"Risky Business – But For Whom? Taxpayers Deserve To Know Their Exposure To Shortfalls In Obamacare's So-Called Private Health-Insurance Exchanges"

Statement of

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"Poised to Profit:
How Obamacare Helps Insurance Companies Even If It Fails Patients"

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Chairman Jordan and Members of the Committee, I am John R. Graham, Senior Fellow at the National Center for Policy Analysis, a nonprofit, nonpartisan public policy research organization dedicated to developing and promoting private alternatives to government regulation and control, solving problems by relying on the strength of the competitive, entrepreneurial private sector. I welcome the opportunity to share my views and look forward to your questions.

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, which began on October 1, 2013. Insurers knew that they would struggle to price policies in the exchanges accurately.

So, Obamacare included three mechanisms to backstop insurers' risk: Risk adjustment, reinsurance, and risk corridors. The first, risk adjustment, is perpetual, transfers money from unexpectedly profitable insurers to unexpectedly loss-making insurers, and is – at least in concept – a necessary way to mitigate risk in a market where insurers are forbidden to charge beneficiaries actuarially accurate premiums.

The last two, reinsurance and risk corridors, are politically motivated tools that are critical to insurers' ability to survive the exchanges through the end of 2016. Both persist only through the first three years of Obamacare, by the end of which its architects believed that the actuarial risks in the exchanges would have stabilized.

The first is reinsurance. 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). This tax revenue is supplemented by a little extra from the U.S. Treasury. In total, the reinsurance sums are targeted to be: $12 billion for 2014, $8 billion for 2015, and $5 billion for 2016.[1] Although these sums are a burden on beneficiaries and taxpayers, at least they are limited.

For each of the three years, the U.S. Department of Health & Human Services (HHS) must publish a notice (the previous March) explaining how it will distribute this money to insurers. In March 2013, HHS issued its notice of payment parameters for 2014.[2] The attachment point for reinsurance was $60,000, with a co-insurance rate of 80 percent, 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.

At the end of 2013, HHS released its proposed rule for payment parameters for 2015. However, as well as proposing the parameters for the second year of the Obamacare exchanges, the proposed rule changed what it had previously announced for 2014.

The one that jumps out is the change to the attachment point for reinsurance. The December rule has lowered the attachment point for 2014 to $45,000 from $60,000. 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 that it lowered the attachment point 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, suggest that our prior estimates of the payment parameters may *overestimate the total covered claims* costs of individuals enrolled in reinsurance-eligible plans in 2014" (italics mine).[3] This is a remarkable claim. Indeed, evidence suggests that the exchanges are attracting older and sicker applicants than originally anticipated.

For example, Express Scripts, the country's largest provider of pharmacy benefits, has released an analysis of medication utilization in the exchanges:

> …[U]se of specialty medications was greater among Exchange enrollees versus patients enrolled in a commercial health plan. Approximately 1.1% of total prescriptions in Exchange plans were for specialty medications, compared to 0.75% in commercial health plans, a 47% difference. Increased volume for higher cost specialty drugs can have a significant impact on the cost burdens…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.

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."[4]

Further, the young people needed in the exchanges are the so-called "young invincibles", who are between the ages of 18 through 34. These comprise only 28 percent of enrollees in Obamacare, almost one third fewer than the 40 percent previously expected.[5] Even worse, our understanding of the characteristics of beneficiaries in the exchanges is deteriorating, because HHS appears to have decided to discontinue its monthly announcements describing these important factors.[6]

As well, the reinsurance fund is financed primarily by a tax of $63 per insured person. That figure was calculated by HHS assuming approximately 191 million insured people. If 2014 sees significantly fewer insured people than assumed, revenues will fall short.

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

That "elsewhere" is the risk corridors. Through 2016, this is an unlimited taxpayer obligation that compensates insurers in the exchanges for medical costs in excess of 103 percent of the target costs for each plan. 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.

A quick read of risk corridors suggest that they are also revenue neutral. But this is not the case. Payments are based on premiums paid, not claims incurred. At the risk of oversimplification, 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 will be on the hook for the difference. If the average of all claims is only $8,000, the Treasury will keep the difference.

Health insurers appear to understand that the exchanges contain more risk than initially appreciated. Last November, after the President announced that he would not enforce the provisions of PPACA 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, stated that "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."[7]

HHS immediately published a letter that promised, in somewhat veiled language, that it would figure out how to exploit the risk corridors to further immunize the 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"* (italics mine)."[8]

This letter was written only two weeks *after* the Federal Register published the final rule for 2014.[9] The black letter of the law defines the risk corridors' calculations, but the inputs are subject to significant regulatory discretion.

That is, the numerators and denominators that determine the ratio of actual to target costs are the result of complicated calculations. The final rules delve into their 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."

This is illustrative of the kind of rule that can be quietly changed by a detail-oriented regulatory-affairs specialist working for an interested party. Furthermore, the goalposts have also been moved at a higher level. This March, the Administration proposed a rule that, among other things, increased taxpayers' exposure to Obamacare's risk corridors:

> We propose to implement an adjustment to the risk corridors formula…Such an adjustment could increase a QHP issuer's risk corridors ratio if administrative expenses are unexpectedly high or claims costs are unexpectedly low, thereby increasing risk corridors payments or decreasing risk corridors charges. We propose to raise the administrative cost ceiling by 2 percentage points, from 20 percent to 22 percent. We also propose to increase the profit margin floor in the risk corridors formula (currently set at 3 percent, plus the adjustment percentage, of after-tax premiums). Such an adjustment could increase a QHP issuer's risk corridors ratio if claims costs are unexpectedly high, thereby increasing risk corridors payments or decreasing risk corridors charges. We propose to raise the profit margin floor by 2 percentage points, from 3 percent to 5 percent. (p. 56)[10]

The table below shows an insurance plan with $10 million cost target versus $11 million of allowable costs. Actual medical claims are $8.8 million. Using the formula for calculating its payout from the risk corridor, allowing 20 percent of administrative costs, the plan gets a $410,000 "bailout" (panel A). If it can add administrative costs up to 22 percent of allowable costs, the payout increases to $635,641 — an increase of 55 percent (panel B).

Table: Risk Corridor Payouts To A Qualified Health Plan

Panel A (20% administrative costs allowed)		**Panel A (22% administrative costs allowed)**	
Qualified Health Plan Target Medical Costs	$10,000,000	Qualified Health Plan Target Medical Costs	$10,000,000
Qualified Health Plan Allowable Cost (including 20% administrative costs)	$11,000,000	Qualified Health Plan 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

However, there is no guarantee whatsoever that this will all wash out over the three-year period of the risk corridors. Nevertheless, the Administration now wants us to believe that it will. As described by the *Washington Post*'s Jason Millman:

- If HHS collects more money than it needs to pay out in risk corridor charges in 2014, it will hang on to the bonus funds for 2015 in case of a shortfall. Under the example HHS provided, if it 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.[11]

So what happens if at the end of the three-year program, HHS hasn't collected enough payments? Well, HHS doesn't know yet what happens then, according to a recent memorandum from the agency explaining the policy.

"We anticipate that risk corridors collections will be sufficient to pay for all risk corridors payments over the life of the three-year program," HHS writes. "However, we will establish in future guidance or rulemaking how we will calculate risk corridors payments if risk corridors collections (plus any excess collections held over from previous years) do not match risk corridors payments as calculated under the risk corridors formula for the final year of the program."[12]

The Congressional Budget Office has relied on the Administration for its estimates of the risk corridors' budgetary effects. In its April update, CBO reduced its estimate of the effect of risk corridors from an $8 billion surplus to budget neutrality[13]. From a taxpayer's perspective, the estimate is moving in the wrong direction.

In May, the Administration published the final rule for 2015, which confirms that it will increase the payout from the risk corridors, as first proposed in March.

Further, it takes a small but significant step towards 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".[14]

The Administration's admission that appropriations are required to use general revenues to make the risk corridors whole appears to go some ways towards agreeing with the Congressional Research Service, which has suggested that payouts from the risk corridors require appropriations.[15]

In conclusion, I believe taxpayers would benefit through Congress using whichever tools and powers are available to it, to ensure that our liabilities in the risk corridors are limited and precisely quantified.

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[2] "HHS Notice of Benefit and Payment Parameters for 2014," Centers for Medicare & Medicaid Services, March 11, 2013. Available at http://www.cms.gov/CCIIO/Resources/Files/Downloads/payment-notice-technical-summary-3-11-2013.pdf.

[3] "Patient Protection and Affordable Care Act: HHS Notice of Benefit and Payment Parameters for 2015," 78 Federal Register 231 (December 2, 2013), p. 72345.

[4] "First Look: Health Exchange Medication Utilization," Express Scripts Holding Company, April 9, 2014. Available at http://lab.express-scripts.com/insights/government-programs/first-look-health-exchange-medication-utilization.

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[8] Gary Cohen, letter to Insurance Commissioners, Centers for Medicare & Medicaid Services, November 14, 2013. Available at http://www.cms.gov/CCIIO/Resources/Letters/Downloads/commissioner-letter-11-14-2013.PDF.

[9] "Patient Protection and Affordable Care Act; Program Integrity: Exchange, Premium Stabilization Programs, and Market Standards; Amendments to the HHS Notice of Benefit and Payment Parameters for 2014," 78 Federal Register 210 (October 30, 2013), pp. 65046-65105.

[10] "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. Available at http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/CMS-9949-P.pdf

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[14] "RIN 0938-AS02: Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond," Centers for Medicare & Medicaid Services, May 21, 2014, pp. 80-81. Available at http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/508-CMS-9949-F-OFR-Version-5-16-14.pdf.

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