Cancer Action Network℠ American Cancer Society®

One of the primary goals of the Patient Protection and Affordable Care Act (PPACA) is to reform the insurance market so that health plans compete for customers based on the quality and price of their products, not by the risk profile of their enrollees. For example, PPACA requires health plans to take all applicants, no matter what their health status. And it disallows charging people higher premiums because they have a higher risk profile, or refusing to cover treatment for pre-existing conditions. And it requires all new plans to cover a set of essential benefits. These are critical reforms that will help make health insurance accessible, adequate, and more affordable for people with health conditions.

However, plans may try to use more subtle mechanisms to attract healthy enrollees and discourage sicker ones. For example, they could employ marketing tactics that attract young, active people. Or they could make refinements to the essential benefits package that make the plan less appealing to people with certain high cost health conditions. To counter this more subtle risk selection, and to help ensure that plans inside and outside the new insurance exchanges are operating on a level playing field, PPACA requires the establishment of three separate programs to reallocate risk among health plans.

# Background

## Risk Adjustment

First, PPACA requires states to set up a permanent risk adjustment program for health plans operating both inside and outside the new insurance exchanges.[1] In essence, risk adjustment acts like Robin Hood: the program assesses a charge on health plans in the state that have low cost enrollees, the revenue from which is then used to pay plans with high cost enrollees.[2]

The law requires the Department of Health and Human Services (HHS) to work with states to establish the risk adjustment criteria and methodology, and encourages it to be modeled after the existing methodology for risk adjustment in the Medicare managed care and prescription drug plan programs.[3] Grandfathered plans and self-insured group plans are exempt from the program.[4]

## Reinsurance

Second, PPACA creates a temporary reinsurance program within each state in order to stabilize the individual market during the first three years of the insurance exchanges, when the risk of adverse selection as a result of the market reforms is the greatest.[5] The law requires each state, by 2014, to establish a non-profit entity within the state to administer the reinsurance program.[6] It is somewhat similar to risk adjustment, except in this case all plans in the state (except grandfathered

1 Patient Protection and Affordable Care Act (PPACA) § 1343.
2 § 1343(a).
3 § 1343(b).
4 § 1343(c).
5 § 1341(c).
6 § 1341(a).

plans) will make annual payments to this entity, which would then use that pool of funds to make payments to certain plans that had enrolled high-risk individuals.

The Department of Health and Human Services (HHS), in consultation with the National Association of Insurance Commissioners (NAIC), is charged with developing a model regulation that states can use to implement the program. The model regulation must define a “high-risk” individual and develop a formula for collecting the annual fee from health plans and then allocating the reinsurance payments among those plans with high-risk enrollees.[7]

This provision of the law will likely be very important in the early years of the state exchanges, when they are likely to pick up most of the participants in the federal high-risk pool program when it ends in 2014. The law also allows states to eliminate or reform their own high-risk pool programs, and employers may cut back on coverage for some workers once the exchanges become available.[8,9] The reinsurance program can help with the transition and keep premiums more affordable for exchange participants.

### Risk Corridors

Third, PPACA requires HHS to establish “risk corridors” for qualified health plans in the individual and small group markets for the first three years of the insurance exchanges.[10] The program will be similar to the risk corridor program HHS runs for Medicare prescription drug plans.[11] The risk corridor program is essentially another form of risk adjustment, except in this case administered by HHS as opposed to the states. The law requires HHS to give payments to plans that have higher than expected costs, and it requires plans that have lower than expected costs to make payments to HHS. Those payments will be based on a methodology HHS must establish by regulation.[12] HHS is required to reduce any payments to plans by any amounts they receive under the state-based risk adjustment and reinsurance programs.[13]

## Issues to Consider

### Practical Challenges

At its best, risk adjustment is an inexact science. The Congressional Budget Office (CBO) has noted that in Medicare, existing risk adjustment systems “tend to overpredict the costs of beneficiaries who end up with low health care spending and to underpredict the costs of those who end up with high health spending.”[14] Even when it is done well, existing programs generally don’t sufficiently compensate for all the costs associated with having sicker enrollees.[15]

---

7 § 1341(b).
8 Jost, T. “Health Insurance Exchanges and the Affordable Care Act: Key Policy Issues,” Jul. 2010, The Commonwealth Fund.
9 § 1341(d).
10 § 1342.
11 §1342(a).
12 § 1342(b).
13 § 1342(c)(1)(B).
14 Congressional Budget Office, “Designing a Premium Support System for Medicare,” December 2006.
15 Lueck, S., “States Should Structure Insurance Exchanges to Minimize Adverse Selection,” Center on Budget and Policy Priorities, Aug. 2010, available at http://www.cbpp.org/cms/index.cfm?fa=view&id=3267.

Risk adjustment will also require that states and HHS have robust data collection systems that accurately reflect insurers' costs based on the populations they enroll. In addition, the states and HHS will need work in partnership to conduct audits of plans to make sure they're accurately reporting their costs and the risk profile of their enrollees. For example, in the Medicare managed care program, the Centers for Medicare and Medicaid Services (CMS) found that insurers had engaged in a pattern of "upcoding", in which they were reporting that their enrollees were sicker than they actually were.[16]

These programs will require continuous monitoring, adjustment, and enforcement. Yet states have little to no experience running risk adjustment programs. And most have never had to confront the challenge of collecting this kind of data from dozens of health plans, inside and outside the exchanges, at a time when they are facing a myriad of new responsibilities to get the exchanges up and running.

### Exchanges and Adverse Selection

Risk adjustment programs both counter risk segmentation among health plans in the marketplace and serve as important tools to discourage adverse selection against the new insurance exchanges. In essence, if plans outside an exchange attract healthier people than those within the exchange, those plans will need to make payments that will help plans inside the exchange cover their higher costs. But for the reasons identified above, these programs alone will not be sufficient to stop adverse selection, and are only part of the new law's efforts to ensure the exchanges' long-term sustainability.[17]

## Conclusion

Risk adjustment, reinsurance, and risk corridors: these three programs are designed to encourage health plans to compete on the basis of quality and value, and discourage the kind of risk segmentation that has led to a market that denies adequate, accessible and affordable coverage to people with health conditions. If done right, these programs can also discourage adverse selection against the new state insurance exchanges, and launch them towards long-term sustainability.

*by Sabrina Corlette*

16 Id.
17 PPACA's initiatives to reduce adverse selection include: (a) requiring many of the new market rules to apply both inside and outside the exchange, (b) requiring all plans (except grandfathered and self-insured plans) to cover a set of "essential benefits", (c) requiring insurers to treat all enrollees, inside and outside the exchange, as members of a single risk pool, (d) establishing three risk adjustment programs to reallocate risk among insurance companies, and, critically, (e) requiring those who are eligible for premium and cost-sharing subsidies to enroll through the exchanges.