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The Economics of the Health Insurance Exchanges

Statement of

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ObamaCare: Why the Need for an Insurance Company Bailout?

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Mr. Chairman and members of the Committee, I am John Goodman, President and CEO of the National Center for Policy Analysis (NCPA), 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. My testimony today is based on work I've done with John R. Graham and Greg Scandlen, both colleagues of mine at the NCPA. I welcome the opportunity to share my views and look forward to your questions.

With fewer glitches to deter them, millions of Americans are successfully logging on to the (ObamaCare) health insurance exchange websites.

When they get there, many are discovering some unpleasant surprises: the deductibles are higher than what most people are used to, the networks of doctors and hospitals are skimpier (in some cases much skimpier), lifesaving drugs are often not on the insurers' formularies and, even after the highly touted subsidies are taken into account, the premiums are often higher than what they previously paid.

Why is this happening? Because of perverse incentives faced by buyers and sellers in the exchanges.

Matters are made worse by other aspects of the Affordable Care Act (ACA). Insurance pools outside the exchange are being allowed to dump their oldest, sickest enrollees into the exchanges, virtually guaranteeing that costs for the participating insurers are higher than they need to be. In anticipation of significant losses — at least initially — the ACA provides for federal government subsidies for the next three years, in addition to the types of risk adjustment one would normally expect.

This puts taxpayers at risk for the cost of serious mistakes in the design of the exchanges.

Perverse Incentives for Sellers. Under the health reform law, the benefits insurers must offer are strictly regulated — right down to free contraceptives and inexpensive preventive care. At the same time insurers have been given enormous freedom to set their own premiums and choose their own networks.

The result has been a race to the bottom. In order to keep premiums as low as possible, the insurers are offering very narrow networks, often leaving out the best doctors and the best hospitals. BlueCross of California, for example, only includes one-third the number of doctors in the exchange plan that it includes in the normal BlueCross plan. An exchange plan in Denver includes only one hospital, the one that usually treats Medicaid patients.

Note: Narrow networks can be good or bad. Walmart has selected half a dozen centers of excellence around the country for its employees. These are places carefully chosen for their high quality and low costs. The exchange health plans, by contrast, appear to care only about cost. They are offering low fees — sometimes even lower than what Medicaid pays — and accepting only those providers who will take whatever fee is offered.

Under health reform, insurers are required to charge the same premium, regardless of the applicants' health status; and they are required to accept anyone who applies. This means they must overcharge the healthy and undercharge the sick. It also means they have strong incentives to attract the healthy (on whom they make a profit) and avoid the sick (on whom they incur a loss). Evidence so far suggests that risk corridors, reinsurance and risk adjustment are not compensating for this incentive.

Perverse Incentives for Buyers. In the ObamaCare exchanges, insurers apparently believe that the healthy buy on price — ignoring other features of the plan. By contrast, only people who plan to spend a lot of health care dollars pay close attention to deductibles and which doctors and hospitals are in the insurer's network. Thus, by keeping deductibles high and fees so low that only a minority of physicians will agree to treat the patients, insurers are able to lower their premiums.

A race to the bottom doesn't happen in normal markets. What makes the ObamaCare exchanges different? Answer: the incentives of buyers.

If I am healthy why wouldn't I buy on price? If I later develop cancer, I'll move to a plan that has the best cancer care. If I develop heart disease, I'll find a plan with the best heart doctors. And by law, these plans will be prohibited from charging me more than the premium paid by a healthy enrollee.

Perverse Incentives Outside the Market. If insurers are acting in perverse ways to keep premiums low, why are so many shoppers shocked by how high they are? Answer: no matter how narrow the provider network is, health plans are going to cost more if the entire market enrolls more people with above-average health care costs. And that is what is about to happen.

The federal (ObamaCare) risk pools will soon close their doors and send their enrollees to the state exchanges. This is the program that allows people who were "uninsurable" to purchase insurance for the same premium healthy people pay. All of the state risk pools are planning to do the same. These risk pools were spending billions of dollars subsidizing insurance for high cost patients. Now those subsidies will have to be implicitly borne by the private sector plans through higher premiums charged to everyone else.

To make matters worse, cities and towns across the country with unfunded health care commitments are readying to dump their retirees on the exchanges, nationalizing the costs. Since retirees are above-average age, they have above-average expected costs. The city of Detroit, for example, is planning to unload the costs of 10,000 retirees on the Michigan exchange. Many private employers face the same temptation.

Then there are the "job-lock" employees — people who are working only to get health insurance because they are uninsurable in the individual market. Under ObamaCare, their incentive will be to quit their jobs and head to the exchange.

To add to this burden, the Obama administration has decided hospitals, AIDS clinics and other providers will be able to enroll uninsured patients in the exchange and pay premiums for them in order to get private insurance to pay the bills.

Bottom line: a lot of high-cost patients are about to enroll through the exchanges, causing overall costs for participating plans to be much higher.

Insurance Company Risks. Because health insurers are no longer allowed to ask any questions about an applicant's health, they have no way of knowing whom they are enrolling in terms of past or present illnesses or health conditions. They might attract a group of pretty healthy people or a group of pretty sick people, but they won't know until people start filing claims. So it is impossible to accurately set premiums, at least for the first few years.

Another problem is that some insurers may attract a whole lot of very sick people while others attract mostly healthy people. In a particular state, BlueCross may be known as the best place to go if you have cancer or heart disease, while Aetna may offer attractive discounts on gym memberships. The healthy people will be drawn to Aetna while the really sick people will prefer the Blues. If companies could set premiums to accurately reflect their enrolled population, BlueCross premiums would be outrageously expensive while Aetna premiums would be cheap. The ACA tries to fix these problems in three ways. (See the Table.)

Table 1: Summary of Risk and Market Stabilization Programs in the Affordable Care Act

	Risk Adjustment	Reinsurance	Risk Corridors
What the program does	Redistributes funds from plans with lower-risk enrollees to plans with higher-risk enrollees	Provides payment to plans that enroll higher-cost individuals	Limits losses and gains beyond an allowable range
Why it was enacted	Protects against adverse selection and risk selection in the individual and small group markets, inside and outside the exchanges by spreading financial risk across the markets	Protects against premium increases in the individual market by offsetting the expenses of high-cost individuals	Stabilizes premiums and protects against inaccurate premium setting during initial years of the reform
Who participates	Non-grandfathered individual and small group market plans, both inside and outside of the exchanges	All health insurance issuers and self-insured plans contribute funds; individual market plans subject to new market rules (both inside and outside the exchange) are eligible for payment	Qualified Health Plans (QHPs), which are plans qualified to be offered on a health insurance marketplace (also called exchange)
How it works	Plans' average actuarial risk will be determined based on enrollees' individual risk scores. Plans with lower actuarial risk will make payments to higher risk plans. Payments net to zero.	If an enrollee's costs exceed a certain threshold (called an attachment point), the plan is eligible for payment (up to the reinsurance cap). Payments net to zero	HHS collects funds from plans with lower than expected claims and makes payments to plans with higher than expected claims. Plans with actual claims less than 97% of target amounts pay into the program and plans with claims greater than 103% of target amounts receive funds. Payments do not have to net to zero.
When it goes into effect	2014, onward (Permanent)	2014 - 2016 (Temporary - 3 years)	2014 - 2016 (Temporary - 3 years)

Source: Kaiser Family Foundation

The First of Three Rs: Risk Adjustment. Risk adjustment is a permanent feature of the new exchanges. It involves taking money from insurance plans with healthier enrollees and giving to plans with sicker enrollees. The adjustment is revenue neutral in the sense that the amount paid in exactly equals the amount paid out.

Health and Human Services has developed a risk adjustment model that assigns one or more of 127 "Hierarchical Condition Categories" (HCCs) to each enrollee and gives each enrollee a "risk score," which results in higher or lower adjustments for payments to the health plan. One surprising feature of the risk

adjustment parameters is that an insurer can actually come out ahead by attracting a sicker-than-average population of enrollees.

For example, carriers would expect to have an 8.8 percent loss on males age 60 and above, but the risk adjustments turn that into a gain of 7.3 percent. For males age 25-29, an expected gain of 34.3 percent becomes a loss of 3.2 percent after the risk adjustments. So a company that wants to make money has every incentive to avoid young males and attract the oldest ones, at least as far as this adjustment is concerned. Overall, a Milliman report[1] says that people with "seven conditions would actually produce profit margins in excess of 1,000 percent of premiums."

With this adjustment alone, insurers would be tempted to attract the sick and avoid the healthy. But there is more to the story.

The Second R: Reinsurance. Each year, there will be a special premium tax levied on all insurers (whether participating in exchanges or not) as well as self-insured plans. This tax revenue is supplemented by a little extra from the U.S. Treasury. In total, the reinsurance sums are: $12 billion for 2014, $8 billion for 2015, and $5 billion for 2016. (For more details, but in laypersons' language, see the analysis by the Wakely Consulting Group.[2])

For each of the three years, the U.S. Department of Health & Human Services (HHS) must publish a notice explaining how it will distribute this money. The notice must be published by the end of March the previous year. Last March, HHS issued its notice of payment parameters[3] for 2014. The attachment point for reinsurance is $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 will 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 will 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. Of course, health insurers also have access to the commercial reinsurance market for claims above $250,000.

Like risk adjustment, the reinsurance program is also revenue neutral — the amount paid in is equal to the amount paid out.

The Third R: Risk Corridors. Under this program, insurers in the exchanges are subsidized for their losses in the following way. If medical costs for a plan are in excess of 103 percent of its target costs, the plan will receive a subsidy equal to 50 percent of its losses between 103 and 108 percent of target. For costs above 108 percent of target, the plan's subsidy will recoup 80 percent of the losses. The converse is that the insurers are taxed on their unexpected gains. Further, the tax thresholds are the mirror image of the subsidy thresholds. So there is a 50 percent tax on the gains for plans with costs below 103 percent and 108 percent of target costs, etc. (See the chart.)

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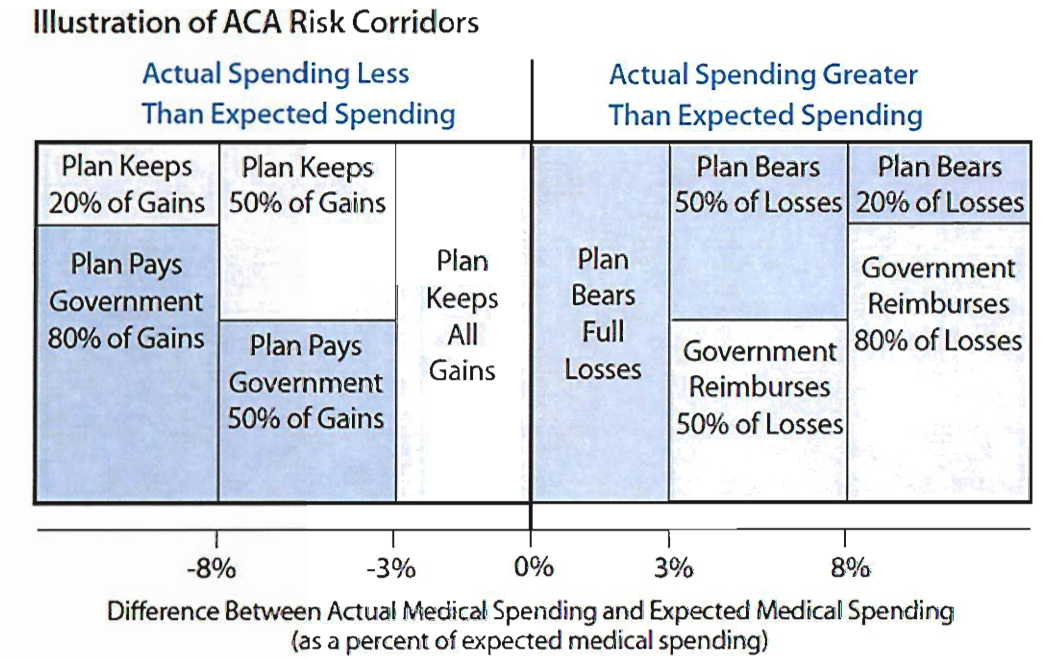
[1] Jason Siegel, Jason Petroske, *When Adverse Selection Isn't: Which Members are Likely to be profitable (Or Not) in Markets Regulated by the ACA, 2013,* Milliman Healthcare Reform Briefing Paper.
[2] Ross Winkelman, Julie Peper, Patrick Holland, Syed Mehmud, James Woolman, *Analysis of HHS Final Rules On Reinsurance, Risk Corridors and Risk Adjustment, 2012,* Robert Wood Johnson Foundation, State Health Reform Assistance Network.
[3] Center for Consumer Information and Insurance Oversight, *Payment Notice Technical Summary, 2013*, Centers for Medicare and Medicaid Services.

Unlike the first two Rs, this adjustment is not revenue neutral. If claims overall are more expensive than the target costs built into the premiums established at the end of 2013, subsidies to those plans that experience losses can exceed the taxes on plans that profit. In fact, there is potentially an unlimited taxpayer liability here — at least for the next three years. (Note, however: in its original analysis, the Congressional Budget Office assumed that the risk corridors would be budget neutral (as noted on pages 10 and 39 of this analysis[4]).

ACA Risk Corridor Program (2014-2016)



(Source: American Academy of Actuaries fact sheet[5])

Comparison to Medicare Part D. Some health economists[6] have noticed that the risk corridors in the ACA exchanges are similar to the risk corridors created in the early years of the Medicare Part D program. In fact, the risk corridors in Part D were actually more protective of the insurance companies than the ACA is. There is one difference, however. The Part D program did not encourage other insurance pools to dump their most costly enrollee into the newly created drug insurance marketplace. In fact employers were actually subsidized for continuing drug insurance programs that were already in place.

Where We Are Now. After one month, there are signs that insurers got their pricing significantly wrong. Because it is so hard to enroll in the ObamaCare exchanges, only the most persistent (that is, those who expect the highest medical claims) spent hours navigating the website to sign up. According to an HHS

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[4] Center for Consumer Information and Insurance Oversight, *Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, Exchange Standards for Employers and Standards Related to Reinsurance, Risk Corridors and Risk Adjustment, 2012*, Centers for Medicare and Medicaid Services.
[5] *Fact Sheet: ACA Risk-Sharing Mechanisms, 2013*, American Academy of Actuaries.
[6] Austin Frakt, *Risk corridors: ACA vs. Part D, in charts, 2014*, The Incidental Economist.

report[7], of those who selected plans from October through December, only one quarter are between the ages of 18 and 34, while one third are between 55 and 64; 55 percent are between the ages of 45 and 54. Priority Health, a Michigan insurer, reported that the average age of new applicants is 51[8], versus 41 in the previous individual market.

It certainly looks like health insurers' ObamaCare exchange adventure will be very expensive. By 2015, they will likely ask the federal government for risk corridor subsidies and those subsidies will be characterized as a "bailout." The administration has no flexibility in this regard. It would be a mistake to blame the insurance industry, however. It would be unreasonable to expect them to lose money on ObamaCare.

The Combined Effect of all Three Rs: A Case Study. Edie Sunby[9] has a rare form of cancer that is almost always fatal. Yet she is alive, thanks to the efforts of doctors in San Diego, at Stanford University and in Texas. Over the past year, UnitedHealthcare spent $1.2 million on her medical expenses. But at the end of last year she was informed that her insurance is being cancelled.

Worse, in the new California exchange, the only plan that will allow her to continue seeing her San Diego doctors will not pay for the doctors at Stanford or in Texas. There is no reimbursement for out-of-network services.

For Edie Sunby, the rules governing the new health insurance exchanges amount to a potential death sentence. She is not alone.

Here is our prediction: unless the Affordable Care Act is radically reformed, the kind of coverage Edie Sunby had will never again be seen in the individual market in this country.

Needed Reform. Wharton school health economist Mark Pauly and his colleagues have studied the individual market in great detail and discovered that despite so much negative rhetoric in the public policy arena this is a market that worked and worked reasonably well[10]. Despite President Obama's repeated reference to insurance plans that cancel your coverage after you get sick, this practice has been illegal for almost 20 years and in most states it was illegal long before that. And despite repeated references to people denied coverage because of a pre-existing condition, estimates are that only 1 percent of the population has this problem[11] persistently. (Remember: only 107,000 people enrolled[12] in the federal government's pre-existing condition risk pool — out of a population of more than 300 million people!) At most, Pauly puts the pre-existing condition problem at 4% of the population.[13]

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[7] *Health Insurance Marketplace: January Enrollment Report for the period: October 1, 2013 – December 28, 2013, 2014*, Department of Health and Human Services.
[8] *Insurers: Early Pool of ACA Exchange Applicants Older than Expected, 2013*, California Healthline.
[9] Edie Littlefield Sundby, *You Also Can't Keep Your Doctor, 2013*, The Wall Street Journal.

[10] Mark Pauly, *Health Reform without Side Effects: Making Markets Work for Individual Health Insurance, 2010*, The Hoover Institution.
[11] Paul Roderick Gregory, *Obama's Pre-existing Conditions Whopper, 2013*, Forbes.
[12] John C. Goodman, *ObamaCare Was Sold To American Voters On Deceptive Terms, 2013*, Forbes.
[13] Mark Pauly, *Health Reform without Side Effects: Making Markets Work for Individual Health Insurance, 2010*, The Hoover Institution.

So we started with a market that was working and working well for 96 to 99 percent of those who entered it and we have completely destroyed that market — ostensibly to help the few people for whom it did not work. We suspect that after the next election members of both parties will want a major return to normalcy. How can that work?

There is a principle that must never be violated. An insurance pool should never be allowed to dump its high cost patients on another pool. Suppose an individual has been paying premiums to insurer A for many years; then he gets sick and transfers to insurer B. Is it fair to let A put all those premium checks in the bank and force B to pay all the medical bills? Of course not. But even more important, if we do that we will create all of the perverse incentives discussed above — plus many more we might have added had time permitted.

The alternative is something we call "health status insurance.[14]" In the above example, the individual would continue paying the same premium to B that he paid to A and B would pay an additional amount to bring the total premium up to a level that equaled the expected cost of the individual's medical care.

Compare this idea to the Medicare Advantage market. Enrollees all pay the same premiums, but when a senior enters an MA plan, Medicare makes an additional payment to make the total amount paid reflect the true expected cost the senior brings to the plan. Because of this system, MA plans do not run away from the sick. In fact, there are special needs plans that specialize in attracting enrollees with high costs (about $60,000 per person on average).

Risk adjustment in Medicare does not work perfectly, however, and because the government runs the procedure, political pressures often interfere. So we recommend risk adjustment within the market rather than by an external government bureau. On this approach, insurer A and insurer B would have to agree among themselves on an appropriate transfer price. Only if they could not agree would the problem be left to an insurance commissioner to resolve.

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[14] John C. Goodman, *Rational Health Insurance, 2009*, John Goodman's Health Policy Blog.
[15] John C. Goodman, *Priceless: Curing the Healthcare Crisis, 2012*, The Independent Institute.