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# Risky Business: Will Taxpayers Bail Out Health Insurers?

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*Despite the president's assurance that "if you like your health plan, you can keep your health plan," Obamacare caused significant disruption to people's coverage as the health insurance exchanges prepared for their first open enrollment. Beginning October 1, 2013, insurers knew they would struggle to price policies in the exchanges accurately.*

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The Affordable Care Act (ACA) included three mechanisms to backstop insurers' risks: risk adjustment, reinsurance and risk corridors. The first, risk adjustment, consists of perpetual transfers of money from unexpectedly profitable insurers to unexpectedly loss-making insurers and is — at least conceptually — necessary to mitigate risk in a market where insurers are forbidden to charge beneficiaries actuarially accurate premiums.

The other two mechanisms, reinsurance and risk corridors, were designed to protect insurers from unforeseen losses in Obamacare's first three years, when insurers would not have enough experience to know how much risk they faced. These financial protections are critical to insurers' ability to survive in the exchanges through the end of 2016. Both schemes persist only through the first three years of Obamacare, by the end of which its architects believed actuarial risks in the exchanges will have stabilized.

**Reinsurance.** Insurance companies typically insure themselves against the risk of financial losses from higher-than-expected claims by purchasing reinsurance policies from specialized, private firms. Instead, Obamacare substitutes the federal government for private reinsurers. Each year, Obamacare levies a special premium tax on all insurers — whether participating in exchanges or not — as well as self-insured (so-called ERISA) plans, in which employers bear the risk of medical costs, and insurers or administrators process claims and advise on plan design.[2] This tax revenue is further supplemented by the U.S. Treasury. The total targeted amount for reinsurance is $12 billion for 2014, $8 billion for 2015 and $5 billion for 2016.[3] Although these sums are a burden on beneficiaries and taxpayers, at least they are limited.

By March of each of the three years, the U.S. Department of Health & Human Services (HHS) must publish a notice explaining how it will distribute reinsurance money to insurers the following year. In March 2013, HHS issued its notice of payment parameters for 2014.[4] The threshold above which 80 percent of an individual's claims would be reinsured was $60,000, with the reinsurance payment to the insurer capped at $250,000. For example:

- If a patient has medical claims of $200,000, the insurer would be compensated $112,000 [($200,000-$60,000) X 80%] by the reinsurance fund.
- If the patient has medical claims of $500,000, the insurer would claim the maximum of $152,000 [($250,000-$60,000) X 80%].
- If reinsurance claims are greater than $12 billion, HHS will prorate the claims.

In December 2013, HHS released its proposed rule for payment parameters for 2015.[5] However, in addition to proposing the parameters for the second year of the Obamacare exchanges, HHS changed the threshold for reinsurance it had previously announced for 2014, lowering the threshold from $60,000 to $45,000. Revisiting the two examples above:

- The patient with medical claims of $200,000 will now cause the insurer to be compensated $124,000 [($200,000-$45,000) X 80%] by the reinsurance fund.
- If the patient has medical claims of $500,000, the insurer will claim the maximum of $164,000 [($250,000-$45,000) X 80%].

HHS asserts it lowered the threshold because there will be *fewer* extraordinary claims than originally anticipated: "…Updated information, including the actual premiums for reinsurance-eligible plans, as well as recent policy changes, suggests that our prior estimates of the payment parameters may *overestimate the total covered claims* costs of individuals enrolled in reinsurance-eligible plans in 2014 [emphasis added]."[6] This is a remarkable claim. Indeed, the evidence suggests the exchanges are attracting older and sicker applicants than originally anticipated. For example, Express Scripts, the country's largest provider of pharmacy benefits, analyzed medication utilization in the exchanges, finding:[7]

> "Approximately 1.1% of total prescriptions in Exchange plans were for specialty medications, compared to 0.75% in commercial health plans, a 47% difference.…Specialty medications now account for more than a quarter of the country's total pharmacy spend.
>
> "In total spend, six of the top 10 costliest medications used by Exchange enrollees have been specialty drugs. In commercial health plans, only four of the top 10 costliest medications were specialty."

Specialty drug use is higher, says Express Scripts. For example, "more than six in every 1,000 prescriptions in the Exchange plans were for a medication to treat HIV. This proportion is nearly four times higher in Exchange plans than in commercial health plans."[8]

Further increasing claims costs, the 18- to 34-year-old "young invincibles" needed in the exchanges comprise only 28 percent of enrollees, almost one-third fewer than the 40 percent previously expected.[9]

In addition, the reinsurance fund is financed primarily by a tax of $63 per insured person. However, HHS calculations assumed there would be approximately 191 million insured individuals, for revenue of $25 billion over three years. If there are significantly fewer insurees in 2014, revenues will fall short.

If the reinsurance fund raises less revenue than expected and 2014 medical claims in the exchanges are higher than HHS anticipates, the fund will fall short of satisfying insurers' claims against losses. They will look elsewhere to be made whole. That "elsewhere" is the risk corridors.

**Risk Corridors.** Through 2016, "risk corridors" are unlimited taxpayer obligations to compensate insurers in the exchanges for medical costs in excess of 103 percent for each plan's target costs (explained below). For costs between 103 percent and 108 percent of target, taxpayers compensate insurers half the excess loss. For costs above 108 percent of target, taxpayers will compensate insurers 2.5 percent of the target medical cost plus 80 percent of the excess over 108 percent.

Superficially, risk corridors appear to be revenue neutral, requiring no increase in government spending of taxpayers' funds. But this is not the case, because payments are based on premiums paid, not claims incurred. A simple example: If the average premium (over all insurers) is $10,000, and the average of all claims is $10,000, the reimbursement will be revenue neutral. However, if the average of all claims is $12,000, taxpayers must pay the difference. If the average of all claims is only $8,000, the Treasury will keep the difference.

Health insurers appear to understand the exchanges

carry more risk than initially appreciated. Last November, after the president announced he would not enforce the provisions of the ACA that caused insurers to cancel millions of policies, insurers reacted badly. Karen Ignagni, CEO of America's Health Insurance Plans, the industry's trade association, said, "Changing the rules after health plans have already met the requirements of the law could destabilize the market and result in higher premiums for consumers. Premiums have already been set for next year based on an assumption of when consumers will be transitioning to the new marketplace."[10]

HHS immediately published a letter promising, in somewhat veiled language, to figure out how to exploit the risk corridors to further immunize insurers from losses: "Though this transitional policy was not anticipated by health insurance issuers when setting rates for 2014, the risk corridor program should help ameliorate unanticipated changes in premium revenue. *We intend to explore ways to modify the risk corridor program final rules to provide additional assistance* [emphasis added]."[11]

This letter was written only two weeks *after* the *Federal Register* published the final rule for 2014.[12] The black letter of the law defines the risk corridor calculations, but the inputs are subject to significant regulatory discretion. That is, the determination of actual to target costs are the result of complicated calculations. The final rules delve into mind-numbing depths. For example, "stand-alone dental claims would not be pooled along with an issuer's other claims for the purposes of determining 'allowable costs' in the risk corridors calculation."

In March 2014, the administration proposed a rule that, among other things, increased taxpayers' exposure to Obamacare's risk corridors by adjusting the risk corridors formula. The rule would "raise the administrative cost ceiling by 2 percentage points, from 20 percent to 22 percent," and "increase the profit margin floor in the risk corridors formula (currently set at 3 percent, plus the adjustment percentage, of after-tax premiums)" from 3 percent to 5 percent.[13]

The table below shows an insurance plan with a $10 million cost target versus $11 million of allowable costs and actual medical claims of $8.8 million. In this example:

- Using the formula for calculating the plan's payout from the risk corridor, allowing 20 percent of administrative costs, it gets a $410,000 "bailout" (Panel A).

**Risk Corridor Payouts to a Qualified Health Plan**

| Panel A (20 percent administrative costs allowed) | | Panel B (22 percent administrative costs allowed) | |
|---|---|---|---|
| Target Medical Costs | $10,000,000 | Target Medical Costs | $10,000,000 |
| Allowable Cost (including 20% administrative costs) | $11,000,000 | Allowable Cost (including 22% administrative costs) | $11,282,051 |
| Allowable/Target | 110% | Allowable/Target | 113% |
| 108% of Target | $10,800,000 | 108% of Target | $10,800,000 |
| Allowable Cost Minus 108% of Target | $200,000 | Allowable Cost Minus 108% of Target | $482,051 |
| Risk Corridor Pays 2.5% of Target | $250,000 | Risk Corridor Pays 2.5% of Target | $250,000 |
| Plus 80% of Allowable Cost Minus Target | $160,000 | Plus 80% of Allowable Cost Minus Target | $385,641 |
| Total Risk Corridor Payment | $410,000 | Total Risk Corridor Payment | $635,641 |

Source: Author's calculations based on "RIN 0938-AS02: Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond," Centers for Medicare & Medicaid Services, March 13, 2014.

- If the plan can add administrative costs of up to 22 percent of allowable costs, the payout increases to $635,641 — an increase of 55 percent (Panel B).

However, there is no guarantee whatsoever the change in the formula will be budget neutral over the three-year period of the risk corridors. For example, as the *Washington Post*'s Jason Millman explained, "If HHS collects…$800 million in 2014 and only has to pay out $600 million, then it will keep the remaining $200 million to use in future years of the program. If HHS doesn't collect enough money to cover the charges, it will pro rate the amount it pays out to insurers that year. In the following year, HHS would then pay out the difference from the previous year first, before paying risk corridors charges for that year."[14] But HHS had not decided what it will do if there are shortfalls or surpluses at the end of the three years, according to another letter to insurers.[15]

In April 2014, based on the administration's assumptions, the Congressional Budget Office lowered its estimate of the effect of risk corridors from an $8 billion surplus to budget neutrality.[16] From a taxpayer's perspective, the estimate is moving in the wrong direction.

In May 2014, the administration published the final rule for 2015.[17] The rule confirmed the increased risk corridor payouts first proposed in March.[18] Further, the final rule takes a small but significant step toward abandoning the fantasy of budget neutrality: "In the unlikely event of a shortfall for the 2015 program year, HHS recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers. In that event, HHS will use other sources of funding for the risk corridors payments, subject to the availability of appropriations."[19]

The administration's admission that appropriations are required to use general revenues to make the risk corridors whole appears to agree with the Congressional Research Service, which has suggested payouts from the risk corridors require appropriations.[20]

**Conclusion.** Taxpayers would benefit if Congress used its available tools and powers to ensure our liabilities in the risk corridors are limited and precisely quantified.

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*References and sources can be found in the online version at www.ncpa.org/pub/ib148.*

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