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IN FOCUS

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Risk Adjustment in the Private Health Insurance Market

Section 1343 of the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) established a permanent risk adjustment program that is designed to assess charges to private health plans in a state that have relatively healthier enrollees and to use collected charges to make payments to private health plans in the same state that have relatively sicker enrollees. The risk adjustment program aims to reduce the incentives insurers may have to avoid enrolling individuals who are at risk of high health care costs. All non-grandfathered, individual (non-group) market and small-group market health plans, both inside and outside of the exchanges, participate in this program.

This In Focus briefly describes risks the ACA's risk adjustment program is expected to mitigate and provides an overview of the program. More information about the risk adjustment program is available in CRS Report R45334, *The Patient Protection and Affordable Care Act's (ACA's) Risk Adjustment Program: Frequently Asked Questions*.

Risk Mitigation

Individuals differ in their risk in the health insurance market based on their health status, with sicker individuals considered *high-risk* individuals and expected to have greater health costs than healthier individuals (i.e., *low-risk* individuals). One phenomenon facing health insurance markets is that high-risk individuals who expect or plan for high use of health services (e.g., older or sicker individuals) tend to seek out coverage and enroll in plans with more benefits than low-risk individuals who do not expect to use many or any of the health services (e.g., younger or healthier individuals).

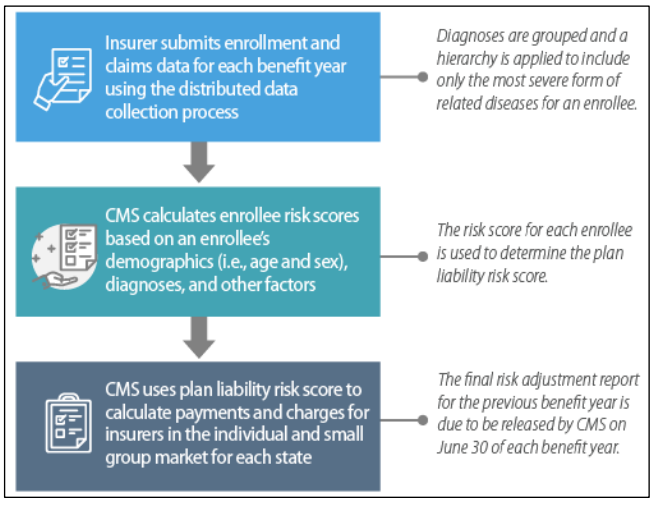
Prior to the ACA, state laws (and federal law under limited circumstances) determined whether insurers could minimize their exposure to this phenomenon by charging higher or lower premiums to consumers based on factors such as age, gender, and health status. However, under current federal law, insurers are unable to set premiums based on gender or health status, and insurers are limited in how much they can vary premiums by age. Without these tools to account for the risk of individuals who expect or plan for high use of health care services, insurers still may attempt to avoid the enrollment of these individuals by designing plans or using marketing techniques that are not likely to appeal to them. Financial assistance, such as premium tax credits and cost-sharing subsidies for on-exchange plans, and the individual mandate (though the penalty has been effectively eliminated as of January 1, 2019) are intended to encourage enrollment for all individuals, including low-risk individuals. Encouraging enrollment for both high-risk and low-risk individuals is intended to reduce the chances that only high-risk individuals—who expect or plan to have high use of health services—purchase health insurance. However, that remains a possibility, and an insurer may experience losses if it enrolls a disproportionate share of high-risk enrollees with high health care costs.

Under current law, absent a risk adjustment mechanism, a plan that enrolls a larger proportion of sicker (i.e., high-risk) enrollees than other plans in the market would need to charge a more costly average premium (across all enrollees) to be financially viable. Under the risk adjustment program, an insurer can set premiums for plans with sicker-than-average (i.e., high-risk) enrollees lower than the expected cost of claims because it will receive a risk adjustment transfer payment to make up some or all of the difference. Conversely, an insurer of a plan with healthier-than-average (i.e., low-risk) enrollees will set premiums higher than what is needed to cover their anticipated claims cost because part of that premium will be a risk adjustment charge owed to other insurers. The risk adjustment program is intended to allow consumers to purchase health care coverage with premiums that reflect differences in plan design and available benefits rather than the risk of enrollees who choose a particular plan.

Risk Adjustment Program Operations

The Centers for Medicare & Medicaid Services (CMS) administers the risk adjustment program, which began in 2014 and is currently in its fifth year of operations (for the 2018 benefit year). **Figure 1** summarizes the risk adjustment process.

Figure 1. Risk Adjustment Process Flow



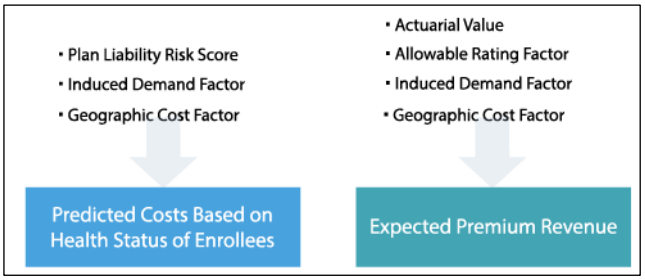
Source: CRS-developed flow chart of the permanent risk adjustment program based on information from CMS.

Notes: CMS = Centers for Medicare & Medicaid Services.

Each benefit year, CMS determines required payments and charges between eligible health plans in each state. It first measures a plan's risk using a risk score for each enrollee in the plan, and it then calculates the payment or charge based on a transfer formula. CMS calculates a risk score for each actual enrollee in a plan using the enrollee's demographic information, diagnoses, and several other factors. The risk score is a relative measure of how costly that enrollee is anticipated to be for the plan.

CMS administers the risk adjustment program on a budget-neutral basis, so the sum of all charges for plans with lower-than-average risk equals the sum of payments made to plans with higher-than-average risk within a state and market (individual or small group). A plan's risk adjustment payment or charge (i.e., transfer) is determined by calculating a plan's predicted costs relative to the statewide average (considering the health status of enrollees by using the risk scores aggregated into the plan liability risk score) and subtracting the expected premium revenue the plan can collect based on allowable rating factors (i.e., individual or family enrollment, geographic rating area, tobacco use, and age), relative to the statewide average, with both terms adjusted for additional factors. The value that results from the difference between predicted costs and expected premiums is then multiplied by the state average premium for the state and the market to determine the charge (if predicted costs are less than expected premiums) or the payment (if predicted costs are greater than expected premiums). **Figure 2** lists the factors used to calculate transfers.

Figure 2. Factors Used in Calculating Transfers



Source: CRS-developed list of factors in the transfer formula based on CMS information about the risk adjustment program.

The risk adjustment program compensates insurers for a portion of financial losses related to having an enrollee population with higher-than-average risk (i.e., sicker) relative to other insurers. However, it is not intended to ensure that premiums can cover the costs of average claims within a state. Premiums are determined before the plans are sold to consumers and thus are based on estimates of expected cost, whereas claims represent the actual costs incurred by an insurer. If the costs of enrollees in a state and market are greater than expected, the statewide average premium likely will be too low. Though the risk adjustment program still would transfer funds between insurers, the premiums may not cover the cost of enrollees in the entire state or market. Also, the risk adjustment program does not ensure more stable premiums from one year to the next.

Table 1 shows an example of how risk adjustment payments and charges may be distributed in a hypothetical state and market with three insurers. Insurer A's premium is 10% below the market average ($270 compared to $300) and it attracted a healthier-than-average population (relative risk is negative 10%). Therefore, Insurer A had a risk adjustment charge of $30 (10% of $300, the state average premium for the market). While the $30 charge is 10% of the state average premium, it amounts to about 11% of Insurer A's actual premium ($270). Given its relative risk, Insurer A would have expected the net premium after the 10% risk adjustment charge to be $243 ($270 in premium, minus a $27 risk adjustment charge). However, since the risk adjustment charge is calculated using the market average premium ($300), the net premium is actually $240 ($270 - $30) after the risk adjustment charge, so Insurer A is left with a shortfall of 1% of premium. Insurer C attracted a sicker-than-average population (relative risk of positive 10%), and it also has a shortfall of about 1% of premium.

Table 1. Hypothetical Risk Adjustment Transfers

	A	B	C	Market
Market Share	15%	70%	15%	100%
Actual Premium PMPM	$270	$300	$330	$300
Relative Risk	-10%	0%	10%	0%
Expected Net Premium PMPM	$243	$300	$363	$301
Transfer Amount PMPM	-$30	$0	$30	$0
Actual Net Premium PMPM	$240	$300	$360	$300
Excess/(Shortfall) PMPM	($3)	$0	($3)	($1)

Source: Barb Klever, MAAA, FSA, Scott Allen, MAAA, FSA, and Bethany Axtman, MAAA, EA, FSA, et al., *Insights on the ACA Risk Adjustment Program*, American Academy of Actuaries, April 2016.
Notes: PMPM = Per member per month.

As demonstrated in this example, if insurers' premiums do not correctly account for how their enrollees' risk differs from the market, then premiums may be incorrect (i.e., too high or too low), which may result in unanticipated losses or gains.

Program Outcomes

There is not a lot of research on the risk adjustment program. However, the American Academy of Actuaries published a report analyzing 2014 benefit year data that suggests some evidence that the risk adjustment program was functioning as intended in that year. It reported that risk adjustment transfers reduced the medical loss ratios for insurers with high loss ratios and increased the loss ratios among insurers with low loss ratios, generally bringing the loss ratios closer together for insurers that received payments and those that experienced charges. The medical loss ratio for an insurer is the percentage of premiums spent on health care claims and other expenses related to improving health care quality. By bringing the loss ratios for insurers closer together, the risk adjustment program worked to even out insurers' experiences in a particular market.

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