Risk Adjustment (RA): Introduction to the Affordable Care Act (ACA) RA Program for New Issuers

February 18, 2016

Health Insurance Marketplace Program Training Series

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

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Session Guidelines

- This is a 90-minute webinar session.
- Frequently Asked Questions (FAQs) will be posted in the coming weeks.
- For questions regarding content, please submit inquiries to REGTAP at https://www.REGTAP.info/.
- For questions regarding logistics and registration, please contact the Registrar at: (800) 257-9520.

Intended Audience

- New issuers of Marketplace and Non-Marketplace plans, in states where the Department of Health and Human Services (HHS) operates the RA and Reinsurance programs.
- Third Party Administrators (TPAs) and support vendors.
- New Amazon and On-Premise External Data Gathering Environment (EDGE) server issuers (Marketplace and Non-Marketplace).

Purpose

This stakeholder training session will provide issuers who are new to HHS-operated RA with an overview of the program.

Risk Adjustment (RA) Overview

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Risk Adjustment Overview

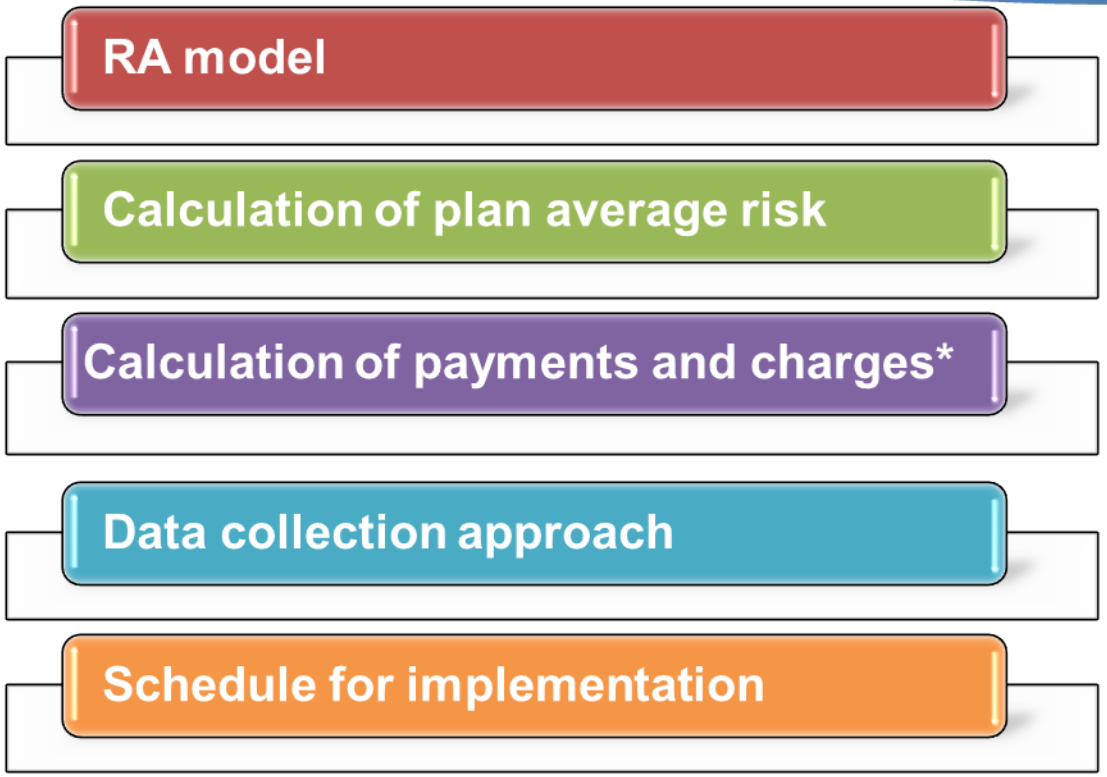
- Risk Adjustment: one (1) of three (3) premium stabilization programs established by the ACA with the overall goal of providing certainty and protecting against adverse selection in the individual and small group markets while stabilizing premiums under new market reforms beginning in 2014.
- The ACA grants authority for HHS to operate a RA program on behalf of any state that chooses not to implement its own state-based program.
- Regulations at 45 CFR Part 153 establish standards for the RA program. The Premium Stabilization Rule, Annual Notices of Benefit and Payment Parameters, and the Program Integrity Rule have all addressed RA policies. Links to these rules can be found in the Resources section of these slides.
- CMS is the HHS entity responsible for implementing the HHS-operated RA program under the ACA.

Risk Adjustment Overview (continued)

- **What**: A budget neutral program that transfers funds from plans with lower risk enrollees to plans with higher risk enrollees in a state market.
- **Who participates**: ACA-compliant non-grandfathered individual and small group plans, inside and outside the Marketplace.
- **How**: Criteria and methods developed by the Secretary of HHS, in consultation with states and issuers.

Risk Adjustment Overview (continued)

RA methodology is defined in the Premium Stabilization final rule as:



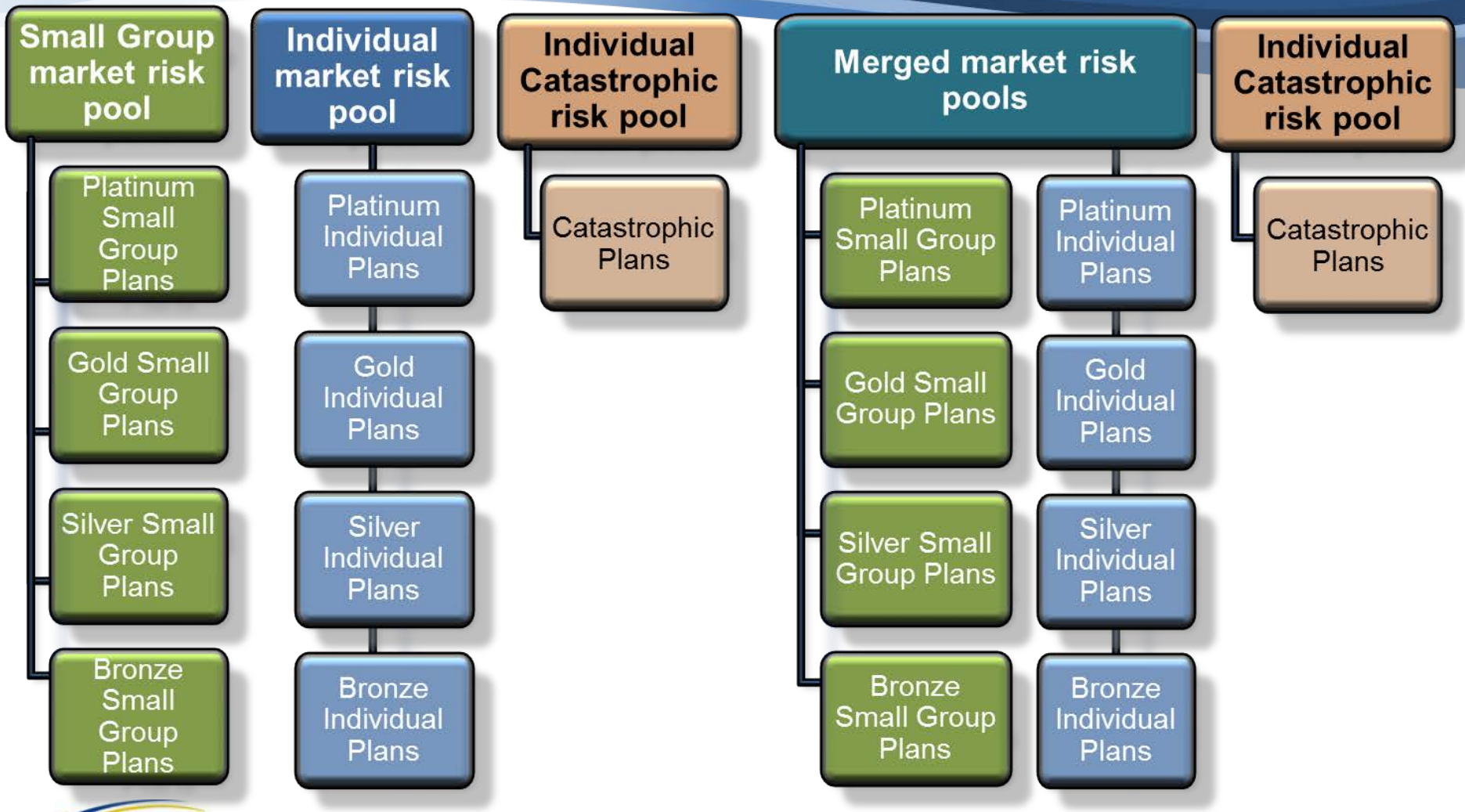
*Includes removing rating variations for age or family tier (based on state rating method) and geography

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RA Overview: Key Concepts

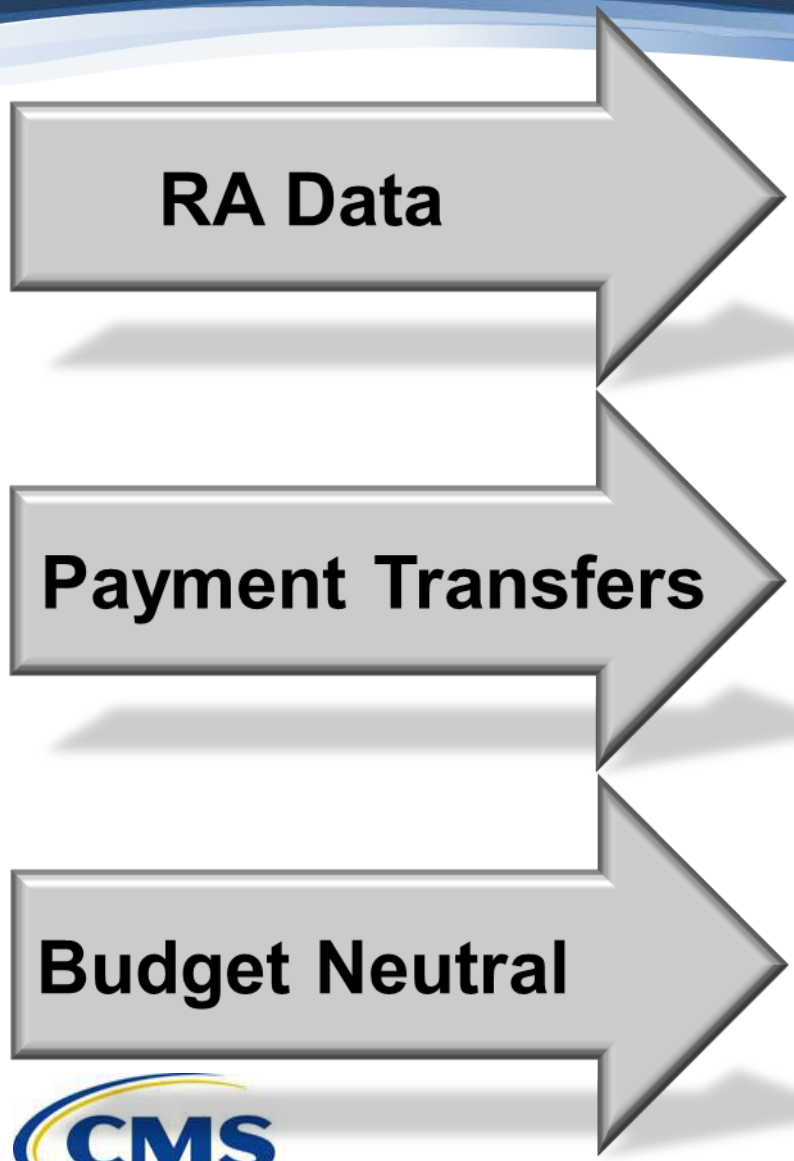
- RA model: A tool used to predict health care costs based on the relative actuarial risk of enrollees.
- Risk pool: a group of plans in the same market.
- Market and risk pool combinations:
  - Small group metal plans (bronze, silver, gold, platinum).
  - Individual metal plans (bronze, silver, gold, platinum).
  - Individual market catastrophic plans.
  - Merged market – two (2) risk pools
    - 1) All metal plans (individual market non-catastrophic and small group market bronze, silver, gold, platinum plans) and,
    - 2) Individual market catastrophic plans.

RA Overview: Risk Pool/Market



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RA Overview: Key Concepts
(continued)



Refers to a subset of issuer data submitted on the EDGE server that will be relevant for RA calculations.

Amounts transferred between plans. Calculated for each plan within a state market risk pool and plan rating area.

RA payments and charges within a market and risk pool should net to zero (0) dollars.

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RA Overview: Key Concepts
(continued)

RA Default Charge

Charge to issuers who fail to comply with regulations in such a way that the RA program cannot perform payment transfer calculations.

RA User Fee

Fee for RA-eligible issuers in the HHS-operated RA program to support RA program administration.

Risk Adjustment Data Validation (RADV)

States (or HHS on behalf of states) validate a statistically-valid sample of data for all issuers every year.

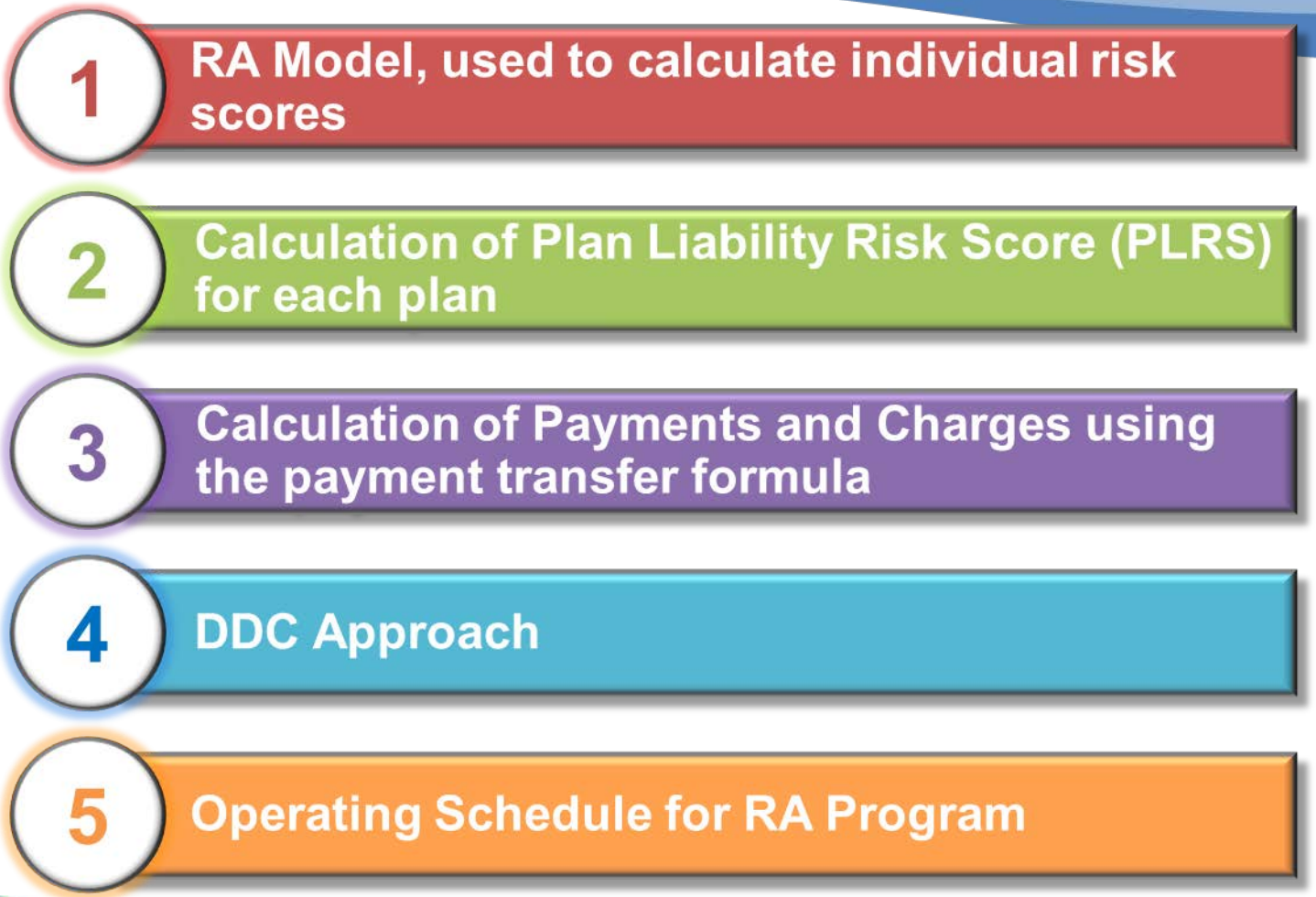
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HHS RA Methodology

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HHS RA Methodology



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HHS RA Methodology: RA Model

1 RA Model

- First, CMS uses the RA model to calculate individual risk scores.
- CMS has developed an RA model for the non-elderly population to be used when HHS is operating RA on behalf of any state.
- The primary source for RA model calibration is Thomson Reuters MarketScan® data which includes:
  - Data from employers and health plans.
  - HIPAA de-identified.
  - Includes data from all 50 States and DC.
- The concurrent model uses data from the current benefit year to predict enrollee health care costs in the same year.

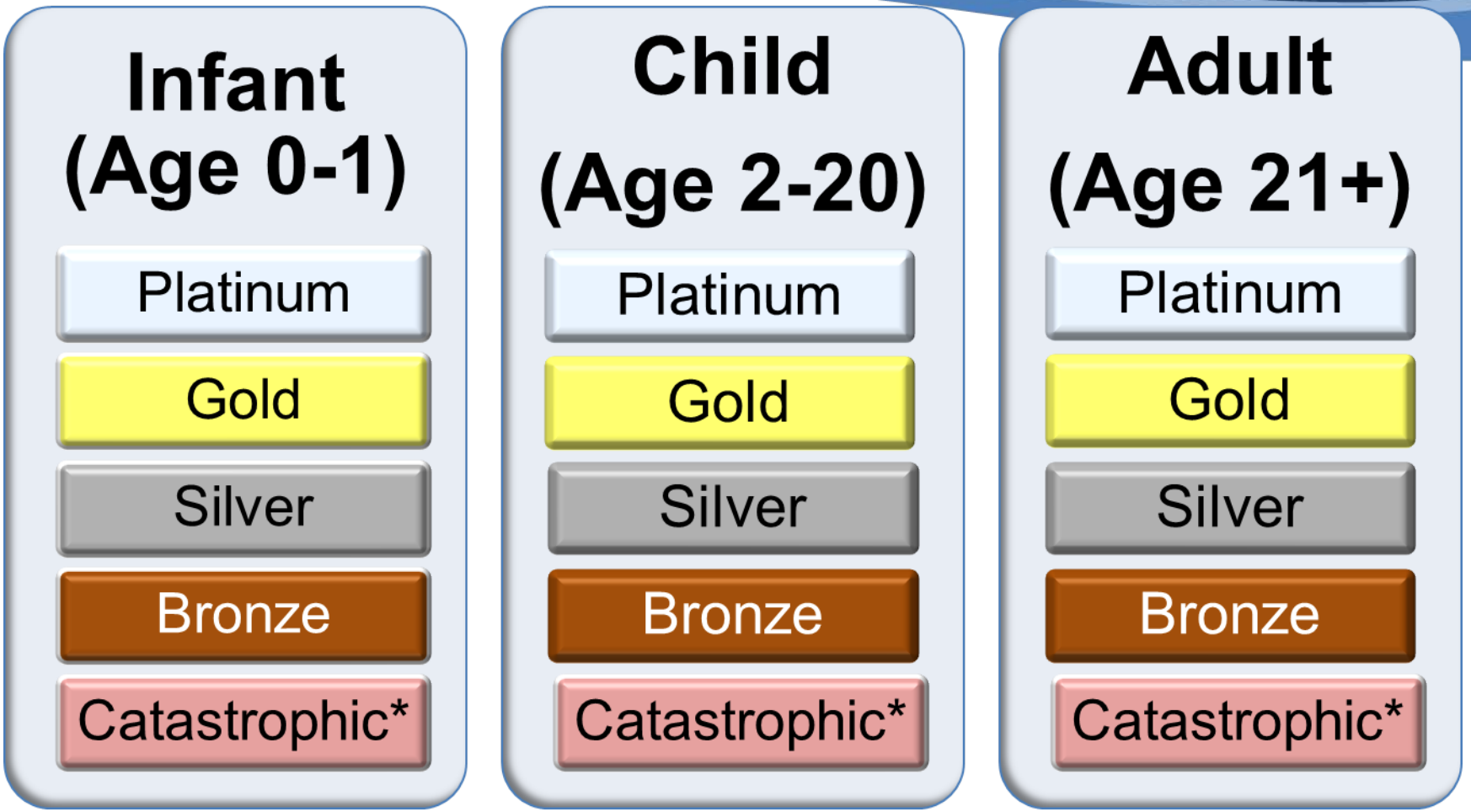
HHS RA Methodology: RA Model (continued)

1 RA Model

The model calculates risk scores for each enrollee in a plan based on four (4) factors:

- an age model factor,
- a demographic factor within the age model,
- diagnostic factor(s),
- and a Cost-Sharing Reduction (CSR) factor, if applicable.
  - Adjustment for increased utilization by enrollees who receive cost-sharing reduction in certain individual market plans.

Risk Score Calculation: 15 Risk Score Models



* Individual market only

HHS RA Methodology: RA Model (continued)

1 RA Model

- Model selection for each enrollee is based on two (2) enrollee factors:
  - Age band (infant, child or adult), and
  - Metal level (platinum, gold, silver, bronze or catastrophic).
- Adult and child models are additive: That is, the relative costs assigned to an individual's age, sex, and diagnoses are added together to produce a risk score.
- Infants are grouped in the infant model: Infants fall into 1 of 25 groups based on the infant's highest maturity and severity level combination from accepted diagnoses.
- Finally, the model multiplies individual risk scores by the CSR factor, if appropriate.

HHS RA Methodology: RA Model (continued)

1 RA Model

Example – Adult model risk score calculation:

- Average Expenditures = $1,000
- Female, 57 = $500 = 0.5 risk factor
- Condition A = $700 = 0.7 risk factor
- Risk Score = 0.5 + 0.7 = 1.2

Calculated relative to average expenditures.

HHS RA Methodology: PLRS

2 Calculation of Plan Liability Risk Score (PLRS)

- Second, CMS uses the individual risk scores to calculate the plan liability risk score (PLRS).
- PLRS is the average enrollee risk score in the plan in a rating area.
- Risk scores are weighted by billable member months, so that enrollees who are in the plan longer have more weight in their scores.

HHS RA Methodology: PLRS
(continued)

2 Calculation of Plan Liability Risk Score (PLRS)

$$PLRS_i = \frac{\Sigma_e (M_e \times PLRS_e)}{\Sigma_b M_b}$$

- $PLRS_i$ = plan's Plan Average Liability Risk Score
- M_e = number of months during the applicable benefit period that each **enrollee** is enrolled in the plan
- Σ_e = sum for all enrollees in the plan
- $PLRS_e$ = Individual-level risk score for each enrollee
- M_b = number of months during the applicable benefit period that each **billable member** is enrolled in the plan

Risk Score Adult Example

Conceptual Overview of Transfers

3 Calculation of Payments and Charges

- The state average premium is used in the transfer formula to develop two (2) plan level premium estimates: 1) Estimate of plan premium with risk selection, and 2) Estimate of plan premium without risk selection.
- Transfers are intended to bridge the gap between a plan's actual revenue requirements and what its revenue requirements would be in the absence of risk selection.



Conceptual Overview of Transfers
(continued)

3 Calculation of Payments and Charges

- The state average premium represents the average revenue requirement to provide insurance coverage.
- The transfer formula predicts a plan's actual revenue requirements by adjusting the state average premium to account for plan-specific cost factors such as risk selection and benefit differences.



- Risk is measured by the difference between the two plan premium estimates which isolates the impact of risk selection on plan liability.

HHS RA Methodology: Payment Transfers



- The payment transfer formula determines the amount of payments and charges assigned to each plan within a risk pool.
- Payment transfers preserve premium differences associated with cost factors ***not attributable to risk selection***, such as differences in plan benefits.
- RA payment transfers provide issuers with higher-than-average risk with a payment to help compensate for a plan's actual risk exposure.
- Issuers that have lower-than-average risk are assessed a charge and issuers that have higher-than-average risk will receive a payment.

HHS RA Methodology: Payment Transfers (continued)

3 Calculation of Payments and Charges

$$T_{PMPM} = \left[\frac{PLRS_i \cdot IDF_i \cdot GCF_i}{\sum_i (s_i \cdot PLRS_i \cdot IDF_i \cdot GCF_i)} - \frac{AV_i \cdot ARF_i \cdot IDF_i \cdot GCF_i}{\sum_i (s_i \cdot AV_i \cdot ARF_i \cdot IDF_i \cdot GCF_i)} \right] \bar{P}_s$$

Where:

- $\bar{P}_s$ = State average premium,
- $PLRS_i$ = plan *i*'s plan liability risk score,
- AV_i = plan *i*'s metal level actuarial value,
- ARF_i = plan *i*'s allowable rating factor,
- s_i = plan *i*'s share of state enrollment,
- and the denominator of premium factor terms is summed across all plans in the state risk pool.

HHS RA Methodology: Payment Transfers (continued)

3 Calculation of Payments and Charges

$$T_i = T_{PMPM} * \sum_b M_b$$

- The final payment transfer amount is calculated by multiplying T_{PMPM} and the sum of the billable member months for an issuer.

HHS RA Methodology: Payment Transfers (continued)

3 Calculation of Payments and Charges

- Premium adjustments:
  - **Actuarial Value** (AV) – adjusts for relative differences between the plan actuarial value in a market.
  - **Induced Demand Factor** (IDF) – accounts for greater utilization of health care services induced by lower enrollee cost sharing in higher metal level plans.
  - **Geographic Cost Factor** (GCF) – accounts for cost differences across rating areas.
  - **Allowable Rating Factor** (ARF) – accounts for the impact of allowable rating factors (age or family tier) based on state rating method.

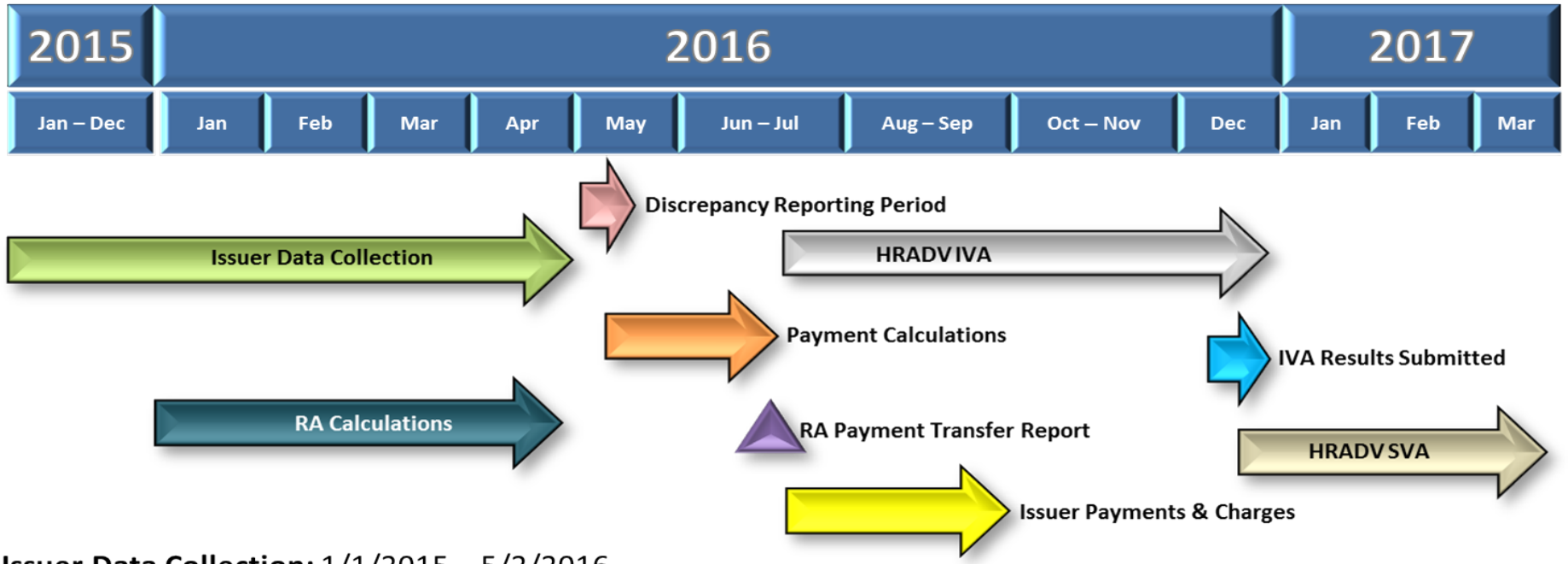
HHS RA Methodology: DDC Approach



- RA data collection is achieved through the HHS operated Distributed Data Collection (DDC) process for the RA and RI programs (also known as the EDGE server).
- Issuers will receive RA specific outputs from files that are processed on the EDGE server.
- The information will include outputs for individual enrollees and claims as well as summary information at the plan and issuer levels on data that will be relevant for RA calculations.

HHS RA Methodology: Schedule

5 Operating Schedule for RA Program



Issuer Data Collection: 1/1/2015 – 5/2/2016
RA EDGE Calculations*: 1/9/2016 – 5/3/2016
Final Discrepancy Reporting Period: 5/3/2016 – 5/18/2016
Payment Calculations: 5/3/2016 – 6/30/2016
RA Payment Transfer Reports Issued: 6/30/2016
Issuer Payments & Charges: 7/1/2016 – 9/30/2016
HHS-operated Risk Adjustment Data Validation (HRADV) Initial Validation Audit (IVA): July 2016 – December 2016
IVA Results and Supporting Documents Submitted: December 2016
HRADV Second Validation Audit (SVA): December 2016 – March 2017

*Issuers can run RA commands locally at any time.

Risk Adjustment Operational Processes

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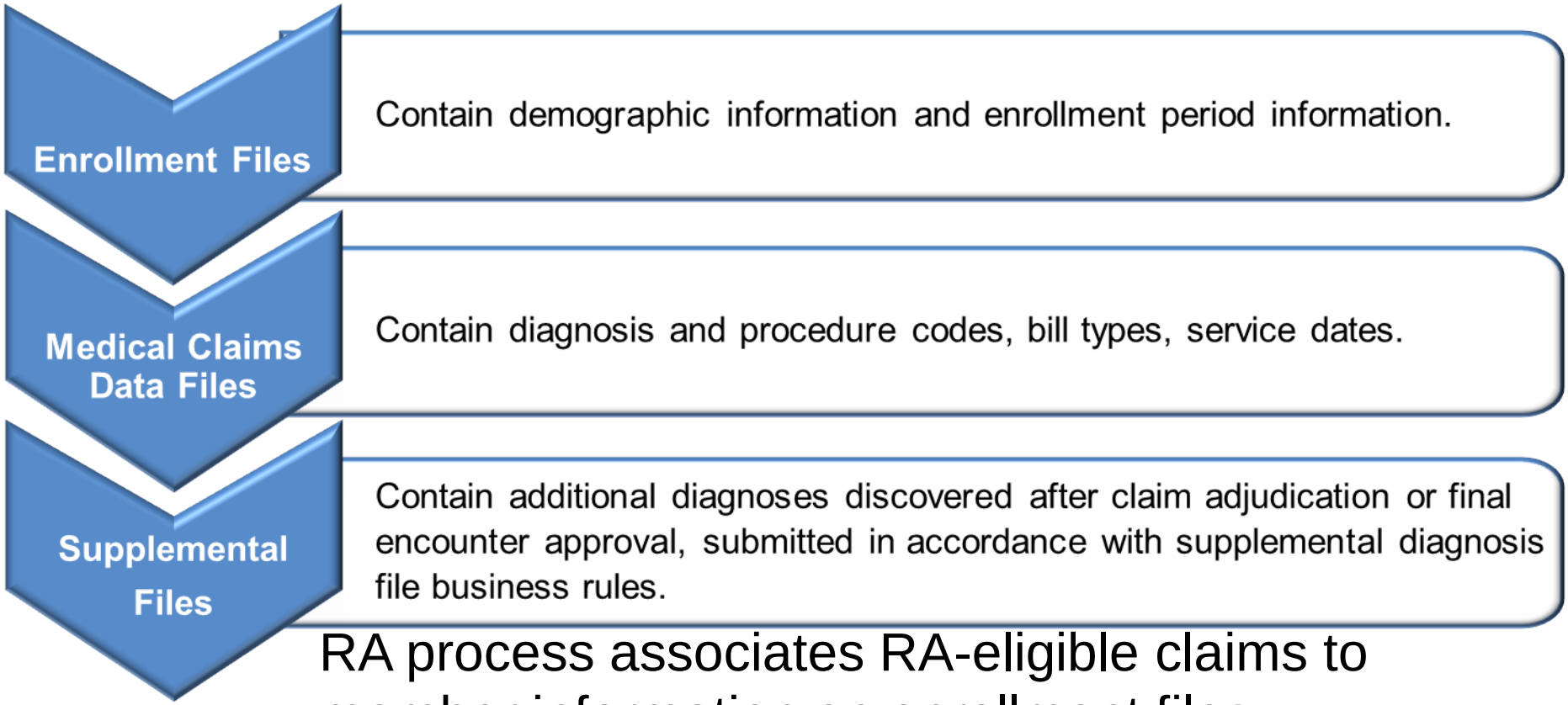
RA Operational Processes



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RA Data Collection

Issuer EDGE data files that are used for RA calculations:



RA process associates RA-eligible claims to member information on enrollment files.

RA Data Collection (continued)

Member enrollment files are used to determine:

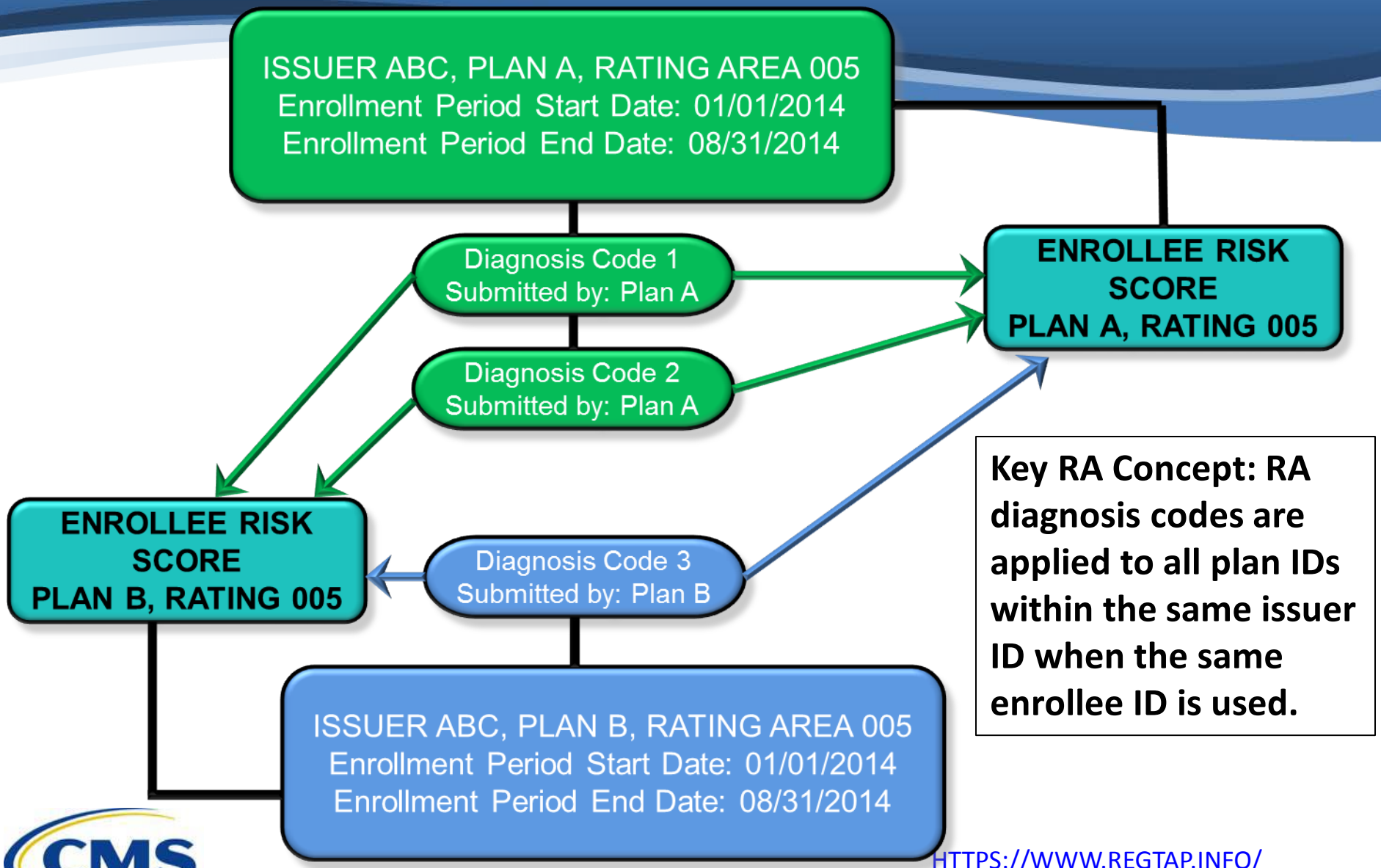
- Eligible enrollment periods and member months for RA calculations.
- Use of enrollment period activity indicator (EPAI) to
  - Track relevant changes to policies based on subscriber and dependent updates.
  - Associate billable member months to a subscriber's policy for RA calculations.
- Three (3) calculations for age:
  - Age at time of service for HCC assignment within a model.
  - Age at last plan of enrollment for PLRS calculation.
  - Age at initial plan enrollment for allowable age rating curves.
- Metal AV level for each enrollee's plan enrollment period.
- CSR for applicable plan enrollment.
- Geographic rating area determined for calculation of PLRS.

RA Data Collection (continued)

Claim and supplemental diagnosis files are used to:

- Identify acceptable RA claims based on subset of hospital and medical claims submitted to each issuer's EDGE server.
- Select acceptable RA diagnoses for risk score calculation.
- Associate RA diagnoses from all enrollment periods for an enrolleeID within an issuer to each risk score for that enrolleeID.

ENROLLEE ZX49



Key RA Concept: RA diagnosis codes are applied to all plan IDs within the same issuer ID when the same enrollee ID is used.

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Risk Score Calculation Operations

Risk Score Operational Concepts

- Individual enrollee risk scores are calculated for each unique enrollment period.
- Relevant age and sex demographic factors are assigned based on age model and metal level.
- Age for risk score calculation will be held constant for all enrollment periods based on enrollee age at last period of enrollment.
- Hierarchical Condition Categories (HCCs) factors based on RA relevant diagnosis codes on the medical claim files.
- A CSR factor is assigned to the risk score of individuals in a CSR plan variant to account for increased benefit utilization with reduced cost-sharing.
- The PLRS is calculated for each plan within an issuer.

Payment Transfer Operations

- The payment transfer formula results in a per member per month (PMPM) amount.
- The PMPM amount is multiplied by the plan's billable member months for the final payment transfer amount for the plan.
- The final amount may be a payment or charge.

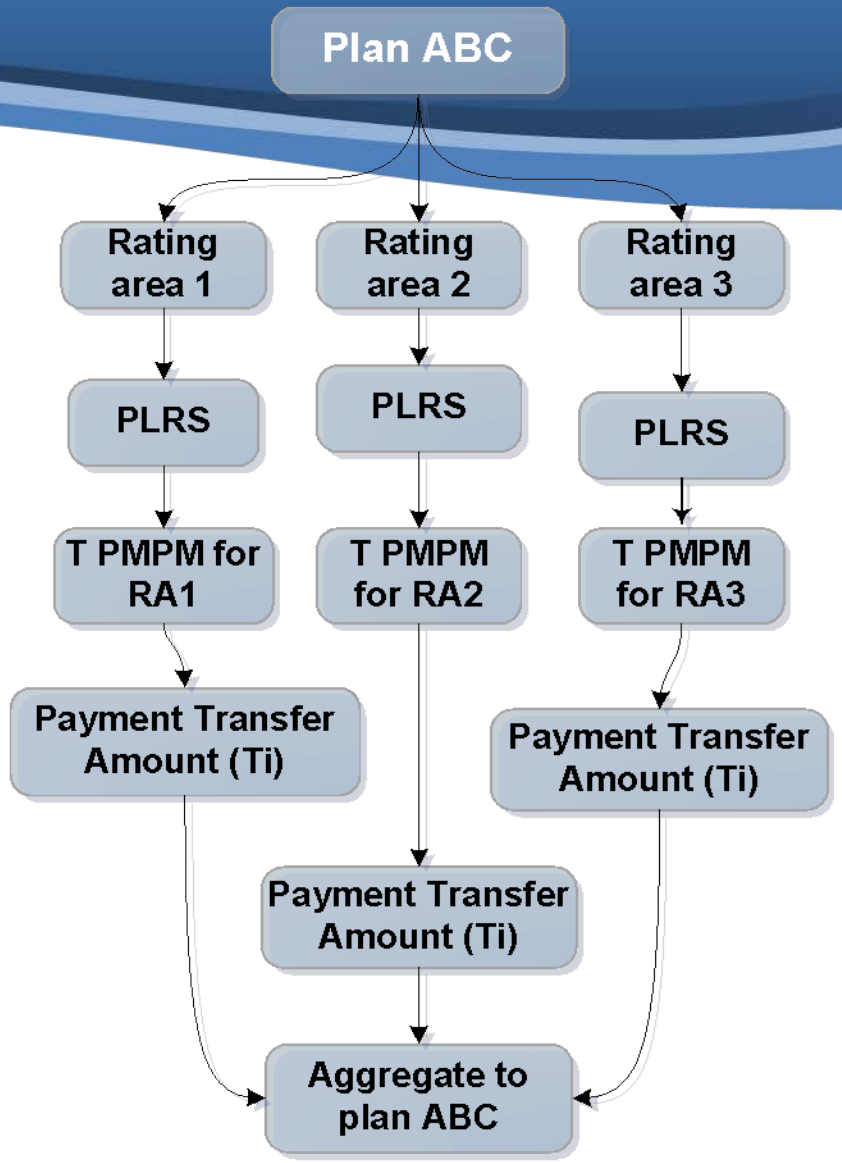
Payment Transfer Operations
(continued)

Payment Transfer Operational Concepts

Payment transfers are calculated at the geographic rating area level for each plan.

Inputs:

- Policy premium amounts.
- Member months and billable member months for subscribers and dependents.
- Age for allowable rating.
- Induced demand factor.
- Geographic cost factor.
- Plan actuarial value.



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RA User Fee

- CMS will charge a user fee to RA issuers in states where HHS is operating the RA program.
- CMS will collect RA user fees from issuers once per year.
    - Collected in summer of the year after the applicable benefit year.

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RA User Fee (continued)

HHS will calculate each issuer's user fee based on:

1. The national per-capita rate announced in the Notice of Benefit and Payment Parameters
    - 2015 rate: $0.08 monthly per-capita.
    - 2016 rate: $0.15 monthly per-capita.
2. The issuer's monthly enrollment, reported as part of the RA data collection process.

Formula: Issuer RA User Fee =

National Per Capita Rate x Issuer Monthly Enrollment*

*Based on monthly data submission

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RA Default Charge

CMS will assign an RA default charge if the issuer:

- Does not establish an EDGE server and submit data for the plan's enrolled members.
- Provides inadequate RA data.
- Does not provide access to RA data by the data submission deadline following the benefit year.

Otherwise, CMS is not able to calculate the plan's RA payment transfer amount.

RA Default Charge (continued)



The default charge is based on payments and charges for plans nationally which are in the same risk pool.

Risk Adjustment Data Validation

- A robust RA process requires high-quality data to calculate accurate risk scores, payments, and charges.
  - A data validation process is essential to the establishment of a credible RA program.
- Data validation is an audit function that promotes confidence in budget-neutral payment transfers by ensuring the integrity and quality of data provided from issuers.

Risk Adjustment Data Validation (continued)

- Issuers are required to engage an independent Initial Validation Audit (IVA) Entity to audit a sample of RA data.
    - The sample will include 200 enrollees per issuer.
- IVAs will report HRADV audit results to CMS.
- CMS will select a subsample from the initial audit for a Second Validation Audit (SVA).
- CMS will adjust payments beginning with the 2016 benefit year based on audit findings.
- Payment transfer adjustments based on 2016 benefit year HRADV audit findings will be applied prospectively to payment transfers in the subsequent year.

Next Steps

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Next Steps: Training Sessions

CMS will continue to support stakeholders through the RA process by hosting webinar and Q&A sessions.

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Next Steps: Training Sessions (continued)

Upcoming Sessions

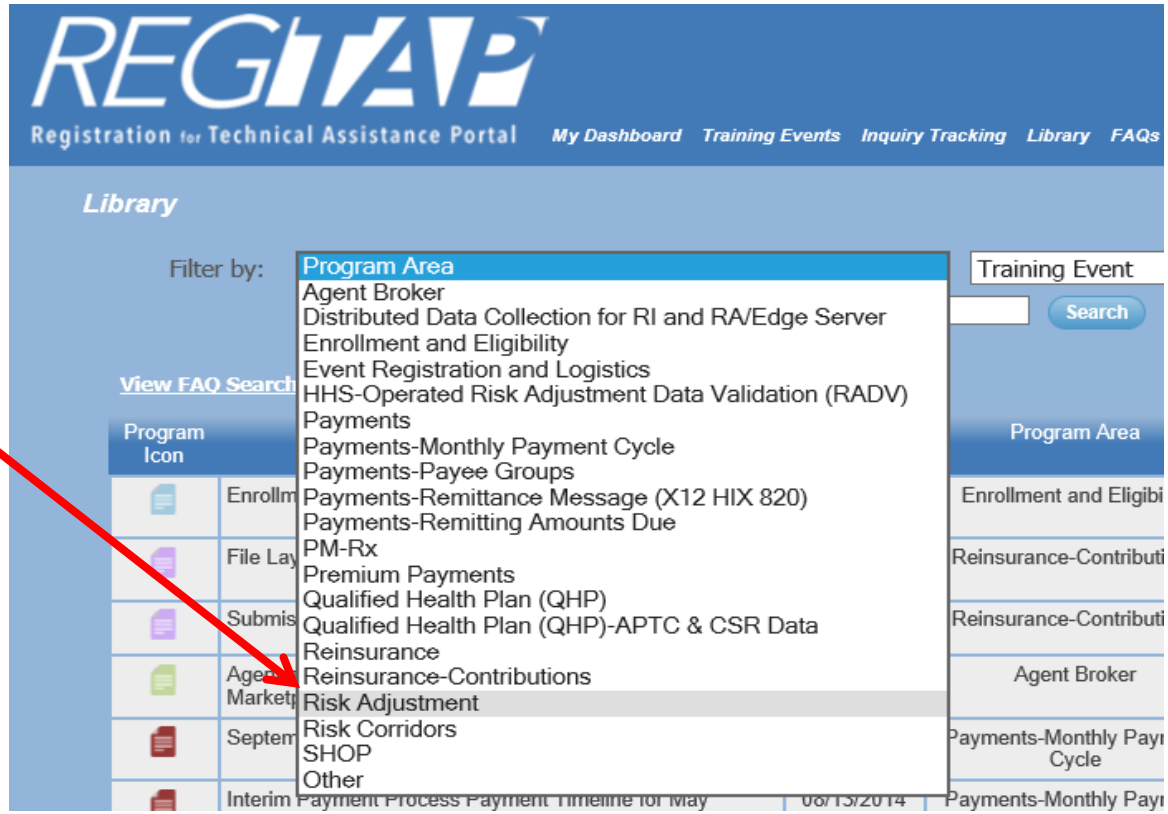
Date	Time	Topic
February 25, 2016	11:30 a.m. – 1:00 p.m. ET	Risk Scores

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Locating RA Documents in REGTAP

Stakeholders can access additional documents at https://www.REGTAP.info in the REGTAP Library.

Under Program Area, select "Risk Adjustment"



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Questions?

To submit questions by phone:

- *dial '14' on your phone's keypad.*
  - *dial '13' to withdraw your question.*

To submit questions by webinar:

- *type your question in the text box under the 'Q&A' tab.*

Resources

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Resources

Resource	Resource Link
U.S. Department of Health & Human Services	http://www.hhs.gov/
Centers for Medicare & Medicaid Services (CMS)	http://www.cms.gov/
The Center for Consumer Information & Insurance Oversight (CCIIO) web page	http://www.cms.gov/cciio
Consumer website on Health Reform	http://www.healthcare.gov/
Registration for Technical Assistance Portal (REGTAP) - presentations, FAQs	https://www.REGTAP.info
Do-It-Yourself (DIY) Software	http://www.cms.gov/cciio/Resources/Regulations-and-Guidance/index.html#Premium_Stabilization Programs https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/DIY-instructions-10-16-15.pdf

Resources (Continued)

Resource	Resource Link
Patient Protection and Affordable Care Act (ACA)	http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/content-detail.html
Standards Related to Reinsurance, Risk Corridors, and Risk Adjustment under the ACA	http://www.gpo.gov/fdsys/pkg/FR-2011-07-15/pdf/2011-17609.pdf
HHS Notice of Benefit and Payment Parameters for 2014 and Amendments to the HHS Notice of Benefit and Payment Parameters for 2014	http://www.gpo.gov/fdsys/pkg/FR-2013-03-11/pdf/2013-04902.pdf
HHS Notice of Benefit and Payment Parameters for 2015 and Amendments to the HHS Notice of Benefit and Payment Parameters for 2015	http://www.gpo.gov/fdsys/pkg/FR-2014-03-11/pdf/2014-05052.pdf

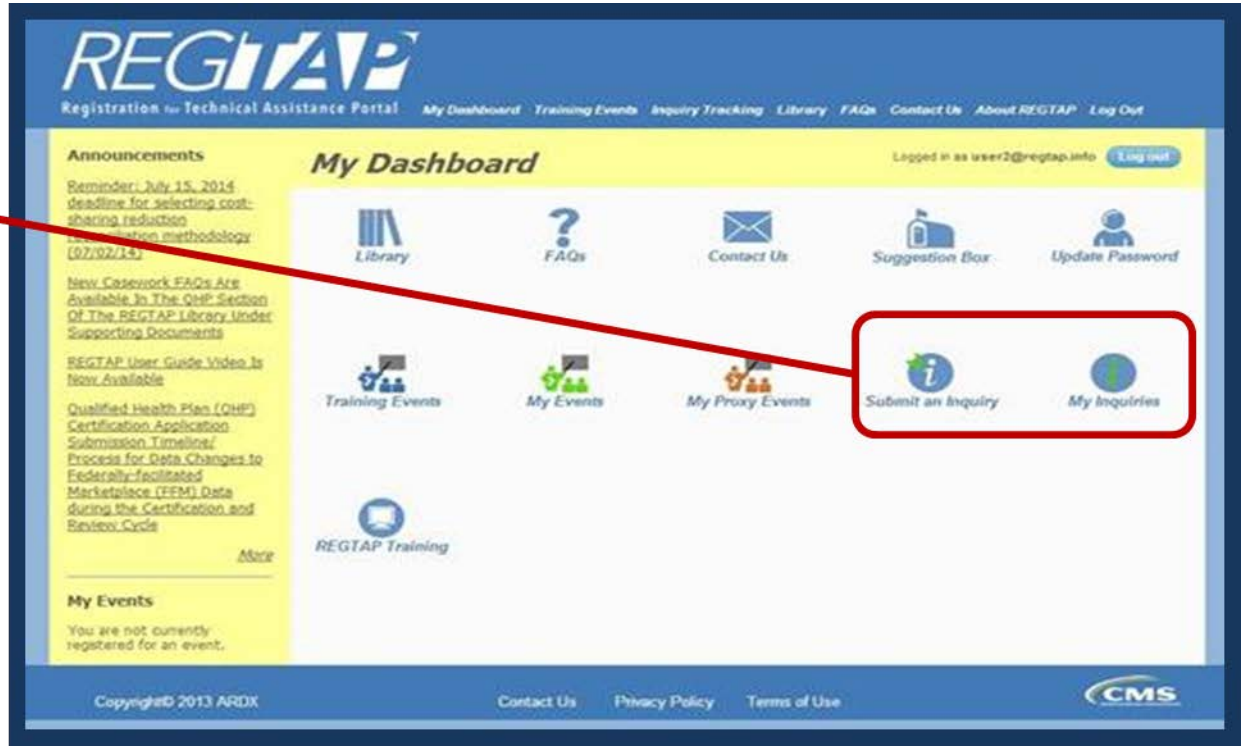
Resources (Continued)

Resource	Resource Link
HHS Notice of Benefit and Payment Parameters for 2015 and Amendments to the HHS Notice of Benefit and Payment Parameters for 2016	http://www.gpo.gov/fdsys/pkg/FR-2015-02-27/pdf/2015-03751.pdf
Standards Related to Reinsurance, Risk Corridors and Risk Adjustment under the ACA	http://www.gpo.gov/fdsys/pkg/FR-2012-03-23/pdf/2012-6594.pdf
Program Integrity: Exchange, Premium Stabilization Programs, and Market Standards; Amendments to the HHS Notice of Benefit and Payment Parameters for 2014	http://www.gpo.gov/fdsys/pkg/FR-2013-10-30/pdf/2013-25326.pdf
Health Insurance Market Rules, Rate Review Final Rule	http://www.gpo.gov/fdsys/pkg/FR-2013-02-27/pdf/2013-04335.pdf

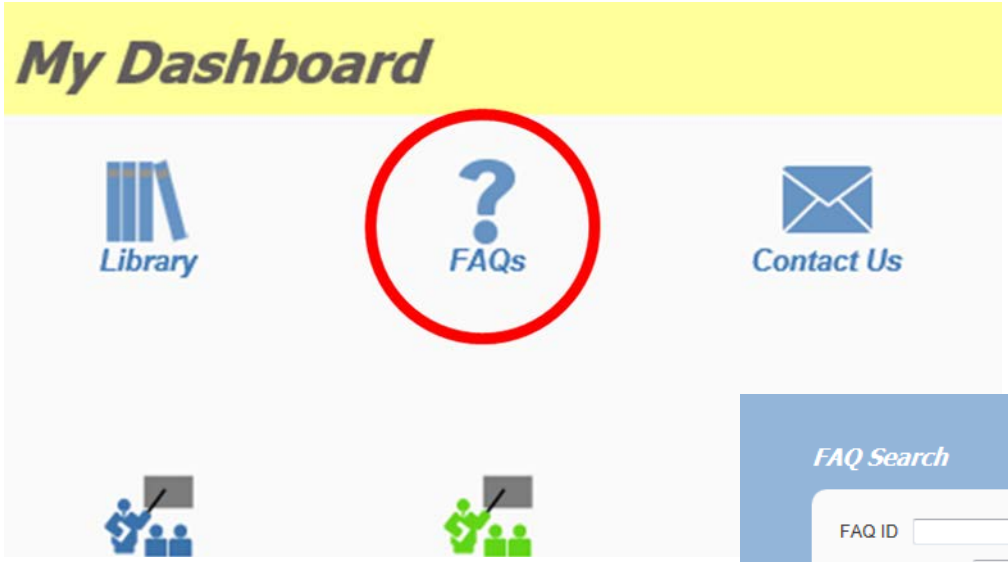
Inquiry Tracking and Management System (ITMS)

Stakeholders can submit inquiries to ITMS at https://www.REGTAP.info

Select 'Submit an Inquiry' from My Dashboard.

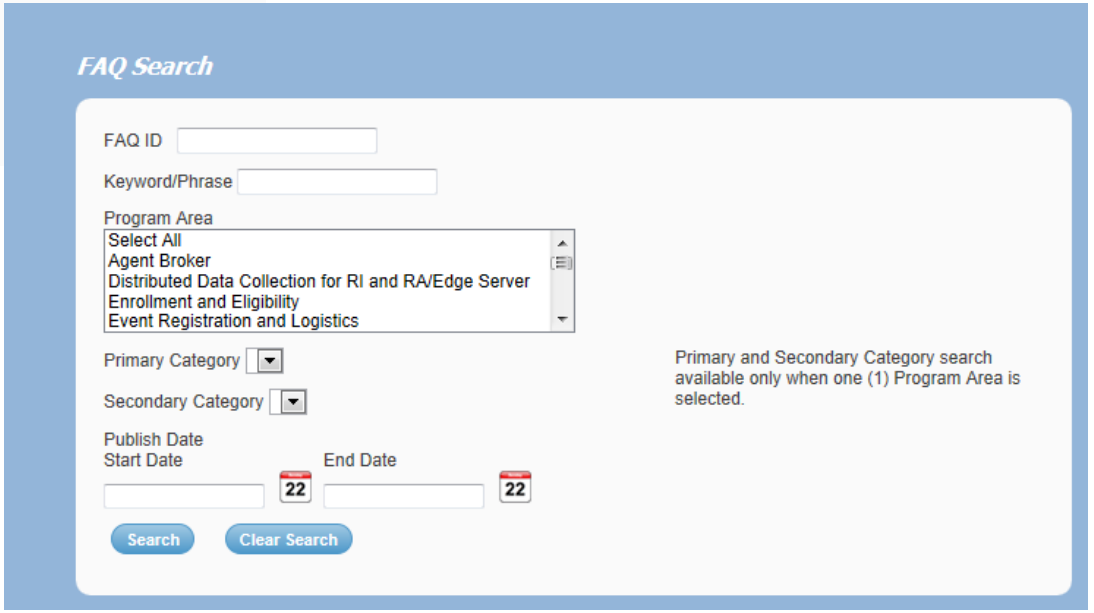


FAQ Database on REGTAP



The FAQ Database allows users to search FAQs by FAQ ID, Keyword/Phrase, Program Area, Primary and Secondary categories, and Publish Date.

FAQ Database is available at https://www.REGTAP.info/



Closing Remarks

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