One of the primary goals of the Affordable Care Act (ACA) is to expand access to affordable health insurance (actually, to free health insurance for many lower-income individuals). The ACA includes various mechanisms to accomplish this goal, including requiring insurers to cover everyone who applies, prohibiting insurers from imposing preexisting conditions limitations, and severely limiting the factors insurers can consider in setting premiums. Obviously, these mechanisms put insurers at financial risk, since their underwriters won't have sufficient data to predict claims costs, such as the number of people likely to enroll, their health status and claims history, or other demographic information on enrollees.

To mitigate these risks, the ACA includes three risk-sharing provisions intended to protect insurers financially, especially in the first few years of the new program. These risk-sharing programs are often called the “3 Rs” because they are Risk Adjustment, Reinsurance, and Risk Corridor.

These risk-sharing programs have been reported on by the mainstream media recently and even discussed in nighttime news shows, because critics of the ACA claim that the botched roll-out of the Exchanges and the transitional rule allowing insurers to renew non-ACA-compliant plans until October 2016 will result in many more healthy people not enrolling in coverage through the Exchange and instead staying in their pre-ACA plans, which will cause the Exchange risk pools to be even worse than the actuaries initially expected.

The 3 Rs are complicated and their names sound similar. This matrix summarizes the salient features of each of the 3 Rs. It is intended as a quick and easy-to-read review of the three risk programs. For additional information (from different perspectives), the articles listed after the matrix will be helpful.
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<td>To combat overall adverse selection since health insurance is now guaranteed issue, carriers cannot impose pre-existing conditions limitations, &amp; cannot vary premiums based on individual’s health status.</td>
<td>To stabilize premiums in the individual market during the first 3 years, because higher-cost (sicker) individuals are more likely to enroll early.</td>
<td>To limit insurer gains and losses in first 3 years, because insurers had limited data on expected enrollment on which to set prices. Intended to encourage competition by limiting risk exposure.</td>
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<td>Redistributes money between...</td>
<td>Shifts money among insurers. Redistributes money from insurers with lower claims enrollees to those with higher claims enrollees</td>
<td>Shifts money from group health plans to certain insurers with QHPs on the individual exchange who have high cost enrollees.</td>
<td>Shifts money from QHPs (in Exchanges) with actual costs less than premiums to QHPs (in Exchanges) with actual costs more than premiums.</td>
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<td>Who Pays</td>
<td>All non-grandfathered insured plans in individual and small group market, whether in or outside the Exchanges. The Risk Adjustment program is intended to be revenue neutral, i.e., not affect the federal budget.</td>
<td>All group health plans, both insured &amp; self-funded, pay for 2014. In 2015 &amp; 2016, self-insured plans that self-administer claims will not have to pay. Transitional Reinsurance Fee does not apply to individual policies, in any year.</td>
<td>Insurers who have actual claims less than expected claims. If funds from these insurers are not sufficient, HHS is directed to pay the excess. Per CRS Opinion letter (1-23-14), ACA did not provide for creation of a specified source of funds or a revolving fund, so it’s unclear exactly how payments will be made, unless future legislation creates such fund or specifies source from which payments will be made.</td>
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<td>Amounts</td>
<td>Depends on the extent to which certain insurers get more than their share of higher-claims enrollees</td>
<td>2014: $10 bil ($63 pmpm) 2015: $8 bil ($44 pmpm) 2016: $5 bil</td>
<td>Depends on how much actual claims vary from expected claims and from premium revenue.</td>
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<td>How it Works</td>
<td>Compares insurers within a state based on the average financial risk of their enrolled population. Then, to more evenly spread the financial risk among insurers, payments are made to insurers who cover a higher-risk population (e.g., people who are older, sicker, or have more chronic conditions)</td>
<td>2014: Once an insurer has paid $45k in claims for an individual (the attachment point), the insurer will be reimbursed for 80% of costs between $45k &amp; $250k per person (Originally $45k was $60k) 2015: $70k attachment point per insured, then insurer will be reimbursed for 50% of costs between $70k &amp; $250k. HHS publishes a Notice of Benefit &amp; Payment Parameters each March, with the numbers for the following year.</td>
<td>If actual claims are within 3% of expected claims, insurers in Exchanges keep the profits or bear the risks. If claims are 3-8% more (or less) than expected, insurers pays the gov’t (or is reimbursed by the gov’t) 50% of the gains (losses) and keeps (or bears the loss of) the other 50%. If claims are at least or &gt; 8% more (or less) than expected, insurer pays the gov’t (or is reimbursed by the gov’t) 80% of the gains (losses) and keeps (or bears the risk of) the other 20%.</td>
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The following articles are helpful if you want to better understand just how the 3 Rs work.

Explaining Health Care Reform: Risk Adjustment, Reinsurance, and Risk Corridors

“The ACA’s risk adjustment, reinsurance, and risk corridors programs are intended to protect against the negative effects of adverse selection and risk selection, and also work to stabilize premiums, particularly during the initial years of ACA implementation. Each program varies by the types of plans that participate, the level of government responsible for oversight, the criteria for charges and payments, the sources of funds, and the duration of the program.” (Kaiser Family Foundation) 1-22-2014

ACA Premium Stabilization Programs: How Reinsurance, Risk Corridors, and Risk Adjustment Protect Consumers (PDF)

The Affordable Care Act (ACA) creates three interconnected risk management programs intended to protect consumers by stabilizing premiums during the initial years of the law’s implementation. . . . Because of the increased uncertainty with the www.healthcare.gov website and the change in treatment of 2013 policies, the ‘3Rs’ [reinsurance, risk corridors, and risk adjustments] will play a more critical role in creating a stable market for consumers. Consumers’ decisions to continue their 2013 policy, purchase an ACA-compliant policy, or forego coverage in 2014 may necessitate adjustments to the 3Rs. Without additional support, consumers may face higher premiums and fewer choices in future years.” (America’s Health Insurance Plans [AHIP]) November 2013 http://www.ahipcoverage.com/wp-content/uploads/2013/11/ACA-Premium-Stabilization-Programs-3.pdf

Risk Adjustments in ObamaCare

The three risk-sharing “programs are all aimed at protecting individual insurance companies from the consequences of ObamaCare enrollment and rating restrictions. None of them ensure the solvency of the market as a whole. Indeed, they do just the opposite — they encourage the sickest people to enroll by subsidizing them while discouraging the healthiest people to enroll by overcharging them. So, while individual companies may be exempt from the ‘death spiral,’ the program as a whole is not.” (by Greg Scandlen, in John Goodman’s Health Policy Blog) 1-22-2014 http://healthblog.ncpa.org/risk-adjustments-in-obamacare/
Funding Not Clearly Provided by ACA for Risk Corridor Payments (PDF)

“While the language of ACA 1342(b)(1) establishes a directive to the Secretary to make such payments, it does not specify a source from which those payments are to be made. Therefore, Section 1342 would not appear to constitute an appropriation of funds for the purposes of risk corridor payments under that section.... [T]he amounts received by HHS from plans that have overestimated premiums for a given year are not explicitly designated to be deposited in a revolving account or otherwise made available for outgoing payments under Section 1342(b)(1). Therefore, there does not appear to be sufficient statutory language creating a revolving fund that would make amounts received under Section 1342(b)(2) available to pay amounts due to eligible plans under Section 1342(b)(1).” (Congressional Research Service) 1-23-2014

Obamacare ‘Bailout’ for One Insurer Will Cost Up to $450 Million in 2014

“Humana announced that it expects to tap the three risk adjustment mechanisms in ObamaCare for between $250 and $450 million in 2014. This amounts to about 25 percent of the insurer’s expected exchange revenue. This money is needed to offset losses that the insurer will take as a result of slower enrollment in its ObamaCare plans, and a skewed risk pool that weighs more heavily toward older and less healthy members than it originally budgeted. More than half of the money will come from the $25 billion reinsurance pool that ObamaCare provides (collected through a tax on employer-sponsored health plans). The other half will come mostly from the risk corridors.” (Forbes) 2/6/2014