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Risk Adjustment and the ACA

State experiences with risk adjustment – California and others

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Risk Adjustment in Medi-Cal

- Used to normalize differences among plans in two-plan model counties
- Uses a prescription drug-only model
- Applies to Adult & Family, and Aged, Blind & Disabled (ABD)/Medicaid only populations

Risk Adjustment in other California health care programs – Health Insurance Plan of California

- Implemented in the mid-1990s to provide an option for group purchasing for small employers
- Developed one of the first operational risk assessment / risk adjustment processes
- Used a primary diagnosis approach, with relatively low quality data that were available at the time
- Program remained operational for approximately 10 years
- Effectively transferred funds from low risk to high risk plans, but was ultimately insufficient to address all risk differences
- Many plans felt their data were inadequate to correctly measure their risk

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Slide 3

Risk Adjustment in other California health care programs – Pacific Business Group on Health

- Examined a wide range of risk assessment / risk adjustment options
- Used demographic adjustment to normalize risk
- Structure of the purchasing pool limited the range of risk adjustment that could be applied, but provided early lessons on group purchasing arrangements

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Risk Adjustment in Other Medicaid Programs

- Numerous Medicaid programs use risk assessment / risk adjustment to determine health plan payments
- Typically use the CDPS model, but some states use ACGs or DxCG models, with a variety of approaches:
 - Medical only model
 - Medical plus drug model
 - Drug only model (similar to California)
 - Concurrent model in some states, prospective in others
 - State specific weights in some, national model in others
 - Typically apply to all eligibility categories for which there are sufficient data (Adults & Families, ABD, Medicaid only)
- Special models are often developed for Long Term Care programs that measure functional status in addition to health status

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Risk Adjustment in Medicaid programs – Lessons learned

- Risk adjustment works – high risk plans tend to remain high risk, and low risk plans tend to remain low risk
- Health plans are able to report the data needed to apply the model, and they are able to understand how it works, although it can take some time for new plans to understand the details
- Health plans often need to invest in technology to ensure their reporting is comparable to that of other plans
- The data used for risk adjustment quickly becomes useful for monitoring the health status of enrollees and encouraging plans to better manage care
- No state that has implemented risk adjustment has stopped doing so, although models have been refined over time

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Discussion

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