# What Happens to High-Risk Populations in 2014: Reinsurance, Risk Corridors, and Risk Adjustment

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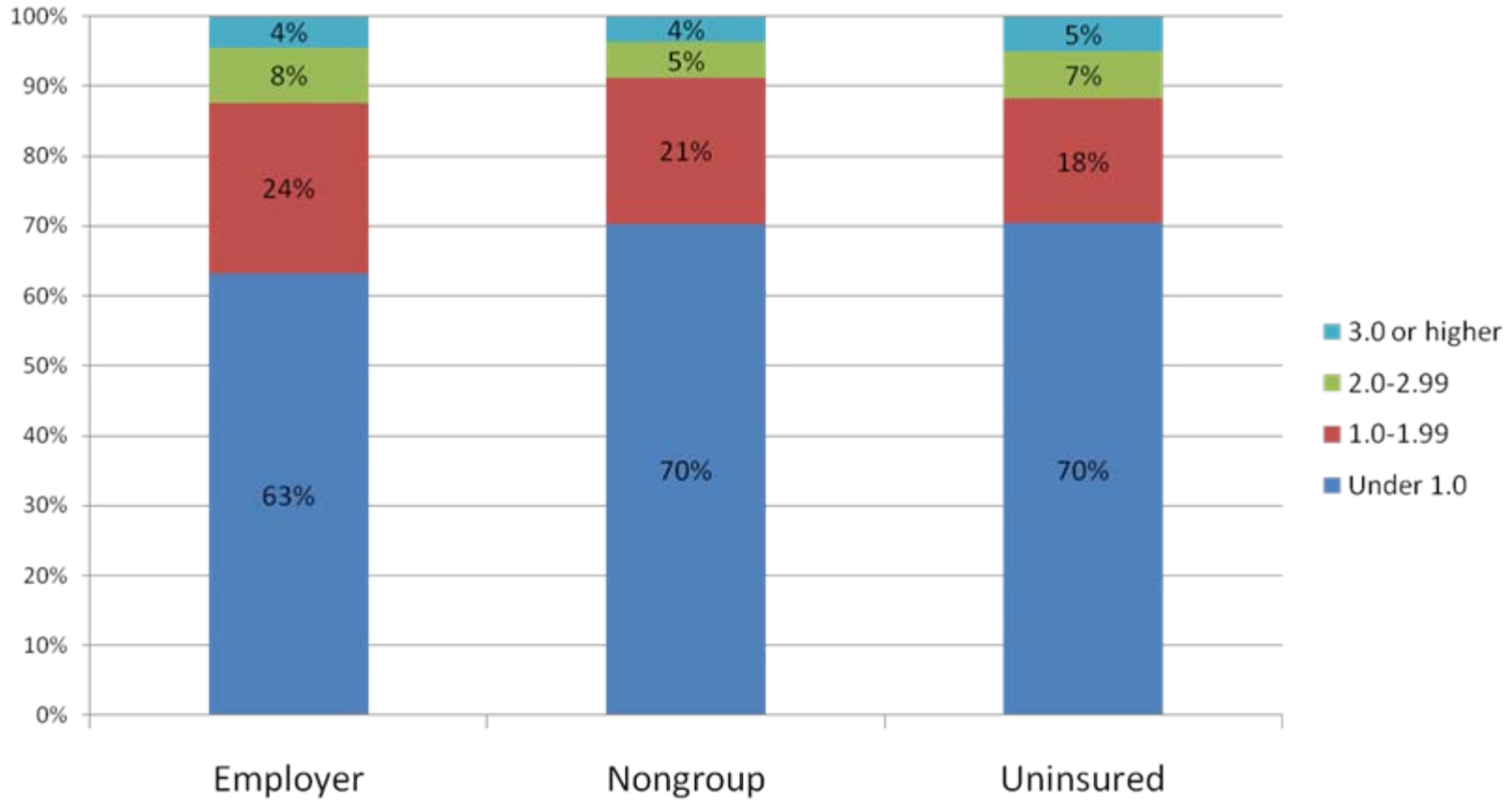
# Key concerns as health reform is implemented:

- Adverse selection
- Pricing uncertainty
- Biased selection

# DCG/HCC Risk Scores, Nonelderly People by Source of Coverage in December 2004




Medical Expenditure Panel Survey, 2004

# Adverse selection

- Limited/delayed effectiveness of individual mandate
- High-risk population shifted from state/federal pools
- Larger high-risk population never enrolled in pools
- Sticker shock for current nongroup enrollees

# Pricing uncertainty

- No prior experience
- Possible utilization spike
- Risk premium

# Biased selection

- Insurers:
  - Manipulation of benefits
  - Targeted marketing
- Employers
  - Grandfathered plans
  - Self-insurance option
- Individuals
  - Plan levels (more precious metal = higher risk)
  - Network arrangements
  - Inertia

# How ACA addresses these concerns

- Temporary programs, 2014-2016, to address adverse selection and pricing uncertainty
  - Reinsurance program
  - Risk corridor protection
- Permanent risk adjustment system to address biased selection

# Defining reinsurance

- Reinsurance passes part of the risk from primary insurer to another entity
- Three basic types:
  - Aggregate stop-loss (resembles risk corridors)
  - Individual stop-loss (private, Medicare Part D)
  - Condition-based (Idaho, former New York system)
- Financing
  - Internal (resembles insurer-financed state risk pools)
  - External (resembles PCIPs)
- Payout – retrospective vs prospective

# ACA reinsurance program

- Administered by one or more nonprofit "reinsurance entities" in each state
- Funded through assessments on all employer group and individual insured and self-insured plans in the state
- BUT Coverage only for non-grandfathered individual insurance plans
- Payout to plans with high-risk enrollees, with method to be determined

# Reinsurance assessments

- Secretary to determine method
  - Fixed per capita contribution or
  - Percent of premiums
- Total $20 billion assessment available for reinsurance:
  - $10 billion for 2014
  - $6 billion for 2015
  - $4 billion for 2016
- Additional $5 billion assessment for 2014-2016 (but used for general fund)

# Reinsurance payout

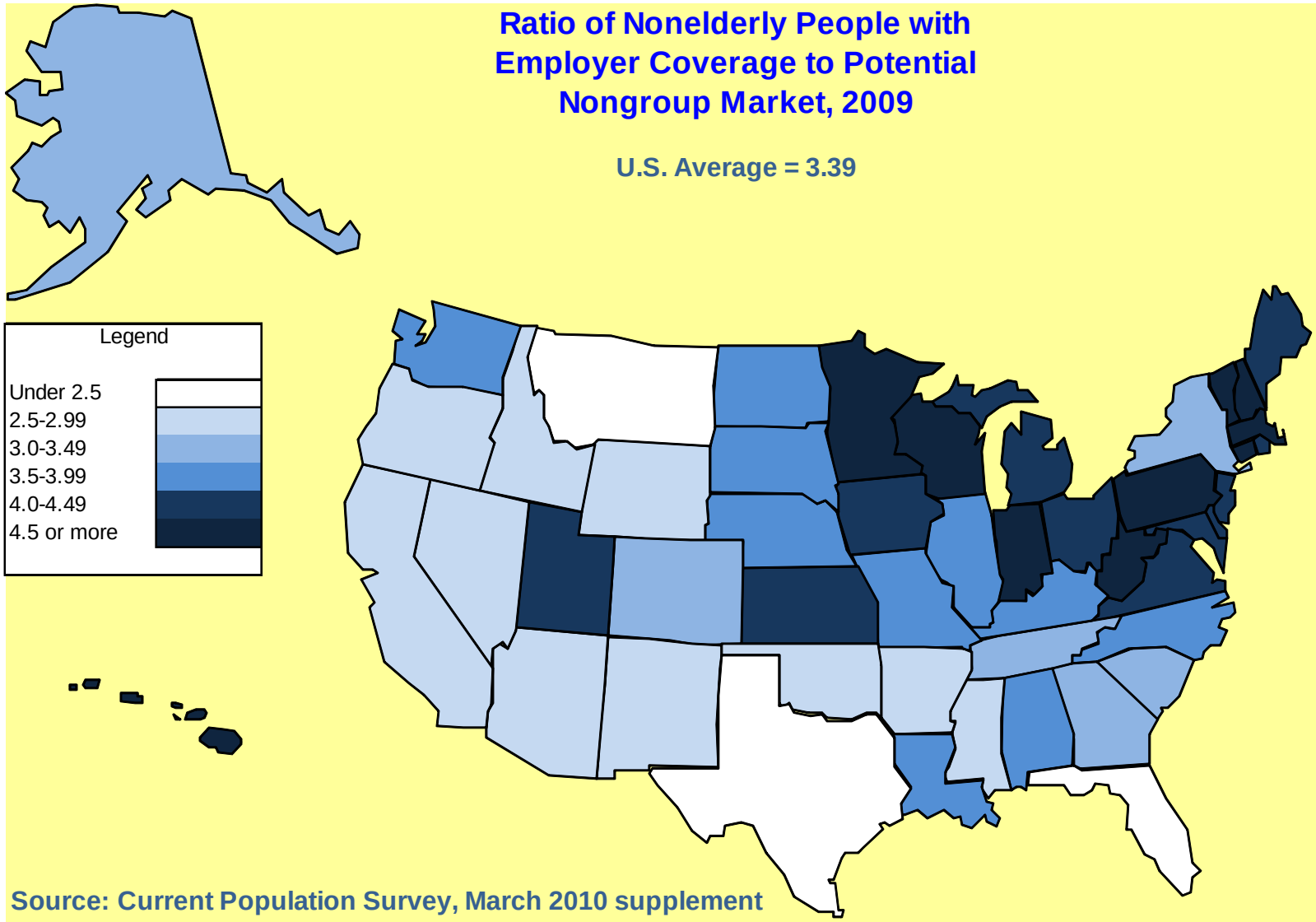
- Defining high-risk individuals
  - Secretary could establish list of 50-100 high-risk conditions or
  - Use alternative method recommended by American Academy of Actuaries
- Reinsurance payments
  - Fixed amount for each condition or
  - Alternative recommended by Academy

# Issues for reinsurance program

- Possibility of inadequate targeting
- Potential for gaming
- Plans unable to predict revenues
- State-by-state financing

# Ratio of Nonelderly People with Employer Coverage to Potential Nongroup Market, 2009

U.S. Average = 3.39




Source: Current Population Survey, March 2010 supplement

# Risk corridors

- Temporary national pooling system for plans in individual and small group market, based on similar system under Medicare Part D
- Benefit costs (not counting administrative costs) during each year are compared to a "target amount"
- Target amount equals total premium revenues, again excluding amounts spent for administration

# Risk corridor payments

- Payments in
  - Plan pays HHS if claims costs are below 97% of the target; higher payments required if costs are below 92% of the target
- Payments out
  - HHS pays the plan if claims costs are more than 103% of the target; higher payments if costs are more than 108% of the target
- Plan fully at risk in “corridor” between 97% and 103%

# Issues for risk corridor program

- If more plans lose money than make a profit, HHS must somehow make up the difference
- Possibility of lowballing to gain market share (Netherlands experience)
- How to coordinate profit-sharing with consumer rebates under medical loss ratio rules

# Risk adjustment systems

- Medicare Advantage and Part D drug program
- Some Medicaid managed care contracting programs
- Rare in employer plans
- Dutch and Swiss systems

# Risk adjustment in the ACA

- Each state will run a risk adjustment system, using method to be developed by HHS
- All plans except self-insured employer plans will participate
- System will transfer funds from plans whose enrollees are below-average risks to plans whose enrollees are above-average risks

# Measuring risk

- Demographic and similar factors
  - Age, gender, industry/occupation, income
  - Poor predictors but easy to collect
- Diagnostic data
  - From hospital and ambulatory claims
    - Better predictors, but costly to collect
  - From pharmacy claims only
    - Limited proxy for diagnostic data, but readily available

# Risk adjustment issues

- Development of uniform data collection across thousands of plans will take time (years?) and be highly controversial
- No system predicts well at individual level; is group level adequate?
- Exemption of self-insured plans

# How important is risk adjustment?

- Theory of “managed competition”: plans complete solely on efficiency and quality
- But…
  - Competitive systems do function despite biased selection (e.g., Federal Employees Health Benefits Program)
  - Medical loss ratio rule limits profit from risk selection
  - Consolidation of insurance industry could mean a few huge groups with normal risk distribution

# Conclusions

- Reinsurance system may not function well everywhere
- May need to consider other options to limit initial adverse selection
  - Limited open enrollment periods and penalties for late entry
  - Continuation of risk pools past 2013
- Risk adjustment likely to be limited to demographics in the short term; better methods are a long-range aspiration