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*CONGRESSIONAL TESTIMONY*

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# Risk Corridors in the Patient Protection and Affordable Care Act

## Testimony before
## Committee on Energy and Commerce
## Subcommittee on Health
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Mr. Chairman, Ranking Member Pallone: thank you for inviting me to testify today. My name is Edmund F. Haislmaier and I am a Senior Research Fellow in Heath Policy at the Heritage Foundation. The views I express in this testimony are my own, and should not be construed as representing any official position of The Heritage Foundation.

The Patient Protection and Affordable Care Act (PPACA) included three programs designed to mitigate the effects of new risks introduced into health insurance markets by other provisions of the legislation.

The first is a three-year "reinsurance" program that taxes health insurance policies and employer group health plans and uses the proceeds to provide individual market plans with additional subsidies for higher-cost enrollees.

The second, "risk adjustment" program, transfers money among insurers to adjust for the possibility that some carriers may get more or less than their proportionate share of costly enrollees. This program applies to the individual and small group markets and is the only one of the three that is permanent. However, this program does not increase the total amount of subsidies flowing to insurers, but rather reallocates money already in the system.

The third, "risk corridor," program will also operate for three years and establishes a range (or "corridor") for profits or losses for insurers selling exchange coverage. If an insurer has higher than expected profits, the government will "claw back" some of the money. Conversely, if an insurer has higher than expected losses, the government will pay the insurer additional subsidies to offset those losses.

The starting point for evaluating these programs is to understand that each of the three is inteneded to address a different, particluar type of risk.

The reinsurance program is designed to mitigate what can be termed "market selection risk." That risk arises when customers have a choice between two or more markets with different characteristics. It is essentially a response to the expectation that the net effect of the PPACA's various provisions will be to induce more individuals in poorer health to migrate into the individual exchange market.

The risk adjustment program is designed to compensate for what can be called "individual selection risk." For any group of individuals who have already made the decision to buy coverage, there is still uncertainty surrounding which insurer and which plan each will pick when presented with a range of choices. At the end of the selection process, some insurers may find that they have either a larger or smaller share of either better or worse risks than they would otherwise have if the individuals in each risk category had been evenly distributed among all the insurers in the market. It is this uncertainty that risk adjustment programs are designed to address through fund transfers among insurers. Like other such risk adjustment programs, the one in the PPACA does not affect either the premiums paid by enrollees or the level of subsidies provided by the

government. Rather, it is simply a statistical and accounting exercise among the participating insurers.

What that leaves is the most contentious of the three; the risk corridor program.

Essentially, the risk corridor program is designed to address potential "profit or loss risk." This risk arises from the fact that the uncertainties involved in predicting claims costs and pricing premiums for a new type of coverage could result in carriers incurring larger than expected profits or larger than expected losses.

Unlike the risk adjustment program, receipts and expenditures for the risk corridor program are not required to balance. In other words, the program is not explicitly required to be budget neutral. Depending on how the program is operated, it could possibly generate either net receipts or net outlays for the federal government. For instance, if it turns out that most (or even all) of the insurers selling exchange coverage overestimated expected claims costs, leading them to price coverage higher, then insurers would have excess profits. Under such a scenario the operation of the risk corridor program would generate net receipts for the federal government. Conversely, if it turns out that most (or even all) of the insurers underestimated expected claims costs, leading them to price coverage lower, then insurers could incur significant losses. Under such an alternative scenario the operation of the risk corridor program would result in net additional outlays by the federal government.

Given the uncertainty that insurers faced in pricing the new coverage, combined with pressure on them from the Administration to keep premiums low, the risk corridor program is more likely to result in additional federal outlays than in additional federal receipts. This is the source of the concern expressed in Congress and elsewhere that the risk corridor program could become a taxpayer funded bailout for insurers selling coverage in the exchanges.

The question, then, is how appropriate is it to operate a risk corridor program for the PPACA exchange plans?

Discussions of the PPACA's risk corridor program often reference the risk corridor program established for the Medicare Part D prescription drug benefit. But while the two programs are structured in similar fashion, there are important differences between the two markets that are relevant.

First, in Medicare Part D insurers were being asked to design and price a product—stand-alone drug coverage for senior citizens—that did not previously exist in the market. Second, their experience with the nearest equivalent coverage—employer group plans covering prescription drugs—did not offer insurers much guidance in projecting claims costs and premiums for the new Part D coverage. In employer plans the drug coverage is integrated into the rest of the plan (not stand-alone), the coverage is provided on a group basis (much less potential for individual selection risk), and the

covered population (working-age adults and children) consumes, on average, only one-fifth as many drugs as senior citizens.

However, such unusual circumstances associated with a completely new type of insurance product for a completely new market are not the case with respect to the PPACA's individual market exchange coverage. Individual market major medical coverage has long been a health insurance product line. While it is true that the PPACA imposes new rules and restrictions on individual coverage—such as additional benefit mandates, new age rating rules and a prohibition on the application of pre-existing condition exclusions—insurers can look for guidance to the experiences in states that previously imposed those same, or similar, rules on their individual markets. Thus, insurers offering coverage in the exchanges were not being asked to create an entirely new product for a new market with which they had no experience, as they were with Medicare Part D.

Furthermore, all of the PPACA's new rules and restrictions apply equally to plans sold both inside and outside the exchanges, yet Congress applied the risk corridor program only to "qualified plans," meaning plans sold through the exchanges. Given that the only distinction between the "on exchange" and "off exchange" plans is the availability of income-related coverage subsidies, there is no risk-mitigation rationale for treating these two subsets differently.

In short, there does not appear to be much of a rationale for the risk corridor program as it is structured in the PPACA. While insurers certainly face a number of uncertainties with respect to how markets will operate under the new PPACA rules, and while it is likely that their "profit or loss risk" will initially be somewhat elevated, the magnitude of the additional risk does not appear to be either unique or high enough to justify a risk-corridor program to mitigate profit and loss risks.

The other two programs—reinsurance and risk adjustment—should be more than adequate to address the principal uncertainties that insurers face in operating under the new PPACA rules namely, market selection risk and individual selection risk.

Indeed, the size of the funding for just the reinsurance program should be sufficient. Last year, prior to the implementation of the changes required by the PPACA, total premiums for the individual major medical market were $28 billion. Using the most generous possible assumptions—that all of the 8 million reported exchange enrollees actually purchased coverage, that all of those new enrollees were previously uninsured, and that all those enrollees chose Silver level plans—I estimate that total premiums for the individual market in 2014 could increase by as much as $35 billion.

Measured against those figures, the $10 billion in reinsurance funding in 2014 equates to 28 percent of the maximum estimated $35 billion in new premiums, or 15 percent of the maximum estimated $63 billion in combined (new and existing) premiums. Put another way, even if *all* insurers underpriced *all* coverage for *all* the new enrollees by as much as 28 percent, they could still *all* be made whole by the $10 billion available in

reinsurance subsidies. Indeed, even if *all* insurers underpriced *all* coverage for *all* enrollees (both new and existing) by as much as 15 percent, they could still *all* be made whole by the $10 billion available in reinsurance subsidies.

I understand that this Committee will be considering two pieces of proposed legislation; one of which would repeal the PPACA's risk corridor program, the other of which would require that HHS operate the program on a budget neutral basis.

Given the lack of an appropriate and sufficient rationale for the PPACA's risk corridor program, yet the potential for the program to create additional taxpayer liabilities, either of those proposed changes would be appropriate in my view.

However, that said, I do recognize that there are some practical arguments for pursuing the approach of amending the program to require budget neutrality as opposed to simply repealing the program.

As the insurance industry points out, carriers have already priced and sold coverage for the 2014 plan year and their pricing decisions reflected, in part, their expectations for how these programs would operate. While it can be reasonably argued that repealing the risk corridor program at this point might disadvantage some carriers, it is debatable whether those effects would be more than just marginal. Nonetheless, legislation clarifying that the risk corridor program is required to operate on a budget neutral basis should be less disruptive for carriers. That approach would also be consistent with the way that the risk adjustment program operates, as well as with the Administration's previously stated intention to operate the program on a budet neutral basis. Finally, it would allay the legitimate concerns expressd in Congress and elsewhere that taxpayers not be liable for the consequenses of insurer pricing decisions.

Mr. Chairman, this concludes my prepared testimony. I thank you and the Committee for inviting me to testify today. I will be happy to answer any questions that you or members of the Committee may have.

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