Risk Selection and CDHPs

Comments on Presentations by Roger Feldman and Laura Tollen

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MAMSI – Who We Are

- NYSE listed, regional health plan based in Rockville, MD
  - MD-IPA and Optimum Choice
    - HMO and HMO/POS
    - Excellent Accreditation NCQA
    - 775,000 enrollees
  - MAMSI Life and Health
    - PPO
    - 225,000 enrollees
  - Alliance Network
    - Provider network access – marketed to TPAs and self-insured groups
    - Approximately 1 million lives
  - Maryland, DC, Virginia, North Carolina, West Virginia, Delaware, Southern Pennsylvania

Our Market

- Insurance Market
  - Highly Competitive – Blues, National Plans, Kaiser
  - Large Group (federal, state, and local governments, national companies)
  - Small Group
- Provider Market
  - All payer hospital rate regulation in Maryland
  - Limited hospital competition elsewhere (consolidations and mergers)
  - Most physicians in small, single specialty practices
  - PCPs paid or FFS or capitation (for own services); specialists paid FFS
- Consumers
  - High expectations

Experience to Date with CDHPs

- Employers are demanding cost containment
  - Some see CDHPs as the answer,
  - Others (more) are focusing on disease and care management
- For now, CDHPs are only a tiny part of the market
  - Mostly as pilot projects by self-funded employers
  - FEHB now has a CDHP option offered by APWU
  - CDHPs seem to be gaining more members from PPOs than HMOs

Comments on Papers

Points of Agreement and Disagreement

- Roger and Laura's papers
  - Agreed in terms of limited enrollment in CDHPs (at least initially)
  - Disagreed in terms of evidence of favorable selection into CDHPs
  - These areas of agreement and disagreement are not surprising

Comments on Papers

First Year Enrollment in CDHPs

- Consumers
  - Are often satisfied with current forms of insurance and thus less likely to switch to new forms of coverage
  - Apt to be cautious with regard to dramatically new types of insurance.

So limited first year enrollment is not surprising

Conflicting Results on Risk Selection – Why?

With regard to selection, there seem to be two possibilities. Either --

- In "reality" risk selection occurred in one setting and not in the other, or
- Differences in study techniques led to conflicting (and possibly misleading) results.

Did Risk Selection Occur in One Case and Not the Other?

- Whether adverse risk selection actually occurs is highly situational.
- Important factors include –
  - Actual and perceived differences in plan offerings
  - Financial terms, including employer/employee contribution formulas
  - Marketing
  - Differences in consumer awareness of future health care needs
  - Consumer sophistication, knowledge, and preferences

Hard to judge, but my guess is that both test cases posed a similar potential for risk selection

Comments on Papers

Do Differences in Methods Explain Conflicting Results on Risk Selection?

- Laura used a claims based method to measure risk
- Roger used a survey question –
  - *Do you or your dependents have a chronic condition such as asthma, hypertension (high blood pressure), diabetes or arthritis?*
- The survey question seems a blunt tool
  - Degrees of risk are not measured. Minor chronic conditions are treated as if equal to extremely costly conditions.
  - Risk is measured at a family level (*Do you or your dependents* …) not at an individual level. The whole family unit is tagged as "high risk", not just one member.

Are the Concerns About the Survey Question Likely to Matter?

Ideally, to answer this question, one would compare survey responses to claims-based risk scores for the same population. We could not do this.

Instead, we used our claims data to "simulate" survey data which we then compared to DCG based risk scores for the same population.

- Study population – MAMSI members active in 2002
  - –Population # 1 -- All persons (regardless of chronic illness)
  - –Population # 2 -- Persons with one or more chronic illness (based on claims)
  - –Population #3 – Families with one or more members with a chronic illness
  - –3787 ICD diagnosis codes were classified as chronic
  - –Primary and secondary diagnoses were considered
- Risk scores were calculated for each member using DCGs
  - –A score > 1.0 corresponds to above average predicted costs for the next 12 months

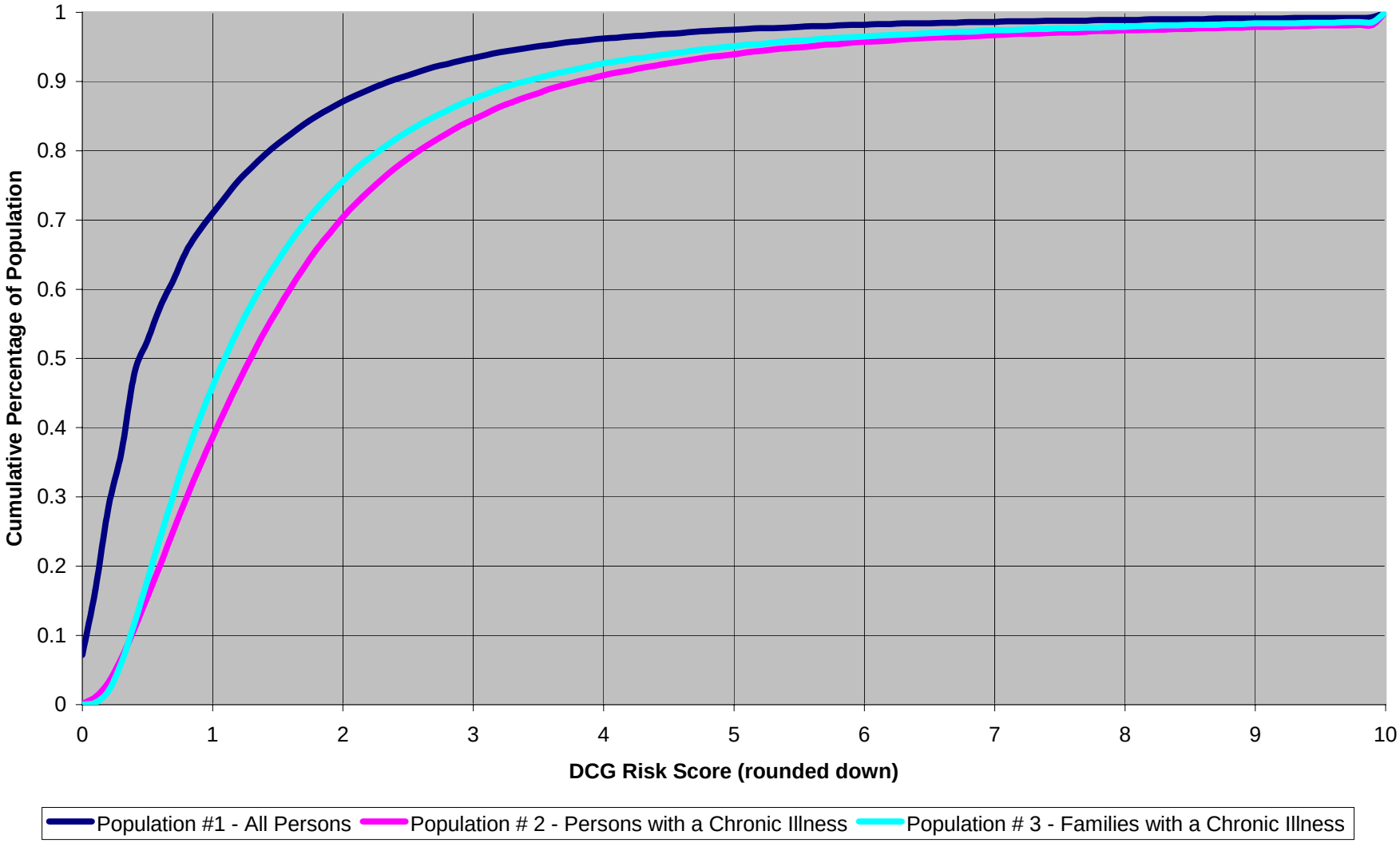
Comments on Papers

Chronic Illness Itself is Not a Good Discriminator

	Population # 1 -- All Members		Population # 2 - Members with a Chronic Illness		Population # 3 - Families with a Chronic Illness	
Quintile	Avg Risk Score	Share of Predicted Costs	Avg Risk Score	Share of Predicted Costs	Avg Risk Score	Share of Predicted Costs
1	0.1	3%	0.5	5%	0.5	5%
2	0.3	6%	0.9	9%	0.8	9%
3	0.6	10%	1.4	13%	1.2	13%
4	1.1	19%	2.8	27%	1.9	20%
5	3.5	62%	4.8	46%	4.8	53%
ALL	1.1	100%	2.1	100%	1.8	100%
Pct of Entire Membership	100%		41%		67%	

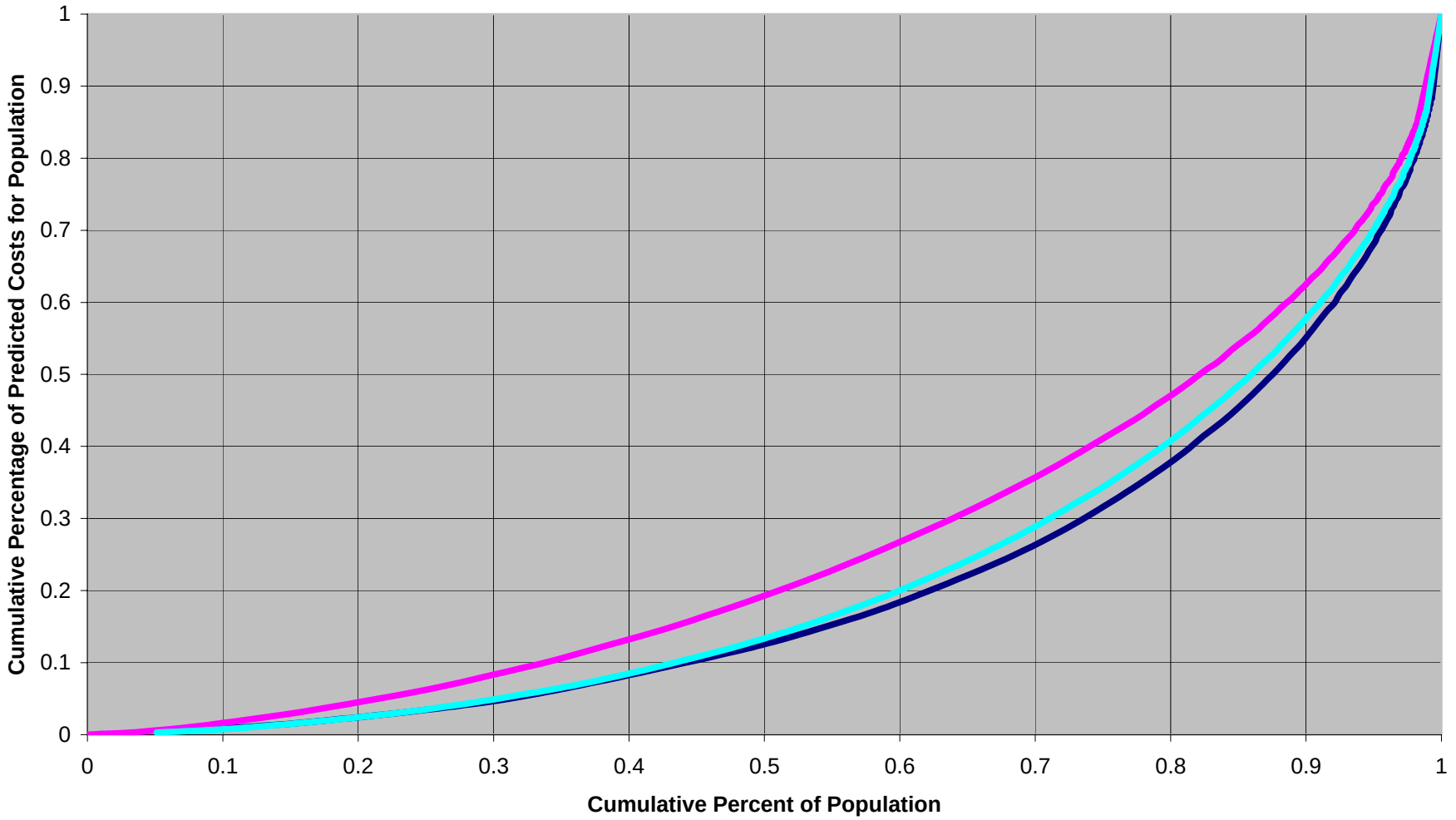
Distribution of DCG Risk Scores

MAMSI Membership 2002



Distribution of Predicted Costs

MAMSI Membership 2002



Comments on Papers

Implications of Data Exploration

- ***Results are not definitive due to methodology***
  - ***Linked survey and claims data were not available***
  - ***So, presence of chronic illness on claims was used as a proxy for survey results***
- ***But suggest that the survey question Roger used may be inadequate for measurement of financially important risk selection.***

Some Observations from the Field - 1

Adverse selection has been documented in the literature, but …

- In practice, adverse selection is difficult to detect
  - Survey based detection methods are almost unheard of in the field
  - Claims based algorithms could be applied, but claims data is rarely available from competing health plans
  - Employers and consultants are likely to ignore the issue or to use age/sex/family as a proxy measure
- Few plan sponsors have the tools and/or experience to manage choice process to minimize selection

Take Home Points - 1

- Offering a CDHP vs. traditional coverage (from different insurers) in an open-enrollment process is "risky" (*especially if unmonitored*)
  - Plan sponsor should use a claims based method (such as DCGs) to monitor for selection
- An undetected risk selection spiral could occur with low risks migrating to the CDHP and higher risks remaining in the traditional plan resulting in -
  - Apparent (but false) success of CDHP in controlling costs
  - Apparent (but false) escalation of cost growth in traditional plan

Take Home Points - 2

- Risk selection in favor of CDHPs also can occur in small group market.
  - Small group regulation would hinder efforts by traditional plans to “level the playing field”
  - So, policy makers and regulators should be careful about allowing entry of CDHPs into this market.
- An extensive follow-up research program (as detailed by Roger in his paper) is needed to assess the magnitude of the potential problem.