COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM
U.S. HOUSE OF REPRESENTATIVES
"OBAMACARE: WHY THE NEED FOR AN INSURANCE COMPANY BAILOUT?"
FEBRUARY 5, 2014, 9:30 AM
TESTIMONY OF DOUG BADGER
RETIRED HEALTH POLICY ANALYST

Chairman Issa, Ranking Member Cummings and distinguished Members of the Committee:

Thank you for inviting me to appear today to discuss provisions of the health care law that have been characterized as "insurance company bailouts" -- specifically, those that establish reinsurance and risk corridors.

People generally understand that the health law includes subsidies for individuals who buy insurance. Most don't realize that it also includes subsidies for corporations that sell it.

Some of these subsidies are written into the law; others are the result of regulatory interpretation. I will not discuss the legitimacy of those interpretations, in part because you've invited a professor of law to speak to that point and in part because such discussion is academic. The rules have been issued. No one who might object has standing to sue. So the subsidies will go forward unless Congress acts.

I urge Congress to act by repealing the health care law's risk corridor and reinsurance provisions.

Before proceeding further, I want to make it clear that, while I am taking a position contrary to that advocated by many in the insurance industry, I bear no animus against insurance companies. On the contrary, I believe that they play a vital and essential role in the health care system. On a personal level, I know that when you face large medical bills, only the insurance companies have your back. My objection is not to the enterprise of private health insurance, but to the

reinsurance and risk corridor provisions that inappropriately provide them subsidies at the expense of taxpayers and group health plans.

The law extends numerous competitive advantages to insurers that sell through the exchanges. It creates carrots and sticks. The biggest carrot: the government will subsidize premiums only for those who enroll in qualified health plans sold through the exchanges. The biggest stick: the IRS will impose a tax penalty on people who refuse to buy insurance.

The two work together for the benefit of insurance companies that participate in the exchanges. The subsidies amount to a government payment of $949 billion over the next 10 years to such companies. That's how much CBO estimates they will receive directly from the federal government.

It's a bit harder to estimate how much benefit insurers derive from the tax penalty on the uninsured. CBO estimates that delaying the so-called individual mandate by a year would result in 2 million fewer people buying coverage sold through the exchanges. To state that slightly differently, the tax will induce 2 million people who don't want health insurance – even if it is subsidized – to buy it anyway. An admittedly rough estimate that assumes annual premiums of $4,000 for a mid-level "silver" plan would mean that those companies would collect $8 billion more next year in premiums than they would in the absence of the so-called individual mandate. Assuming that the 2 million figure is constant and that average premiums increase by 5 percent per year, that would add up to $100 billion in premiums that insurers are collecting only because of the tax penalty.

Policy cancelations are the other stick. Millions of individuals and small firms have been told that it is illegal for them to renew their "non-grandfathered" coverage. Both parties have

expressed sympathy for such people, but most were not provided relief. The Administration adopted an aggressive stance on cancelations in order to force millions of people who liked the coverage they had into the exchanges. I won't hazard even a rough estimate of the monetary effect of this policy, but it clearly inures to the benefit of insurers that sell through the exchanges.

Most people think the special arrangements for such companies stop there. They don't. Some very valuable corporate welfare is concealed deep within the law's plumbing.

Known collectively as "premium stabilization" in the rules, the combination of reinsurance payments, risk adjustment and risk corridors together provide backdoor assistance from taxpayers to insurance companies. Unlike the carrots and sticks, their purpose isn't to induce or compel people to buy insurance but to help insurers turn a profit or, failing that, to limit their losses.

I will not speak this morning to risk adjustment. So far as I have been able to determine, the agency plans to implement this provision in a budget-neutral way, which is appropriate. I would, however, encourage Congress to take a close look at this program to assure that it does not put taxpayers on the hook should insurers end up attracting enrollees that are, on the whole, less healthy than the general population.

Reinsurance is pure corporate welfare, a government-compelled transfer of $20 billion over three years to insurers that participate in the exchanges. Under this provision, these insurers can get out from under the costliest medical claims. The government will pay 80 percent of medical bills that exceed $45,000 but are less than $250,000 out of a "reinsurance fund."

And where does this reinsurance fund get the money to pay these very expensive bills? From an assessment on each of the roughly 158 million people who do not get their coverage from the exchanges: some through union-backed plans, others through plans sponsored by employers. The government is assessing such plans $63 for each member -- which adds to $10 billion -- then giving that money to insurers that sell through the exchanges. And what if the claims eligible for reinsurance payments don't total $10 billion? HHS has announced that it will not rebate that money to those who paid into the fund. Instead, the government will give insurers that sell through the exchanges the full $10 billion anyway. [I'm not entirely clear on what CMS intends to do if eligible claims exceed $10 billion.]

The second form of "premium stabilization" is more subtle. It establishes "risk corridors." CMS's understanding of this provision is that "the Federal government and participating plans [will] share in profits or losses resulting from inaccurate rate setting." That is a short-hand, of course, and not strictly true. Technically, the risk corridor program is governed by the ratio of actual allowable costs (which must be at least 80 percent of premium) to the "target amount," which is the amount that the insurer expects its allowable costs to be. This target amount includes profits. So an insurer could, for example, make a profit of, say, 5 percent and not have to "share" any of it with CMS. It should also be borne in mind that there are complex interactions among the risk adjustment, risk corridor, reinsurance, and medical loss ratio provisions. The sequence of calculations is: 1) reinsurance; 2) risk adjustment; 3) risk corridor; 4) medical loss ratio. For this reason, insurers don't actually submit their risk corridor information until July 31 of the year **following** the benefit year, meaning that companies won't file their 2014 risk corridor paperwork until July 31, 2015. That should temper concerns about Congress changing the rules at the eleventh hour.

The risk corridor calculation involves the ratio of allowable costs actually incurred to its target amount. If that ratio exceeds 103 percent, it is eligible to receive a payment from the government; if below 97 percent, it must pay the government. If a plan's ratio is between 103 and 108 percent, the government will assume half that "loss." The government will pay a plan 80 percent of its "losses" that exceed 108 percent of the target amount. Since the risk corridors are theoretically symmetrical, payments work exactly in reverse.

I say "theoretically" because on its face, one would assume that risk corridor payments could never exceed risk corridor receipts. The "excess profits" of successful insurers are transferred to insurers that suffered "excess losses." The government does not directly limit those losses; it merely administers a transfer of funds from successful insurers to unsuccessful ones in a budget-neutral way.

That's how risk corridors are supposed to work and if you read the statute, how you would assume they work. (CBO also made that erroneous assumption.) They don't. The risk corridors, as defined in a series of regulations, put taxpayers on the hook to protect insurers that sell through the exchanges against "losses."

CMS has made it clear that it will make risk corridor payments even if the aggregate amount of losses in which the government "shares" exceeds the profits in which it "shares." CMS has not provided estimates on just how much this "loss-sharing" might cost. An article that appeared in the October 2013 issue of *Health Watch*, a publication of the Society of Actuaries, says that the costs "could be substantial."

> In the [March 2013] final rule HHS states that '[the Congressional Budget Office] did not separately estimate the program costs of risk corridors, but assumed aggregate collections from some issuers would offset payments made to other issuers.' However, if all of the plans in a market (or even just the most popular ones) end up pricing their products too low and so suffer losses, the government will end up needing to fund this program, and the required funds could be substantial … HHS has clarified that it is conscious of the risk corridor program's non-symmetric nature, and states in the March regulations that funds will be paid out regardless of the balance between payments and receipts.

In its November 2013 rulemaking, written after that article was published, the agency proposed to further increase those corporate welfare payments in light of the President's decision to delay enforcement of certain federal standards that require insurers to cancel "non-grandfathered" policies. The new policy did not require insurers to renew policies, but it did create the possibility that they might, so long as their state insurance commissioner decided to allow such renewals. This "transition policy," CMS feared, would adversely affect insurers selling through the exchanges, since fewer cancelations would compel fewer people to seek coverage there. So the agency decided to use the risk corridor rules to increase payments to certain plans. The preamble to its November 2013 rule states:

> We are proposing an adjustment to the risk corridors formula that would help to further mitigate potential QHP [qualified health plan] issuers' unexpected losses that are attributable to the effects

> of the transition policy. This proposed adjustment may increase the total amount of risk corridors payments that the Federal government will make to QHP issuers, and reduce the amount of risk corridors receipts … We cannot estimate the magnitude of this impact on aggregate risk corridors payments and charges at this time.

So risk corridors will cost more than previously estimated, though their costs have not previously been estimated. At least with subsidies and reinsurance, we have a rough idea of how much taxpayers will be turning over to insurers. With risk corridors, we have none. The Administration refuses even to hazard a guess.

In effect, the agency has turned the risk corridor program, which should be budget-neutral like the risk adjustment program, into a form of corporate welfare. Congress should repeal these programs, particularly in view of all of the other advantages that the law has extended to companies that sell through the exchanges.

Arguments Against Repealing Reinsurance and Risk Corridor Provisions

Those who defend retention of these provisions argue that Part D contains reinsurance and risk corridor provisions and that it's not fair to remove these corporate welfare provisions from insurers at this time.

1. **Part D includes reinsurance and risk corridors.**

Reinsurance. The analogy between the reinsurance program in Part D and in the health care law is inapt. The two have little to do with each other, beyond the fact that the two laws use the same term to describe two very different things.

The reinsurance program in Part D is embedded in the basic benefit. The law stipulates that government will bear 80 percent of the cost of drug expenses above the out-of-pocket limit ($4,550 in 2014). Private prescription drug plans cover 75 percent of the cost between the deductible ($310 in 2014) and the initial coverage limit ($2,850 in 2014) and 15 percent of the cost above the out-of-pocket limit. These rules are clearly spelled out in the statute. They change somewhat from year to year, but are not subject to agency whim.

Compare these hard and fast rules to those in the health care law. Reinsurance is not embedded in the basic benefit. The statute requires participating plans to go at risk for all of the costs associated with the essential health benefits package. The "reinsurance" program is overlaid on top of this in a ham-handed way, providing insurers who sell through the exchanges with $10 billion in money this year and a total of $20 billion over 3 years. The point at which "reinsurance coverage" kicks in has varied wildly. Initially, CMS said that it would pay 80 percent of claims between $60,000 and $250,000. Then last November, they reduced the attachment point to $45,000. They then added that if insurers didn't submit enough claims to exhaust the $10 billion, they would pay it out to the plans anyway by tinkering with the 80 percent number. In other words, the program's parameters still are not finally determined.

These regulatory improvisations suggest that what the law calls reinsurance is instead a subsidy amateurishly disguised as reinsurance – the direct transfer of money from group health plans to

exchange plans. There is no plausible comparison to the Part D program and it should be repealed.

Risk corridors. The risk corridors in the health care law at least bear a superficial resemblance to those in Part D. But that superficial resemblance breaks down on closer examination. The two programs differ so dramatically from one another that it is impossible to equate the two risk corridor provisions.

The Part D program is voluntary, while the coverage under the health care law is mandatory. This is an immense difference that cannot be overstated. No senior is required to have prescription drug coverage of any kind, much less to enroll in a Part D plan. The IRS does not assess tax penalties against seniors who choose to go without drug coverage. This creates the potential for a massive selection problem, one that is exacerbated by certain features of prescription drug-only plans, which will be discussed below. These selection problems make risk corridors more necessary in the Part D program than under the health care law.

The mandatory nature of coverage under the health care law creates significant advantages for companies that sell through the exchanges, particularly since government subsidies can be obtained only there.

Cancelations. The Part D program did not require cancelation of anyone's prescription drug coverage. Indeed, the law provided subsidies to employers to continue their existing coverage, thus denying prescription drug plans access to millions of potential customers. In addition to the choice of remaining uninsured, seniors could keep the coverage they already had. The lone exception was Medicaid, a change that was made because Congress believed that Medicare should be the primary source of medical and prescription drug coverage for all seniors. Given

the frail state of many Medicaid-eligible seniors, including those in nursing homes, this wasn't necessarily a net positive for prescription drug plans.

The health care law, of course, has required the cancelation of millions of individual and small group policies with many more yet to come. These cancelations, as noted above, benefit insurers that sell through the exchanges.

Nature of the product. Prior to enactment of the MMA, stand-alone prescription drug plans did not exist in nature. The potential for adverse selection was considerable, particularly because the Part D program is voluntary. The health care law, by contrast, merely requires insurers to issue a product that's already quite commonly sold in the individual and small group market in the various states. They are not being asked to create a new product subject to adverse selection and offer it to people who are under no obligation to obtain coverage.

Predictability of drug costs. Unlike medical costs, prescription costs are relatively easy for a consumer to predict. Most seniors are on medication that they take daily and they know what their medicines cost. Moreover, CMS designed what can fairly be described as an "adverse selection tool," a website where a senior could enter the drugs they've been prescribed and the pharmacy where they preferred to shop and be told which plans offered them the best value – not merely the lowest premium, but the best combination of premium and cost-sharing for their prescriptions at their favorite pharmacy.

Medical costs, by contrast, are more difficult to predict and vary much more from year to year. The healthcare.gov website provides only the most general information about premiums and cost-sharing and virtually no reliable information about which providers participate in a plan's network. All of that gives insurance companies decisive advantages over against consumers

Cost. Perhaps the most dramatic difference between risk corridors in Part D and in the health care law is their cost. The Part D risk corridors were designed to be budget neutral. The Medicare Trustees report suggests that they actually have saved the government a small amount of money. The risk corridors in the health care law, by contrast, will cost an amount that CMS hasn't bothered to estimate. While CBO assumed they will be cost-neutral, they will not be, as I've discussed above. This is perhaps the biggest practical difference between the two programs – Part D risk corridors have been neutral to mildly positive for taxpayers, while the health care law's risk corridors could be quite expensive.

It is unclear to me why Congress would insist that these two very different laws should maintain superficially similar risk corridors. But if Congress insists on such conformity, a better way to achieve it would be to repeal the risk corridor provisions from both laws. Part D plans are months away from submitting bids for Year 10 of the program. If risk corridors served a useful purpose early on, it is unclear what that purpose might be now. Repealing them in the health care law would eliminate a costly corporate welfare subsidy, saving taxpayers unspecified billions of dollars.

2. It's Unfair to Take Corporate Welfare Subsidies Away From Insurers

Defenders of the health care law's reinsurance and risk corridor provisions advance another line of argument: that insurers are entitled to corporate welfare payments because they've been promised them by regulators. It would be unfair for Congress to take them away now.

It is odd to argue that it is unfair for the government to change its rules governing these provisions. The agency has been changing the rules on these programs repeatedly and they're still not entirely settled. With each regulatory iteration, the provisions become more generous to

insurers – there are lower attachment points for reinsurance and a promise to distribute the entire $10 billion even if insurers don't submit enough claims to justify that sum; the agency will "adjust" risk corridor payments to account for the fact that fewer people will have their insurance canceled than previously anticipated.

The argument that changing the rules to benefit insurers is good, while changing them to their detriment is bad is really little more than special pleading. Congress needs to get the policy right, irrespective of what insurers think they are entitled to. Congress should require the industry to price its products without the distortions of corporate welfare and to accept losses if their projections prove wrong.

Others argue that premiums will rise if these provisions are repealed. That is not a terribly compelling argument. With respect to reinsurance, it is fair to ask, "Whose premiums?" While some have implausibly suggested that taking $10 billion out of group health plans has no effect on their premiums, that is a practical impossibility. Under the health care law, their premiums have to be sufficient to pay, not only the medical claims of their members, but the most costly medical claims of those the plan doesn't cover – people who buy policies through the exchanges. Clearly, if that $10 billion were returned to the group health plans and additional assessments scheduled for 2015 and 2016 were repealed, premiums for those enrolled in such plans would be lower than under current law.

The argument that repealing risk corridors would raise premiums is really quite curious. Complexities aside – and the interactions between reinsurance, risk adjustment payments, medical loss ratio requirements and risk corridors are extremely complex -- symmetric risk corridors should be budget neutral. Plans set their premiums to cover anticipated medical claims, administrative costs and profits. Once the government has made its series of calculations,

revenues should more or less randomly come in "too" high or "too" low. That is why CBO assumed that risk corridors wouldn't cost the taxpayers money and why the Part D risk corridors have actually marginally reduced the program's costs.

It is true that some plans may have badly underestimated their costs. If risk corridors were repealed, such plans may have to raise their premiums next year to recover their losses. But that doesn't mean that every plan will have to raise its premiums, only those that botched their estimates. As in any line of business, if revenues don't cover costs, there are losses. What's troubling about risk corridors in the health care law is that losses may in the aggregate far outweigh gains in the exchanges and insurers want to pass a substantial chunk of these losses onto the taxpayers. That's not how a marketplace is supposed to work.

Indeed, risk corridors that pay out more than they take in present a moral hazard. The previously referenced *Health Watch* article observed that risk corridors "could provide an incentive for an issuer to price its plans competitively (with reasonable but aggressive assumptions), and if its price ends up being too low to cover costs, it will share that burden with HHS, while at the same time gaining market share."

Those who defend these programs are, in essence, arguing that plans may have behaved differently because government created a moral hazard and that it is therefore wrong for Congress to remove the moral hazard. Hardly compelling.

Some also have argued that, if the repeal of risk corridors were to result in a health plan raising its premiums, the government will have to pay bigger subsidies to people who enroll in that plan. That's not entirely true. The most recent report I've seen out of CMS indicates that around 20 percent of those who had selected a plan as of the end of December will not receive subsidies at

all. So these premium increases will be passed through to consumers, who can avoid the increase by selecting another plan during open season.

But even if every plan were to raise its premiums as a result of the repeal of risk corridors (which would be very disturbing, since it would mean that every plan suffered unusually large "losses," suggesting that the effect of the moral hazard was powerful), there is an important policy difference between subsidizing individuals who buy coverage and subsidizing corporations that sell it. Most people would likely be sympathetic to the former; few would find the latter to be appropriate policy.

Then there is the argument that insurers planned on receiving this money and it would therefore be wrong for Congress to take it away. That is not a line of argument that lawmakers have found terribly persuasive when applied to individuals. Millions of individuals and small business owners planned to renew their coverage; they didn't plan to have it canceled, but that didn't stop the government from ordering the cancelations. Many workers were planning to stay in their employer-sponsored plans; they didn't plan to have their employers drop coverage, but that is one indirect result of the health care law. My mother-in-law planned to continue to receive care from the area's largest health system; she didn't plan on having that system dropped from her Medicare Advantage network, but that is one consequence of the Medicare cuts in the health care law.

Millions of Americans have been asked to adjust, adapt and evolve, to endure adverse consequences without complaint and without relief. Congress has not, to this point, chosen to intervene on their behalf. Indeed, the most important lesson one can draw from last fall's controversy over policy cancelations is that the government believes that individuals and small firms can adjust to cancelations better than insurers can adjust to renewals.

Lawmakers may make the same decision here, effectively deciding that the interests of insurance companies outweigh those of taxpayers. But I would urge you to effect a different result by repealing the reinsurance and risk corridor programs.

The health care law has handed insurers that agree to sell through the exchanges enormous opportunities to increase their revenues by selling their products to more people. It subsidizes the cost of their product. It penalizes people who don't buy their product. Regulators have required the cancelation of "non-grandfathered" individual and small group policies and will cancel many more later this year, leaving these people with little choice but to obtain insurance through an exchange. It is a trillion dollar government effort to drive business to those insurers who agree to assist in the implementation of the health care law.

This combination of mandates, subsidies, cancelations and tax penalties is advantage enough, without the addition of corporate welfare that reinsurance and risk corridors provide. The government has laid out its playing field and established its rules. Let the insurers compete.

Brief Bio

Doug Badger retired in January 2013 from the Nickles Group, having served as a partner there since September 2006. Prior to joining the firm, he was Deputy Assistant to the President for Legislative Affairs, where he helped formulate Administration policy and legislative strategy on a broad range of issues, including health care, energy, taxes, financial services, pensions and employee benefits, intellectual property, trade, and telecommunications.

Badger also served for two years as the President's lead health policy adviser, developing the Administration's proposal for adding prescription drug coverage to Medicare and representing the White House in negotiations with Congress that resulted in enactment of the Medicare Modernization Act. He also advised the President on other health-related matters, including Medicare and Medicaid reimbursement issues and the creation of health savings accounts.

Prior to joining the White House, Badger was a partner at Washington Counsel Ernst & Young, where his practice included health care, intellectual property, and employee benefits.

He also served for a decade as a U.S. Senate aide, including stints as Chief of Staff to Assistant Majority Leader Don Nickles and Staff Director of the Senate Republican Policy Committee. Badger also has held senior positions at the U.S. Department of Health and Human Services and the Social Security Administration.

Committee on Oversight and Government Reform
Witness Disclosure Requirement – "Truth in Testimony"
Required by House Rule XI, Clause 2(g)(5)

Name: DOUG BADGER

1. Please list any federal grants or contracts (including subgrants or subcontracts) you have received since October 1, 2011. Include the source and amount of each grant or contract.

NONE

2. Please list any entity you are testifying on behalf of and briefly describe your relationship with these entities.

NONE

3. Please list any federal grants or contracts (including subgrants or subcontracts) received since October 1, 2010, by the entity(ies) you listed above. Include the source and amount of each grant or contract.

N/A

I certify that the above information is true and correct.

Signature: Doug Badger

Date: 2/3/2014