Dutch Risk Equalization Performance: Users of Mental Health Services and Plan Switchers

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Topic 1: Risk Equalization (RE) & Mental Health (MH) services

Is Risk Equalization (RE) working well for MH?

- Impressive 80% reduction of predictable losses from *ex-ante* RE in 2024 for:
  - High risk anxiety and depression patients
  - Enrollees with 4+ MH diagnoses
- MH conditions still likely to be more susceptible to gaming and vagueness and selection efforts
- Counts of diseases causes worries if less severe conditions are under-coded

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Is Risk Equalization (RE) working well for MH?

Which services differ across these enrollee groups?

- OP or IP?
- Anxiety or schizophrenia? Mild depression or bipolar?
- Psychiatrists, psychologists, or social workers?
- Sort stay MH interventions, or long-term IP care

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In US MH very problematic for RE

- Only most severe MH diagnoses is in US RA formulas
- MH spending is strongly correlated with high somatic spending
- MH diseases have substantial variability
- MH services more demand and supply responsive than somatic
- Most MH payments use per diem reimbursements with outlier adjustments (Medicare Advantage, state Medicaid)
- US uses demand side cost sharing to control costs which is inferior to supply side incentives, but helps.
- MH vulnerable to undersupply by ***SELECTIVE CONTRACTING***

Wait Time Standards for Behavioral Health Network Adequacy: Final Report

Prepared for
the Office of the Assistant Secretary for Planning and Evaluation (ASPE)
at the U.S. Department of Health & Human Services
by
RTI International

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link

Wait Time Standards for Behavioral Health Network Adequacy: Final Report

EXECUTIVE SUMMARY

Insufficient access to behavioral health (BH) care and the inability to get timely care are significant problems in the United States. Concerns about BH network adequacy have been prompted by **evidence of narrow networks for BH, variation in network adequacy across plans, and evidence that network adequacy impacts access to certain specialties** [1-3].

Waiting time (WT) standards

- Fourteen states have adopted WT standards for Medicaid managed care networks, private health plan networks, or both.
- Problems with measurement, reporting, and enforcement

Table 2: Federal Regulatory Standards for BH WTs*		
Federally Regulated Markets/Programs	**Service**	**Standards**
Medicare Advantage Plans CMS Final Rule effective January 1, 2024 [1]	Emergency/urgent BH.	Immediate.
	Not emergent/urgent BH but requiring medical attention.	Within 7 business days†.
	Routine and preventive.	Within 30 business days†.
Qualified Health Plans FFEs CMS, CCIIO	No WT standard currently [2].	
Final Rule effective January 1, 2025 [3]	Outpatient BH appointments.	Within 7 business days‡.
Medicaid Managed Care Plans HHS, CMS	No WT standard currently.	
Proposed Rule published May 23, 2023 [4]	Routine outpatient MH and SUD.	No longer than 10 business days‡.

Gruber, Hoe and Stoye **Saving Lives by Tying Hands: The Unexpected Effects of Constraining Health Care Providers.** The Review of Economics and Statistics. 2023;105(1):1-19. doi:10.1162/rest_a_01044

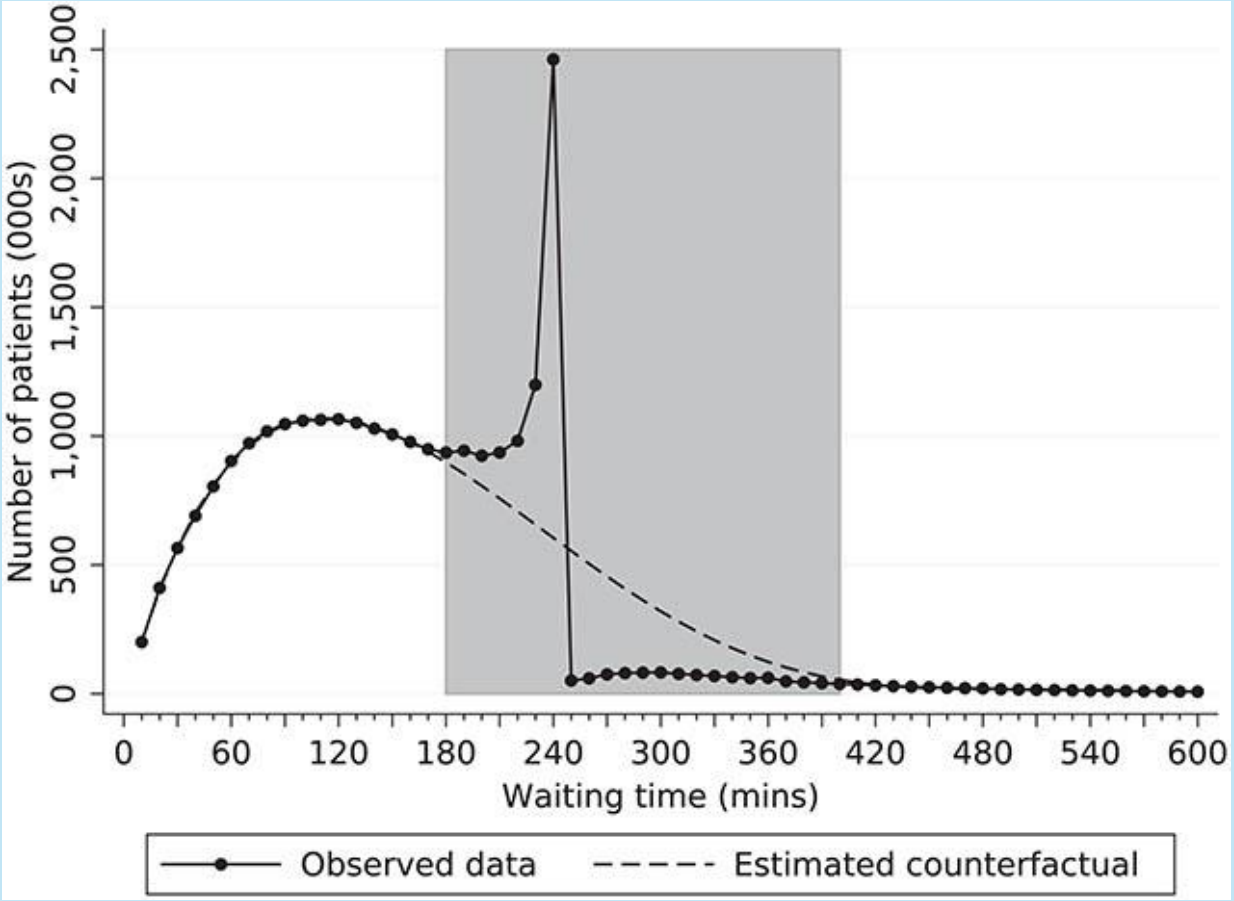

Figure Legend:

Estimated Counterfactual Wait Time Distribution(1) Wait time intervals are ten-minute periods and defined as the time from arrival in the ED to leaving the ED; (2) wait times over 600 minutes not shown; (3) 240 minutes are the four-hour threshold specified in the policy; (4) the estimated counterfactual is obtained from a polynomial regression that omits the exclusion window shown in gray.

Topic 2: Risk Equalization (RE) & Plan Switching

How to Interpret Plan Switching results?

- Explore WHY people switch plans? Do they observe something that makes them switch?
  - Planned or actual pregnancy?
  - Planned elective surgery?
  - Newly occurring chronic illness?
  - Response to new drugs being offered?
  - Change in income, such as recently retired nor promoted?

Plan Switching for premiums or deductibles?

- Both affect plan profitability and riskiness
- How often is switching into new versus already-existing plans?
- New or continuing enrollees?
- Switching rates in Netherlands are higher than in the US or Germany
- How often do enrollees switch in and then out?
- Slide showing that year t+1 is not as different is reassuring, but is this because of the multiple year spending variables?

Key issue: Is it member churning, or is it a migration?

- Concern about plan viability if enrollment steadily worsens
- New enrollees?
- Costs of enrollees in the final year of life ⇔ prospective models?
- Should worry about death spirals and cost of forced switching

Aragao, Filipa, and Randall P. Ellis, "Death spirals, switching costs, and health plan premium payments." UPF Working paper, 2001

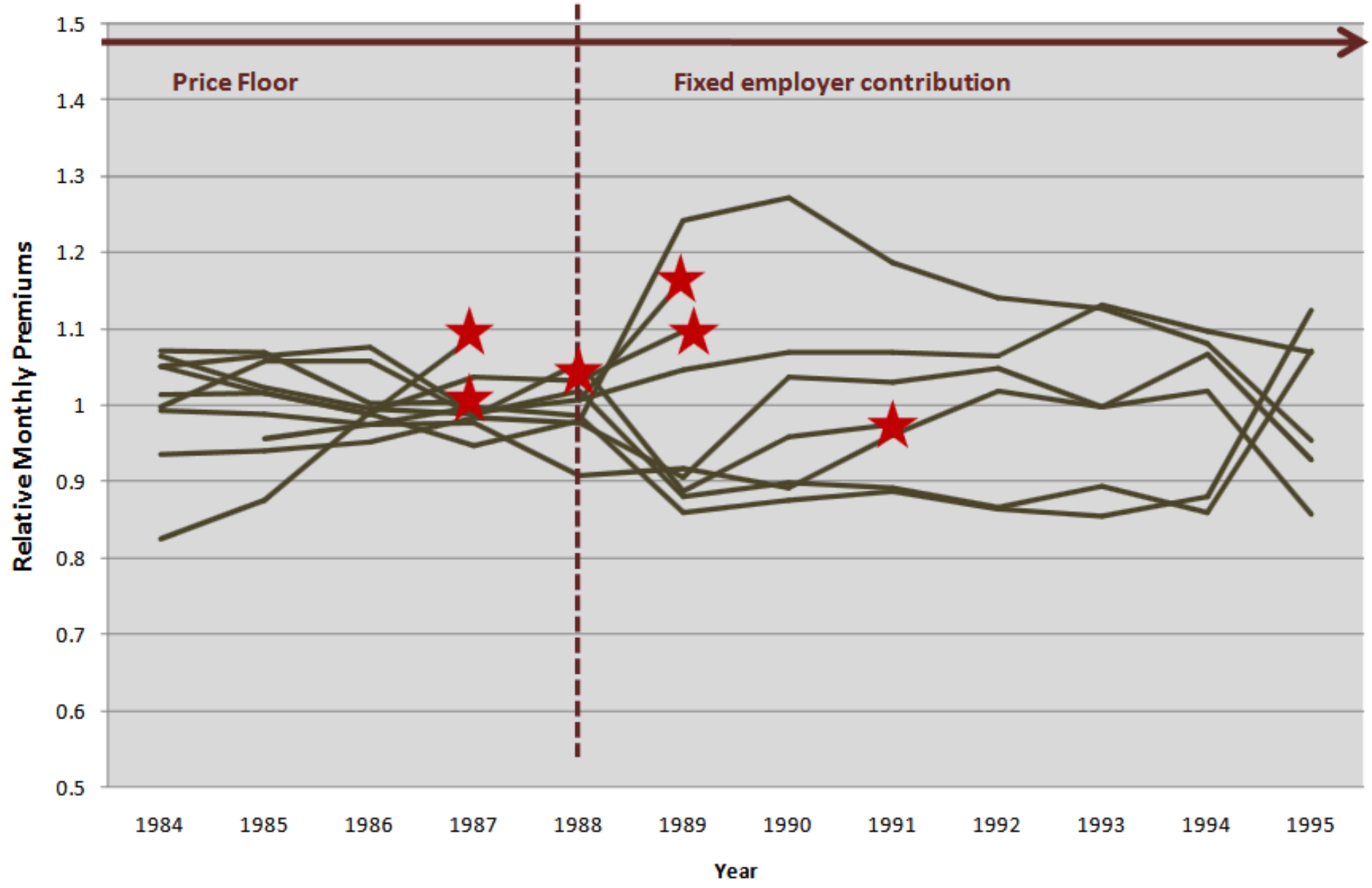

Figure 3: Minnesota Relative Single Premiums 1984-95

Consider new strategies

- US uses both hybrid models concurrent and prospective model.
- Concurrent reduces concerns about switchers
- Active proponents in the US of hybrid and mixed payment
  - Hybrid: Use information from both prospective and concurrent year
  - Mixed payment: Make payments a weighted average of actual and predicted spending
- Netherlands has a tiny bit of hybrid features
  - Pregnancy is paid concurrently
- Hybrid payment can improve fairness and reduce the profit from selected contracting

Manuel García-Goñi , Pere Ibern, José María Inoriza
Hybrid risk adjustment for pharmaceutical benefits
European Journal of Health Economics
2009 Jul;10(3):299-308. DOI: 10.1007/s10198-008-0133-2

- **Abstract**
- This paper analyses the application of hybrid risk adjustment versus either prospective or concurrent risk adjustment formulae in the context of funding pharmaceutical benefits for the population of an integrated healthcare delivery organisation in Catalonia during years 2002 and 2003. We apply a mixed formula and find that, compared to prospective only models, **a hybrid risk adjustment model increases incentives for efficiency** in the provision for low risk individuals in health organisations, not only as a whole but also within each internal department, by reducing within-group variation of drug expenditures.

J. Michael McWilliams **Risk Adjustment Reform: Navigating Ideas And Tradeoffs (Part 2)** *Health Affairs* 10.1377/forefront.20250317.506040
March 27, 2025

Recommendations

- "Scale back the HCC model by excluding diagnoses gathered through chart review or health risk assessments, and consider dropping a limited number of HCCs that are influenced most by coding practices.
- Apply machine learning methods to improve the fit attained by the remaining inputs and consider the use of constrained regression to limit consequential under-compensation for a group that is not well-recognized by the scaled-back set of input diagnoses.
- Implement a two-sided residual-based reinsurance system.

Consider supplementary insurance

- How does supplementary insurance affect switching/profits?
- Do insurers transfer profits from primary to supplementary policies?
- Supplementary insurance is an important selection tool
- Creates inertia for switching => higher profits
- What are the appropriate regulations and information to gather?

Congratulations!

- RE System is more innovative than the US.
  - Change payment variables more frequently
  - Recalibrate model regularly
  - Use risk equalization with fixed budget rather than ex ante formulas that let budget explode
- Wonderful collaboration between university researchers and government agencies and program administrators. Not common in other countries.
- May you continue to innovate!

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Thank you!

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