AMERICAN ACADEMY *of* ACTUARIES

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Subcommittee on Economic Growth, Job Creation and Regulatory Affairs

U.S. House of Representatives

Hearing on
"Poised to Profit: How ObamaCare Helps Insurance Companies Even If It Fails Patients"

Statement of

Cori E. Uccello, MAAA, FSA, FCA, MPP
Senior Health Fellow
American Academy of Actuaries

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Chairman Jordan, Ranking Member Cartwright, and distinguished members of the committee. My name is Cori Uccello, and I am the Senior Health Fellow at the American Academy of Actuaries. I am providing this testimony on behalf of the Academy, which is the non-partisan professional association representing all actuaries in the United States. Our mission is to serve the public by providing independent and objective actuarial information, analysis, and education to help in the formulation of sound public policy.

The Affordable Care Act (ACA) is expanding access to health insurance coverage by requiring insurers to accept all applicants, regardless of any pre-existing conditions, and prohibiting premium variations based on health status. To reduce the adverse selection arising from such requirements, the ACA includes other provisions, such as premium subsidies and an individual mandate, designed to increase overall participation in health insurance plans.

The ACA does not necessarily establish universal participation, however, and therefore some degree of adverse selection is inevitable. In addition, some insurance plans could end up with a disproportionate share of individuals having greater health care needs, putting them at risk for large losses.

The substantial influx of previously uninsured individuals into the new health insurance exchanges created by the ACA also could make it more difficult for insurers to price plans accurately, at least during the early years of the exchanges. In other words, insurers have uncertainty regarding who will sign up for coverage and among the newly insured, what their medical spending will be. Insurers generally do not have sufficiently detailed data and claims experience regarding health spending for the uninsured. In addition, future spending by the newly insured could increase once they obtain coverage, but it is unknown how large any such increase may be. Understating premiums could result in large losses to private insurers, threatening insurer solvency. Overstating premiums could result in large gains to the insurers and/or reduce participation in the plan.

The ACA established three risk-sharing mechanisms to mitigate these risks—risk adjustment, reinsurance, and risk corridors.

Risk Adjustment

The prohibition of denying coverage or charging higher premiums based on health status exposes insurers to adverse selection risk, which occurs when individuals or groups who anticipate high health care needs are more likely to purchase coverage than those who anticipate low health care needs. The ACA's individual mandate and premium subsidies will reduce the adverse selection effect, although some risk remains.

The ACA's permanent risk-adjustment program aims to reduce the incentives for health insurance plans to avoid enrolling people with higher-than-average costs by shifting money among insurers based on the risks of the people they enroll. Insurers with larger shares of low-cost enrollees will contribute to a fund that will make payments to insurers with larger shares of high-cost enrollees. All ACA-compliant plans in the individual and

small group market will participate in the risk-adjustment program, whether they are inside or outside of the exchanges. The risk-adjustment program is designed to be revenue neutral (i.e., no effect on the federal budget).

Reinsurance

For 2014-2016, the ACA includes a transitional reinsurance program that supplements the risk-adjustment program and compensates plans when they have enrollees with especially high claims. As the ACA was being drafted, it was recognized that high-cost individuals would have the greatest incentives to enroll in coverage. Therefore, during the first years of the law's implementation, this population could make up a greater share of enrollment than in subsequent years when the individual market risk pool is anticipated to be larger and more representative of the population as a whole.

The ACA transitional reinsurance program further reduces the incentives for plans to avoid high-cost individuals and helps to stabilize premiums during the initial years. The reinsurance program will offset a portion of the costs of high-cost enrollees in the individual market.

This will reduce the risk to insurers, allowing them to offer premiums lower than they otherwise would be. Funding for the reinsurance program comes from contributions from all health plans, including not only plans in the individual market, but also those in the small and large group markets, as well as self-insured plans. These contributions are then used to make payments to ACA-compliant plans in the individual market.

In 2014, $10 billion will be collected from health plans which will then be used to pay plans in the individual market when an individual's claims exceed $45,000. Plans will be reimbursed for 80 percent of an individual's health claims between $45,000 and $250,000. The program is budget neutral; if necessary, the U.S. Department of Health and Human Services (HHS) will adjust reinsurance payments to ensure that payments do not exceed contributions collected from health plans.

Contributions to and reimbursements from the program will decline over time until the program expires after three years. The transitional nature of this program was designed to address the likelihood that the earliest enrollees in the individual market will be those with higher expected costs, including enrollees transitioning from high risk pools, whereas healthier individuals may delay enrolling.

Risk Corridors

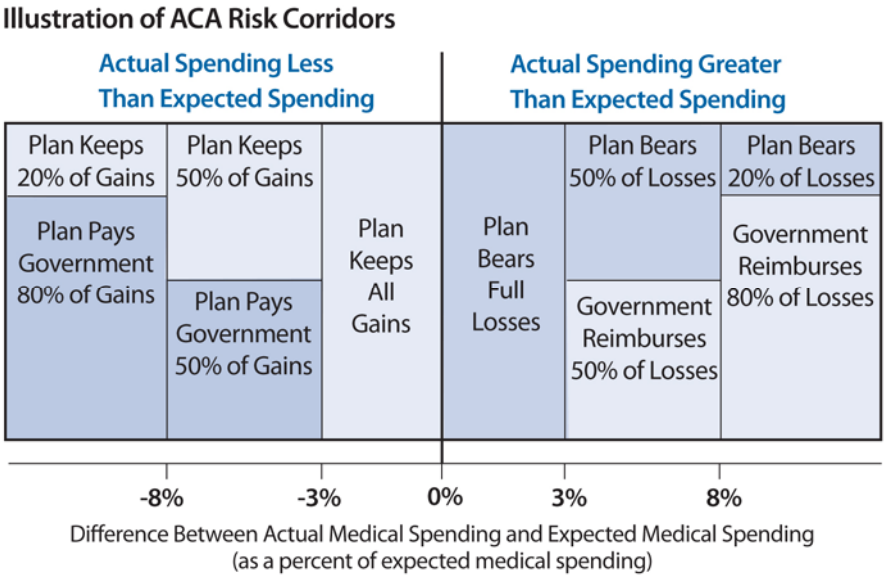
In general, risk corridors are used to mitigate the pricing risk that insurers face when their data on health spending for potential enrollees are limited. Risk corridors provide a payment to insurers if their losses exceed a certain threshold. They also are used to limit an insurer's gains—insurers would make payments if their gains exceed a certain threshold.

The ACA provides for a temporary risk-corridor program that will be effective from 2014 to 2016 for qualified health plans (QHPs) in the individual and small group markets. This program will mitigate the pricing risk introduced because of very limited data available to use to estimate who will enroll in plans operating under the new 2014 ACA rules and what their health spending will be. An objective of risk corridors is to encourage health insurance competition by limiting the risk for insurers entering the exchange market during the early years of implementation.

The ACA risk-corridor program is similar in concept to that in the Medicare Part D prescription drug program. When the Part D program was being contemplated, there was concern that it would be difficult for private insurers to estimate a plan's per capita costs. This pricing risk arose due to the lack of comprehensive data on prescription drug use by seniors, especially among the one-third of the senior population who at that time had no prescription drug coverage. In order to address the prospect that insurers would choose not to offer Part D coverage, thus reducing plan choice and competition, risk corridors were included in the Part D program to mitigate pricing uncertainty. The Part D risk corridors reduce losses to insurers underestimating plan costs and reduce gains to insurers overestimating plan costs. These risk corridors have widened over time, thereby increasing the risk borne by insurers and reducing that borne by the federal government. Insurers have, on net, made risk-corridor payments to the federal government during each year of the Part D program. According to the Centers for Medicare and Medicaid Services (CMS), net risk-corridor payments made by insurers to the government totaled $1.1 billion in 2012.[1]

As in the Medicare Part D program, the ACA contains symmetric risk corridors, or two-sided, which limit not only insurer losses, but also insurer gains. In the ACA risk-corridor program, actual claims are compared to the expected claims that were assumed in the insurer's premiums (see illustration below). If actual claims are within 3 percent of expected, insurers either keep the gains or bear the losses. If actual claims exceed expected claims by more than 3 percent, the federal government reimburses the insurer for 50 percent of the losses between 3 and 8 percent, and 80 percent of the losses exceeding 8 percent. If actual claims fall below expected claims by more than 3 percent, the insurer pays the federal government for 50 percent of the gains between 3 and 8 percent, and 80 percent of the gains exceeding 8 percent. This design means that insurers do not have full protection against losses. Insurers bear a share of the risk even if their losses exceed the risk-corridor thresholds. Such a design encourages insurers to set premiums so they are adequate to pay claims.

[1] For plan years 2006-2012, net Part D risk corridor payments from insurers to the federal government ranged from a low of $0.1 billion in 2008 to a high of $2.6 billion in 2006. Information is not yet available for 2013. Part D risk corridor payment information is available from CMS in each year's Part D Plan Reconciliation file, at http://cms.hhs.gov/Medicare/Medicare-Advantage/Plan-Payment/Plan-Payment-Data.html.



The ACA risk-corridor program is temporary, running only through 2016, since risk corridors are most appropriate during the first few years of a new program, when less expenditure data are available. As more experience emerges on the health spending patterns of the newly insured, the ability for insurers to set premiums accurately should improve, thereby reducing the need for risk corridors.

In the interim, the ACA risk corridors provide an important protection not only to insurers, but also to consumers, and the federal government. By limiting insurer losses due to pricing uncertainty, risk corridors encourage insurer participation in the market. That in turn helps consumers by providing them access to health insurance plans. In addition, because the risk corridors are symmetric, or two-sided, the federal government will receive payments from insurers if their gains exceed the risk-corridor threshold.

Conclusion

Millions of Americans have obtained health insurance under the ACA. However, the law poses some financial risks for health insurers, which could limit plan competition and plan choice for consumers. To address these risks, the ACA includes some protections for insurers, known as risk-sharing provisions, especially in the early years of the new program. These risk-sharing provisions were included in the law with the intent of ensuring plans will be available to consumers and reducing incentives for insurers to avoid high-cost enrollees.

The risk-sharing mechanisms interact not only with each other, but also with other elements of the ACA. Any changes to these provisions should be made with careful consideration of these interrelationships and the impact of how revisions could affect insurer risks, insurance availability, and insurance premiums.