An Overview of the Federal Affordable Care Act 3Rs (Reinsurance, Risk Corridor, and Risk Adjustment Programs)

By Eric King, NAIC Health Actuary

◆ Introduction

One of the primary goals of the health care reforms adopted under the federal Patient Protection and Affordable Care Act (PPACA), along with the Health Care and Education Reconciliation Act of 2010 (jointly referred to as the Affordable Care Act—ACA) is to expand access to health care insurance coverage. The ACA includes various mechanisms to accomplish this goal, including extending dependent care coverage; requiring insurers to accept all applicants, regardless of any pre-existing conditions; and the creation of new state-based health insurance exchanges to help individuals and small businesses purchase insurance. However, the influx of previously uninsured individuals into the new health insurance exchanges could make it difficult for insurers to price plans accurately.

To address these risks, the ACA contains three programs that are intended to stabilize policyholder premiums and mitigate risk that may occur due to ACA insurance market reforms for certain segments of the U.S. major medical insurance market. These are the Transitional Reinsurance Program, the Temporary Risk Corridors Program and the Permanent Risk Adjustment Program. Collectively, these three programs are often referred to as the 3Rs.

The 3Rs play a fundamental role in creating a viable health market for consumers. They are designed to lessen the financial risk health insurers and exchanges will face when enrolling additional individuals and small groups. Together, these interconnected programs aim to protect health insurance companies against unpredictable losses or unmanageable risk selection, and to keep consumers' premiums from spiraling out of control in the early years of the law's coverage provisions. This article provides an overview of the ACA's 3Rs.

◆ Transitional Reinsurance Program

The ACA establishes a temporary reinsurance fund that will compensate plans when they have enrollees with especially high claims. The goal of the Transitional Reinsurance Program is to stabilize premiums during the initial years of the individual market by offsetting the expenses of high-cost individuals.

The Transitional Reinsurance Program is described in Section 1341 of the ACA. This section stipulates that such a program must be established in order to provide reinsurance protection to insurers that sell non-grandfathered (issued after March 24, 2010) individual market major medical insurance plans. The program will only be in effect for plan years 2014, 2015 and 2016. It is funded with contributions from major medical insurers in all three (individual, small group and large group) markets, as well as contributions from self-insured group health plans. The ACA establishes the total amount to be collected ($12 billion in 2014; $8 billion in 2015; and $5 billion in 2016) and distributed ($10 billion in 2014; $6 billion in 2015; and $4 billion in 2016) each year. The contribution amount is then set annually by the United States Department of Health and Human Services (HHS), and is currently $44 per member per year for policies covering the 2015 plan year.

Payments are made from the program to qualified individual major medical market plans that have individual claimants with claim amounts for the given plan year that are between a specified attachment point and reinsurance cap, and the payments for claims between the attachment point and cap are subject to a specified coinsurance rate. The payment parameters for the 2015 plan year are as follows: $70,000 attachment point; $250,000 reinsurance cap; and 50% coinsurance. The payment parameters are subject to change by HHS for the 2016 plan year. The draft proposal for 2016 can be found at the U.S. Government Publishing Office website.[1]

◆ Temporary Risk Corridors Program

The Temporary Risk Corridors Program is designed to mitigate against pricing uncertainty. Health plans with unusually high claims and administrative costs will receive payments from this program, while health plans with unusually low claims and administrative costs will make payments into this program.

The Temporary Risk Corridors Program is described in Section 1342 of the ACA. This section directs the Secretary of the HHS to establish and administer a risk corridors program for Qualified Health Plans[2] (QHPs) in the individual and small

(Continued on page 11)

[1] www.gpo.gov/fdsys/pkg/FR-2014-11-26/pdf/2014-27858.pdf.

[2] A Qualified Health Plan is defined in Section 1301 of the ACA as follows: (a) QUALIFIED HEALTH PLAN—In this title: (1) IN GENERAL.—The term ''qualified health plan'' means a health plan that—(A) has in effect a certification (which may include a seal or other indication of approval) that such plan meets the criteria for certification described in section 1311(c) issued or recognized by each Exchange through which such plan is offered; (B) provides the essential health benefits package described in section 1302(a); and (C) is offered by a health insurance issuer that—(i) is licensed and in good standing to offer health insurance coverage in each State in which such issuer offers health insurance coverage under this title; (ii) agrees to offer at least one qualified health plan in the silver level and at least one plan in the gold level in each such Exchange; (iii) agrees to charge the same premium rate for each qualified health plan of the issuer without regard to whether the plan is offered through an Exchange or whether the plan is offered directly from the issuer or through an agent; and (iv) complies with the regulations developed by the Secretary under section 1311(d) and such other requirements as an applicable Exchange may establish.

group markets. Its intent is to mitigate the risk of errors in QHP rate setting by providing a mechanism for insurers to share gains and losses above or below a specified corridor. The program will only be in effect for plan years 2014, 2015 and 2016.

The risk corridor calculation is performed at the QHP level, and it compares each QHP's actual allowable costs (essentially, claims costs) to its target amount (premiums less administrative costs). If this ratio is below specified corridor percentages, the QHP pays into the program, and if the ratio is above specified corridor percentages, the QHP receives funds from the program. The risk corridor percentages and payment calculations are shown below in Figure 1.

Some examples follow that may help to understand the mechanics of the risk corridor calculation. Assume the target amount for each of these examples is $100. AAC = actual allowable costs, and TA = target amount.

Example 1 – Actual Allowable Costs Greater than 103% of Target Amount, but Less than or Equal to 108% of Target Amount
AAC = $105
Ratio of AAC to TA = $105/$100 = 105%
Payment to QHP from program = 50% of AAC in excess of 103% of TA = 50% x [$105 - (103% x $100)] = 50% x [$105 - $103] = $1

Example 2 – Actual Allowable Costs Greater than 108% of Target Amount
AAC = $120
Ratio of AAC to TA = $120/$100 = 120%
Payment to QHP from program = 2.5% of TA, plus 80% of AAC in excess of 108% of TA = (2.5% x $100) + 80% x [$120 – (108% x $100)] = $2.50 + 80% x [$120 - $108] = $2.50 + $9.60 = $12.10

Example 3 – Actual Allowable Costs Less than 97% of Target Amount, but Greater than or Equal to 92% of Target Amount
AAC = $96
Ratio of AAC to TA = $96/$100 = 96%
Payment from QHP to program = 50% of difference between 97% of TA and AAC = 50% x [(97% x $100) - $96] = 50% x [$97 - $96] = $0.50

Example 4 – Actual Allowable Costs Less than 92% of Target Amount
AAC = $89
Ratio of AAC to TA = $89/$100 = 89%
Payment from QHP to program = 2.5% of TA, plus 80% of difference between 92% of TA and AAC = (2.5% x $100) + 80% x [(92% x $100) - $89] = $2.50 + 80% x [$92 - $89] = $4.90

(Continued on page 12)

FIGURE 1: RATIO OF ACTUAL ALLOWABLE COSTS TO TARGET AMOUNT

	Greater than 103%, but Less than or Equal to 108%	Greater than 108%	Less than 97%, but Greater than or Equal to 92%	Less than 92%
Payment from QHP to Program			50% of Difference between 97% of Target Amount and Actual Allowable Costs	2.5% of Target Amount, Plus 80% of Difference Between 92% of Target Amount and Actual Allowable Costs
Payment to QHP from Program	50% of Actual Allowable Costs in Excess of 103% of Target Amount	2.5% of Target Amount, Plus 80% of Actual Allowable Costs in Excess of 108% of Target Amount		

The ACA regulations assume the Temporary Risk Corridors Program will be budget-neutral; payments to the program from QHPs will equal payments to QHPs from the program.

◆ Permanent Risk Adjustment Program

The ACA's Permanent Risk Adjustment Program is designed to spread risk among health plans to balance the adverse selection[3] some carriers will experience. Its intent is to mitigate the effects of adverse selection against health plans by transferring funds from plans that enroll lower-than-average risk members to plans that enroll higher-than-average risk members.

The Permanent Risk Adjustment Program is described in Section 1343 of the ACA. This section directs the Secretary of the HHS, in consultation with the states, to establish criteria and methods to carry out risk adjustment calculations for individual and small group market plans sold inside and outside the exchanges established in accordance with the ACA. The risk adjustment program for a state can be administered by HHS or the state, if the state operates a state-based exchange.

The HHS risk adjustment methodology uses a hierarchical condition category (HCC) model to determine an insurance plan member's risk score. Each member's risk score begins as a base score that is determined using demographic data (age and gender), as well as the level of the member plan (bronze, silver, gold, platinum or catastrophic). It also uses a separate set of base scores for infants, children and adults. Concurrent claims data (claims data for the current plan year is used to calculate the current risk score) is used to group each member's reported International Classification of Diseases, version 9 (ICD-9) codes present in claims data into HCC groups. Each of these groups maps to a value that is added to the base risk score to produce a final risk score.

The risk adjustment calculation is performed at the market (individual vs. small group), plan and state level. For each state, plan and market combination, the average risk score for all members in the given cell is calculated. If the insurer's risk score for the cell is greater than the average cell risk score, payments are transferred from the risk adjustment program to the insurer. If the insurer's risk score for the given cell is less than the average cell risk score, payments are transferred from the insurer to the risk adjustment program. The amounts transferred from insurers to the risk adjustment program for a given cell are designed to equal amounts transferred from the risk adjustment program to insurers for that cell.

◆ Additional Information

More information about the Transitional Reinsurance Program, the Temporary Risk Corridors Program and the Permanent Risk Adjustment Program can be found at the Center for Consumer Information and Insurance Oversight (CCIIO) website at: www.cms.gov/cciio/index.html.

About the Author

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[3] Adverse selection occurs when individuals who are most in need of health care are more likely to need and seek coverage, while low-risk individuals are more likely to opt out of coverage.

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