

Health Policy Brief

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Risk Corridors. An amendment to the 2015 federal budget continuing appropriation raises a question: Will insurers receive their full 2014 risk corridor payments?

WHAT'S THE ISSUE?

The risk corridor program created by the Affordable Care Act (ACA) has proven to be one of the most controversial aspects of the health care law. Questions have been raised about the source of payments, whether the Department of Health and Human Services (HHS) has the authority to make payments under the program, and whether the program is required to be budget neutral.

In response to questions from the Government Accountability Office (GAO) on its budget authority for risk corridor payments, HHS cited section 1342 of the ACA, which establishes the risk corridor program and requires HHS to collect payments from and make payments to certain qualified health plans. HHS says that the fees collected and the payments made under the risk corridor program are consistent with the definition of user fees.

The fiscal year 2014 appropriation gives the Centers for Medicare and Medicaid Services (CMS) the authority to collect user fees and keep the fees available for use through the 2019 fiscal year. HHS states that this appropriation along with section 1342 gives CMS the authority to collect and distribute risk corri-

dor payments. In an opinion issued September 2014, the GAO agreed that payments collected under the risk corridor program are “properly characterized as user fees.”

In addition, the GAO found that HHS has the authority to use its regular operating funds to finance risk corridor payments should the amounts received under the program be less than the payments required to be made to insurers. This authority was granted under the Program Management Appropriation for fiscal year 2014 that allows transfers of money from the Hospital Insurance Trust Fund and the Supplementary Medical Insurance Trust Fund necessary to carry out the responsibilities of CMS.

The first risk corridor payments are not due until the 2015 fiscal year, however, so similar language was required in the 2015 appropriation bill. While the Consolidated and Further Continuing Appropriations Act of 2015, which funded the government for the 2015 fiscal year, did give HHS the authority to collect user fees, an amendment was included that specifically prohibited HHS from transferring money from either trust fund. The amendment did not eliminate the risk corridor program, nor did it prevent HHS from using payments received from insurers to pay out claims under

“Much of the detail of the risk corridor program was not in the ACA and was left to regulation.”

the program (that is, user fees), but it effectively made the risk corridor program budget neutral unless HHS can find another source of funding. As a result, insurers expecting payments from HHS may not receive the full amount due.

WHAT'S THE BACKGROUND?

In addition to creating health insurance Marketplaces and premium subsidies to make insurance more affordable, the ACA completely changed the way insurance is priced and sold in the individual market. As of 2014 insurers (both those participating in the Marketplaces and those selling on the individual market outside the Marketplaces) face a number of new restrictions.

Insurers must accept every applicant, regardless of health status or any preexisting condition, and cannot charge more for customers based on their medical history, a process known as medical underwriting. Insurers are limited in how much they can vary premiums based on age and tobacco use. Insurers cannot charge women more than men for a comparable policy and must spend at least 80 percent of premiums on medical claims; this is known as the minimum medical loss ratio requirement. (Age, sex, tobacco use, and previous medical claims are highly predictive of future medical expenses and were routinely used by insurers to set premiums or reject applicants before the ACA prohibited the practice.)

Beyond the restrictions on how insurers treat applicants and set premiums, there was a great deal of uncertainty regarding who would purchase health insurance through the Marketplaces. A significant number of people buying Marketplace plans may have been previously uninsured, some of whom may have untreated medical needs or chronic conditions requiring expensive immediate or ongoing medical care. Insurers do not have good data on the health status and medical costs of the uninsured. This uncertainty made it difficult for insurers to set their premiums and could have discouraged insurers from participating in the Marketplaces.

If insurers set premiums too low, they may not have enough money to cover their enrollees' medical expenses and could become insolvent or would need to increase premiums substantially the following year to reflect new assumptions of a prospectively higher-cost risk pool, potentially losing market share. If they set premiums too high, insurers may find

themselves at a competitive disadvantage compared to other insurers offering policies in the Marketplaces. (They may also be required to provide consumers with rebates or lower future premiums if they do not meet the 80 percent medical loss ratio described above.)

With the new restrictions on premium setting and the unpredictability of medical expenses from the newly insured, insurers faced a high level of uncertainty when setting their premiums. To buffer insurers from high losses in the initial years, keep premiums affordable, encourage insurers to participate in the Marketplaces, and minimize year-to-year premium fluctuations, [the ACA authorized three premium stabilization programs: risk adjustment, reinsurance, and risk corridors.](#)

At the time the ACA was passed, risk corridors were noncontroversial. Risk corridors were included in the now popular Medicare Modernization Act of 2003, which established coverage of prescription drugs through Medicare Part D.

This issue was highlighted when [the administration allowed some noncompliant policies to be renewed](#) following outcries over cancelled policies. If people who renewed noncompliant policies were healthier on average than those who purchased insurance through the Marketplaces, risk corridor payments could be higher than initially projected. Changes were made to reinsurance and risk corridor programs to account for the lower enrollment and potential adverse selection in the Marketplaces as a result of people renewing noncompliant plans.

WHAT'S IN THE LAW?

[Section 1342 of the ACA](#) requires HHS to set up a temporary risk corridor program to help reduce pricing uncertainty in the new health insurance Marketplaces. The risk corridor program is for plan years 2014–16. Combined with the other premium stabilization programs, it encourages insurers to participate in the Marketplaces by eliminating some of the unpredictability of newly insured enrollees.

The risk corridor program compares allowable costs to a target amount (see Exhibit 1). The target amount is equal to the premium charged after administrative costs are subtracted. Allowable administrative costs include taxes and regulatory fees, administrative costs, and profit. Allowable costs are the same as those used in the medical loss

ratio calculation and include medical claims, quality improvement efforts, and health information technology. In addition, payments and charges from the risk adjustment and reinsurance programs are included in the risk corridor calculation to adjust the allowed costs and/or target amount.

The law specifies that insurers that have a ratio of allowable costs to the target amount that is within 3 percentage points in either direction (97–103 percent) will keep all of their profits and be responsible for all of their losses. Insurers with actual costs between 92 percent and 97 percent of the target amount would pay HHS half of their gains within that range, while insurers with costs between 103 percent and 108 percent would be reimbursed half of their losses within that range. Insurers with actual spending below 92 percent of the target amount would refund the federal government 80 percent of those gains within that range.

Conversely, insurers with actual spending above 108 percent would be reimbursed 80 percent of those losses within that range by the government. While the risk corridors are symmetric, the ACA does not require the program to be budget neutral. As a whole, if the market suffers from adverse selection and premiums are inadequate, more payments will go out than are collected. On the other hand, if the market is priced too high, the government will receive more payments than it will spend on reimbursements. As is discussed in more detail below, however, it is unclear whether any scheduled payments that exceed collections will be paid.

The amount insurers pay to the government for higher-than-expected gains and the reim-

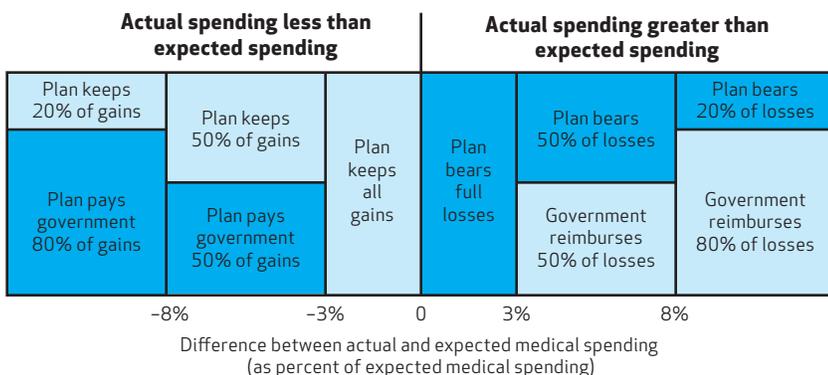
bursements insurers receive for higher-than-expected losses are cumulative. For example, if the target amount was \$500, but an insurer had actual spending of \$550, its ratio would be 110 percent. The insurer would receive no reimbursement for the first \$15 of loss, 50 percent for its losses between 103 percent and 108 percent, and 80 percent for expenses above 108 percent, for a total reimbursement of \$20.50 (see Exhibit 2).

Much of the detail of the risk corridor program was left to regulation. In March of 2012, 2013, and 2014, HHS issued regulations implementing risk corridors, and in May 2014, it finalized regulations implementing the 2015 and 2016 risk corridors. Additional policy guidance has been provided through several frequently asked questions fact sheets. The risk corridor program has evolved somewhat since the March 2012 regulations, both arising from and resulting in concerns from both political opponents and insurers. The latest proposed regulation on benefit and payment parameters for 2016 reiterates the HHS position outlined in previous FAQs that it expects to collect enough money through risk corridor user fees during the three years of the program to make all required risk corridor payments.

Taking into account these potential changes to the risk pool from people renewing non-compliant policies, HHS increased the profit margin floor from 3 percent to 5 percent and increased the allowable administrative costs from 20 percent to 22 percent. For 2014 these adjustments are available only in states that allowed insurers to renew otherwise noncompliant plans. For 2015 and 2016 these changes to the profit margin floor and allowable administrative costs were adopted for all plans in all states. These changes increase the likelihood and amount of scheduled risk corridor payments to insurers. However, increased payments under the reinsurance program reduce the likelihood and amount of scheduled risk corridor payments to insurers.

EXHIBIT 1

ACA Risk Corridors



SOURCE Reprinted with permission from the American Academy of Actuaries, *Fact Sheet: ACA Risk-Sharing Mechanisms*, 2013.

WHAT'S THE DEBATE?

PREMIUM STABILIZATION OR INSURER BAILOUT? The risk corridor program has proven to be one of the more controversial aspects of the ACA with critics, including a number of Republicans in Congress, characterizing the program as an insurer bailout. They argue that as a result of HHS and state officials putting pressure on insurers to keep premiums low in the Marketplaces, the federal govern-

ment will end up picking up the tab to bail out insurers if they underpriced.

Critics also claim that the program encourages insurers to underprice their plans in order to gain market share, knowing the government will offset their losses. As noted in Exhibit 2, however, the risk corridor program does not reimburse all of an insurer's losses (or recapture all of an insurer's gains). An insurer would have its loss reduced under the above scenario but would still lose money. It is worth noting that the medical loss ratio requirement also limits insurer profits but does not limit their losses.

Risk corridors have broad support from economists, health policy experts, insurance companies, and regulators. The ACA risk corridor was modeled after a similar program in Medicare Part D signed by President George W. Bush. The risk corridors in Medicare Part D began with the program in 2006 and are still in effect, with the amount of risk held by plans increasing over time.

In the first year of Part D about 80 percent of insurers made payments back to Medicare, and only 20 percent of insurers received money, according to a report from the HHS Office of Inspector General. Since the inception of Part D risk corridors, the federal government has collected more money from insurers than it paid out through the program. Based on the Medicare Part D experience, the Congressional Budget Office (CBO) at one point projected \$8 billion in revenue from risk corridors. When HHS subsequently stated the intention

to implement risk corridors in a budget neutral way, CBO eliminated its revenue projection from the risk corridor program.

The decision by HHS to enforce budget neutrality in the risk corridor program was disconcerting to insurers because of the possibility that receipts in a given year would not be sufficient to cover risk corridor payments. HHS first raised the issue of budget neutrality in the 2015 proposed rule and expanded on it in policy guidance issued through a series of frequently asked questions (FAQs). In the FAQs, HHS said it anticipated that receipts from insurers would be sufficient to fully make all payments due under risk corridors, but if they were not, all payments would be reduced on a pro rata basis. Any shortfalls would first be made whole the following year using receipts from insurers before making that year's payments. Any receipts in excess of those needed would be held in the event of a shortfall in future years.

In the final regulations released in May 2014, responding to concerns from insurers that a potential shortfall in risk corridor payments introduces additional uncertainty in their rate setting, HHS clarified that the ACA requires full risk corridor payments to be made, regardless of any shortfall, and says that it will find other sources of funding for risk corridor payments, "subject to the availability of appropriations."

A recent report from [Citi Research](#) found that some insurers are expecting significant payments from the risk corridor program. Analyzing statutory filings from public and private insurers, Citi Research found that a handful of insurers estimate that they accrued risk corridor receivables—that is, they expect risk corridor payments from the government—of \$410 million for the first half of 2014. Only one insurer projects that it will have to make a payment to the government of \$3 million. If these figures are accurate once all 2014 claims have been processed, insurers counting on large risk corridor receivables from the government may be left wanting.

Of note, however, is that the majority of the expected risk corridor receivables are from five large insurers. Together these five insurers estimate accruing risk corridor receivables totaling \$223 million. Compared with premiums collected by four of the five insurers, these receivables are about 6 percent of premiums. Most insurers estimate accruing small or zero risk corridor receivables. It is not clear

3

percentage points

The law specifies that insurers that have a ratio of allowable costs to the target amount that is within 3 percentage points in either direction (97–103 percent) will keep all their profits and be responsible for all their losses.

EXHIBIT 2

Examples of Risk Corridors with a Target Spending of \$500

	Above target	Below target
Actual plan spending	\$550	\$440
Ratio before risk corridor	110%	88%
Payment to the insurer or reimbursement to the federal government		
Within 3% of target amount	\$0	\$0
3% to 8% of target amount	\$12.50	-\$12.50
More than 8% of target amount	\$8.00	-\$16.00
Total	\$20.50	-\$28.50
Insurer's total spending after risk corridor	\$529.50	\$468.50
Ratio after risk corridor	106%	94%

SOURCE Author's calculations based on final risk corridor regulations for 2014.

2014-16

The risk corridor program is for plan years 2014-16.

whether insurers not expecting risk corridor receipts have priced their plans adequately so as not to be eligible to receive payments or whether they do not believe money will be available to HHS to make the payments.

Citi Research estimates that its sample includes about 80 percent of people in the individual market covered under the risk corridor program but does not include the small-group market, which is also subject to the risk corridor program. Insurers may adjust their future expectations for risk corridor receivables based on the appropriations language and their own continuing experience with 2014 claims. Citi Research noted that after the first quarter, most insurers estimated accruing a risk adjustment receivable while few estimated accruing payments. After the second quarter, some large insurers are now expecting to make sizeable risk adjustment payments.

A final consideration is that risk corridor payments are made last, after both risk adjustment and reinsurance payments are made. A recent [Milliman report](#) on risk adjustment and risk corridors notes that combined, the two programs have an offsetting impact. The report's authors found that the "potential variability of the combined effect of risk adjusters and risk corridor payments is substantially smaller compared to the variability of either the risk adjuster or risk corridors by themselves." The Citi Research report estimates reinsurance payments of \$1.2 billion for the first half of 2014 based on insurance filings compared with the availability of \$10 billion in reinsurance funds for the year.

INSURERS REACT: Insurance companies and their trade organization the America's Health Insurance Plans (AHIP) are unhappy with the amendment enacted as part of the 2015 appropriations law, claiming it will raise premiums. However, insurers may not get much support from Republicans who oppose the risk corridor program. In a [report](#) from the Republican-led House Committee on Oversight and Government Reform, the committee cited the relationship between the insurance lobby and the White House for securing changes to the risk corridor program that were favorable to the insurance industry.

The language in the appropriation law eliminating the transfer of money from the trust funds was cited in the recent failure of a co-op. CoOpportunity Health, with members in Iowa and Nebraska, was placed into receivership by the Iowa insurance commissioner in Decem-

ber 2014. CoOpportunity Health estimated it was due to receive \$60 million in risk corridor payments. In court documents filed to take over the co-op, the state pointed to the uncertainty surrounding the risk corridor payments as part of the reason for receivership. In addition, Moody's, the credit rating service, has stated that the appropriations language limiting the risk corridor funds is a "credit negative" for insurers who offer Marketplace plans.

WHAT'S NEXT?

HHS has maintained that it expects risk corridors to be budget neutral over the three-year life of the program, even as it has made changes that are expected to increase the expense of the program. But, changes to the reinsurance program will offset some of that increase. How much is unknown. In the latest proposed rule on [benefit and payment parameters for 2016](#), HHS describes a process for adjusting the program should it take in more money under risk corridors than it pays out. HHS also reiterated that should the program fall short on collections needed to make payments, it will use other sources of funding subject to availability of appropriations.

It remains to be seen whether HHS has something in mind should this occur. If risk corridor claims exceed receivables and HHS does not find an alternative source of funding, it seems likely it will revert to its earlier proposal to prioritize paying off shortfalls from previous years before making new payments. If the shortfalls were great enough, this could effectively eliminate payments to insurers for the final two years of the program. Shortfalls to the risk corridor program could have an effect on insurers' ability to set premiums. Insurers must factor into their rates the possibility that the risk corridor payments may not be fully made in a given year.

Legislation has once again been introduced in both the House (Rep. Andy Harris, R-MD) and the Senate (Sen. Marco Rubio, R-FL) to eliminate the risk corridor program. With a Republican-controlled Congress, these bills have a better chance of passing out of Congress than they did in the previous year.

The amendment to the appropriations bill is for fiscal year 2015. HHS will need to make payments under the risk corridor program in fiscal years 2016 and 2017 as well. Congress could include similar language in those appropriations bills that limit HHS' ability to use

other sources of funds or use those vehicles to eliminate risk corridors completely.

Finally, the upcoming Supreme Court decision in *King v. Burwell* on whether premium subsidies are available in all Marketplaces has implications for risk corridors. If the Court finds for the plaintiff and rules that the ACA only provides premium assistance to those purchasing plans in state-based Marketplaces, many people may be forced to drop their health plans.

A recent paper by researchers at the [Urban Institute](#) estimates that eliminating subsidies

for plans purchased on the federal Marketplace would result in 9.3 million people losing premium assistance and 8.2 million becoming uninsured. It is likely that those who remain insured after losing premium assistance will be older and less healthy than those who drop coverage. If premium assistance was eliminated before insurers could set new premiums, the existing premiums will likely be inadequate. In theory, risk corridors could compensate for that scenario, but the money required will likely be insufficient. ■

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American Academy of Actuaries, [Fact Sheet: ACA Risk-Sharing Mechanisms: The 3Rs \(Risk Adjustment, Risk Corridors, and Reinsurance\) Explained](#) (Washington, DC: American Academy of Actuaries, 2013).

Centers for Medicare and Medicaid Services, [Patient Protection and Affordable Care Act: Exchange and Insurance Market Standards for 2015 and Beyond](#) (Baltimore, MD: CMS, May 16, 2014).

Citi Research, [Blessed Are Those Who Can Give Without Remembering & Take without Forgetting: Analyzing the Industry's Individual 3 R Accruals in 1H14](#) (New York, NY: Citi Research, October 21, 2014).

Department of Health and Human Services, Office of Inspector General, [Medicare Part D Sponsors: Estimated Reconciliation Amounts for 2006](#) (Washington, DC: HHS, October 2007).

Department of Health and Human Services, ["Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014 and Amendments to HHS Notice of Benefit and Payment Parameters for 2014; Final Rule,"](#) *Federal Register* 78, no. 47 (March 11, 2013): 15410–541.

Department of Health and Human Services, ["Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2015; Final Rule,"](#) *Federal Register* 79, no. 47 (March 11, 2014): 13744–843.

Department of Health and Human Services, ["Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016; Proposed Rule,"](#) *Federal Register* 79, no. 228 (November 26, 2014): 70674–760.

Department of Health and Human Services, ["Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors, and Risk Adjustment; Final Rule,"](#) *Federal Register* 77, no. 57 (March 23, 2012): 17220–52.

Government Accountability Office, [Department of Health and Human Services Risk Corridor Program](#) (Washington, DC: GAO, September 30, 2014).

Kaiser Family Foundation, [Explaining Health Care Reform: Risk Adjustment, Reinsurance, and Risk Corridors](#) (Menlo Park, CA: KFF, January 22, 2014).

Doug Norris, Daniel Perlman, and Hans K. Leida, [Risk Corridors Episode IV: No New Hope](#) (Seattle, WA: Milliman, December 2014).

Doug Norris, Mary van der Heijde, and Hans K. Leida, ["Risk Corridors under the Affordable Care Act—A Bridge over Troubled Waters, but the Devil's in the Details,"](#) *Health Watch* 73 (October 2013): 1–10.