

Beyond Age Rating: Spreading Risk in Health Insurance Markets

Age rating health insurance premiums—currently a key issue in the health reform debate—forces older people to pay more regardless of their health status. This paper demonstrates that alternative mechanisms to offset risk—such as risk adjustment and risk sharing—can be used to equitably compensate plans, ensure people access to a choice of plans, and encourage insurance plans to manage costs-efficiently.

A key issue facing policymakers involved in health care reform is how much insurance premiums should be allowed to vary between the youngest and oldest enrollees in a plan—a policy known as age rating. Several congressional drafts have proposed limiting age-dependent differences in premiums by a ratio of 2:1. Further, plans would not be able to exclude anyone from coverage or charge more to people with existing health conditions. Given these rules, how can we protect health plans and the people who enroll in them from the effects of selection?

In this paper we present several alternatives to age rating premiums as a means of linking payments with expected costs. We first review the purpose and limitations of age rating. We then discuss risk adjustment and risk sharing, two additional ways of tying payments to expected costs. We examine the use of these tools in three settings: the Medicare Advantage program, Medicare Part D, and the Dutch health system.

When an individual is insured through an employer, the price paid is typically tied to the average expected health care spending across all individuals in the group (community rating). In the case of

individually purchased health insurance, however, the price is often adjusted based on the individual's age, gender, health status, or other factors that are known to affect the expected amount of health care spending for the person. In many states, people with some health conditions cannot buy coverage at all. While varying individual insurance premiums based on factors related to spending might seem fair, it often results in premiums that are too expensive for older or sicker people to buy. Only the young and healthy can afford premiums, leaving many vulnerable individuals without health insurance.

Age-Rated Premiums Are Expensive for Older Individuals

Age rating of premiums is one method of tying the amount an insurer receives from (or on behalf of) an individual to the expected cost of providing care to that person. In age rating, an insurer estimates the expected health care spending for all individuals within a given age group (e.g., 25–34, 35–44, 45–54, 55–64) and then varies premiums for individuals across groups to account for the differences. In contrast, a “community-rated premium” is the same

for everyone, regardless of age. AARP favors community-rated premiums for health insurance, but recognizes that health reform proposals are likely to include at least some age rating.

Regulations may limit the amount of variation insurers apply to their premiums. For example, some states restrict age-related premium variation to a 5:1 ratio, meaning that the premium an individual in the oldest age group pays may not be more than five times the premium someone in the youngest age group pays. Other states restrict the age ratio to 2:1, which means there is less

variation in premiums between the highest and lowest cost groups, or they require community-rated premiums.

The main benefit of age-rated premiums for consumers is that they reduce the cost of insurance for those in the lowest cost band. In the absence of age-rated premiums, the youngest and healthiest individuals would likely find the cost of a plan too high, given their expected use of services, possibly leading them to forgo health insurance.

There are several downsides to age-rated premiums. First, age rating alone does a

Three important “risk”-related concepts:

Risk selection is the disproportionate enrollment of individuals based on their expected use of health care services. Favorable selection occurs when low-risk people make up a larger share of enrollees in a plan, while adverse selection means that high-risk people make up a larger share. Risk selection can occur by chance or by design. Examples of structures or practices that encourage selection include offering benefits that appeal to healthy people, such as gym membership; developing cost-sharing structures, such as high coinsurance for hospital care, that would likely deter enrollment among people likely to require hospitalization; or pursuing marketing practices, such as marketing in senior centers where participants are likely to be active and therefore healthier. Plans that enjoy favorable selection can charge lower premiums, enabling them to attract more enrollees.

Risk adjustment refers to the process of adjusting payments (higher or lower) to insurers or providers to account for differences in expected costs of individual enrollees. Risk adjustment is an important component of capitated payment (an amount paid for each enrollee regardless of resource use) or any payment system that requires prospective payment for individuals based on expected resource use rather than on actual use. Depending on the variables used, risk-adjusted payment can account for larger or smaller proportions of the variation in premiums. For example, risk adjustment that just uses demographic variables, such as age and sex, as an indicator of expected costs accounts for a small part of expected variation, whereas risk adjustment that uses enrollee health status, pharmaceutical experience, previous hospitalization, or other historical cost data to adjust payments accounts for a larger portion of expected variation.

Risk sharing involves paying insurers at least in part on the basis of their actual expenditures on behalf of patients. The purpose of risk sharing is to limit an insurer’s exposure (and therefore its incentive for risk selection or to stint on care), while leaving it some risk so that it still has an incentive to be as efficient as possible. Risk sharing can combine with risk adjustment or can occur on its own. For example, payments can be risk adjusted so that insurers receive capitation payments based on members’ expected health costs; in addition, any losses due to higher than expected actual costs can be shared.

poor job of linking premiums with expected costs. While average spending on health care increases with age, spending is highly dependent on health status for all age groups. Second, age-rated premiums push the costs of insurance disproportionately onto the oldest individuals in the market. Health insurance may become unaffordable for many such individuals, leaving them uninsured. When age-rating ratios are high, such as 5:1, and insurance is very expensive for older individuals, significant subsidies are required to make it more affordable. At a 2:1 premium ratio, insurance is relatively more expensive for younger individuals, requiring a disproportionate share of subsidies for that group. However, a 2009 report by Linda Blumberg and colleagues at the Urban Institute found that “affordability concerns are substantially more pronounced for the older age group.” The analysis found that under 5:1 age rating, half of single adults ages 55–64 with incomes between 400 and 500 percent of the federal poverty level would spend at least 21.6 percent of income on health care.¹

Income data show that older individuals are not necessarily better able to afford health insurance than younger people. As table 1 illustrates, while average family income for individuals ages 50–64 is higher than for any other group, income for uninsured individuals is only marginally greater for the oldest group

| Ages | Total Population | | Uninsured Population | |
|-------|------------------|----------|----------------------|----------|
| | (Mean) | (Median) | (Mean) | (Median) |
| 18–24 | \$65,878 | \$45,000 | \$41,469 | \$28,461 |
| 25–34 | 62,915 | 49,698 | 40,026 | 28,000 |
| 35–49 | 81,846 | 64,545 | 42,884 | 31,200 |
| 50–64 | 83,015 | 63,906 | 44,641 | 30,000 |

Source: AARP Public Policy Institute analysis of March 2008 Current Population Survey.

than for the youngest group. As the table shows, significantly higher health insurance premiums that result from age rating may put a greater premium burden on older uninsured adults.

Other Ways to Spread Risk

In addition to age rating, two other methods—risk adjusted premiums and risk sharing—protect insurers or providers from the potential costs of enrolling large numbers of older or sicker people while keeping premium variations to a minimum. Whatever the method, any mechanism needs to strike a balance between limiting the risk insurers face from enrolling potentially high-cost individuals with maintaining strong incentives to manage costs efficiently.

Risk adjustment and risk sharing are compatible with age rating; they are not mutually exclusive. Regulators could use either method alone or in combination to help balance the need to keep premiums affordable for beneficiaries, to encourage the young and healthy to buy insurance, and to reduce the risk to insurers who enroll potentially high-cost patients.

As used in health care, risk adjustment differs from age rating in several important ways:

1. Age rating uses only one variable (age), while risk adjustment usually uses multiple variables.
2. Age rating typically applies to premiums that individual enrollees pay, while risk adjustment is usually applied to payments made by a purchaser such as the government, employer, or other third party.² Age rating therefore applies to all individuals who qualify for enrollment in a plan, while risk-adjusted payments apply only to enrollees on

whose behalf a third party makes payments directly to insurers.

3. The main purpose of age rating is to reduce the cost of coverage for younger or healthier individuals, thereby making them more likely to opt for coverage. In contrast, risk adjustment reduces the risk to insurance plans of enrolling higher cost individuals. It also recognizes differences in the cost of treating patients arising from health status and other factors. Risk adjustment can also play a role in quality measurement.

Risk Adjustment Discourages Risk Selection

Risk adjustment can be an especially useful tool in health care reform because it eliminates windfalls to plans from enrolling healthier members, so it puts the focus of competition on efficiency and quality. The government could risk adjust the payments it makes on behalf of individuals to individuals.

Risk adjustment means modifying the average payment to reflect the expected differences in costs of individuals. To estimate the expected costs, actuaries analyze data on health care spending and utilization to determine how demographic characteristics, health status factors such as chronic conditions or previous health care use, and other factors change the cost of insuring one individual compared with an “average” individual in the group. Payments are then adjusted up or down to reflect the different expected costs each individual will incur. It is important to note that risk adjustment can be used only to the extent that a third party makes payments to insurers (or providers) on behalf of individuals. If there are no third-party payments, there is nothing to adjust.

The main benefit of risk adjustment is that it reduces incentives for insurers to

keep potentially high-cost patients from enrolling (risk selection). In the absence of risk adjustment, an insurer receives the same amount for each individual regardless of expected cost, and therefore the insurer has a strong incentive to keep high-cost patients from enrolling. Such patients might have a hard time finding a plan in which to enroll, or might find it difficult to access needed services once enrolled. By adjusting payment—increasing it for enrollees with high expected costs and decreasing it for enrollees with low expected costs—we can reduce incentives for risk selection and avoid penalizing plans for taking care of sicker patients.

Good data are the key to developing good risk adjustment models. These data are necessary for building a model that accurately predicts how costs change with variations in demographic and health status factors, and for implementing a risk-adjusted payment system. Data for model development should do the following:

- Mirror as closely as possible the population likely to enroll in the insurance plan. The individuals included in the analysis must have similar demographic and health characteristics to the enrolled population.
- Include details about individuals’ health care spending and utilization, such as prescription drug use, inpatient hospital use, outpatient clinician interactions, and clinical diagnoses.
- Be readily available. The model should use data that can be readily identified for enrollees, either through questionnaires or on the basis of past utilization. Because the data used to build the risk adjustment model will be the same data used to

implement the model, data availability across the two must be consistent.

An ideal risk adjustment model appropriately identifies patients who are likely to incur higher or lower costs and calculates adjustments to recognize those costs. This negates the incentive for insurers to try to keep high-cost patients out of the plan or push them out once they begin to incur higher costs. At the same time, the payment system should retain some element of risk to the insurer so that it has an incentive to provide care as efficiently as possible—managing utilization, negotiating for lower prices with providers, and coordinating care for patients, especially those with chronic illness.

Risk adjustment models rarely perfectly match actual costs to the plan because it is impossible to determine beforehand exactly which patients will incur high costs and exactly which factors are important for predicting costs. Economists note that, to work well, risk adjustment models need to do well enough at adjusting costs for those enrollees that an insurer would otherwise select against, or explain at least 20 to 25 percent of spending variation.³

The purpose of risk adjustment is not to determine exactly how much an insurer needs to get paid for a given enrollee, but to set the *relative* rate of payment for one enrollee vs. another. It is the relative payment amount that determines whether an insurer will want to select against certain individuals. Of course, if average payment amounts across all enrollees are too low, the insurer may decide not to participate in the market at all.

Risk Sharing Helps Protect Insurers from Large Losses

Risk sharing works at the back end of the payment process and includes

various ways that multiple insurers share a pool of funds to compensate for unexpected gains and losses. Basing some portion of payment on actual rather than expected utilization further limits the risk insurers face, thereby reducing their incentives to select against potentially costly individuals and withhold care from those who need it.⁴

Risk sharing can combine with risk adjustment as a back-up strategy for an imperfect risk adjustment model, or it can work on its own. When not used with risk adjustment, risk sharing may shift large amounts of money among plans, since initial payments are less likely to track with actual costs.

Reinsurance

Reinsurance works by having a third party accept responsibility for a portion of spending above a specified threshold. For example, the government might reimburse 90 percent of spending for individuals who incur costs that are more than 200 percent above average. By not reimbursing 100 percent of costs, this method still gives insurers an incentive to manage costs efficiently. The government can be a reinsurer at no cost to plans, or the insurer might purchase a reinsurance plan on the private market to protect itself from potentially high costs.

Reinsurance mechanisms can operate in several different ways. One way is to have insurers identify beforehand which enrollees they want to place in the reinsurance pool and recoup high costs. The other method does not place individuals in the pool beforehand, but reimburses some costs for anyone whose spending exceeds the threshold. This guarantees that insurers will not be fully liable for very high cost enrollees, but it increases the uncertainty for the government, which has to pay the excess costs. Or the insurer could identify an aggregate amount of total spending above which the reinsurer would pay a

predetermined proportion—catastrophic stop-loss.

Reinsurance lets insurers buy protection against high costs from high-cost enrollees. This should help to reduce risk selection problems. But insurers may still face very high, unexpected costs for some enrollees if such enrollees are not placed in the reinsurance pool at the start of the year or if insurers do not otherwise purchase adequate reinsurance coverage. In addition, reinsurance does not completely address the problem of risk selection since it still leaves insurers liable for any unexpected costs for most enrollees. Finally, it reduces somewhat incentives for plans to manage enrollee costs.⁵

Risk Equalization

Where reinsurance typically affects just a small proportion of enrollees, risk equalization calculates the actual costs for *all* individuals covered by participating plans and awards additional payments to plans that had higher than expected costs. Risk equalization kicks in after risk adjustment payments are reconciled against actual spending for an entire year. Plans that have much lower than expected costs might be required to pay an amount back to the central pool.

As with reinsurance, the additional payments should not cover 100 percent of a plan's higher costs, but only those costs associated with unexpected utilization. Higher costs due to a plan's failure to manage efficiently should not be reimbursed. The proportion of risk reimbursed can be adjusted over time. In the early days of a risk-sharing system, the government could reimburse a higher percentage of losses as risk adjustment models are refined and plans gain experience in managing costs. Over time, the percentage of losses reimbursed can be reduced, leaving the insurers with greater incentives for cost control.

Risk equalization can work in various ways. Under a system of risk corridors, the government might reimburse plans when overall costs are much higher than expected (and, as in Medicare Part D, share in profits when costs are significantly lower than expected; see below). Alternatively, insurers might be reimbursed for a portion of total higher than expected costs, as in the Netherlands (see below).

Risk Adjustment and Risk Sharing Already at Work in Medicare

The Medicare Advantage (MA) program and the Part D prescription drug program each use risk adjustment and risk sharing as part of their payment systems. Both programs feature community-rated premiums: premiums charged beneficiaries do not vary by age, health status, or where a person lives. In the MA program, risk adjustment is a central part of Medicare's payment to insurers. In the Part D program, monthly payments are risk adjusted based on expected use, while risk sharing, based on risk corridors, operates at the back end of the payment system.

Medicare Advantage

Prior to 2000, the Medicare+Choice (now Medicare Advantage) program adjusted per-beneficiary payments to plans based on demographic characteristics alone. Since 2000, the risk adjustment model has incorporated increasingly sophisticated measures of enrollees' health status, using diagnoses from inpatient hospitalizations (2004) as well as outpatient and physician office settings (2007).⁶ These factors, together with demographic variables, combine to create hierarchical condition categories (CMS-HCCs) that determine the amount Medicare pays a health plan for a given enrollee, based on the enrollee's relative risk for expected spending.

Each Medicare Advantage enrollee receives a CMS-HCC score based on the following:

- Age
- Sex
- Working age status
- Disabled status
- Medicaid status
- Diagnosis

The diagnosis factor comes from the diagnosis recorded when the member used care in inpatient and outpatient hospital settings and during clinical office visits.

How well does the MA risk adjustment model predict actual costs? Assessing how well risk adjustment models work requires addressing two separate questions: (1) How much variation in cost does the model explain? (2) How accurately does the model predict costs for specific groups? The first question is important for understanding the overall level of uncertainty that plans will face under risk-adjusted payment. The second question is crucial for identifying where incentives for risk selection remain after risk-adjusted payments are applied. In some cases, a model may do a good job of estimating variation overall, but a poor job of predicting costs for specific groups, leaving them vulnerable to selection.

One analysis found that the CMS-HCC risk adjustment model explained 11.2 percent of the variation in costs for MA participants, compared with 6.2 percent for the previous model, and just 1 percent of variation for a model that included demographic variables alone.⁷

The Medicare Payment Advisory Commission (MedPAC) uses the “predictive ratio” to measure how well a risk adjustment model works in predicting costs for different groups of enrollees. The predictive ratio for a group of enrollees is

the group’s mean costliness predicted by a risk adjuster divided by the mean of the group’s actual costliness. A ratio of 1.0 would indicate the model perfectly predicts actual costs. A ratio greater than 1.0 means the model predicts greater than actual costs, while a ratio of less than 1.0 means the model underpredicts actual costs. In a 2005 analysis that compared the predictive ratio for various groups of beneficiaries under the current CMS-HCC risk adjustment model with that of an older demographic model, MedPAC found that the CMS-HCC model did a better job for every defined group. However, as MedPAC noted and table 2 shows, the CMS-HCC risk adjustment model “leaves room for improvement.”⁸

Table 2
Predictive Ratios for Medicare Advantage Risk Adjustment in 2002

| Beneficiary Group | CMS-HCC Predictive Ratio |
|--|--------------------------|
| Quintile of Costliness in 2001 | |
| Lowest | 1.34 |
| Second | 1.30 |
| Third | 1.19 |
| Fourth | 0.98 |
| Highest | 0.83 |
| Number of Inpatient Stays in 2001 | |
| 0 | 1.07 |
| 1 | 0.96 |
| 2 | 0.92 |
| 3 or more | 0.80 |
| Conditions Diagnosed in 2001 | |
| Alcohol/drug dependence | 0.99 |
| Diabetes with complications | 0.99 |
| Diabetes without complications | 0.99 |
| Congestive heart failure | 0.90 |
| Acute myocardial infarction | 0.98 |
| Chronic obstructive pulmonary disease | 0.93 |
| Unspecified stroke | 1.03 |
| Cerebral hemorrhage | 1.09 |
| Hip fracture | 1.08 |

Source: MedPAC, “Medicare Advantage Payment Areas and Risk Adjustment,” in *Report to the Congress: Issues in a Modernized Medicare Program* (Washington, DC: Medicare Payment Advisory Commission, 2005).

In 2007 the Centers for Medicare & Medicaid Services (CMS) introduced further improvements to the model, which should help to move the predictive ratios closer to 1.0.

Nonetheless, these results show that even with increasingly sophisticated risk adjustment, insurers face substantial risk for some groups. Additional forms of risk sharing may be useful for limiting risk and the incentives to exclude costly enrollees.

Data collection and reporting burden have been a key point of contention for MA plans. In the late 1990s and 2000s, many managed care organizations left the program (then called Medicare+Choice), citing data reporting burden as one reason. CMS reduced data collection requirements, which in turn required efforts to build a risk adjustment model that used a limited set of data points while still doing an acceptable job of identifying risk.⁹ (This is consistent with the principle that risk adjustment models should be feasible, as noted above.)

Part D

Risk adjustment and both forms of risk sharing are key elements of the Medicare Part D prescription drug program. The risk adjustment model uses enrollee age, sex, disabled status, and diagnoses to construct the prescription drug hierarchical condition category, or RxHCC, which serves as the basis for the government's premium contribution. Low-income status and long-term care institution status also affect the government's contribution.¹⁰ Enrollees also pay a community-rated premium directly to the plan. Risk adjustment is based on the previous year's utilization experience and applies to all payments in the subsequent year.

A recent study found that the Part D risk adjustment model explains about 12 percent of the variation in drug spending for enrollees.¹¹ The study also found that adding information about

previous prescription drug costs would greatly enhance the model, increasing the proportion of variance explained to 39 percent. When the Part D benefit first began, information on beneficiaries' past drug costs was unavailable, but now that the program is under way, CMS could incorporate that information into the risk adjustment model. However, it should be noted that including previous drug spending in the model significantly weakens incentives for price competition and efficiency.¹² Plans that keep administrative costs low will receive lower risk-adjusted payments in future years, while plans with higher administrative costs will receive higher risk-adjusted payments.

Once a plan year has closed, plans' actual costs are compared with payments and adjustments are made. A reinsurance provision reimburses plans for 80 percent of spending above the catastrophic threshold (\$6,154 in 2009¹³). The Part D reinsurance program does not require plans to assign individuals to the reinsurance pool at the start of the year; reinsurance payments cover all enrollees with spending above the catastrophic threshold.

Medicare also uses a form of risk equalization called risk corridors to limit drug plans' overall gains and losses. Under these risk corridors, Medicare reimburses plans for a portion of the difference between actual costs and expected costs, which are based on the bids plans submit to participate in the Part D program. When the drug benefit began in 2006, Medicare reimbursed losses (and recouped gains) that exceeded 2.5 percent of a plan's expected costs.¹⁴ The corridor has widened over time. In 2009, plans are responsible for the first 5 percent of losses and reimbursed at 50 percent of excess costs between 5 and 10 percent. CMS has authority to further expand the risk corridors over time, making plans increasingly responsible for managing those costs.

The Dutch Experience with Risk Adjustment and Risk Sharing

The Netherlands is at the forefront of using risk adjustment and risk sharing as the basis of subsidizing health insurance for its citizens. A risk adjustment payment methodology is combined with retrospective risk sharing to limit insurers' exposure due to higher than expected costs. The risk sharing includes both reinsurance and risk equalization.

The Dutch finance health insurance subsidies through an income tax. All individuals are required to pay a tax equal to 7.2 percent of income (up to a capped maximum), which goes into a Risk Equalization Fund. From the fund, the government pays the risk-adjusted premium amount to insurers on behalf of individuals and makes the year-end risk sharing payments. In addition, individuals pay a community-rated premium (which varies by plan) directly to the insurer. By law, the tax is set to cover 50 percent of the average basic premium amount.¹⁵

The Dutch risk adjustment model has grown more sophisticated over time. Prior to 2002, payments were based on age, sex, socioeconomic status, and disability indicators. In 2002 an adjustment based on Pharmacy-based Cost Groups (PCGs) was added, and in 2004 two new factors were added: Diagnostic Cost Groups (DCGs) and self-employment status. Additional factors such as DCGs based on outpatient care, mental health status, and multiyear inpatient experience groupings are on the horizon.¹⁶

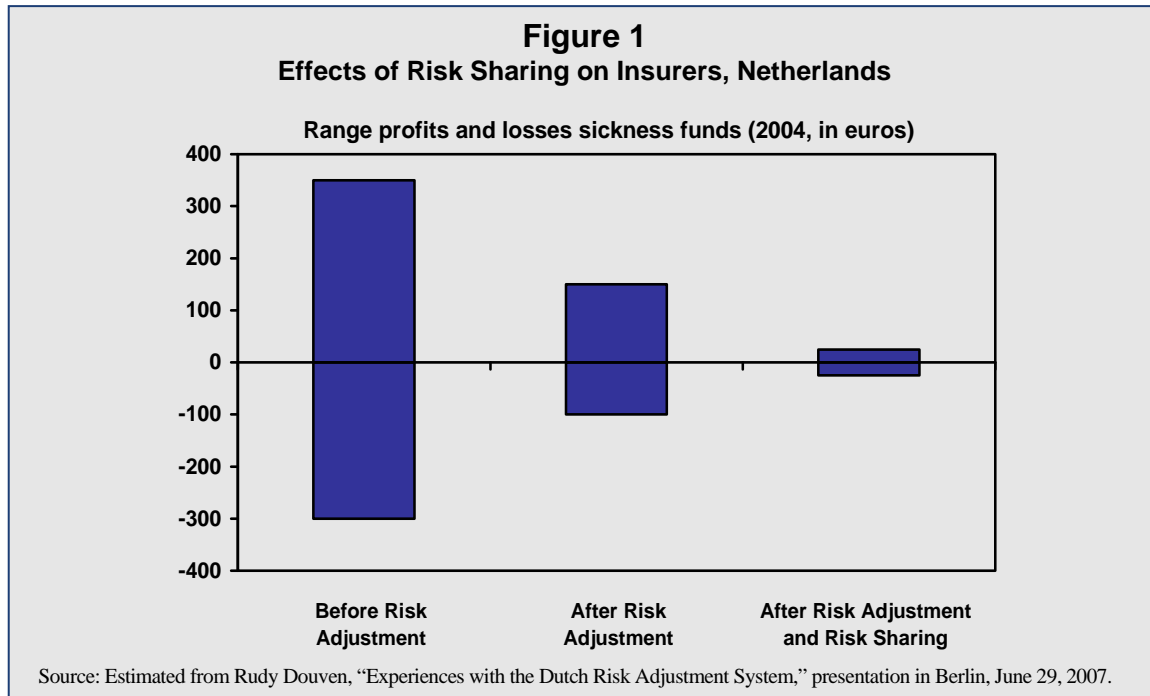
The addition of PCGs and DCGs has greatly improved the accuracy of the risk adjustment model. In a simulation of the Dutch risk adjustment models before and after the incorporation of information on prescription drug use and hospital utilization, van de Ven and colleagues found that PCGs and DCGs nearly tripled the predictive power of the model (measured by the model's R^2 value). At the same time, the application of the refined adjustment reduced the predictable losses for people with the highest expenses by more than 50 percent (compared with the demographic model).¹⁷

In addition to risk-adjusted prospective payments, the Dutch use several types of retrospective risk-sharing mechanisms. First, a year-end reconciliation process occurs to account for any changes in an insurer's population throughout the year. As a result, insurers may receive additional risk-adjusted payments from the fund or may be required to reimburse money to the fund.

In a second phase of risk sharing, reinsurance compensates health plans for individuals who incur very high costs. Insurers are paid 90 percent of costs for individuals who exceed a threshold level of spending.

In the third and final phase of retrospective risk sharing, the fund reimburses insurers a portion (35 percent in 2008) of the difference between actual and expected costs. As risk adjustment becomes more sophisticated, Dutch regulators expect to increase the portion of any difference for which insurers are responsible.

Figure 1 shows the impact on insurers' profits and losses that result from risk adjustment and risk sharing in the Dutch health insurance market. As the figure shows, in the absence of risk adjustment, insurers have the potential to earn large profits by enrolling only relatively healthy individuals, while facing the prospect of large losses if they enroll higher cost people. Risk-adjusted subsidies greatly reduce the risk as well as the potential for significant profits. Risk sharing again reduces both risk and profit opportunity.



Risk Adjustment and Risk Sharing in Health Reform

As this paper has described, several different approaches are available to policymakers for adjusting the amounts insurers receive for beneficiaries with different spending needs. Age-rated premiums are one approach receiving attention in the current health reform debate, but not the only, or even the best, option. In the health reform debate, policymakers are deciding how much age rating to allow, who will be eligible for subsidies to help pay for insurance, and how the amount of subsidy will be determined.

In the absence of subsidies, age rating may offer the easiest way to account for expected health differences. Proposals currently under consideration include age-rating provisions that have premium ratios ranging from 4:1 in a Senate Finance Committee bill¹⁸ to 2:1 in the Senate Health, Education, Labor, and Pension Committee bill (S. 1679)¹⁹ and the House Tri-Committee bill (H.R. 3200).²⁰ Older individuals will likely find it difficult to

afford premiums for policies with 4:1 age-rated premiums. At the same time, without being able to age-rate premiums, insurance plans will have a strong incentive to limit enrollment of older individuals.

Subsidies for individuals with income up to 300 or 400 percent of poverty, as House and Senate committees are proposing, would help make policies more affordable for all. The way the subsidy amounts are determined will be key. Subsidies that are set at the average premium cost for all enrollees, regardless of age, would mean that older enrollees are left with higher out-of-pocket premium costs than younger enrollees. Subsidy amounts that recognize and adjust for age rating would help compensate for the higher premiums charged to older people.

Subsidies also offer the means for regulators to deliver risk adjustment and risk sharing to insurers. For individuals who would qualify for subsidies, risk adjustment and risk sharing will offer a valuable means of promoting affordability and open access. For plans that will receive payments on behalf of

subsidy-eligible enrollees, these risk tools will encourage competition based on providing the best value rather than enrolling the healthiest people.

Risk-adjusting government payments to insurers on behalf of individuals, much as the Medicare Advantage and Part D programs do now, would address both affordability and risk selection. It would reduce the need for age-rated premiums, and it would allow the government to adjust payments based on the many factors that affect higher costs, including demographic variables, health status, and prior health care utilization. Insurers would have fewer incentives to limit enrollment, resulting in greater competition for members on the basis of price, quality, and benefits rather than expected health care costs.

While the experience of the Medicare program in using risk adjustment will be helpful, policymakers are likely to need some time to develop and refine a robust risk adjustment model for the under-65 population, in particular to gather the needed data. In the meantime, risk sharing among the private plans that participate in a new insurance marketplace (or exchange) offers another way to reduce the burden on individual premiums, while limiting risk for insurers. Early on, a risk-sharing program should set a relatively low threshold for the amount of losses that will be reimbursed (partially or fully), by either a public or private reinsurance mechanism. Over time, as the risk adjustment model improves, regulators should raise the threshold for reimbursing losses in order to maintain incentives for efficiency and care management.

¹ Linda J. Blumberg, Matthew Buettgens, and Bowen Garrett, *Age Rating Under Comprehensive Health Care Reform: Implications for Coverage, Costs, and Household Financial Burden* (Washington, DC: The Urban Institute, 2009).

² Other forms of insurance, particularly life insurance, use risk adjustment to set individual premiums based on factors such as age, gender, chronic conditions, and behaviors. Within the Medicare program, variations of risk adjustment also apply to payments to some providers, including hospitals, skilled nursing facilities, and home health agencies. Risk-based variations in payment to these providers are referred to as case mix adjustments, and are not the topic of this paper. For a more complete discussion of case mix adjustment in Medicare, see Gerald F. Kominski, *Medicare's Use of Risk Adjustment* (Washington, DC: National Health Policy Forum, 2007).

³ Joseph P. Newhouse, Melinda Beeuwkes-Buntin, and John D. Chapman, "Risk Adjustment and Medicare: Taking a Closer Look," *Health Affairs* 16, no. 5 (1997): 26–43

⁴ —Ibid.

⁵ —Ibid.

⁶ Kominski, *Medicare's Use of Risk Adjustment*.

⁷ Gregory C. Pope, John Kautter, Randall P. Ellis, et al., "Risk Adjustment of Medicare Capitation Payments Using the CMS-HSS Model," *Health Care Financing Review* 25, no. 4 (2004): 119–141.

⁸ MedPAC, "Medicare Advantage Payment Areas and Risk Adjustment," in *Report to the Congress: Issues in a Modernized Medicare Program* (Washington, DC: Medicare Payment Advisory Commission, 2005).

⁹ Pope, Kautter, Ellis, et al., "Risk Adjustment of Medicare Capitation Payments Using the CMS-HSS Model."

¹⁰ MedPAC, *Part D Payment System* (Washington, DC: Medicare Payment Advisory Commission, 2008).

¹¹ John Hsu et al., "Distributing \$800 Billion: An Early Assessment of Medicare Part D Risk Adjustment," *Health Affairs* 28, no. 1 (2009): 215–225.

¹² NORC at the University of Chicago, "Continuation of Drug Risk Adjustment Final Report," 2006, <http://aspe.hhs.gov/health/reports/06/drugcontinuation/report.pdf> (accessed July 9, 2009).

¹³ AARP Public Policy Institute, *Closing a Gap in Medicare Drug Coverage: How to Help Millions of Beneficiaries Afford Needed Medication* (Washington, DC: AARP, 2009).

¹⁴ In 2006, Medicare reimbursed (or recouped) 75 percent of losses (gains) between 2.5 and

5 percent of expected costs. For costs (profits) that exceeded 5 percent of expected, Medicare reimbursed (recouped) 80 percent. Kip Piper, "Medicare Drug Plans and Risk Mitigation: Risk Corridors, Risk Adjustment, and Federal Reinsurance," 2006, http://www.piperreport.com/archives/2006/04/risk_mitigation.html (accessed July 8, 2009).

¹⁵ Ministry of Health, Welfare, and Sport, *Risk Adjustment Under the Health Insurance Act in the Netherlands* (The Hague: Netherlands Ministry of Health, Welfare, and Sport, 2008).

¹⁶ Wynand P.M.M. van de Ven and Frederik T. Schut, "Universal Mandatory Health Insurance in the Netherlands: A Model for the United States?" *Health Affairs* 27, no. 3 (2008): 771–781.

¹⁷ Wynand P.M.M. van de Ven, Rene C.J.A. van Vliet, and Leida M. Lamers, "Health-Adjusted Premium Subsidies in the Netherlands," *Health Affairs* 23, no. 3 (2004): 45–55.

¹⁸ Senate Finance Committee, Chairman's Mark: America's Health Future Act of 2009, Amended (Washington, DC: United States Senate, 2009).

¹⁹ Senate Health, Education, Labor, and Pension Committee, S. 1679, Affordable Health Choices Act (Washington, DC: Government Printing Office, 2009).

²⁰ United States House of Representatives, H.R. 3200, America's Affordable Health Choices Act of 2009 (Washington, DC: Government Printing Office, 2009).

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