

POINT OF VIEW

RISK ADJUSTMENT ARRIVES FOR COMMERCIAL HEALTH INSURANCE

HHS's risk adjustment program for the small group and individual markets will reduce some of the effects of adverse selection—but it creates several significant new risks

AUTHORS

Jac Joubert, Principal
Tammy Tomczyk, Principal
Tom Mikuckis, Principal

Starting in 2014, health insurers in the individual and small group markets need to quickly master a new skill: working within the framework of the Department of Health and Human Services' new risk adjustment program.

The program was created by the Affordable Care Act (ACA). The ACA's mandate of guaranteed issue and its prohibition against medical underwriting created a potential problem: It severely limited how effectively insurers could control and accurately price for the risk of the populations they insure, magnifying the risks of adverse selection. The risk adjustment program provides a needed safety cushion; a company that insures a disproportionate number of higher risk individuals is compensated through payments funded by companies that have insured a disproportionate number of lower-risk individuals.

While the HHS risk adjustment program will reduce the risk an issuer is exposed to from adverse selection, our analysis shows that it will not eliminate it, and in other ways, it introduces significant additional risk. To successfully operate in the individual and small group markets in the future, it will be crucial for issuers to understand both the mechanics of this new program, as well as the risks and opportunities that it creates. We have identified meaningful actions that issuers can take to mitigate these risks and use the risk adjustment system as a driver of success and profitability.

THE RISK OF LOW-RISK ENROLLEES

Issuers participating in the Medicare Advantage (MA) market are already familiar with CMS's general approach to risk adjustment. The system begins with what HHS calls hierarchical condition categories (HCCs), clinically meaningful groupings of diagnoses—for example, chronic diseases—with similar expected costs. Members are assigned HCCs based on diagnoses found in the claim record over the course of the year, and the HCCs along with demographic data are used to calculate a risk score for the member.

The new risk adjuster for the individual and small-group markets (known as the HHS-HCC risk adjuster) is different from the Medicare risk adjuster (CMS-HCC risk adjuster) in several respects, summarized in Exhibit 1. Perhaps the biggest differences are related to the closed-system design of the program. Unlike in MA, where CMS itself makes risk adjustment payments, under the HHS-HCC risk adjustment model, dollars are moved back and forth among high- and low-risk issuers. The system cannot adjust if overall risk across the program is higher or lower than expected. And because the game is zero-sum, it creates winners and losers.

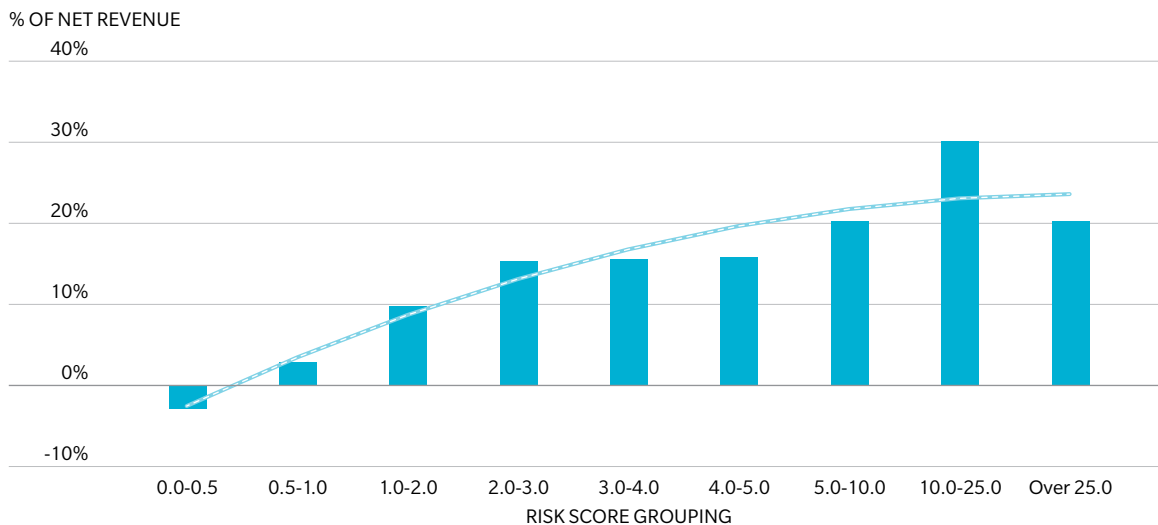
Exhibit 1: Medicare Risk Adjustment and Commercial Risk Adjustment Compared

MEDICARE (CMS-HCC)	COMMERCIAL (HHS-HCC)	IMPLICATIONS OF HHS-HCC MODEL
Prospective: prior year diagnoses are used to predict current year risks	Concurrent: current year diagnoses are used to predict current year risks	<ul style="list-style-type: none"> Different diagnosis codes and model coefficients HHS-HCC model is less likely to under-predict costs of higher risk individuals or acute events, and follows cost more closely in general
About 60% ^{*1} of the population have HCCs	About 20% ^{*2} of the population have HCCs	<ul style="list-style-type: none"> Highest-impact conditions may be substantially different than in the MA population More targeted strategies will be required to effectively identify and code the smaller portion of the commercial population with HCCs
Payments from CMS	Payments between issuers	<ul style="list-style-type: none"> Risk adjuster does not protect against market-wide risk that is higher or lower risk than expected Limitations on the upside reward of enhanced coding due to a closed system Response to risk adjustment becomes a competitive advantage or disadvantage

*1 https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/downloads/Evaluation_Risk_Adj_Model_2011.pdf.

*2 Based on Oliver Wyman analysis of the Truven Health Analytics MarketScan data.

Exhibit 2: Contribution to Fixed Costs and Margin as % of Net Revenue*1



*1 Net Revenue = Premium revenue adjusted for anticipated risk adjustment transfers.

That would be hard enough for issuers if the system were perfectly balanced so that risk adjustment payments and assessments perfectly reflected actual costs. But in fact, our analysis shows that the HHS-HCC model tends to result in overpayments for individuals with high risk scores, and underpayments for those with low risk scores. (See Exhibit 2.) Given this, low-risk individuals may become very problematic. An issuer can face substantial financial risk if competitors in the market are able to effectuate a relatively small change in the percentage of their members with an HCC. This is particularly significant for smaller share players and new market entrants such as provider systems considering launching proprietary exchange products (see Exhibit 3).

Exhibit 3: How Risk Scores Affect Issuer Margins

Issuer Share of the Market	CHANGE TO MARGIN AS A % OF PREMIUM*1		
	Competitors attract 5% more members with HCCs	Competitors attracted similar share of members with HCCs	Competitors attract 5% fewer members with HCCs
10%	-7.7%	0.0%	7.7%
20%	-3.4%	0.0%	3.4%
50%	-0.9%	0.0%	0.9%

*1 Results are based on Oliver Wyman's analysis of the Truven Health Analytics MarketScan data. Carriers in this example are assumed to vary only in the percentage of their membership with an HCC. This analysis does not reflect the impact of payments or charges under the Transitional Reinsurance Program or Temporary Risk Corridors.

For issuers, understanding relative risk is critical, especially for those marketing lower premium products. Indeed, for small market share players, having a risk adjustment strategy may mean the difference between profitable growth and market exit. Successful issuers will quickly move from seeing risk adjustment as an analytical and actuarial exercise to a seeing it as integral to their overall operational strategy, affecting areas such as network and product design and reimbursement and marketing strategies.

A RISK-ADJUSTMENT BATTLE PLAN

Issuers in the individual and small group markets should employ a three-pronged strategy around risk adjustment—diagnose, adapt, and then differentiate.

DIAGNOSE

Make sure you understand the risk profile, disease burden, and resource use of your enrollees (and those you plan to attract). Benchmark and calibrate your risk profile against relevant market averages. How much above or below average risk level are your members? Then use this insight in your financial planning and management: Incorporate the effects of risk-adjustment transfers when you estimate pricing and margins. Model the effects of membership migration among market segments (e.g. small group to individual), which can have a large impact. Understand and embed the potential financial impact of risk adjustment into your overall enterprise risk management planning.

ADAPT

Ensure that you are not “undercoding” relative to your competitors and that you are being appropriately compensated. This “no regrets” move will bring benefits even if future changes to the HHS-HCC model shift the overall impact of risk transfer payments. An important tool here is to rigorously compare the risk profile of your membership to your actual utilization profile to assess how accurately you are coding your members. Look for condition areas where the utilization profile suggests that there is an opportunity to more accurately code. And look for variation across the network.

Many issuers have undertaken programs like this for their Medicare Advantage plans. The idea is the same in the commercial market, but programs need to be adapted to this market’s special characteristics. To be cost-effective, programs in the individual and small group markets need to target population sub-segments likely to have undiagnosed conditions. Higher-cost chart review and home visit programs, while appropriate for MA with its overall higher-risk population, may not produce a positive return on investment in a commercial population. Finally, remember that audit and compliance capabilities will become increasingly critical as regulators scrutinize risk adjustment data.

DIFFERENTIATE

Over time, issuers can expand presence in “desired” risk segments, and tailor product designs and activities to manage profitability of members across different risk profiles. That approach can become a key differentiator, especially when integrated with distinct member experience approaches and aligned with clinical and customer service operations. Some key elements of the strategy include:

- Align care model priorities, clinical collaborations, and other health management initiatives to ensure that appropriate investments are going to the highest-opportunity HCCs
- Monitor costs across HHC groups to better link clinical management to financial outcomes
- Review development of “narrow network” or “ACO network” products that may attract unique risk profiles, and assess risk-adjustment impacts on the profitability of these approaches
- Ensure network participation and reimbursement models reflect risk adjustment to appropriately pay providers for the risk they are managing and ensure networks include key provider types that may help attract desired risk segments

We believe that in order to be successful, issuers will have to rapidly move through risk assessment, to risk mitigation, and then to a response stage in their understanding of these dynamics. Issuers that understand the implications of strategic risk adjustment and proactively embed them in their products and processes will have a significant first-mover advantage. Those that successfully shape the population they attract and retain, developing programs to manage both risk revenue and cost of care, will see material gains in profitability and competitiveness.

BIOGRAPHIES

Please direct inquiries to jamie.bruce@oliverwyman.com and jac.joubert@oliverwyman.com.

Jac Joubert, FSA, MAAA is a principal in Oliver Wyman's Actuarial practice in Chicago. His consulting to the health industry has included working with health plans, state regulators, and integrated systems. Recently his focus has been on supporting clients as they navigate the changed environment from healthcare reform, including support on pricing, financial modeling, and analytics. He can be reached at jac.joubert@oliverwyman.com.

Tammy Tomczyk, FSA, FCA, MAAA is a principal in Oliver Wyman's Actuarial practice group in Milwaukee. She has more than 20 years of experience assisting health insurers and HMOs in the areas of product development, pricing, provider contracting, reserving, and underwriting strategy. She is an expert in the individual and small-group markets and focuses on assessing changes to these markets that are driven by the Affordable Care Act. She can be reached at tammy.tomczyk@oliverwyman.com.

Tom Mikuckis, a principal in Oliver Wyman's Health & Life Sciences practice, advises health plans and providers across a range of strategic priorities related to strategy, growth, and innovation. His work has a particular focus on value-based care, healthcare reform, product and network innovation for retail and consumer markets, and data and analytics-driven decision making and financial planning. He can be reached at tomas.mikuckis@oliverwyman.com.

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