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# Risk Adjustment and Other Risk-Sharing Provisions in the Affordable Care Act

## Key Points

- Risk adjustment is used to adjust payments to health plans based on the relative risk of plan participants.
- Reinsurance is used to reimburse insurers for the cost of individuals who have unusually high claims.
- Risk corridors are used to mitigate the pricing risk insurers face when they lack data on health spending for potential enrollees.

## Additional Resources

Risk Assessment and Risk Adjustment (May 2010 issue brief): http://www.actuary.org/pdf/health/Risk_Adjustment_Issue_Brief_Final_5-26-10.pdf

Comment letter on ACA Reinsurance Provision (Sept 2010): http://www.actuary.org/pdf/health/Reinsurance%20Options%209%2022%202010.pdf

The Affordable Care Act (ACA) includes permanent and temporary risk-sharing mechanisms for health insurers participating inside, and in some cases outside, of the state health insurance exchanges. This issue brief describes the risks that health insurers face as well as how the various risk-sharing mechanisms help to mitigate these risks.

## Risks insurers face related to selection

The Affordable Care Act (ACA) increases access to health insurance coverage by prohibiting insurers from denying coverage, excluding pre-existing conditions, or varying premiums based on an individual's health status. To reduce the adverse selection arising from such requirements, the ACA includes other provisions, such as premium subsidies and an individual mandate, which aim to increase overall participation in health insurance plans. (See the text box for more information on adverse selection.) In the absence of universal participation, however, some degree of adverse selection is inevitable. And even with universal participation, some insurance plans could end up with a disproportionate share of individuals having greater health care needs, putting them at risk for large losses. As a result, plans have an incentive to develop strategies to avoid enrolling high-risk individuals.

The substantial influx of previously uninsured individuals into the new health insurance exchanges authorized by the ACA could also make it more difficult for insurers to price plans accurately, at least



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during the early years of the exchanges. Insurers generally lack detailed data and experience regarding health spending for the uninsured. In addition, future spending by the newly insured could increase once they obtain coverage, but it is unclear how large any such increase would be. Understating premiums could result in large losses to private insurers, threatening plan solvency. Overstating premiums could result in large gains to the insurers and/or reduce participation in the plan.

The ACA establishes three risk-sharing mechanisms designed to mitigate these risks—risk adjustment, reinsurance, and risk corridors.[1]

## Risk Adjustment

Section 1343 of the ACA provides for a permanent risk-adjustment program, beginning in 2014, which applies to non-grandfathered individual and small group plans both inside and outside of the state health insurance exchanges.

Risk adjustment is a tool used to redistribute total payments across health plans to account for the relative risk of plan participants. When insurers are limited in the extent to which premiums can vary by health status or other factors that are associated with health spending, risk adjustment helps ensure that health plans

### WHAT IS ADVERSE SELECTION?

Adverse selection occurs when individuals at greater risk of high health spending are more likely to need and seek coverage, while low-risk individuals are more likely to opt out of coverage. This adverse selection increases the average insured risk and results in higher premiums. The higher premiums that result from adverse selection, in turn, may lead to more low-risk individuals opting out of coverage, which would result in even higher premiums. This process is typically referred to as a premium spiral. Avoiding such spirals requires minimizing adverse selection and instead attracting a broad base of low-risk individuals, over which the costs of high-risk individuals can be spread.

Adverse selection can occur not only broadly across an insurance market, but also between particular health plans. Low-risk individuals may be more likely to enroll in plans with less generous coverage due to the lower premiums, for example, while high-risk individuals may be more likely to enroll in plans with more generous coverage—even though the premiums would be higher.

[1]Although not discussed in this paper, the ACA medical loss ratio (MLR) requirements will also limit gains to insurers arising from overstating premiums.

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are appropriately compensated for the risks they enroll. Under the ACA risk-adjustment program, payments will flow from plans that disproportionately enroll low-risk individuals to those that enroll a greater percentage of high-risk individuals.

Risk adjustment helps to make payments to competing plans more equitable and can reduce the incentives for competing plans to avoid individuals with higher-than-average health care needs. Risk adjustment also may help stabilize the experience among private plans, causing less disruption for plan participants.

Because risk adjustment transfers funds between health plans based on the relative risk of their enrollees, it can reduce the effects of adverse selection between plans. It cannot, however, mitigate the effects of adverse selection against the market as a whole if a disproportionate share of low-risk individuals choose not to purchase coverage from any health plan.

Risk-adjusted payments could be based on a combination of various factors that are correlated with health spending, such as age, gender, income, health indicators (e.g., medical diagnoses), and health care utilization (e.g., inpatient or outpatient claims, prescription drug usage). It is important to note that although risk adjustment can help adjust for the differences in expected health spending across plans, no current risk-adjustment system is designed to compensate each plan for the full financial effects of adverse selection.

## Reinsurance

Reinsurance is another mechanism designed to limit insurers' downside risk. Section 1341 of the ACA provides for a temporary reinsurance program that will be effective from 2014 to 2016. Under this program, payments will be made to non-grandfathered individual market plans (inside and outside the exchanges) that cover high-risk individuals. The funds for those payments will be collected from all individual and group plans, including grandfathered plans and self-funded plans.

The stated goal of this reinsurance program is to stabilize premiums in the individual market during the first three years that the health insurance exchanges are operational. The reinsurance program supplements the ACA risk-adjustment program. Although risk adjustment can help compensate plans that enroll high-risk individuals, risk adjustment typically is not able to compensate plans fully for unusually high claims. Health insurance spending can be quite skewed, with a small share of insureds incurring high health costs. Plans that cover these individuals risk financial losses, even with risk adjustment. The reinsurance program can mitigate this risk and further reduce the incentives for competing plans to avoid individuals with expected high claims.

The transitional reinsurance program will protect individual market plans against financial losses from individuals with unusually high claims. Although insurers already have access to private reinsurance, the ACA reinsurance program payments will be subsidized by group plans (included self-funded plans) and grandfathered plans. As a result, insurers may not have to build as much into the premium to cover expected high claims. The effect of the reinsurance program on premiums, however, would be minor.

## Risk Corridors

Risk corridors are used to mitigate the pricing risk that insurers face when their data on health spending for potential enrollees are limited. In general, the risk corridors provide a govern-

ment subsidy if insurer losses exceed a certain threshold. They also are used to limit an insurer's gains—plans would pay the government if their gains exceed a certain threshold.

Section 1342 of the ACA provides for a temporary risk-corridor mechanism that will be effective from 2014 to 2016 for individual and small group plans in the health insurance exchanges. Risk corridors could encourage competition in state insurance exchanges by limiting the downside risk for insurers entering the exchange market during the early years.

Similar to the risk corridors in the Medicare Part D plan, the ACA contains symmetric risk corridors. That is, plans will set a target amount, equal to total premiums (including premium subsidies) less administrative costs. If actual plan allowable costs (net of risk adjustment and reinsurance payments) come within ± 3 percent of the target, the plan bears the loss or keeps the gains. If actual costs fall outside the 3 percent corridor, the government shares in the gains or losses with the plan. In other words, the government pays the plan if costs are more than expected, and the plan pays the government if costs are lower than expected. The government bears 50 percent of the spending between ± 3 percent and 8 percent of the target and 80 percent of the spending beyond ± 8 percent of the target.

The risk corridors are temporary to reflect that they are most appropriate during the first few years of a new program, when less expenditure data are available. As more data become available on the health spending patterns of the newly insured, the ability to set premiums accurately should increase, thereby reducing the need for risk corridors.

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