Research Brief: Design and Implementation Considerations of ACA Risk-Mitigation Programs

This research brief summarizes key findings and policy implications of a study of the risk mitigation programs created under the Affordable Care Act (ACA)—risk adjustment, reinsurance, and risk corridors. The full report, conducted by Milliman, Inc., and sponsored by the Society of Actuaries (SOA), is available at *http://www.soa.org/Research/Research-Projects/Health/research-health-aca-risk-mitigation.aspx*.

Background: The ACA prohibits health plans from denying coverage or excluding coverage of pre-existing health conditions. It also prohibits health plans from varying premiums by gender or health status and limits premium variations by age. As a result of these provisions, health plans that enroll a relatively less healthy population could be at a greater risk of losses. This could, in turn, create incentives for health plans to avoid enrolling individuals in poor health. The ACA includes three risk-mitigation programs to help ensure that health plans are compensated more fairly for the risks they bear, thereby facilitating competition based on efficient care management and quality rather than risk selection.

The three ACA risk-mitigation programs are:

- A permanent risk-adjustment program, intended to shift funds from health plans that enroll relatively healthy populations to those that enroll relatively less healthy populations.
- A three-year transitional reinsurance program providing additional funds to health plans that enroll individuals with especially high medical spending.
- A three-year transitional risk-corridor program mitigating risks associated with mispricing premiums under certain conditions—the government will provide funding if a health plan's losses exceed a certain threshold, and a health plan will pay the government if its gains exceed a certain threshold.

Projection Methodology: The analysis uses Milliman's Health Care Reform Financing Model (HCRFM) to analyze the impact of these risk-mitigation programs in 2014–2017. Using the model's projections of enrollment and premiums, the analysis focuses on loss ratios—medical claims divided by premiums—to assess the adequacy of premium income, both with and without the risk-mitigation programs.

Five different scenarios were modeled, varying particular aspects of the risk-adjustment method and rules applying to the individual market. For a baseline scenario, two additional subscenarios were modeled that varied the assumptions regarding premium increases. Each scenario was run for three groups of states categorized by pre-ACA regulatory restrictiveness. The results also are presented on a nationwide level. A status quo scenario also was modeled to project the insurance markets in the absence of the ACA provisions scheduled for implementation in 2014.

Key Findings from Research:

The risk-mitigation programs appear to reduce financial risks to health plans. At the same time, overly restrictive limitations on premium rate increases can lead to high federal risk-corridor payments.
Risk-mitigation programs help stabilize the market by adjusting overall health plan revenue to be more in line with the risks undertaken. The results suggest that the transitional risk-corridor program is of particular importance, especially if the rate-review process were to become overly restrictive or plans do not adjust adequately for the post-2013 population, resulting in premiums that are inadequate relative to the risk that plans are bearing.

If the rate-setting process results in premiums that are not adequate to meet claims and expenses, federal payments under the risk-corridor programs will be high to compensate partially for the inadequate premiums.

The impact of inadequate rates on a health plan's financial viability also should be considered. This result illustrates the need for the rate-review process not only to guard against unduly high premiums, but also to ensure that premiums are not set too low. This is especially important in 2017 and beyond, after the expiration of the risk corridor program.

The risk-mitigation programs are especially important for plans in states with less restrictive issue and rating rules prior to ACA.
The results vary fairly significantly between states, depending on the restrictiveness of each state's regulatory environment prior to 2014. As might be expected, plans under the most restrictive state rules (e.g., those that already impose significant rating and underwriting restrictions) already have relatively higher premiums, but are projected to require lower rate increases than plans in other states. Plans in states that are moving from relatively less restrictive rules to the guaranteed issue and community rating rules in 2014 are projected to have more need for the risk-mitigation mechanisms, especially the risk corridors, if premiums do not incorporate anticipated adverse selection and the increase in costs that may result from the expected health status of newly enrolled members.

Grandfathered plans will reflect a relatively healthier population over time.
Prior to 2014, average premium rate increases and loss ratios tend to be higher for grandfathered business because underwriting often restricts less healthy people from changing to other coverage options. Over time, grandfathered plans are projected to become a smaller share of the overall market, with rapid migration to other plans beginning in 2014 as individuals originally in grandfathered plans move to other plans either inside or outside of an exchange. Individuals who would be eligible for lower premiums in non-grandfathered plans, either due to premium subsidies or to the introduction of premium-rate restrictions related to age or health status, are more likely to change plans. As a result, individuals remaining in grandfathered plans are more likely to be younger and/or in better health, with commensurately lower premium increases and loss ratios. This downward pressure on premiums for grandfathered plans should be recognized in the rate-review process, as should possible upward pressure on premiums for non-grandfathered plans.

The individual market is expected to grow rapidly starting in 2014.
Between 2013 and 2017, the total individual market enrollment is projected to increase dramatically. This is primarily the result of the ACA's individual mandate combined with the availability of substantial premium subsidies. Exchange business is expected to grow much faster than nonexchange business due to the availability of subsidies only through exchanges. Much of this increase is expected to come from individuals who are currently uninsured, but some enrollment is expected to come from individuals who are currently insured through coverage provided by employers.

Limitations: As with all models projecting health insurance enrollment, medical spending, and premiums, there is some uncertainty regarding the results. The model's underlying assumptions, which are detailed in the report, were developed using various data sources and professional judgment. The specific results may vary under different sets of assumptions and scenarios. The projections, therefore, are not intended to be predictions of specific outcomes. Rather, they are meant to illustrate the potential impacts of the risk-mitigation programs under certain scenarios. Particular caution must be exercised regarding the premium projections. Premiums can differ across years and across scenarios for several reasons, including rating rules, differences in the relative health status/utilization of the underlying insured population, differences in the age and gender distribution of the underlying insured population, varying health care delivery system structures, practice patterns, provider reimbursement arrangements, and the risk-mitigation programs. Of course, there also can be random fluctuations.

Unless otherwise noted, care must be taken not to attribute premium changes or differences solely to any one of these factors. This analysis focuses largely on loss ratios rather than premiums to isolate the relationship between the underlying risk the health plans bear with respect to medical costs and the premiums received.