Report of AHIP Member Survey on ACA Risk Adjustment

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Executive Summary

A key element of the Affordable Care Act (ACA) is the permanent risk adjustment (RA) program. The risk adjustment program compensates individual and small group issuers that enroll higher than average risk enrollees by transferring funds to them from issuers that enroll lower than average risk enrollees. By compensating plans that disproportionately enroll higher-cost and higher-risk individuals, the ACA risk adjustment program aims to preserve a level playing field among competing plans and mitigate the potential for adverse selection in the individual and small group markets. The goal of RA is to remove incentives for issuers in the individual and small group markets to avoid enrolling people with higher cost health conditions. It is instead designed to encourage issuers to compete on quality, remove cost inefficiencies and offer products that meet the health care needs of all populations. The risk adjustment program works in tandem with the ACA insurance market reforms to create market stability while ensuring that individuals with pre-existing conditions have access to coverage that meets their health care needs.

Since its implementation in 2014, the ACA risk adjustment program has largely worked as intended by transferring funds from issuers with lower average actuarial risk enrollees to those with higher average actuarial risk enrollees.[1] However, there are disagreements as to how it could be improved: such as whether and how best to pursue potential changes to the methodology; the appropriateness of the magnitude of the transfers; and other issues. Consequently, America's Health Insurance Plans (AHIP) engaged Wakely to interview actuarial and operational staff of selected member plans regarding their thoughts about how ACA risk adjustment is currently working and what changes would improve the program. While there was not consensus on all issues, most members interviewed agreed that: 1) the program was working well (in that it transfers funds from issuers with lower than average risk enrollees to issuers with higher than average risk enrollees); 2) changes in RA methodology over time have improved the program; and 3) some aspects of the RA program could still be improved, including changes to promote operational efficiency, greater transparency, earlier access to interim data, and targeted policy changes This paper will provide a brief summary of RA, the methodology used for collecting information

[1] See "Insights on the ACA Risk Adjustment Program" by the American Academy of Actuaries at https://www.actuary.org/sites/default/files/files/imce/Insights_on_the_ACA_Risk_Adjustment_Program.pdf and "Risk Adjustment, Reinsurance Improve Financial Outcomes for the Individual Market Insurers with the Highest Claims" by Jacobs et al at https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.1456

on member opinions on RA, key findings and observations, and recommendations derived from the interviews.

Risk Adjustment Fundamentals

Under the ACA, RA is a permanent program that was effective starting in 2014. The RA program is intended to protect issuers operating in the individual and small group markets, both inside and outside of the Exchanges, against adverse financial results associated with enrolling members with a higher than average health risk. This is done by transferring funds from issuers with relatively lower actuarial risk to plans that have relatively higher actuarial risk within a state and market. Risk adjustment is a necessary component of a functioning health insurance market that requires guaranteed issue, prohibits medical underwriting, and prohibits waiver of coverage for pre-existing conditions. To implement the RA program, HHS designed a methodology that is based on the goal that premiums should reflect differences in benefits, quality, and efficiency, but not health status. The risk adjustment methodology has two components: the risk adjustment model and the risk adjustment transfer formula. Unlike the Medicare Advantage (MA) risk adjustment program, ACA risk adjustment is concurrent (MA is prospective) and is designed so that the transfers are budget neutral for the federal government.

The HHS risk adjustment model calculates a plan liability risk score (PLRS) which measures the average actuarial risk of an individual or small group plan in an issuer's population and is intended to reflect the costs to the issuer for covering services related to the enrollees' medical conditions. It does so by first calculating a PLRS for each individual and small group plan covered by the issuer using demographic and diagnosis data.

The risk adjustment transfer formula uses the relative risk score as an input to determine which issuers receive risk adjustment payments and which issuers are charged. The transfers are designed to eliminate health risk differences in premiums. Consequently, the formula takes into account allowed premium variation. The formula calculates premiums with risk selection (as measured by the risk score) and premiums without risk selection (which takes into account actuarial value (AV) and allowable rating factor (ARF)). The formula multiplies the difference in these two values by the state average premium. By scaling to the state average premium, the formula balances payments and charges and therefore is budget neutral for the federal government.

Methodology

The adequacy of the risk adjustment transfers associated with a given condition as well other concerns with the methodology have been much discussed. To understand RA better, AHIP commissioned Wakely to engage with its member plans regarding the ACA risk adjustment program in order to understand its members' thoughts regarding the effectiveness of the RA program and suggestions for improvement. This took the form of a white paper and webinar, followed by interviews with actuarial and operational staff of selected member plans. The white paper titled "ACA Risk Adjustment: Background and Changes" provided a summary of how the risk adjustment model had changed over time. Overall the paper presented the following:

- The risk score components have changed from 2015 to 2019. Holding constant demographic and morbidity changes, the paper found that the risk scoring model has shifted more weights towards conditions than demographic factors. This means that risk scores are being more heavily influenced by conditions rather than age and gender.

- The paper highlighted changes to the risk adjustment model, namely the inclusion of duration factors, and the inclusion of prescription drugs. The inclusion of duration factors resulted from a recognition of a real phenomenon (because of the time lag between coverage start date and provider visits which result in coding of diagnoses, these factors recognize that shorter duration enrollees often do not have complete capture of existing diagnoses). Additionally, the inclusion of prescription drugs should improve the model's ability to capture diagnoses and severity. It will be important to monitor whether these changes, as well as the yearly coefficient changes, improve the model in terms of adequately compensating issuers for the cost of their enrollees.

- The paper also provided summaries of how the risk adjustment transfer formula has changed, such as adjustment in 2018 to reduce statewide premium amounts by 14% to account for fixed administrative costs and the inclusion of high cost claims pooling.

- Finally, the paper discussed the upcoming effect of risk adjustment data validation (RADV) on risk adjustment transfers and premiums. CMS updated the RADV methodology in 2018 and implemented the changes in its 2016 pilot study. The updated methodology categorizes HCCs by their respective failure rate buckets (low, medium, and high) and will use a 95% confidence interval to determine if issuers' RADV results are deemed an outlier. If an issuer is deemed an outlier, its risk scores will be adjusted as a result of the RADV program. While CMS' updated methodology is expected to reduce the impact, RADV is still expected to have an impact. Moreover, while there is some level of inherent uncertainty within the broader program, the introduction of RADV into the risk adjustment program is expected to introduce a new level of uncertainty into transfers. Carriers will now be expected to project not only how their level of actuarial risk compares to the market average but also how coding inaccuracies in their enrollees' records and those of other issuers in the market will affect transfers. Subsequent to our interviews, CMS released the 2020 Notice of Payment and Parameters, in which they made an adjustment to the timing of the RADV transfer adjustments but not the methodology for determining error rates. CMS released the RADV results in August of 2019.[2] The results show that the RADV program adjusted 2018 risk transfers for 49% of issuers in the individual market and 70% of issuers in the small group market respectively.

The white paper in Appendix A was distributed to AHIP member plans and served as pre-reading for the RA webinar that Wakely presented along with AHIP. Actuarial and operational staff from all AHIP member plans were invited to participate on the webinar. In addition to discussing the key points of the

[2] https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/BY2017-HHSRADV-Adjustments-to-RA-Transfers-Summary-Report.pdf

white paper, the webinar served as a forum for answering participant questions and gathering input on participants' general thoughts on RA program effectiveness.

Following the release of the white paper, Wakely began working on the second phase of the project. This phase involved using interviews to gather specific feedback from AHIP members on RA. Wakely designed semi-structured questions for member response and discussion. Each phone discussion lasted approximately one hour. We engaged the participants on the following:

- Overall assessment of how well RA worked
- Thoughts on the RADV program
- Recommendations for changes or modifications to the program
- Discussion of RA predictability and how the company evaluates transfers
- Other operational or regulatory challenges

AHIP selected specific member plans representing a broad cross-section of its membership for the interviews. In all, we conducted interviews with approximately a dozen member plans, including Blue Cross Blue Shield organizations, national carriers, and issuers with more limited service areas. These companies included organizations with broad and narrow provider networks.

Summary of Observations

Overall Findings

Generally, most of those interviewed thought the risk adjustment program was working well and recent methodology changes (usage of EDGE data in calibration, duration factors, Rx inclusion) moved the program in a positive direction. Most generally agreed that transfers were directionally correct. Disagreements on the methodology tended to be on the magnitude of transfers (some felt they were too high, others too low). For example, most members thought the inclusion of a duration factor and prescription drugs improved the model. There were mixed responses in the ability of actuaries to appropriately estimate risk adjustment transfers; however, most seemed to agree that it is easier now to estimate RA transfers than it was in the initial years of the program. There were some concerns expressed that appear to reflect the circumstances of particular issuers. We have included these below under the topic of possible improvements.

RADV Program

Implementation of the RADV program generated a lot of discussion and member plan concerns during the interviews. While there was strong consensus about the necessity of validating diagnoses and other elements of EDGE data, many believe changes to the program are needed. Issuers expressed concerns about the uncertainty and lack of predictability associated with the RADV program as currently defined. There were similar concerns with how results from RADV could significantly impact risk adjustment payment transfers for insurers. Many issuers raised the concern of the difficulty of getting providers to submit necessary data for validation. There was a good deal of concern over the outlier approach of

RADV (i.e., minor coding differences result in huge differences since only small changes in errors may shift an issuer over the outlier threshold). Many issuers felt this introduced instability into the program.

Specific concerns by members interviewed included:

- The requirements of the RADV program are onerous and administratively costly. There is wide variation in the ability of issuers to justify coded diagnoses because of the required provider cooperation in providing the necessary records. Additionally, there are few, if any, incentives for providers to supply this information. Instances where a provider does not provide the information are counted as errors, which several felt to be inappropriate.
- The transfer adjustments are associated with years for which premiums are already set.
- Issuers with no errors are impacted (errors should only impact offenders).
- Generally, there were several comments that "there are better ways to detect bad actors".
- Many members expressed concerns that RADV results could create volatility and uncertainty, which may put upward pressure on premiums through increased risk margins and more conservative assumptions.

Findings and Observations

Many felt the existing risk adjustment model can be improved. While issuers seem to agree that the risk adjustment model has improved, some concerns continue to be raised and many also felt additional changes are necessary to further strengthen and improve the program.

Specific concerns by members interviewed included:

- Within State Variation. A few issuers expressed concerns that the methodology did not adequately account for variation in markets and costs within each state. Some issuers suggested that risk adjustment could operate at the rating area level or regionally. However, most plans supported the use of a statewide average premium in calculating transfer amounts.
- Between State Variation. A few issuers mentioned that singular national calibration of a model resulted in costs not being effectively measured for an individual state. Some respondents thought more effort to create regional or state-specific models would be helpful.
- Adequacy of Transfers. Some issuers expressed concern that transfer amounts associated with some conditions were not adequate to cover costs. Also, some indicated that there were some conditions that appeared to overcompensate issuers.
- Overcompensation of Transfers. Some issuers expressed concern that transfer amounts were overly compensating for certain conditions. For example, one member expressed concerns that the combination of state reinsurance programs on-top of risk adjustment payments overcompensated some plans.

- Coding and Capture. Some issuers expressed concern that coding and capture was distorting RA transfers (i.e., the model was capturing differences in operational excellence rather than health differences). One issuer suggested including an upcoding adjustment into the methodology.

- Caution about RXCs. In 2018, CMS introduced RXCs as a way of better capturing actuarial risk through the presence of prescription drugs. One interviewee raised concern that RXC-related coefficients reflect pre-rebate prices. Lag times mean that they also do not reflect changing prices in drugs (especially those that have become less expensive).[3]

- Inclusion of More RXCs. Several respondents thought that expansion of RXCs was appropriate to better measure morbidity. While some respondents acknowledged the concern that RXCs could induce additional utilization, many felt additional drug categories could be included.

- Quality Improvement. The RA model currently does not have an explicit quality improvement factor. One interviewee suggested a specific factor could be included to better capture quality improvement activities.

Importance of Consistency and Predictability

One of the most common themes among interviewees is the importance of RA being predictable. From a policy and administration perspective, this means striking the right balance in terms of instituting improvements to improve payment accuracy while maintaining predictability and consistency in program operations. Consequently, most issuers felt that any change to the methodology should be appropriately signaled in advance and phased in so that issuers can accurately estimate the results.

Recommendations

As mentioned earlier, the diverse perspectives gleaned from these interviews offer important insights into the performance of the risk adjustment program and potential improvements. While there was not consensus on all issues, a number of key themes did emerge and plans identified a number of recommendations to improve and strengthen the program. Of particular importance was consistency and predictability of the program. The most common theme mentioned by issuers was the importance of understanding the impact of the methodology and being able to include expected transfers into premiums.

- RADV Improvements Needed. While there was not consensus as to what methodology would be appropriate, there was general consensus that the current methodology may not be working as intended. Furthermore, there was a consensus that greater input by the issuer community would benefit the RADV program. In particular, several members supported a joint CMS/industry workgroup to raise topics and address the issue. Subsequent to the interviews, CMS announced stakeholder engagement sessions and a forthcoming White Paper on the topic.

- Continued evaluation of RXCs. There was support, albeit not unanimous, to expand the number of RXCs. Multiple members thought it appropriate to examine the effects of RXCs to see if changes are necessary. There was general support for continuing to assess the use of RXCs

[3] Please note this interview was completed before the release of the Final 2020 Payment Notice. Hepatitis C RXC was adjusted in the final 2020 Payment Notice to account for this issue.

including the need to expand the specific drugs used, adjustments for new drugs, and repricing or removing of older drugs to reflect changes in the market.

- Operational Considerations. A few issuers wished to see changes in operational aspects of risk adjustment. These included:
    - Additional interim data (i.e., release of baseline data) would be helpful for many issuers as would the earlier release of the results to assist with predictions of payments and receivables. However, this was not universal as at least one interviewee felt that the interim data (given the opaqueness of its completeness) was more harmful than helpful. Greater timeliness in the release of business rules and software releases would help the process.
    - Addressing problems with Plan ID rejections in the early stages of the EDGE data submission cycle would be beneficial. This is possibly due to the timing of updates to the master Plan ID reference table used by CMS/EDGE. Plan ID rejects prevent the EDGE system from running other data checks leading to delay in flagging other data issues and the ability for the issuer to research such issues.
    - Improved timeliness in the release of protocols, business rules and software releases would help issuers with their management and prioritization of business and technical resources. For example, one issuer recommended:
        - CMS should implement earlier release of the RADV protocols. Currently, the protocols are released about the same time as the IVA itself begins. There is advance work that both the issuers and IVAs are doing to prepare for the beginning of the audit and earlier release of the RADV protocols would enable issuers and IVA's to hit the ground running when the samples are available and the audit officially begins.
        - Complete business rules should be released to issuers at least 8 weeks before any system release.
        - CMS should provide at least a 30-day advanced notice for any upcoming software releases.
        - CMS should continue to keep the number of unplanned releases to a minimum as they've done recently.
    - Greater transparency in communications would be helpful. While CMS makes a number of documents via REGTAP available, in the webinars, there are questions that CCIIO instructs issuers to take offline directly with the help desk for further research and a response. To the extent this is not done already, those questions and answers that are likely to be helpful to the broader issuer community should be made available via REGTAP FAQs.

Conclusion

This project was designed to gather AHIP member thoughts and opinions on the risk adjustment program. Over multiple months, productive and informative hour-long conversations were held with approximately a dozen members. Overall, most respondents thought the program, at least directionally, was transferring funds appropriately. There was consensus that the program is working as intended but most also agreed that further improvements would enhance the program and its goal of stabilizing the market. Most felt that further methodological changes should focus on increasing the accuracy of the magnitude of transfers. However, most felt that the changes should be incremental as to allow for members to be able to accurately understand how the policy changes will influence bottom lines and appropriately incorporate the changes into premiums. There was minimal support for large changes (e.g., revisiting statewide average premiums, directly curtailing payment transfers, etc.) as most felt that would increase uncertainty and instability in the market.

Important Considerations Involved with this Report

This report describes Wakely's Risk Adjustment engagement with AHIP and, especially, summarizes the findings of interviews with actuarial and operational staff of selected AHIP member plans. This engagement involved no actuarial assumptions or projections, other than presenting material previously developed and published by Wakely regarding estimated impact of RADV, and the impact of RA changes over time. As such, this report should not be considered an actuarial communication within the scope of Actuarial Standards of Practice. Including ASOP 41, "Actuarial Communications."
With that being noted, there are important considerations and limitations associated with this report.

Al Bingham and Chia Yi Chin are the actuaries responsible for this work and report. They are both, Members of the American Academy of Actuaries and are Fellows or Associates of the Society of Actuaries. They meet the Qualification Standards of the American Academy of Actuaries to issue this report. Michael Cohen, PhD is the policy consultant responsible for this work and report.

Scope of Services. The scope of Wakely's services is described in this report. Wakely's work is limited to consulting services. Wakely is not providing accounting or legal advice.

Intended Users. This information has been prepared for the sole use of AHIP and cannot be distributed to or relied on by any third party without the prior written permission of Wakely. This information is confidential and proprietary.

Risks and Uncertainties. There are no actuarial assumptions or projections associated with the findings and other information included in this report. The regulations that impact risk adjustment and issuer responses do change regularly, and users of this report should be qualified to use it and understand the results.

Conflict of Interest. The responsible actuaries and policy consultant are financially independent and free from conflict concerning all matters related to performing the actuarial services underlying this analysis. In addition, Wakely is organizationally and financially independent to AHIP.

Data and Reliance. We have relied on others for information used in the assignment. Given the nature of the assignment, we have not attempted to verify the accuracy of the information provided by the interviewees.

Subsequent Events. Subsequent to the conclusion of our interviews, CMS released the final 2020 Notice of Payments and Parameters. This contained their latest guidance and decisions related to the RADV program. Given this information, AHIP member issuers may have additional thoughts on RADV.

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ATTACHMENT A

ACA Risk Adjustment: Background and Changes

November 29, 2018

Executive Summary

A key element of the Affordable Care Act (ACA) is the permanent risk adjustment program. The risk adjustment (RA) program compensates individual and small group issuers that enroll higher than average risk enrollees by transferring funds to them from issuers that enroll lower than average risk enrollees. This program was necessary because the ACA's market reform rules such as guaranteed issue, community rating, and the ending of medical underwriting, resulted in increased financial risk for issuers that enrolled sick individuals. The goal of RA is to remove incentives for issuers in the individual, small group and merged markets to avoid enrolling people with higher cost health conditions. It is instead designed to encourage issuers to compete on quality and remove cost inefficiencies.

Since its implementation in 2014, the ACA risk adjustment program has resulted in transfers of funds from issuers with lower average risk enrollees to those with higher average risk enrollees. The total amount transferred under the RA program as a percentage of total premium revenue has remained relatively stable in both the individual and small group markets from 2014 through 2017. This stability is observed despite numerous changes to the program that were made in an attempt to strengthen the correlation between health risk and transfer amounts. Some of the most impactful changes made were the inclusion of enrollment duration and pharmacy factors, and the implementation of a high-cost risk pooling reinsurance program to reimburse issuers for high individual claims costs. Other changes scheduled to take effect in coming years include the use of actual ACA experience data to develop risk adjustment coefficients, the implementation of a risk adjustment data validation (RADV) program to confirm the accuracy of issuers' RA data submissions, and granting states the authority to reduce RA transfer amounts by up to 50%.

The US Department of Health and Human Services (HHS) will likely continue to refine the RA program in future years as more data becomes available. It will be important for all stakeholders to keep a close eye on emerging experience in the RA program and consider the potential impact of future changes.

Risk Adjustment Fundamentals

As noted above the RA program under the ACA is a permanent program that began in 2014. The RA program is intended to protect issuers operating in the individual and small group markets both inside and outside of the Exchange if they attract a higher than average health risk. This is done by transferring funds from issuers with relatively lower actuarial risk to plans that have relatively higher actuarial risk within a state and market. Risk adjustment is a necessary component of a functioning health insurance market that requires guaranteed issue, prohibitions for medical underwriting, and waiver of coverage for pre-existing conditions. To implement the RA program, HHS designed a methodology that is based on a goal that premiums should reflect differences in benefits, quality, and efficiency, but not health status. The risk adjustment methodology has two components: the risk adjustment model and the risk adjustment transfer formula. Unlike the Medicare Advantage risk adjustment program, ACA risk adjustment is designed so that the transfers are budget neutral for the Federal government.

The HHS risk adjustment model calculates a plan liability risk score (PLRS) which measures the average actuarial risk of an individual or small group in an issuer's population and is intended to reflect the costs to the issuer of covering services related to the enrollees' medical conditions. It does so by first calculating a PLRS for each individual and small group covered by the issuer using demographic and diagnosis data.

For adult members, this calculation is performed by applying metal level-specific coefficients to each member based on their age, gender, hierarchical condition categories (HCCs), number of enrolled months in the benefit year, and pharmacy condition categories (RXCs). A member's HCCs and RXCs are determined by reviewing their medical and pharmacy claims data and mapping their ICD-10-CM codes to the corresponding HCCs and mapping their National Drug Codes (NDCs) to the corresponding RXCs using crosswalks[4] provided by HHS. The calculation of PLRS values for children and infants differs slightly from the PLRS calculation for adults. For example, enrollment duration and prescription drug data are not considered when calculating PLRS values for children and infants.[5] Risk adjustment occurs separately for the individual and small group markets.

The issuer's total PLRS is then calculated for each state and market as an enrollment-weighted average of all enrollees' risk scores in that market. The risk scores are then adjusted at the state-market-risk pool level to calculate a relative risk score, which compares the issuer's risk scores to their respective state and market's average risk.

The risk adjustment transfer formula uses the relative risk score as an input to determine which issuers receive risk adjustment payments and which issuers are charged. The transfers are designed to eliminate health risk differences in premiums. Consequently, the formula takes into account allowed premium variation. The formula calculates premiums with risk selection (as measured by the risk score) and premiums without risk selection (which takes into account actuarial value (AV) and allowable rating factor (ARF). The formula multiplies the difference in these two values by the state average premium. By scaling

[4] HHS periodically provides updated crosswalks and additional guidance on their Regulation and Guidance page

[5] More information on how risk scores are calculated for children and infants can be found on pages 14-17 of "The HHS-HCC Risk Adjustment Model for Individual and Small Group Markets under the Affordable Care Act"

to the state average premium the formula balances payments and charges and therefore is budget neutral for the Federal government.

More formally, the risk adjustment methodology can be summarized with the following mathematical equation:

$$\text{HHS Transfer formula: } T_i = \left[\frac{PLRS_i \times IDF_i \times GCF_i}{\sum_i (s_i \times PLRS_i \times IDF_i \times GCF_i)} - \frac{AV_i \times ARF_i \times IDF_i \times GCF_i}{\sum_i (s_i \times AV_i \times ARF_i \times IDF_i \times GCF_i)}\right] \overline{P_s}$$

Where:
$\boldsymbol{T_i} =$ Transfer for issuer i
$\overline{\boldsymbol{P_s}} =$ State Average Premium
$\boldsymbol{PLRS_i} =$ Issuer i's plan liability risk score
$\boldsymbol{IDF_i} =$ Issuer i's induced demand factor
$\boldsymbol{ARF_i} =$ Issuer i's allowable rating factor
$\boldsymbol{AV_i} =$ Issuer i's metal level actuarial value
$\boldsymbol{GCF_i} =$ Issuer i's geographic cost factor
$\boldsymbol{s_i} =$ Issuer i's share of State enrollment, and the denominator is summed across all issuers in the risk pool in the market + state

Summary of RA Transfers

Table 1 below shows the absolute value of transfer amounts and as a percentage of total premium for each year from 2014 through 2017. Since risk adjustment transfers are tied to the aggregate amount of premiums, when premiums or enrollment increase, holding constant methodological changes, the aggregate risk adjustment payments (or charges) also increase. Total transfers as a percentage of premium have remained fairly stable for the individual and small group markets with approximately 10% of individual market premiums being transferred and 5% of small group premiums being transferred. The higher transfer amounts in the individual market reflect the greater risk selection between issuers.

Table 1: Risk Adjustment Transfer Amounts by Year

Market	Total Net Transfer ($ Billions)				As % of Premium			
	2014	2015	2016	2017	2014	2015	2016	2017
Individual[6]	$3.50	$5.61	$7.19	$7.55	10%	10%	11%	10%
Small Group	$1.13	$2.16	$2.68	$2.58	6%	6%	6%	5%

When reviewing the results in all the tables in this document, it is important to consider that 2014 may not be comparable to other years. 2014 was the first year for the EDGE data collection process in which issuers submitted their premiums, claims, demographic, and diagnoses data. As such, many issuers

[6] The Individual market transfers include transfers associated with the catastrophic market. Catastrophic plans are risk adjusted separately from the rest of the individual market. Merged Markets are also included as part of the individual market.

experienced considerable difficulties compiling the data, often resulting in significant impacts on transfers. This was largely corrected in 2015 and later years. Additionally, since 2014, many issuers have implemented programs and processes to improve their diagnosis capture and reporting, which has impacted their PLRS. These differences, combined with changes in the risk adjustment coefficients and formula over time (as we describe in the next section), mean that the yearly results are not directly comparable. Most importantly, because of this, the yearly changes do not accurately measure the overall change in risk pool morbidity.

A lot has been written and discussed about the adequacy of the risk adjustment transfers associated with a given condition. It is important to note that the actual transfer amounts, as shown in the formula, are directly related to the state average premium. There have been situations, especially in the first year of the ACA, in which the state average premium proved to be inadequate and resulted in low risk transfers in terms of dollars. Risk adjustment transfers are also, by nature, not intended to be adequate to fully compensate for extremely large (outlier) claims.

How has the RA Model Changed Since 2014?

HHS publishes the risk adjustment methodology for the forthcoming benefit year annually in the notice of benefit and payment parameters (NBPP). As part of the regulatory process, HHS solicits feedback from the public on the methodology. In addition, HHS solicits feedback regarding potential changes to the risk adjustment program several times per year in other venues. HHS has made changes to the risk adjustment methodology each year, although some years reflect more significant changes than others. Below is a list of changes to the risk adjustment model for each year since 2014. Many changes have been the result of input from issuers, industry associations, and the actuarial profession.

2015 Benefit Year

HHS did not make any structural changes to the RA model for the 2015 benefit year. In the 2015 NBPP, HHS confirmed that they would apply the same induced utilization factors to the risk scores of members enrolled in premium assistance Medicaid alternative plans as they used for members enrolled in the corresponding cost-sharing plans.

ICD-10 was implemented on October 1, 2015. Therefore, a new mapping of diagnosis codes to condition categories (CCs) were introduced for all claims starting October 1, 2015.

2016 Benefit Year

HHS recalibrated the RA model coefficients for the first time to reflect more current data and trends. The 2016 HCC coefficients were calculated as an average based on 2011, 2012, and 2013 MarketScan data. This is in contrast to the 2014/2015 model coefficients, which were calculated based only on 2010 MarketScan data. As seen in Table 2 and Table 3 below, this recalibration resulted in lower raw risk scores and an increase in the percentage of total risk score represented by HCCs in 2016 compared with 2015.

HHS also finalized a change in how age 0 infants with no birth HCCs were to be classified in the model; stating that age 0 infants with no birth HCCs should be assigned to age 1 by severity level. Additionally, HHS constrained the coefficients for six transplant statuses other than kidney in the child model.

2017 Benefit Year

Similar to the 2016 benefit year, HHS recalibrated the RA model coefficients based on a blend of 2012, 2013, and 2014 MarketScan data. The model coefficients were also adjusted to reflect preventive services. HHS commented in their March 2016 RA white paper,[7] "Adjusting for preventive services increases age-sex coefficients relative to HCC coefficients, especially in the lower metal tiers (bronze and silver), and in age/sex ranges with higher preventive services expenditures (for example, young adult females)." Therefore, the preventive service adjustment to the model coefficients is likely to produce favorable transfer changes (compared to the previous model coefficients) for issuers with high-risk populations.

An enrollment duration factor (EDF) was also applied to the adult risk score calculations for 2017 to better reflect the true risk of partial year enrollees. Members are assigned an EDF based on the number of months the member is enrolled during the year and their metal level. Members with fewer months of enrollment receive a larger adjustment to their risk scores than members with more eligibility during the benefit year. The EDF component is currently limited to the adult model.

The addition of the EDF component was a result of numerous issuers experiencing higher than expected claims costs and financial losses for partial year enrollees in the initial years of the RA program. In 2017, the EDF score represented roughly 2% - 3% of the total risk score for both the individual and small group markets.

2018 Benefit Year

HHS recalibrated the RA model coefficients based on a blend of 2013, 2014, and 2015 MarketScan data. In addition to updating the RA model coefficients, HHS modified the age rating curve for children to include multiple child age bands for members aged 0 through 20. Prior to this change, all individuals between the ages of 0 and 20 received the same age rating factor.

Starting in 2018, a "high-cost risk pool" reinsurance process was embedded into the RA methodology. Under this program, issuers will be reimbursed for high cost claims. For the 2018 and 2019 benefit years high cost reimbursement parameters were set at 60% of members' paid claims above $1,000,000 in the individual, small group, and merged markets. All issuers will be assessed an additional charge based on their total membership to contribute toward these reinsurance payments. Based on an analysis performed in May 2018 through the Wakely National Risk Adjustment Reporting (WNRAR)[8] project, Wakely estimates that issuers will be assessed 0.27% and 0.30% of individual market premiums and 0.34% and 0.38% of small group market premiums to fund high-cost risk pooling payments in 2018 and 2019, respectively.

[7] https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/RA-March-31-White-Paper-032416.pdf

[8] More information on the WNRAR project can be found here: https://wramodel.com/wakelyraf/

Another important change to the RA model starting in 2018 was the inclusion of certain high-cost prescription drugs in the calculation of a member's risk score. This meant that issuers' risk scores can change based on pharmacy data. HHS made the decision to include pharmacy data in the RA model due to pharmacy data's ability to compensate for potential missing diagnoses and provide an indication of severity for a specific diagnosis. In the 2018 NBPP,[9] HHS noted several possible concerns with incorporating prescription drugs into the RA model, including:

- More frequent updates to the model could become necessary to reflect rapidly changing clinical indications for drugs.
- This change could create an incentive for providers to overprescribe certain medications.
- Health insurers in rural areas or issuers with lower prescribing rates for key medications could be attributed a lower risk score than justified by the actual health status of their population.

To address the above concerns, HHS decided to include only a small number of prescription drugs in the RA model for the 2018 benefit year and monitor whether the inclusion of these drugs in the model impacts their utilization. Depending on the results of their analysis, HHS may add or remove certain drugs from the model for future benefit years.

Lastly, HHS introduced an adjustment to the state average premium to consider that a portion of issuers' premiums represent fixed administrative costs which do not vary with claims volume or levels. The adjustment was a 14% reduction in the state average premium. Thus, all transfer amounts were reduced by 14%.

2019 Benefit Year

For the first time ever, the HHS RA model includes actual ACA data from the EDGE server. HHS recalibrated the RA model coefficients based on a blend of 2014 and 2015 MarketScan data, and also 2016 EDGE data (i.e., ACA individual and small group data). HHS also removed two conditions triggered by prescription drugs but left the remaining prescription drug coefficients in.

Impact of Model Changes on Raw Risk Scores

Starting with the 2018 benefit year,[10] an issuer's raw risk score (PLRS) is calculated as a sum of the following four components:

- Demographics score (Demo): reflects the age and gender characteristics of an issuer's population
- Hierarchical condition category score (HCC): reflects the medical claims data of an issuer's population

[9] https://www.federalregister.gov/documents/2016/12/22/2016-30433/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2018

[10] The EDF and RXC components were not included in the risk score calculation before the 2017 and 2018 benefit years, respectively. PLRS in the 2014 through 2016 benefit years was calculated as a sum of the demographic score and HCC score. PLRS for the 2017 benefit year included the EDF component but not the RXC component.

- Enrollment duration factor score (EDF): reflects the enrollment patterns of an issuer's population
- Pharmacy score (RXC): reflects the pharmacy claims data of an issuer's population

Table 2 below shows how each component of individual and small group risk scores have changed from year to year as a result of the changes in the RA model. Table 3 below displays the corresponding year-over-year percentage changes of each risk score component. The risk scores shown in the table were calculated by pulling 2017 full-year data from Wakely's National Risk Adjustment Reporting project (WNRAR) and rescoring the data under the 2015, 2016, 2018 and 2019 risk adjustment models. Consequently, Wakely is measuring how the risk adjustment model is changing, holding constant enrollment and claims data.

Table 2: Risk Score Changes by Year

Risk Score Component	Individual					Small Group				
	2015	2016	2017	2018	2019	2015	2016	2017	2018	2019
Demographics	0.426	0.389	0.307	0.293	0.242	0.449	0.417	0.338	0.313	0.267
Duration Factor	NA	NA	0.035	0.035	0.029	NA	NA	0.038	0.037	0.031
HCC (Diagnosis)	1.164	1.182	1.100	0.899	0.867	0.910	0.928	0.864	0.719	0.702
RXC (Prescription Drugs)	NA	NA	NA	0.145	0.175	NA	NA	NA	0.104	0.125
Total	1.590	1.571	1.442	1.372	1.313	1.360	1.345	1.239	1.173	1.126

Table 3: % Change in Risk Score Components by Year

Risk Score Component	Individual				Small Group			
	2015-2016	2016-2017	2017-2018	2018-2019	2015-2016	2016-2017	2017-2018	2018-2019
Demographics	-9%	-21%	-5%	-17%	-7%	-19%	-7%	-14%
Duration Factor				-18%				-16%
HCC (Diagnosis)	2%	-7%	-18%	-4%	2%	-7%	-17%	-2%
RXC (Prescription Drugs)				20%				21%
Total	-1%	-8%	-5%	-4%	-1%	-8%	-5%	-4%

These tables show the resulting change in average risk score from applying the risk adjustment model for a given year to the same set of experience data. These results do not account for changes that impacted transfers and not risk scores, such and the administrative expense adjustment to the state

average premium and high cost claims pooling described below. For example, the tables show that for the individual market, the impact of the risk adjustment model change for 2016 resulted in a 1% reduction to the average risk score. It is important to note that tables two and three **do not** show morbidity change from year to year. For example, the analyses do not show that morbidity in the individual single risk pool improved by 1% in 2016 over 2015. This is because the two years' risk adjustment models were applied to the same set of experience data.[11]

As the risk adjustment model has evolved, the composition of the risk scores (i.e. the "weight" given to each component of the risk score) has changed as shown below in Table 4. It is interesting to note that - holding constant enrollment and claims data - the demographic score continues to decrease through 2019 as a percentage of total PLRS, while the percentage of total PLRS represented by the HCC and EDF components has remained stable and the percentage of total PLRS represented by the RXC component increased from 2018 to 2019. This suggests that the risk scoring model has shifted more weights towards conditions than demographic factors.

These changes also indicate that issuers whose RXC scores account for a significantly larger portion of their total risk scores than the market will likely see their relative risk increase (i.e. experience favorable transfer changes) under the 2018 and 2019 models if membership and coding efforts remain unchanged from 2017. As a result, issuers will likely increase the attention given to their pharmacy claims coding practices going forward.

Table 4: Changes in Weight of Risk Score Components

Risk Score Component	Individual					Small Group				
	2015	2016	2017	2018	2019	2015	2016	2017	2018	2019
Demo	27%	25%	21%	21%	18%	33%	31%	27%	27%	24%
EDF	0%	0%	2%	3%	3%	0%	0%	3%	3%	3%
HCC	73%	75%	77%	66%	66%	67%	69%	70%	61%	62%
RXC	0%	0%	0%	10%	13%	0%	0%	0%	9%	11%
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

The question remains as to whether the risk adjustment model changes have or will have improved the accuracy of the model. At this point, we believe it is too early to tell. Certainly, the inclusion of duration

[11] To get an idea of how morbidity changes from one year to the next, a constant risk adjustment model should be applied to each years' experience data. The resulting risk scores will give an indication of the morbidity change (although this is not a pure measure since issuers may have improved diagnosis coding and capture, changed EDGE processes, and/or had changes in metal level composition) For a discussion of morbidity changes from 2015 through 2017, please see the study "National vs. California Comparison: Detailed Data Help Explain the Risk Differences Which Drive Covered California's Success" at https://www.healthaffairs.org/do/10.1377/hblog20180710.459445/full/

factors resulted from a recognition of a real phenomenon. Additionally, the inclusion of prescription drugs should improve the model's ability to capture diagnoses and severity. It remains to be seen if these changes, as well as the yearly coefficient changes, improve the model in terms of adequately compensating issuers for the cost of their enrollees. As mentioned elsewhere, risk adjustment coefficients are calibrated at a national level rather than local. If a state has conditions that are relatively different than the national calibration, the model may be less accurate. Also, risk adjustment transfers are directly related to the state average premium, and risk adjustment, by its nature, is not intended to fully compensate for "outlier" type claims costs. While future research may show that the model changes improved the accuracy of the risk measurement, the adequacy will likely vary by issuer.

Summary of Risk Adjustment Transfer Formula Changes

Beginning with the 2018 benefit year, HHS finalized a change[12] in the risk adjustment transfer formula to reduce the statewide premium amount by 14% to account for fixed administrative costs. This change was made to ensure that the final transfer amount more accurately reflects the risk of the issuer's population and does not vary based on market-wide administrative practices. The high-cost risk pool reinsurance process beginning in 2018 can also be considered a change to the transfer formula since issuers will be making payments to contribute to the fund and receiving reimbursements for high-cost individuals.

Please note that changes to premium development also affect risk transfers. For example, changes to the child rating factors impacted transfer amounts since the child-age rating factors influence a key component in the transfer formula (ARF).

[12] https://www.gpo.gov/fdsys/pkg/FR-2016-12-22/pdf/2016-30433.pdf

State Flexibilities

In the 2019 NBBP, HHS granted states the flexibility to dampen the level of risk adjustment transfers between plans. This is not to be confused with the ability for states to implement an approved state-specific risk adjustment methodology (an option that states have had since the beginning of the ACA, but which no state currently uses). The HHS risk adjustment methodology uses the state average premium to scale risk adjustment transfers, thus making them state specific. In the 2019 Payment Notice, HHS admits that the current methodology may require some adjustment to risk adjustment transfers to more accurately account for unique state-specific factors. HHS is allowing states to apply for a modification to the historical risk adjustment methodology to improve the accuracy of the resulting transfers. States may request that risk adjustment transfers be dampened by up to 50% in their individual, small group, or merged markets.[13]

To receive approval for the reduction, states must first identify the state-specific rules (e.g., rating rule) or market dynamic that warrants an adjustment to risk adjustment transfers. Then the state must identify the reduction percentage requested (e.g., any value up to 50%) that is appropriate given the state-specific rule or market dynamic. This can be done either through analysis that demonstrates how the transfer adjustment is warranted given the state specific factors or it must show that the adjustment is estimated to have an impact so small that it will have a de minimis effect (less than 1%) on issuers who receive risk adjustment payments. To date no state has publicly made the request for such an adjustment.

Other Changes – RADV

In the 2019 NBBP, HHS released updated details for the methodology and calculations used in the risk adjustment data validation (RADV) program. The RADV program aims to ensure consistency in the accuracy of chart coding by issuers nationally.

The validation process requires each issuer to engage an independent auditor to perform the initial validation audit (IVA). A random sample of 200 members are chosen through the EDGE server for the IVA. Once the IVA is completed, issuers send their results to HHS for a secondary validation audit (SVA). Then national benchmarks are established to determine the average failure rates of substantiating HCCs identified in issuer's data. Using national data, confidence intervals are also developed around the average failure rates. Through the failure rates, an error rate is computed for each issuer. The error rates are used to prospectively adjust the issuer's risk scores. For example, the 2017 RADV results will impact 2018 risk scores, therefore impacting 2018 risk transfer amounts (collected and paid in 2019).

[13] https://www.gpo.gov/fdsys/pkg/FR-2016-12-22/pdf/2016-30433.pdf-
The ability of states to have influence risk adjustment transfers under state law, as New York does.

Generally, the RADV Program timeline that first influences payments and charges is as follows:

Wakely compiled and reviewed 2016 RADV results nationally and released a whitepaper on its impact to overall market risk scores. While 2016 RADV was a pilot year, we found that 47 markets out of 61 sampled markets would have their market average risk scores adjusted if 2016 RADV results were used to adjust 2017 risk scores. After excluding outliers (as defined by HHS), we observed that 24 markets would have the marketwide average risk scores adjusted based on their RADV results.[14]

Overall, the introduction of RADV into the risk adjustment program is expected to introduce a level of uncertainty into transfers. Carriers will now be expected to project not only how their level of actuarial risk compares to the market average but also how coding inaccuracies in their enrollees' records and those of other issuers in the market will affect transfers.

Conclusion

Risk adjustment is a cornerstone of a functioning market that also uses guaranteed issue and community rating. The HHS risk adjustment methodology is designed to transfer funds from issuers with relatively low actuarial risk to issuers with relatively high actuarial risk, in a budget neutral manner. As HHS learns through experience and issuer feedback, it has continued to modify the RA methodology in order to better achieve the overall objectives of the program, which include eliminating the health status of an issuer's population as a driver of profitability. The RA program and its evolution will continue to influence issuer behavior and overall market stability.

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[14] https://www.wakely.com/blog/2016-radv-market-average-error-rates