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THE PPACA'S HIGH RISK POOL REGIME: HIGH COST, LOW PARTICIPATION

HEARING

BEFORE THE

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

OF THE

COMMITTEE ON ENERGY AND COMMERCE

HOUSE OF REPRESENTATIVES

ONE HUNDRED TWELFTH CONGRESS

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THE PPACA'S HIGH RISK POOL REGIME: HIGH COST, LOW PARTICIPATION

FRIDAY, APRIL 1, 2011

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 10:05 a.m., in room 2123 of the Rayburn House Office Building, Hon. Cliff Stearns (chairman of the subcommittee) presiding.

Members present: Representatives Stearns, Terry, Sullivan, Murphy, Burgess, Blackburn, Myrick, Bilbray, Gingrey, Scalise, Gardner, Griffith, DeGette, Schakowsky, Markey, Green, Christensen, Dingell, and Waxman (ex officio).

Staff present: Carl Anderson, Counsel, Oversight; Stacy Cline, Counsel, Oversight; Julie Goon, Health Policy Advisor; Todd Harrison, Chief Counsel, Oversight & Investigations; Sean Hayes, Counsel, Oversight & Investigations; Carly McWilliams, Legislative Clerk; Andrew Powaleny, Press Assistant; Krista Rosenthall, Counsel to Chairman Emeritus; Ruth Saunders, Detailee, ICE; Alan Slobodin, Deputy Chief Counsel, Oversight; Sam Spector, Counsel, Oversight; John Stone, Associate Counsel; Phil Barnett, Democratic Staff Director; Brian Cohen, Democratic Investigations Director and Senior Policy Advisor; Karen Lightfoot, Democratic Communications Director, and Senior Policy Advisor; Ali Neubauer, Democratic Investigator; and Anne Tindall, Democratic Counsel.

OPENING STATEMENT OF HON. CLIFF STEARNS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Mr. STEARNS. Good morning, everybody, and let me welcome the members here, and our witness to the Subcommittee on Oversight and Investigations, and I will start with my opening statement.

We convene this hearing of the Subcommittee on Oversight and Investigation today to gather information concerning the Patient Protection and Affordable Care Act High Risk Pool Regime. The Administration's healthcare allocated $5 billion to provide healthcare coverage for individuals who have been locked out of insurance market. The President and the Democrats try to sell this law to the American people by telling us how many people were unable to get health insurance, and how this law was going to protect these individuals, while somehow saving the American taxpayers money.

It has been 1 year since the healthcare law was forced on the American people. It has been 9 months since the high risk pools

became operational. The chief actuary of Medicare and Medicaid estimated that 375,000 people would enroll in these high risk pools by the end of 2010, but only 12,000 actually did enroll. CMS informed us that they have conducted a massive outreach campaign to try to advertise this program in order to get people to sign up. Who is paying for this advertising tour is a good question. The taxpayers. Through the $5 billion allotted to this program in the healthcare reform law, this means money that was allocated to help the uninsured is being used to help the Administration save face and rescue this program.

This is on top of the previous Democrat majority spending an entire year talking about nothing but this healthcare law. If countless speeches by the President can't advertise these high risk pools, how can a bureaucratic advertising campaign hope to accomplish the same goal?

Just as alarming as the law enrollment numbers, this Committee has learned through its investigation that low enrollment does not equal low costs. For example, California expects to accumulate $1 billion in claims over the lifetime of this program, with approximately 70 percent of the tab paid for by the Federal Government. This means that California alone, one state, that is, expects claims to eat up almost one-fifth of the total cost of the program. Our investigation revealed that not a single state expects premium revenue to be near the cost of claims over the life of this program.

Now back in December, The Washington Post reported that "New Hampshire's plan has only about 80 members, but they have actually spent nearly double the $650,000 that the state was allocated for this program. HHS agreed to give New Hampshire more money." So this is a program that must operate within a fixed budget of $5 billion. HHS has not explained how it intends to keep the program running through 2014 without additional funding.

Our investigation has also uncovered problems with the implementation of the high risk pool. In order to get the program up so quickly, HHS used the CHIP formula to allocate money between the States. While the CHIP formula is used to determine the number of uninsured children in each State, we would think that HHS would use a formula that measures the number of uninsured children with preexisting conditions in each State, since this fund is supposed to help the uninsured with the preexisting condition. This program uses a non-relevant formula simply because it was easy and already available. This inequity could mean people in some states are getting more than they need, while people in others aren't getting enough. We want to make sure that the money is being allocated fairly and properly.

Obamacare was supposed to be the solution to our Nation's healthcare ills, but here we are, 1 year later, and has a single promise made by the President and the healthcare plan that the Democrats passed—promises they made about this law come true? The high risk pool program is yet another promise that has fallen short, in our opinion. We were supposed to enroll over a quarter of a million Americans. We didn't even reach 5 percent of that goal.

Steve Larsen, the Deputy Administrator and Director of the Center for Consumer Information Insurance Oversight was before the Subcommittee back in February to talk about the waivers—you re-

member that—that HHS has been granting to states and entities that can't afford the Administration's healthcare plan. Since he testified just 2 months ago, we have seen more states' struggling companies all seek waivers. A big indicator to me that we are on the wrong track is the number of people in need of waivers to relieve them of the legislative and financial burdens of the Democrat healthcare plan. As we have seen through our investigations, this is a problem that is getting worse. We intend to hold HHS accountable today for what we see as low enrollment, skyrocketing costs, and poor implementation of a program that was promised to help support one of our most vulnerable populations.

So I welcome Mr. Larsen returning, and recognize the ranking member, my colleague, Ms. DeGette from Colorado.

[The prepared statement of Mr. Stearns follows:]

PREPARED STATEMENT OF HON. CLIFF STEARNS

We convene this hearing of the Subcommittee on Oversight and Investigations today to gather information concerning The Patient Protection and Affordable Care Act's High Risk Pool Regime. Obamacare allocated $5 billion to provide health coverage for individuals who have been locked out of the insurance market. Obama and the Democrats tried to sell this law to the American people by telling us how many people were unable to get health insurance and how this law was going to protect these individuals, while somehow saving the American taxpayer money.

It has been one year since the health care law was forced on the American people. It's been nine months since the high risk pools became operational. The Chief Actuary of Medicare and Medicaid estimated that 375,000 people would enroll in these high risk pools by the end of 2010. But only 12,000 actually did enroll. CMS informed us that they've conducted a massive outreach campaign to try to advertise this program in order to get people to sign up. Who is paying for that advertising tour? The taxpayers.through the $5 billion allotted to this program in the health care reform law. That means money that was allocated to help the uninsured is being used to help the administration save face and rescue the program. This is on top of the previous Democrat majority spending an entire year talking about nothing but this health care law-if countless speeches by the President can't advertise these pools, how can a bureaucratic advertising campaign hope to accomplish this goal?

Just as alarming as the low enrollment numbers, this committee has learned through its investigation that low enrollment does not equal low costs. For example, California expects to accumulate $1 billion in claims over the lifetime of the program, with approximately 70 percent of the tab paid for by the federal government. That means that California alone, one state, expects claims to eat up almost one fifth of the total cost of the program. Our investigation revealed that not a single state expects premium revenue to be near the cost of claims over the life of the program.

Back in December, the Washington Post reported that "New Hampshire's plan has only about 80 members, but they have already spent nearly double the $650,000 the state was allotted. HHS agreed to give New Hampshire more money." This is a program that must operate within a fixed budget of $5 billion. HHS has not explained how it intends to keep the program running through 2014 without additional funding.

Our investigation has also uncovered problems with the implementation of the high-risk pool. In order to get the program up so quickly, HHS used the CHIP formula to allocate money between the states. While the CHIP formula is used to determine the number of uninsured children in each state, we would think HHS would use a formula that measures the number of uninsured children with pre-existing conditions in each state, since this fund is supposed to help the uninsured with pre-existing conditions. This program uses a non-relevant formula simply because it was easy and already available. This inequity could mean people in some states are getting more than they need, while people in others aren't getting enough. We want to make sure that the money is being allocated fairly.

ObamaCare is supposed to be the solution to our nation's health care ills but here we are, one year later, and has a single promise made by President Obama and the Democrats about this law come true? The high risk pool program is yet another

enormous promise that has fallen short: we were supposed to enroll over a quarter of a million Americans. We didn't even reach five percent of that goal.

Steve Larsen, Deputy Administrator and Director of the Center for Consumer Information and Insurance Oversight, was before the Subcommittee back in February to talk about the waivers that HHS has been granting to states and entities that can't afford Obamacare. Since he testified just two months ago, we've seen more states and struggling companies seek waivers. A big indicator to me that we are on the wrong track is the number of people in need of waivers to relieve them of the legislative and financial burdens of ObamaCare. As we've seen through our investigations, this is a problem that is getting worse. We intend to hold HHS accountable today for what we see as low enrollment, skyrocketing costs, and poor implementation of a program that was promised to help support one of our most vulnerable populations.

With that, I welcome Mr. Larsen, and recognize the ranking member, Congresswoman Degette.

OPENING STATEMENT OF HON. DIANA DEGETTE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF COLORADO

Ms. DEGETTE. Thank you so much, Mr. Chairman.

Before I give my opening statement, I would like to take a moment of personal privilege and introduce my sister Cathy and her family who have come here to visit and see how sausage is made all week long.

Mr. STEARNS. Cathy, you are welcome.

Ms. DEGETTE. Mr. Chairman, President Obama signed the historic healthcare reform legislation into law just 1 year ago. When the law's full benefits have been implemented, every American will have access to affordable health insurance, and abuse of insurance industry practices like discrimination with people—against people with preexisting conditions will be banned entirely. Millions of Americans are already benefiting from the law, including Americans with preexisting conditions. Thousands of these individuals, thanks to the subject of this hearing, the preexisting condition insurance pools, or PCIPs, have access to affordable individual coverage for the first time. Prior to the passage of the Affordable Care Act, health insurance for people with illnesses like diabetes, asthma, cancer, arthritis, or HIV/AIDS was either not available on the individual market or was so expensive as to make it effectively unavailable. But the Affordable Care Act immediately banned the egregious practice of denying coverage to children with preexisting conditions. The Affordable Care Act also offered immediate benefits to adults with preexisting conditions through the PCIP program. These plans also offer individuals with preexisting conditions insurance at the standard individual market rate, not the exorbitant rates offered on the private market. These plans began accepting applications in late 2010, and over 12,000 people are now enrolled in them.

One of the enrollees is John Barzel, who is a constituent of mine from Colorado. Mr. Barzel, a bartender who works on his feet all day long, suffered from a condition I am well aware of, severe arthritis in both hips and desperately needed two hip replacements to keep his job, but his employer doesn't offer health insurance and he could not obtain health insurance on the individual market. When he learned about PCIP, he signed up immediately. He has since had two hip replacements and in his words to my staff, he

got a new lease on life. He says that, and I quote, "The health insurance coverage provided for me under the Affordable Care Act took me from chronic pain to free daily life and restored by ability to support myself." Now Mr. Chairman, I wanted to have Mr. Barzel come here in person at this hearing, but we were told that he would not be allowed to testify, so I am disappointed by this decision, but I would at least ask unanimous consent that his letter to the Committee be included in the record.

Mr. STEARNS. By unanimous consent, so ordered.

Ms. DEGETTE. Thank you.

Mr. WAXMAN. I would like to object, and I do so to inquire why he was not allowed to come. Here is a man who could tell us from his own experience what these high risk pools meant to him. Why wouldn't we allow him to come, Mr. Chairman?

Mr. STEARNS. Mr. Waxman, you understand that we are going to have continued hearings on this, and we will have another opportunity to bring your witness in. I thought as we started this process, dealing with one specific subject we would have just the government explain exactly what the status is, and so that is why we have just one witness. I think——

Mr. WAXMAN. How many hearings do you intend to call on this subject?

Mr. STEARNS. Well, I would be glad to sit down with you at a later date. We are just in the early stages of this. As you know, we have got plenty of hearings on the healthcare plan, and this is just one of many. So at this point, by unanimous consent, so ordered the letter will be entered into the record.

[The information appears at the conclusion of the hearing.]

Ms. DEGETTE. Chairman, not to put too fine a point on it, this is the second hearing the Minority was denied their witness, so I hope we can work this out for future hearings.

I know that we are going to hear—in fact, we already heard from the chairman that PCIP enrollment is lower than anticipated, and I appreciate that CCIIO, in recognition of these concerns, has outreaches—has improved its outreach efforts. I hope we will hear more about those efforts from our witness, but I find it a little ironic that my friends across the aisle would complain about low enrollment in a plan that every single one of them voted to repeal, because when I hear about stories like John Barzel, I find repeal efforts impossible to understand. These thousands of people who now have access to insurance for the first time would have it whisked away immediately. So it seems to me that the solution to the problem is to try to increase outreach efforts so that we can get a lot of people who are uninsurable because of preexisting conditions to be enrolled in insurance.

Now, PCIP is not a permanent solution to the problems faced by people with preexisting conditions, that is for sure. It is a transitional benefit that will be superseded by the full panoply of the Affordable Care Act's reforms in 2014. But what the program is right now is critically important to that slice of people who are and will be enrolled. That is why we should not repeal this law. Doing so would rob thousands of PCIP enrollees of the healthcare coverage they now have and take it away.

A more productive discussion would be a discussion about how we can enroll more people with preexisting conditions in this program until we transition to full coverage in 2014.

Thank you.

[The prepared statement of Ms. DeGette follows:]

PREPARED STATEMENT OF HON. DIANA DEGETTE

President Obama signed the historic healthcare reform legislation into law just over 1 year ago. When the law's full benefits have been implemented, every American will have access to affordable health insurance, and abusive insurance industry practices, like discrimination against people with pre-existing conditions, will be banned entirely.

Millions of Americans are already benefiting from the law, including Americans with pre-existing conditions. Thousands of these individuals, thanks to the subject of this hearing—the pre-existing condition insurance pools (P–CIPs), have access to affordable individual coverage for the first time.

Prior to passage of the Affordable Care Act, health insurance for people with illnesses like diabetes, asthma, cancer, arthritis, or HIV/AIDS was either not available on the individual market, or was so expensive as to make it effectively unavailable.

But the Affordable Care Act immediately banned the egregious practice of denying coverage to children with pre-existing conditions. And the Affordable Care Act also offered immediate benefits to adults with pre-existing conditions through the PCIP program. PCIP plans offer individuals with pre-existing conditions insurance at the standard individual market rate—not the exorbitant rates offered on the private market.

PCIP plans began accepting applications in late 2010, and over 12,000 people are now enrolled in them. One of those enrollees is John Barthell, a constituent of mine from Colorado.

Mr. Barthell, a bartender who works on his feet all day long, suffered from severe arthritis in both hips and desperately needed two hip replacements to keep his job. But his employer doesn't offer health insurance, and he could not obtain affordable insurance on the individual market. When he learned about PCIP, he signed up immediately. He has since had two hip replacements, and in his words to our staff, "got a new lease on life." He says that—and I quote—"the health insurance coverage provided for me under the Affordable Health Care Act took me from chronic pain to a pain-free daily life and restored my ability to support myself."

I wanted to hear from Mr. Barthell in person at this hearing. I thought that it would be obviously worthwhile to learn about PCIP from the perspective of someone enrolled in the program. But we were told by the Majority that he would not be allowed to testify. I'm very disappointed by this decision, and I would at least like to ask that Mr. Barthell's letter to the Committee be included in the record.

I know that we will hear from my Republican colleagues today that PCIP enrollment is lower than anticipated. And I appreciate that CCIIO, in recognition of these concerns, has improved their outreach efforts. I hope we will hear more about those efforts from our witness.

It is ironic, however, that my friends across the aisle would complain about low enrollment in a plan that every single one of them voted to repeal. When I hear stories about what that would mean to people like John Barthell, I find these repeal efforts impossible to understand. Repeal would mean that thousands of people who now have access to insurance for the first time will have it whisked away from them immediately. One of those people, Suzanne Hannon of Maryland, also spoke with our staff.

Suzanne's husband worked for Bethlehem Steel for decades, but when he turned 65, they cancelled his health benefits, leaving her uninsured. She was unable to obtain affordable coverage because of a pre-existing condition: moderately high cholesterol.

Then last fall, Suzanne heard about PCIP and enrolled. A month later, she went in for a check-up-something she would not have done without insurance-and learned she had uterine cancer. She caught it early, and her prognosis is good, as long as she can continue her treatment. She is terrified, however, that the Affordable Care Act will be repealed and that she'll have to end her chemotherapy. In her words, the repeal of PCIP would be "a death sentence."

PCIP is not a permanent solution to the problems faced by people with pre-existing conditions. It is a transitional benefit that will be superseded by the full panoply of the Affordable Care Act's reforms in 2014.

But the program is critically important to the people who are and will be enrolled. That's why it would be shameful for Congress to repeal this law. Doing so would rob thousands of PCIP enrollees of the health coverage they now have, and take away their rights to even better coverage in the future.

Mr. BURGESS [presiding]. The gentlelady yields back. I will yield myself 2 minutes, and then we will hear from other members on the Majority side.

This hearing, once again, represents legitimate oversight of ongoing federal activities over this healthcare law, what we should be doing in this committee, and I would just address to the ranking member, we are doing it this year as opposed to last year, when we had not a single oversight hearing on the implementation of the healthcare law.

And those with preexisting conditions was identified as one of the major reasons that the healthcare law was necessary, but I guess I would just simply ask the question, I don't really recall the provision in H.R. 3200 that we marked up in this committee on preexisting conditions, but was it really necessary to spend $1 trillion to fix this problem, which after all, is what we have done with the Patient Protection and Affordable Care Act? We all want to help, but was it necessary to go to the lengths that we did and essentially upset the system that was working arguably for two-thirds of the population in implementing this program?

We have heard that the universe of people with a medical diagnosis who were locked out of the system was vast. We were led to believe that it was in the millions, at different times eight million, 12 million were used by the President in his addresses during the summer of 2009. But at the end of the first year, 2010, we had 8,000 people and then with a massive advertising campaign, we signed up 12,000 people. Well, why is that? Is it because the premiums were too high? Is it because we mandated that you had to go uninsured for 6 months to qualify? That is kind of risky. Is it because people don't know we spent a lot of money in advertising, or was it because the problem just wasn't as bad as we thought? Despite the low enrollment, the program's finances are high. It begs the question, was this the proper path to take or could we have provided subsidized risk pools?

The last Congress, the ranking member of the Health Subcommittee, Nathan Deal and I introduced H.R. 4019 and 4020, which actually attempted to get this population as locked out of the current system while providing the right incentives for those who have lost their jobs.

At this point, let me yield 2 minutes to—1 minute to the gentleman from Nebraska, Mr. Terry.

Mr. TERRY. Well, thank you, Mr. Chairman—acting chairman. I appreciate the opportunity to hear from this agency how we can remove waste and perhaps even abuse of funds under their control. So it concerns me that my friends on the other side of the aisle do not wish us to press to find wasteful use of taxpayer dollars or abuse. Hopefully we can get an explanation on the early retirement and insurance program where there has been, in the last day or two, several news articles that concern me about waste and possible abuse of $5 billion that seem to be going—sent to companies

that are quite healthy and wouldn't need government subsidies for early retirees.

For example, the United Auto Workers received the most this last year at $206 million. A healthy company, AT&T, received $140 billion. Verizon received $91 billion. General Electric, I guess if you hug the President enough, you will get $36 billion. General Motors received an additional $19 billion. I would like an explanation of why these companies were even eligible for government subsidies for an early retirement program.

I yield back.

Mr. BURGESS. The gentleman's time has expired. Yield the balance of our time to gentlelady from Tennessee, Ms. Blackburn.

Mrs. BLACKBURN. Thank you, Mr. Chairman. Yes indeed, if my colleagues are wondering why we are not calling or if we are going to call other witnesses on programs such as this early retirement program, I think we need to call the American taxpayer who is footing the bill for this and is livid with the lack of accountability and the lack of measurable results that they see coming from these programs. It is not hard to understand, in my book, why we would vote to repeal these programs.

When you look at this program and the burn rate of this money, I am curious as to why you have flown through $1.3 billion over the last 2½ months when you have a total of $5 billion which was supposed to last you for a few more years? You know, this is a little bit of a head scratcher. Why are you trying to get this money out the door? Why are there so few people enrolled in this program? Why is it not giving the results that are necessary, and of course, as I have said many times, there is no successful example of public option healthcare being implemented and achieving a savings, either a near-term or a long-term savings. The wasteful spending has to stop. The American taxpayer is growing ill and fatigued with the practices they see in Washington, DC.

I thank the chairman for calling the hearing. I yield back.

Mr. STEARNS. Gentlelady yields back, and the gentlelady from Colorado.

Ms. DEGETTE. The gentleman from California——

Mr. STEARNS. The gentleman from California is recognized for 5 minutes.

OPENING STATEMENT OF HON. HENRY A. WAXMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. WAXMAN. Thank you, Mr. Chairman.

I have been involved in congressional oversight for decades. I have seen firsthand how oversight can, when it is done right, educate and inform the public and make government programs work better, but I have also seen how the oversight process can be abused for no purpose other than to fight partisan ideological battles, and that is what I see here today.

This hearing is ironic because it is about the new state of federal preexisting condition insurance plans, or high risk pools, established under the Affordable Care Act. These plans are supposed to be a transition for people who couldn't buy insurance. They can't go to the individual market because insurance companies won't

give them coverage because of preexisting medical conditions. So we set up some high risk pools for them until we get to the transition where we will insist that insurance companies cover those people at the same time that we are requiring everybody to be covered so that the costs are being spread so that everybody gets coverage. Not the kind of situation we have had up until now where it doesn't make sense, but insurance companies will not give a policy to somebody with a preexisting condition because they are just very likely to be expensive. So the insurance companies want to exclude people, not cover people.

This is ironic because this is exactly what the Republicans proposed instead of the bill that we passed. You would think the Republicans would love this idea. These high risk pools were the centerpiece of their health reform. They didn't want to actually eliminate the insurance company discrimination against people with preexisting conditions. What they wanted to do was to let the insurance companies treat them differently in a high risk pool.

Mr. Burgess, who I seem to believe is an outspoken opponent of the healthcare reform law, said "The programs to deal with preexisting conditions would involve risk pools to be sure." Politico described high risk pools as one of the old GOP standbys.

So when we have this high risk pool to give people care until we transition into the new healthcare system, suddenly Republican leaders decide they don't like them anymore. Why don't they like them? Well, they don't like them because not enough people are taking advantage of these high risk pools. This hearing isn't about why some are taking advantage and others not. We are not hearing from people, we are only hearing from the administrator of this program. Mr. Barthell, a constituent of Representative DeGette, who is enrolled in one of these preexisting condition insurance programs, was denied the ability to be here for this hearing. Now maybe in the next five or six hearings on the subject he will get a chance to come in and talk about it. But Republicans are attacking this program because it is not popular enough and it has too low an enrollment. Then they are attacking the Early Retiree Reinsurance Program for being too popular and having enrollment that is too high. There is just nothing you can do that won't bring Republican criticism, because what they see is their job is to whine and complain and attack and confuse people about the health insurance law so that people won't start realizing that it is a pretty good law. It ends the worst insurance company abuses. It helps seniors in Medicare. It helps small businesses afford healthcare coverage. It makes sure that all Americans have access to high quality, affordable healthcare.

Now, they say they want to repeal and reform, repeal and replace. Well, we haven't seen their replacement, but we do note that they did propose some ideas as alternatives, and one of the ideas they proposed were high risk pools. Now we are having a series of hearings on high risk pools and why they are not successful enough. High risk pools could have been the ones we would have adopted on a bipartisan basis, but they wouldn't work with us to do anything on a bipartisan basis.

This hearing is not a serious hearing. This hearing is not really trying to get facts that will help bring about some understanding

that could lead to reforms. This is just a partisan show. It is not a legitimate oversight hearing, and unfortunately, that seems to be par for the course for this committee, even though this subcommittee is called the Oversight Subcommittee. I think at some point we need to stop these partisan games, learn how to work together for the benefit of the American people.

[The prepared statement of Mr. Waxman follows:]

PREPARED STATEMENT OF HON. HENRY A. WAXMAN

I've been involved in congressional oversight for decades, and I've seen firsthand how oversight, when done right, can educate and inform the public and make government programs work better. And I've also seen how the oversight process can be abused, for no purpose other than to fight ideological battles.

This kind of partisan oversight helps nobody, but it is apparently becoming the norm in this Subcommittee.

Today's hearing is about the new state and federal pre-existing condition insurance plans, or high-risk pools, established under the Affordable Care Act. These plans are a good example of the immediate benefits provided by the landmark health care reform law. They have allowed thousands of individuals desperately in need of health care coverage to purchase insurance. They have provided an essential lifeline to individuals who were shut out of the market for individual health insurance.

Thanks to the Affordable Care Act, discrimination by insurance companies against individuals with pre-existing conditions will be banned. In 2014, everyone will have a wide variety of choices of health care plans through state-based exchanges. Families will receive subsidies to help pay for coverage if they cannot afford it.

Until then, the high-risk pools available in every state will serve as a bridge to these state-based exchanges, allowing individuals with pre-existing conditions to purchase coverage at market-based rates.

You would think Republicans would love this program. In fact, these high-risk pools were the centerpiece of Republican health care reform proposals. Last Congress, Republicans introduced 11 bills creating state-based high-risk pools. One Committee member, Mr. Burgess, an outspoken opponent of the health care reform law, said: "The programs to deal with preexisting conditions would involve risk pools to be sure." Politco has described high-risk pools as one of "the old GOP standbys."

But when these high-risk pools were included in the health care reform law, suddenly Republican leaders in Congress decided they don't like them anymore.

We have one excellent witness today, Steve Larsen from HHS. He's responsible for administering the program, and I'm glad he's here to share his insights with us. But we asked Chairman Stearns for an additional witness: John Barthell, a constituent of Rep. Degette's from Colorado who is enrolled in the pre-existing condition insurance program. We wanted to get his perspective on the value of the program. We heard Ms. DeGette read some of his testimony for the record.

This request was denied. Apparently, the Committee does not want to hear from individual Americans who disagree with Republican orthodoxy.

Last week, Committee Republicans put out a memo attacking one part of the law—the Early Retiree Reinsurance Program—for being too popular and having enrollment that is too high. In today's hearing, they will attack the high-risk pools for exactly the opposite reason: they are not popular enough and have too low an enrollment.

The Affordable Care Act is simply not going to get a fair hearing from the Republicans on this Committee.

And that's a shame, because it's a good law. It ends the worst insurance company abuses, helps seniors in Medicare, helps small businesses afford health care coverage, and makes sure that all Americans have access to high-quality, affordable health care coverage. Americans of all ages in all 50 states are already benefitting from the health care reform law.

Our country faces grave challenges. We need to grow our economy and create jobs. We need an energy policy that protects our national security and our environment. We need a health care system that provides quality, affordable coverage to all Americans.

But to achieve these goals, we need to stop these partisan hearings and learn how to work together for the American people.

Mr. STEARNS. I thank the gentleman, and with that, there are no additional opening statements. At this point, we will ask Steve Larsen, the Deputy Administrator and Director of the Center for Consumer Information and Insurance Oversight, who is part of the Democrat administration, to stand before the committee.

Mr. Larsen, you are well aware that the committee is holding an investigative hearing, and when doing so, has had the practice of taking testimony under oath. Do you have any objection to taking testimony under oath?

Mr. LARSEN. No, I don't.

Mr. STEARNS. The chair then advises you that under the rules of the House and the rules of the committee, you are entitled to be advised by counsel. Do you desire to be advised by counsel during your testimony today?

Mr. LARSEN. I don't.

Mr. STEARNS. In that case, if you please rise, raise your right hand. I will swear you in.

[Witness sworn.]

Mr. STEARNS. Thank you. You are now under oath and subject to the penalties set forth in Title 18, Section 1001 of the United States Code, and you may now give your 5-minute summary of your written statement.

TESTIMONY OF STEVEN B. LARSEN, DEPUTY ADMINISTRATOR AND DIRECTOR, CENTER FOR CONSUMER INFORMATION & INSURANCE OVERSIGHT, CENTERS FOR MEDICARE AND MEDICAID SERVICES

Mr. LARSEN. Thank you, Chairman Stearns, Ranking Member——

Mr. STEARNS. I think you should put the mic just a little closer, if you don't mind.

Mr. LARSEN. Is that better?

Mr. STEARNS. I think that is. Yes, that is good.

Mr. LARSEN. Chairman Stearns, Ranking Member DeGette, members of the subcommittee, thank you for the chance to appear before you this morning. I have submitted my full testimony for the record.

As was mentioned, I serve as Deputy Administrator and Director of the Center for Consumer Information and Insurance Oversight, or CCIIO, within CMS. I have been involved in implementing many of the provisions of the Affordable Care Act, including overseeing private health insurance reforms, working with States to establish exchanges, and ensuring that consumers have access to information about their rights and coverage options.

At this time last year, Congress passed and the President signed into law the Affordable Care Act, which will expand access to affordable quality coverage to over 30 million Americans, and ensure individuals have coverage when they need it most. Just 1 year after the Affordable Care Act became law, many reforms have taken effect, including eliminating preexisting condition exclusions for children, prohibiting insurance companies from rescinding insurance policies simply because a consumer may have made an error on a form, ending lifetime dollar limits on health benefits,

and enabling many young people to stay on their parent's insurance plans up to the age of 26.

The Affordable Care Act also established new programs to expand and support coverage options as a bridge to 2014. In 2014, everyone will have access to affordable health insurance choices through the new competitive marketplaces, the exchanges which prohibit discrimination based on preexisting conditions.

The bridge to 2014 includes the Preexisting Condition Insurance Plan, or PCIP. The Affordable Care Act created PCIP to make health insurance available to people whom private insurance companies denied coverage because of their preexisting conditions. The presence of a preexisting condition is one of the major barriers to obtaining health insurance for individuals, and the fact that so many people are denied coverage for these conditions is yet another reason why healthcare reform is so important.

PCIP provides health coverage options for people who have been uninsured for at least 6 months, have a preexisting condition, or have been denied health coverage because of a condition, and are U.S. citizens or residing in the U.S. legally. The program covers a broad range of health benefits, including primary and specialty care. PCIP eligibility is not based on income, and the plan does not charge people higher premiums because of their medical condition.

Previously, many states have run high risk pools or other programs that offer insurance to people with preexisting conditions. While the PCIP and existing state pools cannot be combined, states have the option to build on their current programs and choose to run the new program under contract with HHS, or elect to rely on HHS to provide PCIP coverage in their State. Twenty-seven states run PCIP programs, and HHS, along with the Office of Personnel Management and the Department of Agriculture's National Finance Center, are running the federal PCIP programs, which cover 23 states and the District of Columbia. The Federal Government is contracting with the National Finance Center to administer benefits in those states covered by the federal PCIP program, and we are flexible about how each state chooses to implement the state program, allowing every State-administered PCIP to be uniquely tailored to their local market.

The law appropriates $5 billion of federal funds to support PCIP beginning on July 1, 2010, through July 1, 2014, and an allocation of these funds was made across the states based on the CHIP formula that takes into account the population of the State, the number of uninsured in the State, and local cost factors. A 10 percent cap limits administrative expenses in the PCIP program over the life of the program, and CCIIO and the states work together to monitor expenditures to ensure we are maximizing the value of the program while staying within the 10 percent administrative cost limit, and within the total funds that were allocated.

Based on the data released in March, PCIP has 12,437 members. Of this total, over 8,000 people have been enrolled in the State-run PCIPs in the 27 States, and over 3,000 have been enrolled in the federal PCIP in the 23 States. I am very pleased that enrollment in the PCIP program increased by over 50 percent in the last few months, and we expect it to continue to grow between now and 2014.

I am proud of all that we have accomplished over the past year and look forward to 2014 when Americans will have access to more affordable, comprehensive health insurance plans without worrying about preexisting conditions. PCIP is an important part of the bridge to the exchanges in 2014. Until then, I look forward to continuing to implement the Affordable Care Act and strengthening CCIIO's partnership with Congress, the States, consumers, and other stakeholders across the country.

Thank you so much for the opportunity to discuss the work that CCIIO has been doing to implement the Affordable Care Act and to help people with preexisting conditions, and I look forward to your questions.

[The prepared statement of Mr. Larsen follows:]

STATEMENT OF

STEVEN B. LARSEN

DEPUTY ADMINISTRATOR AND DIRECTOR,
CENTER FOR CONSUMER INFORMATION & INSURANCE OVERSIGHT,
CENTERS FOR MEDICARE & MEDICAID SERVICES

ON

THE PRE-EXISTING CONDITION INSURANCE PLAN PROGRAM
IN THE AFFORDABLE CARE ACT

BEFORE THE

U. S. HOUSE COMMITTEE ON ENERGY AND COMMERCE,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

APRIL 1, 2011

House Committee on Energy and Commerce
Subcommittee on Oversight and Investigations

April 1, 2011

Chairman Stearns, Ranking Member DeGette, and Members of the Subcommittee, thank you for the opportunity to discuss the Department of Health and Human Services' work implementing the Affordable Care Act. I serve as Deputy Administrator and Director of the Center for Consumer Information & Insurance Oversight (CCIIO) within the Centers for Medicare & Medicaid Services (CMS). Since taking on this role, I have been involved in CCIIO's implementation of many of the provisions of the Affordable Care Act, including overseeing private health insurance reforms, assisting States to implement Health Insurance Exchanges (Exchanges), and ensuring that consumers have access to information about their rights and coverage options. Prior to becoming the Director of CCIIO, I served as the Director of the Office of Oversight within CCIIO, which is charged with working with the States to ensure compliance with the new insurance market rules, such as the prohibitions on pre-existing condition exclusions for children and rescissions, as well as ensuring consumer value for premium payments through the medical loss ratio standards and the review of unreasonable rate increases as well as the enforcement of the new restrictions on annual dollar limits on benefits.

As a former State Insurance Commissioner, I understand the key role that States play in the regulation of insurance and insurance markets. I have seen first-hand the importance of holding insurance companies accountable, and understand the need to make quality, affordable coverage more accessible to all health care consumers. I have also served as an executive in a for-profit, publicly-traded managed care company, and understand the need for competitive and robust markets as well as reasonable regulations. The Affordable Care Act appropriately balances these objectives.

At this time last year, Congress passed and the President signed into law the Affordable Care Act, which expands access to affordable, quality coverage to over 30 million Americans and strengthens consumer protections to ensure individuals have coverage when they need it most. Immediate reforms include a critical foundation of patients' rights in the private health

insurance market that help put Americans in charge of their own health care. Over the past year, we have already implemented historic private market reforms including eliminating pre-existing condition exclusions for children, prohibiting insurance companies from rescinding coverage absent fraud or intentional misrepresentation of material fact and from imposing lifetime dollar limits on coverage, and enabling many dependent young adult children to stay on their parent's insurance plan up to age 26. These changes have empowered consumers and eliminated some of the worst insurance industry practices. We have heard from many people across the country that these new rights and protections are providing them with the assistance they need to keep their coverage, see the doctors of their choice, and choose the careers that best suit their talents.

Development of the Pre-Existing Condition Insurance Plan (PCIP)

The PCIP program is based on existing high-risk pools which have a history of bipartisan support. Established under section 1101 of the Affordable Care Act, the PCIP program provides a lifeline to uninsured Americans who private insurers have either refused to insure because of a pre-existing condition or have offered coverage that excludes benefits associated with that condition. These Americans can now receive health coverage without limitation on benefits because of their condition. The PCIP program provides a critical bridge from the existing insurance market to the new patient-centered insurance system that will come into effect with the Health Insurance Exchanges in 2014.

I'm proud of the fact that the States and the Federal government have been able to stand up programs in every State in record time. We are working with the States and our partners in the patient advocacy community to increase public awareness of this important bridge program. Already, thousands of Americans who were locked out of accessible private insurance coverage before the passage of the law have this valuable and needed coverage. For example, the PCIP program has provided invaluable help to people like Jerry Garner. Mr. Garner, a real estate agent from Gowen, Michigan who was recently featured in the *New York Times*, lost his health insurance after undergoing a kidney transplant. Because of his pre-existing condition, he was unable to obtain new insurance to cover the $2,000 monthly drug bills for the immunosuppressive medications that transplant patients must take to prevent rejection of a new

organ. Mr. Garner signed up for Michigan's PCIP program and is now paying lower premiums than he did under his previous insurance and is receiving more comprehensive coverage. Mr. Garner's wife told the *New York Times* that the PCIP program "was definitely an answered prayer."[1]

I'm pleased that enrollment in PCIP programs has increased by 50 percent from our November release to our February release of enrollment data, and we expect it to continue to grow between now and 2014. As we implement this benefit, CCIIO is actively working with States, consumer groups, patient advocates, voluntary health organizations, health care providers, social workers, other Federal agencies, and the insurance industry to promote the program, including holding meetings with State officials, consumer groups, and others. The remainder of my testimony will discuss the details of this significant new program.

By statute, the PCIP program is specifically targeted to U.S. citizens and people who reside in the U.S. legally who have been denied coverage because of a pre-existing condition and have been without coverage for at least 6 months. PCIP is intended to be a bridge program to provide uninsured people with a pre-existing condition access to comprehensive coverage between now and 2014. In 2014, most insurers will no longer be able to discriminate based on pre-existing conditions, and individuals and small businesses will have access to more affordable and robust private insurance choices through new competitive Exchanges. Until then, uninsured people who have been denied care or charged more because of a pre-existing condition – such as cancer, diabetes, high blood pressure, or high cholesterol – now have a chance for more affordable coverage where they may never have had one before. A March 2011 report from the Government Accountability Office (GAO) noted that insurance application denial rates varied significantly across insurance issuers, with a quarter of issuers having denial rates of 15 percent or less and another quarter having denial rates of 40 percent or more.[2]

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[1] Walecia Konrad, "Pre-existing Condition? Now, a Health Policy May Not Be Impossible." The New York Times, March 18, 2011, link here.
[2] GAO Report, Private Health Insurance: Data on Application and Coverage Denials, GAO-11-268 (Mar. 2011).

The PCIP program was required to be operational within 90 days of enactment of the Affordable Care Act, and CCIIO worked with States to meet that aggressive deadline. The Affordable Care Act appropriated $5 billion for the PCIP program, and allows States the choice of administering their own PCIP program or, in a State that declines to do so, having CCIIO administer the program. To implement the Federally-administered PCIP program, CCIIO partnered with the Office of Personnel Management (OPM) to issue a competitive solicitation to entities that provide health insurance coverage on a national level, including Federal Employees Health Benefits (FEHB) plan carriers. CCIIO proceeded to contract with the Government Employees Health Association (GEHA) to serve as the third-party administrator for the Federal PCIP program, with OPM managing the contract for CCIIO. In addition, the U.S. Department of Agriculture's National Finance Center performs eligibility and enrollment processing.

In April 2010, we proposed an allocation of PCIP funding among the States, based on the formula used for distributing funds in the Children's Health Insurance Program (CHIP). In July 2010, we issued an interim final rule with a 60-day comment period which outlined the design of the program and solicited input from stakeholders.[3] Twenty-seven States are now administering their own PCIP program, while twenty-three States and the District of Columbia instead chose the Federal government to administer their State PCIP programs. CCIIO has also issued five guidance documents since the regulation's publication, which explain: general compliance requirements for Federal PCIP contractors; how newborns are covered under a PCIP program; how portability of coverage and third party payments work under the PCIP program; how a child under the age of 19 may qualify for the Federally-administered PCIP program; and that a PCIP program may not deny coverage to an otherwise qualified individual eligible for other coverage.

Enrollment

Individuals can apply to the PCIP program that serves their State by completing an application and providing the supporting documentation that the PCIP program requires to establish eligibility. Once enrolled, applicants have access to a wide array of benefit designs in the States, including plans that are compatible with health savings accounts, and tools designed

[3] Pre-Existing Conditions Insurance Plan Program, 75 Fed. Reg. 45014 (July 30, 2010).

to improve health such as a health risk assessment and care management. In some States, enrollees in the PCIP program who take the health risk assessment qualify for a financial incentive. While enrollees are given a choice of benefit designs, all 2011 plan options provide the following: first-dollar preventive care; no lifetime maximum benefits; no waiting periods; coverage for all major medical services; and an annual out-of-pocket limit on spending.

The PCIP program is designed to meet the needs of beneficiaries with pre-existing conditions and provide coverage for people with significant medical expenses and few available coverage options until 2014. According to enrollment data reported as of February 1, 2011, a total of 12,437 individuals have been enrolled in PCIP programs across the country. Of this total, 8,762 people have been enrolled in State-run PCIPs in 27 States and 3,675 have been enrolled in Federally-administered PCIPs in 23 States and the District of Columbia. In addition to the payment of medical and other claims, spending has included one-time program design and development costs, as well as enrollment, eligibility processing, billing, premium collection and consumer support functions including an online web application and call center to help facilitate enrollment.

Partnerships with States

In implementing the PCIP program, we worked closely with our State partners to ensure they were able to appropriately tailor their State-administered PCIP programs to their local insurance markets. The PCIP program was modeled after the high-risk pool programs that exist in many States to assist individuals who could not obtain coverage in the private market and were ineligible for such public programs as Medicare and Medicaid. The PCIP program also draws many features from the popular bipartisan CHIP program – covering a broad range of health benefits, including those for pre-existing conditions, and allowing for significant State flexibility in design and details. The program ensures maximum efficiency in distribution of funding by permitting individual States to determine when to draw down their allocated funds. If necessary, unused State allocations could be redistributed to other States that have consumers in need.

We are closely monitoring Federal and State expenditures to ensure that States appropriately manage their funding and do not exhaust their allocations prematurely. Each State contract includes an early warning or trigger provision; when a State has reached 75 percent of its projected enrollment or expenditures are on track to exceed a State's allotment, the State must consult with CCIIO to ensure plans are in place to manage the remainder of their allocation appropriately. Similar to CHIP, administrative expenses in the PCIP program are limited by a 10 percent cap for the duration of the program. CCIIO and States work together closely to monitor expenditures to ensure we are maximizing the value of the program while staying within the 10 percent administrative cost limit and within the total funds allocated.

The flexibility for States that is a hallmark of the PCIP program means that no two State-administered programs are identical. PCIP programs are uniquely tailored to the insurance market conditions in each State. For example, some States have chosen to build their PCIP programs off of their existing high risk pools, while others chose to establish a new pool. Additionally, because each State insurance market is different, premiums vary among the different States. It also means that, together with the States, we have had the opportunity to improve the affordability of coverage and to enhance our outreach efforts. For example, we recently adjusted the Federal PCIP program to reduce premiums by approximately 20 percent, and added two new plan choices which improve benefit design for all current enrollees and new applicants. States such as North Carolina have also reduced premiums in 2011. In this State, since January 1, 2011, premiums for people up to age 55 declined by about 10 percent, while premiums declined as much as 31 percent for people above age 55.

Outreach Efforts

CCIIO has an aggressive strategy to encourage enrollment of eligible individuals, meeting with local doctors, hospitals, consumer groups and chapters of advocacy groups like the American Cancer Society and American Diabetes Association. For example, we are working to reach local stakeholders and providers who come into contact with people with chronic care needs in need of insurance to spread awareness about the PCIP program. We have actively reached out to provider groups through webinars, arranged meetings with potential partners in at

least six States, and will continue this outreach in the coming months. CMS is also working with agencies that have a history serving individuals with disabilities, such as the Social Security Administration. Since February 15, 2011, all applicants for Social Security disability benefits have been informed about the PCIP program through application receipts. These collaborations leverage existing communication channels with individuals who have a pre-existing condition and may therefore be eligible for the PCIP program.

I am pleased to report that enrollment has grown significantly over the past several months and we anticipate continued growth. We believe that PCIP programs administered by the States and the Federal government will continue to fill a market void and provide valuable health insurance coverage to a population that desperately needs it until 2014. In 2014, State-based Health Insurance Exchanges will provide affordable, quality health insurance coverage to any American who needs it. We believe that the PCIP program is a vital bridge to 2014 which provides comprehensive coverage to vulnerable individuals and their families, and we look forward to continuing to improve the program.

Moving Forward

As we lay the groundwork for 2014, it is our intention to continue implementing vital consumer protections while offering enough flexibility to ensure that the market is not disrupted. We are proud of all that we have accomplished over the past year and look forward to 2014 when Americans will have access to more affordable, comprehensive health insurance plans. With the new coverage options available in the PCIP program, uninsured individuals with pre-existing conditions no longer need to wait and worry that their illness will bankrupt them, or that they will have to choose between a roof over their head and paying for the cancer treatment they so desperately need. The PCIP program is another important program that will lead our transition to the new era of health insurance coverage for all Americans, through the Exchanges, in 2014.

In the meantime, I look forward to continuing to work on implementing provisions of the Affordable Care Act, strengthening CCIIO's partnership with Congress, the States, consumers,

and other stakeholders across the country. Thank you for the opportunity to discuss the work that CCIIO has been doing to implement the Affordable Care Act.

Mr. STEARNS. Mr. Larsen, thank you very much. I will take the opportunity to ask the first set of questions.

As you know, as everybody in the room knows, this is an oversight investigation committee that is looking at high risk insurance program, and I thought I would, before we start on that, a recent AP story just came out this morning indicating that your office has given out large sums of money under the Early Retiree Healthcare Program. You are familiar with that program?

Mr. LARSEN. I am.

Mr. STEARNS. And you were cited as the person who was involved with this. So we wanted to just, in passing, ask a few questions, that it appears that a lot of corporations, including General Electric, got $36 million for their early retirees. It appears that United Auto Workers got over 200 million, Verizon Communications got 91 million, AT&T got 140 million, and so the list goes on and on. It is a huge amount of money that you are giving out to subsidize retirees—early retirees. I guess the question is how can you justify giving out so much of taxpayers' money to these corporations?

Mr. LARSEN. Well, these——

Mr. STEARNS. These are profitable corporations.

Mr. LARSEN. The Early Retiree Reimbursement Program in fact has been an incredibly successful program in accomplishing the goals that we set out to accomplish. The fact is that history has shown that the rate in which large companies are dropping coverage—insurance coverage for early retirees——

Mr. STEARNS. But these are corporations that are profitable, and when you talk about AT&T and General Electric and Verizon Communications, United Auto Workers, why would they need taxpayers to subsidize them, and why do—I mean, you have Northrop-Grumman, Boeing Company, the State Teachers Retirement System Ohio. If this is a healthcare program that is going to work, why would you be taking taxpayers' money and giving so much out to companies that are very successful and have a very good profitable history?

Mr. LARSEN. Well, those companies are companies that, in fact, continue to offer retiree benefits, health benefits for early retirees——

Mr. STEARNS. But shouldn't they have the responsibility of taking care of that themselves and not asking for the taxpayers— basically giving them free money?

Mr. LARSEN. Well, the program allows them and positions them to continue to offer this critical benefit to early retirees, because I will tell you, early retirees, folks that are between 50 and 65, when they are put out into the individual market, are the ones that are the most at risk for not being able to get insurance.

Mr. STEARNS. Well I understand that, but that was part of when they got to work for GE or AT&T or Verizon, this is part of the package they understood. I guess are you going to give money out like this to all major corporations, all the unions, all the public employee retiree systems? I think the point would be that if you think the healthcare system that the Democrats passed is so successful, why in the flip are you giving out so much money of taxpayers so freely and overwhelming to companies that are very profitable?

Mr. LARSEN. Well, I would respond with a couple points.

First of all, there are a number of different types of recipients. Certainly, State and local governments are also one of the main recipients so that employees and retirees of State and local governments can continue to have retiree benefits.

Mr. STEARNS. OK, but Mr. Larsen, I have a statement from you. You said, "The overwhelming response to this program demonstrates exactly how broken the current healthcare system is, exactly why we needed reform in the first place." Is the reform you are talking about is taking taxpayers' money and giving it out to successful, profitable corporations? Is that your definition of why we need the Democrat healthcare bill?

Mr. LARSEN. We think the program is successful because it has allowed these companies and State and local governments and nonprofits and commercials to continue to be able to offer coverage for early retirees.

Mr. STEARNS. Now, you followed the recent publicity with General Electric paying no taxes on the huge amount of money they paid, so I understand you gave General Electric $36 million to help their early retirees. Do you think it was absolutely necessary the taxpayers fund early retirees for General Electric? Is that your position today?

Mr. LARSEN. Well, when a sponsor in the program receives the money, it must apply the money to the benefits that are received by the retirees or to the costs that the company incurred——

Mr. STEARNS. OK, I understand. Let me—my time is almost expired, but let me just move on to what we are here for also is the high risk insurance program.

Enrollment in the high risk pool was supposed to be about 375,000 in the first year, according to the chief actuary of Medicare. Is that correct?

Mr. LARSEN. That is my understanding, yes.

Mr. STEARNS. OK. You know, based upon what we have seen so little, as you saw in my opening statement, how can you justify those costs if you have only done so little at this point? Where are you going to get the money to do this high risk for everybody?

Mr. LARSEN. Well, it has been a fact across the country as States, and certainly for the federal high risk pool, that the pools are generally slow to start up. When the bill was passed, we devoted our efforts to standing the program up——

Mr. STEARNS. I will just close by saying if you have only got 12,000 in the program today, and you have indicated 375,000 people is your goal, and you spent this huge amount of money on 12,000, you won't possibly have enough money to do 375,000. Wouldn't you and I agree that you won't have the money to do 375,000, based just upon the 12,000 you have done?

Mr. LARSEN. I don't think, respectfully, we agree because we have not spent a large amount of money on the program to date.

Mr. STEARNS. OK. All right, my time is expired.

The gentlelady from Colorado.

Ms. DEGETTE. Thank you, Mr. Chairman.

Mr. Larsen, how much money has the program spent to date?

Mr. LARSEN. For outlays or incurred expenses associated with——

Ms. DEGETTE. Either one.

Mr. LARSEN. The federal program and the state program combined is about $33 million as of February 28.

Ms. DEGETTE. OK, and how much was set aside in the healthcare for this program?

Mr. LARSEN. Five billion.

Ms. DEGETTE. Five billion. So you have spent several hundred million of the 5 billion?

Mr. LARSEN. Well, not—we have spent about $33 million on what I will call program costs, and then additional funds on administrative costs, but together it is less than $100 million.

Ms. DEGETTE. OK, it is less than $100 million of the $5 billion, correct?

Mr. LARSEN. That is correct.

Ms. DEGETTE. Now, you are making efforts to try to enroll more people with preexisting conditions in this program, correct?

Mr. LARSEN. In fact, I think they have been successful.

Ms. DEGETTE. And why do you think that?

Mr. LARSEN. Well, we had several phases of enrollment initiatives. The second phase started from January to March in which we conducted outreach with staff, by the way, just—hitting nine cities, talking with providers, and we have seen enrollment double—well, increase by 50 percent between November and February. So we have made those efforts and enrollment is going up.

Ms. DEGETTE. So is your projection you are going to wildly exceed this $5 billion before the 2014?

Mr. LARSEN. I don't think we are prepared to say that yet.

Ms. DEGETTE. OK, thank you. Well, that is what the chairman is implying, but you have spent less than $100 million.

Mr. LARSEN. We will work within the appropriation.

Ms. DEGETTE. Thank you. Now, let me just ask you one question. I know the topic of this hearing is about the PCIP program, but let us talk about this early retirement reinstatement program for a minute. That was—what was happening was a lot of employers who had early retires, retirement programs, were cutting those healthcare problems when the economy turned down, right?

Mr. LARSEN. Correct.

Mr. DEGETTE. So then what would happen would be people between the ages of 50 and 65 wouldn't have insurance and they would have to go out on the individual market, right?

Mr. LARSEN. Correct.

Ms. DEGETTE. And so then those people couldn't get insurance, right?

Mr. LARSEN. Correct.

Ms. DEGETTE. So that is what this is designed to help, is that correct?

Mr. LARSEN. Correct.

Ms. DEGETTE. And that program is also going to phase out by 2014, right?

Mr. LARSEN. Yes.

Ms. DEGETTE. But at this moment, it is helping—Congress can't require these companies to continue these programs for their early retirees, can we? No. And so therefore the people that these pro-

grams are helping are those early retirees who have no other way to get insurance, right?

Mr. LARSEN. And there are millions of people who are conversed in the retiree programs that have been helped by this program.

Ms. DEGETTE. Right, and it helps them get insurance.

Mr. LARSEN. It helps them keep their coverage.

Ms. DEGETTE. Now, let us talk about the subject of this hearing, again the PCIP program.

Before the healthcare bill became the law of the land. Let us say that somebody was diagnosed with cancer, and they wanted to by health insurance on the private insurance market. What sort of options would those people be offered?

Mr. LARSEN. Well, they are generally limited to the individual market, which they would be either offered exclusionary riders or denied coverage.

Ms. DEGETTE. So you mean the individual market would say we are not going to cover you for your cancer because it was preexisting, right?

Mr. LARSEN. That is correct.

Ms. DEGETTE. Let us say they wanted to get coverage for the cancer. How much will that cost them?

Mr. LARSEN. Well, I don't think they could get coverage for that, without going to a state higher risk pool.

Ms. DEGETTE. OK, and let us talk about the state high risk pools. How many states had high risk pools?

Mr. LARSEN. I think there are about 35 that had state high risk pools.

Ms. DEGETTE. OK, and where in those 35 states were they providing affordable coverage to anybody who needed it?

Mr. LARSEN. Well, the difference between the PCIP program and the state high risk pools is they often have a standard rate that is up to 150 percent or 200 percent of some——

Ms. DEGETTE. The state program?

Mr. LARSEN. The state program, which is not the way the PCIP program is structured.

Ms. DEGETTE. OK. How is the PCIP program——

Mr. LARSEN. The PCIP program has a cap of no more than 100 percent of the standard market rate. So the state programs, although available, are often viewed as not affordable for some people.

Ms. DEGETTE. OK. I just have one last question. What would happen to these PCIP plans if the Affordable Care Act was repealed?

Mr. LARSEN. You would have a lot of people that have no good option to get coverage, and these are the sickest of the sick, in many cases.

Ms. DEGETTE. Their plans would be cancelled, right, and then they would have to go to these other options that you talked about, right?

Mr. LARSEN. That is correct.

Ms. DEGETTE. Thank you.

Thank you, Mr. Chairman. I yield back.

Mr. STEARNS. Gentlelady yields back.

Gentleman from Texas, Mr. Burgess, is recognized for 5 minutes.

Mr. BURGESS. Thank you, Mr. Chairman.

I don't want to spend too much time on this, but I feel obligated to answer the ranking member of the committee. It always seems that they want to paint Republicans as a friend of the insurance companies. Just a quick review by a simple country doctor on his iPhone app tells me that Cigna and Aetna have done extremely well in the year since the passage of the Patient Protection and Affordable Care Act. Apparently when people are required to buy insurance, the companies that sell insurance seem to be able to manage OK.

Let us talk for just a minute, because you were giving Ranking Member DeGette some information about the amount of money you spend in the program. You said about $100 million, is that correct?

Mr. LARSEN. No, I said no more than that. The approximate number on her sleeve would be the program spending of about $33 million, and then administrative costs of about $25, which includes a significant portion of startup costs that you incur anytime you start up a major program.

Mr. BURGESS. Yes, I will accept that, but that seems a little bit—$33 million in benefits, is that correct, did I understand——

Mr. LARSEN. Well remember, these are the amounts that are paid to the states or to fund the federal program beyond the premiums that are collected from the folks that are covered in the programs. But that is the level of federal spending for the program combined for both the state and federal.

Mr. BURGESS. So that is combined help for people against a backdrop of $25 million of administrative costs, is that correct?

Mr. LARSEN. Well again, the 25 million, there are at least 10 million of kind of one time——

Mr. BURGESS. Yes. This would all be easier——

Mr. LARSEN [continuing]. Startup costs.

Mr. BURGESS. We talked about this before. Boy, if we had a breakdown of your budget, it would just be so helpful and you promised that to us, and I am having to ask these questions because I don't have that information yet.

Mr. LARSEN. It is my hope and expectation that you will have that next week.

Mr. BURGESS. Next week, OK. So we will mark the calendar and we are all anxiously awaiting that.

Now you previously testified that you added 300 new jobs to implement the program, is that correct?

Mr. LARSEN. Not just this program, that is——

Mr. BURGESS. For all of society.

Mr. LARSEN. For all of society, yes, that is correct. Less than 300.

Mr. BURGESS. Do you know how much you spent on salaries for those 300 people?

Mr. LARSEN. I am sorry, could you repeat the question?

Mr. BURGESS. The amount you spent on salaries for those 300 jobs?

Mr. LARSEN. I don't know off the top of my head.

Mr. BURGESS. Well, is that money coming out of the administrative or the non-administrative funds?

Mr. LARSEN. Oh, you mean the salaries that administer—that would be in the administrative portion. It is a very lean and small staff that administers the PCIP program.

Mr. BURGESS. Now on the issue that has come up, and unfortunately, we haven't had a lot of time to work though it because of the retiree program information that has come through this morning. But eight of the 17 companies had more than $10 billion in profit last year. I mean, are those not companies that could have afforded to do some of this on their own?

Mr. LARSEN. Well, I can't speak to their capability, I can only say that, as I mentioned earlier, when they receive funds through the ERRP program, they are required to devote those funds to either reducing their own costs or reducing the costs of the beneficiaries, and I think 80 percent direct the funds to directly lowering the costs of people that participate in the programs, so we think that is a success.

Mr. BURGESS. Yes, but you have got a big company whose initials I won't mention, but they haven't paid any taxes this past year, they post an enormous profit, and you are providing them $36 million. You know, the only problem with that—and I want to help people, too, but we are borrowing 42 cents of every dollar we spend, so was there perhaps a way to tighten this up and run it just a little bit leaner? You know, even Karl Marx said "Each according to his disability, each according to his need."

That is a non-response response. It is very difficult for the recording clerk to record that.

Let me just ask you one more question. Was it—I have no problem with risk pools. I think the state risk pools, although they were underfunded, certainly provided good help, and when I would do town halls and talks in my district, and even in talking to doctor groups around the State, someone would always come forward and say, you know, don't do anything to mess up what I have got with this risk pool. But at the same time, why was it necessary to reinvent the wheel? You already said that you have 35 of the states with something up there in a risk pool arrangement. You have additional states that have reassurance programs, so you are already getting to a pretty significant number of the states already. Now we come and overlay a federal program. Hailey Barbour, when he was here, actually testified that he had 3,600 people on his risk pools in the State of Mississippi, and with the infusion of—he did not participate at the federal level, but what the additional federal funds at a significant cost were able to provide additional benefits to 58 new people. That almost seems like we are not being smart about how we are spending this money.

Mr. LARSEN. I guess I have two responses. First, I would say that this is a compliment to the state pools because it has different design elements. For example, often the state pools have waiting periods before they start to cover——

Mr. BURGESS. Yours is 6 months.

Mr. LARSEN. Well, it is a little different for the federal program. That is you can't have been insured for 6 months, because we didn't want people migrating across pools. So in the state pools, you often have a waiting period, so that even if you come into the pool, you don't have coverage necessarily right away.

Mr. BURGESS. Six months seems like a waiting period.

Mr. LARSEN. And then as we discussed earlier, typically the standard rate for the state pools is 125 percent, 150 percent or higher, and so there are features of the federal program that complement what is going on at the state level.

Mr. BURGESS. I get that. It just seems like it would have been better to streamline those two together, rather than reinvent the wheel.

Mr. STEARNS. Gentleman's time has expired.

The gentleman from Michigan, the emeritus of the committee, Mr. Dingell is recognized for 5 minutes.

Mr. DINGELL. Thank you. Thank you, Director Larsen——

Mr. STEARNS. I think you will have to pull the mic a little——

Mr. DINGELL [continuing]. For implementing the Affordable Care Act. You have a large task before you, including the critical patient bill of rights and State-based exchanges, as well as today's focus, the Preexisting Condition Insurance Plan. I appreciate the work that you have done in getting the pool up and running in Michigan, including the work you have done to make a difference in the lives of Michiganders like Jerry Garner, who you pointed out in your testimony.

Now, as my colleagues on the other side of the aisle question the effectiveness of high risk pools, I think it would be useful to remind them of the strong support of these pools as a way to expand coverage. In fact, members of this committee offered their own legislation appropriating far more money than laid out in the—or expended in the Affordable Care Act to implement high risk pools nationwide.

Now, Director Larsen, a few questions. Please answer yes or no.

The PCIP was designed to be a temporary program to help the sickest of the sick and those most in need to have access to coverage until health insurance exchanges are up and running in 2014. You point out that more than 12,400 individuals have enrolled in these programs across the country. In your experience, have the states been able to set up affordable premiums for individuals in need? Yes or no.

Mr. LARSEN. Have states been able to set up affordable programs? No, they have not completely.

Mr. DINGELL. They have not.

You point out in your testimony that CCIIO recently adjusted the federal PCIP program to reduce premiums and to add two plan choices. You point out that the enrollment in PCIP programs has increased by 50 percent from November to January—rather, November to February. In your opinion, will increased plan choices in the PCIP program encourage further enrollment? Yes or no.

Mr. LARSEN. Yes.

Mr. DINGELL. Now, you also discussed in your testimony the outreach efforts in CCIIO that have been used to encourage enrollment, working with Social Security Administration, American Cancer Society, Diabetes Association, and other agencies. It is my opinion it seems to be a very targeted approach in enrolling individuals. In your opinion, do you believe this targeted approach is working? Yes or no.

Mr. LARSEN. We think it is showing results and working, yes.

Mr. DINGELL. Now, how do you know that this targeted approach is working?

Mr. LARSEN. Well, as I mentioned and referenced, we have seen significant increases in the rate of enrollments in the period between November and February, in addition to the overall enrollment. There were several states in which the number of individuals in the program doubled, five or six states that doubled their enrollment in that period, so it is very encouraging.

Mr. DINGELL. Thank you.

Now, is every PCIP program conducting a public campaign to recruit eligible individuals? Yes or no.

Mr. LARSEN. Yes.

Mr. DINGELL. Now, has CCIIO shared the best practices with the states who have lower enrollments than others to help them recruit eligible individuals they may be missing? Yes or no.

Mr. LARSEN. Yes, we are in constant contact with the States.

Mr. DINGELL. Is—in your opinion, has CCIIO learned some best practices in terms of enrolling eligible individuals that will help to ensure successful enrollment of individuals in the exchange beginning in 2014? Yes or no.

Mr. LARSEN. Yes.

Mr. DINGELL. Now, am I fair in observing that when the situation in 2014 when everybody is covered in the exchanges, am I assuming correctly that at that point it will no longer be necessary to have this high risk pool?

Mr. LARSEN. That is correct.

Mr. DINGELL. OK. Now, would you like to comment, if you please, sir, in the very brief time that we have on what are the best practices or any other comments that you might like to make with regard to the previous questions?

Mr. LARSEN. Well, as you mentioned we have learned that it really is a targeted outreach campaign. This is not necessarily mass marketing so that you work closely with high volume providers, hospital associations, medical associations. We have worked with the insurance companies that issue denial notices to take note of the availability of the PCIP program——

Mr. DINGELL. One very quick question. The companies that you have helped have had no responsibility, other than their contractual responsibilities to cover either their active employees or their retirees, is that correct?

Mr. LARSEN. Yes.

Mr. DINGELL. Thank you.

Thank you, Mr. Chairman. One second left.

Mr. STEARNS. Thank the gentleman from Michigan.

The gentlelady from Tennessee is recognized for 5 minutes.

Mrs. BLACKBURN. Thank you, Mr. Chairman.

Mr. Larsen, I am going to cut right into this. What are the standards on your application, and what does your application look like for these companies that apply for this many—for the early retiree process?

Mr. LARSEN. Well, first they have to submit an application to be a planned sponsor, requiring basic information about the plan, about the company and their retiree plan, and then in the process

of submitting claims, then they have to submit claims information. As you may know——

Mrs. BLACKBURN. OK. Let me—OK. They submit a claim to be—they submit an application to be a planned sponsor, so do they need to show financial need when they submit an application to you, that they need this money, that they are short of money, that they are not going to be able to cover the cost of those that are enrolled in the plan that they are choosing to sponsor? Do they have to demonstrate that financial need?

Mr. LARSEN. The statute doesn't require a need——

Mrs. BLACKBURN. How long is the application they submit?

Mr. LARSEN. It is not particularly long. I don't recall exactly.

Mrs. BLACKBURN. OK, so they don't have to demonstrate any financial need, they just need to show that they want to set up a plan for their early retirees, is that correct?

Mr. LARSEN. They need to demonstrate that they have a current program to cover their early retirees.

Mrs. BLACKBURN. So they have a current—that they have a current program.

OK, let me ask you this. Some of these companies have early retirees that they may have incentivized to take early retirement. Do you ask them how they achieved their universe of early retirees? Did they incentivize these people, give them early parachutes—early retirement parachutes, give them extra benefits if they chose to retire? Did you ask them if they are doing that?

Mr. LARSEN. I don't believe that is part of the application.

Mrs. BLACKBURN. It is not part of the application, so therefore, in order to make their bottom line look better, they could actually go to a universe of employees and say we are going to incentivize your early retirement, and then move them into this plan that they are going to submit an application to sponsor, then come to you with their hand down and say hey, we need your millions, Federal Government. Do you not see why the American people are so frustrated with what you all are pouring out of these bureaucracies every day on the American taxpayer? I mean, does this—is this lost on you?

Mr. LARSEN. Well first of all, I don't think we have seen——

Mrs. BLACKBURN. You have spent $100 million in setting up a program we don't want for services we don't need, giving money to corporations that are profitable corporations, giving money to people like GE who are exporting their power job growth, giving money to people like GE who are no longer making light bulbs in the United States, but have shipped all those jobs to China, and you think this—you think we should be happy and pleased and applaud you for creating new federal jobs to take money out of the taxpayer's pocket?

Let me ask you something else. Let me move to the PCIP. Let me move to the PCIP program. I don't want to run out of time. Did you have any existing program that you used for a model when you set up PCIP? Was there any program in existence that you went to? You already said you didn't think the states were doing a very good job with their high risk pools, so——

Mr. LARSEN. Well, I don't think that is quite what I said. I said that there are 35 state programs——

Mrs. BLACKBURN. You said it was incomplete.

Mr. LARSEN. I am sorry?

Mrs. BLACKBURN. I think you said they were incomplete.

Mr. LARSEN. No, they have different sets of standards, and the federal standard is different. So we certainly looked to the way that the high risk pools were administered.

Mrs. BLACKBURN. Yes, yours has a different design element, were your exact words.

Mr. LARSEN. That is right.

Mrs. BLACKBURN. OK. Is there any program that you have looked at that you think has been successful? When you have a State like Tennessee, and you and I have discussed Tennessee before, we have been down this road. We know public option healthcare does not work, that it breaks the bank, and we know where some of the pitfalls are, but you all are not willing to listen to some of that guidance. So, did you work from a model that has actually yielded a savings?

Mr. LARSEN. Well, high risk pools by definition will not yield savings. They——

Mrs. BLACKBURN. They should reduce costs.

Mr. LARSEN. Well, here is the problem. When you are insuring sick people, you can't collect enough premiums to cover the costs, and so high risk pools are always subsidized in some way. Typically in States, it is subsidized through assessments on insurance companies or general revenue. In this case, it is subsidized through the PCIP program for the federal and State——

Mrs. BLACKBURN. Do you think that putting a federal program along side a state program, even though it has, in your words, different design elements, is redundant?

Mr. LARSEN. No, I don't.

Mrs. BLACKBURN. You don't?

Mr. LARSEN. I do not.

Mrs. BLACKBURN. You don't see a problem with the duplications?

Mr. LARSEN. No, because I said I think we attracted a different element of the population that has preexisting conditions, so it is complimentary to the program.

Mrs. BLACKBURN. So in other words, you think the Federal Government needs to pick these programs up and pull them to the federal level, not trust the states for oversight, and then turn around and out of your $5 billion, give it to corporations who don't need the money who are firing American workers and shipping the jobs overseas?

I yield back.

Mr. STEARNS. Gentlelady yields back.

The gentlelady Jan Schakowsky is recognized for 5 minutes.

Ms. SCHAKOWSKY. Well, I am just loving this debate. I particularly appreciate Dr. Burgess quoting Karl Marx in his rationale on why this program really doesn't work, and I appreciate hearing the fury about companies that don't pay taxes and then outsource jobs. I would certainly endorse those concerns and would certainly welcome an opportunity to work with my colleagues across the aisle to address just that. The problem we have is that these greedy companies that legally don't pay any taxes also are not going—are

not providing, are increasingly dropping early retirees from these healthcare programs. Is that not true, Mr. Larsen?

Mr. LARSEN. That is correct.

Ms. SCHAKOWSKY. So we have seen that while all of this outrage may be going on with no solutions, you know, we could sit down and establish criteria for companies that, when they make a certain amount of money, must provide this kind of coverage for early retirees. I welcome that conversation.

But in the meantime, are we going to sit here and say the burden, then, will be on the shoulders of those very retirees who, in many cases in the past, used to get help from their companies who aren't. And the problem is that these are, in fact, you know, expensive people to insure, these high risk people, and that is precisely why we passed the Affordable Care Act, and why, in 2014, we are going to prevent discrimination. Is this not a bridge program, Mr. Larsen?

Mr. LARSEN. That is exactly right.

Ms. SCHAKOWSKY. And what would happen to those retirees if we did not provide that?

Mr. LARSEN. I think they would have great difficulty finding coverage in the individual market.

Ms. SCHAKOWSKY. So if there is another solution that my Republican colleagues would like to find to require corporations to pay their fair share of taxes, to come up with a way to force them to cover their retirees, then why don't we talk about that? I haven't heard anything like that, except to criticism now in Marxian language of what these nasty, outsourcing corporations are doing.

Would the Chairman——

Mr. STEARNS. I would be glad to, I think, repeal Obamacare and start anew and try to come up with a healthcare plan that every American would support.

Ms. SCHAKOWSKY. And put every American at risk again, when we have a plan that we would be happy to look at various ways to make it better.

In the meantime, Mr. Larsen, I congratulate you on this program to make sure that we aren't setting adrift the victims of some of these very corporations that the Republicans have supported.

In the Medicare—let me find it—there was a loophole created in 2003 with the Medicare Modernization Act that allowed companies—this was a Republican initiative—to receive a 28 percent subsidy from taxpayers to help cover the cost of prescription drugs for retirees without counting the money as income. When they spent the money, then the companies were allowed to turn around and get a deduction for it on their taxes, even though the money was a gift from taxpayers. There was no outrage from the Republicans who wrote that provision into the legislation that the Obama Administration saw as a double subsidy from the taxpayers. But now at the very moment we are looking how to get these vulnerable employees to make it to 2014, now we are looking at these rich corporations and how are we letting them get away with it? Well, if there is a way that they suggest that we can get GE and AT&T to cover those, I welcome that, and until that point, we are not going to set those employees adrift with no healthcare coverage.

I yield back.

Mr. STEARNS. Gentlelady yields back.

Mr. Gingrey is recognized for 5 minutes.

Mr. GINGREY. Mr. Chairman, thank you.

Mr. Larsen, Ms. Blackburn was just trying to point out something to you in regard to a lot of these companies and one in particular, I won't name the company, but the initials are GE, in regard to these early retirement incentive packages that they give to their advantage to the advantage of their bottom line. That is the only reason why a company would do something like that. But what it amounted to was a lump sum early retirement bonus worth 75 percent of their annual pay, and her outrage, of course, was over the fact that when these companies do that and then they come to you, to the Federal Government with this ERRP program and say, oh, sign us up for the money to help us now pay these same people for their health retirement benefits. So that is where the outrage is coming from.

CMS just released a new report yesterday announcing that this program, Early Retiree Reinsurance Program, ERRP, created under Obamacare, spent nearly $1.8 billion in reimbursements which have helped preserve the availability of health benefits for early retirees and reduce increases in plan participant costs. In deference to my limited time, I have a series of questions, and if you don't mind, please try to answer yes or no on these, Mr. Larsen.

Number one, does the Center for Consumer Information Insurance Oversight oversee this Early Retiree Reinsurance Program for CMS?

Mr. LARSEN. Yes.

Mr. GINGREY. And you are the deputy administrator and director of the Center for Consumer Information?

Mr. LARSEN. That is correct.

Mr. GINGREY. Was the Early Retiree Program created in PPACA, otherwise known as Obamacare, was it created?

Mr. LARSEN. It was part of the what we call the Affordable Care Act.

Mr. GINGREY. The answer is yes, thank you. Next question. The law appropriated $5 billion to pay the claims for early retirees, correct?

Mr. LARSEN. Yes.

Mr. GINGREY. That is the same amount appropriated to the high risk pools for people who cannot obtain insurance. Is that correct?

Mr. LARSEN. Yes, there is a separate appropriation——

Mr. GINGREY. It is essentially the same amount. CMS just released a report yesterday announcing that it has spent nearly $1.8 billion of the 5 billion appropriated to date, is that correct?

Mr. LARSEN. For the Early Retiree program?

Mr. GINGREY. Yes.

Mr. LARSEN. That is correct.

Mr. GINGREY. Next question. I would like you to go over some of the payments made in the $5 billion Early Retiree Program with you. My staff has presented you with a copy, and—thank you, Robert—tabbed, numbered, highlighted. Again, a simple yes or no answer, please. Did AT&T receive $140 million from this retiree fund?

Mr. LARSEN. That is my recollection from——

Mr. GINGREY. Are you aware that AT&T filed a billion-dollar loss with the SEC on March 26 of last year, and in papers accompanying the filing charged the losses stemmed from the passage of Obamacare?

Mr. LARSEN. I am not familiar with the reference.

Mr. GINGREY. Well, the answer is yes, they did.

Are you also aware that AT&T stated in its March 26 SEC filing that it would be forced to evaluate prospective changes to the active and retiree health plan benefits offered to their employees?

Mr. LARSEN. Again, what we focused on is trying to make sure that these companies that get this money continue to——

Mr. GINGREY. Mr. Larsen——

Mr. LARSEN [continuing]. Provide it to retirees.

Mr. GINGREY [continuing]. In the interest of my time, the answer to that question is yes, they did.

Did Valero Energy Corporation receive over $1 million from this retiree fund? You have got the information in front of you.

Mr. LARSEN. If you want me to flip through the list, I can. I don't have all the recipients memorized.

Mr. GINGREY. Well in the interest of time, I will answer that one for you, too. Yes, they did.

Are you aware that Valero Energy Corporation filed a 15 to $20 million loss with SEC on the same day as AT&T, once again citing Obamacare as the reason? And the answer to that, since you are a little slow on it, is yes, they did.

The whole point here of my line of questioning, Mr. Larsen, is this system, this ERRP, Early Retiree Reinsurance Program, to me is just a makeup for the money that was taken away from corporations that was given at the time of the Medicare Part D prescription plan was put in place to keep them from dropping their retiree health insurance plans. It is a kiss and make up, which is ridiculous. They should have left that program as it existed, but they had to have money to generate and a score from the CBO to pay for this whole new entitlement program. So that is the line of my questioning and the point of it.

I am over time now, so unfortunately I will have to yield back.

Mr. STEARNS. Gentleman yields back.

The gentleman from Texas, Mr. Green is recognized for 5 minutes.

Mr. GREEN. Thank you, Mr. Chairman, and I am glad my good friend from Georgia pointed out two Texas companies. Valero is headquartered in San Antonio and AT&T used to be San Antonio. Now they are Dallas, somewhere up there, but they got that assistance.

I served on this committee in 2003 when we considered the prescription drug plan, and you know, it is almost like déja vu all over again because the same issues were brought up then, that a lot of companies has retiree prescription drug plans were all of a sudden benefiting from this. So I just want to point that out, but the shoe is on a different foot this time. I appreciate you being here, Mr. Larsen. Thank you for appearing.

I am from the State of Texas, as I said, and we already have a high risk pool that has been operational since 1992 and covers

27,000 Texans. How many states currently operate their own separate pool from those established by the PPACA?

Mr. LARSEN. Right, I believe it is about 35 States.

Mr. GREEN. OK. Were these states given the option to move the individuals currently in their high risk pool program over to the new high risk pool established by PPACA?

Mr. LARSEN. Because of the different rules between the state and the federal, it runs in parallel to the state pools, but states can set up a PCIP pool.

Mr. GREEN. And if the states set up a PCIP pool, they would not have to have their own pool?

Mr. LARSEN. Well, they have their own pool which has one set of rules, and they have the federal—they have the PCIP pool that they run under a contract with HHS, and they design, subject to the standards in the ACA, the rates and the benefit design. So there are—there is a State-run pool and then a different type of insured, if you will, is eligible for this pool.

Mr. GREEN. One of the concerns I have is the slowness in the number of people who are signing up for high risk plan, and I will give you my understanding what happens in the State of Texas.

Texans are given the option to establish the high risk plan under health reform, and our governor declines, citing a financial burden on the amount of federal funds received and Texas continues to operate its own high risk program. Last year, a number of us sent a letter to Secretary Sebilius asking states who opt out of PPACA to establish high risk pools that we would have a similar to exchange in Texas. We would have an option for PPACA in Texas, and I will go into that in a few minutes on the benefit.

In 2009, before we passed the Affordable Care Act, Texas received $10.5 million to run their current high risk through grant program funding through Congress. That is nearly 6 million more than any other State to fund their program. What we found out under the state program, the average program for a Texan participating in the high risk program must be twice the average premiums for healthy individual in the market. Is that true with the other 29 States, if they have something like that?

Mr. LARSEN. Something like that. Not all of them are 200 percent or twice as much, but they are generally substantially above the market rate, and that can create affordability issues.

Mr. GREEN. And that is the problem we have. For example, the premium for a 40-year-old woman in Houston, where I represent, under the Texas high risk pool is about $750. Under the PPACA plan, that same woman would only pay $387 a month. Why would anybody sign up for a state plan when they can actually save almost 300 or $400 a month?

Mr. LARSEN. Yes, well there is one limitation that was in the ACA regarding the PCIP program, that is that you not have insurance for 6 months. So the people that are eligible for the PCIP program are people that have had nothing up until the implementation of the program.

Mr. GREEN. So if somebody was under the state plan, they would have to wait 6 months before they could apply for PCIP?

Mr. LARSEN. That is correct.

Mr. GREEN. How many states have that 6-month plan, do you know, in their current program and their separate program? Do you have to be without insurance for 6 months?

Mr. LARSEN. Well, every State that administers a PCIP pool has to abide by that same 6 months.

Mr. GREEN. But what about their separate state plan? Do they have—do states have something comparable to that——

Mr. LARSEN. Typically it is more that there are waiting periods or exclusionary periods so that you can sign up right away, but you may not have coverage. That is to avoid people circulating in and out of the pool when they are sick, so there are waiting periods for coverage for your high risk condition.

Mr. GREEN. Well, I understand, although, you know, I have folks on Social Security disability, once they receive disability they have to wait 24 months before they can get Medicare, so 6 months is a long time, but not near 24 months like we have under Medicare for disabled folks.

Under the PCIP, Texas would have benefited by about 493 million to run a high risk pool, is that true?

Mr. LARSEN. I am sorry——

Mr. GREEN. Four hundred ninety-three million under the PCIP program, Texas, would have benefited by received about 493 million to run a high risk pool from the Federal Government.

Mr. LARSEN. Well, that may be the allocation to Texas across the life of the program. I would have to go back and look at the numbers that you are referring to.

Mr. GREEN. OK.

Mr. STEARNS. Gentleman's time has expired.

Mr. GREEN. Thank you, Mr. Chairman. I was just asking some information because it is—so we can find out what we need to do to make sure our constituents get the cheapest program in the high risk pool. Thank you.

Mr. STEARNS. I advise all the members, we have a series of votes. We will reconvene right after the votes, probably between 12:00 and 12:15. Mr. Larsen, we are going to continue with another series of questions, and then we will reconvene—recess and come back.

Mr. Bilbray is recognized for 5 minutes.

Mr. BILBRAY. Thank you, Mr. Chairman. It was interesting, the reference you made right off, I think it was the second or third paragraph where you were pointing out that U.S. citizens or otherwise those who are legally residing in the United States, and I think you clarify that all U.S. citizens reside in the United States are legally present. But my question is about the verification.

First of all, let me back up. You made a reference to the fact that there were how many states that were allowing you to administer their program?

Mr. LARSEN. Twenty-three states and the District of Columbia.

Mr. BILBRAY. OK. Do you realize that about 65 percent of those states are states that have basically told us to go to hell and are engaged in the blocking, so a lot of that participation, 65 percent of the participation, looks like it does not trust in the Federal Government to administer the program, but basically a position that they don't want to participate in the program in any form?

Mr. LARSEN. Well, I can't speak to their motives for not participating, but I know that we administer in 23 States.

Mr. BILBRAY. But 65 percent sounds——

Mr. LARSEN. Yes, I don't know.

Mr. BILBRAY. OK. The verification system, you made a statement that only those legally in the country are to participate in the system. Is there a reason why we didn't use the same verification that we use for all other programs—benefit programs in this country?

Mr. LARSEN. I am not sure what your question is.

Mr. BILBRAY. My question is why aren't we using the verification systems for this benefit that we use in other benefits in the federal system?

Mr. LARSEN. I am not sure that we aren't.

Mr. BILBRAY. OK, let me double-back here. Do you require biometrics for identified foreign nationals to participate in the program?

Mr. LARSEN. I would have to get back to you on the details of the verification.

Mr. BILBRAY. OK, I would——

Mr. LARSEN. What we work through——

Mr. BILBRAY [continuing]. Question the fact that because we don't, you say no, there is no biometrics. Now, I understand that U.S. citizens or people who claim to be U.S. citizens just have to state their name, their Social Security number, and their date of birth, right?

Mr. LARSEN. I think we still verify that information.

Mr. BILBRAY. You verify them through which documents?

Mr. LARSEN. I will have to confirm with you exactly how we——

Mr. BILBRAY. OK. I am just saying that you don't use biometrics on the United States, but you do not use—are you aware you are not using biometrics for stated foreign nations to participate in this program?

Mr. LARSEN. I don't know the answer to that question.

Mr. BILBRAY. OK. Well let me just say for the record, there is no reason why anyone who says they are a foreign national of the United States that we should not have biometrics as a requirement, because every foreign national that I know of—and somebody correct me—but at least the overwhelming majority of foreign nationals in this country have biometric confirmable identification, and we are not using that technology right now. This is one of those issues of someone saying just because you say that somebody legally in the country is not participating, if you don't have appropriate verification, you can't sit here before this committee and make a statement like that with any degree of certainty. It is what you may think might happen or you hope may happen.

But I think we need to clarify, without the verification systems, we are lying to the American people. I don't care who it is, the guy at the top or the guy at the bottom, to look at the American people and say that I can assure that people illegally in this country are not participating——

Mr. LARSEN. I will be happy to follow up with you on that.

Mr. BILBRAY. OK, I appreciate that.

Mr. Chairman, I yield back.

Mr. STEARNS. OK. Will the gentleman allow me just to——

Mr. BILBRAY. To the gentleman.

Mr. STEARNS. We are going to recess, but I just have a question for Mr. Larsen. If it turns out a company gets—or a State gets a waiver from Obamacare, would you still give money to early retirees, even thought they got a waiver from all the healthcare provisions? Just yes or no.

Mr. LARSEN. Well, I don't—which waiver are——

Mr. STEARNS. Let us take——

Mr. LARSEN. There is only really one——

Mr. STEARNS. Like the State of New York got $47 million, so the question is, the State of New York is putting in for a waiver. Did they get their wavier yet, the State of New York?

Mr. LARSEN. You mean the waiver from their annual limits——

Mr. STEARNS. Yes.

Mr. LARSEN [continuing]. Requirement? I am not sure.

Mr. STEARNS. OK, but let us say hypothetically if the State of New York got the waiver, would you still go ahead and give money to early retirees who are——

Mr. LARSEN. Right, but the waiver that they get or a state can get on behalf of insurance carriers in the state is not a waiver from the provisions of the Affordable Care Act. It is a waiver from that one narrow provision——

Mr. STEARNS. OK, I understand.

Mr. LARSEN. So they wouldn't be ineligible, for example.

Mr. STEARNS. So the waiver does not apply then—extend to the requirement——

Mr. LARSEN. Yes, it is a very narrow provision.

Mr. STEARNS. Thank you for that clarification.

With that, the subcommittee will recess and come right after the votes, which hopefully is between 12:00 and 12:15.

[Recess.]

Mr. STEARNS. The subcommittee will reconvene, and if the witness will come to the table, I think our next member is Ms. Christensen. You are recognized for 5 minutes.

Mrs. CHRISTENSEN. Thank you, Mr. Chairman, and thank you, Mr. Larsen, for not only being here, but the work that you are doing to make sure that our—those who could not receive insurance otherwise are receiving it.

I just want to say for the record, though, that I really regret that we were unable to include the Territories in this, because we are U.S. citizens and there are many of our constituents in the Territories who are unable to get insurance because of preexisting disease.

Before they had even heard your testimony, the majority of this committee was already attacking the PCIP program for being too expensive, but the fact of the matter really is that it is going to run very efficiently, as I see it. In fact, it is my understanding that the administrative costs for the program are capped at 10 percent over the life of the program. Is that correct?

Mr. LARSEN. That is correct.

Mrs. CHRISTENSEN. And do you expect to stay within that cap?

Mr. LARSEN. We will stay within the cap, and we are ensuring that the states will stay within the cap as well.

Mrs. CHRISTENSEN. Thank you. There have also been some concerns that the startup costs have pushed the initial costs above projections. So can you give us some perspective on these startup costs and how they compare to startup costs for other programs, like Medicare Part D?

Mr. LARSEN. Well, first let me clarify that I am not concerned that the startup costs will push us over any projections, it is simply that they represent in the first 6 months of a program a disproportionate amount, but over the life of the program, which is the statutory standard for the 10 percent, we will be within the 10 percent.

Mrs. CHRISTENSEN. Thank you.

Mr. LARSEN. But the startup costs are things you might imagine programming, hiring people initially, getting the scripts ready for the call center, so there are a lot of one-time things that you have to put into place.

Mrs. CHRISTENSEN. Can you compare them, your setup costs with the Medicare Part D program?

Mr. LARSEN. I am probably not in a position to do that because I am not as familiar with those startup costs.

Mrs. CHRISTENSEN. And how does a 10 percent administrative cost compare with what we would see in the private insurance market?

Mr. LARSEN. Well, in fact, under the medical loss ratio standard, we provided, you know, headroom, if you will, for a 20 percent of administrative costs and 80 percent, so it is quite a bit tighter than what we are even requiring for the private insurance market.

Mrs. CHRISTENSEN. Right. So this sounds like an example of government-run healthcare working pretty well, and it is providing critical access to health insurance for people with preexisting conditions, and doing so in what I think is a lean and efficient way.

There have been certain media accounts of the program, as well as some of the comments I have heard from across the aisle that suggest that at the current rate, the PCIP plans in some states will run through their funding before the program ends in 2014. Are you concerned about that happening?

Mr. LARSEN. I am not concerned about it. We have the ability to address the specific rates that states draw down on their initial allocation. Certainly, as I think we announced, New Hampshire was a State that was running ahead of projections, but we have other states that are running behind projections, and again, we have the ability to manage the funds within the allocations and within the 5 billion, so I am not concerned about the fact that there may be one state or a small number of states that are ahead of projections.

Mrs. CHRISTENSEN. So thank you, Mr. Larsen. It sounds to me like the program enrollees and the American people will be getting a substantial bang for their buck with this program.

In your testimony, you talked about the thousands of Americans who were locked out of the accessible private insurance coverage before the Affordable Care Act, and then you talked about the difference in what they would have had to pay in the regular high risk pools versus what they pay for us. You talked about Mr. Garner, who was reported on in the New York Times and how his insurance might have cost, you know—been prohibitive, but this pro-

gram helped him. Do you have any other examples that you would like to share with us?

Mr. LARSEN. Well, I don't have a specific example. I can only tell you that for people that have conditions like diabetes, heart conditions, heart diseases, cancer of course, that if coverage is available, and in some cases, it simply isn't other than through a State-run high risk pool, they are going to pay a lot either way, and that creates significant affordability issues for individuals. So they are really in a no-win situation, and that is why this program is so important.

Mrs. CHRISTENSEN. Thank you. Mr. Chairman, I yield back the balance of my time. Thank you for your quick answers.

Mr. STEARNS. Gentlelady yields back the balance of her time.

Mr. Gardner is recognized from Colorado for 5 minutes.

Mr. GARDNER. Thank you, Mr. Chairman, and thank you, Mr. Larsen, for your time here today.

I just wanted to talk a little bit more about this issue of the Early Retiree Reinsurance Program. You previously stated your position, and I just want to double check on that. Is it really your position that these corporations that you have listed on your Web site, who have billions of dollars in profits needed to get taxpayer money in order to fund their early retiree program?

Mr. LARSEN. My position is we want to make sure that companies that are currently providing early retiree benefits continue to do so, and this program helps ensure that they do that.

Mr. GARDNER. This is all programs in the United States, or just a few that you have listed on your Web site?

Mr. LARSEN. Well, these—this program helps the sponsors who come in for reimbursement requests to be able to continue their retiree program, so this helps cover the costs that they would otherwise incur.

Mr. GARDNER. So companies like Shell Oil Company that had a contractual obligation that they would otherwise incur were given $4.4 million too?

Mr. LARSEN. Well, ultimately the money is for the benefit of the retirees.

Mr. GARDNER. But it is money that taxpayers have that we are just giving to Shell Oil Company?

Mr. LARSEN. Well, we are helping make sure that Shell Oil and other companies continue their retiree program.

Mr. GARDNER. So other companies like General Electric, the Boeing Company, AT&T, Verizon, DuPont, Mars, those kinds of companies?

Mr. LARSEN. Well, there are many other smaller companies, I think if you look through the list, there are a large number of companies that got, you know, $1 million or less in reimbursements. So it is not all just big companies, and in fact, the biggest recipients are state and local government for this program.

Mr. GARDNER. Do you think they should have had to pay for their own?

Mr. LARSEN. I think that we want to make sure that retirees of the ages between 50 to 65 before Medicare have an option for coverage, because if they don't, they are in a very hard place in the marketplace.

Mr. GARDNER. Do you think it is the government's responsibility, then, to pick up the obligations of a privately-agreed to contract?

Mr. LARSEN. Well, I don't know in which cases there are specific obligations or not, but we, in any case, want to make sure that there are funds available to make sure that these programs are continued.

Mr. GARDNER. Was that part of the discussion, though, in who got this bailout, was which companies had an obligation or a contract to do that, or did it just—the money came because they asked?

Mr. LARSEN. No, the way the program is established under the ACA is they apply as a sponsor, we review it, and once approved as a sponsor, then they submit the claims for reimbursement.

Mr. GARDNER. So you would know which of these companies were contractually obligated to make these payments anyway?

Mr. LARSEN. That is not part of the, you know, the provisions of the ACA.

Mr. GARDNER. So you just gave this money without knowing whether or not they may be under contractual obligation? So the United Auto Workers, who got $207 million, weren't contractually obligated to pay for these healthcare costs?

Mr. LARSEN. Well, it is actually—and I think we have corrected that. It is the United Auto Workers Trust Fund, so the United Auto Workers didn't get the money, the trust fund that administers the early retiree benefits gets it. But whether or not they are contractually obligated to do it, it just provides benefits to the early retirees.

Mr. GARDNER. So what standards were many of these Fortune 500 companies had in order to get this free money?

Mr. LARSEN. Well, they have to demonstrate that they have claims experienced between the threshold that is set up in the Affordable Care Act, so the ACA requires or provides that under this program, 80 percent of the costs for retirees between the $15,000 and $90,000 limit is reimbursed under the reimbursement program.

Mr. GARDNER. So pretty much anybody who applied was accepted in this program for free money?

Mr. LARSEN. Well, I wouldn't say that, although I think that the—most of the companies that applied were approved as sponsors. There were some that weren't.

Mr. GARDNER. So if—you issued the regulations for this program, correct?

Mr. LARSEN. CCIIO issued the regulations, yes.

Mr. GARDNER. Was there a need for more restrictive regulations, or——

Mr. LARSEN. Well, we issued the regulations that were called for under the language in the Affordable Care Act for the program.

Mr. GARDNER. Do you think they needed to be more restrictive?

Mr. LARSEN. I think the program is working well as it is. If Congress wanted to revisit the program, we would be happy to work with people to make sure that we continue to be able to provide ongoing retiree benefits.

Mr. GARDNER. I mean, do you think it is right, though, that the taxpayers gave free taxpayer money to GE, that is making billions

of dollars, not paying any taxes, needed another $36 million of Federal Government money?

Mr. LARSEN. Well, I think it is hard to look at this program in isolation. I mean, we have got a number of bridge programs in place. We have got the PCIP program, we have got ERRP, all of which help get us to 2014 that avoid uncompensated care, avoid the burden that some particularly sick or vulnerable populations may experience if they don't have coverage.

Mr. GARDNER. Now, you said get us to 2014, but you are ending the program soon, correct?

Mr. LARSEN. Well, not soon. It could—the money could run out in fiscal year 2012.

Mr. GARDNER. So the money is going to run out soon, and then what happens?

Mr. LARSEN. Well then that is the end of the program, unless Congress appropriates additional money to the program.

Mr. GARDNER. Is it your opinion that Congress ought to appropriate, and will you be asking for more money?

Mr. LARSEN. We would be happy to work with Congress, you know, should they choose to look at other options to extend the program.

Mr. GARDNER. But you think continuing these bailouts is the proper role for the Federal Government?

Mr. LARSEN. Well again, I think we disagree on the bailout terminology, but we think this is a good program.

Mr. GARDNER. Mr. Chairman, I yield back.

Mr. STEARNS. The gentleman's time has expired. Before I go to the next speaker, I just ask unanimous consent to put into the record the ERRP memos that are issued by CCIIO on March 2 and March 31, our staff memo of March 23, the Chief Actuary report of April 22, HHS response to the committee on high risk pools February 28, and the New York Times article on GE. No objection, it is agreed upon.

[The information appears at the conclusion of the hearing.]

Mr. STEARNS. And at this point, we recognize the gentlelady, Ms. Myrick, for 5 minutes.

Mrs. MYRICK. Thank you. I really have a lot of similar questions to what Mr. Gardner asked because of the same type of concerns that this $5 billion in money in the Early Retiree Reinsurance Program has gone to corporations and unions. Again, I just have a hard time understanding when companies like one of them that made $20 billion in profit can't afford to do their own programs. And if the healthcare plan wasn't there, that they can dump their employees on anyway if they chose to do that. I mean, all of this just doesn't make any sense to me, and so I guess how do you justify—you said and I heard you when you answered Mr. Gardner, that you say well, it is because you want them to continue to have coverage. But it just doesn't make any sense that we are using taxpayer money to fund their early retirement program so they are making huge profits. And he mentioned the United Auto Workers Trust Fund, which you clarified, but they reported assets last year of over $1 billion, and only 4.5 million liabilities, so why was it necessary to give it to them?

Mr. LARSEN. Well, and as we have, I think, discussed earlier, history shows that the number of large employers that are even offering retiree benefits, health insurance coverage for their early retirees has dropped dramatically from, I think, two-thirds to about one-third. So I don't know whether those companies were profitable or not. I am sure many of them were, and yet, many of them continued to drop their retiree coverage. So this provision of the ACA is a way to ensure, as best we can, that that rate of dropping of retiree coverage does not continue.

Mrs. MYRICK. Well again, I just go back to the fact that I am willing to bet that people in my district who—our unemployment is 11.1%, and they are having a heck of a time making it today, and they are giving their tax money to the Federal Government and now that tax money has gone to these corporations to pay for their retirement programs. I don't think they think very highly of that, and it really aggravates me, too, quite frankly.

Mr. LARSEN. Well again, as I have said earlier, the benefit of this is for the retirees themselves and to ensure that they have continued coverage. The money can only be used to reduce the costs for the retirees, like coinsurance, or the cost of the company as it relates to the provision of the retiree benefits.

Mrs. MYRICK. But there really weren't any real specific guidelines they had to follow to apply for this program? I mean, pretty much most of them—you said a few of them didn't get it but most of them——

Mr. LARSEN. Well, they had to send in a list of how many people they covered, who their retirees were, so there's documentation certainly that goes along with becoming an approved sponsor in the program.

Mrs. MYRICK. To me, again, this program proves that the notion that healthcare reform—the law is going to lower the cost is just preposterous. You take $5 billion to allocate for what I think is a dubious program, because the Administration is just anxious to give it away, and it already looks like it won't last until, you said 2012. I thought it was 2014. There are commitments made to like 5,000 entities already, $1,8 billion has been paid out, so how is that $5 billion going to be nearly enough for the corporations and the unions that you are giving it to?

Mr. LARSEN. Well, at the rate now, it is unlikely that it will last until 2014, certainly. I think we did announce yesterday that we would stop taking new applications for approved sponsors after—I think at the end of April, so we are going to stop the pipeline, if you will, of eligible companies and State and local governments that can apply.

Mrs. MYRICK. I know you have already talked and I am sorry I was unable to be here earlier. I was in another hearing about the high risk pools, but I did have a question particularly relating to North Carolina, because they have had a functional high risk insurance pool in operation prior to the passage of the health reform law, and when the new law went into effect, they were required to set up a new pool alongside the state pool they already have which is functioning. It is very confusing to consumers, but it just seems kind of odd that the federal program would essentially require the operation of these two separate pools, and why couldn't North

Carolina just have had the option to take the federal money and expand the pool that was already working, because it has been working for them?

Mr. LARSEN. Well, there is certainly no requirement that they set up a separate pool. For the states that declined to do so, HHS through our contractors operates pools in 23 states and the District of Columbia, and the statutory provisions relating to the federal PCIP are different than the terms that apply under state law for the state high risk pools.

Mrs. MYRICK. Right.

Mr. LARSEN. So for example, there is no waiting period for coverage for a high cost condition in the federal program, so it really serves as a compliment to the existing state programs. And states have been able to leverage off their state pools in terms of advertising and knowledge about this pool as another alternative for individuals to be able to go into if they have been denied coverage for preexisting conditions.

Mrs. MYRICK. I am a little confused. What I was told in North Carolina, a person must go without insurance for 6 months before he is eligible for federal coverage——

Mr. LARSEN. Correct.

Mrs. MYRICK [continuing]. But the state pool doesn't have this requirement.

Mr. LARSEN. It is a little confusing, because they sound the same but they are different requirements. For the federal pool, you are not eligible if you have had insurance for the preceding 6 months. Typically in a state pool, there isn't a requirement like that, but there are often requirements that when you come into the pool that you may have coverage for your preexisting condition excluded or there is a "waiting period" for coverage for your condition. So they each have different provisions relating to waiting periods and insurance coverage.

Mrs. MYRICK. Yes, I——

Mr. STEARNS. I think the gentlelady's time has expired.

Ms. DEGETTE. Mr. Chair, I move to strike the last word. I just have——

Mr. STEARNS. The gentlelady is recognized.

Ms. DEGETTE. Thank you. I think that my colleague from North Carolina is onto something, but—and maybe we can work to figure this out. Here is the problem. She is absolutely correct, and Mr. Chairman, you are correct and everybody is correct. These large companies and unions that have very high assets and profits are taking advantage of this program. The problem is there is no legal requirement that these companies offer insurance to their early retirees, and so what is happening is as the economy went down, people took early retirement, then the companies discontinued their health insurance. And we can't make them offer health insurance, it is a contractual obligation that they have with their employees so if they don't have that, then they can't make their—we can't make them give their early retirees health insurance. So then they won't have health insurance. But I think maybe something we can work on, especially since this program is running out of money, is maybe we can find some other way to incentivize employers giving

health insurance to their early retirees that doesn't consist of just simply subsidizing it.

Short of that, what we would have to do is we would have to pass some kind of legal requirement that they offer insurance to early retirees, and I don't think that is going to be acceptable to Republicans or most Democrats. That is—I am just brainstorming, because I think we can probably modify the program so that we wouldn't just be paying out the money, but maybe some kind of incentive. I would love to work with——

Mr. STEARNS. Well, I am very glad the gentlelady, the ranking member is also as outraged as we are that taxpayers' money is being spent on large corporations who are very profitable who——

Ms. DEGETTE. Mr. Chairman, you don't need to characterize what I just said.

Mr. STEARNS. Certainly I can characterize what you just said, so I am glad you agree with us that this is obscene. Let us see. The next—you mentioned before that companies were rejected from the ERRP program. Will you be kind enough to submit this list for us for the record?

Mr. LARSEN. For applications that weren't accepted?

Mr. STEARNS. Yes.

Mr. LARSEN. I will.

Mr. STEARNS. OK. We are going to Mr. Scalise, the gentleman from Louisiana, is recognized for 5 minutes.

Mr. SCALISE. I thank the chairman for yielding, and I thank the gentleman, Mr. Larsen, for coming before us to testify.

One of the things, as I look through this list, back during the beginning of this whole debate, I think everybody recognized there were problems with the cost of healthcare and problems that needed to be fixed, like preexisting conditions being discriminated against, that those of us that supported alternative legislation addressed directly without these taxes and mandates that are creating all of these problems. In fact, our bill was scored to lower the cost of healthcare by 10 percent. What we are seeing now, and I think one of the reasons you are seeing so many of these companies on this list come to the Federal Government saying give me taxpayer money so that I can fund early retiree programs is because what these companies are seeing is since Obamacare passed, the cost of healthcare has dramatically increased. It is something we have seen. There is a consolidation in the industry. We have already seen a number of other problems from it, but you, yourself, just testified earlier that some of these companies that got millions of dollars, tens of millions of dollars in some cases, could have just been giving early retirement to their employees that otherwise would have been still working for the company, but because of the high cost of healthcare and the things that they had to do to contract, they pushed some people into early retirement. I will ask you to clarify if I am incorrect, but you did say there is nothing you saw in the reports that you got, the requests for these companies, could they have done that? Could the companies have said because of the high cost of healthcare and these new burdens and mandates and taxes because of Obamacare, we are now going to have to squeeze some of our employees out into early retirement? And if they did that and they packaged those employees and put them into early

retirement and asked for money from you from this program, they could have gotten the money. Is that correct?

Mr. LARSEN. What I said was that we didn't evaluate as part of the process——

Mr. SCALISE. So they could have done that, is that correct? Or did you prohibit them from doing that?

Mr. LARSEN. We didn't evaluate the process by which they have an early retiree program. If they have a program——

Mr. SCALISE. So if they did what I just said, if they moved some employees that would today be working but now were pushed into early retirement because the company couldn't afford the higher cost of healthcare because of Obamacare, and then they pushed them and sought State—federal taxpayer money for the ERRP program, they could have gotten it, and some probably did. Right?

Mr. LARSEN. Well, I don't know. If it cost money to provide them health insurance and as employer it is going to cost money to provide them early retiree health insurance——

Mr. SCALISE. You didn't even ask that question when they asked for the money. If they did what I just categorized, they could have gotten the money and you would have no way of knowing that. Is that correct?

Mr. LARSEN. If I am understanding what you are saying, we didn't evaluate the process by which they ended up with——

Mr. SCALISE. That is exactly right, so basically if a company said because of the higher cost of healthcare due to Obamacare, we have got to consolidate——

Mr. LARSEN. Well, that is where we part company.

Mr. SCALISE. Well, but I mean, the marketplace has shown that healthcare has gone up, and in fact, you are seeing consolidation of health insurance providers——

Mr. LARSEN. It has been going up for decades.

Mr. SCALISE [continuing]. Who are saying it happened specifically, but the consolidation that is occurring right now they will tell you is because of Obamacare. Talk to business owners, I mean, maybe you don't ask those questions when you review these forms. I talk to businesses every day. Small businesses will tell you, medium size and even large companies will tell you that the mandates and new taxes from Obamacare is one of the things that is pushing them to have to cut costs in other ways, including pushing people into early retirement.

And so when I look at this list, first of all, the largest—unless you have got somebody higher, the largest recipient was 206 million to the United Auto Workers Trust Fund. Was there anybody that got more than that?

Mr. LARSEN. Well collectively state and local government was the largest recipient.

Mr. SCALISE. Well right, you bailed out the State of California to the tune of $57 million, you bailed out the State of New York for 47 million.

You talked earlier in your testimony that you categorized this as a successful program. I mean, the program is going bankrupt because you are giving away so much money to bail out states and unions. I mean, did you really think it was going to be hard to give that money away? I mean, how was that a successful program

when companies who were making big profits and corporations and unions and states took tens and hundreds of millions of dollars from you? How is that successful?

Mr. LARSEN. The program is not going bankrupt. Congress allocated $5 billion——

Mr. SCALISE. You said in the press yesterday that you have allocated $1.8 billion——

Mr. LARSEN. I don't think that is the word——

Mr. SCALISE [continuing]. Already and that you are going to have to close the enrollment period earlier than expected because you are going to run out of money.

Mr. LARSEN. Sure, but that is not a bankrupt program.

Mr. SCALISE. Well, it is a program that is running out of money.

Let me ask you this. Do you know how much money we spend every day that is borrowed money?

Mr. LARSEN. I don't know the answer to your question.

Mr. SCALISE. OK. Forty-two cents—from the numbers I have seen, 42 cents of every dollar that the Federal Government spends is borrowed money, and when you look at this program, I don't know if you can appreciate how offended some of us are, that you are giving away $57 million to bail out a State like California. You are giving away $206 million to bail out United Auto Workers Trust Fund. I understand you gave $5 million of taxpayers' money to BP. Is that correct?

Mr. LARSEN. You can't lose sight of the millions of——

Mr. SCALISE. Did you give $5 million to BP?

Mr. LARSEN. If it is on the list, then we did.

Mr. SCALISE. I mean, my God, you wonder why people are offended by this program when they are seeing all of this money going out the window, money that we don't have, 42 cents of every dollar, and correct me if I am wrong on that number. But this shows that the program is broken and that the law itself has created more problems. We have already seen companies are dumping prescription drug programs because of the taxes in Obamacare where you increased taxes on them, so people are dumping their prescription drug programs because of the law.

Mr. LARSEN. This program will help——

Mr. SCALISE. And so again, you have got a program here——

Mr. LARSEN [continuing]. Them continue that for retirees. That is exactly right.

Mr. SCALISE. Right, and so now we are seeing that companies are pushing more people into early retirement because of the higher costs due to Obamacare, and now you are giving them taxpayer money, 42 cents of every dollar which we don't have. Maybe you don't understand why that offends some of us, but it is very offensive.

I yield back.

Mr. STEARNS. Gentleman's time has expired.

The gentleman from Virginia, Mr. Griffith, is recognized for 5 minutes.

Mr. GRIFFITH. I might be the last, I might not. Who knows. But hopefully it is.

Let me ask you a question. You were talking earlier and you said you can't look at this in an isolated situation, that there are lots

of things going on out there. That was in response to a question related to the money given to GE. Has GE gotten more money from you all under different programs?

Mr. LARSEN. No, no. I just meant that we have a number of bridge programs to get us from kind of the broken market, the preexistent healthcare to 2014. This is one of them. PCIP is one of them until we have full reform implemented in 2014.

Mr. GRIFFITH. All right. Here is my problem with this program as I have been listening to the testimony here today. It sounds like that as long as you provided employees with—retirees with health insurance plan, you were eligible to get money. I am just wondering, you all set up the regulations for this. Why wasn't there a requirement that there at least be some indication that the company, following what you have said was the reason for it—that the company was not going to provide it? Because it sounds like to me from what I have heard that what you all have said is if they provide the benefits, they get the money, but we did it because we were afraid they were going to discontinue. So we may very well as taxpayers have given an awful lot of money to big companies like GE and AT&T and all of the other ones that have been mentioned here today who had no intentions. But like any good business, if the Federal Government is handing out candy for free, they are going to take it, and they have the people who are able to go out there and look for it, where we may have actually shortchanged—if this is what you were trying to do—some small businesses or micro-businesses even that might have been wanting to do this but had no clue there was a program like this.

I am just wondering why you didn't have regulations that it would have at the very minimum required that the company state they were going to discontinue their program if they didn't receive assistance within 90 days?

Mr. LARSEN. Yes. Well, we tracked the statutory provisions when we put the regulations together, but I am not sure we would have been able to get those representations in advance of the program.

Mr. GRIFFITH. So we were so—in such a big hurry to get Obamacare on the books, to get Obamacare into place that we didn't bother to take a look at what was going to happen to the taxpayers? Is that what I just heard you tell me?

Mr. LARSEN. We——

Mr. GRIFFITH. We had to get the program started. We couldn't take time to make sure that we weren't just giving money to giant corporations who had no intentions of discontinuing their health insurance to retirees. That is what I heard your answer say.

Mr. LARSEN. Well, we had statutory deadlines under which we wanted to get the program operational, but that is not why we didn't do as you suggested. We implemented the program as it was set out in the provisions of the Affordable Care Act.

Mr. GRIFFITH. How much notice was there—you said that most of the beneficiaries were state and local governments, and I am just wondering, did the Virginia VRS get any of this money?

Mr. LARSEN. I can—I would have to go back and look at the list. I am not sure if they did.

Mr. GRIFFITH. I am just wondering, because, based on your criteria they would have qualified.

Mr. LARSEN. I think all——

Mr. GRIFFITH. That is all right. They will get me an answer later.

Other than just looking at the bill itself—and I am glad you found yourself constrained by the bill, because we have had some other agencies in here that seem to think they can make up the rules as they go—but in that regard, you don't think you had the ability to create a regulation or rule that would say that you had to be getting ready to discontinue your benefits in order to hand out these checks?

Mr. LARSEN. I will confirm back to you, but I don't believe—and I wasn't here when we drafted those regulations—but I don't believe that we saw the statute as creating the type of program that you just described.

Mr. GRIFFITH. OK.

Mr. LARSEN. But I will—we will confirm that with you.

Mr. GRIFFITH. And you just came in in what, December or January?

Mr. LARSEN. Well, as the head of the CCIIO. I was running oversight but not ERRP.

Mr. GRIFFITH. OK. So these regulations would have been the previous initialed name, which what was that, CCIIO before they changed the name?

Mr. LARSEN. OCCIIO.

Mr. GRIFFITH. OCCIIO, and so that would have been—the regulations would have been created by that administrator at that time?

Mr. LARSEN. Well, it was the same individual. I am just saying I wasn't personally involved in the regs at that point. I am just saying I believe that we did not conclude that we could have created a—kind of a needs-based program as you just described.

Mr. GRIFFITH. That would have been the same fellow who got hired 5 weeks before the bill passed but was hired under the authority of the bill that had not yet passed, would it not? You were here for that testimony earlier. I was too, so I am correct, am I not?

Mr. LARSEN. I think I know who you are referring to. I am not sure I agree with the characterization.

Mr. GRIFFITH. I am just repeating what he said.

All right, Mr. Chairman, I yield back my time.

Mr. STEARNS. I thank you, and—my colleagues, we are going to go one more round here, so Mr. Larsen, I appreciate your patience staying until we voted.

Following up with what Mr. Griffith just said, is there any way you can confirm that all these companies that my colleagues have talked about, that when they said that they are going to drop their coverage, do you have the ability to go back and certify what they say is correct?

Mr. LARSEN. Well under the current program, they did not—they are not required to certify——

Mr. STEARNS. My question is GE comes to you and said that we cannot pay for all these employees that are doing an early retirement and we need 36 million. And you say OK, you look at it and you give them the money, but you certified that——

Mr. GRIFFITH. Mr. Chairman——

Mr. STEARNS [continuing]. All these people would lose—yes?

Mr. GRIFFITH. Mr. Chairman, if you would yield for just a second. My concern was and I think his testimony was was that they didn't even ask that question.

Mr. STEARNS. Right, so I am following up——

Mr. GRIFFITH. Oh, OK.

Mr. STEARNS. Not only did they not ask, the question is do you have anything in statute that says you should have certified this and you didn't? So my question is is there something in statute that says you have to certify that they will lose their coverage——

Mr. LARSEN. No.

Mr. STEARNS [continuing]. And did you do that?

Mr. LARSEN. There is nothing——

Mr. STEARNS. So there is nothing in statute that says you have to certify that they will indeed lose their——

Mr. LARSEN. No, the only thing—the CEO has an attestation that the information that they are providing in connection with the application——

Mr. STEARNS. So the CEO does this and that——

Mr. LARSEN. No, just to be clear, the CEO doesn't attest nor does the statute provide for a requirement——

Mr. STEARNS. Well how do you prevent somebody from telling you that these employees are going to lose it——

Mr. LARSEN. No, all they have to do is tell us that they have an early retiree program——

Mr. STEARNS. Right.

Mr. LARSEN [continuing]. And provide the documentation for the claims that satisfy the statutory threshold. They, of course, must continue the program——

Mr. STEARNS. Can an outside source or anybody that confirms in your office that what they provide in these papers is accurate?

Mr. LARSEN. Oh, yes, we audit and validate the claims data that they provide, but again, they are not representing to us nor does the statute require them to represent that if they don't get the money, they won't continue their program.

Mr. STEARNS. I mean, is it possible that a lot of companies will come in and say they need the money—after they see this list will come in and say I need the money, they will submit the papers to you, and they really have a profit that they can cover it themselves. How do you know that they can't cover it themselves is my question.

Mr. LARSEN. Well, the premise of the program is that the best way to ensure that these programs continue is to provide the assistance that is set out in the program, because again, we know that many companies have continued to drop this——

Mr. STEARNS. Let me interrupt you.

Mr. LARSEN. Probably many that were profitable——

Mr. STEARNS. Mr. Larsen, you told the press yesterday that you are closing enrollment for this program, and you just said it to Mr. Griffith and Mr. Scalise.

Mr. LARSEN. Right.

Mr. STEARNS. You reported that you have already spent $1.8 billion, is that correct?

Mr. LARSEN. Right, that is correct.

Mr. STEARNS. OK. Is that all that is accounted for today, or are there additional claims that have not yet been included in that report?

Mr. LARSEN. You mean of the 1.8 billion?

Mr. STEARNS. No, no. OK, you have already spent that.

Mr. LARSEN. Right.

Mr. STEARNS. But are there other claims out there that have not been included in this report that you are going to approve and are going to make the list longer? Yes or no.

Mr. LARSEN. Yes.

Mr. STEARNS. OK.

Mr. LARSEN. But can I—may I——

Mr. STEARNS. Has all the $5 billion of the program already been obligated?

Mr. LARSEN. No.

Mr. STEARNS. And how much is left?

Mr. LARSEN. Well, that is what I am trying to say. So we——

Mr. STEARNS. Just approximately.

Mr. LARSEN. I am going to tell you.

Mr. STEARNS. OK.

Mr. LARSEN. We have gotten 1.8 billion in paid claims——

Mr. STEARNS. Right.

Mr. LARSEN. At any given point, we can tell you what has been paid, and then there are claims being processed that we know about but haven't yet been paid. They have to be verified. The decision that we made to close—it is not to enrollees, but it is to plan sponsors. So all of the companies that have been approved as plan sponsors—and sponsors just means you are eligible to——

Mr. STEARNS. Are you going to have enough money?

Mr. LARSEN. What is that?

Mr. STEARNS. Are you going to use up all the $5 billion?

Mr. LARSEN. Oh, I think we will use up the $5 billion.

Mr. STEARNS. OK.

Mr. LARSEN. But I think that will happen——

Mr. STEARNS. How many have not been verified and are waiting?

Mr. LARSEN. It is a small number. We have——

Mr. STEARNS. One hundred, 50, 10?

Mr. LARSEN. It could be.

Mr. STEARNS. One hundred? It could be 100?

Mr. LARSEN. It is not 100. I think it is——

Mr. STEARNS. It could be 1,000?

Mr. LARSEN. I don't think it is 1,000, no.

Mr. STEARNS. How much money is left or waiting to be verified?

Mr. LARSEN. I just want to be clear, when you say waiting to be verified, do you mean claims or applicants? Applicants to me is a company.

Mr. STEARNS. Claims.

Mr. LARSEN. Oh, it is not a large amount.

Mr. STEARNS. OK.

Mr. LARSEN. I mean, we can get that to you, but it is not like there is another billion dollars in claims that are out there. We have reported what claims are out the door. There is always going to be a small amount of claims that are in progress.

Mr. STEARNS. You are really in a position of being Santa Claus, and here we are at Easter. So I think a lot of us just find this unbelievable that you can just hand out this kind of money based upon a criteria that is not clear and based upon not certifying, except through your staff, their word of mouth that they cannot pay these early retirees.

I think you said you are going to close this down, but refresh my memory. Wasn't this program supposed to go to 2014 originally? Isn't that true?

Mr. LARSEN. Yes, ideally.

Mr. STEARNS. OK. So the fact is that you have run out of money, so that is why you are forced to close it. So I mean, isn't this a bad reflection on this program that the fact is that you are running out of money that is supposed to——

Mr. LARSEN. I think it is a reflection of the success of the program, because there are a lot of companies that have——

Mr. STEARNS. Well, can I tell you an honest——

Mr. LARSEN. Yes.

Mr. STEARNS [continuing]. Secret? Everybody takes free money. If you get free money—I think you and your friends and your neighbors would take the money if it is free, so you are going to always run out of money if it is free.

With that, my time is expired. I will recognize the ranking member.

Ms. DEGETTE. Thank you, Mr. Chairman.

So the title of this hearing today is "The PPACA's High Risk Pool Regime: High Cost, Low Participation." So really, the entirety of the questions on the other side have been about the Early Retiree Reinsurance Program, so I guess we can stipulate that the PPACA's high risk pool regime is in pretty good shape.

So the first thing I want to do, Mr. Larsen, is thank you for answering all of these questions that I don't know how prepared you were to come and answer them, but I certainly had not been brief by the Majority staff that they would be focusing this hearing on this topic. So I think you have done an admirable job trying to answer these questions about this other program.

I want to try to clarify some things for some of the members who perhaps don't understand the basic facts of the Early Retiree Reinsurance Program, and maybe even for my own edification, what is the purpose of the program, briefly, Mr. Larsen?

Mr. LARSEN. The purpose is to ensure the continued availability of health benefits for early retirees that are provided by the range of applicants that we see.

Ms. DEGETTE. OK, and that is people between 50 and 65——

Mr. LARSEN. Typically, yes.

Ms. DEGETTE [continuing]. Who have retired from their jobs?

Mr. LARSEN. That is right.

Ms. DEGETTE. Many of them are employed by large corporations or—correct?

Mr. LARSEN. But many are not.

Ms. DEGETTE. Many are not. About how many individuals have enrolled in this early retiree program?

Mr. LARSEN. Well to clarify, we don't enroll individuals, per se.

Ms. DEGETTE. Right, you enroll the companies, but how——

Mr. LARSEN. There are about 5,000 plus, maybe 5,900 sponsors.

Ms. DEGETTE. And how many people—how many employees are involved in——

Mr. LARSEN. Well, I think at least four million early retirees are in programs that have benefited from ERRP.

Ms. DEGETTE. Right, so by——

Mr. LARSEN. Millions of people.

Ms. DEGETTE. The way the law was set up as this bridge program until 2014 is that the companies and the union trust funds and others could sign up for the program and then they would use that to insure the employees. So there is like four million people who might not have insurance right now who are getting insurance, right?

Mr. LARSEN. Yes.

Ms. DEGETTE. And if those four million—and as far as you know, the companies are not obligated to offer insurance to those early retirees. You don't know one way or the other, right?

Mr. LARSEN. We don't know, but I also believe that even profitable companies are known to stop providing retiree benefits, health insurance benefits to their retirees.

Ms. DEGETTE. Right. So you know, this program is modeled on the Part D Medicare drug benefit that Republicans passed last time they were in the Majority, which gave $70 billion to companies to provide drug benefits to seniors. Isn't that correct?

Mr. LARSEN. There can be parallels there, yes.

Ms. DEGETTE. OK. Now, do you know that large firms who provide workers with retiree health coverage dropped from 66 percent in 1988 to 29 percent in 2009?

Mr. LARSEN. Yes, it is a big problem.

Ms. DEGETTE. It is a big problem because it leaves people between 50 and 65 who are not eligible for Medicare yet, but many of whom have preexisting conditions or health problems going out into the individual insurance market and trying to buy policies, right?

Mr. LARSEN. That is correct.

Ms. DEGETTE. So if we hadn't have done some kind of a bridge like this, then that would have potentially left millions of Americans out there with—it would have added to the number of uninsured until 2014 when they can enroll in the exchanges and so on, right?

Mr. LARSEN. That is exactly right.

Ms. DEGETTE. Now look, I am not sure that—even though maybe this is modeled on the Part D program which just gave $70 billion to companies, maybe the way we have got it structured is not perfect. Maybe as we go forward, since it has been so popular, we should require employers to certify somehow that they are not going to be able to offer these benefits. But the bottom line is, the benefits ultimately inure to the employees, not to the employers, correct?

Mr. LARSEN. Correct.

Ms. DEGETTE. And that is four million people that might not otherwise have health insurance, correct?

Mr. LARSEN. That is right.

Ms. DEGETTE. Thank you.

Thank you, Mr. Chairman, I yield back.

Mr. STEARNS. All right, gentlelady yields back.

The gentleman from Virginia for the second round of questioning.

Mr. GRIFFITH. Thanks. Well, I thought I was going to be last, but we are going to do a couple more rounds, apparently.

I think that in response to my colleague, I think that the reason you have gotten so many questions today is that the news didn't break until yesterday about the other program, and so a lot of folks were a little bit surprised that we were giving away the free money so to speak, and that was the concern that you have heard a lot today. But I do think that there are some concerns that overlap with the program that initially this hearing was about, and that—and what I am hearing in this is that you said that the program for the retirement money, you know, it will go until the 5 billion is used up and then it is over with. But for the high risk pools, however, it looks like you all are spending money on that to a point where it may actually—that 5 billion may not be able to survive, and I look——

Mr. LARSEN. Not able to survive, meaning run out?

Mr. GRIFFITH. Run out of the 5 billion before——

Mr. LARSEN. For the PCIP program?

Mr. GRIFFITH. For the PCIP program, because you have got—I mean, I am looking——

Mr. LARSEN. We are going to work within that, but we are off to a slower start than was projected. But we believe that we are going to continually increase the rate of enrollment.

Mr. GRIFFITH. Well, let us touch on that before we get back to the money issues.

Mr. LARSEN. OK.

Mr. GRIFFITH. You are off to a slower rate than anticipated, and in fact, wasn't it anticipated that there would be about 375,000 people who would be involved in that program in 2010 alone, but there were only 12,000? So isn't it, in fact, at least for 2010 and even into early 2011, isn't it, in fact, the program has been a failure?

Mr. LARSEN. No, I wouldn't at all characterize it that way.

Mr. GRIFFITH. Well, OK, I disagree but that is OK. That is what life is about.

Now that being said, let us go back to the money issue because it appears, according to—and I am looking at some notes here that say Washington Post reported on December 27 that New Hampshire has only about 80 members but they spent double the $650,000, and then HHS agreed to give New Hampshire more money and is basically taking it out of money that they anticipated that they would be spending in later years——

Mr. LARSEN. That is right.

Mr. GRIFFITH. California has indicated that they think they will spend over the life of the program $1 billion, and Alaska, while only anticipates having 132 enrollees, anticipates spending $7 million or $56,000 per—56,000 plus per enrollee. Looking at those numbers is why it looks like to me that even with the failed numbers coming into the high risk pools, that you are not possibly going to be able to do it on $5 billion. Isn't that a fair assessment?

Mr. LARSEN. I understand your point, but I don't agree and here is why.

Mr. GRIFFITH. You don't agree, but it is a fair assessment. Reasonable people can disagree, but you would agree it is a fair assessment coming from my philosophical position, would you not?

Mr. LARSEN. I would not.

Mr. GRIFFITH. All right, well go ahead with your position.

Mr. LARSEN. So it is very early in the program, and there are certainly some states that are running ahead of their projections. Every state had to provide within their allocation projections regarding the number of members and the costs, and that was part of the contract. There are certainly some states that are running ahead of projections, meaning like New Hampshire. The people that they have are much more costly than they projected, so they are running through their money faster. There are many other states that are not running ahead of projections, so we will continue to monitor exactly how they do with monthly reports that we get from the states each month where they are in terms of their costs and their enrollment, and we will work within the $5 billion appropriation through the cycle that we have.

Mr. GRIFFITH. So then doesn't that mean that if you are one of the states that is looking at this thing that you are much better to spend your money now and get your up front money, because at some point you are going to have to marshal the funds and not give as much to the states that might come in late?

Mr. LARSEN. Well——

Mr. GRIFFITH. Isn't that what you just said?

Mr. LARSEN. States can't run ahead and spend the money. It is a function of at what rate people come in to the program.

Mr. GRIFFITH. So if New Hampshire is spending more money than they were allocated in the first year and you allow them to have more money coming in, and if a few other states start doing that, isn't it possible that if enrollees in a state that is not doing that right now come in too late in the process, there may not be money there to take care of them? Isn't that accurate?

Mr. LARSEN. Not to be argumentative, I suppose it is theoretically possible. We don't envision that happening, though.

Mr. GRIFFITH. Yes, if you envisioned that happening, you would have put more money in the program.

Mr. LARSEN. We are limited to the 5 billion.

Mr. GRIFFITH. It is not only theoretical, but based on the early data it is possible.

Mr. LARSEN. I don't think it is likely.

Mr. GRIFFITH. All right. I yield back my time.

Mr. STEARNS. Gentleman yields back. I am going to ask some more questions, and certainly give the ranking member, if she wants additional questions.

She brought up the fact that the hearing was really scheduled dealing with the high risk pools, and I think it is important also to recognize that we have been asking for all this information on the Early Retirement Reinsurance Program. We just got it, so—the breaking news on it, so we thought since you are here you could accommodate both. But I think her point is well taken that we are

also here because of the high risk pool, so I have a few questions for you before you go.

How many people are enrolled in the high risk pools today?

Mr. LARSEN. I believe that the number that we posted in March as of February 1 was 12,000 plus, and since that time there have been additional enrollments. Enrollment continues to grow at a pretty fast clip, so——

Mr. STEARNS. How many people enroll solely in the plan that is run by the Health and Human Services?

Mr. LARSEN. I think it is over 3,000 of the 12,000.

Mr. STEARNS. OK. Does HHS publicly disclose the number of individuals enrolled in each State's high risk pool? Do you publish that?

Mr. LARSEN. Yes.

Mr. STEARNS. OK, and is it easy to get access to find—go to each state and find——

Mr. LARSEN. I will confirm, but I believe that we do.

Mr. STEARNS. So I could go—I could find in the State of Florida——

Mr. LARSEN. Yes, actually, I am sorry. Of course we do, yes. We do. In the posting that we put up in November and the posting that we put up in March for February, it lists the state enrollments and then it lists the number for the federal PCIP enrollment. So you can go back and you can see what is happening in each State.

Mr. STEARNS. And towards that end, will HHS please submit a detailed breakdown of the number of individuals currently enrolled in each state pool and the federal high risk pool for the record?

Mr. LARSEN. We can, but I am pretty sure that is what posted on the Web site.

Ms. DEGETTE. If the chairman will yield, healthcare.gov—I have got the listing right here and I would ask unanimous consent to put it in the record.

Mr. STEARNS. All right, so ordered.

[The information appears at the conclusion of the hearing.]

Mr. STEARNS. Now we have been talking on this side, obviously, and you have admitted that you are going to run out of funds dealing with the Early Retirement Reinsurance Program, isn't that correct?

Mr. LARSEN. It is likely at the pace that we are going.

Mr. STEARNS. And in fact, you are going to—you indicate you are going to shut down the program?

Mr. LARSEN. No, just to be clear, we will——

Mr. STEARNS. I mean, if you run out of money you are going to shut down the program.

Mr. LARSEN. Well, if I can just clarify. We announced we would stop taking new applications for new sponsors.

Mr. STEARNS. Which is an indication you are slowing down or stopping the program.

Mr. LARSEN. But for existing sponsors we will continue to process claims until the $5 billion appropriation runs out.

Mr. STEARNS. OK. Dealing with the high risk pool program, you have about $5 billion in funding, is that correct?

Mr. LARSEN. Correct.

Mr. STEARNS. OK. To date, how much funding has been spent of this 5 billion?

Mr. LARSEN. I think that was the number that we were discussing earlier, which is the 33 million and roughly 25 million minus the startup costs, so it is in the $60 million range total.

Mr. STEARNS. It is safe to say that this program is going to run out of money before 2014?

Mr. LARSEN. I don't think so. I don't think so.

Mr. STEARNS. But you are not sure?

Mr. LARSEN. Well, I don't think we are going to run out of money.

Mr. STEARNS. We have asked you for a number of documents related to creating a waiver process, and we have had previous hearings. Your response has been very slow in this process. Will you commit to getting these documents and e-mails to us next week? Is that—Mr. Larsen, can that be possible?

Mr. LARSEN. We are committed to continuing to produce the records that you have requested. We have continued to prioritize our production in response to requests from the committee. I know we have responded to many of them but not all. I will do my best to get them to you as soon as we can. I am not sure for those particular records I can commit under oath that I will have them next week.

Mr. STEARNS. Do you know it has been over 2 months since we requested them?

Mr. LARSEN. We have had many, many requests from you and others that we are really trying to work on. We respect the committee's ability to get this information and we will continue to push to get it to you.

Mr. STEARNS. We have also asked for Medicare fraud estimates. Is that in your——

Mr. LARSEN. I will take it back to my colleagues.

Mr. STEARNS. OK, you can ask them.

OK. Let me say thank you for your attendance here, and ranking member, would you like to close with anything additional?

Ms. DEGETTE. No, just thank Mr. Larsen for coming.

Mr. STEARNS. OK. We appreciate again your forbearance here as we went through our voting process, and again, it is very helpful for us to have you here to answer our questions.

And so with that, nothing further, the subcommittee is adjourned.

Mr. LARSEN. Thank you.

[Whereupon, at 1:52 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

PREPARED STATEMENT OF HON. FRED UPTON

Thank you, Chairman Stearns, for holding this hearing on the high risk pools included in last year's health care law. We all know the administration rushed to push the bill over the finish line with a very narrow margin of support. Apparently in that haste, there was not time to conduct studies on the economics of their plan. For this program and others, the numbers just don't add up.

am troubled by how this program seems to have been vastly oversold. Shortly after passage of the health care law, the administration's own Chief Actuary for Medicare and Medicaid Services estimated that in the first year alone 375,000 indi-

viduals would enroll in this program. Today, only approximately 12,000 have enrolled.

This is a shocking difference from what was originally promised, and it raises a number of questions: Was the need for this program oversold, perhaps as a way to strong-arm moderate Democrats into voting for a trillion dollar expansion of the government? Or is the need for the program real, and it was the ability of the federal government to understand and administer such a system that was oversold?

What should concern everyone in this room is that even though only four percent of those expected to enroll in this program have actually done so, it appears that this program will still have no problem spending the entirety of its $5 billion budget between now and 2014. If we expected 375,000 enrollees and only got 12,000-shouldn't we be getting some of that money back? I am interested in hearing whether our witness can explain this today.

Thank you, Mr. Chairman. I yield back the balance of my time.

PREPARED STATEMENT OF HON. JOHN D. DINGELL

Today's hearing offers a great opportunity for this Subcommittee to learn more about how Director Larsen and the Center for Consumer Information and Insurance Oversight or CCIIO is implementing the temporary high-risk insurance pools created in the Affordable Care Act.

These high-risk insurance pools are designed to help those most in need in our society—those with cancer, diabetes or asthma—who are routinely denied insurance in the private market. For those not denied in the private market, they often find that the cost of insurance still makes health coverage out of their reach.

Starting in 2014 insurance companies will no longer be able to deny coverage to any individual with a pre-existing condition, but until then the Pre-Existing Condition Insurance Plan is serving as a temporary bridge to help those receive coverage until the Exchanges open in 2014.

CCIIO faced an enormous task in front of them in setting up the PCIP programs, and I would commend Director Larsen and CCIIO for meeting the 90-day deadline and for aggressively working with the states to assist them in setting up PCIP programs.

Enrollment in PCIP is now over 12,400 and has grown 50 percent from November 2010 to February 2011. While this is an achievement, there is much more we need to do.

I am pleased to see CCIIO conduct a unique and targeted outreach campaign to help enroll individuals most in need. The Center has reached out on the grassroots level through the American Cancer Society and the American Diabetes Society, and partnering with government agencies such as the Social Security Administration. In addition, the Center has offered webinars and has met with various stakeholders including providers, hospitals, and consumer groups, among others. These steps are necessary to target eligible individuals, and I believe these steps show CCIIO's commitment to bridging the gap for the sickest of the sick.

Now I know some of my friends on the other side of the aisle are critical of PCIP. I would remind them that the creation of high risk pools was proposed by Congressional Republicans. In fact, Members of the Energy and Commerce Committee have offered their own legislation appropriating far more money than laid out in the Affordable Care Act to implement high risk pools nationwide.

High risk pools and PCIP are designed to ensure that our constituents across the country suffering from chronic disease are not bankrupt due to their medical bills or forced to foreclose their home to pay for the medical bills that continue to stack up. This vulnerable population deserves our help.

March 31, 2011

To Whom It May Concern:

This letter is respectfully submitted to chronicle my experience with health insurance that I obtained through the Affordable Health Care Act. Since I enrolled in a health insurance plan in September 2010, I have had two arthritic hips replaced.

I was diagnosed with arthritis in one hip joint in 1997. At that time, I had health insurance provided to me through the employee benefits plan of the company where I worked. While hip replacement surgery was recommended at that time, I chose not to have the operation, as I wanted to maintain an active lifestyle. I was not ready to accept the physical constraints imposed by an artificial hip. I was optimistic that I could accommodate the discomfort and physical limitations imposed by arthritis until such time that medical technology advances would allow me to maintain an active lifestyle with mechanical hip joints. I took it for granted that I would always have the option available to me because I would always have health insurance coverage. Health insurance had always been provided to me through employee benefits packages by the companies I worked for since graduating college.

In 2006 I quit my job to start my own company, with a partner, in the manufacturing industry. I wasn't concerned about giving up health insurance, even though my hip condition had significantly deteriorated over the years. I assumed we would be providing health insurance to our employees with the profits of the new company. Eventually, I invested all of the financial resources I had into the startup company. I didn't take any salary from the company instead relying solely on income from a part-time bartending job that I had held since 1990.

Unfortunately, the projected profits of the new company never materialized, as can happen. Health insurance, for me, my partner, and my employees quickly became a luxury item. The company ultimately failed. Simultaneously, my arthritic hip had substantially deteriorated. Ironically, at a time when I had never needed it more, I found myself without health insurance coverage.

By this point in time, the pain from two arthritic hips was chronic. My bartending job is in a high volume nightclub, and therefore, requires significant mobility and the ability to stand for 10 hours shifts. While my employer did what he could to accommodate my limitations, it was obvious I would not be able to continue at this job as my condition exponentially worsened.

As I investigated obtaining health insurance in order to afford two hip replacement operations I was acutely aware of the pre-existing condition constraints that the major insurance providers used to deny or exempt coverage. Application discussions with a health insurance broker confirmed that my status precluded me from obtaining health insurance that would ultimately provide for hip replacement surgery. A friend with a pre-existing cancer condition, who was buying her own health insurance, informed me she was paying $800 per month, an amount that was unaffordable to me in my current financial situation. It was evident to me that my only hope for obtaining health insurance was to obtain a job that provided group health insurance plans as part of a benefit package, and wait out the time interval that pre-existing condition clauses would not be applicable. Given my physical condition, it was difficult to present myself as a viable candidate for anything but sedentary jobs. I was in the process of pursuing this direction when I became aware of a program under the Affordable Health Care Act for people who were denied health insurance in the existing system as a result of pre-existing conditions.

I first heard of the program in May of 2010. Since it was a new program, specific enrollment information was not yet available. I applied for enrollment in the program in July. The enrollment process was straightforward and expeditious and I was approved in early August. My health insurance is now purchased from an independent major health care provider. The monthly rates that I pay are the same rates that a person my age pays who does not have any pre-existing conditions. In other words, the financial penalty for pre-existing conditions has been removed from my premium rates allowing me to obtain affordable health care coverage. Insurance coverage became available on September 1. I had my first hip replacement surgery on September 20th, and the second operation on November 29th.

I can't overstate how the hip surgeries have changed my life, my ability to support myself, and my prospect for the future. Without this health insurance program, and the subsequent operations it enabled me to obtain, I would not have been able to maintain my job as a bartender. This is currently my sole source of income and provides me the funds I need to pay my mortgage. The sedentary jobs that I was applying for did not provide the level of income that would afford my mortgage payment. My ability to work two jobs to afford a mortgage payment was hampered by chronic arthritic pain. It was obvious that I would have soon been forced to sell my house. Now that I have my health restored, I am in a position to obtain a second job that will not only let me keep my house but will allow me to begin restoring my financial health as well.

The health insurance coverage provided for me under the Affordable Health Care Act took me from chronic pain to a pain free daily life and restored my ability to support myself. It is important for me to point out that while the story of how my life has turned around is personally gratifying to me, it does not begin to represent the desperate situation in which some families, who can not obtain health insurance as a result of pre-existing conditions, find themselves. Self employed, and small business owners, who don't have the luxury of employee benefits packages to provide health insurance, are frozen out of the current health insurance system as a result of pre-existing conditions and un-affordably high premiums. Children and elderly citizens who don't have the flexibility to make financial adjustments to survive are simply left without healthcare. They are left behind to deal with illnesses and disabilities that could be mitigated or corrected (as mine were), restoring their ability to be productive citizens.

I will reserve my thoughts on the partisan politics, (that I read about in the paper almost every day), that are inhibiting healthcare reform from coming to full fruition, as I know you don't need advice from me on how to do your job. But please recognize that the current system is obviously ineffectual in helping the people who need it the most, and you have not only the responsibility, but also the power, to make the necessary changes that will help millions of Americans lead more independent and productive lives.

Thank you for your time and consideration in this matter. If you have questions regarding this information, please contact me at your convenience.

Sincerely

John Barthell
[redacted]

March 2, 2011

REPORT ON IMPLEMENTATION AND OPERATION OF THE EARLY RETIREE REINSURANCE PROGRAM DURING CALENDAR YEAR 2010

Overview of ERRP

The Early Retiree Reinsurance Program (ERRP) was established by section 1102 of the Patient Protection and Affordable Care Act (the Affordable Care Act) enacted on March 23, 2010. Congress appropriated $5 billion for this temporary program and directed the Secretary of Health and Human Services (HHS) to set up the program within 90 days of enactment. Accordingly, HHS published an Interim Final Rule to implement the ERRP on May 5 with an effective date of June 1, 2010, and the program began accepting applications on June 29, 2010. The ERRP is scheduled to end no later than January 1, 2014 and will serve as a bridge to the new health insurance marketplace to be established through State-based Health Insurance Exchanges in 2014.

The ERRP was designed to provide financial assistance for health plan sponsors – including for-profit companies, schools and other educational institutions, unions, State and local governments, religious organizations and other non-profits – to help early retirees and their families continue to have access to quality, affordable health coverage. People in the early retiree age group (i.e., ages 55 to 65) often face difficulties obtaining insurance in the individual market because of age or chronic conditions that make coverage unaffordable and inaccessible. The ERRP provides needed financial help to group health plans that provide health coverage to retirees and their families, who depend on this coverage for their health care needs. The ERRP reimburses participating plan sponsors for a portion of the costs of providing health coverage to early retirees and their spouses, surviving spouses, and dependents.

Eligibility Requirements

Employers and unions that maintain, either directly or through an insurer, an employment-based group health plan that provides health benefits to early retirees or the spouses, surviving spouses, and dependents of early retirees may participate in the ERRP. Sponsoring employers and unions that are accepted into the program can receive reinsurance reimbursement for a portion of the medical claims for health benefits, as specified by the Secretary, for early retirees age 55 and older who are not eligible for Medicare, and their spouses, surviving spouses, and dependents.

The Affordable Care Act requires participating employment-based plans to implement programs and procedures to generate cost savings with respect to enrollees with chronic and high-cost conditions. The Interim Final Rule explained that activities designed to generate cost savings for plan participants with chronic and high-cost conditions can promote better, more cost-effective management of these conditions because plan participants may be more apt to seek out proper and timely treatment and management when such services are financially manageable.

To participate in the ERRP, employers and unions must have an approved application, be able to document claims, implement programs and procedures that have the potential to generate cost savings for plan participants with chronic and high-cost conditions, and have policies and procedures in place to detect and reduce fraud, waste, and abuse, among other requirements.

Employers that are plan sponsors are responsible for ensuring that individuals for whom claims are made under the ERRP are U.S. citizens or legally present in the U.S. For sponsors that are not employers, such as a board or committee that operates a multi-employer plan, the ERRP expects sponsors to make a reasonable, good faith effort to solicit written assurances from employers that contribute to its plan that the employer completed such tasks.

Reimbursements

Health benefits claims that qualify for reimbursement include medical, surgical, hospital, prescription drug, and other benefits, as determined by the Secretary of HHS. In general, the ERRP applies the Medicare benefit standard to determine whether a given item or service is a health benefit and thus eligible for ERRP reimbursement. The effect of this approach is to generally exclude ERRP reimbursement for services related to, for example, routine vision care, routine dental care, custodial care, abortion (except in the case of rape or incest, or where the life of the woman would be endangered), hearing aids, cosmetic surgery, infertility, and care outside the U.S.

ERRP provides reimbursement to participating sponsors of qualified plans providing health benefits to early retirees, their spouses, and surviving spouses and dependents equal to 80 percent of the actual cost of health expenses paid by or on behalf of an individual between a cost threshold ($15,000) and cost ceiling ($90,000). The cost threshold and ceiling will be adjusted in future years based on the Medical Care Component of the Consumer Price Index. Reimbursement may be used to reduce a sponsor's health benefit costs or health premium costs; plan participants' premium costs, co-payments, deductibles, co-insurance or other out-of-pocket health benefit costs; or a combination thereof. Program reimbursements may not be used for general revenue. ERRP reimburses qualified health benefit claims beginning on or after June 1, 2010 in order to provide needed funds to plan sponsors to assist with the support of their employment-based plans.

Program Results

Application Approvals

As of December 31, 2010, over 5,000 plan sponsors were approved for participation in ERRP. The number of approved sponsors varied significantly by State; in several States, more than 100 sponsors were approved. A State-by-State breakdown of approved sponsors is provided in Table 1.

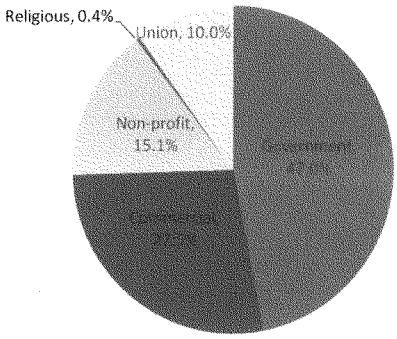
Table 1
Approved ERRP Applications (i.e. Plans) by State, as of 12/31/2010

State	Approved Applications	State	Approved Applications
Alabama	34	Nebraska	40
Alaska	8	Nevada	24
Arizona	40	New Hampshire	39
Arkansas	11	New Jersey	192
California	518	New Mexico	5
Colorado	45	New York	521
Connecticut	141	North Carolina	129
Delaware	12	North Dakota	11
District of Columbia	33	Ohio	175
Florida	205	Oklahoma	28
Georgia	74	Oregon	102
Hawaii	13	Pennsylvania	350
Idaho	57	Puerto Rico	2
Illinois	337	Rhode Island	21
Indiana	220	South Carolina	37
Iowa	127	South Dakota	17
Kansas	57	Tennessee	92
Kentucky	33	Texas	200
Louisiana	62	Utah	38
Maine	16	Vermont	11
Maryland	106	Virginia	138
Massachusetts	207	Washington	79
Michigan	229	West Virginia	21
Minnesota	226	Wisconsin	188
Mississippi	12	Wyoming	7
Missouri	138		
Montana	24	**TOTAL**	**5,452**

State and local governments represent the majority of approved ERRP sponsors, followed by commercial organizations (see Figure 1). Participating entities may include States or subdivisions (e.g., counties, cities, special districts), or organizations representing government employees (e.g., teachers, police officers). For example, the Universities of Oklahoma, Arkansas, Iowa, and Indiana are approved sponsors, among others.

Figure 1

Approved ERRP Sponsors, by Type of Organization



Note: Organization types based on sponsors' self-categorizations. For example, some Taft-Hartley Health and Welfare Funds report themselves in the "non-profit" category while others report themselves in the "commercial" or "union" category.

Program Reimbursements

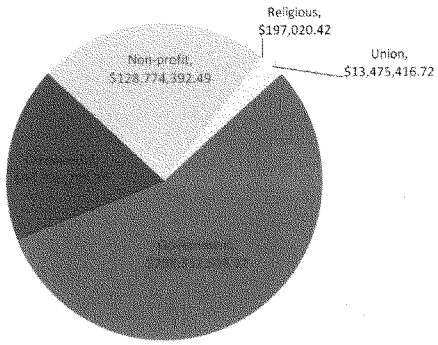
Through December 31, 2010, ERRP issued $535 million in reimbursements to 253 approved sponsor applications (i.e., plans). The largest share of these reimbursements went to State government-sponsored entities, followed by non-profit, commercial, union, and religious organizations. Payments made to individual sponsor health plans ranged from $285.13 to $108.6 million for claims in 2010. Approved sponsors sought reimbursement for the claims associated with 60,859 individuals who had total plan costs that exceeded the $15,000 ERRP threshold.

The $535 million in reimbursements provided in 2010 will directly or indirectly benefit millions of retirees, dependents and current workers. A selected sample of sponsors receiving approximately 58 percent of the funding disbursed in 2010 reported that program payments will benefit, either directly or indirectly, more than 4.5 million retirees, spouses, dependents, and active workers (See Table 5 for reporting sponsors).

Figure 2 provides the distribution of reimbursements to approved ERRP sponsors by their organizational type. This distribution includes all approved ERRP sponsors that received reimbursement during 2010.

Figure 2

Reimbursements to Approved ERRP Sponsors, by Type of Organization



Several State governments received reimbursement in 2010; reimbursement amounts for State governments varied from $718,101 to more than $57 million. A detailed breakdown of payments received by State governments is included in Table 2.

Table 2

Plan Sponsor	Reimbursement Received
California Public Employees' Retirement System	$57,834,267
Commonwealth of Kentucky	$29,666,516
Employees Retirement System of Texas	$20,982,299
Georgia Department of Community Health, State Health Benefit Plan	$34,916,832
Mississippi Department of Finance and Administration	$5,462,645
Missouri Consolidated Health Care Plan	$2,983,486
State and Education Employees Group Insurance Board	$4,988,061
State of Arizona	$2,456,920
State of Arkansas., Department of Finance and Administration	$718,101
State of Louisiana, Division of Administration, Office of Group Benefits	$6,085,967
State of Michigan	$3,948,233
State of New Jersey Treasury Department, Pension Accounting Services	$38,622,698

Reimbursement requests require plan sponsors to submit early retiree lists of plan participants whose incurred annual covered health costs exceeded the $15,000 ERRP cost threshold. During

2010, plan sponsors based their reimbursement requests on the claims of 60,859 individual plan participants, distributed among sectors as illustrated in Figure 3.

Figure 3

Early Retirees Whose Costs Exceed the Cost Threshold, by Type of Organization

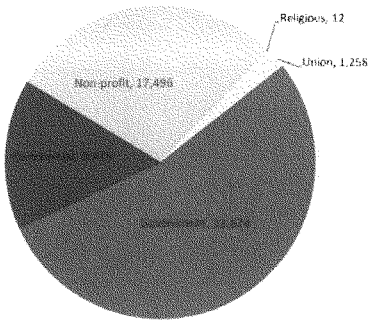


Table 3 displays reimbursement amounts, number of retirees with claims exceeding the cost threshold, and number of applications, by state.

Table 3

Data Associated with ERRP Applications that Received Payments in 2010			
State	**Paid Amount**	**Number of Retirees with Claims Exceeding Cost Threshold**	**Number of Applications**
AK	$649,290.28	39	1
AR	$911,576.47	132	2
AZ	$2,499,053.32	267	2
CA	$64,896,205.76	5,965	24
CT	$19,121,584.33	2,119	4
DC	$481,060.77	58	2
FL	$305,996.09	42	5
GA	$51,909,990.18	4,477	7
IA	$660,454.26	76	5
IL	$40,779,922.72	3,922	28
KS	$1,792,150.16	196	2
KY	$29,789,793.25	3,149	3
LA	$6,108,480.26	1,953	2
MA	$1,349,959.31	127	4
MD	$26,995.90	5	2
MI	$141,506,723.25	19,557	20
MN	$4,243,495.28	546	39
MO	$6,207,825.84	655	10
MS	$5,512,810.27	528	2
NC	$2,591,408.29	270	4
NE	$227,863.83	16	2
NJ	$45,824,556.80	4,710	12
NM	$186,501.24	40	1
NY	$4,800,391.41	521	15
OH	$6,908,351.28	750	5
OK	$5,057,540.92	508	5
OR	$549,479.73	63	3
PA	$10,125,638.11	929	5
TN	$1,766,299.56	192	10
TX	$74,413,108.77	8,690	15
VA	$3,044,309.33	274	3
WA	$238,141.06	16	3
WI	$589,232.69	51	5
WV	$299,945.67	16	1
Total	**$535,376,136.39**	**60,859**	**253**

Plans that received ERRP reimbursements during 2010 indicated to HHS that they would use the funds as follows:

- 20% of plans will use reimbursements to reduce the sponsor's health benefit costs or the sponsor's health benefit premium costs;
- 20% of plans will use reimbursements to reduce, or offset increases to, individual plan participants' premium costs, co-payments, deductibles, co-insurance or other out-of-pocket health benefit costs; and
- 60% of plans will use reimbursements for a combination of reducing sponsor and plan participants' costs.

Thus, 80% of plans who received reimbursement in 2010 – 205 plans that claimed 59,346 individuals for reimbursement – used or will use some or all of the ERRP funding received to reduce or offset increases to the amounts that enrollees pay for health care or coverage. These sponsors collectively account for nearly $521 million in program reimbursement, or 97 percent of the program reimbursement in 2010 (see Figure 4).

Figure 4

Indicated Use of ERRP Reimbursements by Approved Sponsors

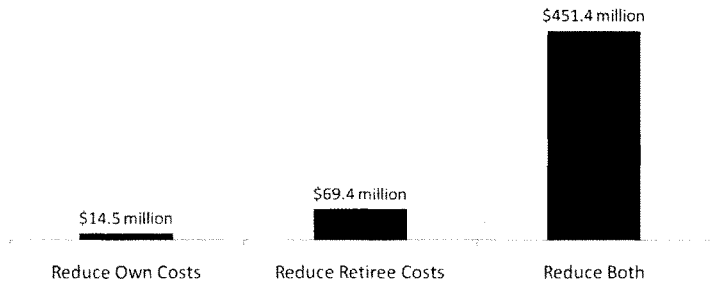


Table 4 summarizes, by state, the data associated with plan sponsors that indicated that they would use some or all of the reimbursements received under the ERRP to reduce retiree costs.

Table 4

Data Associated with Applications Using Funds to Reduce Retiree Costs or Both the Sponsor and Retiree Costs			
State	Paid Amount	Number of Retirees	Number of Applications
AZ	$2,499,053.32	267	2
CA	$64,582,615.58	5,934	23
CT	$19,121,584.33	2,119	4
DC	$481,060.77	58	2
FL	$305,996.09	42	5
GA	$51,909,990.18	4,477	7
IA	$600,636.93	61	3
IL	$39,784,357.42	3,817	17
KS	$1,750,446.49	193	1
KY	$29,789,793.25	3,149	3
LA	$6,085,966.54	1,951	1
MA	$1,325,298.09	124	3
MD	$26,995.90	5	2
MI	$139,299,826.21	19,279	16
MN	$2,370,463.59	311	31
MO	$6,161,108.40	651	9
MS	$5,512,810.27	528	2
NC	$2,591,408.29	270	4
NE	$227,863.83	16	2
NJ	$45,757,440.48	4,698	11
NM	$186,501.24	40	1
NY	$1,753,195.84	219	10
OH	$6,238,739.04	711	4
OK	$5,057,540.92	508	5
OR	$549,479.73	63	3
PA	$10,125,638.11	929	5
TN	$1,634,300.91	186	9
TX	$74,209,412.58	8,674	12
VA	$116,667.07	7	1
WA	$15,884.68	2	2
WI	$552,474.64	41	4
WV	$299,945.67	16	1
Total	**$520,924,496.39**	**59,346**	**205**

Some sponsors have already applied ERRP funds to reduce costs for plan participants. For example, CalPERS, the California Public Employees' Retirement System, requested reimbursement on behalf of 5,302 early retirees, spouses, surviving spouses, and dependents in 2010. In anticipation of ERRP reimbursement CalPERS worked with its benefits carriers to mitigate 2011 premium increases by three percent – a savings of up to $200 million. According to CalPERS officials, the ERRP funding will directly benefit 1.1 million public employees, retirees, and their dependents (including 115,000 ERRP eligible early retirees), many of whom have been subject to declining wages due to state furloughs imposed to address budget shortfalls.

The sponsors that received some of the largest reimbursement amounts in 2010 report that program payments will benefit, either directly or indirectly, more than 4.5 million retirees, spouses and surviving spouses, dependents, and other plan participants. An illustration of the direct and indirect effects of ERRP funds on plan participants is in Table 5.

Table 5
Detailed Breakdown of Plan Participants for Selected Sponsors*

Plan Sponsor	Early Retirees with Claims above Cost Threshold	Total Plan Participants (incl. Active Workers)
United Auto Workers Retiree Benefits Trust	11,679	852,900**
CalPERS	5,302	1,100,000
State of New Jersey Treasury Department	4,040	829,000
Commonwealth of Kentucky	3,136	290,000
Georgia Department of Community Health	2,832	696,000
Employees Retirement System of Texas	2,772	525,000
State of Louisiana	1,951	224,000
Alcatel-Lucent USA Inc.	1,141	125,000**

*Note: Data points approximate.
** Plan enrollment does not include active workers

Sponsors' Programs to Address Chronic and High Cost Conditions

The ERRP regulation requires ERRP plan sponsors to have programs and procedures in place to generate cost-savings, or that have the potential to generate cost savings, with respect to plan participants with chronic and high cost conditions. The ERRP application requires sponsors to describe their programs and procedures. Examples of specific programs for approved program participants include the following:

- A major computer systems manufacturer applies prescription drug utilization management to encourage participants to utilize cost-effective drugs, and works with prescribing physicians to facilitate changes in therapy and utilization.

- A national technology company offers customized telephone counseling from a clinician, as well as education, and tools that enable plan participants to manage their conditions more effectively.

- Both a teachers' retirement plan and a major telecommunications corporation, among other sponsors, manage costs through separate Disease Management Programs to control costs for conditions such as coronary artery disease, chronic obstructive pulmonary disease, diabetes, asthma, and osteoarthritis.

- A city government provides case management services to facilitate coordination of complex care needs and services, maximize plan participants' effective use of the services available under the health benefit plan, and increase plan participants' knowledge about plan resources and tools for health care decision-making.

- A teachers' retirement plan seeks to manage costs following hospitalizations through post-discharge planning. Specifically, a nurse reviewer works with the hospital or other in-patient facility to develop a transition plan from one level of care to the next and to ensure patients' post-discharge needs are met.

Program Administration

The Centers for Medicare & Medicaid Services (CMS) utilizes contractors to manage the ERRP information technology (IT) and program operations. The ERRP IT/Operations contractor established the ERRP public website (http://www.errp.gov) in June 2010 to communicate with program stakeholders. To date, the website has been visited more than 160,000 times. The contractor also implemented and maintains secure systems and software to make reimbursements to sponsors, store data, and report program data. Additionally, the contractor supports CMS in delivering valuable and timely education, training, and outreach materials to sponsors. For example, CMS is about to publish educational materials to assist sponsors with the submission of more detailed claims data with each reimbursement request.

The ERRP Contact Center contractor responds to telephone and email inquiries, refers technical issues to the IT/Operations contractor, and conducts special outreach projects as needed. By the end of 2010 the ERRP Call Center had received nearly 10,000 phone calls and over 3,000 emails. Special outreach projects may be necessary from time to time to increase the sponsors' understanding of and compliance with program rules and operations. The contractor also participates in testing systems developed by the IT/Operations Contractor.

With the assistance of the contractors, the ERRP launched the secure website on August 30, 2010. Claims reimbursement began in October 2010.

March 2, 2011

Conclusion

Program experience in 2010 indicates that ERRP is already having a meaningful impact on employers, as well as for millions of early retirees and their families. There is substantial participation from all major sectors of the economy, with additional sponsors applying to participate every day. Early data indicate that the majority of ERRP plan sponsors are using some or all funds received to reduce health care costs for plan participants. The program also has indirect benefits, such as ensuring the availability of programs to manage high-cost and chronic conditions. In sum, early program data indicate that ERRP is realizing the purpose envisioned by Congress: preserving access to affordable health coverage for millions of early retirees, active workers, and their families

Progress Report on the Early Retiree Reinsurance Program

March 31, 2011

The Early Retiree Reinsurance Program (ERRP) was established by section 1102 of the Affordable Care Act enacted on March 23, 2010. Congress appropriated $5 billion for this temporary program and directed the Secretary of Health and Human Services (HHS) to set up the program within 90 days of enactment. By law, the ERRP is scheduled to end no later than January 1, 2014.

People in the early retiree age group (i.e., ages 55 to 64) often face difficulties obtaining insurance in the individual market because of age or chronic conditions that make coverage unaffordable or inaccessible. The availability of group health insurance coverage for America's retirees age 55 to 64 has declined significantly over the past 20 years, as the percentage of large firms providing workers with retirement health coverage has dropped from 66 percent to 28 percent.[1] The ERRP was designed to stabilize this market by providing financial assistance to health plan sponsors that make coverage available to millions of early retirees and their families – including for-profit companies, schools and educational institutions, unions, State and local governments, religious organizations and other non-profit plan sponsors. The ERRP assists both early retirees, and any active workers covered under the same plan, by reimbursing participating plan sponsors that offer such benefits for a portion of the costs of providing health coverage to retirees age 55 to 64 and their families. ERRP subsidizes 80 percent of the actual cost of certain health expenses paid by the plan or by an early retiree or his/her enrolled spouse, surviving spouse, or dependent between a cost threshold ($15,000) and cost limit ($90,000). Costs reimbursed by ERRP include medical, surgical, hospital, behavioral health, prescription drug, and other benefits similar to those covered by Medicare.

ERRP payments cannot be used as general revenue by the group health plan that provides early retiree benefits, or the employer or union that sponsors it. ERRP payments must be used to reduce or offset increases in plan participants' costs, to offset increases in employers' costs to provide coverage, or both. Program payments are thus targeted to encourage plans to continue providing coverage to early retirees and their families, and all ERRP payments to date are being used to make coverage more affordable. Data recently collected by the Centers for Medicare & Medicaid Services (CMS) indicate that 80 percent of plans that received funding in 2010 used or will use some or all of the ERRP funding received to reduce or offset increases to the amounts that enrollees pay for health care or coverage.

To participate in the ERRP, employers must have an approved application, be able to document claims, have programs and procedures that have the potential to generate cost savings for plan participants with chronic and high-cost health conditions, and have policies and procedures in place to detect and reduce fraud, waste, and abuse, among other requirements.

The ERRP launched a secure website for plan sponsors in August 2010 and began disbursing payments to approved plan sponsors in October 2010, for claims incurred on or after June 1, 2010.

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[1] Kaiser Family Foundation and Health Research and Educational Trust. (2010). Employer Health Benefits, 2010 Annual Survey. Washington, DC.

Program Participation and Results

As of March 17, 2011 approximately 5,850 applications, submitted by nearly 5,400 plan sponsors, have been approved for the program. These applications represent a variety of for-profit companies, schools and other educational institutions, unions, State and local governments, religious organizations, and other non-profits.

As of March 17, 2011, program reimbursements provided to over 1,300 participating state and local governments, commercial and nonprofit entities, union plans and religious organizations total nearly $1.8 billion. ERRP funds disbursed so far have been used to reimburse expenses of covering over 100,000 individuals who have each incurred health plan costs that exceed the program's $15,000 threshold. These reimbursements also benefit millions of retirees, their families, and even active workers covered under the same plan as retirees, by helping to preserve the availability of health benefits, and by reducing the out of pocket costs that most participating plans indicate would otherwise be charged to enrollees for coverage. Today's report demonstrates both the popularity and success of the program and also builds on previously collected data, which revealed that 97% of the funds disbursed in 2010 were used in whole or part to help reduce health insurance costs for retirees and their families – putting dollars back into consumers' hands. The sponsors that received some of the largest reimbursement amounts in 2010 report that program payments will benefit, either directly or indirectly, more than 4.5 million retirees, spouses and surviving spouses, dependents, and other plan participants.

Some sponsors have already applied ERRP funds to reduce costs for plan participants. For example, CalPERS, the California Public Employees' Retirement System, requested reimbursement for claims incurred by 5,302 early retirees, spouses, surviving spouses, and dependents in 2010. In anticipation of ERRP reimbursement CalPERS worked with its benefits carriers to mitigate 2011 premium increases by three percent – a savings of up to $200 million. According to CalPERS officials, the ERRP funding will directly benefit 1.1 million public employees, retirees, and their dependents including 115,000 ERRP eligible early retirees, many of whom have been subject to declining wages due to state furloughs imposed to address budget shortfalls.

The ERRP continues to support a variety employer retirement health plans, of diverse sizes and from all sectors of the economy. While some large plans received significant amounts from the program, most of the individual ERRP reimbursement payments made in 2010 were for less than a $1 million, and 43 percent of individual payments made to employment based early retirement health plans were for less than $100,000. As more data on implementation become available, CMS looks forward to working with Congress to address emerging issues.

Appendix A: ERRP Payments by Location Designated on Application, through March 17, 2011

State	Total Payment
AK	$918,471
AL	$13,604,184
AR	$1,426,430
AZ	$5,265,382
CA	$111,721,133
CO	$9,833,194
CT	$51,947,446
DC	$25,949,770
DE	$14,584,557
FL	$15,051,611
GA	$89,357,479
HI	$24,322
IA	$6,915,670
ID	$1,418,620
IL	$102,556,381
IN	$4,815,420
KS	$4,131,632
KY	$30,405,588
LA	$14,908,672
MA	$27,245,432
MD	$9,180,840
ME	$171,061
MI	$319,806,424
MN	$15,611,844

MO	$19,498,627
MS	$5,746,849
MT	$2,183,704
NC	$17,974,951
ND	$800,829
NE	$6,722,466
NH	$2,631,852
NJ	$158,830,329
NM	$8,673,390
NV	$1,512,517
NY	$104,402,728
OH	$123,187,291
OK	$6,504,883
OR	$12,953,600
PA	$53,809,213
RI	$1,611,322
SC	$27,863,706
SD	$158,710
TN	$14,804,452
TX	$276,245,149
UT	$6,690,678
VA	$27,064,448
VT	$692,050
WA	$7,314,717
WI	$19,463,102
WV	$4,949,745
WY	$306,740

Appendix B: ERRP Payments to Approved Sponsors through March 17, 2011*

Plan Sponsor	Reimbursement
Abbott Laboratories	$2,824,238
Administrative Office of the PA Courts	$337,452
Advantage Health Plans Trust	$35,013
Aerospace Contractors' Trust	$8,936
Aetna, Inc.	$925,746
Air Conditioning & Refrigeration Industry Trust	$29,339
Air Products and Chemicals, Inc.	$695,272
Alaska Electrical Health and Welfare Fund	$649,290
Alaska Teamster-Employer Welfare Trust	$130,024
Albany International Corporation	$64,114
Albemarle Corporation	$133,433
Alcan Corporation	$40,504
Alcatel-Lucent USA, Inc.	$12,512,340
Alcoa, Inc.	$5,966,491
ALCON Laboratories, Inc.	$652,141
Alenco, Inc.	$73,852
Alex Lee, Inc.	$133,363
Alhambra Unified School District	$313,590
Allegheny College	$60,000
Allegheny County Schools Health Insurance Consortium	$936,491
Allegro MicroSystems, Inc.	$7,374
Allete, Inc.	$588,739

Alliant Techsystems, Inc.	$387,192
Allstate Insurance Company	$505,160
Alon USA Energy, Inc.	$45,642
Alon USA, LP	$6,698
Altria Client Services, Inc.	$7,060,277
American Airlines, Inc.	$8,773,569
American Automobile Association, Inc.	$2,096
American Axle and Manufacturing, Inc.	$1,916,847
American Crystal Sugar Company	$39,355
American Electric Power Service Corporation	$2,663,473
American Fed. of State, County and Municipal Employees Council # 31	$37,152
American Federation of State, County and Municipal Employees	$21,108
American International Group, Inc.	$214,164
American Postal Workers Union Health Plan	$57,465
Ameriprise Financial, Inc.	$130,550
Ameritas Holding Company	$83,509
Amica Mutual Insurance Company	$582,924
Amsted Industries Incorporated	$191,163
Anadarko Petroleum Corporation	$859,792
Andersen Corporation	$1,280,062
Annandale Public School	$50,956
Appleton Papers, Inc.	$78,684
Arcelormittal USA	$2,298,399
Arch Chemicals, Inc.	$178,985
Arch Coal, Inc.	$216,740

Archer Daniels Midland Company	$273,805
ARINC Incorporated	$18,544
Arkansas Blue Cross Blue Shield	$64,387
Arkansas Municipal League	$175,419
Arkansas State Police	$246,185
Armstrong World Industries, Inc.	$1,378,167
Aromas-San Juan Unified School District	$105,972
ArvinMeritor, Inc.	$980,926
Asbestos Workers Local # 42	$8,625
Asbestos Workers Local 24	$1,586
Asbestos Workers Local 34	$43,183
Asbestos Workers Philadelphia	$23,053
Assa Abloy, Inc.	$54,687
Assistant Superintendant	$352,032
Association of Orange County Deputy Sheriffs	$57,063
Astrazeneca Pharmaceuticals, LP	$339,453
AT&T, Inc.	$140,022,949
Athens Regional Health Services, Inc.	$227,470
Atmos Energy Corporation	$431,825
Attica Central School	$8,789
Auburn Enlarged City School District	$220,213
Automatic Data Processing, Inc.	$36,409
Avista Corporation	$432,325
Avon Products, Inc.	$606,820
Babcock & Wilcox Technical Services Y-12, LLC	$961,528

Bakery & Confectionery Union & Industry International Health Benefits Fund	$208,372
Baldwin Park Unified School District	$11,578
Ball Corporation	$404,153
Baltimore County, MD	$1,757,863
Bank of America Corporation	$2,324,163
Barnes Group, Inc.	$35,691
Barry-Wehmiller Companies, Inc.	$167,799
Bartholomew Consolidated School Corporation	$42,105
Basell North America, Inc.	$176,839
Basin Resources, Inc.	$12,440
Bath Central School	$17,080
Battelle Energy Alliance, LLC	$561,234
Baugo Community Schools	$96,492
Baxter International, Inc.	$1,489,027
Bay County	$48,551
Bay County Medical Care Facility	$50,057
Belk Stores Services, Inc.	$82,654
Berkshire Health Group	$123,916
Blue Cross & Blue Shield of MA, Inc.	$163,378
Blue Cross & Blue Shield of Mississippi	$64,969
Blue Cross & Blue Shield of Rhode Island	$19,482
Blue Cross and Blue Shield of Alabama	$399,442
Blue Cross and Blue Shield of Arizona, Inc.	$108,009
Blue Cross and Blue Shield of Kansas City	$197,558
Blue Cross and Blue Shield of Kansas, Inc.	$382,100

Blue Cross and Blue Shield of MN , Inc.	$301,201
Blue Cross Blue Shield of Michigan	$1,816,509
Blue Cross Blue Shield of Nebraska	$19,692
Blue Cross of Idaho Health Service, Inc.	$50,569
BNI Coal, Ltd.	$11,072
Board Of Education City School City Of Rochester	$1,415,033
Board of Education Geneva City School District	$40,823
Board of Police Commissioners	$184,463
Board of School Directors - Milwaukee Public Schools	$1,016,318
Board of Trustees - Pipe Industry Health and Welfare Fund of Colorado	$136,099
Board of Trustees IBEW Local # 640 Arizona Chapter	
NECA Health & Welfare Fund	$3,821
Board of Trustees New Jersey Building Laborers Statewide Welfare Fund	$536,639
Board of Trustees of Local # 295/851 Employer Group Welfare Fund	$431,490
Board Of Trustees Of Plumbers Local # 75 Health Fund	$66,499
Board of Trustees of the Employers and	
Operating Engineers Local # 520 Health and Welfare Fund	$27,753
Board of Water Commissioners	$443,727
Boddie-Noell Enterprises, Inc.	$51,884
Boilermakers National Health and Welfare Fund	$1,750,446
Boise Cascade, LLC	$56,125
Boise Paper Holdings, LLC	$850
BorgWarner, Inc.	$370,958
Borough of South Plainfield	$30,320
Boston Scientific Corporation	$241,715

BOT of Local Unions # 19 & # 127	$17,212
BOT of the Wisconsin Pipe Trades	$22,050
Boy Scouts of America	$481,838
BP Corporation North America, Inc.	$5,316,605
Bradford Central School District	$7,582
Brevard County Board of County Commissioners	$141,370
Brevard County Public Schools	$208,415
Bricklayers & Allied Craftworkers International Health Fund	$60,000
Bricklayers & Allied Craftworkers Staff Health Plan	$61,155
Bristol-Myers Squibb Company	$1,069,198
Brittany Dyeing & Printing Corporation	$22,190
Broadalbin Perth Central School District	$14,811
Brown-Forman Corporation	$75,298
Building Services 32BJ Health Fund	$430,913
Burlington Community School District	$5,067
Butler Memorial	$52,096
Byron-Bergen Central School District	$1,212
C&O Employees Hospital Association	$352,893
Caddo Parish School Board	$1,195,468
Cahill Gordon & Reindel, LLP	$64,573
CAHP Health Benefits Trust	$944,283
California Correctional Peace Officers Association Benefit Trust	$1,053,618
California Physicians' Service	$48,107
California Public Employees' Retirement System (CalPERS)	$57,834,267
California's Valued Trust	$3,481,114

Calumet County	$1,956
Calvert County Government	$8,933
Campbell Soup Company	$369,094
Canandaigua City School District	$14,859
CareFirst, Inc .	$202,905
Cargill, Inc.	$449,719
Carmel Clay Schools	$114,963
Carmeuse Lime, Inc.	$156,207
Carpenters & Joiners Welfare Fund	$550,474
Carpenters' District Council of Kansas City and Vicinity	$385,538
Carpenters Health & Security Trust of Western Washington	$438,705
Carpenters of Philadelphia & Vicinity Health & Welfare Fund	$1,409,935
Carthage R-9 School District	$2,212
Case New Holland, Inc.	$3,607,602
Cattaraugus/Allegany Board of Cooperative Educational Services	$191,851
Cayuga-Onondaga Area School	$76,771
CB&I	$414,040
CBS Corporation	$722,388
Cecil County Public Schools	$37,612
Central Pennsylvania Teamsters Health and Welfare	$932,463
Central School District 1, Towns of Wolcott, Butler, Huron, Rose, Sodus	$31,201
Central Southern Tier Health Care Plan Trust	$924,722
Central Steel and Wire Company	$270,341
Central Texas Health and Benefit Trust Fund	$958
Central Vermont Public Service Corporation	$77,592

Century Aluminum Company	$458,389
CH2M-WG Idaho, LLC	$320,483
Charlotte County Board of Commissioners	$20,309
Charter County of Wayne, MI	$717,946
Charter Township of Bloomfield	$56,053
Charter Township of Canton	$112,964
Charter Township of Clinton	$144,518
Charter Township of Redford	$59,060
Charter Township of Shelby	$49,431
Charter Township of Waterford	$69,957
Chas Levy Company & Subs	$13,647
Chauttauqua County School Districts' Medical Health	$434,485
Chesapeake Public Schools	$550,427
Chesterfield County Administrator	$339,775
Chesterfield County School Board	$593,852
Chicago District Council of Carpenters Welfare Fund	$1,611,367
Chicago Tile Institute Welfare Fund	$6,450
Chicago Transit Authority-Retiree Healthcare-Trust	$1,566,246
Chrysler Group, LLC	$3,264,964
Chubb & Son, a division of Federal Insurance Company	$374,656
Church Pension Group Services Corporation ("CPGSC")	$247,019
Cincinnati Bell, Inc.	$1,111,203
CITGO Petroleum Corporation	$1,225,331
Citigroup, Inc.	$1,767,406
City & County of San Francisco	$3,692,576

City County Insurance Services	$359,301
City of Amarillo, TX	$309,119
City of Anaheim	$160,055
City of Ann Arbor	$735,818
City of Attleboro	$254,259
City of Aurora	$179,236
City of Austin	$1,754,095
City of Battle Creek	$34,298
City of Berkley	$25,884
City of Beverly	$233,943
City of Billings	$350,084
City of Bloomfield Hills	$719
City of Bloomington, IN	$39,469
City of Bloomington, MN	$26,175
City of Blue Island	$28,738
City of Boca Raton	$160,559
City of Boston	$2,296,983
City of Bridgeport, CT	$487,418
City of Bristol	$153,616
City of Brownsville	$68,629
City of Cedar Hill	$5,631
City of Charlotte	$275,212
City of Clearwater	$115,507
City of Colorado Springs	$205,772
City of Dallas	$648,937

City of Dearborn	$255,225
City of Dearborn Heights	$49,033
City of DePere	$82,607
City of Des Moines	$182,791
City of Detroit Lakes	$267
City of Ecorse	$3,843
City of Eden	$27,880
City of Etowah Utilities Department	$60,000
City of Eugene	$175,660
City of Everett	$14,199
City of Fall River	$56,951
City of Farmington Hills	$35,669
City of Flint	$532,487
City of Fort Wayne	$242,893
City of Garden City	$20,499
City of Gardner	$132,290
City of Garland, TX	$174,849
City of Geneva	$35,107
City of Glendale Finance Division	$179,295
City of Graham	$38,418
City of Grants Pass	$1,357
City of Grapevine	$60,143
City of Green Bay	$237,419
City of Greenville, TX	$33,241
City of Grosse Pointe	$17,311

City of Grosse Pointe Farms	$34,233
City of Grosse Pointe Woods	$17,718
City of Haverhill	$131,320
City of Hazel Park	$26,254
City of Hialeah	$169,540
City of High Point, NC	$60,000
City of Hollywood, FL	$598,349
City of Irving, TX	$236,402
City of Jacksonville FL	$1,437,828
City of Jamestown	$84,218
City of Kansas City, MO	$508,686
City of Keene	$109,675
City of Largo	$3,585
City of Lawrence	$12,693
City of Leominster	$26,373
City of Lewisville Health Benefit Trust	$82,704
City of Lincoln	$54,913
City of Lincoln Park	$262,028
City of Longmont	$19,872
City of Madison Heights	$50,863
City of Mankato	$135,520
City of Maple Grove	$6,150
City of Marysville	$92,944
City of Meriden	$162,765
City of Mesquite	$251,770

City of Miami	$631,655
City of Middletown and Middletown Board of Education	$94,812
City of Midland	$113,488
City of Midland, MI	$188,313
City of Minot	$27,451
City of Morgan City	$31,325
City of Morganton	$43,350
City of Mound	$20,245
City of Naples	$5,807
City of New York	$1,507,024
City of North Kansas City	$9,465
City of North Richland Hills, TX	$44,995
City of Northampton	$64,313
City of Norwalk	$230,956
City of Oak Park	$74,706
City of Omaha	$1,219,402
City of Peabody	$154,660
City of Pembroke Pines	$196,951
City of Phoenix	$619,418
City of Pittsburgh	$1,660,337
City of Port Huron	$91,044
City of Revere	$157,249
City Of River Rouge	$44,844
City of Roanoke	$107,067
City of Rochester	$9,389

City of Royal Oak	$78,981
City of Saginaw	$709,502
City of Saint Paul	$346,694
City of Salisbury, MD	$28,256
City of San Marcos	$22,307
City of Scottsdale	$108,258
City of Seattle Police Relief and Pension Fund	$484,913
City of Sparks	$94,877
City of Springfield, MO	$206,375
City of St. Louis Park	$114,158
City of St. Petersburg	$217,575
City of Sterling Heights	$113,916
City of Syracuse, NY	$651,955
City of Tell City	$12,707
City of Troy	$129,364
City of Warren	$598,133
City of Waterbury	$1,575,022
City of Watertown	$44,055
City of Wauwatosa	$36,758
City of Wayne	$38,360
City of West Allis	$149,512
City of West Haven	$161,695
City of Westfield	$144,127
City of Winter Haven, FL	$117,457
City of Wisconsin Rapids	$172,708

City School District of Batavia, NY	$30,788
Clark County Firefighters Local 1908 Security Fund	$187,985
Claxton-Hepburn Medical Center	$12,507
Cleveland Clinic Foundation	$217,515
Cleveland UtilitiesDepartment of City of Cleveland	$3,253
CMTA-IAM Joint Retiree Health and Welfare Trust	$32,830
Cobb Energy Management Corporation	$40,904
Coca-Cola Enterprises, Inc.	$639,854
Colonial Williamsburg Foundation	$86,306
Colorado Permanente Medical Group, P.C.	$28,515
Columbia Falls School District 6	$1,286
Commonwealth of Kentucky	$29,666,516
Commonwealth of Massachusetts - Main Account	$5,816,783
Commonwealth of Pennsylvania	$24,522,631
Commonwealth of Virginia	$7,111,557
Communications Workers of America	$182,051
Community Hospital of the Monterey Peninsula	$463,760
Concordia Plans of The Lutheran Church Missouri-SY	$711,938
Connecticut Carpenters Health Fund	$19,661
Connecticut Ironworkers Local 15 & 424 Extended Benefit Fund	$40,362
Connecticut Laborers' Health Fund	$41,934
Conservation Employees' Benefit Plan Trust Fund	$65,977
Consolidated Communications Holdings, Inc.	$290,980
Consolidated Edison Company of New York, Inc.	$3,916,585
Construction and General Laborers' District Council of Chicago	$939,469

Construction Industry and Laborers Health and Welfare Plan	$345,394
Consumers Energy Company	$1,478,162
Continental Casualty Company	$768,394
Con-way, Inc.	$418,429
Cooper Tire & Rubber Company	$200,611
Cooperating Railway Labor Organizations	$985,306
Cooperative 90S Health Plan	$60,000
Coral Gables Fraternal Order of Police Health Trust	$104,891
Cork & Seal USA, Inc.	$564,944
Corning, Inc.	$959,407
County Commissioners for St. Mary's County, MD	$107,862
County Commissioners of Carroll County, MD	$277,727
County Commissioners of Charles County, MD	$9,703
County Commissioners of Frederick Co.	$31,537
County of Allegheny	$159,073
County of Benton School Dist 51 Foley Public Schools	$178,587
County of Blue Earth	$27,969
County of Calhoun	$7,873
County of Cambria	$190,638
County of Cayuga	$171,444
County of Douglas	$22,894
County of Eaton	$39,933
County of Fairfax	$1,212,771
County of Genesee	$204,956
County of Greenville	$104,786

County of Huron	$70,342
County of Imperial	$204,506
County of Itasca	$95,861
County of Kern	$556,114
County of Lane School District 28J	$23,817
County of Livingston	$91,350
County of Macomb	$255,316
County of Maricopa Tempe School District #3	$33,151
County of Marquette	$73,325
County of Mendocino	$334,168
County of Midland	$61,754
County of Milwaukee	$2,525,430
County of Missoula	$92,729
County of Monmouth, NJ	$356,993
County of Monroe	$143,229
County of Onondaga	$505,570
County of Ontario	$58,433
County of Orange	$1,132,075
County of Oswego	$138,410
County of Outagamie	$5,153
County of Ramsey	$548,331
County of Rutherford, TN	$14,059
County of Saginaw	$82,067
County of San Joaquin	$193,721
County of Suffolk	$2,560,243

Courage Center	$14,549
Cox Enterprises, Inc.	$1,090,191
Cramer-Krasselt Company	$26,621
Craven County	$15,136
Crook County	$732
Crouse Hospital	$159,467
Crowley Holdings, Inc.	$6,676
CSD Insurance	$1,156,560
CSX Corporation	$1,378,878
Curators of the University of Missouri	$719,585
Cytec Industries, Inc.	$300,593
D.C. Everest Area School District	$217,255
Dade County Fire Fighters Insurance Trust Fund	$438,486
Dakota County, MN	$75,161
Dakotas and Western Minnesota Electrical Industry Health & Welfare Fund	$27,475
Dallas School District	$65,264
Dalton-Nunda Central School District	$1,544
Dansville Central School District	$6,596
Danville School Board	$116,667
Deere & Company	$8,699,250
Del Monte Foods	$144,036
Delaware Valley Health Insurance Trust	$268,177
Deleware County	$78,922
Delphi Salaried Retiree Association Benefit Trust	$6,101,107
Des Moines Area Community College	$11,341

Des Moines Iron Workers Welfare Fund	$102,119
Deschutes County	$93,496
Detroit & Vicinity Trowel Trades Health & Welfare	$1,666
Detroit Annual Conference of the United Methodist Church	$19,859
Detroit Millmen's Health and Welfare Fund	$17,110
Directors Guild of America-Producer Health Plan	$187,851
District Council #16 Northern California Health & Welfare Fund	$314,306
District Council #3 Painters and Allied Trades Welfare Fund	$46,717
District Council #37 Health & Security Plan	$114,658
District Council Iron Workers Welfare Fund of Northern NJ	$5,721
Diversey	$210,327
Dominion Resources, Inc.	$2,914,704
Douglas County, NB	$180,918
Dresser, Inc.	$400,081
DTE Energy Company	$1,836,754
Duke Energy Corporation	$2,017,334
Duke University	$335,162
Dundee Central School	$192
DuPage County	$295,090
Duval County School Board	$205,953
East Bay Municipal Utility District	$136,205
East Bay Regional Park District	$113,126
East Bloomfield Central School District	$13,714
East Central Indiana School Trust	$89,407
Eastman Chemical Company	$2,912,546

Eaton Corporation	$1,813,950
Ector County Hospital District	$142,912
Educators Health Alliance, Inc.	$3,841,887
Edward D. Jones & Co., LP	$255,742
EI duPont de Nemours and Company	$12,796,589
Eighth District Electrical Benefit Fund	$191,993
El Centro School District	$37,089
Electric Power Board of Metropolitan Nashville and Davidson Counties	$231,583
Electrical Insurance Trustees	$1,258,858
Electrical Workers Health & Welfare Fund	$126,593
Electrical Workers Insurance Fund	$568,068
Elmira City School District	$79,370
Emerson Electric Company	$232,325
Employee Trustee	$374,265
Employees Retirement System of Texas	$30,175,627
Employer-Teamsters Locals #175 & #505 Health & Welfare	$299,946
Energy Future Holdings Corporation	$1,187,290
Entergy Corporation	$2,225,341
Equifax, Inc.	$169,940
Equity League Health Trust Fund	$202,650
Ericsson, Inc,	$197,168
Ernst & Young U.S., LLP	$583,126
Estes Express Lines	$65,785
Eugene Water & Electric Board	$212,780
Evonik Cyro, LLC	$23,838

Evonik Degussa Corporation	$160,468
Evonik Goldschmidt Corporation	$51,581
Evonik Rohmax USA, Inc.	$60,526
Excellus Health Plan, Inc.	$909,840
Exelon Corporation	$7,582,887
Factory Mutual Insurance Company	$194,357
Federal Express Corporation	$1,472,305
Finger Lakes Community College	$9,495
Fireman's Fund Insurance Company	$142,959
First Dakota National Bank	$11,715
First Interstate BancSystem, Inc.	$146,336
First Merchants Corporation	$4,018
First National of Nebraska, Inc.	$103,657
Flint Area Sheet Metal Workers Health & Welfare Fund	$5,740
Fluor Corporation	$120,843
Foley & Lardner, LLP	$40,935
Food Employers Labor Relations Association & UFCW Health & Welfare Fund	$1,244,308
Ford Motor Company	$7,124,437
Formosa Plastics Corporation, U.S.A.	$57,617
Forrest County General Hospital	$79,621
Foster Wheeler, Inc.	$208,218
Fox Valley & Vicinity Construction Workers Welfare Fund	$21,530
Fox Valley Laborers Health and Welfare Fund	$60,426
Francis Howell School District	$53,608
Frederick County Public Schools	$122,875

Freeport-McMoRan Copper& Gold, Inc.	$42,133
Freeport-McMoRan Corporation	$1,066,106
Fresno Unified School District	$150,335
Frontier Communications	$203,173
Fulton City School District	$58,650
G.M.P. - Employers Retiree Trust	$1,912,270
Gananda Central School District	$166
Gannett Co., Inc.	$673,486
GCC-IBT Local 1-M Health and Welfare Fund	$82,362
GCIU Local 119B, NY-Printers League Welfare Trust	$63,328
GEA North America, Inc.	$24,919
GenCorp Inc.	$52,174
General Brd of Pension & Health Benefits: United Methodist Church	$821,769
General Electric Company	$36,607,818
General Motors, LLC	$19,002,669
General Re Corporation	$52,165
General Shale Brick, Inc.	$174,988
Genesee County Community Health	$81,570
Genesee County Road Commission	$30,490
Genesee County Water and Waste Services	$37,168
Genesee-Livingston-Steuben-Wyoming Genesee Valley BOCES	$2,030
Geneseo Central School	$1,509
Georgia Department of Community Health	$57,936,127
Gerdau Ameristeel US, Inc.	$228,530
GKN North America Services, Inc.	$406,495

GlaxoSmithKIine, LLC	$2,184,005
Glenbard Twp. High School District 87	$429,420
Global Aero Logistics Inc.	$24,606
Gloversville Enlarged School District	$20,012
Gold Coast Joint Benefits Trust	$210,703
Goodrich Corporation Group Benefits and Insurance Program	$292,222
Gorton's, Inc.	$45,200
Governing Committee	$1,761,219
Graphic Communications Local #1 B Health & Welfare	$25,649
Great Northern Corporation	$57,906
Great Plains Communications, Inc.	$479
Great Plains Energy Inc.	$267,492
Great River Energy	$11,524
Greater Johnstown School District	$19,256
Greater New Bedford Regional Vocational Technical High	$45,679
Greater Orlando Aviation Authority	$34,537
Green Bay Packaging, Inc.	$105,104
Greencastle Community School Corporation	$40,017
Greenport Union Free School District	$15,992
Guardian Industries Corporation	$48,955
Guardian Life Insurance Company of America	$960,571
GuideStone Financial Resources of the Southern Baptist Convention	$197,020
H.J. Heinz Company	$246,459
Haldex Hydraulics Corporation	$52,545
Hallmark Cards, Inc.	$875,490

Hampshire Council of Governments	$492,026
Hancock Regional Hospital	$32,311
Harley-Davidson Motor Company Group, LLC	$455,445
Harris County	$2,061,271
Harris N.A.	$220,998
Haverstraw-Stony Point Central School District	$312,539
Health and Welfare Benefit Trust for Employees of Bechtel Jacobs	$589,731
Heartland Healthcare Fund	$60,757
Heat and Frost Insulators of Northern California-Local Union 16	$22,346
Heat and Frost Insulators St. Louis Welfare Fund	$15,130
Heavy & General Laborers' Local 472 & Local 172 of NJ Welfare Fund	$460,910
Hennepin County	$697,291
Henniges Automotive Holdings, Inc.	$137,859
Henry County	$10,156
High Desert & Inland Employee Employer Trust FKA	$431,097
Highmark, Inc.	$696,432
Hill-Rom Holdings, Inc.	$218,291
HNI Corporation	$199,745
Holly Corporation	$114,851
Honeoye Central School District	$23,972
Hoosier Heartland School Trust	$45,935
Hormel Foods Corporation	$633,242
Hospira, Inc.	$227,809
Houghton Mifflin Harcourt Publishing Company	$312,681
Houston Refining, LP	$216,104

Howard County, MD	$4,276
Huntsman International, LLC	$989,401
Iberia Parish School Board	$238,786
Idaho Plumbers and Pipefitters Health and Welfare Agreement and Declaration of Trust	$48,762
Idaho Power Company	$417,952
Illinois Central Railroad Company	$874,351
Independent School Dist 31 Beltrami County	$94,585
Independent School Dist 318 Itasca County	$128,593
Independent School Dist 728	$280,663
Independent School Dist 879	$7,360
Independent School District	$95,354
Independent School District # 15	$4,600
Independent School District # 2134	$6,650
Independent School District # 273, Edina Public Schools	$13,706
Independent School District # 2752	$16,902
Independent School District # 332	$24,219
Independent School District # 623	$13,119
Independent School District # 625	$478,846
Independent School District # 701	$101,821
Independent School District # 834 Stillwater Area Public Schools	$75,511
Independent School District # 885	$9,876
Independent School District of Boise City # 1	$158,220
Indian Electric Cooperative, Inc.	$58,129
Indiana State Police	$624,303

Ingersoll-Rand Company	$882,249
Ingham County, MI	$214,442
Inland Empire IBEW-NECA Health Plan	$3,371
Inlandboatmen's Union of the Pacific National Health Benefit Trust	$9,305
InSinkErator Division Emerson Electric Corporation	$51,171
Insulators Local # 45 Health Care Plan	$38,064
Insurance Committee of the Assessors' Insurance Fund	$58,382
Insurance Services Office, Inc.	$183,548
Intel Corporation	$949,712
International Bank For Reconstruction & Development	$997,977
International Brotherhood of Boilermakers, Iron Ship Builders, Blacksmith	$90,779
International Brotherhood of Electrical Workers	$25,360
International Brotherhood of Electrical Workers # 17 Welfare Fund	$71,293
International Brotherhood of Electrical Workers # 292 Health Care Plan	$195,677
International Brotherhood of Electrical Workers Employees	$4,666
International Brotherhood of Electrical Workers Local # 1	$141,795
International Brotherhood of Electrical Workers Local #102	$372,941
International Brotherhood of Electrical Workers Local #18	$281,264
International Brotherhood of Electrical Workers Local #22/NECA	$44,105
International Brotherhood of Electrical Workers Local #226	$9,822
International Brotherhood of Electrical Workers Local #234	$60,000
International Brotherhood of Electrical Workers Local #347	$27,167
International Brotherhood of Electrical Workers Local #595	$89,138
International Brotherhood of Electrical Workers Local #701	$271,266
International Brotherhood of Teamsters Union Local # 710	$93,530

International Business Machines Corporation ("IBM")	$12,989,690
International Flavors & Fragrances, Inc.	$204,888
International Matex Tank Terminals	$22,514
International Union of Bricklayers and Allied Craft	$4,400
International Union of Partners and Allied Trades District Council # 11 Health Fund	$1,833
International Union, UAW	$568,800
Iowa Bankers Benefit Plan	$32,961
Iowa Department of Administrative Services	$3,318,404
Iowa Schools Employee Benefits Association	$35,516
IPALCO Enterprises, Inc.VEBA Committee	$378,956
Iron Workers' Health Fund of Eastern Michigan	$7,195
Iron Workers Local # 395 Trust Fund	$3,367
Iron Workers Tri-State Welfare Plan	$78,627
Ironworkers Intermountain Health and Welfare Trust	$112,588
Irvine Unified School District	$727,180
J.M. Huber	$485,275
Jackson County Employees	$25,251
John D. Brush & Co., Inc./ DBA: Sentry Group	$1,738
Johnson & Johnson	$2,479,465
Johnson County, Kansas Government	$36,748
Joint Plan Committee	$5,918,174
Joint Welfare Fund Local # 164	$674,970
Jones Dairy Farm	$42,228
JPMorgan Chase & Co.	$2,922,102
Kaiser Foundation Health Plan, Inc.	$948,844

Kansas Building Trades Open End Health and Welfare	$25,297
Katonah-Lewisboro School District	$31,483
Kellogg Company	$1,720,297
Kelsey-Hayes Company	$107,422
Kendall Central School	$8,005
Kentucky Laborers District Council Health & Welfare	$125,392
KeyCorp	$404,857
KeySpan Corporation	$649,872
Kimberly Area School District	$805
Kinder Morgan, Inc.	$194,463
King Kullen Grocery Corporation, Inc.	$50,314
Kingston Trust Fund	$320,012
KLM Royal Dutch Airlines	$137,701
Knoxville Utilities Board	$154,982
KPMG, LLP	$160,045
Kraft Foods Global, Inc.	$2,844,339
Labor- Management Healthcare Fund	$1,825,271
Lafayette Parish School Board General Fund	$621,529
Lafayette School Corporation	$36,860
Lake County	$393,026
Lake County, Indiana NECA-IBEW Health and Benefit Plan	$231,137
Lancaster County	$24,305
Land O' Lakes, Inc.	$81,717
Lane County Oregon	$147,518
Lane County School District # 19	$204,756

Lane County School District # 52	$24,833
Lansing Board of Water & Light	$137,484
LANXESS Corporation	$341,950
Las Vegas Firefighters Health and Welfare Trust # 1285 Local	$200,833
Las Vegas Metropolitan Police Department. Employees Health & Welfare Trust	$300,451
Latham & Watkins, LLP	$61,032
Law Enforcement Health Benefits (LEHB) Medical Retiree Fund	$867,746
Lear Corporation	$7,574
Legislative Retirement System	$119,391
LeRoy Central School	$499
Letchworth Central School	$692
Libbey Inc.	$168,495
Liberty Mutual Group Inc	$2,420,704
Liberty Public School District # 53	$34,019
Linn County	$7,473
Livonia Central School	$12,586
Local # 1, International Alliance of Theatrical Stage Employees	$93,998
Local # 342 Health Care Fund	$49,858
Local # 342 Health Care Fund Plan Z	$545
Local # 705 International Brotherhood of Teamsters Health & Welfare Fund	$562,826
Long Beach Unified School District	$412,756
Longview Fibre Paper and Packaging, Inc.	$406,229
Loomis, Sayles & Company	$35,568
Lorillard Tobacco Company	$477,314
Los Alamos National Security, LLC	$1,323,668

Loudoun County School Board	$467,788
Louisiana Electrical Heath and Welfare Fund	$285
Louisiana Health Service & Indemnity Company	$39,224
Louisiana Laborers Health and Welfare Fund	$3,564
Lower Valley Energy, Inc.	$40,080
Lyondell Chemical Company	$772,793
Lyons Central School District	$820
Madison Area Construction Employees Trust - Health & Welfare	$23,230
Madison Area Technical College	$298,145
Madison Board of Education	$4,082
MAHLE Industries, Incorporated	$131,999
Manchester-Shortsville Central School	$448
Marathon County	$51,926
Marathon Oil Company	$1,738,914
March of Dimes Foundation	$46,635
Marcus Whitman Central	$6,244
Marion Central School District	$25,226
Mars, Inc.	$3,453,868
Marsh & McLennan Companies, Inc.	$924,087
Marshall & Ilsley Corporation	$68,307
Marshall Public Schools # 413 Ind. School District	$18,993
Martignetti Corporation	$111,430
Martin County School District	$96,560
Martin Memorial Health Systems, Inc.	$82,876
Maryland Electrical Industry Health Fund	$134,644

Masonry Security Plan	$13,531
Massachusetts Bay Health Care Trust Fund	$23,181
Massachusetts Bricklayers and Masons Health & Welfare Fund	$139,249
Massachusetts Institute of Technology	$380,718
Mayfield Central School District	$4,510
Mayflower Municipal Health Group (MMHG)	$386,899
Mayor and City Council, Town of Ocean City	$2,148
McCormick & Company, Inc.	$112,928
McDonald's Licensees Health & Welfare Trust	$225,426
McDonald's Corporation	$45,414
McKinsey & Company, Inc.	$138,326
McMaster-Carr Supply Company	$18,077
McNaughton-McKay Electric Company	$77,988
MDU Resources Group, Inc. Health and Welfare Benefits	$662,649
Mecklenburg County Government	$678,640
Medical Mutual of Ohio	$43,329
Medtronic, Inc.	$427,753
Mendocino County Superintendent of Schools	$56,042
Mercedes-Benz U.S. International, Inc.	$17,572
Mercy Health System Corporation	$154,933
Meredith Corporation	$174,300
Meriter Health Services	$176,120
Mesabi East School District # 2711	$76,902
Metro-ILA Benefit Fund	$131,528
Metropolitan Council	$852,549

Metropolitan Government of Nashville and Davidson County	$1,505,763
Metropolitan Utilities District of Omaha	$225,694
Miami-Dade County	$2,920,067
MIB Group, Inc.	$5,138
Michigan Conference of Teamsters Welfare Fund	$2,785,027
Michigan Regional Council of Carpenters Employee Benefit Fund	$443,583
Mid Central Operating Engineers Health and Welfare Fund	$223,802
MidAmerican Energy Company	$820,541
Middletown Works Hourly and Salaried Union Retiree	$1,928,654
Midland National Life Insurance, Company	$14,273
Mid-South Transportation Management, Inc.	$59,446
MidWest America Federal Credit Union	$22,058
Midwest Area School Employees' Insurance Trust	$161,605
Midwest Operating Engineers Welfare Fund	$2,742,839
MIIAA Health Benefits	$6,139,331
Milbank, Tweed , Hadley & McCloy, LLP	$42,227
Millennium America Holdings, Inc.	$28,985
Mine Safety Appliances Company	$73,020
Minnesota Annual Conference of the United Methodist Church	$23,253
Minnesota Cement Masons	$60
Minnesota Council Number # 5 of American Federation of State, County and Municipal Employees	$17,831
Minnesota Life Insurance Company	$155,991
Minnesota Teamsters Construction Division	$17,115
Minnesota Teamsters Health & Welfare Plan	$321,684

Minnewaska Area Schools	$300
Misc Drivers & Helpers Local # 638 Health, Welfare, Eye & Dental	$127,368
Mississippi Department of Finance and Administration	$5,462,645
Missouri Consolidated Health Care Plan	$6,242,378
Missouri State University	$34,461
Mitsubishi International Corporation	$33,567
Mitsubishi Polyester Film, Inc.	$131,905
Mitsui O.S.K. Lines America, Inc.	$18,566
Mohawk Carpet Corporation	$239,442
Mo-Kan Sheet Metal Workers: Welfare Fund	$261,175
Moline School District # 40	$196,018
Monroe Community College	$157,173
Montana Retail Store Employees Health and Welfare Plan	$161,638
Montana Teamsters-Contractors/Employers Trust	$5,024
Mosinee Schools	$123,300
Motion Picture Industry Health Plan	$576,629
Motorola, Inc.	$2,518,193
Mower County Government	$61,708
Multnomah County	$581,833
Munich Reinsurance America, Inc.	$185,704
Murphy Oil Corporation	$139,157
Mutual of Omaha Insurance Company	$70,524
N.O.I.T.U. Insurance Trust Fund	$10,276
NACCO Materials Handling Group, Inc.	$423,598
NALC Health Benefit Plan for Employees and Staff	$82,052

Naples Central School	$33,620
National AM Benefit Trust Fund	$123,862
National Carriers' Conference Committee	$14,161,277
National Council of Young Men's Christian Associations of the USA	$107,055
National Elect Contractors Association IBEW Local 176 ("Board of Trustees")	$88,108
National Elect. Contractors Association IBEW Family Medical Care TF	$395,428
National Grid USA Service Company, Inc.	$2,383,746
National Railroad Passenger Corporation	$769,901
National Rural Electric Cooperative Association	$4,431,754
Navistar, Inc.	$4,522,496
NEBCO, Inc.	$261,076
Nebraska Public Power District	$340,654
NECA - IBEW Local 35 Health Fund	$22,543
Neosho R-5 School District	$48,896
Nevada Energy, Inc., fka Sierra Pacific Resources	$815,872
New Castle Community School Corporation	$75,695
New England Biolabs, Inc.	$12,099
New England Carpenters Health Benefits Fund	$317,499
New England Electrical Workers Benefits Fund	$257,774
New Hampshire School Health Care Coalition	$758,847
New Jersey B.A.C. Health Fund	$76,387
New Jersey Carpenters Funds	$359,364
New Mexico Retiree Health Care Authority	$5,915,300
New Orleans Electrical Health Plan	$86,570
New York #44 Health Benefits Plan Trust	$15,251

New York State Department of Education Caledonia Mumford C S	$33,617
Newark Central School District	$52,357
Newell Operating Company	$636,134
NewPage Corporation	$322,218
NewPage Wisconsin System, Inc.	$1,180,935
Newtown Board of Education	$1,482
NGM Insurance Company	$6,114
Nicor, Inc.	$403,004
Nissan North America, Inc.	$1,011,690
Noble Corporation	$102,117
Noridian Mutuai Insurance Company	$72,182
NORPAC Foods, Inc.	$32,802
North Central Illinois Laborers Health and Welfare	$77,627
North Central Indiana School Ins Consortium TR	$31,808
North Central States Regional Council of Carpenters' Health Fund	$564,767
North Gibson School Corporation	$60,000
North Syracuse Central Schools	$50,266
Northeast Utilities Service Company	$671,927
Northern California Pipe Trades Health and Welfare TR	$49,097
Northern Trust Company	$313,685
Northrop Grumman Corporation	$2,090,040
Northwest Forest Products Association Western States Regional Council	$218,671
Northwest Metal Crafts	$43,937
Northwest Natural Gas Company	$85,010
Northwest R-I School District	$142,562

Northwest Sheet Metal Workers Welfare Fund	$222,256
Novartis Corporation	$81,466
Novelis Corporation	$597,023
Novo Nordisk, Inc.	$44,334
NYSE Group Inc.	$996,252
Oakfield-Alabama Central School	$53,930
Oakland County Employees Retirement	$67,399
Oberlin College	$1,957
Ocean Spray Cranberries, Inc.	$99,246
OCI Chemical Corporation	$130,455
Oconee County	$10,020
Oglebay Norton Company	$86,941
Ohio Carpenters' Health Fund	$915,545
Ohio Operating Engineers Health & Welfare Plan	$657,374
Oklahoma Conference of the United Methodist Church	$145,840
Oklahoma Electric Cooperative	$89,150
Oneida-Herkimer-Madison Board of Coordinated Education Services	$446,347
ONEOK, Inc.	$585,701
Operating Engineers Local # 324 Health Care Plan	$339,032
Operating Engineers Local # 474 Health and Welfare Fund	$19,855
Operating Engineers Local # 49 Health & Welfare Fun	$125,242
Operating Engineers Public and Miscellaneous Employees Health and Welfare	$72,039
Orange and Rockland Utilities, Inc.	$354,518
Orange County Government Board of County Commissioners	$330,564
Orange County School Board	$606,645

Oregon Educators Benefit Board	$8,440,167
Oswego County BOCES	$98,806
Otsego County	$211,362
Owens Corning	$260,190
Owens-Illinois, Inc.	$4,710
P. H. Glatfelter Company	$648,766
PACCAR Inc	$521,120
Pacific Gas and Electric Company	$2,692,720
PacifiCorp	$761,723
Painters and Allied Trades District Council # 82	$55,258
Painters Union Insurance Fund	$80,722
Palm Beach County Firefighters Employee Benefits Fund	$79,410
Palm Beach County Sheriffs' Office	$329,696
Palmyra-Macedon Central School District	$56,153
Pan American Life Insurance Company	$39,589
Park Hill School District	$48,859
Park Rapids Schools Independent School District # 309	$31,155
Parr Instrument Company	$33,098
Patrick County School Board	$4,626
Patriot Coal Corporation	$4,639,853
Pavilion Central School	$726
Pechiney Plastic Packaging, Inc. (PPPI)	$577,653
Pella Corporation	$306,323
Pembroke Central School District	$574
Penn Yan Central School District	$23,251

Penn-Harris-Madison School Corporation	$100,860
Pennsylvania National Mutual Casualty Insurance Company	$5,032
Pennsylvania State Education Association (PSEA)	$9,980
Pennsylvania State System of Higher Education	$223,346
Pension, Hospitalization and Benefit Plan	$1,197,837
Pensioned Operating Engineers Health and Welfare Trust Fund	$926,894
Peoples Energy Corporation	$382,723
Peoples Telephone Cooperative, Inc.	$80,164
PepsiCo, Inc.	$1,816,602
Perry Central School	$9,956
Phelps-Clifton Springs Central School District # 1	$7,325
Phoenix Life Insurance Company	$286,624
Physicians Mutual	$60,144
Pilkington North America, Inc.	$92,763
Pioneer Hi-Bred International, Inc.	$229,330
Pipe Fitters' Welfare Fund, Local # 597	$1,096,827
Pipe Trades District Council # 36 Health & Welfare Fund	$177,017
Pipe Trades Industry Health And Welfare Plan	$142,932
Pipefitters Local # 533 Health and Welfare Fund	$48,459
Pitney Bowes, Inc.	$980,561
Pittsburgh Public Schools	$1,042,680
Plasterers & Cabinet Makers Health Fund	$18,081
Plumbers & Pipe Fitters Local # 430 Health and Welfare Fund	$2,638
Plumbers & Pipefitters & Mechanical Equipment Services Local # 392	
Health & Welfare Fund	$270,398

Plumbers & Pipefitters Local # 172 Welfare Fund	$147,386
Plumbers & Pipefitters Local # 333 Health & Welfare	$23,577
Plumbers & Pipefitters Local # 502 Health and Welfare Plan	$42,881
Plumbers & Pipefitters Medical Fund	$62,555
Plumbers & Pipefitters Welfare Educational Fund	$292,199
Plumbers & Steamfitters Local # 267 Insurance Fund	$27,306
Plumbers & Steamfitters Local # 33 Health & Welfare Fund	$32,651
Plumbers & Steamfitters Local # 42 Health & Welfare Trust Fund	$47,496
Plumbers & Steamfitters Local #400 and MCA	$138,165
Plumbers & Steamfitters Local Union # 25 Welfare Fund	$55,262
Plumbers and Pipefitters Local Union #286 Health and Welfare Fund	$8,076
Plumbers and Steamfitters Local # 131 Health and Welfare Fund	$31,973
Plumbers and Steamfitters Local # 166 Health and Welfare Fund	$80,392
Plumbers and Steamfitters Local # 440 Health and Welfare Fund	$94,290
Plumbers Local # 210 Health & Welfare Fund	$19,609
Plumbers Local # 93 Health & Welfare Fund	$32,424
Plumbers Local # 98 Insurance Fund	$102,432
Plumbers Local Union # 690 Health Plan	$275,452
Plumbers' Welfare Fund Local # 130 United Association	$133,758
Port Authority of Allegheny County	$1,819,139
Porter County School Employees' Insurance Trust	$95,711
Potlatch Corporation	$504,675
PPG Industries, Inc.	$2,238,995
PPSTA Trust Fund	$173,105
Praxair, Inc.	$413,050

President and Fellows of Harvard College	$441,297
Pressman Welfare Fund	$844
Prince William County Government	$56,348
Prince William County School Board	$36,524
Principal Financial Group	$707,556
ProHealth Care, Inc.	$137,319
Public Education Employees Health Insurance Fund	$13,011,376
Public Employees' Retirement Association of Colorado	$8,101,677
Public Employees Retirement System of Ohio	$70,557,764
Public School Teachers Pension and Retirement Fund	$5,465,564
Public Service Enterprise Group Incorporated	$2,737,872
Public Utility District # 1 of Chelan County	$4,697
Public Utility District # 1 of Snohomish County	$44,845
Purdue Pharma L.P.	$5,349
Putnam Investments, LLC	$24,661
Putnam/Northern Westchester Health Benefits Consortium	$489,069
Racine County	$705,365
Raley's	$89,358
Raytheon Company	$3,745,272
Recreation and Park Commission for East Baton Rouge (BREC)	$39,213
Red Dot Corporation $39,473	
Regional School District # 14	$120,323
Reichhold, Inc.	$60,000
Retail Meat Cutters and Food Handlers Health & Welfare Fund	$102,380
Retails Clerks Retiree Welfare Trust	$440,471

Retiree Health Trust	$3,785
Riverside Sheriffs' Association Benefit Trust	$295,187
Road Commission for Oakland County	$152,213
Rochester Institute of Technology	$238,342
Rockwell Automation, Inc.	$1,181,845
Romulus Central School District	$3,345
Roofers Local # 149 Security Benefit Trust Fund	$23,499
Roofers Local # 96 Health and Welfare Fund	$8,247
Roosevelt County	$16,821
Royalton Hartland Central School District	$112
Rubicon LLC	$118,794
S&C Electric Company	$82,454
S.C. Johnson & Son, Inc	$1,114,536
Sacramento Municipal Utility District	$626,721
Saint-Gobain Containers	$110,810
Saint-Gobain Corporation	$1,051,558
Salt Lake Community College	$11,391
San Antonio Water System	$82,701
San Diego Gas & Electric Company	$141,609
San Francisco Culinary, Bartenders & Service Employees	$68,398
San Francisco Electrical Workers Health & Welfare Trust	$41,129
Sandia Corporation	$982,981
Sandvik, Inc.	$67,116
Santa Ana Unified School District	$304,258
Santa Cruz City Schools	$83,821

Sara Lee Corporation	$581,836
Sarasota County Board of County Commissioners	$312,254
Sauer-Danfoss (US) Company	$230,434
SCA Tissue North America	$127,985
SCANA Corporation & Subsidiaries	$366,037
Schindler Elevator Corporation	$56,078
Schneider Electric USA, Inc.	$836,991
School Administrators	$53,713
School Board of Frederick Co.unty, VA	$12,734
School District # 1 Health and Welfare Trust Fund	$455,969
School District # 12 Reorganized	$228,817
School District # 7 Reorganized	$115,367
School District of Alexander New York State-Alexander Central School	$1,344
School District of Greenfield	$65,877
School District of Lake Holcombe	$5,037
School District of Palm Beach County	$476,771
School District of the City of Ladue	$4,519
School District R-3 Camdenton	$28,957
School Employees' Benefit Trust (SEBT)	$134,126
School Employees Retirement System of Ohio	$2,260,337
School Risk & Insurance Management Group	$567,451
Schurz Communications, Inc.	$126,638
Scott Rice & Le Sueur Counties Independent School Dist # 721	$20,400
Screen Actors Guild-Producers Health Plan	$1,279,074
Seattle Area Plumbers	$9,763

Sedalia School District # 200	$2,083
SEMCO Energy, Inc.	$15,163
Seminole County Public Schools	$500,344
Seminole County Sheriff's Office	$124,280
Sempra Energy	$8,052
Sentry Insurance a Mutual Company	$557,108
Service Employees International Union # 1199	$2,056,576
Severstal Wheeling, Inc.	$661,221
Sewerage & Water Board of New Orleans	$342,981
SFM Mutual Insurance Company	$4,998
Shasta-Trinity Schools Insurance Group	$170,187
Shawnee Mission Unified School District # 512	$188,016
Sheet Metal # 10 Benefit Fund	$171,610
Sheet Metal Workers Health Plan	$128,764
Sheet Metal Workers Local # 7, Zone 1 Welfare Fund	$160,374
Sheet Metal Workers Local # 104 Health Care Plan	$696,218
Sheet Metal Workers Local # 33, Cleveland District Health Benefits Fund	$64,812
Sheet Metal Workers Local # 7, Zone 3 Welfare Fund	$22,545
Sheet Metal Workers Local # 73 Welfare Fund	$714,955
Sheet Metal Workers Local # 91 Health & Welfare Fund	$21,965
Sheet Metal Workers Local Welfare Fund # 85	$65,787
Shelby Public Schools	$2,441
Shell Oil Company	$4,456,640
Shenandoah School Corporation	$24,946
Siemens Corporation	$1,364,159

Sierra Pacific Industries	$231,630
Silgan Containers Manufacturing Corporation	$246,152
Silgan White Cap Americas	$13,801
Simpson Investment Company	$16,167
Sisc III Health and Welfare Fund	$10,207,960
Skadden, Arps, Slate, Meagher & Flom LLP	$102,819
SMART (Suburban Mobility Authority for Regional Transport)	$87,061
SMWIA Local Union # 28 Welfare Fund	$403,739
Sodus Central School	$12,052
Solvay America, Inc.	$169,013
Somerset County Public Schools	$31,328
Sonoco Products Company	$108,456
Soo Line Railroad Company	$211,306
South Carolina Budget & Control Board Employee Insurance Program	$27,142,502
South Windsor Board of Education	$114,055
Southeastern Massachusetts Health Group (SMHG)	$266,741
Southern California Edison Company	$1,087,041
Southern California Local # 831 Employer Health Plan	$42,999
Southern California Painting and Drywall Industries Health & Welfare	$60,962
Southern California Permanente Medical Group	$46,936
Southern Company Services, Inc	$3,084,158
Southern Connecticut International Brotherhood of Electrical Workers Health Insurance Plan	$16,105
Southern Farm Bureau Life Insurance Company	$139,614
Southern Operators Health Fund	$17,566

Southwest Carpenters Health and Welfare Trust Fund	$94,629
Southwestern Teamsters Security Fund	$73,181
Southwestern Wisconsin Community School District	$3,508
Spectra Energy Corp	$319,145
Springs Valley Community Schools	$93,314
Sprint Nextel Corporation	$942,623
St. Bernard Parish Government	$25,459
St. Clair County	$176,908
St. Louis County Schools	$43,220
St. Mary Parish Sheriff's Office	$4,697
State and Education Employees Group Insurance Board	$4,988,061
State of Arizona	$2,886,334
State of Arkansas Department of Finance and Administration	$718,101
State of Connecticut Office of the Comptroller	$4,675,710
State of Delaware	$1,448,515
State of Louisiana, Division of Administration, Office of Group Benefits	$9,296,315
State of Michigan	$20,247,338
State of Michigan Public School Employees Retirement System	$22,620,604
State of Montana	$1,440,204
State of New Hampshire	$1,763,330
State of New Jersey Treasury Department, Pension Accounting Services Department	$38,622,698
State of New York	$47,869,044
State of South Dakota	$132,722
State of Tennessee	$4,915,431
State of Vermont, Department of Finance & Management	$599,449

State of Wyoming	$266,660
State Street Corporation	$280,480
State Teachers Retirement System of Ohio	$20,334,357
Stationary Engineers Welfare Fund	$68,430
Steamfitters and Plumbers Local Union # 464 Welfare Fund	$3,522
Stearns County Independent School District # 740	$7,386
Steelcase, Inc.	$246,182
Stevens Point Area Public Schools	$291,729
Stockton Port District	$3,118
Strattec Security Corporation	$209,537
Suburban Teamsters of Northern Illinois Welfare Fund	$190,973
Suffolk School Employees Health Plan	$1,369,312
SunTrust Banks, Inc.	$487,903
Swiss Re America Holding Corporation	$119,314
Syngenta Crop Protection, Inc.	$420,971
TAC HEEIP	$224,409
Talbot County Board of Education	$144,759
Teacher Retirement System of Texas	$68,074,118
Teachers & State Employees, Board, Major Medical Plan	$10,094,161
TEAM Industries, Inc.	$20,419
Teamsters # 206 Employers Trust	$78,754
Teamsters Benefit Trust	$529,161
Teamsters Joint Council # 83 of Virginia Health & Welfare Fund	$267,977
Teamsters Local # 631 Security Plan for Southern Nevada	$39,166
Teamsters Local Union # 856 Health and Welfare Trust Fund	$71,458

Teamsters Retiree Trust	$283,302
Technicolor USA, Inc.	$339,156
Telcordia Technologies, Inc.	$474,558
Tennant Company	$44,141
Tenneco Automotive Operating Company, Inc.	$173,143
Tesoro Corporation	$312,568
Texas Association of Counties Health and Employee Benefits Pool	$203,687
Texas Instruments Incorporated	$968,174
Textron Inc.	$814,559
The Allstate Corporation	$1,190,211
The Bledsoe Health Tr	$169,178
The Board of Pensions of the Presbyterian Church	$270,915
The Board of Trustees of Michigan State University	$147,054
The Boeing Company	$18,759,499
The Bossier Parish School Board	$420,413
The City of Auburn, Alabama, A Municipal Corporation	$59,619
The City of Grand Rapids	$1,350,500
The City of Idaho Falls	$14,098
The City of Longview	$278,331
The Coteau Properties Company	$74,954
The County of Smith	$13,993
The County of Will in Illinois	$221,068
The Depository Trust & Clearing Corporation	$229,001
The Dow Chemical Company	$5,164,319
The Falkirk Mining Company	$23,483

The Gorman-Rupp Company	$185,133
The Hartford Fire Insurance Company	$1,065,950
The Hershey Company	$2,245,959
The Hertz Corporation	$460,178
The Indiana State Council of Rooters Health and Welfare Fund	$242,093
The ISD622 Education Center	$11,542
The Jewish Federation of Metropolitan Chicago	$32,564
The Kroger Co.	$678,167
The Milton S. Hershey Medical Center	$41,622
The North American Coal Corporation	$58,007
The Northwestern Mutual Life Insurance Company	$955,640
The Ohio Police and Fire Pension Fund	$5,919,051
The Port Authority of New York and New Jersey	$2,771,875
The Presidents & Directors: Georgetown College, Georgetown University	$30,867
The Procter & Gamble Company	$6,597,553
The Prudential Insurance Company of America	$4,898,407
The Queen's Health Systems	$24,322
The Regence Group	$174,407
The School Board of Broward County, Florida	$335,724
The School District of Escambia County	$422,497
The Sherwin-Williams Company	$343,546
The South Jefferson Central School District	$37,434
The South Jefferson Central School District Group	$10,087
The State of Maryland	$2,688,262
The Timken Company	$1,701,522

The Toro Company	$12,046
The Travelers Companies, Inc.	$975,114
The Turner Corporation	$342,501
The University of Iowa	$417,846
The Wackenhut Corporation (TWC)	$28,158
The Washington Post Company	$573,217
The Western and Southern Life Insurance Company	$669,612
The Williams Companies, Inc.	$600,352
Thomson Reuters Holdings	$161,981
ThyssenKrupp Waupaca, Inc.	$383,103
Tiffany and Company	$140,397
Titan Atlantic Cement Industrial and Commercial SA	$11,994
TML Intergovernmental Employee Benefits Pool	$519,992
Tompkins Financial Corporation	$60,263
Town of Arlington	$394,401
Town of Bellingham	$13,600
Town of Billerica Massachusetts	$3,106
Town of Bourne	$56,239
Town of Dracut	$58,931
Town of Duxbury	$323,416
Town of East Hartford, CT	$23,320
Town of Foxborough	$364
Town of Jupiter	$62,428
Town of Lexington	$51,120
Town of Manchester	$186,416

Town of Milton	$148,329
Town of Newington	$98,440
Town of Normal	$152,095
Town of North Andover	$153,654
Town of Plymouth	$201,051
Town of Southold	$31,339
Town of Stonington	$135,687
Town of West New York	$42,794
Town of West Springfield	$32,991
Town of Wolcott	$10,570
Township High School District 113	$8,189
Township of Belleville	$68,364
Township of East Hanover	$38,635
Trane U.S. Inc.	$226,496
Tri County Building Trades Health Fund	$160,447
Tri-County Schools Insurance Group	$1,353,655
Truck Drivers & Helpers Local # 355 Health & Welfare Fund	$296,093
Trustees of Carpenters Health and Welfare Trust Fund of St. Louis	$406,954
Trustees of the Central States, SE & SW Areas Health and Welfare Fund	$8,901,198
TRW Automotive U.S., LLC	$299,506
Twin City Glaziers Health & Welfare Plan	$10,974
Twin City Iron Workers Health & Welfare Fund	$38,191
Twin City Sprinkler Fitters Health Care Plan	$116,653
Tyson Foods, Inc.	$222,338
U.S. Bank, National Association	$356,726

Unified School District # 232	$5,801
Unified School District of Antigo	$58,914
Unilever United States, Inc.	$1,303,737
Union Construction Workers Health Plan	$416,221
Union Pacific Railroad Employees Health Systems	$4,555,696
United Airlines, Inc.	$5,868,926
United Association Local # 290 Plumber	
Steamfitter Industry Health and Welfare Plan	$299,346
United Association Local # 393 Health & Welfare Trust Fund	$131,583
United Association Local #85 Insurance Fund	$95,403
United Auto Workers Retiree Medical Benefits Trust	$206,798,086
United Auto Workers Retirees of the Dana Corporation Health and Welfare Trust	$1,419,777
United Firefighters of Los Angles City Local # 112	$267,727
United Food and Commercial Workers	$765,494
United Food and Commercial Workers & Employers Benefit Trust	$4,545,472
United Food and Commercial Workers & Employers	$328,792
United Food and Commercial Workers International Union	$824,344
united Food and Commercial Workers National Health and Welfare Fund	$499,413
United Food and Commercial Workers of Central Ohio	$708,198
United Mine Workers of America	$89,536
United Mine Workers of America # 1993 Benefit Plan	$459,953
United Parcel Service of America, Inc.	$12,312,873
United States Enrichment Corporation	$561,471
Unity Health System	$23,618
University of Kentucky	$415,104

University of Maine	$171,061
University of New Mexico	$451,441
University of Texas at Austin	$5,352,357
UPM-Kymmene, Inc.	$255,514
Utah Pipe Trades Welfare Trust Fund	$66,266
Utah Public Employees Health Program Trust	$1,708,849
Utah State University	$43,895
UT-Battelle, LLC	$339,610
Utica College	$60,000
Valero Energy Corporation	$1,064,122
Vectren Corporation	$46,922
Verizon Communications Inc.	$91,702,538
Vermont State Colleges	$15,009
Verona Area School District	$96,808
Victor Central School District	$40,692
Village of Alsip	$11,709
Village of Downers Grove	$187,717
Village of East Hampton	$10,233
Village of Ossining	$41,140
Village of Rosemont	$77,396
Vinson & Elkins LLP	$54,087
W.W. Grainger, Inc.	$172,135
Waddell & Reed, Inc.	$62,609
Wake Forest University Health Sciences	$123,491
Washington County	$139,353

Washington Gas Light Company	$365,966
Washington Teamsters Welfare Trust	$6,291
Washington-Idaho Operating Engineers-Employers Health & Security Trust	$100,869
Washtenaw County	$394,363
Washtenaw County Road Commission	$90,887
Water Works and Sanitary Sewer Board of the City of Montgomery, Alabama	$116,176
Waterloo Central School District	$61,219
Wausau Paper Corp.	$405,880
Wausau School District	$58,998
Waushara County Government	$38,082
Wawasee Community School Corporation	$1,941
Wayland-Cohocton Central School District	$1,289
Wayne County Health Care Plan Trust	$80,630
Webb City R-VII School District	$10,603
Welfare Fund of Engineers Local # 513	$487,271
Wells Fargo & Company	$3,318,769
West Des Moines Community School District	$74,106
West Feliciana Parish School Board	$55,210
West Virginia Department of Administration/PEIA	$3,926,073
West Windsor Township	$8,725
Westar Energy, Inc.	$438,698
Western Michigan University	$8,445
Western Teamsters Welfare Trust	$188,120
Westmoreland Coal Company	$86,603
Weyerhaeuser Company	$3,234,690

Wheeling-Pittsburgh Steel Corporation Retiree Benefits Plan	$62,505
Whirlpool Corporation	$1,422,270
Wicomico County, Maryland	$7,134
Will County Carpenters Local # 174 Welfare Fund ("Board of Trustees")	$253,634
William Floyd Union Free School District	$183,282
Williams College	$41,110
Williamson Central School District	$11,737
Wipfli LLP	$11,410
Wisconsin Laborers Board of Trustees Health Fund	$212,577
Wisconsin Public Service Corporate	$324,332
Wolf Creek Nuclear Operating Corporation	$186,000
Wood County	$113,214
Woodbridge Township	$392,377
Writers' Guild-Industry Health Fund	$158,545
WV/WCI School Trust	$188,611
Xcel Energy Inc.	$2,017,007
Yellowstone County School District # 7	$112,445
York Central School District	$1,184
Ypsilanti Community Utilities Authority	$62,802
Zachry Group, LLC	$60,000
Zachry Holdings, Inc.	$48,272
Zeon Chemicals L.P.	$80,396
Zimmer Holdings, Inc.	$61,951
Zionsville Community Schools	$10,936
Zurich American Insurance Company	$334,009

*Note: Reflects all amounts paid or approved for payment as of March 17, 2011.

**This document was updated to correct errors in the legal names of recipients.

THE COMMITTEE ON ENERGY AND COMMERCE

INTERNAL MEMORANDUM

MEMORANDUM

March 23, 2011

To: Energy and Commerce Committee Members

Fr: Subcommittee on Oversight and Investigations Majority Staff

Re: Impending Exhaustion of Funding for Early Retiree Reinsurance Program

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The Early Retiree Reinsurance Program (ERRP), a $5 billion fund hailed as one of the key early benefits of the Patient Protection and Affordable Care Act (PPACA), will exhaust its resources long before the planned sunset on January 1, 2014, according to information provided by the Center for Consumer Information and Insurance Oversight (CCIIO). Recent figures show that CCIIO has approved over 5,000 entities to participate in the program. In 2010, however, CCIIO doled out $535 million to just 253 of those entities. Based on those spending patterns, the fund will exhaust its resources much sooner than originally estimated, with the majority of that money going to state and local governments. If the fund runs out of money, it is highly unlikely that the remaining beneficiaries, including unions and large corporations, would be able to obtain Congressional approval or public support for assistance on an individual basis.

This memorandum summarizes information the Subcommittee on Oversight and Investigations Majority staff has gathered about the program.[1]

Overview of the Early Retiree Reinsurance Program

The ERRP was established by Section 1102 of the PPACA. The PPACA created two programs to act as a bridge to the new health insurance exchanges that would begin in 2014: the temporary high-risk pools for individuals with pre-existing conditions and the ERRP. The PPACA appropriates $5 billion to each of these programs, for a total of $10 billion. Richard Popper, Director of the Office of Insurance Programs at CCIIO, informed Committee staff that the ERRP was intended to address trends that have led employers to reduce or eliminate health benefits for early retirees.

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[1] The information contained in this report was obtained at a staff briefing on March 3, 2011, from the report issued by CCIIO on March 2 ("Implementation and Operation of the Early Retiree Reinsurance Program During Calendar Year 2010."), and through additional information gathered from representatives from the Centers for Medicare and Medicaid Services.

Employers and unions that provide an employment-based group health plan to early retirees, their spouses or dependents are eligible to participate in the ERRP. To participate in the program, employers and unions must have an approved application, be able to document health claims, implement procedures that have the potential to generate plan savings, and have policies in place to detect and reduce fraud or waste. The ERRP reimburses the employer 80 percent of the actual cost of an early retiree's health expenses between $15,000 and $90,000.[2] These reimbursements may be used to reduce a sponsor's health benefit costs or premiums, plan participants' premiums, co-payments, deductibles, co-insurance, or other out-of-pocket health benefit costs, or a combination thereof. Reimbursements may not be used for general revenue. The ERRP reimburses for qualified claims beginning on or after June 1, 2010.

Majority Committee Staff Findings

- CCIIO estimates ERRP will exhaust its funds in 2012, far sooner than expected.

In 2010 the ERRP paid out $535 million in reimbursements to 253 plan sponsors, while approving a total of 5,452 applications to participate in the program. Richard Popper informed Committee staff that the program will exhaust its resources in 2012, yet Majority Committee staff believes that the program could exhaust its resources even sooner.

In the seven months that the ERRP was reimbursing claims in 2010, 5% of the program's enrollees managed to spend 10% of the available funding. If the remaining 5,199 applicants require a similar level of reimbursement, the program will quickly spend all available funding as early as this year. In order for the program to avoid exhausting resources, the remaining 5,199 sponsors would have to request, on average, no more than 40% of the reimbursement level doled out to the 253 sponsors reimbursed in 2010.

- The ERRP acts as another bailout of state and local governments.

Over one-third of the $535 million spent by the ERRP in 2010 was spent on five government entities. Fifty-six percent of the ERRP funding spent in 2010 ($298 million) went to government organizations. Of that amount well over half was sent to the following five government entities:

- California Public Employees' Retirement System: $57,834,267
- State of New Jersey Treasury Department, Pension Accounting Services: $38,622,698
- Georgia Department of Community Health, State Health Benefit Plan: $34,916,832
- Commonwealth of Kentucky: $29,666,516
- Employees Retirement System of Texas: $20,982,299

- Total: $182, 022,612

The remaining $116 million was spent on additional state governments and a variety of cities, counties and other government entities. According to CCIIO, 47 percent of the 5,452 approved plan sponsors are government organizations. Because of the rate at which government entities

[2] Medical, surgical, hospital, and prescription drug benefits qualify for reimbursement. According to CCIIO's report reimbursement for services related to routine vision, dental, or custodial care are generally excluded.

collected reimbursements from the ERRP in 2010, and the fact that CCIIO has stated there are over 2,000 government entities approved to collect reimbursements in 2011, it is likely the majority of ERRP funding will be spent on these groups. Neither the ERRP nor the PPACA was intended as a de facto bailout for state and local governments.

- The ERRP is an inefficient and inappropriate use of funding.

Majority Committee staff has learned that funds the ERRP will not spend on government entities will go to companies that do not appear to need the financial assistance of the federal government. Information obtained by Majority Committee staff indicates that Fortune 500 companies with billions of dollars in revenue and Hollywood unions are among those taking advantage of the taxpayer money being provided by the ERRP. Subsidizing these groups may not be the most efficient or appropriate use of taxpayer money, especially considering that the ERRP was given the same amount of funding as the high-risk pool program for individuals with pre-existing conditions.

We have attached the full list of sponsors that received ERRP funding in 2010.

Conclusion

The ERRP will exhaust its funding long before the intended program end date January 1, 2014. The majority of the funding in 2010 went to state and local governments. Based on enrollment trends this pattern will continue. Finally, among the entities receiving funding are a number of large corporations that do not need the assistance of the federal government, and other entities that would not receive public support for assistance on an individual basis.

2010 ERRP Program Disbursements by State and Plan Sponsor

Plan Name	Plan State
1199SEIU Natl Benefit Fund For Health and Human Service Employees	NY
Advantage Health Plans Trust	OK
Aerospace Contractors' Trust	TN
Aetna Inc.	CT
Airconditioning & Refrigeration Industry Health & Welfare Trust	CA
Alaska Electrical Health and Welfare Fund	AK
Albany International Corp.	NY
Alcatel-Lucent USA Inc.	GA
Alcoa Inc.	PA
Alhambra Unified School District	CA
Alon USA, LP	TX
American Fed. of State, County and Municipal Employees (Council 31)	IL
American Federation of State, County and Municipal Employees AFLCIO	DC
Ameriprise Financial, Inc.	MN
Annandale Public School	MN
Arch Coal, Inc.	MO
Arkansas State Police	AR
Asbestos Workers Union Local 42 Welfare Fund	MD
Assistant Superinten	NY
Automatic Data Processing, Inc.	NJ
Avon Products, Inc	NY
Barnes Group Inc.	CT
BCBSM, Inc. (dba: Blue Cross and Blue Shield of MN	MN
Blue Cross & Blue Shield of Mississippi, A Mutual	MS
Blue Cross Blue Shield of Michigan	MI
Board of Trustees of Local 295/851 Employer Group Welfare Fund	NY
Board of Trustees of the Employers and Operating Engineers Local 520 Health and Welfare Fund	IL
Boilermakers National Health and Welfare Fund	KS

Boy Scouts of America	TX
Brittany Dyeing & Printing Corp.	MA
C&O Employees Hospital Association	VA
Cahill Gordon & Reindel LLP	NY
California Correctional Peace Officers Association Benefit Trust	CA
California Physicians' Service	CA
California Public Employees' Retirement System (CalPERS or PERS)	CA
Carpenters' District Council of Kansas City and Vi	MO
Central Pennsylvania Teamsters Health and Welfare	PA
City of Anaheim	CA
City of Ann Arbor	MI
City of Aurora	IL
City of Bloomington, MN	MN
City of Blue Island	IL
City of Des Moines	IA
City of Garland, Texas	TX
City of Grapevine	TX
City of Hollywood, Florida	FL
City of Mankato	MN
City of Marysville	MI
City of Mound	MN
CITY OF NAPLES	FL
City of Saginaw	MI
City of Saint Paul Finance-Accounting	MN
City of Springfield MO	MO
City of Warren	MI
City of Wauwatosa	WI
City of Winter Haven, FL	FL
Cleveland Clinic Foundation	OH

Commonwealth of Kentucky	KY
Consolidated Communications Holdings, Inc.	IL
Construction Industry and Laborers Health and Welfare Plan	MN
COUNTY OF BLUE EARTH	MN
County of Huron	MI
County of Onondaga	NY
County of Orange	CA
County of Outagamie	WI
County of Ramsey	MN
Courage Center	MN
Cox Enterprises, Inc.	GA
Crowley Holdings, Inc	FL
CSD Insurance TR	MO
Dakota County, Minnesota	MN
Danville School Board	VA
Deere & Company	IL
Delphi Salaried Retiree Association Benefit Trust	MI
Department of Finance and Administration	MS
Directors Guild of America-Producer Health Plan	CA
District Council #3 Painters and Allied Trades Welfare Fund	MO
DRESSER INC	TX
DTE Energy Company	MI
Duke Energy Corporation	NC
Eastman Chemical Company	TN
Ector County Hospital District (dba Medical Center Hospital)	TX
Emerson Electric Co.	MO
Employee Trustee	OR
Employees Retirement System of Texas (ERS)	TX
Employer-Teamsters Local Nos. 175 & 505 Health & W	WV

Excellus Health Plan, Inc	NY
Foster Wheeler Inc.	NJ
Freeport-McMoRan Copper& Gold Inc. ("Freeport-McMo	AZ
FRESNO UNIFIED SCHOOL DISTRICT	CA
GCC-IBT LOCAL 1-M HEALTH AND WELFARE FUND	MN
GCIU Local 119B, NY-Printers League Welfare Trust	NY
GEA NORTH AMERICA, INC.	MD
General Electric Company	CT
Georgia Department of Community Health	GA
GlaxoSmithKline LLC	PA
Glenbard Twp. High School District 87	IL
Gold Coast Joint Benefits Trust	CA
Graphic Communications Local #1 B Health & Welfare	MN
Great River Energy	MN
GuideStone Financial Resources of the Southen Bapt	TX
Haldex Hydraulics Corporation	IL
Hallmark Cards, Incorporated	MO
Harris County	TX
Heartland Healthcare Fund	MN
Hennepin County	MN
Houghton Mifflin Harcourt Publishing Company	MA
IBEW Local 102 Welfare Fund	NJ
IBEW Local Union #347 Health and Welfare Plan	IA
IBEW Local Union No. 22/NECA Health & Welfare Fund	NE
Independent School District 273, Edina Public Scho	MN
Independent School District 885	MN
Independent School District No 15	MN
Independent School District No. 623	MN
Indian Electric Cooperative, Inc.	OK

International Brotherhood of Boilermakers, Iron Ship Builders, Blacksmith	KS
International Brotherhood of Electrical Workers 17 Welfare Fund	MI
International Flavors & Fragrances Inc.	NY
International Matex Tank Terminals	LA
ISD #834 Stillwater Area Public Schools	MN
Johnson & Johnson	NJ
Joint Welfare Fund Local 164	NJ
Kimberly Area School District	WI
Kingston Trust Fund	NY
Knoxville Utilities Board	TN
Liberty Mutual Group Inc	MA
Louisiana Electrical Heath and Welfare Fund	TN
Louisiana Laborers Health and Welfare Fund	TN
MAHLE Industries, Incorporated	TN
Marathon Oil Company	OH
Mars Incorporated	NJ
Masonry Security Plan	WA
McNaughton-McKay Electric Company	MI
Metropolitan Council	MN
Metropolitan Utilities District of Omaha	NE
Michigan Regional Council of Carpenters Employee Benefit Fund	MI
Midwest Operating Engineers Welfare Fund	IL
Millennium America Holdings Inc.	TX
Minnesota Teamsters Health & Welfare Plan	MN
Minnewaska Area Schools #	MN
Misc Drivers & Helpers Union Local #638 Health, Welfare, Eye & Dental	MN
Missouri Consolidated Health Care Plan	MO
Mohawk Carpet Corporation	GA
Mower County Government	MN

NACCO Materials Handling Group, Inc.	NC
National Rural Electric Cooperative Association	VA
Na'tl Council of Young Men's Christian Associations of the USA	IL
New Jersey Carpenters Funds	NJ
New Orleans Electrical Health Plan	TN
NGM Insurance Company	FL
Noble Corporation	TX
North Central States Regional Council of Carpenters' Health Fund	WI
Northrop Grumman Corporation	CA
Northwest Metal Crafts	WA
Northwest Sheet Metal Workers Welfare Fund	WA
Oakland County Employees Retirement	MI
OCI Chemical Corporation	GA
Oklahoma Conference of the United Methodist Church	OK
Oklahoma Electric Cooperative	OK
Operating Engineers Local 474 Health and Welfare Fund	TN
Park Rapids Schools ISD 309	MN
Pilkington North America, Inc.	OH
Pipe Fitters'Welfare Fund, Local 597	IL
Pittsburgh Public Schools	PA
Plasterers & Cabinet Makers Health Fund	MN
Plumbers & Pipefitters Local 502 Health and Welfare Plan	KY
Plumbers & Steamfitters Local 33 Health & Welfare Fund	IA
PLUMBERS'& PIPEFITTERS WELFARE EDUCATIONAL FUND	MO
PPSTA Trust Fund	NY
Putnam Investments, LLC	MA
Putnam/Northern Westchester Health Benefits Consortium	NY
Raley's	CA
Roofers Local #96 Health and Welfare Fund	MN

Sandvik, Inc.	NJ
Sara Lee Corporation	IL
School Risk & Insurance Management Group	CA
Screen Actors Guild-Producers Health Plan	CA
Sheet Metal #10 Benefit Fund	MN
Sheet Metal Workers' Health Plan	TN
Sheet Metal Workers' Local 73 Welfare Fund	IL
Sheet Metal Workers Welfare Fund #85	GA
Siemens Corporation	NJ
Sierra Pacific Industries	CA
Southern Company Services, Inc	GA
Southern Operators Health Fund	TN
State and Education Employees Group Insurance Board	OK
State of Arizona	AZ
State of Ark., Dept. of Finance and Admin., Employ	AR
State of Louisiana, Division of Administration, Office of Group Benefits	LA
State of Michigan	MI
State of Michigan Public School Employees Retirement System	MI
State of New Jersey Treasury Dept - Pension Accounting Services	NJ
STRATTEC SECURITY CORPORATION	WI
Syngenta Crop Protection, Inc.	NC
TAC HEEIP	TX
Teacher Retirement System of Texas	TX
Teamsters 206 Employers Trust	OR
Teamsters Retiree Trust	CA
The Boeing Company	IL
The City of Grand Rapids	MI
The ISD622 Education Center	MN
The Jewish Federation of Metropolitan Chicago	IL

The Ohio Police and Fire Pension Fund	OH
THE REGENCE GROUP	OR
The South Jefferson Central School District Group	NY
The Toro Company	MN
The University of Iowa	IA
The Western and Southern Life Insurance Company	OH
Thomson Reuters Holdings	NY
Township High School District 113	IL
Trustees of Carpenters' Health and Welfare Trust Fund of St. Louis	MO
Trustees of the Central States, SE & SW Areas H&W Fund	IL
Twin City Iron Workers Health & Welfare Fund	MN
U.S. Bank, NA	MN
UAW Retiree Medical Benefits Trust	MI
United Mine Workers of America1993 Benefit Plan	DC
University of New Mexico	NM
University of Texas at Austin, Office of Acctg.	TX
UPM-Kymmene, Inc.	IL
Village of Alsip	IL
Village of Rosemont	IL
Vinson & Elkins LLP	TX
Wake Forest University Health Sciences	NC
Washington County	MN
Washtenaw County	MI
Writers' Guild-Industry Health Fund	CA
Ypsilanti Community Utilities Authority	MI
Zeon Chemicals L.P.	KY

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop N3-01-21
Baltimore, Maryland 21244-1850

Office of the Actuary

DATE: April 22, 2010

FROM: Richard S. Foster
Chief Actuary

SUBJECT: Estimated Financial Effects of the "Patient Protection and Affordable Care Act," as Amended

The Office of the Actuary has prepared this memorandum in our longstanding capacity as an independent technical advisor to both the Administration and the Congress. The costs, savings, and coverage impacts shown herein represent our best estimates for the Patient Protection and Affordable Care Act. We offer this analysis in the hope that it will be of interest and value to policy makers and administrators as they implement and monitor these far-reaching national health care reforms. The statements, estimates, and other information provided in this memorandum are those of the Office of the Actuary and do not represent an official position of the Department of Health & Human Services or the Administration.

This memorandum summarizes the Office of the Actuary's estimates of the financial and coverage effects through fiscal year 2019 of selected provisions of the "Patient Protection and Affordable Care Act" (P.L. 111-148) as enacted on March 23, 2010 and amended by the "Health Care and Education Reconciliation Act of 2010" (P.L. 111-152) as enacted on March 30, 2010. For convenience, the health reform legislation, including amendments, will be referred to in this memorandum as the Patient Protection and Affordable Care Act, or PPACA.

Included are the estimated net Federal expenditures in support of expanded health insurance coverage, the associated numbers of people by insured status, the changes in Medicare and Medicaid expenditures and revenues, and the overall impact on total national health expenditures. Except where noted, we have not estimated the impact of the various tax and fee provisions or the impact on income and payroll taxes due to economic effects of the legislation. Similarly, the impact on Federal administrative expenses is excluded. A summary of the data, assumptions, and methodology underlying our national health reform estimates will be available in a forthcoming memorandum by the OACT Health Reform Modeling Team.

Summary

The table shown on page 2 presents financial impacts of the selected PPACA provisions on the Federal Budget in fiscal years 2010-2019. We have grouped the provisions of the legislation into six major categories:

(i) Coverage provisions, which include the mandated coverage for health insurance, a substantial expansion of Medicaid eligibility, and the additional funding for the Children's Health Insurance Program (CHIP);

(ii) Medicare provisions;

(iii) Medicaid and CHIP provisions other than the coverage expansion and CHIP funding;

(iv) Provisions aimed in part at changing the trend in health spending growth;

(v) The Community Living Assistance Services and Supports (CLASS) program; and

(vi) Immediate health insurance reforms.

The estimated costs and savings shown in the table are based on the effective dates specified in the law as enacted. Additionally, we assume that employers and individuals would take roughly 3 to 5 years to fully adapt to the new insurance coverage options and that the enrollment of additional individuals under the Medicaid coverage expansion would be completed by the third year of implementation. Because of these transition effects and the fact that most of the coverage provisions would be in effect for only 6 of the 10 years of the budget period, the cost estimates shown in this memorandum do not represent a full 10-year cost for the new legislation.

Estimated Federal Costs (+) or Savings (−) under Selected Provisions of the Patient Protection and Affordable Care Act as Enacted and Amended
(in billions)

	Fiscal Year										Total,
Provisions	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-19
Total*	$9.2	−$0.7	−$12.6	−$22.3	$16.8	$57.9	$63.1	$54.2	$47.2	$38.5	$251.3
Coverage†	3.3	4.6	4.9	5.2	82.9	119.2	138.2	146.6	157.6	165.8	828.2
Medicare	1.2	−4.7	−14.9	−26.3	−68.8	−60.3	−75.2	−92.1	−108.2	−125.7	−575.1
Medicaid/CHIP	−0.9	−0.9	0.8	4.5	8.6	5.1	4.6	3.4	1.3	1.7	28.3
Cost trend‡	—	—	—	—	−0.0	−0.1	−0.2	−0.4	−0.6	−0.9	−2.3
CLASS program	—	−2.8	−4.5	−5.6	−5.9	−6.0	−4.3	−3.4	−2.8	−2.4	−37.8
Immediate reforms	5.6	3.2	1.2	—	—	—	—	—	—	—	10.0

* Excludes Title IX revenue provisions except for sections 9008 and 9015, certain provisions with limited impacts, and Federal administrative costs.

† Includes expansion of Medicaid eligibility and additional funding for CHIP.

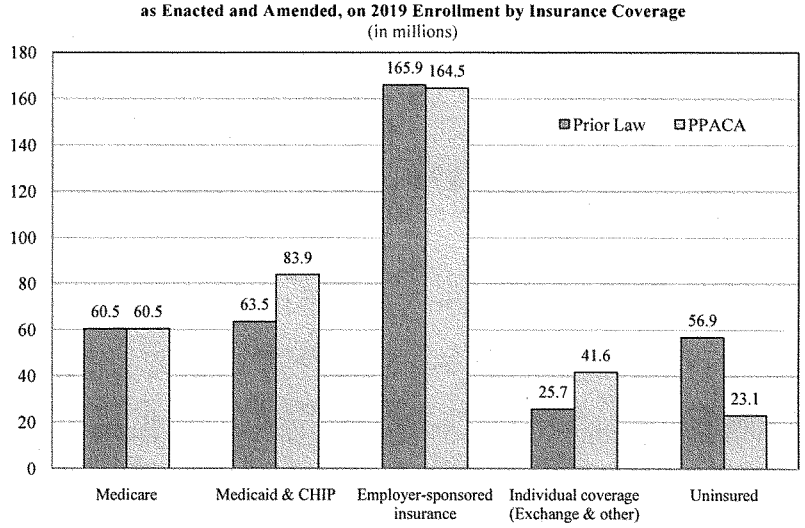
‡ Includes estimated non-Medicare Federal savings from provisions for comparative effectiveness research, prevention and wellness, fraud and abuse, and administrative simplification. Excludes impacts of other provisions that would affect cost growth rates, such as the productivity adjustments to Medicare payment rates (which are reflected in the Medicare line) and the section 9001 excise tax on high-cost employer plans.

As indicated in the table above, the provisions in support of expanding health insurance coverage (including the Medicaid eligibility changes and additional CHIP funding) are estimated to cost $828 billion through fiscal year 2019. The Medicare, Medicaid, growth-trend, CLASS, and immediate reform provisions are estimated to result in net savings of about $577 billion, leaving a net overall cost for this period of $251 billion before consideration of additional Federal administrative expenses and the increase in Federal revenues that would result from the excise tax on high-cost employer-sponsored health insurance coverage and other revenue provisions. (The additional Supplementary Medical Insurance revenues from fees on brand-name prescription drugs under section 9008 of the PPACA, and the additional Hospital Insurance payroll tax income under section 9015, are included in the estimated Medicare savings shown here.) The Congressional Budget Office and the Joint Committee on Taxation have estimated that the total net amount of Medicare savings and additional tax and other revenues would

somewhat more than offset the cost of the national coverage provisions, resulting in an overall reduction in the Federal deficit through 2019.

The following chart summarizes the estimated impacts of the PPACA on insurance coverage. The mandated coverage provisions, which include new responsibilities for both individuals and employers, and the creation of the American Health Benefit Exchanges (hereafter referred to as the "Exchanges"), would lead to shifts across coverage types and a substantial overall reduction in the number of uninsured, as many of these individuals become covered through their employers, Medicaid, or the Exchanges.

Estimated Effect of the Patient Protection and Affordable Care Act, as Enacted and Amended, on 2019 Enrollment by Insurance Coverage
(in millions)



Note: Totals across categories are not meaningful due to overlaps among categories (e.g., Medicare and Medicaid).

By calendar year 2019, the mandates, coupled with the Medicaid expansion, would reduce the number of uninsured from 57 million, as projected under prior law, to an estimated 23 million under the PPACA. The additional 34 million people who would become insured by 2019 reflect the net effect of several shifts. First, an estimated 18 million would gain primary Medicaid coverage as a result of the expansion of eligibility to all legal resident adults under 133 percent[1] of the Federal Poverty Level (FPL).[2] (In addition, roughly 2 million people with employer-

[1] The health reform legislation specifies an income threshold of 133 percent of the Federal Poverty Level but also requires States to apply an "income disregard" of 5 percent of the FPL in meeting the income test. Consequently, the *effective* income threshold is actually 138 percent of the FPL. For convenience, we refer to the statutory factor of 133 percent in this memorandum.

[2] This provision would extend eligibility to two significant groups: (i) individuals who would meet current Medicaid eligibility requirements, for example as disabled adults, but who have incomes in excess of the existing State thresholds but less than 133 percent of the FPL; and (ii) people who live in households with incomes below 133 percent of the FPL but who have no other qualifying factors that make them eligible for Medicaid under prior law, such as being under age 18, age 65 or older, disabled, pregnant, or parents of eligible children.

sponsored health insurance would enroll in Medicaid for supplemental coverage.) Another 16 million persons (most of whom are currently uninsured) would receive individual insurance coverage through the newly created Exchanges, with the majority of these qualifying for Federal premium and cost-sharing subsidies. Finally, we estimate that the number of individuals with employer-sponsored health insurance would decrease overall by about 1 million, reflecting both gains and losses in such coverage under the PPACA.

As described in more detail in a later section of this memorandum, we estimate that overall national health expenditures under the health reform act would increase by a total of $311 billion (0.9 percent) during calendar years 2010-2019, principally reflecting the net impact of (i) greater utilization of health care services by individuals becoming newly covered (or having more complete coverage), (ii) lower prices paid to health providers for the subset of those individuals who become covered by Medicaid, (but with net Medicaid costs from provisions other than the coverage expansion), and (iii) lower payments and payment updates for Medicare services. Although several provisions would help to reduce health care cost growth, their impact would be more than offset through 2019 by the higher health expenditures resulting from the coverage expansions.

The actual future impacts of the PPACA on health expenditures, insured status, individual decisions, and employer behavior are very uncertain. The legislation would result in numerous changes in the way that health care insurance is provided and paid for in the U.S., and the scope and magnitude of these changes are such that few precedents exist for use in estimation. Consequently, the estimates presented here are subject to a substantially greater degree of uncertainty than is usually the case with more routine health care legislation.

The balance of this memorandum discusses these financial and coverage estimates—and their limitations—in greater detail.

Effects of Coverage Provisions on Federal Expenditures and Health Insurance Coverage

Federal Expenditure Impacts

The estimated Federal costs of the coverage provisions in the PPACA are provided in table 1, attached, for fiscal years 2010 through 2019. We estimate that Federal expenditures would increase by a net total of $251 billion during this period as a result of the selected PPACA provisions—a combination of $828 billion in net costs associated with coverage provisions, $575 billion in net savings for the Medicare provisions, a net cost of $28 billion for the Medicaid/CHIP provisions (excluding the expansion of Medicaid eligibility and the additional CHIP funding), $2 billion in savings from provisions intended to help reduce the rate of growth in health spending, $38 billion in net savings from the CLASS program, and $10 billion in costs for the immediate insurance reforms. These latter five impact categories are discussed in subsequent sections of this memorandum.

Of the estimated $828 billion net increase in Federal expenditures related to the coverage provisions of the PPACA, about one-half ($410 billion) can be attributed to expanding Medicaid coverage for all adults who live in households with incomes below 133 percent of the FPL. This cost reflects the fact that newly eligible persons would be covered with a Federal Medical Assistance Percentage (FMAP) of over 99 percent for the first 3 years, declining to 93 percent by the sixth year; that is, the Federal government would bear a significantly greater proportion of

the cost of the newly eligible enrollees than is the case for current Medicaid beneficiaries.[3] Also included in this cost is the additional funding for the CHIP program for 2014 and 2015, which would increase such expenditures by an estimated $29 billion. The remaining costs of the coverage provisions arise from the refundable tax credits and reduced cost-sharing requirements for low-to-middle-income enrollees purchasing health insurance through the Exchanges ($507 billion) and credits for small employers who choose to offer insurance coverage ($31 billion). The increases in Federal expenditures would be partially offset by the penalties paid by affected individuals who choose to remain uninsured and employers who opt not to offer coverage; such penalties total $120 billion through fiscal year 2019, reflecting the relatively low per-person penalty amounts specified in the legislation.[4]

The refundable premium tax credits in section 1401 of the PPACA (as amended by section 1001 of the Reconciliation Act) would limit the premiums paid by individuals with incomes up to 400 percent of the FPL to a range of 2.0 to 9.5 percent of their income and would cost an estimated $451 billion through 2019. An estimated 25 million Exchange enrollees (79 percent) would receive these Federal premium subsidies. The cost-sharing credits would reimburse individuals and families with incomes up to 400 percent of the FPL for a portion of the amounts they pay out-of-pocket for health services, as specified in section 1402, as amended. These credits are estimated to cost $55 billion through 2019.

The PPACA establishes the Exchange premium subsidies during 2014-2018 in such a way that the reduced premiums payable by those with incomes below 400 percent of FPL would maintain the same share of total premiums over time. As a result, the Federal premium subsidies for a qualifying individual would grow at the same pace as per capita health care costs during this period. Because the cost-sharing assistance is based on a percentage of health care costs incurred by qualifying individuals and families, average Federal expenditures for this assistance would also increase at the same rate as per capita health care costs. After 2018, if the Federal cost of the premium and cost-sharing subsidies exceeded 0.504 percent of GDP, then the share of Exchange health insurance premiums paid by enrollees below 400 percent of the FPL would increase such that the Federal cost would stay at approximately 0.504 percent of GDP. We estimate that the subsidy costs in 2018 would represent about 0.518 percent of GDP, with the result that the enrollee share of the total premium would generally increase in 2019 and later.

As noted previously, the Federal costs for the coverage expansion provisions are somewhat offset by the individual and employer penalties stipulated by the PPACA. We estimate that individual penalties would provide $33 billion in revenue to the Federal government in fiscal years 2014-2019, taking into account the time lag associated with collecting the penalty amounts through the Federal income tax system. (A discussion of the estimated number of individuals who would choose to remain uninsured is provided below.) Additionally, for firms that do not

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[3] For the newly eligible enrollees, the FMAP for fiscal year 2020 and later will be 90 percent, compared to an average of 57 percent for the previously eligible enrollee population. In addition, the estimated cost includes new Medicaid enrollments by previously eligible individuals as a result of the publicity, enrollment assistance through the Exchanges, and reduced stigma associated with Federal assistance for health care. Also included here are the Medicaid costs for the provision to extend Medicaid coverage to individuals up to age 26 who were previously in foster care.

[4] Employer penalties would be $2,000 per employee in 2014, generally, which is substantially less than the cost of providing health insurance coverage. The relationship between penalties and premiums is much more complicated for individuals than for employers; still, for many individuals the applicable penalty would be considerably smaller than the cost of coverage.

offer health insurance and are subject to the "play or pay" penalties, we estimate that the penalties would total $87 billion in 2014-2019.

The penalty amounts for noncovered individuals will be indexed over time by the CPI (or, in certain instances, by growth in income) and would normally increase more slowly than health care costs. As a result, penalty revenues for nonparticipating individuals are estimated to grow more slowly than the Federal expenditures for the premium assistance credits. Penalties for employers who do not offer health insurance will be indexed by premium levels and will thus keep pace with health care cost growth.

The health reform act specifies maximum out-of-pocket limits in 2014 equal to the corresponding maximums as defined in the Internal Revenue Code for high-deductible health plans. We estimate that these limits would be $6,645 for an individual and $13,290 for a family with qualified creditable coverage (including employer-sponsored health insurance). For future years, the limits are indexed to the growth in the average health insurance premium in the U.S. Under this approach, the proportion of health care costs above the out-of-pocket maximum would be relatively stable over time. For the basic "bronze" benefit plan for individuals, with an actuarial value of 60 percent, we estimate that the cost-sharing percentage applicable before the out-of-pocket maximum is reached would average about 76 percent in 2014 and later. The corresponding cost-sharing rate for family coverage is 64 percent. For the "silver" benefit package, the individual and family cost-sharing rates below the out-of-pocket maximums would average about 47 percent and 40 percent, respectively. For the more comprehensive "gold" and "platinum" benefit packages authorized through the Exchanges, these initial cost-sharing levels would be significantly lower.

Health Insurance Coverage Impacts

The estimated effects of the PPACA on health insurance coverage are provided in table 2, attached. As summarized earlier, we believe that these effects will be quite significant. By calendar year 2019, the individual mandate, Medicaid expansion, and other provisions are estimated to reduce the number of uninsured from 57 million under prior law to 23 million after the PPACA. The percentage of the U.S. population with health insurance coverage is estimated to increase from 83 percent under the prior-law baseline to 93 percent after the changes have become fully effective.

Of the additional 34 million people who are estimated to be insured in 2019 as a result of the PPACA, a little more than one-half (18 million) would receive Medicaid coverage due to the expansion of eligibility to adults under 133 percent of the FPL. (Included in the total are an estimated 50,000 individuals who would gain Medicaid coverage as former children in foster care programs and who could be covered up to age 26 under the new law.) We anticipate that the intended enrollment facilitation under the PPACA—i.e., that the Health Benefits Exchanges help people determine which insurance plans are available and identify whether individuals qualify for Medicaid coverage, premium subsidies, etc.—would result in a high percentage of eligible persons becoming enrolled in Medicaid. We further believe that the great majority of such persons (15 million) would become covered in the first year, 2014, with the rest covered by 2016. About 2 million people who currently have employer-sponsored health insurance are estimated to enroll in Medicaid as a supplement to their existing coverage.

We estimate that 16 million people would receive health coverage in 2019 through the newly created Exchanges under the PPACA. (Another 15 million, who currently have individual health insurance policies, are also expected to switch to Exchange plans.) We modeled the choice to purchase coverage from the Exchanges as a function of individuals' and families' expected health expenditures relative to the cost of coverage if they were insured (taking into account applicable premium subsidies). We also considered the required penalty associated with the individual mandate if they chose to remain uninsured, along with other factors.[5] Our model indicated that roughly 63 percent of those eligible for the Exchanges would choose to take such coverage, with the principal incentive being the level of premium assistance available. For many individuals, the penalty amounts for not having insurance coverage were not sufficiently large to have a sizable impact on the coverage decision. Also, in this regard, individuals or families would not be subject to a penalty for failing to enroll in an Exchange plan if the "bronze" premium level (reduced by the premium tax credit, if applicable) would exceed 8 percent of income. We estimate that this provision would exempt individuals and families with incomes between about 400 percent and 542 percent of the FPL, representing about 16 percent of the non-aged population.

The new legislation would require the Office of Personnel Management to arrange for at least two private, multi-State health plans to be offered through each health insurance Exchange. The multi-State plans would generally meet the same benefit, cost-sharing, network, and other requirements applicable to private Exchange plans and would negotiate payment rates with providers. (A State could enact a requirement for additional benefits in the multi-State plans, beyond the essential benefits specified for a qualified plan, but would have to make payments on behalf of eligible individuals to defray the cost of the additional benefits.) We estimate that the multi-State plans would have costs that were very similar to those for other Exchange plans.

Employer-sponsored health insurance has traditionally been the largest source of coverage in the U.S., and we anticipate that it would continue to be so under the PPACA. By 2019, an estimated 13 million workers and family members would become newly covered as a result of additional employers offering health coverage, a greater proportion of workers enrolling in employer plans, and an extension of dependent coverage up to age 26. However, a number of workers who currently have employer coverage would likely become enrolled in the expanded Medicaid program or receive subsidized coverage through the Exchanges. For example, some smaller employers would be inclined to terminate their existing coverage, and companies with low average salaries might find it to their—and their employees'—advantage to end their plans, thereby allowing their workers to qualify for heavily subsidized coverage through the Exchanges. Somewhat similarly, many part-time workers could obtain coverage more inexpensively through the Exchanges or by enrolling in the expanded Medicaid program. Finally, as mentioned previously, the per-worker penalties assessed on nonparticipating employers are relatively low compared to prevailing health insurance costs. As a result, the penalties would not be a substantial deterrent to dropping or forgoing coverage. We estimate that such actions would collectively reduce the number of people with employer-sponsored health coverage by about 14 million, or slightly more than the number newly covered through

[5] Such other factors include age, gender of head of household, race, children, marital status, health status, and employment status (for both the head of household and the spouse), as well as adjustments to reflect the availability of health insurance on a guaranteed-issue basis and at community-rated, group insurance premium rates. Finally, we also considered the general desire to comply with the intent of the law, even in the significant number of cases in which the penalty amount would be small or would not apply.

existing and new employer plans under the PPACA. As indicated in table 2, the total number of persons with employer coverage in 2019 is estimated to be 1 million lower under the reform legislation than under the prior law.

For the estimated 23 million people who would remain uninsured in 2019, roughly 5 million are undocumented aliens who would be ineligible for Medicaid or the Exchange coverage subsidies under the health reform legislation. The balance of 18 million would choose not to be insured and to pay the penalty (if applicable) associated with the individual mandate. For the most part, these would be individuals with relatively low health care expenses for whom the individual or family insurance premium would be significantly in excess of any penalty and their anticipated health benefit value. In other instances, as happens currently, some people would not enroll in their employer plans or take advantage of the Exchange opportunities even though it would be in their best financial interest to do so.

Impact on Medicare and Medicaid

Medicare

The estimated financial impacts of the Medicare provisions in the PPACA are provided in detail in table 3, attached, which is organized by section of the legislation.[6] Net Medicare savings are estimated to total $575 billion for fiscal years 2010-2019. Substantial savings are attributable to provisions that would, among other changes, reduce Part A and Part B payment levels and adjust future "market basket" payment updates for productivity improvements ($233 billion); eliminate the Medicare Improvement Fund ($27 billion); reduce disproportionate share hospital (DSH) payments ($50 billion); reduce Medicare Advantage payment benchmarks and permanently extend the authority to adjust for coding intensity ($145 billion); freeze the income thresholds for the Part B income-related premium for 9 years ($8 billion); implement an Independent Payment Advisory Board together with strict Medicare expenditure growth rate targets ($24 billion); and increase the HI payroll tax rate by 0.9 percentage point for individuals with incomes above $200,000 and families above $250,000 ($63 billion). Other provisions would generate relatively smaller amounts of savings, through such means as reporting physician quality measures, reducing payments in cases involving hospital-acquired infections, reducing readmissions, refining imaging payments, increasing Part D premiums for higher-income beneficiaries, and implementing evidence-based coverage of preventive services.

These savings are slightly offset by the costs of closing the Part D coverage gap ($12 billion); reducing the growth in the Part D out-of-pocket cost threshold ($1 billion); extending a number of special payment provisions scheduled to expire, such as the postponement of therapy caps ($5 billion); and by the costs for improving preventive health services and access to primary care ($6 billion).

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[6] For ease of interpretation, we have incorporated the Medicare and Medicaid provisions of the managers' amendments, as specified in Title X of the PPACA, into the corresponding provisions of Titles II through VII and Title IX. For example, the savings shown for section 3403 (Independent Payment Advisory Board) represent the impact of this provision from the original bill as amended by Senate managers' amendment section 10320. Similarly, any further amendments introduced by the Reconciliation Act and managers' amendments to the Reconciliation Act have also been included with the corresponding title of the PPACA. For example, the costs under section 1101 of the Reconciliation Act, to close the Part D coverage gap or "donut hole," are included with the Part D provisions of PPACA, as are the costs of slowing the growth in the enrollee out-of-pocket cost threshold, as added by the managers' amendments to the Reconciliation Act.

The Reconciliation Act amendments introduced a new 3.8-percent "unearned income Medicare contribution" on income from interest, dividends, annuities, and other non-earnings sources for individual taxpayers with incomes above $200,000 and couples filing joint returns with incomes above $250,000. Despite the title of this tax, this provision is unrelated to Medicare; in particular, the revenues generated by the tax on unearned income are not allocated to the Medicare trust funds (and thus are not shown in table 3).

Conversely, the revenues from fees on manufacturers and importers of brand-name prescription drugs under section 9008 of the PPACA are earmarked for the Part B account in the Medicare Supplementary Medical Insurance trust fund. From the standpoint of the Federal Budget, these amounts are new receipts and serve to reduce the Budget deficit. From a trust fund perspective, however, the situation is more complicated. No changes were made in the existing statutory provisions for Part B beneficiary premiums and general revenue matching amounts, which by law are set each year at a level adequate to finance Part B expenditures. With no change to the existing financing, the additional revenues under section 9008 would result in an excessive level of financing for Part B and an unnecessary accumulation of account assets. It would be reasonable to establish a negative "premium margin" to maintain Part B assets at an appropriate contingency level, which would reduce beneficiary premium rates and matching general revenues by an amount equal to the new revenues from prescription drug fees. The estimated savings amounts shown in table 3 for section 9008 represent the net Budget impact (additional fee receipts less the reduction in beneficiary premiums). In practice, there would be no net impact on the operations of the Part B trust fund account.

Based on the estimated savings for Part A of Medicare, the assets of the Hospital Insurance trust fund would be exhausted in 2029 compared to 2017 under the prior law—an extension of 12 years. The combination of lower Part A costs and higher tax revenues results in a lower Federal deficit based on budget accounting rules. However, trust fund accounting considers the same lower expenditures and additional revenues as extending the exhaustion date of the HI trust fund. In practice, the improved HI financing cannot be simultaneously used to finance other Federal outlays (such as the coverage expansions) and to extend the trust fund, despite the appearance of this result from the respective accounting conventions.

It is important to note that the estimated savings shown in this memorandum for one category of Medicare provisions may be unrealistic. The PPACA introduces permanent annual productivity adjustments to price updates for most providers (such as hospitals, skilled nursing facilities, and home health agencies), using a 10-year moving average of economy-wide private, non-farm productivity gains. While such payment update reductions will create a strong incentive for providers to maximize efficiency, it is doubtful that many will be able to improve their own productivity to the degree achieved by the economy at large.[7] Over time, a sustained reduction in payment updates, based on productivity expectations that are difficult to attain, would cause Medicare payment rates to grow more slowly than, and in a way that was unrelated to, the

[7] The provision of most health services tends to be very labor-intensive. Economy-wide productivity gains reflect relatively modest improvements in the service sector together with much larger improvements in manufacturing. Except in the case of physician services, we are not aware of any empirical evidence demonstrating the medical community's ability to achieve productivity improvements equal to those of the overall economy. The Office of the Actuary's most recent analysis of hospital productivity highlights the difficulties in measurement but suggests that such productivity has been small or negligible during 1981 to 2005.
(See http://www.cms.hhs.gov/HealthCareFinancingReview/downloads/07-08Winterpg49.pdf.)

providers' costs of furnishing services to beneficiaries. Thus, providers for whom Medicare constitutes a substantive portion of their business could find it difficult to remain profitable and, absent legislative intervention, might end their participation in the program (possibly jeopardizing access to care for beneficiaries). Simulations by the Office of the Actuary suggest that roughly 15 percent of Part A providers would become unprofitable within the 10-year projection period as a result of the productivity adjustments.[8] Although this policy could be monitored over time to avoid such an outcome, changes would likely result in smaller actual savings than shown here for these provisions.

A related concern is posed by the requirements that will be placed on the Independent Payment Advisory Board. The Board will be charged with recommending changes to certain Medicare payment categories in an effort to prevent per-beneficiary Medicare costs from increasing faster than the average of the CPI and the CPI-medical for "implementation years" 2015 through 2019.[9] The Secretary of HHS is required to implement the Board's recommendations unless the statutory process is overridden by new legislation.

Average Medicare costs per beneficiary usually increase over time as a function of (i) medical-specific price growth, (ii) more utilization of services by beneficiaries, and (iii) greater "intensity" or average complexity of these services. In general, limiting cost growth to a level below medical price inflation alone would represent an exceedingly difficult challenge. Actual Medicare cost growth per beneficiary was below the target level in only 4 of the last 25 years, with 3 of those years immediately following the Balanced Budget Act of 1997; the impact of the BBA prompted Congress to pass legislation in 1999 and 2000 moderating many of the BBA provisions. As an additional comparison, during the last 25 years the average increase in the target growth rate has been 0.33 percent per year below the average increase in nominal GDP per capita—which is approximately the target level for the physician sustainable growth rate (SGR) payment system. Congress has overridden the SGR-based payment reductions for each of the last 7 years (and, to date, for the first 5 months of 2010).

The Board's efforts would be further complicated by provisions that prohibit increases in cost-sharing requirements and that exempt certain categories of Medicare expenditures from consideration. We have estimated the savings for section 3403 under the assumption that the provision will be implemented as specified; in particular, we have not assumed that Congress would pass subsequent legislation to prevent implementation of the Board's recommendations. Although the savings from the other Medicare provisions in the PPACA are quite substantial, they would not be sufficient to meet the growth rate targets specified in conjunction with the Advisory Board. We estimate that meeting the growth rate targets in 2015-2019 would require changes that would reduce Medicare growth rates by another 0.3 percent per year, on average, in addition to the impacts of the productivity adjustments, MA and DSH reductions, and other provisions in the PPACA.

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[8] The simulations were based on actual fiscal year 2007 Medicare and total facility margin distributions for hospitals, skilled nursing facilities, and home health agencies. Provider revenues and expenditures were projected using representative growth rates and the Office of the Actuary's best estimates of achievable productivity gains for each provider type, and holding all other factors constant. A sensitivity analysis suggested that the conclusions drawn from the simulations would not change significantly under different provider behavior assumptions.

[9] Maximum growth rate reductions of 0.5, 1.0, and 1.25 percentage points would apply to 2015, 2016, and 2017, respectively, and the maximum would be 1.5 percentage points thereafter. After implementation year 2019, the target growth amount would be based on the increase in per capita GDP plus 1 percentage point.

After 2019, further Advisory Board recommendations for growth rate reductions would generally not be required. The other Medicare savings provisions, if permitted to continue, would normally reduce expenditure growth rates to slightly below the post-2019 target level based on per capita GDP growth plus 1 percent. Even if Medicare growth rates exceeded the targets, recommendations might not be required if the projected Medicare growth rate were less than that for overall national health expenditures on a per capita basis—as would tend to be the case, given the continuing Medicare savings. (This exemption from the requirement to make recommendations could not be applied in 2 successive years.) Although the Advisory Board process would have no impact after 2019 based on the specific assumptions underlying these estimates, it would still serve as a brake during any periods of unusually rapid spending growth.

Under the prior law, Medicare Advantage payment benchmarks were generally in the range of 100 to 140 percent of fee-for-service costs. Section 1102 of reconciliation amendments sets the 2011 MA benchmarks equal to the benchmarks for 2010 and specifies that, ultimately, the benchmarks will equal a percentage (95, 100, 107.5, or 115 percent) of the fee-for-service rate in each county. During a transition period, the benchmarks will be based on a blend of the prior ratebook approach and the ultimate percentages. The phase-in schedule for the new benchmarks will occur over 2 to 6 years, with the longer transitions for counties with the larger benchmark decreases under the new method.

The PPACA, as amended, also introduces MA bonuses and rebate levels that are tied to the plans' quality ratings. Beginning in 2012, benchmarks will be increased for plans that receive a 4-star or higher rating on a 5-star quality rating system. The bonuses will be 1.5 percent in 2012, 3.0 percent in 2013, and 5.0 percent in 2014 and later. An additional county bonus, which is equal to the plan bonus, will be provided on behalf of beneficiaries residing in specified counties. The percentage of the "benchmark minus bid" savings provided as a rebate, which historically has been 75 percent, will also be tied to a plan's quality rating. In 2014, when the provision is fully phased in, the rebate share will be 50 percent for plans with a quality rating of less than 3.5 stars; 65 percent for a quality rating of 3.5 to 4.49; and 70 percent for a quality rating of 4.5 or greater.

The new provisions will generally reduce MA rebates to plans and thereby result in less generous benefit packages.[10] We estimate that in 2017, when the MA provisions will be fully phased in, enrollment in MA plans will be lower by about 50 percent (from its projected level of 14.8 million under the prior law to 7.4 million under the new law).

Medicaid/CHIP

The estimated Federal financial effects of the Medicaid and CHIP provisions in the PPACA are shown in table 4, attached. As noted earlier, the costs associated with the expansion of Medicaid eligibility to individuals and families with incomes below 133 percent of the FPL and to children previously in foster care are included with the national coverage provisions shown in table 1. The additional funding for the CHIP program is also included in table 1 with the other coverage provisions.

[10] MA plans use rebate revenues to reduce Medicare coinsurance requirements, add extra benefits such as vision or dental care, and/or reduce enrollee premiums for Part B or Part D of Medicare. The new law also requires adjustments to offset the impact of excess "coding intensity" in determining plan risk scores. These adjustments would prevent increases in future payments to MA plans as a result of such coding.

The total net Federal cost of the other Medicaid and CHIP provisions is estimated to be $28 billion in fiscal years 2010-2019 and reflects numerous cost increases and decreases under the individual provisions. Those with significant Federal savings include various provisions increasing the level of Medicaid prescription drug rebates ($24 billion) and reductions in Medicaid DSH expenditures ($14 billion). Interactions between the different sections of the legislation, such as the lower Medicare Part B premiums under the PPACA, contribute an additional $9 billion in reduced Medicaid outlays.

The key provisions that would increase Federal Medicaid and CHIP costs are the Medicaid "Community First Choice Option" and other changes to encourage home and community-based services ($29 billion), higher Federal matching rates for States with existing childless-adult coverage expansions ($24 billion), a temporary increase in payments to primary care physicians ($11 billion), and increased payments to the territories ($7 billion). (The net impact of the Medicaid and CHIP provisions on State Medicaid costs is a reduction totaling $33 billion through fiscal year 2019. These savings result in part because certain of the provisions reallocate costs from States to the Federal government.)

Impact of Provisions on the Rate of Growth in Health Care Costs

The PPACA includes a number of provisions that are intended, in part, to help control health care costs and to change the overall trend in health spending growth. Many of these are specific to the Medicare program, and their estimated financial effects are shown in table 3. While some of the Medicare provisions would have a largely one-time impact on the *level* of expenditures (for example, the reduction in MA benchmarks), others would have an effect on expenditure *growth rates*. Examples of the latter include the productivity adjustments to Medicare payment updates for most categories of providers, which would reduce overall Medicare cost growth by roughly 0.6 to 0.7 percent per year, and the Independent Payment Advisory Board process, which would further reduce Medicare growth rates during 2015-2019 by about 0.3 percent per year. As discussed previously, however, the growth rate reductions from productivity adjustments are unlikely to be sustainable on a permanent annual basis, and meeting the CPI-based target growth rates prior to 2020 will be very challenging as well.

The Independent Payment Advisory Board will also be required to periodically submit recommendations to Congress and the President regarding methods of slowing the growth of non-Federal health care programs. In many cases, Federal or State legislation would need to be enacted to implement these recommendations. In other cases, they could be adopted voluntarily by private health insurance plans or by health providers or introduced administratively by government entities. Because the nature of these broader recommendations is not known and there is no mandate to adopt them, we have not estimated an explicit impact on health care spending growth.

Another provision that would tend to moderate health care cost growth rates is the excise tax on high-cost employer-sponsored health insurance coverage (section 9001), which is described in more detail in the section of this memorandum on national health expenditures. In reaction to the tax, which would take effect in 2018, many employers would reduce the scope of their health benefits. The resulting reductions in covered services and/or increases in employee cost-sharing requirements would induce workers to use fewer services. Because plan benefit values will generally increase faster than the threshold amounts for defining high-cost plans (which, after

2019, are indexed by the CPI), additional plans would become subject to the excise tax over time, prompting many of those employers to scale back coverage. This continuing cycle would have a moderate impact on the overall growth of expenditures for employer-sponsored insurance. It should be noted, however, that an estimated 12 percent of insured workers in 2019 would be in employer plans with benefit values in excess of the thresholds (before changes to reduce benefits) and that this percentage would increase rapidly thereafter. The effect of the excise tax on reducing health care cost growth would depend on its ongoing application to an expanding share of employer plans and on an increasing scope of benefit reductions for affected plans. Since this provision is characterized as affecting high-cost employer plans, its broader and deeper impact could become an issue.

Certain other provisions of the PPACA are also intended to help control health care costs more generally, through promotion of comparative effectiveness research, greater use of prevention and wellness measures, administrative simplification, and augmented fraud and abuse enforcement. For fiscal years 2010 through 2019, we estimate a relatively small reduction in non-Medicare Federal health care expenditures of $2 billion for these provisions, all of which is associated with comparative effectiveness research.

Comparative Effectiveness Research

We reviewed literature and consulted experts to determine the potential cost savings that could be derived from comparative effectiveness research (CER). We found that the magnitude of potential savings varies widely depending upon the scope and influence of comparative effectiveness efforts. Small savings could be achieved through the wide availability of non-binding research, while substantial savings could be generated by a comparative effectiveness board with authority over payment and coverage policies.

Our interpretation of the CER provisions in the PPACA, which allow the Secretary of HHS to use evidence and findings from CER within defined limits in making coverage determinations under Medicare, is consistent with a low level of influence, translating into an estimated total reduction in national health expenditures of $8 billion for calendar years 2010 through 2019, and Federal savings of about $4 billion for fiscal years 2010 through 2019 (including Medicare). We anticipate that such savings would develop gradually, as changes in provider practice and culture evolved over time. Expert input on this subject suggests that the full impact of comparative effectiveness research, together with dissemination and application of its results, would take many years to develop.

Other Provisions

We show a negligible financial impact over the next 10 years for the other provisions intended to help control future health care cost growth. There is no consensus in the available literature or among experts that prevention and wellness efforts result in lower costs. Several prominent studies conclude that such provisions—while improving the quality of individuals' lives in important ways—generally increase costs overall. For example, while it is possible that savings can be achieved for many people by diagnosing diseases in early stages and promoting lifestyle

and behavioral changes that reduce the risk for serious and costly illnesses, additional costs are incurred as a result of increased screenings, preventive care, and extended years of life.[11]

Regarding the general fraud and abuse and administrative simplification provisions (that is, excluding the Medicare and Medicaid provisions), we find that the language is not sufficiently specific to provide estimates.

CLASS Program

Title VIII of the health reform act establishes a new, voluntary, Federal insurance program providing a cash benefit if a participant is unable to perform at least two or three activities of daily living or has substantial cognitive impairment. The program will be financed by participant premiums, with no Federal subsidy. Participants will have to meet certain modest work requirements during a 5-year vesting period before becoming eligible for benefits. Benefits are intended to be used to help purchase community living assistance services and supports (CLASS) that would help qualifying beneficiaries maintain their personal and financial independence and continue living in the community. Benefits can also be used to help cover the cost of institutional long-term care.

As shown in the table on page 2, we estimate a net Federal savings for the CLASS program of $38 billion during the first 9 years of operations—the first 5 of which are prior to the commencement of benefit payments. After 2015, as benefits are paid, the net savings from this program will decline; in 2025 and later, projected benefits exceed premium revenues, resulting in a net Federal cost in the longer term.[12]

We estimate that roughly 2.8 million persons will participate in the program by the third year. This level represents about 2 percent of potential participants, compared to a participation rate of 4 percent for private long-term care insurance offered through employers. Factors affecting participation in CLASS include the program's voluntary nature, the lack of a Federal subsidy, a minimal premium for students and individuals with incomes under 100 percent of the FPL (initially $5 per month), a relatively high premium for all other participants as a result of adverse selection and the effect of subsidizing participants paying the $5 premium, a new and unfamiliar benefit, and the availability of lower-priced private long-term care insurance for many.

Compounding this situation will be the probable participation of a significant number of individuals who already meet the functional limitation requirements to qualify for benefits. In the sixth year of the program (2016), these participants would begin to receive benefits, along with others who had developed such limitations in the interim. We estimate that an initial

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[11] Title IV in the PPACA creates a Prevention and Public Health Fund and authorizes the appropriation of $15 billion for these purposes. We consider these expenditures to be primarily administrative in nature and thus have not included them as program costs in this memorandum.

[12] The CLASS program is intended to be financed on a long-range, 75-year basis through participant premiums that would fully fund benefits and administrative expenses. If this goal can be achieved, despite anticipated serious adverse selection problems (described subsequently), then annual expenditures would be met through a combination of premium income and interest earnings on the assets of the CLASS trust fund. The Federal Budget impact would be the net difference between premium receipts and program outlays. Thus, the trust fund would be adequately financed in this scenario, but the Federal Budget would have a net savings each year prior to 2025 and a net cost each year thereafter.

average premium level of about $240 per month would be required to adequately fund CLASS program costs for this level of enrollment, adverse selection, and premium inadequacy for students and low-income participants. (Except for those paying the $5 premium, individuals enrolling in a given year will pay a constant premium amount throughout their participation, unless trust fund deficits necessitate a premium increase. Premiums will vary by age at enrollment and by year of enrollment.)

In general, voluntary, unsubsidized, and non-underwritten insurance programs such as CLASS face a significant risk of failure as a result of adverse selection by participants. Individuals with health problems or who anticipate a greater risk of functional limitation would be more likely to participate than those in better-than-average health. Setting the premium at a rate sufficient to cover the costs for such a group further discourages persons in better health from participating, thereby leading to additional premium increases. This effect has been termed the "classic assessment spiral" or "insurance death spiral." The problem of adverse selection is intensified by requiring participants to subsidize the $5 premiums for students and low-income enrollees. Although Title VIII includes modest work requirements in lieu of underwriting and specifies that the program is to be "actuarially sound" and based on "an actuarial analysis of the 75-year costs of the program that ensures solvency throughout such 75-year period," there is a very serious risk that the problem of adverse selection will make the CLASS program unsustainable.[13]

Immediate Insurance Reforms

A number of provisions in the PPACA have an immediate effect on insurance coverage. Most of these provisions, however, do not have a direct impact on Federal expenditures. (A discussion of their impact on national health expenditures is included in the following section of this memorandum.) Section 1101 of the PPACA authorizes the expenditure of up to $5 billion in support of a temporary national insurance pool for high-risk individuals without other health insurance. Section 1102 requires the Secretary of HHS to establish a Federal reinsurance program in 2010-2013 for early retirees and their families in employer-sponsored health plans. Participation by employers is optional, and the law authorizes up to $5 billion in Federal financing for the reinsurance costs. No other financing is provided, and reinsurance claims would be paid only as long as the authorized amount lasts. We estimate that the full amount of the authorizations for sections 1101 and 1102 would be expended during the first 1 to 3 calendar years of operation.

National Health Expenditure Impacts

The estimated effects of the PPACA on overall national health expenditures (NHE) are shown in table 5. In aggregate, we estimate that for calendar years 2010 through 2019, NHE would increase by $311 billion, or 0.9 percent, over the updated baseline projection that was released on June 29, 2009.[14] Year by year, the relative increases are largest in 2016, when the coverage expansions would be fully phased in (2.0 percent), and gradually decline thereafter to 1.0 percent

[13] An analysis of the potential adverse selection problems for the CLASS program was performed by a nonpartisan, joint workgroup of the American Academy of Actuaries and the Society of Actuaries. Their report was issued on July 22, 2009 and is available at http://www.actuary.org/pdf/health/class_july09.pdf .

[14] R. Foster and S. Heffler, "Updated and Extended National Health Expenditure Projections, 2010-2019." Memorandum dated June 29, 2009. Available online at http://www.cms.hhs.gov/NationalHealthExpendData/Downloads/NHE_Extended_Projections.pdf.

in 2019, as the effects of the Medicare market basket reductions compound and as the excise tax on high-cost employer health plans becomes effective. The NHE share of GDP is projected to be 21.0 percent in 2019, compared to 20.8 percent under prior law.

The increase in total NHE is estimated to occur primarily as a net result of the substantial expansions in coverage under the PPACA, together with the expenditure reductions for Medicare. Numerous studies have demonstrated that individuals and families with health insurance use more health services than otherwise-similar persons without insurance. Under the health reform legislation, as noted above, an estimated 34 million currently uninsured people would gain comprehensive coverage through the health insurance Exchanges, their employers, or Medicaid. The availability of coverage would typically result in a fairly substantial increase in the utilization of health care services, with a corresponding impact on total health expenditures. These higher costs would be partially offset by the sizable discounts imposed on providers by State Medicaid payment rules and by the significant discounts negotiated by private health insurance plans. We estimate that the net effect of the utilization increases and price reductions arising from the coverage provisions of the PPACA would increase NHE in 2019 by about 3.4 percent.

The PPACA will also affect aggregate NHE through the Medicare savings provisions. We estimate that these impacts would reduce NHE by roughly 2.4 percent in 2019, assuming that the productivity adjustments to Medicare payment updates and the impacts of the Independent Payment Advisory Board can be sustained through this period. The legislation would have only a slight impact on the utilization of health care services by Medicare beneficiaries (subject to the caveat mentioned previously regarding possible access issues under the provision to permanently reduce annual provider payment updates by economy-wide productivity gains). Medicaid outlays for health care would increase under some provisions and decrease under others; excluding the coverage expansion, the overall higher level of such costs would lower total U.S. health expenditures in 2019 by about 0.1 percent.

The immediate insurance reforms in Title I will affect national health expenditures as well, although by relatively small amounts. We estimate that the creation of a national high-risk insurance pool will result in roughly 375,000 people gaining coverage in 2010, increasing national health spending by $4 billion. By 2011 and 2012 the initial $5 billion in Federal funding for this program would be exhausted, resulting in substantial premium increases to sustain the program; we anticipate that such increases would limit further participation. An estimated 2.7 million retirees and dependents would be affected by the Federal reinsurance program for early retirees with employer-sponsored insurance. Although the reinsurance program would increase Federal costs by the allotted $5 billion, we estimate that the impact on total national health expenditures would be negligible.

Beginning in 2010, qualified child dependents below age 26 who are uninsured will be allowed to enroll under dependent coverage. An estimated 485,000 dependent children will gain insurance coverage through their parents' private group health plans, increasing national health spending by $0.9 billion. These impacts are expected to persist through 2013. Additionally, because this provision would not expire when the Medicaid expansion, individual mandate, and Exchanges start in 2014, we anticipate that these individuals would continue to remain covered as dependents even though they may be newly eligible for other coverage. Finally, we did not estimate NHE coverage or cost impacts for the other immediate reform provisions, such as prohibiting limitations on pre-existing conditions or elimination of lifetime aggregate benefit

limits. We believe that each of these provisions would have only a relatively minor upward impact on national health spending.

Section 9001 of the PPACA places an excise tax on employer-sponsored health insurance coverage with a benefit value above specified levels (generally $10,200 for individuals and $27,500 for families in 2018, adjusted in 2019 by growth in the CPI plus 1 percentage point and by growth in the CPI thereafter).[15] The tax is 40 percent of the excess benefit value above these thresholds. We estimate that, in aggregate, affected employers will reduce their benefit packages in such a way as to eliminate about three-quarters of the excess benefit value. The resulting higher cost-sharing requirements for employees would have an initial impact on the overall level of health expenditures, reducing total NHE by an estimated 0.1 percent in 2019. Moreover, because health care costs will generally increase faster than the CPI, we anticipate additional, incremental benefit coverage reductions in future years to prevent an increase in the share of employer coverage subject to the excise tax. These further adjustments would contribute to a small reduction in the growth in total health care costs (but an increase in out-of-pocket costs) for affected employees in 2019 and later.[16] As mentioned earlier, the proportion of workers experiencing reductions in their employer-sponsored health coverage as a result of the excise tax is estimated to increase rapidly after 2019.

The health reform legislation, as enacted, imposes collective annual fees on manufacturers and importers of brand-name prescription drugs and on health insurance plans. In addition, the PPACA establishes an excise tax on non-personal-use retail sales by manufacturers and importers of medical devices. For manufacturers and importers of brand-name prescription drugs, the fee is $2.5 billion in 2011, increasing to a maximum of $4.1 billion by 2018, and then is set at $2.8 billion per year in 2019 and beyond.[17] For insurers, the annual fee is set at $8.0 billion starting in 2014 and rises to $14.3 billion by 2018; thereafter, the fee increases by the rate of premium growth. In each case, the total annual fee amount would be assessed on the specified industry as a whole; the share of the fee payable by any given firm in that industry would be determined based on sales (for manufacturers and importers of drugs) and on net premiums (in the case of insurers), with some limited exemptions. The excise tax on medical device sales is effective in 2011 and is set at 2.3 percent of first sales in each year. We anticipate that these fees and the excise tax would generally be passed through to health consumers in the form of higher drug and device prices and higher insurance premiums, with an associated increase in overall national health expenditures ranging from $2.1 billion in 2011 to $18.2 billion in 2018 and $17.8 billion in 2019.

Although, compared to prior law, the *level* of total national health expenditures is estimated to be higher through 2019 under the PPACA, two particular provisions of the legislation would help reduce NHE *growth rates* after 2016. Specifically, the productivity adjustments to most Medicare payment updates would reduce NHE growth by about 0.10 to 0.15 percent per year. In addition, the excise tax on high-cost employer health plans (with benefit thresholds indexed by the CPI plus 1 percent for 2019 and by the CPI thereafter) would exert a further decrease in NHE

[15] Higher thresholds apply in the case of qualified retirees and individuals in high-risk occupations. Additionally, a higher threshold applies for employers with above-average proportions of older and/or female workers.

[16] We have not included the excise taxes under this provision in the estimated financial effects of the PPACA shown in this memorandum. Similarly, the indirect impacts on Federal income taxes and social insurance payroll taxes are not shown.

[17] These fees are allocated to the Part B account of the Medicare Supplementary Medical Insurance trust fund.

growth rates of an estimated 0.05 percent in 2019 and slightly more than that for some years after. Although these growth rate differentials are not large, over time they would have a noticeable downward effect on the level of national health expenditures. Such an outcome, however, would depend critically on the sustainability of both provisions. As discussed previously, the Medicare productivity adjustments could become unsustainable even within the next 10 years, and over time the reductions in the scope of employer-sponsored health insurance could also become an issue. For these reasons, the estimated reductions in NHE growth rates after 2016 may not be fully achievable.

Underlying the overall moderate effects of the PPACA on NHE will be various changes by payer. Based on the net impact of (i) the substantial coverage expansions, (ii) the significant cost-sharing subsidies for low-to-middle-income persons, (iii) the maximum out-of-pocket limitations associated with the qualified health benefit, and (iv) the increases in workers' cost-sharing obligations in plans affected by the excise tax on high-cost employer-sponsored health insurance coverage, we estimate that overall out-of-pocket spending would be reduced significantly by the PPACA (a net total decline of $237 billion in calendar years 2010-2019).

Public spending would increase under the PPACA as a result of the expansion of the Medicaid program and additional CHIP funding but would be reduced by the net Medicare savings from the legislation. Private expenditures would decrease somewhat because of the net reduction in the number of persons with employer-sponsored health insurance and the reduced benefits for plans affected by the excise tax on high-cost employer coverage. The sizable growth in health insurance coverage through Exchange plans would also affect NHE amounts by payer. Prior to the PPACA, public expenditures (principally Medicare and Medicaid) were estimated to represent 52 percent of total NHE in 2019. Under the PPACA, the public share would be roughly 51 percent if health expenditures by Exchange plans are classified as private spending.[18]

Caveats and Limitations of Estimates

The Federal costs and savings, changes in health insurance coverage, and effects on total national health expenditures presented in this memorandum represent the Office of the Actuary's best estimates for the PPACA. Although we believe that these estimates are reasonable and fairly portray the likely future effects of this comprehensive package of health care reforms, they are

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[18] The allocation of NHE *by payer* is based on the entity that is responsible for establishing the coverage and benefit provisions and that has the primary responsibility to ensure that payment is made for health care services. (Auxiliary analyses of NHE *by sponsor* are also prepared, based on the financing of health expenditures in the U.S.) Because all Exchange plans will be private plans, under the traditional NHE classification approach these expenditures would be considered private health insurance spending. However, the classification of health expenditures made by Exchange plans is complicated by three factors:

(i) The Exchanges will be government entities, with a role in setting minimum benefit standards, but they will not directly provide health insurance coverage. The same situation applies to the multi-State Exchange plans arranged by the Office of Personnel Management.

(ii) The Federal government, through the refundable tax credits and cost-sharing reductions, will subsidize a significant portion of Exchange plan premiums and cost-sharing liabilities.

(iii) The premium subsidies will vary between zero and 100 percent from one person to another, and the cost-sharing subsidies from zero to 80 percent on an insurance-value basis.

A more precise determination of the appropriate classification of the Exchange plan expenditures based on national health expenditure accounting principles will be conducted in the future.

subject to much greater uncertainty than normal. The following caveats should be noted, and the estimates should be interpreted cautiously in view of their limitations.

- These financial and coverage impacts are based on the provisions of the PPACA as enacted on March 23, 2010 and amended on March 30 by the Health Care and Education Reconciliation Act of 2010.

- Many of the provisions, particularly the coverage expansions, are unprecedented or have been implemented only on a smaller scale (for example, at the State level). Consequently, little historical experience is available with which to estimate the potential impacts.

- The behavioral responses to changes introduced by national health reform legislation are impossible to predict with certainty. In particular, the responses of individuals, employers, insurance companies, and Exchange administrators to the new coverage mandates, Exchange options, and insurance reforms could differ significantly from the assumptions underlying the estimates presented here.

- The nominal dollar amounts of costs and savings under national health reform are sensitive to the assumed trajectory of future health cost trends. Relative measures, such as the cost as a percentage of GDP, are less sensitive.

- Due to the very substantial challenges inherent in modeling national health reform legislation, our estimates will vary from those of other experts and agencies. Differences in results from one estimating entity to another may tend to cause confusion among policy makers. These differences, however, provide a useful reminder that all such estimates are uncertain and that actual future impacts could differ significantly from the estimates of any given organization. Indeed, the future costs and coverage effects could lie outside of the range of estimates provided by the various estimators.

- The existing number of uninsured persons in the U.S. is difficult to measure, and the number of uninsured persons who are undocumented aliens is considerably more uncertain. Medicaid coverage and Exchange premium subsidies under the PPACA are not available to undocumented aliens. As a result of these measurement difficulties, the actual costs under the PPACA and the reduction in the number of uninsured persons may be somewhat higher or lower than estimated in this memorandum.

- Certain Federal costs and savings were not included in our estimates if (i) a provision would have no, or only a minor, impact; (ii) the legislative language did not provide sufficient detail with which to estimate a provision's impact; or (iii) the estimates are outside of the scope of the Office of the Actuary's expertise and will be prepared by other agencies. In particular, we did not include any Federal savings pertaining to the excise tax on high-cost employer-sponsored health insurance coverage, the fees on insurance plans, the excise tax on devices, and other non-Medicare revenue provisions of the PPACA, as those estimates are provided by the Department of the Treasury. (In contrast, the impacts of these provisions on national health expenditures are reflected.) Similarly, Federal administrative expenses associated with the PPACA are not included here and will be estimated separately. The Congressional Budget Office and the Joint Committee on Taxation have estimated that the total amount of Medicare savings and additional excise tax and other revenues would somewhat more than offset the cost of the national coverage provisions, resulting in an overall small reduction in the Federal

deficit through 2019, and for the following 10 years as well, if all of the provisions continued to be fully implemented.

- In estimating the financial impacts of the PPACA, we assumed that the increased demand for health care services could be met without market disruptions. In practice, supply constraints might initially interfere with providing the services desired by the additional 34 million insured persons. Price reactions—that is, providers successfully negotiating higher fees in response to the greater demand—could result in higher total expenditures or in some of this demand being unsatisfied. Alternatively, providers might tend to accept more patients who have private insurance (with relatively attractive payment rates) and fewer Medicare or Medicaid patients, exacerbating existing access problems for Medicaid enrollees. Either outcome (or a combination of both) should be considered plausible and even probable initially.

  The latter possibility is especially likely in the case of the substantially higher volume of Medicaid services, for which provider payment rates are well below average. Therefore, it is reasonable to expect that a significant portion of the increased demand for Medicaid would be difficult to meet, particularly over the first few years.

  We have not attempted to model that impact or other plausible supply and price effects, such as supplier entry and exit or cost-shifting towards private payers. A specific estimate of these potential outcomes is impracticable at this time, given the uncertainty associated with both the magnitude of these effects and the interrelationships among these market dynamics. We may incorporate such factors in future estimates, should we determine that they can be estimated with a reasonable degree of confidence. For now, we believe that consideration should be given to the potential consequences of a significant increase in demand for health care meeting a relatively fixed supply of health care providers and services.

- As stated in the section on Medicare estimates, reductions in payment updates to health care providers, based on economy-wide productivity gains, are unlikely to be sustainable on a permanent annual basis. If these reductions were to prove unworkable within the 10-year period 2010-2019 (as appears probable for significant numbers of hospitals, skilled nursing facilities, and home health agencies), then the actual Medicare savings from these provisions would be less than shown in this memorandum. Similarly, the further reductions in Medicare growth rates mandated for 2015 through 2019 through the Independent Payment Advisory Board may be difficult to achieve in practice.

- In estimating the financial impact of the Medicaid eligibility expansion, we assumed that existing and new Medicaid enrollees would be appropriately classified for FMAP purposes.

- As discussed in the section on the CLASS program, we believe that there is a very serious risk that the program, as currently specified, will not be sustainable because of adverse selection.

Conclusions

The national health care reform provisions in the Patient Protection and Affordable Care Act, as amended, make far-reaching changes to the health sector, including mandated coverage for most people, required payments by most employers not offering insurance, expanded eligibility for Medicaid, Federal premium and cost-sharing subsidies for many individuals and families, a new system of health benefits Exchanges for facilitating coverage, and a new Federal insurance

program in support of long-term care. Additional provisions will reduce Medicare outlays, make other Medicaid modifications, provide more funding for the CHIP program, add certain benefit enhancements for these programs, and combat fraud and abuse. Federal revenues will be increased through an excise tax on high-cost insurance plans; fees or excise taxes on drugs, devices, and health plans; higher Hospital Insurance payroll taxes for high-income taxpayers; a new tax on investment revenues and other unearned income; and other provisions.

The Office of the Actuary at CMS has estimated the effects of the non-tax provisions of the PPACA on Federal outlays, overall national health expenditures, and health insurance coverage in the U.S. Our estimates are based on available data sources and what we believe are reasonable assumptions regarding individual, employer, and health plan responses to the legislation, together with analyses of the likely changes in the cost and use of health care services. Our primary estimates for the PPACA are as follows:

- The total Federal cost of the national insurance coverage provisions would be about $828 billion during fiscal years 2010 through 2019.

- By 2019, an additional 34 million U.S. citizens and other legal residents would have health insurance coverage meeting the essential-benefit requirements.

- Total net savings in 2010-2019 from Medicare provisions would offset about $575 billion of the Federal costs for the national coverage provisions. The Medicaid and CHIP provisions, excluding the expansion of Medicaid and increased CHIP funding, would raise costs by $28 billion. Additional Federal revenues would further offset the coverage costs; however, the Office of the Actuary does not have the expertise necessary to estimate all such impacts. The Congressional Budget Office and the Joint Committee on Taxation have estimated an overall reduction in the Federal Budget deficit through 2019 under the PPACA.

- The new Community Living Assistance Services and Supports (CLASS) insurance program would produce an estimated total net savings of $38 billion through fiscal year 2019. This effect, however, is due to the initial 5-year period during which no benefits would be paid. Over the longer term, expenditures would exceed premium receipts, and there is a very serious risk that the program would become unsustainable as a result of adverse selection by participants.

- Total national health expenditures in the U.S. during 2010-2019 would increase by about 0.9 percent. The additional demand for health services could be difficult to meet initially with existing health provider resources and could lead to price increases, cost-shifting, and/or changes in providers' willingness to treat patients with low-reimbursement health coverage.

- The mandated reductions in Medicare payment updates for providers, the actions of the Independent Payment Advisory Board, and the excise tax on high-cost employer-sponsored health insurance would have a downward impact on future health care cost growth rates. During 2010-2019, however, these effects would be outweighed by the increased costs associated with the expansions of health insurance coverage. Also, the longer-term viability of the Medicare update reductions is doubtful. Other provisions, such as comparative effectiveness research, are estimated to have a relatively small effect on expenditure growth rates.

We hope that the information presented here will be of value to policy makers and administrators as they endeavor to implement and monitor the health reform act.

Richard S. Foster, FSA, MAAA
Chief Actuary

Attachments: 5

Table 1 — Estimated Federal Costs (+) or Savings (-) under the Patient Protection and Affordable Care Act, as Enacted and Amended, in billions

	Fiscal Year										Total, FY
Provisions	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	2010-2019
Total*	$9.2	-$0.7	-$12.6	-$22.3	$16.8	$57.9	$63.1	$54.2	$47.2	$38.5	$251.3
Coverage Provisions:	3.3	4.6	4.9	5.2	82.9	119.2	138.2	146.6	157.6	165.8	828.2
Medicaid Expansion and CHIP Funding	—	—	—	—	38.8	62.9	78.7	72.2	76.3	81.2	410.3
Credits:	3.3	4.6	4.9	5.2	49.6	67.6	77.9	99.1	110.3	115.5	537.9
Individual Exchange Subsidies:	—	—	—	—	43.9	61.4	76.3	99.1	110.3	115.5	506.5
Refundable Premium Tax Credits	—	—	—	—	38.4	54.2	68.3	88.6	98.7	103.0	451.1
Reduced Cost-Sharing Requirements	—	—	—	—	5.5	7.2	8.0	10.5	11.6	12.5	55.4
Small Employer Credits	3.3	4.6	4.9	5.2	5.7	6.2	1.6	0.0	0.0	0.0	31.4
Penalties:	—	—	—	—	-5.5	-11.3	-18.4	-24.7	-29.0	-30.9	-119.9
Individual Penalties	—	—	—	—	0.0	-2.4	-5.3	-7.6	-8.6	-9.2	-33.1
Employer Penalties	—	—	—	—	-5.5	-9.0	-13.0	-17.1	-20.4	-21.8	-86.8
Medicare	1.2	-4.7	-14.9	-26.3	-68.8	-60.3	-75.2	-92.1	-108.2	-125.7	-575.1
Medicaid/CHIP (Excluding Coverage Expansions)	-0.9	-0.9	0.8	4.5	8.6	5.1	4.6	3.4	1.3	1.7	28.3
Cost Trend Proposals:	—	—	—	—	0.0	-0.1	-0.2	-0.4	-0.6	-0.9	-2.3
Comparative Effectiveness Research†	—	—	—	—	0.0	-0.1	-0.2	-0.4	-0.6	-0.9	-2.3
Prevention and Wellness	—	—	—	—	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Fraud and Abuse	—	—	—	—	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Administrative Simplification	—	—	—	—	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Additional Proposals:	5.6	0.4	-3.3	-5.6	-5.9	-6.0	-4.3	-3.4	-2.8	-2.4	-27.8
CLASS Program	—	-2.8	-4.5	-5.6	-5.9	-6.0	-4.3	-3.4	-2.8	-2.4	-37.8
Immediate Reforms	5.6	3.2	1.2	—	—	—	—	—	—	—	10.0

* Excludes Title IX revenue provisions except for sections 9008 (fees on manufacturers and importers of brand-name prescription drugs) and 9015 (additional HI payroll tax). Also excludes certain provisions with limited impacts and Federal administrative costs.

† Excludes the Medicare impact of CER, which is included in the Medicare savings total.

Source: Centers for Medicare & Medicaid Services, Office of the Actuary.

April 22, 2010

Table 2 — Estimated Effects of the Patient Protection and Affordable Care Act, as Enacted and Amended, on Enrollment by Insurance Coverage, in millions

	Calendar Year									
Prior Law Baseline	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Medicare	46.9	48.0	49.4	50.9	52.4	53.9	55.4	57.1	58.7	60.5
Medicaid/CHIP	59.2	60.5	61.6	62.0	60.6	60.3	61.1	61.9	62.7	63.5
Other Public	12.3	12.6	12.9	13.2	13.6	13.9	14.2	14.6	14.9	15.2
Employer-Sponsored Private Health Insurance	163.8	163.2	164.5	165.0	166.1	166.6	166.4	166.2	166.0	165.9
Other Private Health Insurance*	26.1	25.3	25.5	25.6	25.8	25.8	25.8	25.8	25.8	25.7
Uninsured	48.3	48.6	47.9	48.1	50.0	51.7	53.1	54.4	55.6	56.9
Insured Share of US Population†	84.4%	84.5%	84.8%	84.9%	84.4%	84.0%	83.8%	83.5%	83.3%	83.0%

	Calendar Year									
New Law — PPACA	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Medicare	46.9	48.0	49.4	50.9	52.4	53.9	55.4	57.1	58.7	60.5
Medicaid/CHIP	59.2	60.5	61.6	62.0	83.6	84.6	84.1	82.1	82.9	83.9
Other Public	12.6	12.6	12.9	13.2	13.6	13.9	14.2	14.6	14.9	15.2
Employer-sponsored Private Health Insurance	164.3	163.7	164.9	165.5	168.1	169.0	166.6	164.7	163.7	164.5
Other Private Health Insurance*	26.1	25.3	25.5	25.6	12.6	12.2	11.5	10.9	10.4	10.0
Exchanges	—	—	—	—	16.9	18.6	24.8	29.8	31.4	31.6
Uninsured	47.5	48.1	47.4	47.6	23.8	22.2	21.0	22.0	22.8	23.1
Insured Share of US Population†	84.7%	84.6%	85.0%	85.0%	92.6%	93.2%	93.6%	93.3%	93.1%	93.1%

	Calendar Year									
Impact of PPACA	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
Medicare	—	—	—	—	—	—	—	—	—	—
Medicaid/CHIP	—	—	—	—	23.0	24.3	23.1	20.2	20.2	20.4
Other Public	0.4	—	—	—	—	—	—	—	—	—
Employer-sponsored Private Health Insurance	0.5	0.5	0.5	0.5	2.0	2.5	0.2	-1.5	-2.4	-1.4
Other Private Health Insurance*	—	—	—	—	-13.2	-13.7	-14.3	-14.9	-15.3	-15.7
Exchanges	—	—	—	—	16.9	18.6	24.8	29.8	31.4	31.6
Uninsured	-0.9	-0.5	-0.5	-0.5	-26.2	-29.5	-32.1	-32.4	-32.9	-33.8
Insured Share of US Population†	0.3%	0.2%	0.2%	0.2%	8.2%	9.1%	9.8%	9.8%	9.9%	10.1%

* In the prior-law baseline, other private health insurance includes private Medicare supplemental coverage and individual coverage. In the new-law estimates, other private health insurance includes only those with Medicare supplemental coverage.

† Calculated as a proportion of total U.S. population, including unauthorized immigrants.

Source: Centers for Medicare & Medicaid Services, Office of the Actuary.

April 22, 2010

Table 3—Estimated Medicare Costs (+) or Savings (–) under the Patient Protection and Affordable Care Act, as Enacted and Amended
(Amounts in millions)

Sec.	Provision	Fiscal year 2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Total, 2010-14	2010-19
	TITLE III-IMPROVING THE QUALITY AND EFFICIENCY OF HEALTH CARE												
	SUBTITLE A-TRANSFORMING THE HEALTH CARE DELIVERY SYSTEM												
	PART I-LINKING PAYMENT TO QUALITY OUTCOMES IN THE MEDICARE PROGRAM												
3001	Hospital Value-Based Purchasing	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
3002	Physician Quality Reporting Initiative	0	0	0	210	120	-190	-390	-580	-560	-530	330	-1,920
3003	Expansion of Physician Feedback Program	0	0	0	0	0	0	0	0	0	0	0	0
3004	Quality Reporting for Long-Term Care Hospitals, Inpatient Rehabilitation Hospitals, and Hospice Programs	0	0	0	0	-30	-30	-30	-30	-20	-20	-30	-160
3005	Quality Reporting for PPS-exempt Cancer Hospitals	0	0	0	0	0	0	0	0	0	0	0	0
3006	Value-based Purchasing for SNF, HHA, & ASC	0	0	0	0	0	0	0	0	0	0	0	0
3007	Value-based Payment Modifer under Physician Fee Schedule	0	0	0	0	0	0	0	0	0	0	0	0
3008	Payment Adjustment for Conditions Acquired in Hospitals	0	0	0	0	0	-520	-610	-660	-700	-750	0	-3,240
	PART II-NATIONAL STRATEGY TO IMPROVE HEALTH CARE QUALITY												
3011	National Strategy	0	0	0	0	0	0	0	0	0	0	0	0
3012	Interagency Working Group on Health Care Quality	0	0	0	0	0	0	0	0	0	0	0	0
3013	Quality Measure Development	0	0	0	0	0	0	0	0	0	0	0	0
3014	Quality and Efficiency Measurement	0	0	0	0	0	0	0	0	0	0	0	0
3015	Data Collection; Public Reporting	0	0	0	0	0	0	0	0	0	0	0	0
	PART III-ENCOURAGING DEVELOPMENT OF THE NEW PATIENT CARE MODELS												
3021	CMS Innovation Center	0	0	0	0	0	0	0	0	0	0	0	0
3022	Medicare Shared Savings Program	0	0	0	0	0	0	0	0	0	0	0	0
3023	National Pilot Program on Payment Bundling	0	0	0	0	0	0	0	0	0	0	0	0
3024	Independence at Home Demonstration Program	0	0	0	0	0	0	0	0	0	0	0	0
3025	Hospital Readmissions Reduction Program	0	0	0	-530	-630	-1,180	-1,320	-1,410	-1,510	-1,620	-1,160	-8,200
3026	Community-Based Care Transitions Program												
	Part A	0	100	100	100	100	100	0	0	0	0	400	500
	Part B	0	0	0	0	0	0	0	0	0	0	0	0
3027	Extension of Gainsharing Demonstration	0	0	0	0	0	0	0	0	0	0	0	0
	SUBTITLE B-IMPROVING MEDICARE FOR PATIENTS AND PROVIDERS												
	PART I-ENSURING BENEFICIARY ACCESS TO PHYSICIAN CARE AND OTHER SERVICES												
3101	Increase in Physician Payment Update	0	0	0	0	0	0	0	0	0	0	0	0
3102	Extension of Floor on Medicare Work Geographic Adjustment	510	780	290	0	0	0	0	0	0	0	1,580	1,580
3103	Extension of Exceptions for Therapy Caps	520	1,160	500	10	10	20	20	20	20	20	2,200	2,300
3104	Extension of Treatment of Certain Physician Pathology Services	40	80	40	0	0	0	0	0	0	0	160	160
3105	Extension of Ambulance Add-ons	20	10	0	0	0	0	0	0	0	0	30	30
3106	Extension of Long-Term Care Hospital Provisions	30	440	530	140	10	0	0	0	0	0	1,150	1,150
3107	Extension of Physician Fee Schedule Mental Health Add-on	40	20	0	0	0	0	0	0	0	0	60	60
3108	Permitting Physician Assistants to Order Post-Hospital Extended Care Services	0	0	0	0	0	0	0	0	0	0	0	0
3109	Exemption of Certain Pharmacies from Accreditation Requirements	0	0	0	0	0	0	0	0	0	0	0	0
3110	Part B Special Enrollment for Disabled TRICARE	0	10	20	30	40	40	40	40	50	50	100	320

Table 3—Estimated Medicare Costs (+) or Savings (–) under the Patient Protection and Affordable Care Act, as Enacted and Amended
(Amounts in millions)

Sec.	Provision	Fiscal year 2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Total, 2010-14	2010-19
3111	Bone Density Tests	20	40	20	0	0	0	0	0	0	0	80	80
3112	Revision to Medicare Improvement Fund												
	Part A	0	0	0	0	-15,350	0	0	0	0	0	-15,350	-15,350
	Part B	0	0	0	0	-11,890	0	0	0	0	0	-11,890	-11,890
3113	Treatment of Certain Complex Diagnostic Lab Tests	0	0	0	0	0	0	0	0	0	0	0	0
3114	Improved Access for Certified Midwife Services	0	0	0	0	0	0	0	0	0	0	0	0
	PART II-RURAL PROTECTIONS												
3121	Extend of Outpatient Hold Harmless Provision	50	20	0	0	0	0	0	0	0	0	70	70
3122	Extend Reasonable Cost Reimbursement for Laboratory Services in Small Rural Hospitals	0	0	0	0	0	0	0	0	0	0	0	0
3123	Extend Rural Community Hospital Demonstration Program	0	0	0	0	0	0	0	0	0	0	0	0
3124	Extend Medicare Dependent Hospital Program	0	0	100	10	0	0	0	0	0	0	110	110
3125	Improvements to Hospital Payments for Low-volume Hospitals	0	100	110	10	0	0	0	0	0	0	220	220
3126	Demonstration Project on Community Health Integration Models	0	0	0	0	0	0	0	0	0	0	0	0
3127	MEDPAC Study on Payments in Rural Areas	0	0	0	0	0	0	0	0	0	0	0	0
3128	Technical Correction to Critical Access Hospital Services	0	0	0	0	0	0	0	0	0	0	0	0
3129	Medicare Rural Hospital Flexibilty Program	0	0	0	0	0	0	0	0	0	0	0	0
	PART III-IMPROVING PAYMENT ACCURACY												
3131	Payment Adjustment for Home Health Care												
	Part A	20	-220	-370	-410	-690	-1,140	-1,710	-2,340	-2,700	-2,900	-1,670	-12,460
	Part B	20	-260	-450	-510	-860	-1,410	-2,120	-2,900	-3,350	-3,600	-2,060	-15,440
3132	Hospice Reform	0	0	0	0	0	0	0	0	0	0	0	0
3133	Improvement to Medicare DSH Payments	0	0	0	0	-110	-7,100	-9,170	-10,610	-11,180	-11,760	-110	-49,930
3134	Misvalued Codes under Physician Fee Schedule	0	0	0	0	0	0	0	0	0	0	0	0
3135	Equipment Utilization Factor for Advanced Imaging Services	0	-110	-170	-200	-210	-230	-240	-260	-270	-290	-690	-1,980
3136	Revision of Payment for Power Wheelchairs	0	-40	-50	-50	-50	-60	-70	-70	-80	-80	-190	-550
3137	Hospital Wage Index Improvement	260	30	0	0	0	0	0	0	0	0	290	290
3138	Treatment of Certain Cancer Hospitals	0	0	0	0	0	0	0	0	0	0	0	0
3139	Payment for Biosimilar Biological Products												
	Part B	0	0	0	10	20	-350	-810	-960	-1,150	-1,360	30	-4,600
	Part D	0	0	0	10	-20	-80	-130	-150	-180	-220	-10	-770
3140	Hospice Concurrent Care Demonstration	0	0	0	0	0	0	0	0	0	0	0	0
3141	Budget Neutrality in Calculation of Hospital Wage Index Floor	0	0	0	0	0	0	0	0	0	0	0	0
3142	Study on Urban Medicare-dependent Hospitals	0	0	0	0	0	0	0	0	0	0	0	0
	SUBTITLE C-PROVISIONS RELATING TO PART C												
3201	Medicare Advantage Payment												
	Part A	0	-3,170	-5,170	-7,170	-9,000	-10,160	-11,350	-12,480	-13,270	-14,190	-24,510	-85,960
	Part B	0	-2,090	-3,400	-4,720	-5,840	-6,700	-7,700	-8,670	-9,560	-10,390	-16,050	-59,070
3202	Benefit Protection and Simplification	0	0	0	0	0	0	0	0	0	0	0	0
3203	Coding Intensity Adjustment During MA Payment Transition	0	0	0	0	0	0	0	0	0	0	0	0
3204	Simplification of Annual Beneficiary Election Periods	0	0	0	0	0	0	0	0	0	0	0	0
3205	Specialized MA Plans for Special Needs Individuals	0	0	0	0	0	0	0	0	0	0	0	0
3206	Extension of Reasonable Cost Contracts	0	0	0	0	0	0	0	0	0	0	0	0

Table 3—Estimated Medicare Costs (+) or Savings (–) under the Patient Protection and Affordable Care Act, as Enacted and Amended
(Amounts in millions)

Sec.	Provision	Fiscal year 2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Total, 2010-14	2010-19
3207	Technical Correction to MA Private FFS Plans	0	0	0	0	0	0	0	0	0	0	0	0
3208	Making Senior Housing Facility Demonstration Permanent	0	0	0	0	0	0	0	0	0	0	0	0
3209	Authority to Deny Plan Bids	0	0	0	0	0	0	0	0	0	0	0	0
3210	Development of New Standards for Certain Medigap Plans												
	Part A	0	0	0	0	0	0	0	0	0	0	0	0
	Part B	0	0	0	0	0	-50	-70	-80	-90	-90	0	-380
1103	Savings from limits on MA adminstrative costs	0	0	0	0	0	0	0	0	0	0	0	0
	SUBTITLE D-MEDICARE PART D IMPROVEMENTS FOR PRESCRIPTION DRUG PLANS AND MA-PD PLANS												
3301	Medicare Coverage Gap Discount Program	0	110	140	160	180	200	240	250	250	310	590	1,840
3302	Improving the Determination of Part D Low-Income Benchmarks	0	90	120	130	140	140	150	170	180	190	480	1,310
3303	Voluntary De Minimus Policy for Low-Income Subsidy Plans	0	20	20	20	20	30	30	30	30	30	80	230
3304	Special Rule for Widows and Widowers Regarding Eligibility for Low-Income Assistance	0	0	0	0	0	0	0	0	0	0	0	0
3305	Improved Information for Subsidy Eligible Individuals	0	0	0	0	0	0	0	0	0	0	0	0
3306	Funding Outreach and Assistance of Low-Income Programs	45	45	45	0	0	0	0	0	0	0	135	135
3307	Improving Formularies with Respect to Certain Categories or Classes of Drugs	0	0	0	0	0	0	0	0	0	0	0	0
3308	Reducing the Part D Premium Subsidy for High-Income Beneficiaries	0	-390	-590	-670	-760	-860	-980	-1,110	-1,260	-1,430	-2,410	-8,050
3309	Elimination of Cost Sharing for Certain Dual Eligible Individuals	0	0	0	0	0	0	0	0	0	0	0	0
3310	Reducing Wasteful Dispensing of Outpatient Prescription Drugs	0	0	0	0	0	0	0	0	0	0	0	0
3311	Improved Plan Complaint System	0	0	0	0	0	0	0	0	0	0	0	0
3312	Uniform Exception and Appeals Process	0	0	0	0	0	0	0	0	0	0	0	0
3313	OIG Studies and Reports	0	0	0	0	0	0	0	0	0	0	0	0
3314	Cost Incurred by AIDS Drug Assistance and HIS	0	50	70	70	80	90	100	110	120	130	270	820
9012	Elimination of deduction for Medicare Part D subsidy	0	0	0	40	100	130	170	190	190	200	140	1,020
1101	Closing the Medicare presription drug "donut hole"	0	990	170	380	560	860	1,250	1,760	2,340	3,470	2,100	11,780
—	Reducing growth rate of out-of-pocket threshold	0	0	0	0	40	70	170	240	320	480	40	1,320
1206	Drug rebates for new formulations of existing drugs	0	0	0	0	0	0	0	0	0	0	0	0
	SUBTITLE E-ENSURING MEDICARE SUSTAINABILITY												
3401	Market Basket Revisions and Productivity Adjustments												
	Skilled Nursing Faciltities	0	-30	-440	-1,000	-1,560	-2,160	-2,920	-3,700	-4,530	-5,660	-3,030	-22,000
	Long-Term Care Hospitals	-10	-50	-120	-220	-340	-450	-590	-780	-980	-1,250	-740	-4,790
	Inpatient Rehabilitation Facilities	-10	-40	-130	-250	-390	-530	-700	-930	-1,180	-1,510	-820	-5,670
	Hospitals Paid Under the Inpatient Prospective Payment System	-140	-870	-2,670	-4,940	-7,630	-10,360	-13,940	-18,550	-23,510	-29,990	-16,250	-112,600
	Inpatient Psychiatric Facilities--Productivity Adjustments	-10	-30	-100	-190	-290	-400	-530	-700	-890	-1,130	-620	-4,270
	Inpatient Psychiatric Facilities--Quality Reporting	0	0	0	0	-10	-10	-10	-10	-10	0	-10	-50
	Hospice	0	0	0	-220	-450	-690	-980	-1,330	-1,700	-2,120	-670	-7,490
	Hospital Outpatient Services	0	0	-820	-1,280	-1,850	-2,460	-3,180	-4,210	-5,490	-6,970	-3,950	-26,260
	Durable Medical Equipment	0	-20	-50	-80	-110	-140	-180	-230	-280	-330	-260	-1,420
	All Other Part B Fee Schedules, Except Physicians' Services	0	-100	-300	-520	-750	-1,010	-1,310	-1,680	-2,100	-2,600	-1,670	-10,370
	Home Health--Part A	0	-60	-160	-290	-350	-440	-610	-780	-970	-1,230	-860	-4,890
	Home Health--Part B	0	-70	-180	-320	-380	-490	-680	-870	-1,080	-1,370	-950	-5,440

Table 3—Estimated Medicare Costs (+) or Savings (–) under the Patient Protection and Affordable Care Act, as Enacted and Amended
(Amounts in millions)

Sec.	Provision	Fiscal year 2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Total, 2010-14	2010-19
3402	Temporary Adjustment to Calculation of Part B Premiums												
	Part B Income (additional premiums)	0	-70	-190	-320	-510	-740	-990	-1,320	-1,700	-2,300	-1,090	-8,140
	Part B Benefits	0	0	0	-10	-10	-10	-20	-20	-50	-70	-20	-190
3403	Independent Payment Advisory Board												
	Part A	0	0	0	0	0	-370	-710	-1,200	-2,010	-3,000	0	-7,290
	Part B	0	0	0	0	0	-440	-830	-1,430	-2,420	-3,680	0	-8,800
	Part D	0	0	0	0	0	-330	-670	-1,190	-2,090	-3,290	0	-7,570
10323	Hazards												
	Part A	10	10	10	10	10	20	20	20	20	20	50	150
	Part B	0	10	10	10	10	10	10	10	10	20	40	100
10324	Protection for Frontier States												
	Part A	0	190	230	250	260	280	300	320	340	370	930	2,540
	Part B	0	80	150	170	170	190	200	230	240	280	570	1,710
10325	Delay Implementation of RUG-IV	0	0	0	0	0	0	0	0	0	0	0	0
10326	Pilot Testing for Pay-for-Performance	0	0	0	0	0	0	0	0	0	0	0	0
10327	Improvments to Physician Quality Reporting System	0	0	0	110	120	140	160	0	0	0	230	530
10328	Improvments to Part D Medication Therapy Management	0	0	0	0	0	0	0	0	0	0	0	0
10329	Methodology to Assess Health Plan Value	0	0	0	0	0	0	0	0	0	0	0	0
10330	Modernizing CMS Computer and Data System	0	0	0	0	0	0	0	0	0	0	0	0
10331	Public Reporting of Performance Information	0	0	0	0	0	0	0	0	0	0	0	0
10332	Availability of Medicare Data for Perfomance Measurement	0	0	0	0	0	0	0	0	0	0	0	0
10333	Community Based Collaborative Care Networks	0	0	0	0	0	0	0	0	0	0	0	0
10334	Minority Health	0	0	0	0	0	0	0	0	0	0	0	0
10335	Technical Correction to Hospital Value-based Purchasing	0	0	0	0	0	0	0	0	0	0	0	0
10336	Report on Access to High-quality Dialysis Services	0	0	0	0	0	0	0	0	0	0	0	0
	SUBTITLE F-HEALTH CARE QUALITY IMPROVEMENTS												
3501	Health Care Delivery System Research	0	0	0	0	0	0	0	0	0	0	0	0
3502	Support Patient-Sentered Medical Home	0	0	0	0	0	0	0	0	0	0	0	0
3503	Medication Management Services	0	0	0	0	0	0	0	0	0	0	0	0
3504	Regionalized Systems for Emergency Care	0	0	0	0	0	0	0	0	0	0	0	0
3505	Trauma Care Centers	0	0	0	0	0	0	0	0	0	0	0	0
3506	Shared Decisionmaking	0	0	0	0	0	0	0	0	0	0	0	0
3507	Prescription Drug Benefit and Risk Information	0	0	0	0	0	0	0	0	0	0	0	0
3508	Demonstration to Integrate Quality Care and Patient Safety	0	0	0	0	0	0	0	0	0	0	0	0
3509	Improving Woman's Health	0	0	0	0	0	0	0	0	0	0	0	0
3510	Patient Navigator Program	0	0	0	0	0	0	0	0	0	0	0	0
3511	Authorization of Appropriations	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL, TITLE III		1,415	-3,235	-12,685	-22,020	-58,080	-48,770	-62,690	-77,850	-92,760	-110,160	-94,605	-486,835

Table 3—Estimated Medicare Costs (+) or Savings (–) under the Patient Protection and Affordable Care Act, as Enacted and Amended
(Amounts in millions)

Sec.	Provision	Fiscal year 2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Total, 2010-14	2010-19
	TITLE IV-PREVENTION OF CHRONIC DISEASE AND IMPROVING PUBLIC HEALTH												
	SUBTITLE A-MODERNINZING DISEASE PREVENTION AND PUBLIC HEALTH SYSTEMS												
4001-4004		0	0	0	0	0	0	0	0	0	0	0	0
	SUBTITLE B-INCREASING ACCESS TO CLINICAL PREVENTIVE SERVICES												
4103	Annual Wellness Visit Providing a Personalized Plan	0	230	380	380	390	420	470	530	590	650	1,380	4,040
4104	Removing Barriers to Preventive Services	0	110	190	200	210	230	250	270	300	330	710	2,090
4105	Evidence-Based Coverage of Preventive Services	-60	-140	-160	-170	-170	-180	-200	-220	-240	-260	-700	-1,800
	SUBTITLE C-CREATING HEALTHIER COMMUNITIES												
4201-4207		0	0	0	0	0	0	0	0	0	0	0	0
	SUBTITLE D-SUPPORT FOR PREVENTION AND PUBLIC HEALTH INNOVATION												
4301-4306		0	0	0	0	0	0	0	0	0	0	0	0
	Additional Provisions	0	0	0	0	0	0	0	0	0	0	0	0
	SUBTITLE E-MISCELLENEOUS PROVISIONS												
4401-4402		0	0	0	0	0	0	0	0	0	0	0	0
TOTAL, TITLE IV		-60	200	410	410	430	470	520	580	650	720	1,390	4,330
	TITLE V-HEALTH CARE WORKFORCE												
	SUBTITLE A-PURPOSE AND DEFINITIONS												
5001-5002		0	0	0	0	0	0	0	0	0	0	0	0
	SUBTITLE B-INNOVATIONS IN HEALTH CARE WORKFORCE												
5101-5103		0	0	0	0	0	0	0	0	0	0	0	0
	SUBTITLE C- INCREASING THE SUPPLY OF THE HEALTH CARE WORKFORCE												
5201-5210		0	0	0	0	0	0	0	0	0	0	0	0
	SUBTITLE D-EHANCING HEALTH CARE WORKFORCE EDUCATION AND TRAINING												
5301-5315		0	0	0	0	0	0	0	0	0	0	0	0
	SUBTITLE E-SUPPORTING THE EXISTING HEALTH CARE WORKFORCE												
5401-5405		0	0	0	0	0	0	0	0	0	0	0	0
	SUBTITLE F-STRENGTHENING PRIMARY CARE AND OTHER WORKFORCE IMPROVEMENTS												
5501	Expanding Access to Primary Care/General Surgery Services	0	170	260	260	260	270	110	0	0	0	950	1,330
5502	Medicare Federally Qualified Health Center Improvements	0	10	10	20	20	70	90	100	100	110	60	530
5503	Distribution of Additional Residency Positions	0	0	0	0	0	0	0	0	0	0	0	0
5504	Counting Resident Time in Outpatient Setting	0	0	0	0	0	0	0	0	0	0	0	0
5505	Rules for Counting Resident Time for Didactic/Scholarly Activities	0	0	0	0	0	0	0	0	0	0	0	0
5506	Preservation of Resident Cap Positions	0	0	0	0	0	0	0	0	0	0	0	0
5507	Demonstration to Address Health Professions Workforce Needs	0	0	0	0	0	0	0	0	0	0	0	0
5508	Increasing Teaching Capacity	0	0	0	0	0	0	0	0	0	0	0	0
5509	Graduate Nurse Education Demonstration Program	0	0	0	0	0	0	0	0	0	0	0	0

Table 3—Estimated Medicare Costs (+) or Savings (–) under the Patient Protection and Affordable Care Act, as Enacted and Amended
(Amounts in millions)

Sec.	Provision	Fiscal year 2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Total, 2010-14	2010-19
	SUBTITLE G-IMPROVING ACCESS TO HEALTH CARE SERVICES												
5601-5605		0	0	0	0	0	0	0	0	0	0	0	0
	SUBTITLE H-GENERAL PROVISIONS												
5701	Reports	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL, TITLE V		0	180	270	280	280	340	200	100	100	110	1,010	1,860
	TITLE VI-TRANSPARENCY AND PROGRAM INTEGRITY												
	SUBTITLE A-PHYSICIAN OWNERSHIP AND OTHER TRANSPARENCY												
6001	Limitation on Medicare Exception to the Prohibition on Certain Physician Referrals for Hospitals	0	0	0	0	0	0	0	0	0	0	0	0
6002	Transparency Reports on Physician Ownership	0	0	0	0	0	0	0	0	0	0	0	0
6003	Disclosure Requirements for in-Office Ancillary Services	0	0	0	0	0	0	0	0	0	0	0	0
6004	Prescription Drug Sample Transparency	0	0	0	0	0	0	0	0	0	0	0	0
6005	Pharmacy Benefit Managers Transparency Requirements	0	0	0	0	0	0	0	0	0	0	0	0
	SUBTITLE B-NURSING HOME TRANSPARENCY AND IMPROVEMENT												
6101-6121		0	0	0	0	0	0	0	0	0	0	0	0
	SUBTITLE C-NATIONWIDE PROGRAM FOR BACKGROUND CHECKS ON DIRECT PATIENT ACCESS EMPLOYEES OF LONG-TERM CARE FACILITIES AND PROVIDERS												
6201	Nationwide Program for Background Checks	0	0	0	0	0	0	0	0	0	0	0	0
	SUBTITLE D-PATIENT CENTERED OUTCOMES RESEARCH												
6301	Patient Centered Outcomes Research	0	0	0	0	0	0	0	0	0	0	0	0
6302	Federal Coordinating Council for CER	0	0	0	0	0	0	0	0	0	0	0	0
	SUBTITLE E-MEDICARE, MEDICAID, AND CHIP PROGRAM INTEGRITY												
6401	Provider Screening and Other Enrollment Requirements												
	Part A	0	0	0	0	0	0	0	0	0	0	0	0
	Part B	-10	-20	-20	-30	-30	-30	-30	-30	-40	-40	-110	-280
6402	Enhanced Program Integrity Provisions												
	Part A	0	0	-10	-20	-30	-30	-30	-40	-40	-40	-60	-240
	Part B	0	0	-10	-10	-20	-20	-20	-20	-20	-20	-40	-140
6403	Elimination of Duplication between Data Banks												
	Part A	0	0	0	0	0	0	0	0	0	0	0	0
	Part B	0	0	0	0	0	0	0	0	0	0	0	0
6404	Maximum Period for Submission of Medicare Claims to Not More Than 12 Months												
	Part A	0	60	70	70	80	80	90	100	100	110	280	760
	Part B	0	50	50	50	50	60	60	70	70	80	200	540
6405	Physicians Required to Be Enrolled Physicians												
	Part A	-10	-20	-20	-20	-30	-30	-30	-30	-30	-40	-100	-260
	Part B	-30	-50	-50	-50	-60	-60	-60	-70	-70	-80	-240	-580

Table 3—Estimated Medicare Costs (+) or Savings (–) under the Patient Protection and Affordable Care Act, as Enacted and Amended
(Amounts in millions)

Sec.	Provision	Fiscal year 2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Total, 2010-14	2010-19
6406	Documentaion on Referrals to Programs at High Risk of Waste and Abuse												
	Part A	0	0	0	0	0	0	0	0	0	0	0	0
	Part B	0	0	0	0	0	0	0	0	0	0	0	0
6407	Face to Face Encounter with Patient Required Before Physician May Certify for HHA or DME												
	Part A	-50	-70	-70	-80	-80	-90	-100	-100	-110	-120	-350	-870
	Part B	-70	-110	-120	-130	-140	-150	-160	-170	-180	-190	-570	-1,420
6408	Enhanced Penalties												
	Part A	0	0	0	0	0	0	0	0	0	0	0	0
	Part B	0	0	0	0	0	0	0	0	0	0	0	0
6409	Medicare Self-referral Disclosure Protocal												
	Part A	0	0	0	0	0	0	0	0	0	0	0	0
	Part B	0	0	0	0	0	0	0	0	0	0	0	0
	Adjustments to DME, Prosthetics, Orthotics, and Supplies												
6410	Competitive Acquisition Program												
	Part A	0	0	0	0	0	0	0	0	0	0	0	0
	Part B	0	-10	-20	-20	-20	-20	-80	-120	-130	-140	-70	-560
6411	Expansion of Recovery Audit Contractor (RAC) program												
	Part A	0	-20	-30	-40	-40	-40	-50	-50	-50	-60	-130	-380
	Part B	0	0	-10	-10	-10	-10	-10	-10	-10	-10	-30	-80
	Part D	0	-10	-20	-30	-30	-30	-30	-40	-40	-50	-90	-280
1301	Limit MH Center Providers												
	Part A	0	0	0	0	0	0	0	0	0	0	0	0
	Part B	0	0	-10	-10	-20	-20	-20	-20	-20	-30	-40	-150
1302	Repeal Limits on Claims Review												
	Part A	0	0	0	0	0	0	0	0	0	0	0	0
	Part B	0	0	0	0	0	-10	-10	-10	-10	-10	0	-50
1303	CMS-IRS Data Match to Find Fraudulent Providers												
	Part A	0	0	0	0	0	-10	-10	-10	-10	-10	0	-50
	Part B	0	0	0	-20	-60	-110	-130	-140	-150	-160	-80	-770
1304	Funding for Fraud and Abuse Activities												
	Part A	0	0	0	0	0	0	0	0	0	0	0	0
	Part B	0	0	0	0	0	0	0	0	0	0	0	0
1305	Enhanced Claims Review of New DME Providers												
	Part A	0	0	0	0	0	0	0	0	0	0	0	0
	Part B	0	0	-10	-10	-10	-10	-10	-20	-20	-20	-30	-110
	SUBTITLE G-ADDITIONAL PROGRAM INTEGRITY PROVISIONS												
6601	Prohibition on false Statements and Representations	0	0	0	0	0	0	0	0	0	0	0	0
6602	Clarifying Definition	0	0	0	0	0	0	0	0	0	0	0	0
6603	Development of Model Uniform Report Form	0	0	0	0	0	0	0	0	0	0	0	0
6604	Applicability of State Law to Combat Fraud and Abuse	0	0	0	0	0	0	0	0	0	0	0	0
6605	Administrative Summary Cease and Desist Orders	0	0	0	0	0	0	0	0	0	0	0	0

Table 3—Estimated Medicare Costs (+) or Savings (–) under the Patient Protection and Affordable Care Act, as Enacted and Amended
(Amounts in millions)

Sec.	Provision	Fiscal year 2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Total, 2010-14	2010-19
6606	MEWA Plan Registration	0	0	0	0	0	0	0	0	0	0	0	0
6607	Permitting Evidentiary Privilege and Confidential Communications	0	0	0	0	0	0	0	0	0	0	0	0
	Additional Provisions	0	0	0	0	0	0	0	0	0	0	0	0
	SUBTITLE H-ELDER JUSTICE ACT												
6701	Short Title of Subtitle	0	0	0	0	0	0	0	0	0	0	0	0
6702	Definitions	0	0	0	0	0	0	0	0	0	0	0	0
6703	Elder Justice	0	0	0	0	0	0	0	0	0	0	0	0
	SUBTITLE I-SENSE OF THE SENATE REGARDING MEDICAL MALPRACTICE												
6801	Sense of the Senate Regarding Medical Malpractice	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL, TITLE VI		-170	-200	-280	-360	-450	-530	-630	-710	-760	-830	-1,460	-4,920
	TITLE IX-REVENUE PROVISIONS												
9008	Fees on Brand-Name Pharmaceutical Manufacturers & Importers	0	-1,650	-2,590	-2,720	-2,850	-2,900	-2,900	-3,640	-3,970	-3,060	-9,810	-26,280
9015	Additional hospital insurance tax on high-income taxpayers[1]	0	0	0	-1,936	-8,090	-8,901	-9,735	-10,580	-11,504	-12,484	-10,026	-63,230
TOTAL, TITLE IX		0	-1,650	-2,590	-4,656	-10,940	-11,801	-12,635	-14,220	-15,474	-15,544	-19,836	-89,510
	TOTAL IMPACT, III-VI and IX	1,185	-4,705	-14,875	-26,346	-68,760	-60,291	-75,235	-92,100	-108,244	-125,704	-113,501	-575,075

[1] Estimates prepared by the Office of the Chief Actuary, Social Security Administration.

Notes: The effects of the managers' amendments, in Title X of P.L. 111-148 and in P.L. 111-152, on provisions in other titles have been incorporated with the estimates shown for those titles.
New proposals included in Title X have been grouped with the corresponding category of proposal in the estimates shown for earlier titles.
The estimates for provisions affecting Medicare Part B are net of premium offset.
The estimates for Medicare provisions that affect fee-for-service benefits also reflect interactions with payments to managed care plans.

Table 4— Estimated Federal Medicaid and CHIP Costs (+) or Savings (–) under the Patient Protection and Affordable Care Act, as Enacted and Amended, in millions

Sec.	Provision	Fiscal Year 2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Total, 2010-14	2010-19
	Patient Protection and Affordable Care Act (P.L. 111-148)												
	TITLE II—ROLE OF PUBLIC PROGRAMS												
	Subtitle A—Improved Access to Medicaid												
2001	Medicaid coverage for the lowest income populations	1/	1/	1/	1/	1/	1/	1/	1/	1/	1/	1/	1/
	Impact of sections not affecting Medicaid expansion	$0	$0	$0	$30	$1,760	$3,010	$3,800	$4,180	$4,960	$5,780	$1,790	$23,520
2002	Income eligibility for nonelderly determined using modified gross income	1/	1/	1/	1/	1/	1/	1/	1/	1/	1/	1/	1/
2003	Requirement to offer premium assistance for employer-sponsored insurance	1/	1/	1/	1/	1/	1/	1/	1/	1/	1/	1/	1/
2004	Medicaid coverage for former foster care children	1/	1/	1/	1/	1/	1/	1/	1/	1/	1/	1/	1/
2005	Payments to territories	0	191	764	764	930	930	930	930	930	930	2,648	7,300
2006	Special adjustment to FMAP for major disaster recovery	0	255	90	0	0	0	0	0	0	0	345	345
2007	Medicaid Improvement Fund rescission	0	0	0	0	-100	-150	-150	-150	-150	0	-100	-700
	Subtitle B—Enhanced Support for CHIP												
2101	Additional federal financial participation for CHIP	1/	1/	1/	1/	1/	1/	1/	1/	1/	1/	1/	1/
2102	Technical corrections	0	0	0	0	0	0	0	0	0	0	0	0
	Subtitle C—Enrollment Simplification												
2201	Enrollment simplificiation and coordination with State health insurance exchanges	1/	1/	1/	1/	1/	1/	1/	1/	1/	1/	1/	1/
2202	Permitting hospitals to make presumptive eligibility determinations for all Medicaid eligible populations	1/	1/	1/	1/	1/	1/	1/	1/	1/	1/	1/	1/
	Subtitle D—Improvements to Medicaid services												
2301	Coverage for freestanding birth center services	0	0	0	0	0	0	0	0	0	0	0	0
2302	Concurrent care for children	15	15	15	15	20	20	20	25	25	25	80	195
2303	State eligibility option for family planning services	1	0	0	-2	-4	-6	-9	-12	-15	-18	-5	-65
2304	Clarification of definition of medical assistance	0	0	0	0	0	0	0	0	0	0	0	0
	Subtitle E—New State Options for Long-term Services & Supports												
2401	Community First Choice Option	0	0	820	1,060	1,815	2,585	3,520	3,940	4,630	5,210	3,695	23,580
2402	Removal of barriers to providing home and community-based services	25	50	80	120	170	190	215	240	270	300	445	1,660
2403	Money Follows the Person Rebalancing Demonstration	0	0	450	450	450	450	450	0	0	0	1,350	2,250
2404	Protection for recipients of home and community-based services against spousal impoverishment	0	0	0	0	125	190	215	240	270	75	125	1,115
2405	Funding to expand State Aging and Disability Resource Centers	10	10	10	10	10	0	0	0	0	0	50	50
2406	Sense of the Senate regarding long-term care	0	0	0	0	0	0	0	0	0	0	0	0
	Subtitle F—Medicaid Prescription Drug Coverage												
2501(a)(1)	Increase minimum rebate percentage for brand drugs	-240	-440	-440	-470	-500	-530	-560	-590	-630	-670	-2,090	-5,070
2501(a)(2)	Recapture of total savings	-230	-610	-680	-720	-770	-820	-870	-920	-980	-1,040	-3,010	-7,640
2501(b)	Increase rebate percentage for generic drugs	-20	-30	-30	-30	-40	-40	-40	-40	-50	-50	-150	-370
2501(c)	Extension of prescription drug discounts to enrollees of Medicaid managed care organizations	-580	-720	-720	-770	-820	-870	-930	-990	-1,040	-1,100	-3,610	-8,540
2501(d)	Rebates on new drug formulations	-110	-210	-210	-220	-230	-250	-260	-280	-290	-310	-980	-2,370
2501(e)	Maximum rebate amount	0	0	0	0	0	0	0	0	0	0	0	0
2501(f)	Conforming Amendment	0	0	0	0	0	0	0	0	0	0	0	0
2502	Elimination of exclusion of coverage of certain drugs	0	0	0	0	25	30	30	40	45	45	25	215

Table 4— Estimated Federal Medicaid and CHIP Costs (+) or Savings (–) under the Patient Protection and Affordable Care Act, as Enacted and Amended, in millions

Sec.	Provision	Fiscal Year 2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Total, 2010-14	2010-19
2503	Providing adequate pharmacy reimbursement	0	135	275	290	310	325	345	370	390	415	1,010	2,855
	Subtitle G—Medicaid Disproportionate Share Hospital Payments												
2551	Disproportionate share hospital payments	0	0	0	0	-500	-600	-600	-1,800	-5,000	-5,600	-500	-14,100
	Subtitle H—Dual Eligibles												
2601	5-year period for demonstration projects	0	0	0	0	0	0	0	0	0	0	0	0
2602	Providing Federal coverage and payment coordination for low-income Medicare beneficiaries	0	0	0	0	0	0	0	0	0	0	0	0
	Subtitle I—Medicaid Quality												
2701	Adult health quality measures	40	50	60	70	80	0	0	0	0	0	300	300
2702	Payment Adjustment for Health Care-Acquired Conditions	0	-1	-4	-5	-5	-5	-6	-6	-7	-7	-15	-46
2703	State option to provide health homes for enrollees with chronic conditions	0	35	90	115	145	175	150	135	135	135	385	1,115
2704	Demonstration project to evaluate integrated care around a hospitalization	0	0	0	0	0	0	0	0	0	0	0	0
2705	Medicaid Global Payment System Demonstration Project	0	0	0	0	0	0	0	0	0	0	0	0
2706	Pediatric Accountable Care Organization Demonstration Project	0	0	0	0	0	0	0	0	0	0	0	0
2707	Medicaid emergency psychiatric demonstration project	15	15	15	15	15	0	0	0	0	0	75	75
	Subtitle J—Improvements to the Medicaid and CHIP Payment and Access Commission (MACPAC)												
2801	MACPAC assessment of policies affecting all Medicaid beneficiaries	0	0	0	0	0	0	0	0	0	0	0	0
	Subtitle K—American Indians and Alaska Natives												
2901	Special rules relating to Indians	1/	1/	1/	1/	1/	1/	1/	1/	1/	1/	1/	1/
2902	Elimination of sunset for reimbursement for all Medicare Part B services furnished by certain Indian hospitals and clinics	0	20	20	20	30	30	30	30	30	30	90	240
	TITLE III—IMPROVING THE QUALITY AND EFFICIENCY OF HEALTH CARE												
	Subtitle B—Improving Medicare for Patients and Providers												
	PART III—Improving payment accuracy												
3139	Payment for biosimilar biological products - Medicaid impact	0	0	0	0	-10	-30	-50	-60	-80	-90	-10	-320
	TITLE IV—PREVENTION OF CHRONIC DISEASE AND IMPROVING PUBLIC HEALTH												
	Subtitle A—Modernizing Disease prevention and Public Health Systems												
4004(i)	Public awareness of preventive and obesity-related services	0	0	0	0	0	0	0	0	0	0	0	0
	Subtitle B—Increasing Access to clinical Preventive Services												
4101	School-based health centers	155	200	105	115	125	135	145	160	175	190	700	1,505
4106	Improving access to preventive services for eligible adults	0	0	0	6	9	9	10	11	11	12	15	68
4107	Coverage of comprehensive tobacco cessation services for pregnant women	0	0	0	0	-10	-10	-10	-10	-10	-20	-10	-70
4108	Incentives for prevention of chronic disease	0	20	20	20	20	20	0	0	0	0	80	100
	Subtitle D—Support for Prevention and Public Health Innovation												
4302(b)	Addressing health care disparities in Medicaid and CHIP	0	0	0	0	0	0	0	0	0	0	0	0
4306	Funding for Childhood Obesity Demonstration Project	5	5	5	5	5	0	0	0	0	0	25	25

Table 4— Estimated Federal Medicaid and CHIP Costs (+) or Savings (–) under the Patient Protection and Affordable Care Act, as Enacted and Amended, in millions

Sec	Provision	Fiscal Year 2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Total, 2010-14	2010-19
	TITLE VI—TRANSPARENCY AND PROGRAM INTEGRITY												
	Subtitle E—Medicare, Medicaid & CHIP Program Integrity Provisions												
6201	Background checks for certain employees of LTC facilities	0	30	20	30	30	30	30	30	30	30	110	260
6401	Provider screening and other enrollment requirements under Medicare, Medicaid & CHIP	0	0	0	0	0	0	0	0	0	0	0	0
6402	Enhanced Medicare and Medicaid program integrity provisions	0	0	0	0	0	0	0	0	0	0	0	0
6403	Elimination of duplication between the Healthcare Integrity and Protection Data Bank and the National Practitioner Data Bank	0	0	0	0	0	0	0	0	0	0	0	0
6407	Face to face encounter with patient required before physicians may certify eligibility for home health services or durable medical equipment under Medicare	0	0	0	0	0	0	0	0	0	0	0	0
6408	Enhanced penalties	0	0	0	0	0	0	0	0	0	0	0	0
6411	Expansion of the Recovery Audit Contractor Program	0	-80	-170	-250	-310	-330	-360	-390	-420	-450	-810	-2,760
	Subtitle F—Additional Medicaid Program Integrity Provisions												
6501	Termination of provider participation under Medicaid if terminated under Medicare or other State plan	0	0	0	0	0	0	0	0	0	0	0	0
6502	Medicaid exclusion from participation relating to certain ownership, control, and management affiliations	0	0	0	0	0	0	0	0	0	0	0	0
6503	Billing agents, clearinghouses, or other alternate payees required to register under Medicaid	0	0	0	0	0	0	0	0	0	0	0	0
6504	Requirement to report expanded set of data elements under MMIS to detect fraud and abuse	0	0	0	0	0	0	0	0	0	0	0	0
6505	Prohibition on payments to institutions or entities located outside of the United States	0	0	0	0	0	0	0	0	0	0	0	0
6506	Overpayments	260	480	-65	-70	-75	-80	-85	-90	-95	-105	530	75
6507	Mandatory State use of national correct coding initiative	-10	-25	-40	-45	-55	-75	-85	-90	-95	-100	-175	-620
6508	General effective date	0	0	0	0	0	0	0	0	0	0	0	0
	TITLE VII—IMPROVING ACCESS TO INNOVATIVE MEDICAL THERAPIES												
	Subtitle B—More Affordable Medicines for Children and Underserved Communities												
7101(d)	Expanded participation in 340B programs - Medicaid credits	2/	2/	2/	2/	2/	2/	2/	2/	2/	2/	2/	2/
	TITLE X—STRENGTHENING QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS												
	Subtitle B—Provisions Relating to Title II												
	Part I—Medicaid and CHIP												
10202	Incentives for States to offer home and community-based services as a long-term care alternative to nursing homes	0	0	800	910	1,030	260	0	0	0	0	2,740	3,000
SUBTOTAL, P.L. 111-148		*-664*	*-605*	*1,279*	*1,463*	*3,675*	*4,593*	*5,875*	*4,903*	*3,040*	*3,617*	*5,149*	*27,177*

Table 4— Estimated Federal Medicaid and CHIP Costs (+) or Savings (–) under the Patient Protection and Affordable Care Act, as Enacted and Amended, in millions

Sec.	Provision	Fiscal Year 2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Total, 2010-14	2010-19
	Health Care and Education Reconciliation Act of 2010 (P.L. 111-152)												
	TITLE I—Coverage Medicare, Medicaid, and Revenues												
	Subtitle C—Medicaid												
1202	Payment to primary care physicians	0	0	0	3,670	5,460	1,450	0	0	0	0	9,130	10,580
SUBTOTAL, P.L. 111-152		*0*	*0*	*0*	*3,670*	*5,460*	*1,450*	*0*	*0*	*0*	*0*	*9,130*	*10,580*
	Interaction - Prescription Drugs	-190	-250	-270	-280	-300	-320	-330	-360	-390	-410	-1,290	-3,100
	Interaction - Medicaid Expansion	0	0	0	0	200	-90	-270	-300	-320	-350	200	-1,130
	Interaction with Medicare Premium Provisions	0	-70	-220	-320	-400	-520	-670	-840	-1,010	-1,140	-1,010	-5,190
TOTAL, P.L. 111-148 and P.L. 111-152, with interactions		**-854**	**-925**	**789**	**4,533**	**8,635**	**5,113**	**4,605**	**3,403**	**1,320**	**1,717**	**12,179**	**28,337**

[1] Included with Title I impacts.
[2] Insufficient detail for estimation.

Table 5 — Estimated Increases (+) or Decreases (–) in National Health Expenditures under the Patient Protection and Affordable Care Act, as Enacted and Amended, in billions

Prior Law Baseline	Calendar Year 2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Total, CY 2010-2019
Total National Health Expenditures (NHE)	$ 2,632.2	$ 2,778.7	$ 2,944.4	$ 3,125.4	$ 3,325.5	$ 3,551.5	$ 3,798.5	$ 4,067.7	$ 4,358.8	$ 4,670.6	$ 35,253.3
Medicare	515.5	550.5	591.0	634.1	679.7	732.1	790.4	857.2	930.9	1,010.9	7,292.3
Medicaid/CHIP	436.1	473.0	512.4	553.4	593.9	641.7	696.6	755.9	821.7	893.2	6,377.9
Federal	282.2	277.9	292.7	315.9	337.8	364.3	395.0	427.9	464.6	504.5	3,662.8
State & Local	153.9	195.1	219.6	237.6	256.1	277.4	301.5	328.0	357.1	388.7	2,715.1
Other Public	307.7	325.1	343.9	364.6	386.6	410.5	436.4	464.0	493.2	523.6	4,055.5
Out of Pocket	285.1	297.7	308.9	322.3	340.3	359.4	379.1	400.2	422.8	446.7	3,562.4
Employer-Sponsored Private Health Insurance	847.0	879.0	919.3	966.0	1,024.5	1,088.4	1,156.0	1,228.7	1,305.6	1,387.3	10,801.8
Other Private Health Insurance*	49.2	51.0	54.6	57.7	59.4	61.5	63.5	65.9	68.2	70.6	601.7
Other Private†	191.6	202.4	214.5	227.3	241.1	257.8	276.4	296.0	316.4	338.3	2,561.8
NHE as percent of Gross Domestic Product (GDP)‡	17.8%	17.9%	18.1%	18.3%	18.6%	19.0%	19.4%	19.8%	20.3%	20.8%	

New Law — PPACA	Calendar Year 2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	Total, CY 2010-2019
Total National Health Expenditures (NHE)	$ 2,636.4	$ 2,774.4	$ 2,932.7	$ 3,101.5	$ 3,358.8	$ 3,615.9	$ 3,875.2	$ 4,139.6	$ 4,413.1	$ 4,716.5	$ 35,564.0
Medicare	516.0	545.7	577.1	604.8	626.1	682.1	726.1	778.1	836.4	897.9	6,790.2
Medicaid/CHIP	434.2	471.4	513.3	557.7	657.3	716.6	779.4	832.7	900.8	977.9	6,841.4
Federal	281.2	277.4	294.5	321.4	398.3	435.7	478.2	503.6	543.8	588.7	4,122.7
State & Local	153.0	194.1	218.9	236.3	259.0	280.8	301.2	329.1	357.1	389.2	2,718.7
Other Public	312.3	325.2	344.0	364.9	381.7	406.2	434.6	463.4	493.5	523.6	4,049.4
Out of Pocket	285.1	297.9	308.6	321.6	313.6	323.9	334.7	352.5	381.4	405.8	3,325.1
Employer-Sponsored Private Health Insurance	848.2	881.0	921.3	968.3	1,038.8	1,112.3	1,160.7	1,212.2	1,259.7	1,336.1	10,738.7
Other Private Health Insurance*	49.3	50.9	54.1	57.0	14.9	14.9	14.5	14.2	13.9	13.6	297.4
Other Private†	191.4	202.3	214.3	227.2	234.8	251.9	272.8	293.4	314.5	335.6	2,538.1
Exchanges	—	—	—	—	91.7	107.9	152.4	193.1	212.8	225.8	983.7
NHE as percent of Gross Domestic Product (GDP)‡	17.8%	17.9%	18.0%	18.2%	18.8%	19.3%	19.8%	20.2%	20.5%	21.0%	

Table 5, continued — Estimated Increases (+) or Decreases (–) in National Health Expenditures under the Patient Protection and Affordable Care Act, as Enacted and Amended, in billions

Impact of PPACA	Calendar Year										Total, CY 2010-2019
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019	
Total National Health Expenditures (NHE)	$ 4.2	-$ 4.3	-$ 11.7	-$ 24.0	$ 33.4	$ 64.4	$ 76.7	$ 71.9	$ 54.3	$ 45.8	$ 310.8
Medicare	0.4	-4.8	-13.9	-29.4	-53.6	-50.0	-64.3	-79.1	-94.5	-113.0	-502.1
Medicaid/CHIP	-1.9	-1.5	1.0	4.3	63.4	74.8	82.8	76.8	79.2	84.7	463.5
Federal	-1.1	-0.5	1.7	5.6	60.4	71.4	83.2	75.7	79.2	84.2	459.9
State & Local	-0.8	-1.0	-0.8	-1.3	2.9	3.5	-0.4	1.1	0.0	0.5	3.6
Other Public	4.6	0.1	0.2	0.3	-4.9	-4.3	-1.9	-0.6	0.3	0.0	-6.1
Out of Pocket	-0.1	0.2	-0.3	-0.7	-26.7	-35.5	-44.4	-47.6	-41.3	-40.9	-237.3
Employer-Sponsored Private Health Insurance	1.2	2.0	2.0	2.3	14.3	24.0	4.8	-16.4	-45.9	-51.2	-63.1
Other Private Health Insurance*	0.1	-0.1	-0.4	-0.7	-44.5	-46.5	-49.1	-51.7	-54.3	-57.0	-304.2
Other Private†	-0.2	-0.2	-0.2	-0.1	-6.3	-5.9	-3.7	-2.6	-2.0	-2.7	-23.7
Exchanges	—	—	—	—	91.7	107.9	152.4	193.1	212.8	225.8	983.7
NHE as percent of Gross Domestic Product (GDP)‡	0.0%	0.0%	-0.1%	-0.1%	0.2%	0.3%	0.4%	0.3%	0.3%	0.2%	

*In the prior-law baseline, other private health insurance includes private Medicare supplemental coverage and individual coverage. In the new-law estimates, other private health insurance includes only those with Medicare supplemental coverage.

†In the NHE accounts, other private spending includes philanthropic giving and income from non-patient sources, such as parking and investment income, for institutional providers.

‡Based on Gross Domestic Product (GDP) projections that accompanied the February 24, 2009 NHE projections release for 2008-2018. (http://www.cms.hhs.gov/NationalHealthExpendData/downloads/proj2008.pdf)

Source: Centers for Medicare & Medicaid Services, Office of the Actuary.

April 22, 2010

DEPARTMENT OF HEALTH & HUMAN SERVICES OFFICE OF THE SECRETARY

Assistant Secretary for Legislation
Washington, DC 20201

FEB 28 2011

The Honorable Fred Upton
Chairman
Committee on Energy and Commerce
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

Thank you for your recent letter inquiring about the Pre-Existing Condition Insurance Plan (PCIP). The PCIP program, created by the Affordable Care Act, provides a bridge to health insurance for people who: 1) are U.S. citizens or are otherwise residing in the U.S. legally; 2) have a pre-existing condition or have been denied health insurance coverage because of their health condition; and 3) have been without coverage for at least six months. The Affordable Care Act bans pre-existing condition exclusions and "rate-ups" based on health status starting in 2014. In the meantime, the Affordable Care Act bans pre-existing condition exclusions of children under age 19 starting with plan or policy years that began on or after September 23, 2010.

The PCIP program was required to be operational within 90 days of the enactment of the Affordable Care Act, and the Department of Health and Human Services (HHS) worked with states to meet that deadline. The Affordable Care Act appropriates $5 billion for the PCIP program, and allows states the option of administering their own PCIP program or, in a state declining to do so, having HHS administer the PCIP program. In April 2010, HHS proposed an allocation of PCIP funding among the states, based on the formula used by the Children's Health Insurance Program (CHIP), which was included in the interim final regulation published on July 31, 2010. Twenty-seven states are administering the PCIP program for their residents themselves, while twenty-three states plus the District of Columbia have opted to have HHS administer the PCIP program for their residents. Similar to the CHIP program, administrative expenses in the PCIP program are limited by a 10 percent cap for the duration of the program. State contractors must be twice as efficient as private insurers, which under the new law may spend up to 20 percent of premium dollars on administrative costs.

In implementing the PCIP program, HHS worked closely with its state partners to ensure they were able to appropriately tailor their state-administered PCIP programs to their local insurance markets. The PCIP program draws many features from the popular bipartisan CHIP program – covering a broad range of health benefits, including those for pre-existing conditions, and allowing for significant state flexibility in design and details. The program ensures maximum efficiency in distribution of funding by permitting, if necessary, unused state allocations to be redistributed to other states that have consumers in need.

We are pleased to report that enrollment has increased by 50 percent in the past three

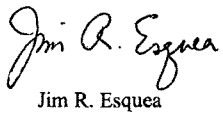
months, and the PCIP program is helping more than 12,000 previously uninsured individuals get back in control of their health care. The PCIP program fills a void in the current market, providing temporary relief for many Americans who want and need health insurance coverage but until 2014 have no other feasible option.

The flexibility that is a hallmark of this program means that no two state-administered PCIP programs are identical. It also means that, together with the states, we have had the opportunity to refine the program in order to increase enrollment and enhance the affordability of premiums. For example, we recently adjusted the federally administered PCIP program to reduce premiums by approximately 20 percent, added two new plan choices (including one tailored for children only), and improved benefit structures for all current enrollees and new applicants. In addition, we have launched an outreach effort designed to expand enrollment and further educate Americans who are eligible for this program to benefit from this coverage under the Affordable Care Act. We believe that enrollment in the PCIP program will continue to fill a market void until 2014, when state-based health insurance exchanges will be available to provide affordable, quality coverage to all Americans who need it. We look forward to continuing to improve the program.

Enclosed with this letter are responses to many of the specific questions you posed in your letter. We are continuing to gather additional responsive material and will provide this information as soon as it becomes available. Please note that some of the enclosed documents may contain proprietary, confidential, or commercially sensitive information. We ask that you and your staff handle such documents with the appropriate safeguards.

We appreciate your interest in this matter and look forward to forging a collaborative relationship with you on this innovative bipartisan program.

Sincerely,



Jim R. Esquea
Assistant Secretary for Legislation

Enclosure

cc: The Honorable Henry A. Waxman
Ranking Member

The Honorable Cliff Stearns
Chairman
Subcommittee on Oversight and Investigations

The Honorable Diana DeGette
Ranking Member
Subcommittee on Oversight and Investigations

Attachment

Question 1 – According to the Department of Health and Human Services (HHS) website, each state was able to choose one of five options to provide coverage under the PPACA for individuals with pre-existing conditions. Please provide a list of the option chosen by each state. If HHS has allowed any deviations from the five options, please provide a detailed explanation.

Each of the fifty states and the District of Columbia has chosen one of the five options referred to in the question. The following chart shows the options selected.

State	Operate a new pool alongside a current state pool	Establish a new pool	Build upon existing coverage program	Contract with a carrier of last resort	Allow HHS to operate PCIP
Alabama					X
Alaska	X				
Arizona					X
Arkansas	X				
California	X				
Colorado				X	
Connecticut	X				
Delaware					X
DC					X
Florida					X
Georgia					X
Hawaii					X
Idaho					X
Illinois	X				
Indiana					X
Iowa	X				
Kansas	X				
Kentucky					X
Louisiana					X
Maine			X		
Maryland	X				
Massachusetts					X
Michigan				X	
Minnesota					X
Mississippi					X
Missouri	X				
Montana	X				

Nebraska					X
Nevada					X
New Hampshire	X				
New Jersey		X			
New Mexico	X				
New York				X	
North Carolina	X				
North Dakota					X
Ohio				X	
Oklahoma	X				
Oregon	X				
Pennsylvania		X			
Rhode Island				X	
South Carolina					X
South Dakota	X				
Tennessee					X
Texas					X
Utah	X				
Vermont					X
Virginia					X
Washington	X				
West Virginia					X
Wisconsin	X				
Wyoming					X

Question 2. Please provide the following information concerning the budget of the PCIP:

Question 2.a. How the total funding for the PCIP has been allocated. Explain if the $5 billion was divided among each state through the end of the program on January 1, 2014; and will it be allocated each fiscal or calendar year; will be used to pay each state's expenses as they arise; or whether another method will be utilized. Please provide the original allocation of funding among states.

Section 1101(g)(1) of the Affordable Care Act appropriates $5 billion for the PCIP program. For purposes of allocating this funding among states, HHS utilized a formula similar to that used in the Children's Health Insurance Program (CHIP), which distributed funding to states on the basis of population and a state cost factor.

HHS distributed funds based on a combination of factors including non-elderly population, non-elderly uninsured, and geographic cost. The allocation considered both the total number of non-elderly in each state, as compared to the U.S. population, and the total number of uninsured non-elderly in each state, as compared to the U.S. population.

A distribution based on the non-elderly population in each state compared to the total U.S. non-elderly population does not penalize those states that have done a good job providing health coverage for people who are uninsured. At the same time, distributing funds based on the number of non-elderly uninsured in each state compared to the U.S. total non-elderly uninsured population provides greater funding to states that arguably need more funding to accommodate a greater number of uninsurable people. Additionally, adjusting the allocations for variation in input prices allows larger allocations to states in which health care costs are higher, which is more likely to get funds to those states where the funds are most needed. The variation in health care costs by geographic area is measured by the variation in costs for health care services—the same measurement utilized for the funding allocations in CHIP.

Based on the above considerations, HHS determined estimated caps on the amount of funds allocated for the PCIP program in each state using the following methodology:

(1) Population. One half of the available funds was allocated based on the relationship of each state's total non-elderly population to the U.S. total non-elderly population, using the most recent annual data available at the time from the U.S. Census Bureau's American Community Survey.

(2) Uninsured. One half of the available funds was allocated based on the relationship of each state's total non-elderly uninsured population to the U.S. total non-elderly uninsured population using the most recent annual data available at the time from the U.S. Census Bureau's American Community Survey.

(3) Geographic costs. The sum of the pools' allocated amounts for both total non-elderly population and total non-elderly uninsured population was adjusted for state cost variations. Similar to the CHIP formula, 15 percent of the cost factor was held constant, while 85 percent reflected how each state's average wage compares to the U.S. average. The resulting funding distribution was further adjusted to the total available PCIP funds. HHS used as a cost adjustment the wages of employees in the health services industry using wage data available at the time developed by the Bureau of Labor Statistics of the Department of Labor through its Quarterly Census of Employment and Wages. HHS used a weighted average of the wages in the health services industry represented by ambulatory health care services, hospitals, and nursing and residential care facilities.

(4) For consistency, the same year of data was used to calculate population, number of uninsured, and geographic costs.

The accompanying table presents the state allocations based on the above methodology. (Appendix A)

Question. 2.a.i. Please provide all documents relating to the allocation of the $5 billion among the states.

We are continuing to gather responsive material and will provide this information as soon as it becomes available.

Question 2.a.ii. Please provide all documents of communications from any HHS personnel relating to the allocation of the $5 billion among the states.

We are continuing to gather responsive material and will provide this information as soon as it becomes available.

Question 2.b. The amount of money each state received in calendar year 2010. Include states opting to let HHS carry out their high risk pool programs and what portion of the $5 billion they represent individually.

The following chart shows the amount of federal funding that was obligated according to each state-based PCIP contractor for the calendar year 2010 portion of the contract to operate a PCIP. The chart also indicates the amount of obligated funding that the state drew down during calendar year 2010 to meet its expenses in operating the PCIP. The total funding drawn by states in 2010 is lower than their obligations in part because the program began 90 days after enactment of the Affordable Care Act and hence was open to enrollment for less than a year and because the states and the Department focused much of their initial efforts in 2010 on establishing the program.

State	2010 Obligation	Total Drawn
AK	$361,523.00	$231,783.19
AR	$2,884,000.00	$186,959.17
CA	$28,934,875.00	$2,874,140.00
CO	$2,617,681.00	$1,723,524.95
CT	$2,003,732.00	$0.00*
IL	$18,877,800.00	$169,309.20
IA	$1,151,552.00	$425,362.74
KS	$1,482,792.00	$688,002.60
ME	$2,168,630.00	$0.00*
MD	$489,700.00	$192,183.00
MI	$724,362.00	$604,767.58
MO	$5,667,600.00	$153,160.14
MT	$1,183,236.00	$631,315.00
NH	$1,142,161.00	$914,148.48
NJ	$17,171,624.00	$639,645.11
NM	$1,133,192.00	$602,173.35
NY	$6,573,668.00	$3,406,199.84
NC	$3,028,597.00	$1,293,271.56
OH	$1,882,000.00	$1,882,000.00
OK	$2,588,100.00	$807,076.49
OR	$1,010,104.00	$731,189.59
PA	$14,243,280.00	$2,167,309.16
RI	$645,840.00	$122,532.35

SD	$610,332.00	$368,046.00
UT	$1,058,854.00	$329,616.97
WA	$1,275,913.00	$1,169,061.72
WI	$5,943,755.00	$755,811.38

*The amounts in the "Total Drawn" column reflect federal funds drawn by states during 2010, not total 2010 expenditures for the states' PCIP programs. For 2010 expenditures, see response to Question 3.a below.

Federally-Run PCIPs	**Total Drawn**
Total	$10,292,597.15**

**Reported as of December 2010

The remaining states and the District of Columbia chose to have HHS operate a PCIP in their jurisdictions. HHS operates that PCIP as one pool and does not track claims payments or administrative expenses on a state-by-state basis.

Question 2.c. The amount of money each state can expect to receive in calendar years 2011, 2012, and 2013. Include states opting to let HHS carry out their high risk pool programs and what portion of the $5 billion they represent individually.

The amount of obligated funds for each state is based on yearly cost projections submitted by the state-based contractor (a state or a state's designated non-profit entity) and approved by HHS. State-based contractors were given an opportunity to adjust their yearly cost projections during the process under which HHS exercises option years on the PCIP contracts. As is evident in the response to Question 2.b, most state-based contractors ended calendar year 2010 with unspent funds that were obligated to those state-based contractors. The 2011 obligation amounts in the chart below represent new obligations made to state-based contractors when HHS exercised the 2011 option in the PCIP contracts. When HHS exercised the 2011 option year on these contracts, it also authorized state-based contractors to use unspent funds obligated in 2010 toward 2011 costs. Therefore, the total funding amount available to state-based contractors for 2011 equals the unspent funds obligated in 2010 in addition to newly obligated funds for 2011. Only the newly obligated funds are depicted in the chart below.

The projected obligations for 2012 and 2013 in the chart below are based on state-based contractor estimates. These funds are not currently obligated and will not be obligated until HHS exercises these option years on the state-based PCIP contracts. These projected obligations are subject to change based on revised state projections. Additionally, the state-based contracts contain a close-out period that extends into 2014, which is not included on this chart. The close-out period will allow the PCIP program to pay providers for claims and help ensure a seamless transition of individuals into the exchanges.

States	CY 2011 Obligated Funds	CY 2012 Projected Obligation	CY 2013 Projected Obligation
Alaska	$1,535,381.00	$4,074,152	$5,568,654
Arkansas	$3,243,000.00	$18,623,000	$20,476,000
California	$171,811,721.00	$239,999,553	$254,068,966
Colorado	$10,053,652.00	$26,227,872	$42,554,251
Connecticut	$8,124,094.00	$16,140,573	$17,338,784
Illinois	$17,352,788.00	$69,708,162	$89,469,250
Iowa	$3,585,156.00	$10,686,244	$16,746,089
Kansas	$4,613,601.00	$10,891,267	$14,075,354
Maine	$2,749,566.00	$5,845,986	$5,227,064
Maryland	$12,824,800.00	$30,828,800	$40,619,065
Michigan	$22,717,163.00	$47,773,013	$61,446,261
Missouri	$11,478,832.00	$25,245,339	$40,533,444
Montana	$4,767,954.00	$4,794,815	$4,736,872
New Hampshire	$4,017,232.00	$5,795,032	$7,235,313
New Jersey	$0.00*	$28,391,833	$61,152,048
New Mexico	$7,525,672.00	$12,321,778	$13,679,324
New York	$44,939,297.00	$100,798,639	$143,112,784
North Carolina	$13,666,694.00	$42,478,342	$69,681,225
Ohio	$22,615,000.00	$49,491,000	$65,377,000
Oklahoma	$13,469,343.00	$20,462,888	$23,240,724
Oregon	$15,224,887.00	$21,122,256	$23,814,632
Pennsylvania	$33,702,786.00	$55,255,033	$54,896,431
Rhode Island	$2,536,651.00	$4,285,449	$5,459,363
South Dakota	$1,894,376.00	$3,013,976	$4,646,631
Utah	$9,876,111.00	$14,022,222	$12,520,630
Washington	$10,190,113.00	$28,048,893	$51,690,495
Wisconsin	$6,459,768.00	$27,970,447	$31,653,841

* Unspent funds obligated in 2010 are projected to cover 2011 costs.

The remaining states and the District of Columbia chose for HHS to operate a PCIP in their jurisdictions. HHS operates that PCIP as one pool and does not obligate funding on a state-by-state basis for the federal PCIP program. Based on the President's FY 2012 Budget, we project $969 million in spending for the federal PCIP program in FY 2011.

Question 2.d. According to the HHS website, "HHS intends to reallocate allotments after a period of not more than 2 years, based on an assessment of state actual enrollment and expenditure experiences."

Question 2.d.i. Please provide an explanation of how this assessment will take place and any information available if it has already begun.

If HHS determines, based on actual and projected enrollment and claims experience, that the PCIP in a given state will not make use of the total estimated funding allocated to that state, HHS may reallocate unused funds to other states, as needed, as stated in 45 C.F.R. §152.34. At this time HHS has not developed specific plans for reallocating funds.

Question 2.d.ii. *The Washington Post* reported on December 27, 2010, that "New Hampshire's plan has only about 80 members, but they already have spent nearly double the $650,000 the state was allotted...HHS agreed to give New Hampshire more money." Please explain the situation New Hampshire encountered, how the additional funds affect the funding available to other states, and whether this indicates that the cost of the PCIP will exceed $5 billion.

New Hampshire revised its cost estimate for 2010, leading to an additional obligation from HHS for that year. However, New Hampshire has not revised its overall cost estimate for the lifespan of the PCIP program, and we currently do not expect New Hampshire to require HHS funding beyond its total original allocation.

Each state-based PCIP contractor submitted a cost proposal as part of its proposal to operate a PCIP program. The New Hampshire Individual Plan Benefit Association, a non-profit entity contracted as the PCIP operator serving New Hampshire, submitted a cost proposal during the summer of 2010. In that proposal, the New Hampshire Individual Plan Benefit Association projected its costs for operating the program in the base year of the contract (2010), each of the option years of the contract (2011-2013), and the close-out period of the contract (2014). This original proposal projected costs requiring an HHS allocation of $20 million for the PCIP in New Hampshire.

On December 10, 2010, the New Hampshire Individual Plan Benefit Association formally notified HHS that it needed additional funds obligated during calendar year 2010. As part of this request, the Association provided a revised cost proposal. This request entailed HHS obligating an additional $512,397 to the New Hampshire PCIP for calendar year 2010. However, this request did not require HHS to allocate any additional funding to New Hampshire for the lifespan of the PCIP program. The change merely involved shifting funds forward in the contracting process. New Hampshire still projects that it can operate the PCIP program for the duration of the program within its allocation of $20 million.

In fact, as referenced in the response to Question 2.b above, New Hampshire did not draw down $228,013 of the newly obligated funds in 2010 and will use those carryover funds to meet its obligations in 2011.

Given that the revised cost projections submitted by New Hampshire are still within the original $20 million allocation, and that the state-based contractors collectively did not spend approximately $100 million in originally requested 2010 funding, we do not believe that New Hampshire's revised cost projection indicates that the cost of the PCIP program will exceed $5 billion.

Question 2.d.iii. Please provide details on any other states HHS has reason to believe will need more money than originally allocated along with an explanation of how this will affect that state, the other states, and the entire PCIP.

All state-based PCIP contractors have provided cost proposals that indicate that they will operate the PCIP program within the funding amounts allocated over the life of the program.

The remaining states and the District of Columbia opted to have HHS operate a PCIP in their jurisdictions. HHS operates that PCIP as one pool and has not allocated claims payments and costs by state.

Question 2.d.iv. Please provide details on any other states HHS has reason to believe will need less money than originally allocated along with an explanation of how this will affect that state, the other states, and the entire PCIP.

Currently, Michigan, New Jersey, North Carolina, and Pennsylvania have submitted cost proposals for 2011-2013 and the close-out period that project a total funding need lower than the amount originally allocated by HHS. The differences between the proposals and the original allocations are shown in the chart below.

State	Approximate Difference Between HHS Allocation and State Cost Proposals
Michigan	$8 million
New Jersey	$29 million
North Carolina	$2 million
Pennsylvania	$2 million

Based on the state-based contractor cost proposals, there is no negative impact to these states. The cost proposals simply reflect the projected rate of enrollment and projected claims amounts for the remaining years of the PCIP program.

Because it is still early in the PCIP program's development and because these estimates are based on early cost projections only, there is currently no effect on any other states in the program. If actual expenditures reflect these projections, HHS may have some flexibility

resulting from states needing less funding than originally allocated. However, HHS has made no decisions in terms of these funds at this time.

Question 3. Section 1101(g)(2) of the PPACA states that if the Secretary of HHS estimates that the funding available for payment of high risk pool expenses will be less than the actual amount of expenses, the Secretary "shall make such adjustments as are necessary to eliminate such deficit."

Question 3.a. Please provide a detailed explanation of expenses incurred thus far and future expected expenses.

2010 expenses and future expected expenses for the twenty-seven state-based contractors are detailed in the attached chart. (Appendix B) The amounts in this chart reflect revised cost projections for calendar years 2010-2013 as submitted by state-based PCIP contractors in December 2010.

The remaining states and the District of Columbia opted to have HHS operate a PCIP in their jurisdictions. HHS operates that PCIP as one pool and to date has not allocated payments and cost by state.

Question 3.b. Please provide an explanation of whether HHS believes the $5 billion available to the PCIP will be sufficient funding or whether additional funding will be needed.

HHS is closely monitoring spending levels across the entire PCIP program. The current cost projections from the twenty-seven state-based PCIP contractors, each of which has been attested to by a state-contracted actuary, and agencies overseeing the federal program indicate that the program will operate through 2013 and the close-out period within the $5 billion appropriation.

Question 3.c. If the $5 billion will not cover incurred or expected expenses for the PCIP, what "adjustments" will HHS pursue? Please provide an explanation of whether HHS will limit enrollment, limit benefits, use of funding in the HHS budget, or pursue any other alternatives.

HHS is committed to working closely with all PCIPs to monitor enrollment and claims experience, and has instituted several mechanisms to monitor funding capacity. For example, PCIP contracts include detailed reporting responsibilities for the development of mitigation strategies and recommended adjustments should the amounts available to a PCIP be less than projected expenses. Should funding sufficiency become an issue, we will work to implement appropriate program adjustments.

Question 3.d. All documents relating to HHS's interpretation of Section 1101(g)(2) of the PPACA.

Contracts with states administering the PCIP program in their jurisdiction reflect the Department's interpretation of this section and therefore are being provided in response to this

question. We are continuing to gather any additional responsive material and will provide this information as soon as it becomes available.

Question 4. Please provide the following information on enrollment and the calculation of premiums in the PCIPs:

Questions 4.a. A list of enrollment in the PCIP by state:

A list of enrollment by state is available at http://www.healthcare.gov/news/factsheets/pcip02102011a.html. HHS is pleased to report that enrollment has increased by 50 percent in the past three months, and the PCIP program is helping more than 12,000 previously uninsured individuals get back in control of their health care.

Questions 4.b. Please provide all documents relating to enrollment in the PCIP.

We are continuing to gather responsive material and will provide this information as soon as it becomes available.

Questions 4.c. Please provide all documents of communications from any HHS personnel relating to enrollment in the PCIP.

We are continuing to gather responsive material and will provide this information as soon as it becomes available.

Questions 4.d. Please provide all documents relating to the methodology for calculating premiums per member per month.

We are continuing to gather responsive material and will provide this information as soon as it becomes available.

Questions 4.e. Please provide all documents relating to the actual premiums per member per month.

We are continuing to gather responsive material and will provide this information as soon as it becomes available.

Question 5. Please provide all documents of communications from any HHS personnel relating to the implementation of the PCIP or the status of the PCIP.

We are continuing to gather responsive material and will provide this information as soon as it becomes available.

Appendix A

Total Allocation of Federal PCIP Funding

State		
Alabama	$	69,087,417
Alaska	$	13,105,828
Arizona	$	128,740,847
Arkansas	$	45,566,395
California	$	761,044,961
Colorado	$	90,311,018
Connecticut	$	50,040,481
Delaware	$	13,012,128
District of Columbia	$	9,074,715
Florida	$	350,545,524
Georgia	$	176,511,317
Hawaii	$	16,073,978
Idaho	$	23,706,011
Illinois	$	196,162,291
Indiana	$	92,637,453
Iowa	$	34,539,621
Kansas	$	36,481,462
Kentucky	$	62,951,384
Louisiana	$	70,659,371
Maine	$	17,189,565
Maryland	$	84,704,297
Massachusetts	$	76,669,617
Michigan	$	140,837,012
Minnesota	$	68,175,393
Mississippi	$	47,205,066
Missouri	$	81,321,481
Montana	$	15,825,584
Nebraska	$	22,567,616
Nevada	$	61,127,378
New Hampshire	$	19,843,824
New Jersey	$	140,626,506
New Mexico	$	37,451,667
New York	$	296,838,152
North Carolina	$	145,330,356
North Dakota	$	7,862,696
Ohio	$	152,442,116
Oklahoma	$	59,691,141
Oregon	$	65,956,738
Pennsylvania	$	159,791,653
Rhode Island	$	13,460,498
South Carolina	$	74,313,576
South Dakota	$	10,657,091
Tennessee	$	96,753,956
Texas	$	492,694,563

Utah	$	40,140,660
Vermont	$	7,811,569
Virginia	$	112,664,768
Washington	$	101,620,717
West Virginia	$	26,812,490
Wisconsin	$	73,001,555
Wyoming	$	8,358,497
United States	$	5,000,000,000

Preliminary, as published April 2010. Final allotments may increase or decrease by +/- 1%. Includes administrative expenses as authorized by law. Data sources: ACS State Population 2008; BLS Wage Data 2008.

Appendix B

PCIPTable2_AdminCostsClaims_OY1

State	State Name	Year	Average Enrollment	Premium Revenue	Total Claims	Administrative Costs	Total Claims Against Federal Fund Allotment
AK	Alaska	Total	N/A	$4,725,153.00	$15,146,024.00	$1,118,839.00	$11,539,710.00
		2010	10	$40,280.00	$67,108.00	$195,200.00	$222,028.00
		2011	56	$722,984.00	$2,075,660.00	$322,200.00	$1,674,876.00
		2012	120	$1,759,974.00	$5,529,576.00	$304,550.00	$4,074,152.00
		2013	132	$2,201,915.00	$7,473,680.00	$296,889.00	$5,568,654.00
AR	Arkansas	Total	N/A	$43,432,000.00	$81,582,000.00	$7,075,000.00	$45,224,000.00
		2010	111	$169,000.00	$183,000.00	$145,000.00	$158,000.00
		2011	1293	$5,910,000.00	$10,936,000.00	$941,000.00	$5,968,000.00
		2012	3797	$18,221,000.00	$33,958,000.00	$2,886,000.00	$18,623,000.00
		2013	3797	$19,132,000.00	$36,505,000.00	$3,103,000.00	$20,475,000.00
CA	California	Total	N/A	$420,710,031.72	$1,021,996,202.14	$93,528,945.00	$694,815,115.41
		2010	650	$539,500.00	$714,618.16	$4,336,695.00	$4,511,813.16
		2011	24297	$120,999,433.18	$287,503,466.48	$29,730,750.00	$196,234,783.30
		2012	24297	$139,149,348.16	$349,418,151.19	$29,730,750.00	$239,999,553.03
		2013	24297	$160,021,750.38	$384,359,966.31	$29,730,750.00	$254,068,965.92
CO	Colorado	Total	N/A	$43,929,174.00	$117,362,555.00	$8,020,075.00	$81,453,456.00
		2010	368	$527,319.00	$2,370,000.00	$775,000.00	$2,617,681.00
		2011	1425	$6,452,312.00	$14,486,995.00	$2,018,969.00	$10,053,652.00
		2012	2803	$14,103,243.00	$38,047,321.00	$2,283,794.00	$26,227,872.00
		2013	3983	$22,846,300.00	$62,458,239.00	$2,942,312.00	$42,554,251.00
CT	Connecticut	Total	N/A	$26,193,657.00	$64,219,119.00	$5,581,721.00	$43,607,183.00
		2010	8	$21,503.00	$28,983.00	$5,768.00	$13,248.00
		2011	1392	$7,983,940.00	$16,171,101.00	$1,927,417.00	$10,114,578.00
		2012	1392	$8,702,495.00	$22,975,615.00	$1,867,453.00	$16,140,573.00
		2013	1392	$9,485,719.00	$25,043,420.00	$1,781,083.00	$17,338,784.00
IA	Iowa	Total	N/A	$13,694,957.00	$43,262,739.00	$2,601,259.00	$32,169,041.00
		2010	57	$96,900.00	$189,012.00	$359,800.00	$451,912.00
		2011	376	$1,983,992.00	$5,623,488.00	$645,300.00	$4,284,796.00
		2012	833	$4,753,338.00	$14,673,144.00	$766,438.00	$10,686,244.00
		2013	1113	$6,860,727.00	$22,777,095.00	$829,721.00	$16,746,089.00
IL	Illinois	Total	N/A	$53,478,219.00	$243,646,719.00	$5,239,500.00	$195,408,000.00
		2010	698	$912,551.00	$3,258,784.00	$171,100.00	$2,517,333.00
		2011	2527	$10,246,574.00	$42,786,329.00	$1,173,500.00	$33,713,255.00

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PCIPTable2_AdminCostsClaims_OY1

State	State Name	Year	Average Enrollment	Premium Revenue	Total Claims	Administrative Costs	Total Claims Against Federal Fund Allotment
		2012	4475	$19,958,727.00	$87,772,789.00	$1,894,100.00	$69,708,162.00
		2013	4635	$22,360,367.00	$109,828,817.00	$2,000,800.00	$89,469,250.00
KS	Kansas	Total	N/A	$10,751,209.00	$38,115,240.00	$3,698,983.00	$31,063,014.00
		2010	70	$149,227.00	$239,506.00	$361,442.00	$451,721.00
		2011	400	$1,851,369.00	$6,463,485.00	$1,032,556.00	$5,644,672.00
		2012	695	$3,629,644.00	$13,395,951.00	$1,124,960.00	$10,891,267.00
		2013	870	$5,120,969.00	$18,016,298.00	$1,180,025.00	$14,075,354.00
MD	Maryland	Total	N/A	$43,137,900.00	$119,696,082.00	$8,204,183.00	$84,762,365.00
		2010	268	$276,600.00	$559,505.00	$206,795.00	$489,700.00
		2011	2145	$7,102,000.00	$18,330,569.00	$1,596,231.00	$12,824,800.00
		2012	4641	$16,668,900.00	$44,412,828.00	$3,084,872.00	$30,828,800.00
		2013	4906	$19,090,400.00	$56,393,180.00	$3,316,285.00	$40,619,065.00
ME	Maine	Total	N/A	$21,576,184.89	$35,409,812.01	$2,157,618.49	$15,991,245.60
		2010	8	$41,228.39	$69,572.91	$4,122.84	$32,467.36
		2011	970	$6,204,099.90	$10,469,418.58	$620,409.99	$4,885,728.67
		2012	1090	$7,423,473.84	$12,527,112.11	$742,347.38	$5,845,985.65
		2013	1090	$7,907,382.76	$12,343,708.41	$790,738.28	$5,227,063.92
MI	Michigan	Total	N/A	$57,945,503.73	$183,571,140.94	$7,035,161.20	$132,660,798.41
		2010	100	$130,780.77	$347,079.53	$508,062.93	$724,361.69
		2011	1818	$9,511,031.76	$30,446,386.66	$1,781,808.49	$22,717,163.39
		2012	3716	$21,058,515.31	$66,605,075.57	$2,226,452.52	$47,773,012.78
		2013	4435	$27,245,175.89	$86,172,599.18	$2,518,837.26	$61,446,260.55
MO	Missouri	Total	N/A	$38,007,202.00	$106,457,739.00	$10,922,558.00	$79,373,096.00
		2010	50	$171,463.00	$327,925.00	$1,143,563.00	$1,300,025.00
		2011	951	$5,539,640.00	$15,538,772.00	$2,295,155.00	$12,294,288.00
		2012	1899	$12,187,207.00	$34,185,299.00	$3,247,247.00	$25,245,339.00
		2013	2850	$20,108,892.00	$56,405,743.00	$4,236,593.00	$40,533,444.00
MT	Montana	Total	N/A	$2,522,279.00	$16,910,252.00	$1,094,904.00	$15,482,877.00
		2010	125	$207,347.00	$1,229,179.00	$161,404.00	$1,183,236.00
		2011	175	$779,412.00	$5,221,966.00	$325,400.00	$4,767,954.00
		2012	157	$771,618.00	$5,255,833.00	$310,600.00	$4,794,815.00
		2013	142	$763,902.00	$5,203,274.00	$297,500.00	$4,736,872.00
NC	North Carolina	Total	N/A	$62,128,978.00	$179,494,806.00	$11,489,030.00	$128,854,858.00

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PCIPTable2_AdminCostsClaims_OY1

State	State Name	Year	Average Enrollment	Premium Revenue	Total Claims	Administrative Costs	Total Claims Against Federal Fund Allotment
		2010	378	$690,032.00	$929,833.00	$931,757.00	$1,171,558.00
		2011	2419	$8,783,092.00	$21,539,747.00	$2,767,078.00	$15,523,733.00
		2012	5640	$20,479,649.00	$58,041,381.00	$4,916,610.00	$42,478,342.00
		2013	8861	$32,176,205.00	$98,983,845.00	$2,873,585.00	$69,681,225.00
NH	New Hampshire	Total	N/A	$6,272,587.00	$23,051,205.00	$1,411,121.00	$18,189,738.00
		2010	36	$120,899.00	$984,107.00	$278,953.00	$1,142,161.00
		2011	243	$1,276,594.00	$4,923,847.00	$369,980.00	$4,017,232.00
		2012	405	$2,239,585.00	$7,653,230.00	$381,387.00	$5,795,032.00
		2013	450	$2,635,509.00	$9,490,021.00	$380,801.00	$7,235,313.00
NJ	New Jersey	Total	N/A	$128,002,013.52	$205,879,761.55	$19,617,395.68	$97,495,143.70
		2010	200	$71,250.00	$61,071.43	$354,933.93	$344,755.36
		2011	3150	$10,533,600.00	$16,312,911.43	$1,827,195.73	$7,606,507.16
		2012	8363	$38,342,304.00	$60,962,457.60	$5,771,679.75	$28,391,833.35
		2013	13472	$79,054,859.52	$128,543,321.09	$11,663,586.27	$61,152,047.83
NM	New Mexico	Total	N/A	$10,217,692.00	$41,775,723.00	$3,101,934.00	$34,659,965.00
		2010	113	$219,657.00	$944,689.00	$408,160.00	$1,133,192.00
		2011	470	$2,371,216.00	$9,026,578.00	$870,309.00	$7,525,671.00
		2012	655	$3,631,819.00	$15,093,500.00	$860,097.00	$12,321,778.00
		2013	655	$3,995,000.00	$16,710,956.00	$963,368.00	$13,679,324.00
NY	New York	Total	N/A	$87,638,342.40	$350,126,413.85	$32,936,316.46	$295,424,387.91
		2010	1000	$798,739.20	$3,003,432.00	$3,889,990.02	$6,094,682.82
		2011	4000	$12,700,800.00	$51,037,547.73	$7,081,533.87	$45,418,281.60
		2012	7000	$29,937,600.00	$119,764,715.48	$10,971,523.88	$100,798,639.36
		2013	8000	$44,201,203.20	$176,320,718.64	$10,993,268.69	$143,112,784.13
OH	Ohio	Total	N/A	$80,154,000.00	$211,903,000.00	$7,616,000.00	$139,365,000.00
		2010	800	$875,000.00	$1,372,000.00	$1,385,000.00	$1,882,000.00
		2011	3150	$14,669,000.00	$35,207,000.00	$2,077,000.00	$22,615,000.00
		2012	5613	$28,456,000.00	$75,895,000.00	$2,052,000.00	$49,491,000.00
		2013	6502	$36,154,000.00	$99,429,000.00	$2,102,000.00	$65,377,000.00
OK	Oklahoma	Total	N/A	$8,375,562.00	$64,882,488.00	$3,254,129.00	$59,761,055.00
		2010	131	$129,398.00	$1,198,351.00	$203,184.00	$1,272,137.00
		2011	726	$2,191,507.00	$15,943,015.00	$1,033,798.00	$14,785,306.00
		2012	1002	$2,988,852.00	$22,408,718.00	$1,043,022.00	$20,462,888.00

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PCIPTable2_AdminCostsClaims_OY1

State	State Name	Year	Average Enrollment	Premium Revenue	Total Claims	Administrative Costs	Total Claims Against Federal Fund Allotment
		2013	903	$3,065,805.00	$25,332,404.00	$974,125.00	$23,240,724.00
OR	Oregon	Total	N/A	$42,336,870.00	$99,318,165.00	$4,190,584.00	$61,171,879.00
		2010	687	$1,983,120.00	$2,614,496.00	$378,728.00	$1,010,104.00
		2011	1974	$11,647,268.00	$25,702,490.00	$1,169,665.00	$15,224,887.00
		2012	2044	$13,750,984.00	$33,522,372.00	$1,350,868.00	$21,122,256.00
		2013	1999	$14,955,498.00	$37,478,807.00	$1,291,323.00	$23,814,632.00
PA	Pennsylvania	Total	N/A	$67,702,981.04	$211,251,730.12	$14,548,780.49	$158,097,529.17
		2010	5597	$1,585,070.00	$4,141,845.00	$500,000.00	$3,056,774.60
		2011	5500	$15,037,920.00	$55,244,284.20	$4,682,926.83	$44,889,291.03
		2012	5600	$22,837,248.00	$73,409,353.92	$4,682,926.83	$55,255,032.75
		2013	5700	$28,242,743.04	$78,456,247.00	$4,682,926.83	$54,896,430.79
RI	Rhode Island	Total	N/A	$7,480,019.00	$18,943,962.00	$1,463,359.00	$12,927,304.00
		2010	155	$150,269.00	$387,257.00	$408,852.00	$645,840.00
		2011	328	$1,395,150.00	$3,573,928.00	$357,872.00	$2,536,651.00
		2012	550	$2,580,600.00	$6,545,498.00	$320,551.00	$4,285,450.00
		2013	650	$3,354,000.00	$8,437,279.00	$376,084.00	$5,459,363.00
SD	South Dakota	Total	N/A	$4,492,498.00	$13,925,757.00	$732,056.00	$10,165,315.00
		2010	42	$149,601.00	$659,880.00	$100,053.00	$610,332.00
		2011	105	$755,700.00	$2,484,557.00	$165,519.00	$1,894,376.00
		2012	177	$1,406,748.00	$4,194,291.00	$226,433.00	$3,013,976.00
		2013	250	$2,180,449.00	$6,587,029.00	$240,051.00	$4,646,631.00
UT	Utah	Total	N/A	$35,847,642.00	$70,102,914.00	$3,222,545.00	$37,477,817.00
		2010	386	$598,367.00	$1,535,545.00	$121,676.00	$1,058,854.00
		2011	1766	$8,649,594.00	$17,700,130.00	$825,575.00	$9,876,111.00
		2012	2430	$12,757,641.00	$25,642,216.00	$1,137,647.00	$14,022,222.00
		2013	2430	$13,842,040.00	$25,225,023.00	$1,137,647.00	$12,520,630.00
WA	Washington	Total	N/A	$34,596,695.00	$118,711,001.00	$7,091,107.00	$91,205,413.00
		2010	95	$207,827.00	$811,186.00	$672,553.00	$1,275,912.00
		2011	621	$4,369,078.00	$13,056,585.00	$1,502,606.00	$10,190,113.00
		2012	1425	$11,033,242.00	$36,952,447.00	$2,129,688.00	$28,048,893.00
		2013	2229	$18,986,548.00	$67,890,783.00	$2,786,260.00	$51,690,495.00
WI	Wisconsin	Total	N/A	$96,697,322.52	$156,779,235.19	$11,945,898.93	$72,027,811.57
		2010	185	$304,968.30	$514,238.81	$780,776.37	$990,046.88

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PCIPTable3_AdminCostsClaims_CY1

State	State Name	Year	Average Enrollment	Premium Revenue	Total Claims	Administrative Costs	Total Claims Against Federal Fund Allotment
		2011	4607	$15,202,215.79	$24,368,941.74	$2,217,849.93	$11,413,475.87
		2012	11430	$39,604,845.58	$63,016,704.57	$4,558,685.48	$27,970,447.46
		2013	11430	$41,585,182.85	$68,850,250.07	$4,388,754.15	$31,853,641.33

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March 24, 2011

G.E.'s Strategies Let It Avoid Taxes Altogether

By DAVID KOCIENIEWSKI

General Electric, the nation's largest corporation, had a very good year in 2010.

The company reported worldwide profits of $14.2 billion, and said $5.1 billion of the total came from its operations in the United States.

Its American tax bill? None. In fact, G.E. claimed a tax benefit of $3.2 billion.

That may be hard to fathom for the millions of American business owners and households now preparing their own returns, but low taxes are nothing new for G.E. The company has been cutting the percentage of its American profits paid to the Internal Revenue Service for years, resulting in a far lower rate than at most multinational companies.

Its extraordinary success is based on an aggressive strategy that mixes fierce lobbying for tax breaks and innovative accounting that enables it to concentrate its profits offshore. G.E.'s giant tax department, led by a bow-tied former Treasury official named John Samuels, is often referred to as the world's best tax law firm. Indeed, the company's slogan "Imagination at Work" fits this department well. The team includes former officials not just from the Treasury, but also from the I.R.S. and virtually all the tax-writing committees in Congress.

While General Electric is one of the most skilled at reducing its tax burden, many other companies have become better at this as well. Although the top corporate tax rate in the United States is 35 percent, one of the highest in the world, companies have been increasingly using a maze of shelters, tax credits and subsidies to pay far less.

In a regulatory filing just a week before the Japanese disaster put a spotlight on the company's nuclear reactor business, G.E. reported that its tax burden was 7.4 percent of its American profits, about a third of the average reported by other American multinationals. Even those figures are overstated, because they include taxes that will be paid only if the company brings its overseas profits back to the United States. With those profits still offshore, G.E. is effectively getting money back.

Such strategies, as well as changes in tax laws that encouraged some businesses and professionals to file as individuals, have pushed down the corporate share of the nation's tax receipts — from 30 percent of all federal revenue in the mid-1950s to 6.6 percent in 2009.

Yet many companies say the current level is so high it hobbles them in competing with foreign rivals. Even as the government faces a mounting budget deficit, the talk in Washington is about lower rates. President Obama has said he is considering an overhaul of the corporate tax system, with an eye to lowering the top rate, ending some tax subsidies and loopholes and generating the same amount of revenue. He has designated G.E.'s chief

executive, Jeffrey R. Immelt, as his liaison to the business community and as the chairman of the President's Council on Jobs and Competitiveness, and it is expected to discuss corporate taxes.

"He understands what it takes for America to compete in the global economy," Mr. Obama said of Mr. Immelt, on his appointment in January, after touring a G.E. factory in upstate New York that makes turbines and generators for sale around the world.

A review of company filings and Congressional records shows that one of the most striking advantages of General Electric is its ability to lobby for, win and take advantage of tax breaks.

Over the last decade, G.E. has spent tens of millions of dollars to push for changes in tax law, from more generous depreciation schedules on jet engines to "green energy" credits for its wind turbines. But the most lucrative of these measures allows G.E. to operate a vast leasing and lending business abroad with profits that face little foreign taxes and no American taxes as long as the money remains overseas.

Company officials say that these measures are necessary for G.E. to compete against global rivals and that they are acting as responsible citizens. "G.E. is committed to acting with integrity in relation to our tax obligations," said Anne Eisele, a spokeswoman. "We are committed to complying with tax rules and paying all legally obliged taxes. At the same time, we have a responsibility to our shareholders to legally minimize our costs."

The assortment of tax breaks G.E. has won in Washington has provided a significant short-term gain for the company's executives and shareholders. While the financial crisis led G.E. to post a loss in the United States in 2009, regulatory filings show that in the last five years, G.E. has accumulated $26 billion in American profits, and received a net tax benefit from the I.R.S. of $4.1 billion.

But critics say the use of so many shelters amounts to corporate welfare, allowing G.E. not just to avoid taxes on profitable overseas lending but also to amass tax credits and write-offs that can be used to reduce taxes on billions of dollars of profit from domestic manufacturing. They say that the assertive tax avoidance of multinationals like G.E. not only shortchanges the Treasury, but also harms the economy by discouraging investment and hiring in the United States.

"In a rational system, a corporation's tax department would be there to make sure a company complied with the law," said Len Burman, a former Treasury official who now is a scholar at the nonpartisan Tax Policy Center. "But in our system, there are corporations that view their tax departments as a profit center, and the effects on public policy can be negative."

The shelters are so crucial to G.E.'s bottom line that when Congress threatened to let the most lucrative one expire in 2008, the company came out in full force. G.E. officials worked with dozens of financial companies to send letters to Congress and hired a bevy of outside lobbyists.

The head of its tax team, Mr. Samuels, met with Representative Charles B. Rangel, then chairman of the Ways and Means Committee, which would decide the fate of the tax break. As he sat with the committee's staff

members outside Mr. Rangel's office, Mr. Samuels dropped to his knee and pretended to beg for the provision to be extended — a flourish made in jest, he said through a spokeswoman.

That day, Mr. Rangel reversed his opposition to the tax break, according to other Democrats on the committee.

The following month, Mr. Rangel and Mr. Immelt stood together at St. Nicholas Park in Harlem as G.E. announced that its foundation had awarded $30 million to New York City schools, including $11 million to benefit various schools in Mr. Rangel's district. Joel I. Klein, then the schools chancellor, and Mayor Michael R. Bloomberg, who presided, said it was the largest gift ever to the city's schools.

G.E. officials say the donation was granted solely on the merit of the project. "The foundation goes to great lengths to ensure grant decisions are not influenced by company government relations or lobbying priorities," Ms. Eisele said.

Mr. Rangel, who was censured by Congress last year for soliciting donations from corporations and executives with business before his committee, said this month that the donation was unrelated to his official actions.

Defying Reagan's Legacy

General Electric has been a household name for generations, with light bulbs, electric fans, refrigerators and other appliances in millions of American homes. But today the consumer appliance division accounts for less than 6 percent of revenue, while lending accounts for more than 30 percent. Industrial, commercial and medical equipment like power plant turbines and jet engines account for about 50 percent. Its industrial work includes everything from wind farms to nuclear energy projects like the troubled plant in Japan, built in the 1970s.

Because its lending division, GE Capital, has provided more than half of the company's profit in some recent years, many Wall Street analysts view G.E. not as a manufacturer but as an unregulated lender that also makes dishwashers and M.R.I. machines.

As it has evolved, the company has used, and in some cases pioneered, aggressive strategies to lower its tax bill. In the mid-1980s, President Ronald Reagan overhauled the tax system after learning that G.E. — a company for which he had once worked as a commercial pitchman — was among dozens of corporations that had used accounting gamesmanship to avoid paying any taxes.

"I didn't realize things had gotten that far out of line," Mr. Reagan told the Treasury secretary, Donald T. Regan, according to Mr. Regan's 1988 memoir. The president supported a change that closed loopholes and required G.E. to pay a far higher effective rate, up to 32.5 percent.

That pendulum began to swing back in the late 1990s. G.E. and other financial services firms won a change in tax law that would allow multinationals to avoid taxes on some kinds of banking and insurance income. The change meant that if G.E. financed the sale of a jet engine or generator in Ireland, for example, the company would no longer have to pay American tax on the interest income as long as the profits remained offshore.

Known as active financing, the tax break proved to be beneficial for investment banks, brokerage firms, auto and farm equipment companies, and lenders like GE Capital. This tax break allowed G.E. to avoid taxes on lending income from abroad, and permitted the company to amass tax credits, write-offs and depreciation. Those benefits are then used to offset taxes on its American manufacturing profits.

G.E. subsequently ramped up its lending business.

As the company expanded abroad, the portion of its profits booked in low-tax countries such as Ireland and Singapore grew far faster. From 1996 through 1998, its profits and revenue in the United States were in sync — 73 percent of the company's total. Over the last three years, though, 46 percent of the company's revenue was in the United States, but just 18 percent of its profits.

Martin A. Sullivan, a tax economist for the trade publication Tax Analysts, said that booking such a large percentage of its profits in low-tax countries has "allowed G.E. to bring its U.S. effective tax rate to rock-bottom levels."

G.E. officials say the disparity between American revenue and American profit is the result of ordinary business factors, such as investment in overseas markets and heavy lending losses in the United States recently. The company also says the nation's workers benefit when G.E. profits overseas.

"We believe that winning in markets outside the United States increases U.S. exports and jobs," Mr. Samuels said through a spokeswoman. "If U.S. companies aren't competitive outside of their home market, it will mean fewer, not more, jobs in the United States, as the business will go to a non-U.S. competitor."

The company does not specify how much of its global tax savings derive from active financing, but called it "significant" in its annual report. Stock analysts estimate the tax benefit to G.E. to be hundreds of millions of dollars a year.

"Cracking down on offshore profit-shifting by financial companies like G.E. was one of the important achievements of President Reagan's 1986 Tax Reform Act," said Robert S. McIntyre, director of the liberal group Citizens for Tax Justice, who played a key role in those changes. "The fact that Congress was snookered into undermining that reform at the behest of companies like G.E. is an insult not just to Reagan, but to all the ordinary American taxpayers who have to foot the bill for G.E.'s rampant tax sheltering."

A Full-Court Press

Minimizing taxes is so important at G.E. that Mr. Samuels has placed tax strategists in decision-making positions in many major manufacturing facilities and businesses around the globe. Mr. Samuels, a graduate of Vanderbilt University and the University of Chicago Law School, declined to be interviewed for this article. Company officials acknowledged that the tax department had expanded since he joined the company in 1988, and said it now had 975 employees.

At a tax symposium in 2007, a G.E. tax official said the department's "mission statement" consisted of 19 rules and urged employees to divide their time evenly between ensuring compliance with the law and "looking to exploit opportunities to reduce tax."

Transforming the most creative strategies of the tax team into law is another extensive operation. G.E. spends heavily on lobbying: more than $200 million over the last decade, according to the Center for Responsive Politics. Records filed with election officials show a significant portion of that money was devoted to tax legislation. G.E. has even turned setbacks into successes with Congressional help. After the World Trade Organization forced the United States to halt $5 billion a year in export subsidies to G.E. and other manufacturers, the company's lawyers and lobbyists became deeply involved in rewriting a portion of the corporate tax code, according to news reports after the 2002 decision and a Congressional staff member.

By the time the measure — the American Jobs Creation Act — was signed into law by President George W. Bush in 2004, it contained more than $13 billion a year in tax breaks for corporations, many very beneficial to G.E. One provision allowed companies to defer taxes on overseas profits from leasing planes to airlines. It was so generous — and so tailored to G.E. and a handful of other companies — that staff members on the House Ways and Means Committee publicly complained that G.E. would reap "an overwhelming percentage" of the estimated $100 million in annual tax savings.

According to its 2007 regulatory filing, the company saved more than $1 billion in American taxes because of that law in the three years after it was enacted.

By 2008, however, concern over the growing cost of overseas tax loopholes put G.E. and other corporations on the defensive. With Democrats in control of both houses of Congress, momentum was building to let the active financing exception expire. Mr. Rangel of the Ways and Means Committee indicated that he favored letting it end and directing the new revenue — an estimated $4 billion a year — to other priorities.

G.E. pushed back. In addition to the $18 million allocated to its in-house lobbying department, the company spent more than $3 million in 2008 on lobbying firms assigned to the task.

Mr. Rangel dropped his opposition to the tax break. Representative Joseph Crowley, Democrat of New York, said he had helped sway Mr. Rangel by arguing that the tax break would help Citigroup, a major employer in Mr. Crowley's district.

G.E. officials say that neither Mr. Samuels nor any lobbyists working on behalf of the company discussed the possibility of a charitable donation with Mr. Rangel. The only contact was made in late 2007, a company spokesman said, when Mr. Immelt called to inform Mr. Rangel that the foundation was giving money to schools in his district.

But in 2008, when Mr. Rangel was criticized for using Congressional stationery to solicit donations for a City College of New York school being built in his honor, Mr. Rangel said he had appealed to G.E. executives to make the $30 million donation to New York City schools.

G.E. had nothing to do with the City College project, he said at a July 2008 news conference in Washington. "And I didn't send them any letter," Mr. Rangel said, adding that he "leaned on them to help us out in the city of New York as they have throughout the country. But my point there was that I do know that the C.E.O. there is connected with the foundation."

In an interview this month, Mr. Rangel offered a different version of events — saying he didn't remember ever discussing it with Mr. Immelt and was unaware of the foundation's donation until the mayor's office called him in June, before the announcement and after Mr. Rangel had dropped his opposition to the tax break.

Asked to explain the discrepancies between his accounts, Mr. Rangel replied, "I have no idea."

Value to Americans?

While G.E.'s declining tax rates have bolstered profits and helped the company continue paying dividends to shareholders during the economic downturn, some tax experts question what taxpayers are getting in return. Since 2002, the company has eliminated a fifth of its work force in the United States while increasing overseas employment. In that time, G.E.'s accumulated offshore profits have risen to $92 billion from $15 billion.

"That G.E. can almost set its own tax rate shows how very much we need reform," said Representative Lloyd Doggett, Democrat of Texas, who has proposed closing many corporate tax shelters. "Our tax system should encourage job creation and investment in America and end these tax incentives for exporting jobs and dodging responsibility for the cost of securing our country."

As the Obama administration and leaders in Congress consider proposals to revamp the corporate tax code, G.E. is well prepared to defend its interests. The company spent $4.1 million on outside lobbyists last year, including four boutique firms that specialize in tax policy.

"We are a diverse company, so there are a lot of issues that the government considers, that Congress considers, that affect our shareholders," said Gary Sheffer, a G.E. spokesman. "So we want to be sure our voice is heard."

HealthCare.gov

Newsroom

State by State Enrollment in the Pre-Existing Condition Insurance Plan, as of February 1, 2011

The Affordable Care Act created the new Pre-Existing Condition Insurance Plan (PCIP) program to make health insurance available to Americans denied coverage by private insurance companies because of a pre-existing condition. Coverage for people living with such conditions as diabetes, asthma, cancer, and HIV/AIDS has often been priced out of the reach of most Americans who buy their own insurance, and this has resulted in a lack of coverage for millions. The temporary program covers a broad range of health benefits and is designed as a bridge for people with pre-existing conditions who cannot obtain health insurance coverage in today's private insurance market. In 2014, all Americans – regardless of their health status – will have access to affordable coverage either through their employer or through new competitive marketplaces called Exchanges, and insurers will be prohibited from charging more or denying coverage to anyone based on the state of their health.

The PCIP program is administered by either the State or the Federal government: 23 States and the District of Columbia elected to have their PCIP program administered by the Federal government while 27 States have chosen to run their own programs.

The PCIP program began accepting applications for enrollment this summer (July 1 for the Federal program, dates for State programs varied). The chart below details the date when each State began providing benefits to people accepted into the program and the number of people enrolled in the program as reported by each State as of February 1, 2011.

= Federally Administered PCIP

State	Date Coverage for Enrollees Began (in 2010)	Number of People Enrolled, reported as of February 1, 2011*
Alabama	August 1	61
Alaska	September 1	20
Arizona	August 1	270
Arkansas	September 1	147

California	October 25	706
Colorado	September 1	434
Connecticut	September 1	22
Delaware	August 1	34
District of Columbia	October 1	10
Florida	August 1	613
Georgia	August 1	399
Hawaii	August 1	23
Idaho	August 1	42
Illinois	September 1	943
Indiana	August 1	131
Iowa	September 1	80
Kansas	August 1	112
Kentucky	August 1	56
Louisiana	August 1	92
Maine	August 1	13
Maryland	September 1	145
**Massachusetts	August 1	0
Michigan	October 1	89
Minnesota	August 1	29
Mississippi	August 1	58
Missouri	August 15	166
Montana	August 1	153
Nebraska	August 1	39
Nevada	August 1	125
New Hampshire	July 1	78
New Jersey	August 15	216
New Mexico	August 1	198
New York	October 1	411
North Carolina	August 1	674
North Dakota	August 1	5
Ohio	September 1	726
Oklahoma	September 1	190
Oregon	August 1	483
Pennsylvania	October 1	2046
Rhode Island	September 15	85
South Carolina	August 1	242
South Dakota	July 15	62
Tennessee	August 1	171

Texas	August 1	1007
Utah	September 1	117
**Vermont	September 1	0
Virginia	August 1	204
Washington	September 1	139
West Virginia	September 1	15
Wisconsin	August 1	307
Wyoming	August 1	49
	Total	12,437

* Enrollment with respect to the federally-administered is shown as of February 1, 2011 while enrollment with respect to the state-administered PCIPs is reported as of December 31, 2010. This is because the deadline for State reporting lags by 1 month.

** Massachusetts and Vermont are guarantee issue States that have already implemented many of the broader market reforms included in the Affordable Care Act that take effect in 2014. Existing commercial plans offering guaranteed coverage at premiums comparable to PCIP are already available in both States.

Past enrollment data is available here.

Posted: February 10, 2011