

Pairing risk adjustment to support state 1332 waiver activities

Lessons learned from a Minnesota Legislative Study

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Introduction

Section 1332 of the Affordable Care Act (ACA) allows states, starting in 2017, to waive certain ACA market rules to allow for more tailored commercial individual and small group market solutions. A number of states have either applied for a 1332 Waiver or are in the process of applying. Generally speaking, these states are hoping to use the Waiver to address the challenges they are facing in the commercial individual market, such as an imbalanced risk pool and increasing premium rates, as well as the lack of health plans offered on the exchanges for 2018.

Risk adjustment in the commercial individual and small group markets

Under current market rules, the commercial individual and small group markets are subject to specific rules including guaranteed issue and renewal, adjusted community rating, prohibition on health status rating, and pricing across a single risk pool. These rules limit a health insurer's ability to select or price for health status risk in their enrolled populations. Recognizing this limitation, the ACA included specific risk mitigation mechanisms: "transitional reinsurance," "risk corridors," and "risk adjustment" (commonly referred to as the "3Rs"). Risk adjustment is the only permanent program that extended beyond the first three years of the ACA's implementation.¹ Under risk adjustment, health plans enrolling sicker-than-average individuals may receive a payment from the rest of the market to offset the excess risk they are unable to reflect in pricing.² In theory, under perfect risk adjustment, health insurers would be made agnostic with respect to the relative health status of their enrollees, and would instead focus on competing over health care quality and outcomes. In practice, however, risk adjustment is not perfect and requires continual refinement both methodologically and operationally to ensure market balance.

1 Starting in 2017; risk-adjustment also includes a high-cost risk pool, reinsurance-like program for enrollees with expenditures over \$1 million. (2017 NBPP <https://www.gpo.gov/fdsys/pkg/FR-2016-12-22/pdf/2016-30433.pdf>.)

2 March 31, 2016, HHS-Operated Risk Adjustment Methodology Meeting. Discussion Paper. Retrieved May 5, 2016, from <https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/RA-March-31-White-Paper-032416.pdf>.

However, risk adjustment does not address problems related to the overall imbalance of the risk pool statewide or the resulting steep premium rate increases being filed in many states.

Tailoring Risk Adjustment to State-Specific Market Conditions

As noted above, risk adjustment is a policy tool and market stabilization mechanism designed to be paired with rules of the market at both the federal and state levels. To be most effective, it is necessary for 1332 Waiver proposals and other state market reforms that significantly modify market rules to be paired with a risk adjustment program tailored to address these changes. By doing so, risk adjustment can be designed to address factors affecting the underlying costs insurers cannot cover in their premiums. As market rules change, it is important these modifications be taken into account.

At the federal level, U.S. Department of Health and Human Services (HHS) uses a default methodology designed for the standard ACA non-grandfathered commercial individual and small group market to determine the direction and magnitude of funds transfers within a market.

HHS also provides states the flexibility to design their own risk adjustment methodology tailored to market rules that may be different than those existing in the federal default. For example, in Massachusetts, the Massachusetts Health Connector implemented a federally-certified state alternative methodology,³ developed with the assistance of Milliman, to fit its unique market conditions: a merged individual and small group market, a subsidized insurance program, ConnectorCare, which offers additional state wrap subsidies to member cost-sharing, and a state All-Payer Claims Database (APCD) for data collection, simulation, and funds settlement.

In a report to the Minnesota State Legislature⁴ to help explain and explore options for state-based risk adjustment, Milliman modeled several market reform scenarios using the Minnesota

3 https://betterhealthconnector.com/wp-content/uploads/reports-and-publications/Risk_Adjustment/MANoticeofBenefitPaymentParameters.pdf.

4 <http://www.health.state.mn.us/divs/hpsc/hep/publications/legislative/raLegislativeRpt2016.pdf>.

APCD to estimate the direction and magnitude of risk adjustment funds transfer under market scenarios, including a **state-based reinsurance program**.

Using data collected from the Minnesota APCD and from carriers directly, we modeled a state-based reinsurance program with the following specifications: a \$90,000 attachment point, 50% coinsurance, and a cap at \$250,000. Using data from the APCD and collected by the Minnesota Department of Health from health insurers in Minnesota, we estimated that approximately \$118 million in claims volume would have been subject to reinsurance, for a total payment of \$25 million.⁵ We found that under the modeled⁶ hypothetical reinsurance configuration, the federal risk adjustment model, which does not account for state-based reinsurance, would have potentially transferred premium payments of \$13 per member per month for the entire individual market (\$663 per member per month for high-cost members) without an equivalent plan liability, i.e., overcompensation. This could create economic inefficiencies in both the reinsurance program and in risk adjustment.

Next, we demonstrated how to correct the overcompensation by developing a risk adjustment model to reflect the plan claims liability after reinsurance. While our work conceptualized reinsurance as operating on a dollar threshold basis, other approaches, such as those proposing to offset costs for members with certain high-risk conditions, should likewise take into account interaction with risk adjustment. Our finding: The current federal risk adjustment methodology does not account for payments from a state-based reinsurance program and can result in double compensation for high-risk members, both from the reinsurance program and from risk adjustment. This finding is likely to have importance to many other states considering reinsurance-like proposals under Section 1332 to help stabilize their markets. Specifically, if appropriate changes to risk-adjustment are not made, a reinsurance program could lead to pricing inefficiencies and distortions that negatively impact the market and could work against the goals of the reinsurance program overall.

5 Only the portion of claims that is above \$90,000 and below \$250,000 is paid by the reinsurance program. For instance, for a member with \$100,000 total cost, the insurer would receive $50\% \times (\$100,000 - \$90,000) = \$5,000$ from the reinsurance program.

6 As noted, the reinsurance model implemented by HHS in 2014, differed from the specifications in this scenario in the following ways: The attachment point was at \$45,000 (instead of \$90,000) and the coinsurance amount was 80 percent (instead of 50 percent). The cap in the federal reinsurance program, like the specification for this report, was set to \$250,000. Parameters varied over the three years of the federal program based on differing enrollments and appropriated funds each year.

The interaction of reinsurance and risk adjustment as it relates to a “high cost risk pool” program beginning in 2018 as part of the federal risk adjustment model is another important factor. How these various components—risk adjustment, high cost pooling, and reinsurance—fit together and interact will be important to understand, model, and ultimately take into account as part of program design.

Beyond reinsurance, other 1332 proposals and state reform efforts may contemplate changes to AV levels, cost sharing amounts, age rating,⁷ or coverage purchase mandates, all of which have significant implications for the nature of the risk pool and how health insurers develop products and premiums. Risk adjustment is a mechanism to address risks that cannot be reflected in premiums and, therefore, should be tailored to the changing market rules to be fully effective.

Conclusions

When states consider market reforms such as reinsurance under the 1332 Waiver with the goal of stabilizing the market and providing affordable coverage, it is important to examine the challenges and options in the context of their effects on other market stabilization mechanisms like risk adjustment. States should ensure that all policy instruments and tools are properly aligned and supportive of each other to further the desired market outcomes.

7 While changes in age-rating are not specifically part of 1332 waiver authority, some states (e.g., Vermont) have modified their age-rating bands under state authority. To date, these modifications have focused on narrowing such age-rating bands. Under current law, a broadening of age band variation beyond the current 3:1 limit for adults has been thought not to be permitted.

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