

Reinsurance
and
Risk Adjustment
Leveling the Playing Field

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Background

What is it and why do we need it?

The 3 Rs

Adverse Selection Protection

- **Reinsurance**
 - Intended to protect health plans operating in individual market from specific high-cost individuals
- **Risk Adjustment**
 - Intended to protect health plans operating in the small group and individual markets (in and out of Exchange) from attracting higher than average health risk
- Risk Corridor
 - Intended to stabilize the market by sharing risk at a time when implementation of reform makes accurate rate setting challenging. Limits the gains and losses of a QHP operating in the Exchange.

3 Rs ~ Market & Administration

	Sold Inside Exchange		Sold Outside Exchange			Who Administers	
	Individual	Small Group	Individual	Small Group	Grand-fathered	State Run HIX	Fed Run HIX
Reinsurance <i>Temporary</i>	Yes	No	Yes	No	No	State or HHS	State or HHS
Risk Adjustment <i>Permanent</i>	Yes	Yes	Yes	Yes	No	State or HHS	HHS
Risk Corridor <i>Temporary</i>	Yes	Yes	No	No	No	HHS	HHS

REINSURANCE

Reinsurance Concepts

- Most health plans carry commercial reinsurance to help pay for large catastrophic claims.
- The Reinsurance Program is NOT intended to replace commercial coverage.
- The Reinsurance Program is intended to help share the cost of mid-range high claims...those outliers that are higher than majority of claims but not yet as high as catastrophic claims covered by commercial reinsurance.
- The Reinsurance Program is intended to ease the way into effective risk adjustment and rate setting methodologies.

Reinsurance Parameters

- **Key Reinsurance Parameters:**
 - **Attachment point** ~ *What size claim triggers reinsurance?*
 - **Maximum coverage level** ~ *What is maximum claim covered by program, after which commercial reinsurance kicks in for catastrophic coverage?*
 - **Coinsurance level** ~ *Does the program pay 100% of claim or just a portion?*
- **EXAMPLES:**
 - Reinsurance covers 60% of claims between \$25,000 and \$50,000, OR
 - Reinsurance covers 80% of claims between \$50,000 and \$100,000

How much money is
available?

What are NM claims like?

Estimated \$ Available to NM Reinsurance

	Nation	NM	NM %
Population	281 million	2.1 million	0.76%
Under Age 65	246 million	1.8 million	0.74%
2014 % in Commercial Insurance	71%	61%	
2014 # in Commercial Insurance	175 million	1.1 million	0.63%
2014 Reinsurance Funding and Contribution Rate	\$10 Billion \$4.76 PMPM	\$63 million	0.63%
2015 Reinsurance Funding and Contribution Rate	\$6 Billion \$2.86 PMPM	\$38 million	0.63%
2016 Reinsurance Funding and Contribution Rate	\$4 Billion \$1.91 PMPM	\$25 million	0.63%

Estimated % of Claims That Can Be Reinsured

	Count	Est. Claims
Current Individual Market	56,000	\$350 PMPM
State High Risk Pool	8,400	\$1,200 PMPM
Federal High Risk Pool	1,100	\$2,800 PMPM
Half of Uninsured	<u>109,600</u>	<u>\$400 PMPM</u>
Total 2014 Individual Market	175,100	\$437 PMPM

Annual Individual Market Claims \$919 Million

2014 Reinsurance as % of Claims **6.9 %**

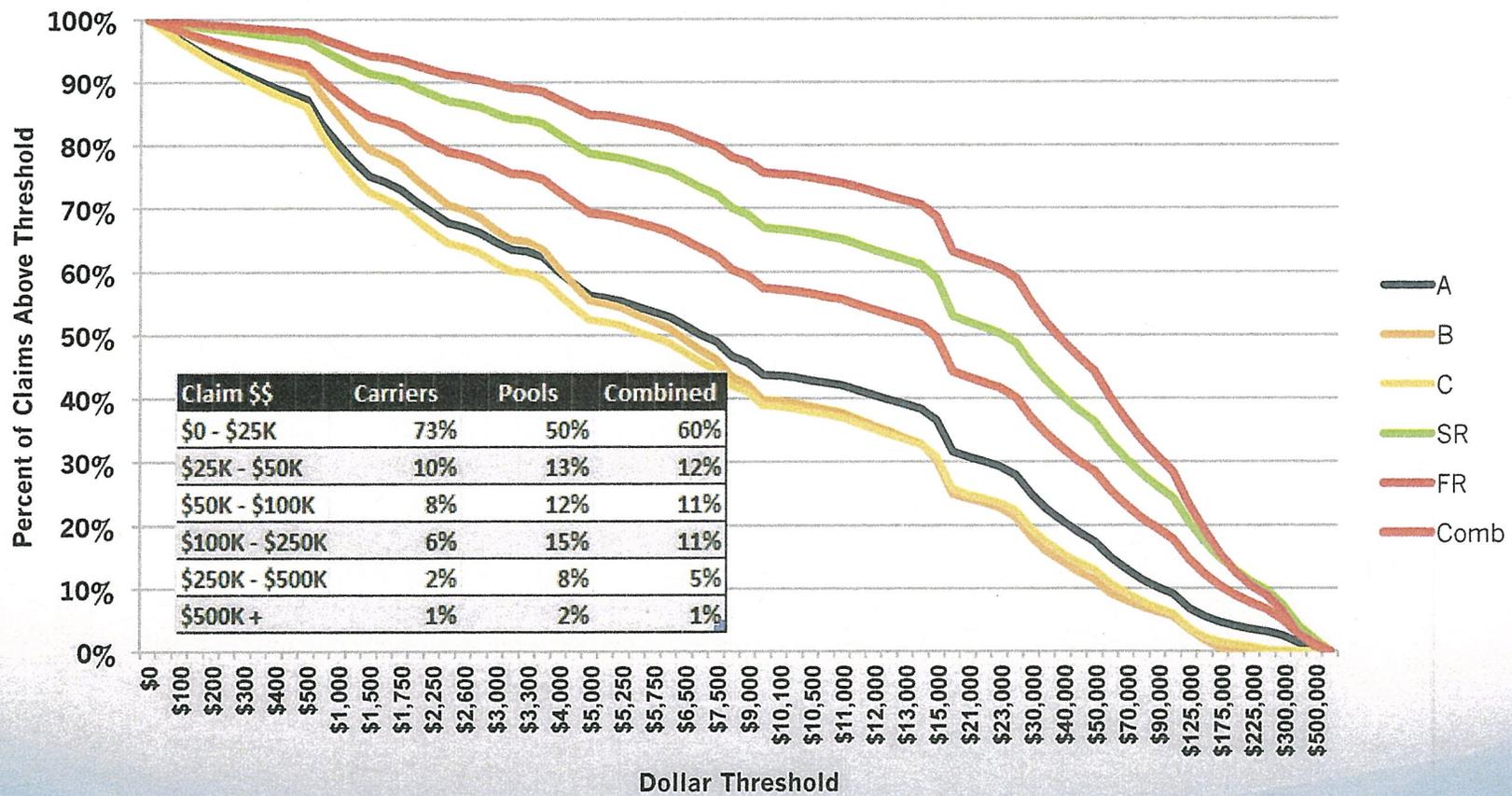
2015 Reinsurance as % of Claims **4.1 %**

2016 Reinsurance as % of Claims **2.8 %**

Claims Distribution Individual Market 2011

Claim \$\$	Carriers	Pools	Combined
\$0 - \$25K	73%	50%	60%
\$25K - \$50K	10%	13%	12%
\$50K - \$100K	8%	12%	11%
\$100K - \$250K	6%	15%	11%
\$250K - \$500K	2%	8%	5%
\$500K +	1%	2%	1%

Individual Market Claims Distribution



Reinsurance Program

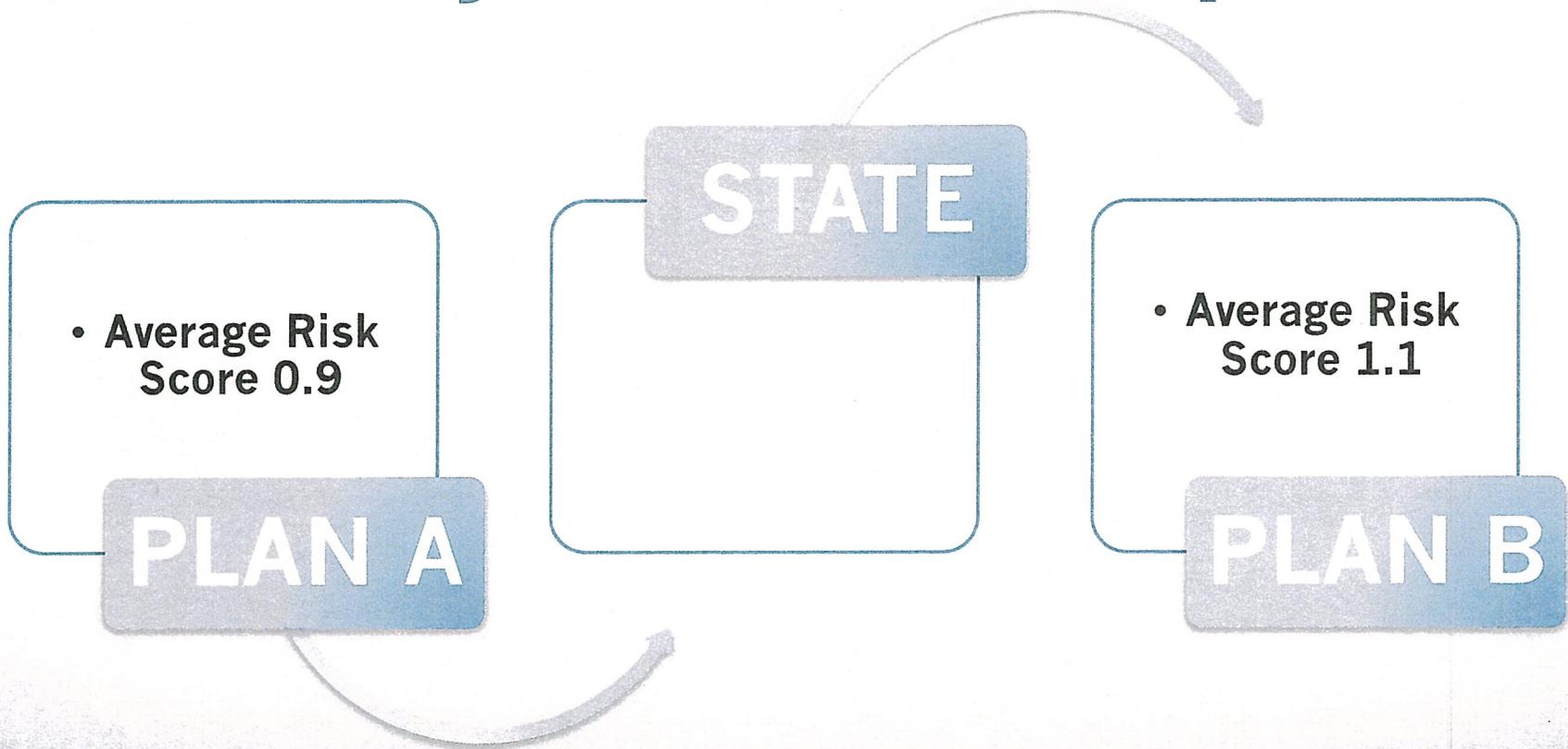
- **Temporary program** ~ 2014, 2015 and 2016
- **Individual market only** ~ Inside & Outside Exchange
- **State MAY operate** ~ Even if Feds operate Exchange
- **State MAY use Federal reinsurance parameters or develop its own**
- **All health insurers and TPAs must financially contribute**
- **Contribution rate will be set uniformly on national basis at a PMPM rate** ~ All insurers/TPAs contribute same rate
- **State MAY increase the contribution rate** ~ can't decrease

Decision Points

- **Outstanding Questions:**
 - Federal Contribution Rate – Will it be enough for NM?
 - Federal Parameters – Will it make sense for NM based on our claims distribution?
 - Federal Payment Methodology – How will equity be assured for claims filed late in the year?
- **Recommendation:**
 - New Mexico should operate its own Reinsurance program to allow for flexibility in setting contribution rate, parameters and payment methodology.

RISK ADJUSTMENT

Risk Adjustment Simplified



Avg. Premium Rate = \$500 PMPM

Plan A pays Plan B \$50 PMPM

What is Risk Adjustment? (At Member Level)

Example 1: John Smith, 32, has the following medical history:

Risk Marker	Risk Weight
Male, Age 32	0.22
Diabetes with significant co-morbidities	1.32
Asthma/COPD	0.96
Low cost dermatology	0.30
Total Risk Score	2.80

If the average risk score is 1.0, John Smith is expected to be 2.8 times more costly than the average enrollee.

Source: American Academy of Actuaries: Issue Brief, "Risk Assessment and Risk Adjustment," 5/2010

Example 2: Mark Johnson, 32, has no medical history:

Risk Marker	Risk Weight
Male, Age 32	0.22
Total Risk Score	0.22

If the average risk score is 1.0, Mark Johnson is expected to be 78% less costly than the average enrollee.

NM Data Collection

- Carriers:
 - BCBSNM, Lovelace, Presbyterian, NMMIP and NMHIA (Molina added later)
- Markets:
 - Alliance, SCI and Commercial (including NMMIP)
- Lines of Business:
 - Individual, Small group (2-50) and “large” small group (51-100)
- Claims from 2010 and 2011
- More than 3 Million member months
- More than \$1.3 Billion in claims
- Demographic, diagnoses and Rx data (added later)

Risk Score Models

	ACG-HIE	CDPS	CMS-HCC	WRA
Developer	Johns Hopkins	University of San Diego	CMS	Wakely
In Use Since	1991	1996	2004	2012
Used For	Medicaid, but new version for Exchanges	Medicaid	Medicare Advantage	Designed for commercial populations
Modeling Inputs	Diagnosis only in HIE version	Diagnosis only, Rx NDC only, or combined	Demographics, diagnoses	Demographics, diagnosis, NDC
User Support	None for HIE version	Limited	Available	Available
Pros	<ul style="list-style-type: none"> •ICD10 compliant •Software updated quarterly •Used in 16 state Medicaid agencies 	<ul style="list-style-type: none"> •Routinely updated •Many states use for Medicaid 	<ul style="list-style-type: none"> •Open code and lookup tables •CMS developed 	<ul style="list-style-type: none"> •Designed for this purpose •Built on CMS-HCC (medical) and CDPS (Rx) •Ease of use
Cons	<ul style="list-style-type: none"> •No user support for HIE version 	<ul style="list-style-type: none"> •Free, but code is written in SAS which isn't free •Based on Medicaid experience 	<ul style="list-style-type: none"> •Uses SAS •Based on Medicare experience 	<ul style="list-style-type: none"> •New, no history of successful use

New Mexico Modeling

- Selected 3 models to try:
 - CPDS – Built on a base Medicaid population
 - HCC – Built on a base Medicare population
 - Wakely – Built on a base Commercial population
- Initially, did not use Rx
- Best “fit” = Wakely Model
- Further refined, adding Rx data, additional diagnoses and included Molina data
- NEXT STEP – Run same data through Federal model when released and compare results and ease of use.

Federal Model Under Development

- HHS developing new model for this use
- It will use demographics (age/gender) and medical claims data ~ not Rx data
- Concurrent model – diagnoses in the current year used to predict expenditures in current year
- Separate model for each metal plan
- Same model for individual and small group plans
- Distributive model ~ carriers will hold data, run through model and report summary results to HHS

Risk Adjustment Program

- **Permanent program** beginning in 2014
- **Individual and Small Group market** sold inside and outside the Exchange
- **State MAY operate ONLY** if operates Exchange
- **State MAY use Federally developed model, develop its own or adopt model certified for another state**
- **Audits** to validate data

Decision Points

- **Federal Model –**
 - Is it a better “fit”/better predictor?
 - Is there flexibility in use of model?
 - Ease of use?
- **IF NEW MEXICO OPERATED –**
 - Federal model or alternate model?
 - Distributive or centralized data collection?
 - Merge individual and small group markets?
 - What entity will provide oversight?
- **Recommendation –**
 - Unless there are substantial differences in “fit” of Federal model, there are no advantages to New Mexico operated.

Questions