnosis codes need to be input and

<sup>2</sup> U.S. Department of Health and Human Services (December 7, 2012). Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014; Proposed Rule. Federal Register Vol. 77 No. 236, p. 73129. Retrieved August 3, 2015, from <http://www.gpo.gov/fdsys/pkg/FR-2012-12-07/pdf/2012-29184.pdf>.

reported in the correct format. Additionally, many systems only store a certain amount of diagnosis codes. Anything that limits the diagnosis codes and therefore reduces the breadth of the claim data for risk adjustment purposes can lower a carrier's risk score.

## 8. AGE/GENDER COEFFICIENTS

A portion of every member's risk score is derived directly from the age and gender of the member, and the HHS age/gender coefficient is higher for females than for males at every age along the curve (other than infants and younger children, where the reverse is true). The age/gender coefficients used in the HHS risk adjuster are intended to account for risk relativities between ages that are not otherwise captured within the risk score derived from conditions. However, there may still be some portion of actual costs that are not captured by the sum of the age/gender coefficients and the risk adjuster coefficients. In other words, the total predictions of the HHS risk adjuster could overstate or understate risk for certain age/gender cells.

Because older members are more likely to have conditions flagged, the per-member impact of the risk adjustment program is greater at older ages. The transitional reinsurance program also has a greater impact on the costs of older members, which is due to their higher average claims. An in-depth study taking into account the impact of all of the "3 Rs" risk mitigation programs was completed by Milliman consultants Jason Siegel and Jason Petroske.<sup>3</sup> Their study found that risk adjustment, along with the other 3 Rs programs, had large effects on the profitability of these older members, to the point that older members may be more profitable than younger members after incorporating the effects of the 3 Rs.

## 7. PHARMACY DATA ARE NOT USED

While many risk adjusters utilize prescription drug data as an input to developing risk scores, the HHS risk adjuster does not use pharmacy data to predict costs. Although risk scores predict total cost (including both medical and drug costs), the determination of a risk score is solely based on medical claim information. In the HHS Notice of Benefit and Payment Parameters for 2016, it was noted that the government may consider how to include prescription drugs in future models.<sup>4</sup>

<sup>3</sup> Siegel, J., & Petroske, J. (December 2013). When adverse selection isn't: Which members are likely to be profitable (or not) in markets regulated by the ACA. Retrieved August 3, 2015, from <http://us.milliman.com/uploadedFiles/insight/2013/adverse-selection-aca.pdf>.

<sup>4</sup> U.S. Department of Health and Human Services (February 27, 2015). Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment

Prescription drug claims are often processed and paid more quickly than medical claims, meaning that prescription drug data gives a more complete picture at any given time. Because only medical claims are being used, timely coding and processing of claims is important to ensure that all conditions are flagged by April of the following calendar year, the deadline for submitting diagnoses to the government. The risk adjuster only tags a subset of conditions, many of which are serious chronic conditions and often exhibit longer claim payment run-out patterns, amplifying this consideration even further.

## 6. INJURIES NOT INCLUDED

There are few conditions related to injuries (wounds, fractures, or trauma) included in the HHS risk adjuster. These conditions can be costly, but generally are not reflected in any risk transfer payments. Although injuries are difficult to predict prospectively, because this is a concurrent model it would have been possible to include them in the risk score; however, HHS has largely chosen not to do so.

Injuries may occur more often in younger, active members who would otherwise have lower claim costs. If a carrier were to have a more accident-prone population, the risk adjuster generally would not give credit for those costs.

## 5. DEGREES OF SEVERITY NOT ALWAYS DIFFERENTIATED

The highest-cost instances of many illnesses occur in members who have other complicating illnesses. This is especially true for chronic conditions such as diabetes. However, the HHS risk adjuster does not distinguish in most cases between degrees of severity within illnesses. Furthermore, where many risk adjusters differentiate between those who have chronic illnesses with or without complications, the HHS risk adjuster has just one risk score for each chronic condition such as diabetes. There are limited exceptions to this rule involving "interaction terms" for certain severely ill adults and severity scores for infants.

Because everyone with a condition is generally given the same score regardless of complications, having members with less severe forms of illnesses that still trigger the risk adjuster provides the greatest opportunity for a favorable transfer that exceeds actual claim costs.

Parameters for 2016; Final Rule. Federal Register Vol. 80 No. 39, Page p. 10762. Published February 27, 2015. Retrieved August 3, 2015, from <http://www.gpo.gov/fdsys/pkg/FR-2015-02-27/pdf/2015-03751.pdf>.

#### 4. TRANSFERS ARE BASED ON MARKET AVERAGE RISK SCORE AND ALLOWABLE RATING FACTORS

The risk transfer payments are calculated within a market in a given state, and each carrier's risk score is compared with other business written in that market. It is difficult—if not impossible—to estimate risk transfer payments based on a carrier's risk score alone. The average risk score is not 1.00 for each market. Therefore, just knowing the carrier's risk score does not mean the carrier knows if it will pay or receive funds from this program. In fact, it is even possible for a carrier with a risk score greater than the statewide average to have a risk transfer payment obligation if the rest of the business in that state has a higher average risk score *after accounting for differences in allowable rating factors*. Statewide average risk scores and rating factors released for 2014 may give some idea regarding risk scores in future years, but some deviation from those scores is to be expected as ACA markets continue to evolve.

Because carriers face this uncertainty well into the following calendar year, financial forecasting is significantly affected. This makes loss ratios difficult to estimate for medical loss ratio (MLR) rebate purposes because the market average risk score is not known until it is released by the government in the following June. In the past, many companies decided to employ rebate abatement strategies such as a premium holidays in group markets to avoid paying rebates and meet minimum loss ratio requirements. This practice has become very difficult because the loss ratio can vary widely from traditional calculation methods, in large part because of risk transfer payments.

#### 3. TRANSFER PAYMENTS CAN COME UP TO 20 MONTHS AFTER THE CLAIM OCCURS

Risk transfer payments are determined in June of the calendar year following the plan year, with payments coming in August of the calendar year following the plan year. A claim that triggers a significant risk transfer payment may occur in January of the plan year. This means that the issuer is not compensated for the risk for over 20 months after the claim was incurred. Furthermore, for plan year 2014 payments, some of these payments are being withheld until after fiscal year 2015 because of sequestration, and an additional portion of these payments are being held for appeals, until the later of November 2015 or whenever appeals in each market are resolved. During this period, the plan is still required to pay high claims for the condition.

#### 2. TOBACCO USE STATUS IS NOT CONSIDERED

Tobacco use status is not included in the allowable rating factors when determining risk transfer payments. However, the conditions that arise from tobacco use are considered in risk transfer payments. In other words, the transfer formula does not take into account the additional premium an insurer may collect from tobacco users. Most likely, this factor was not included for practical reasons: each insurer is allowed to determine its own factor (within the 1.5:1 limit), and in group coverage members can avoid the surcharge by signing up for tobacco cessation programs. Thus, estimating the factor would have been very difficult.

Considering tobacco use in the formula would effectively lower risk transfer payments for those plans with a higher-than-average tobacco usage rate or a higher tobacco rating factor. However, this is not the case because tobacco status is not a factor in the risk transfer formula. Therefore, having a higher proportion of tobacco users would not necessarily be disadvantageous from a risk adjustment standpoint.

#### 1. RISK SCORES WILL BE AUDITED

This is a significant and potentially onerous process. There will be a formal review process for the risk score data that each carrier must undertake. Latest word is that the audit process, originally slated to begin with the 2014 plan year, has been delayed and will begin in 2015.<sup>5</sup>

Each carrier's claim and enrollment data are stored on EDGE servers from which HHS can extract summarized information in order to calculate transfers. By June of the following calendar year, claims are processed and risk scores and transfer payments are to be determined by HHS. However, a sample of members and their HCCs will subsequently be put through a formal review process by an independent auditor. HHS will also conduct a secondary audit of conditions. This validation process will determine whether medical records support the coding used to identify HCCs.

In March 2014, HHS released the proposed guidelines for the validation process. It will be a multiple-step process, with some steps completed by issuers and others by HHS. Issuers are required to engage one or more qualified and independent auditors to perform an initial validation of a sample of 200

<sup>5</sup> CMS Center for Consumer Information and Insurance Oversight (CCIIO, July 16, 2015). Risk Adjustment Data Validation – Implementation Timeline. Retrieved August 14, 2015, from [https://www.regtap.info/uploads/library/HRADV\\_timeline\\_jobaid\\_071615\\_v2\\_5C\\_R\\_071615.pdf](https://www.regtap.info/uploads/library/HRADV_timeline_jobaid_071615_v2_5C_R_071615.pdf).

enrollees selected by HHS from their risk adjustment data in each state and market. This sample size will likely be used for the first year of risk adjustment audits in 2015; in later years, a sample size based on the size of the issuer may be used. These samples will be chosen by dividing the population into a number of “strata” representing different demographic and risk score bands.

This sampling methodology reflects a disproportionate selection of enrollees with flagged conditions. A risk stratification methodology similar to the one currently used in Medicare Advantage will be used to assess error rates, at least until enough data is available to develop an alternative. HHS will retain an auditor to perform a second validation audit to verify the accuracy of the initial audit using a subset of the initial enrollee sample.

Upon completion of both audits, HHS will derive a risk score adjustment and confidence interval for each issuer. In cases where the “corrected” risk score is different from the reported score at a 95% confidence level, an adjustment to the risk adjustment transfer payment will be made. Because any adjustment factor will be directly included in the transfer formula, what will ultimately matter is how the issuer’s adjustment factor compares with the corresponding factor for other issuers in the market (that is, if all issuers have the same error rate, there will be no net result on transfers).

This creates several challenges for issuers. First, issuers often have little control over the recordkeeping and coding processes of their providers. Errant coding in conditions selected for validation can result in issuers uncovering mistakes during the validation audit at little fault of the issuer.

Second, risk scores and risk transfer payments will ultimately be affected by results of the validation process. HHS has advised that risk transfer payments for the first two years will not be adjusted as a result of the validation process. Risk score adjustments will be applied on a prospective basis, meaning that adjustments will not be applied to the plan year in which errors occurred, but instead will be applied to the following plan year during which the validation takes place (and the transfer for that year will actually take place in the subsequent year—two years from the year where the errors were measured). For example, the first transfer adjustments will be made beginning with benefit year 2016, meaning that the payments would be adjusted in 2018 as part of the payment transfers for 2017.

Because the ultimate adjustment will depend not only on an issuer’s own error rate but also those of other issuers in the market, it will be even more difficult to manage and measure MLR and profitability. Issuers should take care in ensuring that

providers are correctly coding conditions to avoid any issues with the validation process.

## CONCLUSION

The federal risk adjuster program provides many challenges as well as strategic opportunities. The program makes it more difficult to manage profitability and loss ratio requirements, given the timing and uncertainty of the associated transfers. Issuers will have to show greater concern for accurate provider coding and billing to ensure they can capture all conditions subject to risk transfer receipts, while also reducing the risk of incorrect coding, causing a failure in the validation process.

Even with these concerns and challenges, the program allows for strategic planning. Degrees of severity are not differentiated when determining the risk scores of many illnesses. If issuers can effectively treat conditions, they can reduce claim costs while also receiving a set risk transfer payment. Insurers that are cost-effective in treating illnesses may find an advantage by receiving more in risk transfer payments than it costs to treat that condition.

Mary van der Heijde is a principal and consulting actuary with the Denver office of Milliman. Contact Mary at [mary.vanderheijde@milliman.com](mailto:mary.vanderheijde@milliman.com) or at 303.672.9081.

Jordan Paulus is a consulting actuary with the Denver office of Milliman. Contact Jordan at [jordan.paulus@milliman.com](mailto:jordan.paulus@milliman.com) or at 303.672.9064.

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