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Risk Sharing Among Plans Under the Affordable Care Act's Reinsurance, Risk Corridor, Risk Adjustment Programs

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The Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act of 2010 (the ''Affordable Care Act'') requires the creation of reinsurance, risk corridor, and risk adjustment programs that will begin to operate on Jan. 1, 2014. The reinsurance and risk corridor programs are intended to be transitional and will be in effect only through year-end 2016; the risk adjustment program is intended to be permanent.[1] On March 16, 2012, the U.S. Department of Health and Human Services issued its final rule implementing the standards relating to these three programs (the ''Final Regulations'').

The stated goal of the three programs—which have been colloquially referred to as the three ''Rs''—is to ''mitigate the impact of potential adverse selection and stabilize premiums in the individual and small group markets as insurance reforms and the Affordable Insurance Exchanges are implemented starting in 2014.''[2] The three ''Rs'' seek to accomplish this goal through mechanisms which spread risk among health plans.

The reinsurance and risk corridor programs provide for risk sharing through mechanisms comparable to excess of loss and aggregate stop loss protections currently available in the insurance and reinsurance markets. As such, issuers of health plans may be familiar with these types of programs and, in any event, the Final Regulations provide significant detail regarding how those programs will operate during the three years they are in effect.

The risk adjustment program, on the other hand, provides for risk sharing based upon actuarial analyses of the relative risk being insured under individual and small group plans, not the actual losses sustained by the plans. The Final Regulations provide little information regarding the risk adjustment methodology that will be utilized beginning in 2014 or how that methodology will spread risk among health plans. As such, health insurance issuers remain in the dark regarding the specifics of this program.

A. Reinsurance

The Affordable Care Act requires the establishment of state-based reinsurance programs that will be in effect from 2014 through 2016.[3] The reinsurance will be provided through not-for-profit entities denominated as ''applicable reinsurance entities.'' The HHS will estab-

[1] 18 U.S.C. §§ 18063-65.

[2] 45 C.F.R. Part 153, Summary, at page 17220 (2011).

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[3] 18 U.S.C. § 18061.

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lish and operate a reinsurance program on behalf of any state that does not establish its own.[4]

The reinsurance program will provide what is essentially excess of loss coverage to health insurance issuers with individual plans. Reinsurance payments will be calculated by multiplying (i) the ''coinsurance rate'' by (ii) the claim costs incurred by the issuer for an individual's covered benefits between the ''attachment point'' and the ''reinsurance cap.''[5] The values for the coinsurance rate, the attachment point, and the reinsurance cap for each benefit year will be established by the HHS in its notice of benefit and payment parameters (the ''HHS Notice''), the initial publication of which will be in mid-October two calendar years before the benefit year (e.g., October 2012 for the 2014 benefit year), followed by a one-month comment period before being finalized in mid-January.[6] While states have the ability to modify the reinsurance payment formula established by the HHS, a state may do so only if (i) it uses a uniform coinsurance rate, attachment point, and reinsurance cap throughout the entire state; and (ii) its modifications are ''reasonably calculated'' to ensure that the reinsurance contributions received by the state's applicable reinsurance entity are sufficient to cover the reinsurance payments that it will be required to make.[7]

Although all health insurance issuers are required to contribute to the reinsurance pool, only health insurance issuers providing coverage in the individual market, both inside and outside the insurance exchanges, are eligible to receive reinsurance payments.[8] Included within the health insurance issuers required to contribute to the reinsurance pool are third party administrators of self-insured group health plans, which will be required to make reinsurance contribution on behalf of the plan and then presumably obtain reimbursement via the plan.

Health insurance issuers will be required to make reinsurance contributions on a per capita basis at the ''national contribution rate.'' The national contribution rate for each year will be set forth in the HHS Notice.[9]

Reinsurance contributions will fund on a national basis: (i) reinsurance payments totaling $10 billion in 2014, $6 billion in 2015, and $4 billion in 2016, and (ii) U.S. Treasury contributions totaling $2 billion in 2014, $2 billion in 2015, and $1 billion in 2016. A state may collect additional reinsurance contributions to provide funding for its administrative expenses or additional reinsurance payments. Except for the state's share of the U.S. Treasury contributions and the HHS's reinsurance-related administrative expenses, any reinsurance contributions collected within a state establishing a reinsurance program will be used solely to pay reinsurance claims submitted by health plans within that state.[10]

The cost of reinsurance contributions will, in turn, be passed on to policyholders or plan sponsors in the form of premium increases or otherwise, which could include higher premium contributions or reduced benefits for individual covered persons. In 2014, it is estimated that (i) the cost of reinsurance contributions will be passed on to covered individuals through premium increases (or reduced benefits) of approximately 1 percent; and (ii) the benefits of reinsurance will result in premium decreases (or enhanced benefits) in the individual market between 10 percent and 15 percent.[11]

Each state is responsible for ensuring that the applicable reinsurance entity does not make reinsurance payments that exceed the reinsurance contributions received to date. If it is determined that reinsurance payments in any particular benefit year will likely exceed the reinsurance contributions for that year, a state may require a reduction in the reinsurance payments ''so long as the manner in which the payments are reduced are fair and equitable for all health insurance issuers in the individual market.''[12] Alternatively, as discussed above, the state may collect additional reinsurance contributions to fund some or all of the projected shortfall.[13]

B. Risk Corridors

The Affordable Care Act requires the establishment of a risk corridor program that will apply to issuers of qualified health plans (''QHPs'') in the individual and small group markets, both inside and outside the insurance exchanges, from 2014 through 2016.[14] The risk corridor program is intended ''to shift costs from plans that overestimate their risk to plans that underestimate their risk.''[15] Unlike reinsurance and risk adjustment, the risk corridor program will be established and administered by the HHS at the national level.[16]

The risk corridor program provides what is essentially aggregate stop loss protection based upon the QHP's combined ratio for the benefit year, specifically, the percentage of the QHP's ''allowable costs'' to its ''target amount.''[17]

A QHP's ''allowable costs'' is the amount of the QHP's incurred claims plus its expenditures (i) for activities that improve health care quality and (ii) related

[4] 45 C.F.R. § 153.210.
[5] 45 C.F.R. § 153.230.
[6] 45 C.F.R. Part 153, Section II, Subpart B – State Notice of Benefit and Payment Parameters, at page 17223.
[7] 45 C.F.R. § 153.230(d).
[8] 45 C.F.R. §§ 153.20, 153.400 and 153.410.
[9] 45 C.F.R. §§ 153.20, 153.220, 153.400.
[10] 45 C.F.R. § 153.220.
[11] The Regulatory Impact Analysis for Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, Exchange Standards for Employers (CMS-9989-FWP) and Standards Related to Reinsurance, Risk Corridors and Risk Adjustment (CMS-9975-P) (March 2012) (the ''Regulatory Impact Analysis''), at 44 (citation omitted).
[12] 45 C.F.R. § 153.240(b).
[13] 45 C.F.R. § 153.220(h).
[14] 18 U.S.C. § 18062.
[15] Regulatory Impact Analysis at 45-46.
[16] 45 C.F.R. § 153.510.
[17] 45 C.F.R. § 153.510(b), (c).

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to health information technology and meaningful use requirements. A QHP's allowable costs will also include any reinsurance contributions/payments and risk adjustment charges/payments applicable to the benefit year.[18]

A QHP's ''target amount'' is the amount of the QHP's total earned premium reduced by the plan's ''allowable administrative costs.'' In order to limit the amount that an issuer with high administrative costs may recover under the risk corridor program, the amount of ''allowable administrative costs'' is capped at 20 percent of the plan's earned premiums.[19]

Charges and payments under the risk corridor program will be made as follows:[20]

- If a QHP's allowable costs for a benefit year are less than 92 percent of the target amount, the QHP issuer will remit a charge to the HHS in an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of the difference between the allowable costs and 92 percent of the target amount.
- If a QHP's allowable costs for a benefit year are between 92 percent and 97 percent of the target amount, the QHP issuer will remit a charge to the HHS in an amount equal to 50 percent of the difference between the allowable costs and 97 percent of the target amount;
- If a QHP's allowable costs for a benefit year are between 103 percent and 108 percent of the target amount, the HHS will pay the QHP issuer an amount equal to 50 percent of the allowable costs in excess of 103 percent of the target amount.
- If a QHP's allowable costs for a benefit year are more than 108 percent of the target amount, the HHS will pay the QHP issuer an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of allowable costs in excess of 108 percent of the target amount.

In short, the risk corridor program shifts monies from plans that are profitable to plans that are unprofitable.

By way of example, if a QHP's target amount in a particular benefit year is $1 million and its allowable costs are:

- $900,000, the QHP would remit $41,000 to HHS, *i.e.*, $25,000 (2.5 percent of the target amount) plus $16,000 (80 percent of the difference between the allowable costs and 92 percent of the target amount). In this example, the QHP's combined ratio before the application of the risk corridor program is 90 percent and its combined ratio after the application of the program is 94.1 percent .
- $940,000, the QHP would remit $15,000 to HHS, *i.e.*, 50 percent of the difference between the allowable costs and 97 percent of the target amount. In this example, the QHP's combined ratio before the application of the risk corridor program is 94 percent and its combined ratio after the application of the program is 95.5 percent.
- $980,000, the QHP would neither remit nor receive any payment from the HHS. In this example, the QHP's combined ratio, both before and after application of the risk corridor program, is 98 percent.
- $1,020,000, the QHP would neither remit nor receive any payment from the HHS. In this example, the QHP's combined ratio, both before and after application of the risk corridor program, is 102 percent.
- $1,060,000, the QHP would receive $15,000 from the HHS, *i.e.*, 50 percent of the allowable costs in excess of 103 percent of the target amount. In this example, the QHP's combined ratio before the application of the risk corridor program is 106 percent and its combined ratio after the application of the program is 104.5 percent.
- $1,100,000, the QHP would receive $41,000 from the HHS *i.e.*, $25,000 (2.5 percent of the target amount) plus $16,000 (80 percent of the allowable costs in excess of 108 percent of the target amount). In this example, the QHP's combined ratio before the application of the risk corridor program is 110 percent and its combined ratio after the application of the program is 105.9 percent.

Significantly, the Final Regulations do not expressly address the possibility that the total amount of risk corridor charges will be less than the total amount of risk corridor payments in a particular benefit year. The Final Regulations thus provide no guidance regarding how HHS would address such a situation.

C. Risk Adjustment

The Affordable Care Act requires the establishment of state-based risk adjustment programs for all non-grandfathered plans in the individual and small group markets both inside and outside the insurance exchanges. Just like with respect to reinsurance, if a state does not establish a risk adjustment program, the HHS will establish one on behalf of the state.[21]

Although the Affordable Care Act requires the Final Regulations to include the ''criteria and methods to be used in carrying out the risk adjustment activities under this section,'' the Final Regulations do not do so.

The risk adjustment program is intended to transfer funds from plans that enroll the lowest risk individuals to plans that enroll the highest risk individuals. The goal of the program is to protect insurers against overall adverse selection and allow them to set premiums according to the average actuarial risk in the individual and small group market.[22]

Although the Affordable Care Act requires the Final Regulations to include the ''criteria and methods to be

[18] 45 C.F.R. §§ 153.500, 153.520(d).
[19] 45 C.F.R. §§ 153.500.
[20] 45 C.F.R. §§ 153.510(b), (c).
[21] 45 C.F.R. § 310.
[22] Regulatory Impact Analysis at 48-49.

used in carrying out the risk adjustment activities under this section,''[23] the Final Regulations do not do so. Instead, the Final Regulations provide merely that states must utilize either (i) the ''risk adjustment methodology'' developed by the HHS and published in the HHS Notice, or (ii) an ''alternate risk adjustment methodology'' developed by a state and certified by the HHS.[24] The specifics of the HHS's risk adjustment methodology, including the actuarial model that will be used ''to predict health care costs based on the relative actuarial risk of enrollees in [the subject] plans,'' will likely not be released until the initial publication of the HHS Notice in mid-October 2012.[25] In order to provide information and hear from interested parties, HHS is holding a two-day public meeting about the risk adjustment program on May 7-8, 2012.

The Affordable Care Act also provides that, in developing the risk adjustment methodology, the HHS ''may utilize criteria and methods similar to'' those utilized in the risk adjustment methodology under the Medicare Advantage and the Medicare Part D prescription drug benefit programs.[26] Accordingly, health insurance issuers may look to the risk adjustment model and methodology developed by the Centers for Medicare & Medicaid Services to get a sneak preview regarding the model and methodology that the HHS is in the process of developing.

The risk adjustment program is intended to be deficit neutral, with the payments under the program funded entirely by amounts collected from other issuers. The Congressional Budget Office estimates that risk adjustment payments will total $22 billion between 2014 and 2016 and, thereafter through 2019, range annually between $19 billion and $22 billion.[27]

Because the risk adjustment program will be based upon analyses of each plan's ''relative actuarial risk,'' and not its actual claims and losses, health plans that are profitable in any given year may receive risk adjustment payments, while plans that suffer an overall loss in that same year may be required to make risk adjustment payments. This should not be the case over the long run, assuming, of course, a plan's actual claims and losses are consistent with its relative actuarial risk.

Conclusion

In sum, the Final Regulations provide a great deal of clarity regarding how the reinsurance and risk corridor programs will operate to spread risk among health plans. Conversely, the Final Regulations shed little light on how the risk adjustment program will operate to spread risk among health plans, and health insurance issuers will likely remain in the dark on this subject until the initial publication of the HHS Notice in October 2012.

Adding to this uncertainty is the potential impact that the U.S. Supreme Court's decision regarding the constitutionality of the Affordable Care Act's individual mandate could have on the three ''Rs.'' The Supreme Court is expected to issue that decision by the end of June.

[23] 18 U.S.C. § 18063(b).
[24] 45 C.F.R. § 153.320(a).
[25] 45 C.F.R. §§ 153.20. 153.320.
[26] 18 U.S.C. § 18063(b).

[27] Regulatory Impact Analysis at 48-49; Congressional Budget Office's March 20, 2010, Letter to the Honorable Nancy Pelosi, Table 2.

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