

**Principles & Practices Board**

**ISSUE ANALYSIS**

# Questions and Answers on the Affordable Care Act's Premium Stabilization Programs (The 3 Rs)

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**hfma**

healthcare financial management association

### **About P&P Board Issue Analyses**

The Healthcare Financial Management Association through its Principles and Practices (P&P) Board publishes issue analyses to provide short-term practical assistance on emerging issues in healthcare financial management. To expedite information to the industry, issues analyses are not sent out for public comment. Therefore, they are factual, but not authoritative. The purpose of this issue analysis is to provide some clarity to the healthcare industry on certain accounting and reporting issues resulting from the Affordable Care Act, which imposed fees and premium stabilization provisions on entities that issue commercial health insurance. Consultation on these matters with independent auditors is highly recommended.

The Affordable Care Act (ACA) provided for three premium stabilization programs—risk corridor, reinsurance, and risk adjustment (the “3 Rs”)—to limit risks to insurance payers. The risk corridor and reinsurance programs are temporary and will expire at the end of 2016. The risk adjustment program will continue indefinitely.

Statutory filings of approximately 90 large health insurers’ disclosures were evaluated to assess the impact these programs have had on their results and to highlight issues that insurers should pay attention to in the coming years.

#### **What are the attributes of the three different premium stabilization programs?**

- **The risk adjustment program** is designed to even out the premium payments received by insurers. If an insurer has a relatively unhealthy population, it will be cross-subsidized by other insurers in the market that have relatively healthy members. While it is easy to know the health status of an insurer’s members based on its claims history, there is no centralized database of the relative risk scores of the marketplace. This makes comparison difficult, particularly in the first year. The nature of this program requires that risk adjustments within a market be reviewed and reconciled every year.
- **The risk corridor program** is meant to support insurers if their actuarially sound projections turn out to miss the mark. Because the health insurance exchanges brought an entirely new set of customers into the health insurance marketplace and underwriting is prohibited, there was significant risk in pricing the products offered on the exchanges. At the beginning of the program, there was an expectation that roughly the same number of insurers would underprice their products as those that overpriced, thus balancing the program. The expected balance has not been achieved, resulting in risk corridor receivables that are much greater than payables.
- **The reinsurance program** is intended to reduce the incentive for plans to avoid enrollees who are likely to incur catastrophic claims by compensating insurers for a percentage of these claims. The reinsurance program is transitional, designed to provide assistance to insurers in the initial years of the health insurance exchanges to account for the likelihood that early entrants to the insurance pool are likely to be those with high claim costs, with healthier individuals entering the insurance pool more slowly. For 2014 and 2015, claims in excess of \$45,000 up to a cap of \$250,000 are 80 percent covered in 2014 and 50 percent covered in 2015. For 2016, the attachment point has been increased to between \$90,000 and \$250,000 at 50 percent coverage. Compensation for these catastrophic claims comes from a government pool funded by an annual per capita fee (\$63 in 2014, \$44 in 2015, and \$27 in 2016) charged to substantially all individuals who purchase health insurance on the commercial market.

## **The ACA did not have a budget neutrality requirement for the risk corridor program (unlike the risk adjustment and reinsurance programs, which are designed to be budget neutral and funded by health plans). What are the issues around and status of funding of the risk corridor program?**

At year-end 2014, across all companies, recorded risk corridor receivables exceeded payables by approximately \$850 million to \$900 million. In our sample, insurers recorded \$701 million in risk corridor recoveries offset by only \$12 million in payables. In other words, results were worse than expected for products priced for the exchanges in 2014. It is important to note that these are receivables that insurers feel met the criteria for recognition (e.g., insurers deemed “recovery probable” for these receivables). When we looked back to the third quarter of 2014, we found some interesting comparisons with year’s end. Twelve companies had recorded \$300 million in receivables as of Sept. 30, 2014, and reversed those accruals as of year’s end. This was most likely due to passage of the “Cromnibus” (the Consolidated and Further Continuing Appropriations Act) in December 2014, so the actual calculated receivables owed to these insurers is probably higher for our sample.

## **How did passage of the “Cromnibus” affect the funding of the risk corridor program?**

Section 227 of the Cromnibus states that funds made available by the act from the Hospital Insurance (HI) trust fund or the Federal Supplemental Medical Insurance Trust Fund or transferred from other accounts funded by the act may **not** be used for risk corridor program payments. Prior to passage of the Cromnibus, insurers were under the assumption that the U.S. Department of Health & Human Services (HHS) would find a mechanism to support the risk corridor program if industry payables into the program did not offset receivables. Section 227 made this assumption uncertain and some companies changed their position and wrote off amounts that they were technically owed. Other companies continue to record the full amount owed in accordance with the program’s intention.

When we look at first-quarter 2015 filings, we see that companies have generally kept the same accounting position that they took at year-end 2014. In other words, if the receivable was written off, then they continue to have no risk corridor program receivables recorded in 2015. For those companies that do record a risk corridor receivable, the amounts continue to grow, so it does not appear that industry pricing will fix the imbalance between program receivables and payables in 2015.

## **Could you explain the timeline and any uncertainty surrounding the funding requirements for the three-year (2014-16) risk corridor program?**

There are a couple of ways this could ultimately play out:

- Industry results could be better than expected in 2015 and 2016, which would naturally draw down the receivables owed to insurers. We don’t believe this is likely for a couple of reasons. Given that our sample of insurers recorded another \$93 million in risk corridor receivables in their first-quarter 2015 filings, we believe that the issue will not be fixed in the 2015 plan year. Moreover, while companies may like to recover prior deficits by pricing above actuarial indications, this is difficult to implement in a competitive marketplace where competition will price to an appropriate margin in that year. What the industry would need is an unanticipated positive change in expected medical costs.
- Another potential scenario would take money that was left over in the reinsurance program in 2014 and use it to change thresholds in future years that lower costs incurred by insurers. It may be reasonable to

expect that the good news from 2014—money left over in the program—will recur in 2015. Although this scenario is not as clean as fixing the risk corridor issue directly, any additional money flowing to the reinsurance program will, by the nature of this program’s interaction with the risk corridor program, result in lower receivable balances.

**Accounting for the 3 Rs has been a challenge for insurers due to the lack of historical data for projecting estimates on their financial statements. What accounting considerations do health plans need to recognize when projecting significant accounting management assumptions and estimates?**

Risk adjustment accruals should be estimated based on the experience of the insurer and the insurer’s view of the overall health risks in the marketplaces in which it operates. We now have much more clarity on the marketplace level risk based on the 2014 settlements. Insurers should also ensure their assumptions are consistent among estimates. For example, the risk adjustment and reinsurance provisions affect the risk corridor results, so the assumptions used in those calculations should all be consistent. Lastly, insurers should ensure they have proper controls over the data used in the calculations.

**What other accounting and actuarial considerations need to be assessed in the estimations?**

When determining reinsurance receivables, an adjustment for cost-sharing reduction (CSR) enrollees should be included to account for the CSR payments that insurers receive from HHS to avoid overestimating reinsurance receivables.

**How is the uncertainty surrounding funding of the risk corridor program affecting accounting considerations?**

The collectability of risk corridor receivables shall be assessed for each reporting period. If the insurer believes that recovery is not probable, these amounts should be written down to their recoverable amount, which could be zero. Currently, industry opinion is divided on whether collection is probable. Based on our analysis of 2014 year-end results, 29 companies recorded risk corridor receivables. As we noted above, 12 companies recorded a receivable through Sept. 30 and then reversed this amount in the fourth quarter.

**Are there any changes in the Final HHS Notice of Benefit and Payment Parameters for 2016 that need to be considered for future estimations?**

- **For the risk adjustment program:** The risk factors published in the 2014 Payment Notice for use in 2014 and 2015 were developed using the Truven Health Analytics 2010 MarketScan® Commercial Claims and Encounters database (MarketScan).

The 2016 rule proposes to recalibrate the HHS risk adjustment models to provide risk adjustment factors that best reflect more recent treatment patterns and costs by using 2010, 2011, and 2012 claims data from the MarketScan database. HHS has also proposed that when 2013 MarketScan data become available, HHS may recalculate these factors for publication in the final rule. A comparison of the updated model indicates that the demographic components of the risk scores are generally lower than the respective coefficients in the current model for many age/sex cohorts. Conversely, the health status coefficients in the 2016 model seem to be higher. This observation indicates that the magnitude of the risk score gap between the healthy enrollees and the sicker enrollees is wider in the updated model than in the current

model. The general direction of the movement in the coefficients in the updated model may have important implications in terms of enrolling healthy versus sicker members into a plan.

- **For the reinsurance program:** The attachment point, reinsurance cap, and coinsurance rates were expected to yield payments of \$10 billion in 2014 and \$6 billion in 2015, based on modeling by HHS. For the 2014 benefit year, and possibly future years, HHS proposes that if reinsurance contributions exceed the amount of payments requested, then that year's reinsurance payments to insurers will be increased proportionately. Similarly, if reinsurance contributions fall short of the amount requested for payments, then that year's reinsurance payments will be decreased proportionately.

For 2014, claims subject to reinsurance were not as high as anticipated. So, while collections also didn't meet expectations, there is a surplus of \$1.9 billion that can fund claims in future years. Because payments into the system were under \$10 billion, all of these monies revert back to the program and will not revert to the U.S. Treasury. This could provide capacity for the government to widen the thresholds or share of losses, which would ultimately lower retained losses for insurers.

- **For the risk corridor program:** HHS has repeatedly stated that it anticipates that risk corridors collections will be sufficient to pay for all risk corridor payments. HHS also notes that if risk corridors collections are insufficient to make risk corridor payments for a year, all risk corridor payments for that year will be reduced pro rata to the extent of any shortfall.

### **What should organizations be doing?**

- For the risk adjustment program, insurers have a much clearer understanding of market risk this year. This should reduce the uncertainty of the market level risk and provide companies with better understanding of their risk adjustment estimate. There will be new exchange participants in 2015 and general fluctuations in demographics that affect market-wide health scores, but these fluctuations should continue to diminish as the years pass.
- For the reinsurance provision, companies should monitor whether HHS proposes any changes to the program through either increased risk sharing or changes to thresholds that adjust the reinsurance calculation.
- Similarly, companies that are in a risk corridor receivable position should monitor the results of the industry to see if the issue fixes itself and, if not, whether HHS has a mechanism to support the risk corridor.

For more information on the premium stabilization programs and additional issues of interest to insurers, please reference the additional resources listed below.

### **Additional HFMA Resources for Insurers:**

- <http://www.hfma.org/healthplan/>

### **CMS Resources on the Premium Stabilization Programs:**

- <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/index.html>
- <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2015-Press-releases-items/2015-06-30-2.html>

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