Affordable Care Act:
Risk Management Aspects of Legislation – 3 R’s

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Background

- Congress passed the Patient Protection and Affordable Care Act in 2010. A centerpiece of the legislation is the creation of state and/or federal insurance exchanges.

- The exchanges sell insurance to individuals and small employer groups. The focus of this presentation will be on the individual coverage sold by the exchanges, which is the overwhelming amount of “Obamacare” enrollment.

- Individuals who have a household income of less than 400% of the Federal Poverty Level (FLP) are eligible for a subsidy to purchase insurance coverage on the exchanges. FPL is based on the number of individuals living in a household. For a single individual, 400% of FPL is $47,080. For a family of 4, 400% of FPL is $97,000

Background - Continued

- The base ACA plan design is a “Silver” level plan which has a 70% actuarial value (AV). This means that the insurance coverage pays 70% of covered medical expenses. The remaining 30% of expenses are paid by the member in the form of deductibles, coinsurance, and copays.

- Households who have an FPL less than 250% of FPL are eligible for “Cost Sharing Reduction” subsidies or known as CSR. Mechanically, the way these CSR subsidies are administered is that the members are enrolled in a plan design with a higher AV:
  - 100% to 150% of FPL – 94% AV Plan
  - 151% to 200% of FPL – 87% AV Plan
  - 201% to 250% of FPL – 73% AV Plan

Risk Management Provisions for Health Insurance Carriers

- Several key risk issues existed for insurance carriers who opted to sell insurance coverage on the state exchanges:
  - Health underwriting is not allowed, so the insurance carriers are being "randomly" selected by individuals choosing an insurance plan from a website. Its possible for some carriers to enroll members with a higher level of claim morbidity than other carriers.
  - There is no claim experience for these individuals, so pricing is a challenge. Many of these individuals were uninsured prior to 1/1/2014.
  - The ACA legislation passed by Congress included some risk management provisions into the law. ***These relatively unpublicized provisions are known as the 3 R's.***

ACA 3 R's

- **Risk Adjustment** – The purpose of Risk Adjustment (RA) is to deal with the possibility that certain health insurance carriers will members who have a higher than average level of claim morbidity. The basic idea is that health insurance carriers in a given market will transfer cash amongst themselves to adjust for differences in the claim morbidity of enrolled members. RA is budget neutral.

- ***Transitional Reinsurance*** – Provides "free" reinsurance to insurance carriers to protect against random high dollar claims. The reinsurance is funded by group insurance plans so it is budget neutral. This program ends in 2016.

- ***Risk Corridors*** – The purpose of the Risk Corridor (RC) provision of the law is to "tax" health insurers who have a very low loss ratio and provide a financial backstop to health insurers who have a high loss ratio. The purpose of the RC provision is to recognize that the insurance companies didn't have good data to use when pricing Obamacare individual coverage. This program ends in 2016.

Risk Adjustment

- The purpose of Risk Adjustment (RA) is to quantify the level of risk of each enrolled member and compare the overall morbidity level of different health insurance plans in a given state and/or market. The Center for Medicare and Medicaid Services (CMS) approved a RA algorithm that states can use OR the states can develop their own RA methodology. Nearly all states are using the federal methodology.
- Health insurers upload claim and member data to CMS. A risk score is calculated for each member in a health plan. The risk score is based on the following:
  - Diagnosis codes
  - Age/Gender
  - Procedure Codes
  - Metal Tier
  - CSR Level
  - Length of Enrollment
- After quantifying risk scores by health insurer in a given market, a cash settlement is calculated at year end which results in cash flowing from plans with lower than average risks to plans with higher than average risks.

Risk Adjustment - Continued

- Health insurers have been “optimizing” their risk scores in an effort to maximize the financial impact of the RA settlement among insurance carriers in their market:
  - Insurance carriers are using predictive analytics to make lists of members for whom they believe it is likely have “under-coded” risk score parameters. The carriers higher consultants to pull the medical charts of these members and look for opportunities to “upcode” the members medical chart. For example, the attending physician may have coded a certain diagnosis code(s) BUT after review of the chart, the health plan may make updates to the patient’s claim coding for the purpose of increasing their risk score.
    - When optimizing, the insurers may be pulling as many as 20% to 305 of all enrolled member’s medical charts.
    - Insurance companies may perform free health screening (blood tests, etc.) to try to get diagnosis codes for plan members with no medical claims.
    - This optimization process is expensive and favors the large insurance carriers which large amounts of surplus and qualified staff to devote to RA optimization.
- ***RA Optimization has been more effectively performed by large companies results in large insurance companies taking money from smaller companies.***

Transitional Reinsurance

- The Transitional reinsurance program provided free reinsurance to health insurance carriers offering individual insurance coverage on the state or federal exchanges.
- In 2014, the coverage paid 80% of member level claims between $45,000 and $250,000.
- For 2015, the reinsurance coverage will pay 80% of member level claims between $70,000 and $250,000.
- This reinsurance coverage was paid for by employers who offer group insurance coverage AND cannot access any of these dollars for their own plans:
  - $63 per member per year in 2014
  - $44 per member in 2015
  - $27 per member in 2016
- Most of the dollars raised from group insurance plans comes from self insured employer plans. Even those these employer plan sponsors are taking the risk for their own plan, they cannot access this reinsurance program.
- 2016 is the last year of this program.

Temporary Risk Corridors

- The deviations between “allowable cost” and “target amount” are shared with the federal government.
- Loosely speaking, “allowable cost” is loss in claims and “target amount” is revenue.
- Both gains and losses are shared; the program ends in 2016.