

# Bulletin on the Risk Adjustment Program: Proposed Operations by the Department of Health and Human Services

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## **Background**

The Affordable Care Act established a number of programs to stabilize premiums in the individual insurance market and minimize the effects of adverse selection that may occur in the initial years of operation of Affordable Insurance Exchanges (Exchanges) as coverage is expanded and market-wide insurance reforms are implemented. These programs include transitional reinsurance, temporary risk corridors programs, and a permanent risk adjustment program. This bulletin sets forth and seeks comment on HHS's broad-based intended approach to implement risk adjustment when the Department of Health and Human Services (HHS) is operating the risk adjustment function on behalf of a State. This bulletin is not comprehensive and does not include specific risk adjustment parameters that will be proposed in the draft annual notice of benefit and payment parameters. Comments received on this bulletin will inform future guidance.

## **Purpose and Scope**

Section 1343 of the Affordable Care Act directs States, or HHS on behalf of a State, to operate a risk adjustment program that includes all non-grandfathered plans in the individual and small group market both inside and outside of the Exchange market. The primary goal of the risk adjustment program is to spread the financial risk borne by issuers more evenly in order to stabilize premiums and provide issuers the ability to offer a variety of plans to meet the needs of a diverse population. More specifically, the risk adjustment program is intended to reduce or eliminate premium differences between plans based solely on expectations of favorable or unfavorable risk selection, or choices by higher risk enrollees in the individual and small group market. The risk adjustment program also serves to level the playing field inside and outside of the Exchange, reducing the potential for excessive premium growth or instability in markets inside or outside the Exchange.

The Affordable Care Act directs the Secretary, in consultation with the States, to establish criteria and methods to be used in determining the actuarial risk for plans within a State. Under the risk adjustment program, payments will be transferred from issuers with relatively lower-risk populations to issuers with relatively higher-risk populations. Because the risk adjustment program will need to balance payments within a State and within a market, HHS will not remit payments to issuers until after receipt of charges owed by issuers in a given State. Policy parameters governing risk adjustment programs for States and health insurance issuers are available for review in the recently published final rule, the Standards Related to Reinsurance, Risk Corridors and Risk Adjustment Final Rule (45 CFR Part 153), published at <http://www.gpo.gov/fdsys/pkg/FR-2012-03-23/pdf/2012-6594.pdf> on March 23, 2012. This rule is herein referred to as the Premium Stabilization final rule.

The Affordable Care Act allows HHS to operate risk adjustment on behalf of a State where the State does not operate the program. Under the final rule, a State electing to establish an Exchange is eligible to establish a risk adjustment program. Given the flexibility afforded to States in the final rule, it might be helpful to States, issuers, consumers, and other stakeholders to understand how HHS might operate risk adjustment when HHS operates it on behalf of a State. The purpose of this bulletin is to provide an initial

view into how the Federal government will implement risk adjustment when operating the risk adjustment function on behalf of a State.

In keeping with our commitment to a transparent policy-making process and to providing information as soon as possible, we are outlining our initial thinking around the policy and operational choices that must be made in implementing risk adjustment. We acknowledge the importance of consulting with various stakeholders and providing technical assistance to States and issuers to ensure that risk adjustment is appropriately and efficiently implemented. We also recognize that regular consultation with and assistance to States and health insurance issuers are important to a smooth risk adjustment implementation process. We are planning a number of venues for consultation, including the opportunity for written comment and a public meeting outlining our proposed methodological and operational approach.

In this bulletin, we outline our operational approach to implementing risk adjustment when HHS implements the program on behalf of a non-electing State. More detailed information on the risk adjustment methodology that HHS will adopt will be published in the first draft HHS Notice of Benefit and Payment Parameters in the fall of 2012. The final notice is slated to be published in January 2013.

**The bulletin contains the following sections:**

- Section I: Risk Adjustment Methodology.
- Section II: Operating Risk Adjustment.
- Section III: Data Collection Approach and General Data Requirements.
- Section IV: Assessing Existing State Data Resources and Market Characteristics.
- Section V: Timeline and Stakeholder Communication.

## **Section I: Risk Adjustment Methodology**

**The Premium Stabilization final rule defines five parts of a risk adjustment methodology**

1. The risk adjustment model.
2. The calculation of plan average actuarial risk.
3. The calculation of payments and charges.
4. The data collection approach.
5. The schedule for implementation.

The risk adjustment model calculates individual risk scores. These individual risk scores are used to develop the plan average actuarial risk, which in turn is used for the calculation of payments and charges for risk adjustment covered plans.

HHS recognizes the importance of selecting a robust risk adjustment methodology to address the concerns of risk selection and to maintain stability in the individual and small group markets in 2014 and beyond. We also recognize the importance of providing as much information as soon as possible about

the risk adjustment methodology to develop the associated policies using a transparent process. As such, we have proposed and finalized a rule that provides broad policy parameters for the risk adjustment methodology. In addition, on September 12, 2011, HHS released a White Paper titled, “Risk Adjustment Implementation Issues” ([http://cciio.cms.gov/resources/files/riskadjustment\\_whitepaper\\_web.pdf](http://cciio.cms.gov/resources/files/riskadjustment_whitepaper_web.pdf)) that outlined a number of methodological decisions that need to be made in developing the Federal risk adjustment methodology. We sought and received comments on these methodological choices. These comments have been useful in informing model development and the approach to data collection.

In particular, the White Paper outlined a number of issues including how to account for other elements of the Affordable Care Act in the risk adjustment methodology including the insurance market reforms to rating and the use of metal levels for differentiating plans. We have been considering all comments received as we develop the risk adjustment methodology.

## **Section II: Operating Risk Adjustment**

### **A. Determining who operates risk adjustment**

The Premium Stabilization final rule allows States that are approved to operate an Exchange the option to operate risk adjustment. If a State is not approved to operate an Exchange, it may not operate a risk adjustment program and HHS will do so on its behalf. While the final rule does not specify a date by which a State that has received certification as an Exchange must notify HHS of its intention to implement risk adjustment, we encourage States to communicate their intentions to HHS as soon as possible.

HHS intends to make its Federal risk adjustment methodology available for use by States, in its entirety or to help a State develop its own methodology. Only States approved to operate an Exchange and that choose to operate their own risk adjustment program can elect an alternate methodology. The final rule specifies that States operating risk adjustment in 2014 and wishing to submit an alternate risk adjustment methodology for HHS approval must do so within 30 days after issuance of the draft HHS Notice of Benefit and Payment Parameters which is slated to be released in fall 2012. HHS will be providing more detail about the process and criteria for HHS approval of State alternate methodologies in the draft HHS Payment Notice.

### **B. Payment and Charge Transfer Timing and Process**

Under the risk adjustment program, payments will be transferred from issuers with relatively lower-risk populations to issuers with relatively higher-risk populations. Where HHS is running the risk adjustment program on behalf of a State, HHS will develop a payment transfer methodology that will compensate issuers for liability incurred due to the health status of their enrollee populations. The payment methodology will be based on a plan’s average risk score across all enrollees. The Risk Adjustment Methodology White Paper discussed many of the factors that must be taken into account in the payment methodology. Plan level differences in factors such as metal level or actuarial value, permissible rating variation, and induced demand have an impact on plan liability. These factors can be

controlled for in the methodology so that payment transfers compensate for liability differences due to health status. Additionally, the payment methodology needs to be balanced: the payments to plans with higher risk selection must equal the charges to plans with favorable selection. This condition has significant implications for the equation that is used for calculating payments. The White Paper discussed several options for achieving neutral transfers. HHS will specify the payment methodology including all the applicable calculations and adjustments in the draft HHS Notice of Benefit and Payment Parameters, which will be open for public comment before finalization.

To ensure proper balancing between payments and charges, all of the payments made to issuers must be completely funded through the charges assessed to other issuers within the same market in the same State. Consequently charges will be invoiced prior to processing issuer payments. The final rule stipulates that the calculation must be complete and issuers invoiced no later than June 30 of the year following the risk adjustment year (June 30, 2015 for plan year 2014). Once the calculations of payments and charges are complete, the next step in the process is to notify the issuer of the results, including the amount owed by the issuer or payable by HHS and the details of the underlying basis of all risk adjustment calculations. Following the notification of results, HHS will send an invoice to issuers that owe charges within any State. An issuer must remit net charges payable to HHS on behalf of the State, within 30 days of notification. To ensure equity within any State's risk adjustment program, HHS will treat each State's risk adjustment charges and payments as separate accounts. HHS will not offset charges for an issuer for one State based on payments due to that same issuer in another State. HHS will only be able to pay issuers in a State the amount they are owed after receipt of funds owed by issuers in that State. If full charges are not received from issuers in that State, HHS could determine to issue interim payments that are pro-rated across issuers in a State based on the total charges remitted to date. After the remaining charges have been collected, HHS will remit the remainder of outstanding payment balances.

### **Section III: Data Collection Approach and General Data Requirements**

In order to operate the risk adjustment model and calculate individual risk scores, information is needed about the demographic and health status of enrollees in each plan. In many risk adjustment programs, data to determine the health status of enrollees is based on medical diagnoses (in the form of ICD-9-CM codes or with eventual ICD-10 code adoption) contained on medical claims or medical encounter records. HHS has stipulated that it will not collect medical claims or medical encounter records from issuers for the calculation of individual risk scores. HHS is firmly committed to protecting individuals' private health information as it develops and operates a robust risk adjustment program that will help stabilize premiums and the marketplace in 2014 and beyond.

While the Premium Stabilization final rule gives States flexibility when they operate risk adjustment to choose the data collection approach that best suits their program needs, HHS will use a distributed approach when we operate risk adjustment on behalf of a State. This approach was adopted in the final rule to address concerns that were expressed in response to the NPRM.

In a distributed approach, the data required to operate risk adjustment is collected and stored by issuers; no data is transmitted to HHS. The policy objectives for the federal risk adjustment distributed data approach are to ensure that issuer proprietary data remains within the issuer environment to minimize transfers of protected health information in order to lower privacy and data security risks. A major advantage of the distributed model in general is that it allows HHS to leverage existing issuer data to the extent possible.

HHS is considering various approaches to implement a distributed data approach. The overall distributed data concept requires issuers to map claims data into a common HHS defined data format.

**HHS laid out two potential distributed data approaches for consideration in the preamble to the Premium Stabilization final rule**

1. HHS runs software: HHS would run risk adjustment software on enrollee data that reside on an issuer's server, calculate enrollee-level risk scores and plan average risk, and provide enrollee-level risk scores back to the issuer.
2. Issuer runs software provided by HHS: Issuer would run HHS risk adjustment software using enrollee data on the issuer's own server and report back enrollee risk scores to HHS in order to calculate plan average risk scores.

In weighing operational considerations for either option, the policy objective would be to standardize software processes, timing, and rules to apply risk adjustment uniformly across issuers and finally, to ensure an audit sample is controlled and maintained. HHS recognizes that this will require detailed instructions to issuers on technology associated with both approaches. HHS recognizes issuers could have to purchase server capacity and install software for both approaches. In addition, we understand that issuers store different kinds and amounts of information in a variety of ways. These differences mean that the impact of implementing a distributed model on health insurance issuers may vary. HHS notes that the majority of issuer commenters on the proposed rule recommended the use of the distributed approach. HHS will continue to engage with issuers on various technology platforms to implement a distributed approach. We intend to hold telephone calls with issuers to discuss these issues beginning in summer 2012.

HHS also will continue to consult with States and issuers about their current data collection tools and capacity.

**We welcome input on potential ways to address the following issues with regard to the distributed model including**

- What is the issuer's ability to ensure data is accurately formatted and mapped?
- What issuer support will be necessary to ensure validity and accuracy of data?
- To the extent possible, how can HHS leverage any existing issuer data?

**A. Minimum Data Needed for Risk Adjustment and Data Validation**

Regardless of the specific mechanism for data collection, HHS plans to leverage commonly-used data elements from existing claims data standards, including those currently used in the Medicare Advantage and Prescription Drug programs, for risk adjustment in order to minimize burden on issuers. For

example, the data elements and parameters that could be required to operate risk adjustment under the Federally-operated risk adjustment program are primarily those which are required to run risk adjustment under the Medicare Advantage and Prescription Drug programs. The data gathered for risk adjustment is used for a variety of calculations informing the risk adjustment model, including model selection for risk selection, risk score calculation, variable rating calculation, and calculating the premium basis for payments/charges. To that end, HHS intends to outline a minimum data set needed to perform risk adjustment model calculations and validate data submissions early in the process to ensure high quality data is available.

As a first step to assist issuers, HHS plans to define each of the data sets needed in detail to assist issuers in their efforts to understand all underlying elements needed to make these data available in order to perform risk adjustment model calculations. Below is a sample data set that HHS could utilize to produce plan average risk scores.

**Possible Potential Data Elements for Risk Adjustment. Not for Final Requirement Purposes.**

Sample Data Parameter	Sample Data Elements	Sample Purposes for Data
Enrollee-level data	<ul style="list-style-type: none"> <li>• Enrollment effective dates</li> <li>• Enrollment plan type</li> <li>• Premium amount</li> <li>• Date of birth</li> <li>• Cost-sharing reductions</li> <li>• Sex</li> <li>• Tobacco use*</li> <li>• Pharmacy data</li> <li>• Medical claims data for cost and diagnosis selection</li> <li>• Location (e.g. zip code, geographic rating area or both)</li> </ul>	<ul style="list-style-type: none"> <li>• Model selection for risk calculation</li> <li>• Risk score calculation</li> <li>• Variable rating calculation</li> <li>• Premium basis for payments/charges</li> <li>• Weighting for state and plan average</li> <li>• Actuarial risk</li> <li>• Data validation</li> </ul>
Plan level data	<ul style="list-style-type: none"> <li>• Metal level*</li> <li>• Actuarial value*</li> <li>• Benefit year</li> <li>• Individual versus small-group*</li> </ul>	<ul style="list-style-type: none"> <li>• Model selection for risk score calculation</li> <li>• Payments and charges calculation</li> <li>• State average actuarial risk</li> <li>• Data validation</li> </ul>
Market level data	<ul style="list-style-type: none"> <li>• State average actuarial risk (HHS-sourced)*</li> <li>• State rating curve*</li> </ul>	<ul style="list-style-type: none"> <li>• Risk score normalization</li> <li>• Rating variation</li> </ul>

*\*The asterisk denotes all data elements not currently collected under Medicare Advantage but are unique features of the individual and small group market rating practices. All other data elements are those which are currently being collected under the Medicare Advantage and Prescription Drug programs.*

**B. Ongoing Coordination Efforts**

In addition to regular consultation and ongoing technical assistance that HHS will offer, we hope to minimize burden on health insurance issuers by closely coordinating with other HHS’ data collection efforts to the extent possible. HHS will schedule monthly or quarterly user groups to provide technical

assistance and feedback. HHS plans to establish an issuer instruction website or support system as well that will help provide technical assistance and an interational platform for guidance.

HHS also seeks comment on and plans to consult with health insurance issuers and States in the development of common data format that takes into account current data formats already used by States. This format will need to specify coding systems, data-layout, file structuring, and uniform definitions to data requirements. At the conclusion of this process, in January 2013, HHS will release detailed common data format requirements for use in the Federally-operated risk adjustment program or for States to use if they are operating their own risk adjustment program. In order to lower implementation risk, HHS will require issuers to run test files with common data formats well in advance of the implementation of risk adjustment.

### **C. Privacy and Security Standards for Data**

HHS is committed to protecting the personal health information of all enrollees and is working to establish privacy and security standards at a high standard while ensuring that risk adjustment functions properly. In order to address privacy standards, States operating their own risk adjustment program must utilize specific privacy standards for their data collection and risk adjustment procedures. The standards in the final rule are meant to represent a minimum standard to be used in the risk adjustment program. We expect risk adjustment programs will build on these minimum privacy and security standards. As specified in §153.340 of the Premium Stabilization final rule, to ensure adequate data privacy standards, the State, or any official, employee, agent, or representative of the State must not collect or store individual identifiers unless those identifiers are encrypted by the issuer, with the key to that encryption withheld from the State except for purposes of audit. The rule also requires that states operating a risk adjustment program implement security standards that provide administrative, physical, and technical safeguards for the individually identifiable health information consistent with Health Insurance Portability and Accountability Act of 1996 (HIPAA) security standards. HHS also plans to provide further direction in the form of user group calls, guidance or technical assistance detailing specifications for encryption of data and security standards for risk adjustment programs and databases stored by the issuer.

### **D. Proposed Data Validation Approach**

The Premium Stabilization final rule directs States, or HHS on behalf of States, to validate a statistically valid sample of data for all issuers that submit data for risk adjustment every year, and provide for an appeals process. The rule also allows States, or HHS on behalf of States, to make adjustments to payments based on data validation sample error rates.

HHS will provide additional guidance on its development of the data validation methodology as we address oversight and financial integrity in future rulemaking, under sub-regulatory technical guidance or other communication engaging stakeholders, especially in the first year of the program.

The overall objectives of data validation are to promote confidence in the risk adjustment data that will be used for application of a Federally-certified risk adjustment methodology across the market, and to account for accurate health status of both healthy and sick enrollees. HHS seeks to promote consistency

and a level playing field by establishing uniform audit requirements, and to protect privacy information by limiting data transfers through the data validation process. We also recognize the need to promote flexibility and minimize burden by allowing issuers to set their own internal deadlines for completing the initial audits, and to leverage existing resources to conduct data validation.

HHS considered several current data validation standards familiar to health insurers including those used in Medicare Advantage and the Healthcare Effectiveness Data and Information Set (HEDIS) Compliance Audits. Under an approach similar to Medicare Advantage, issuers would first submit full medical records for HHS review in a specified timeframe. In an effort to reduce burden on insurers, HHS is instead considering for its data validation approach incorporating concepts from the best practices of industry audit standards such as HEDIS compliance audits. The HEDIS audit allows issuers to audit their own data based on specific methodologies, samples and standards set forth by NCQA. For example, building on standards such as HEDIS compliance audits, HHS would select a representative enrollee audit sample from across the full distribution of enrollees for each issuer. This distribution could include enrollees with and without risk adjustment diagnoses. HHS is also considering covering verification of enrollee demographics through review of source plan enrollment information, and enrollee health status through review of medical record documentation.

In addition, similar to the HEDIS compliance audits, HHS is considering having issuers or their companies to hire independent audit entities to validate their risk adjustment data. This would allow issuers to more effectively leverage existing resources to conduct their own data validation activities. In order to establish uniform audit requirements and a level-playing field across issuers, HHS would also establish baseline audit requirements to be used by the independent audit entities for validation of issuer risk adjustment data. Finally, HHS proposes to conduct second level validation and oversight audits to confirm the data validation findings from each independent audit entity. These various data validation approaches are not intended to be alternatives to each other, but rather HHS intends to implement each of these concurrently.

HHS looks forward to receiving input from a variety of stakeholders to inform development of the data validation approach. HHS understands the complex nature of data validation for risk adjustment. The proposed approach is expected to ensure HHS is able to verify the accuracy of the plan's risk score while minimizing operational burden on issuers. Additionally, the proposed data validation approach for the federally-operated risk adjustment program could offer a less burdensome process and differ substantially from the more traditional data validation models that have been developed under the Medicare Advantage program. This is primarily due to the unique nature of how risk adjustment is administered with respect to assessment and flow of payments and charges.

Furthermore, HHS plans to carefully evaluate the data validation findings in the first year of the risk adjustment program. HHS does not intend to make retroactive adjustments to prior years' payments and charges based on data validation error results. More specifically, the risk score error results based on the data validation for benefit year 2014 would apply prospectively during the risk score and payments and charges calculation processes for benefit year 2015. Therefore, the initial application of

risk score error adjustments based on data validation would not occur until calendar year 2016, as part of the process for assessing payments and charges for benefit year 2015.

Finally, HHS needs to assure balancing the flow of payments and charges since payments cannot be made until charges are collected. Therefore, HHS is considering application of a data validation error rate adjustment, based on prior year's data validation results, during the process for determining enrollee and plan average actuarial risk. Consequently, risk score accuracy based on data validation results would be taken into account when HHS assesses payments and charges. Again, HHS looks forward to input on this type of approach.

#### **Section IV: Proposed Assessment of Existing State Data Resources and Market Characteristics**

As discussed above, HHS will use a distributed approach when operating risk adjustment on behalf of a State. In some of the States where HHS operates risk adjustment, there may be an All Payer Claims Database (APCD) or other database already in place. HHS understands that many States have invested significant resources into building these databases and therefore will work with States to assess whether we could incorporate their existing data sources into our data collection approach at a future date. It is important to note that States operating their own risk adjustment program can use their APCD, but in cases where HHS runs the risk adjustment program, HHS will utilize the distributed approach to accessing data at least in the initial years.

As set forth in the final rule, States that elect to operate risk adjustment may submit alternate methodologies, which include data collection approaches such as APCDs or other existing databases, within 30 days of the release of the draft HHS payment notice. If the data collection approach is approved through the payment notice process, then the existing database can be used for risk adjustment. HHS will announce criteria which will be used to evaluate alternate data collection approaches in the draft HHS payment notice. HHS proposes to continue studying these databases as a potential data collection approach and we welcome feedback during this process. As part of these efforts to assess State's current data collection and storage capacities, we propose to explore with States the following questions:

- What issuers are included in existing data collection?
- What claims types are included?
- Are all data elements required for risk adjustment collected? If not, are there mechanisms to collect the remaining data?
- What privacy and security standards are in place to protect sensitive data?
- Does the State have the legal authority to use data from the existing database to operate risk adjustment?
- Are there any validity or quality checks when collecting data? If so, what data elements are checked and what (if any) processes are in place to allow issuers to make corrections?
- What is the timing of the data collection?

In addition, HHS is committed to working with States to help assess market characteristics that might have an impact on the risk adjustment program. For example, under 1312 (c) of the Affordable Care Act, States have the option to merge individual and small group markets for purposes of rating. Since this is a state insurance market reform decision that will interact with the risk adjustment program, HHS will work with States to understand the impact of separate or combined individual and small group risk pools if HHS is operating risk adjustment on behalf of a State.

## Section V: Timeline and Stakeholder Communication

As outlined above, HHS is committed to assisting health insurance issuers understand and implement operational requirements associated with risk adjustment. To this end, HHS will communicate through a series of regular public meetings, technical user group calls and instruction bulletins. HHS will also post instructions and other communication via a dedicated website at <http://cms.cciio.gov>.

**The chart below details key dates related to the establishment and operation of the risk adjustment program.**

Item	Date
HHS issues Premium Stabilization Rule.	March 23, 2012
Public risk adjustment meeting held to discuss: <ul style="list-style-type: none"> <li>• Risk Adjustment Model.</li> <li>• Calculation of Plan Average Actuarial Risk.</li> <li>• Calculation of Payments and Charges.</li> <li>• Process and Timing for Data Collection Methodology and Options.</li> <li>• State Flexibility and Considerations.</li> </ul>	May 7th & 8th, 2012
User group calls continue to be conducted with stakeholders	Spring/Summer 2012
Proposed date for HHS to engage issuers to test data processing concept.	Fall 2012
HHS publishes the draft annual HHS notice of benefit and payment parameters, which includes Federal risk adjustment parameters. This will include requirements for data validation.	Fall 2012
States Submit Alternative Methodology if Approved State Based-Exchange elects to operate risk adjustment.	Within 30 days after issuance of the draft final annual Federal notice of benefit and payment parameters.
HHS publishes the final annual HHS notice of benefit and payment parameters.	January 2013
HHS releases requirements for data storage to issuers and continues to work with issuers to implement.	Early 2013
Final deadline for States to publicly select Alternative Methodology for Approved State-Based Exchange.	No later than March 1st 2013
Payments and Charges implementation	Completed by June 30, 2015

HHS will solicit feedback on other technical concerns and potential topics for future discussions during our public meeting outlining our progress to date on developing the methodology. The public meeting will be held in Arlington, VA on May 7th and 8th, 2012. Please visit the CCIIO website for details on the meeting including how to register at <http://cciio.cms.gov/resources/other/index.html#fm>. We look forward to a wide ranging discussion at that meeting to hear from a variety of stakeholders on our intended methodology.

# Proposed Technical Concept: Distributed Data Processing

Centers for Medicare & Medicaid Services  
Department of Health and Human Services



May 8, 2012

# CONTEXT

The contents of this presentation represent preliminary information with the purpose of soliciting stakeholder feedback. Proposed policies for the risk adjustment program will be announced in the draft HHS notice of benefit and payment parameters, which will be subject to comment before finalized. More information on the HHS proposed operational approach when operating risk adjustment on behalf of non-electing States can be found in the Risk Adjustment Bulletin at <http://cciio.cms.gov/resources/files/ppfm-risk-adj-bul.pdf>.

# Proposed HHS Risk Adjustment Distributed Data Goals

- To ensure that issuer proprietary data remains within the issuer environment.
- To minimize data transfers to minimize privacy and data security risks
- To ensure an audit sample is controlled and maintained
- To standardize software processes, timing and rules in order to apply risk adjustment uniformly across issuers and ensure a level playing field.

# Proposed Operational Model: Distributed Data Processing

- Issuer houses the claims information
- HHS invokes the distributed data processing function on claims information without requiring a copy to be sent to HHS
- Claims information will be stored in a secure system within the issuer's technology environment (e.g., hosting facility/data center or secure cloud environment)
- Through the distributed data processing model, HHS would obtain and retain plan-level summarized results via data analysis and access to de-identified individual-level risk scores
- Proposed distributed data processing model does not centrally store any proprietary or individually identifiable data

# Proposed Distributed Data Processing: Technical Approach

- Secure, technical design using a stand-alone (or segregated physical/virtualized) set of dedicated system components and services to ensure a stable operational environment with performance efficiencies
- Dedicated environment operates independently of other operational processes and supports risk adjustment processing with no impact to issuer production systems, but does require coordination of operational schedules
- Design partitions environment to ensure adequate “firewall” separation of Issuer data and HHS summarized/aggregate data and provides for security and privacy safeguards
- Dedicated environment restricts access to only designated, authenticated users with the proper roles and permissions
- Current plan is to maximize the use of ‘open source’ software

# Proposed Deployment Timeline

Development Phase	Task Item	Responsible Party	Target Date
Development	Edge Server / RA process development	HHS	SUMMER 2012
Quality Assurance	System & Integration Test	HHS	SEP 2012
Quality Assurance	Select Sample Issuers for Beta	HHS	SEP 2012
Quality Assurance	Beta Test	Issuers / HHS	DEC 2012
Issuer Instructions	Develop Instruction Guides	HHS	DEC 2012
Issuer Instructions	Publish for Issuers	HHS	JAN 2013
Implementation	Acquire Servers	Issuer	JAN 2013
Implementation	Establish server connectivity	Issuer	JUN 2013
Implementation	Training and Support	HHS	JAN 2013 <sup>1</sup>

<sup>1</sup>Training and support to be ongoing for issuers

# State Flexibility and Risk Adjustment Implementation

Center for Consumer Information and  
Insurance Oversight  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services



May 8, 2012

# CONTEXT

The contents of this presentation represent preliminary information with the purpose of soliciting stakeholder feedback. Proposed policies for the risk adjustment program will be announced in the draft HHS notice of benefit and payment parameters, which will be subject to comment before finalized. More information on the HHS proposed operational approach when operating risk adjustment on behalf of non-electing States can be found in the Risk Adjustment Bulletin at <http://cciio.cms.gov/resources/files/ppfm-risk-adj-bul.pdf>.

# Issues Covered

- Background
- State Flexibility and Leverage
- Important Questions for States to Consider for Operating Risk Adjustment
- Administration of Risk Adjustment Program
- Process for Proposing an Alternate Risk Adjustment Methodology
- State Flexibility in Proposing an Alternate Risk Adjustment Methodology
- Risk Adjustment Data Collection
- State Notice Requirements in Premium Stabilization Final Rule
- Major Milestones for Risk Adjustment for 2012-2013

# Background

- States that are approved to operate a State-based Exchange may also choose to operate their own risk adjustment program.
- The process that States will need to undertake to set up a risk adjustment program includes:
  1. **State Exchange Approval:** States will notify HHS about their plans to operate a State-based Exchange and risk adjustment program.
  2. **Development of Risk Adjustment Methodology:** States can work with HHS to develop a methodology to be approved by HHS or States can choose any Federally certified methodology.

# State Flexibility and Leverage

- States have flexibility when designing their risk adjustment programs to:
  - Propose certain components of the risk adjustment methodology to tailor the program to their needs and to local market conditions; and
  - Leverage existing State-wide data sources and data collection tools
- States will have the opportunity to collaborate with HHS upfront and build off of existing HHS systems and processes if they so choose.
- HHS will work one-on-one with States on an ongoing basis to ensure that their risk adjustment programs operate smoothly or are phased-in appropriately if States opt not to operate risk adjustment in 2014.

# Important Questions for States to Consider for Operating Risk Adjustment

## 1) Operating Risk Adjustment:

Does the State plan to operate risk adjustment?



## 2) Administration of Risk Adjustment Program:

What is the State's legal authority to operate risk adjustment? What government agency or other entity will be overseeing the risk adjustment program?



## 3) Implementation of Risk Adjustment Program:

Has the State considered the data collection approach that will be used or necessary system changes associated with accessing complete data? What is the schedule for implementation?

# Administration of Risk Adjustment Program

- **Eligible Entity**: Any entity that meets the requirements to serve as an Exchange including those that relate to the entity's governing board structure and governance principles as specified in 45 CFR 155.110.
- Examples of eligible entities:
  - **State Medicaid Agency**
  - **Department of Insurance**
  - **Any Entity, except for health insurance issuers**, that has demonstrated experience on a State or regional basis in the individual and small group health insurance markets and in benefits coverage.

# Process for Proposing an Alternate Risk Adjustment Methodology

- Within 30 days of release of the draft HHS payment notice, States must submit to HHS:
  - Risk adjustment model description
  - Calculation of plan average actuarial risk
  - Data collection approach
  - Schedule for implementation
  - Schedule for recalibration
- HHS will consider alternate methodologies based on criteria established in 45 CFR 153.330 (i.e. uses data that is complete, high quality, and available in a timely fashion) and detailed in the draft HHS payment notice
- HHS will publish the list of approved methodologies in the final HHS payment notice
- States can choose any Federally certified methodology when operating risk adjustment. The State must notify issuers and the public in the State Notice of Benefit and Payment Parameters

# State Flexibility in Proposing an Alternate Risk Adjustment Methodology

- States can modify:
  - Risk adjustment model
  - Calculation of plan average actuarial risk
  - Calibration data
  - Data collection approach
  - Schedule for implementation
- For example, a State could propose an alternate model that:
  - Incorporates a prospective model approach
  - Has State-specific weights different from the weights in the model developed by HHS
- States cannot initially vary from the HHS methodology for payments and charges

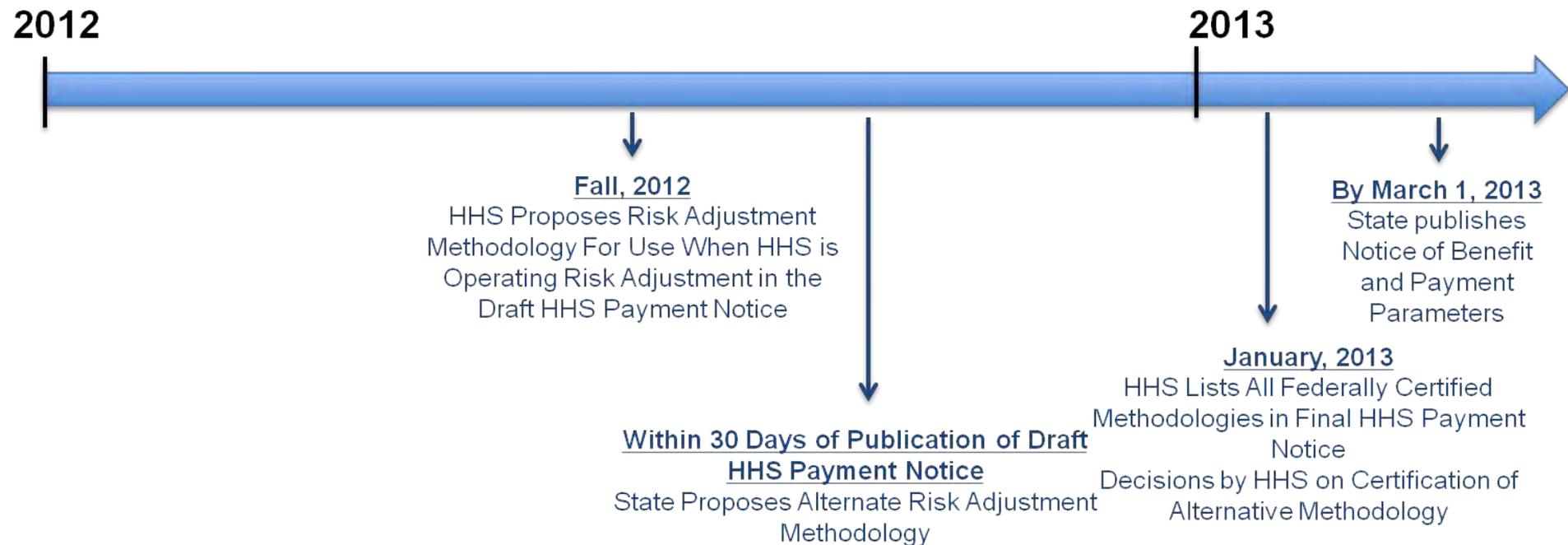
# Risk Adjustment Data Collection

- The Premium Stabilization final rule gives States operating risk adjustment the flexibility to determine a data collection approach that best suits their program's needs
- States must develop privacy and security standards to protect any risk adjustment data that is collected
- States must ensure that a statistically valid sample of risk adjustment data from each issuer is validated annually
- States can request approval to use a data collection approach that aligns with its alternate risk adjustment model

# State Notice Requirements in Premium Stabilization Final Rule

- States that operate their own risk adjustment program must publish information on their risk adjustment methodology by March 1, 2013
- Information on what should be in the State notice can be found in 45 CFR 153.100
- States are encouraged to have a transparent process and to interact with stakeholders leading up to their State notice

# Major Milestones for Risk Adjustment for 2012-2013



# Risk Adjustment Program: HHS Operations

Center for Consumer Information and  
Insurance Oversight  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services



May 8, 2012

# CONTEXT

The contents of this presentation represent preliminary information with the purpose of soliciting stakeholder feedback. Proposed policies for the risk adjustment program will be announced in the draft HHS notice of benefit and payment parameters, which will be subject to comment before finalized. More information on the HHS proposed operational approach when operating risk adjustment on behalf of non-electing States can be found in the Risk Adjustment Bulletin at <http://cciio.cms.gov/resources/files/ppfm-risk-adj-bul.pdf>.

# Contents

- Overview and background
- HHS operated risk adjustment program
- HHS data collection approach
- Coordination with existing State risk adjustment data collection
- Timeline and process for implementation

# Background

## Overall goals:

- Mitigate the impacts of potential adverse selection
- Stabilize premiums in the individual and small group markets

## Aim:

- Premiums reflect differences in benefits and plan efficiency, not health status of enrolled population

# Risk Adjustment Under the ACA

- **What:** Transfers funds from lower risk plans to higher risk plans
- **Who participates:** Non-grandfathered individual and small group market plans, inside and outside the Exchange
- **How:** Criteria and methods developed by the Secretary, in consultation with States. May be similar to criteria and methods utilized under Part C or D of Medicare

# Risk Adjustment Methodology

- Risk adjustment methodology is defined in Premium Stabilization final rule as:
  - Risk adjustment model
  - Calculation of plan average actuarial risk
    - Includes removing rating variation for age, geography, tobacco use, and family status
  - Calculation of payments and charges
  - Data collection approach
  - Schedule for implementation

# Overview of Risk Adjustment Methodologies

- HHS, in consultation with States, will develop a risk adjustment methodology for use when operating risk adjustment on behalf of a State
- A State may propose an alternate risk adjustment methodology for certification by HHS
- Any Federally certified risk adjustment methodology (including the methodology developed by HHS) could be used by a State operating risk adjustment

# Risk Adjustment Timeline

2012

2013

**March 23, 2012**  
HHS Released the Premium  
Stabilization Final Rule

**May 7 & 8, 2012**  
HHS hosts the Risk  
Adjustment Public Meeting

**Fall, 2012**  
HHS Proposes Risk  
Adjustment Methodology  
For Use When HHS is  
Operating Risk Adjustment  
in the Draft HHS Payment  
Notice

**January, 2013**  
HHS Lists All Federally  
Certified Methodologies in  
Final HHS Payment  
Notice

# HHS Operated Risk Adjustment Program: Payments and Charges Timing

- The risk adjustment program would balance payments within a State and within a market
- HHS would not remit payments to issuers until after receipt of charges owed by issuers in that State. HHS may adjust payments based on receipt of funds to ensure that payments and charges remain balanced
- The intent is that payments and charges would be calculated at the plan level, and would be aggregated up to the issuer level

# HHS Risk Adjustment Data Collection: Policy Objectives

- To minimize data transfers in order to lower privacy and data security risks
- To ensure that issuer proprietary data remains within the issuer environment
- To standardize software processes, timing and rules in order to apply risk adjustment uniformly across issuers
- To ensure an audit sample is controlled and maintained

# HHS Risk Adjustment Data Collection Approach

- HHS intends on utilizing a distributed approach to data collection
- Two distributed approaches are being considered:
  1. HHS runs software. HHS would run risk adjustment software on enrollee data that resides on issuer's server and provides enrollee level risk scores to the issuer. HHS would calculate enrollee level risk scores.
  2. Issuer runs software provided by HHS. Issuer would run HHS risk adjustment software using enrollee data on its own server and reports back enrollee risk scores to HHS. The issuers would calculate enrollee level risk scores.

# HHS Distributed Model in IT Infrastructure

- **Who:** Issuer would house the claims data. HHS would run software on issuer claims information.
- **Where:** Copy of claims information would be stored in a secure system within the issuer's data environment (e.g. edge server or secure cloud storage center). Claims data would not be sent to HHS.
- **What:** HHS would obtain and retain plan-level summarized and individual, de-identified risk score results to run risk adjustment, rather than collect enrollee-level claims information

# HHS Coordination with Existing State Data Collection

- HHS will work with States that express an interest in utilizing existing data to assess the appropriateness of the data for risk adjustment. States certified to run an Exchange can elect to run the risk adjustment program
- Potential considerations include:
  - Do States have the authority to collect risk adjustment data?
  - What issuers are included in the existing data?
  - Are data elements required for risk adjustment being collected?
  - What kind of quality checks, audit or review of data is conducted?

# HHS Coordination with States

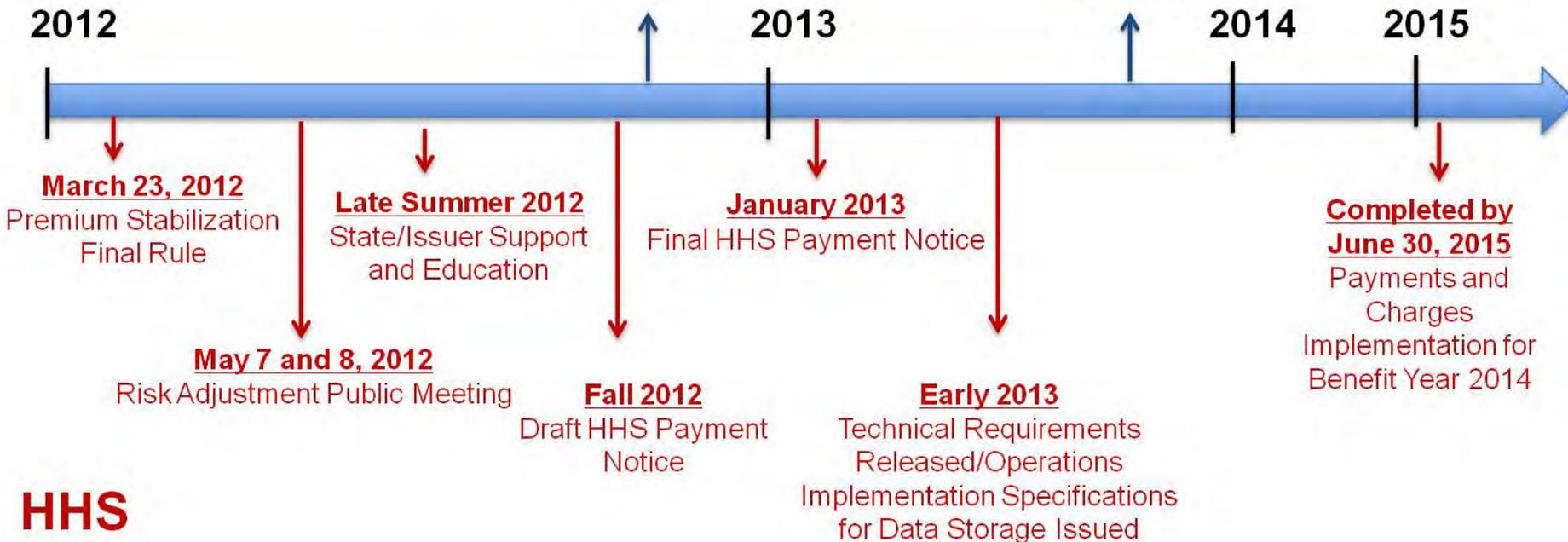
- HHS would enter into agreements or memoranda of understanding (MOUs) with States when HHS operates risk adjustment on behalf of States.
- The purpose of these agreements would be to collaborate and build on existing State resources to help carry out risk adjustment functions.

# Summary of Risk Adjustment Process Timeline

## States

Within 30 days after release of draft HHS notice  
State Proposes Alternate Risk Adjustment Methodology

By March 1, 2013  
State Publishes Notice of Benefit and Payment Parameters



## HHS

# HHS Operated Risk Adjustment Data Validation

# Purpose

The purpose of data validation is to promote confidence in the application of a Federally certified risk adjustment methodology

# Background

- The Premium Stabilization Final Rule requires States, or HHS on behalf of States, to:
  - Validate a statistically valid sample of data for all issuers that submit for risk adjustment every year
  - Provide an appeals process
- The rule allows States, or HHS on behalf of States, to:
  - Adjust average actuarial risk for each plan based on the error rate found in validation
  - Adjust payments and charges based on the changes to average actuarial risk

# HHS Considerations for Proposed Approach

- **Integrity.** Promote confidence in risk adjustment data across market
- **Flexibility.** Allow issuers to set their own internal timelines and workflows for completing the initial audits within the period specified by HHS
- **Privacy.** Limit data transfers and apply privacy protections
- **Consistency.** Permit HHS to establish uniform audit requirements to ensure a level playing field across issuers
- **Burden.** Issuers are better able to leverage existing resources to conduct their data validation
- **Data.** Leverage issuer access to data to conduct data validation activities
- **Accurate Relative Risk.** Account for accurate health status of both healthy and sick enrollees
- **Precedent.** Adopt and build on concepts from other standard industry audit practices

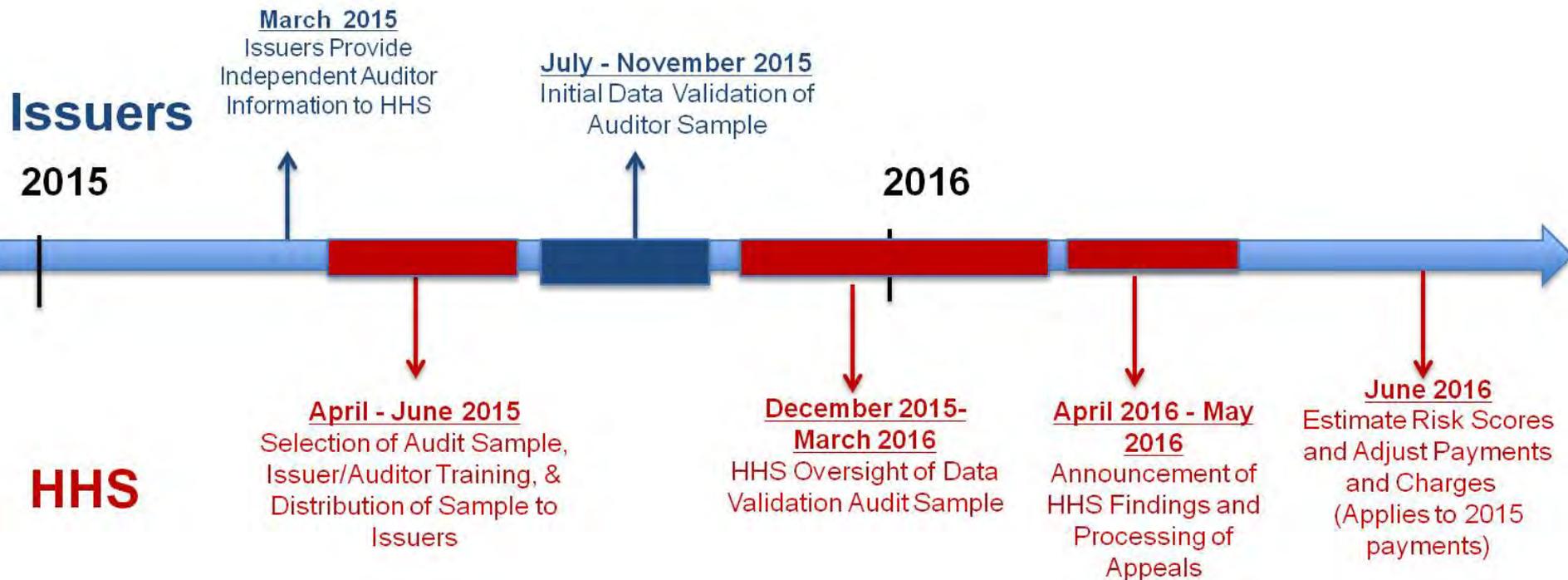
# HHS Proposed Data Validation Approach

- In a process similar to HEDIS audits, issuers would hire independent auditors to conduct validation of their risk adjustment data
- HHS would audit the independent auditors to confirm findings
- HHS would establish baseline requirements to be used by initial and second validation auditors when conducting the validation process

# HHS Proposed Data Validation Approach

- Risk score error would be extrapolated to the issuer level using a representative sample of enrollees
- Risk score error from 2014 validation would not apply to payments and charges for 2014 benefit year
- HHS would evaluate error rates using 2014 data for potential adjustments beginning in 2016 for calculations of payments and charges for the 2015 benefit year
- Adjustments would not be applied retroactively

# Proposed Data Validation Process Set Up and Implementation Timeline for Benefit Year 2014



# Proposed Key Roles in the Data Validation Process

- **HHS:** Establishes sampling; Performs Second Validation Audit; and Estimates Error Rates
- **Issuers:** Provide access to information to support risk adjustment data for the audit sample
- **Initial Validation Auditors:** Validate issuer-submitted risk adjustment data
- **Second Validation Auditors:** Confirm initial findings and compliance with audit requirements

# Proposed Data Validation Process

- **Stage 1. Sampling.** HHS selects a statistical sample of enrollees from each issuer
- **Stage 2. Initial Validation Audits**
  - Issuers provide relevant review documentation to the Initial Validation Audits
  - Initial Validation Audits review documentation in accordance with HHS baseline standards and report findings to HHS within the established timeframe
- **Stage 3. HHS Second Validation Audits**
  - HHS performs oversight audits to confirm data validation findings from the Initial Validation Audits
  - HHS provides the opportunity for appeals
- **Stage 4. Payment Adjustments**
  - HHS calculates error rates
  - HHS evaluates error rates for potential adjustments to payments and charges

# Risk Adjustment Payment Transfer Methodology

Center for Consumer Information and Insurance Oversight  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services



May 7, 2012

# CONTEXT

The contents of this presentation represent preliminary information with the purpose of soliciting stakeholder feedback. Draft policies for the risk adjustment program will be announced in the draft HHS notice of benefit and payment parameters, which will be subject to comment before finalized.

# Risk Adjustment Goals

## Overall goals:

- Mitigate the impacts of potential adverse selection
- Stabilize premiums in the individual and small group markets

## Aim:

- Premiums reflect differences in benefits and plan efficiency, not health status of enrolled population

# Sequence of Payment Transfer Process

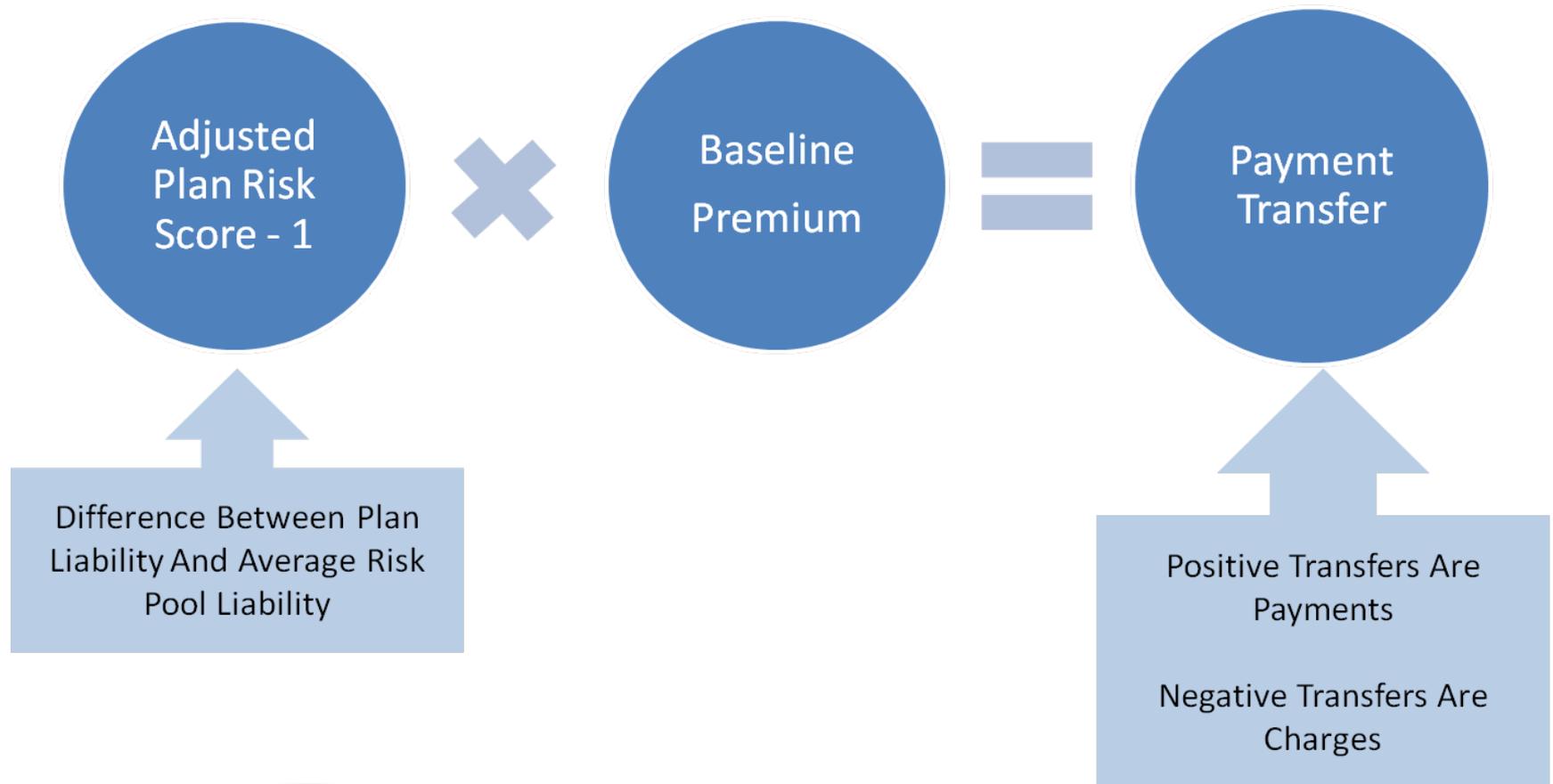
Calculation of individual risk scores

Calculation of plan average risk score

Adjustments to plan average risk score

Payment transfer calculation based on adjusted plan average risk score

# Basic Form of the Payment Transfer Calculation



# Example of the Payment Transfer Calculation

Plan A	
Plan risk score	1.1
Baseline premium	\$1,000
Plan net claims cost	\$1,100
Transfer = [Risk score -1]*Baseline premium <i>((1.1 - 1)*\$1,000)</i>	\$100
Post-transfer net claims cost <i>(\$1,100 -\$100)</i>	\$1,000

# Methodology Elements

- Actuarial Value Differences: Risk scores must be adjusted to remove the impact of AV on predicted plan liability
- Permissible Rating Variation: Transfers must be adjusted to account for risk selection compensation that's built into plan's rating structure
- Normalization: RA model is based on a national sample. Risk scores must be adjusted to account for State differences in predicted liability
- Balanced Transfers: Payments and charges must net to zero

# Sequence of Payment Transfer Process

Calculation of individual risk scores

Calculation of plan average risk score

Adjustments to plan average risk scores

Payment transfer calculation based on adjusted plan average risk score

- Normalization
- AV Adjustment
- Rating Adjustment

Balanced Transfers

# Adjustments to Plan Average Risk Scores: Normalization

# Risk Score Normalization

- Risk scores predict how a plan's liability will differ from the State average due to the health status of its enrollees
- The risk adjustment model is being developed using a national sample.
- Average predicted State costs may differ from the average predicted costs in the model sample.
- A State-specific adjustment must be applied to risk scores to account for the difference between the State average predicted cost and the average predicted cost in the model sample.

# Risk Score Calculation

An enrollee's risk score is equal to the sum of the model coefficients for the relevant conditions

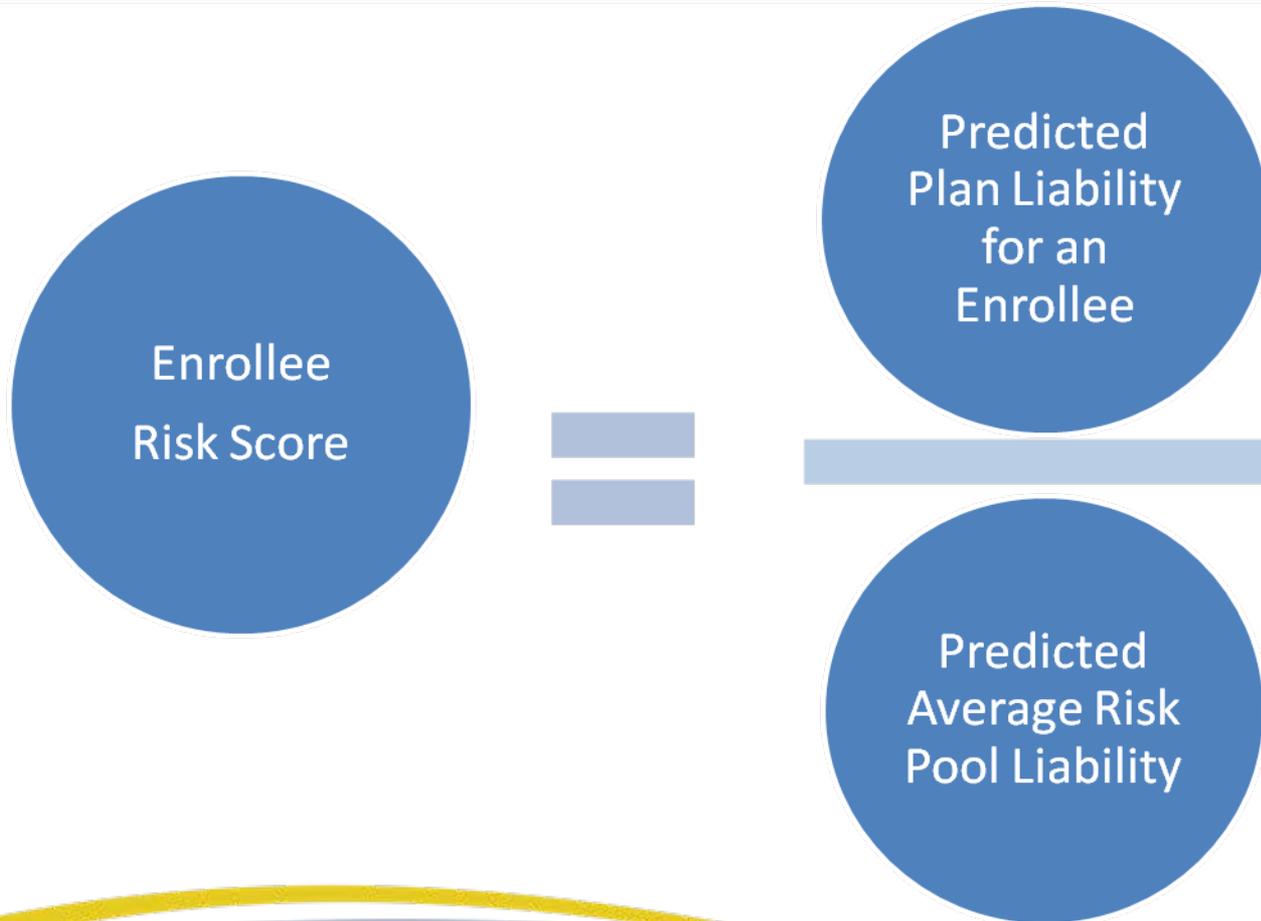
Enrollee Risk Score =

$.5[\text{Condition A}] + 1.3[\text{Condition B}] + .8[\text{Condition C}] \dots$

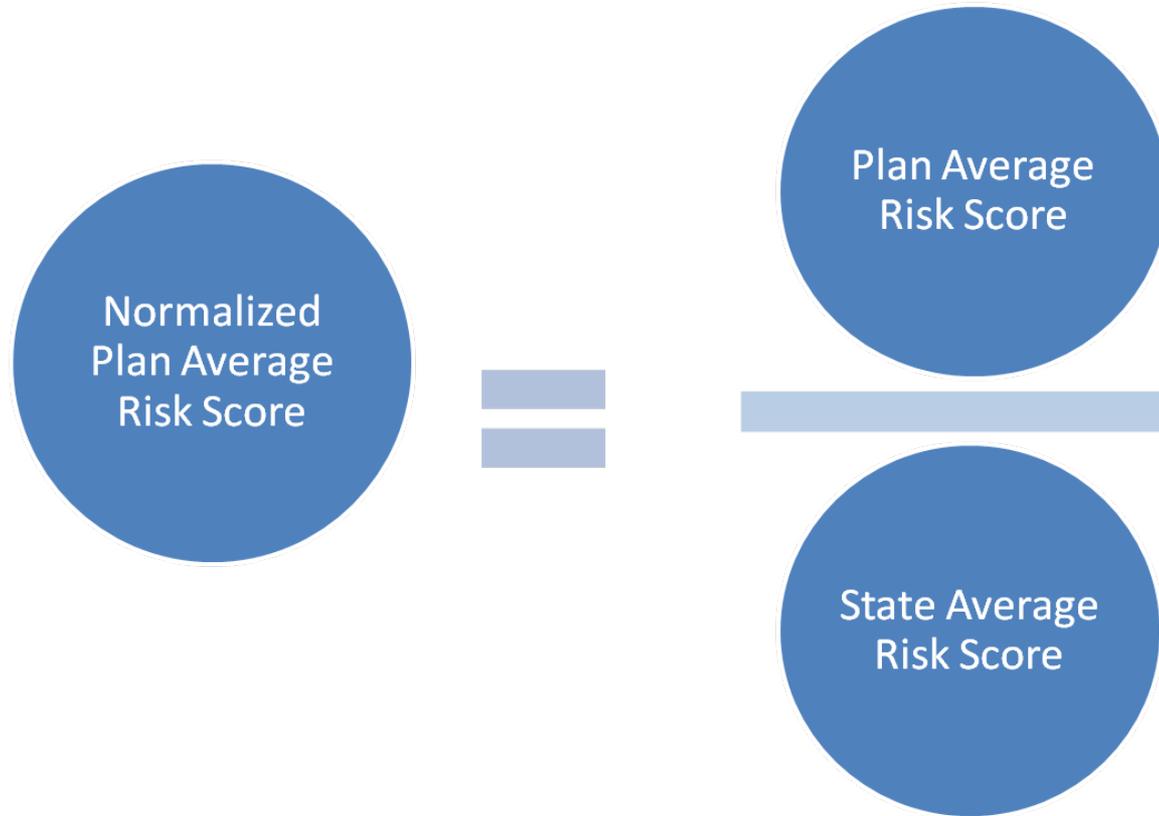
Coefficients provide predicted relative costs

Coefficients equal the ratio of condition costs to average enrollee total costs

# Risk Score Calculation



# Risk Score Normalization

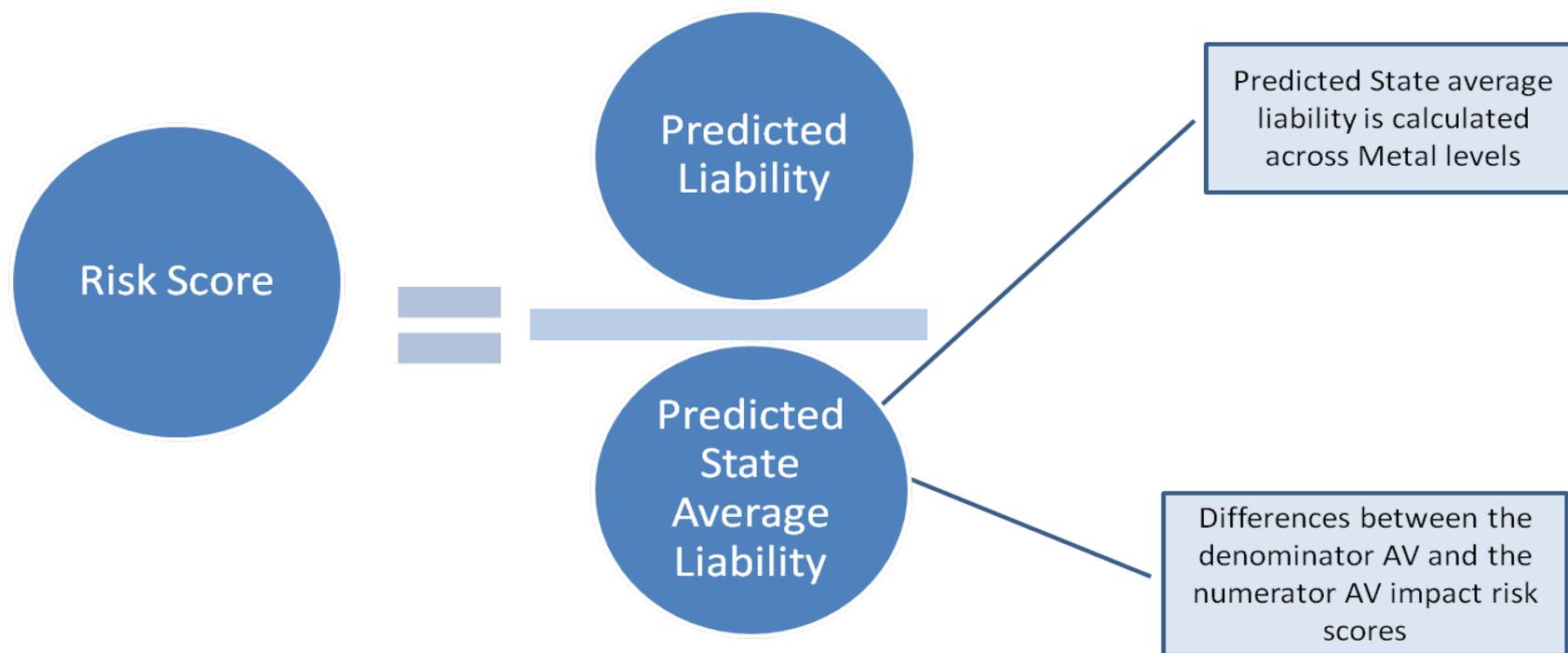


# Adjustments to Plan Average Risk Scores: Actuarial Value Adjustment

# Actuarial Value Adjustment

- Plan AV differences impact plan liability risk scores (e.g. Gold plans have higher risk scores than Bronze plans).
- Risk scores may be adjusted for AV in order to ensure that payment transfers do not compensate plans for actuarial value differences.

# Unadjusted Risk Scores Reflect Differences in Plan Selection and AV



# Example of Impact of AV on Unadjusted Risk Scores

- In this example, there is no risk selection in either plan.
- The unadjusted risk scores do not equal 1.0 due to differences in the numerator and denominator of the AV in the risk score calculation

	Plan A	Plan B	Average
Actuarial value	.6	.8	.7
Predicted total expenditures	\$1,000	\$1,000	\$1,000
Predicted liability	\$600	\$800	\$700
Liability risk score	.86 <i>(\$600/\$700)</i>	1.14 <i>(\$800/\$700)</i>	1.0

# Actuarial Value Adjustment

AV Adjustment =

$$\frac{\text{Plan Metal Level AV}}{\text{Enrollment-Weighted Average Risk Pool AV}}$$

- This adjustment provides the relative difference between a plan's AV and the risk pool average AV.
- This adjustment is subtracted from the risk score.

# Actuarial Value Adjustment

$$\text{AV Adjustment}(p) = \text{AV}(p) / [\sum S(p) * \text{AV}(p)]$$

where

$\text{AV}(p)$  = Metal-level AV for plan p

$S(p)$  = Risk pool enrollment share of plan p

# Actuarial Value Adjustment Example

	Plan A	Plan B	Average/Total
Actuarial value	.6	.8	.7
Predicted total expenditures	\$1,000	\$1,000	\$1,000
Predicted liability	\$600	\$800	\$700
Unadjusted liability risk score	.86 <i>(\$600/\$700)</i>	1.14 <i>(\$800/\$700)</i>	1.0
AV adjustment	.86 <i>(.6/.7)</i>	1.14 <i>(.8/.7)</i>	
Adjusted risk score	1.0 <i>(.86 - .86+1)</i>	1.0 <i>(1.14 - 1.14 +1)</i>	

# Adjustments to Plan Average Risk Scores: Permissible Rating Variation Adjustment

# Permissible Rating Variation Adjustment

- Under the Affordable Care Act, issuers are only permitted to vary rates based on:
  - Age (up to 3:1)
  - Tobacco use (up to 1.5:1)
  - Family size
  - Geography
- Payment transfers should not compensate plans for health status related liability that is already built into the premium rating structure

# Permissible Rating Variation Adjustment Example

- Rating provides partial compensation for risk selection
- Risk adjustment aims to compensate for liability that is not built into a plan's rating structure

Plan A Rating Cells	Total Expenditures	Bronze Plan Liability	Maximum Allowable Age-Rated Premiums
Younger cohort	\$200	\$120	Young Cohort Premium
Older cohort	\$1,200	\$760	3 X Young Cohort Premium

Plan Liability is 6 times higher in the Old cohort

# Permissible Rating Variation Adjustment

Risk Score Rating Adjustment =

$$\frac{\text{Plan Premium Rating Factor}}{\text{Enrollment-Weighted Average Premium Rating Factor}}$$

- This adjustment shows the extent to which a plan's premiums are affected by rating variation relative to the market average. This adjustment would be subtracted from risk scores.

# Permissible Rating Variation Adjustment

$$\text{RF Adjustment}(p) = \text{RF}(p) / [\sum S(p) * \text{RF}(p)]$$

where

RF(p) = rating factor for plan p

S(p) = risk pool enrollment share of plan p

# Permissible Rating Variation Adjustment Example

1. Market Consists of four plans

2. One market rating structure with a Young and Old rate

3. In this example, the Old cohort premiums are 3 times higher than the Young cohort's premiums

Bronze Plans	% Young Enrollees	% Old Enrollees	Rating Factor
Plan 1	100%	0%	1.0 $((1*1) + 0*3)$
Plan 2	50%	50%	2.0 $((.5*1) + (.5*3))$
Plan 3	25%	75%	2.5 $((.25*1) + .75*3)$
Plan 4	0%	100%	3.0 $((0*1) + (1*3))$
Total/Average	43.8%	56.3%	2.13

4. Rating Factor shows how much the average plan premium is scaled up or down based on the rating structure and plan enrollment

# Permissible Rating Variation Adjustment Example (Cont'd)

Bronze Plans	% Young Enrollees	% Old Enrollees	Rating Factor	Rating Factor Adjustment
Plan 1	100%	0%	1.0	0.47 <i>(1/2.13)</i>
Plan 2	50%	50%	2.0	0.94 <i>(2/2.13)</i>
Plan 3	25%	75%	2.5	1.18 <i>(2.5/2.13)</i>
Plan 4	0%	100%	3.0	1.41 <i>(3/2.13)</i>
Total/ Average	43.8%	56.3%	2.13	1.00

The rating factor adjustment is calculated as the ratio of the plan rating factor to the average market rating factor

Plan 4's premiums are scaled upwards due to age rating 41% more than the market average

# Permissible Rating Variation Example (Cont'd)

Bronze Plans	Rating Factor	Predicted Liability Per Enrollee	Rating Factor Adjustment	Unadjusted Plan Liability Risk Score	Adjusted Risk Score
Plan 1	1.0	\$200	.47 (1/2.13)	.26 (\$200/\$762)	.79 (.26 - .47 +1)
Plan 2	2.0	\$700	.94 (2/2.13)	.92 (\$700/\$762)	.98 (.92 - .94 +1)
Plan 3	2.5	\$950	1.18 (2.5/2.13)	1.25 (\$950/\$762)	1.07 (1.25 - 1.18 +1)
Plan 4	3.0	\$1,200	1.41 (3/2.13)	1.57 (\$1,200/\$762)	1.16 (1.57 - 1.41 +1)
Total/ Average	2.13	\$762	1.00	1.00	1.00

The rating adjustment reduces plan 4's risk score by 41%

# Payment Transfer Calculation

# Impact of Balanced Transfers Requirement on Payment Transfers

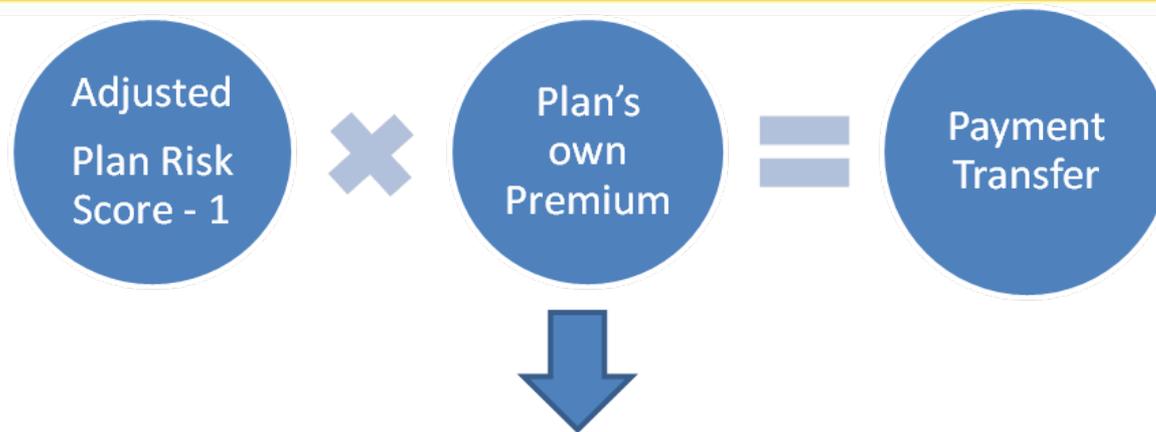
	Plan A	Plan B	Average/Total
Actuarial value	.6	.8	.7
Predicted total expenditures	\$900	\$1,100	\$1,000
Predicted liability	\$540 <i>(.6*\$900)</i>	\$880 <i>(.8*\$1,100)</i>	\$710
Liability for an average risk enrollee (risk standardized premium)	\$600 <i>(.6*\$1,000)</i>	\$800 <i>(.8*\$1,000)</i>	\$700
Transfer required to remove selection	-\$60 <i>(\$540-\$600)</i>	\$80 <i>(\$880-\$800)</i>	

Plan B's payment exceeds  
Plan A's charge

# Options for Addressing Imbalances in Payments and Charges

1. Plans' own premiums can be used as the basis for determining transfers and a balancing adjustment can be applied to transfers
2. The risk pool average premium can be used to set transfers. Under this approach no post-transfer balancing is required

# Risk Adjusting on a Plan's Own Premiums Could Lead to Payment Imbalances

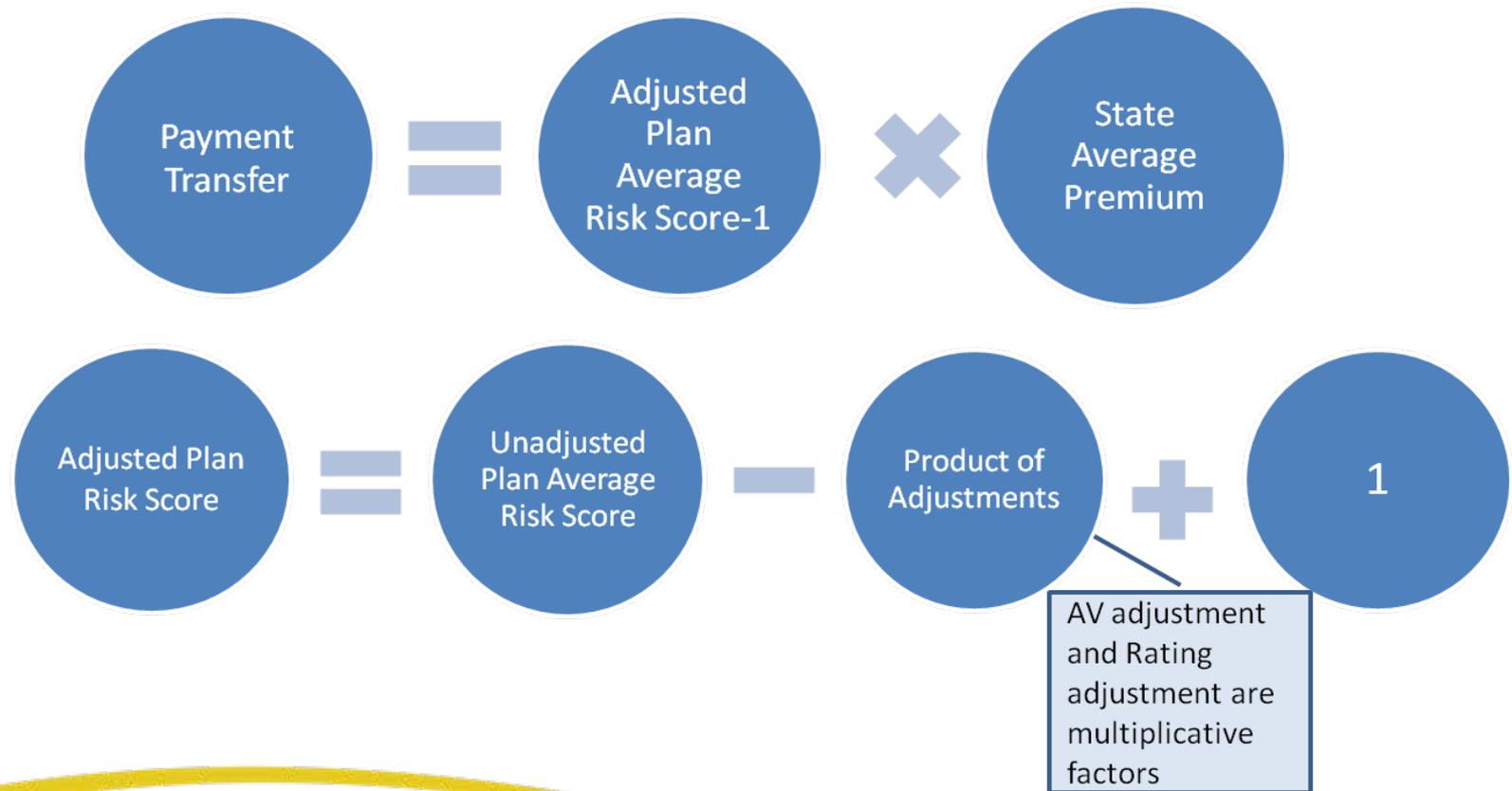


	Plan A	Plan B
Actuarial value	.6	.8
Predicted total expenditures	\$900	\$1,100
Predicted liability	\$540	\$880
Transfers	-\$60	\$80

# Using the State Average Premium as the Baseline Premium

- HHS is considering using a payment methodology based on the State average premium.
- This approach could:
  - Results in balanced transfers
  - Provide a practical and straightforward approach to calculating transfers
- Aim is for transfers that promote premiums that reflect differences in actuarial value

# Payment Transfers Using the State Average Premium



# Risk Score Adjustment

$$\text{Adjustment (p)} = [\text{AV(p)} * \text{RF(p)}] / [\sum \text{S(p)} * \text{AV(p)} * \text{RF(p)}]$$

Where

Adjustment (p) = risks score adjustment for plan p

RF(p) = rating factor of plan p

AV(p) = metal level actuarial value for plan p

S(p) = risk pool enrollment share for plan p

# State Average Methodology Example

	Plan A	Plan B	Average/Total
Actuarial value	.6	.8	.7
Predicted total expenditures	\$4,900	\$5,100	\$5,000
Predicted liability	\$2,940 (.6*\$4,900)	\$4,080 (.8*\$5,100)	\$3,510
Plan risk score	.84 ( $\$2,940/\$3,510$ )	1.16 ( $\$4,080/\$3,510$ )	1.0
AV adjustment	.86 (.6/.7)	1.14 (.8/.7)	1.0
Adjusted plan risk score	.98 (.84-.86+1)	1.02 (1.16-(1.14+1))	1.0

# State Average Methodology Example (Cont'd)

	Plan A	Plan B	Average/Total
Actuarial value	.6	.8	.7
Predicted total expenditures	\$4,900	\$5,100	\$5,000
Predicted liability	\$2,940 (.6*\$4,900)	\$4,080 (.8*\$5,100)	\$3,510
Adjusted plan risk score	.98 (.84-.86+1)	1.02 1.16-(1.14+1)	1.0
Transfer	-\$68.57 ((.98-1)*(\$3,510))	\$68.57 ((\$1.02-1)*(\$3,510))	\$0
Plan premiums (premiums are set to cover liability and transfer)	\$3,009 (\$2,940 +\$68.57)	\$4,011 (\$4,080-\$68.57)	\$3,510

# State Average Methodology Example (Continued)

	Plan A	Plan B	Average
Predicted liability for an average enrollee (risk standardized premium)	\$3,000 <i>(\$5,000*.6)</i>	\$4,000 <i>(5,000*.8)</i>	\$3,500
Plan premium	\$3,009 <i>(\$2,940 + \$68.57)</i>	\$4,011 <i>(\$4,080-\$68.57)</i>	\$3,510
Ratio of premium to risk standardized premium	1.003 <i>(\$3009/\$3000)</i>	1.003 <i>(\$4011/\$4000)</i>	1.003

# Next Steps

- HHS is still working on developing the payment transfer methodology. Draft policies will be announced in the draft HHS payment notice
- HHS would like feedback on the methodology described in this presentation
- HHS is considering adding adjustments to this methodology to account for geography, tobacco use, and induced utilization

## Next Steps (cont'd)

- HHS is aware that geographic cost differences across State rating areas can impact risk adjustment payments and charges when the State average premium is used as the baseline premium
- It is possible to develop a transfer equation that controls for geographic cost differences:
  - Requires using the rating area average premium for the baseline premium
  - Requires using a more complex transfer equation

# HHS Risk Adjustment Model

- Center for Consumer Information and Insurance Oversight.
- Centers for Medicare & Medicaid Services.
- Department of Health and Human Services.



# CONTEXT

The contents of this presentation represent preliminary information with the purpose of soliciting stakeholder feedback. Draft policies for the risk adjustment program will be announced in the draft HHS notice of benefit and payment parameters, which will be subject to comment before finalized.

# Agenda

- Introduction.
- Calibration data.
- Risk adjustment model.
- Variable selection.
- Potential adjustments to the model.

# Risk Adjustment Goals

## Overall goals:

- Mitigate the impacts of potential adverse selection.
- Stabilize premiums in the individual and small group markets.

## Aim:

- Premiums reflect differences in benefits and plan efficiency, not health status of enrolled population.

# Risk Adjustment Methodology

- Risk adjustment methodology is defined as:
  - Risk adjustment model.
  - Calculation of plan average actuarial risk.
    - Includes removing rating variation for age, geography, tobacco use, and family status.
  - Calculation of payments and charges.
  - Data collection approach.
  - Schedule for implementation.

# Risk Adjustment Model

- Risk adjustment model means an actuarial tool used to predict health care costs based on the relative actuarial risk of enrollees in risk adjustment covered plans (45 CFR 153.20).
- HHS is developing a risk adjustment model for the nonelderly population to be used when HHS is operating risk adjustment on behalf of a State. States operating a risk adjustment program may choose to use this model or an HHS certified alternate risk adjustment methodology.

# Risk Scores

- Individual risk scores
  - Each enrollee risk score is based on the individual's demographic and health status information.
  - A risk score is calculated as the sum of these demographic and health factors weighted by their estimated marginal contributions to total risk.
- Calculated relative to average expenditures:
- For example:
  - Average = \$1,000.
  - Female, 57 = \$500 = .5 risk factor.
  - Condition A = \$700 = .7 risk factor.
  - Risk Score =  $0.5 + 0.7 = 1.2$ .

# Risk Model Calibration Data

- The primary source for risk adjustment model calibration is Thomson Reuters MarketScan® data.
  - Data from employers and health plans.
  - HIPAA de-identified.
- 2010 MarketScan® database.
  - Initial Sample Size: 49.2 million in 2009, 45.2 million in 2010.
  - Male (49%), Female (51%).
  - Ages 0 to 64.
  - Includes data from all 50 States and DC.

# Sample Selection

- Preliminary modeling sample criteria.
  - Rx coverage required.
  - Mental health coverage required.
  - Claims paid on a capitated basis in 2010 excluded.
  - Minimum months of claims history data requirements still being explored.

# Diagnosis Classification

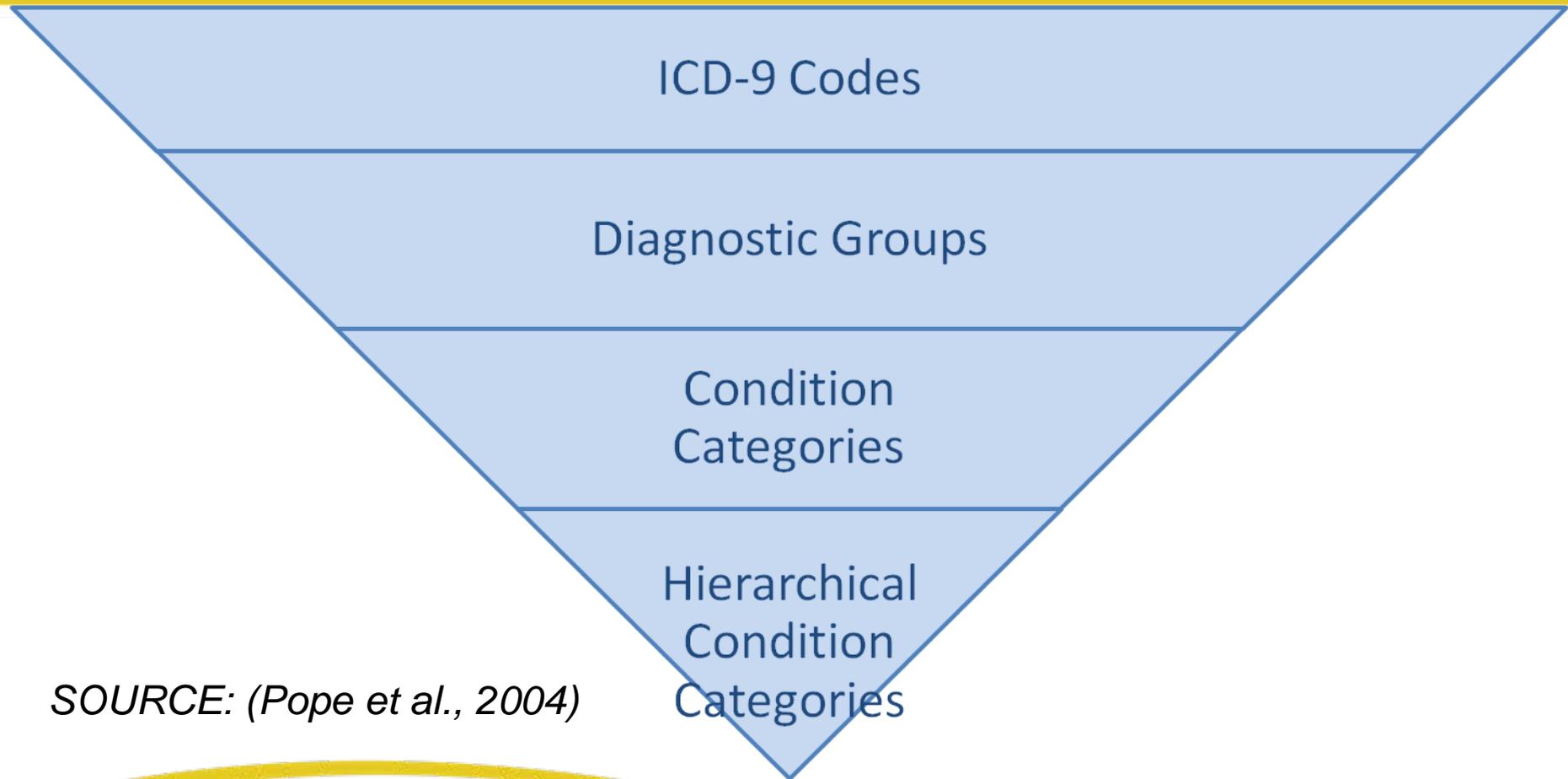
- HHS will use the Hierarchical Condition Category (HCC) classification system as a basis for the HHS risk adjustment model.
- HHS will review and refine the HCC classification system for private insurance populations where needed
  - Includes review of medical literature, empirical data analysis, and clinical review consultants.

# Hierarchical Condition Categories

- The HCC classification system provides the diagnostic framework for developing a risk adjustment model to predict medical spending.
- HCC diagnostic classification system.
  - 1) Classifies each diagnosis into a diagnostic group (DxGroup).
  - 2) Each DxGroup is then coded into a Condition Category (CC).
  - 3) Hierarchies are imposed among related CCs (individual is only coded for the most severe manifestation among related diseases).

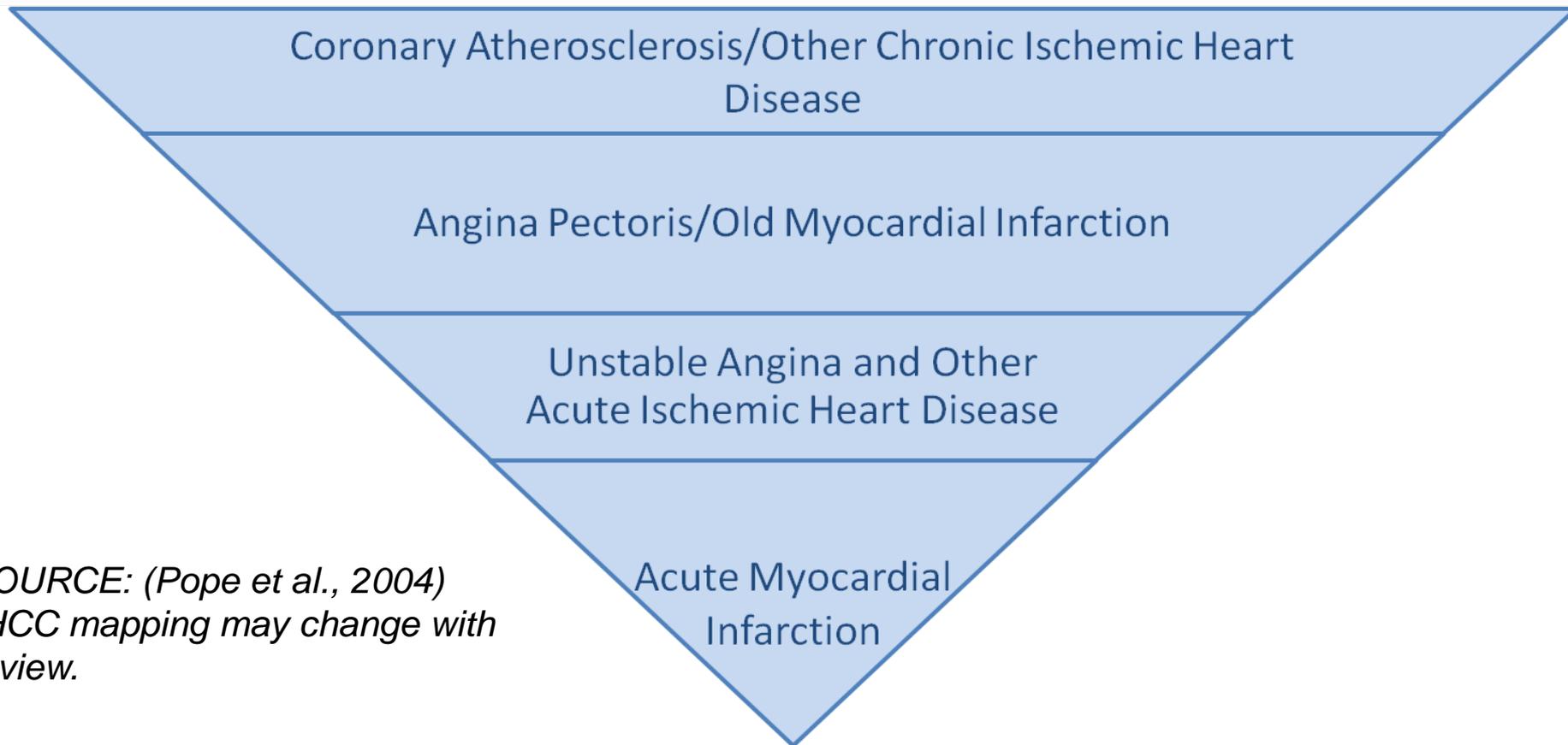
*SOURCE: (Pope et al., 2004)*

# Hierarchical Condition Categories (cont'd)



*SOURCE: (Pope et al., 2004)*

# HCCs: Coronary Artery Disease Hierarchy



*SOURCE: (Pope et al., 2004)  
\*HCC mapping may change with review.*

# Concurrent Model

- HHS intends to use a concurrent model when operating risk adjustment.
  - A model that uses diagnoses in the current year to predict expenditures in the current year.
  - HHS will likely not be using Rx as a predictor in the initial model.

# Variable Selection

- HHS will select a different set of HCCs for the Federal risk adjustment methodology than Medicare to reflect differences in population.
- HCCs may be excluded from the risk adjustment model if they are not empirically predictive of costs or their corresponding diagnoses are:
  - Vague/nonspecific (e.g., symptoms).
  - Discretionary in medical treatment or coding (e.g., osteoarthritis).
  - Not medically significant (e.g., muscle strain).

# Risk Adjustment Occurs Across Metal Levels: Total Expenditure v. Plan Liability

- Risk adjustment occurs across metal levels. Plans in different metal levels will not only have different expenditures for the same condition, the range of the relative expenditures for low and high risk individuals will be farther apart in a bronze plan than in a platinum plan.
- There are multiple options to calibrate a risk adjustment model in light of differing metal levels.
  - Total expenditure: The risk adjustment weight is total expenditure and resulting risk score is multiplied by the plan AV.
    - A person would have the same risk score across metal levels
    - One model for all metal levels.
  - Plan liability: The risk adjustment weight is expenditures a plan would pay for each benefit tier.
    - A person's risk score would depend on their metal level.
    - Separate model for each metal level.

# Total Expenditure v. Plan Liability (cont'd)

- HHS is considering the plan liability approach.
  - More accurately reflects plan liability for initial expenditures in light of differing deductibles.
  - More accurately reflects plan liability for people with higher versus lower expenditures across plan benefit tiers.
- HHS is also considering how to address costs for individuals with higher total expenditures.
  - Individuals with multiple conditions may produce different coefficients than predicted due to differences in plan liability.

# Total Liability v. Plan Liability (Example)

- Assume a Bronze plan has a deductible of \$3,000, coinsurance of 20%, and out of pocket maximum of \$6,000.
- Assume a Platinum plan has a deductible of \$150, a coinsurance rate of 20% and a out of pocket maximum of \$1,500.

# Total Expenditure v. Plan Liability (Example)

- Different plan designs will produce different liabilities for the same condition.

Condition	Total Expenditure	Bronze Plan Liability	Platinum Plan Liability
A	\$5,000	\$1,600	\$3,880
B	\$20,000	\$14,000	\$18,500

# Additional Issues to be Addressed: Reinsurance

- Plans in the individual market that receive risk adjustment payments may also receive ACA transitional reinsurance payments for the same high risk enrollees. Adjusting for transitional reinsurance payments would address concerns that a plan could be compensated twice for the same high-risk individuals.
- HHS is inclined to propose not to adjust for transitional reinsurance payments given the temporary nature of the program.
- Adjusting would:
  - Reduce incentives for issuers to enroll high risk individuals.
  - Increase model complexity and may increase uncertainty.
  - Raise analytic issues to correctly calibrate a risk adjustment adjusted for reinsurance payments.
- Comments welcome.

# Additional Issues to be Addressed: Cost Sharing Reductions

- Individuals who qualify for cost sharing reductions may have higher utilization patterns because cost sharing reductions lower the financial burden of medical care.
  - Adjusting for receipt of cost sharing reductions would adjust for differences in utilization among individuals in the individual market but not in SHOP exchange.
  - We are considering whether the HHS risk adjustment model should include receipt of cost sharing reductions as a factor in the model to account for the utilization.

# Next Steps

- Content enclosed in these slides reflect proposed thinking.
- Comments are requested.

# Risk Adjustment Overview

- Center for Consumer Information and Insurance Oversight.
- Centers for Medicare & Medicaid Services.
- Department of Health and Human Services.



May 7, 2012

# CONTEXT

The contents of this presentation represent preliminary information with the purpose of soliciting stakeholder feedback. Draft policies for the risk adjustment program will be announced in the draft HHS notice of benefit and payment parameters, which will be subject to comment before finalized.

# Contents

- Introduction and overview.
- Context.
- Market environment.
- Meeting agenda.

# Risk Adjustment Under the Affordable Care Act

- **What:** Transfers funds from plans with lower risk enrollees to plans with higher risk enrollees.
- **Who participates:** Non-grandfathered individual and small group market plans, inside and outside the Exchange.
- **How:** Criteria and methods developed by the Secretary, in consultation with States. May be similar to criteria and methods utilized under Part C or D of Medicare.

# Need for Risk Adjustment

- History.
- ACA policy context.
- Purpose.

# Affordable Care Act vs. Medicare Risk Adjustment

Category	ACA Risk Adjustment	Medicare
<b>Plan Benefits</b>	Benefit tiers based on actuarial value; benefit structure varies within tiers.	Plans provide, at a minimum, Medicare benefits.
<b>Plan-level premiums</b>	Can vary based on age, tobacco use, geography and family size.	Uniform plan premiums.
<b>Monetary basis for transfers</b>	Based on premiums seen in market.	Standardized bid.
<b>Transfer of funds</b>	Charges assessed at plan level; lower risk plans are charged and higher risk plans make payments after the benefit year.	Prospective payment adjustments (up or down) to individual standardized bid.
<b>Budget</b>	Budget-neutral.	Not budget-neutral.

# Market Context: Rating Reforms

- Rating reforms.
  - Age (up to 3:1).
  - Tobacco use (up to 1.5:1).
  - Family size.
  - Geography.
  - Single risk pool.
- Metal levels
  - Bronze, silver, gold, platinum, catastrophic.
  - Silver variants for cost-sharing reductions.

# Market Context: New Enrollees

- Currently uninsured.
- Individual market – current enrollees.
- PCIP enrollees.
- Individuals with prior employer sponsored insurance.

# Agenda

- Final rule summary.
- HHS developed risk adjustment model.
- Plan average actuarial risk calculations & payments and charges calculations.
- State flexibility for risk adjustment.
- Tomorrow: HHS operated risk adjustment.

# Reinsurance, Risk Corridors, and Risk Adjustment Final Rule

- Center for Consumer Information and Insurance Oversight.
- Centers for Medicare & Medicaid Services.
- Department of Health and Human Services.



# Contents

- Background.
- Overview.
- Methodology.
- Data collection.
- Notice of benefit and payment parameters.
- Next steps.

# Background

- The Affordable Care Act establishes State-based reinsurance and risk adjustment programs, and a Federal risk corridors program.
- The overall goal of these programs is to provide certainty and protect against adverse selection in the market while stabilizing premiums in the individual and small group markets as market reforms and Exchange begin in 2014.
- The Premium Stabilization final rule establishes standards to ensure effective program implementation while providing significant State flexibility and imposing minimal burden on States and issuers.

# Overview of Risk Adjustment Program

- Section 1343 of the Affordable Care Act provides for a permanent risk adjustment program.
  - Applies to non-grandfathered individual and small group plans inside and outside Exchanges.
- Provides payments to health insurance issuers that disproportionately attract higher-risk populations (such as individuals with chronic conditions).
- Transfers funds from plans with relatively lower risk enrollees to plans with relatively higher risk enrollees to protect against adverse selection.

# Overview of Risk Adjustment Program (cont.)

- States that are approved to operate a State-based Exchange are eligible to establish a risk adjustment program:
  - States operating a risk adjustment program may have an entity other than the Exchange perform this function.
  - HHS will operate a risk adjustment program for each State that does not operate risk adjustment.

# Overview of Risk Adjustment Program (cont.)

- HHS will develop, publish, take comment, and finalize a risk adjustment methodology for use when operating risk adjustment on behalf of a State.
- A State operating risk adjustment may use the Federal methodology or propose alternate risk adjustment methodologies for certification by HHS.
  - Any federally certified risk adjustment methodology can be used by a State operating risk adjustment.

# Overview of Risk Adjustment Program: The Methodology

- The final rule defines a risk adjustment methodology as:
  - Risk adjustment model.
  - Calculation of plan average actuarial risk.
    - Includes removing rating variation for age, geography, tobacco use and family status.
  - Calculation of payments and charges.
  - Data collection approach.
  - Schedule for implementation.

# Overview of Risk Adjustment Program: Data Collection Approach

- States operating risk adjustment may adopt data collection approach that best suits their program's needs provided that they collect only information that is reasonably necessary for their risk adjustment methodology.
- States must develop privacy and security standards, and must ensure annual validation of risk adjustment data.
- HHS will use a distributed approach when operating risk adjustment on behalf of a State – data needed to operate risk adjustment will reside with the issuer.

# Notices of Benefit and Payment Parameters

- HHS will publish a draft HHS notice of benefit and payment parameters in the Fall of 2012 for the benefit year 2014.
- There will be a 30 day comment period, and a final notice will be published in January 2013.
- State notices of benefit and payment parameters must be published by March 1, 2013:
  - State must publish a notice if it establishes a reinsurance program and plans to modify the Federal parameters, or if it plans to operate a risk adjustment program.

# Next Steps

- Ongoing HHS Technical Support for States and Issuers.
- Draft HHS payment notice in Fall 2012.
- Final HHS payment notice in January 2013.

# State Flexibility and Alternate Methodologies

- Center for Consumer Information and Insurance Oversight.
- Centers for Medicare & Medicaid Services.
- Department of Health and Human Services.



# CONTEXT

The contents of this presentation represent preliminary information with the purpose of soliciting stakeholder feedback. Draft policies for the risk adjustment program will be announced in the draft HHS notice of benefit and payment parameters, which will be subject to comment before finalized.

# Agenda

- Background.
- Overview of alternate methodology.
- Process.
- Content.
- Technical assistance.
- Questions.

# Background

## Overall goals:

- Mitigate the impacts of potential adverse selection.
- Stabilize premiums in the individual and small group markets.

## Aim:

- Premiums reflect differences in benefits and plan efficiency, not health status of enrolled population.

# Overview of Risk Adjustment Methodologies

- HHS will develop a risk adjustment methodology for use when operating risk adjustment on behalf of a State.
- A State may propose alternate risk adjustment methodologies for certification by HHS.
- Any Federally certified risk adjustment methodology (including the methodology developed by HHS) can be used by a State operating risk adjustment.

# Risk Adjustment Methodology

- Risk adjustment methodology is defined in Premium Stabilization final rule as:
  - Risk adjustment model.
  - Calculation of plan average actuarial risk.
    - Includes removing rating variation for age, geography, tobacco use, and family status.
  - Calculation of payments and charges.
  - Data collection approach.
  - Schedule for implementation.

# State Flexibility

- States can modify the:
  - Risk adjustment model.
  - Calculation of plan average actuarial risk.
  - Calibration data.
  - Data collection approach.
  - Schedule for implementation.
- For example, a State could propose an alternate model that:
  - Incorporates a prospective model approach.
  - Has State-specific weights different from the weights in the model developed by HHS.
- States cannot initially vary from the HHS methodology for payments and charges.

# Process for Proposing a State Alternate Risk Adjustment Methodology

- Within 30 days of release of the draft HHS payment notice, States interested in using an alternate methodology would submit to HHS:
  - Risk adjustment model description.
  - Calculation of plan average actuarial risk.
  - Data collection approach.
  - Schedule for implementation.
  - Schedule for recalibration.
- HHS will consider alternate methodologies based on criteria established in 45 CFR 153.330 (i.e. uses data that is complete, high quality, and available in a timely fashion) and detailed in the draft HHS payment notice.
- HHS will publish the list of certified methodologies in the final HHS payment notice.
- States can choose any Federally certified methodology when operating risk adjustment. The State must notify issuers and the public in the State Notice of Benefit and Payment Parameters.

# Process for Proposing a State Alternate Risk Adjustment Methodology (cont'd)

- A State request to HHS for the certification of an alternate risk adjustment methodology will include:
  - Information noted in 45 CFR 153.330.
  - Additional information that will be forthcoming in the draft HHS payment notice.
- Information will likely include:
  - Underlying clinical and predictive logic and organization of the alternative risk adjustment model.
  - Description of how each plan's average actuarial risk will be calculated.
  - Description of data collection approach.
  - Statistical model performance.
  - Written evaluations of model performance.

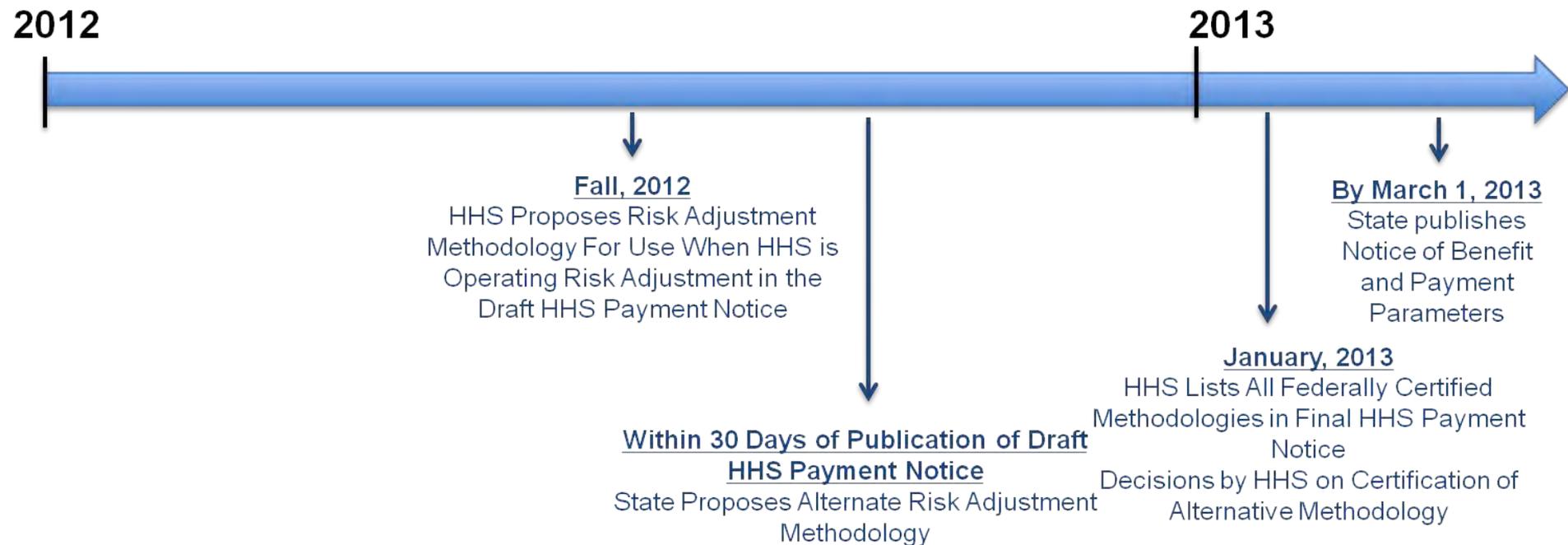
# Evaluation Criteria for State Alternate Risk Adjustment Methodology

- Criteria for evaluating alternate methodologies will be finalized in the draft HHS payment notice.
- HHS is considering some of the following criteria to review alternate methodologies:
  - Model would produce risk scores based on individual level data.
  - Risk factors are calibrated on a sample reasonably representative of the anticipated risk adjustment population.
  - Risk scores produced would reflect the relative health care expenditures or resource use associated with the required covered benefits.
  - Methodology would have a reasonable level of transparency.
  - Model track record will be evaluated.

# State Notice Requirements in Premium Stabilization Final Rule

- States that are approved to operate their own risk adjustment program would publish information on their risk adjustment methodology by March 1, 2013.
- Information on what should be in the State notice can be found in 45 CFR 153.110.
- States are encouraged to have a transparent process and to interact with stakeholders leading up to their State notice.

# Major Milestones for Risk Adjustment Methodology for 2012-2013



# Technical Assistance

- HHS will provide technical assistance to any State that is thinking about developing an alternate methodology.
- States that are considering submitting an alternate methodology are encouraged to contact HHS at any point in their development for assistance.
- States can propose an alternate methodology after the initial year.