Risk Corridors and Other Risk Mitigation Measures in the Affordable Care Act:

Lessons from Medicare Part D

Statement of

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Before the

Subcommittee on Health

House Committee on Energy and Commerce

July 28, 2014

Good afternoon, Mr. Chairman and Members of the Committee. My name is Jack Hoadley, and I am a Research Professor at Georgetown University's Health Policy Institute. I am a long-time student of health policy, and I have published a wide variety of papers on Medicare, Medicaid, and private health insurance programs. I appreciate the opportunity to speak to the Committee on issues relating to risk corridors in the Affordable Care Act.

Two times in recent history, the Congress has introduced new health insurance programs. In 2003, the Medicare Modernization Act created the Medicare Part D prescription drug program. In 2010, the Affordable Care Act (ACA) created the program of health insurance exchanges as part of a broader initiative to expand health insurance coverage. In both cases, Congress was building a new kind of insurance program not previously in operation. Also in both cases, policymakers were uncertain about how many health plans would choose to participate in the new program and how many Americans would sign up for the coverage offered by these plans. Other uncertainties

included the cost of delivering benefits, the mix of enrollment by health status, and the ongoing stability of the program in the early years. Furthermore, policymakers were concerned that these uncertainties would reinforce each other. Plans would be less likely to participate when they were unsure of how many enrollees they might attract and the health status of these enrollees. If they did participate, they would likely set higher premiums to reflect the uncertainties.

To address these uncertainties, the Congress in both the Medicare Modernization Act and the Affordable Care Act included a set of risk mitigation measures: risk adjustment, reinsurance, and risk corridors – sometimes called the "3 Rs." These measures were designed to help the new markets run more predictably by encouraging entry of insurers in the new insurance markets and stabilizing premiums as the programs got started.

Here is a quick review of the "3 Rs." **Risk adjustment** is a way to adjust payments to plans based on the health status of a plan's enrollees. The idea is to make sure plans and their enrollees are not penalized if their enrollees are sicker than average or rewarded if they are healthier than average coming into the program. Effective risk adjustment also deters plans from trying to avoid being chosen by people with more health risks. Risk adjustment is a permanent part of both Medicare Part D and the ACA's insurance system.

Reinsurance is a means of insuring the insurers by providing extra payments if an excessive number of their enrollees incur unusually high costs, such as having more accidents or more cancer diagnoses than average. As with risk adjustment, the intent is to make sure that plans are not penalized or rewarded based on how many high-cost people they enroll and to reduce incentives to avoid high-cost individuals. In Medicare Part D, plans receive reinsurance payments to cover most of a beneficiary's drug claim costs above a specified annual dollar threshold. These payments are figured into the overall level of federal payments to the drug plans so that overall federal costs are

not increased. In the ACA, money is collected from plans to fund a reinsurance pool. Payments are adjusted to ensure that the program remains budget neutral. The ACA reinsurance program expires after 2016, whereas the law did not call for an end to reinsurance in the Medicare Part D program.

Risk corridors (or **risk sharing**) involve creation of a fund so that plans with unusually high gains pay back some of those gains and those with unusually high losses are partially compensated. The idea is to keep premiums affordable and to reduce the risk faced by plans during the first years of the program as they learn from experience how to price their plans accurately. The risk corridors in both programs are designed on a two-sided basis to limit both health plan losses and health plan gains. If plans underestimate costs, they receive payments from the government to reduce, but not eliminate, the loss. If plans overestimate costs, they make payments to the government to reduce, but not eliminate, the gain. In the ACA risk corridor system, which expires after 2016, health plans retain all gains or losses if claims are within 3 percent of expected spending. If actual claims exceed expectations by more than 3 percent, the federal government reimburses 50 percent of the loss between 3 percent and 8 percent or 80 percent of any loss exceeding 8 percent. Similarly, the health plan pays the federal government 50 percent of gains between 3 percent and 8 percent and 80 percent of any gains over 8 percent. Under this design, all health plans maintain a share of the risk for any losses and thus retain an incentive to set premiums as accurately as possible.[1]

These risk mitigation measures have been in use for Part D for nine years. So how have these measures worked in Part D?[2] The best measure of their success is that participation by both health plans and Medicare beneficiaries is still robust in the program's ninth year, and the program is popular with both plans and enrollees. Although the science of risk adjustment is imperfect, the risk

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[1] Cori Uccello, Statement before the House Committee on Oversight and Government Reform, Subcommittee on Economic Growth, Job Creation and Regulatory Affairs, June 18, 2014.

[2] Jack Hoadley, "How the '3 Rs' Contributed to the Success of Medicare Part D," CHIRBlog, January 27, 2014, http://chirblog.org/how-the-3rs-contributed-to-the-success-of-part-d/

adjusters have been refined since the program's start. Among the standalone Part D plans in 2011, risk-adjustment scores ranged from 72 percent to 146 percent of the average plan score. The plans at the high end would either have suffered significant losses or been forced to charge much higher premiums in the absence of risk adjustment. The opposite would have been true on the low end; the plans with the lowest-risk enrollees would have been paid far more than their actual claims costs. Reinsurance payments in 2012 for Part D plans averaged about $40 per member per month; as such, they helped discourage plans from trying to avoid enrollees with unusually high drug costs.

In contrast to the idea that risk corridors are solely a means of bailing out plans, the experience in Part D suggests that they have actually protected taxpayers. In each of the program's first seven years, plans as a whole made net payments back to the government as a result of greater profits than expected from their bids, as opposed to receiving payments from the government. In 2012, the most recent year for which data are available, the plans paid $1.1 billion back to the government. Overall, three-fourths of all Part D plan sponsors, representing a similar share of Part D enrollees, made payments back to the government. In effect, and perhaps contrary to what some have expected, the risk corridors in Part D have been protecting the government from excessive profits by health plans as opposed to protecting health plans against pricing too low.

All of the "3 Rs" continue to operate in Part D. But in the Affordable Care Act, two of them (risk corridors and reinsurance) were designed as short-term measures that will go away after 2016 after the Marketplaces have been in place for three years. Although one could argue that the role of risk corridors and reinsurance could be reduced or eliminated in Part D after nine years, there is a good case that can be made for the role they played in establishing a functional, sustainable and robust market. The Part D experience also demonstrates that risk corridors have protected the program from uncertainty both in its first years and beyond.