In the Spotlight: Health Care Reform and Risk Assessment

The Affordable Care Act (ACA) has been projected to expand coverage to an estimated 32 million people who previously were uninsured. However, the increased coverage means that a group of people who have not had access to health care in the past will suddenly enter the system and, with them, come increased costs. There are risks to the insurance industry due to adverse selection, and certain unhealthy groups of individuals entering the insurance pool can make it difficult to balance health care costs with premiums. ACA restricted the ability of insurers to charge people based on their health status and, therefore, everyone in an insurance pool will pay roughly the same premiums, regardless of their health care costs. This can prove costly, not only for the insurer, but for everyone involved.

The government recognized the increased risk to insurers and there are three programs ACA implements to attempt to address these concerns: 1. temporary reinsurance program, 2. temporary risk corridor protections, and 3. a permanent risk adjustment system. Two of the programs affect coverage both in and out of the Exchange, while one of the programs – risk corridors – is only for qualified health plans within the Exchange. Most insurers expect the newly insured people to have higher claims costs due to pent up demand since they have not previously had access to health care. The reinsurance and risk corridors programs are implemented to help offset this initial risk to insurers. Risk adjustment is an ongoing program that attempts to address the change in the rating formula that no longer allows insurers to consider health status. All of these programs have the ultimate goal of making premiums more affordable for health insurance consumers.

Reinsurance

Geared only toward the individual market, the reinsurance program begins in 2014 and lasts until 2016. The reinsurance program, in some ways, functions like a high risk pool that is run by the state if the state runs its own exchange. If a state does not have a state-run exchange, it may elect to administer its own reinsurance program or have HHS administer it. Health insurers and third party administrators for self-insured plans fund the program through an assessment, which helps to stabilize premiums in the individual market (non-grandfathered plans) in a state during the first three years after enactment of the individual market rating reforms when the risk of adverse selection is the greatest. The reinsurance entity collects payment from insurers/TPAs using a national uniform contribution rate (a percentage of premiums or flat fee per member for fully insured plans and a percentage of claims for self-insured plans) and then uses amounts collected to make reinsurance payments to health insurers that cover high-risk individuals for the three-year period. ACA determined the amount of the assessment in aggregate as $25 billion for the three years, with $12 billion collected in 2014, $8 billion collected in 2015, and $5 billion collected in 2016. Insurers become eligible for reinsurance payment when the plan's costs for essential health benefits exceed a certain amount.

Risk Corridor

The risk corridor exists only for three years (2014 – 2016) as well. In this program, the federal government shares some of the risk of insuring the new population with the insurance companies. The Secretary of HHS must establish a risk corridor program that applies to qualified health plans in the individual and small group markets. Health insurers with costs that are at least 3% less than the issuers’ costs projections will share those savings with
HHS; for health insurers with costs greater than 3% of their projections, HHS will offset some of those losses. From 3% to 8% difference, HHS will assume 50% of the favorable or unfavorable results. If the actual costs are 8% or more than projected, HHS will assume 80% of the favorable or unfavorable results.

**Risk Adjustment**

Beginning in 2014 as a permanent program, risk adjustment is intended to help protect health insurers that operate in the individual and small group markets in and out of the exchange. The goal of the program is to distribute risk more evenly among insurers, after accounting for the legal rating variables (tobacco use, 3:1 age ratio, and geographic area). Risk adjustment programs will transfer funds from plans whose enrollees have below-average risks to plans whose enrollees have an above-average risk. States may choose to administer the risk adjustment program themselves if they operate their own exchange; if not, HHS will administer it for them. HHS has yet to share specifics of the federal model that states can use but has provided that states may develop their own model or use a model which another state has developed as long as the performance is similar to or better than the federal model. Activity reports will be required of states, detailing the average actuarial risk for each plan, the charges and payments, and probably some additional information. States must have privacy and security standards in place to protect individually identifiable information.

Modeled after the risk assessment program for Medicare Advantage (MA), state programs must meet certain criteria:

- Accurately explain cost variation;
- Choose risk factors that are clinically meaningful to providers;
- Encourage favorable behavior and discourage unfavorable behavior;
- Use data that is complete, high quality, and timely;
- Provide stable risk scores over time and across plans;
- Minimize administrative burdens.

Currently, MA and supplemental drug (Part D) plans receive payments based on the risk score of their members. Risk score is calculated by using information like age, health status, and gender. Much like ACA risk assessment tools, the MA and Part D plans were put in place to help protect insurers from restricted or inaccurate ratings. In July of 2011, the US Department of Health and Human Services (HHS) issued the proposed rules for these programs in an effort to reduce the financial risk for insurers.

<table>
<thead>
<tr>
<th>Reinsurance</th>
<th>Risk Corridors</th>
<th>Risk Adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Function</td>
<td>Provide funding to plans that enroll high cost individuals</td>
<td>Limit risk to insurers for gains or losses</td>
</tr>
<tr>
<td>Purpose</td>
<td>Offset high cost outliers</td>
<td>Protect against inaccurate rate settings</td>
</tr>
<tr>
<td>Timeframe</td>
<td>2014 – 2016 (3 years)</td>
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</tr>
<tr>
<td>Who Participates</td>
<td>All insurers and self funded plans contribute; non-grandfathered individual market plans are eligible to receive payments</td>
<td>Only qualified health plans inside the exchange (individual and small employer)</td>
</tr>
<tr>
<td>Administrator</td>
<td>State or HHS</td>
<td>HHS</td>
</tr>
</tbody>
</table>
BCBSNC Views

Blue Cross and Blue Shield of North Carolina supports these attempts to stabilize the insurance industry and offset adverse selection, in the new health insurance landscape which includes guaranteed issue and the removal of health status rating. However, we caution that the programs should be implemented well in order to fully counteract the potentially expensive effects of adverse selection and rating restrictions.

There are several issues surrounding all three of these programs that will need to be considered as they are implemented. The existing risk adjustment programs in MA and Part D almost always predict more healthy and fewer sick people in the pool than there actually are, as evidenced by a Milliman performed study in 2011. Exacerbating the problem, the exchange will likely attract a disproportionate number of unhealthy people and this under-prediction could lead some insurers to avoid the exchange.

Predictive accuracy is obviously of great importance. If the formulas used for the programs are not good predictors of actual costs, the programs will be of little use. The basis of the risk assessment tools provided in ACA is strong data collection. Additionally, ease of use, costs, and transparency should all be considered while developing the regulations.

When considering the risk regulations, HHS should coordinate all three programs as well as medical loss ratio reporting and rate setting since all three interact with each other. We encourage the federal regulations to be finalized by January of 2012 so that insurers have time to prepare for open enrollment in 2013. Since these models are not perfect, insurers must be prepared to implement other methods to mitigate adverse selection.

For More Information


Center for Budget and Policy Priorities: http://www.cbpp.org/cms/index.cfm?fa=view&id=3497