



Fact Sheet: ACA Risk-Sharing Mechanisms

The 3Rs (Risk Adjustment, Risk Corridors, and Reinsurance) Explained

While potentially tens of millions of Americans could gain health insurance under the Affordable Care Act (ACA), many for the first time, the law poses some financial risks for health insurers. To address these risks, the ACA includes some protections for insurers, known as risk-sharing provisions, especially in the early years of the new program. These risk-sharing provisions were included in the law with the intent of ensuring plans will be available to consumers and reducing incentives for insurers to avoid high-cost enrollees.

The risk-sharing mechanisms interact not only with each other, but also with other elements of the ACA. Any changes to these provisions should be made with careful consideration of these interrelationships and the impact of how revisions could affect insurer risks, insurance availability, and insurance premiums.

At the beginning of 2014, insurers will be prohibited from denying coverage to individuals and families, excluding pre-existing conditions, or varying premiums based on an individual's health status. This will be a dramatic change from the pre-2014 rules governing health insurance issue and rating rules in most states, especially in the individual market, resulting in uncertainty regarding who will sign up for coverage and, among the newly insured, what their medical spending will be. Due to this uncertainty, insurers will face several risks, including: what if a particular insurance plan enrolls a disproportionately large number of very sick beneficiaries; or what if a plan's average medical spending is higher than expected due perhaps to less-than-expected enrollment of lower-cost people?

The ACA includes three risk-sharing programs to mitigate these risks—a permanent risk-adjustment program, a transitional reinsurance program that will run from 2014-2016, and a temporary risk-corridor program that will run from 2014-2016.

Question: *What is the permanent risk-adjustment provision?*

Answer: The prohibition of denying coverage or charging higher premiums based on health status exposes insurers

to adverse selection risk, which occurs when individuals or groups who anticipate high health care needs are more likely to purchase coverage than those who anticipate low health care needs. The ACA's individual mandate and premium subsidies will reduce the adverse selection effect, although some risk remains.

The permanent risk-adjustment program aims to reduce the incentives for health insurance plans to avoid enrolling people with higher-than-average costs by shifting money among insurers based on the risks of the people they enroll. Insurers with higher shares of low-cost enrollees are to contribute to a fund that will make payment to insurers with larger shares of high-cost enrollees. All non-grandfathered plans in the individual and small group market will participate in the risk-adjustment program, whether they are inside or outside of the exchanges. The risk-adjustment program is designed to be revenue neutral (i.e., no effect on the federal budget).

Q: *What is the transitional reinsurance provision?*

A: The transitional reinsurance program supplements the risk-adjustment program and compensates plans when they have enrollees with especially high claims. As the ACA was being drafted, it was recognized that high-cost individuals would have the greatest incentives to enroll in coverage. Therefore, during the first years of the law's implementation, this population could make up a greater share of enrollment than in subsequent years when the individual market risk pool is anticipated to be larger and more representative of the population as a whole.

The ACA transitional reinsurance program further reduces the incentives for plans to avoid high-cost individuals and helps to stabilize premiums during the initial years. The reinsurance program will offset a portion of the costs of high-cost enrollees in the individual market.

This will reduce the risk to insurers, allowing them to offer premiums lower than they otherwise would be. Funding for the reinsurance program comes from contributions from all health plans, including not only plans in the individual market, but also those in the small and large group markets, as well as self-insured plans.

These contributions are then used to make payments to non-grandfathered plans in the individual market.

In 2014, \$10 billion will be collected from health plans, which will then be used to pay plans in the individual market when an individual's claims exceed \$60,000.¹ Plans will be reimbursed for 80 percent of an individual's health claims between \$60,000 and \$250,000. The program is budget neutral; if necessary, the U.S. Department of Health and Human Services (HHS) will adjust reinsurance payments to ensure that payments do not exceed contributions collected from health plans.

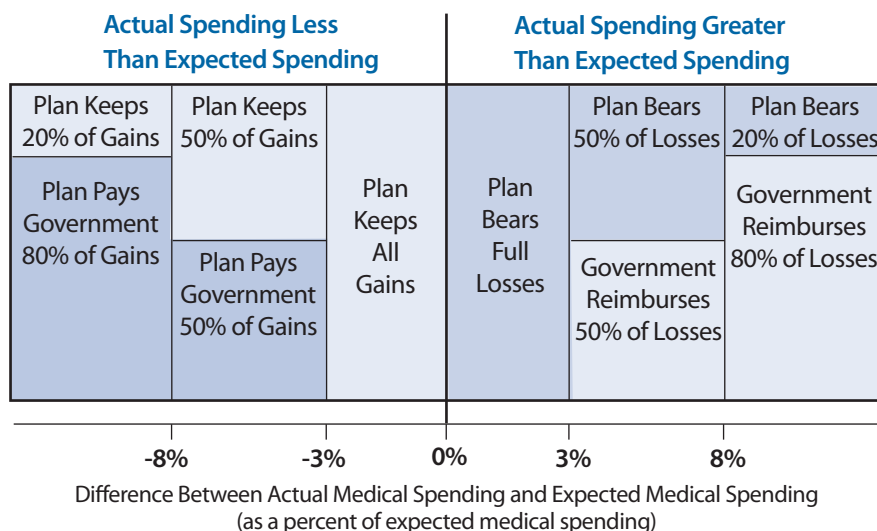
Contributions to and reimbursements from the program will decline over time until the program expires after three years. The transitional nature of this program was designed to address the likelihood that the earliest enrollees in the individual market will be those with higher expected costs, including enrollees transitioning from high risk pools, whereas healthier individuals may delay enrolling.

Q: What is the temporary risk-corridor program?

A: Under the ACA, risk corridors have been established to mitigate the pricing risk that insurers face because they have very limited data to use to estimate who will enroll in plans operating under the new 2014 ACA rules and what their health spending will be. These temporary risk corridors limit insurer gains and losses—insurers receive a payment from HHS if their losses exceed a certain threshold; insurers pay the HHS if their gains exceed a certain threshold. An objective of risk corridors is to encourage health insurance competition by limiting the risk for insurers entering the exchange market during the early years of implementation. This provision applies to qualified health plans (QHPs) in the individual and small group markets.

The way the risk-corridor program works is that actual

Illustration of ACA Risk Corridors



claims are compared to the expected claims that were assumed in the insurer's premiums. If actual claims are within 3 percent of expected, insurers either keep the gains or bear the losses. If actual claims exceed expected claims by more than 3 percent, HHS reimburses the plan for at least 50 percent of the excess loss. If actual claims fall below expected claims by more than 3 percent, the plan pays HHS at least 50 percent of the excess (see graph above).

The risk corridors are temporary since they are most appropriate during the first few years of the 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 improve, thereby reducing the need for risk corridors.

Q: Are risk-sharing provisions used in other programs?

A: The Medicare Part D program incorporates risk adjustment, reinsurance, and risk corridor provisions. The Medicare Advantage program uses risk adjustment.

For more information, see the Academy's issue brief, [Risk Adjustment and Other Risk-Sharing Provisions in the Affordable Care Act](#).

¹Proposed rules released by the Center for Consumer Information and Insurance Oversight (CCIIO) on Nov. 25 would reduce the 2014 attachment point from \$60,000 to \$45,000: <http://www.gpo.gov/fdsys/pkg/FR-2013-12-02/pdf/2013-28610.pdf>

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