

# **Do Purchaser Characteristics Influence How Health-Based Risk Adjustment Is Implemented?**

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## **Background**

One goal of the Risk Adjustment Impact Study (RAIS) is to evaluate the health-based risk-adjustment implementation experiences of health care purchasers. These purchasers share some characteristics and differ on others. One obvious commonality among purchasers is that they all purchase health benefits on behalf of beneficiaries. Another commonality is that each offers beneficiaries a choice of managed care organizations (MCOs). Having a choice of health plans raises a concern for adverse risk selection and the concomitant need for risk adjustment. This paper explores how purchaser characteristics may influence the implementation of health-based risk adjustment.

## **Public versus Private Purchasers**

Purchasers are often thought of as either public or private. The private purchasers are represented by private employers or employer coalitions. Public purchasers manage public programs, namely, Medicare and Medicaid. Closer inspection reveals a middle group--public employers--who share characteristics of both private employers and public programs. This group is composed of federal, state, and county employers who purchase benefits for their employees.

To understand how these three types of purchasers may implement health-based risk adjustment differently, we examine the influence of other purchaser characteristics as well as some attributes of the health-based risk adjustment implementation process. These purchaser characteristics include the degree of autonomy in payment policy, the purchaser's relationship to beneficiary, and the nature of the geographic constraints faced by the purchaser. Some important attributes of implementation include the rationale for implementing health-based risk adjustment, identification of stake holders, the nature of the planning process, and the technical issue of data access. The relationship of all these factors is indicated in Table 1 and described further below.

## **Purchaser Characteristics**

Purchasers vary in their degree of autonomy to set payment policy. Private employers have the greatest autonomy in deciding program payment policy, and public program administrators have the least autonomy. The autonomy of public programs is restricted primarily because payment

policy is often embodied in legislation, and the MCOs have formal and informal access to lobby elected officials directly. The legislation often includes rules about how changes in payment policy, such as health-based risk adjustment, are decided.

Purchasers also differ on whether they are purchasing for employees or for beneficiaries of a public entitlement program. Employers purchase health benefits primarily to attract and retain employees. Although employee relations are a key constraint on the decisions of management, their primary interest is elsewhere (in their core business). These employee relations and compensation issues are often formalized in union contracts, thus, bringing unions directly into the decision making process. Public program administrators, on the other hand, administer entitlement programs that are mandated by legislation. As such, purchasing health benefits is more like a core mission for public programs.

Purchasers differ in the nature of the geographic constraints that they face. Although health care is delivered locally, local purchasing decisions may be influenced by state or national policy for purchasers who have purchasing responsibilities beyond the community. For example, the scope of Medicare introduces a set of national geographic equity constraints. Other purchasers, such as Medicaid and many employers, experience constraints only at a state or local level.

### **Attributes of the Implementation Process**

The reasons for implementing health-based risk adjustment are similar across purchasers and include assuring access to specialists, reaching parity between fee-for-service and managed care payments, and reducing costs. Individual purchasers, however, may vary in degree of emphasis on each objective. For example, some purchasers may value increasing access to specialists more than constraining or reducing costs. This variation in priority results from local or historical considerations that are not predictable by purchaser characteristics.

Stake holders for private purchasers are limited to the benefits manager and employees (who may be represented by a union). MCOs will have a limited role. Stake holders for state-level public entitlement programs include the legislative and executive branches of government as well as the MCOs. The stake holders for the national public purchaser (HCFA) include the Congress, national advocacy groups, and national associations of MCOs. Stake holders with a national perspective may constrain the pace and choices for implementation of health-based risk adjustment for a specific community. Public employers have the most complex stake holder

group, comprising elements of both private employers and public entitlement programs. They must include representation of their state legislature and executive branch as well as the benefits manager, employees, unions, and MCOs.

Purchasers also differ in regard to whether decision making about risk adjustment policies and methods are open and must formally involve MCOs, or whether they are relatively closed with voluntary MCO input. In the private sector, purchasers can select the MCOs that they wish to offer to their employees. These MCOs may have modest and informal input into the design of the health-based risk adjustment implementation scheme decided on by the purchaser. In contrast, the open environment of public employers and public programs puts restrictions on the ability of the purchaser to limit participation of willing plans. In addition, the participating plans will have formal input into the design of the implementation process.

Finally, purchasers differ with regard to data access. The public program purchaser has direct access to encounter data, in contrast to employers, either public or private, who must be sensitive to confidentiality issues for their employees and who avoid direct access to encounter data. Employers must use an independent intermediary to calculate and maintain individual beneficiary risk scores.

### **Conclusions**

Implementation of health-based risk adjustment is strongly influenced by the public or private nature of the purchaser. Public employers represent a blend and share the constraints of both worlds, private and public.

**Table 1**  
Purchaser Characteristics and  
Their Influence on the Implementation Process for Health-based Risk Adjustment

Purchaser Characteristics	Purchaser			
	Private Employer	Public Employer	State Public Entitlement Program	National Public Entitlement Program
Autonomy in payment policy	Unrestricted	Restricted	Minimum autonomy	Minimum autonomy
Relationship to beneficiary	Not core business	Not core business	Core mission	Core mission
Geographic constraints	State constraints	State constraints	State constraints	National constraints
<b>HBRA Implementation</b>				
Rationale/objective	Access to specialists Price equity Reduce costs	same	same	same
Stake holders involved	Executive management Employees (Unions)	State legislature Commissioner Executive management Employees (Unions) MCOs	State legislature Commissioner Benefit manager MCOs	Congress President Benefit manager National MCO associations National advocacy groups
Planning process	Closed; informal	Open; formal	Open; formal	Open; formal
Data access	Independent claims administrator	Independent claims administrator	Directly receives encounter data	Directly receives encounter data
<b>Examples of purchasers who have implemented HBRA (can link to key facts)</b>	BHCAG PacAdvantage	WSHCA	Colorado Medicaid Maryland Medicaid Oregon Medicaid Minnesota Medicaid	Medicare + Choice