

A Look Behind the Curtains

A review of the debut of the ACA's risk adjustment data validation program

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Even well-prepared issuers have been swept up in the drama created from the Affordable Care Act (ACA) risk adjustment data validation (RADV) program.

When RADV enters the discussion, many ACA issuers tell a common tale—years coordinating and building an approach to meet the requirements; diligently shoring up gaps before outcomes mattered; optimism heading into the 2017 audit. At the end of the process, that optimism grew for those managing to achieve a 0% error rate. It seemed all the right steps were taken, and all the hard work paid off . . . but then their 2018 risk adjustment transfer changed for the worse anyway. So what happened?

Setting the stage¹

The U.S. Department of Health and Human Services (HHS) established RADV as a mechanism to protect risk adjustment integrity by assessing certain data elements supporting risk transfers.

In simple terms, HHS adjusts risk scores to reflect material errors in medical record coding. If, after incorporating results for all issuers, a state's error rate is negative, then the state's average risk score increases, and some issuers must transfer funds into the risk pool.²

While error rate bi-directionality was conceptually understood before 2017 RADV, the potential prevalence and magnitude of the impacts, and thus the short- and long-term ramifications, perhaps, were not.

RADV makes its debut

Following a lackluster performance in the 2016 pilot year, what did 2017 RADV tell us? There certainly is value in reviewing the protocols³ to gain an awareness into how the program *should* work, but experiencing the results firsthand provides critical insights into how the program functions in the real world.

The initial RADV report by the Centers for Medicare and Medicaid Services (CMS) published May 31, 2019,⁴ focused mostly on overall program results. CMS's follow-up report on August 1, 2019,⁵ added some issuer-level information. While these publications enhance the industry's knowledge of the program, they alone are insufficient to fully understand, assess, and address RADV's impacts. Published 2018 issuer-level experience, however, provides much more context and adds information helpful in analyzing the themes within the RADV storyline.

On December 6, 2019, CMS released a white paper⁶ exploring the RADV-centric impacts of various program modifications. The CMS white paper focuses on a wide range of potential changes to the program, from minor tweaks to major restructuring. This Milliman whitepaper takes a different direction—it evaluates the implications of RADV from the perspective of issuer results, with an eye for what the actual financial impacts say about the program's performance.

Within each section of this paper, we address a specific RADV impact. We combine HHS reporting with other data sources to broaden our perspective on the results and shine a spotlight on RADV's unintended consequences and potential future challenges.

¹ The technical details of RADV can be rather complex. Refer to the following article for a primer on the program structure and the error rate calculation: <http://www.milliman.com/insight/2019/A-breakdown-of-ACA-risk-adjustment-validation/>

² This can include an issuer with a negative error rate if its error rate level is higher (i.e., closer to zero) than the state average error rate. Issuers already paying risk transfers will be liable for additional payments if the state's error rate is negative.

³ 2017 protocols are available at https://www.regtap.info/uploads/library/HRADV_2017Protocols_Updates_v2.0_081018_v1_5CR_060419.pdf. 2018 protocols are available at https://www.regtap.info/uploads/library/HRADV_2018Protocols_070319_5CR_070519.pdf.

⁴ CMS (May 31, 2019). 2017 Benefit Year HHS Risk Adjustment Data Validation Results. Retrieved January 14, 2020, from <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/2017-Benefit-Year-HHS-Risk-Adjustment-Data-Validation-Results.pdf>.

⁵ CMS (August 1, 2019). Summary Report of 2017 Benefit Year Risk Adjustment Data Validation Adjustments to Risk Adjustment Transfers. Retrieved January 14, 2020, from <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/BY2017-HHSRADV-Adjustments-to-RA-Transfers-Summary-Report.pdf>.

⁶ CMS (December 6, 2019). HHS Risk Adjustment Data Validation (HHS-RADV) White Paper. Retrieved January 14, 2019, from <https://www.cms.gov/files/document/2019-hhs-risk-adjustment-data-validation-hhs-radv-white-paper>.

Impact 1: Zero percent error rate, zero problems?

WHAT'S THE ISSUE?

Leading into 2017, many issuers concentrated on avoiding a positive (unfavorable) error rate. Unfortunately, this narrow focus may have distracted from other imminent impacts—many of which were beyond the issuer's control.

WHAT DO THE RESULTS SHOW?

Although issuers were better prepared during 2017 RADV, the outcomes in many respects did not meet expectations. The following sections outline some of those results.

The number and mix of outliers were different from what was expected

RADV identified more outlier issuers than we would expect given HHS's 95% confidence interval (CI) approach.

- About 20%^{7,8} of issuers were outliers. Given market dynamics,⁹ we expect outlier issuers to represent *less than* 15% of total issuers (or 5% in each failure rate group implied by a 95% CI).¹⁰
- The approximate 50 outliers in each failure rate group represent a 9% failure rate—almost twice the anticipated 5%.

Outlier directionality was also contrary to what might have been anticipated.

- Over 60% of issuer error rates were unfavorable (69 positive and 41 negative), which is quite far from the presupposed even split.
- Although the majority of issuer-level error rates were positive, about two-thirds of *state* error rates were *negative*, suggesting negative error rate issuers are much larger, on average, than positive error rate issuers.

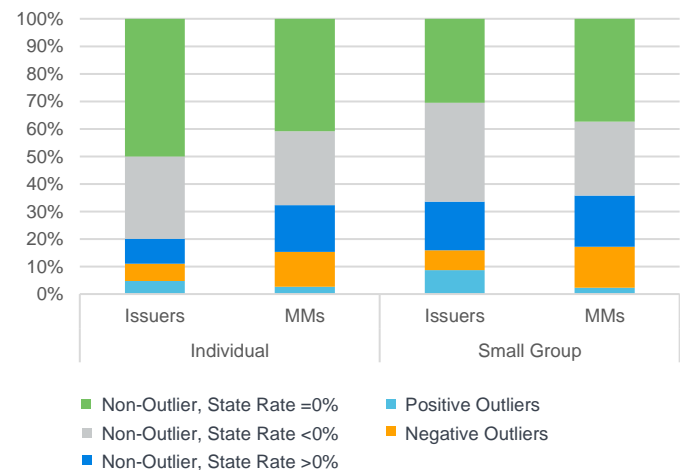
RADV's reach was quite extensive

Because a single outlier affects the entire risk pool,¹¹ the proportion of risk transfer adjustments was much higher than the proportion of true RADV outliers. The bias toward unfavorable transfer adjustments further exacerbates this effect.

- 50% of individual market issuers and 70% of small group market issuers experienced a *non-zero* RADV transfer.
- Directionally, about two-thirds of those transfer adjustments were unfavorable.

Figure 1 shows a larger number of non-outlier issuers in negative error rate states (light gray bars) than in positive error rate states (blue bars).

FIGURE 1: DISTRIBUTION OF NON-OUTLIERS BY STATE ERROR RATE



And, as discussed in detail later, the issuers most affected by RADV's unfavorable impacts tended to be smaller than their positive error rate state counterparts.

Transfer adjustments were material and highly variable

The materiality of the impacts surprised many participants, particularly non-outliers.

- On an absolute value basis, transfer adjustments in outlier states were over 1.25% of total 2018 market premium, with the largest impact for a single state over 5%. This represents a significant portion of the overall impact from the risk adjustment program.
- Two-thirds of outliers and 10% of *non-outliers* experienced a transfer adjustment over a typical priced-for profit margin of 3% of premium. A majority of these adjustments were unfavorable.
- Variability for *non-outliers* was quite high, with an impact of between -8% and 28% of premium across both markets.

⁷ CMS (May 31, 2019), op cit., Table 4.

⁸ 110 out of 580. Note that we equate "issuer" with a distinct HIOS issuer ID. A HIOS Issuer ID is not unique by legal entity and state but is the same across all markets in a given state. As an example, we represent an insurer operating both a preferred provider organization (PPO) and a health maintenance organization (HMO) entity in two states as four distinct issuers.

⁹ We expect an outlier issuer, on average, to be an outlier in multiple failure rate groups, as provider coding performance should not vary considerably across each. Keep in mind that as an issuer is an outlier in more failure rate groups, RADV adjusts a larger portion of its EDGE risk scores, which amplifies the transfer adjustment.

¹⁰ CMS addressed this dynamic in its December 6, 2019, white paper, and it appears to be driven by issuers with small numbers of HCCs relative to the average.

¹¹ Unique combination of state and market. Unless rolled into individual risk pool results within HHS reporting, we do not explicitly report metrics for the catastrophic risk pool. HHS considers merged markets as part of the individual risk pool. Further, we refer to the combination of state and market (e.g., individual, small group, or combined) as a "market" to align with risk pools.

WHAT DOES IT MEAN FOR THE MARKET?

While many expected HHS's new approach to soften RADV's effects, the program still impacted most of the market. In some cases, the outcomes actually penalized issuers meeting RADV's standards by increasing statewide risk scores (an unfavorable adjustment for these issuers) as a result of other issuers being in outlier positions. Now issuers face the real challenge of devising more accurate predictions that account for RADV's impacts, with the significant obstacles of data availability and timely market intelligence.

This much is clear: the present RADV methodology essentially guarantees outliers, even as the process matures and medical record documentation improves. Simultaneously, the zero-sum nature of risk adjustment means more issuers will feel the impacts than the actual number of outliers. While CMS does

investigate a variety of options to address error rate size and frequency, none of the modifications offered to date change this zero-sum nature. In other words, RADV's effects will continue to extend across a large portion of the ACA market.

RADV impacts are driven primarily by external factors that issuers cannot measure directly and cannot readily mitigate. In the absence of demonstrable stability and because of uncertainty in the program's evolution, issuers may consider higher margins in financial estimates, projections, and pricing to preempt the potential negative impacts of non-zero error rates on their risk pools. Ultimately, issuers need to be mindful of RADV's effects on non-outliers and understand that experiences may vary broadly among issuers, states, and markets.

Impact 2: Are you small? Are you regional? That must be challenging

WHAT'S THE ISSUE?

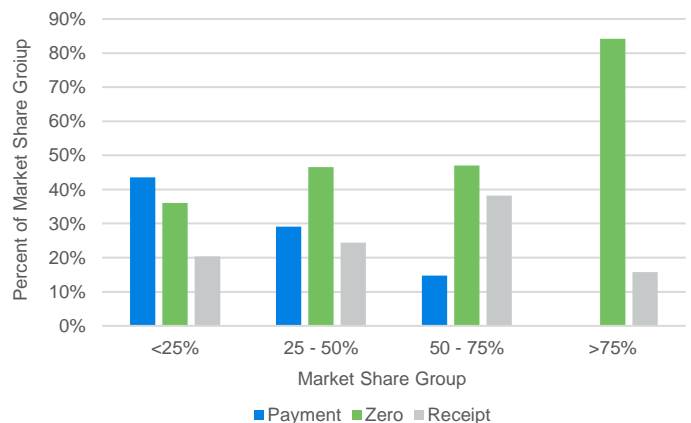
RADV's influence was widespread and non-uniform. The perceived trade-off between volatility and market share¹² has been a hallmark of the ACA, and concerns expressed by issuers about program bias against smaller, growing, and/or more efficient issuers¹³ may apply to RADV as well. As such, we base our analysis in this section on an assumed level of 2017 issuer market share.¹⁴

WHAT DO THE RESULTS SHOW?

The presence of negative error rate states despite a higher number of positive error rate issuers occurred because large issuers with negative error rates drove many statewide results. This creates consequences for all issuers chasing the market leader.

Expanding on Figure 1 in the previous section, the high-level results show RADV outliers usually had low market share. Nearly every positive outlier had under 25% market share—most of those controlling under 5%. Those numbers dip for negative outliers but are still relatively high. Further, Figure 2 suggests smaller issuers also experience higher financial uncertainty and bear the burden of unfavorable RADV transfer adjustments.

FIGURE 2: TRANSFER ADJUSTMENTS BY ISSUER MARKET SHARE



Aggregate RADV transfer adjustments not only are less favorable but also, much like risk transfers themselves, are more volatile as issuer market share decreases, as displayed in Figure 3.¹⁵

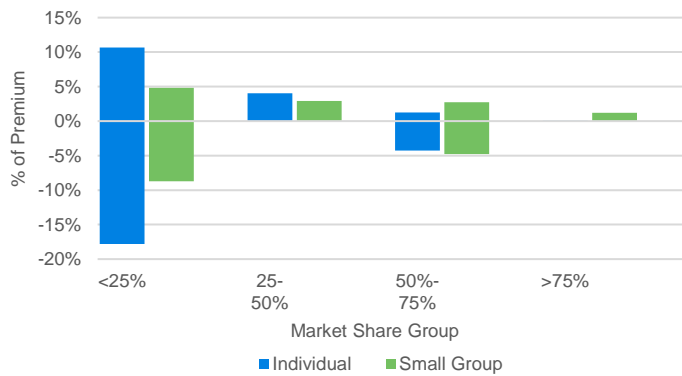
¹² Jason Petroske and Alan Vandagriff discussed the innate volatility of ACA risk adjustment by market share in the research paper available at <https://www.milliman.com/insight/sizing-up-aca-risk-adjustment-volatility-how-the-interplay-between-risk-adjustment-and-is>.

¹³ Consumers for Health Options, Insurance Coverage in Exchanges in States (November 4, 2015). Technical Issues with Risk Adjustment and Risk Corridor Programs. Letter to U.S. Department of Health and Human Services Secretary Sylvia Burwell. Retrieved January 31, 2020, from <https://web.archive.org/web/20170128053231/http://nashco.org/wp-content/uploads/2015/11/CHOICES-White-Paper-on-Risk-Adjustment-Issues.pdf>

¹⁴ Initially, we defined several categories of issuer size, including absolute size, regionality, and market share for both 2017 and 2018. Because each yielded similar conclusions, we selected market share in the RADV benefit year as the final metric.

¹⁵ We analyzed the 80th percentile of positive and negative transfers. Higher percentiles had minimal impact on larger issuers but presented significantly larger values for the under 25% segment, providing further evidence of the volatility of RADV results for smaller issuers.

FIGURE 3: 80TH PERCENTILE OF TRANSFER ADJUSTMENTS BY RISK POOL AND ISSUER MARKET SHARE



This pattern adds another element of uncertainty for issuers to consider. While some of CMS’s proposed changes in its RADV white paper have the potential to reduce the number of outliers, it is likely the patterns of transfer magnitude illustrated in Figure 3 will remain.

WHAT DOES IT MEAN FOR THE MARKET?

Are there any positives for smaller issuers? Recognizing the operational burden, the HHS methodology targets full audits for smaller issuers¹⁶ every three years, on average, rather than annually. HHS has been less clear about what happens to an exempt issuer during the non-audit years.¹⁷ Regardless, exemptions will bypass most of the operational burdens accompanying RADV. And, depending on HHS’s implementation, an exempt issuer could alter its strategies in non-audit years, such as instituting more “aggressive” coding.¹⁸

As with many aspects of ACA programs, the dust won’t settle for years, and there is little an issuer (especially a small issuer) can control outside its own performance. Other than staying on top of RADV requirements and providing feedback when appropriate, the best strategy may involve a thoughtful examination of the current market dynamics and the incentives in play now and in the future.

Impact 3: Searching for confidence in the confidence intervals

WHAT’S THE ISSUE?

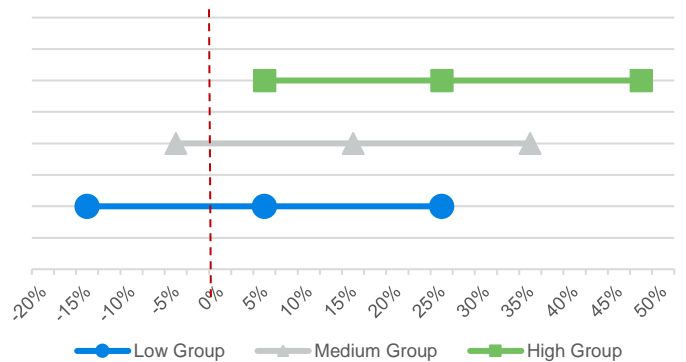
Issuers are looking for ways to solidify expectations about future RADV performance and mitigate its adverse impacts. But, results are unpredictable and can change dramatically if any issuer in the market falls only one tenth of a percent on the wrong side of a confidence interval (CI).

This CI approach adopted by HHS is designed to limit the number of issuers receiving adjustments to their own risk scores. But, the way in which adjustments are calculated for those outside of each CI creates a complex dynamic in the market and influences how individual outlier issuers may react to the results.

WHAT DO THE RESULTS SHOW?

The 2017 RADV failure rate group CIs were very wide and skewed positive. In fact, an issuer with “perfect” coding accuracy in the high failure rate group would actually be a negative outlier. Figure 4 provides a visual of the 2017 CIs.

FIGURE 4: 2017 FAILURE RATE GROUP CONFIDENCE INTERVALS



¹⁶ Defined as those with under \$15 million in total state ACA premium. Additionally, issuers with fewer than 500 billable member months in the state are always exempt from RADV.

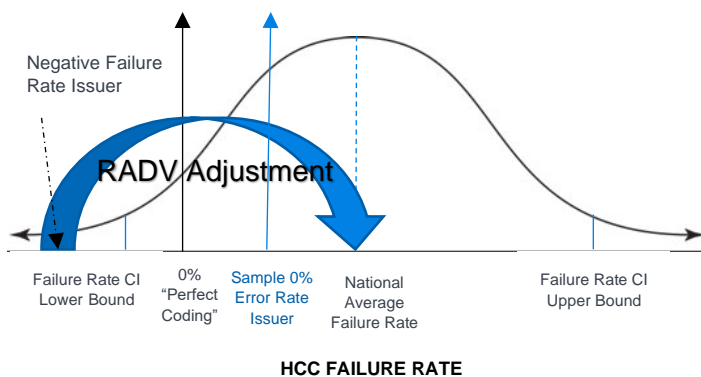
¹⁷ HHS states in the 2018 payment notice that the default error rate will equal the lesser of the national average error rate and the statewide error rate. This would ensure, at worst, an exempt issuer would be unaffected and, potentially, could be a RADV recipient. See <https://www.federalregister.gov/d/2016-30433/p-518>. However, HHS states in the 2019 payment notice that issuers exempt from RADV “will not have their risk adjustment transfers adjusted,” per <https://www.federalregister.gov/d/2018-07355/p-334>. More recently, CMS notes in its white paper that exempt issuers “not exempt from transfer adjustments,” which suggests these issuers will simply receive a 0% error rate.

¹⁸ This strategy is possible but risky, because issuers do not know in advance of the EDGE submission deadline whether they will participate in RADV and too many over-coded HCCs may lead to a positive error rate.

But why are CIs a big deal? With respect to EDGE reporting accuracy, there's little difference between an issuer barely inside or outside a CI. From a RADV standpoint though, the issuer inside the CI receives no adjustment while the issuer outside the CI is adjusted to the center of the CI (the national average failure rate). This means negative outliers move past "perfect" coding to the average rate of "over-coding"—often leapfrogging issuers inside the CI—and are essentially rewarded for EDGE reporting errors and/or less intense coding efforts.

Consider an issuer with a -10% failure rate in the medium failure rate group. If this issuer were adjusted to the lower bound of the CI in Figure 4, its risk score would increase by roughly six percentage points. However, by adjusting to the center of the CI, the risk score increase is 25 percentage points. This effect is illustrated in Figure 5.

FIGURE 5: ILLUSTRATION OF FAILURE RATE ADJUSTMENT



While the above methodology is applied universally, the market impacts can vary widely. As our example issuer with a -10% failure rate controls a greater portion of the market, the adjustment in Figure 5 increases market-wide risk scores more. We already have some evidence of this happening in certain negative error rate states, with the dominant issuer receiving a materially favorable transfer adjustment at the expense of most other issuers.

CMS dedicated a fair amount of time to this topic in its recent RADV white paper and expressed concern about solutions allowing issuers with aggressive coding practices to avoid appropriate correction for their efforts, leaving open the likelihood this effect will continue into the future.

WHAT DOES IT MEAN FOR THE MARKET?

Ironically, even though 2017 RADV is known, future results remain no less uncertain. Some of the unpredictability stems from unreliable estimates of an issuer's own error rates, particularly in light of program changes that may or may not take place. Other forms come from the various incentives RADV now presents to the market:

- Issuers with positive error rates want to reduce over-reported EDGE Hierarchical Condition Categories (HCCs) and move within the HCC failure rate group CIs.
- Issuers with 0% error rates are probably content with their position but look to reduce under-reported EDGE HCCs to increase risk scores.¹⁹
- Issuers with negative error rates face conflicting incentives between addressing risk adjustment transfers directly through diagnosis coding and the potential rewards of retaining negative outlier status.

In the current RADV structure, a negative outlier issuer can only improve its position by increasing its EDGE risk score beyond the RADV-adjusted risk score, which may be difficult and expensive to achieve. And, as market share grows, negative outliers are increasingly motivated to accept the RADV adjustment rather than raise risk scores organically through improved medical record documentation. At the end of the day, those issuers currently in risk pools with large negative outliers should be prepared for the possibility of those same negative outliers in the near future.

So how can issuers in these markets counteract the adverse outcomes? Regardless of how much and in which direction others influence risk adjustment, there will always be some benefit to improving under-coded HCC accuracy because of its direct, favorable effects on risk adjustment transfers—even for issuers squarely within the failure rate group CI. This may still be the most reliable means of improving results, and ACA issuers have known about the positive effects of these initiatives for a while now. However, not every solution to RADV is straightforward, and, as described below, some considerations are completely new.

¹⁹ In actuality, an issuer close to the positive error rate threshold would not be incentivized to increase or reduce its efforts to combat medical coding errors. Similarly, an issuer close to the negative error rate threshold is more incentivized to increase under-reported HCCs on EDGE than to expend tremendous effort improving EDGE accuracy. Given the inability to know in advance the positioning within a failure rate group CI, issuers targeting specific actions based on an expected failure rate position take on great risk that the strategy will backfire (as opposed to simply trying to improve coding accuracy to avoid positive error rates). In its white paper, CMS also notes it does not believe it is a viable issuer strategy to adjust behaviors based on a projection of where the failure rates will lie.

Impact 4: Your strategies may be lagging behind

WHAT'S THE ISSUE?

Early in the RADV process, HHS established an adjustment lag whereby a current year's results affect the next year's transfers. More recently, HHS also announced a much longer collection and disbursement lag. These two delays now form opposite sides of the same coin—both appearing well-intended but receiving some criticism from stakeholders.²⁰

In this final section, we highlight how RADV's two intrinsic timing lags create a disconnect between the experience used to adjust risk transfers, the adjustment itself, and the revenue which is directly impacted by the adjustment. This disconnect compounds marketplace uncertainty and may alter issuer decisions.

WHAT DO THE RESULTS SHOW?

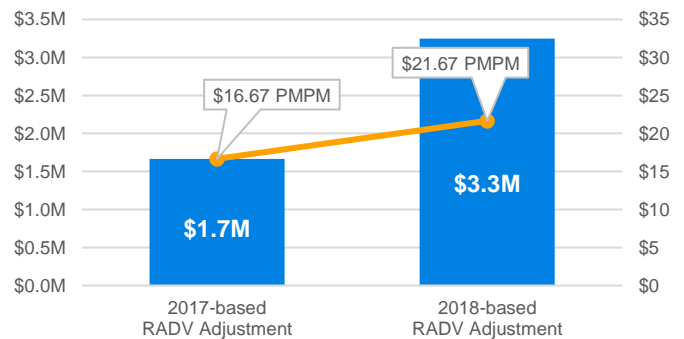
We limit our analysis to two specific consequences caused by error rate direction and annual marketplace changes. To facilitate the discussion, we carry an example issuer through this section, subject to the following assumptions:

- 1 100,000 member months (MMs) in 2017, increasing to 150,000 in 2018.
- 2 All risk transfer factors equal to the state averages (i.e., no 2017 risk transfer), which are the same in 2017 and 2018.
- 3 \$350 per member per month (PMPM) 2017 state average premium, increasing by 30% in 2018.
- 4 0% issuer error rate; -5% state error rate.

Misaligned risk adjustment compensation²¹

RADV measures errors in EDGE reporting for a specific benefit year, which reflect a fixed-dollar misstatement in that year's risk transfer based on market conditions at that time. However, HHS applies error rates to the next year's risk score, even though market changes can distort the intended correction. We illustrate this effect for our example issuer in Figure 6.

FIGURE 6: ILLUSTRATION OF RISK TRANSFER ADJUSTMENTS



The example demonstrates that, had the -5% state error rate been applied to 2017 experience, the PMPM risk transfer payment would have been 20% less while the total transfer payment would have been over 45% less. It may seem as though this effect is more of a theoretical concern only, but what did the marketplace actually experience in 2018?

- Almost 55% of 2018 issuers experienced at least a 25% member month change (growth or decline) over 2017.
 - Smaller issuers, not unexpectedly, changed by larger amounts year-over-year and with higher frequency.
 - Perhaps more surprising, though, nearly one-third of issuers with over 500,000 reported member months experienced at least a 25% membership change in 2018.
- Based on HHS risk adjustment reporting, statewide average premiums increased by over 25% across the nation in the individual market in 2018.²²
- Accounting for the most impactful items, nearly two-thirds of issuers in outlier states received a RADV adjustment that may have been *at least* 20% too high or too low.

²⁰ The American Academy of Actuaries in particular commented on this issue on October 3, 2019. See https://www.actuary.org/sites/default/files/2019-10/RADV_Timing_Comments_100319.pdf.

²¹ We measure the impacts from enrollment and state average premium changes, although issuer risk score, metallic mix, and geography changes (all relative to the market) can lead to inappropriate compensation to lesser extents. Further, the example we use is based on a growing issuer in a negative error rate state. Analogous patterns exist for other combinations of assumptions.

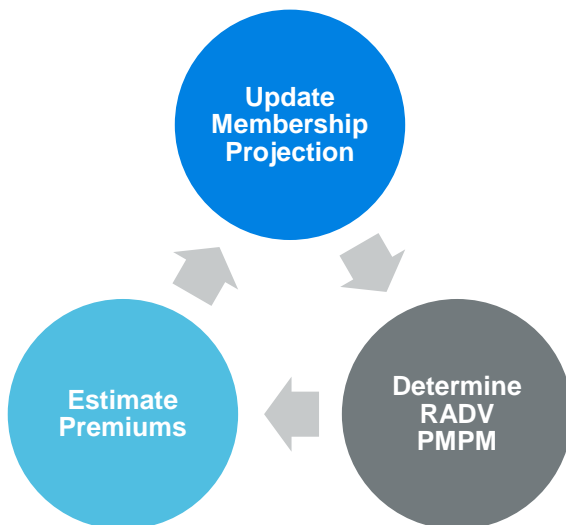
²² This increase was mostly related to the unfunded cost share reduction (CSR) subsidy liability. However, RADV is indifferent to cause, and large, unexpected rate changes (such as the one in 2018) highlight the interconnectedness of ACA components. It is worth noting that the average rate change in the small group market in 2018, using the same methodology, was approximately 6%.

Misaligned pricing

RADV also may affect enrollment and premium projections when pricing future rates.

Continuing with our example from Figure 6, we now assume no further membership growth by 2021 in absence of RADV. After reflecting the nearly \$22 PMPM payment from the 2017 audit, this example plan may feel pressure to reduce its membership projection to account for an increasingly uncompetitive premium position. Because the total dollar RADV amount is fixed at a \$3 million payment, the plan will now recalculate the PMPM value and find it is higher than the \$22, which could lead to a feedback loop of reduced membership and increased premium to cover the higher PMPM RADV payment, as highlighted in Figure 7.

FIGURE 7: ILLUSTRATION OF ITERATIVE PRICING IMPACTS FROM RADV



At this point, each state will decide whether issuers are required to price RADV transfers in rates. CMS intends to include 2017 RADV adjustments to 2018 risk adjustment transfers in the 2021 medical loss ratio (MLR) reporting, which could create additional distortions in MLRs for issuers that do not reflect RADV results in premiums.

WHAT DOES IT MEAN FOR THE MARKET?

The consequences of the collection and disbursement lags could have real implications on all those affected by the ACA insurance market:

- Issuers need to expand their growing lists of pricing assumptions and must consider the ramifications in financial reporting. They may also alter their strategies when market expansion or contraction is expected, particularly in highly competitive regions where issuers vie for subsidized populations.
- Consumers will bear much of the consequences of shifting premiums, issuer participation changes, and network realignments.
- State regulators must now spend additional resources interpreting rules, writing regulations, and reviewing insurance filings to fulfill their due diligence obligations and ensure a viable and stable health insurance market.
- Providers should anticipate increased engagement from issuers looking to improve coding accuracy and documented support for existing member conditions.

The current structure of RADV increases the likelihood that premium rates will be misaligned with underlying risk, which will naturally play into an issuer's propensity to counteract the lack of confidence with margin and conservatism.

Rewriting the script

ACA issuers have had their share of uncertainty. At first, there was the shock of the initial risk transfer results, then the unending extension of transitional plans, the 2017 market rate corrections, removal of the individual mandate, CSR defunding, risk corridor non-appropriation, association health plans and short-term insurance, material changes to the risk transfer equation, and the saga of repeal and replace. Now RADV enters the scene and adds to an already overcrowded stage. These items have challenged the ability to predict market responses and navigate the ambiguity. Some issuers have even questioned market viability and long-term ACA participation.

RADV is now arguably one of the largest remaining causes of instability in the ACA market. An issuer has no ability to reasonably project its own error rate, marketplace results, or, by extension, the magnitude of the impacts. Further, RADV shifts responsibility for deficiencies in medical documentation to the issuer, even though the available solutions are resource-intensive and providers are often difficult to influence. If the Medicare Advantage market is any indication, reformulations of RADV audits and their implementation will likely not free issuers any time soon from material revenue uncertainty and variability. And, any item affecting the issuer necessarily has downstream impacts on all healthcare stakeholders.

It is unclear how RADV will mature. HHS continues to support the program's intent and promote its results²³ but has already introduced noteworthy changes between the pilot years and the current program. And, the recent CMS RADV whitepaper presents several additional modifications that could alter the program again—including on the margins and with significant methodological changes. But, operational challenges mean issuers will likely see at least one and possibly two more RADV benefit years under the current program, with little certainty that changes will sufficiently address issuer concerns from the first year of results.

In the meantime, perhaps the best action available to issuers is increasing attention and awareness to all things RADV and identifying areas to mitigate future risk:

- Analyze the 2017 results in your market and integrate them into your budgets, forecasts, and rate development, including your expectations for how other issuers will react in subsequent years in response to the initial RADV outcomes.
- Learn from the Initial Validation Audit and strengthen your processes directly linked to data/information capture and transmission.
- Keep tabs on all proposed changes:
 - Understand proposals related to RADV and give HHS feedback when the changes impact your business.
 - Be mindful of risk score model changes and understand their influence on your future risk transfers and RADV transfer adjustments.
- Weave coding accuracy initiatives into the fabric of your organization:
 - Set realistic goals and appropriately prioritize your efforts.
 - When necessary, establish robust retrospective solutions. When possible, be proactive.²⁴

The adversity precipitated by the RADV program has stolen the spotlight. Some aspects are within your control; some are not. To remain successful in the ACA, you must continue to pivot your actions and evolve your strategy. If not, you might feel like RADV is an impossible act to follow.

²³ HHS noted issuers improved RADV accuracy and was pleased with the number of markets without adjustments—one of the goals of the revised RADV methodology introduced in the 2019 payment notice. See <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/2017-Benefit-Year-HHS-Risk-Adjustment-Data-Validation-Results.pdf>.

²⁴ For more information on establishing a successful risk adjustment management program, refer to <http://us.milliman.com/insight/2017/ACA-risk-adjustment-management-Cracking-the-code/>.

Methodology and key caveats

METHODOLOGY AND DATA SOURCES

We utilized several publicly available data sources to supplement the HHS RADV reporting. The following list describes the main sources and our methodology for summarizing the information.

Data type: 2017 state population

- **Source:** CMS Medicare Advantage program statistics
- **Relevant methodology notes:** We used population statistics from CMS rather than directly from the U.S. Census Bureau for convenience with other data sources pulled. We compared high-level figures from CMS with the Census Bureau and did not find material deviation. Although preferred, we did not truncate data above age 65 due to the inherent difficulties in obtaining accurate census data by age at the county level, which we needed in our service area analysis.

Data type: 2017 and 2018 issuer MMs, premium, and claims

- **Source:** 2019 and 2020 Unified Rate Review Template (URRT) Public Use Files (PUFs); 2017 and 2018 Medical Loss Ratio (MLR) PUFs.
- **Relevant methodology notes:** We filtered information to non-“not applicable” metallic tiers and linked data from various sources on HHS’s Health Insurance and Oversight System (HIOS) Issuer ID. For Massachusetts only, we removed all “Small Group” entries, as they are identical to the “Individual” entries. We ignored issuers who exited the market as of 2020 (and, therefore, would not have 2018 information in an URRT format) and confirmed the number was immaterial enough as not to affect the integrity of the analyses. Exiting issuers were reviewed against MLR filings for reasonability, although MLR data was not directly used due to the inclusion of transitional and grandfathered plans in the data.

Data type: Benefit year 2018 risk transfers by issuer and risk transfer factors by state

- **Source:** “Summary Report on Permanent Risk Adjustment Transfers for the Benefit Year 2018” released June 28, 2019
- **Relevant methodology notes:** N/A

Data type: Benefit year 2017 RADV results

- **Source:** “2017 Benefit Year HHS Risk Adjustment Data Validation Results” released May 31, 2019; “Summary Report of 2017 Benefit Year Risk Adjustment Data Validation Adjustments to Risk Adjustment Transfers” released August 1, 2019; “HHS Risk Adjustment Data Validation (HHS-RADV) White Paper” released December 6, 2019.
- **Relevant methodology notes:** We flagged outlier issuers by first merging 2017 RADV transfer adjustments with 2018 issuer premium and MMs and then determining which issuers

had the largest (positive and negative) PMPM and/or percentage-of-premium RADV impacts. The number of issuers selected was dependent on the outlier counts by state and market in the 2017 RADV reports. Some issuers that were potential outliers exited the market by 2020 and, therefore, did not have 2018 MM and premium data in the URRTs. In those cases, we were required to individually assess, based on the data available, whether each issuer was a likely outlier.

Data type: 2017 service area

- **Source:** 2017 Service Area PUF and 2017Q2 Rate and Benefits Information System (RBIS) submissions
- **Relevant methodology notes:** The Service Area PUFs contain the areas (partial or statewide) each issuer offers coverage. For issuers selling across the entire state, we linked 2017 population data from the CMS source already referenced. For issuers selling only in specific regions, we merged the county list provided by each issuer with county-level population statistics based on county name and/or Federal Information Processing Standard (FIPS) code. We manually adjusted some county names to ensure consistency across each data source. To simplify, we assumed each issuer covers an entire county. This information is available for the individual market only.

In addition to these sources, we leveraged large, internal data sets to assign conditions and risk scores and to determine HCC prevalence rates. We assigned HCCs and risk scores using our implementation of the HHS-released “Do-it-Yourself” software and linked this information to failure rate groups from the HHS RADV reports.

CAVEATS

Readers should consider the following caveats when reviewing the results presented:

- Public files are issuer-populated, and not all information will be complete, accurate, or consistent. After a cursory overview of the data, we found the information to be reasonable and in line with expectations. To the extent the data is not accurate, our conclusions would likely change.
- HHS did not release the names of HIOS IDs of outlier issuers, and we relied on 2018 URRT premium data in combination with outlier counts in the HHS RADV reports to identify issuers with positive and negative error rates. This methodology does not guarantee the correct selection of outliers, although, given the magnitude of most RADV adjustments, the results of our analysis should generally be aligned with reality.
- At this time, RADV represents a single data point, and recent results may not be representative of future experience as issuers shift behaviors and HHS revises its rules and regulations. Assuming the current RADV structure and with many proposed changes, however, we believe the patterns will generally hold in future years.

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Caveats and limitations

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in actuarial communications. The authors Cameron Gleed, Jason Karcher, and Jason Petroske are actuaries with Milliman. The authors are members of the American Academy of Actuaries and meet the qualification standards of the American Academy of Actuaries to render the actuarial analyses herein.

In preparing this article, they relied upon several federal publications, including:

- The Premium Stabilization rule
- The HHS Notice of Benefit and Payment Parameters for 2014 through 2020
- The 2018 Benefit Year RADV Protocols for PPACA HHS Risk Adjustment Data Validation, Version 7.0 dated June 25, 2019, and published on the Registration for Technical Assistance Portal (REGTAP) July 5, 2019, and the 2016 Benefit Year RADV Protocols for PPACA HHS Risk Adjustment Data Validation Version 14.0 dated and published on October 20, 2017, on REGTAP.
- Published RADV Reports, including the August 1, 2019, Summary Report of 2017 Benefit Year Risk Adjustment Data Validation Adjustments to Risk Adjustment Transfers, the 2017 Benefit Year HHS Risk Adjustment Data Validation Results published May 31, 2019, and the 2016 pilot year RADV summary report.

- 2018 Benefit Year Risk Adjustment Updated HHS-Developed Risk Adjustment Model Algorithm "Do It Yourself (DIY)" software published on April 4, 2019.
- 2020 benefit year Unified Rate Review Template PUFs
- 2019 benefit year Unified Rate Review Template and Service Area Template PUFs
- 2018 MLR PUFs
- 2017 MLR PUFs
- CMS Medicare Advantage program statistics
- 2017 Service Area PUF and 2017Q2 RBIS submissions
- Census Bureau population information

Any changes to RADV regulations or guidance in future rule making or as a result of legislation or litigation may impact the results discussed.

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Differences between the theory discussed in this article and actual results depends on the extent to which future experience conforms to the assumptions made for this analysis. It is certain that actual experience will not conform exactly to the assumptions used in this analysis. Actual impacts will vary from the theoretical impacts for a variety of reasons, and issuers subject to RADV should monitor their results and take corrective action when necessary.

We are not lawyers and, therefore, cannot provide legal advice. Readers are advised to confer with counsel before use of the information herein.



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