Committee on Oversight and Government Reform
U.S. House of Representatives

Hearing on
ObamaCare:
Why the Need for an Insurance Company Bailout?

Statement of

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February 5, 2014

Chairman Issa, Ranking Member Cummings, 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 prohibiting insurers from denying coverage, excluding pre-existing conditions, and varying premiums based on an individual's 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. And even with universal participation, 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. Insurers generally do not have sufficiently detailed data and 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 establishes three risk-sharing mechanisms to mitigate these risks—risk adjustment, reinsurance, and risk corridors. The following testimony will focus on risk corridors, which aim to mitigate pricing uncertainty; however, more information on each of the mechanisms can be found in the American Academy of Actuaries fact sheet on ACA risk-sharing mechanisms.[1]

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

[1] See http://actuary.org/files/ACA_Risk_Share_Fact_Sheet_FINAL120413.pdf.

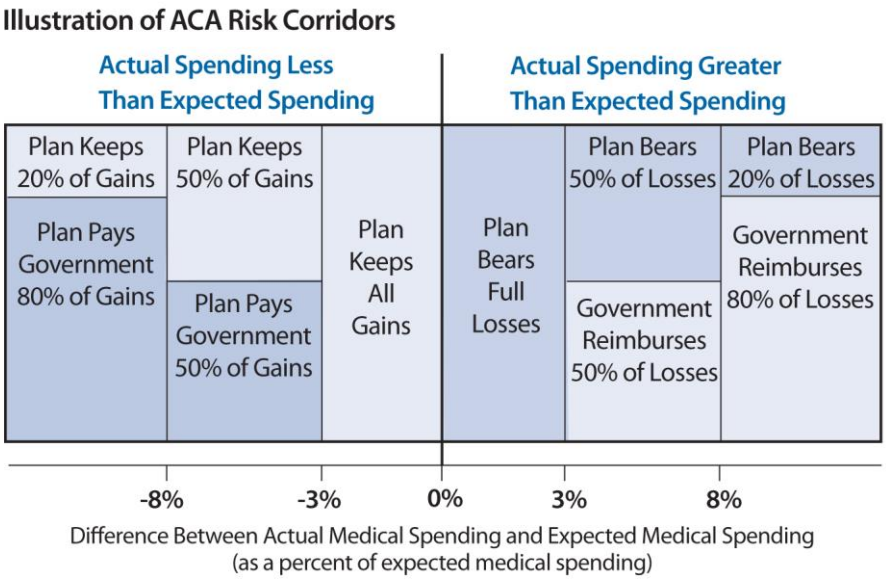
use to estimate who will enroll in plans operating under the new 2014 ACA rules and what their health spending will be. An objective of risk corridors is to encourage health insurance competition by limiting the risk for insurers entering the exchange market during the early years of implementation.

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.[2]

As in the Medicare Part D program, the ACA contains symmetric risk corridors, 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. The Congressional Budget Office (CBO) estimates that the ACA risk-corridor program will result in net payments from insurers to the government of $8 billion for the 2015 to 2017 period.[3]

[2] 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.

[3] Congressional Budget Office, The Budget and Economic Outlook: 2014-2024 (February 2014). Available at http://cbo.gov/sites/default/files/cbofiles/attachments/45010-Outlook2014.pdf.



As mentioned, 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.