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Issue Brief

Health Insurance Risk Mitigation Mechanisms and COVID-19

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Key Points

- Risk mitigation mechanisms could help address the increased uncertainty health insurers face due to COVID-19.
- One-sided risk corridors can shield insurers from unusually large losses due to COVID-19; two-sided risk corridors would also protect against unusually high insurer gains.
- Reinsurance can offset the costs of high-cost enrollees, regardless of whether the insurer faced unexpected losses.
- Medical loss ratio (MLR) requirements could provide a backstop on unanticipated insurer gains under either one-sided risk corridors or reinsurance.
- Risk mitigation efforts directed at insurers won't address other risks in the health system, including declining enrollment in employer-sponsored insurance, increased pressures on state Medicaid programs, and declines in provider revenues that threaten their financial stability and patient access.

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Executive Summary

The COVID-19 pandemic is affecting the U.S. health system in numerous ways, many of which will have downstream effects on health insurers and group health benefit plans, and ultimately on health insurance premiums.

Although many hospitals are seeing a surge in patients with severe respiratory needs, physical distancing has led to dramatic declines in non-emergency services, including nonessential office visits and high-revenue-producing elective surgeries. Telehealth is filling in some, but not nearly all, of the gaps. As a result, many health care providers are experiencing declines in revenues and the need to lay off staff. At the same time, insurers have been required to cover cost-sharing for COVID-19-related testing and some insurers are waiving cost-sharing for COVID-19 treatments as well. The net effect on 2020 health insurance claims is uncertain—total costs could be higher or lower than expected. The net effect depends in part on whether deferred services are provided later in 2020, are delayed to 2021, or are forgone altogether. This result in turn depends on whether there is another wave of the outbreak this year and whether consumers are comfortable seeking health care.

At the same time, COVID-19's effects on the economy are causing shifts in health insurance enrollment. Nearly all states that operate their own Affordable Care Act (ACA) marketplaces provided a special enrollment period for the uninsured; the federal ACA marketplace did not offer a similar special enrollment period. Workers facing a loss of group insurance coverage due to lower incomes or job losses may have access

to COBRA coverage[1] (which can be expensive), coverage through the individual market (potentially with premium subsidies, which are based on annual income), or Medicaid coverage (eligibility varies by state and is based on monthly income). There could be big shifts in enrollment from the employer group market into Medicaid, the individual market, and the ranks of the uninsured, especially at higher unemployment rates.[2]

In the midst of so much uncertainty regarding 2020, insurers are developing premiums for 2021. It is unknown whether there will be additional COVID-19 waves in 2021; how many services and treatments deferred in 2020 will take place in 2021; what the risk pools will look like; whether new treatments, vaccines, or antibody tests will be available; and, if so, what their associated costs will be and how they will be paid for. Because not all deferred care is nonessential, greater future health care needs could arise due to worsening of untreated conditions.

Health insurance by its nature deals with risk and uncertainty. But if risks and uncertainty are unusually high, they can also lead to unintended consequences, such as higher premiums or even insurer decisions to leave the market. Various risk mitigation mechanisms can be used to help address risks, thereby leading to more competition and stable premiums. This issue brief provides a primer of the risks that insurers face and the mechanisms that are designed to address those risks. It then assesses the implications of these mechanisms, especially risk corridors and reinsurance, for the heightened risks and uncertainty arising due to the COVID-19 pandemic.

Historically, insurers have faced several types of risks. These include pricing risk, plan-specific adverse selection risk, and the risk of particularly high-cost enrollees. Mechanisms to mitigate pricing risk have included risk corridors, medical loss ratio (MLR) requirements, aggregate reinsurance, and especially for Medicaid managed care plans, supplemental payments and midyear rate adjustments. Risk adjustment is often used to mitigate plan-specific adverse selection risk, and individual reinsurance is used to mitigate the risk of particularly high-cost enrollees.

1 As enacted through the Consolidated Omnibus Budget Reconciliation Act (COBRA), it allows eligible employees and their dependents continued benefits of health insurance coverage if an employee loses their job.
2 Health Management Associates, *COVID-19 Impact on Medicaid, Marketplace, and the Uninsured, by State*, April 3, 2020. Bowen Garrett and Anuj Gangopadhyaya, *How the COVID-19 Recession Could Affect Health Insurance Coverage*, Urban Institute, May 2020.

COVID-19 has exacerbated some of these risks. One-sided risk corridors could be used to provide insurers relief from unusually large losses due to COVID-19 and would target those insurers rather than providing payments to all insurers. Two-sided risk corridors could also be used to protect against unusually high insurer gains. Reinsurance could be used to provide additional funds to insurers, offsetting the costs of high-cost enrollees generally or only those with COVID-19 diagnoses or treatments. Such reimbursements would be available regardless of whether insurers face total costs (net of reductions for deferred care) that are higher or lower than expected. With either one-sided risk corridors or reinsurance, MLR requirements could provide a backstop on unanticipated insurer gains.

Risk mitigation efforts directed at insurers won't be able to address other risks in the health system, including declining enrollment in employer-sponsored insurance, increased pressures on state Medicaid programs, and declines in provider revenue that threaten their financial stability and patient access.

Risks Insurers Face and Typical Risk Mitigation Mechanisms

Pricing Risk

Pricing risk can result in premiums that are not adequate to cover actual claims. It can also result in unintended windfalls to insurers if premiums are set too high relative to actual claims. Notably, insurers cannot increase future premiums to recover past losses. Health insurers[3] set premiums based on their best estimates of who will enroll in their coverage (i.e., the distribution of enrollees by age, gender, health status, etc.), the expected health care utilization of their enrollees (e.g., number and type of office visits and surgeries), and the anticipated costs associated with that utilization (e.g., the prices paid to providers, prescription drug costs). There will always be uncertainty regarding these factors, and insurers typically build some uncertainty into their projections. They also build up surplus specifically to be prepared for unexpected events.

But there are sometimes situations when uncertainty is higher than usual, exposing insurers to more pricing risk. For instance, when a new insurance program begins, it can be especially difficult for insurers to set premiums when their data on health spending for potential enrollees is limited. This was the case during the early years of the Medicare Part D prescription drug program and in the individual market after implementation of the ACA market reforms. Pricing risk also arises because it is not always possible to foresee the availability of new treatment options, as was the case when new and expensive hepatitis C treatments became available.

3 In many Medicaid programs, the state sets the Medicaid managed care rate.

Several mechanisms can be used to mitigate pricing risk, including risk corridors, medical loss ratio rebates, aggregate reinsurance, and midyear rate adjustments.

Risk corridors. Risk corridors can be used to limit insurer losses and/or gains if claims experience is very different from what was expected when developing premiums. Risk corridors can be one-sided—the government pays insurers if their losses exceed a certain threshold, or two-sided—including a provision for insurers to pay the government if their gains exceed a certain threshold. By limiting insurer losses, risk corridors can encourage competition during periods of greater uncertainty and can protect insurer solvency if unforeseen events cause claims to be much higher than expected.

Two-sided symmetric risk corridors are currently used in the Medicare Part D program. Private Part D plans bear the full risk if actual spending is within 5% of expected spending. If actual spending exceeds expected spending by more than 5%, the federal government reimburses the insurer for a share of the losses. If actual claims fall below expected claims by more than 5%, the insurer pays the federal government a share of the gains. Notably, these risk corridors are not constrained to be budget-neutral—there could be a net cost or a net revenue to the federal government.

Two-sided symmetric risk corridors were also included temporarily for ACA-compliant plans in the individual market from 2014 to 2016, the first years of the ACA market reforms. The risk corridors followed the same general structure as the Part D risk corridor program, although with different thresholds.[4] Some states have also incorporated risk corridors for their Medicaid managed care plans. In contrast to commercial markets in which insurers set the premiums, states typically set the Medicaid managed care rate. Two-sided risk corridors in Medicaid can help mitigate large losses in managed care plans if plan spending exceeds the capitation rate, and can help ensure the state doesn't overspend if plan spending falls below the capitation rate.

Risk corridors can allow insurers to reduce their risk charges, although risk charges are usually a fairly small percentage of the premium (e.g., 2%-4%). Another way risk corridors can result in lower premiums is that having a backstop can allow insurers to price using less conservative assumptions.

4 Although not required to be budget-neutral, the Department of Health and Human Services (HHS) issued guidance that it would implement risk corridors in a budget-neutral manner. Because aggregate insurer losses exceeded gains, this decision lowered risk corridor payments relative to what would have been expected through the program parameters. However, a recent Supreme Court decision in *Maine Community Health Options v. United States* ruled that insurers are entitled to full risk corridor payments.

Medical loss ratio (MLR) requirements. Medical loss ratio requirements limit the share of premiums that goes toward administrative expenses and profits, as opposed to being used to pay for health care claims. Under MLR rules, insurers whose claims fall below a certain threshold must refund a portion of the premium. This is somewhat akin to a one-sided risk corridor, in which insurers would bear all of the risk for having claims greater than expected but are required to provide refunds if their claims relative to expenses are lower than expected.

Most insurance markets include MLR requirements. In the individual and small group markets, the minimum MLR is 80%; for fully insured large group plans, the minimum MLR is 85%, recognizing the economies of scale in administrative costs for larger group plans.[5] To determine any applicable refunds to *policyholders*, claims and expenses are averaged over a three-year period. This can lower the likelihood of refunds and the refunds themselves if within the three-year average period an insurer experiences one year of a low MLR but two other years with a higher MLR. Recall that under risk corridors, insurers would need to make payments to the *government*, as opposed to refunding money to *policyholders*.

Medicare Advantage (MA) and Part D plans must meet an 85% MLR threshold or make payments to the Centers for Medicare and Medicaid Services (CMS) based on that year's difference (as opposed to being averaged over three years). Similarly, Medicaid and Children's Health Insurance Program (CHIP) managed care organizations are also subject to 85% federal MLR standards. However, states have discretion on whether to require rebates below a state-defined threshold (which may be higher than 85%), with any applicable refund payments made to federal and state governments.

Aggregate reinsurance. Aggregate reinsurance is another option to limit insurers' downside risk by paying all or a percentage of claims once a private plan's aggregate claims paid exceed a predetermined threshold. This threshold is typically expressed as a percentage of aggregate expected claims (for example, an aggregate limit might be 102% of projected paid claims). Insurers would keep all gains if actual claims are lower than expected. Government-provided aggregate reinsurance protection would be similar to a one-sided risk corridor that shields insurers from unexpected losses. In other words, the insurer would keep all gains, regardless of the size, if actual spending is less than expected, but would bear the losses only up to a certain point if spending is greater than expected.

5 MLR calculations are performed after any other risk mitigation program transfers to or from insurers are made. In other words, claims and premiums used in MLR calculations include any transfers from risk adjustment and risk corridor programs. MLR requirements do not apply to self-funded plans.

Aggregate private reinsurance is available currently to private insurers and self-funded employer plans (i.e., stop-loss coverage) rather than through the government. For instance, a typical aggregate stop-loss attachment point is 125% of total expected claims for the self-funded employer. An insurer's reinsurance expenses are part of the insurer's administrative costs and would be paid through higher insurance premiums. Notably, private reinsurance and stop-loss coverage are not offered on a guaranteed issue basis; groups can be denied coverage or charged higher premiums, and particular individuals can be excluded from coverage (i.e., lasering).

Supplemental payments. Supplemental payments (or direct reimbursements) are generally payments made outside of the normal capitation rate once a predefined trigger has occurred. The use of supplemental payments has been limited primarily to the Medicaid program. The payment is a per-occurrence payment as opposed to an amount included in the capitation rate, transferring the risk of the triggering event away from the managed care organization. This approach is used extensively in Medicaid managed care for payments related to maternity delivery and neonatal care. Supplemental payments also have been used when a new treatment has been added to Medicaid managed care but there was not sufficient experience to determine the expected utilization of the treatment.

Prospective or retroactive midyear capitation rate adjustments. Instead of making supplemental payments in the case of new or unexpected treatments, capitation plans potentially could be changed to reflect the change in expected costs. Rate adjustments could be made prospectively or retroactively and could reflect upward or downward rate changes.[6] CMS is allowing states to make prospective Medicaid capitation rate adjustments to reflect COVID-19-related changes. In addition, CMS may allow states to make retroactive Medicaid capitation rate adjustments based on updated experience.[7]

Plan-Specific Adverse Selection Risk

When insurers are prohibited from denying coverage or charging higher premiums based on health status or expected health care needs, they are exposed to greater adverse selection risk, which occurs when individuals or groups who anticipate higher health care needs are more likely to purchase coverage than those who anticipate lower health care needs. Even if adverse selection is minimized in an insurance market as a whole, a particular plan could end up with a disproportionate share of enrollees with higher health care costs. If payments to the plan do not reflect this, then the plan could be at risk for large losses, which in turn gives them incentives to avoid enrolling people with higher-than average costs. Risk adjustment is the primary mechanism to address plan-specific adverse selection risk.

6 Although rate adjustments are not typically seen in commercial insurance, UnitedHealth has announced premium discounts to employers and individuals in its commercial plans. See Reed Abelson, "United Health Customers Will See a Discount on Next Month's Bill," *New York Times*, May 7, 2020.
7 CMS, "Medicaid Managed Care Options in Responding to COVID-19," May 14, 2020.

Risk adjustment. Risk adjustment is used to adjust payments to plans based on the risks of the people they enroll. When premiums are not allowed to reflect fully the factors affecting health spending (e.g., health status), risk adjustment helps to make payments to competing plans more equitable and can reduce the incentives for competing plans to avoid enrollees with higher-than-average health care needs. The most simple risk adjustment models have been based on age and gender. More complex risk adjustment models also incorporate health care diagnoses or social determinants of health. Although risk adjustment can help account for the differences in participant health status across plans, no current risk adjustment system is designed to compensate each competitor for the full financial effects of adverse selection.

The ACA individual market and small group market each have a budget-neutral risk adjustment program that operates at the state level. Insurers with higher shares of lower-cost enrollees contribute to a fund that makes payments to insurers with larger shares of higher-cost enrollees, such that the net impact is zero across all insurers. It is a concurrent program—diagnoses coded during the plan year are used to develop the plan year risk scores, on which the risk adjustment payments are based.

The Medicare Advantage and Part D programs also use risk adjustment programs, but their programs are prospective in nature—diagnoses coding during the prior year are used to develop the current plan year risk scores and corresponding payments from CMS. Unlike the ACA program, the MA risk adjustment program does not shift money among participating MA sponsors and is not a zero-sum exercise. Instead, MA plans receive higher payments when they have higher risk scores, regardless of the risk scores of other MA plans. The MA bid process and the CMS budget account for the expected payments.

States have discretion to apply risk adjustment to their Medicaid managed care programs. These programs must be budget-neutral and tend to be prospective.

Risk of Particularly High-Cost Enrollees

Plans also face a risk of having individual enrollees with particularly high health spending. Risk adjustment is not intended to address high-cost outliers. Also, because risk adjustment is meant to address costs that can be predicted in advance in order to lower plan incentives to avoid those with higher expected costs, costs from health needs that arise unexpectedly are not typically included in risk adjustment programs. Individual reinsurance can address this risk.

Individual reinsurance. Individual reinsurance (also known as specific reinsurance or stop-loss) can protect a plan from high claims from individual enrollees. Under a dollar threshold-based government-provided reinsurance program, the government would pay all or a percentage of claims once an enrollee's annual claims exceed a predetermined threshold (e.g., $200,000). Under a condition-based program, reinsurance is triggered if an enrollee is diagnosed with a particular condition.

Individual reinsurance is used in the Medicare Part D program; the federal government funds 80% (the coinsurance percentage) of spending for Part D enrollees after their out-of-pocket spending exceeds the catastrophic threshold ($6,350 in 2020). Individual market reinsurance was also used temporarily under the ACA for plans in the individual market during 2014–2016. For instance, in 2014, the ACA reinsurance program was designed to reimburse individual market plans for 80% of an individual's claims between $60,000 and $250,000.[8] Because it was mostly funded through external sources, the ACA reinsurance program reduced premiums by about 10% to 14% in 2014, and less in the subsequent two years as the attachment point increased and the coinsurance rate declined.[9] After 2016, several states extended the use of reinsurance through section 1332 waivers.[10] Most are dollar-threshold based, but Alaska and Maine use condition-based programs.

As with aggregate reinsurance, private reinsurance can be used to provide individual (i.e., specific) reinsurance or stop-loss coverage. The attachment points for specific stop-loss coverage typically vary by group size, ranging from about $35,000 for mid-sized groups (51-100 employees) to $1 million or more for groups exceeding 20,000 employees. But again, insurer reinsurance expenses would be paid through higher insurance premiums and private reinsurers and stop-loss carriers can deny coverage, charge higher premiums, or exclude particular individuals from coverage.

8 The ACA reinsurance program was funded through contributions from all health plans and used to offset high claims for individual market health plans. Initial reinsurance parameters were changed retroactively so that reinsurance claims equaled contributions. For 2014, the attachment point was reduced to $45,000 and the reinsurance percentage was increased to 100%.

9 American Academy of Actuaries, *Drivers of 2016 Premium Changes*, August 2015.

10 Kaiser Family Foundation, "Tracking Section 1332 Waivers," January 7, 2020.

Implications of Risk Mitigation Mechanisms for COVID-19-Related Risks

Policymakers have enacted and are considering further efforts to provide relief for health care providers, businesses, and individuals affected by the medical and economic effects of the coronavirus. Although not part of legislation enacted to date, risk mitigation provisions have been included in earlier legislative proposals[11] and have been put forward by others.[12] These mechanisms have generally focused on using one-sided risk corridors or reinsurance to mitigate risks and stabilize premiums for most types of health insurance. This section examines the implications of those mechanisms for addressing COVID-19-related insurer risks and also highlights how these risks vary by insurance market.

As noted above, insurers face several COVID-19-related risks. Through April 2020, increased claims due to COVID-19 appear to be offset (or even more than offset) by a reduction in non-COVID-19 claims, but it's unclear how that pattern will continue through the rest of the year. Medical care deferred in the first half of the year could be provided later in the year; COVID-19 claims could spike in a second wave. Shifts in insurance enrollment due to the virus's effects on the economy will also change 2020 claims from what was expected. In addition, particular insurers or plans could experience higher costs than expected if they enroll especially vulnerable populations (e.g., enrollees dually eligible for Medicare and Medicaid). The uncertainty will continue in 2021 and perhaps beyond, depending on whether there are future waves of the outbreak and the availability of treatments and vaccines.

Risk Corridors

As noted above, risk corridors can be designed to be either one-sided—shielding insurers from unusually large losses, or two-sided—also mitigating against unusually large insurer gains.

If implemented for 2020, one-sided risk corridors would shield insurers against unusually large losses arising from COVID-19. Government funds could be used to make payments to insurers for a portion of losses exceeding a threshold. Rather than providing payments to the health insurance industry as a whole, risk corridors would target those particular insurers that experienced large losses. If 2020 health spending continues to fall below insurer expectations, it is possible that few insurers would receive risk corridor payments.

11 *Take Responsibility for Workers and Families Act* (H.R. 6379).
12 See for instance Sherry Glied and Katherine Swartz, "Using Federal Reinsurance to Address the Health Care Financial Consequences of COVID-19," *Health Affairs* blog, April 1, 2020.

One-sided risk corridors could be used to help insurers withstand losses, but wouldn't put them at risk of making payments if they have significant gains. However, the MLR requirements would provide some protections against insurers experiencing large gains due to having lower claims than expected. MLR refunds would be provided to policyholders in the individual and group markets if the three-year average MLR fell below the required threshold. If the risk corridors were extended to Medicare Advantage and Medicaid managed care plans, any MLR refunds would be made by insurers to the federal government (and states for Medicaid programs with refund requirements).

Alternatively, risk corridors could be two-sided, to protect against both unusually high insurer losses and unusually high insurer gains. But as opposed to providing rebates to policyholders in the individual and group markets, any risk corridor payments made by insurers would go to the government.[13]

If implemented for 2021, risk corridors would protect insurers from the pricing risk they face because of the continued uncertainty regarding whether and how COVID-19 will affect 2021 claims. By providing a backstop, risk corridors could result in lower premiums, through reductions in risk charges (usually 2%-4% of premiums)[14] and less conservative pricing assumptions.[15]

Setting up a risk corridor program for fully insured commercial plans and Medicare Advantage plans could be relatively straightforward. MLR reporting requirements already include the data elements that would be needed for a risk corridor program. Risk corridors would be calculated after factoring in any transfers from risk adjustment and reinsurance programs.

Risk corridor implementation could be more complicated for self-funded plans. Whereas fully insured plans have premium and other info that can be used to determine an expected claims target, there is not a common standard for determining such a target for self-funded plans. Trending forward prior per capita claims could potentially be used, but adjustments could be needed to reflect any changes in enrollee demographics.

13 In the ACA and Medicare Part D risk corridor programs, any required insurer payments are made to the federal government. Presumably, a two-sided risk corridor program could be structured so that insurer payments to the government are directed to fund payments to health care providers or for other COVID-19-related purposes.

14 In the absence of risk corridors, the increased uncertainty regarding COVID-19 could cause insurers to increase their risk charges above the usual 2%-4%. Such increases could be constrained by MLR requirements, which limit the amount of premiums that can be used for non-claims items, including risk charges.

15 In the face of uncertainty, insurers will consider various scenarios using different assumptions regarding the recurrence of COVID-19 waves, the availability of treatments and vaccines, the degree of pent-up demand that will occur, etc. The availability of risk corridors would allow insurers to use less conservative assumptions regarding 2021 claims expectations.

Risk corridor targets usually reflect expected claims costs and do not include administrative costs. However, administrative costs could also differ due to COVID-19. Although some administrative costs vary with the number and amount of claims, other costs are fixed and are spread across all enrollees. Large enrollment shifts could cause changes in per enrollee administrative costs. For instance, a decline in employer coverage could cause per enrollee administrative costs to be higher than expected; a large increase in Medicaid enrollment could cause per enrollee administrative costs to be lower than expected.

Reinsurance

A federal reinsurance program could be used to reimburse plans for their higher-cost enrollees. Payments could be triggered based on dollar thresholds or it could be condition based. If focused on individuals with a COVID-19 diagnosis, it would need to be determined whether reinsurance payments would be made for all health expenditures or only COVID-19-related treatments and, if the latter, how those would be defined.

If implemented for 2020, reinsurance would provide additional funds to insurers, regardless of whether they face net costs for 2020 that are higher or lower than expected. Plans with unexpected gains due to 2020 costs being lower than expected might have additional gains under a reinsurance program. The MLR requirements could provide a backstop on unanticipated gains and result in refunds to policyholders. However as noted above, MLR refunds for the individual and group markets are based on three-year averages.

If reinsurance is implemented for 2021, it could result in lower 2021 premiums, as some health care claims would now be paid for through the reinsurance program, thereby lowering insurer costs. However, reinsurance wouldn't necessarily address the pricing risk that insurers face because of the continuing uncertainty regarding how COVID-19 will affect 2021 health spending.

Reinsurance could be relatively straightforward to implement and wouldn't be as complicated as risk corridors for self-funded plans. That said, any government reinsurance program may need to be coordinated with private reinsurance and stop-loss coverage, increasing administrative complexity. Implementation for ACA individual market plans could be more complicated in the states that already operate their own reinsurance programs under 1332 waivers. It would need to be determined whether a federal reinsurance program would be the primary or secondary reinsurance payer.

Other Considerations

Although risk corridors and reinsurance could help mitigate some COVID-19-related risks that insurers face, other risks might be better addressed through other mechanisms. For instance, group insurers and self-funded employer plans face declining enrollment due to workers losing their jobs. Lower enrollment reduces the economies of scale for administrative expenses. It also raises selection concerns. For instance, past recessions resulted in morbidity increases among some small group insurers along with enrollment declines. New COBRA guidance[16] that extends the time for eligible workers to choose to enroll in COBRA could exacerbate selection issues. Multiemployer plans have the added concern that because contributions on behalf of active workers typically subsidize coverage for retirees, a reduction in active workers could threaten the financial stability of retiree coverage.

Workers losing coverage may be eligible for COBRA, but that coverage can be expensive. There are some proposals to subsidize COBRA premiums, by as much as 100 percent.[17] During the Great Recession, COBRA premiums were subsidized by 65%. Making coverage more affordable could keep people in employer plans and mitigate adverse selection or other problems that can arise due to declining enrollment. Facilitating COBRA coverage for workers who are laid off can limit health care disruptions arising from shifts to different coverage designs and provider networks, especially if layoffs are shorter term in nature and workers eventually return to their prior jobs.

Risk adjustment is already in place for many insurance markets. But its effectiveness at addressing plan-specific adverse selection could be affected by the COVID-19 outbreak. In particular, the Medicare Advantage risk adjustment program uses diagnoses from the prior year to determine risk scores and risk adjustment payments for the plan year. With many MA enrollees deferring care in 2020, diagnoses may be understated, potentially understating 2021 risk scores. Although CMS has released guidance that diagnoses recorded during 2020 telehealth visits will count toward 2021 risk scores, many conditions will go unrecorded. There may be less of an issue for the individual and small group markets risk adjustment programs, as those are concurrent in nature; diagnoses recorded during 2020 and 2021 will be used to determine 2020 and 2021 risk scores, respectively. That said, the risk adjustment program could advantage insurers with populations that can't defer care compared to plans with some deferred chronic care that results in additional unintended costs.

16 Internal Revenue Service and Employee Benefits Security Administration, "Extension of Certain Timeframes for Employee Benefit Plans, Participants, and Beneficiaries Affected by the COVID-19 Outbreak," May 4, 2020.
17 See for instance the *HEROES Act* (H.R. 6800).

The Medicaid program will be especially affected by COVID-19. Some Medicaid enrollees are especially vulnerable to COVID-19 due to age, disability, or underlying health conditions. And due to COVID's effects on the economy, Medicaid will likely experience enrollment increases, with new enrollees shifting from group coverage and possibly individual coverage as well. These enrollment increases will occur at the same time state revenues are declining, which will put more pressure on state budgets. The Families First Coronavirus Response Act temporarily increases the federal share of Medicaid spending, or Federal Medical Assistance Percentage, (FMAP), by 6.2 percentage points. This increase will help state budgets in the short term, but some states have already announced Medicaid cuts.[18] In addition, increased Medicaid costs due to higher enrollment and pent-up demand from deferred care could continue even after the FMAP bump is eliminated.

Finally, although COVID-19 is straining some parts of the health system with increased needs for respiratory care, the deferral of non-COVID care has reduced provider revenue across the system. In April, health care employment declined by 1.4 million workers.[19] Such declines lead to concerns regarding access to care, the sustainability of health care providers, possible facility closures, and the potential for increased provider consolidation that can result in higher provider prices. There are particular concerns for safety net providers that already receive lower payment rates. Some insurers are advancing payments to health care providers, typically on a month-to-month basis, with reconciliation. These payments address providers' short-term cash flow concerns but are not meant to act as larger or longer-term loans. Through the various COVID-relief bills that have been enacted, the federal government is paying hospitals and other providers for health care expenses or lost revenues due to COVID-19. More information is needed on how these funds are being distributed, but it is possible that funds appropriated to date will be insufficient to meet provider revenue needs.

18 Rachel Roubein and Dan Goldberg, "States Cut Medicaid as Millions of Jobless Workers Look to Safety Net," *Politico*, May 5, 2020.
19 Bureau of Labor Statistics, "The Employment Situation—April 2020," USDL-20-0815, May 8, 2020.

Conclusions

The COVID-19 pandemic has had profound effects on the U.S. health system, both directly through its effects on medical needs and indirectly through its related effects on the economy. Health insurers face uncertainty regarding the pandemic's impacts on their 2020 financial experience and 2021 premium setting. This issue brief examines the different types of risks that insurers can face and the various risk mitigation mechanisms that can be used to address them. Some of these mechanisms, particularly risk corridors and reinsurance, have been put forward as ways to address COVID-19-related risks. Risk corridors can target those insurers that experience unexpected losses. Reinsurance would provide financial assistance more generally across insurers, which could benefit both insurers with unexpected losses and those without. Current MLR requirements could limit unexpected insurer gains, however.

When assessing whether to pursue risk mitigation mechanisms, policymakers should consider whether they would address the risk in question; be relatively easy to administer, especially if the mechanism is meant to be temporary; and be fair to different insurers. Because risk mitigation mechanisms are focused on health insurer financial results and are not structured to address all of the issues facing the economy and the health system, other efforts may be needed, such as COBRA subsidies, changes to risk adjustment mechanisms, or increased payments to providers or states.