# Winning with risk adjustment

**Scott A. Weltz**, FSA, MAAA

CEOs of Affordable Care Act (ACA) issuers often ask me, in one fashion or another, "If you were CEO of our plan, what would you be focused on?" My answer every time is, "Ensure that you are maximizing your profit margins net of risk adjustment." It is easy to understand why, with the report released by the Centers for Medicare and Medicaid Services (CMS) on June 30, 2015,1 summarizing the millions of dollars trading hands among issuers in each state. Issuers must make risk adjustment a core element throughout their strategic plans or they risk running significant losses both financially and in terms of market share. And this goes far beyond coding improvement. Issuers should discuss risk adjustment in every aspect of their operations and strategic decision-making—from provider network offerings to formulary design to care management to data reporting. This article highlights some areas where issuers should focus in order to maximize profit margins net of risk adjustment transfers.

### #1: Change internal reporting immediately to focus on medical loss ratio (MLR) net of risk adjustment by member

Some of my clients can probably still hear me saying, "It's all about the net MLR" in their sleep. This reporting capability is critical to driving strategic decisions. The new MLR equation is:

> Net MLR = (Claims +/- Risk Adjustment - CSR & Federal Reinsurance Receipts) / Premium

Performing this net MLR reporting at the member level is important because it allows you to analyze data by any cut desired. Even if you are paying out $100 million via risk adjustment, keep in mind it is entirely possible that $200 million is effectively being transferred to your plan for some high-risk members while $300 million is leaving your plan because of other lower-risk members. Understanding which members are driving these payments versus receipts is vital to making informed management decisions.

Some issuers we work with used member-level net MLR reporting to make the following decisions:

- Adjust broker commissions based on performance by metallic tier
- Modify service area when developing 2016 products
- Introduce 2016 plans with design features that improved net 2014 margins

A challenge, of course, is that CMS does not report risk adjustment results until six months after year-end. In some instances, issuers are in states with simulation studies and can get a line of sight earlier on their overall transfer. However, even in these cases, reports are not granular enough to assign MLR at the member level and the market-wide information is not provided in enough detail. In either situation, we have found it is possible to reasonably project MLR by member by utilizing member-level HHS-HCC risk scores, along with other analyses that allow issuers to annualize member-level scores based on year-to-date diagnoses and then quantify the projected transfer payment or receipt that any given member will generate.

### #2: Optimize your product portfolio to maximize margins net of risk adjustment transfers

When it comes to risk adjustment, the make-up of your ACA product portfolio matters a lot. This may be counterintuitive given the handcuffs placed on plan design. One might think, "How can differences in my silver plans really affect my results when designs are so much alike and actuarial values only vary from 0.68 to 0.72?" Yet actual results from 2014 for some issuers indicate that net MLRs are as much as 50 percentage points better for some plan designs versus others *in the same metallic tier for the same issuer*.

The reason for such disparities centers around the HHS-HCC risk adjustment transfer formula—it favors issuers that enroll certain chronically ill individuals,[2] identify diagnoses at the correct level of severity, and properly manage their costs. It pays to design products that encourage good consumerism and well- managed care as long as you offer plans not deemed to be discriminatory. Issuers that do so are in the best position to maintain sustainable product portfolios.

### #3: Work your risk adjustment member target list continuously

Many issuers have begun to focus on diagnosis coding to improve their risk scores in the ACA markets, particularly when they do not have dominant market share. Best practices observed include the following:

- **Develop a target list monthly.** Many members have conditions that are not properly coded, but the key is finding the ones offering the most risk adjustment "bang for the buck." Issuers increase their success significantly when developing target lists from longitudinal claims data and using sophisticated machine learning algorithms that identify members based on both medical and pharmacy markers.

1 CMS (June 30, 2015). Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2014 Benefit Year. Retrieved September 1, 2015, from http://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RI-RA-Report-Draft-6-30-15.pdf.

2 Petroske, J. & Siegel, J. (December 17, 2013). When Adverse Selection Isn't: Which Members Are Likely to Be Profitable (or Not) in Markets Regulated by the ACA. Milliman Healthcare Reform Briefing Paper. Retrieved September 1, 2015, from http://us.milliman.com/insight/2013/When-adverse-selection-isnt-Which-members-are-likely-to-be-profitable-or-not-in-markets-regulated-by-the-ACA/.

- **Leverage care management staff.** I worked for a care management vendor for four years. Besides doctors, care managers often influence your highest-risk members' medical care more than anyone else. Weaving suspect lists into your care managers' call lists is one of the quickest avenues to encouraging a member to visit the doctor for a given condition.

- **Incentivize providers to work with you.** Doctors may sometimes balk at the idea of coding improvement, but one thing is clear: cash is king. Put incentives in place to accurately code and watch your risk adjustment scores improve.

- **Chase charts and find supplemental codes.** Chase charts for a minimum of the last three months of the year and first three months following year-end. Also, be sure to chase any potential high-risk members who disenroll throughout the year as soon as possible.

### #4: EDGE data accuracy is paramount

All of this work means nothing unless your External Data Gathering Environment (EDGE) data is submitted accurately to CMS. Several issuers were very surprised by how many records were omitted from their EDGE submissions. From omitted diagnosis codes to losing significant claims dollars for federal reinsurance recoveries, some issuers are learning the hard way that EDGE submissions are far more than a typical IT exercise and should have sophisticated dedicated analytic resources. We have found the following are best-in-class approaches to EDGE data management:

- **Data processing and reconciliation.** Process data monthly and reconcile EDGE submission data to external membership and claims totals.

- **Data quality audits.** Perform a rigorous battery of data audits on a quarterly basis to ensure items such as reinsurance payments and risk scores are maximized and consistent with other calculations performed outside the EDGE environment.

- **EDGE file creation and submission.** After transforming client data into the necessary XML files, process the XML files through the EDGE server test and production execution zones and review results. Work edits and errors and resubmit data until all possible errors are removed.

- **EDGE output summary and detailed reporting.** Create summary and detail-level reporting following each data submission to ensure the final data is in line with benchmarks.

### #5: Grow with caution

Growing a book of business is always challenging, but doing so with ACA risk adjustment in play has made it even more so.[3] The challenge is that, with growth, many members come to issuers without claims histories available. Such claims histories are key to ensuring proper coding. This phenomenon is evident when reviewing the small group transfer payments in 2014 of new market entrants, such as the Consumer Operated and Oriented Plans (CO-OPs). CO-OPs often grew throughout 2014 by adding small groups to their books. While at a competitive disadvantage in both markets on the risk adjustment front, CO-OPs were arguably on a more level playing field with their competitors in the individual market in 2014 because many new members entered the individual market for the first time. But for small group, many existing issuers likely leveraged their historical claims databases to identify members who would trigger risk adjustment payments because so many of the groups were previously insured. CO-OPs clearly did not have that luxury. The result: only two of 23 CO-OPs received risk adjustment money in the small group market while almost half received risk adjustment transfers in the individual market.

Issuers in high growth situations should consider ways to capture data to target high-risk individuals via health risk assessments, pharmacy clearinghouses, or other means available via wellness programs and the like. Even so, be prepared for potential first-year losses in such situations until a credible amount of claims history is available to properly implement coding improvement initiatives.

*Risk adjustment can materially alter the financial situation for commercial individual and small group issuers. Issuers must consider risk adjustment's impact in every key decision they make in order to maximize their margins net of risk adjustment transfer payments.*

*This article was first published in the Health Plan Alliance Newsletter.*

Scott A. Weltz, FSA, MAAA, is a principal and consulting actuary with the Milwaukee office of Milliman.
Contact him at scott.weltz@milliman.com.

3 Liner, D. & Siegel, J. (July 2, 2015). ACA Risk Adjustment: Special Considerations for New Health Plans. Retrieved September 1, 2015, from http://www.milliman.com/insight/2015/ACA-risk-adjustment-Special-considerations-for-new-health-plans/.



**FOR MORE ON MILLIMAN'S HEALTHCARE REFORM PERSPECTIVE**

Visit our reform library at www.milliman.com/hcr
Visit our blog at www.healthcaretownhall.com
Or follow us on Twitter at www.twitter.com/millimanhealth