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EXPLAINING HEALTH CARE REFORM: Risk Adjustment, Reinsurance, and Risk Corridors

As of January 1, 2014, insurers are no longer able to deny coverage or charge higher premiums based on preexisting conditions (under rules referred to as guaranteed issue and modified community rating, respectively). These aspects of the Affordable Care Act (ACA) – along with tax credits for low and middle income people buying insurance on their own in new health insurance marketplaces – make it easier for people with preexisting conditions to gain insurance coverage. However, if not accompanied by other regulatory measures, these provisions could have unintended consequences for the insurance market: insurers may try to compete by avoiding sicker enrollees rather than by providing the best value to consumers; in addition, insurers may face uncertainty as to how to price coverage in the early years of market reform as new people (including those previously considered “uninsurable”) gain coverage, leading to the possibility of premium volatility. This brief explains three provisions of the ACA – risk adjustment, reinsurance, and risk corridors – that are intended to promote insurer competition on the basis of quality and value and promote insurance market stability, particularly in the early years of reform.

Background: Adverse Selection & Risk Selection

One concern with the guaranteed availability of insurance is that consumers who are most in need of health care may be more likely to purchase insurance. This phenomenon, known as **adverse selection**, can lead to higher average premiums, thereby disrupting the insurance market and undermining the goals of reform. Uncertainty about the health status of enrollees could also make insurers cautious about offering plans in a reformed individual market or cause them to be overly conservative in setting premiums. To discourage behavior that could lead to adverse selection, the ACA makes it difficult for people to wait until they are sick to purchase insurance (i.e. by limiting open enrollment periods, requiring most people to have insurance coverage or pay a penalty, and providing subsidies to help with the cost of insurance).

Risk selection is a related concern, which occurs when insurers have an incentive to avoid enrolling people who are in worse health and likely to require costly medical care. Under the ACA, insurers are no longer permitted to deny coverage or charge higher premiums on the basis of health status. However, insurers may still try to attract healthier clients by making their products unattractive to people with expensive health conditions (e.g., in what benefits they cover or through their drug formularies). Or, certain products (e.g., ones with higher deductibles and lower premiums) may be inherently more attractive to healthier individuals. This type of risk selection has the potential to make the market less efficient because insurers may compete on the basis of attracting healthier people to enroll, as opposed to competing by providing the most value to consumers.

The ACA’s risk adjustment, reinsurance, and risk corridors programs are intended to protect against the negative effects of adverse selection and risk selection, and also work to stabilize premiums, particularly during the initial years of ACA implementation.

Each program varies by the types of plans that participate, the level of government responsible for oversight, the criteria for charges and payments, the sources of funds, and the duration of the program. The table below outlines the basic characteristics of each program.

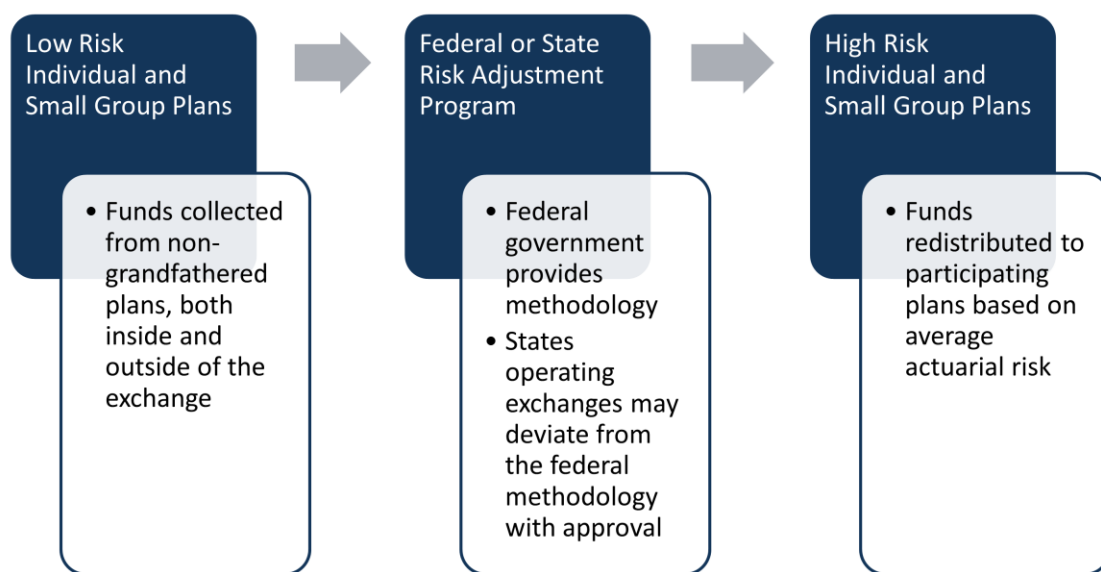
Table 1: Summary of Risk and Market Stabilization Programs in the Affordable Care Act

	Risk Adjustment	Reinsurance	Risk Corridors
<i>What the program does</i>	Redistributes funds from plans with lower-risk enrollees to plans with higher-risk enrollees	Provides payment to plans that enroll higher-cost individuals	Limits losses and gains beyond an allowable range
<i>Why it was enacted</i>	Protects against adverse selection and risk selection in the individual and small group markets, inside and outside the exchanges by spreading financial risk across the markets	Protects against premium increases in the individual market by offsetting the expenses of high-cost individuals	Stabilizes premiums and protects against inaccurate premium setting during initial years of the reform
<i>Who participates</i>	Non-grandfathered individual and small group market plans, both inside and outside of the exchanges	All health insurance issuers and self-insured plans contribute funds; individual market plans subject to new market rules (both inside and outside the exchange) are eligible for payment	Qualified Health Plans (QHPs), which are plans qualified to be offered on a health insurance marketplace (also called exchange)
<i>How it works</i>	Plans’ average actuarial risk will be determined based on enrollees’ individual risk scores. Plans with lower actuarial risk will make payments to higher risk plans. Payments net to zero.	If an enrollee’s costs exceed a certain threshold (called an attachment point), the plan is eligible for payment (up to the reinsurance cap). Payments net to zero	HHS collects funds from plans with lower than expected claims and makes payments to plans with higher than expected claims. Plans with actual claims less than 97% of target amounts pay into the program and plans with claims greater than 103% of target amounts receive funds. Payments do not have to net to zero.
<i>When it goes into effect</i>	2014, onward (Permanent)	2014 – 2016 (Temporary – 3 years)	2014 – 2016 (Temporary – 3 years)

Risk Adjustment

The ACA's risk adjustment program is intended to reinforce market rules that prohibit risk selection by insurers. Risk adjustment accomplishes this by transferring funds from plans with lower-risk enrollees to plans with higher-risk enrollees. The goal of the risk adjustment program is to encourage insurers to compete based on the value and efficiency of their plans rather than by attracting healthier enrollees. To the extent that risk selecting behavior by insurers – or decisions made by enrollees – drive up costs in the health insurance marketplaces (for example, if insurers selling outside the Exchange try to keep premiums low by steering sick applicants to Exchange coverage), risk adjustment also works to stabilize premiums and the cost of tax credit subsidies to the federal government.

Risk Adjustment Under the Affordable Care Act



Source: Kaiser Family Foundation



PROGRAM PARTICIPATION

The risk adjustment program applies to non-grandfathered¹ plans in the individual and small group² insurance markets, both inside and outside of the exchanges, with some exceptions.³ Plans that were renewed prior to January 1, 2014, and are therefore not subject to most ACA requirements, are not part of the risk adjustment system. Multi-state plans and Consumer Operated and Oriented Plans (COOP) are subject to risk adjustment. Unless a state chooses to combine its individual and small group markets, separate risk adjustment systems will operate in each market.

GOVERNMENT OVERSIGHT

States operating an exchange have the option to either establish their own state-run risk adjustment program or allow the federal government to run the program. States choosing not to operate an exchange or marketplace (and thus utilizing the federally-run exchange, called the Health Insurance Marketplace) do not have the option

to run their own risk adjustment programs and must use the federal model. In states for which HHS operates risk adjustment, issuers will be charged a fee to cover the costs of administering the program.⁴

HHS developed a federally-certified risk adjustment methodology to be used by states or by HHS on behalf of states. States electing to use an alternative model must first seek federal approval and must submit yearly reports to HHS. States electing to run their own risk adjustment program must publish a notice of benefit and payment parameters by March 1 of the year prior to the benefit year; otherwise they will forgo the option to deviate from the federal methodology. Once a state's alternative methodology is approved, it becomes federally-certified and can be used by other states.

CALCULATION OF PAYMENTS & CHARGES

Under risk adjustment, eligible insurers are compared based on the average financial risk of their enrollees. The HHS methodology estimates financial risk using enrollee demographics and medical diagnoses. It then compares plans in each geographic area and market segment based on the average risk of their enrollees, in order to assess which plans will be charged and which will be issued payments.

Under HHS's methodology, **individual risk scores** – based on each individual's age, sex, and diagnoses – are assigned to each enrollee. Diagnoses are grouped into a Hierarchical Condition Category (HCC) and assigned a numeric value that represents the relative expenditures a plan is likely to incur for an enrollee with a given category of medical diagnosis.⁵ If an enrollee has multiple, unrelated diagnoses (such as prostate cancer and arthritis), both HCC values are used in calculating the individual risk score. Additionally, if an adult enrollee has certain combinations of illnesses (such as a severe illness and an opportunistic infection), an interaction factor is added to the person's individual risk score. Finally, if the enrollee is receiving subsidies to reduce their cost-sharing, an induced utilization factor would be applied to account for induced demand.⁶

Once individual risk scores are calculated for all enrollees in the plan, these values are averaged across the plan to arrive at the plan's **average risk score**. The average risk score, which is a weighted average of all enrollees' individual risk scores, represents the plan's predicted expenses (based on the demographics of enrollees). Under the HHS methodology, adjustments are made for a variety of factors, including actuarial value (i.e., the extent of patient cost-sharing in the plan), allowable rating variation, and geographic cost variation. Under risk adjustment, plans with a relatively low average risk score will make payments into the system, while plans with relatively high average risk scores will receive payments.

Transfers (both payments and charges) are calculated by comparing each plan's average risk score to a baseline premium (the average premium in the state). Transfers are calculated at the geographic rating area, such that insurers offering coverage in multiple rating areas in a given state will have multiple transfer amounts that will be grouped into a single invoice. Transfers within a given state will net to zero. HHS proposes to use the same methodology in 2014 and 2015.

DATA COLLECTION & PRIVACY

Under the federal risk adjustment program, to protect consumer privacy and confidentiality, insurers are responsible for providing HHS with de-identified data, including enrollees' individual risk scores. States are not required to use this model of data collection, but are required to only collect information reasonably

necessary to operate the risk adjustment program and are prohibited from collecting personally identifiable information. Insurers may require providers and suppliers to submit the appropriate data needed for risk adjustment calculations.

To ensure accurate reporting, HHS proposes that insurers first validate their data through an independent audit and then submit the data to HHS for a second audit. For the first two benefit years (2014 and 2015) no adjustments to payments or charges will be made as HHS optimizes the data validation process. In 2016 and onward, if any errors are found through these audits, the insurer's average actuarial risk will be adjusted, along with any payments or charges. Because the audit process is expected to take more than one year to complete, the first adjustments to payments (for the 2016 benefit year) will be issued in 2018.

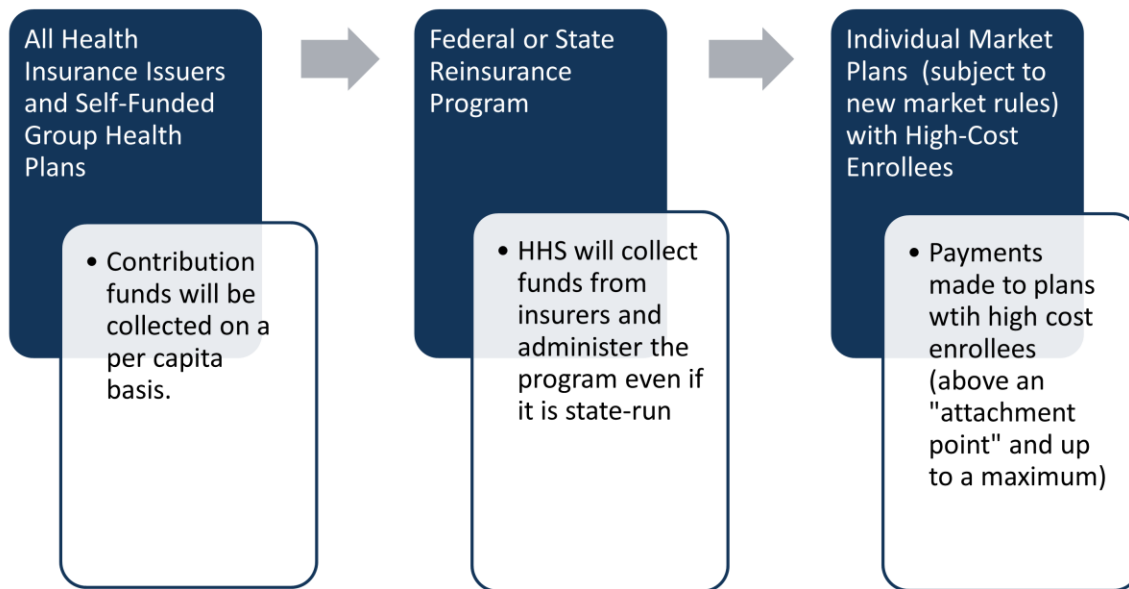
Reinsurance

The goal of the ACA's temporary reinsurance program is to stabilize individual market premiums during the early years of new market reforms (e.g. guaranteed issue). The temporary program will be in place from 2014 through 2016. The program transfers funds to individual market insurance plans with higher-cost enrollees in order to reduce the incentive for insurers to charge higher premiums due to new market reforms that guarantee the availability of coverage regardless of health status.

Reinsurance differs from risk adjustment in that reinsurance is meant to stabilize premiums by reducing the incentive for insurers to charge higher premiums due to uncertainty about the health status of enrollees, whereas risk adjustment is meant to stabilize premiums by mitigating the effects of risk selection across plans. Thus, reinsurance payments are only made to individual market plans that are subject to new market rules (e.g., guaranteed issue), whereas risk adjustment payments are made to both individual and small group plans. Additionally, reinsurance payments are based on actual costs, whereas risk adjustment payments are based on expected costs.⁷

While risk adjustment payments net to zero within the individual and small group markets, reinsurance payments represent a net flow of dollars into the individual market, in effect subsidizing premiums in that market for a period of time. To cover the costs of reinsurance payments and administering the program, funds are collected from all health insurance issuers and third party administrators (including those in the individual and group markets). HHS will issue reinsurance payments to plans based on need, rather than issuing payments proportional to the amount of contributions from each state.

Reinsurance Under the Affordable Care Act



Source: Kaiser Family Foundation



PROGRAM PARTICIPATION

All individual, small group, and large group market issuers of fully-insured major medical products,⁸ as well as self-funded plans,⁹ will contribute funds to the reinsurance program. Reinsurance payments will be made to individual market issuers that cover high-cost individuals (and are subject to the ACA's market rules).¹⁰ State high risk pools are excluded from the program.¹¹

GOVERNMENT OVERSIGHT

States have the option to operate their own reinsurance program or allow HHS to run one for the state. For states that choose to operate their own reinsurance program, there is no formal HHS approval process. However, states' ability to deviate from the HHS guidelines is limited: HHS collects all reinsurance contributions – even if the program is state-run – and all states must follow a national payment schedule. Additionally, states that wish to modify data requirements must publish a notice of benefit and payment parameters. States may collect additional funds if they believe the cost of reinsurance payments and program administration will exceed the amount specified at the national level. States wishing to continue reinsurance programs after 2016 may do so, but they may not continue to use funds collected as part of the ACA's reinsurance program after the year 2018.

CALCULATION OF PAYMENTS AND CHARGES

The ACA sets national levels for reinsurance funds at \$10 billion in 2014, \$6 billion in 2015, and \$4 billion in 2016. Based on estimates of the number of enrollees, HHS set a uniform reinsurance contribution rate of \$63 per person in 2014 and has proposed a rate of \$44 per person in 2015.

Eligible insurance plans will receive reinsurance payments when the plan's cost for an enrollee crosses a certain threshold, called an **attachment point**. HHS proposes to set the attachment point (a dollar amount of insurer costs, above which the insurer will be eligible for reinsurance payments) at \$45,000 in 2014 and \$70,000 in 2015. HHS also proposes to set a **reinsurance cap** (a dollar-amount threshold, above which the insurer is no longer eligible for reinsurance) at \$250,000 in both 2014 and 2015.¹² Finally, HHS proposes to set the **coinsurance rate** (the percentage of the costs above an attachment point and below the reinsurance cap that will be reimbursed through the reinsurance program) at 80 percent in 2014 and 50 percent in 2015.

The attachment point, reinsurance cap, and coinsurance rates above are expected to yield payments of \$10 billion in 2014 and \$6 billion in 2015, based on modeling by HHS. For the 2014 benefit year, and possibly future years, HHS proposes that if reinsurance contributions exceed the amount of payments requested, then that year's reinsurance payments to insurers will be increased proportionately. Similarly, if reinsurance contributions fall short of the amount requested for payments, then that year's reinsurance payments will be decreased proportionately. This means total payments cannot exceed the amount collected through contributions by insurers and third-party administrators. States opting to raise additional reinsurance funds may do so by decreasing the attachment point, increasing the reinsurance cap, and/or increasing the coinsurance rate. States may not make changes to the national attachment point, reinsurance cap, or coinsurance rate that would result in lower reinsurance payments.

DATA COLLECTION & PRIVACY

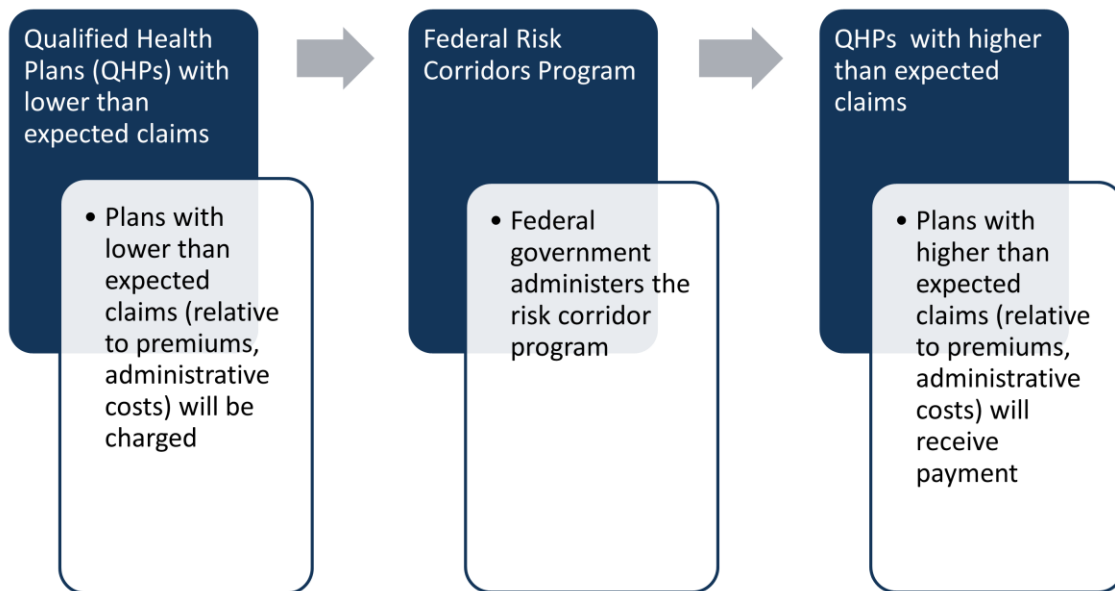
Payment amounts made to eligible individual market insurers will be based on medical cost data (to identify high-cost enrollees, for which plans will receive reinsurance payment). Therefore, in order to calculate reinsurance payments, HHS or state reinsurance entities must either collect or be allowed access to claims data as well as data on cost-sharing reductions (because reinsurance payments will not be made for costs that have already been reimbursed through cost sharing subsidies). In states for which HHS runs the reinsurance program, HHS will utilize the same distributed data collection approach used for the risk adjustment program and will similarly ensure that the collection of personally identifiable information is limited to that necessary to calculate payments. State reinsurance entities may either use this approach or may directly collect privacy-protected data from issuers. HHS proposes to conduct audits of participating insurers as well as states conducting their own reinsurance programs.

Risk Corridors

The ACA's temporary risk corridor program is intended to promote accurate premiums in the early years of the exchanges (2014 through 2016) by discouraging insurers from them from setting them high in response to

uncertainty about who will enroll and what they will cost. The program will work by cushioning insurers participating in exchanges and marketplaces from extreme gains and losses.

Risk Corridors Under the Affordable Care Act



Source: Kaiser Family Foundation



The Risk Corridors program sets a target for exchange participating insurers to spend 80% of premium dollars on health care and quality improvement. Insurers with costs less than 3% of the target amount must pay into the risk corridors program; the funds collected will be used to reimburse plans with costs that exceed 3% of the target amount.

This program is intended to work in conjunction with the ACA's medical loss ratio (MLR) provision, which requires most individual and small group insurers to spend at least 80% of premium dollars on enrollee's medical care and quality improvement expenses, or else issue a refund to enrollees.

PROGRAM PARTICIPATION

All Qualified Health Plans (or QHPs, plans qualified to participate in the exchanges)¹³ are subject to the risk corridor program. Only those plans with expenses falling outside of allowable ranges make payments to the program (or qualify to receive payments).

GOVERNMENT OVERSIGHT

The risk corridor program is federally administered. HHS charges plans with larger than expected gains and make payments to plans with larger than expected losses.

CALCULATION OF PAYMENTS AND CHARGES

Each year, each Qualified Health Plan will be assigned a target amount for what are called **allowable costs** (expenditures on medical care for enrollees and quality improvement activities) based on its premium.¹⁴ If an insurer's actual claims fall within plus or minus three percent of the **target amount**, it makes no payments into the risk corridor program and receives no payments from it. In other words, the plan is fully at risk for any loss or gain. QHPs with lower than expected claims pay into the risk corridor program:

- A QHP with claims falling below its target amount by 3% – 8% pays HHS in the amount of 50% of the difference between its actual claims and 97% of its target amount.
- A QHP with claims falling below its target amount by more than 8% pays 2.5 percent of the target amount plus 80% of the difference between their actual claims and 92% of its target.¹⁵

Conversely, HHS reimburses plans with higher than expected costs:

- A QHP with actual claims that exceed its target amount by 3% to 8% receives a payment in the amount of 50% of the amount in excess of 103% of the target.
- A QHP with claims that exceed its target amount by more than 8% receives payment in the amount of 2.5% of the target amount plus 80% of the amount in excess of 108% of the target.

In other words, plans take full responsibility (or receive the full benefit) for small gains or losses, while the federal government shares in larger gains and losses. Unlike reinsurance or risk adjustment payments, risk corridor payments are not required to net to zero, meaning that the federal government could experience an increase in revenues or an increase in costs under the program.

In response to reports of individual market plan cancellations in November 2013, HHS announced a transitional policy allowing certain plans to be reinstated if state regulators agree to adopt a similar transitional policy.¹⁶ As this policy change could affect the composition of the exchange risk pool, HHS is considering modifying the risk corridors program. One possible change would be an increase to the way allowable costs are calculated (i.e., increasing the profit margin floor and the administrative costs ceiling). HHS is also considering state-specific adjustments to allowable costs because the transitional policy's effects will vary by state. Because the risk corridors program is closely tied to the MLR provision, HHS may also consider similar modifications to the MLR formula in future rulemaking.

DATA COLLECTION & PRIVACY

In order to calculate payments and charges for the risk corridors program, QHPs are required to submit financial data to HHS, including the actual amount of premiums earned as well as any cost-sharing reductions received. To reduce the administrative burden on insurers, HHS proposes to tie the data collection and validation requirements for the risk corridors to that of the Medical Loss Ratio (MLR) provision of the ACA. HHS also proposes to conduct audits for the risk corridors program in conjunction with audits for the reinsurance and risk corridors program to minimize the burden on insurers.

Conclusion

The Affordable Care Act's risk adjustment, reinsurance, and risk corridors programs are designed to work together to mitigate the potential effects of adverse selection and risk selection. All three programs will provide stability in the early years of a reformed health insurance market, with risk adjustment continuing over the long-term. Many health insurance plans are subject to more than one premium stabilization program, and while the programs have similar goals, they are designed to be complementary. Specifically, risk adjustment is designed to mitigate any incentives for plans to attract healthier individuals and compensate those that enroll a disproportionately sick population. Reinsurance compensates plans for their high-cost enrollees, and by the nature of its financing provides a subsidy for individual market premiums generally over a three-year period. And, risk corridors reduce the general uncertainty insurers face in the early years of implementation when the market is opened up to people with pre-existing conditions who were previously excluded.

¹ Plans in existence at the time the ACA was enacted in March 2010 were grandfathered under the law and are subject to fewer requirements. Plans lose their grandfathered status if they make significant changes (such as significantly increasing cost-sharing or imposing new annual benefit limits)

² For the purposes of the Risk Adjustment program, small group is defined according to the definition set forth by the state in which the insurer is operating (i.e. up to 50 or 100 employees).

³ Plans that are not subject to the ACA's market reforms (such as guaranteed issue, single risk pools, and essential health benefits), as well as student health plans are not subject to risk adjustment. Risk adjustment does not apply to private plans that contract with Medicare or Medicaid (such as Medicare Advantage plans), nor does it apply to self-insured plans.

⁴ The risk adjustment user fee will be charged on a per-enrollee basis and is expected to be less than \$1 per enrollee per year in 2014 and 2015.

⁵ As the cost of a given medical condition will differ by the enrollee's demographics and type of insurance plan, HHS proposes using 15 separate risk adjustment models, one for each combination of broad age category (infants, children, and adults) and type of plan (platinum, gold, silver, bronze, catastrophic). Additionally, there are 26 categories for combinations of sex (male/female) and age groups (9 for adults and 4 for children).

⁶ Plans with enrollees that receive cost-sharing reductions under the ACA receive an adjustment because cost-sharing reductions may induce demand for health care and are not otherwise accounted for in the other premium stabilization programs. No adjustment will be made for reinsurance payments.

⁷ As reinsurance is based on actual rather than predicted costs, reinsurance payments will also account for low-risk individuals who may have unexpectedly high costs (such as costs incurred due to an accident or sudden onset of an illness). Under reinsurance, some plans may receive payments for high-cost/high-risk enrollees, and still be eligible for payment for those enrollees under risk adjustment.

⁸ Expatriate plans are not included. Plans with limited coverage (e.g. hospital indemnity, dread disease coverage, or plans that only cover prescription drug benefits) are not considered major medical plans for the purposes of the reinsurance program.

⁹ Self-funded plans are those plans in which the plan sponsor pays the cost of health benefits from its own assets. Some self-funded plans contract with third party administrators (TPAs) to process the plan's claims and enrollment. Those self-funded plans that do not contract with a TPA are called self-administered self-funded plans. In 2014, all self-funded plans are subject to reinsurance contributions. However, in 2015 and 2016, HHS proposes to exempt self-administered self-funded plans from reinsurance contributions.

¹⁰ Non-grandfathered individual market plans are only eligible for reinsurance payments for costs incurred after the adoption of 2014 market reform rules (guaranteed issue, guaranteed renewal, single risk pool, and essential health benefits).

¹¹ In the final rule, HHS notes that "if a high-risk pool were to be structured as individual market coverage subject to the market reform rules, it would be eligible for reinsurance payments and would also, therefore, be a contributing entity." As state high risk pools and the transitional reinsurance programs both target high-cost enrollees, states may decide whether to keep, eliminate, or phase out their high-risk pools to the extent necessary to carry out the reinsurance program. States may not use funds from reinsurance for their high risk pools.

¹² The ACA's reinsurance program is not intended to replace existing commercial reinsurance programs, which typically set their attachment points at around \$250,000.

¹³ Qualified Health Plan (QHP) issuers may also offer QHPs outside of the exchange, in which case the QHP outside of the exchange is also subject to the risk corridors program. For more information on QHPs and health insurance exchanges, see: <http://www.kff.org/healthreform/upload/7908-02.pdf>

¹⁴ Allowable costs include medical claims and costs associated with quality improvement efforts, as defined in the ACA's medical loss ratio (MLR) calculations. Insurers must also account for any cost-sharing reductions received from HHS by reducing their allowable costs by this amount.

¹⁵ HHS provides an example of an insurer with a \$10 million target amount and actual claims of \$8.8 million (or 88% of the target amount). The insurer would have to pay \$570,000 to the risk corridors program because $(2.5\% * \$10 \text{ million}) + (80\% * ((92\% * 10 \text{ million}) - 8.8 \text{ million})) = 570,000$.

¹⁶ For more details on the transitional policy, see November 14, 2013 letter from Gary Cohen, Director of the Center for Consumer Information and Insurance Oversight (CCIIO) to Insurance Commissioners, available here: <http://www.cms.gov/CCIIO/Resources/Letters/Downloads/commissioner-letter-11-14-2013.PDF>