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Risk adjustment continues to vex small insurers

The ACA's risk adjustment program, designed to provide extra compensation to health plans with sicker members, continues to trouble smaller, newer insurers that have attracted younger, healthier customers.

Having those lower-risk enrollees means some small insurers will have to make substantial risk adjustment payment contributions, meaning they will essentially send a percentage of what they received in premium payments to other insurers with higher-risk enrollment.

Struggling ACA health insurance cooperatives—nonprofit, member-owned organizations that market to younger and healthier populations—are taking hits, too (see Table 1). Colorado Health Insurance Cooperative, for instance, must contribute $42 million; Montana Health Cooperative is on the hook for $6.4 million; and Group Health Cooperative in Washington will send more than $13 million to the risk pool. The risk adjustment payment was cited in the recent decision to shutter Land of Lincoln Health, a cooperative in Illinois.

Table 1: Most cooperatives must contribute to the risk program
Though health plans of all sizes and experience fall under the risk adjustment program, newer cooperatives may struggle absorbing some of the losses.

Co-op	*State*	*Risk Adjustment Payments—Individual and catastrophic (in millions)*	*Risk Adjustment Payments—Small group market (in millions)*
Colorado Health Insurance Cooperative, Inc.	CO	$41.2	$0.8
Montana Health Cooperative	ID	$6.4	$0.2
Louisiana Health Cooperative, Inc.	LA	$ 8.7	$0.2
Evergreen Health Cooperative, Inc.	MD	$3.4	$20.8
CoOportunity Health	NE	$10.2	$ 7.1
Freelancers CO-OP of New Jersey, Inc.	NJ	$38.6	$7.7
Group Health Cooperative	WA	$9.9	$3.7

Source: CMS and HRI analysis

To CMS, the program is working as intended. The agency sees the balance between higher- and lower-risk enrollment as proof that risk adjustment is doing what it was created to do. Still, CMS plans to update the models it uses as more data become available. All told, 821 insurers participated in the program during the 2015 benefit year.

Even if the program works, some issues have emerged. For one, smaller, less-experienced insurers may not have accurately priced their premiums to anticipate the level of their risk

At a glance

CMS said 821 insurers participated in the risk adjustment program in 2015.

In 2015, the value of risk adjustment transfers averaged 10% of premiums in the individual market, and 6% in the small group market.

Insurers with relatively high per capita paid claims amounts were more likely to be compensated by risk adjustment payments, while issuers with relatively low per capita paid claims amounts were more likely to be assessed charges.

Raw risk scores were relatively higher in 2015 than 2014, in part because the average enrollee was covered for more months in 2015 than they were in 2014. Longer enrollment periods mean payers can submit more claims. Additionally, insurers had more experience with CMS's claims data submittal process.

CMS is expected to make changes to the risk adjustment formula.

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adjustment payment contributions. As a result, they may not have the reserves in place to send tens of thousands of dollars—or even millions—to the risk program.

Less experienced insurers may not have the same technical abilities to capture data and process claims as their more established counterparts. They also may lack the infrastructure that's needed to predict risk relative to the market and capture complete risk adjustment data in a sophisticated way, making it harder to plan and set rates in the future.

Larger national players are also required to contribute money into the program. Overall, Aetna and Molina Healthcare, for instance, will make some of the highest payments under the program. But in most cases, established insurers are better equipped to absorb the payments than their newer peers both by anticipating the payments in their premium rates, and having greater capital reserves.

Overall, CMS said that risk adjustment transfers averaged about 10% of premiums in 2015 in the individual market, and 6% of premiums in the small group market. Those numbers are on par with what insurers experienced in 2014.

Nevertheless the data underscore some of the struggles insurers of all sizes face when it comes to assessing risk. Many health plans have yet to adapt to guaranteed issue—the ACA's requirement that they must cover all individuals regardless of prior adverse health conditions. As a result, some insurers have not priced health plans to account for these sicker enrollees, or, in some cases, a flood of healthier ones, which could trigger risk adjustment program payments.

Industry implications

1) Factor risk into premium-pricing. Insurers catering to lower-risk individuals should ensure that the premiums are priced so that they can cover risk adjustment payments. On the flip side, insurers attracting higher-risk enrollees may be able to lower their premiums to account for risk payments. Insurers also have to anticipate how their enrollment will compare to other payers in the market, as risk adjustment is cost neutral within markets.

2) Uncertainty around risk adjustment results in higher premiums. As more insurers struggle with accurately pinpointing their risk, premium prices may ultimately climb higher before levelling out. As insurers gain a deeper understanding of how the risk adjustment model works, the need to add a risk margin to their premiums should decrease.

3) Supporting risk adjustment activities and programs may require additional resources. To optimize risk scores, payers must ensure that complete and accurate risk adjustment information flows successfully throughout the organization, including its carve-out vendors. This extends to providers, too. In addition, regular monitoring of provider coding and vendor performance, such as chart reviewers, is critical to address both under-and over-coding of submitted data impacting risk scores.

4) Insurers should remove barriers between Government and commercial health plans. Claims monitoring programs can be similar between the Medicaid side of the business and commercial offerings. The goal is to monitor how provider groups are performing within each of the products offered. There's also the potential for overlap, especially if members tend to move between Medicaid and commercial plans.

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