Headwinds cause 2014 risk corridor funding shortfall

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Insurers can now expect to receive only 12.6%[1] of 2014 risk corridor receivables in 2015, with the remainder to be potentially funded in future years. Last week's announcement validates prior concerns regarding a 2014 risk corridor funding shortfall because of Cromnibus[2] and higher-than-expected 2014 claim costs. This shortfall occurred despite two earlier injections of additional transitional reinsurance program recoveries into the Patient Protection and Affordable Care Act of 2010 (ACA) individual market.

The shortfall will have a significant negative financial impact on insurers who find themselves in a risk corridor receivables position, not only for the 2014 benefit year but also possibly for 2015 and 2016. A 2014 funding shortfall puts the collectability of 2015 and 2016 payouts in increased jeopardy–2014 receivables that were not paid in 2015 will be first in line to receive payments in later years if funds are available.[3]

This paper explores some of the root causes underlying the funding shortfall for the program, highlights how the funding shortfall would have been even greater without the increased individual market reinsurance recoveries announced in June, and considers funding implications for 2015 and 2016.

BACKGROUND

The risk corridor program is a key component of the risk mitigation protections put in place by the ACA (along with transitional reinsurance and risk adjustment). Heading into 2014, insurers faced great uncertainty as to the cost and risk level of the post-ACA insured population. This uncertainty stems from the competing influences of guaranteed issue and community rating requirements and the offsetting impacts of premium and cost-sharing subsidies and the individual mandate. The risk corridor program was intended to buffer unexpected losses incurred by insurers due to these uncertainties. At the same time, the program would also buffer unexpected gains realized by insurers if experience came in better than expected.

Without the protection afforded by this program, insurers likely would have been much more reluctant to participate in the ACA marketplace in the face of these uncertainties. This program provided an incentive for insurers to participate in the market without having to be overly conservative due to the many unknowns.

As it turned out, there were many additional "unknowns" that came into play after insurers had set their 2014 premium rates:

- The federal government implemented the transitional policy, which in most states allowed individuals to keep their pre-ACA coverage in 2014 and beyond.
- Federal regulators relaxed the qualifications to claim a hardship exemption from the individual mandate penalty.
- There were doubts that the ACA's individual mandate would be upheld by the Supreme Court.
- And finally, the federal exchange website issues may have discouraged healthier individuals from buying ACA coverage given the difficulty and time required to submit a successful application.

The risk corridor program is set to be in place until the end of 2016. Presumably, when the ACA was enacted, the hope was that by the time insurers set their 2017 premium rates, they would have usable data and much more stable populations and cost levels in the reformed markets, removing the need for the risk corridor protection. Unfortunately, the transitional policy and other regulatory changes have in large part delayed the advent of this stability.[4]

RISK CORRIDOR HEADWINDS

Several causes underlie the 2014 funding shortfall, and these factors will continue to have implications for 2015 and 2016 receivables.

The risk corridor program was designed as a two-sided program requiring insurers with better-than-expected financial results to pay the federal government a portion of their earnings, while at the same time requiring the federal government to reimburse a portion of losses to insurers with worse-than-expected financial results. The program was not originally required to be budget neutral. In other words, payments out of the program could be greater than payments in.

1 https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RiskCorridorsPaymentProrationRatefor2014.pdf.
2 H.R. 83 (113th): Making consolidated appropriations for the fiscal year ending September 30, 2015, and for other purposes. Also see http://us.milliman.com/uploadedFiles/insight/2014/risk-corridors-no-new-hope.pdf for a further discussion on the impact of Cromnibus on the risk corridor program.
3 https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/faq-risk-corridors-04-11-2014.pdf.
4 The Actuary Magazine October/November 2014 – Volume 11, Issue 5 https://www.soa.org/Library/Newsletters/The-Actuary-Magazine/2014/october/act-2014-vol11-iss-05.pdf.

That started to change in 2014, well after premium rates were set, when federal regulators began to talk about budget neutrality. This concept became official with the Cromnibus bill passed by Congress in late 2014. That bill required that 2014 risk corridor receivables paid in 2015 be funded through payables into the program from other insurers. Even before the 2014 funding shortfall was officially announced on October 1, 2015, many industry analysts foresaw that program receivables would far outstrip payables.[5,6] Several factors contributed to the excess of insurer receivables relative to payables:

1. **High 2014 market-wide claims levels** – Enrollment in ACA-compliant plans was lower than expected in 2014 in part due to the transitional policy allowed by the federal government and also due to difficulties with launching the federal health insurance exchange website. These issues arose well after insurers finalized 2014 premium rates. Those individuals who did enroll in the marketplace tended to have higher morbidity and cost levels, resulting in higher market-wide average cost levels than expected. As a result, insurers incurred higher costs than anticipated with many qualifying for risk corridor receivables.

This factor is important because it skews the experience in the entire market. The next item shows how the risk corridors can result in excess receivables over payables even when market-wide experience is not skewed.

2. **Markets favor plans in a receivables position** – Plans in a risk corridor receivables position tend to enroll more members than plans in a payables position, resulting in an excess of receivables over payables overall. The general pattern is as follows:

a. All else being equal, lower-priced plans are more likely to be in a risk corridor receivables position while higher-priced plans are more likely be in a payables position. In other words, if two health plans have the same claim costs and administrative expenses but different premium rates, the lower-priced plan is more likely to be in a receivables position than the higher-priced plan.

b. Lower-priced plans tend to attract a greater volume of enrollment than higher-priced plans.

c. As a result, enrollment will be more heavily concentrated in lower-priced plans with higher likelihood of being in a risk corridor receivables position than in higher-priced plans.

This does not mean that all lower-priced plans will trigger a risk corridor receivable. It means only that these plans are more likely to be in this position than higher-priced plans.

As background, there was good reason for significant price differentials in the 2014 market. The 2014 ACA market had many new and unique characteristics that led to uncertainty in price setting, namely: 1) guaranteed issue and community rating requirements, which tend to result in higher market-wide costs, and 2) premium and cost-sharing subsidies and the individual mandate, both of which tend to encourage lower cost individuals to enter the market. The uncertain and competing influences of these factors resulted in carriers putting vastly different premium rates into the market, resulting in a ripe environment for market selection between lower- and higher-priced plans.

This dynamic is likely to be most pronounced in 2014 because the market uncertainty leading to variations in premium rates should be greatest in that year. Although insurers had greater knowledge of emerging cost levels when preparing 2015 and 2016 premium rates, that knowledge was limited and incomplete. The risk of underestimated market-wide costs will thus continue to play a role in 2015 and, to a lesser extent, in 2016.

3. **Risk corridor formula asymmetry** – The risk corridor algorithm itself will tend to result in higher insurer receivables, compared to payables, due to an asymmetry in calculating the "target amount" (or expected cost) for each insurer. The asymmetry introduced by the target amount calculation increases the likelihood that risk corridor receivables will exceed payables when there is variation in insurer financial performance across the market. This would be true even if aggregate claim costs across the entire market had developed in line with the average expectation of all insurers.

COMPARISON TO MEDICARE PART D RISK CORRIDORS

The ACA risk corridor program is often compared to the Medicare Part D risk corridor program. In fact, in February 2013,[7] the Congressional Budget Office (CBO) used the Medicare Part D program to inform their projections that the federal government would actually be a net receiver of ACA risk corridor funds – i.e., that the funds paid into the program by carriers doing better than expected would be greater than the funds paid out of the program to carriers experiencing worse-than-expected results.

However, unlike the ACA program, the Medicare Part D program is symmetric. In the Table 1 example previously discussed, Insurer 1 and 2 would have the same target amount under the Medicare Part D program parameters. This is because the Part D target amount is calculated solely based on pricing assumptions and not actual profit and administrative expense levels. Under that program, symmetric claim cost deviations would result in symmetric risk corridor payables and receivables. This is a key and material difference between the two programs, resulting in a systemic bias for the ACA program to be underfunded when compared to the Part D program.

5 https://ir.citi.com/T75ur7JO9TmjgZE8xXjGDxftykEMbKPXghCs4GqkDqE%3D.
6 https://www.globalcreditportal.com/ratingsdirect/renderArticle.do?articleId=1396705&SctArtId=314008&from=CM&nsl_code=LIME&sourceObjectId=9141430&sourceRevId=5&fee_ind=N&exp_date=20250430-20:51:02.
7 http://www.cbo.gov/sites/default/files/cbofiles/attachments/45010-Outlook2014_Feb.pdf.

TABLE 1: ILLUSTRATION OF ASYMMETRIC RISK CORRIDOR RESULTS

($ Millions)	Insurer 1: +10% Claims Deviation[1]	Insurer 2: -10% Claims Deviation[1]
Premiums	$100.0	$100.0
Claims[2]	88.0	72.0
Taxes/fees	3.0	3.0
Quality improvement expenses	1.0	1.0
Other admin expenses	15.0	15.0
Profit	(7.0)	9.0
Target amount[3]	$79.1	$77.6
Allowable cost[4]	89.0	73.0
Allowable cost / target amount – 1	12.5%	-5.9%
Risk corridor percent of target Amount[5]	6.1%	-1.5%
Risk corridor receivable/(payable)	**$4.8**	**($1.1)**

(1) Both carriers used identical pricing assumptions, including an 80% target loss ratio

(2) Net of transitional reinsurance and risk adjustment transfers

(3) Calculated using 3% profit minimum and 20% admin expense + profit cap. See Appendix tables 2a to 2c for details.

(4) See Appendix table 3 for details

(5) 0% of first ±3%, 50% of next ±5%, 80% of difference above ±8%

This asymmetry is due to the formula's incorporation of minimum profit levels and maximum allowable administrative costs in the target amount. Table 1 illustrates this asymmetry by calculating risk corridor receivables and payables for two similarly situated insurers with the same premium volume and administrative expenses. In this example, suppose that Insurer 1 experiences 10% higher claim costs than expected, while Insurer 2 experiences 10% lower-than-expected claim costs.

Despite the symmetric claim cost deviations for the two insurers, the resulting risk corridor outcomes are not symmetric. The risk corridor algorithm results in an excess of receivables for Insurer 1 when compared against the payables owed by Insurer 2. Similar results can be shown for a wide array of claim cost, administrative cost, and profit assumptions.

To reiterate, the cause of this asymmetry is due to the calculation of each insurer's target amount. The calculation of the target amount is very similar to the calculation of the allowable cost, except that the minimum profit floor and maximum administrative expense plus profit cap come into play in the former. In Table 1, Insurer 1's target amount is calculated using a minimum profit of $2.9, which is 3% of the after-tax premiums (3% x [$100 - $3]) instead of the actual profit of -$7.0. The difference between these two profit values results in the $9.9 difference between the target amount and the allowable cost.

For Insurer 2, the administrative expense plus profit values used to calculate the target amount are capped at $19.4 (20% of after-tax premiums) instead of the actual value of $24.0 ($15.0 + $9.0). Insurer 2's target amount in effect includes profit of $4.4 ($19.4 minus $15.0 administrative expenses) instead of its actual profit of $9.0.

Here is the key difference between Insurer 1 and Insurer 2: Insurer 1 only gets to include $2.9 as its target profit level, while Insurer 2 gets to include $4.4. Thus, even though both insurers are similarly situated with identical administrative costs, premium rates, and pricing assumptions, their target amounts are calculated differently.

Due to the asymmetry described here, variation in insurer financial performance will tend to result in an excess of receivables over payables, even when overall market claim costs develop in line with the average expectation of all insurers in the market.

Ultimately, the profit floor and administrative expense cap in the formula are needed because the calculation of the target amount is based on actual results rather than pricing targets. (The administrative expense cap also attempts to better coordinate the risk corridor program with the minimum medical loss ratio program under the ACA.) In particular, if these adjustments were removed from the formula, the target amount would in effect assume that each insurer intended to achieve whatever profit or loss actually occurred, resulting in no transfers of funds and negating the purpose of the program.

The example above uses the original risk corridor program parameters outlined by the U.S. Department of Health and Human Services (HHS). These were later modified by HHS to help buffer the adverse impact to insurers caused by the federal transitional policy by making the formula even more asymmetric. These adjustments are described in more detail under item 4.

4. **Risk corridor formula adjustments increase receivables versus payables gap** – HHS announced adjustments to the risk corridor formula for 2014 and 2015 to help offset the impact of the federal government's transitional policy in the ACA market. The 2014 adjustment increased the 3% profit floor and 20% allowable administrative expense cap to higher levels on a state-by-state basis, and 2015 features a 2% across-the-board upward adjustment to both parameters. This results in higher risk corridor receivables and/or lower risk corridor payables than would otherwise be calculated. This is because, as explained previously, the impact of the transitional policy made market-wide claim costs higher than expected. Since market-wide claim costs were skewed upwards, the risk corridor formula adjustments were intended to skew the results of the program the other way - just enough to offset the additional claim costs.

Although budget neutrality was under discussion at the time, these formula adjustments were implemented prior to Cromnibus, when budget neutrality wasn't a technical requirement of the program.

REINSURANCE PROGRAM DECREASED THE FUNDING GAP

In June 2015, HHS retroactively increased the 2014 transitional reinsurance program coinsurance percentage from 80% to 100%[8], resulting in additional individual market recoveries of $1.6 billion.[9] Earlier, HHS had already increased transitional reinsurance recoveries by decreasing the program's attachment point from $60,000 to $45,000. Without these adjustments, the 2014 risk corridor funding shortfall would have been even greater.

These additional reinsurance recoveries became available because there were fewer eligible ACA individual market enrollees over which to spread the program's budget and not because of any funding increases for the program. In fact, program funding came in lower than expected, but ACA individual market enrollment came in low enough to allow for higher per-member recoveries despite this. Another key driver was the government's decision to prioritize payments to insurers under the program over those to the Treasury, which was originally supposed to collect $2 billion as part of the reinsurance collections made for 2014. The resulting higher recoveries caused a higher-than-expected proportion of market claims being offset by the program's fixed budget. Even with this adjustment, HHS still has unspent contributions from 2014 that can be used to fund increased reinsurance recoveries in 2015 or 2016.

Note that to the extent that market-wide enrollment levels come in lower than expected in 2015 and 2016, a similar dynamic will affect the ACA individual market, resulting in higher-than-expected per member reinsurance recoveries. If higher reinsurance recoveries result in these years, risk corridor receivables will be reduced, similar to the effect observed for 2014.

IMPLICATIONS FOR 2015 AND 2016

The 2014 risk corridor funding shortfall also puts 2015 and 2016 risk corridor receivables at an increased risk of being underfunded. This is because HHS has stated that funds collected in 2015 and 2016 from insurers in a risk corridor payables position would first be used to fund any remaining 2014 receivables before being used on 2015 or 2016 receivables.[10] To the extent that funding shortfalls continue over the next two years and budget neutrality remains in place, 2015 and 2016 receivables will not be fully funded.

Here are a few additional considerations insurers should account for in evaluating the future collectability of risk corridor receivables:

1. The language in the Cromnibus bill is currently limited to 2014 risk corridor amounts because it governs the federal fiscal year in which those amounts will be paid. If different language is enacted for 2015

8 http://us.milliman.com/insight/2015/Transitional-reinsurance-at-100-coinsurance-What-it-means-for-2014-and-beyond/.

9 Calculated from values included in June 30 report, https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RI-RA-Report-Draft-6-30-15.pdf.

10 https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/faq-risk-corridors-04-11-2014.pdf.

and 2016, then the collectability of risk corridor receivables becomes less of an issue. However, given the current political sensitivity surrounding the risk corridors, it may be more likely that budget neutrality is here to stay. Even if budget neutrality remains in place in future years, it is possible that HHS may find other sources of funds to draw on to fund risk corridor receivables.[11]

2. To the extent that 2015 and 2016 ACA market-wide enrollment levels come in lower than expected, the transitional reinsurance program should be paid out at higher-than-expected levels on a per member basis, similar to 2014. This should mitigate some of the resulting excess costs in the market, although the impact will be dampened compared to 2014 results due to the phase-out of the reinsurance program as mandated by the ACA.

3. With many insurers having very limited ACA experience data when setting 2015 premium rates, underestimated market-wide cost levels could still be a significant risk in the 2015 market. Because markets tend to favor lower-priced plans, as described in the previous section, this could contribute to future funding shortfalls.

On the other hand, most insurers had significantly more knowledge on ACA market costs when setting 2016 premiums, although the effects of the transitional policy will continue into 2017. Insurers were also wary of the implications of risk corridor budget neutrality and the possible lack of protection for plans in 2016. As a result, the risk of underestimating market-wide costs should be lower in 2016, at least in markets where regulators allowed insurers to adjust rates to appropriate levels.

4. The asymmetry of the risk corridor algorithm described previously will continue to skew market results, tending to increase receivables compared to payables.

Thus, in addition to the pecking order of 2014 receivables receiving priority over 2015 and 2016 receivables, the original drivers contributing to the 2014 funding gap will continue to affect insurer financials and influence the market in 2015 and 2016. Insurers will need to stand ready to adjust their course as needed to steer safely through these headwinds.

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11 http://us.milliman.com/uploadedFiles/insight/2014/risk-corridors-no-new-hope.pdf.

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APPENDIX

The following tables outline the calculation of the Target Amount and Allowable Costs values in Table 1. As noted above, this calculation is solely illustrative in nature.

TABLE 2A: CALCULATION OF TABLE 1 TARGET AMOUNT

($ Millions)	Insurer 1	Insurer 2
Premium	$100.0	$100.0
- Allowable Administrative Cost	20.9	22.4
= Target Amount	**$79.1**	**$77.6**

TABLE 2B: CALCULATION OF TABLE 2A ALLOWABLE ADMINISTRATIVE COST

($ Millions)	Insurer 1	Insurer 2
Other Admin Expenses	$15.0	$15.0
+ Risk Corridor "Profit"	2.9	9.0
+ Impact of 20% Cap	0.0	(4.6)
+ Taxes/Fees	3.0	3.0
= Allowable Administrative Cost	**$20.9**	**$22.4**

TABLE 2C: CALCULATION OF TABLE 2B RISK CORRIDOR "PROFIT"

($ Millions)	Insurer 1	Insurer 2
Maximum of: Actual Profit	($7.0)	$9.0
3% of After-Tax Premium	2.9	2.9
= Risk Corridor "Profit"	$2.9	$9.0

TABLE 3: CALCULATION OF TABLE 1 ALLOWABLE COST

($ Millions)	Insurer 1	Insurer 2
Claims*	$88.0	$72.0
+ Quality Improvement Expenses	1.0	1.0
= Allowable Cost	$89.0	$73.0

* Net of transitional reinsurance and risk adjustment transfers.