Risk Sharing

Legislative Commission on Health Care Access:
Exchange Work Group

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Risk Sharing Components

- **Risk Pooling:** Individual market plans inside and outside Exchange are in same risk pool. Small group plans inside and outside Exchange are in same risk pool.

- **Reinsurance:** From 2014-2016 reallocates $25 billion to individual market plans inside and outside Exchange with high risk individuals. States to choose reinsurer.

- **Risk Corridors:** HHS to establish from 2014-2016 for individual and small group plans inside and outside Exchange. Similar to Part D where plan payments or receipts are based on ratio of claims to premiums.

- **Risk Adjustment:** HHS in consultation with states to establish criteria and methods for risk adjustment for individual and small group plans inside and outside Exchange.

- **Market Merger:** States may merge their individual and small group markets.

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Reinsurance

- **What is Reinsurance?:** Insurance for insurers. It protects purchasers from unpredictable swings in costs that can occur despite the existence of a risk-adjustment system.

- **Reinsurance Provisions in PPACA:** HHS Secretary to issue model reinsurance regulation that States must adopt by January 1, 2014.
  - It is a temporary reinsurance program for plan years 2014-2016
  - HHS shall consult with the NAIC on this regulation
  - Reallocates $25 billion to individual market plans inside and outside Exchange
  - Program compensates insurers for “high risk individuals”. Secretary shall consult with the American Academy of Actuaries on identifying high risk conditions.
  - Funded by fully and self-insured plans

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Reinsurance Options

- Reinsurance entities must be non-profit organizations with the purpose of stabilizing premiums in the individual market for the first three years of Exchange operation.

- States to choose reinsurer:
  - States may have more than one reinsurance entity
  - Two or more states may enter into agreements
  - States may collect additional amounts from issuers

- MCHA has limited authority to act as a reinsurer

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Risk Adjustment

- **What is risk adjustment?:** The process of adjusting payments to organizations/insurers based on differences in the risk characteristics or health status of people enrolled.
- **Why is it needed?:** In a community rated and guarantee issue environment where premiums do not fully reflect the relative costs of healthy and sick individuals, insurers have the financial incentive to compete for healthy individuals rather than compete on efficiency, quality, and value.
- **General goals of risk adjustment:**
  - Maximize accuracy
  - Limit incentive for insurers to avoid risk/sicker individuals
  - Create incentive for insurers to want to enroll and effectively manage sicker individuals
  - Minimize gaming or upcoding
  - Protect the solvency of insurers through fair and equitable compensation for assumed and managed risk

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Examples of Risk Adjustment

- **Medicare:** Medicare Advantage and Part D payments are adjusted for enrollee demographics and diagnoses from historical claims data.
- **Medicaid:** Payments for health plans with families and kids in Medicaid and MNCare are based on individual enrollee demographics and aggregate health plan historical claims data.
- **Employer Coverage:** Some employers offering multiple products pay risk-adjusted premiums to insurers to account for product risk selection by employees.
- **Massachusetts:** Risk adjustment based on demographics and diagnoses is being used for Commonwealth Care, but not Commonwealth Choice.
- **Utah:** Utah established a “Risk Adjuster Board” for its Exchange. Enrollees complete a health assessment used by insurers to compare actual to risk-adjusted premiums. Aggregate differences between the two result in fund transfers. Method was designed by insurers.

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Risk Adjustment Options

- HHS has yet to actively consult with states on risk adjustment
- HHS to consult with the NAIC on risk adjustment models for the states, this has yet to fully start
- States are in different places regarding data availability and methods expertise
- Risk adjustment will mitigate, but not eliminate adverse selection, so consideration is needed regarding mechanisms to address adverse selection inside vs outside an Exchange.

Risk Adjustment Options: Methods

- **Prospective:** Use of historical health data to determine risk-adjusted payments in a subsequent period. Risk scoring is generally, but not always, done at an individual level
  - Accurate assessment of predictable risk, but less accurate than concurrent
  - More resistant to gaming/upcoding
  - Greater incentive to manage care for higher risk individuals
- **Concurrent:** Use of current health data for current risk-adjusted payments. Generally requires retrospective payment reconciliation. Risk scoring is generally, but not always, done at an aggregate insurer level
  - More accurate assessment of predictable and unpredictable risk than prospective
  - Less resistant to gaming/upcoding
  - Less incentive to effectively manage care for higher risk individuals, but better than typical reinsurance mechanisms
  - May be simpler to administer if done at an aggregate vs. individual level

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Risk Adjustment Options: Data

- **Diagnosis Claims Data**
  - Most accurate data source, but excludes uninsured and new to state
  - Substantial cost and time for states without an APCD to set up

- **Insurer Diagnosis Reporting**
  - Accurate data source, but excludes uninsured and new to state. Generally requires auditing
  - Less costly for states without an APCD to set up, but there would be costs for auditing

- **Enrollee Health Assessment Questionnaire**
  - Less accurate, but more inclusive of population
  - Lower cost and may be easier to use/administer

- **Demographic Data Only**
  - Less accurate, may be more inclusive of population
  - Lower cost and easier to administer

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Risk Adjustment Options: Organization

- **Affiliated with Exchange**
  - Ease of administration and lower cost for those participating in Exchange (i.e. enrollment information, collection and transfer of funds, etc.)
  - Separate mechanism for those outside Exchange related to any collection of information and collection and transfer of funds
  - Federal start-up funding for Exchanges could potentially be used to establish risk-adjustment functions

- **Separate Entity**
  - Single streamlined mechanism for the collection and analysis of information and collection and transfer of funds
  - Financing mechanism unclear

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Market Merger

- PPACA gives states the option of merging their individual and small group markets

- 2014 changes in the market to consider:
  - Benefit and rating rules for both markets will be the same
  - Definition of small group will include groups of 1 or the self-employed
  - New and sizeable populations will be added to the individual market (uninsured, MCHA, and potentially MNCare)
  - Allowed wellness discounts for group plans increase to 30% (potentially up to 50%) and states may participate in a wellness discount demonstration for the individual market

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Market Merger

Pros

- Addresses risk of adverse selection by self-employed between markets
- Creates larger, more stable risk pool
- Larger risk pool may encourage new insurers to enter the market
- May encourage small groups to participate in Exchange
- Simplifies consumer experience and encourages portability – consumers moving between small group and individual market can keep the same plan at the same premium
- Simplifies administration and cost of Exchange - limits different functionalities needed for individuals and small groups
- Potentially reduces administrative costs for insurers

Cons

- Premiums could increase for small groups - magnitude unknown
- Potential premium increase for small groups could lead some to self insure - groups 51-100 more likely
- Potential premium increase for small groups could lead some to drop coverage
- In early years, potential individual market premium instability could also impact small groups
- Lack of wellness discounts for both markets could be problematic

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