Nationally recognized thought-leader on risk adjustment, health plan performance improvement, and population health

Actively involved in the development of risk adjustment systems for over 25 years
  - Johns Hopkins ACG Development Team, 1991-2005
  - Implemented the risk-adjusted payment system for Maryland Medicaid
  - Designed the clinical model for the first-to-market revenue management “suspecting” engine

Developer of integrated decision-support platforms coalescing quality measurement, risk adjustment, and population health metrics

Disseminator of risk adjustment and quality measurement technology and intellectual property to health plans, services vendors, and consultants
TODAY’S AGENDA

• An exploration of the myriad of reasons for exchange instability going into 2017 and 2018
• CMS response in the draft 2018 Notice of Benefit and Payment Parameters
  • How pharmacy data is being integrated into risk adjustment
  • Policy changes to reduce adverse financial impacts from members with short enrollment spells
  • Significant changes to the Risk Adjustment Data Validation process
  • Reducing opportunities for enrollee gaming by restricting Special Enrollment Periods
• Government actions outside of the formal notice–and–comment rulemaking process
After risk adjustment, risk corridor, and reinsurance (3R) payments are factored in, the health insurance industry’s aggregate pre-tax margin in the 2014 individual market was -5.2%. The aggregate post-tax margin was -4.8%, amounting to a loss of $2.7 billion nationwide.

Issuer-specific characteristics were the strongest predictors of better-than-average financial performance, rather than system-wide geographic or regulatory factors.

- HMOs performed better than PPOs
- Narrow networks and

Although the evidence is rather weak, geographic variation in financial performance was probably augmented by:

- the allowance of transitional policies
- enrollment trends (more is better)
- silver-plan price dispersion (less is better).
• Risk corridor “shenanigans”
  • The $2.7 after-tax loss is almost identical to the amount of risk corridor funds denied to the issuers

• Provider network type
• PPO and other unmanaged benefit designs failed to perform
• Industry markedly underpriced individual coverage
• CO-OP disasters
In late 2013, many health insurers began cancelling existing health insurance policies that were not compliant with the new ACA market rules. The cancellation of these policies created significant political chaos, as many people had believed that the ACA would not cause them to lose their existing coverage. Insured members in the pre-2014 individual market were either paying a large premium with a significant deductible (because they had been sick or were older) or a lower premium for a policy that probably didn’t cover much. About 5 percent of the population or somewhere between 7 and 12 million people who had individual policies were impacted by these cancellations.
UNINTENDED CONSEQUENCES ARE WHAT HAPPENS WHEN POLITICS TRIES TO DRIVE PUBLIC POLICY!

And that means that no matter how we reform health care, we will keep this promise to the American people: If you like your doctor, you will be able to keep your doctor, period. If you like your health care plan, you'll be able to keep your health care plan, period. No one will take it away, no matter what.

— Barack Obama —
On November 14, 2013, CMS responded by announcing a “transitional policy” designed to curb the cancellation of existing policies:

- Any coverage in effect on October 1, 2013 was not considered noncompliant for failure to comply with certain ACA reforms that otherwise became effective on January 1, 2014.
- Transitional policy as originally crafted was intended to operate for one year.
- Transitional policy removed millions of potential members from the ACA exchange market, most of whom would have been relatively healthy, low cost enrollees.
- Transitional policy was enacted after the issuers had set their rates for plan year 2014.
The Administration gave states the option of letting insurers continue individual and small group plans that would otherwise have been cancelled in 2014, because they did not comply with ACA standards, until October 1, 2017.

31 states have allowed issuers to extend these plans in the individual and small-group markets through the end of 2017.

- California and West Virginia allow grandmothered plans to continue in the small-group market only.

It is estimated that 1.2 million people remain enrolled in these products.
In a recent study, the Urban Institute compared unsubsidized 2016 Marketplace premiums with average premiums for employer sponsored insurance (ESI), after adjusting for differences in actuarial value and age distribution. The key findings were:

- Nationally, the average second-lowest-cost silver plan was 10 percent lower than the average 2016 ESI premium using the actuarial value, utilization, and age-distribution adjustments.

- 39 states had lower Marketplace premiums than comparable ESI coverage. The exceptions are Alaska, Arkansas, Delaware, Georgia, Louisiana, Missouri, Nebraska, North Carolina, South Dakota, Vermont, West Virginia and Wyoming.

- Given substantial 2017 premium increases by Marketplace issuers, ESI premiums may actually now be lower, but not by much.
  - ESI enrollees may not be as sick as Marketplace enrollees.
The Three R’s: Risk Adjustment, Reinsurance, and Risk Corridors
ONE “R”: RISK ADJUSTMENT

Risk Adjustment Under the Affordable Care Act

Low Risk Individual and Small Group Plans
- Funds collected from non-grandfathered plans, both inside and outside of the exchange

Federal or State Risk Adjustment Program
- Federal government provides methodology
- States operating exchanges may deviate from the federal methodology with approval

High Risk Individual and Small Group Plans
- Funds redistributed to participating plans based on average actuarial risk

Source: Kaiser Family Foundation
THE SECOND “R”: REINSURANCE

Reinsurance Under the Affordable Care Act

All Health Insurance Issuers and Self-Funded Group Health Plans
- Contribution funds are collected on a per capita basis.

Federal or State Reinsurance Program
- HHS collects funds from insurers and administers the program even if it is state-run.

Individual Market Plans (subject to new market rules) with High-Cost Enrollees
- Payments made to plans with high cost enrollees (above an "attachment point" and up to a maximum)

Source: Kaiser Family Foundation
THE THIRD “R”: RISK CORRIDORS

Risk Corridors Under the Affordable Care Act

Qualified Health Plans (QHPs) with lower than expected claims
- Plans with lower than expected claims (relative to premiums, administrative costs) are charged

Federal Risk Corridors Program
- Federal government administers the risk corridor program

QHPs with higher than expected claims
- Plans with higher than expected claims (relative to premiums, administrative costs) receive payment

Source: Kaiser Family Foundation
REGULATORY AND SUB-
REGULATORY RESPONSES
In an effort to begin the process of stabilizing the Marketplace risk pools, CMS issued its proposed Benefit and Payment Notice (NBPP)

- Pharmacy data will be incorporated but in a very limited way
- Adjustments for short-term enrollees
- Initial reform to the problem caused by third-party premium payers
- Allows a broader actuarial value for Bronze plans

The NBPP was released several months earlier than usual (8/31/2016)

In addition, record amounts of sub-regulatory guidance is being promulgated to deal with other pressing issues negatively impacting issuers

In addition, there have been some key statutory changes
• The risk corridors program is one of three premium stabilization policies under the ACA
  • Risk corridors are intended to smooth and reduce risk to health insurers during the first three years of ACA implementation
  • Unlike risk adjustment, risk corridors are transitional; only in effect through the end of CY2016
  • The program is designed to reduce the amount of gains and losses to health care plans by requiring plans with higher than expected profit margins to remit profits above a certain threshold to the government
    • The government, in turn, will reimburse plans that prove to be less profitable
PAYMENT METHODOLOGY. —

(1) Payments out. — The Secretary shall provide under the program established under subsection (a) that if —

A) a participating plan’s allowable costs for any plan year are more than 103 percent but not more than 108 percent of the target amount, the Secretary shall pay to the plan an amount equal to 50 percent of the target amount in excess of 103 percent of the target amount; and

B) a participating plan’s allowable costs for any plan year are more than 108 percent of the target amount, the Secretary shall pay to the plan an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of allowable costs in excess of 108 percent of the target amount.
MEDICARE PART D RISK CORRIDOR PROGRAM

Part D Risk Corridor Program (2006-2007)

<table>
<thead>
<tr>
<th>Actual Spending Less Than Expected Spending</th>
<th>Actual Spending Greater Than Expected Spending</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan Keeps 20% of Gains</td>
<td>Plan Bears 20% of Losses</td>
</tr>
<tr>
<td>Plan Pays Government 80% of Gains</td>
<td>Plan Bears 25% of Losses</td>
</tr>
<tr>
<td>Plan Pays Government 75% of Gains</td>
<td>Plan Bears Government Reimburses 75% of Losses*</td>
</tr>
<tr>
<td>Plan Keeps All Gains</td>
<td>Government Reimburses 80% of Losses</td>
</tr>
<tr>
<td>Plan Bears Full Losses</td>
<td></td>
</tr>
</tbody>
</table>

Difference Between Actual Medical Spending and Target Medical Spending (as a percent of target medical spending)

*If >60% of plans fall into this category, Government share increases to 90% and Plan share decreases to 10%

Part D Risk Corridor Program (2008-2013)

<table>
<thead>
<tr>
<th>Actual Spending Less Than Expected Spending</th>
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<td>Plan Bears 50% of Losses</td>
</tr>
<tr>
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<td>Plan Keeps 50% of Losses</td>
</tr>
<tr>
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<td>Plan Bears 50% of Losses</td>
</tr>
<tr>
<td>Plan Bears Full Losses</td>
<td>Plan Keeps All Gains</td>
</tr>
<tr>
<td></td>
<td>Plan Pays Government 80% of Losses</td>
</tr>
<tr>
<td></td>
<td>Government Reimburses 80% of Losses</td>
</tr>
</tbody>
</table>

Difference Between Actual Medical Spending and Target Medical Spending (as a percent of target medical spending)

In terms of risk corridors alone, the Part D and ACA programs are remarkably similar, with the exception that the ACA risk corridors are somewhat more generous for the first three years.

- **But Part D risk corridors are permanent feature of the program, while the ACA risk corridors are a transitional strategy.**

- For plans that spend less than expected, ACA issuers keep a smaller amount of the surplus (3%), than do Part D plans.

- **Which political party created the Part D risk corridor program?**
• Of the 220 votes in favor of passing the Medicare Modernization Act, not a single Democrat voted in favor of the legislation
  • Nowadays, both parties actively support Medicare Part D and the Medicare Modernization Act
  • Final vote for passage was 220-215

• Rep. Walter Jones (R-N.C.) called the frenzy to pass the Medicare prescription drug bill in the U.S. House of Representatives the "ugliest night" he has ever seen in politics. "I've been in politics for 22 years and it was the ugliest night I have ever seen in 22 years."
• Section 227 of the Consolidated and Further Continuing Appropriations Act, 2015 (Public Law 113-235) prohibits funds from the Federal Hospital Insurance Trust Fund or the Federal Supplemental Medical Insurance Trust Fund, or transferred from other accounts funded by this Act to the Centers for Medicare and Medicaid Services—Program Management account, from being used for payments relating to the risk corridors program established by PPACA for health plans.

• As a result, risk corridors payments to insurers for the 2014 benefit year were limited to $362 million (or 12.6 percent) of the $2.87 billion requested by insurers.
• The risk corridor litigation “soap opera” continues with new twists and turns:

  • Several exchange issuers have sued in the Federal Court of Claims, claiming the statutory text of the ACA promised them the risk corridor payments
    • Congress inserted language in a “must-pass” bill that imposed budget neutrality on the program
    • Issuers are owed approximately $2.3 billion for contract year 2014; $5 billion total for 2014 & 2015
  • Although the Administration is defending the Federal government against the issues, they have made no secret of their desire to settle the case
• There is a Judgement Fund created by the Tucker Act. The fund contains infinite resources to allow the government to pay private entities that prevail in the U.S. Federal Court of Claims
  • Now the Administration appears to be backing off its stated intentions

• The House insists the Administration move to dismiss an insurer's $5 billion class complaint on the grounds that HHS has no obligation to make so-called risk corridor payments to insurers under the ACA
• Rx-based risk adjustment systems are structurally similar to diagnosis-based models but often identify less-specific conditions
  • For example, MedicaidRx has a large category of drugs mapped to “Depression”

• For the most part, Rx-based risk adjustment models are just a list of NDC codes mapped to disease categories. But, unlike diagnosis-based systems…
  • There is often a many-to-one relationship between NDC codes and diseases
    • Drugs are approved by the FDA for multiple indications
    • Off-label prescribing is common
Many stakeholders view pharmacy claims data as the solution to their risk adjustment woes

- They are likely to be disappointed!
- Many exchange issuers that are failing are blaming the lack of an Rx-component to risk adjustment

CMS’ “go-slow” approach to the integration of pharmacy data is the right solution

- Situations like Hepatitis C treatment with Sovaldi are perfect applications for prescription drug data
- But the exception does not prove the rule!
THE STRUCTURE OF AN NDC CODE

NDC 0777-3105-02

- Distal Products
- Prozac Capsules 20mg
- Total 100
THE SAME DRUG CAN HAVE MULTIPLE NATIONAL DRUG CODES

<table>
<thead>
<tr>
<th>NDC Codes</th>
<th>NDC Descriptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>99073070827</td>
<td>FreeStyle Lite Test Strips- 100 ct</td>
</tr>
<tr>
<td>99073070822</td>
<td>FreeStyle Lite Test Strips- 50 ct</td>
</tr>
<tr>
<td>99073070819</td>
<td>NFRS FreeStyle Lite Test Strips 50 ct</td>
</tr>
<tr>
<td>99073071230</td>
<td>NFRS FreeStyle InsulinX Test Strips 50 ct</td>
</tr>
</tbody>
</table>
RISKS OF USING PHARMACY DATA FOR RISK ADJUSTMENT

• **RISK #1:** Linking drug utilization to specific diagnoses can be challenging
  • Many drug therapeutic classes are used for multiple clinical conditions
  • The diagnostic indications for drugs can change and expand or contract over time
  • Physicians can prescribe drugs “off label” as they deem medically appropriate

• **RISK #2:** The National Drug Code (NDC) system is much more fluid than diagnosis codes—FDA makes changes are frequently as weekly!

• **RISK #3:** NDC codes are created by the manufacturers
  • Most drugs have multiple NDC codes, sometimes even hundreds of NDCs
CMS created a parsimonious set of Prescription Drug Categories (RXCs). A subset of National Drug Codes are mapped to these RXCs. Each RXC can either:

- impute (substitute for) missing diagnoses; and/or
- serve as a severity indicator for a specific diagnosis

For 2018, CMS is proposing nine RXCs to operate as imputation/severity RXCs, and two additional RXCs that will be severity only
### Drug-Diagnosis Pairs for Both Imputation and Severity Adjustment

<table>
<thead>
<tr>
<th>RXC</th>
<th>RXC Label</th>
<th>HCC</th>
<th>HCC Label</th>
<th>Proposed RXC use</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Hepatitis C Antivirals</td>
<td>037C, 036,</td>
<td>Chronic Hepatitis C, Cirrhosis of Liver, End-Stage Liver Disease, and Liver</td>
<td>imputation/severity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>035, 034</td>
<td>Transplant Status/Complications</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>HIV/AIDS Antivirals</td>
<td>001</td>
<td>HIV/AIDS</td>
<td>imputation/severity</td>
</tr>
<tr>
<td>3</td>
<td>Antiarrhythmics</td>
<td>142</td>
<td>Specified Heart Arrhythmias</td>
<td>imputation/severity</td>
</tr>
<tr>
<td>4</td>
<td>End Stage Renal Disease</td>
<td>184, 183,</td>
<td>End Stage Renal Disease, Kidney Transplant Status, Chronic Kidney Disease,</td>
<td>imputation/severity</td>
</tr>
<tr>
<td></td>
<td>(ESRD) Phosphate Binders</td>
<td>187, 188</td>
<td>Stage 5, Chronic Kidney Disease, Severe (Stage 4)</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Anti-inflammatories for</td>
<td>048, 041</td>
<td>Inflammatory Bowel Disease, Intestine Transplant Status/Complications</td>
<td>imputation/severity</td>
</tr>
<tr>
<td></td>
<td>inflammatory bowel disease (IBD)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6a</td>
<td>Anti-Diabetic Agents,</td>
<td>019, 020,</td>
<td>Diabetes with Acute Complications, Diabetes with Chronic Complications,</td>
<td>imputation/severity</td>
</tr>
<tr>
<td></td>
<td>Except Insulin and</td>
<td>021, 018</td>
<td>Diabetes without Complication, Pancreas Transplant Status/Complications</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Metformin Only</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6b</td>
<td>Insulin</td>
<td>019, 020,</td>
<td>Diabetes with Acute Complications; Diabetes with Chronic Complications;</td>
<td>imputation/severity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>021, 016</td>
<td>Diabetes without Complication, Pancreas Transplant Status/Complications</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Multiple Sclerosis Agents</td>
<td>118</td>
<td>Multiple Sclerosis</td>
<td>imputation/severity</td>
</tr>
<tr>
<td>8</td>
<td>Immune Suppressants and</td>
<td>056, 057,</td>
<td>Rheumatoid Arthritis and Specified Autoimmune Disorders, Systemic Lupus</td>
<td>imputation/severity</td>
</tr>
<tr>
<td></td>
<td>Immunomodulators</td>
<td>048, 041</td>
<td>Erythematosus and Other Autoimmune Disorders, Inflammatory Bowel Disease,</td>
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</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Intestine Transplant Status/Complications</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Cystic Fibrosis Agents</td>
<td>159, 158</td>
<td>Cystic Fibrosis, Lung Transplant Status/Complications</td>
<td>imputation/severity</td>
</tr>
</tbody>
</table>
### DRUG–DIAGNOSIS PAIRS FOR SEVERITY ADJUSTMENT ONLY

<table>
<thead>
<tr>
<th>RXC</th>
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<th>HCC</th>
<th>HCC Label</th>
<th>Proposed RXC use</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>Ammonia Detoxicants</td>
<td>036, 035,</td>
<td>Cirrhosis of Liver, End-Stage Liver Disease, Liver Transplant</td>
<td>severity-only.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>034</td>
<td>Status/Complications</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Diuretics, Loop and Select</td>
<td>130, 129,</td>
<td>Congestive Heart Failure, Heart Transplant, Heart Assistive Device/A</td>
<td>severity-only.</td>
</tr>
<tr>
<td></td>
<td>Potassium-Sparing</td>
<td>128</td>
<td>Artificial Heart</td>
<td></td>
</tr>
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</tr>
</tbody>
</table>
THIRD PARTY PAYMENTS: GREAT IDEA, BUT IN PRACTICE…

• In 2014, third-party payments were described as an, “innovative strategy where private organizations help pay for premiums and out-of-pocket costs for consumers enrolled in marketplace coverage.”

• But by 2016, one Medicaid MCO described third-party payments as, “paying existing private or group health insurance premiums for members with existing high-cost medical conditions. Purchasing health coverage for these members helps shift the cost of their medical care to the other insurance carrier, allowing CenCal Health to limit its financial exposure to only the monthly insurance premiums.”
THE GENESIS OF THIRD PARTY PAYMENTS

• Third party payments were first raised on 10/31/2013 when HHS informed Congress that QHPs were not federal health care programs and thus presumably were not subject to the anti-kickback laws, which generally prohibit payments by providers for business
  • This raised the possibility that hospitals or other providers could pay premiums for QHP enrollees to keep them insured and the hospitals’ bills covered. This possibility was attractive to hospitals, which could often at minimal expense help high-cost, low-income patients cover their hospital bills through health insurance
• The guidance issued by CMS allows third-party payments if they are made on behalf of QHP enrollees that are based on financial status and do not consider enrollees’ health status. The premium and any cost sharing payments must cover the entire policy year.
THIRD PARTY PAYMENTS AND UNINTENDED CONSEQUENCES

- Blue Shield of California alleged in a lawsuit that CenCal transferred 40 ESRD members on dialysis into Blue Shield individual commercial plans. CenCal targeted its sickest members and advertised the scheme to providers who would benefit from higher rates for these members, even paying the member’s premiums using a CenCal employee’s corporate credit card.

- Much of the third party payment steering center around dialysis clinics, but also extend to a range of other providers and entities, including drug co-pay programs and rehabilitation facilities.
  - Issuers have seen claims for dialysis more than double in one year, and one plan cites a 20-fold increase from $1.7 million in 2013 to $36.8 million in 2015.
WHAT IS A SPECIAL ENROLLMENT PERIOD (SEP)?

• A Special Enrollment Period is a time outside the yearly Open Enrollment Period when someone can sign up for health insurance. Marketplace purchasers qualify for a Special Enrollment Period if they have had certain life events, including losing health coverage, moving, getting married, having a baby, or adopting a child.

  • 1.6 million enrollees used a special enrollment period during 2015, with the vast majority of consumers doing so because they lost minimal essential coverage
BCBSA argues that claims are significantly higher for SEP enrollees, or about 41 percent more in the first three months of coverage, than for those enrolling during open enrollment. Examples supplied by the Blue Cross Blue Shield Association in their comments on the NBPP include:

- One issuer’s SEP population expanded from 5 percent to 21 percent of its enrollments between 2014 and 2015, and its SEP spending is 25 percent higher for SEP enrollees than OEP enrollees.
- Another issuer found SEPs were 43 percent higher in general, and 20 percent higher specifically during the first three months of coverage.
- Yet another issuer determined that the medical cost ratio for SEP enrollees was 191 percent -- that is, the issuer spent $1.91 for every $1 in premium collected from SEP enrollees. Sixteen percent of the issuer’s total individual market membership paid for three months of service or less in 2015 (representing a 45 percent increase from 2014).
MAKING THE BRONZE PLAN MORE ATTRACTION TO BOTH CONSUMERS AND ISSUERS

• Over 70 percent of consumers purchase silver plans

• Proposed changes to bronze plans would allow issuers to add services pre-deductible; rewarding them with changes to the de minimus actuarial value variation rules

• "This proposal is intended to help ensure that issuers can offer bronze plans with at least one major service before the deductible, as well as offer high-deductible health plans (that can be paired with health savings accounts) at the bronze level of coverage. Enrollment data from the Federally-facilitated Marketplaces shows that consumers prefer plans that cover and pay for services below the deductibles."
THE RISK ADJUSTMENT DATA VALIDATION PROCESS

• The ACA tried to learn from its mistakes gleaned from the Medicare-Advantage RADV audit process

• The ACA statute subjects every Marketplace issuer to annual data validation audits
  • Issuers have to hire an Initial Validation Auditor (IVA) to review a sample of medical records

• The 2018 NBPP proposes to rationalize this audit process somewhat
  • While widespread auditing will promote payment integrity, issuers with good track records do not need to be audited year in and year out
Risk adjustment is a permanent solution designed to protect issuers that enroll a disproportionate number of sicker-than-average members. Issuers that enroll healthier-than-average members have to pay the plans who enroll more sicker members so that these plans don’t enjoy a windfall by avoiding sicker-than-average members. Yet there are issuers and various ACA naysayers claiming that risk adjustment alone is the scourge of evil, single-handedly responsible for “Obamacare’s” woes!
DID ONLY SMALL PLANS LOSE MONEY FROM RISK ADJUSTMENT?

- There are allegations that ACA risk adjustment represents a conspiracy to:
  - Doom small health plans (such as the CO-OPs)
  - Transfer money to large, established payers
  - Tax low premium offerings
- In its complaint filed in the U.S. District Court, Minuteman Health Plan alleges that, “Over the last two years, CMS has in effect levied a $5.8 million plus tax on Minuteman for doing exactly what the ACA intended: offering a low cost, high quality product to consumers.”
- In addition to arguing that the government illegally penalizes issuers with lower premiums, the Complaint also alleges that it penalizes issuers who sell Bronze products and fails to correctly calculate actuarial risk of members.
IF ONLY THE SMALL PLANS WERE IMPACTED…

• Then why did:
  • Aetna transfer $628 million to other issuers?
  • Molina transfer $254 million?
  • Kaiser transfer $237 million?
  • Centene transferred $150 million (while experiencing positive financial results)?
  • Humana: $96 million?
  • United Healthcare: $69 million?
• 40-50 percent of all monies transferred due to risk adjustment were charged to large, established insurance companies
Some issuers have left the Exchange market or scaled back their participation dramatically.

For those issuers that remain, what should they do?

- 2017 will be the first year that issuers have data from the typical member of a Marketplace product. Issuers need to do a better job of pricing.
- Focus on actually partnering with providers to manage care and ultimately bend the cost curve. Managing care will actually increase risk scores.
- Risk adjustment success is determined by comprehensive data.

ISSUER RESPONSES TO ADVERSE FINANCIAL PERFORMANCE
This legal claim is emblematic of what the entire risk adjusted health plan industry experiences:

• “A common scenario is a diabetic patient who does not receive a diagnosis during his...enrollment, but nevertheless is filling prescriptions for insulin. Without the diagnosis, this patient’s risk score will not reflect that he has diabetes...if the enrollee visits a doctor and receives an HCC diagnosis that is properly transmitted to the issuer, the enrollee’s risk score will be adjusted to reflect the HCC. However, if the enrollee does not receive the diagnosis from his or her doctor...the issuer will have no knowledge of it and the enrollee’s risk score will be understated.”

• The standard of care for diabetes includes provisions for providers to provide office-based care to their diabetic members. Plans know who is receiving what prescription drugs. Shouldn’t they intervene with the patient and provider to ensure the member is receiving optimal care including diabetes education and the management of other comorbidities?

Sources:
In a word, “No.”

Certainly risk adjustment can be improved. But it is how issuers respond to the risk adjustment paradigm that determines whether they reap its benefits equitably.

CMS has acknowledged, by way of the proposed changes for 2018, that diagnosis-based risk score calculation can be improved with the limited inclusion of pharmacy data.

Incorporating risk score adjustments for length of enrollment as of the 2017 adapts a system that was thought to operate for a full year, but instead has a not insignificant number of partial year enrollees.

The Marketplace suffers from the syndrome of, “building the plane while flying it!”
Widespread (and largely politically motivated) misinformation has spread like wildfire about products offered both on and off the exchanges

- Common belief that all increases in deductibles and copayments (common in HDHPs) are the fault of “Obamacare”
- There are only ~11 million Obamacare customers, of which over 85% receive subsidies
• It is impossible to move from a system in which people with preexisting conditions can be denied health coverage or charged much higher premiums to a system where people pay the same premium regardless of their health without some who have previously benefited having to pay more
  • Some of the winners might perceive themselves as losers
• Prior reforms of the US health care system typically created only winners
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To Complete the Program Evaluation

The URL below will take you to HFMA on-line evaluation form. You will need to enter your member I.D. # (can be found in your confirmation email when you registered)

**Enter this Meeting Code:** 16AT62

**URL:** [http://www.hfma.org.awc/evaluation.htm](http://www.hfma.org.awc/evaluation.htm)

Your comments are very important and enables us to bring you the highest quality programs!