Strategies for Leveraging the ACA Risk Adjuster

By Jason Siegel

Traditionally, commercial health plans have had to monitor a small number of key activities in order to ensure satisfactory financial performance. These include such factors as underwriting, provider reimbursement contracting and medical management. When the major provisions of the Patient Protection and Affordable Care Act (ACA) go into effect in 2014, there will be another powerful metric that plans will need to manage: risk score. The risk adjustment mechanism implemented by the ACA will likely have a material impact on the financial results of many insurance companies, it exposes carriers to new types of risks, and in some cases can turn business strategies that were once viable upside down.

Smaller carriers, in particular, will be more exposed to these risks because their populations and risk scores are more volatile than those of large firms. And because risk scores will be compared between plans, many carriers will find that a great deal of coding effort is required just to avoid losing ground to competitors. This article outlines the issues that plans will need to consider going forward in order to manage the risk adjuster.

Comparison to Medicare

Risk adjustment has been an integral part of Medicare Advantage for many years and has evolved over time.[1] However, there are several important differences between the HHS-HCC risk adjustment model that will be used in the commercial market and the CMS-HCC model used in Medicare Advantage, largely driven by the differing philosophies and intents of the two mechanisms.

First, Medicare Advantage is at its heart a capitation arrangement where the federal government pays health plans to provide Medicare benefits to individuals who choose a private plan instead of the standard plan offered by the government. In Medicare Advantage, the risk adjuster is a mechanism to ensure that the amount of that capitation appropriately reflects the underlying health status of the enrolled population. In contrast, the commercial risk adjuster is not designed to create subsidies to commercial plans in aggregate (although other portions of the ACA will do that). Rather, its purpose is to reduce the incentive for carriers to cherry-pick the most profitable business and to protect plans from uncertainties resulting from the prohibition of medical underwriting. Under the commercial risk adjustment model, the risk adjustment transfers sum to a "net zero" among all carriers. To achieve this, the reimbursements under the commercial model will be set using an intricate formula involving the average risk scores of all the carriers in the market (along with other factors such as geographic and age factors), whereas under the Medicare risk adjustment model the primary determinant of each plan's level of reimbursement is the diagnoses it alone submits.

Second, the commercial risk adjustment model is concurrent, as opposed to the Medicare Advantage model, which is prospective. This means that the risk score calculated for each member is based on diagnoses from the same year as the associated revenue. In the Medicare model, risk scores are based on diagnosis codes from the prior year. The result is that commercial plans will have a much shorter window for identifying any potential diagnoses not in their claim data and ensuring those diagnoses are appropriately reflected in the additional allowable data submitted to the U.S. Department of Health and Human Services (HHS).

Third, the risk scores used in Medicare Advantage represent a measure of each member's health status only. In contrast, under the HHS-HCC model risk scores will represent a combination of the member's health status and choice of benefit plan. Hence, if a member changes from, say, a bronze to a silver plan, and nothing else changes, that member's risk score will increase. The risk settlement calculation will then normalize the average risk score calculated for each entity based on its average plan richness (among other factors) compared to the state average. The result is that to the extent the actual benefit relativities of a

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carrier's benefit plans differ from those of the hypothetical plans used to calibrate the risk score model, carriers will be exposed to risks regarding the mix of plans members select. That is to say, it may be advantageous to promote plans of certain metallic levels (e.g., platinum, gold, etc.) over other plans solely because of unintended impacts from the risk settlement methodology.

Finally, Medicare Advantage covers an older population with inherently more medical conditions than exist under most commercial plans. Models designed to predict missing diagnoses in a commercial population must be more targeted and discriminating to assure administrative expenses aren't wasted pursuing nonexistent conditions.

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Why Current Strategies Won't Work

In the past, health plans that have been able to do well at medical underwriting have traditionally kept their premium rates the most competitive and have experienced the best margins compared to plans without a disciplined selection process. Depending on exactly how the risk adjustment model is applied to their populations, these plans could potentially be at a disadvantage relative to the rest of the industry. Preliminary research on the HHS-HCC risk adjuster suggests that for members with certain conditions the model may create transfer payments that exceed the expected additional costs typically associated with those conditions. Given the interactions of the risk score with other rating factors and the new populations expected to take up coverage in the commercial insurance market, it is not yet clear to what extent this will occur in practice.

If it does occur, this effect may be compounded since premium is used as the basis of the risk settlement calculation instead of expected claims. In fact, the payments a carrier with a low retention load will make into the risk adjustment pool will be further leveraged because the settlement amounts will be based on the state average premium instead of the plan's own premium. Because the transfer payments incorporate the entire premium rate and not just claims, insurers with lower than average retention loads will inordinately benefit from receiving transfers compared to insurers with high retention loads.

In addition, these effects may be further compounded in the individual market since the ACA also provides reinsurance recoveries for certain large claims, yet the risk adjustment and reinsurance calculations do not interact with one another. This design can cause total reimbursements for costly members to partially double count large claims. Of course, this issue is temporary in nature, since the federal reinsurance program is only slated to last three years.

There are many strategies commercial health plans are implementing in response to the introduction of risk adjustment and the other ACA provisions. For example, some plans are keeping members out of the risk adjustment pool through the use of grandfathered plans as these plans are not subject to risk adjustment. Some are renewing plans near the end of 2013 to delay subjecting those members to the risk adjuster for nearly a full year. However these are short-term strategies. Farsighted carriers will need to focus on improving diagnosis coding, thinking through membership mix issues, and managing the care of their members to truly be competitive in the future health care market.

Coding

When health plans discuss coding they are referring to their ability to ensure that all relevant diagnoses for a member are included in their data and that these diagnoses include the most severe form of each condition appropriately attributable to the member. Medicare Advantage plans have typically increased risk scores by 1 to 2 percent a year through progressively better coding, and in response the Centers for Medicare and Medicaid Services (CMS) have instituted adjustments to account for this effect. A study performed by the U.S. Government Accountability Office (GAO)

estimated that, due to coding differences, Medicare Advantage risk scores were between 4.8 and 7.1 percent higher in 2010 than they would have been had the same members been enrolled in fee-for-service Medicare.

There are multiple reasons why proper coding may not occur in practice, including:

- Communication difficulties
- Incorrect lab procedures that are due to a lack of knowledge on the clinician's part
- Nonspecific presentation of the disease of the member
- Level of experience of the coder
- Paper trail errors.[2]

Each of these reasons presents plans and providers with its own difficulties in identifying and resolving problems.

Perhaps the most important causes of improper coding involve the human element. Full elaboration of a member's diagnoses is often not needed by a physician to get reimbursed for services. Hence, misdiagnosis or a lack of a diagnosis could occur on purpose. For example, Rost, Smith, Matthews and Guise completed research in which 382 physicians were surveyed regarding their coding practices and found that 50.3 percent of the physicians reported using a different code for a patient being seen for major depression; 30 percent of the total physicians admitted deliberately misdiagnosing the condition.[3] The research showed that physicians intentionally substitute diagnosis codes that are not accurate for a variety of reasons, including the physician trying to avoid problems with reimbursement and concerns for the patient being able to obtain future health insurance or other benefits.

The ACA prohibition on underwriting may mitigate this eventually, but that will take time and provider education. This is cause for concern because under the ACA risk adjustment program if physicians are deliberately not providing diagnosis codes for members, the health plans will incur the expenses of having less healthy members without the benefits of receiving the risk score adjustment and future potential payment from the risk adjustment model. There are different strategies health plans can potentially use to improve their coding abilities. Chronic medical conditions are one example of low-hanging fruit. These conditions are sometimes poorly coded because other diagnoses could be part of a physician visit, instead of the underlying condition. However, these conditions might be identified using longitudinal data, and they offer additional opportunities for care management of the member on the part of the plan.

National drug codes (NDCs), which are used to identify unique drugs by name and strength, have also proven to be a powerful marker for member conditions. Because there are numerous drugs commonly used for specific clinical conditions, they might be an indicator of diagnoses missing from the member's data. Coding systems such as the diagnosis-related groups (DRGs) and current procedural terminology (CPTs) also provide opportunities as potential markers that can be used to identify conditions a member might have.

In addition, analyzing the frequency of office visits, specialists' visits, and the use of lab work can all lead to potential future improvements in identifying under-coded members by looking at their data for indications that a diagnosis code may be missing. Even looking for conditions that tend to run in a family may catch instances in which one family member shows up with a condition, and another family member with the same condition is missing the corresponding diagnosis code in the data. Educating providers on best coding practices and their impact on the health plan's financial results (and potentially physician reimbursement) is often a key element in a company's strategy for improving coding. In fact, provider-owned plans may have an advantage in this area as they will have all the chart data readily available and have the most direct incentives to provide accurate and

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complete codes. Insurance companies, on the other hand, will need to build models to identify members with a high probability of missing diagnoses and then complete chart reviews for those members. Insurance companies may also need to design risk-sharing mechanisms to align financial incentives between the plan and provider.

Finally, health plans will need to consider their methods of data warehousing and data processing in order to ensure that all the necessary elements are captured to calculate a complete risk score (and to support those risk scores during annual audits) or identify missing diagnoses. For example, in some cases simple differences in programming might ensure lab results are not only obtained but may be accessed and reviewed easily, potentially providing valuable information. Or members changing plans midyear may cause diagnoses not to be linked across the plans in the data warehouse, resulting in risk scores that are lower than they should be.

Member Mix

The complexities and likely imperfections in the commercial risk adjuster create additional opportunities and risks as health plans evaluate the impact of enrolling a different membership mix than the rest of the market. One way in which this has been exhibited in Medicare Advantage is with respect to special needs plans (SNPs). Some carriers have proven adept at identifying arbitrage opportunities in the Medicare risk adjustment model, including situations in which the risk adjustment reimbursement for a certain set of conditions results in reimbursements higher than the actual claim burden of the individuals. Time will tell whether or not commercial plans are able to design competitive benefit packages aimed at high-needs populations. Of course, by introducing these plans carriers would take on the risk that changes to the risk adjuster in future years will make once profitable populations unsustainable.

A member's choice of benefit plans is another area in which the risk adjuster potentially turns traditional thought upside down. The standard belief has always been that to the extent members are able to select between plans the sickest will gravitate toward the richer plans, and the healthiest to the leaner plans, to their own benefit. This type of anti-selection has always been to the disadvantage of the health plan. However, the risk adjustment model explicitly builds in the impact of each member's plan design when calculating risk scores, so this is not necessarily the case any longer. Rather, health plans will need to understand how their risk scores vary because of members choosing different benefit plans, and whether this slope is steeper or flatter than the actual benefit variation between benefit plans. This is an area in particular in which the commercial risk adjuster may not be accurate given that it was calibrated using one set of hypothetical plan designs, whereas carriers in the market sell plans with widely varying benefit parameters and associated benefit slopes.

Finally, health plans will need to analyze the impact of demographics. The ACA requires a great deal of age compression (3:1) and forbids the use of gender as a rating variable. Presumably, through the risk adjuster, plans are made whole if they enroll a more or less costly demographic mix than the rest of the market. Nevertheless, to the extent the demographic claim slope experienced by a health plan is different than that underlying the data used to calibrate the HHS-HCC model, additional risks will be created with respect to demographic mix.

Care Management

To really harness the power of improved coding and help members with chronic conditions, coding initiatives should be paired with care management protocols. If a health plan can manage care well, the costs associated with the member having a medical condition will decrease while the payment received through the risk adjuster will remain the same and the quality of care will go up. Predictive models capable of identifying missing diagnoses can result in a strategic advantage in terms of care management because potentially costly members can be identified earlier. Several external vendors can provide prior prescription drug data for new members, which could be used to identify care management opportunities from day one.

Conclusion

The timeline that health plans face in adapting to a risk-adjusted environment is daunting. The risk adjustment settlement amounts for benefit year 2014 aren't expected to be known until June 2015, whereas many states will likely require that 2016 premium rates be filed before that information is available. This means that health plans won't have solid data backing up this calculation until filing 2017 rates. Furthermore, health plans generally accrue and track financial performance at least quarterly, and publish annual statement exhibits shortly after year-end. They will need to certify accruals near the start of 2015, likely well in advance of the first reports on risk adjustment settlements.

Furthermore, many techniques that plans will want to make a part of their strategic toolboxes, such as controlling membership mix and identifying members who will benefit from managed care protocols, will require building analytics and other infrastructure up front, resulting in additional time pressures. While these challenges are real, they bring corresponding opportunities to health plans that are the most agile and proactive when it comes to tracking their own data and seeking out available external data sources that can be used to develop benchmarks. State hospital databases, all-payer databases, state simulation studies, and aggregations of employer group data are all examples of data sources that companies are looking at to make these estimates.

Finally, risk adjustment models tend to be relatively more complex than other financial models that businesses use on a daily basis. Companies will need to build teams that combine the analytic skills required to extract information from these models with the business savvy to identify and communicate these opportunities and challenges across the organization. This is a prime area of study in which actuaries can contribute meaningful insights.

END NOTES

[1] United States Government Accountability Office. (2012). *Medicare Advantage: CMS Should Improve the Accuracy of Risk Score Adjustments for Diagnostic Coding Procedures* (GAO-12-51). Retrieved from h*ttp://www.gao.gov/assets/590/587637.pdf.*

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