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# Risk Adjustment

## Report from the Commissioner of Health and the Commissioner of Commerce to the Legislature

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January 1995

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*Economics Program*



Minnesota Department of Commerce



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# Table of Contents

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<b>EXECUTIVE SUMMARY</b> .....	Executive Summary i
<b>SUMMARY OF RECOMMENDATIONS</b> .....	Executive Summary xvii
<b>CHAPTER I: INTRODUCTION AND SCOPE OF REPORT</b> .....	1
LEGISLATIVE BACKGROUND .....	1
ASSISTANCE OF EXPERT ADVISORY PANEL .....	2
<b>CHAPTER II: PURPOSE, GOALS, AND GUIDING PRINCIPLES FOR RISK ADJUSTMENT</b> .....	3
GUIDING PRINCIPLES .....	3
<b>CHAPTER III: INTRODUCTION TO RISK ADJUSTMENT</b> .....	5
DEFINITIONS .....	5
WHY IS RISK ADJUSTMENT NEEDED? .....	7
CAPABILITIES AND LIMITATIONS OF RISK ADJUSTMENT .....	8
Risk Adjustment and Risk Assessment for Other Purposes .....	8
Risk Adjustment is an Emerging Science .....	9
How much variation in health care costs must be or should be accounted for in the risk adjustment model? .....	9
Risk Adjustment and Other Policy Goals .....	10
RELATIONSHIP OF RISK ADJUSTMENT TO OTHER REFORMS .....	11
Guaranteed Issue and Open Enrollment .....	11
Community Rating and Rating Restrictions .....	12
Plan Design Variation .....	13
Risk Adjustment as a Part of Health Care Reform .....	13
<b>CHAPTER IV: MARKETS TO BE RISK ADJUSTED</b> .....	15
DEFINED MARKETS .....	15
Individual and Small Group Markets .....	16
Current and Proposed Insurance Reforms .....	16
The Effects of Reforms on the Risk Adjustment Mechanism .....	16
Market Definition .....	17
Separate or combined pools? .....	17
Minnesota Comprehensive Health Association .....	17
Large Employer Market and ERISA .....	18
Definition of Large Employer versus Small Employer .....	19
Public Programs Pool .....	20
Medicare Supplement Policies .....	20
<b>CHAPTER V: METHODOLOGIES FOR RISK ASSESSMENT AND ADJUSTMENT</b> .....	23
PROPOSED METHODOLOGICAL APPROACH .....	23
Initial Approach .....	23
Continued Testing of Other Methods .....	23

THE OPERATION OF A RISK ADJUSTMENT SYSTEM . . . . .	24
Example of Risk Adjustment . . . . .	25
HOW WE ARRIVED AT THESE RECOMMENDATIONS . . . . .	26
Criteria for Evaluating Possible Risk Assessment Mechanisms . . . . .	26
Methods Reviewed . . . . .	27
Demographic Adjustments . . . . .	27
Targeted Risk Adjustment . . . . .	28
Ambulatory Care Groups (ACGs) Combined with Diagnostic Cost Groups (DCGs) . . . . .	28
Self-reported Health Status . . . . .	29
Reinsurance . . . . .	30
Clinical indicators . . . . .	30
 <b>CHAPTER VI: PLAN FOR TESTING . . . . .</b>	 33
SPECIFIC TESTING ISSUES AND WORKPLAN . . . . .	33
Demographic Adjustments . . . . .	33
Issue 1: Standardization of the rating tiers . . . . .	33
Issue 2: Develop age/sex factors . . . . .	33
Issue 3: Translation of age/sex factors to dollars . . . . .	34
Issue 4: Possible inclusion of other demographic factors . . . . .	34
Targeted Risk Adjustment . . . . .	34
Issue 1: Selecting the conditions/treatments . . . . .	34
Issue 2: Defining the conditions . . . . .	34
Issue 3: Determining payment levels for each condition . . . . .	35
Issue 4: Comparing different groups of conditions . . . . .	35
Issue 5: Changes in medical treatment and costs over time . . . . .	35
Issue 6: Setting the assessments . . . . .	35
ACGs/DCG's . . . . .	36
Issue 1: Data Issues . . . . .	36
Issue 2: Additional factors . . . . .	36
Issue 3: Translating ACG/DCG score into dollars . . . . .	36
Issues Related to System Operation . . . . .	36
Issue 1: Population changes . . . . .	36
Issue 2: Process of payments . . . . .	36
Issue 3: Market behavior and response to risk adjustment . . . . .	37
Issue 4: Auditing and Appeals . . . . .	37
Issue 5: Phase-in of risk adjustment . . . . .	37
DATA AND INFORMATION NEEDED FOR TESTING AND DEVELOPMENT . . . . .	37
Data Modelling . . . . .	37
Simulation Exercise . . . . .	38
Antitrust Issues Regarding the Testing and Development Phase . . . . .	38
Plan for Continuous Improvement . . . . .	39
 <b>CHAPTER VII: DISCUSSION OF CONCERNS . . . . .</b>	 41
HIGH RISK POPULATION CONCERNS . . . . .	41

PROVIDER ISSUES . . . . .	42
HEALTH PLAN COMPANY CONCERNS . . . . .	43
Incentives for Efficiency and Managed Care . . . . .	43
RAPO (Regulated All-Payer Option) Concerns . . . . .	43
Solvency Issues . . . . .	43
Small Health Plan Company Concerns . . . . .	43
MARKET CONDUCT RULES . . . . .	44
 <b>CHAPTER VIII: OPERATIONAL ISSUES . . . . .</b>	 47
DEVELOPMENT AND IMPLEMENTATION OF THE RISK ADJUSTMENT SYSTEM . . . . .	47
The Development Phase of the Risk Adjustment System . . . . .	47
Role of the Association . . . . .	47
Role of the State . . . . .	47
Implementation of the Risk Adjustment System . . . . .	48
Role of the Association . . . . .	48
Role of the State . . . . .	49
Legal Issues Regarding Operation of the Risk Adjustment Mechanism . . .	49
Funding . . . . .	50
 <b>APPENDICES: . . . . .</b>	 53
APPENDIX 1: 1994 MinnesotaCare Law on Risk Adjustment . . . . .	55
APPENDIX 2: Membership on the Risk Adjustment Expert Advisory Panel . . . .	57
APPENDIX 3: Membership on the Technical Work Groups . . . . .	59
APPENDIX 4: Glossary of Risk Adjustment Terms . . . . .	63
APPENDIX 5: Summary of Minnesota Health Care Reforms . . . . .	69
APPENDIX 6: Summary of the New York Risk Adjustment Model . . . . .	73
APPENDIX 7: Options for Testing and Evaluation . . . . .	77
APPENDIX 8: Bibliography . . . . .	81
APPENDIX 9: Minutes of Risk Adjustment Expert Advisory Panel Meetings . . .	87

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# EXECUTIVE SUMMARY

## BACKGROUND OF THIS REPORT

The 1994 MinnesotaCare law requires the Departments of Health and Commerce to prepare a report to the legislature on risk adjustment. The report is to cover the process for defining, developing and implementing a risk adjustment system in Minnesota by July 1, 1997. The Departments were assisted in the development of this report by the Risk Adjustment Expert Advisory Panel. The Expert Advisory Panel consists of members of the Interim Board of Directors of the Risk Adjustment Association (a 19-member board representing health plan companies, providers, public programs, consumers, and state agencies), and experts in health services research, health economics, and epidemiology. In addition to the Expert Advisory Panel, four work groups were assembled to tackle issues related to methodologies, testing, operations, and public programs.

## INTRODUCTION TO RISK ADJUSTMENT

*Risk adjustment* is a financial mechanism through which monetary transfers are made from health plan companies that insure lower risk populations to those that insure higher risk populations. Thus, health plan companies that enroll a more costly population receive more revenue without charging higher premiums.

The goals of risk adjustment are to:

- *Achieve a more equitable, efficient system of health care financing;*
- *Remove current disincentives in the health care system to insure and provide adequate access for high risk and special needs populations;*
- *Promote fair competition among health plan companies on the basis of their ability to efficiently and effectively provide services rather than on the risk status of those in a given insurance pool; and*
- *Help maintain the viability of health plan companies by protecting them from the financial and marketplace effects of enrolling a disproportionate number of high cost individuals.*

Risk adjustment strives to reduce the incentives health plan companies face to attract healthy, low cost enrollees and to discourage those likely to need health care services (*risk selection*)<sup>1</sup>. Some insurance reforms, such as rate band restrictions and community rating increase incentives for risk selection, because health plan companies can no longer charge high risk groups higher premiums to match their higher expected expenses.

In addition to risk selection by health plan companies, high risk individuals tend to select certain health plans over others (*adverse selection or antiselection*). Risk selection and adverse selection together contribute to *risk segmentation*, in which health plan companies experience different levels of risk in their covered populations. Without risk adjustment, this is fundamentally destructive to intra-plan competition.

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<sup>1</sup> *NOTE: Terms such as risk selection, adverse selection, risk segmentation and other related terms are often used differently by different groups. For clarity and consistency, we have defined these terms and have attempted to use them consistently. Other writings on risk adjustment may use these terms differently, or may use other terms.*

Risk adjustment is a two-part process. *Risk assessment* is a mechanism for quantifying the relative level of risk in a health plan company's population. *Risk adjustment* translates the results of risk assessment into a financial transfer from health plan companies with relatively low risk members to health plan companies with relatively high risk members. **The risk in all of these terms refers to the risk of anticipated high health care costs.**

In such a system, health plan companies are aware of the risk adjustment mechanism, predict their payments into or out of the risk adjustment system, and adjust their premiums to reflect these payments. Without risk adjustment, health plan companies that have a low risk population would have lower premiums than health plan companies that have a high risk population, other things being equal. With risk adjustment, health plan companies that have a relatively low risk population will expect to pay into the pool and will adjust their premiums up while health plan companies that expect to receive money from the pool because they have a high risk population will adjust their premiums down. Remaining premium differences will be more attributable to differences in the plan design, medical and administrative efficiency, and other health plan company characteristics, rather than differences in the risk of the population enrolled.

### **Why is Risk Adjustment Needed?**

The purpose of risk adjustment is to reduce the effects of selection on health insurance premiums by making appropriate transfers among health plan companies undertaking different levels of risk. The need for a risk adjustment mechanism is created in large part by elements of the health care reforms contained in the MinnesotaCare legislation. Risk adjustment is needed to counter the effects of rating restrictions and guaranteed issue requirements, to reduce incentives for health plan companies to avoid high risk (cost) populations, and to facilitate competition on the basis of quality and medical and administrative efficiencies.

### **Capabilities and Limitations of Risk Adjustment**

There are many misunderstandings about what risk adjustment is, and what it can and cannot accomplish. It is important to remember that risk adjustment will not fix all problems in the health care system. Misunderstandings about risk adjustment relate to the status of risk adjustment as an emerging science, to the desire on the part of some to have risk adjustment accomplish other goals, and confusion over the distinction between financial risk adjustment and other efforts to predict the prevalence of disease or measure other types of risk.

Risk adjustment, in this context, relates to risk of high health care costs. It should not be confused with efforts to measure risk or prevalence of illness, or risk of poor outcomes. These other activities are important to the health care system, and they sometimes overlap with financial risk adjustment, but they are separate projects with different purposes, methods, and goals. (This issue is discussed in more detail in Chapter 3).

Risk adjustment is an emerging science. Most models for risk adjustment have only weak predictive power and most are largely untested. This means that any model chosen will be likely to account for only a portion of the targeted variation in health care expenditures across health plan companies. Even if financial risk adjustment were perfected, there would still be variations in expenditures across health plan companies either due to random factors which cannot be predicted and therefore cannot be included in the model, or due to factors that the health plan company controls. In addition, risk adjustment need not (in fact should not) account for all cost variation across health

plan companies.

Another confusion over risk adjustment has arisen out of the desire on the part of some to have risk adjustment address other policy goals. Some have been concerned that risk adjustment might be used as a mechanism to subsidize public programs or low income individuals. Risk adjustment should not be used to try to further other social policy goals unrelated to risk adjustment. Needs such as financing public programs or subsidies for low income individuals must be addressed separately through other programs.

Also, risk adjustment is not designed to account for all catastrophic (random, unpredictable) costs. Therefore, there will always be a residual role for a private reinsurance market.

Finally, no matter how we develop a risk adjustment mechanism, it won't be perfect. Our goal is to develop a system that addresses the most serious concerns related to coverage of high risk populations, within a system that is relatively easy to administer and inexpensive.

### Relationship of Risk Adjustment to Other Reforms

**Recommendation:** Risk adjustment is an important part of health care reform. The need for risk adjustment is critical in a guaranteed issue, community rated environment. Even without a movement to community rating, risk adjustment may still be valuable to reduce the incentive to avoid high risk populations, and to facilitate health plan company competition on the basis of quality. Given the significant effort and time required to develop an effective risk adjustment mechanism, it is important for Minnesota to continue to *develop* a risk adjustment system. The importance of an early implementation date (such as the July 1, 1997 date specified in legislation) will depend on the extent of insurance reforms actually implemented.

Risk adjustment can be viewed as a financial mechanism to facilitate health care reforms. Both the need for risk adjustment and the appropriate adjustment methodology and design will depend on the reforms adopted. The establishment of new rating and underwriting limitations, proposed as part of Minnesota's health care reforms, contributes greatly to the need for a risk adjustment mechanism. (Note that Governor Carlson has recommended a repeal of statutes calling for future implementation of community rating, thus leaving current rating restrictions in place). Risk adjustment is a necessity if rating restrictions do not allow up-front matching of premiums or contributions with the relative risk factors of the purchasers.

Under the current rating and underwriting restrictions, the need for risk adjustment is somewhat less critical. In the small employer and individual markets, premium variations are permitted within limits. Premiums, therefore, match expected costs to a certain extent. The significant exceptions are the prohibition on the use of gender as a rating variable, the guaranteed issue requirement in the small employer market, and the "pure community rating" requirement in the Medicare Supplement market. Under current rating and underwriting restrictions, implementation of risk adjustment could proceed at a somewhat less hurried pace, and Minnesota would be able to take advantage of more of the research projects being conducted nationally.

Although the need for risk adjustment is critical under proposed insurance reforms such as

guaranteed issue and community rating, there are additional benefits to developing a risk adjustment mechanism in Minnesota. Risk adjustment may be valuable to reduce the incentives to avoid high risk populations, and to facilitate health plan company competition on the basis of quality and administrative efficiencies. Further, the methods developed could be used by large employers or purchasing pools offering multiple health plans to their employees, or by public programs as part of their health plan company reimbursement methods. Finally, guaranteed issue requirements and rating restrictions have already been implemented in several markets.

Given the significant effort and time required to develop an effective risk adjustment mechanism, Minnesota must proceed to develop risk adjustment. The importance of an early implementation date (such as the July 1, 1997 date currently specified in legislation) will depend on the extent of the insurance reforms actually enacted.

## **RECOMMENDATIONS FOR A RISK ADJUSTMENT SYSTEM MARKETS<sup>2</sup> TO BE INCLUDED**

***Recommendation:*** Risk adjustment must take place in a defined market, with free entry and exit from the risk adjustment mechanism prohibited. Therefore, the risk adjustment mechanism should apply across-the-board to all employers and/or individuals within the applicable market regardless of the mechanism through which they obtain coverage.

***Recommendation:*** Risk adjustment will be developed for the individual and small group markets, state-run public programs including Medical Assistance, General Assistance Medical Care and MinnesotaCare (as a separate pool), and the Medicare Supplement market.

### **Should Participation Be Mandatory?**

The establishment of a defined market is a critical element to the successful operation of the risk adjustment system. Participation must be mandatory for all health plan companies participating in the markets included in the defined pool(s). If participation were voluntary, some, if not all, health plan companies with disproportionately favorable risks would choose not to participate in the risk adjustment system, thereby defeating the goals of risk adjustment.

### **Individual and Small Group Markets**

Risk adjustment is clearly needed in the individual and small employer<sup>3</sup> markets under proposed health care reform. The proposed guaranteed issue and community rating requirements prohibit the up-front matching of premiums with the relative risk factors of the purchasers. In the absence of a risk adjustment mechanism, these reforms will create an environment in which health plan companies

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<sup>2</sup> "Markets" means insurance markets (such as the individual market, small-group, large group, public programs, etc).

<sup>3</sup> As of 7/1/95, the small group market consists of employer groups with between 2 and 49 employees.

may be motivated to avoid high risks, and purchaser choice will be influenced by the effects of risk selection on premiums. We will explore the question of whether to combine the individual and small employer markets into one risk adjustment pool as part of the development process.

### **Minnesota Comprehensive Health Association (MCHA)**

During the development phase, consideration will be given to the MCHA population. Currently, MCHA (a pool mechanism for the uninsurable) is supported by a premium tax across all insured plans. With a guaranteed issue in the individual market, the Association shall consider whether the MCHA population are disproportionately merged into the individual market, and determine whether or not there is inappropriate subsidization by the individual and small group markets of these high cost cases.

### **Large Employer Market and ERISA**

The federal law known as the Employee Retirement Income Security Act (ERISA), prohibiting state authority over employee benefit plans, creates many hurdles for health care reform efforts. Although ERISA permits states to regulate insured plans through insurance regulation, employers who self-fund are outside of almost all state authority or state requirements. As long as ERISA permits employers to self-fund, adverse selection by groups that can save substantial premium dollars through self-funding would have a significant impact on the premium rate needed for the groups that remain. This is a particular problem with large groups, as the feasibility and attractiveness of self-funding increases substantially with group size. Including large groups in the risk adjustment sector is not recommended under current provisions of ERISA.

### **Medicare Supplement Market**

**Recommendation:** The Medicare Supplement market has the type of restrictions which necessitate risk adjustment. The Association shall convene a work group to evaluate the need for risk adjustment in the Medicare Supplement market, and to develop that system as a separate pool. Because Medicare Supplement policies are supplemental to Medicare, a targeted conditions adjustment may not be necessary. Risk adjustment in this market will be based on a demographic adjustment.

The Medicare Supplement market has the type of restrictions which necessitate risk adjustment. There is a 6-month open enrollment (guaranteed issue) period upon becoming eligible for and covered by Medicare. Pure community rating has been required on Medicare Supplement policies since January 1, 1993.

The Medicare Supplement market is very different from the under-65 markets, so will require a separate risk adjustment pool. The coverage differences may also lead to different methodologies. Because Medicare Supplement policies are supplementary payers to Medicare, we believe that a demographic adjustment system would suffice for this market, and that a targeted conditions system would not be needed. The question of whether TEFRA Risk Contracts should, or even can, be included in the risk adjustment pool will need to be addressed in the development process. Any federal changes to the Medicare Supplement market will also need to be addressed.

### **Public Programs Market**

**Recommendation:** A separate risk adjustment pool should be developed for the state-run public programs, including Medical Assistance, General Assistance Medical Care, and MinnesotaCare. During the testing and development phase, a work group will be convened to study this, and to recommend an approach to risk adjustment for the public programs.

The public programs will also be part of the risk adjustment system, as a separate pool. Keeping the public programs separate from the individual and small group markets is necessary, to avoid having the risk adjustment system cause subsidization of public programs by the individual and small group markets, and due to differences in the benefits, reimbursement methodology, and eligibility criteria. Risk adjustment is needed in the public programs because individuals are given the option to choose among a number of health plan companies. This type of individual choice, which includes a guaranteed issue component, leads to risk segmentation among the health plan companies as individuals often choose plans according to their health needs. Risk adjustment for public programs will be especially important as Medicaid begins enrolling the under-65 disabled into prepaid health plan companies.

This risk adjustment system should be similar to the overall risk adjustment system, but may contain additional demographic or other adjustments, and may involve different conditions. Measurement issues may also differ for the public programs pool. The public program pool may require additional adjustment factors, to reflect special needs related to poverty, cultural or language barriers, and other needs of some segments of the public program population.

Risk Adjustment in public programs will be done in a way which is compatible with the payment system for public programs. The state, as the payer for public programs, will have primary responsibility for the development and implementation of risk adjustment for the public programs.

## METHODS FOR RISK ASSESSMENT

**Recommendation:** After reviewing a number of possible risk assessment methods, we recommend that a combination of an age/sex **demographic** risk adjustment system and payments for **targeted conditions** be developed for implementation by July 1, 1997. We also recommend that testing be done concurrently on an **Ambulatory Care Groups (ACG)/Diagnostic Costs Group (DCG)** system which, if found to be superior, could replace the targeted approach at some future time when data systems make it feasible.

The Risk Adjustment Expert Advisory Panel assisted us in outlining the criteria we felt to be most important in evaluating possible risk assessment mechanisms for use in Minnesota. These including:

- accuracy,
- administrative feasibility,
- timeliness and predictability,
- efficiency/effectiveness,
- resistance to gaming,
- adaptability, and
- acceptability.

### **Methods selected for development and further study**

Using these criteria, we narrowed our options to the most promising, so that these methods could be evaluated and developed in more detail prior to implementation in 1997. We recommend that a combination of a demographic adjustment system with a targeted conditions system be developed for implementation in 1997. We further recommend that an ACG/DCG system be studied for possible implementation in the future.

#### ***Demographic Adjustments***

With demographic adjustment, the proportion of patients with various demographic characteristics (such as age and gender) is calculated for each health plan company. This model was chosen because it is conceptually simple and based on well-established concepts within the industry. Health plan companies have used age/sex adjusters as predictors of risk, and feel that it accounts for significant variation among groups. It is easy to apply and audit, the data are simple and available. By itself, however, it does not adjust for risk selection based on factors other than demographics. For this reason, we proposed to implement it along with a targeted condition risk adjustment method.

#### ***Targeted Condition Risk Adjustment***

Under this method, a number of specific high-cost conditions would be selected and expected costs of treating each condition would be determined. Some conditions may be split into more than one category, to reflect predictable differences in the costs associated with patients with different levels of severity within the condition. For each patient with the selected condition, the health plan company would receive a payment based on the expected costs of treating that condition from the Risk Adjustment pool. The pool would be based on an assessment of all health plan companies. This method is selected because it can be targeted to conditions that represent a significant portion of the variation across health plan companies, it would not require extensive data collection, and can be applied to individuals with no prior health insurance history. We further recommend that Minnesota develop its own list of conditions, based on our state's objectives.

#### ***Ambulatory Care Groups (ACGs) Combined With Diagnostic Cost Groups (DCGs)***

ACGs is a risk adjustment model which uses ICD-9 (International Classifications of Diseases-Version 9) diagnosis codes assigned during ambulatory care with age and sex to classify patients into 51 similar risk (cost) categories. The system was designed to be a conceptually simple, statistically valid, clinically meaningful measure useful in the prediction of ambulatory resource use. It is designed to work with data that are routinely collected through claims or encounter forms. DCGs is a prior history model that uses inpatient diagnostic data to classify individuals into risk (cost) categories. The combination of ACGs and DCGs is being recommended for study, to evaluate whether or not it would be a feasible, superior model to a demographics and targeted conditions model. Conceptually, this model has many strengths, including the fact that diagnoses (rather than prior use) act as the triggers. It has been shown to produce the best statistical results, accounts for a high portion of variation at the individual and group level, and is based on data that are or will be collected for other purposes. However, the data required include diagnostic data that, although usually recorded by the provider, is not retained by many health plan companies. For these health plan companies, using this model would require substantial modification of their information systems.

### **Other methods evaluated**

In addition to the three methods we have selected for implementation or further study, we reviewed

several other methods, including self-reported health status, reinsurance, and clinical indicators. These models were not viewed as being as feasible or effective as the models we ultimately selected for implementation and further study.

## THE OPERATION OF THE RISK ADJUSTMENT SYSTEM

In addition to determining the methods of risk assessment, it is also necessary to determine the adjustment system- how the assessment of risk is translated into a system of financial transfers.

In Minnesota, we are targeting risk adjustment at the market level<sup>4</sup>. The intended features of Minnesota's risk adjustment system include:

- All health plan companies participating in each targeted market must participate in the risk adjustment mechanism by contributing money into a pool (when required), assessing the risk of their enrolled population, and receiving payments from the risk adjustment system (when appropriate).
- Health plan companies remain responsible for setting their own premiums.
- The risk adjustment system allows health plan companies to estimate what their likely payments into and out of the risk adjustment system will be.
- Health plan companies estimate their expected payments into and out of the risk adjustment pool, and adjust their premiums accordingly (raising them if they anticipate having to pay into the pool, and lowering them if they intend to receive payments from the pool).

## PLAN FOR TESTING

**Recommendation:** During the development/testing phase, the Risk Adjustment Association and the Departments will pursue a multiple-tier approach focusing on Minnesota experience, national studies, and expert assistance. The models will be tested with Minnesota data wherever possible, and market behavior will be modelled with a simulation exercise. Testing will focus on the individual and small group market, the Medicare Supplement market, and public programs.

### Specific Testing Issues and Workplan

We have outlined a number of specific issues that must be addressed through the testing period, prior to implementation of risk adjustment. These issues are described here, followed by a description of the data or information that will be necessary for evaluation of the issue.

#### *Demographic Adjustments*

For development of the demographic adjustment pool, there are several key issues which must be

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<sup>4</sup> The risk **adjustment** process is different from that included in national reform proposals which center on alliances or purchasing pools. Under an alliance model, employer groups become members of an alliance. The individuals within the groups can each select their health coverage from among a wide range of competing health plan companies, exacerbating the problem of adverse selection. Under the alliance approach, the alliance adjusts the health plan company's premiums to reflect the risk differences in their populations. Note that the methods used for risk **assessment** could be the same under either scenario.

addressed, including the standardization of the rating tiers, development of the adjustment factors, translation of the factors to dollars, possible inclusion of other demographic factors in addition to age, sex, and family size (or calculation of age/sex on member-specific data.)

### ***Targeted Risk Adjustment***

For development of a targeted conditions risk adjustment mechanism, we have identified a number of issues which will need to be addressed. These issues include selecting high cost conditions or treatments, specifically defining the conditions, and determining the amount health plan companies would be paid for each of these conditions. We will evaluate conditions both that are high cost per episode (acute conditions) as well as conditions which are high cost over a period of time (chronic conditions). We will need to balance the need for homogeneity in the condition categories (to prevent gaming within categories) with the data intensity of the definitions (to avoid increasing the complexity of the system). Conditions will be chosen for which there are relatively clear, proven treatment options to avoid creating improper incentives. We will need to consider the possibility of selecting different conditions for the public programs pool and possibly for the Medicare Supplement pool. We will also need to evaluate the impact the condition list may have on high risk populations, and recommend additional actions wherever necessary. Finally, we will need to develop a system to collect assessments from health plan companies to form the targeted condition pool.

### ***ACGs/DCG's***

To test the ACG/DCG system, we have identified a number of issues that need to be resolved. We will need to evaluate how administratively difficult it would be for health plan companies to provide the data required to implement and maintain this model, and how much standardization in data reporting across health plan companies is necessary to make the system work effectively. We will need to explore how difficult it would be for health plan companies to retain a specified number of diagnosis codes in their systems, and how this requirement relates to other data initiatives (such as those of the Data Institute) which might make this information more readily available. The implications of using the ACG/DCG model for the Medicare Supplement and public programs risk adjustment pool will also be explored.

### ***Issues Related to System Operation***

In addition to the issues related to risk assessment methods, there are also issues related to the operation of the risk adjustment system itself which need to be addressed. Population changes and coverage of populations with no history of use to base risk adjustment on, such as residents new to Minnesota, will need to be explored. We will need to explore the possibility of setting a limit on the amount (or percentage) of money transferred, particularly in the beginning. We will need to evaluate the timing of transfers, what happens if the pool is short, how the market is likely to respond to the risk adjustment system, and what unintended effects might be created under different operational scenarios. We will discuss auditing mechanisms, the need for an appeals mechanism, and the possibility for phasing in the risk adjustment system.

### **Testing approach**

To address the above issues, there are a number of activities that will be necessary.

#### ***Data Modelling***

A number of the issues mentioned above will require some type of data modelling. Data to address the issues related to the Demographic Risk Adjustment system could include claims data obtained from a sample of Minnesota payers and national or Minnesota data from a consulting actuarial firm. Alternatively, information from the payers on the age/sex factors they use could be collected and combined to arrive at age/sex factors for risk adjustment. The public programs will require claims data from the state-run public programs to evaluate other factors which might be added to the age/sex adjustment. To select conditions, we will need claims data on high cost claims from payers in the small group, individual, public program markets. Claims data could include all claims over a threshold amount, or claims for a list of conditions selected as being likely high cost conditions. Some high-cost conditions (such as those involving a high degree of provider discretion about treatment) may not be appropriate candidates.

Once the conditions are selected, we will also need to pull together claims data on the costs of these specific conditions to develop the payment amounts for each condition. We will also use information from the literature to assist in the development of the payment amounts. Claims data from health plan companies, including inpatient claims with DRGs (Diagnosis Related Groups), and outpatient claims with ICD-9 codes will be necessary to model use of ACGs and DCGs. The source of claims data could be voluntary submission of claims data from the payers involved in the risk adjustment markets. In addition, we will explore the use of the Department of Health's pilot study of claims data to see if the timing of that project would facilitate use of the data for risk adjustment.

The data used for testing and development of risk adjustment will be coordinated with other data initiatives, to be sure that duplication of data collection is avoided. Finally, it is important to note that no matter what data is used for modelling, it will not necessarily represent accurately what will happen after implementation of risk adjustment and other insurance reforms. Therefore, it will be critical to build into the model a mechanism for continuous improvement over time.

#### ***Simulation Exercise***

To evaluate the operational issues, we will develop some type of simulation that will use data modelling and/or a simple role-playing simulation to explore the logistics of the risk adjustment system. This simulation could allow some of the actual health plan company staff to go through simulated market situations by playing the role they would play in a real-life risk adjustment scenario. This will provide information on market behavior and the effects of various payment procedures on health plan company behavior, and give us information on potential gaming behaviors. In addition to a simulation, we will assemble information from the literature and other projects.

### **CONCERNS OF SPECIAL GROUPS**

In addition to the issues that must be worked through prior to implementing a risk adjustment system, there are a set of concerns for specific populations and industry groups that will need to be addressed as well.

## HIGH RISK POPULATION CONCERNS

**Recommendation:** The risk adjustment mechanism will be transparent to individual enrollees. The testing/development phase of the risk adjustment process will include specific evaluations of the proposed methods and how those methods might unintentionally affect high risk and special needs populations. If needed, specific recommendations will be developed regarding legislative or other activities that should be implemented along with risk adjustment to alleviate these impacts.

One of the primary goals of risk adjustment is to remove current incentives for health plan companies to avoid enrolling high risk and special needs populations. (*High risk and special needs populations refers to populations who are at risk for high health care costs and who are believed to have special, costly treatment needs.*) Risk adjustment achieves this goal in conjunction with community rating and guaranteed issue requirements: health plan companies must issue coverage to anyone in the health plan company's catchment area, the premium must be at the health plan company's community rate, and the health plan company's revenues will be adjusted for the risk of the population it enrolls. Risk adjustment removes the incentive to find other ways (gaming) of attracting healthy enrollees and discouraging costly ones. The operations of the risk adjustment system itself should be completely transparent to individual enrollees. Those in the individual and small group markets should see improved access to health coverage options, but otherwise should not be aware of risk adjustment in the marketplace.

Under the targeted conditions risk adjustment system, conditions will be selected using specific criteria. Not all conditions involving high risk or special needs populations can, or should, be part of the risk adjustment mechanism. The risk adjustment system will cover enough condition areas to avoid leaving incentives for gaming in place for specific high risk groups. Conditions will also be defined narrowly enough to prevent gaming within a condition category (where costly individuals with a specific condition could be predicted and discouraged from enrolling). For some high cost, predictable conditions which are determined to not be feasible for risk adjustment, we will attempt to develop other mechanisms to protect individuals and improve their access to health insurance coverage. These other mechanisms may include market conduct rules, revisions to the risk adjustment system itself, redefinition of condition areas, or other mechanisms.

## PROVIDER ISSUES

**Recommendation:** The risk adjustment mechanism will not intervene directly in the financial arrangements between health plan companies and providers. The Risk Adjustment Association and the Departments will ensure that information on risk adjustment and how the system works is available to providers (no black box).

The risk adjustment system will not directly intervene in the financial arrangements between health plan companies and providers, nor dictate payment levels. Providers may want to be aware of the risk adjustment mechanism and how it operates, particularly in risk-sharing arrangements where the provider is partially at risk for the costs of treating patients.

## HEALTH PLAN COMPANY CONCERNS

### Incentives to Manage Care

The risk adjustment system will be designed to avoid creating incentives for inefficiency, or reduction of prevention efforts. Health plan companies that are able to demonstrate measurable, plan-induced improvements in the health status of their enrollees will not be penalized by the risk adjustment system for that success.

### RAPO (Regulated All-Payer Option) Concerns

RAPO health plan companies have special efficiency concerns. The MinnesotaCare law precludes these health plan companies from engaging in activities related to managed care, thus preventing them from being as efficient as ISNs and CISNs. We will need to explore ways to prevent the risk adjustment system from unduly penalizing these health plan companies for legislated inefficiencies.

### Solvency Issues

We will need to develop the risk adjustment system so that the risk adjustment system does not cause solvency problems for health plan companies. The risk adjustment mechanism must allow health plan companies setting premium rates to predict the value of the transfer and its impact on premiums with a fair degree of accuracy.

### Small Health Plan Company Concerns

Small health plan companies may have special concerns related to risk adjustment as well. In addition to solvency concerns mentioned above, some small health plan companies may experience difficulties in developing the necessary data capacities for risk adjustment. We will explore ways of being sensitive to these issues in the development of the system.

## MARKET CONDUCT RULES

**Recommendation:** Market conduct rules must be developed to accompany the risk adjustment mechanism, to improve the effectiveness of the risk adjustment system, to safeguard against gaming and to further address problems of access for high risk groups.

The risk adjustment mechanism must be accompanied by other efforts designed to facilitate the proper implementation of risk adjustment and to further address problems of access for high risk and special needs groups. The development of specific, clear, and understandable market conduct rules will assist in communicating the intent of the risk adjustment system. Market conduct rules should outline the specific intent of the risk adjustment reforms. We propose that market conduct rules will be developed by the Departments of Health and Commerce, with the advice of the Risk Adjustment Association. These rules will be incorporated into risk adjustment legislation, in broad outline form, and the Departments of Health and Commerce will be charged with revising and expanding the rules as they deem necessary.

## OPERATIONAL ISSUES

### Development and Implementation of the Risk Adjustment System

There are operational issues related to two distinct phases of the risk adjustment project. First, there is a **development phase** which concerns the testing and development of the risk adjustment system to be implemented in Minnesota. This phase began with the passage of the MinnesotaCare law in 1994,

and will continue until implementation begins. Second, there is an **implementation phase**, which may begin on July 1, 1997 and continues into the future and involves the implementation and administration of the risk adjustment system.

### **The Development Phase of the Risk Adjustment System**

**Recommendation:** The risk adjustment system will be developed by the Risk Adjustment Association, with active state participation and oversight by the Departments of Health and Commerce. The Association and the State each will have specific authority and responsibilities outlined in statute, and will work together cooperatively to develop risk adjustment in Minnesota.

The current statute requires the Commissioners of Health and Commerce to prepare a report based upon input from the Risk Adjustment Expert Advisory Panel. The statute anticipates the role of the Risk Adjustment Association as the entity to develop and implement a risk adjustment mechanism. The development of risk adjustment includes the need to test different methods. The recommendation places responsibility for developing and testing risk adjustment methods with the Association, subject to regulatory oversight by the Commissioners of Health and Commerce.

#### ***Role of the Association***

The Association would be responsible for overseeing the development of the private sector risk adjustment system. The Risk Adjustment Association would have responsibility to assemble Technical Advisory Groups in development of methodologies and other areas identified by the Association or the Departments. The Association must invite members of the Risk Adjustment Expert Advisory Panel to participate on its Technical Advisory Groups.

#### ***Role of the State***

The state would provide specific active state oversight of the activities of the Risk Adjustment Association. The role of the state would be to review and approve a plan for testing, review and approve the methods used in risk adjustment, review and approve any changes to those methods, to attend and participate in all meetings of the Risk Adjustment Association and its committees and work groups, to have access to data collected by the Association for the purpose of risk adjustment activities, to approve any administrators or consultants used by the Association. The state will also have primary responsibility for development of the risk adjustment system for public programs, and will work with the Association to coordinate risk adjustment in the public sector with risk adjustment in the private sector. In addition, the state will provide some staff support for risk adjustment development activities. There are still a number of open questions concerning the collection of data, including integration of data collection activities with other data activities, data privacy issues, etc.

### **The Implementation Phase of the Risk Adjustment System**

**Recommendation:** The Association will be responsible for implementing the system, with necessary active state oversight by the Departments of Health and Commerce. The appropriate implementation date will depend on the reforms enacted and will be determined by the Association and the Departments. The Association and the State each will have specific authority and responsibilities outlined in statute, and will work together cooperatively to implement the risk adjustment system.

### ***Role of the Association***

The Association is responsible for the implementation and operation of the Risk Adjustment system in accordance with the plan to be developed by the State and the Risk Adjustment Association. The Association must abide by the Open Meeting Law in conducting all its functions. The Association must report to the legislature at least twice a year, on the status and performance of the risk adjustment system. The Association must establish three classes of membership on the Board of Directors. These classes will be: 1) health plan companies (including ISNs and indemnity insurers), 2) Providers (including hospitals, physicians, and other providers), and 3) Public (including representatives of public programs, counties, and other public members). For any affirmative action by the Board, there must be at least one affirmative vote from each class. The legislature should consider the possibility of requiring the Association to be subject to the Data Practices Act as well.

### ***Role of the State***

The Departments of Health and Commerce will provide active oversight of the operations of the Risk Adjustment Association, and will assist the Association in carrying out its tasks and responsibilities. This oversight will be in accordance with the following specified tasks and responsibilities: The Departments will review and approve the Association's Plan of operation, the methods used in risk adjustments, and any changes to those methods proposed by the Association. The Departments have the authority to attend and participate in all meetings of the Risk Adjustment Association. The Departments have the responsibility for enforcing regulations relating to risk adjustment. The Departments have access to data collected by the Association for the purpose of risk adjustment activities. The Departments may require the Association to provide quarterly status reports. The Departments approve any administrators or consultants used by the Association.

## **LEGAL ISSUES**

### **Antitrust Issues Regarding the Development Phase**

Antitrust law is designed to prohibit collaboration and other activities which work against market competition. Risk adjustment raises potential antitrust concerns for two reasons. First, the process of risk adjustment involves competing health plan companies making monetary transfers to and from one another based upon the relative risk of their insured populations. This type of activity does not occur in a traditional competitive market. Second, the basis upon which monetary transfers are made requires a sharing of information. If appropriate safeguards are not in place, the sharing of information necessary for the development and testing of various risk adjustment methodologies may raise antitrust concerns.

Anti-trust exceptions are possible under certain, specific conditions. The state action doctrine provides immunity from anti-trust law, when two conditions are met. First, the intent to substitute regulation for competition to achieve a public purpose must be clearly articulated. Second, there must be active state supervision of the activity. Minnesota must address these two conditions, to avoid anti-trust problems which could adversely impact implementation of risk adjustment.

Because the risk adjustment mechanism involves the sharing of competitive information, appropriate means for this to occur must be in place. For example, if responsibility for development and testing is vested with the Association, the information needed for testing will need to be provided to the state and/or a third party vendor. These entities would need to retain the privacy of any of the individual health plan company data received. It will be necessary to create appropriate

classifications for the data under the Government Data Practices Act (Chapter 13). The Association should establish procedures and safeguards to ensure that data released does not identify or reasonably lead to identification of an individual's name or health status. Aggregate information which could reasonably lead to identification of an individuals name or health status should be considered private data.

If the responsibility for development and testing are vested in the Association it will also be necessary to make the activities of the association subject to regulatory oversight by the Commissioners of Health and Commerce. This oversight will ensure that the public interest concerns arising from a risk adjustment system and the need for such a system are carried out in the development stage. Specific details about this state oversight are provided above.

### **Legal Issues Regarding Operation of the Risk Adjustment Mechanism**

The ongoing operations of the Association require several specific legislative changes similar to those made for the Health Coverage Reinsurance Association (HCRA) created by Minnesota Statute 62L.13. For example, the Association should be exempt from state taxes; it should be allowed to execute all of the powers of a corporation formed under chapter 317A, and should be subject to regulatory oversight by the Commissioners of Health and Commerce.

For purposes of establishing that the activities of the Association are subject to the state action immunity from antitrust law, there must be a clear articulation of the public purpose for risk adjustment and that risk adjustment activities would be subject to active state supervision. To establish a clear public purpose, it is necessary to acknowledge that risk adjustment is designed to facilitate competition based on quality and efficiency rather than from avoiding the risk of insuring less healthy individuals. The articulated public purpose of this regulatory function is to remove current disincentives in the health care system to insure and serve high risk and special needs populations, and to promote competition on the basis of quality and efficiency. To fulfill the active supervision requirement, specific oversight activities should be outlined in statute. In this way, the statute in essence works to guarantee active state supervision. Areas of regulatory activity which could be put in legislation are outlined in the role of the state above.

### **Funding**

**Recommendation:** Funding for the *development phase* of risk adjustment will be needed to support testing and development of risk adjustment. Funding for development of risk adjustment in the private sector shall be the responsibility of the Association. Funding for the development phase of risk adjustment in the public programs shall be the responsibility of the state. Foundation and grant support will be sought to supplement public and private funding.

**Recommendation:** Funding for the *operation phase* of risk adjustment should be obtained through an assessment of health plan companies participating in the risk adjusted markets. These funds will support administration of the system and the actual payments to health plan companies that have enrolled a more costly population.

Funding of risk adjustment will also be in two phases: the development phase and the ongoing operation or implementation phase. In the **development phase**, funding will be needed to develop and test the risk adjustment models. Public sector support will include legislative appropriations (some new, some existing) and in kind staff support. Public sector funds will be used to support the testing and development of risk adjustment in the public programs. Private sector funding will be obtained through an assessment of health plan companies and other groups (such as providers) not just individual and small group plans. Foundation and federal grant support will sought to supplement the public and private sector funding.

During the ongoing operations or **implementation phase**, funding will be needed for administration of the risk adjustment system, and for the actual payments to health plan companies undertaking high risk populations. The ongoing funding of the risk adjustment system will be through assessments on the health plan companies participating in the risk adjusted markets.

## CONTINUOUS IMPROVEMENT OF THE RISK ADJUSTMENT SYSTEM

**Recommendation:** Prior to implementation of the risk adjustment system, the Risk Adjustment Association, with approval of the Departments, will have developed a detailed plan for evaluation and continuous improvement of the risk adjustment system.

We will also develop a plan for continuous improvement of the risk adjustment system, to ensure that our methods advance to keep the risk adjustment system the most effective system possible. This plan will include methods for dealing with changes in medical treatment (new treatments that are very costly for specific conditions, or specific patients). The plan will also provide mechanisms to deal with specific problems uncovered after implementation.

## SUMMARY OF RECOMMENDATIONS

**Recommendation 1:** Risk adjustment is an important part of health care reform. The need for risk adjustment is critical in a guaranteed issue, community rated environment. Even without a movement to community rating, risk adjustment may still be valuable to reduce the incentive to avoid high risk populations, and to facilitate health plan company competition on the basis of quality. Given the significant effort and time required to develop an effective risk adjustment mechanism, it is important for Minnesota to continue to *develop* a risk adjustment system. The importance of an early implementation date (such as the July 1, 1997 date specified in legislation) will depend on the extent of insurance reforms actually implemented.

**Recommendation 2:** Risk adjustment must take place in a defined market, with free entry and exit from the risk adjustment mechanism prohibited. Therefore, the risk adjustment mechanism should apply across-the-board to all employers and/or individuals within the applicable market regardless of the mechanism through which they obtain coverage.

**Recommendation 3:** Risk adjustment will be developed for the individual and small group markets, state-run public programs including Medical Assistance, General Assistance Medical Care and MinnesotaCare (as a separate pool), and the Medicare Supplement market.

**Recommendation 4:** The Medicare Supplement market has the type of restrictions which necessitate risk adjustment. The Association shall convene a work group to evaluate the need for risk adjustment in the Medicare Supplement market, and to develop that system as a

separate pool. Because Medicare Supplement policies are supplemental to Medicare, a targeted conditions adjustment may not be necessary. Risk adjustment in this market will be based on a demographic adjustment.

**Recommendation 5:** A separate risk adjustment pool should be developed for the state-run public programs, including Medical Assistance, General Assistance Medical Care, and MinnesotaCare. During the testing and development phase, a work group shall be convened to study this, and to recommend an approach to risk adjustment for the public programs.

**Recommendation 6:** After reviewing a number of possible risk assessment methods, we recommend that a combination of an age/sex **demographic** risk adjustment system and payments for **targeted conditions** be developed for implementation by July 1, 1997. We also recommend that testing be done concurrently on an **Ambulatory Care Groups (ACG)/Diagnostic Costs Group (DCG)** system which, if found to be superior, could replace the targeted approach at some future time when data systems make it feasible.

**Recommendation 7:** During the development/testing phase the Risk Adjustment Association and the Departments will pursue a multiple-tier approach focusing on Minnesota experience, national studies, and expert assistance. The models will be tested with Minnesota data wherever possible, and market behavior will be modelled with a simulation exercise. Testing will focus on the individual and small group market, the Medicare Supplement market, and public programs.

**Recommendation 8:** The risk adjustment mechanism will be transparent to individual enrollees. The testing/development phase of the risk adjustment process will include specific evaluations of the proposed methods and how those methods might unintentionally affect high risk and special needs populations. If needed, specific recommendations will be developed regarding legislative or other activities that should be implemented along with risk adjustment to alleviate these impacts.

**Recommendation 9:** The risk adjustment mechanism will not intervene directly in the financial arrangements between health plan companies and providers. The Risk Adjustment Association and the Departments will ensure that information on risk adjustment and how the system works is available to providers (no black box).

**Recommendation 10:** Market conduct rules must be developed to accompany the risk adjustment mechanism, to improve the effectiveness of the risk adjustment system, to safeguard against gaming and to further address problems of access for high risk groups.

**Recommendation 11:** The risk adjustment system will be developed by the Risk Adjustment Association, with active state participation and oversight by the Departments of Health and Commerce. The Association and the State each will have specific authority and responsibilities outlined in statute, and will work together cooperatively to develop risk adjustment in Minnesota.

**Recommendation 12:** The Association will be responsible for implementing the system, with necessary active state oversight by the Departments of Health and Commerce. The appropriate implementation date will depend on the reforms enacted, and will be determined by the Association and the Departments. The Association and the State each will have specific authority and responsibilities outlined in statute, and will work together cooperatively to implement the risk adjustment system.

**Recommendation 13:** Funding for the development phase of risk adjustment will be needed to support testing and development of risk adjustment. Funding for development of risk adjustment in the private sector shall be the responsibility of the Association. Funding for the development phase of risk adjustment in the public programs shall be the responsibility of the state. Foundation and grant support will be sought to supplement public and private funding.

**Recommendation 14:** Funding for the *operation phase* of risk adjustment should be obtained through an assessment of health plan companies participating in the risk adjusted markets. These funds will support administration of the system and the actual payments to health plan companies that have enrolled a more costly population.

# CHAPTER I

## INTRODUCTION AND SCOPE OF REPORT

### LEGISLATIVE BACKGROUND

The 1994 MinnesotaCare law (Chapter 625 Article 2 Section 15 62Q.03) outlines a process for defining, developing, and implementing a risk adjustment system in Minnesota. The purpose of this system is to remove the current disincentives to enroll high risk and special needs populations, and to promote fair competition among health plan companies on the basis of the efficiency and quality of care they provide, rather than on their ability to attract healthy, low-risk individuals. The legislation specifies that the risk adjustment system must be developed and implemented by July 1, 1997, and it must be amenable to continuing improvements over time.

The 1994 MinnesotaCare legislation directed the Commissioners of Health and Commerce to prepare a report to the legislature by January 15, 1995 to outline the process that will be used to develop and implement a risk adjustment system in Minnesota. The report is required to identify a specific methodology or methodologies that may serve as a starting point for risk adjustment (Chapter 5 page 23), explain the advantages and disadvantages of each such methodology (Chapter 5 page 27), and provide a specific workplan for implementing the methodology (Chapter 6 page 33). The legislation also identifies twelve specific issues to be addressed in the report:

- The relationship of risk adjustment to the implementation of universal coverage and community rating (See Chapter 3 page 10);
- The role of reinsurance in the risk adjustment system, as a short term alternative in the absence of a risk adjustment methodology (See Chapter 2 page 4);
- The relationship of the risk adjustment system to the implementations of other reforms in underwriting and rating requirements (See Chapter 3 page 10);
- The potential role of the health coverage reinsurance association in the risk adjustment system (See Chapter 2 page 3);
- The need for mandatory participation of all health plan companies in the risk adjustment system (See Chapter 4 page 15);
- Current and emerging applications of risk adjustment methodologies used for reimbursement purposes at the state and national level and the reliability and validity of current risk assessment and risk adjustment methodologies (See Chapter 5 page 23);
- The levels and types of risk to be distributed through the risk adjustment system (See Chapter 3 page 5);
- The extent to which prepaid contracting by public programs needs to be addressed by the risk adjustment system (See Chapter 4 page 20);

- A plan for testing of the risk adjustment options being proposed, including simulations using existing health plan company data, and development and testing of models on simulated data to assess the feasibility and efficacy of specific methodologies (See Chapter 6 page 33);
- The appropriate role of the state in the supervision of the risk adjustment association (See Chapter 8 page 47);
- Risk adjustment methodologies that take into account differences among health plan companies due to their relative efficiencies, characteristics, and relative to existing insured contracts, new business, underwriting, or rating restrictions required or permitted by law (See Chapter 5 page 23);
- Methods to encourage health plan companies to enroll high risk populations (See Chapter 7 page 41).

## **ASSISTANCE OF EXPERT ADVISORY PANEL**

The 1994 MinnesotaCare law also created an Expert Advisory Panel to provide technical expertise and advice to the Commissioners of Health and Commerce in the development of this report. The advisory panel consists of members of the Interim Board of Directors of the Risk Adjustment Association, which represents the major constituency groups, and experts in the fields of health services research, health economics, and epidemiology. (Appendix 2 contains a list of the members of the Expert Advisory Panel.) The group was assembled in July and met monthly from August through January. In addition to the Expert Advisory Panel, four technical workgroups were established to discuss technical issues related to risk adjustment: 1) Methodologies, 2) Plan for Testing, 3) Operational Issues, and 4) Public Programs. These workgroups included members of the Expert Advisory Panel and other experts. (Appendix 3 contains a listing of members of each of these workgroups.)

# CHAPTER II

## PURPOSE, GOALS, AND GUIDING PRINCIPLES FOR RISK ADJUSTMENT

This section outlines the purpose, goals and guiding principles for risk adjustment in Minnesota. They were developed, using the legislative charge as a resource, by the Risk Adjustment Expert Advisory Panel.

**The purpose** of the risk adjustment mechanism is to reduce the effect of selection on health insurance premiums by making appropriate transfers among health plan companies serving populations with different levels of risk. Risk adjustment is necessary in markets where rating restrictions prohibit the up front matching of premiums with risk factors.

**The goals/objectives** of risk adjustment for Minnesota's health care reform are to:

*Achieve a more equitable, efficient system of health care financing;*

*Remove current disincentives in the health care system to insure and provide adequate access for high risk and special needs populations;*

*Promote fair competition among health plan companies on the basis of their ability to efficiently and effectively provide services rather than on the risk status of those in a given insurance pool; and*

*Help maintain the viability of health plan companies by protecting them from the financial and marketplace effects of enrolling a disproportionate number of high risk individuals.*

### GUIDING PRINCIPLES:

- The risk adjustment system will possess an acceptable level of accuracy, will not reward controllable inefficiencies, will not penalize health plan companies for verifiable improvements in enrollee health status, will be practical, timely, comprehensive, resistant to gaming, and adaptable to changes over time.
- All health plan companies participating in the covered markets will be required to participate in risk adjustment. The role of the existing Minnesota Health Care Reinsurance Association and the Minnesota Comprehensive Health Association will be discussed as part of the planning process. Public programs (including Medical Assistance, General Assistance Medical Care, and MinnesotaCare ) will be included in the risk adjustment system as a separate pool.
- The risk adjustment system recognizes that Regulated All-Payer System (RAPO) health plan companies contain inherent inefficiencies due to their legislated inability to contract or negotiate with providers of health care services (MN Laws 62P.31) and will not penalize

those health plan companies for inefficiencies resulting from those restrictions.

- Risk adjustment cannot be expected to fix all current financing problems in the health care system. The risk adjustment system will deal with the problem of unequal distributions of risk between health plan companies. Other needs such as financing public programs and subsidies for low-income individuals must be addressed separately through other mechanisms.
- The risk adjustment mechanism alone cannot solve all problems of serving high risk populations, but should be used in concert with other mechanisms, such as market conduct rules and health plan company report cards, to assure access to insurance and services for high risk groups.
- Risk adjustment is not designed to account for all catastrophic (random) costs, and therefore there will always be a residual role for a private reinsurance market.
- The risk adjustment system will be developed and implemented by the Risk Adjustment Association with joint oversight by the Department of Health and the Department of Commerce.
- The risk adjustment system will be designed so that it can be continually improved and adapted over time, as methods improve and as health care reform legislation moves forward.

# CHAPTER III

## INTRODUCTION TO RISK ADJUSTMENT

### DEFINITIONS

*Risk adjustment* is a financial mechanism through which monetary transfers are made from health plan companies that insure a relatively low risk (low cost) population to those that insure a relatively higher risk (higher cost) population. Thus, health plan companies that enroll a more costly population receive more revenue without charging higher premiums. The concept of risk adjustment has been receiving increased attention recently, in light of state and national health care reform and the interest in increasing access to affordable insurance.

The purpose of risk adjustment is to reduce the effects of selection on health insurance premiums by making appropriate transfers among health plan companies undertaking different levels of risk.

In Minnesota, risk adjustment is being developed out of a concern that under reform, health plan companies face growing incentives to attract healthy, low risk (low cost) enrollees and avoid those who are likely to become sick and need health care services (*risk selection*)<sup>5</sup>. If health plan companies can attract a healthy, low cost population, their risk is minimized and they in turn can offer low premiums that help the plan compete for new low-cost groups. Health plan companies with a higher cost population must charge higher premiums to cover their costs. Individuals or groups with high expected health care costs often must pay high premiums to receive coverage.

The incentives to attract healthy enrollees are further magnified by the movement toward *community rating*, where each health plan company must charge the same rate to all groups and individuals they cover regardless of the groups' claims history or risk profile. Groups or individuals which health plan companies believe to be at higher risk for health care expenses cannot be charged higher premiums than individuals believed to be lower risk. Community rating prevents health plan companies from matching premiums to expected health care expenditures for specific individuals or groups. While correcting the problem of high premiums for certain high risk groups, community rating creates a greater incentive for health plan companies to avoid high cost populations. (See section below for discussion of community rating and its relationship to risk adjustment).

Even without specific attempts at avoiding high risk populations, sicker and more costly enrollees tend to select some health plan companies over others because of plan design or network (*adverse selection, or anti-selection*). The combination of risk selection on the part of health plan companies

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<sup>5</sup> NOTE: Terms such as risk selection, adverse selection, risk segmentation and other related terms are often used differently by different groups. For clarity and consistency, we have defined these terms and attempted to use them consistently in this report. Other writings on risk adjustment may use these terms differently, or may use other terms.

and adverse selection on the part of enrollees result in *risk segmentation*, where health plan companies end up with different levels of risk in the populations they cover. Risk segmentation makes premium differences across health plan companies difficult to interpret, and can also create a premium spiral in which health plan companies with a more costly patient pool are forced to raise their premiums, forcing the healthier, lower cost enrollees they did have out, leaving an even higher cost pool and forcing the health plan company to raise its rates again.

Risk adjustment is a two part process, including a risk assessment method and an adjustment mechanism. *Risk assessment* is a process of quantifying the level of risk (of high health care costs) of the health plan company's population relative to the average risk of health plan populations. The *risk adjustment mechanism* then translates that risk into a financial transfer: the health plan company either pays into a pool or receives payments from a pool, depending on the extent to which the company's population differs from the average. Premium dollars are then redistributed from those health plan companies with a relatively low risk (cost) population to those health plan companies with a relatively costly population. In such a system, health plan companies are aware of the mechanisms and how they work. They can estimate their risk situation up front and reflect these payments in the premiums they charge. Health plan companies that expect to pay into the pool (because they have a healthy population) will raise their community rate to cover this cost and health plan companies that expect to receive payments (because they have a more costly population) will lower their rate. This brings the rates charged by different health plan companies closer together. **Although rates will still vary across health plan companies, these variations will be less attributable to risk differences in the plan populations and more attributable to differences in quality and medical and administrative efficiencies.** Appendix 4 contains a glossary of other important terms relating to risk adjustment.

## WHAT DO WE MEAN BY RISK ADJUSTMENT?

Risk adjustment is a mechanism for adjusting for different levels of relative risk (versus some average or expected risk) within a population or sub population. *Risk adjustment means many different things to different people.* The key difference between the definitions are in their *measurement objectives*, ie. what "risk" is being measured and for what purpose. In health care for example, "Risk" can mean:

- risk of costs related to health care,
- risk of poor outcome,
- risk of disease.

These three types of risk overlap and are sometimes, *but not always*, related. For example, higher risk of disease often relates to higher expected health care costs, and to poorer expected outcomes. These three are not always related, however. For example, increased disease does not always translate into increased health care costs (consider a disease which is fatal early versus a less severe disease which results in a continuous need for health care services over a long period of time). For this reason, not all of the factors that might be used to predict risk of disease will be useful in predicting risk of health care costs, and vice versa. Also, a variable that is connected with both an increase in risk of disease and an increase in health care costs may not have the same **degree** of association. Therefore, it is important to focus discussion on the objective for a specific risk adjustment project, and to examine methods of risk adjustment that best meet that objective.

*The objective for the Risk Adjustment project initiated by the 1994 MinnesotaCare law is focused on the risk of health care costs. The risk adjustment model discussed here involves assessing the risk of health care costs for the purposes of redistributing premium dollars among health plan companies on the basis of how much their patient population "should" or "is expected to" cost given the characteristics of the patients in each health plan company.*

## **WHY IS RISK ADJUSTMENT NEEDED?**

The need for a risk adjustment mechanism is created in large part by elements of the health care reforms contained in the MinnesotaCare legislation. Risk adjustment is needed to remove the incentives for health plan companies to avoid high cost populations, and to facilitate competition among health plan companies on the basis of quality and medical and administrative efficiencies. Guaranteed issue and community rating requirements have been enacted or are proposed for the individual, small employer and Medicare Supplement markets. Under a guaranteed issue requirement, each health plan company is required to accept anyone applying for coverage. Under community rating requirements or rate restrictions, the premiums charged by a health plan company must be the same for everyone, or may only vary based on certain allowed risk characteristics within specified limits on the amount of variation.

In an unregulated health insurance system, each health plan company assesses the risk of individuals and groups as part of the underwriting process. The health plan company then determines whether to cover the individual or group, and if so sets the appropriate premium level. Differences in expected costs are accounted for in the premiums. For example, older individuals are charged higher rates than younger individuals reflecting their higher expected health care costs. Under this system, there is no need for risk adjustment as differences in risk are already reflected in the health plan company's premiums.

A system operating under guaranteed issue and community rating differs from the unregulated system in that a health plan company must accept all individuals and groups, and must charge one

- **"A reformer's nightmare:** Health reformers devise a system in which risk-bearing health plans compete on the basis of price and quality, but premiums are not adjusted for risk. Unfortunately, the most efficient health plan in the region- a plan with top-notch physicians, excellent protocols for treating serious illnesses, a proven record of favorable outcomes, and lower-than-average treatment costs- ends up going out of business because its premiums are too high. Over the years, it has attracted too many customers who can gain the most from its services- sick people. Their presence has elevated the cost of premiums, has deterred healthier people from joining, and eventually has led to unaffordable premiums.
- **A reformer's dream:** Researchers develop a way to adjust premiums so that a health plan that has developed a high-quality, low-cost method of treating chronic illnesses, such as diabetes, can advertise its expertise without fear of losing customers and going under."

*Excerpted from Karl Polzer "The Role of Risk Adjustment in National Health Reform" Issue Brief No. 641. February, 1994, National Health Policy Forum, Washington, DC*

"community rate" to everyone covered under each benefit plan. Without risk adjustment, the "community rate" will be based on the health plan company's risk pool, and will reflect the types of risks covered by the health plan company. For example, health plan companies with better risks will be able to charge a lower community rate than health plan companies with higher risks. This will provide incentives to health plan companies to avoid high risk individuals in order to maintain the most competitive premiums. Purchasers will make decisions based on premium differences that reflect the health plan company's risk pool, rather than the company's medical and administrative efficiency. In the extreme, this could bankrupt health plan companies that have an unusually high proportion of high risk individuals.

There are likely to be significant differences in risk pools among health plan companies under health care reform. Risk segmentation occurs through both selection of risks by health plan companies (risk selection) and selection decisions made by purchasers (adverse selection). Risk segmentation will be impacted by plan design variations, degree of provider choice, high quality specialists, health plan company location, targeted advertising and marketing, health plan companies' prior underwriting methods and risk pools, and the tendency of new health plan companies to attract low-risk individuals. For example, individuals with high expected costs tend to select health plans with rich benefits, low cost-sharing requirements, and a wide choice of providers and specialists. Without risk adjustment, risk segmentation may dominate differences in premiums among different types of plans and health plan companies. Without risk adjustment, the health plan company's best investment may be in better underwriting, rather than in better medical management.

## **CAPABILITIES AND LIMITATIONS OF RISK ADJUSTMENT**

The purpose of the risk adjustment mechanism is to remove the distortions due to selection from health insurance premiums by making appropriate transfers among health plan companies undertaking different levels of risk. The goals of risk adjustment include: a) premiums which reflect the administrative and medical efficiencies of health plan companies, rather than the health plan companies' risk pools, and b) financial indifference by health plan companies regarding the risks they assume.

There are many misunderstandings about what risk adjustment is, and what it can and cannot accomplish. These issues relate to the status of risk adjustment as an emerging science, to the desire on the part of some to have risk adjustment accomplish other policy goals, and confusion over the distinction between financial risk adjustment and other efforts to predict the prevalence of disease or other types of risk.

### **Risk Adjustment and Risk Assessment for Other Purposes**

Risk adjustment, in this context, relates to risk of health care expenditures. It should not be confused with efforts to measure risk or prevalence of illness, or risk of poor outcomes. (See page 6 for additional discussion.) Financial risk adjustment will not impact the need for public health programs, population health status assessment, risk assessment for outcomes studies, or other activities. These other activities are important to the health care system, and they sometimes overlap with financial risk adjustment, but they are separate projects with different purposes, methods, and goals.

### **Risk Adjustment is an Emerging Science**

At present, risk adjustment alone cannot completely solve all of the problems it is specifically meant

to address. Risk adjustment is an emerging science. Most models for risk assessment are not particularly powerful, and most are largely untested. This means that any model chosen will be likely to account for only a portion of the targeted variation in health care expenditures across health plan companies. Even if financial risk adjustment were perfected, there would still be unexplained (random) variations across health plan companies due to random factors which cannot be predicted and therefore cannot be included in the model. In addition, there may be other, non-financial, reasons for health plan companies to attempt to avoid some high-risk populations. Other solutions to these issues will need to be examined and implemented along with the risk adjustment process.

### How much variation in health care costs must be or should be accounted for in the risk adjustment model?

Health care costs vary from health plan company to health plan company. These variations can be attributed to characteristics of the plan/provider (how efficiently they provide services for example), measurable characteristics of the patient population (what conditions they have, age, and other factors), non-measurable patient characteristics, and other random factors which cannot be measured (See figure 1). A risk adjustment model which would meet our objectives would be designed to adjust only for risk that is outside of the control of the health plan company, (ie. measurable patient characteristics). If a risk adjustment model adjusted for 100% of the total variation in health care expenditures across health plan companies (which could easily be done simply by paying health plan companies on the basis of "actual costs") it would reward inefficiency, penalize efficient health plan companies and would work against the goals of health care reform. An ideal risk adjustment model would

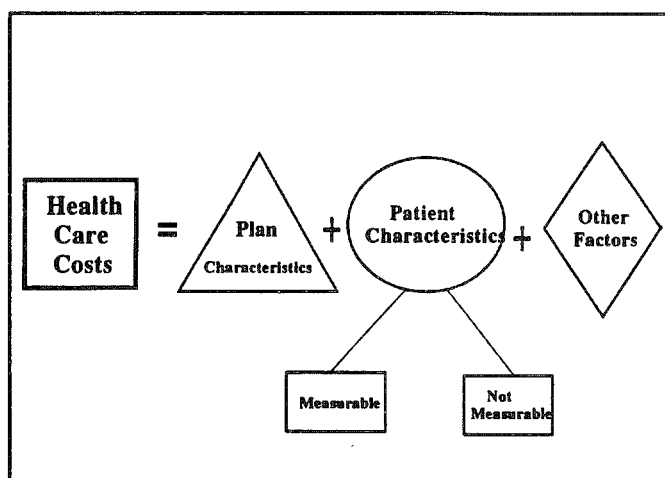


Figure 1

adjust for all of the variation *attributable to differences in the patient population*. This would include patient factors that are demonstrated to be correlated with increased (or decreased) health care costs. The actual model will likely account for only a portion of the health care costs attributable to patient characteristics because some characteristics are too difficult or too costly to measure.

How much predictive power is necessary to meet the objectives of risk adjustment for this project? In order to remove the financial incentive for health plan companies to avoid enrolling high-risk populations, it is desirable for the adjustment model to account for nearly as much variation as the health plan companies are able to account for. Health plan companies would then be financially indifferent to the risk level of their covered population and the incentive for avoiding high risk populations would be removed. Our goal is to develop a risk adjustment system which successfully balances the need for an adequate risk adjustment system with the need to minimize the cost of that system.

To know how much variation the model should account for we would need to know how much of the variation is due to patient factors versus plan factors versus other factors, which may be beyond current measurement models. Risk rating using age, sex, and prior use accounts for approximately

6-8% of total variation (including plan and patient factors). Other research-based models, using combinations of age, sex, diagnosis, prior use, and health status, account for 20-30% of total variation. Some researchers feel that it is possible to account for up to 50% of total variation. These measures of variation are often based on regression models, and the variation represents a measure of how well the model explains *individual* variation in a population. Some researchers feel that this measure of variation is too stringent a standard to evaluate risk adjustment models. They believe that the model should be evaluated on its ability to reduce variation among *groups* of patients, rather than across individuals. On the other hand, others feel that the possibility of individual plan selection (such as occurs with large purchasing pools where individuals can choose among health plan companies, or in the individual market) as well as the need to remove incentives to exclude individuals requires a focus on individual variation in costs.

### **Risk Adjustment and Other Policy Goals**

Risk adjustment should not be used as a means to subsidize public programs or low-income individuals. While we do not take issue with the importance of addressing these concerns, risk adjustment is not the proper vehicle to achieve these ends. These issues will need to be addressed via explicit mechanisms specifically developed for that purpose.

Risk adjustment mechanisms should not try to further other social policy goals unrelated to health risk adjustment. Needs such as financing public programs and subsidies for low-income individuals must be addressed separately through other mechanisms.

Concerns have been expressed regarding the effect of risk adjustment on eligibility for public programs' wrap-around<sup>6</sup> services. Eligibility for any wrap-around services is unrelated to the purpose of risk adjustment in this context. Any eligibility criteria should be developed by the appropriate service experts.

Risk adjustment is sometimes confused with reinsurance. Reinsurance is used to protect health plan companies from random catastrophic claims such as organ transplants or burns. The purpose of risk adjustment is to account for non-random differences in expected costs. Risk adjustment is not designed to account for all random catastrophic costs, and will not replace the role of the private reinsurance market.

**It is important to remember that risk adjustment will not fix all of the current problems in the health care system.** Its sole purpose is to remove the effects of selection from premiums, thus alleviating the problems that would otherwise be created by the proposed underwriting and rating reforms. Requiring the risk adjustment system to try to fulfill other purposes, could compromise the ability to fulfill its central purpose.

Finally, no matter how we implement risk adjustment, it will not be perfect. Our goal is to develop a system that addresses the most significant problems related to coverage of high cost populations,

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<sup>6</sup> Wrap-around services are services that are non-medical in nature, but which must be provided in order to effectively deliver of medical services.

within a risk adjustment system that is easy to administer and low-cost.

## RELATIONSHIP OF RISK ADJUSTMENT TO OTHER REFORMS

This section includes a brief discussion of the impact of insurance reforms on risk adjustment. Appendix 5 contains an outline of Minnesota's insurance reforms for each market; it includes both those requirements currently in effect and those requirements in current law with future effective dates (See Table 1 for a summary of those reforms).

RATING AND UNDERWRITING REQUIREMENTS Current and Proposed		
Market	Rating Requirements	Underwriting requirements
Individual	Rate Bands, Gender Prohibited. 7/1/97 Pure Community Rating	Underwriting permitted. 7/1/97- Guaranteed Issue.
Small Employer Group	Rate Bands, Gender Prohibited. 7/1/97 Pure Community Rating	Guaranteed Issue
Large Employer Group	Typically Experience-Rated. Gender Prohibited.	Not Typically Underwritten.
Medicare Supplement	Pure Community Rating	6 Month Open Enrollment at Age 65

Table 1

### Guaranteed Issue and Open Enrollment

Under a guaranteed issue requirement, health plan companies must accept all individuals and groups applying for coverage. A guaranteed issue requirement increases adverse selection problems as insureds have a chance to change health plan companies after becoming ill, enrolling in a plan with richer benefits or with a health plan company offering greater choice of providers or high quality specialty care. Risk adjustment is needed to protect health plan companies from the effects of covering a disproportionate number of high risks.

The selection problem arising from a guaranteed issue requirement is lessened where coverage is provided through employers, since health plan company selection is made by the employer for the entire group. This is related to group size, since for a very small group the employer's primary consideration in health plan company and plan selection may be the health coverage needs of the employer's family. Thus a guaranteed issue requirement may cause selection problems in the small employer market.

### Community Rating and Rating Restrictions

Standard underwriting and rating methods incorporate factors such as age, sex, geographic region, health status, and claims experience into the rate development. Rates vary across each factor based on the expected costs. (For example, older individuals are charged more than younger individuals reflecting their higher expected health care costs.)

Community rating is a method of rating that produces identical rates for all members of an identified pool or class, based on the expected costs for these members as a group. *Pure community rating* is a rating method that recognizes only family composition, geographical area, plan design, and overall experience of the "community." *Modified community rating* or *community rating by class* refines this approach by adding demographic characteristics such as age and sex. *Adjusted community rating* refers to the addition of historical claims experience. Modification to these rating methods also occur. For example, a rating method may recognize a risk factor such as age or claim experience, but the variation in rates may be limited to less than the variation in expected costs.

Risk adjustment may be needed to remove effects of selection from health plan companies' overall premium level under any rating system where variations in expected costs are not fully reflected in rate variations. Without risk adjustment, a health plan company with a large proportion of higher cost individuals, unable to reflect the higher costs through rate variations, will have to charge a higher "community rate" than other health plan companies. **The need for risk adjustment increases as the rating restrictions increase, or the closer the rating system is to "pure community rating."**

The appropriate risk adjustment mechanism is a direct consequence of the rating restrictions. Risk adjustment is needed for those rating factors not allowed to vary to reflect the relative risk factors of the purchasers. For example, risk adjustment under a community rating by class environment where health plan companies are allowed to vary their rates based only upon age would need to be based only on health status and gender. Risk adjustment in a pure community rating environment would need to be based on health status, gender, *and age*.

Where variation in a rating factor is permitted, but restricted to less variation than that in expected costs, the risk adjustment mechanism must reflect the remaining variation. For example, if variation in rates by age is allowed but is limited to a 2:1 ratio, the demographic risk adjustor will be developed based on the difference between expected costs and premiums *at each age*. This introduces a manageable degree of complexity; the risk adjustment mechanism needs only to have the rating structure fixed and constant with the methodology matched to the rating structure.

The magnitude of the risk adjustment transfer is also directly related to the level of rating restrictions in the system. Transfers between health plan companies will be larger under "pure community rating" than under community rating by class where variation in costs by age are reflected up front in the premiums.

### **Plan Design Variation**

Variation in benefit packages will affect both the complexity of the risk adjustment mechanism and the risk segmentation occurring in the market. Benefit design has a significant impact on selection. Individuals with high expected costs tend to select health plans with richer benefits and less out-of-pocket requirements. If permitted, health plan companies may also tailor benefit packages to attract different risk groups, by omitting coverage for certain conditions or certain providers. Wide variations in benefit design will thus increase the selection problems in the market.

Variations in benefit packages will also add complexity to the risk adjustment calculation. Risk adjustment mechanisms are often based on relative values; transfer payments are based on the differences between the health plan company's relative risk factor and the market average risk factor

applied to some amount. This amount will need to vary with the benefit package, thus the greater the variety in benefit packages the more complex the system. Further, benefit design changes the relationship between age and expected costs. If demographic adjustments are part of the risk adjustment mechanism, different sets of age/sex factors may need to be developed for different types of benefit packages.

### **Risk Adjustment as a Part of Health Care Reform**

**Recommendation:** Risk adjustment is an important part of health care reform. The need for risk adjustment is critical in a guaranteed issue, community rated environment. Even without a movement to community rating, risk adjustment may still be valuable to reduce the incentive to avoid high risk populations, and to facilitate health plan company competition on the basis of quality. Given the significant effort and time required to develop an effective risk adjustment mechanism, it is important for Minnesota to continue to *develop* a risk adjustment system. The importance of an early implementation date (such as the July 1, 1997 date specified in legislation) will depend on the extent of insurance reforms actually implemented.

The establishment of new rating and underwriting limitations, proposed as part of Minnesota's health care reforms, contributes greatly to the need for a risk adjustment mechanism. Risk adjustment is a necessity if rating restrictions do not allow up-front matching of premiums or contributions with the relative risk factors of the purchasers. Risk adjustment can be viewed as a financial mechanism to facilitate health care reforms. Both the need for risk adjustment and the appropriate adjustment methodology and design will depend on the reforms adopted.

Under the current rating and underwriting restrictions, the need for risk adjustment is somewhat less critical. In the small employer and individual markets, premium variations are permitted within limits. Premiums, therefore, match expected costs to a certain extent. The significant exceptions are the prohibition on the use of gender as a rating variable, the guaranteed issue requirement in the small employer market, and the "pure community rating" requirement in the Medicare Supplement market. Under current rating and underwriting restrictions, implementation of risk adjustment could proceed at a somewhat less hurried pace, and Minnesota would be able to take advantage of more of the research projects being conducted nationally.

Although the need for risk adjustment is critical under proposed insurance reforms such as guaranteed issue and community rating, there are additional benefits to developing a risk adjustment mechanism in Minnesota. Risk adjustment may be valuable to reduce the incentives to avoid high risk populations, and to facilitate health plan company competition on the basis of quality and administrative efficiencies. Further, the methods developed could be used by large employers or purchasing pools offering multiple health plans to their employees, or by public programs as part of their health plan company reimbursement methods. Finally, guaranteed issue requirements and rating restrictions have already been implemented in several markets.

Given the significant effort and time required to develop an effective risk adjustment mechanism, Minnesota must proceed to develop risk adjustment. The importance of an early implementation date (such as the July 1, 1997 date currently specified in legislation) will depend on the extent of the insurance reforms actually enacted.



# CHAPTER IV

## MARKETS TO BE RISK ADJUSTED

**Recommendation:** Risk adjustment must take place within a defined market. Free entry and exit from the risk adjustment mechanism must be prohibited. Therefore, the risk adjustment mechanism should apply across-the-board to all employers and/or individuals within the applicable market regardless of the mechanism through which they obtain coverage.

**Recommendation:** Risk adjustment will be developed for the individual and small group markets, state-run public programs including Medical Assistance, General Assistance Medical Care, and MinnesotaCare (as a separate pool), and the Medicare Supplement market.

This chapter addresses the issues of pool definition and design, including a discussion of the issues affecting each market sector. We have looked at the issues of pool design within the context of the health care environment as proposed in current legislation. Significant changes in health care reforms may affect the design/definition of the pool(s).

### DEFINED MARKETS

The critical element in pool design is the establishment of a defined pool(s), where movement in and out of the pool is very difficult, if not impossible. If "escape hatches" are available to employers, individuals, and/or health plan companies, the risk adjusted pool itself will be selected against.

For example, if health plan company participation is voluntary, the health plan companies with lower risk populations will opt out of the risk adjustment pool. Similarly, if employers can choose whether their health plan is risk adjusted or not, the employers with the lower risk groups (either due to age or health status) will opt out, leaving only the high risk groups in the risk adjustment pool. This will drive up the premiums to those remaining in the pool.

The size of the risk adjusted market is not necessarily crucial to the success of risk adjustment. The purpose of risk adjustment is to remove the effects of selection from health care premiums and is not dependent on the size of the risk adjusted sector. Concerns regarding the size of the sector subject to risk adjustment relate to the potential added costs that may be imposed on the sector, such as the establishment of a defined market is a critical element to the successful operation of the risk adjustment system. Participation must be mandatory for all health plan companies participating in the markets included in the defined pool(s). If participation were voluntary, some, if not all, health plan companies with disproportionately favorable risks would choose not to participate in the risk adjustment system, thereby defeating the goals of risk adjustment.

## **Individual and Small Group Markets**

### ***Current and Proposed Insurance Reforms***

A guaranteed issue requirement was enacted in the small employer market<sup>7</sup> on July 1, 1993. The implementation of the guaranteed issue requirement was accompanied by the creation of a reinsurance pool for small employer plans (Minnesota Health Coverage Reinsurance Association). Health plan companies are protected from the effects of covering a disproportionate number of high risks, by ceding these individuals or groups to the reinsurance association. It is not yet clear whether the reinsurance association is an adequate risk adjustment mechanism given the current small employer underwriting and rating reforms. The 1994 MinnesotaCare legislation anticipates a guaranteed issue requirement in the individual market on July 1, 1997, but predicates this requirement on an individual mandate for coverage and a subsidy for low-income individuals.

Rating restrictions in the form of "rate bands" were implemented on July 1, 1993 in both the individual and small employer markets. There are two rate bands restricting the allowed variation in premium rates; the age rating band and the general premium rating bands. The age band limits the rate variation due to age between any two insured persons to +/- 50% of the index rate, which is a ratio of 3:1. The general premium rating band limits variation by other factors between any two groups to +/- 25% of the index rate, which is a ratio of 1.67:1. Rate variation based upon gender is prohibited.

Chapter 625 of the 1994 Laws proposes a specified timetable of rate band reductions resulting in pure community rating in the individual and small employer markets on July 1, 1997. The proposed timetable of rate band reductions is not effective without additional legislative action, however. Our understanding is that the legislature intends to consider the advisability and feasibility of implementing the rate band reductions during the 1995 legislative session.

### ***The Effects of Reforms on the Risk Adjustment Mechanism***

The legislature's decisions on both the rate band reductions and the guaranteed issue requirement for the individual market affect both the need for and the appropriate risk adjustment methodology in these markets.

Risk adjustment is clearly needed if all the proposed requirements are enacted. As previously discussed, guaranteed issue and pure community rating requirements prohibit the up-front matching of premiums with the relative risk factors of the purchasers. In the absence of a risk adjustment mechanism, this will create an environment where health plan companies may be motivated to avoid high risks, and purchaser choice will be influenced by the effects of risk selection on premiums.

Under the current restrictions, the need for risk adjustment is somewhat less critical. Premium variations are permitted within limits. Premiums, therefore, match expected costs to a certain extent. The significant exceptions are the prohibition on the use of gender as a rating variable, and the guaranteed issue requirement in the small employer market. In this scenario, development of a risk adjustment mechanism could proceed at a slower pace, and Minnesota would perhaps be better able to take advantage of the research projects being conducted nationally.

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<sup>7</sup> As of July 1, 1995, a small employer is defined as an employer having between 2 and 49 employees.

In the event that further restrictions are adopted which are somewhat less extreme than "pure community rating" with a guaranteed issue requirement in the individual market, risk adjustment is needed but the magnitude of the transfers between health plan companies will be less and the design of the risk adjustment mechanism will change.

### ***Market Definition***

It is critically important that the markets be precisely defined and all employers meeting the definition be included in the risk adjustment mechanism. As previously discussed, one danger to the system is the possibility that employers (or individuals) with lower risk groups will take advantage of any opportunities to opt out of the risk adjustment system. This will drive up the premiums to those remaining, producing the same access and affordability problems that created the need for small employer health care reform originally. Note that under the guaranteed issue requirement, groups opting out of the risk adjusted sector may return at any time.

Current opportunities for small employers to opt out of current small employer reforms include: Government units are allowed to choose whether to be considered a small employer. Employers can choose to self-insure, putting them outside of the state's authority. Employers that were members of associations prior to July 1, 1993, are not considered small employers if coverage is received through the association. Although we cannot require self-insured employers to participate in the risk adjustment system, all other employers must be included. Both MEIP (the Minnesota Employers Insurance Plan) and PEIP (Public Employers Insurance Plan) are part of the small group market for purposes of risk adjustment. For risk adjustment to be effective, health plan companies must include all small employers in their risk adjustment calculation, including those small employers covered through associations or purchasing pools, and those government units which otherwise meet the definition of a small employer.

### ***Separate or combined pools?***

The question of whether to combine the individual and small employer markets into one risk adjustment pool is a complex issue that needs to be visited as part of the development process. The appropriate answer may depend in part on the reforms which are adopted for each market.

The current individual and small employer markets are very different and operate under different rating and underwriting requirements. Given these differing requirements, it would be difficult to combine the two markets into one risk adjustment pool. Moving to a guaranteed issue, community rated environment will eliminate many of the differences in rating and underwriting practices. In fact, there may be few differences whatsoever between the market for individuals and very small employer groups. A further consideration is the subsidization across markets which would result from combining the two markets into one risk adjustment pool. Although initially the individual market may subsidize the small employer market (due to the difference in current underwriting requirements), in the long run the small employer market will subsidize the individual market if guaranteed issue is required in the individual market.

### ***Minnesota Comprehensive Health Association***

The Minnesota Comprehensive Health Association (MCHA) is a pool mechanism for the uninsurable. It is currently being funded through a premium tax on all insured health products. Thus, the MCHA population is therefore subsidized by enrollees in all insured health plans. If a guaranteed issue requirement is adopted in the individual market, MCHA would no longer be

needed. Current MCHA enrollees would obtain coverage in the individual market. It is likely that the individual market will then include a disproportionate representation of the high cost population. This would shift the current subsidy for this population from **all** markets to the individual and small group markets. The Association will therefore evaluate the impact of MCHA on the individual and small group markets and determine if the risk adjustment system is contributing to an unfair subsidization by these markets.

### **Large Employer Market and ERISA**

The federal law known as the Employee Retirement Income Security Act (ERISA), prohibiting state authority over employee benefit plans, union trusts, and Multiple Employer Welfare Associations (MEWAs) creates many hurdles for health care reform efforts. Although ERISA permits states to regulate insured plans through insurance regulation, employers which self-fund are outside of state authority or state requirements. As long as ERISA permits employers to self-fund, adverse selection by groups that can save substantial premium dollars through self-funding would have a significant impact on the premium rate needed for the groups that remain.

This is a particular problem with large employer groups, as the availability and attractiveness of self-funding increases substantially with group size. We do not recommend including large groups in the risk adjustment sector under current ERISA provisions.

The decision to exclude the large employer market from the risk adjustment system could be different in the absence of the ERISA problems. If the provisions of ERISA were to change, or if Minnesota were to receive an ERISA waiver, the primary considerations in determining whether the large employer market be included in the risk adjustment system become: a) the need for risk adjustment in this market, and b) the resulting subsidization across markets.

Because the purpose of risk adjustment is to minimize the effects of selection on premiums, there is little need to extend risk adjustment to the large employer market which is inherently stable and "walled-off" from other segments of the market. Large employer group insurance has been successful in pooling risk broadly. With many employees and dependents in a single firm, variations in risk and costs average out. Also, since employees choose employers for reasons other than the health plan, the potential for adverse selection between health plan companies is lowered. The rating and underwriting reforms have not been enacted in this market, as the problems existing in the small employer and individual markets have not occurred in this market<sup>8</sup>.

Inclusion of large employer groups in the risk adjustment system, pooled with the small employer and/or individual markets, would result in subsidization of these markets by the large employer market. (This can be perceived as a positive or negative effect, depending on one's perspective.) Note that this subsidy would only occur given a change in ERISA; under the current ERISA preemption, the subsidization could very well go the other way.) In the absence of changes to the ERISA preemption clause, we do not believe that the large employer group market should be included in the risk adjustment system.

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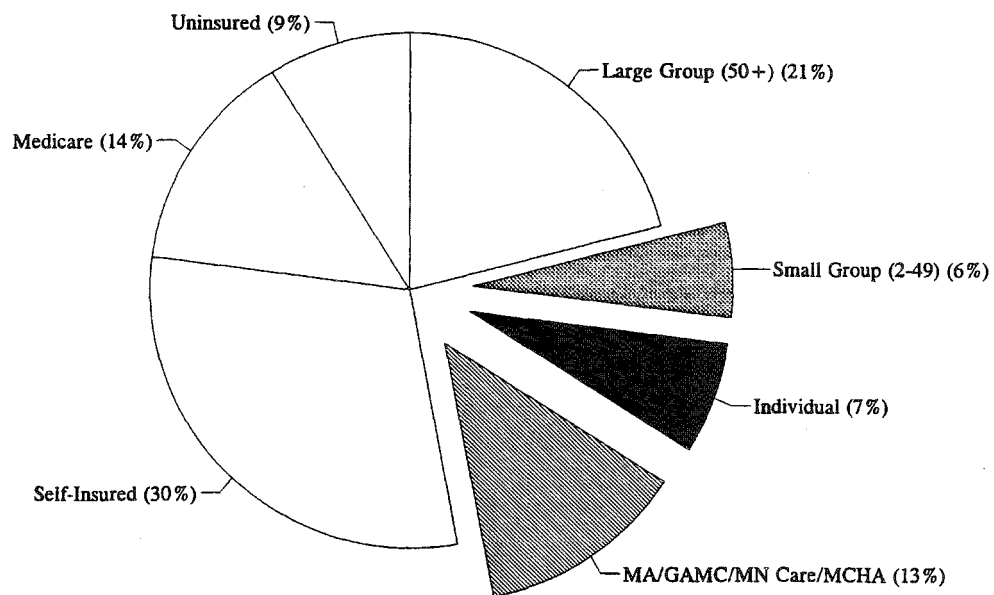
<sup>8</sup> Large employers which offer multiple health plan companies to their employees may, however, choose to use the risk adjustment mechanism to adjust contributions or subsidies across competing health plan companies.

### ***Definition of Large Employer versus Small Employer***

There are two competing considerations in looking at the appropriate definition of large and small employers. Employer groups with 50 to 100 (or possibly more) employees are vulnerable to many of the same problems as small employers, such as lack of rating stability which would suggest that these employers should also be included in the risk adjustment sector. On the other hand, as the availability and attractiveness of self-funding increases with group size self-insurance is a viable option to groups of this size. Adverse selection by groups that can save substantial premium dollars through self-funding would have a significant impact on the premium rate needed for the groups that remain. The adverse selection will increase, the closer rating restrictions are to "pure community rating." See Figure 2 for a chart showing the estimated size of each of these markets.

## **Estimated Distribution of Population by Source of Coverage**

State of Minnesota, 1993



Minnesota Department of Health, Health Care Delivery Policy Division, Health Economics Program

Source: 1993 RAND Employer Survey; 1993 RWJ Household Survey; MN Dept of Human Services; MDH-HEP Revenue Report

**Figure 2**

## Public Programs Pool

**Recommendation:** A separate risk adjustment pool should be developed for the state-run public programs, including Medical Assistance, General Assistance Medical Care, and MinnesotaCare. During the testing and development phase, a work group shall be convened to study this, and to recommend an approach to risk adjustment for the public programs. This risk adjustment system should be similar to the overall risk adjustment system, but may contain additional demographic or other adjustments, and may involve different conditions.

The public programs will be part of the risk adjustment system as a separate pool. Risk adjustment is needed in the public programs because, under prepaid contracts, public program recipients choose from among several health plan companies. This type of individual choice often leads to adverse selection, as individuals often choose their health plan based on their health care needs. In addition, as Medicaid expands to include the under-65 disabled population, risk adjustment will be even more critical.

It will be necessary to separate the public programs from the individual and small group markets, to avoid having the risk adjustment system cause subsidization of public programs by the individual and small group markets, and also because of differences in covered benefits, reimbursement, and eligibility across the markets. The risk adjustment system for public programs should be similar to the overall risk adjustment system, but may contain additional demographic or other adjustments, and may involve different conditions. Measurement issues may also differ from the risk adjustment system for individual and small group markets and may differ within the public programs pool based on covered benefits and type of eligibility. The public program pool may require additional adjustment factors, to reflect special needs related to poverty, cultural or language barriers, and other needs of some segments of the public program population.

## Medicare Supplement Policies

**Recommendation:** The Medicare Supplement market has the type of restrictions which necessitate risk adjustment. The Association shall convene a work group to evaluate the need for risk adjustment in the Medicare Supplement market, and to develop that system as a separate pool. Because Medicare Supplement policies are supplemental to Medicare, a targeted conditions adjustment may not be necessary. Risk adjustment in this market may be based on a demographic adjustment.

We believe that risk adjustment is needed in the Medicare Supplement market. There is a 6-month open enrollment (guaranteed issue) period upon becoming eligible for and covered by Medicare. Pure community rating has been required on Medicare Supplement policies since January 1, 1993. A health plan company's single rate for each benefit plan thus reflects the risk factors of those covered under the benefit plan. The effect of age is particularly significant. In 1991, standardized benefit plans were required for all new insureds in this market. All insureds that purchased plans prior to 1991 are thus in "closed" (no longer sold) plans, where the increasing average age of those covered necessitates increases in premiums.

Medicare Supplement coverage is very different from health plans for the under 65 markets, so will require a separate risk adjustment pool. The coverage differences may also lead to different

methodologies. There is less high-end exposure in Medicare Supplement coverage because of the relationship to Medicare. It is therefore less necessary to include adjustments for high cost conditions or claims. A risk adjustment mechanism based on demographic adjustments alone may be adequate.

Medicare TEFRA Risk Contracts are another type of coverage for individuals eligible for Medicare. These contracts not only provide benefits supplementing Medicare benefits, but provide the Medicare benefits as well. The question of whether these contracts should, or even can, be included in the risk adjustment pool (or whether a separate pool should be created for these contracts) will need to be addressed in the development process.

Changes now being considered at the federal level may affect the need for risk adjustment in this market. Any federal changes will be reviewed by the Association during the development process, prior to implementation of risk adjustment in the Medicare Supplement market.



# CHAPTER V

## METHODOLOGIES FOR RISK ASSESSMENT AND ADJUSTMENT

### PROPOSED METHODOLOGICAL APPROACH

**Recommendation:** After reviewing a number of possible risk assessment methods, we recommend that a combination of an age/sex demographic risk adjustment system and payments for targeted conditions be developed for implementation by July 1, 1997. We also recommend that testing be done concurrently on an ACG/DCG system which, if found to be advantageous, could replace the targeted approach at some point in the future when data systems make it feasible.

Because risk adjustment is a relatively new concept, none of the available methods have been tested sufficiently under actual operational conditions. On the other hand, we do not feel that it is practical for Minnesota to create a new risk adjustment system "out of whole cloth," given the timetable specified by the legislature. Our approach, therefore, is to recommend that we take several of the best available systems and test them with Minnesota data, modifying them as necessary to achieve the best possible system. We envision the need for development and testing of a feasible option, which can be implemented by 1997, and concurrent study of another approach to risk adjustment that *may* be a stronger risk adjustment system but which would take longer to implement successfully. Through testing, we may also discover that our short term solution is successful and will be a viable long term solution as well. We expect that any system ultimately implemented will be revised and improved over time as our techniques and experience improve.

#### Initial Approach

After reviewing the methodologies currently available, we believe that our best option for implementation by 1997 is a combination of an age/sex adjustment system with a targeted conditions approach based on the New York model (Appendix 6 contains a description of the New York model). This approach would necessitate two separate categories of risk adjustment pools, one for the age/sex adjustment and a separate pool for the condition-specific targeted approach.

We recommend that Minnesota develop its own list of conditions, based on our objectives and criteria. We believe that this system offers us the best chance at successful implementation by 1997, because the data needed for the system are more likely to be available. In addition, the system is simple and understandable and has the potential to address a significant portion of the variation in health care expenditures across health plan companies. There are a number of significant issues which will need to be addressed through the testing process. These issues are discussed in Chapter 6: Plan for Testing.

#### Continued Testing of Other Methods

Concurrently with the above, we proposed to further test the ACG/DCG system for implementation in Minnesota. We believe that the ACG/DCG method could be a more effective and robust risk adjustment

system than the targeted approach (although testing would be necessary to confirm or refute this), but that the data needs for this system would preclude it from being considered for 1997 implementation. We therefore propose that we test this model for possible use. If this system were implemented in the long term, the risk adjustment pools (age/sex and targeted conditions) would be combined into one integrated pool for each market segment. In addition, we will continue to monitor activity at the national level on risk adjustment methods. We expect to benefit from a number of national studies on different aspects of risk adjustment, and will attempt to incorporate information from these studies into our evaluation and into improvements to the risk adjustment system.

## THE OPERATION OF A RISK ADJUSTMENT SYSTEM

In addition to determining the methods of risk assessment, it is also necessary to determine the adjustment system- how the assessment of risk is translated into a system of financial transfers. In Minnesota, we are targeting risk adjustment at the market level<sup>9</sup>. The features of Minnesota's risk adjustment system include:

- All health plan companies participating in each targeted market must participate in the risk adjustment mechanism by contributing money into a pool (when required), assessing the risk of their population, and receiving payments from the risk adjustment system (when appropriate).
- Health plan companies remain responsible for setting their own premiums.
- The risk adjustment system allows health plan companies to estimate up front what their likely payments into and out of the risk adjustment system will be.
- Health plan companies estimate their expected payments into and out of the risk adjustment pool, and adjust their premiums accordingly. Health plan companies that expect to receive money from the pool (because they have a costly population) will lower their premiums, and health plan companies that expect to pay into the pool (because they have a relatively healthy population) will raise their premiums.

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<sup>9</sup> The risk **adjustment** process is different from that included in national reform proposals which center on alliances or purchasing pools. Under an alliance model, employer groups become members of an alliance. The individuals within the groups can each select their health coverage from among a wide range of competing health plan companies, exacerbating the problem of adverse selection. Under the alliance approach, the alliance adjusts the health plan company's premiums to reflect the risk differences in their populations. Note that the methods used for risk **assessment** could be the same under either scenario.

### Example of Risk Adjustment

This is a simplified illustration of how a risk adjustment mechanism based on relative values is expected to work. The example assumes that there are four health plan companies in a certain market, each with a market share of 25%.

	Risk Adjustment Example	A	B	C	D
a)	Premium rate charged today (no risk adjustment)	\$112.00	\$ 97.00	\$ 97.00	\$ 94.00
b)	Relative risk (market average = 1.00)	1.09	1.00	.97	.94
c)	Average risk rate (a/b)	\$102.75	\$97.00	\$100.00	\$100.00
d)	Risk adjustment (based on lowest average risk rate)	\$8.73	\$ 0.00	\$ -2.91	\$ -5.82
e)	Premium rate with risk adjustment (a-d)	\$103.27	\$ 97.00	\$99.91	\$99.82

#### **Step (a) Premium Rate Charged Today (No Risk Adjustments)**

We have created some sample premium rates. For ease of illustration, we have used a single rate for each health plan company. (In reality, rates will vary by plan, family composition, geographic area, and allowable rating variations.)

#### **Step (b) Relative Risk (Market Average = 1.00)**

Each health plan company calculates a relative risk factor based on the risk assessment model. The risk assessment model could be based on demographic factors, self-reported health status, an ACG/ DCG model, or some other model.

#### **Step (c) Average Risk Rate (a/b)**

The premium rate of step (a) is divided by the relative risk factor of step (b). This yields the rate that would be charged by each health plan company if the entire market were insured with that company. Health plan companies C and D, although their rates are different, are actually charging the same average risk rate.

#### **Step (d): Risk Adjustment Based on Lowest Average Risk Rate**

Each health plan company's reimbursement is adjusted as follows: The health plan company is credited with the difference between their relative risk factor and the market average risk factor applied to the lowest average risk rate. In this example, the lowest average risk rate is \$97.00 (health plan company B).

For health plan company A, the calculation is:  $(1.09 - 1.00) \times \$97.00 = \$8.73$ . Health plan company A, having the worst risk pool, will receive a transfer through the risk adjustment mechanism. Health plan company B, with a risk pool reflecting the market average, is not affected by the risk adjustment mechanism. Health plan companies C and D, each with better than average risk pools, will pay out through the risk adjustment system.

#### **Step (e) Premium Rate with Risk Adjustment**

The premium rates now reflect the risk adjustment transfers. Health plan company A, which receives a risk adjustment transfer, decreases the \$112.00 premium to \$103.27. Health plan companies C and D, both of which pay out, must increase premium rates.

**Results:** Health plan company D, previously able to charge the lowest rate due to the best risk pool, now has a rate very close to the market average. Health plan companies B and C, which initially charged the same rate, now have rates reflecting their relative efficiencies. Health plan company B is approximately 3% more efficient than health plan company C. Health plan company A is able to charge a competitive rate although having the worst risk pool. The effects of selection have been removed from the premium rates. The remaining premium differences reflect differences in medical and administrative efficiencies.

## HOW WE ARRIVED AT THESE RECOMMENDATIONS

### Criteria for Evaluating Possible Risk Assessment Mechanisms

The Risk Adjustment Expert Advisory Panel assisted us in outlining the criteria we felt to be most important in evaluating possible risk assessment mechanisms for use in Minnesota. It is important to remember that these criteria define the ideal risk adjustment mechanism and may not be completely achieved.

#### *Accuracy*--The risk adjustment mechanism:

- predicts the relative costs of health plan companies' risk pools attributable to significant differences in characteristics of the persons covered in the pool.
- explains close to as much variation in costs among individuals as the health plan companies can predict for those sources of variation vulnerable to gaming.
- results in a system where health plan companies are financially indifferent to the characteristics of persons covered.
- avoids systematic bias (systematic understatement or overstatement of the risk associated with one or more of the factors used).
- is stable, performing consistently over time with actual costs correlating well with projected costs.

#### *Administrative Feasibility*--The risk adjustment mechanism:

- does not add significant cost to the health care system.
- is reasonably simple to administer.
- is based on data that are generally available and accessible.
- is able to handle frequent status changes in the population such as location, family, and employment.
- protects both confidential/sensitive data and proprietary data.

#### *Timeliness and Predictability*--The risk adjustment mechanism:

- allows health plan companies setting premium rates to predict the value of the transfer and its impact on premiums with a fair degree of accuracy, in order to avoid solvency concerns.

#### *Efficiency/Effectiveness*--The risk adjustment mechanism:

- does not reward controllable inefficiency.
- does not penalize health plan companies for provable improvements in or maintenance of health status (effectiveness).
- is independent of modality of care (does not favor use of inpatient services).

#### *No Manipulation*--The risk adjustment mechanism:

- is resistant to attempts by specific health plan companies to benefit financially by "gaming" the mechanism.
- is based on verifiable records and transactions to minimize fraud.
- prevents providers from influencing the measurement by the course of care they deliver or their recording of care.

- does not increase incentives for employers to self-insure.

***Adaptability***--The risk adjustment mechanism:

- will incorporate changes and improvements over time.
- can be adapted along with legislative changes related to health care reform.

***Acceptability***--The risk adjustment mechanism:

- is acceptable to legislators, providers, and other affected parties.
- is perceived by health plan companies to be equitable.
- is transparent to the insureds.

The criteria listed above engender many tradeoffs. The most significant tradeoff is between accuracy and cost. It will always be possible for us to improve the accuracy of our risk adjustment system, however, we will need to balance the need for improvements with the costs they would bring.

### **Methods Reviewed**

There are a number of risk assessment methodologies that could be used for the purpose of financial risk adjustment. Some of these methods were developed to measure risk of illness, rather than high cost, while others were developed specifically for risk of health care costs. Some of these methods have been tested extensively, but never implemented on a wide scale. Others have been implemented on a statewide scale, but do not yet have a long history to fully evaluate their effectiveness. Using the above criteria, we began to evaluate some of the most feasible methods for risk assessment. We narrowed our options to the most promising, so that these methods could be evaluated in more detail prior to implementation in 1997. Below is a list of the major methods we reviewed and considered for use in Minnesota's risk adjustment process and an outline of their strengths and weaknesses.

### **Demographic Adjustments**

Under a demographic adjustment, the proportion of patients with various demographic characteristics (such as age and gender) is calculated for each health plan company. Those health plan companies with a higher than average proportion of patients with costly characteristics would receive payments from the pool based on how far from average the health plan company is. Health plan companies with lower than average proportions of such patients would pay into the pool. Age and gender are the most common demographic characteristics. Other characteristics might be included, if they are demonstrated to be sufficiently important as predictors of increased health care costs.

#### ***Strengths***

- Conceptually simple
- Based on well-established concepts within the industry: has been used widely
- Relatively practical and inexpensive to administer
- Less subject to gaming
- Factors easy to apply and audit
- Data is available, no privacy issues

### ***Weaknesses***

- Alone, does not explain much of the variance at the individual level
- Could allow within-cell gaming if age/sex bands are wide
- Would not meet objectives of encouraging enrollment of high risk populations unless used in conjunction with other methods
- Further research would be necessary to identify factors other than age and sex which would improve the model.

### **Targeted Risk Adjustment**

Under this method, a number of specific high-cost conditions would be selected, including both acute and chronic high cost conditions, and expected costs of treating each condition would be determined. For each patient with the selected condition, the health plan company would receive a payment based on the expected costs of treating that condition from the Risk Adjustment pool. The pool would be developed based on an assessment of all health plan companies. This approach is sometimes referred to as a type of reinsurance, although it is not intended to replace traditional reinsurance. The approach is based on one implemented in New York State, although the number and types of conditions would be expanded beyond those covered in New York.

### ***Strengths***

- Does not reward inefficiency if payments are set for "best practice"
- Relatively practical and inexpensive to administer
- Conditions can be defined to discourage gaming (conditions with little predictable variation in costs, conditions with clear treatment protocols)
- May not require extensive data collection
- Has been implemented in NY with some success
- Can be applied to individuals not previously insured

### ***Weaknesses***

- If conditions are not set narrowly (if there is too much variation in costs within the condition), may create gaming incentives (cream-skimming within the condition)
- If conditions are set narrowly, may affect diagnosis decisions (stigma, upcoding) and may result in more complex data requirements
- Proof of condition may require unavailable data
- May become more and more complex, if there is an increasing need to subdivide conditions to overcome gaming or fairness issues
- Selection of conditions could become political, undermining the intended incentives

### **Ambulatory Care Groups (ACGs) Combined with Diagnostic Cost Groups (DCGs)**

ACGs is a risk adjustment model developed by Jonathan Weiner and others at Johns Hopkins University. ACGs use age, sex and ICD-9 diagnosis codes assigned during ambulatory care to classify patients into similar risk (cost) categories. The system was designed to be a conceptually simple, statistically valid, clinically meaningful measure useful in the prediction of ambulatory resource use. The model collapses over 10,000 different possible diagnoses into 51 ACG categories to which patients are assigned based on their age, sex and constellation of diagnoses. It is designed to work with data that is routinely collected through claims or

encounter forms. ACGs do not require any data that cannot be obtained through a **complete** standard claim form, which is required (by 1996) for use by all providers and health plan companies in Minnesota, although many health plan companies would have to modify their systems to retain all diagnostic information reported by providers. Further, health plan companies often do not receive data for insureds who do not reach their deductible. DCGs is a prior history model that uses inpatient hospital diagnostic data to classify individuals into risk (cost) categories. This model was developed by Arlene Ash and others at Boston University.

#### ***Strengths***

- Research has shown that ACGs use with DCGs produce the best statistical result
- ACGs account for 50% of ambulatory and 20-30% of total expenditure variation upon retrospective review. Inclusion of DCGs would increase those percentages
- Could be easily improved over time, with addition of other variables
- Could be used prospectively or retrospectively
- Less "within-cell" gaming than models which are less clinically precise because it adjusts for severity
- Is based on data that may be needed for other purposes, and that are or will be available to many health plan companies (HEDIS quality studies for HMOs, state data requirements).
- Marginal costs may be less given EDI, other uses of the data
- Allows for continual updating over the year, rather than a "point-in time" approach

#### ***Weaknesses***

- Data requirements are significant, some health plan companies would have to invest in new information systems
- Would require work-arounds for individuals with no recent history (patients who were not insured, came from out of state, etc)
- Adjustments may fluctuate from year to year, particularly for smaller populations (but possibly true for any method?)
- Data requirements result in "aging" of data used
- Has not been used as a mechanism to transfer money between health plan companies
- Administrative costs may be large

### **Self-reported Health Status**

Risk assessment using self-reported health status measures have been developed by a number of researchers. These methods rely on a survey of patients, which is designed to measure how these patients perceive their functional health status. These methods are designed to evaluate the risk of illness or of lower health status. They were not developed to directly measure the risk of high health care costs, however some feel that these measures would be a good proxy for health care utilization and costs. The RAND Short Form 36 is an example of a self-reported health status measure.

#### ***Strengths***

- Can be applied to individuals not previously insured: does not require prior-use data
- Fewer opportunities for within-cell gaming
- Could be handled consistently for all health plan companies, if administered by a neutral third party

- Some feel that self-reported health status is a good indicator of future use
- Could be improved over time, with modification/addition of questions

#### *Weaknesses*

- Very costly to survey all enrollees annually specifically for this, follow up is costly
- Alternative of sampling would not be likely to pick up expensive cases
- Cultural/language biases could result from survey method, difficult to survey disabled, mentally incompetent, children
- Privacy/sensitivity issues: responses may not be accurate because of the sensitive nature of the questions, concern about impacting provider behavior.
- Some feel this method is less predictive of expenses than other models
- Literature suggests that some health plan companies' members systematically over-report their health status on simplistic measures.
- Predictive power may be in the center rather than in the tail of the distribution
- Existing surveys were not developed to measure risk of expenditures
- Has not been used to transfer money between health plan companies

#### **Reinsurance**

A reinsurance program is one where an insurer (the reinsurer) accepts all or part of the risk of loss over a threshold amount underwritten by another insurer (the ceding insurer). There currently is a voluntary reinsurance association for the small group market. Reinsurance options for risk adjustment include mandatory participation, or leaving the status quo.

#### *Strengths*

- Relatively practical and inexpensive to administer
- Could be implemented quickly
- Will assist health plan companies in dealing with random variation, accounts well for high-cost outliers
- Works for individuals not previously insured

#### *Weaknesses*

- Encourages health plan companies to allow claims to exceed threshold and encourages improper management of high cost claims
- May rely on medical underwriting to determine individuals included in the reinsurance system which may attach a stigma for the individual
- Difficult to administer where providers are paid a capitated amount (In Minnesota, reforms assume an increasing number of Minnesotans will enroll in capitated plans)
- Highly sensitive to details of case determination

#### **Clinical indicators**

Under this approach, specific clinical conditions are selected (as in the targeted risk adjustment method above), however rather than receiving a fixed dollar amount for each case, the health plan company receives an overall score based on the prevalence of these high-cost conditions, and the score (which rates the health plan company in relationship to the other health plan companies in the market) is translated to a payment either into the pool (for health plan companies with a low score) or out of the pool (for health plan companies with a high score).

### *Strengths*

- Possible to include more conditions than a targeted approach
- Gaming would be reduced over that of targeted approach because individual patients would not be targeted directly
- Potentially could be combined with demographic adjustments into one mechanism.

### *Weaknesses*

- What source of data would determine prevalence of condition? Survey: same cons as self-reported health status. Claims: some of the same cons as ACGs. Other method: could use same method as targeted to get at conditions
- Has not been implemented as a mechanism to transfer money among health plan companies



# CHAPTER VI

## PLAN FOR TESTING

**Recommendation:** During the development/testing phase the Risk Adjustment Association and the Departments will pursue a multiple-tier approach focusing on Minnesota experience, national studies, and expert assistance. The models will be tested with Minnesota data wherever possible, and market behavior will be modelled with a simulation exercise.

**Recommendation:** Prior to implementation of the risk adjustment system, the Risk Adjustment Association, with approval of the Departments, will have developed a detailed plan for evaluation and continuous improvement of the risk adjustment system.

The Risk Adjustment Expert Panel's Workgroup on Testing has discussed a continuum of testing approaches, and has discussed how each might be used for testing different aspects of the risk adjustment system. These various options are described in detail in Appendix 7.

### SPECIFIC TESTING ISSUES AND WORKPLAN

We have outlined a number of specific issues that must be addressed through the testing period, prior to implementation of risk adjustment. These issues are described here, along with a description of the data or information that will be necessary for evaluation of the issue, the possible sources of that information, expertise needed, and other resources needed.

#### Demographic Adjustments

For development of the demographic adjustment pool, there are several key issues which must be addressed:

##### *Issue 1: Standardization of the rating tiers*

Currently, health plan companies use many different rating tiers: some have a two-tier system (with a single rate and a family rate), others have a three tier system (single, employee plus spouse, and employee plus family), others have four or more tiers. We recommend that the rating tiers be based on individual members, although the ability of health plan companies to provide member-specific data will need to be explored. If rating is not on a member basis, an adjustment based on family size will be developed. This issue will be addressed by the Risk Adjustment Association and the Departments prior to implementation of the risk adjustment system.

##### *Issue 2: Develop age/sex factors*

Risk adjustment is made simpler under a system of a uniform benefit set. If there is no uniform benefit set established, it will be necessary to develop adjustments for benefits and

cost sharing differences. It will also be necessary to evaluate whether or not we need different sets of age/sex factors for the HMO and indemnity markets, or if one set of factors will suffice. We will also need to define age cells and age factors allowed in rates, so that we can be sure that the risk adjustment system does not reimburse for costs already covered in the rate system.

***Issue 3: Translation of age/sex factors to dollars***

We will explore methods of converting the age/sex factors into dollars for payment into or out of the pool. We will need to determine the average age factor in each market. We will evaluate the possibility of using average costs versus costs of the most efficient health plan company.

***Issue 4: Possible inclusion of other demographic factors***

What other factors in addition to age and sex should be studied for possible inclusion? Would inclusion of other factors beyond age/sex be useful? Possible?

**Targeted Risk Adjustment**

***Issue 1: Selecting the conditions/treatments***

Development of a targeted condition risk adjustment system requires selecting the conditions we feel are high cost conditions. In evaluating which conditions should be targeted for payments, we will need to evaluate conditions both that are high cost per episode (acute conditions) as well as conditions which are high cost over a year time period (chronic conditions).

Also, conditions will need to be evaluated to be certain that there are relatively clear, proven treatment options for each condition. If there are not, improper incentives may be created. We will not select conditions that represent random, unpredictable events (eg. car accidents), since health plan companies cannot predict these expenses in advance and therefore cannot underwrite to avoid them.

We will also need to evaluate how many conditions categories we can accommodate in the first year, and will need to specify our criteria up front. For this system of risk adjustment to work, conditions must be selected for appropriate reasons. We intend to provide information to patient advocacy groups to facilitate understanding that not all illnesses or conditions can be or should be a part of the risk adjustment system. We will need to evaluate the possibility of selecting different conditions for the public programs pool.

***Issue 2: Defining the conditions***

Once the conditions are selected, we will need to develop specific definitions for each condition. These definitions will affect how the payment amounts are determined, and what kind of data health plan companies will need to provide in order to receive payment for the condition. A central issue for the definitions of conditions will be how homogenous each condition should (or can) be. If there is a great deal of variation in the expected costs of treating a condition, gaming will be possible. To prevent this, we may decide to split some conditions into two or more condition categories. For example, AIDS may be a condition

selected, but may be defined in two or more condition categories to reflect predictable severity differences and different average costs. We will have to balance the need for homogeneity in the condition categories with the data intensity of the definitions, to avoid increasing the complexity of the system.

***Issue 3: Determining payment levels for each condition***

Once the condition categories are defined, we will need to determine how much it *should* cost to treat that condition category. This could be done in several ways. We could collect information from Minnesota (or national) payers on each condition category and determine what the "average" cost is for treatment. We could select an "efficient" provider (within Minnesota or outside Minnesota), and determine what the costs for each condition category have been for this provider. We could assemble an expert panel on each condition and ask them to develop (or draw on existing) protocols to determine what treatments should be provided for each condition category and place a price on that treatment. The Risk Adjustment Association could facilitate a negotiation process (utilizing information from data and/or protocol experts) among the payers to determine a fair payment amount. We will need to determine whether the payment should be set at the level of the most efficient health plan company, or the average health plan company.

We will need to determine if RAPO health plan companies need to be treated differently, perhaps with a separate schedule for RAPO health plan companies which reflects their legislated inability to utilize managed care procedures.

We will also need to decide if the whole payment amount is automatically paid to the health plan company for each reported case of the condition, or if the payment amount is a maximum and the health plan company receives either the amount they actually spent on the case or the maximum, whichever is smaller.

***Issue 4: Comparing different groups of conditions***

We will need to evaluate what would constitute a successful test of this method. As we begin to outline possible condition categories, we will need to have an objective method of comparing the different options. How will we evaluate these options in terms of the amount of variation they adjust for? Data modelling will be necessary to evaluate how different health plan companies would be affected by selection of different sets of conditions.

***Issue 5: Changes in medical treatment and costs over time***

Can the costs of specific treatments be built into the methodology? (New treatments that are very costly for specific conditions, or specific patients). Depends on methodology.

***Issue 6: Setting the assessments***

We will have to develop a method for determining the assessments health plan companies pay into the pool from which payments for conditions are drawn, and whether health plan companies that utilize specific managed care techniques should receive discounts.

## **ACGs/DCG's**

### ***Issue 1: Data Issues***

To begin testing the ACG/DCG method, we will need to evaluate how administratively difficult it would be for health plan companies to provide the data required to implement and maintain this model. We will need to evaluate how much standardization in data reporting across health plan companies is necessary to make the system work effectively, and compare that level of standardization with current and projected levels of standardization. There is evidence that ACGs and DCGs are fairly robust to variations in data, but some standardization may be necessary. Minnesota's Administrative Simplification Act (ASA) passed in 1994 will require much of this standardization by 1996. One important area that is not covered by the ASA is the number of diagnosis codes that must be submitted by providers or retained by the health plan company. We will need to explore how difficult it would be for health plan companies to retain a specified number of diagnosis codes in their systems. We will also explore how this would relate to other data initiatives (such as those of the Data Institute) which might make this information more readily available.

We will evaluate how much prior data is needed to assess the population. The authors of the system indicate that 6 months of data is the minimum necessary. We will evaluate the implications of this requirement on timing of risk assessment and adjustment.

The possibility of utilizing the ACG/DCG model for the Medicare Supplement and public programs risk adjustment pool will also be explored.

### ***Issue 2: Additional factors***

We will also explore the possibility of adding other factors to the ACG/DCG model which would strengthen its predictive power.

### ***Issue 3: Translating ACG/DCG score into dollars***

We will explore methods of converting the ACG/DCG score into dollars for payment into or out of the pool. We will need to determine the average ACG score in each market. We will evaluate the possibility of basing the payment on average costs versus costs of an efficient provider.

## **Issues Related to System Operation**

In addition to the issues related to the methods of risk assessment, there are also issues related to the operation of the risk adjustment system itself which will need to be addressed.

### ***Issue 1: Population changes***

Population changes and coverage of populations with no history of use to base risk adjustment on, such as residents new to Minnesota will need to be explored.

### ***Issue 2: Process of payments***

How much money is going to be transferred? Are there health plan companies that would be contributing or receiving an excessive percentage of their revenue? Can we choose a reasonable limit? What is the best timing of transfers (how frequently, when)? What happens

if pool is short?

***Issue 3: Market behavior and response to risk adjustment***

How will the market respond to the risk adjustment system, and what unintended effects are created under different operational scenarios?

***Issue 4: Auditing and Appeals***

What auditing methods should be put in place?

We will need to evaluate the need for an appeals mechanism for health plan companies that feel the method is unfair for their population. This appeals mechanism will be overseen by the Risk Adjustment Association so that fairness is achieved without an undue administrative burden.

***Issue 5: Phase-in of risk adjustment***

We will explore the possibility for phasing in the risk adjustment system, so that the system can be improved without unnecessarily jeopardizing the fiscal solvency of health plan companies.

This phase in should be linked with the movement toward community rating, so that as we get closer to true community rating, the risk adjustment mechanism is closer to complete implementation. We will evaluate if additional factors should be introduced into the phase-in process.

## **DATA AND INFORMATION NEEDED FOR TESTING AND DEVELOPMENT**

To address the above issues, there are a number of activities that will be necessary.

### **Data Modelling**

A number of the issues mentioned above will require some type of data modelling. We will need to do some data modelling to address the issues related to the demographic adjustment part of risk adjustment. Data for these issues could include claims data obtained from a sample of Minnesota payers, or national or Minnesota data from a consulting actuarial firm. Alternatively, information from the payers on the age/sex factors they use could be collected and combined to arrive at age/sex factors for risk adjustment. The public programs will require claims data from the state-run public programs to evaluate other factors which might be added to the age/sex adjustment. To select conditions, we will need claims data on high cost claims from payers in the small group, individual, public program, and Medicare Supplement markets. This claims data could include all claims over a threshold amount (perhaps \$5,000), or claims for a list of conditions selected as being likely high cost conditions. Once the conditions are selected, we will also need to pull together longitudinal claims data on the costs of these specific conditions to develop the payment amounts for each condition. We will also utilize information from the literature to assist in the development of the payment amounts.

Claims data from payers, including inpatient claims with DRGs, and outpatient claims with ICD-9 codes will be necessary to model use of ACGs and DCGs. The source of this could be voluntary submission of claims data from the payers involved in the risk adjustment markets. In addition, we will explore the use of MDH's pilot study of claims data to see if the timing of that project would facilitate use of the data for risk adjustment. There are a number of open questions which remain concerning data collection, including integration with other data initiatives, data privacy, etc. Finally, it is important to note that any data used for modelling of risk adjustment will necessarily not be truly representative of what *will* happen when risk adjustment and other insurance reforms are implemented. For this reason, we will need to build into the risk adjustment system a mechanism for continuous update and improvement as data from actual experience becomes available.

One major issue related to the data used in model development concerns how the "expected" costs are derived. For example, if data from all types of health plan companies are used and expected costs are derived directly, the risk adjustment system will be calibrated to this statewide average. In other words, we will be aiming at average (or status quo) efficiency. This will provide an incentive for the health plan companies who are above average in costs to become more efficient. Health plan companies that are below average cost will not face additional incentives to become more efficient. As an alternative, the data could be weighted towards more efficient health plan companies, moving the average or "expected" costs down. This would put more pressure on the system to improve efficiency. Of course, if the "most efficient" health plan company were used to derive expected costs, there would likely be some health plan companies who would have significant difficulty improving their efficiency over the short run and thereby suffer financial hardships.

### **Simulation Exercise**

To evaluate the operational issues, we will develop some type of simulation that will utilize data modelling and/or a simple role-playing simulation to explore the logistics of the risk adjustment system. This simulation could allow some of the actual plan staff to go through simulated market situations by playing the role they would play in a real-life risk adjustment scenario. This will provide information on timing issues, market behavior, and the effects of various payment procedures on health plan company behavior, and give us information on potential gaming behaviors. In addition to a simulation, we will assemble information from the literature and other projects.

### **Antitrust Issues Regarding the Testing and Development Phase**

Antitrust law is designed to prohibit collaboration and other activities which work against market competition. Risk adjustment raises potential antitrust concerns for two reasons. First, the process of risk adjustment involves competing health plan companies making monetary transfers to and from one another based upon the relative risk of their insured populations. Absent government intervention, this type of activity does not occur in a traditional competitive market. Second, the basis upon which monetary transfers are made requires a sharing of information. If appropriate safeguards are not in place, the sharing of information necessary for the development and testing of various risk adjustment methodologies may raise antitrust concerns.

Anti-trust exceptions are possible under certain, specific conditions. The state action doctrine provides immunity from anti-trust law, when two conditions are met. First, the intent to substitute regulation for competition to achieve a public purpose must be clearly articulated. Second, there must be active state supervision of the activity. Minnesota must address these two conditions, to avoid anti-trust problems which could adversely impact implementation of risk adjustment.

Because the risk adjustment mechanism involves the sharing of competitive information, appropriate means for this to occur must be in place. For example, if responsibility for development and testing is vested with the Association, the information needed for testing will need to be provided to the state and/or a third party vendor. These entities would need to retain the privacy of any of the individual health plan company data received. It will be necessary to create appropriate classifications for the data under the Government Data Practices Act (Chapter 13). The Association should establish procedures and safeguards to ensure that data released is in a form that does not identify or reasonably lead to identification of an individual's name or health status. Aggregate information which could reasonably lead to identification of an individual's name or health status should be classified as private data under Minnesota Statute Chapter 13.

If the responsibility for development and testing are vested in the Association it will also be necessary to make the activities of the association subject to regulatory oversight by the Commissioners of Health and Commerce. This oversight will ensure that the public interest concerns arising from a risk adjustment system and the need for such a system are carried out in the development stage. Specific details about this state oversight are provided above.

#### **Plan for Continuous Improvement**

We will also develop a plan for continuous improvement of the risk adjustment system, to ensure that our methods advance to keep the risk adjustment system the most effective system possible.



# CHAPTER VII

## DISCUSSION OF CONCERNS

### HIGH RISK POPULATION CONCERNS

**Recommendation:** The risk adjustment mechanism will be transparent to individual enrollees. The testing/development phase of the risk adjustment process will include specific evaluations of the proposed methods and how those methods might unintentionally affect high risk and special needs populations. If needed, specific recommendations will be developed regarding legislative or other activities that should be implemented along with risk adjustment to alleviate these impacts.

One of the primary goals of risk adjustment is to remove current incentives for health plan companies to avoid enrolling high risk and special needs populations. (In this context, *high risk and special needs populations* refers to populations who are at risk for high health care costs and who are known to have special, costly treatment needs.) Risk adjustment achieves this goal in conjunction with community rating and guaranteed issue requirements: health plan companies must issue coverage to anyone in the health plan company's catchment area (guaranteed issue), the premium for this coverage must be at the health plan company's community rate (community rating), and the health plan company's revenues will be adjusted for the risk of the population it does enroll (risk adjustment). Health plan companies are not permitted to refuse coverage or to price coverage so high as to discourage enrollment of costly groups. Risk adjustment removes the incentive to find other ways (gaming) of attracting healthy enrollees and discouraging costly enrollees.

**The operations of the risk adjustment system itself should be completely transparent to individual enrollees.** Individuals will not be aware that they are (or are not) triggering a payment under the risk adjustment system. Those in the individual and small group markets should see improved access to health coverage options, but otherwise should not be aware of risk adjustment in the marketplace. Guaranteed issue provisions will prevent health plan companies from excluding any group from coverage, and market conduct rules will provide additional protections for high risk populations.

Under a targeted conditions risk adjustment system, conditions will be selected using specific criteria. Not all conditions involving high risk or special needs populations can, or should, be part of the risk adjustment mechanism. Conditions which are unpredictable, for example, need not be part of the risk adjustment system. If health plan companies cannot predict who would be at high risk for a future car accident for example, the health plan company cannot discourage enrollment by this group. Conditions will be selected which represent costly, predictable conditions, in order to remove the adverse incentives related to these groups. Health plan companies can (and surely will) propose addition of new conditions, whenever they

identify a condition that is significantly costly to them and that is not covered by risk adjustment.

The risk adjustment system will be designed to assure that there will be no perverse incentives or unintended side effects relating to diagnosis/classification of illness. Conditions will be defined in ways that do not encourage inappropriate labeling of individuals which could have undesirable consequences to that individual or to the system as a whole.

The risk adjustment system will be broad enough (cover enough condition areas) to avoid leaving incentives for gaming in place for specific high risk groups. Conditions will also be defined specifically (narrowly) enough to prevent gaming within a condition category (where costly individuals with a specific condition could be predicted and discouraged from enrolling).

Some conditions which involve high, predictable costs and gaming incentives will still not be feasible for inclusion in a risk adjustment system. Some conditions where no accepted treatment protocols have been developed, or where treatment protocols vary significantly for example, would be problematic for risk adjustment. The risk adjustment system will need to avoid creating incentives for health plan companies to shift treatment patterns away from prevention, for example. For high cost, predictable conditions which are not feasible for risk adjustment, we will develop other mechanisms to protect individuals and improve their access to health insurance coverage. These other mechanisms may include market conduct rules, revisions to the risk adjustment system itself, redefinition of condition areas, or other mechanisms.

During the testing phase, and through ongoing quality improvement efforts once implemented, the system will be evaluated to determine if the system creates unintended effects relating to high risk populations. If such effects are detected, measures will be taken to correct or offset these impacts.

## PROVIDER ISSUES

**Recommendation:** The risk adjustment mechanism will not intervene directly in the financial arrangements between health plan companies and providers. The Risk Adjustment Association and Departments will ensure that information on the risk adjustment system and how it works is available to providers. There will be no "black box."

The risk adjustment system will not directly intervene in the financial arrangements between health plan companies and providers. Risk adjustment will not dictate payment levels. Providers will need to be aware of the risk adjustment mechanism and how it operates, particularly in risk-sharing arrangements where the provider is partially at risk for the costs of treating patients. Providers will want to be aware of any additional payments received by the health plan company through the risk adjustment system (because the health plan company has a more costly population) to be sure that those extra payments are passed through to providers to cover cost of increased health care. Health plan companies, on the other hand will want

providers to be aware of any payments the health plan company has to make into the risk adjustment system (because the health plan company has a healthier mix of patients) so that payment rates to providers also reflect this.

Providers will often be more aware of the health needs of patients they are caring for than the health plan company. This, together with knowledge of how the risk adjustment system works, will allow providers to negotiate appropriate payment arrangements with health plan companies that assure that the risk adjustment payments-- which are intended to cover increased costs of providing care to patients-- are actually used for this purpose. The Risk Adjustment Association and the Departments of Health and Commerce will ensure that providers are informed of the risk adjustment system.

## **HEALTH PLAN COMPANY CONCERNS**

### **Incentives for Efficiency and Managed Care**

The risk adjustment system must not create incentives for inefficiency, or penalize health plan companies attempts to manage care appropriately. The risk adjustment system should also not create disincentives to provision of preventive services. Health plan companies that are successful in improving the health of their population should not be penalized through the risk adjustment system for this success. As the risk adjustment system is developed, we will explore mechanisms to achieve these objectives.

### **RAPO (Regulated All-Payer Option) Concerns**

RAPO health plan companies are in a unique situation with regard to efficiency. Under current MinnesotaCare law, RAPO health plan companies are precluded from engaging in many managed care behaviors such as establishing provider networks. These prohibitions will make it difficult for RAPO health plan companies to be as efficient as ISNs and CISNs. The risk adjustment system should not exacerbate this problem by penalizing RAPO health plan companies for legislated inefficiencies. During the design phase, we will consider possible solutions to this problem, including the possibility of developing a separate RAPO pool.

### **Solvency Issues**

There are solvency concerns related to risk adjustment which must be addressed. If the risk adjustment mechanism transfers a large proportion of money, some health plan companies may be placed at risk of insolvency. Small health plan companies, or health plan companies with a particularly unusual population may be at risk for paying a large portion of their revenues into a risk adjustment pool. We will evaluate the possibility of setting limits to the amount any health plan company is obligated to pay or receive as a percentage of premiums.

### **Small Health Plan Company Concerns**

Small health plan companies also have special concerns related to risk adjustment. Solvency, as mentioned above, will be a particular issue for smaller health plan companies. In addition, data systems will need to be sensitive to the financial burden on small health plan companies that don't currently maintain data.

## MARKET CONDUCT RULES

**Recommendation:** Market conduct rules must be developed to accompany the risk adjustment mechanism, to improve the effectiveness of the risk adjustment system, to safeguard against gaming, and to further address problems of access for high risk groups.

The risk adjustment mechanism must be accompanied by other efforts designed to facilitate the proper implementation of risk adjustment and to further address problems of access for high risk and special needs groups. The development of specific, clear, and understandable market conduct rules will assist in communicating the intent of the risk adjustment system. By clearly delineating the types of behavior considered unacceptable, gaming can be reduced.

Market conduct rules should outline the specific intent of the risk adjustment reforms and will be updated if creative means of avoiding high risk groups through loopholes becomes apparent. One recent article on risk adjusters provided instructions for insurers for gaming of risk adjustment:

*"A health plan that is positioning itself for reform by underwriting to acquire lower-than-average risk characteristics should strive to identify the characteristics within each (risk adjustment) group that produce losses. The health plan then can reposition its products to create disincentives for individuals with those loss characteristics,...."<sup>10</sup>*

Although not all health plan companies operate under this type of strategy, many do. This illustrates the importance of communicating the intent of risk adjustment and the unacceptability of gaming behavior.

We propose that market conduct rules will be developed by the Departments of Health and Commerce, with the advise of the Risk Adjustment Association. These market conduct rules will be incorporated into risk adjustment legislation, in broad outline form, and the Departments of Health and Commerce will be charged with revising and expanding the rules as they see necessary.

Market Conduct Rules may include the following:

1. Any marketing, enrollment, plan design, or service behavior which attempts specifically to exclude or discourage high risk individuals from enrolling, encourages high risk individuals to disenroll, or attempts to enroll a disproportionate share of healthy individuals is considered gaming and is unacceptable.
2. Attempting to enroll a healthier pool (or avoiding high risk individuals) by "red-lining" or by limiting access to types of specialists is not acceptable.

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<sup>10</sup> Edres, Steve and Guner, Peter "Get Ready for Risk Adjusters" Ernst and Young publication 1994.

3. Attempting to attract healthier individuals within a risk category (marketing to attract healthy diabetics for example) is considered gaming and is unacceptable.
4. Altering coding protocols, or attempting to influence provider diagnosis and treatment of conditions for the purpose of inflating the risk assessment of the health plan company is not acceptable.
5. Health plan companies must cooperate with the Risk Adjustment Association and the Departments of Health and Commerce when these entities are attempting to investigate potential gaming problems or reviewing the need for additional market conduct rules.
6. Disenrollment will be monitored to assure compliance with these market conduct rules and to detect other problems which may need to be addressed through new market conduct rules or other mechanisms.



# CHAPTER VIII

## OPERATIONAL ISSUES

### DEVELOPMENT AND IMPLEMENTATION OF THE RISK ADJUSTMENT SYSTEM

There are operational issues related to two distinct phases of the risk adjustment project. First, there is a **development phase** which concerns the testing and development of the risk adjustment system to be implemented in Minnesota. This phase began with the passage of the MinnesotaCare law in 1994, and will continue until implementation begins. Second, there is an **implementation phase**, which may begin July 1, 1997 and continues into the future and involves the implementation and administration of the risk adjustment system.

#### The Development Phase of the Risk Adjustment System

**Recommendation:** The risk adjustment system will be developed by the Risk Adjustment Association, with active state oversight by the Departments of Health and Commerce. The Association and the State will have specific authority and responsibilities outlined in statute, and will work together cooperatively to develop risk adjustment in Minnesota.

The current statute requires the Commissioners of Health and Commerce to prepare a report based on input from the Risk Adjustment Expert Advisory Panel. The statute anticipates that the Risk Adjustment Association would be the entity to develop and implement a risk adjustment mechanism. The development of risk adjustment includes the need to test different methods. Our recommendation is to place responsibility for development and testing risk adjustment methods with the Association, subject to regulatory oversight by the Commissioners of Health and Commerce.

#### *Role of the Association*

We recommend that responsibility for development of the private sector risk adjustment system be vested in the Risk Adjustment Association. The Risk Adjustment Association would have responsibility to assemble Technical Advisory Groups for development of methodologies (utilizing experts in research methods, health economics, actuarial methods, and other experts), and other areas identified by the Association or the Departments. The Association must invite members of the Risk Adjustment Expert Advisory Panel on its Technical Advisory Groups.

#### *Role of the State*

The role of the state would be: to review and approve the plan for testing; review and approve methods used in risk adjustments, and any changes to those methods; to attend and participate in all meetings of the Risk Adjustment Association and its committees and work groups; to have access to data collected by the Association for the purpose of risk adjustment activities and have the responsibility for maintaining such data appropriately under the Data Practices

Act, to approve any administrators or consultants used by the Association.

The state will have primary responsibility for development of the risk adjustment mechanism for public programs, and will convene a work group on risk adjustment in public programs. The state will also work with the Association to facilitate coordination of the public programs risk adjustment system with the risk adjustment system for other markets. The state would also provide some staff support for risk adjustment development activities.

There are still a number of open questions concerning the collection of data for risk adjustment, including integration of the data collection activities with other data activities to avoid duplication, data privacy issues, etc. We will work with the Risk Adjustment Association to resolve as many of these issues as possible in the early development phase.

### **Implementation of the Risk Adjustment System**

***Recommendation:*** The Risk Adjustment System will be implemented by the Risk Adjustment Association, with active state oversight by the Departments of Health and Commerce. The appropriate implementation date will be dependent on the reforms enacted and will be determined by the Association and the Departments. The Association and the Departments will have specific authorities and responsibilities outlined in statute and will work together to implement risk adjustment.

We recommend that the Association be responsible for implementing the system, with necessary active state oversight by the Departments of Health and Commerce.

#### ***Role of the Association***

The Risk Adjustment Association is responsible for the development, implementation and operation of the risk adjustment system. Specific tasks and responsibilities are outlined below:

- The Association must create Technical Advisory Groups in the following areas; risk adjustment in public programs, development of market conduct rules, methodologies (including experts in research methods, health economics, actuarial methods, and other experts), and other areas identified by the Association or the Departments. The Association must invite members of the Risk Adjustment Expert Advisory Panel on its Technical Advisory Groups.
- The Association must abide by the Open Meeting Law in conducting all its functions.
- The Association must report to the legislature at least twice a year, on the status and performance of the risk adjustment system.
- The Association must establish three classes of membership on the Board of Directors. These classes will be: 1) payers (ISNs and indemnity insurers), 2) Providers (hospitals, physicians, and other providers), and 3) Public (representatives of public programs, counties, and other public members). For any affirmative action by the Board, there

must be at least one affirmative vote from each class.

### ***Role of the State***

The Departments of Health and Commerce will provide active oversight of the operations of the Risk Adjustment Association, and will assist the Association in carrying out its tasks and responsibilities. This oversight will be in accordance with the following specified tasks and responsibilities:

- The Departments will review and approve the Association's Plan of operation.
- The Departments will review and approve the methods used in risk adjustments, and any changes to those methods proposed by the Association.
- The Departments have the authority to attend and participate in all meetings of the Risk Adjustment Association and its committees and work groups.
- The Departments have the responsibility for enforcing regulations relating to risk adjustment.
- The Departments have access to data collected by the Association for the purpose of risk adjustment activities and have the responsibility for maintaining such data appropriately under the Data Practices Act.
- The Departments may require the Association to provide quarterly status reports.
- The Departments approve any administrators or consultants used by the Association.

### **Legal Issues Regarding Operation of the Risk Adjustment Mechanism**

The ongoing operations of the Association require several specific legislative changes similar to those made for the Health Coverage Reinsurance Association (HCRA) created by Statute 62L.13. For example, the Association should be exempt from state taxes; it should be allowed to execute all of the powers of a corporation formed under chapter 317A, and should be subject to regulatory oversight by the Commissioners of Health and Commerce.

For purposes of establishing that the activities of the Association are subject to the state action immunity from antitrust law, there must be a clear articulation of the public purpose for risk adjustment and that risk adjustment activities would be subject to active state supervision. To establish a clear public purpose, it is necessary to acknowledge that risk adjustment is designed to facilitate competition based on quality and efficiency rather than from avoiding the risk of insuring less healthy individuals. The articulated public purpose of this regulatory function is to remove current disincentives in the health care system to insure and serve high risk and special needs populations, and to promote competition on the basis of quality and efficiency. To fulfill the active supervision requirement, specific oversight activities should be outlined in statute. In this way, the statute in essence works to guarantee active state supervision. Areas of regulatory activity which could be put in legislation are outlined above.

## **Funding**

**Recommendation:** Funding for the *development phase* of risk adjustment will be needed to support testing and development of risk adjustment. Funding for development of risk adjustment in the private sector shall be the responsibility of the Association. Funding for the development phase of risk adjustment in the public programs shall be the responsibility of the state. Foundation and grant support will be sought to supplement public and private funding.

**Recommendation:** Funding for the *operation phase* of risk adjustment should be obtained through an assessment of health plan companies participating in the risk adjusted markets. These funds will support administration of the system and the actual payments to health plan companies that have enrolled a more costly population.

Funding for risk adjustment falls into two categories: **development** or testing and **operations** or implementation.

In the **development phase** of risk adjustment, funding will be needed to develop and test the risk adjustment model(s). Public funding for the risk adjustment process will come from legislative appropriations (new and existing) and in-kind staff support. Public funds will be used to support testing and development of risk adjustment for the public programs. Private sector funding will come from an assessment of health plan companies, providers, and others (not just from health plan companies in the individual and small group markets). This reflects the need to have the cost of development of risk adjustment borne by the whole system, rather than a segment of it. Foundation and grant support will be sought to supplement the public and private sector contributions.

For the **operations phase**, funding will be necessary for administration of the system, as well as for actual payments to health plan companies that undertake a high risk population. Funding for this phase of risk adjustment will come from assessments of the health plan companies participating in the risk adjustment markets.

# APPENDICES



# APPENDICES

## APPENDIX 1

### 1994 MinnesotaCare Law on Risk Adjustment

#### Sec. 15. 62Q.03 PROCESS FOR DEFINING, DEVELOPING, AND IMPLEMENTING A RISK ADJUSTMENT SYSTEM.

**Subdivision 1. PURPOSE.** Risk adjustment is a vital element of the state's strategy for achieving a more equitable, efficient system of health care delivery and financing for all state residents. Risk adjustment is needed to: remove current disincentives in the health care system to insure and serve high risk and special needs populations; promote fair competition among health plan companies on the basis of their ability to efficiently and effectively provide services rather than on the health status of those in a given insurance pool; and help assure the viability of all health plan companies, including community integrated service networks. It is the commitment of the state to develop and implement a risk adjustment system by July 1, 1997, and to continue to improve and refine risk adjustment over time. The process for designing and implementing risk adjustment shall be open, explicit, utilize resources and expertise from both the private and public sectors, and include at least the representation described in subdivision 4. The process shall take into account the formative nature of risk adjustment as an emerging science, and shall develop and implement risk adjustment to allow continual modifications, expansions, and refinements over time. The process shall have at least two stages, as described in subdivision 2 and 3.

**Subd. 2. FIRST STAGE OF RISK ADJUSTMENT DEVELOPMENT PROCESS.** The objective of the first stage is to report to the legislature by January 15, 1995, with recommendations on the process, organization, resource needs, and specific work plan to define, develop, and implement a risk adjustment mechanism by July 1, 1997, and to continually improve risk adjustment over time. The report shall address the specific issues listed in subdivision 5, and shall also identify any additional policy issues, questions and concerns that must be addressed to facilitate development and implementation of risk adjustment.

**Subd. 3. SECOND STAGE OF THE RISK ADJUSTMENT DEVELOPMENT PROCESS.** The second stage of the process, following review and any modification by the legislature of the January 15, 1995 report, shall be to carry out the work plan to develop and implement a risk adjustment mechanism by July 1, 1997, and to continue to improve and refine a risk adjustment over time. The second stage of the process shall be carried out by the association created in subdivision 6.

**Subd. 4. EXPERT PANEL.** The commissioners of health and commerce shall convene an

expert advisory panel comprised of, but not limited to, the board members of the Minnesota risk adjustment association, as described in subdivision 8, and experts from the fields of epidemiology, health services research, and health economics. The commissioners may also convene technical work groups that may include members of the expert advisory panel and other persons, all selected in the sole discretion of the commissioners. The expert advisory panel and the workgroups shall assist and advise the commissioners of health and commerce in preparing the implementation report described in subdivision 5.

**Subd. 5. IMPLEMENTATION REPORT TO THE LEGISLATURE.** The commissioners of health and commerce shall submit a report to the legislature by January 15, 1995, with recommendations on the process, organization, resource needs, and specific work plan to define, develop, and implement a risk adjustment system by July 1, 1997, and to continually improve risk adjustment over time. In developing the January 15, 1995 report, the commissioners of commerce and health must consider and describe the following:

- (1) the relationship of risk adjustment to the implementation of universal coverage and community rating;
- (2) the role of reinsurance in the risk adjustment system, as a short-term alternative in the absence of a risk adjustment methodology;
- (3) the relationship of the risk adjustment system to the implementation of reforms in underwriting and rating requirements;
- (4) the potential role of the health coverage reinsurance association in the risk adjustment system;
- (5) the need for mandatory participation of all health plan companies in the risk adjustment system;
- (6) current and emerging applications of risk adjustment methodologies used for reimbursement purposes at the state and national level and the reliability and validity of current risk assessment and risk adjustment methodologies;
- (7) the levels and types of risk to be distributed through the risk adjustment system;
- (8) the extent to which prepaid contracting by public programs needs to be addressed by the risk adjustment methodology;
- (9) a plan for testing of the risk adjustment options being proposed, including simulations using existing health plan data, and development and testing of models on simulated data to assess the feasibility and efficacy of specific methodologies;
- (10) the appropriate role of the state in the supervision of the risk adjustment association created pursuant to subdivision 6;
- (11) risk adjustment methodologies that take into account differences among health plan companies due to their relative efficiencies, characteristics, and relative to existing insured contracts, new business, underwriting, or rating restrictions required or permitted by law; and
- (12) methods to encourage health plan companies to enroll higher risk populations.

To the extent possible, the implementation report shall identify a specific methodology or methodologies that may serve as a starting point for risk adjustment, explain the advantages and disadvantages of each such methodology, and provide a specific workplan for implementing the methodology.

Subd. 6. **CREATION OF RISK ADJUSTMENT ASSOCIATION.** The Minnesota risk adjustment association is created on July 1, 1994, and may operate as a nonprofit unincorporated association.

Subd. 7. **PURPOSE OF ASSOCIATION.** The association is established to carry out the purposes of subdivision 1, as further elaborated on by the implementation report described in subdivision 5 and by legislation enacted in 1995 or subsequently.

Subd. 8. **GOVERNANCE.** (a) The association shall be governed by an interim 19-member board as follows: one provider member appointed by the Minnesota Hospital Association; one provider member appointed by the Minnesota Medical Association; one provider member appointed by the governor; three members appointed by the Minnesota Council of HMOs to include an HMO with at least 50 percent of total membership enrolled through a public program; three members appointed by Blue Cross and Blue Shield of Minnesota, to include a member from a Blue Cross and Blue Shield of Minnesota affiliated health plan with fewer than 50,000 enrollees and located outside the Minneapolis-St. Paul metropolitan area; two members appointed by the Insurance Federation of Minnesota; one member appointed by the Minnesota Association of Counties; and three public members appointed by the governor, to include at least one representative of a public program. The commissioners of health, commerce, human services, and employee relations shall be nonvoting ex-officio members.

(b) The board may elect officers and establish committees as necessary.

(c) A majority of the members of the board constitutes a quorum for the transaction of business.

(d) Approval by a majority of the board members present is required for any action of the board.

(e) Interim board members shall be appointed by July 1, 1994, and shall serve until a new board is elected according to the plan developed by the association.

(f) A member may designate a representative to act as a member of the interim board in the member's absence.

Subd. 9. **DATA COLLECTION.** The board of the association shall consider antitrust implications and establish procedures to assure that pricing and other competitive information is appropriately shared among competitors in the health care market or members of the board. Any information shared shall be distributed only for the purposes of administering or developing any of the tasks identified in subdivisions 2 and 4. In developing these procedures, the board of the association may consider the identification of a state agency or other appropriate third party to receive information of a confidential or competitive nature.

Subd. 10. **SUPERVISION.** The association's activities shall be supervised by the commissioners of health and commerce.

Subd 11. **REPORTING.** The board of the association shall provide a status report on its activities to the health care commission on a quarterly basis.



## APPENDIX 2

<b><i>Risk Adjustment Expert Advisory Panel</i></b>		
<b>Risk Adjustment Association Board Members</b>		<b>Health and Commerce Commissioner Appointees</b>
Steve Bjorum President & CEO First Plan Community Health Center Two Harbors, MN	Judy Busse Vice President, Actuarial & Statistics Blue Cross Blue Shield of MN St. Paul, MN	Bruce Carlson Allianz Life Insurance Company Champlin, MN
Timothy Crimmins, MD, FACEP Dept of Emergency Medicine Hennepin Faculty Associates Minneapolis, MN	Michael Emerson Vice President and Chief Actuary MidAmerica Mutual Life Insurance Company Roseville, MN	Deborah Chase Director, Health Policy Hennepin County Health Policy Center Minneapolis, MN
Ron Esau Public Member Eden Prairie, MN	James Fox Sr Vice President Fairview Hospital & Healthcare Services Minneapolis, MN	Roger Evans, PhD Head, Section of Health Services Evaluation Mayo Clinic Rochester, MN
Lynn R Gruber Executive Director MN Comprehensive Health Assn St. Louis Park, MN	Earl Hoffman Second Vice President and Actuary Employee Benefits Division Northwestern National Life Insurance Company Minneapolis, MN	Jinnet Fowles, PhD Vice President and Executive Director Health Research Center Park Nicollet Medical Foundation Minneapolis, MN
Mark Hudson UCare Minnesota St. Paul, MN	Raymond J Martin Jr Health Plan Relations Allina Health Systems Minneapolis, MN	David Knutson Director, Health Systems Studies Park Nicollet Medical Foundation Minneapolis, MN
James Minnich Medica/UHC Edina, MN	Dick Niemiec Sr Vice President, Corporate Affairs Blue Cross Blue Shield of MN St. Paul, MN	Willard G Manning Jr, PhD Professor Institute for Health Services Research School of Public Health University of Minnesota Minneapolis, MN
Robert Power HealthPartners Minneapolis, MN	Melvin J Ptacek Farm Equipment Association Owatonna, MN	David M Radosevich, PhD Director, Implementation and Analysis Health Outcomes Institute Bloomington, MN
Mark Rhyner Associate Director Association of MN Counties St. Paul, MN		Harry L Sutton Jr Allianz Life Insurance Company Minneapolis, MN



## APPENDIX 3

### Membership on the Technical Work Groups

<i>Risk Adjustment Workgroup 1 - Methodologies</i>		
Bruce Carlson Allianz Life Insurance Company Champlin, MN	Deborah Chase Director, Health Policy Hennepin County Health Policy Center Minneapolis, MN	Roger Evans, PhD Head, Section of Health Services Evaluation Mayo Clinic Rochester, MN
Jinnet Fowles, PhD Vice President and Executive Director Health Research Center Park Nicollet Medical Foundation Minneapolis, MN	Lynn R Gruber Executive Director MN Comprehensive Health Assn St. Louis Park, MN	Earl Hoffman Second Vice President and Actuary Employee Benefits Division Northwestern National Life Insurance Company Minneapolis, MN
Al Johnson Metropolitan Health Plan Minneapolis, MN	Lisa Kern MidAmerican Life Insurance Co. Roseville, MN	David Knutson Director, Health Systems Studies Park Nicollet Medical Foundation Minneapolis, MN
Willard G Manning Jr, PhD Professor Institute for Health Services Research School of Public Health University of Minnesota Minneapolis, MN	Dan McLaughlin Administrator Hennepin County Medical Center Minneapolis, MN	James Minnich Medica/UHC Edina, MN
Dick Niemiec Sr. Vice President, Corporate Affairs Blue Cross Blue Shield of Minnesota St. Paul, Minnesota	Paul Olson DHS St. Paul, MN	Robert Power HealthPartners Minneapolis, MN
Melvin J Ptacek Farm Equipment Association Owatonna, MN	David M Radosevich, PhD Director, Implementation and Analysis Health Outcomes Institute Bloomington, MN	Janet Silversmith Minnesota Medical Association Suite 300, Broadway Place East Minneapolis, MN
Harry L Sutton Jr Allianz Life Insurance Company Minneapolis, MN		

## ***Risk Adjustment Workgroup 2 - Plan for Testing***

Judy Busse Vice President, Actuarial & Statistics Blue Cross Blue Shield of MN St. Paul, MN	Jinnet Fowles, Ph.D. Vice President and Executive Director Health Research Center Park Nicollet Medical Foundation Minneapolis, MN	Stan Hamilton Medica - MN07-7080 Minneapolis, MN
David Knutson Director of Health Systems Studies Park Nicollet Medical Foundation Minneapolis, MN	Raymond Martin, Jr. Allina Health Systems Health Plan Relations Minneapolis, MN	Robert Power HealthPartners Minneapolis, MN
David Radosevich Director, Implementation and Analysis Health Outcomes Institute Bloomington, MN		

## ***Risk Adjustment Workgroup 3 - Operations***

Steve Bjorum President & CEO First Plan Community Health Center Two Harbors, MN	Trudy Gutowski BCBSMN St. Paul, MN	Mark Movic Second Vice President and Actuary The Principal Financial Group Des Moines, Iowa
Robert Power HealthPartners Minneapolis, MN	Kathleen Schuler Health Care Management State of MN Department of Human Services Human Services Building St. Paul, MN	Lois Wattman Allina Minnetonka, MN

## ***Risk Adjustment Workgroup 4 -Public Programs***

Deborah Chase Director Health Policy Hennepin County Health Policy Center Minneapolis, MN	Nancy Feldman Medica Minneapolis, MN	Jinnet Fowles Vice President and Executive Director Health Research Center Park Nicollet Medical Foundation Minneapolis, MN
Debbie Glass BCBSM St. Paul, MN	Virginia Greenman Mendota Heights, MN	Ann Henry MN Disability Law Center Minneapolis, MN
Earl Hoffman Second Vice President and Actuary Employee Benefits Division Northwestern National Life Insurance Company Minneapolis, MN	Mark Hudson UCare MN St. Paul, MN	David Knutson Director of Health Systems Studies Park Nicollet Medical Foundation Minneapolis, MN
Patricia MacTaggart DHS St Paul, MN	Paul Olson DHS St Paul, MN	Karen Peed DHS St Paul, MN
Donna Peterson MDH Minneapolis, MN	Robert Power HealthPartners Minneapolis, MN	Mike Rhyner, Associate Director Association of MN Counties St. Paul, MN



## **APPENDIX 4**

### **Glossary of Risk Adjustment Terms**

#### **Adverse Selection, Antiselection**

Refers to behavior of individuals in which individuals attempt to maximize the value for their premium dollar. For example, sicker and more risk averse consumers are more likely to join high-option health plan companies.

#### **All-payer insurer**

A health carrier not defined as an ISN or CISN.

#### **Ambulatory Care Groups (ACG's)**

A model that uses age/sex and ICD-9 diagnosis codes assigned during ambulatory care to classify risks. It was developed by Jonathan Weiner and others at Johns Hopkins University.

#### **Assigned Risk Pool**

A market device that provides insurance for entities or individuals that cannot obtain coverage from an insurer on a voluntary basis, by sharing premiums and losses for such entities or individuals among insurers participating in the pool.

#### **Bias**

Non-random errors in statistical processes, i.e. errors that tend to go in one direction.

#### **Churning**

Tendency of insureds to lapse their current policies or switch health plan companies very frequently (as often as every year) to purchase new policies, usually at a lower premium.

#### **Community Integrated Service Network (CISN)**

A formal arrangement for providing pre-paid health services to enrolled populations of 50,000 or fewer enrollees, including enrollees who are residents of other states. CISNs are licensed by the Commissioner of Health under section 62N.25.

#### **Community Rating**

A method of rating that produces identical rates for all members of an identified pool or class, based on the expected costs for these members as a group. Standard community rating allows rates to vary for family status, geography, plan design. Community rating by class adds new factors, such as age to the standard community rating factors. Adjusted community rating refers to the addition of several more factors- past experience, duration of coverage, and/or health status- and is used to set rates prospectively. Minnesota currently prohibits the use of sex as a rating factor.

#### **Continuous Coverage**

The maintenance of continuous and uninterrupted qualifying coverage. In Minnesota, an individual is considered to have maintained continuous coverage if the individual requests enrollment in qualifying coverage within 30 days of termination of the prior qualifying coverage (62L.02 Subd.9).

#### **Diagnostic Cost Groups (DCGs)**

This is a prior history model that uses inpatient hospitalization data to classify individuals into risk categories. This model was developed by Arlene Ash and others at Boston University.

**ERISA**

The Employee Retirement Income Security Act of 1974. ERISA is a federal law which governs employee welfare benefit and pension plans. It has several major provisions concerning health and welfare plans, including the preemption of state insurance laws. This preemption prohibits state law from affecting self-insured or other self-funded plans.

**Experience**

The prior claim statistics of a given group or individual.

**Experience Rating**

The process by which a group or individual policyholder is given the financial benefit of, or held financially accountable for, its past claim experience in insurance rating calculations.

**Gaming**

Methods used by health plan companies and insureds to gain benefit for themselves, by using creative techniques to circumvent the intent of a law or insurance guideline.

**Group Purchasers**

From MinnesotaCare law 62J.03 Subd. 6: a person or organization that purchases health care on behalf of an identified group or persons, regardless of whether the cost of coverage or services is paid for by the purchaser or by the persons receiving coverage or services. Includes: ISNs, CISNs, health insurance companies, HMOs, BCBSM, other health plan companies, employee health plans offered by self-insured employers, trusts established in a collective bargaining agreement under the federal Labor-Management Relations Act of 1947, MCHA, group health coverage offered by fraternal organizations, professional associations, or other organizations, state and federal health care programs, state and local public employee health plans, worker's compensation plans, and the medical component of automobile insurance coverage.

**Guaranteed Issue**

In Minnesota by July 1, 1997: A health plan company may not refuse an application by an individual for any individual health plan offered by that company, including coverage for a dependent of the individual to whom the health plan has been or would be issued. A health plan company may not refuse an application by a group for any health plan offered by that company and shall not decline to cover any person eligible for coverage under the group's eligibility requirements including persons who become eligible after initial issuance of the group health plan. Currently in Minnesota, small employers who meet contribution and participation requirements are guaranteed the issuance of small group policies.

**HCFA 1500**

The Uniform Billing Form HCFA 1500, standard billing form for non-institutional services developed by the Uniform Claims Forms Task Force of the Federal Health Care Financing Administration and required for use in Minnesota after January 1, 1996.

**Health Carrier**

From Minnesota Statutes 62A.011 Sub. 2: An insurance company licensed to offer, sell, or issue a policy of accident and sickness insurance, a non-profit health services plan corporation operating under 62C (BCBSM), health maintenance organizations (HMOs) licensed under 62D, a fraternal benefit society operating under chapter 64B, or a joint self-insurance employee health plan operating

under 62H.

### **Health Plan Company**

From 1994 MinnesotaCare law: A health carrier (defined above), an ISN, an all-payer insurer or a Community ISN.

### **Integrated Service Network (ISN)**

A formal arrangement permitted by 62N.02 and licensed by the Commissioner of Health for providing health services to enrollees for a fixed payment per time period.

### **Intergenerational Transfer**

A subsidy in which younger insureds have higher premiums in order to subsidize older insureds' premiums. This occurs in standard community rating, where age is not a rating factor.

### **Manual Premium Rates**

Prospective rates based on the demographic or other underwriting characteristics of the group, but not on its specific claim experience. (When manual rates are based on the combined experience of a pool of similar policies, they are called pooled rates.)

### **MCHA**

The Minnesota Comprehensive Health Association, which is the state's high risk pool. It currently enrolls about 35,000 people.

### **Medical Underwriting(See Underwriting)**

### **Outliers**

A claimant whose claims cost falls outside the normal amount for an average claimant.

### **Payment Amounts for Capitated Systems (PACS)**

This is a risk assessment model that uses age/sex, disability status, major diagnostic category, and level of ambulatory use to classify risks. It was developed by Gerard Anderson at Johns Hopkins University.

### **Preexisting Condition Exclusion or Limitation**

A contract provision which excludes or limits coverage for charges or expenses incurred during a specified period after that employee's effective date of coverage, as to a condition for which medical advice, diagnosis, care, or treatment was recommended or received during a specified period immediately preceding the effective date of coverage. After July 1, 1997, in Minnesota no health plan company may sell, offer, or issue a health policy that contains a pre-existing condition limitation or exclusion or exclusionary rider that applies to a Minnesota resident (except a limitation which is no longer than 12 months and applies only to a person who has not maintained continuous coverage).

### **Prospective Rating**

The evaluation of probable experience for a future rating period, leading to gross premium rates to be charged to a group.

**RAND-36 (Short Form 36)**

A self-reported health status survey consisting of 36 questions. It was developed by the RAND Corporation as a mechanism to rate patient's perception of their health status.

**RAPO**

The Regulated All-Payer Option.

**Reinsurance**

Acceptance by one insurer (the reinsurer) of all or part of the risk of loss underwritten by another insurer (the ceding insurer).

**Retrospective Rating**

The evaluation and measurement of financial experience for a past period of time, for use in determining the cost of providing insurance for that period to the group or individual policy holder.

**Retrospective True-up**

First, an estimate is made on a prospective basis, of a risk adjustment amount. Subsequently, the actual data for the period are used to correct or "true-up" the original estimate.

**Risk Assessment**

The determination of the relative risks of subsets of persons within a defined population. A process of measuring on some objective basis the amount by which one group's expected health care costs will exceed the expected health care costs of another group.

**Risk Adjustment**

Translation of risk assessment into a modification of payments to compensate health plan companies for the risk related to patient characteristics outside of the plan's control.

**Risk Selection (or Cream-skimming, or Cherry-picking)**

Refers to the actions of health plan companies and insurers in which the plan attempts to enroll individuals and groups whose expected costs are less than the premium income associated with them. Risk selection can be accomplished through medical underwriting, benefits design, provider contracting, marketing strategies, and other strategies.

**Risk Segmentation**

The process by which health plan companies end up with differing levels of risk, as a result of risk selection on the part of health plan companies or adverse selection on the part of individual, or both.

**Staff Model Health Plan Company**

A health plan company which employs one or more types of health care providers to deliver health care services to the health plan company's enrollees.

**UB92**

Uniform Billing Form HCFA 1450, standard billing form for institutional services developed by the National Uniform Billing Committee, and required for use in Minnesota after January 1, 1996.

**Underwriting**

The process of identifying and classifying the potential degree of risk represented by a proposed

insured or group of insureds. For health plan companies, medical underwriting is sometimes used to identify substandard risks (individuals or groups likely to incur high medical costs). This process may include a questionnaire about health status and prior treatment, attending physician statements, and/or physical exams.

**Underwriting restrictions**

Limitations on the factors that may be used by an insurer for the purpose of determining the premium rate, or any other underwriting decision including initial issuance. Currently in Minnesota, gender cannot be used for underwriting in the small group and individual insurance markets. After January 1, 1995, gender may not be used in any underwriting decision.



## **APPENDIX 5**

### **Summary of Health Care Reforms**

#### **INDIVIDUAL MARKET - CURRENT REQUIREMENTS**

##### ***Underwriting Restrictions***

- Policies are guaranteed renewable which means that renewal cannot be declined nor coverage changed except for nonpayment or fraud. Rates can be revised on a class basis. (Note that the insured retains the right to original classification - if you were issued a policy at the standard rate, you continue to pay the standard rate regardless of changes in health status.)
- Underwriting is allowed (market is not currently guaranteed issue.) Individuals unable to purchase individual insurance qualify for coverage in MCHA.
- Exclusionary riders are prohibited. Exclusionary riders on policies in force on 6/30/93 may be retained.
- Cannot apply preexisting condition limitation to individuals maintaining continuous coverage except for any unexpired limitation under the previous coverage.

##### ***Rating Restrictions***

- Rates must be filed and approved.
- Minimum loss ratio standards, applied on a policy form basis.
- Gender-based rates are prohibited.
- May establish no more than three geographic regions, with one region being the Minneapolis/St. Paul metro region. Rates between any two regions may not vary by more than 20%.
- Age-based premium variations are limited to +/- 50% of the index rate.
- General premium variations are limited to +/- 25% of the index rate. General premium variations may be based *only* on health status, claims experience, and occupation.

##### ***Benefit Plans***

- Wide variety of benefit plans available. All plans must include mandated benefits.
- Required offer of 62E qualified plans.

#### **SMALL EMPLOYER MARKET - CURRENT REQUIREMENTS**

##### ***Definition***

- Current: 2 - 29 Employees
- As of 7/1/95: 2 - 49 Employees
- Voluntary exemptions for employers that were members of associations as of 7/1/93 and for political subdivisions.

##### ***Underwriting Restrictions***

- Guaranteed issue for groups meeting minimum participation and contribution requirements.
- Exclusionary riders are prohibited.
- Cannot apply preexisting condition limitation to individuals maintaining continuous coverage except for any unexpired limitation under the previous coverage.

##### ***Rating Restrictions***

- Rates must be filed and approved.
- Minimum loss ratio standards, applied on an aggregate basis.
- Gender-based rates are prohibited.

- May establish no more than three geographic regions, with one region being the Minneapolis /St. Paul metro region. Rates between any two regions may not vary by more than 20%.
- Index rates for different benefit plans may vary only based on actuarially valid differences in the benefit designs.
- Age-based premium variations are limited to +/- 50% of the index rate.
- General premium variations are limited to +/- 25% of the index rate. General premium variations may be based *only* on health status, claims experience, industry of the employer, and duration of coverage from the date of issue.

#### ***Benefit Plans***

- Wide variety of benefit plans available. All plans must include mandated benefits.
- Required offer of 62L.05 standardized plans - Copayment-type small employer plan and deductible-type small employer plan.

#### ***Additional***

- Minnesota Health Coverage Reinsurance Association - prospective reinsurance system, carrier participation is voluntary.
- Must offer conversion policy to individuals previously covered under the group. Rates for the conversion policy may not exceed 90 percent of MCHA's rate.
- Issuance of individual policies to a small group is prohibited. (Individuals may independently purchase individual policies.)

### **LARGE EMPLOYER MARKET - CURRENT REQUIREMENTS**

#### ***Underwriting Restrictions***

- Large employers are not typically underwritten.
- Cannot apply preexisting condition limitation to individuals maintaining continuous coverage except for any unexpired limitation under the previous coverage.

#### ***Rating Restrictions***

- Minimum loss ratio standards.
- Gender rating is prohibited (as of 1/1/95).
- Insured large employer groups are typically experience-rated.

#### ***Benefit Plans***

- Wide variety of benefit plans available. All plans must include mandated benefits.

#### ***Additional***

- Must offer conversion policy to individuals previously covered under the group. Rates for the conversion policy may not exceed 90 percent of MCHA's rate.

### **MEDICARE SUPPLEMENT - CURRENT MARKET**

#### ***Underwriting Restrictions***

- Six-month open enrollment upon becoming eligible and covered by Part B of Medicare.
- Guaranteed renewable.
- Preexisting condition limitation can be no more restrictive than the exclusion or limitation of benefits for a loss incurred six months from coverage effective date due to a condition treated or identified 3 months prior to effective date.

***Rating Restrictions***

- Rates must be filed and approved. Additional federal reporting requirements.
- Minimum loss ratio standards, applied on a policy form basis.
- Pure community rating - one rate per policy form.

***Benefit Plans***

- Can only offer standardized plans - Basic with optional riders and Extended Basic. (Note - there are a wide variety of different benefit plans in force, which were issued under prior benefit plan requirements.)

**INDIVIDUAL MARKET - CHANGES (in current law, effective dates in future)*****Underwriting Restrictions***

- Guaranteed issue - 7/1/97.
- Individual mandate - 7/1/97.

***Rating Restrictions***

- Possible contraction of the age-based premium variations to:
  - +/- 25% as of 7/1/95;
  - +/- 15% as of 7/1/96; and
  - no variation as of 7/1/97.
- Possible contraction of the general premium variations to:
  - +/- 12.5% as of 7/1/95;
  - +/- 7.5% as of 7/1/96; and
  - no variation, except for health lifestyle discount, as of 7/1/97.

***Benefit Plans***

- Universal standard benefit set.

**SMALL EMPLOYER MARKET - CHANGES (in current law, effective dates in future)*****Rating Restrictions***

- Possible contraction of the age-based premium variations to:
  - +/- 25% as of 7/1/95;
  - +/- 15% as of 7/1/96; and
  - no variation as of 7/1/97.
- Possible contraction of the general premium variations to:
  - +/- 12.5% as of 7/1/95;
  - +/- 7.5% as of 7/1/96; and
  - no variation, except for health lifestyle discount, as of 7/1/97.

***Benefit Plans***

- Universal standard benefit set.

**LARGE EMPLOYER MARKET - CHANGES (in current law, effective dates in future)*****Benefit Plans***

- Universal standard benefit set.



## APPENDIX 6

### Summary of New York Model

(Excerpted from "Community Rating: Issues and Experience" by Deborah Chollet and Rebecca Paul, Alpha Center, Washington D.C. December 1994. pp 19-22)

#### Reinsurance and Risk Adjustment under New York's Community Rating and Open Enrollment Law (C.501).

"To stabilize premiums and protect insurers from the erratic changes in the number and risk of beneficiaries, C. 501 required the Department of Insurance to promulgate regulations that encourage insurers to remain in or enter the individual and small group markets. Regulation 146 complies by creating a process of risk adjustment based on two prospective demographic pools and one retrospective Specified Medical Conditions pool in each of seven geographic regions. All insurers in each region pay a calculated amount into each of these pools. The pools then disburse back to insurers amounts that are intended to offset the financial effects of their having enrolled groups or individuals that are more likely than the average to have adverse claims experience.

**"The Demographic Pools:** Regulation 146 created two Demographic Pools in each region, one for non-Medicare population and one for Medigap policies. In each pool, an Average Demographic Factor (ADF) reflects the demographics of each insurer's enrolled population averaged over their entire book of business within a market segment. Each insurer calculates its ADF using a standard age/sex relative morbidity table. A Regional Demographic Factor (RDF) is then calculated as the average of the ADFs of all health plan companies in each of seven geographic regions in the state. Finally, the disbursement from or payment to the pools is calculated by multiplying the insurer's projected claims<sup>1</sup> by the difference between the ADF and RDF as a percent of its ADF:

Disbursement from (payment to) the Demographic Pool =  
Expected claims x [(ADF-RDF)/ADF]

"In turn, expected claims are calculated by applying each insurer's expected loss ratio (expected benefits paid per premiums collected, as filed with the Department of Insurance) to actual premiums.

"These calculations give each insurer a unique risk adjustment that reflects its demographic risk selection within each region and is scaled to its own claims experience. Note that these regions may not coincide with the regions used by each insurer to establish community rates, as insurance rates may reflect the demographics of geographic areas as small as a single county.

"Insurers and HMOs with an average demographic factor that is less than the regional demographic factor prospectively contribute funds to the regional pool, while those with greater than average risk prospectively receive funds from the pool. Insurers and HMOs reflect these transfers in their premium calculations as either revenues or benefit expenses. At the end of the first year, the state reconciles each insurer's projected and actual claims experience, and adjusts payments to and from the pool. Insurers that owe the pool then have one year to make payments to the pool; the state also has one year to disburse adjustments to other health plans.

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<sup>1</sup> Expected claims are calculated as premiums times the insurer's expected loss ratio.

"For the second and third quarters of 1993, the non-Medicare Demographic Pools collected \$15 million. For the fourth quarter, receipts increased to more than \$30 million, as the pools began to use the actual demographics of enrollees instead of estimates.<sup>2</sup>

**"Specified Medical Conditions Pool:** In each region, insurers and HMOs also pay a prospective amount per enrollee into a Specified Medical Conditions (SMC) Pool. Each insurer in the small group and individual markets is required to contribute a fixed dollar amount per enrollee per quarter; this amount varies between individual and family coverage, and by the product design.<sup>3</sup> The insurer then receives a retrospective payment back from the pool if any of their enrollees submit claims for any of a number of specified procedures or conditions: organ transplantation, low birth-weight infants, AIDS, or conditions leading to ventilator dependency. Payments from the pool for each procedure or condition are established in law as a flat dollar amount. To encourage efficiency, that amount is significantly less than the costs of these procedures or conditions in a managed care system.

"To date, the SMC pool has collected as much as \$7.5 million per quarter. Only minimal disbursements have been made from the pool, in part because the health plans have a full year following the calendar year of claims to submit claims and receive reimbursement. The state has been asked to consider expanding the list of conditions which the pool can reimburse.<sup>4</sup> To alter the list of conditions, a majority of carriers in two of the three classifications (Blue Cross and Blue Shield, HMOs, and commercial insurers) must agree to the change.

"New York's system of risk adjustment is designed to "promote an insurance marketplace where premiums do not unduly fluctuate and insurers and health maintenance organizations are reasonably protected against unexpected significant shifts in the number of persons insured." (The New York Community Rating and Open Enrollment Law C. 501, § 6.) By offsetting at least some of the impact of potentially biased risk selection, these pools help to ensure the survival of insurers that happen to enroll unusually high cost groups, while community rating as a whole increases the incentives for insurers to manage care efficiently. The pools also reduce insurers' financial incentives to subvert the intent of the law by seeking to enroll only good risks.

"Although the pools redistribute a relatively small fraction of the premiums that are collected in the market, the Department of Insurance believes that they are probably adequate to stabilize the insurance market. To date, the Demographic Pools have collected about 3.5% of total (annualized) premiums in the small group and individual markets; the SMC Pool has collected less than 1% of

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<sup>2</sup> Medicare pool receipts varied between \$2 million and \$3 million per quarter.

<sup>3</sup> Comprehensive plans pay \$5 or \$10; Basic hospital/surgical plans pay \$3.75 or \$7.50; and supplemental major medical or wrap-around plans pay \$1.25 or \$2.50. HMOs and point-of service plans may be given a discount against the contribution required of comprehensive plans depending on their benefit design.

<sup>4</sup> For instance, health plans do not qualify for an adjustment for AIDS cases until the patient has a CD4 count of less than 50 for two consecutive months. As health plans often do not collect these data and most patients are quite sick by the time their CD4 counts reach this level, some have urged New York to expand its definition of AIDS.

(annualized) premiums.<sup>5</sup> However, this level of revenue redistribution (ignoring the impact of the SMC adjustment) is expected to produce a "spread" of 14 percentage points between the median contributing insurer's community rate and the median recipient insurer's community rate for the same product type.<sup>6</sup> Although it is unclear whether these risk adjustments are sufficient to stabilize the health insurance market in the long term (and acknowledging that they have only placed a "toe in the water"), the Department of Insurance chose to create a simple method of risk adjustment as a way to implement the law as quickly as possible."

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<sup>5</sup> Benedict, Robert, Chief of Accident and Health Rating of the New York Department of Insurance. Personal communication, March 1994.

<sup>6</sup> This calculation assumes that one-half of insurers (by premium volume) are contributors to each Demographic Pool (and one half receive a distribution from the pool), and that premiums levels fully reflect all risk adjustment amounts. Based on current revenues as a percent of premiums, the risk adjustment process would transfer 7% of contributors premiums to the insurers that receive a distribution. Receivers would reduce their community rate by 7%, producing an 14-point spread between the median community rate in each group.



## **APPENDIX 7**

### **Options for Testing and Evaluation**

#### **Simulation**

Under this evaluation mechanism, individuals representing payers, providers, consumers and regulators would be asked to participate in a simulation of the risk adjustment mechanism. This simulation would provide each participant with information on the market, the health plan options, characteristics of various potential enrollee groups, as well as information on the risk adjustment system. Participants would then play the roles they normally play in the market, plans deciding how to set premium levels under various scenarios, to model the way the system would be affected by risk adjustment. The underlying assumptions or risk adjustment mechanisms can be changed to see how the market would be likely to respond. The goal of the simulation would be to try to ascertain how various components of the market would respond and be affected by risk adjustment prior to actually implementing risk adjustment across a broad scale. Specifically, simulation would be useful for collecting information on market forces and behavior and for evaluating possible gaming opportunities. Elaborate simulations have been successfully conducted in the health arena and those involved feel that it provides useful information on behavior which is not available through other testing methods.

#### **Pilot Study**

Under a pilot study, a section of the market (a geographic region, a specific market) would be targeted for risk adjustment implementation prior to full implementation. Those participating in the pilot study would be fully subject to the risk adjustment mechanism. This would allow for improvements to the risk adjustment system before a larger group of plans are affected. A pilot study would provide a source of information on all aspects of the risk adjustment model, including logistics, distribution of risks in the state, solvency implications, market forces and behavior, gaming, predictive power, and translation of risk to dollars. The difficulty in specifying a market segment, and the equity problems associated with forcing some plans or groups to be impacted by the risk adjustment system and not others make this option a difficult one to envision, and we are therefore recommending against a pilot study.

#### **Review of Literature and Ongoing Research Projects**

Another mechanism for evaluation and testing is to utilize information from the literature and from other similar projects that may be in operation in other states, or within programs or organizations. This will serve as a useful source of information on all aspects of risk adjustment, especially for evaluation the predictive power of the models.

#### **Specific Local Projects**

There are specific local projects which will provide other useful information on various aspects of risk adjustment. **PMAP** (Prepaid Medical Assistance Program) will provide some information on the logistical aspects of risk adjustment. **BHCAG** (Business Health Care Action Group) has been interested in risk adjustment within their membership. This will be a source of information on logistics, predictive power, and the translation of risk to dollars. The **Data Institute's Patient Satisfaction Survey**. The Minnesota Health Data Institute is fielding a patient satisfaction survey to members of health plans in the state. The risk adjustment project has an opportunity to add

several questions to this survey on health status. This would provide information on the current distribution of risks in the state. **Data Institute Data Collection Activities.** Also, the Data Institute is working towards implementing a data collection process that may allow for more sophisticated risk adjustment models, and their experience to date will provide some information on the logistics of data collection for risk adjustment. **1995 Medicare Demonstration Project**, which a number of local plans are involved in, will provide information on logistics and the distribution of risks in the state.

**Areas that need evaluation and source of evaluation**

Area for evaluation	Simulation	Pilot Study	Literature & projects	PMAP <sup>1</sup>	BHCAG <sup>2</sup>	Patient Satisfaction	Data Institute	Medicare 1995 demo	Data Modelling
Logistics		+	+	*	+	+	*	+	+
Distribution of risks in MN		+	+			*		+	+
Solvency implications	+	+	+						+
Market forces, Behavior, Gaming	*	+	+						+
Predictive Power		+	*		+				+
Translation of risk to dollars		*	+	*	+				+

<sup>1</sup> Prepaid Medical Assistance Program    <sup>2</sup> Business Health Care Action Group



## APPENDIX 8

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## **APPENDIX 9**

### **Minutes of meetings**

#### **Risk Adjustment Expert Advisory Panel August 30, 1994 Meeting Notes**

##### **Members Present:**

Dennis Mackey	Department of Employee Relations
Steve Bjorum	First Plan
Judy Busse	BCBSM
Deborah Chase	Hennepin County
Tim Crimmins	Hennepin Faculty Associates
Michael Emerson	MidAmerica
Ronald Esau	Public member
Roger Evans	Mayo Clinic
Jinnet Fowles	Park Nicollet Medical Foundation
James Fox	Fairview Health System
Kathleen Cota	Department of Human Services
Lynn Gruber	Minnesota Comprehensive Health Association
Earl Hoffman	Northwestern National Life Insurance
Mark Hudson	UCare
David Knutson	Park Nicollet Medical Foundation
Ray Martin	HealthSpan
James Minnich	Medica/UHC
Dick Niemiec	BCBSM
Mary Jo O'Brien	Department of Health
Barbara Nerness	Department of Health
Robert Power	HealthPartners
Melvin Ptacek	Farm Equipment Association
Mike Rhyner	Association of MN Counties
Harry Sutton	Allianz Life Insurance
James Ulland	Department of Commerce

##### **Members Absent:**

Bruce Carleson	Allianz Life Insurance
Will Manning	Institute for Health Services Research
David Radosevich	Health Outcomes Institute

##### **Staff Participating:**

Lynn Blewett	Department of Health
Dori Petersen	Department of Commerce
Gini Weslowski	Department of Health
John Gross	Department of Commerce
Liz Quam	Department of Health
Scott Wilensky	Attorney General's Office

Lynn Blewett of the Department of Health convened the meeting. Each member of the expert panel introduced themselves and described who they represent.

Commissioner Mary Jo O'Brien welcomed the group and described the importance of the tasks the group has ahead. She described how other states and national reform will look to what we do, and hoped that we would also benefit from work other states have done. She described some of the history of risk adjustment in the MinnesotaCare laws. She thanked the group for volunteering to

participate in this project. Commissioner Ulland also welcomed the group, and expressed concern for Minnesota's move toward community rating and indicated that the more we can build risk differences into premiums, the less dollars would need to be moved through risk adjustment. He also outlined several criteria he recommends for a risk adjustment model, including low data intensity, simplicity, minimizing dollar transfers and conflict, incentives for managed care, timeliness, and predictability.

Ms. Blewett then went over some ground rules for the expert advisory panel (EAP). These ground rules include the following:

- The EAP is advisory to the Commissioners of Health and Commerce, and is focused on assisting with the development of the report due to the legislature on January 15, 1995
- Dori Peterson and Lynn Blewett will co-chair the meetings.
- The EAP will meet between now and January, once a month for about 3-4 hours.
- There will not be alternates to the EAP, because the group is so large (27 members) and to encourage continuity.
- Members may nominate an alternate to participate on the Technical Work Groups.
- Meeting notes (not detailed minutes) will be kept as a record of the meetings.
- No formal votes will be taken, but instead all issues, concerns and points of view will be reflected and incorporated into the meeting notes. Consensus will be sought wherever possible.
- Technical Work Groups will be convened by the Departments of Health and Commerce on an as needed basis.

Ms. Blewett then reviewed the legislative charge to the EAP.

Dori Petersen and Gini Weslowski presented an outline of the issues involved in risk adjustment. The presentation included a discussion of the definition of risk adjustment and risk assessment, description of some of the existing models, criteria for selecting a model, review of some studies and risk adjustment activities, and outline of some data issues.

Liz Quam of the Department of Health and John Gross of the Commerce Department then provided a review of the development of the risk adjustment legislation and the draft guiding principles developed last year. EAP members were asked to review these guiding principles and prepare to discuss them at the next meeting.

Ms. Petersen then reviewed a draft outline of the report due to the legislature prepared by staff, and Ms. Weslowski reviewed a draft workplan for the workgroups. EAP members offered suggestions for additions to the outline and workplan:

- The future of MCHA, and the small employers reinsurance association
- The disabled population now covered by state programs, which may move into private coverage.
- A discussion and definition of the scope of risk adjustment. What portions of the health care dollar are under risk adjustment.
- The impacts of community rating on risk adjustment. How will the rate band constrictions impact on risk adjustment.
- Many current models look only at the population using services, and would not pick up plans that have a high proportion of enrollees not using services.
- Even if we don't have time to do testing of models before the January report, wherever we can we should find empirical tests of models.

- Funding opportunities may be available for testing models through HCFA, or foundations.
- Need to identify impacts on outstate MN
- Need to make sure that the small players can provide the data necessary to participate in the risk adjustment model. The model may need to be less robust than otherwise to be sure all players can get the data. This is potentially a solvency issue for small plans.
- We need to avoid pushing more employers into the self-insured market.
- We will need to coordinate with the Data Institute, and consider adding them to workgroup 2.
- We need to watch out for vulnerable populations through our public advocacy role.

EAP members were asked to fill out a sign-up sheet for work group participation. The meeting was adjourned, and the Risk Adjustment Board of Directors meeting followed.

**Risk Adjustment Expert Advisory Panel  
September 28, 1994  
Meeting Notes**

**Members Present:**

Steve Bjorum	First Plan
Judy Busse	BCBSM
Bruce Carleson	Allianz Life Insurance
Tim Crimmins	Hennepin Faculty Associates
Michael Emerson	MidAmerica
Ronald Esau	Public member
Roger Evans	Mayo Clinic
Jinnet Fowles	Park Nicollet Medical Foundation
James Fox	Fairview Health System
Kathleen Cota	Department of Human Services
Lynn Gruber	Minnesota Comprehensive Health Association
Mark Hudson	UCare
David Knutson	Park Nicollet Medical Foundation
James Minnich	Medica/UHC
Dick Niemiec	BCBSM
Robert Power	HealthPartners
David Radosevich	Health Outcomes Institute

**Members Absent:**

Deborah Chase	Hennepin County
Earl Hoffman	Northwestern National Life Insurance
Dennis Mackey	Department of Employee Relations
Will Manning	Institute for Health Services Research
Ray Martin	HealthSpan
Melvin Ptacek	Farm Equipment Association
Harry Sutton	Allianz Life Insurance
Mike Rhyner	Association of MN Counties

**Staff Participating:**

Lynn Blewett	Department of Health
Dori Petersen	Department of Commerce
Gini Weslowski	Department of Health
Scott Wilensky	Attorney General's Office
John Gross	Department of Commerce

The Expert Advisory Panel reviewed the meeting notes from the last meeting on August 30, and no corrections or changes were suggested. The panel was advised that future meetings would be held at the Department of Health's Delaware Street building (where the August meeting was held).

Dave Knutson provided a report on the activities of Workgroup 1: Methodologies to the panel. Workgroup 1 has developed drafts of criteria for evaluation of risk adjustment models and systems, and a list of issues that will need to be addressed. Discussion of these documents followed, and several issues were raised.

The role of the Regulated All-Payer Option (RAPO) will need to be considered. The criteria that states that the Risk Adjustment system will not reward inefficiencies may mean additional problems for RAPO plans, because there are legislative prohibitions on some management techniques which will prevent RAPO plans from being as efficient as ISNs (eg. no contracting

with providers). There is a need to consider how to treat RAPO plans for this reason; possibilities include separate weights for RAPO, separate pools for RAPO and ISNs. Also, the system should not reward RAPO plans where there is discretionary choice about treatment modality-- that is the system should not reward inefficiency where efficiency is possible.

Providers concerns were also identified. Providers are concerned that plans may not pass all of the adjustments (positive and negative) to providers who may be sharing the financial risk of treating high cost patients. Providers will need to be aware of the risk adjustment system to be sure that any providers who are bearing some of the risk along with plans factor risk adjustment into their contract arrangements with plans. The risk adjustment system will need to be understandable to providers, and clinically meaningful and acceptable to them so that they can take it into account. NO BLACK BOX. Clinicians will have better information on the risk of the patients they are treating than the risk adjustment system will, at least in the beginning. The risk adjustment system should not, however, directly intervene in or prescribe the relationship between providers and plans. Potential risk adjustment arrangements between plans and providers will be outside of the scope of the risk adjustment system we are developing.

The panel then discussed the Guiding Principles put together last year, to revise and update them. The panel discussed the removal of the emphasis on reinsurance, which was emphasized during the 1994 legislative session because it was assumed that a mechanism needed to be in place for 1995. Reinsurance should be mentioned as a mechanism to account for the truly random high-cost cases and that there will always be a residual role for a private market in reinsurance apart from any risk adjustment system.

Staff agreed to revise the Guiding Principles to remove emphasis on reinsurance, and to incorporate the criteria which have been worked on by Workgroup 1 and the Panel. Staff will fax a draft to members for comment prior to the next meeting.

Jinnet Fowles then presented findings from the study she and Dave Knutson are working on for the Physician Payment Review Commission (PPRC) on risk adjustment. PPRC was interested in risk adjustment because of the possibility of national health reform, however, now they are more interested in risk adjustment for its use within health plans.

The study used data from the Park-Nicollet Clinic to evaluate several alternative methods of risk measurement and to analyze administrative feasibility issues associated with the application of these methods. Key findings included the ability of claims level data and self-reported chronic conditions to explain resource use at both the individual and group level.

Discussion followed, and several questions were raised. What are the key differences in outcomes using Medicare only vs. 18-65 population? What about adding children under age 18? Aren't children under 18 a large part of enrollee population? What are the costs of doing a survey vs. using claims data. They found that the range of prices for a survey was between \$12-15 for telephone survey. Including a post card follow up or two mailings is more costly but gets better response rate.

Dori Petersen then reviewed a draft of an outline of Chapter 3, and requested that members fax any comments or issues as soon as possible. This will be the first discussion item for the next meeting October 26.

**Risk Adjustment Expert Advisory Panel  
October 26, 1994  
Meeting Notes**

**Members Present:**

Steve Bjorum	First Plan
Bruce Carleson	Allianz Life Insurance
Deborah Chase	Hennepin County
Tim Crimmins	Hennepin Faculty Associates
Michael Emerson	MidAmerica
Ronald Esau	Public member
Roger Evans	Mayo Clinic
Jinnet Fowles	Park Nicollet Medical Foundation
James Fox	Fairview Health System
Lynn Gruber	Minnesota Comprehensive Health Association
Mark Hudson	UCare
David Knutson	Park Nicollet Medical Foundation
Will Manning	Institute for Health Services Research
James Minnich	Medica/UHC
Paul Olson	Department of Human Services
Robert Power	HealthPartners
Melvin Ptacek	Farm Equipment Association
David Radosevich	Health Outcomes Institute
Mike Rhyner	Association of MN Counties
Harry Sutton	Allianz Life Insurance

**Members Absent:**

Judy Busse	BCBSM
Earl Hoffman	Northwestern National Life Insurance
Dennis Mackey	Department of Employee Relations
Ray Martin	HealthSpan
Dick Niemiec	BCBSM

**Staff Participating:**

Lynn Blewett	Department of Health
Dori Petersen	Department of Commerce
Gini Weslowski	Department of Health
John Gross	Department of Commerce

The Expert Advisory Panel reviewed the meeting notes from the last meeting on September 28, one correction was suggested: the last line on the second page is corrected to read: "The study used data from ~~the Park Nicollet Clinic~~ *MedCenters*..."

The Panel then began discussion of Draft Report Section III. The first topic was how to define the scope of the risk adjustment system in terms of what plans and enrollees would be covered by risk adjustment. The legislative intent was that all plans (both in ISNs and RAPO) would participate. The group did not raise objections to this concept.

The discussion then turned to what markets should be in the risk adjustment system. Below is a brief outline of major points discussed.

**Individual and Small Groups**

Individual and small group markets should be in the risk adjustment system, as rating restrictions in those markets don't allow up front matching of premiums with risk factors.

There was some discussion of the definition of small group (currently in state law small group are 49 and below covered lives). Several members suggested that 49 was too low a cut off, and that we may want to go to 100 lives as other states are.

The Panel discussed whether or not the individual and small group plans should be in the same or separate pools. In the short term, the individual market may subsidize the small group but in the long run the opposite may be true.

### **Large Groups**

It may not be necessary (or feasible) to include large groups.

ERISA would make it difficult if not impossible, because ERISA is a huge escape hatch for large groups in particular. On the other hand, we should not give up on ERISA: the January report should identify how our recommendations would change if we were to receive an ERISA exemption of some sort. Without ERISA, several members supported inclusion of large groups.

There was some discussion of the need for many large groups which offer multiple health plans to risk adjust within their system. Discussion included pointing out that our scope does not include developing methods for this purpose, but that we should coordinate and share research with these employers. Many large employers already use risk adjustment in multi-choice situations. Also, with good risk adjustment, more employers may move toward offering multiple plans. Small CISNs may have difficulty as a multi-choice offering where the employer does not use risk adjustment.

One member suggested that an alternative to basing inclusion on size of employer might be to consider basing inclusion on the financial underpinnings of the plan-employer relationship (including plans where there was true risk transfer from employer to plan- as in full insurance.) We could determine inclusion in risk adjustment on the basis of the premium tax (premium tax in, no premium tax out). There was not consensus on this as an option.

### **Importance of Closing "Escape Hatches"**

The need to close "escape hatches" as much as possible to avoid the problem of groups gaming the system (coming in when they are high risk, exiting when they are low risk) which would undermine the function of risk adjustment. (associations, Taft-Hartley trusts, government units)

It will be important to clearly define "self-insured" (ie. plans with very low attachment points that are not real self-insurance), and also to clearly define employers (branches, border issues).

The group discussion was summarized along these points:

Our conclusions as to what plans and markets are part of risk adjustment may differ with and without ERISA.

We would like to look at expanding the definition of small group.

The report should address the issue of large employers with multiple choice of plans.

We should attempt to identify and close escape hatches.

### **MedSupp Market**

The panel then discussed a staff proposal that Med Supp plans, which are now under pure community rating, be included in the risk adjustment implementation plan.

Can we include TEFRA risk-contracts? Probably not, we will need to consider the effects of

excluding them.

It may be less important to do risk adjustment in this market because there may not be the high-end exposure in the MedSupp market because of the nature of its relationship to Medicare.

### **Public Programs**

The role of public programs was discussed. Public programs could be included and they could be a separate pool, to avoid having the risk adjustment mechanism serve as a means of subsidizing public programs. There was agreement on the panel for inclusion of public programs as a separate pool.

Having risk adjustment in public programs could allow individuals in public programs to choose among different health plans. The measurement process may need to be different for public programs, but lessons from that pool might be useful for consideration in the overall risk adjustment system.

### **Voluntary or Mandatory**

Participation must be mandatory for all carriers participating in the included markets.

### **Other Business**

Several members who attended gave a brief update on the visit of Alice Rosenblatt, an actuary from Coopers and Lybrand who chairs the American Academy of Actuaries' Task Force on Risk Adjustment. She came to Minnesota at the request of Blue Cross and Blue Shield and met with members of the Expert Panel, staff, and the Commissioners of Health and Commerce. She expressed support for the New York model of targeted risk adjustment, especially as a short term solution while other models are developed.

A report on the progress of Workgroup 3 was given by staff. Workgroup 3: Operational Issues, is discussing some of the legal issues related to the long-term operational structure of the risk adjustment system. They are reviewing models for the Association that focus on a private sector structure, with appropriate oversight by the State.

### **Guiding Principles**

The Panel then reviewed the revised draft of the Guiding Principles. Suggested changes included:

- 1.a. Consider removing the word delivery to be consistent with our focus on the financing side of the system.
- 1.a. delete "all state residents."
- 1.b. change "serve" to provide adequate access to."
- 1.d. Consider removing or rewording so as to be clear that we do not intend to support health plans that are not competing efficiently in the market.
2. adding "risk adjustment will not penalize health plans for verifiable improvements in health status of enrollees."
2. Also, add "controllable" to inefficiencies.
3. change "all insured health plans" to "all health plan companies participating in the covered markets."

Needs to address which markets are included.

Needs to include public programs. Debbie Chase agreed to draft language on inclusion of public programs.

Adding a bullet on the special concerns of the Regulated All-Payer System (RAPO), in light of legislative prohibitions against some management activities which may limit efficiency. Bruce Carleson and Mike Emerson volunteered to draft language for this point.

Staff will revise the guiding principles and fax the new draft to members before the next meeting. The panel requested that for next meeting, staff prepare some quantification of the size of different segments of the market.



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