Economics of Risk Adjusted Markets

Healthcare Financial Management Association
Washington-Alaska Chapter
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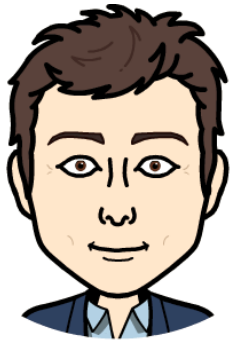
About the Speaker



JOHN SULLIVAN

Current

Director of Risk Adjustment

Premera Blue Cross

Direct accountability and oversight of Premera's Risk Adjustment programs for the Individual, Small Group, and Medicare Advantage lines of business in Washington and Alaska.

Previous

Healthcare Management Consultant

HealthScape Advisors

Business consultant and strategic advisor to healthcare organizations operating in commercial insurance (group and individual), government programs (Medicare, Medicaid, TRICARE, Veteran Affairs), specialty health (pharmacy, dental, and behavioral health).

Auditor

Deloitte

Financial Statement auditor in Real Estate, Hospitality, and Government industries

Education and Credentials

Certified Public Accountant – licensed Illinois and Washington

Certified Fraud Examiner

Master of Science in Accounting – University of Illinois at Chicago

Bachelor of Business Administration – University of Iowa

Risk Adjustment – Uses and Sources

Uses

- Last of 3Rs
- Premium Stabilizer
  (guaranteed issue | adverse selection)
  - Premium offset?
  - Medical cost offset?
- Risk Contracting
- Population risk stratification
- Clinical quality

Risk Adjustment

MLR Stabilizer

Cost Normalizer

Risk Identifier

Sources

Traditional

- Medicare Advantage - DHHS
- Medicaid – state-by-state variations

New

- Affordable Care Act – choice of Fed or State models
- Proprietary Models

Stakeholders

Patient | Customer | Purchaser | Insured | Consumer

Government	Payors	Providers
Guaranteed Issue Community Rating Bands Adverse Selection	Premium Stabilization Risk Contracting Inventive Payments Population Profiling **Back-office Function** **vs.** **Program**	[intentionally left blank]

Payor financials are largely dependent on providers' ability to completely and accurately code patients

Commercial Risk Adjustment – 3Rs

Program	Market Segments	Time Frame	Type of Risk Addressed	Funding Source
Reinsurance	Individual	2014-2016 (Temp – 3 years)	High cost members entering the market	Assessments from insurers and self insured over 3 years
Risk Adjustment	Individual and Small Group	Permanent	Adverse selection	Transfer payments between plans (zero sum game)
Risk Corridors	Individual and Small Group	2014-2016 (Temp – 3 years)	Excessive profits and losses	Plans with actual claims less than % of target amounts pay into the program and plans with claims greater than % of target amounts receive funds.

Local Market View – ACA Transfer Payments 2015 Measurement Year

WASHINGTON - INDIVIDUAL					
	Transfer Receipt (Payable)	Est. Members		RA PMPM	Relative Risk
Premera Blue Cross	$ 18,747,955	90,000	$	17	1.05
Regence	$ 31,139,432	63,000	$	41	1.11
Life Wise Health Plan	$ (22,413,845)	52,000	$	(36)	0.90
Group Health	$ (9,859,754)	46,000	$	(18)	0.95
Coordinated Care	$ (34,636,348)	28,000	$	(103)	0.72
Moda Health Plan	$ 6,134,915	16,000	$	32	1.09
Kaiser NW	$ 1,500,350	5,000	$	25	1.07
Time Insurance Company	$ 1,137,460	5,000	$	19	1.05
Molina Healthcare	$ 1,537,385	4,000	$	32	1.08
Community Health Plan (CHP)	$ 6,748,060	1,000	$	562	2.21
Trustmark	$ (35,609)	100	$	(30)	0.92
	$ -	**310,100**			

Complexities and Challenges

---Massive variation across plans---

---Financial Planning: pricing, budgeting, accruing ---

---Competitive Environment---

Big plans vs. little plans

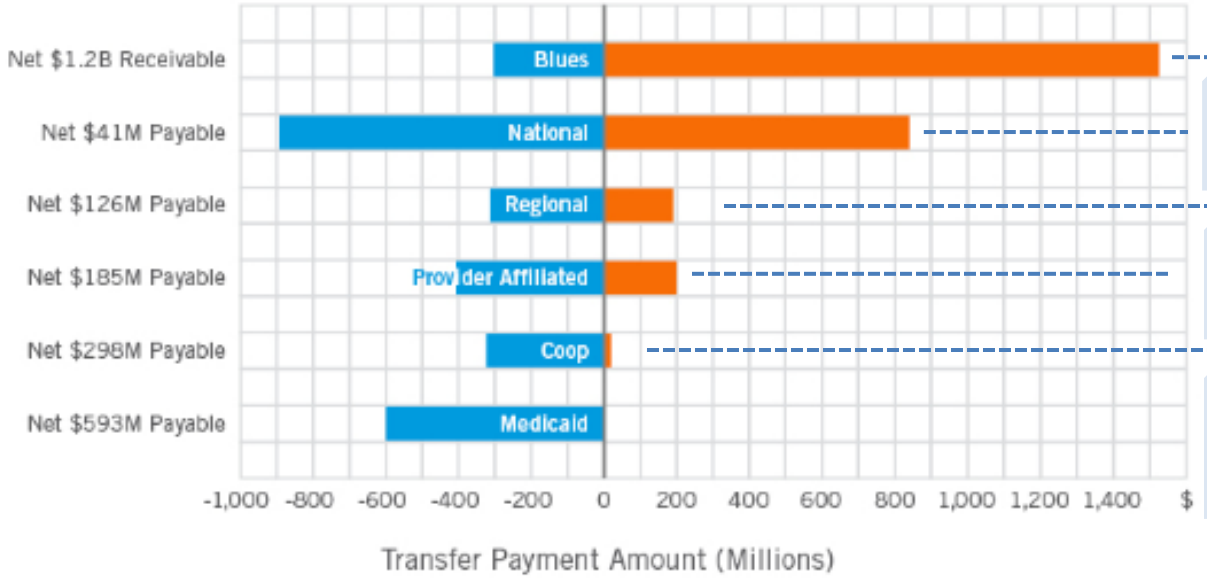
Dedicating resources

Reliance on providers

Source: CMS June 30, 2016 RA and RI Summary Report

National Market View

2015 Payable and Recievables[1]



Examples[2]

- Anthem Connecticut to receive $51 million
- Blue Shield of California to receive 161 million

- Oscar Insurance Corp. (tech start-up plan) – owed $33 million for NJ and NY
- Kaiser Permanente in California owed $169 million

- Land of Lincoln Health in IL owes $31.8 M
- New Mexico Health CT owes $14.6 M
- HealthyCT in CT owes $13.4 M
- Evergreen Health Cooperative in MD owes $24.2 M

1 - HealthScape Advisors and Express Scripts - Understanding 2015 Risk Adjustment Results, August 16, 2016
2 - Modern Healthcare - ACA's risk adjustment hammers small plans again, June 30, 2016

A Closer Look – Transfer Payment Financial Impacts

Commercial

State Avg. Transfer Payments (Receipts)[1]

MLR Impacts - Illustrrative	Before	After	
	Unadjusted	With Transfer Receipt	With Transfer Payable
Members	$ 28,000	$ 28,000	$ 28,000
Premium	$ 400	$ 400	$ 400
RA Transfer PMPM	$ -	$ 28	$ (47)
RA Adjusted Premium	$ 400	$ 428	$ 353
Medical Cost	$ 340	$ 340	$ 340
MLR	85%	79%	96%
Profit (Loss)	$ 20,160,000	$ 29,483,663	$ 4,490,637

Transfer payment MLR Impact

Medicare Advantage

Annual Member Payment[2]
(**<u>without</u>** coded chronic conditions)

$ 3,914

Male | 77 Years Young
Acute MI | Vascular Disease
$700 Premium

Annual Member Payment[2]
(**<u>with</u>** coded chronic conditions)

$ 8,375

1 - Excludes Coordinated Care and CHP (outliers)
2 - Illustrative example obtained from Altegra Health

Disparities in Populations

Demographics

Diagnoses

Platimum Product			
	Age 21-24	**Age 60-64**	**Δ**
Male	0.236	0.843	0.607
Female	0.379	0.909	0.530
Δ	0.143	0.066	0.673

HCC	
Hemophilia	46.436
End-Stage Liver Disease	7.119
Diabetes without Complication	1.187

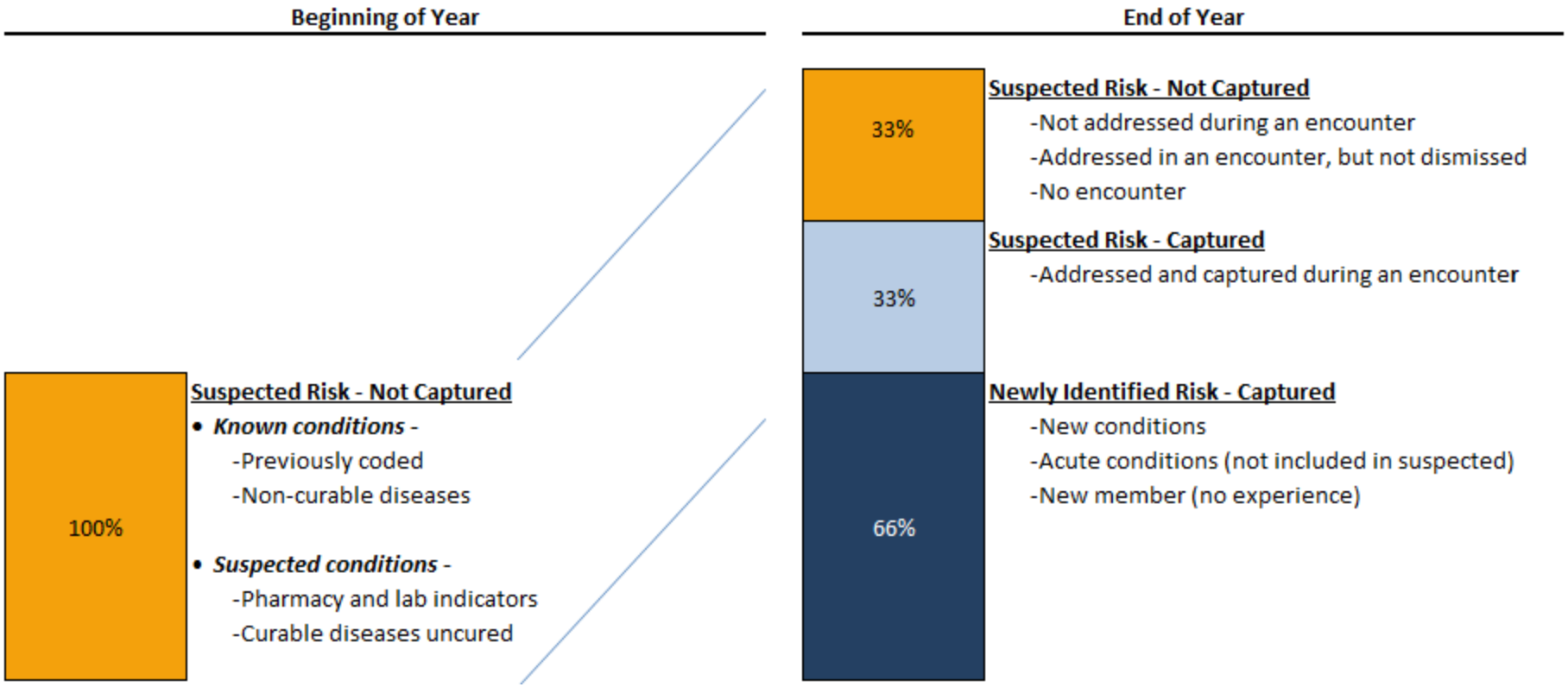
Bronze Product			
	Age 21-24	**Age 60-64**	**Δ**
Male	0.082	0.372	0.290
Female	0.138	0.395	0.257
Δ	0.056	0.023	0.313

HCC	
Hemophilia	45.939
End-Stage Liver Disease	6.736
Diabetes without Complication	0.822

Source: CMS March 31, 2016, HHS-Operated Risk Adjustment Methodology Meeting – Discussion Paper

Not Just Closing the Gap

Risk Score Distribution



Implications

1. **Product Design and Pricing**
   The way products are priced and designed

2. **Member Attraction and Retention**
   How plans attract and retain profitable members

3. **Provider Contracting**
   The mechanics by which providers performance is compensated

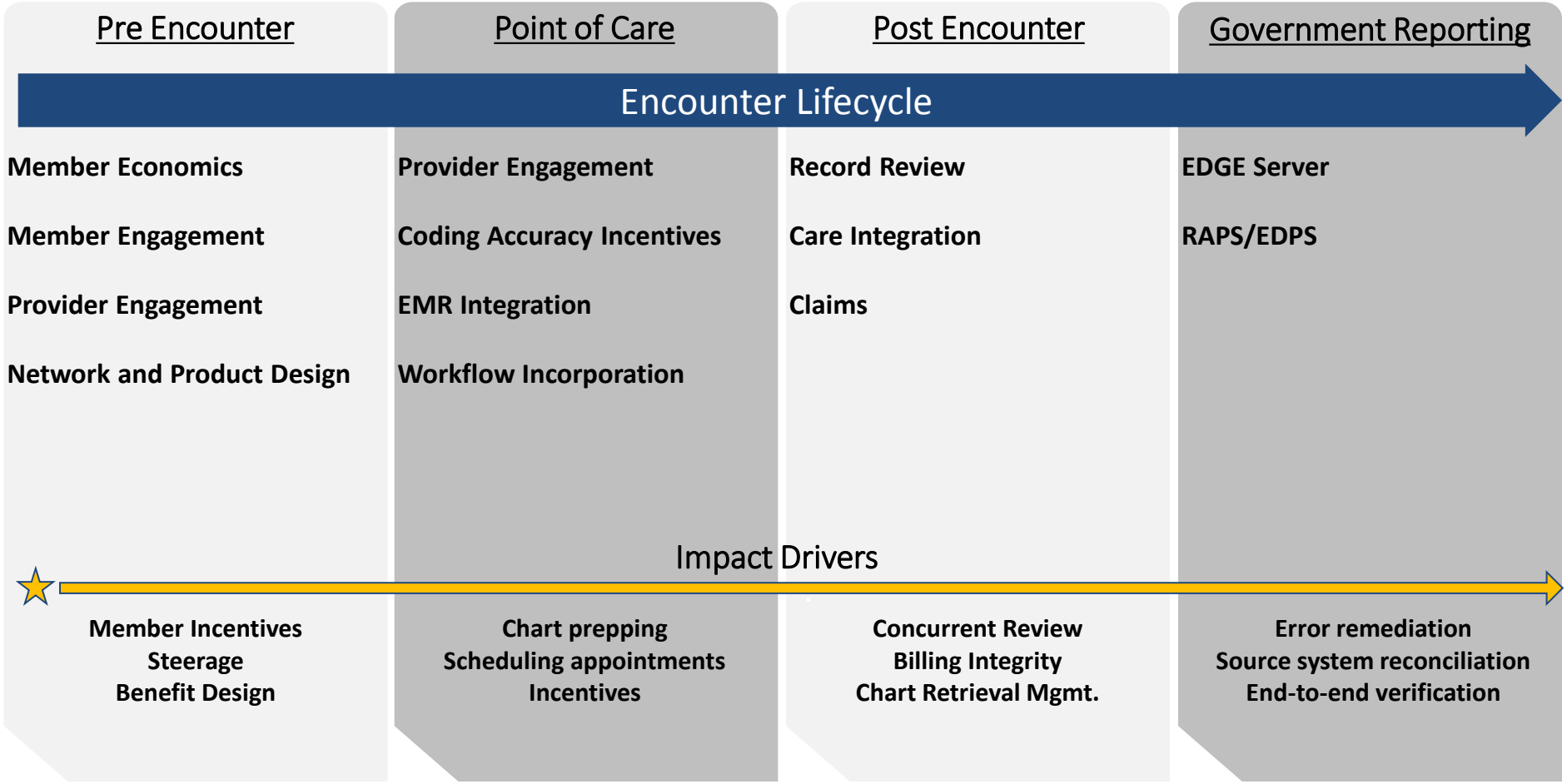
4. **Provider Relations**
   Consulting model from payors to lend a hand

5. **Geographic Differentiation**
   Balancing price competitiveness with risk-adjusted cost of care

Evolution

	Early Stages	Now	Ahead
Compliance	**Stand up** the program through uncertainty - CMS Compliance	**Monitoring** CMS program adjustments	**Adjusting** to "Trumpcare" – Repeal/Replace
Build/Buy	Heavy **vendor reliance** (analytics, EDGE Server, Chart Chasing, Coders)	**Insource functions**	**Strategic vendors** to supplement internal expertise
Analytics	**Minimal experience** to predict health status	**2-3 year experience** of retained members - robust analytics	**Robust health records**
Coding	**Land grab** for capturing diagnosis codes	**Recapture** of diagnosis codes, closing the gap on missed	**Leveling off** - focus on new members without experience
Provider Operations	**Educate** Providers - risk adjustment basics	**Sharing data** with providers **Embedding resources** in clinics Building Risk Adjustment into **provider workflows** **Incentive** contracts	**Bi-directional data sharing** **Risk-sharing** arrangements and value-based contracts **Clinical quality integration** Network design and **preferred networks**

Pulling Out All the Stops



Outlook

Market Forces

Heightened Focus on Medicare

- Medicare and CHIP Reauthorization ACT (MACRA)
- 50% FFS payments shifted to value by 2018

Continued Shift Toward Value-based models

- Accountable Care Organizations
- Upside and downside risk

Transferring Power Back Over to States

- Increased age-bands with state flexibility?
- Age-adjusted tax credits?
- State-flexibility on essential health-benefits?
- State-based risk adjustment models?
- State exchanges?

Implications to Risk Adjustment

Greater portion of provider payments under risk-adjusted reimbursement models

Proprietary risk-adjustment models – data is king

Risk Adjusted Tax credits?

Elimination of "zero-sum" program?

Risk Adjustment without federal funding?

Until then, and for now…
3 More Years of
Commercial Risk Adjustment

THANK YOU

Open Discussion