United Hospital Fund

**The *Big Picture* Snapshot Series**

Since 2009, UHF's Health Insurance Project has been publishing *The Big Picture*, a series analyzing health plan enrollment and financial results in New York's private and public health insurance markets. The rollout of the Affordable Care Act (ACA) made 2014 a watershed year for New York's marketplace; we are marking that event with a series of snapshots highlighting specific issues related to the ACA, as a complement to the forthcoming *Big Picture* chartbook on health plan operations.

Together, these briefs will provide a fuller picture of issues and trends affecting the health insurance market since implementation of the ACA.

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# After the Reinsurance Is Gone: A New Challenge for New York's Individual Market


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A Special Report from United Hospital Fund

## Introduction

Good health insurance protects families from catastrophic medical expenses that could bankrupt them financially. In the same way, reinsurance—insurance for insurers, in effect, and an important component of the Affordable Care Act (ACA)—shields health plans from the expenses of high-cost enrollees in the Exchange and off-Exchange individual market segments. In this *Big Picture* snapshot, we examine the New York operations of the ACA's Transitional Reinsurance Program (TRP) for the individual market, one of three federal premium stabilization programs known as the "3 Rs," for reinsurance, risk corridors, and risk adjustment. Our focus in this brief is on the way the program also improves the affordability of coverage for consumers by reducing needed premium increases, and the policy issues that arise from the expiration of the program in 2016.

## How the TRP Works

The TRP was funded at $10 billion nationally for calendar year 2014, the first year of the three-year program, through a $63 per-person, per-year assessment on health plans and administrators participating in all fully insured and self-funded market segments. Federal regulators established a "reinsurance corridor" that started at $45,000 in claims for an individual (known as the "attachment point") in calendar year 2014, and ended at $250,000 (the "cap"); claims within this corridor were fully reimbursed by the TRP at a 100 percent "coinsurance" rate, with health plans responsible for claims up to $45,000 and over $250,000 for a particular enrollee in a calendar year.[1]

Federal officials establish the risk corridor parameters each year based on available funding, adjusting the variables, but the TRP's focus continues to be reimbursing claims from high-cost individuals. This is an efficient way to encourage health plans to participate in markets (before the ACA, health plans in many states, though not in New York, could screen out enrollees likely to generate claims or charge higher premiums) and to stabilize premiums, as the reinsurance offsets a portion of the expenses generated by high-cost individuals who account for a large proportion of overall claims. One recent study found that the top 1 percent of commercially insured individuals accounted for one-quarter of all health expenses, an average of $91,000 per enrollee,[2] and studies based on all

1 45 Code of Federal Regulations 153.220. Collection of reinsurance contribution funds. http://www.gpo.gov/fdsys/pkg/FR-2015-02-27/pdf/2015-03751.pdf. The final total for national TRP distributions was $7.9 billion. Federal officials indicated that unallocated funding for 2014 would be used for the 2015 benefit year. *Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2014 Benefit Year*, revised September 17, 2015. https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RI-RA-Report-REVISED-9-17-15.pdf

2 National Institute for Health Care Management Foundation. July 2012. *The Concentration of Health Care Spending*. Data brief. http://www.nihcm.org/pdf/DataBrief3%20Final.pdf



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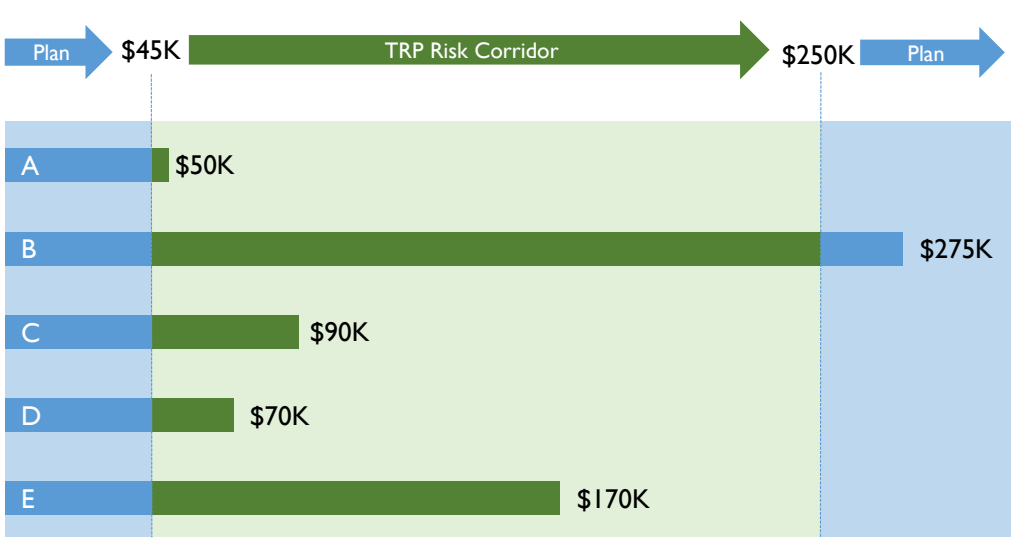
## Figure 1. How Reinsurance Reduces Needed Premium Increases




| Medical Claims | | |
|---|---|---|
| | *With TRP* | *No TRP* |
| A: $45K | $50K | |
| B: $70K | $275K | |
| C: $45K | $90K | |
| D: $45K | $70K | |
| E: $45K | $170K | |
| **Total: $250K** | **$655K** | |

*Lower total → Lower rate increase*

types of coverage and on just Medicaid enrollees found similar patterns.[3] Figure 1 shows how reinsurance works, and how it also helps keep premium rates down for all individuals. Based on a hypothetical health plan with 500 individual members, the figure tracks how the TRP reduces claims costs for the 1 percent of members with TRP-eligible claims ranging from $50,000 to $275,000. The $400,000 decrease in medical expenses reimbursed by the TRP results in lower premiums for enrollees in the plan, because it decreases the medical claims that health plans project as part of the rate approval process, which is a key component of rate change applications.

Table 1 shows the TRP distribution of about $288 million in reinsurance funds to New York health plans operating in both the Exchange and off-Exchange individual market in 2014, further broken down by enrollment and per member per year (PMPY) allocations, with some surprising results. Health Republic, the new cooperative insurer with the highest Exchange enrollment of any plan in 2014, received the largest share of funds ($58 million). Despite this significant TRP support, Health Republic encountered significant financial problems and was directed to shut down in 2015 by the Department of Financial Services (DFS) and the Centers for Medicare & Medicaid Services (CMS). Another popular Exchange insurer, Empire BCBS, received the second highest allocation. Some health plans ranked high in TRP allocations without participating in the Exchange market at all, or with limited enrollment. For example, the third-ranked plan, Oxford HMO, reported no Exchange enrollment in 2014 and modest off-Exchange individual membership, but it received by far the highest PMPY allocation of any health

3 IMS Institute for Healthcare Informatics. February 2012. *Healthcare Spending Among Privately Insured Individuals Under Age 65*. https://www.imshealth.com/files/web/IMSH%20Institute/Reports/Healthcare%20Spending%20Among%20Age%2065/IHII_Spending_Report.pdf; Government Accountability Office. May 2015. *A Small Share of Enrollees Consistently Accounted for a Large Share of Expenditures*. GAO-15-460. http://www.gao.gov/assets/680/670112.pdf

plan. The fourth highest plan, Excellus BCBS, had very limited Exchange enrollment, but reported significant individual membership outside the Exchange.

In addition to offsetting the medical expenses of people with high claims, these TRP payments have lowered premiums for all individual market enrollees significantly. In its rate filing instructions, DFS cited federal data to project an overall premium rate reduction of about 12 percent for individuals in 2014 because of the TRP, but lowered that estimate to 6 percent for 2015 to reflect national TRP collections and allocations set at $6 billion for 2015. New York health plans have already calculated the impact of the reduced TRP support in their rates for 2016, when national reimbursement under the TRP will drop to $4 billion. Excellus BCBS estimated that declining TRP support will require a 2.6 percent increase for individual plans in 2016, and HealthFirst PHSP estimated that a decrease of 4.5 percent in TRP support for medical claims alone is driving a 4.5 percent increase in its requested premiums for 2016.

**Table 1. Distribution of Reinsurance Funds to New York Health Plans, 2014**

| Health Plan | Reinsurance Payment | Total Individual Enrollment | Reinsurance Payment PMPY |
|---|---|---|---|
| Health Republic | $58,217,807 | 86,401 | $673.81 |
| Empire BCBS HMO | $38,100,184 | 63,367 | $601.26 |
| Oxford Health Plans HMO | $37,810,244 | 11,618 | $3,254.45 |
| Excellus BCBS | $25,521,166 | 67,884 | $375.95 |
| HIP | $24,545,381 | 27,764 | $884.07 |
| MVP Heath Plan, Inc. | $20,053,743 | 33,421 | $600.03 |
| Oscar Insurance Corporation | $17,524,069 | 16,944 | $1,034.23 |
| Aetna Life Insurance Company | $14,885,554 | 5,669 | $2,625.78 |
| Fidelis Care | $13,745,381 | 46,186 | $297.61 |
| UnitedHealthcare of New York, Inc. | $9,905,407 | 5,857 | $1,691.21 |
| North Shore-LIJ CareConnect | $5,663,264 | 9,587 | $590.72 |
| CDPHP | $5,393,821 | 4,035 | $1,336.76 |
| MetroPlus Health Plan | $4,200,475 | 36,086 | $116.40 |
| HealthFirst PHSP, Inc. | $4,031,461 | 6,377 | $632.19 |
| HealthNow BCBS | $3,203,678 | 10,428 | $307.22 |
| Independent Health | $2,847,602 | 4,455 | $639.19 |
| Total | $287,750,992 | | |

Sources: *Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2014 Benefit Year,* www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RI-RA-Report-REVISED-9-17-15.pdf; author's analysis of 2014 New York Supplements, 2014 Supplemental Health Care Exhibits, and 2014 New York MMCORs.

Notes: Included in total are smaller TRP payments to five health plans totaling $2,101,755: Freelancers Insurance Company, American Progressive Life and Health (Today's Options), Affinity, GHI, and Blue Shield of Northeastern New York.

## The Choices Ahead

The expiration of the TRP presents policymakers with a number of issues to consider, some involving the remaining "2 Rs," the Risk Corridor Program (RCP), designed to protect health plans participating in the Exchange from "pricing errors" that caused higher than anticipated losses, and the Risk Adjustment Program (RAP), which equalizes the costs of high-cost enrollees among all health plans by collecting and distributing assessments. The most pressing issue is determining whether it is possible to replace the TRP subsidy funds, at a time when New York hopes to maintain affordability for existing individual market enrollees so they renew their coverage, and attract new enrollees. Following are some options to consider, though none would be an easy lift in terms of implementation, and some would require the cooperation of federal officials.

**A State Reinsurance Program.** Replacing the TRP with a New York reinsurance program is one option. New York once operated its own reinsurance program for the individual market[4] and Healthy New York programs, funded initially from a market-wide assessment that includes large self-funded plans as part of the Health Care Reform Act (HCRA) financing system.[5] Even with New York's past experience, reviving this program would be a complex undertaking, and would continue a subsidy from large groups to individuals that is unpopular with large employers.

**Full Funding for the Risk Corridor Program.** As noted earlier, Health Republic's TRP payments were significant but not sufficient to keep it afloat; its demise resulted partly from how it fared in allocations from the RCP. The RCP was modeled on a permanent Medicare Part D drug benefit mechanism and designed to safeguard health plans from "pricing errors" that occurred because of uncertainty about the relative risk of the population that would sign up for coverage under the ACA. In essence, the RCP allowed health plans to recoup a proportion of their losses if their expenses significantly exceeded the premiums they took in. Congressional cuts to the RCP, tarred as an "insurer bailout," led to more than a 75 percent reduction in the $140 million Health Republic expected from the program, a proportional cut that applied to all plans.[6] In a recent directive, federal regulators pledged to continue the RCP and increase funding, but Congress recently extended cuts to the program,[7] effectively closing that window unless further action is taken.

**Reducing Existing State Fees and Assessments.** In addition to fees and assessments related to the ACA, New York health insurance premiums also reflect the costs of state assessments, taxes, and surcharges to fund a wide range of health-related programs, an approach unique to this state. New York's budget for 2016 included over $4 billion in surcharges and assessments on health plans under the Health Care Reform Act[8] financing system, not counting premium taxes and assessments supporting the cost of the DFS, all of which increase the cost of coverage for individuals and employers. Reducing these state assessments has long been a goal of the health insurance industry and business groups.[9] While reducing these

4 For background information, see Administration of the Individual Direct Payment Health Insurance Program Report 2008-S-167. State of New York Office of the State Comptroller. June 4, 2009. http://osc.state.ny.us/audits/allaudits/093009/08s167.pdf

5 New York Public Health Law, section 2807-v (g).

6 Demko P. January 9, 2015. Republicans seek to eliminate risk-corridor program. *Modern Healthcare*. http://www.modernhealthcare.com/article/20150109/NEWS/301099975

7 H.R. 2029, the Consolidated Appropriations Act, 2016, section 225.

8 New York State Division of the Budget. FY 2016 Enacted Budget Financial Plan. May 2015. https://www.budget.ny.gov/budgetFP/FY16FinPlan.pdf

9 New York State Conference of Blue Cross and Blue Shield Plans. January 2013. *Taxes on New York's Privately Insured*. http://www.nysblues.org/pdf/TaxesonPrivatelyInsured2013.pdf

costs would help offset declining TRP funding, targeting a reduction to the individual market would be difficult, and policymakers would face the problem of identifying alternative sources of funding for programs currently funded through HCRA or curtailing support.

**Getting the Numbers Right.** Implementing the premium stabilization programs was among the most challenging implementation tasks both government agencies and health plans faced under the ACA. Regulators and plans also grappled with mid-stream changes to the programs adopted by Congress and federal regulators, and challenges that come with the retrospective nature of the program, which requires reconciling the estimates of payments or reimbursement, with actual claims experience at the end of the year. Now that both sides have an actual year's experience under their belts, it will be important that remaining reinsurance payments are calculated properly so that consumers continue to see the benefit of reinsurance support, rates for health plans accurately reflect reduced TRP payments, and that health plans meet federal minimum loss ratio requirements.[10] Finally, regulators and policymakers will have to monitor the permanent Risk Adjustment Program to ensure that it is meeting its goal of protecting health plans from absorbing a disproportionate share of higher-risk individuals.

Although in 2014 the RAP collected and distributed $141 million to the individual market and $195 million to small group plans,[11] it assessed and distributed funds only from plans within the individual and small group markets, a zero-sum game that does not provide support from other sources to lower premiums. Federal officials recently solicited suggestions on how the program could be improved.[12] One question worth examining is why Health Republic was a recipient of $58 million in TRP funds for 2014, but paid out over $80 million in RAP funds, including over $28 million in the individual market. RAP collections and allocations are based on how a health plan's risk score, derived from the detailed demographic and diagnostic data reported on enrollees, compares to that of other health plans in the region.[13] It is hard to reconcile why a health plan would receive significant TRP payments for high-cost individuals at the same time it is paying out RAP payments to plans with a presumably higher-risk enrolled population. Some observers have maintained that incumbent plans were more skilled at the complex reporting required for the RAP, and a coalition of newer health plans has called on CMS to address shortcomings in the design of the program.[14]

10 Federal regulators notified two New York insurers, Independent Health and UnitedHealthcare, that they owed individual market rebates of $896,102 and $827,366 for 2014, respectively, based on minimum medical loss ratio requirements. Center for Consumer Information & Insurance Oversight. Issuers Owing Rebates for 2014. https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/Issuers_Owing_Refunds_for_2014.pdf

11 *Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2014 Benefit Year*, revised September 17, 2015. https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RI-RA-Report-REVISED-9-17-15.pdf

12 Department of Health and Human Services, Notice of Meeting. HHS-Operated Risk Adjustment Methodology Meeting, March 25, 2016. www.federalregister.gov/articles/2016/01/11/2016-219/hhs-operated-risk-adjustment-methodology-meeting-march-25-2016

13 Kautter J, GC Pope, M Ingber, et al. 2014. The HHS-HCC Risk Adjustment Model for Individual and Small Group markets under the Affordable Care Act. *Medicare & Medicaid Research Review* 4(3): E1–E46. https://www.cms.gov/mmrr/Articles/A2014/MMRR2014_004_03_a03.html

14 Goldstein A. January 13, 2016. Critics say ACA "risk" strategies are having reverse Robin Hood effect. *The Washington Post*. http://wpo.st/0Il91. Correspondence from CHOICES to the Honorable Sylvia Burwell, Secretary Department of Health and Human Services. November 4, 2015. http://nashco.org/wp-content/uploads/2015/11/CHOICES-White-Paper-on-Risk-Adjustment-Issues.pdf

## Conclusion

The sunset of the TRP and reduced funding for the RCP have now created an additional upward pressure on premium rates for the individual market, in addition to increasing prices for services and other factors. While policymakers contemplate whether the loss of TRP and RCP program support can or should be offset—a difficult policy decision involving competing priorities that would be equally hard to implement—the focus will shift to longer-term collaborative efforts by health plans and providers to reduce costs and improve quality through new payment arrangements, ways to improve the pooling of risks in the markets, and other options.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## Sources and Methodology

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