High Risk Pools and Risk Adjustment

Al Bingham, Jr, FSA, MAAA
404.788.8306 • Al.Bingham@wakely.com

Evan Morgan, ASA, MAAA, PhD
720.206.1392 • EvanM@wakely.com

As proposals emerge for changes to the Affordable Care Act (ACA) and the individual and small group markets, a concept frequently mentioned is the use of high risk pools to provide coverage for qualifying enrollees with high risk/high cost chronic conditions. While the American Health Care Act (AHCA) appears to be at least in hibernation for now, states may be allowed additional flexibility in administering the ACA, especially where that flexibility might line up with components of the AHCA.

Because of its complexities and administrative burden, some policy makers and researchers have indicated that the risk adjustment mechanism could possibly be eliminated with the introduction of high risk pools.

In an effort to illustrate the interaction of high risk pools and risk adjustment, we modeled the impact of excluding enrollees with high cost chronic conditions (those that could be expected to be part of a high risk pool) from the risk pool for the individual market.

Our modeling suggests that if such enrollees are removed from the individual market (into separate high risk pools), differences in measurable risk across issuers decreases considerably, but significant differences still exist. In addition, we believe removing risk adjustment would create significant incentives for risk selection through marketing and plan design. Therefore, we believe there is a need for a risk adjustment program in a guaranteed issue market even after the introduction of a high risk pool.

We found that risk adjustment transfers decrease as high-risk members are removed, but even after removing __all__ forty-two conditions in the four tiers, significant transfer amounts remain.

Methodology

The Wakely National Risk Adjustment Reporting (WNRAR) Project is a national risk adjustment simulation that currently operates in 36 states, collecting data on individual and small group plans in the ACA and non-ACA markets. Participation in most markets is above 95%. Wakely provides market averages, transfer estimates, and significant additional detail five times throughout the year to help issuers with rate setting, reserving, general strategy, EDGE Server review, and ad-hoc analyses.

To model the impact of incorporating high risk pools into the individual market and the continuing need for risk adjustment, we developed lists of high cost chronic conditions that might be candidates for inclusion in high risk pools. Our selection method involved first determining which HCCs are largely chronic, ordering them by 2015 risk weight, dividing them up into tiers of roughly ten HCCs, and then considering the four top tiers. The HCC list is included in the Appendix.

Using data from 2015 year-end WNRAR reporting in the individual market, we removed these HCCs from the market average and transfer calculations.

The WNRAR data does not allow us to distinguish individual members. We are able to remove conditions from the risk score calculation, but the members and their comorbidities remain. Given that members with the serious conditions specified in this study are likelier to have more additional HCCs than other members, we made an additional adjustment to risk scores to compensate for this limitation. Using other internal data sources, we estimated that removing members with the identified chronic conditions has around 50%-70% more impact on risk scores than just removing those same conditions from risk scores. The adjustment we made to risk scores was to magnify the issuer-specific impact of the removal of conditions by the appropriate adjustment factor. We then recalculated transfer amounts based on the adjusted risk scores. See the Appendix for more detail on the adjustment factors.

Regarding transfers, we chose to report transfer amounts as a percent of state average premium. The metric we chose to highlight is average absolute transfer, and we calculated it in two ways: as a pure average (with one data point per state, market, and HIOS ID), and as a member-month weighted average (using same data points).

It is important to note that this analysis does not include any other potential individual market changes being considered in the current health reform debates. For example, we did not adjust the underlying data or RA model for changes to the age curve, rating rules, or changes in enrollment which might result from changes to individual subsidies or other elements of the ACA.

Findings

We found that transfers decrease as high-risk members are removed, but even after removing all forty-two conditions in the four tiers, significant transfer amounts remain. See Table 1 for results.

Table 1. Average Transfer Amounts

Iteration	Risk Score of Remaining Members (scaled to 1.0)	Average Absolute Transfer	Average Absolute Transfer (Member-Month Weighted)
All Conditions Included	1.00	22.3%	10.4%
Remove Tier 1	0.85	17.2%	8.8%
Remove Tier 1+2	0.78	16.1%	8.1%
Remove Tier 1+2+3	0.67	14.9%	6.9%
Remove Tier 1+2+3+4	0.60	14.5%	6.2%

Conclusion

It is important for policymakers to understand the interaction of various market changes, including the continuing need for risk adjustment in a guaranteed issue environment. As illustrated in this analysis, even when many high risk/high cost chronic conditions are removed from the market risk pool (conditions that might trigger eligibility in a high risk pool) there are still significant risk adjustment transfers between issuers.

Considerations

This modeling is meant to inform discussions related to the need for risk adjustment in a guaranteed issue individual market that does not allow rate variations or coverage denial on the basis of health status. We have not simulated any additional changes in the individual market structure, rating rules, or subsidies under the ACA. It will be important to understand the overall impact of market changes as a whole, considering all components of any reform legislation. Results for any given state could vary considerably from our results which represent the average impact   across 30+ states. Any

states or other entities considering making important changes to the design of their marketplace and risk sharing mechanisms should collect state specific data and consider the impact of other, potentially overlapping policy decisions.

Analysis of Data Should Inform Policy Decisions

The current individual health insurance market differs considerably from that which existed during the prior round of health reform discussions and debate leading to the ACA. Beginning in 2014, all individual health insurance plans (except for Grandfathered and Transition plans) cover a common set of services (Essential Health Benefits). Also, consistent and standardized experience data on those plans now exist because of the EDGE data submissions. Such data and consistent coverages were not the case prior to the ACA, resulting in difficulty in modeling and evaluating the impact of policy proposals. Wakely believes that it is vital that today's health policy considerations be informed by robust actuarial analyses and modeling.

About Wakely Consulting Group

Wakely Consulting Group delivers professional actuarial services and health care reform consulting beyond expectation for the health care industry at a very cost-effective price. Our reputation for providing personal value-added services is an additional benefit that sets us apart from other actuarial firms. Our expertise is paired with unmatched data on the individual and small group markets – developed through the Wakely National Risk Adjustment Reporting project and the Wakely Risk Insight National Reporting projects.

Additionally, Wakely consultants have significant experience in health policy and strategic advisory services to policymakers, including state and federal government leaders.

Acknowledgements

Please contact Al Bingham **(Al.Bingham@wakely.com)** or Evan Morgan **(EvanM@wakely.com)** with any questions or to follow up on any of the concepts presented here.

Appendix

The following is the list of conditions considered in this paper, as well as the tier assignment.

Table 2. Tiered List of Chronic HCCs

Tier	HCC	HCC Description
1	HCC008	Metastatic Cancer
1	HCC034	Liver Transplant Status/Complications
1	HCC041	Intestine Transplant Status/Complications
1	HCC066	Hemophilia
1	HCC125	Respirator Dependence/Tracheostomy Status
1	HCC158	Lung Transplant Status/Complications
1	HCC183	Kidney Transplant Status
1	HCC184	End Stage Renal Disease
1	HCC251	Stem Cell, Including Bone Marrow, Transplant Status/Complications
1	G14	Heart Assistive Device, Artificial Heart and Heart Transplant
2	HCC009	Lung, Brain, and Other Severe Cancers, Including Pediatric Acute Lymphoid Leukemia
2	HCC018	Pancreas Transplant Status/Complications
2	HCC035	End-Stage Liver Disease
2	HCC046	Chronic Pancreatitis
2	HCC118	Multiple Sclerosis
2	HCC121	Hydrocephalus
2	HCC122	Non-Traumatic Coma, Brain Compression/Anoxic Damage
2	G06	Disorders of Bone Marrow
2	G10	Quadriplegia and Traumatic Complete Lesion Cervical Spinal Cord
2	G11	Paraplegia and Traumatic Complete Lesion Dorsal Spinal Cord
3	HCC001	HIV/AIDS
3	HCC038	Acute Liver Failure/Disease, Including Neonatal Hepatitis
3	HCC096	Prader-Willi, Patau, Edwards, and Autosomal Deletion Syndromes
3	HCC110	Spinal Cord Disorders/Injuries
3	HCC115	Myasthenia Gravis/Myoneural Disorders and Guillain-Barre Syndrome/Inflammatory and Toxic Neuropathy
3	HCC130	Congestive Heart Failure
3	HCC150	Hemiplegia/Hemiparesis
3	HCC151	Monoplegia, Other Paralytic Syndromes
3	HCC254	Amputation Status, Lower Limb/Amputation Complications
3	G07	Diseases of the Blood
3	G08	Disorders of Immunity
4	HCC037	Chronic Hepatitis
4	HCC048	Inflammatory Bowel Disease
4	HCC056	Rheumatoid Arthritis and Specified Autoimmune Disorders
4	HCC075	Coagulation Defects and Other Specified Hematological Disorders
4	HCC087	Schizophrenia
4	HCC094	Anorexia/Bulimia Nervosa
4	HCC111	Amyotrophic Lateral Sclerosis and Other Anterior Horn Cell Disease
4	HCC112	Quadriplegic Cerebral Palsy
4	G04	Disorders of Musculoskeletal System & Connective Tissue
4	G12	Parkinson's and Huntington's, other motor control Diseases
4	G16	Chronic Kidney Disease (Stage 4 & Stage 5)

The following table contains information on the adjustment to risk scores to account for the difference between removing conditions from risk scores and removing members from the population.

Table 3. Adjustment Factors

Tier	Base Risk Score (All Members)	Risk Score with Specified Conditions Removed	Risk Score with Specified Members Removed	Multiplicative Adjustment to Multiplicative Impact
1	1.0	0.90	0.85	1.57
1+2	1.0	0.86	0.78	1.61
1+2+3	1.0	0.80	0.67	1.70
1+2+3+4	1.0	0.76	0.60	1.66