Pension & Health Benefits Committee

California Public Employees' Retirement System

Agenda Item 9a

February 20, 2013

ITEM NAME: Health Premium Risk Adjustment – Proposed Methodology

PROGRAM: Health Benefits

ITEM TYPE: Information

EXECUTIVE SUMMARY

This information item provides an overview of the proposed methodology for risk-adjusting 2014 health plan premiums. Risk adjustment is an actuarial tool used to calibrate payments to health plans based on the relative risk of the population.

STRATEGIC PLAN

This item supports California Public Employees' Retirement System (CalPERS) Strategic Goal A: Improve long-term health benefit sustainability by implementing new approaches and expanding efforts already proven to reduce health care costs and improve health outcomes.

BACKGROUND

In January 2012, staff presented to the Board of Administration a list of strategies and initiatives which included risk adjustment. These were presented to the Pension and Health Benefits Committee (PHBC) again in March 2012. The PHBC supported these initiatives and directed staff to move forward with obtaining statutory and regulatory authority.

Staff worked with Assembly Member Furutani, following the Board's direction, and Assembly Bill 2142 was chaptered into law on September 22, 2012. In September 2012, the PHBC approved staff's recommendation to pursue regulations relating to risk adjustment procedures. The final regulations are presented to the Committee for adoption as Item 9b on this Agenda.

CalPERS has been working with actuarial firms on risk adjustment alternatives over the last several years and has procured the services of a third-party actuary to validate and refine the risk adjustment methodology proposed by staff as needed.

The U.S. Health and Human Services Agency (HHS) released several regulations and guidance related to risk adjustment under the Affordable Care Act (ACA) which CalPERS staff has been monitoring:

- January 15, 2013 – Instructions for the Proposed HHS Risk Adjustment Model and Technical Details on the Proposed HHS Risk Adjustment Model

- December 7, 2012 – CMS-9964-P: HHS Benefit and Payment Parameters for 2014, and Medical Loss Ratio
- November 26, 2012 – CMS-9980-P: Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation
- May 1, 2012 – Bulletin on the Risk Adjustment Program: Proposed Operations by the Department of Health and Human Services
- March 23, 2012 – CMS-9975-F: Standards Related to Reinsurance Risk Corridors and Risk Adjustment
- July 15, 2011 – CMS-9975-P: Standards Related to Reinsurance, Risks Corridors and Risk Adjustment

In describing the program, HHS states:

> *Risk adjustment is a permanent program created by the Affordable Care Act. The primary goal of the risk adjustment program is to better spread the financial risk borne by health insurance issuers. This will ensure that premiums remain stable so that issuers will be able to offer a variety of plans to meet the needs of a diverse population. The … program is intended to provide payments to health insurance issuers that attract higher risk populations by transferring funds from plans that enroll the lowest risk individuals to plans that enroll the highest risk individuals. Thus, the risk adjustment program is intended to reduce or eliminate premium differences among plans based solely on favorable or unfavorable risk selection in the individual and small group markets. All non-grandfathered plans in the individual and small group markets are subject to risk adjustment, inside and outside of the Exchange.*
> (Source: http://www.healthcare.gov/news/factsheets/2012/03/risk-adjustment03162012a.html).

On January 15, 2013, staff attended the Assembly Committee on Health's Informational Hearing titled "What Policy Makers Need to Know About Risk Pools and Adverse Selection." The Committee is chaired by Dr. Richard Pan. Presenters included academicians, actuaries, industry experts, and State regulators. Presenters viewed risk adjustment as essential to sustainability of the Exchange.

ANALYSIS

Given a choice of health plans with different premium rates, benefit design, and cost-sharing, members with no health problems are more likely to select the lowest premium plans; and conversely members with serious health problems are more likely to enroll in higher premium plans with lower out-of-pocket maximum plans and broader networks. This is referred to as risk selection and is evident in CalPERS plan enrollments. For example, of the non-association Basic plans, PERSCare has the highest average age of 59 among the plans and the highest premium ($1,030

State single); whereas, PERS Select has the lowest average age of 33 and lowest premium ($463 State single).

This type of risk selection creates the dynamic often referred to as a “death spiral.” As the least healthy members select certain plans and cause premium inadequacy, the plan must raise premiums, causing healthier members to leave the plan. This can also be seen in the CalPERS plans as the least expensive plan, PERS Select increased enrollment at an average annual rate of 62 percent over the last four years, while premiums increased at an average rate of 1 percent. At the same time, the most expensive plan, PERSCare, lost members at an average rate of 20 percent per year while premiums increased at an average rate of 7 percent. This dynamic further degrades the expensive plan population’s health status as a whole, exacerbating the problem and causing premiums to rise to the point that the plan becomes unaffordable.

An environment with multiple carriers and funding arrangements will inherently result in fragmentation of the pool. A high premium plan with lower out-of-pocket costs will attract members who anticipate higher than average health care costs; and a lower premium plan will attract members who expect lower than average health care costs. In this way the risk pool will ultimately always become fragmented into high cost and low cost pools. One measure aimed at mitigating the risk to carriers in the California Exchange is that every carrier is required to offer every metal level (aiming to thereby spread risks among carriers). Still, this measure does not fully mitigate against adverse selection, making risk adjustment essential to the sustainability of the Exchange.

The objective of the CalPERS risk adjustment program is to encourage health plans to compete on the basis of medical and administrative efficiency and quality of care rather than on their ability to attract healthier members. The proposed CalPERS risk adjustment methodology is very similar to the HHS methodology for health benefit exchanges that are being established as a result of ACA. It will use individual diagnosis data and other factors such as geography to assess risk, predict average group costs to account for risks across plans, and then apply a payment transfer formula. Premiums will be risk-adjusted prior to being published and payments to participating plans will be adjusted during the plan year as CalPERS receives updated claims data. To ensure fairness and accuracy, a final reconciliation will be performed in the following plan year when CalPERS receives finalized claims data.

All aspects of the methodology will be transparent to participating plans. Staff recently met with Kaiser to discuss risk adjustment. Kaiser is the only CalPERS carrier not participating in the procurement process for 2014 plans. Staff is considering the input from Kaiser and may refine its methodology accordingly. Staff will continue seeking input from interested parties moving forward. CalPERS

intends to use commercial off-the-shelf software and well established methods, working collaboratively with its health plan partners.

NEXT STEPS

In the next few months, CalPERS will:

- Complete third-party actuarial review of the proposed methodology
- Refine the methodology as appropriate
- Present risk-adjusted rates to the PHBC
- Monitor HHS rules and regulations that pertain to risk adjustment methodologies to ensure consistency to the greatest degree possible.

ATTACHMENT

Health Premium Risk Adjustment – Proposed Methodology

DOUG P. McKEEVER, Chief
Health Policy Research Division

ANN BOYNTON
Deputy Executive Officer
Benefit Programs Policy and Planning