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# A Comparison Between the ACA Exchange and Medicare Risk Adjustment Programs

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**W**ith the increasing movement to individual health insurance products with no medical underwriting, the use of a risk adjustment mechanism to adjust premium based on the underlying risk of a population has become increasingly important. While pricing for a large employer group can rely on credible historical information and a stable population, the rating approaches for individual products with no medical underwriting require a pricing structure that develops an average rate for the entire risk pool with a risk adjustment methodology that accounts for the relative risk of individuals attracted to each health plan. In making this adjustment to the average payment, the risk adjustment mechanism incents health plans for providing efficient care rather than selecting a healthy population.

Although the methodology has differed among the programs, Medicare and state-level Medicaid programs have implemented risk adjustment mechanisms that have been largely successful in adjusting revenue to account for populations that differ from the average. While the extent of the adjustment and the specific technical details have been debated, most people would agree that the underlying structure of providing risk adjustment payments has been successful in adjusting revenue for health plans based on their unique population. These risk adjustment programs have also proven that a well-designed risk adjustment program can be effective in the absence of medical underwriting.

Using the other government programs as a basis, the Affordable Care Act (ACA) exchanges have also adopted a risk adjustment program for both the transitional period (2014 to 2016) and the long term (2017 and after). During the transitional period, in addition to the risk adjustment program, health plans will be offered additional financial protections through the reinsurance and risk corridor programs.<sup>1</sup> Because these additional financial risk mitigation programs will be eliminated after the initial transitional period, the risk adjustment program will become an increasingly important mechanism to ensure appropriate payment for 2017 and after.



In this article, I will compare the risk adjustment programs among the Medicare and ACA exchange programs and highlight the key differences that could lead to challenges once the risk adjustment program becomes the sole financial protection mechanism in the exchange. As I will discuss, the mechanics of the ACA exchanges will make the actual revenue associated with the risk adjustment program difficult to estimate and subject to significant change from one year to the next. These factors have the potential to impact the extent of insurance company participation once the reinsurance and risk corridor financial protections are removed in 2017.

## Medicare Risk Adjustment

As the program has evolved over several years, the Medicare risk adjustment program has developed features that have allowed health plans to have visibility into the expected revenue associated with the risk adjustment program. The specific features include:

**Prospective Risk Score Methodology.** The Medicare program uses the Hierarchical Condition Categories (HCC) risk adjustment methodology with historical diagnosis information as the basis to



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adjust premium revenue for the next calendar year. Although the mechanics of the development are somewhat complicated, the broad intent is to ensure that the risk score for an individual is properly calibrated against a fee-for-service population using historical data to adjust prospective rates. Because the risk scores are based on historical data and a published methodology, the health plans can have a reasonably accurate picture of their revenue for the upcoming year. In addition, as highlighted in the upcoming discussion on the ACA exchanges, this methodology does not require a comparison with other health plan risk scores in order to determine a revenue impact.

**Risk Score Adjustments to Revenue.** Health plans in the Medicare program receive an immediate risk score for each enrollee at the beginning of the plan year. This initial risk score is then updated with two additional reviews that allow updated data and additional run-out from the historical experience period. The following schedule highlights the risk analysis for the calendar year 2014:

| Risk Score Basis   | Applicable Payment Period  | Historical Experience Basis for the Risk Score Development    |
|--|--|---|
| Initial Risk Score   | 1/1/2014 to 6/30/2014  | 7/1/12 to 6/30/2014   |
| Mid-Year Adjustment—Initial Risk Score Adjusted and the Risk Score Adjusted for the Remainder of the Calendar Year | 1/1/2014 to 6/30/2014 (retrospectively adjusted)<br>7/1/2014 to 12/31/2014 (adjusted to account for new information) | 1/1/2013 to 12/31/2013—<br>with paid claims through 3/21/2014 |
| Final Adjustment   | 1/1/2014 to 12/31/2014   | 1/1/2013 to 12/31/2013—<br>with paid claims through 1/31/2015 |

**Consistency of Risk Scores.** The risk scores are also likely to be relatively consistent from one year to the next because a health plan’s Medicare population is not likely to undergo substantial change over this timeframe—relative to other populations, seniors are much less likely to move from one plan to another. In addition to ensuring a bid consistent with the underlying risk and revenue of the population, this consistency also helps the health plan ensure adequate medical management support and allow for accurate budget estimates.

The net effect of these features is a risk adjustment transfer payment that is known in advance of developing the Medicare bid and a revenue stream that can be predicted with some certainty after the open enrollment period. Most importantly, this program creates a feedback loop that ensures a health plan can make changes in operations—including contracting or medical management activities—that could influence both the quality of care and financial results.

## The ACA Exchanges

While the ACA exchanges were developed to accomplish a similar goal as the Medicare program—develop an overall payment structure that is appropriate to the risk accepted by the health plan—the mechanism is much different. While the Medicare program allows health plans to have visibility into their premium, in the exchange program, health plans are required to rely on risk scores that will not be known until after the calendar year and the actual revenue impact will not be developed until a final reconciliation is completed relative to the other health plans. In this final reconciliation, the risk scores are compared among the plans, and payments are either made or received among the health plans depending on the relative risk attracted to each health plan. The specific features are highlighted below:

**Concurrent Risk Scores.** Although the model uses a similar HCC methodology as Medicare, the model is based on the diagnosis information within

the policy year rather than from the prior period. While this approach provides a theoretically more accurate approach to adjusting premium, this mechanism does not allow health plans to have information on their own risk scores until their experience matures throughout the plan year.

**Risk Adjustment Timing.** While the Medicare model provides an immediate impact on revenue, the true impact of the ACA exchange revenue payments is not known until the risk level is compared with other health plans in the middle of the following calendar year (June 30, 2015 for the final invoice with the final settlements made later). In the meantime, unlike in the Medicare program, the ultimate revenue during the current calendar year will be unknown. This potential uncertainty in payments will also be magnified by the potential changes in the exchange risk pool and the potential for consumer switching among health plans.

- *Exchange risk pool changes.* Because the risk scores are based on a score relative to other health plans, even if a health plan was able to estimate its own risk score, it couldn't be translated into a revenue figure until it had been compared with the other plans. In the 2014 and 2015 filing, this was certainly the case as health plans had no reliable information to compare with other health plans. This limitation may improve for the 2016 filings as the actual results from the risk pool are developed and published for 2014 (this will likely vary by state). This uncertainty, however, will be mitigated by the impact of the other risk protections (the reinsurance and risk corridor) that will limit any downside associated with a misestimate of the risk adjustment payments.

The most impactful challenge will occur in 2017 once the other risk protections are removed. In order to estimate the risk adjustment impact by comparing an individual health plan's risk scores to the broader exchange pool, health plans will be required to estimate the financial impact of a risk pool that could differ substantially from the 2014

and potentially the 2015 risk pool experience (presumably, this would be the only information available in the middle of 2016 for the 2017 filing). The ultimate 2017 risk pool could be impacted by a far different participation rate caused by a higher tax associated with the individual mandate, the migration of individuals currently on the transitional plans to the exchange, and the potential for the disenrollment of the young and healthy as rates are increased to account for the elimination of two of the risk protection programs.

- *Consumer switching among plans.* In addition to the potential risk pool change, an individual health plan could experience substantial population changes from one year to the next as its net premium changes in relation to the second-lowest silver plans (see sidebar describing the effect). This population change among health plans could make the financial tracking of this population very difficult because the revenue and underlying risk of the population would be unknown during most of the year. Unlike in Medicare where the populations are fairly stable and the revenue associated with the risk score known, this switching will make the operations and pricing more difficult without the financial results to initiate change.

## Conclusion

Taken in total, the ACA exchanges provide a much different risk adjustment framework than Medicare. While the Medicare risk adjustment process can be technical, it does allow health plans to have a reasonable understanding of its total revenue—an important factor in guiding strategies to improve important aspects of a health plan's operations including provider contracting, medical management, pricing and revenue management. The ACA exchange, on the other hand, does not allow for this immediate feedback on ultimate premium levels. Instead, the risk adjustment settlement process requires health plans to wait until the middle of the next year for a final premium accounting. This delay in understanding the risk adjusted premium is particularly challenging because the changes in the broad risk pool and

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consumer switching among plans make the overall pricing estimates and a true understanding of the health risk subject to substantial error. Ultimately, these features have the potential to impact insurance company participation. Along with the typical risk associated with running a health plan—estimating trend, for example—health plans will not have visibility to key variables that will define the success in the ACA program—their true aggregate premium level associated with a population. ■

The following example from a Milliman briefing paper “The Proposed Federal Exchange Auto-Enrollment Process: Implications for Consumers and Insurers” by Susan Pantely and Paul Houchens highlights the potential for consumer switching. In the chart below, the authors highlighted the premium and subsidy level offered to an exchange participant at 150 percent of the federal poverty limit. Consistent with ACA policy, the subsidy level in this example is based on the second-lowest silver plan premium—in this case, the maximum expenditure individual is 4 percent of a household’s income or \$57. The resulting subsidy amount (\$268) can then be applied to all the plans to produce a higher or lower net premium.

| ACA Component   | Plan 1 | Plan 2 | Plan 3 |
|---|--------|--------|--------|
| Full Premium  | \$300  | \$325  | \$350  |
| Subsidy Amount (based on the second-lowest silver plan) | \$268  | \$268  | \$268  |
| Monthly Net Premium                                     | \$32   | \$57   | \$82   |
| % of Income   | 2.2%   | 4.0%   | 5.7%   |

As highlighted above, a significant percentage differential in actual net premium levels—\$32 compared to \$57 and \$82—could prompt an individual with an income level slightly above the federal poverty limit to choose the lowest-cost plan.

This switching could be magnified over time as some health plans change premium rates to increase market share. The authors highlighted the following example where Plan 3 purposely reduced its premium and Plan 2 maintained its initial rate in an effort to increase market share.

| ACA Component   | Plan 1 | Plan 2 | Plan 3 |
|---|--------|--------|--------|
| Full Premium  | \$320  | \$325  | \$350  |
| Percentage Change from 2014                             | 7%     | 0%     | -16%   |
| Subsidy Amount (based on the second-lowest silver plan) | \$263  | \$263  | \$263  |
| 2015 Net Premium  | \$57   | \$62   | \$32   |
| 2014 Monthly Net Premium                                | \$32   | \$57   | \$82   |
| % Net Premium Change from 2014                          | 78%    | 9.0%   | -61%   |

In this case, a member in Plan 1 where the health plan proposed a modest 7 percent increase would still see a large net premium change caused by two factors—an increase in the premium by 7 percent and a reduction in the subsidy caused by a reduction in the second-lowest silver plan (\$325 to \$320). Because the member would see the entire burden of the rate increase and the reduced subsidy, the incentive to switch to a lower-cost plan would increase significantly.

**END NOTES**

<sup>1</sup> The reinsurance program provides financial protection to the health plan if a member has costs between above a defined threshold. The risk corridor program provides additional revenue or imposes costs on a health plan that has claims that are either substantially higher or lower than the amount built into the premium.