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POISED TO PROFIT: HOW OBAMACARE HELPS INSURANCE COMPANIES EVEN IF IT FAILS PATIENTS

HEARING

BEFORE THE

SUBCOMMITTEE ON ECONOMIC GROWTH, JOB CREATION AND REGULATORY AFFAIRS

OF THE

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

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POISED TO PROFIT: HOW OBAMACARE HELPS INSURANCE COMPANIES EVEN IF IT FAILS PATIENTS

Wednesday, June 18, 2014,

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON ECONOMIC GROWTH, JOB CREATION AND REGULATORY AFFAIRS,
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10:00 a.m. in room 2154, Rayburn House Office Building, the Honorable Jim Jordan [chairman of the subcommittee], presiding.

Present: Representatives Jordan, DeSantis, Lummis, Meadows, Bentivolio, Desjarlais, Cummings, Cartwright, Connolly and Kelly.

Staff Present: Ali Ahmad, Majority Professional Staff Member; Melissa Beaumont, Majority Assistant Clerk; Brian Blase, Majority Senator Professional Staff Member; Molly Boyl, Majority Deputy General Counsel and Parliamentarian; Caitlin Carroll, Majority Press Secretary; Sharon Casey, Majority Senior Assistant Clerk; Katelyn E. Christ, Majority Professional Staff Member; Adam P. Fromm, Majority Director of Member Services and Committee Operations; Meinan Goto, Majority Professional Staff Member; Tyler Grimm, Majority Senior Professional Staff Member; Christopher Hixon, Majority Chief Counsel for Oversight; Mark D. Marin, Majority Deputy Staff Director for Oversight; Laura L. Rush; Majority Deputy Chief Clerk; Andrew Shult, Majority Deputy Digital Director; Tamara Alexander, Minority Counsel; Aryele Bradford, Minority Press Secretary; Jennifer Hoffman, Minority Communications Director; Elisa LaNier, Minority Director of Operations; Una Lee, Minority Counsel; Dave Rapallo, Minority Staff Director; Katie Teleky, Minority Staff Assistant and Michael Wilkins, Minority Staff Assistant.

Mr. JORDAN. The committee will come to order.

Senator, we appreciate your being here. You know how this works. We do our opening statements, myself and Ranking Member Cartwright. Other members are going to be joining us. We have a conference going on at this time and some issues that the Republican conference obviously has to deal with, so we expect members to be here shortly.

Let us get started. I know how sensitive your time is. We appreciate the work you have done and your being here today.

Today's hearing is the committee's second hearing examining Obamacare's provisions that bail out health insurance companies.

Today's hearing will also examine how the disastrous implementation of the law and the President's extra-legal actions to unilaterally change the law have likely increased the size of the health insurance industry bailout.

In addition to providing health insurance companies with the mandate for individuals to purchase their product as well as providing expensive subsidies for people who purchased coverage in the Obamacare exchange, the law provided large bailouts of health insurance companies. The American people have a right to know how much these backdoor bailouts will likely cost.

One day before the committee's last hearing on this issue in February, the Congressional Budget Office estimated there would not be a taxpayer bailout. Incredibly, CBO estimated that insurers would make so much money on their exchange plans that they would have to return an excess amount of the profits to the taxpayers through Obamacare's Risk Corridor Program.

While I have great respect for the analysts at CBO, their findings in this area do not square with the evidence presented by numerous health policy experts. However, my friends on the other side of the aisle trumpeted the CBO analysis at that hearing, assuring the public that there would be no bailout.

Due to the contradiction between Administration statements, CBO estimates and the widespread sentiment among health policy experts, the committee conducted additional oversight of health insurance companies' expectations of payments through Obamacare's bailout provisions.

The committee obtained information from 15 traditional health insurance companies and 23 Obamacare co-op companies that represent about three-quarters, again about 75 percent of all the individuals enrolled in Obamacare exchange plans. We talked to 15 traditional insurance companies and 23 co-ops representing three quarters of the people in the exchange plans.

While the committee is still analyzing the information provided by these companies, our initial review has uncovered some striking information. First, 13 of the 15 traditional health insurance companies expect to collect payments from the Obamacare Risk Corridor Bailout Program. None of the traditional insurers expect to pay into the program, so 13 expect to get money from the taxpayers, none of them expect to pay as the CBO originally estimated and two say it will break even.

Eight Obamacare co-ops expect to collect payments from the Obamacare Risk Corridor Bailout Program. Only one co-op expects to pay into the program.

Third, these health insurance companies and Obamacare co-op companies currently expect payments of nearly $730 million through Obamacare's Risk Corridor Bailout Program.

Finally, the health insurance industry expects its taxpayer bailout to be about 33 percent larger than it did at the start of open enrollment. The information provided by the insurers suggests that the total taxpayer bailout could, in fact, well exceed $1 billion this year alone.

The information obtained by the committee shows that CMS testimony at today's hearing is simply out of touch with the reality. According to CMS' written testimony, "We anticipate that Risk

Corridor collections will be sufficient to pay for all Risk Corridor payments."

Now that we know that the odds of a taxpayer bailout are a near certainty, it is crucial for us to understand how the Administration plans to funnel taxpayer money to health insurance companies to subsidize their profits and under what legal authority—I know the Senator will talk about this—the Administration claims to be able to do that.

In addition to examining Obamacare's Risk Corridor Program, today we will also examine Obamacare's Reinsurance Program and the Risk Adjustment Program. The effect of these two programs is to subsidize health insurance companies offering coverage in the exchanges with higher insurance premiums on the vast majority of Americans.

The committee has learned that insurance companies directly lobbied the White House for the Administration to make the bailout programs more generous to insurers. In response to the insurers' lobbying campaign, the Administration made several changes to increase the size of payments insurers will receive through both the Risk Corridor Program and the Reinsurance Program.

Mr. JORDAN. Again, I want to thank Senator Sessions, the Ranking Member of the Senate Budget Committee, for both his work on this issue and for coming here this morning. Senator Sessions and his staff on the Budget Committee have produced an analysis confirming that the Department of Health and Human Services will need an appropriation from Congress to spend any money through Obamacare's Risk Corridor. Again, we want to thank you for your work, Senator.

First, we will recognize the Ranking Member on the subcommittee, Mr. Cartwright, the gentleman from Pennsylvania, who is recognized for five minutes.

Mr. CARTWRIGHT. Thank you, Chairman Jordan.

Welcome to you, Senator Sessions. It is good to have you here today. I am looking forward to a robust discussion.

Were you ever at a social gathering where there is somebody you didn't know who walks up to you and introduces himself. He is very pleasant and then he moves on and introduces himself to others in the gathering. Then he circles around the whole room and gets back to you and introduces himself to you again.

We have had that happen and you sort of laugh it off as an innocent, honest mistake. Then that person goes around the room again and he circles back to you a third time and introduces himself to you again. I have never had that happen to me, nor have I had it happen 50 times because after the third time, you start to think wow, this guy is weird,

Today is the 27th hearing our committee has held on the Affordable Care Act. To date, House Republicans have voted more than 50 times to repeal, defund or otherwise undermine the law. These numbers are truly preposterous and a poor use of the committee's and the House of Representatives' limited resources at a time when our country faces immense challenges that are largely being ignored.

I want to start out by highlighting for my Republican colleagues the number that matters most here today. More than 8 million

Americans have signed up for health insurance plans through the Federal and State exchanges. More than 8 million Americans can now see a doctor and get critical health services that every American should have.

Insurance companies are no longer allowed to discriminate against women, people with cancer, diabetes or other preexisting conditions. You people are able to stay on their parents' plans until they are 26. Millions of individuals can finally access free, preventive health care.

We have seen the lowest growth in health care costs in 50 years and billions of dollars in rebate checks have been sent to consumers across the country.

Unfortunately, today's hearing is the latest in a long series of Republican attempts to criticize the Affordable Care Act. The issue before us today involves three risk management provisions in the ACA, reinsurance, risk adjustment and risk corridors.

The committee already examined these provisions in a hearing on February 5 of this year. Republicans also failed to mention that they were the ones who first proposed the reinsurance, risk adjustment and risk corridor mechanisms in Medicare Part D where they have been tremendously successful.

They discourage plans from avoiding enrollees with unusually high drug costs and they help lower premiums for consumers by stabilizing the insurance market. Now in its ninth year, Medicare Part D has robust participation with 39 million seniors enrolled. I appreciate the Senator who is here to testify before us today voted in favor of that legislation, as did 41 of his Senate Republican colleagues and 204 House Republicans.

Nevertheless, Republicans continue inaccurately to describe these risk mitigation mechanisms as a bailout to health insurance companies. This is a characterization that is just plain wrong. Reinsurance is funded solely by contributions from insurance companies. Risk adjustment is funded by transfers between insurance companies making it budget neutral.

Under the Risk Corridor Program, the government collects funds from insurers with extreme financial gains and makes payments to those with extreme losses. It is not a bailout.

The reinsurance pool amount is set by statute. Payments may not exceed the amounts collected from insurers. In April, the nonpartisan CBO confirmed that the Risk Corridor Program would be budget neutral over three year life of the program.

None of these facts sounds like a bailout to me. The Affordable Care Act is the law, already debated for years, passed by Congress, signed by the President and helping millions of Americans to obtain quality, affordable health insurance.

Rather than continuing to look for any conceivable way to attack this law, as my Republican colleagues have done for years, my sincere hope is that we can start examining ways to help the program run more efficiently and effectively as it continues to be implemented.

Again, I would like to thank the witness for coming to testify before us today. I look forward to an informative discussion about managing risk in insurance pools.

Thank you, Mr. Chairman.

Mr. JORDAN. I thank the gentleman from Maryland, the Ranking Member of the full committee, and wish to recognize him.

Mr. CUMMINGS. Thank you very much for your courtesy, Mr. Chairman.

Let me extend a warm welcome to our colleague, Senator Sessions.

This is an important topic and I look forward to hearing from all of our witnesses today.

For far too long, in this country, we have been adding to the ranks of the uninsured. Before the Affordable Care Act, the number of uninsured Americans climbed year after year, amounting to what can only be described as a crisis of public health. At the peak of this crisis, nearly 50 million people went uninsured in America.

I have always believed that, as a nation, we must and can do better. It is a moral issue. This is one of the reasons I came to Congress. I am proud to say today that we are doing better. More than 8 million people have now enrolled in health insurance through the Affordable Care Act exchanges. Millions more now have access to care through State expansions in the Medicaid Program. Young adults across the country now have access to care through their parents' insurance plans.

Today, I would like to place into the record new data that our committee has obtained on this issue. Over the past several months, the Majority staff of the committee has been contacting health insurance companies that are participating in the Affordable Care Act exchanges. They have been requesting data about insurance company enrollment projections before the Affordable Care Act went into effect, as well as data about the actual levels of enrollment after October 1.

Although the data has some limitations, several conclusions may be drawn. First, at the highest level, this new data obtained by the committee shows that actual enrollment exceeded insurance company projections by four percent. This result was achieved despite significant challenges with federal and State websites.

Importantly, the data provided by these insurance companies already removed individuals whose plans were canceled because they did not pay the first month premium. In addition, there has been a lot of concern about whether young people between the ages of 18 and 34 were going to sign up for the insurance under the Affordable Care Act.

The new data from these insurance companies shows that enrollment among adults in this key age group exceeded insurance company projections by nearly 11 percent. The data also shows that this age group represented the single largest proportion of new enrollees at nearly 27 percent. They are getting insured so that they can stay healthy.

Insurance companies also provided data broken down by State. This data shows that enrollment exceeded projections in 18 of 31 States for which the committee obtained data. Notably, some of the largest enrollment increases occurred in Republican-controlled States that were hostile to the Affordable Care Act.

For example, the data obtained by the committee shows that the actual enrollment exceeded insurance company projections by more than 500 percent in Florida. This data is only a sample which is

one of its limitations, whether this clearly demonstrates there is extremely strong demand for quality affordable health care, even despite vocal opposition from Republican governors, State legislatures and insurance commissioners.

Mr. Chairman, I ask unanimous consent that a fact sheet prepared by my staff setting forth this data be entered in the official hearing record.

Mr. JORDAN. Without objection.

Mr. CUMMINGS. Thank you.

Today, we will discuss the Reinsurance Risk Adjustment and Risk Corridor Programs under the ACA. These programs are critical mechanisms to health insurance company transition from a market in which they discriminated—discriminated—against people with preexisting conditions to one in which they must compete on the basis of quality and efficiency.

These programs are key features of the Medicare Part D Program, one of President Bush's signature legislative initiatives. They were adopted by a Republican Congress. They have been extremely successful in the Part D Program and they will be successful for the Affordable Care Act.

Mr. Chairman, again, I thank you for the opportunity and I look forward to hearing from a man I have a lot of respect for, Senator Sessions.

Mr. JORDAN. I thank the gentleman from Maryland.

The gentleman from Virginia?

Mr. CONNOLLY. Mr. Chairman, I would ask unanimous consent, Mr. Chairman, that my opening statement be entered in the record at this point prior to Senator Sessions testimony.

Mr. JORDAN. I thank the gentleman.

Mr. CONNOLLY. I also welcome Senator Sessions to our committee.

Chairman JORDAN. You beat me to the punch.

Members have seven days to submit opening statements for the record who any of my Republican members who want to do that.

The Honorable Jeff Sessions is with us today. Senator, we appreciate that. We appreciate the good work you have done on this issue and so many others. The gentleman from Alabama is recognized.

STATEMENT OF THE HONORABLE JEFF SESSIONS, A UNITED STATES SENATOR FROM THE STATE OF ALABAMA

Senator SESSIONS. Thank you, Mr. Chairman, Ranking Member Cartwright and members of the subcommittee. Thank you for your kind words. It is an honor for me to appear before the people's House and to share some thoughts that are the product of research by my Budget Committee staff.

They have identified that there are problems with the Risk Corridor Program in the President's health law but the issue is broader than health care because it impacts the constitutional power of Congress.

As you know, President Obama's healthcare law created a Risk Corridor Program in an effort to mitigate risk for private companies that participate in the federally-controlled health insurance market. The government would collect a portion of the profits if a

company makes money and pay off a portion of the losses if a company loses money.

Under our constitutional system of government, HHS must receive an appropriation from Congress before it can make payments to insurance companies that lose money under this law. It seems quite clear that the healthcare law left any funding of the Risk Corridor Program to a future Congress by not appropriating such money as part of the original law.

According to our own Congressional Research Service, "Under longstanding GAO interpretations, an appropriation must consist of both a direction to pay and a specified source of the funds." The law does not meet those requirements.

This principle flows from the plain language of Article I, Section 9, Clause 7 of the Constitution which the House jealously guards and the Senate should, which states "No money shall be drawn from the Treasury but in consequence of an appropriation made by law."

Already this year, CRS has twice issued this statement seeming to accept the GAO interpretation. Yet it does appear that HHS intends to make risk corridor payments without congressional appropriations. The regulations and statements to insurance companies and the budget they have submitted suggest that.

Without an explicit appropriation, any money spent on this program would be an illegal transfer of funds. It is bedrock constitutional law.

It has been suggested that the Obamacare Risk Corridor Program is the same as the Risk Corridor Program for Part D of Medicare. This is plainly false. That law, Part D, included a mandatory appropriation for just that purpose. President Obama's healthcare law contains no such language.

To carry out their plans, the President's fiscal year 2015 budget requests the authority to collect and spend money from authorized user fees. HHS would also apparently use the authority as justification to redistribute money collected from profitable plans or to even raid other funds for this purpose. Such authority from the budget is unlikely to happen.

If approved, this would give HHS unchecked discretion over these funds creating a multibillion dollar slush fund. Our research indicates that if Congress does not either provide a funding source through appropriations or grant the Administration new authority to shift around funds, then any risk corridor payment HHS makes would be illegal.

Should the Administration persist in doing so, it would be subject to prosecution under the Antideficiency Act. Of course, we hope they will avoid taking that step. Your hearing today could help impact their decision.

Although they seem to have clearly indicated they intend to do so at this date, the implementation of the President's health law has been marked by a series of unilateral actions by the President and the Executive Branch officials that undermine the rule of law, in my opinion, and public confidence. This is far the larger pattern of executive lawlessness and unilateralism that has caused great unease throughout the country.

Sadly, the Senate has failed to defend Congress' congressional prerogative. The House, by contrast, is to be applauded for its defense of the Constitution as exemplified by the hearing today. I would urge lawmakers in both parties to act in defense of Congress and the authorities delegated to it by the Constitution. James Madison would expect no less.

Thank you, Mr. Chairman, for the opportunity to share these thoughts with you.

[Prepared statement of Senator Sessions follows:]

HOUSE OVERSIGHT TESTIMONY ON RISK CORRIDORS

Chairman Jordan, Ranking Member Cartwright, and members of the Committee: thank you for inviting me here today to discuss an issue that our committee has identified with the risk corridor program in the President's health law.

As you know, President Obama's health law created a risk corridor program in an effort to mitigate risk for the private companies that participate in the federally-controlled health insurance market. Risk corridors function by having the government limit the profits or losses that a company can incur.

The government collects a portion of the profits if a company makes money and pays off a portion of the losses if a company loses money.

But, under our constitutional system of government, HHS must receive an appropriation from Congress before it can make payments to insurance plans that lose money. It seems quite clear that the health law left funding of the risk corridor program up to a future Congress by declining to appropriate money for the program as part of the original health law.

According to our own Congressional Research Service (CRS), "under longstanding GAO interpretations, an appropriation must consist of both a direction to pay and a specified source of funds." Nothing in the law meets these requirements. This interpretation flows from the plain language of Article I, Section 9, Clause 7 of the Constitution, which states that "No Money shall be drawn from the Treasury, but in Consequence of Appropriations made by Law." Already this year, CRS has twice issued this statement, approving the GAO interpretation.

Since Obamacare does not specify a source of funding for the risk corridor program, the law and the Constitution leave the task of appropriating that money exclusively to Congress.

Yet, it appears that HHS intends to make risk corridor payments without congressional appropriation. Without an explicit appropriation, any money spent on this program would be an illegal transfer of funds. This is bedrock constitutional law, as you know.

Different from Medicare Part D

It has been suggested that the Obamacare risk corridor program is the same as the risk corridor program for Medicare Part D. This is plainly false.

The legislation establishing Medicare Part D stated that payments would come from a specific, newly created account within the Federal Supplementary Medical Insurance Trust Fund. It included a mandatory appropriation for that purpose. President Obama's health law contains no such language.

Why this matters

The President's FY2015 budget requests the authority to collect and spend money from "authorized user fees." HHS would also apparently use that authority as justification to redistribute money collected from profitable insurance plans.

This would give HHS unchecked discretion over these funds, creating a multi-billion-dollar slush fund.

On the other hand, if there are not enough profitable plans paying into the risk corridor program, HHS could raid other programs within CMS program management to fund a shortfall.

If Congress does not either provide a funding source through appropriations or grant the Administration new authority to shift funds around, then any risk corridor payments that HHS makes would be illegal. Should the Administration persist in doing so, it would be subject to prosecution under the Antideficiency Act.

The implementation of the President's health law has been marked by a series of unilateral actions that undermine public confidence and the constitutional rule of law. This is part of a larger pattern of executive branch lawlessness and unilateralism that has caused great unease throughout the nation. Sadly, the Senate Democrat majority has failed to defend Congress' constitutional prerogatives. The House, by contrast, is to be applauded for its defense of the Constitution, as exemplified by this hearing today. I would urge lawmakers in both parties to act in defense of Congress and the authorities delegated to it by the Constitution.

Mr. JORDAN. Thank you, Senator. Again, we appreciate your work on this issue and so many others, and your focus here today on the importance of adhering to the Constitution and the rule of law.

Senator Sessions, thank you again very much.

We will now take a short recess to get ready for our first panel.

[Recess.]

Mr. JORDAN. The committee will come to order.

We want to welcome our distinguished panel: Mr. John R. Graham, Senior Fellow, National Center for Policy Analysis; Mr. Seth J. Chandler, Foundation Professor of Law, University of Houston Law Center; Ms. Cori E. Uccello, Senior Health Fellow, American Academy of Actuaries; and finally, Mr. Edmund F. Haislmaier, Senior Research Fellow, Center for Health Policy Studies, The Heritage Foundation.

Pursuant to committee rules, all witnesses will be sworn before they testify. Please rise and raise your right hand.

Do you solemnly swear or affirm that the testimony you are about to give will be the truth, the whole truth, and nothing but the truth?

[Witnesses respond in the affirmative.]

Mr. JORDAN. Let the record show everyone answered in the affirmative. We will start with Mr. Graham.

Mr. Graham, you are recognized for five minutes. You know how the light system works. Make sure microphone is on and fire away.

STATEMENT OF JOHN R. GRAHAM

Mr. GRAHAM. Thank you, Chairman Jordan, Ranking Member Cartwright and members of the committee.

My name is John R. Graham, Senior Fellow at the National Center for Policy Analysis, a nonprofit, nonpartisan, public policy research organization. I welcome the opportunity to share my views and look forward to your questions.

Despite the President's assurance that if you like your health plan, you can keep your health plan, Obamacare has caused significant disruption to peoples' coverage. As the health insurance exchanges prepared for their first open enrollment, which began last October, insurers knew that they would struggle to price policies in the exchanges accurately.

Obamacare includes three mechanisms to backstop insurers' risk: risk adjustment, reinsurance and risk corridors. I will focus on the last two. These last two, reinsurance and risk corridors, are politically motivated tools that are critical to insurers' ability to profit in the exchanges through the end of 2016. Both persist only through the first three years of Obamacare.

The first is reinsurance. Each year, Obamacare levies a special premium tax on all insurers, as well as self insured plans. This tax revenue is supplemented by a little extra from the general revenues to add up to a total of $25 billion over the three year period.

For each of the three years, the U.S. Department of Health and Human Services must publish a notice explaining how it will distribute this money to insurers. In March 2013, HHS issued its first notice. My written testimony goes through the arithmetic which

concludes that the maximum payout per expense of policyholder would have been $150 to $1,000.

However, at the end of 2013, HHS changed that rule, increasing the maximum payout to $164,000 by changing the attachment point. HHS asserts that it changed the attachment point because there would be fewer extraordinarily expensive claims than originally anticipated. This is a remarkable claim.

Evidence suggests that the exchanges are attracting older and sicker applicants than originally anticipated. For example, Express Scripts, the country's largest provider of pharmacy benefits has released an analysis of medication utilization in the exchanges.

"Increased volume for higher cost specialty drugs can have a significant impact on the cost burdens. Specialty medications now account for more than a quarter of the country's total pharmacy spend and total spend six of the top ten costliest medications used by exchange enrollees have been specialty drugs.

"In commercial plans, only four of the top ten costliest medications were specialty. More than 6 in every l,000 prescriptions in the exchange plans were for medication to treat HIV. This proportion is nearly four times higher in exchange plans than in commercial health plans."

Further, the exchanges need so-called young invincibles who are between the ages of 18–34. However, these comprise only 28 percent of enrollees in Obamacare plans, almost one-third fewer than the 40 percent previously expected.

Even worse, our understanding of the characteristics of the beneficiaries in the exchanges is deteriorating because HHS appears to have decided to discontinue its monthly announcements that describe these important factors.

The Reinsurance Fund is primarily financed by a tax levied on unassumed approximately 191 million insured people in the United States. If 2014 sees significantly fewer insured people, then assumed revenues will fall short. It is likely the Reinsurance Fund will fall short of satisfying insurers' claims and they will look elsewhere to be made whole which brings us to the risk corridors.

This is an unlimited taxpayer obligation that compensates insurers and the exchanges according to the formula I describe in my written testimony. A quick read of this corridor suggests they are revenue neutral, but this is not the case. Payments are based on premiums paid, not claims incurred.

At the risk of over simplification, if the premium of all insurers is $10,000 and the average of all claims is $10,000, the risk corridor is revenue neutral, but if the average of all claims is greater than that, taxpayers are on the hook for the difference.

Health insurers appear to understand that the exchanges contain more risk than initially appreciated and HHS has responded to their concerns in a series of communications that have promised in somewhat veiled language that it will adjust the risk corridors, quoting from a letter, "modify the Risk Corridor Program final rules to provide additional assistance."

Also, the HHS has increased the administrative costs that it will compensate plans for if they incur too many claims in the risk corridors.

In its most recent communication, the HHS appears to have accepted the need for appropriations as the Congressional Research Service has suggested and I would conclude by encouraging Congress to use whatever tools and powers available to it to ensure the taxpayer liabilities in these risk corridors are limited and precisely quantified.

Thank you.

[Prepared statement of Mr. Graham follows:]

Chairman Jordan and Members of the Committee, I am John R. Graham, Senior Fellow at the National Center for Policy Analysis, a nonprofit, nonpartisan public policy research organization dedicated to developing and promoting private alternatives to government regulation and control, solving problems by relying on the strength of the competitive, entrepreneurial private sector. I welcome the opportunity to share my views and look forward to your questions.

Despite the President's assurance that "if you like your health plan, you can keep your health plan", Obamacare caused significant disruption to people's coverage as the health-insurance exchanges prepared for their first open enrollment, which began on October 1, 2013. Insurers knew that they would struggle to price policies in the exchanges accurately.

So, Obamacare included three mechanisms to backstop insurers' risk: Risk adjustment, reinsurance, and risk corridors. The first, risk adjustment, is perpetual, transfers money from unexpectedly profitable insurers to unexpectedly loss-making insurers, and is – at least in concept -- a necessary way to mitigate risk in a market where insurers are forbidden to charge beneficiaries actuarially accurate premiums.

The last two, reinsurance and risk corridors, are politically motivated tools that are critical to insurers' ability to survive the exchanges through the end of 2016. Both persist only through the first three years of Obamacare, by the end of which its architects believed that the actuarial risks in the exchanges would have stabilized.

The first is reinsurance. Each year, Obamacare levies a special premium tax on all insurers (whether participating in exchanges or not) as well as self-insured (so-called ERISA) plans (in which employers bear the risk of medical costs and insurers or administrators process claims and advise on plan design). This tax revenue is supplemented by a little extra from the U.S. Treasury. In total, the reinsurance sums are targeted to be: $12 billion for 2014, $8 billion for 2015, and $5 billion for 2016.[1] Although these sums are a burden on beneficiaries and taxpayers, at least they are limited.

For each of the three years, the U.S. Department of Health & Human Services (HHS) must publish a notice (the previous March) explaining how it will distribute this money to insurers. In March 2013, HHS issued its notice of payment parameters for 2014.[2] The attachment point for reinsurance was $60,000, with a co-insurance rate of 80 percent, capped at $250,000.

For example, if a patient has medical claims of $200,000, the insurer would be compensated $112,000 [($200,000-$60,000) X 80%] by the reinsurance fund. If the patient has medical claims of $500,000, the insurer would claim the maximum of $152,000 [($250,000-$60,000) X 80%]. If reinsurance claims are greater than $12 billion, HHS will prorate the claims.

At the end of 2013, HHS released its proposed rule for payment parameters for 2015. However, as well as proposing the parameters for the second year of the Obamacare exchanges, the proposed rule changed what it had previously announced for 2014.

The one that jumps out is the change to the attachment point for reinsurance. The December rule has lowered the attachment point for 2014 to $45,000 from $60,000. Revisiting the two examples above, the patient with medical claims of $200,000 will now cause the insurer to be compensated $124,000 [($200,000-$45,000) X 80%] by the reinsurance fund. If the patient has medical claims of $500,000, the insurer will claim the maximum of $164,000 [($250,000-$45,000) X 80%].

HHS asserts that it lowered the attachment point because there will be *fewer* extraordinary claims than originally anticipated: "...Updated information, including the actual premiums for reinsurance-eligible plans, as well as recent policy changes, suggest that our prior estimates of the payment parameters may *overestimate the total covered claims* costs of individuals enrolled in reinsurance-eligible plans in 2014" (italics mine).[3] This is a remarkable claim. Indeed, evidence suggests that the exchanges are attracting older and sicker applicants than originally anticipated.

For example, Express Scripts, the country's largest provider of pharmacy benefits, has released an analysis of medication utilization in the exchanges:

> ...[U]se of specialty medications was greater among Exchange enrollees versus patients enrolled in a commercial health plan. Approximately 1.1% of total prescriptions in Exchange plans were for specialty medications, compared to 0.75% in commercial health plans, a 47% difference. Increased volume for higher cost specialty drugs can have a significant impact on the cost burdens...Specialty medications now account for more than a quarter of the country's total pharmacy spend.
>
> In total spend, six of the top 10 costliest medications used by Exchange enrollees have been specialty drugs. In commercial health plans, only four of the top 10 costliest medications were specialty.

For example, "more than six in every 1,000 prescriptions in the Exchange plans were for a medication to treat HIV. This proportion is nearly four times higher in Exchange plans than in commercial health plans."[4]

Further, the young people needed in the exchanges are the so-called "young invincibles", who are between the ages of 18 through 34. These comprise only 28 percent of enrollees in Obamacare, almost one third fewer than the 40 percent previously expected.[5] Even worse, our understanding of the characteristics of beneficiaries in the exchanges is deteriorating, because HHS appears to have decided to discontinue its monthly announcements describing these important factors.[6]

As well, the reinsurance fund is financed primarily by a tax of $63 per insured person. That figure was calculated by HHS assuming approximately 191 million insured people. If 2014 sees significantly fewer insured people than assumed, revenues will fall short.

If the fund raises less revenue than expected, and 2014 medical claims in the exchanges are higher than HHS anticipates, the reinsurance fund will fall short of satisfying insurers' claims against losses. They will look elsewhere to be made whole.

That "elsewhere" is the risk corridors. Through 2016, this is an unlimited taxpayer obligation that compensates insurers in the exchanges for medical costs in excess of 103 percent of the target costs for each plan. For costs between 103 percent and 108 percent of target, taxpayers compensate insurers half the excess loss. For costs above 108 percent of target, taxpayers will compensate insurers 2.5 percent of the target medical cost plus 80 percent of the excess over 108 percent.

A quick read of risk corridors suggest that they are also revenue neutral. But this is not the case. Payments are based on premiums paid, not claims incurred. At the risk of oversimplification, if the average premium (over all insurers) is $10,000, and the average of all claims is $10,000, the reimbursement will be revenue neutral. However, if the average of all claims is $12,000, taxpayers will be on the hook for the difference. If the average of all claims is only $8,000, the Treasury will keep the difference.

Health insurers appear to understand that the exchanges contain more risk than initially appreciated. Last November, after the President announced that he would not enforce the provisions of PPACA that caused insurers to cancel millions of policies, insurers reacted badly. Karen Ignagni, CEO of America's Health Insurance Plans, the industry's trade association, stated that "changing the rules after health plans have already met the requirements of the law could destabilize the market and result in higher premiums for consumers. Premiums have already been set for next year based on an assumption of when consumers will be transitioning to the new marketplace."[7]

HHS immediately published a letter that promised, in somewhat veiled language, that it would figure out how to exploit the risk corridors to further immunize the insurers from losses: "Though this transitional policy was not anticipated by health insurance issuers when setting rates for 2014, the risk corridor program should help ameliorate unanticipated changes in premium revenue. *We intend to explore ways to modify the risk corridor program final rules to provide additional assistance*" (italics mine)."[8]

This letter was written only two weeks *after* the Federal Register published the final rule for 2014.[9] The black letter of the law defines the risk corridors' calculations, but the inputs are subject to significant regulatory discretion.

That is, the numerators and denominators that determine the ratio of actual to target costs are the result of complicated calculations. The final rules delve into their mind-numbing depths. For example, "stand-alone dental claims would not be pooled along with an issuer's other claims for the purposes of determining 'allowable costs' in the risk corridors calculation."

This is illustrative of the kind of rule that can be quietly changed by a detail-oriented regulatory-affairs specialist working for an interested party. Furthermore, the goalposts have also been moved at a higher level. This March, the Administration proposed a rule that, among other things, increased taxpayers' exposure to Obamacare's risk corridors:

> We propose to implement an adjustment to the risk corridors formula...Such an adjustment could increase a QHP issuer's risk corridors ratio if administrative expenses are unexpectedly high or claims costs are unexpectedly low, thereby increasing risk corridors payments or decreasing risk corridors charges. We propose to raise the administrative cost ceiling by 2 percentage points, from 20 percent to 22 percent. We also propose to increase the profit margin floor in the risk corridors formula (currently set at 3 percent, plus the adjustment percentage, of after-tax premiums). Such an adjustment could increase a QHP issuer's risk corridors ratio if claims costs are unexpectedly high, thereby increasing risk corridors payments or decreasing risk corridors charges. We propose to raise the profit margin floor by 2 percentage points, from 3 percent to 5 percent. (p. 56)[10]

The table below shows an insurance plan with $10 million cost target versus $11 million of allowable costs. Actual medical claims are $8.8 million. Using the formula for calculating its payout from the risk corridor, allowing 20 percent of administrative costs, the plan gets a $410,000 "bailout" (panel A). If it can add administrative costs up to 22 percent of allowable costs, the payout increases to $635,641 — an increase of 55 percent (panel B).

Table: Risk Corridor Payouts To A Qualified Health Plan

Panel A (20% administrative costs allowed)		Panel A (22% administrative costs allowed)	
Qualified Health Plan Target Medical Costs	$10,000,000	Qualified Health Plan Target Medical Costs	$10,000,000
Qualified Health Plan Allowable Cost (including 20% administrative costs)	$11,000,000	Qualified Health Plan Allowable Cost (including 22% administrative costs)	$11,282,051
Allowable/Target	110%	Allowable/Target	113%
108% of Target	$10,800,000	108% of Target	$10,800,000
Allowable Cost Minus 108% of Target	$200,000	Allowable Cost Minus 108% of Target	$482,051
Risk Corridor Pays 2.5% of Target	$250,000	Risk Corridor Pays 2.5% of Target	$250,000
Plus 80% of Allowable Cost Minus Target	$160,000	Plus 80% of Allowable Cost Minus Target	$385,641
Total Risk Corridor Payment	$410,000	Total Risk Corridor Payment	$635,641

However, there is no guarantee whatsoever that this will all wash out over the three-year period of the risk corridors. Nevertheless, the Administration now wants us to believe that it will. As described by the *Washington Post*'s Jason Millman:

- If HHS collects more money than it needs to pay out in risk corridor charges in 2014, it will hang on to the bonus funds for 2015 in case of a shortfall. Under the example HHS provided, if it collects $800 million in 2014 and only has to pay out $600 million, then it will keep the remaining $200 million to use in future years of the program.
- If HHS doesn't collect enough money to cover the charges, it will pro rate the amount it pays out to insurers that year. In the following year, HHS would then pay out the difference from the previous year first before paying risk corridors charges for that year.[11]

So what happens if at the end of the three-year program, HHS hasn't collected enough payments? Well, HHS doesn't know yet what happens then, according to a recent memorandum from the agency explaining the policy.

"We anticipate that risk corridors collections will be sufficient to pay for all risk corridors payments over the life of the three-year program," HHS writes. "However, we will establish in future guidance or rulemaking how we will calculate risk corridors payments if risk corridors collections (plus any excess collections held over from previous years) do not match risk corridors payments as calculated under the risk corridors formula for the final year of the program."[12]

The Congressional Budget Office has relied on the Administration for its estimates of the risk corridors' budgetary effects. In its April update, CBO reduced its estimate of the effect of risk corridors from an $8 billion surplus to budget neutrality[13]. From a taxpayer's perspective, the estimate is moving in the wrong direction.

In May, the Administration published the final rule for 2015, which confirms that it will increase the payout from the risk corridors, as first proposed in March.

Further, it takes a small but significant step towards abandoning the fantasy of budget neutrality: "In the unlikely event of a shortfall for the 2015 program year, HHS recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers. In that event, HHS will use other sources of funding for the risk corridors payments, subject to the availability of appropriations".[14]

The Administration's admission that appropriations are required to use general revenues to make the risk corridors whole appears to go some ways towards agreeing with the Congressional Research Service, which has suggested that payouts from the risk corridors require appropriations.[15]

In conclusion, I believe taxpayers would benefit through Congress using whichever tools and powers are available to it, to ensure that our liabilities in the risk corridors are limited and precisely quantified.

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[1] Ross Winkelman, *et al.*, "Analysis of HHS Final Rules on Reinsurance, Risk Corridors, and Risk Adjustment," Robert Wood Johnson Foundation, April 2012. Available at http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf72568.

[2] "HHS Notice of Benefit and Payment Parameters for 2014," Centers for Medicare & Medicaid Services, March 11, 2013. Available at http://www.cms.gov/CCIIO/Resources/Files/Downloads/payment-notice-technical-summary-3-11-2013.pdf.

[3] "Patient Protection and Affordable Care Act: HHS Notice of Benefit and Payment Parameters for 2015," 78 Federal Register 231 (December 2, 2013), p. 72345.

[4] "First Look: Health Exchange Medication Utilization," Express Scripts Holding Company, April 9, 2014. Available at http://lab.express-scripts.com/insights/government-programs/first-look-health-exchange-medication-utilization.

[5] Glenn Kessler, "Spinning Obamacare: The President highlights a less relevant number," Washington Post, April 22, 2014. Available at http://www.washingtonpost.com/blogs/fact-checker/wp/2014/04/22/spinning-obamacare-success-the-president-highlights-a-less-relevant-number/

[6] Charles Gaba, "HHS to Stop Issuing Monthly Reports UPDATE: Confirmed)," ACASignups.net, May 21, 2014. Available at http://acasignups.net/14/05/21/hhs-stop-issuing-monthly-reports.

[7] John R. Graham, "Can Obama Bail Out The Health Insurers?" NCPA Health Policy Blog, November 26, 2013. Available at http://healthblog.ncpa.org/can-obama-bailout-the-health-insurers/.

[8] Gary Cohen, letter to Insurance Commissioners, Centers for Medicare & Medicaid Services, November 14, 2013. Available at http://www.cms.gov/CCIIO/Resources/Letters/Downloads/commissioner-letter-11-14-2013.PDF.

[9] "Patient Protection and Affordable Care Act; Program Integrity: Exchange, Premium Stabilization Programs, and Market Standards; Amendments to the HHS Notice of Benefit and Payment Parameters for 2014," 78 Federal Register 210 (October 30, 2013), pp. 65046-65105.

[10] "RIN 0938-AS02: Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond," Centers for Medicare & Medicaid Services, March 13, 2014. Available at http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/CMS-9949-P.pdf

[11] Jason Millman, "Remember the Obamacare 'bailout?' The administration has a plan to avoid that," Washington Post, April 15, 2014. Available at http://www.washingtonpost.com/blogs/wonkblog/wp/2014/04/15/remember-the-obamacare-bailout-the-administration-has-a-plan-to-avoid-that/.

[12] "Risk corridors and budget neutrality," Centers for Medicare & Medicaid Services, April 11, 2014. Available at http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/faq-risk-corridors-04-11-2014.pdf.

[13] "Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act," Congressional Budget Office, April 2014, p. 18.

[14] "RIN 0938-AS02: Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond," Centers for Medicare & Medicaid Services, May 21, 2014, pp. 80-81. Available at http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/508-CMS-9949-F-OFR-Version-5-16-14.pdf.

[15] Edward C. Liu, "Funding of Risk Corridor Payments Under ACA § 1342," Congressional Research Service, January 23, 2014.

Mr. JORDAN. Thank you, Mr. Graham.

Mr. Chandler?

STATEMENT OF SETH J. CHANDLER

Mr. CHANDLER. I am Seth Chandler, Professor of Law, University of Houston. My credentials are set forth in my written testimony.

I live with and am friends with many people whose politics probably align better with those of the House Minority. I suspect I don't need to work as hard today to persuade members of the Majority as to the merits of my written testimony. Let me see if I can articulate what I have said in a way that aligns with some shared values and that speak to a broad segment of my friends.

All of you ought to be very concerned about the way risk corridors is being implemented. First, about the Obama Administration's sabotage of its own delicate mechanisms for adverse selection containment by what it calls a transitional policy by violating the law you passed and permitting insurers in many States to sell policies that fail to provide essential health benefits and that otherwise violate the ACA.

That action increased the cost of risk corridors substantially, even as it challenged separation of powers.

Second, you ought to be concerned about the revisions this spring to 45 C.F.R. Section 153.500, a decision to fiddle with the risk corridors formula it had earlier written not in a way that has anything to do with a reappraisal of real costs, but as just about taking care of everybody's friend, big insurers.

Having started down the road of tampering with the delicate balance contained in the ACA, for which some of you in here voted, the Obama Administration, instead of backing off, has to keep scrambling to go beyond the statute or normal precepts of administrative law in order to keep propping it up, this time at the taxpayers' expense.

When you let precedents like this stand, when you say it is all for the greater good or for temporary political advantage, before you complain again that this is all some tiresome political stunt, think about what happens when the future Cruz Administration or some other Executive Branch leader not to your taste, has the same sort of powers over the purse and over the law that this Executive Branch is claiming.

Finally, you ought to be concerned about the state of your own House. In my written testimony, I go through the bizarre history of the Congressional Budget Office's accounting for risk corridors. I have studied it with every tool I have and I cannot make mathematical sense of what they did in February or their about face in April.

The latter time was the worst. The CBO simply capitulated to the assertion of the Executive Branch that it would balance risk corridor books by paying off any deficiencies in one year's risk corridor bill with proceeds from what it hoped would be the following year's surplus.

CMS admitted in its April 11 fact sheet not having an answer to the obvious question of what happens when it has borrowed so much against future receipts that there is not enough money to pay off in year three. Scoring risk corridors as budget neutral, CBO

simply capitulated to this vacuous response that relied on vapor dollars and an unlawful withholding of money to the insurance industry to balance the books.

It should have and it could have done much better. If you want to enact interventionist, complex, delicate laws, okay. I understand that. Perhaps that is sometimes what it takes. If you are going to go down that path, you must have independent and technically adept information on the benefits and costs of doing so.

No matter the minor transitory benefits today of looking the other way, when congressional majorities come and go, you ought to be very concerned about a precedent in which at least the appearance of politics starts to infect the CBO.

What I want to do in the 52 seconds remaining is to go where the CBO feared to tread. I want to estimate for you the real cost of risk corridors before the transitional policy, after the transitional policy and after the CMS fiddled with the computation of the risk corridors ratio. I am going to do so using the same software that underlies my written testimony.

What you see in the blue line is what risk corridors would have cost the Federal Government under various levels of profitability for the insurance industry. More profitable is to the left; less profitable is to the right.

The orange line is what happens—at least a decent scenario of what happens after the transitional policy is enacted. You can see that for all levels of insurer profitability, the cost of risk corridors goes up.

The green line is the add-on created by the fiddling with 153.500 and adding what are in effect phantom costs to risk corridors.

You can see the bill increasing. I would add this estimate is roughly in conformity to what the committee investigation found in its speaking to insurance companies.

I see my red light is more than on, so I will quit. Thank you.

[Prepared statement of Mr. Chandler follows:]

An estimate of the cost of Executive branch actions on the costs of the Risk Corridors program

Seth J. Chandler, Foundation Professor of Law
University of Houston Law Center

- Testimony before the Subcommittee on Economic Growth, Job Creation and Regulatory Affairs, June 18, 2014

Introduction

I am Seth J. Chandler, a Foundation Professor of Law at the University of Houston Law Center where I have taught for the past 24 years. My areas of expertise include insurance law and the use of mathematics in the understanding of legal rules. I am also the principal of a blog http://acadeathspiral.org which has examined issues associated with the Affordable Care Act with significant emphasis on the so-called 3Rs of Transitional Reinsurance, Risk Corridors and Risk Adjustment.

I am here primarily to advise Congress on the effects of insurer profitability on Congressional expenditures under the Risk Corridors program contained in 42 U.S.C. § 18032 and to discuss the costs of recent executive branch decisions in the implementation of Risk Corridors. I am concerned that a combination of insurer losses and the recent Executive Branch changes to the Risk Corridors program will result in this provision costing the federal government more than budgeted or anticipated. I am equally concerned that the contrary predictions of the Congressional Budget Office are difficult to reconcile with mathematical reality. I also hope to be able to advise Congress on some areas of inquiry relating to the Risk Adjustment program contained in 42 U.S.C. § 18033.

Risk Corridors can best be thought of as a derivative, not unlike a synthetic collateralized debt obligation, issued by the government to insurers participating on the Exchanges. The program significantly shifts the risk of entering an insurance market whose characteristics are not well known from participating insurers to the federal government. Unlike the transitional reinsurance program (42 U.S.C. § 18031) and the permanent risk adjustment program (42 U.S.C. § 18033), there simply are no failsafe mechanisms in the Risk Corridor statute or the regulations enacted thereunder that induce it to be budget neutral. Although it is not impossible that, as the CBO has most recently asserted, Risk Corridors will be budget neutral or, as the CBO earlier asserted -- it could even be a source of net revenue for the

federal government, it is more likely, in my view, that it will add significantly to the cost of Title I of the Affordable Care Act over the three years in which it is projected to be in effect. Despite significant research, I have not been able to figure out how the CBO concluded, as it did in February of 2014, that Risk Corridors would be likely to earn the government $8 billion. Nor have I been able to figure out how the changes in implementation of the ACA -- in particular the changes in the profit margin floor and administrative cost allowance created by HHS in April of 2014 would, as the CBO now asserts (see CBO table below), wipe out that $8 billion gain and leave the program budget neutral.

14 UPDATED ESTIMATES OF THE EFFECTS OF THE INSURANCE COVERAGE PROVISIONS OF THE AFFORDABLE CARE ACT APRIL 2014 APRIL 2014

Table 4.

Comparison of CBO and JCT's Current and Previous Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act

	February 2014 Baseline	April 2014 Baseline	Difference
	Change in Insurance Coverage Under the ACA in 2024 (Millions of nonelderly people, by calendar year)[b]		
Insurance Exchanges	24	25	*
Medicaid and CHIP	13	13	1
Employment-Based Coverage[3]	7	7	1
Nongroup and Other Coverage[4]	5	5	*
Uninsured[5]	25	26	1
	Effects on the Cumulative Federal Deficit, 2015 to 2024[c] (Billions of dollars)		
Exchange Subsidies and Related Spending[7]	1,197	1,032	-164
Medicaid and CHIP Outlays	792	792	**
Small Employer Tax Credits[8]	15	15	**
Gross Cost of Coverage Provisions	2,004	1,839	-165
Penalty Payments by Uninsured People	52	46	-6
Penalty Payments by Employers[9]	151	139	-12
Excise Tax on High-Premium Insurance Plans[4]	108	120	12
Other Effects on Revenues and Outlays[6]	206	152	-54
Net Cost of Coverage Provisions	1,487	1,383	-104
Memorandum:			
Net Collections and Payments for Risk Adjustment, Reinsurance, and Risk Corridors	8	0	8

old estimate new estimate

Source : http : // www.cbo.gov/sites/default/files/cbofiles/attachments/43900 - 2014 - 02 - ACAtables.pdf

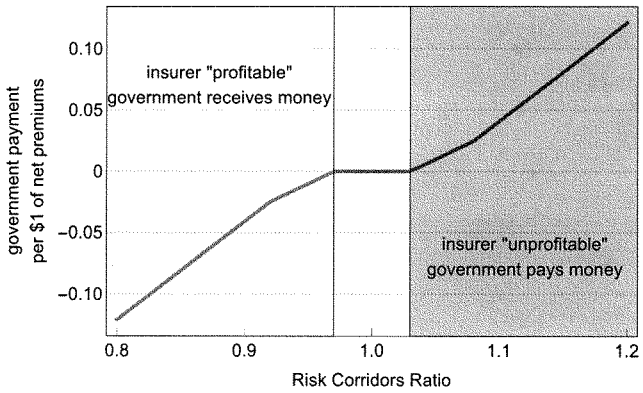
- Figure 1

The idea behind the Risk Corridors statute

Individual insurer level

The graphic below illustrates the idea behind Risk Corridors. It looks at the situation from the perspective of an individual insurer and the federal government. The line going from bottom left to top right shows the amount of money paid under the Risk Corridors program by the government per $1 of net premiums an insurer receives. The line shows this payment amount as this statutory creation called the Risk Corridor Ratio varies. As a first approximation, you can think of the Risk Corridors Ratio as a

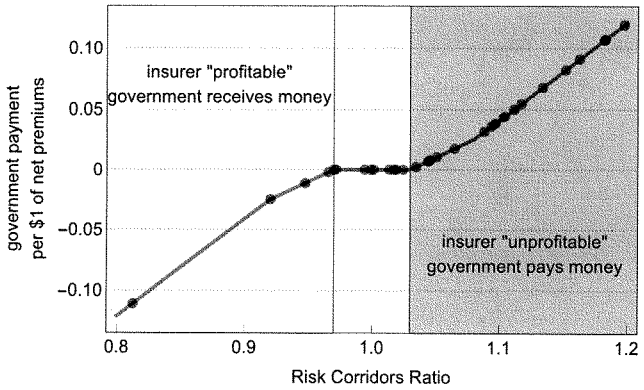
measure of insurer profitability. Roughly speaking, if the Risk Corridor Ratio is below 0.97, the government thinks of the insurer as it it were profitable and taxes the insurer on its ACA-based profits, potentially at a rate of up to 80%. If the Risk Corridor Ratio is above 1.03, the government thinks of the insurer as if it were unprofitable and covers up to 80% of the insurers losses. Between 0.97 and 1.03, the government does nothing.



■ Figure 2

Aggregate level

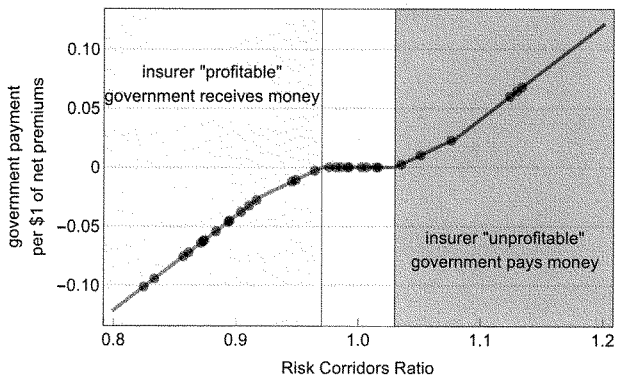
We now start looking at the situation in aggregate. If insurers are mostly in the gray zone on the right side, which is illustrated in the graphic below -- or, to oversimply a bit -- if insurers are "unprofitable" as computed by the government -- the government pays money to insurers.



■ Figure 3

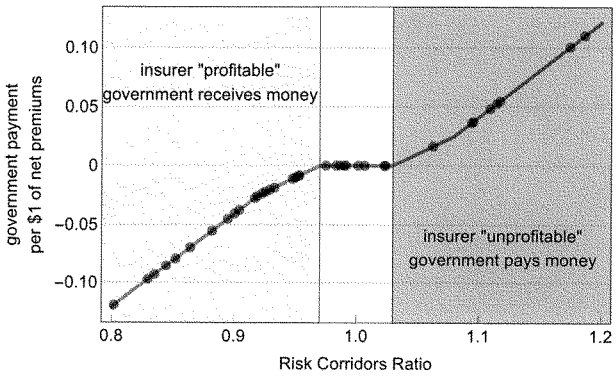
If insurers are mostly in the white zone, in which the Risk Corridors Ratio is less than 1 or -- again to

oversimplify a bit -- if insurers are "profitable" as computed by the government, the government receives money from insurers.



■ Figure 4

And if insurers are scattered pretty evenly throughout the gray and white zones, the government will break even.



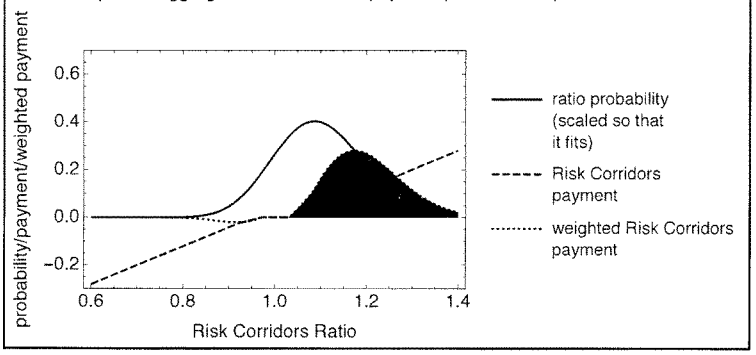
■ Figure 5

Now let's look more closely at the situation in aggregate. What I hope you can see even before I get more elaborate is that the profitability of insureds selling in the Exchanges will affect the aggregate amount of money the government receives from insurers or -- more likely -- pays to insurers through the Risk Corridors program. You can see this in the graphics below. In each of the three graphics, the dashed line is the Risk Corridors payment as a function of the Risk Corridors Ratio. The dotted line is the probability of an insurer incurring that Ratio and the sold line shows what happens when I multiply each Risk Corridor payment by the probability of the government paying that sum. The dark gray area

thus becomes a geometric representation of the amount of money the government pays to "unprofitable" insurers and the light gray area becomes a geometric representation of the amount of money the government receives from "profitable insurers." (In a color version of this testimony, the colors are red and green respectively). This means that the dark gray area minus the light gray here is a geometric representation of the amount the government owes. I've also included a little table at the top to summarize that arithmetic.

In the first example, insurers tend to be unprofitable and the government pays about 5.5 cents for every dollar of net premium insurers receive.

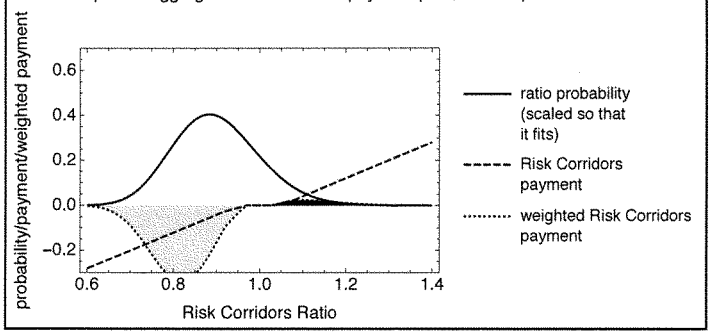
expected positive aggregate Risk Corridors payment per $1 of net premiums	0.057
expected negative Risk Corridors payment per $1 of net premiums	−0.002
expected aggregate Risk Corridors payment per $1 of net premiums	0.055



▪ Figure 6

In the second example, insurers tend to be profitable and the government receives about 5.4 cents for every dollar of net premium insurers receive.

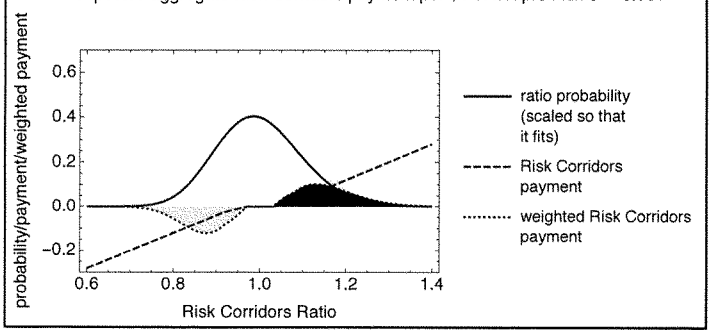
expected positive aggregate Risk Corridors payment per $1 of net premiums	0.004
expected negative Risk Corridors payment per $1 of net premiums	−0.058
expected aggregate Risk Corridors payment per $1 of net premiums	−0.054



■ Figure 7

In the third and final example, insurers are equally likely to be profitable and unprofitable so Risk Corridors is essentially budget neutral.

expected positive aggregate Risk Corridors payment per $1 of net premiums	0.017
expected negative Risk Corridors payment per $1 of net premiums	−0.016
expected aggregate Risk Corridors payment per $1 of net premiums	0.001



■ Figure 8

Implementation of Risk Corridors by the Obama administration

The two relevant Executive branch actions

Thus far I have presented Risk Corridors as it was actually enacted by Congress. The Executive Branch, however, has implemented Risk Corridors and other ACA provisions, however, with definitions and various complications that push the Risk Corridors Ratio away from insurer profitability.

There are two Executive branch actions of which Congress needs to be mindful in evaluating the real costs of Risk Corridors. The first is the effect of the so - called "transitional policy" created by the Obama administration after the political firestorm created by the realization that people were not going to be able to keep their health plans, period, even if they liked them. Without statutory authorization, the Obama administration delegated to states the authority, now exercised by about 60%, to permit insurers to continue selling policies that violated numerous provisions of the ACA such as bars on more health-based underwriting and pricing and requirements to provide Essential Health Benefits. This action undermined the delicate mechanisms in the ACA intended to prevent an adverse selection death spiral. It meant that generally healthier insureds could leave the community rated pools of policies sold inside the Exchange, perhaps forgo benefits they did not want, and leave the pools inside the Exchange generally smaller, less healthy, and thus more likely to result in losses for insurers. The second step, taken to try to prevent the unraveling of the ACA mechanism created by the first executive action, and also without statutory authorization, was to modify 45 C.F.R. § 153.500 (shown below) essentially to permit certain insurers to count phantom costs in the computation of its Risk Corridor Ratios. It was and is a mechanism by which the Obama administration has, quite frankly, decided to make sure that insurers -- on whose voluntary participation in the Exchanges the whole ACA edifice depends -- are "taken care of." As I will discuss, CMS changed these parameters this past spring for 2014 in certain states not because there was anything wrong with the old formula -- indeed the only comments it published on the matter argued for the reverse of what it most recently did -- - but, as it admitted, to provide insurers selling in the Exchanges in those states more money.

§ 153.500 Definitions.

* * * * *

Adjustment percentage means, with respect to a QHP:

(1) For benefit year 2014, for a QHP offered by a health insurance issuer with allowable costs of at least 80 percent of after-tax premium in a transitional State, the percentage specified by HHS for such QHPs in the transitional State; and otherwise

(2) Zero percent.

* * * * *

Allowable administrative costs mean, with respect to a QHP, the sum of administrative costs of the QHP, other than taxes and regulatory fees, plus profits earned by the QHP, which sum is limited to the sum of 20 percent and the adjustment percentage of after-tax premiums earned with respect to the QHP (including any premium tax credit under any governmental program), plus taxes and regulatory fees.

* * * * *

Profits mean, with respect to a QHP, the greater of:

(1) The sum of three percent and the adjustment percentage of after-tax premiums earned; and

(2) Premiums earned of the QHP minus the sum of allowable costs and administrative costs of the QHP.

* * * * *

Transitional State means a State that does not enforce compliance with §§ 147.102, 147.104, 147.106, 147.150, 156.80, or subpart B of part 156 of this subchapter for individual market and small group health plans that renew for a policy year starting between January 1, 2014, and October 1, 2014, in accordance with the transitional policy outlined in the CMS letter dated November 14, 2013.

■ Figure 9

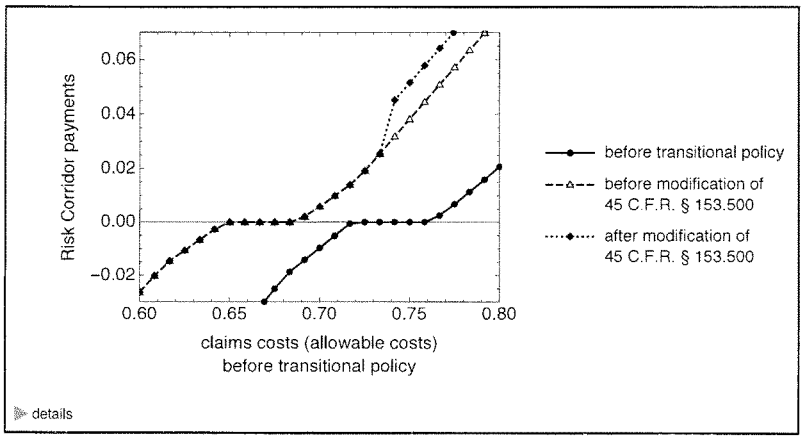
But how much money are we talking about? I have researched in some detail the likely costs of the Risk Corridors program using the methodologies described by CMS in its Notice of Benefit and Payment Parameters dated March 11, 2013 and the subsequent revisions of that methodology by CMS. (See Appendix 2). That research has permitted me to derive a mathematical formula for the Risk Corridor payments by the government per dollar of adjusted premiums. The formula, which is provided in the Appendix to my written testimony, is a function of such items as claims costs incurred and of regulatory parameters. These parameters include esoteric and non-statutory values such as the "profit margir floor" and the "allowable administrative costs cap. " I first consider the effect of the two Executive branch actions at the level of an individual insurer and the government. Then, as before, I consider the

effect of these two actions at an aggregate level.

Effects at an individual insurer level

Although the formula is gruesomely complex, we can use computer algebra systems to visualize the effects of both of these administrative actions. To do so, I am going to use the case of the hypothetical insurer created by CMS in its March 11, 2013, exposition of Risk Corridor mechanics. This insurer earns $200 in gross premiums and has claims costs of $140. I've attached a copy of the relevant pages of the CMS document as Appendix 2 to make it easier to follow along.

The graphic below shows the relationship between what the claims cost of the insurer would have been but for either of the administrative actions and the Risk Corridor payment by the government. The circle line (the lowest line) shows the situation before either of the executive branch actions. Notice that the government breaks even or makes money so long as the claims costs would have been below about 76% of the adjusted premiums. The triangle line (the one next above the circle line) shows the situation resulting from the transitional policy. Lower cost insureds disproportionately exit the exchanges resulting in higher per member mean claims costs and fewer insureds over which to spread non-claims costs of running the plan. As a result, insurers that would have been profitable now lose money and are entitled to Risk Corridor benefits. But, Risk Corridors never fully indemnifies an insurer for its losses. So, the diamond line (the highest line) shows the situation after the second executive action, tampering with section 153.500 by creating this "adjustment percentage" that modifies the minimum profits an insurer is permitted to claim and the maximum amount of non-claims expenses an insurer, most of whom sell all sorts of plans, can attribute to plans sold on an Exchange. Notice that the diamond line tracks the triangle line up until claims costs as a fraction of net premiums hits a certain threshhold. At that point, in the transitional states, the "adjustment percentage" kicks in, the Executive branch treats insurers as losing more money than before, and Risk Corridor payments can grow significantly.

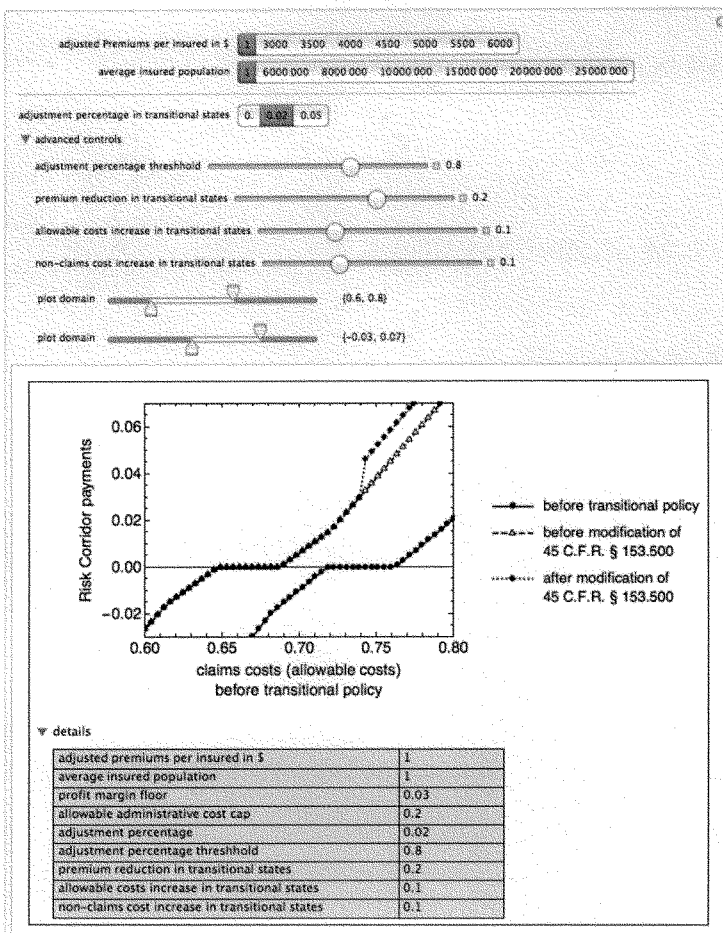


■ Figure 10

I want to be clear that the first Executive action -- the per se refusal to enforce provisions of the ACA in certain states -- indeed created a problem for the Obama administration, even if it was one of its own

making. If the Obama administration had not subsequently changed the way in which the internal computations of Risk Corridors worked, insurers selling on the Exchanges would have lost money relative to what would have happened had no "transitional policy" been developed. Some might have fled the Exchanges or decided not to reenlist for 2015. The Affordable Care Act is extraordinarily vulnerable to voluntary participation by private and often profit-driven insurance companies. But, instead of coming to Congress and asking that the Risk Corridor parameters be changed or that Transitional Reinsurance be made more generous to compensate for the shift in the likely distribution of claims costs induced by the Transitional Policy, or, for that matter, seeking a statutory change that would align campaign rhetoric with the realities of the ACA, the Obama administration added a conditional "adjustment percentage" to further complicate its Risk Corridor algorithm. (45 C.F.R. § 153.500) and move it farther away from what the statute specified. By regulation, CMS increased in certain states the minimum amount an insurer could claim as profit and it increased the amount an insurer could treat as an administrative expense. It did so in states that would permit insurers to continue to sell policies that violate various provisions of the Title I of the ACA. Doing so made insurers look less profitable than they had been under the prior regulations and thus increased the amount the government would owe them under Risk Corridors or, at least, decrease the amount the insurers would pay the government to help balance the Risk Corridor account. The upside, at least in some eyes, of having taken this latter action is that the entire ACA edifice retained a higher probability of stability. The downsides, however, is the expensive, heightened subsidization of the insurance industry by the federal government.

In the oral presentation of this testimony I hope to be able to show an interactive graphic that will demonstrate these effects yet more clearly and that will permit examination of different assumptions. Here is what it will look like.



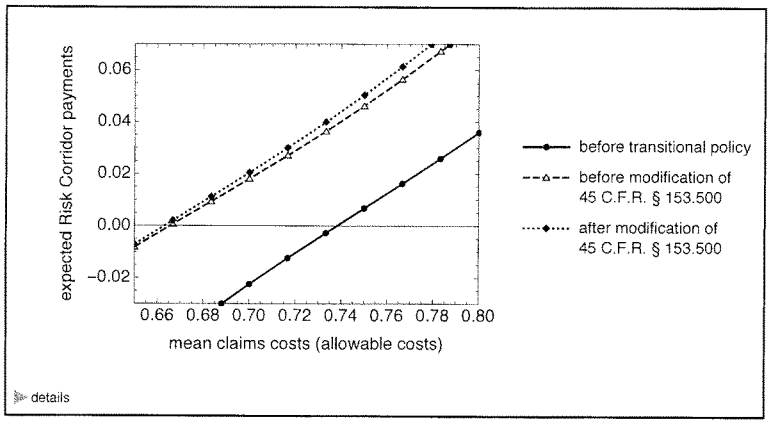
adjusted premiums per insured in $	1
average insured population	1
profit margin floor	0.03
allowable administrative cost cap	0.2
adjustment percentage	0.02
adjustment percentage threshhold	0.8
premium reduction in transitional states	0.2
allowable costs increase in transitional states	0.1
non-claims cost increase in transitional states	0.1

■ Figure 11

Aggregate effects

The above graphic and analysis looks only at an individual insurer, however. What should matter more to Congress is the effect of these Executive branch changes on the overall cost of the Risk Corridors program. And this depends substantially on the distribution of claims costs relative to premiums. What I show in the graphic below is how various assumptions about overall premium revenue under the ACA and the distribution of claims costs relative to premiums for insurers selling on the Exchanges affect the expected costs of the Risk Corridors program. I do not pretend that this computation will be accurate to the penny -- there are far too many variables to do so -- but I do claim that it provides a pretty good estimate of what is likely to happen.

The graphic below illustrates the computation. It shows the cost to the government per dollar of net premium from running Risk Corridors as the mean of the distribution of claims costs varies. The y-axis shows the expected Risk Corridor payment as a fraction of the adjusted premiums collected by insurers. One can see that as the mean claims cost increases, the expected Risk Corridor payment increases in a fairly linear way. The circle line shows how matters might have stood had no transitional policy been announced. The triangle line shows the situation with just the transitional policy in effect but no attempt to further subsidize -- or "bailout" as some have termed it -- the insurance industry. And the diamond line shows matters given both the transitional policy and the changes to section 153.500 of the Code of Federal Regulations.

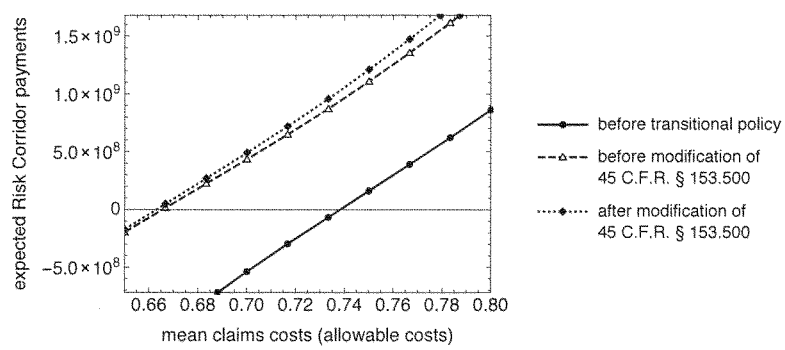


■ Figure 12

This is just the payment per dollar. How many dollars are involved? CMS says 153.500 is just modified for 2014, but it also says it reserves the right to rethink. It would be doing a disservice to the insurance industry to suggest that it would not urge continuation of the more liberal formula through 2015 and 2016 and substituting hope for realism to suggest that, if insurers indeed lose money, the Executive branch and some in Congress would not be sympathetic to such pleas. We also don't know what future enrollments and premiums will look like. Finally, we don't know how many states will continue to be "transitional states" assuming the Obama administration permits continued violation of the ACA by insurers in order to preserve its campaign promises. In the end, we have to make some reasonable assumptions.

The graphic below shows the situation for one set of assumptions. I accept CMS's hedged promise that the transition and the relief lasts just one year. In that setting, the transition probably increased the Risk

Corridors bill by about $1 billion and the modification to section 153.500 probably tagged on an extra $100 million to the price tag. These bills are on top of whatever the cost would be of running Risk Corridors in the first place in a setting in which insurers stand a good likelihood of losing money in the Exchanges.

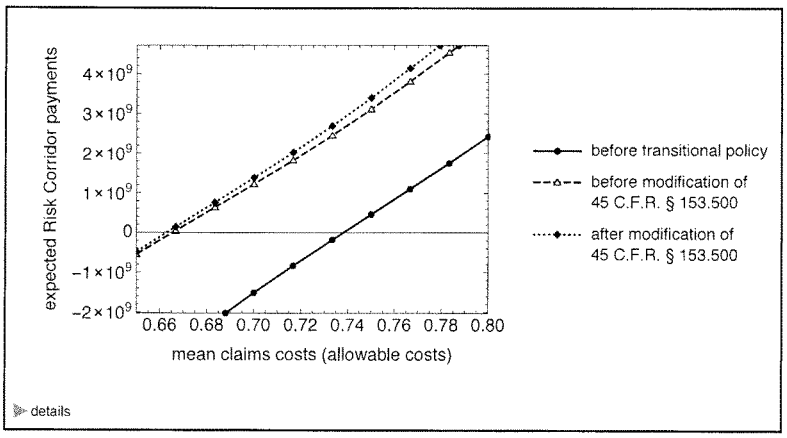


details

adjusted premiums per insured in $	4000
average insured population	6 000 000
standard deviation of mean claims cost distribution	0.08
transitional state percentage	0.6
profit margin floor	0.03
allowable administrative cost cap	0.2
adjustment percentage	0.02
adjustment percentage threshhold	0.8
premium reduction in transitional states	0.2
allowable costs increase in transitional states	0.1
non-claims cost increase in transitional states	0.1

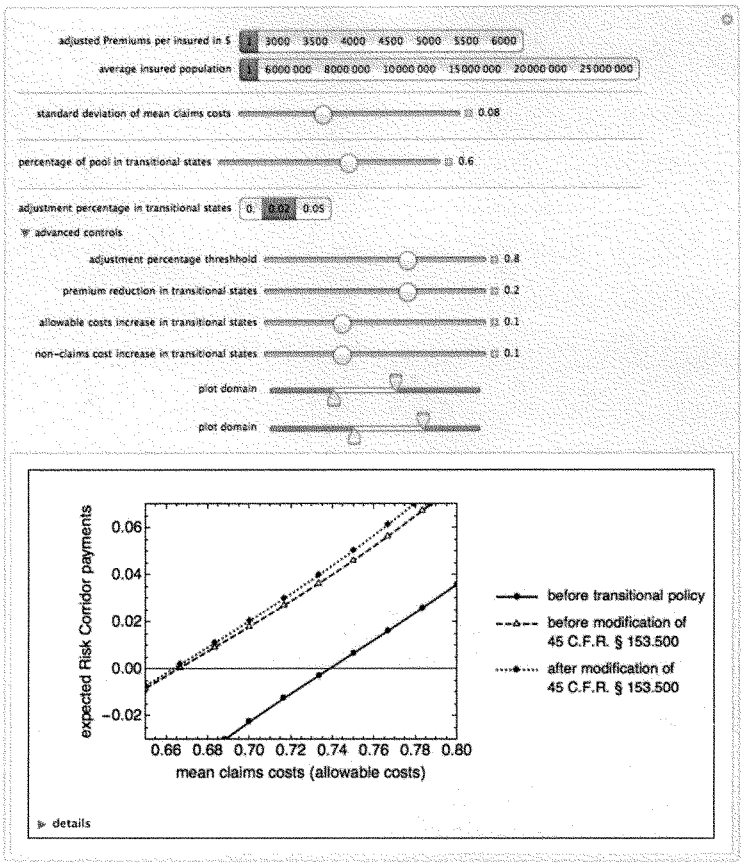
■ Figure 13

The second graphic shows the situation for an alternative scenario: the transition lasts for three years and so too does the modification to section 153.500. In that case, the incremental average cost for Risk Corridors could be $2.5 billion per year from the transition and perhaps $200 million from the modification to section 153.500. Of course, if more states become transitional states, the bill goes higher.



■ Figure 14

Again, in the oral presentation of this testimony I hope to be able to show an interactive version of this graphic that looks like this. It would permit different assumptions to be used.



■ Figure 15

In sum, Risk Corridors might possibly have been budget neutral had the Executive branch not sabotaged the ACA by creating incentives for healthier insureds to drop out of the Exchanges and then not compounded the situation by propping up insurers by inserting an "adjustment percentage" into the regulations that made insurers appear poorer than perhaps they were. Having taken both of these actions, however, the probability that Risk Corridors will, ultimately, cost the federal government and taxpayers money is high. The Executive branch has asserted that any such costs should not be a cause for concern since fact that the Obama administration will attempt to hide this imbalance by violating the statute and shorting insurers for a year, making up the deficit the following year using that year's collections. This is the position taken by CMS in its Fact Sheet of April 11, 2014. (http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/faq-risk-corri-

dors-04-11-2014.pdf). The problem, of course, in addition to the fact that the statute does not call for insurers to float the federal government a loan, is that there is an end game. In the final year or years of the program there may be no future receipts with which to make the statutorily required payments to insurers. CMS says it does not anticipate this problem occurring but says, "[W]e will establish in future guidance or rulemaking how we will calculate risk corridor payments if risk corridor collections ... do not match risk corridors payments as calculated under the risk corridors formula for the final year of the program." I believe a pithier translation of this comment is that "We have no idea what to do if in the end there is not enough revenue." Congress should monitor CMS's promised attempt to escape this predicament.

The Congressional Budget Office Scoring

The issue I must confront in saying all of this is that the Congressional Budget Office seems to disagree. It is worth noting that the CBO did not include Risk Corridors in any visible way in their scoring of the cost of the Affordable Care Act. Then, as shown in Figure 1 above, in February of 2014, after a bill was introduced by Senator Marco Rubio to repeal Risk Corridors, the CBO said it would actually net the government $8 billion ($16 billion in revenue from profitable insurers and $8 billion in payments to unprofitable insurers). (http://www.cbo.gov/sites/default/files/cbofiles/attachments/45010-breakout-AppendixB.pdf) The CBO purported to base its analysis on a comparison with Medicare Part D programs without perceptible consideration as to whether that program was fully relevant to the far more complex provisions of the Affordable Care Act and without apparent consideration of what then appeared to be the then-woefully low levels of enrollment (or the unknown level of actual purchases) in the Exchanges. No comparison was made with a more recent part of the ACA, the Pre-Existing Condition Insurance Program, in which claims expenses had proven to be about triple of what had been expected. Moreover, even if, as the CBO claimed, insurer premiums would exceed costs by "a few percent" such as the 2% or 3% levels it cited with respect to Medicare Part D, the mathematical analysis done here suggests that such modest insurer profits would not have raised the $8 billion in Risk Corridor revenues asserted by the CBO. Raising $8 billion it would have required insurers to have premiums 7% or higher of costs on average -- a level for which there was (and is) no factual support.

Then, in April of 2014, after the "transitional policy" was announced, the CBO said Risk Corridors would break even. Apparently it did so based on an April 11, 2014, "Fact Sheet" issued by CMS purporting to resolve the question of "What risk corridors payments will HHS make if risk corridors collections for a year are insufficient to fund risk corridors payments for the year, as \.08calculated under the risk corridors formula?" (http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/faq-risk-corridors-04-11-2014.pdf). CMS asserted that it would simply use the proceeds from the following year to pay off insurers from the preceding year. This, of course, would hurt insurer cashflow. More importantly, however, what would happen if, as we headed for the end of of the Risk Corridors program, because of all this borrowing against future receipts, there was no money to pay the 2016 or 2017 Risk Corridor obligations? As discussed above, CMS has presently not expressed any idea as to what it would do in such a scenario.

I doubt many accountants would accept that a program that depended on nebulous future revenues would be considered budget neutral. Rather than consider the actual likelihood, however, that there would be any money left to pay for the final years of Risk Corridors payments, the CBO apparently just accepted CMS's vapor funding. Had CBO used critical thinking skills, I believe the picture would be less benign. Insurance policy sales in the Exchange are subject to "The Winner's Curse" in which the policies most likely to be purchased are those most likely to be underpriced. While perhaps insurer pricing in the final year of the Risk Corridors program will be better informed than it is presently, the spectres of adverse selection and moral hazard create a substantial risk that losses in the first years of the program will be sufficiently large to make the entire program a loser for the government. What appears to have happened here is a CBO capitulation to the Executive Branch's ipse dixit that the program would break even.

I would urge Congress to take a closer look at the CBO methodology here. If we are going to have government programs as complex as the ACA and with as long a time horizon as it envisions, it becomes even more critical that we have a strong, independent and technically adept agent to estimate their costs as well as possible. To be sure, it may well be that were Congress to take a closer look it would find that the CBO's methodology was plausible and that it is just a case of two experts disagreeing in good faith. It might even find that the CBO with superior resources and information was taking into

account facts and issues I have neglected. The world can live with this testimony being wrong. What it will not do well with, however, is a CBO that is not acutely aware of the need to separate as much as is possible politics and opinion from law and fact. Unfortunately, in my opinion there is enough smoke here to warrant a closer look by Congress.

The Risk Adjustment Program

Let me spend a few brief moments on the Risk Adjustment Program; it, unlike Risk Corridors, is a permanent feature of the ACA. In my opinion, Risk Adjustment contains incentives for insurer fraud and manipulation that need to be monitored carefully but whose very monitoring creates the potential for patient privacy invasions, not just among those who accept subsidies for policies purchased on the Exchanges but also for insureds in the small group market who are in plans protected by Risk Adjustment.

The idea of Risk Adjustment is again to detach insurer profitability from the relative riskiness of the pool it insures. But one needs to state the form of protection afforded by this program very carefully. Risk Adjustment will not protect insurers against the risk most likely to materialize -- the aggregate pool -- the one covered by all relevant insurers -- having higher medical expenses than expected. Risk Adjustment leaves that risk on the insurance industry. Instead, insurers are expected by 2017 to figure out how much it should cost to insure a pool if it is composed of average pool members and to do so without the protection currently afforded by Transitional Reinsurance or Risk Corridors. Risk Adjustment just protects the insurer who prices accurately on the basis of a standard pool but finds for some reason that its pool is populated by those government models say are likely to incur higher than average medical expenses.

The incentives for an insurer under Risk Adjustment are simple. First, seek out those insureds for whom the government estimated cost is most at variance with the actual projected costs. There is no current legal barrier against this behavior. Indeed, there is already a study by the Milliman Actuarial firm on how to undertake this coding arbitrage for fun and profit. (http://us.milliman.com/uploadedFiles/insight/2013/adverse-selection-aca.pdf) The government expense model, though complex, is not as complex either as reality or as insurers are able themselves to create. Second, give as many insureds as possible those diagnoses that the federal government, using Hierarchical Condition Codes, believes create high medical expenses.

Congress needs to be vigilant in making sure that opportunities for coding arbitrage are few and short lived. This will require oversight of administrative agencies to ensure that they are gathering the proper information on the actual costs of treatment for each condition code and to consider whether finer grained methods should be employed in determining the projected claims costs of individuals.

Congress also needs to be very concerned about enforcement of Risk Adjustment. Laxity will result in insurers getting away with upcoding: honest insurers will end up subsidizing the shady based on the latter's bogus projections of future claims costs. Overly vigilant enforcement is problematic as well, however. Insurers can not operate in an environment of terror in which a mistake in selecting from among closely competing diagnoses leaves them vulnerable to recapture or claims of fraud. Moreover, the opportunities for release of private, sensitive information abound in the validation process necessitated by Risk Adjustment. Auditors of Risk Adjustment coding by insurers will need to take a look at the complete medical histories of sexual assault victims, HIV patients, cancer patients, individuals suffering miscarriages, persons with various mental illnesses and other areas of medical sensitivity in order to determine whether the insurer coded correctly and whether any errors are the product of mistake or

fraud. Moreover, audits will need to be done of the auditors to ensure that any of their claims of error are in fact correct. The more people that poke around in these records, the greater the opportunity for inadvertent or advertent release.

Conclusion

I wish to make clear that the cost of Risk Corridors is not congruent to the wisdom of Title I of the ACA. There may be some who believe that, even if Risk Corridors costs billions, it is a necessary component of a system that manages to insulate insureds from most of the costs of their own medical characteristics but remains sufficiently attractive to insurers that they voluntarily participate in an insurance market notwithstanding the many prior failures and continuing hazards of community rating. There is also nothing automatically wrong with subsidizing insurers, even ones who have earlier achieved high profits in a fair market, to achieve government goals if they are worthy. Elimination of Risk Corridors could have serious consequences on the stability of the insurance Exchanges and, indeed, the complex web of Obamacare. But because the complexities of the ACA are by no means the only way of extending access to healthcare to more Americans or improving the health of Americans, the true aggregate cost of Title I of the ACA -- of which Risk Corridors is a component -- are highly relevant for Congress to examine. And because insurance companies would not usually be high on my list of those in need of government assistance, Congress should consider whether the implementation of Risk Corridors has been consistent with the statutory objectives. Congress should pay close attention to executive branch decisions regarding administration of Risk Corridors that significantly affect its ultimate price tag. It should be concerned about responses from the Executive branch such as that found in the April 11 Fact Sheet that induce the federal budget to be viewed as a discretionary fund rather than a set of appropriations and have the potential to reallocate taxpayer funds to large insurance corporations. Finally, Congress needs to make sure that its own budgeting office is engaged in independent, objective, and replicable research in determining the cost of large and complex government programs.

Disclaimer

The views expressed here are my own and do not necessarily represent those of the University of Hosuton.

Appendix 1 : Derivation of Relationship between mean and standard deviation of a lognormal distribution and the aggregate net payment under Risk Corridors

Government payment

The Risk Corridor payment of the government is equal to the following :

$$(\phi - \mathrm{Min}[\delta, \epsilon + \mathrm{Max}[\alpha, \beta]]) \begin{pmatrix} \begin{cases} -\begin{cases} \frac{1}{40} + \frac{4}{5}\left(\frac{23}{25} - \gamma\right) & \gamma < \frac{23}{25} \\ \frac{1}{2}\left(\frac{97}{100} - \gamma\right) & \frac{23}{25} \le \gamma < \frac{97}{100} \\ 0 & \mathrm{True} \end{cases} & \gamma < 1 \\ \begin{cases} \frac{1}{2}\left(-\frac{103}{100} + \gamma\right) & \frac{103}{100} \le \gamma < \frac{27}{25} \\ \frac{1}{40} + \frac{4}{5}\left(-\frac{27}{25} + \gamma\right) & \gamma \ge \frac{27}{25} \\ 0 & \mathrm{True} \end{cases} & \gamma \ge 1 \end{cases} \\ 0 \quad \mathrm{True} \end{pmatrix}$$

where

```
γ → (ac (1 + aci) (1 - pr)) /
   (pe (1 - pr) - (1 + nci) (1 - pr) t -
     Min[aacc (pe (1 - pr) - (1 + nci) (1 - pr) t),
      ncc (1 + nci) (1 - pr) - (1 + nci) (1 - pr) t +
       Max[-ac (1 + aci) (1 - pr) -
         ncc (1 + nci) (1 - pr) - pe (1 - pr),
        pmf (pe (1 - pr) - (1 + nci) (1 - pr) t)]])
α →
 -ac (1 + aci) (1 - pr) - ncc (1 + nci) (1 - pr) + pe (1 - pr)
β → pmf (pe (1 - pr) - (1 + nci) (1 - pr) t)
aacc (pe (1 - pr) - (1 + nci) (1 - pr) t) →
 aacc (pe (1 - pr) - (1 + nci) (1 - pr) t)
ϵ → ncc (1 + nci) (1 - pr) - (1 + nci) (1 - pr) t
ϕ → pe (1 - pr) - (1 + nci) (1 - pr) t
```

where aacc is the allowed administrative cost cap, ac is allowable costs (claims and related), aci is the percentage increase in per member allowable costs caused by the transitional policy, ncc is the non-claims cost, nci is the percentage increase in per member non-claims costs caused by the transitional policy, pe is the (gross) premiums earned, pmf is the profit margin floor, pr is the percentage reduction in (gross) premiums caused by the transitional policy, and t are the fees and taxes.

Expected government payment

If we assume that allowable costs (ac) follow a lognormal distribution (bounded below by zero) of which the mean is μ and the standard deviation is σ then we can find the expected Risk Corridor payment is equal to the following:

$$\int_0^\infty \frac{\text{payment(ac)} \exp\left(-\frac{\left(\log(\text{ac})+\frac{1}{2}\left(\log\left(\frac{\mu^2+\sigma^2}{\mu^2}\right)-2\log(\mu)\right)\right)^2}{2\log\left(\frac{\mu^2+\sigma^2}{\mu^2}\right)}\right)}{\sqrt{2\pi}\ \text{ac}\sqrt{\log\left(\frac{\mu^2+\sigma^2}{\mu^2}\right)}}\, d\text{ac}$$

This is so in part because, as shown below, a conventionally parameterized lognormal distribution can be reparameterized directly using its mean and standard deviation. The *Mathematica* code below shows how this is done.

```
reparameterizationEquations = Reduce[{Mean[LogNormalDistribution[a, b]] == μ,
    StandardDeviation[LogNormalDistribution[a, b]] == σ, b > 0},
  {a, b}, Reals, Backsubstitution → True]
```

$$\mu \neq 0 \;\&\&\; \sigma \neq 0 \;\&\&\; \mu > 0 \;\&\&\; \sigma \geq 0 \;\&\&\; a == \frac{1}{2}\left(2\,\text{Log}[\mu] - \text{Log}\left[\frac{\mu^2+\sigma^2}{\mu^2}\right]\right) \;\&\&\; b == \sqrt{\text{Log}\left[\frac{\mu^2+\sigma^2}{\mu^2}\right]}$$

The probability density function of such a reparameterized lognormal distribution is computed using the following *Mathematica* code :

```
Refine[PDF[LogNormalDistribution[1/2 (2 Log[μ] - Log[(μ^2 + σ^2)/μ^2]), Sqrt[Log[(μ^2 + σ^2)/μ^2]]], ac],
  ac > 0] // TraditionalForm
```

$$\frac{\exp\left(-\frac{\left(\log(\text{ac})+\frac{1}{2}\left(\log\left(\frac{\mu^2+\sigma^2}{\mu^2}\right)-2\log(\mu)\right)\right)^2}{2\log\left(\frac{\mu^2+\sigma^2}{\mu^2}\right)}\right)}{\sqrt{2\pi}\ \text{ac}\sqrt{\log\left(\frac{\mu^2+\sigma^2}{\mu^2}\right)}}$$

Appendix 2 : The CMS Explanation of its computation

The preamble to our proposed rule contained an example that illustrated the proposed operation of the risk corridors calculation. We have included a minor correction to the calculation of profits in this example:

Premiums earned: Assume a QHP with premiums earned of $200.

Allowable costs: Assume allowable costs of $140, including expenses for health care quality and health information technology, and other applicable adjustments.

Non-claims costs: Assume that the QHP has non-claims costs of $50, of which $15 are properly allocable to licensing and regulatory fees and taxes and assessments described in Sec. 158.161(a), Sec. 158.162(a)(1), and Sec. 158.162(b)(1) (that is, ``taxes'').

The following calculations result:

``Taxes'': Under the proposed definition of taxes, the QHP's ``taxes'' will be $15.

Administrative costs are defined as non-claims costs. In this case, those costs would be $50. Administrative costs other than ``taxes'' would be $35.

After-tax premiums earned are defined as premiums earned minus ``taxes,'' or in this case $200 - $15 = $185.

Profits are proposed to be defined as the greater of: 3 percent of premiums earned, or 3 percent * $185 = $5.55; and premiums earned by the QHP minus the sum of allowable costs and administrative costs, or $200 - ($140 + $50) = $200 - $190 = $10. Therefore, profits for the QHP would be $10, which is greater than $5.55

Allowable administrative costs are defined as the sum of administrative costs, other than ``taxes,'' plus profits earned by the QHP, which sum is limited to 20 percent of after-tax premiums earned by the QHP (including any premium tax credit under any governmental program), plus ``taxes.''

= ($35 + $10), limited to 20 percent of $185, plus $15
= $45, limited to $37, plus $15
= $37, plus $15
= $52.

The target amount is defined as premiums earned reduced by allowable administrative costs, or $200 - $52 = $148.

The risk corridors ratio is the ratio of allowable costs to target amount, or the ratio of $140 to $148, or approximately 94.6 percent (rounded to the nearest one-tenth of one percent), meaning that the QHP issuer would be required to remit to HHS 50 percent of approximately (97 percent - 94.6 percent) = 50 percent of 2.4 percent, or approximately 1.2 percent of the target amount, or approximately

0.012 * $148, or approximately $1.78.

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[Rules and Regulations]
[Pages 15409-15541]

Mr. JORDAN. Thank you, Mr. Chandler. Well done.
Ms. Uccello.

STATEMENT OF CORI E. UCCELLO

Ms. UCCELLO. That is a tough act to follow.

Good morning, Chairman Jordan, Ranking Member Cartwright and members of the subcommittee.

I am Cori Uccello, Senior Health Fellow, American Academy of Actuaries, which is the non-partisan public policy and professionalism association for actuaries in the U.S. Thank you for inviting me to speak today.

Millions of Americans have obtained health insurance under the Affordable Care Act. However, the law poses some financial risks for insurers which could limit competition and plan choice.

To address these risks, the ACA includes three risk sharing programs: risk adjustment, reinsurance and risk corridors. My remarks will provide a framework for understanding these programs. Taken together, they encourage plan choice and competition and reduce the incentives for insurers to avoid high cost enrollees.

I will first discuss the permanent Risk Adjustment Program. Requiring insurers to accept all applicants, regardless of preexisting conditions, and prohibiting premium variations based on health status exposes insurers to adverse selection risk which occurs when individuals who anticipate high health care needs are more likely to purchase coverage than those who anticipate lower needs.

The ACA's individual mandate and premium subsidies reduce the adverse selection effect in the market, although some risk remains. Such adverse selection risk could encourage insurers to avoid enrolling people with high health costs.

The Risk Adjustment Program aims to reduce these incentives by shifting money among insurers based on their enrollee risk profiles. Insurers with larger shares of low cost enrollees will contribute to a fund that will make payments to insurers with larger shares of high cost enrollees.

All ACA compliant plans in the individual and small group market will participate in the Risk Adjustment Program, whether they are inside or outside of the exchanges. The program is designed to be budget neutral.

Next, I will turn to the Reinsurance Program. From 2014–2016, the ACA includes a transitional Reinsurance Program which further reduces the incentives for plans to avoid high cost individuals and help stabilize premiums.

The Reinsurance Program will offset a portion of the cost of high cost enrollees in the individual market. This will reduce the risk to insurers, allowing them to offer premiums lower than they otherwise would be.

In 2014, $10 billion will be collected from health plans, which will then we used to pay plans in the individual market for a portion of an individual's claims exceeding $45,000. The program is budget neutral. If necessary, reinsurance payments will be adjusted to ensure that payments do not exceed contributions collected from plans.

Contributions to and reimbursements from the program will decline over the program's three years. The transitional nature was

designed to address the likelihood that the earliest enrollees would be those with higher costs, including those transitioning from high risk pools whereas healthier individuals may delay enrolling.

The third program is the Temporary Risk Corridor Program effective from 2014–2016 for qualified health plans in the individual and small group markets. The ACA risk corridor is similar in concept to that in Medicare Part D.

Risk corridors mitigate the pricing risk that insurers face when they have only limited data to estimate the health spending of the newly insured. An objective of risk corridors is to encourage health plan choice and competition by limiting the risk for insurers participating in the market during its early years.

The ACA Program includes two-sided risk corridors which limit not only insurer losses but also insurer gains. Actual claims are compared to the expected claims that were assumed in the insurer's premiums.

If actual claims are within three percent of expected, insurers either keep the gains or bear the losses. A portion of losses exceeding three percent are reimbursed by the Federal Government. A portion of gains exceeding three percent are paid to the Federal Government.

Insurers do not have full protection against losses. They bear a share of the risk even if losses exceed the thresholds. Such a design encourages insurers to set premiums so that they are adequate to pay claims.

In closing, I want to highlight the importance of these programs. The Risk Adjustment and Reinsurance Programs reduce the incentives for insurers to avoid high cost enrollees. By limiting insurer losses due to pricing uncertainty, risk corridors encourage insurer participation in the market which in turn increases competition and plan choice for consumers.

Because the risk corridors are two-sided, the Federal Government will receive payments from insurers if their gains exceed the threshold.

Thank you. I look forward to your questions.

[Prepared statement of Ms. Uccello follows:]

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

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

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

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

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

Risk Adjustment

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

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

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

Reinsurance

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

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

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

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

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

Risk Corridors

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

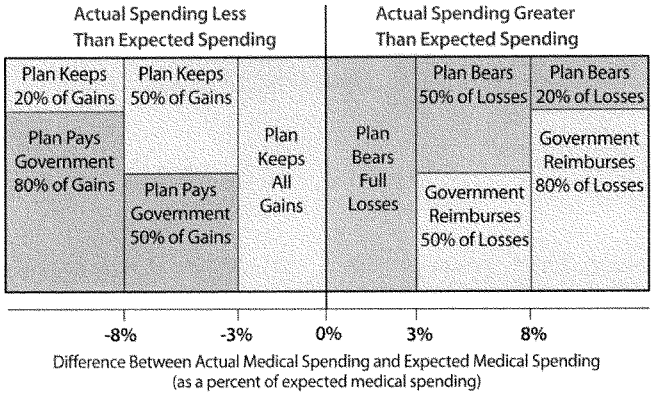
The ACA provides for a temporary risk-corridor program that will be effective from 2014 to 2016 for qualified health plans (QHPs) in the individual and small group markets. This program will mitigate the pricing risk introduced because of very limited data available to use to estimate who will enroll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

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

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

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

Illustration of ACA Risk Corridors



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

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

Conclusion

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

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

Mr. JORDAN. Thank you.
Mr. Haislmaier.

STATEMENT OF EDMUND F. HAISLMAIER

Mr. HAISLMAIER. Mr. Chairman, Ranking Member Cartwright and members of the committee, thank you for inviting me to testify today.

My name is Ed Haislmaier, Senior Research Fellow in Health Policy Studies at the Heritage Foundation.

As I am sure you already aware, this is a complicated and sometimes an opaque topic. I would hope to maybe put it into a perspective that you could use in evaluating it.

The perspective I suggest is to approach this from the same perspective that a mechanic would approach trying to fix something. That is, what is the problem, given the problem, what is the right tool? Do I use a screwdriver, a pair of pliers, a wrench or a hammer?

In the case of risk in insurance, there are all different types of risk. Let me briefly describe what I see as the three types of risk being addressed by these three risk mitigating strategies. I think that might give us a way to evaluate the programs separately.

The first is what could be called a market selection risk. There are many changes that this law makes to existing markets and it is very uncertain how people will sort themselves out when they respond to those changes with respect to people who already have insurance, including those with employer group coverage who may continue it or may not, with respect to the uninsured, et cetera.

When people have choices of markets, it is oftentimes difficult to predict who is going to wind up where. The underlying assumption—I think it is a valid assumption—behind the Reinsurance Program is that there will be a shift due to market selection of less healthy individuals towards the individual market, particularly through the exchanges.

Therefore, the Reinsurance Program, based on that premise, essentially taxes the other 90 percent of the market to subsidize that 10 percent of the market on the expectation that there will be more people of lower risk moving into that smaller individual subset. That is a market selection risk, which markets are people going to wind up in, individual, employer groups, self insured, uninsured, that is the uncertainty.

The second uncertainty is sort of a wholesale risk is the retail level, the individual selection risk. Even if you take a pool of people, all of whom are committed to buying insurance, we don't know who is going to pick which insurer and which plan. There are many different factors that will go into their decision, something as simple as brand name. Maybe they will pick Blue Cross because they know it as opposed to an insurer they don't know.

In that market, the concern is—this is true of any market—that the insurers may not get a statistically even distribution of all the risk profiles. The Risk Adjustment Program is there really for the insurers to sort out among themselves that market selection risk.

That brings me to the third and most contentious and this is the risk corridors. Essentially, the Risk Corridor Program functions as

a profit or loss risk mitigation. Will the insurers be profitable or not in this market?

This is where I think it is very important to consider what is and isn't applicable about the often mentioned experience with Medicare Part D. Medicare Part D was an entirely new product design in an entirely new market. The insurers were being asked to do something they had never done before.

They had never offered standalone drug coverage to senior citizens. Furthermore, the closest they could get in approximating that wasn't really very good which was employer group drug coverage but it was not really the equivalent.

It was sold on a group basis, on an individual basis, so there was less risk there. It was integrated with the plans, not standalone. That made it very different. Also, it was sold to a population that used only one-fifth as many drugs as the senior citizens do. It was a very difficult market for the insurers to try to figure out.

In comparison, the market that we have created in the individual market, yes, does make changes, does elevate risks for carriers but it is not an entirely new market. I detail in my testimony where insurers could get experience they can go on.

Finally, I think any argument in favor of the Risk Corridor Program is really undercut by the very design because everything that you could say about why the exchange market is riskier, also applies to the individual market outside the exchange which, in fact, was recognized in the Reinsurance Program that applies to both in and outside exchange.

In this case, in the Risk Corridor Program, it only applies inside the exchange. I think that really undercuts it because the risk would be the same inside and outside.

I would finally note that I think there is enough money in the system already. As I said in my testimony, there is about $28 billion in the individual premiums in the market today, absolute outer bounds, upper estimates I come up with would be an additional $35 billion of premium in an expanded market.

When you compare that to the $10 billion available in reinsurance funding this year, the insurers could be off by as much as 28 percent in their premiums and you could still make them whole through reinsurance.

In conclusion, I think for this and for a number of other reasons mentioned by others about the legal questions, it might be best for Congress to simply scrap the program.

Thank you, Mr. Chairman.

[Prepared statement of Mr. Haislmaier follows:]

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

The Patient Protection and Affordable Care Act imposes new requirements and restrictions on individual and group health insurance plans, mandates that individuals obtain, and employers provide, coverage, and offers means-tested subsidies to eligible individuals purchasing coverage through the new individual insurance exchanges.

How individuals and employers will respond to all these changes is highly uncertain, and that uncertainty makes it difficult for insurers to predict claims costs and set premiums. Anticipating those effects, the PPACA includes three risk-mitigation provisions designed to address these uncertainties.

The first is a "reinsurance" program that taxes health insurance policies and employer group health plans and uses the proceeds to provide individual market plans with additional subsidies for higher-cost enrollees. This program will operate for three years, collecting and redistributing $20 billion. Half of the total amount ($10 billion) is to be collected in the first year (2014). This temporary tax is applied to all individual and group market plans as well as all self-insured employer and union plans. However, the statute specifies that payments under the program will only be made to individual market plans. Because the group market is much larger than the individual market, the net effect is to provide a subsidy to about 10 percent of the total market, with the funding coming principally from the other 90 percent.

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

The third, "risk corridor," program essentially establishes a range (or "corridor") for profits or losses for insurers selling exchange coverage. If an insurer has higher than expected profits, the government will "claw back" some of the money. Conversely, if an insurer has higher than expected losses, the government will pay the insurer additional subsidies to offset those losses. The risk corridor program, like the reinsurance program, is limited to three years (2014-2016).

However, unlike the risk adjustment program, receipts and expenditures for the risk corridor program are not required to balance. In other words, the program is not explicitly required to be budget neutral. Depending on how the program is operated, it could possibly generate either net receipts or net outlays for the federal government. For instance, if it turns out that most (or even all) of the insurers selling exchange coverage

overestimated expected claims costs, leading them to price coverage higher, then insurers would have excess profits. Under such a scenario the operation of the risk corridor program would generate net receipts for the federal government. Conversely, if it turns out that most (or even all) of the insurers underestimated expected claims costs, leading them to price coverage lower, then insurers could incur significant losses. Under such an alternative scenario the operation of and the risk corridor program would result in net additional outlays by the federal government.

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

The starting point for evaluating these programs is to understand the three different types of risk that each is intended to address.

The first is what can be termed "market selection risk." This risk arises when customers have a choice between two or more markets with different characteristics. In the case of the PPACA, the most obvious examples are decisions by employers about offering coverage. The PPACA now makes it possible for employers to discontinue group plans (without penalty, in the case of firms with 50 or fewer workers) and instead send their employees to the exchanges to obtain new, subsidized coverage as individuals.

Indeed, for many workers the subsidies offered for individual exchange coverage could be greater than the tax benefits they now receive for their current employer group coverage. That means that in some instances both employers and their workers will have strong incentives to substitute exchange coverage for their current group coverage. However, insurers have little basis for predicting either the number or the risk profiles of firms that might drop prior group coverage.

Market selection risk is also present with respect to uninsured individuals. Those who qualify for the new premium subsidies will now be more likely to obtain coverage than previously, when they could only purchase coverage on an unsubsidized basis (which is still available outside the exchanges). Furthermore, among both the previously uninsured and those losing access to prior group coverage, it can be expected that individuals in poorer health will be more motivated to obtain coverage than individuals in better health.

Thus, the PPACA's reinsurance program can be seen as principally designed to address market selection risks by taxing the much larger employer group coverage market to provide additional subsidies to the individual market. This design reflects the expectation that the net effect of the PPACA's various provisions will be to induce more individuals in poorer health to migrate into the individual exchange market.

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

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

The question is how appropriate is it to apply a risk corridor program to the PPACA exchange plans?

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

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

However, such unusual circumstances associated with a completely new type of insurance product for a completely new market are not the case with respect to the PPACA's individual market exchange coverage. Individual market major medical coverage has long been a health insurance product line. While it is true that the PPACA imposes new rules and restrictions on individual coverage—such as additional benefit mandates, new age rating rules and a prohibition on the application of pre-existing condition exclusions—insurers can look for guidance to the experiences in states that previously imposed those same, or similar, rules on their individual markets. Thus, insurers offering coverage in the exchanges were not being asked to create an entirely

new product for a new market with which they had no experience, as they were with Medicare Part D.

Furthermore, all of the PPACA's new rules and restrictions apply equally to individual policies sold both inside and outside the exchanges, yet Congress applied the risk corridor program only to individual coverage sold through the exchanges. That fact alone undercuts any potential argument for retaining the PPACA risk corridor program. Given that the only distinction between the "on exchange" and "off exchange" subsets of the individual market is the availability of income-related coverage subsidies, there is no risk-mitigation rationale for treating these two subsets of the same market differently. That this distinction in the risk corridor program is artificial and inappropriate is further confirmed by the fact that the PPACA includes a provision requiring insurers to treat their individual market plans, both on and off the exchanges, as a single risk pool for purposes of claims costs and premium setting, as well as by the fact that the PPACA's reinsurance program subsidizes on exchange and off exchange individual market coverage under the same terms and conditions.

Consequently, there does not appear to be any legitimate risk-mitigation rationale for the risk corridor program as it is structured in the PPACA. While insurers certainly face a number of uncertainties with respect to how a post-PPACA individual market will operate, and while their "profit or loss risk" will initially be somewhat elevated under the new market rules, the magnitude of that risk is neither unique nor abnormal enough to justify a risk-corridor program to mitigate such risks.

The reinsurance and risk adjustment programs alone should be more than sufficient to address the basic uncertainties—market selection and individual selection risks—that insurers face in the post-PPACA market.

Indeed, the size of the funding for just the reinsurance program should be sufficient.

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

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

In sum, given the lack of an appropriate and sufficient rationale for the PPACA's risk corridor program, yet the potential for the program to create additional taxpayer liabilities, I believe that the best solution would be for Congress to simply eliminate the program.

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

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Mr. JORDAN. Thank you, Mr. Haislmaier.

Mr. Chandler, in February of this year, the CBO estimated the risk corridor provision would produce $8 billion for the government. "The CBO projects the government's risk corridor payments will be $8 billion over three years and that its collections will be $16 billion over that same time period." Do you agree with that statement?

Mr. CHANDLER. No, I do not agree with that.

Mr. JORDAN. You do not agree with that. At the time, did you disagree with that statement as well?

Mr. CHANDLER. Yes, I did. I disagreed at the time.

Mr. JORDAN. Your research says there is going to be a cost, correct?

Mr. CHANDLER. My research says that it is most likely that there will be a cost.

Mr. JORDAN. In April of this year when CBO revised their estimates and said, no, no, it is not going to result in $8 billion windfall for the taxpayers; it is going to be a budget neutral break even proposition, do you disagree with that statement as well?

Mr. CHANDLER. Yes, I do. I think it is unlikely to be a break even proposition, nor do I see what happened between February and April that would warrant an $8 billion change in the estimate.

Mr. JORDAN. The staff on this committee actually contacted the people who participated in the program. Imagine that. We went to the insurance companies and the co-ops who participated in the program and asked them what they expect. Guess what they told us. They expect to get paid by the taxpayers to the tune of "approaching $1 billion."

The actual participants and what they expect the people who are operating in this arena with this law, they are actually supporting your research. What do you think it is going to cost the taxpayer in the end?

Mr. CHANDLER. It depends on a number of factors.

Mr. JORDAN. You do believe it is going to cost the taxpayer?

Mr. CHANDLER. I believe it is very likely to cost the taxpayer.

Mr. JORDAN. This is the point I want to stress. That is consistent with the insurance companies and the costs participating in the program?

Mr. CHANDLER. That is correct as I understand what your committee has found.

Mr. JORDAN. Now you can elaborate.

Mr. CHANDLER. It depends on a number of factors. It depends on how many people enroll in the exchanges.

Mr. JORDAN. They quit telling us how many are in there. They quit telling us that a few months ago.

Mr. CHANDLER. It depends on how insurers price their policies going forward. It depends on exactly how the transitional policy that lets people buy policies outside the exchange persists. That being said, I think it is most likely that the Risk Corridors Program will cost somebody—because I am not sure where the money comes from—it will cost somebody in the end.

Mr. JORDAN. It all comes from the taxpayers, Mr. Chandler.

Mr. CHANDLER. That would be my best guess. If Senator Sessions is correct that there is no constitutional authority to spend that money, I don't know what will happen.

Mr. JORDAN. That is another problem. That is the whole constitutional concern and we will get to that sometime this morning in our hearing as well.

Mr. Graham, let me run you through the same thing. Did you agree with the February assessment from CBO?

Mr. GRAHAM. I did not. I did not have the skill. I didn't do the analysis. I was quite skeptical of it and then so soon to change it. The estimate is moving in the wrong direction.

Mr. JORDAN. Exactly the trend line is not where we want to be.

Mr. Haislmaier, did you agree with the February assessment?

Mr. HAISLMAIER. I did not look at it as closely as Mr. Chandler, but my reaction was that I thought CBO had essentially cribbed off what they had come up with on Medicare Part D and just plugged it in there. Frankly, to be fair to CBO, you guys ask them to do a lot of stuff very quickly. I have seen this behavior before, to just sort of take what is on the shelf.

I did not put a lot of weight on their estimate one way or another or on their revision, frankly.

Mr. JORDAN. Ms. Uccello, what did you think if CBO's February and then two months later, their revision to the risk corridor provision?

Ms. UCCELLO. I did not have a particular reaction one way or another on the February numbers. I think those were reflecting some of the experience with Part D which I think factored into the CBO's numbers.

I cannot speak for CBO but my understanding was that the April numbers were produced and revised based on some information from CMS that stated they were going to implement the risk corridors in a budget neutral way. That is how I read their April estimate.

Mr. JORDAN. Here is how I see it as I indicated to Mr. Chandler. First, we say $8 billion pro taxpayer, two months later, we say no, break even. Now that we have talked to the people actually involved, they said it is going to cost the taxpayer.

As Mr. Graham indicated, the trend line is in a direction that is not real good looking for the taxpayers. Do you agree with that trend line that we see?

Ms. UCCELLO. I think it is too early to say. There is still so much uncertainty about this. I think the complicating factor is that not just the transition rule and the changes that were made because of that and how that all else equal would have increased the likelihood of risk corridor payments being made, but at the same time, when they are implementing this, they lower the attachment point for the Reinsurance Program and that could have reduced the likelihood of risk corridor payments being made. There are a lot of factors that we need to integrate.

Mr. JORDAN. I have five seconds left.

Mr. Chandler, do you think the liability for taxpayers is in the millions of dollars or potentially in the billions of dollars?

Mr. CHANDLER. I think they are most likely in the billions of dollars.

Mr. JORDAN. With that, I will yield to the gentleman from Pennsylvania, the Ranking Member.

Mr. CARTWRIGHT. Thank you, Mr. Chairman.

What I find most troubling about labeling the ACA's risk management programs as a bailout to insurers is that these same three mechanisms have been in use in Medicare Part D for the past nine years as several of you mentioned.

Let us not forget that Medicare Part D was signed into law under the George W. Bush Administration, supported by Senators Sessions, McConnell and others, Speaker Boehner, Majority Leader Cantor, Budget Chairman Ryan and the chairman of our full committee, Chairman Issa, all voted in favor of that bill, Medicare Part D.

Ms. Uccello, thank you for coming here and explaining your world, the world of actuary science, to us mere mortals.

You mentioned the word uncertainty and that is a word you deal with as part of your profession, isn't it. You said that it is too soon to be casting these opinions and statements about this program because we don't have enough experience with it yet. You said there was too much uncertainty for us to make these conclusions.

Ms. Uccello, can you explain why insurers face uncertainty in new programs like Medicare Part D and the ACA and how these risk management programs we are here talking about operate to reduce the uncertainty?

Ms. UCCELLO. As I mentioned, in Part D, there was that uncertainty regarding new coverage for a new population and a lot of those same uncertainties exist under the ACA. There is uncertainty regarding who will purchase coverage and what their health spending will be. That creates a lot of pricing uncertainty for insurers when they are determining their premiums.

There is also the issue of whether or not a particular plan is going to get a disproportionate share of high cost people relative to the market as a whole.

Mr. CARTWRIGHT. Mr. Haislmaier, you stated in both your written and oral testimonies, that you believe insurers in the individual market face less pricing uncertainty than the Part D plans faced at the outset of the Part D program. You explained that was because we had no experience in Medicare Part D, whereas with health insurance under the ACA, there is a lot more data to give us guidance. Am I correct in that?

Mr. HAISLMAIER. Yes, sir, that is exactly the point I was making.

Mr. CARTWRIGHT. Ms. Uccello, I want to ask, do you agree with that?

Ms. OCCELLO. I think there is just as much if not more uncertainty with the ACA premiums as there was for Part D in part because the variability of Medicare medical spending is a lot higher than that for prescription drug spending so that can increase the uncertainty.

Mr. CARTWRIGHT. Do I go too far then to say, Ms. Uccello, that in your opinion, the need for risk corridor programs is even greater than with the Medicare Part D program?

Ms. UCCELLO. I would say that it is just as much, if not greater.

Mr. CARTWRIGHT. How did reinsurance, risk management and risk corridors impact the participation of insurers and the cost of premiums in Medicare Part D, Ms. Uccello?

Ms. UCCELLO. I think we have to look back and recall the environment when Part D was first created. There was a lot of concern that insurers would not participate in the market. There was even a fallback provision in there if plans did not participate in certain markets.

What we are actually seeing now is that consumers have a wide array of Part D plan choices. I think that does not prove but it suggests that the risk corridors were successful in encouraging plan participation. In terms of reinsurance, those did help lower the premiums.

Mr. CARTWRIGHT. Do the ACA's risk mitigation programs work the same way to increase participation by insurers and stabilize the cost of premiums?

Ms. UCCELLO. Yes. The Risk Corridor Program's primary goal is to mitigate the pricing uncertainty to encourage plan participation.

Mr. CARTWRIGHT. Why is that important to encourage more insurers to participate in the exchanges?

Ms. UCCELLO. If you have more competition, you have more choice among consumers and more competition could also mean more competing on price and quality of insurance as opposed to risk selection.

Mr. CARTWRIGHT. Thank you.

I yield back.

Mr. DESANTIS. [presiding] The gentleman's time has expired.

The Chair now recognizes himself for a period of five minutes.

Mr. Graham, with respect to the Risk Corridor Program, if insurers systematically set their prices too low, is it correct that basically the taxpayer is on the hook for that mispricing?

Mr. GRAHAM. Yes.

Mr. DESANTIS. As Chairman Jordan mentioned, our committee asked the 15 largest insurers in the country about what they expected in terms of taxpayer payments and 13 insurers expected they would get paid out of the program. Knowing how this is structured, is that something that came as a surprise to you?

Mr. GRAHAM. The specific numbers came as a surprise to be but not really because I think those of us who examined it know when it was promoted by the Administration as budget neutral, that was not a likely reality as it happens.

Mr. DESANTIS. The taxpayer is implicated by this program. Mr. Graham, is it correct that this reinsurance provision is financed by a fee or tax, however you want to term it, on all health insurance plans?

Mr. GRAHAM. Of the $25 billion, $20 billion is the premium tax and $5 billion is general revenue.

Mr. DESANTIS. Basically, you have the vast majority of individuals with health insurance are paying higher premiums to finance the Obamacare Reinsurance Program, correct?

Mr. GRAHAM. Yes, sir.

Mr. DESANTIS. Essentially, the Reinsurance Fund is a transfer from those Americans to a very smaller subsection of Americans who have Obamacare plans?

Mr. GRAHAM. Yes, sir.

Mr. DESANTIS. You mentioned in your testimony that higher than expected reinsurance claims indirectly affect taxpayer exposure to risk corridor bailouts. Can you discuss what you meant by that?

Mr. GRAHAM. I am thinking it is clear from the communications between the Administration and the insurers that the insurers really are looking to the risk corridors and as your research tells us, 13 out of 15 are expecting a payout.

If they run out of the money in the reinsurance plan, the more incentive is for the insurers to focus on the risk corridors and make sure they up their money coming out of that through various communications and relationships with the Administration.

Mr. DESANTIS. Mr. Chandler, the Risk Corridor Program, how does that impact health insurance pricing? Can you explain that for us?

Mr. CHANDLER. In theory, it might slightly lower health insurance pricing because insurers are basically getting what one might call a derivative security issued by the government that hedges their risk.

Mr. DESANTIS. What do you think will happen to insurance premiums after 2016, following my train of thought, if both the risk corridor and the reinsurance provisions are no longer in effect?

Mr. CHANDLER. On the reinsurance provisions, I want to separate those. On the reinsurance provision, there is no question in my mind that insurance premiums will go up in the exchanges and, in fact, we should see an effect as early as this coming year because the size of the reinsurance goes down as we move through time.

For risk corridors, one would expect to see a modest increase in insurance prices because insurers who want to hedge that risk are going to have to go to the market rather than having the government issue a derivative security for them.

Mr. DESANTIS. You mentioned in your opening statement the Administration's transitional policy in November and the background for those who do not know, the famous promise that if you like your plan, you can keep it, is probably going to rank alongside read my lips, no new taxes and the Lewinsky promise.

That really shocked Washington. People were losing their plans. Congress was going to act to basically grandfather these in. The Administration decided—is this how you understand it—the law has not changed. The law says Obamacare plans, it sets out what needs to happen and they have administratively relieved States of having to comply with that.

You actually have insurance policies being issued, which a State like Florida runs from, which are illegal under the law but are simply not being enforced. Is that the way it is working?

Mr. CHANDLER. In one word, yes.

Mr. DESANTIS. In your judgment, knowing the problem that came in November, knowing that people were losing their plans, that had to be addressed legislatively by Congress in terms of the way our separation of powers system operates, correct?

Mr. CHANDLER. Yes.

Mr. DESANTIS. Very good. I have no further questions.

The Chair will now recognize the gentleman from Virginia, Mr. Connolly, for five minutes.

Mr. CONNOLLY. I thank the Chair, although I would be happy to yield to the distinguished Ranking Member if he wishes to go first.

Mr. CUMMINGS. Thank you very much.

Ms. Uccello, you described the state of the individual market prior to the establishment of the Reinsurance Program. What kinds of medical underwriting practices were common place in the individual market?

Ms. UCCELLO. Prior to 2014 in the individual market, in most States, insurers were allowed to underwrite, they were allowed to deny coverage to applicants with preexisting conditions, they were allowed to charge higher premiums to individuals with preexisting conditions or they were allowed to exclude preexisting conditions from coverage. The ACA now prohibits those activities.

Mr. CUMMINGS. They were allowed to charge people higher premiums for preexisting medical conditions, is that correct?

Ms. UCCELLO. That is correct.

Mr. CUMMINGS. What about women? Were insurers allowed to charge women more for coverage than men?

Ms. UCCELLO. Premiums were allowed to vary by gender.

Mr. CUMMINGS. I know from the title of this hearing, my counterparts on the committee believe that Obamacare "fails patients" but to me it is clear that the system that existed prior to the Affordable Care Act is one that failed patients.

Ms. Uccello, can you describe the market reforms the ACA made to the individual market?

Ms. UCCELLO. Under the ACA, there is guaranteed issue which means that consumers who apply for coverage cannot be denied. There are also limits on how much premiums can vary across people. They can vary by a limited range by age. They can vary by geographic location, smoking status and family size, but they cannot vary by health status.

Mr. CUMMINGS. Again, they can no longer decline to offer coverage to individuals, is that right? Is that what you are saying?

Ms. UCCELLO. That is correct.

Mr. CUMMINGS. They cannot charge people higher premiums for preexisting conditions. By the way, I am talking about our constituents.

Ms. UCCELLO. Correct.

Mr. CUMMINGS. I want to underscore the importance of these reforms for the millions of our constituents living with preexisting conditions. For them, health insurance may be a matter of life or death.

I also think it is important to emphasize that this represents a fundamental change in how insurers do business. Instead of competing to avoid the sickest or costliest enrollees, insurers must shift their focus to competing on the basis of quality of care they deliver and how efficiently they deliver it.

Ms. Uccello, how do the three R's help insurers bridge the transition from a medically underwritten individual market to one in which everyone is guaranteed coverage and cannot be charged more due to preexisting medical conditions and why are they important?

Ms. UCCELLO. Because of the guaranteed issue and prohibitions on varying premiums based on health status, there could be an incentive for insurers to avoid some of these high cost people. The reinsurance and the risk adjustment programs reduce those incentives.

The Risk Adjustment Program shifts money, transfers money between plans based on what the risk profile looks like. Those insurers who enroll a less healthy population, presumably their costs are going to be higher, they will be getting some money from those plans that enroll a lower cost population.

Those programs just transfer money between insurers based on average market risk. They don't really help if the market, as a whole, experiences adverse selection or there is more uncertainty in pricing in the market as a whole. That is where the risk corridors come in to mitigate that pricing uncertainty.

Mr. CUMMINGS. Do these programs also play a critical role in discouraging insurance companies from cherry picking the healthiest enrollees and competing on the basis of quality and efficiency rather than risk selection? That is one question. My time is running out.

How do these programs help insurers provide affordable coverage to sicker individuals with preexisting conditions? Finally, do you believe these programs constitute a taxpayer bailout to insurance companies?

Ms. UCCELLO. The Risk Adjustment Program and the Reinsurance Program do get at the issue of avoiding high cost people. The Risk Corridor Program, by reducing that price uncertainty, can encourage more competition which could lead to higher consumer value.

Mr. CUMMINGS. Is it a bailout of the insurance companies?

Ms. UCCELLO. The mechanisms are risk sharing programs.

Mr. CUMMINGS. Thank you very much, Mr. Chairman.

Mr. JORDAN. [presiding] Risk sharing programs of taxpayer money.

The gentleman from North Carolina is recognized, Mr. Meadows.

Mr. MEADOWS. Thank you, Mr. Chairman.

I thank each of you for your testimony.

I want to go a little bit further into this because anytime that you guarantee against losses, there is a cost assumed with that. It also manipulates markets, which is very concerning to me.

All of you have said that right now there is a greater tendency for unhealthy or those who have not had health insurance to enroll now, is that correct?

Ms. UCCELLO. I think that earlier on, it is more likely that the higher cost people but as time goes on, I think the healthier people will come in.

Mr. MEADOWS. As time goes on, the healthier will do that. What would preclude an insurance company today from keeping their premium a little higher than their competition in order to make sure their market mix is healthier right now or vice versa, lowering that to make sure they can increase their market share, i.e., setting their premium at a lower rate to compete with Blue Cross and Blue Shield.

What would stop them from doing that if their losses are mitigated?

Mr. CHANDLER. Can I answer that?

Mr. MEADOWS. Sure.

Mr. CHANDLER. I think you have hit on a key point which is that by backstopping the losses, there is somewhat of an incentive for insurers to underprice, get the business, if things go badly, risk corridors bails them out and if things go okay, well, great.

It is not 100 percent guaranteed because risk corridors is not a 100 percent back stop but it shifts the incentives in a subtle way to cause insurers to have a greater likelihood of risking a low price, bringing people into their network and seeing what happens.

Mr. MEADOWS. As I sit here listening to you, I would say if I were getting into the insurance business right now and competing against a big boy, that is what I would do. I would keep it close but I would make sure when they go on healthcare.gov that my premium was slightly lower.

Based on that premise, would you all agree there is potential for that?

Mr. CHANDLER. Yes, I would. Let me say I read in the news this morning, I haven't checked the actual source, that if you look at consumer behavior, they are seeking out either the first lowest or the second lowest price policy in the exchange.

I understand perfectly well why consumers would do that but that exacerbates the possibility that it will be those insurers who are under-pricing who get the business and that will necessitate the sort of risk corridors payments in the end.

I suspect that is why we are getting the response that the Chairman referred to of 13 out of 15 insurers they polled saying we expect to get money out of risk corridors. Nobody expects to pay in.

Mr. MEADOWS. If that is the case, then is it fair to make the assumption that the rates that many people are paying today are artificially lower than what they may be after the risk corridors run their course?

Mr. CHANDLER. Yes and that is why I said I thought risk corridor disappearance would have an effect on pricing. I do not think it is as great as an effect as the elimination of transitional reinsurance. That is a pure subsidy that runs from a whole variety of health care plans to plans sold in the exchange. It is probably on the order, depending on the policy, of $500 to $600 per policy.

Mr. MEADOWS. As we see this, how can we make sure that this is revenue neutral?

Mr. CHANDLER. The Administration is saying it is revenue-neutral, CBO says it is revenue-neutral. I have found very little in Washington, D.C. that is ever revenue neutral.

Mr. MEADOWS. How can we make sure of that?

Mr. HAISLMAIER. The answer, Congressman, I think is Congress would have to change the statute to specify that and to clarify that. It was not clarified and the Administration in response to the concerns raised in Congress came out and said they would run it on a revenue neutral basis but then later changed in the most recent regulations and backed away from that.

Absent statutory clarification, I am not sure how you would do that but I would defer to those such as Senator Sessions.

Mr. MEADOWS. There needs to be a bipartisan effort to pass legislation that this should be revenue neutral in keeping with the original intent of the law?

Mr. CHANDLER. Representative Meadows, can I add to that?

Mr. MEADOWS. Go ahead.

Mr. CHANDLER. The reinsurance provisions actually have a failsafe mechanism in them that calls for pro rata reductions in payments. Such a thing could be done with the risk corridors provision that might make insurance companies unhappy because they may have banked on having that backstop.

If Congress wanted to make sure that risk corridors was revenue neutral, it would not, in my opinion, be particularly hard to add that into the statute.

Mr. MEADOWS. I thank the indulgence of the Chair.

Mr. JORDAN. You bet.

We have had Cartwright, Cummings and now Connolly, the three Caesars. Mr. Connolly is recognized.

Mr. CONNOLLY. Thank you, Mr. Chairman and thank you to our panel.

Professor Chandler, I think you just put on the table a very productive idea for Congress' consideration. Surely, however, we have to acknowledge that would be the first bipartisan effort.

Mr. CHANDLER. After you got rid of the class act.

Mr. CONNOLLY. Yes, but in terms of actually trying to make it work, there was no bipartisanship and still isn't. It would be a novel thought and welcome one.

My friend from North Carolina, I am delighted to hear his enthusiasm for trying to put together a bipartisan coalition to make the bill better. I certainly would be glad to work with him in that effort because that is really what we ought to be doing with legislation, trying to make it better, trying to make sure it is working and trying to make sure it is efficacious.

Mr. MEADOWS. Would the gentleman yield?

Mr. CONNOLLY. Yes, of course I would yield to my friend.

Mr. MEADOWS. I would note that you were my first bipartisan cosponsor on my bills, so I thank the gentleman.

Mr. CONNOLLY. It is just who I am I would say to my friend from North Carolina. Mr. Chairman, I am going to run out of time and I do have some questions.

Mr. JORDAN. Is the gentleman proposing some legislation that will limit taxpayer liability?

Mr. CONNOLLY. Actually, it was Professor Chandler who was proposing that and Mr. Meadows who picked up on it and I am simply chiming in saying, the whole blowout about bipartisanship with respect to this bill is a welcome shift here in Congress. See what you have started Professor Chandler.

Professor Chandler, did I understand you to say in your testimony and previous questioning that your prediction is insurance premiums actually are going to go up under the ACA, correct?

Mr. CHANDLER. They will go up relative to what would have happened because of the phasing out of the transitional reinsurance provisions as well as the risk corridor provisions.

Mr. CONNOLLY. On that point, it is early on but there is a preliminary report which was just issued, I guess, today by the De-

partment of Health and Human Services, a 28-page report, that suggest that premiums were actually lower than we expected and there was more competition which primarily contributed to that and a healthy subsidy as envisioned by the ACA.

Have you had a chance to look at that report? It is either today or yesterday.

Mr. CHANDLER. I scanned something in the news this morning. I have not had an opportunity to look at it.

Mr. CONNOLLY. I would urge you to take a look at it because I would welcome your feedback. The early on data, which is not dispositive, seems to suggest we are actually lowering costs for consumers and health insurance premiums.

Ms. Uccello, Christopher Holt of the American Action Forum, talking about risk corridors, said, "The risk corridor reinsurance provisions made policy sense at the time of the law being drafted, make policy sense today and protect consumers. They do not constitute a bailout." Do you agree with Mr. Holt's statement?

Mr. UCCELLO. I agree that they make sense, yes.

Mr. CONNOLLY. You agree that it makes sense and that they do not constitute a bailout?

Ms. UCCELLO. Correct.

Mr. CONNOLLY. I am sorry, we have to hear you for the record.

Ms. UCCELLO. Yes.

Mr. CONNOLLY. In your view, why were these risk management provisions necessary when the law was drafted?

Ms. UCCELLO. Again, I think with the risk corridors, there was a lot of pricing uncertainty regarding who was going to purchase a plan, what their health spending would be and the fear was that insurers would be hesitant to participate in the market. Mitigating some of those risks is what the risk corridors do.

Reinsurance and risk adjustment help reduce incentives that insurers may have to avoid high cost enrollees.

Mr. CONNOLLY. An expert from the Manhattan Institute, Mr. Femen, called risk mitigation strategies "a virtuous cycle." He said, "Risk adjustment mechanisms get you the buy in of insurers, they also help keep premiums at manageable levels while insurers develop enough experience to properly price plans of their own. This helps encourage people to enroll and in turn, helps insurers develop necessary pricing experience resulting in a virtuous cycle."

Do you share Mr. Femen's point of view?

Ms. UCCELLO. I think he is right in terms of the risk mitigation programs encouraging participation, yes.

Mr. CONNOLLY. Do you also agree that risk adjustment mechanisms such as that help keep premiums at manageable levels while insurers develop experience to properly price their product?

Ms. UCCELLO. I think that, yes, over time, insurers will have more certainty and will be able to price their premiums with more confidence and in doing so, be able to reduce the risk margin they include.

Mr. CONNOLLY. Finally, with respect to risk corridors, is that a novel idea unique to the ACA? Did we just come up with it or had that been floating around before in academic and economic circles?

Ms. UCCELLO. I think a lot of us have mentioned that it was included in Part D.

Mr. CONNOLLY. Ah, under the Bush Administration?

Ms. UCCELLO. Yes.

Mr. CONNOLLY. Thank you.

Mr. MEADOWS. [presiding] I thank the gentleman from Virginia.

Mr. CONNOLLY. I would like to submit for the record a Los Angeles Times report that would indicate that the premium subsidy is actually going to be about 65 percent higher than CBO originally estimated.

Mr. MEADOWS. Without objection, so ordered.

Mr. CONNOLLY. If I could, Mr. Chairman, I would also like to put in the record maybe something that suggests otherwise.

Mr. MEADOWS. Without objection, so ordered.

Mr. CONNOLLY. I thank the Chair.

Mr. MEADOWS. The Chair would like to recognize the gentlewoman from Wyoming, Ms. Lummis.

Ms. LUMMIS. Thank you, Mr. Chairman.

I am so delighted this panel is here.

Ms. Uccello, I think actuaries are probably the most under-appreciated and unknown group of people that make things tick in this difficult risk management environment, whether it is financial resources or social spending.

I wish the Social Security Administration was turned over to actuaries instead of politicians. I think we would have a more fiscally sound program. When I was on our Wyoming Retirement Board, our actuary's name was Flick Fornia. He was a really funny guy and was able to explain to lay people like me the importance of actuarial soundness. Thanks for what you are doing.

The committee's survey shows that insurance providers expect to receive payments. These are exchange plans, so they think they are going to receive payments, not make payments. How is it possible that given that the Administration thinks the program's receipts and outlays will be equal?

Ms. UCCELLO. I would say a couple of things to that. First is that not having seen this data, it is difficult for me to comment on it. I would also caution that the risk corridors apply to qualified health plans or QHPs regardless of whether they are on or off the exchange.

If this data was collected just reflecting on the exchange, it may be missing some of the off exchange QHP enrollment. That enrollment might be different from that on the exchange. That is one thing I would highlight.

I think over time, again as I mentioned before, there is still a lot of uncertainty, so we are not going to know really for sure until after the end of the year how everything actually shakes out.

Ms. LUMMIS. Mr. Haislmaier, could you respond to that as well?

Mr. HAISLMAIER. Actually, the Risk Corridor Program only applies on the exchange. The Reinsurance Program applies both on and off the exchange. In fact, that was one of the interesting things, that the risk corridor does not apply off the exchange.

Ms. UCCELLO. It applies off the exchange to QHPs.

Mr. HAISLMAIER. A QHP is only on the exchange. That is how the law works.

Ms. UCCELLO. Larger plans that are very similar to QHPs on the exchange. I think the next panelist can probably provide more information on that.

Ms. LUMMIS. I will pursue that line of questioning with him.

For anyone on the panel, do you find it surprising that on October 1, 2013, 6 out of 15 insurers expected to receive payments from the Risk Corridor Program? Does that surprise anyone?

Mr. HAISLMAIER. That is all I would know—not particularly.

Ms. LUMMIS. If insurance or pricing plans actuate, shouldn't their risk corridor payment expectations be zero?

Ms. UCCELLO. I guess I would want to know exactly when. Was it truly October 1 or was it a little time afterwards that they were retrospectively looking at because remember in the early days of the program, there were enrollment problems. That may have played into that. It is not clear without knowing more about the data.

Ms. LUMMIS. Fair enough. I think that is a legitimate point.

Does a positive risk corridor payment prior to the start of open enrollment indicate that insurers may be planning on under pricing their plans, expecting they might get bailouts under the 3R Program, Mr. Chandler?

Mr. CHANDLER. It would not be, in my view, an irrational business strategy for a health insurer to deliberately under price its plan in order to hook people into their network, get them excited about their doctors and if worse came to worse, they would be back stopping most of the way by the Federal Government.

Ms. LUMMIS. Mr. Haislmaier?

Mr. HAISLMAIER. I have looked at the insurers participating in the exchange and written on this. One of the things I am always telling people, including my friends, is that this is not a monolith, they are not all the same.

Other members have asked questions about these kinds of strategies. It is important to realize that different companies will approach this differently based on the kind of company they are.

With that said, I would expect a smaller company, a less well known company, because there are a number of regional HMOs, for example, in these plans—WINhealth in your own State, for example. That is the kind of company that might use a strategy of discounting to gain market share. A more dominant company like Blue Cross in your State probably would not do it.

I found it interesting that a company like Aetna where 60 percent of their business is self insured employer plans, they are in more exchanges than any other company in the country. They are in 17 States and yet, as the CBO said, that is no more than three percent of their business.

Interestingly enough, Aetna took the opposite approach. Aetna, from everything I can see, actually withdrew from four or five States at the last minute when their higher rates were not approved. Basically, from what I can tell, they took the strategy of we are willing to try it but we are not willing to lose money on it. We are going to price the premiums higher.

Depending on the kind of company you are, they are going to come in in different ways. That is all I would point out.

Ms. LUMMIS. Thank you, panel. My time has expired.

I yield back.

Mr. MEADOWS. The Chair would recognize the gentleman from Michigan, Mr. Bentivolio.

Mr. BENTIVOLIO. Thank you very much, Mr. Chairman. Thank you for holding this hearing.

Over the past few years, we have argued that Obamacare was going to disrupt the insurance markets. This health care law has become a perfect example of how not to do health insurance reform.

We should not bailout insurance companies to mask the fact that Obamacare is a disaster and hurts Americans. This hearing shows exactly why.

Reinsurance is funded by an assessment of each of the roughly 158 million people who do not get their insurance coverage from the exchanges, some through union-backed plans and others through plans sponsored by employers. The government is assessing such plans $63 for each member which adds to $10 million, then giving that money to insurers that sell through the exchanges.

Mr. Graham, is it correct that the reinsurance provision is financed by a fee or tax on all health insurance plans?

Mr. GRAHAM. Yes, sir.

Mr. BENTIVOLIO. You made it clear and accurate earlier, if I am not mistaken, that the vast majority of the individuals with health insurance will be paying higher premiums to finance this reinsurance fund, am I correct in this understanding?

Mr. GRAHAM. Yes, sir.

Mr. BENTIVOLIO. Essentially, the reinsurance fund is a large transfer from the vast majority of Americans without an Obamacare insurance plan to the few Americans with an Obamacare plan?

Mr. GRAHAM. Agreed.

Mr. BENTIVOLIO. You mentioned in your testimony that higher than expected reinsurance claims indirectly affect taxpayer exposure to risk corridor bailouts. Can you again discuss what you mean by that?

Mr. GRAHAM. The risk corridors are such a moving target, I think that is one thing that has come out here. The reinsurance is a fixed target, a maximum of $25 billion over the three year period. If they do not collect the revenue expected, they cannot go anywhere else.

If they only collect $18 billion over the three years, as Professor Chandler said, most of it is front end loaded, then the insurer has to look somewhere else. He is going to look for the risk corridor and there is a lot of latitude within the calculation of how you adjust the numerators and denominators to get your target versus your allowed costs that unless Congress steps in, as some of the other panelists suggested, and gets a precise definition and closes the loop on this thing, HHS could really drive a lot through the risk corridor payments.

I think that is where you are getting the idea that 13 out of 15 of the insurers your staff surveyed, we are going to get money out of it. It must be because they are being very creative in how they are thinking they are going to liaise with HHS over the next three years.

Mr. BENTIVOLIO. Earlier, Mr. Meadows and Mr. Connolly were talking about making some fixes, correct, to Obamacare. I just want to assure you the only person I want to hear—should pass it before we can see what is in it—is from my doctor, so be assured I am going to read that bill before it is even voted on.

With that, I yield back. Thank you very much.

Mr. MEADOWS. I thank the gentleman from Michigan.

The Chair would recognize the gentlewoman from Illinois.

Ms. KELLY. Thank you, Mr. Chairman.

First, I want to say I join in Ms. Lummis' statement about how important actuarial are and how we should definitely use their services. The only actual actuary here is you, Ms. Uccello, is that correct.

It is my understanding that the payment formula for the ACA Risk Corridor Program is less generous to insurance companies than the one utilized in Medicare Part D. Specifically, the threshold at which risk sharing payments kick in is higher in the ACA risk corridors and the percentages of losses covered is lower. Do I have that right?

Ms. UCCELLO. Yes. In the initial years of the Part D Risk Corridor Program, I think the thresholds were plus or minus 2.5 percent whereas under ACA, it is plus or minus 3 percent.

Ms. KELLY. When the Republicans passed risk corridors as part of Medicare Part D, the program was even more favorable to insurance companies than it is under ACA, correct?

Ms. UCCELLO. Yes. The corridors were smaller so the threshold at which they had to bear the losses or keep the gains was more narrow.

Ms. KELLY. Do you consider the risk management programs in Medicare Part D to be successful? Please explain your answer.

Ms. UCCELLO. Under Part D, the Risk Corridor Program is intended to encourage plan participation by mitigating the pricing risk because there was fear that there would not be a lot of plans that wanted to participate in this program.

If we look at the experience or even back then, the consumers had and have a wide array of plan choices. I think that suggests that the risk corridor at least helped encourage plan participation.

The Reinsurance Program I think did help reduce premiums below where they would otherwise be without that program.

Ms. KELLY. Is there just as much of a need for these three programs in the ACA as there was in Medicare Part D?

Ms. UCCELLO. I think the risks for ACA are similar to those that existed for Part D, so I think the need is just as much, if not more, under ACA as they were for Part D.

Ms. KELLY. Thank you.

I yield back.

Mr. MEADOWS. I thank the gentlewoman from Illinois.

The Chair recognizes the gentleman from Tennessee, Mr. Desjarlais.

Mr. DESJARLAIS. Thank you, Mr. Chairman.

I thank the panel for being here today. Mr. Chandler, if you do not mind, I will start with you.

As you know, in November 2013, President Obama offered a one year extension to allow individuals whose coverage was being can-

celed by Obamacare to keep their coverage. What kind of effect did this have on the average health of exchange plan risk pools?

Mr. CHANDLER. It deteriorated the health of those pools because it provided an alternative for healthier individuals or people with less broad needs to seek out alternatives that Congress had banned.

Mr. DESJARLAIS. Did the Administration make both the Reinsurance Program and the Risk Corridor Programs more generous to insurers in the fall?

Mr. CHANDLER. Not by statute. In effect, by increasing the per member claims within the exchange plans, they increased the likely bill for the Transitional Reinsurance Program and they increased the likely amount that would be paid out to the Risk Corridors Program.

Mr. DESJARLAIS. Have you estimated how much of a windfall insurers will receive from the Administration's changes to these programs?

Mr. CHANDLER. I have made a series of estimates as to the likely increase in the cost of the Risk Corridors Program. I have not done so with respect to the Transitional Reinsurance Program.

Mr. DESJARLAIS. You discussed in your written statement that risk adjustment contains incentives for insurers, fraud and manipulation that need to be carefully monitored. What did you mean by this?

Mr. CHANDLER. We have not spoken much about risk adjustment. Risk Adjustment requires the insurer to attach some code or set of codes to people. There is a score for each code. If you have cancer, that is a 10. If you have the sniffles, that is a 1.

The insurance industry then gets paid based not on how much they actually paid but on that score. There are occasions in which those scores can be fudged. There are occasions in which an insurer might have an incentive to try to get away with a little more than fudging.

In my view, because of the amount of money involved, and because not all insurers are saintly, that needs to be monitored quite carefully by Congress.

Mr. DESJARLAIS. How does this relate to privacy concerns for the individual?

Mr. CHANDLER. In order to see whether insurers are accurately coding peoples' conditions, including things like prior miscarriages, cancer or HIV, someone has to actually look at the medical records.

Yes, there are deidentification procedures that can be used but it may be that in some instances, those will be advertently or inadvertently breached, so there are at least concerns about privacy that are implicated by risk adjustment.

Mr. DESJARLAIS. Would this privacy concern only be for those on the exchange or for people who do not go on the exchange as well?

Mr. CHANDLER. No, people who are in small groups who are not on the exchanges are also covered by risk adjustment and therefore, even if you did not volunteer to participate in the Obamacare exchanges, there are issues with respect to privacy there too.

Mr. DESJARLAIS. Thank you.

Mr. Graham, with regard to Risk Corridor Program, what happens if insurers systematically set their prices too low?

Mr. CHANDLER. The risk to the taxpayer increases proportionally.

Mr. DESJARLAIS. The taxpayer is on the hook?

Mr. CHANDLER. Absolutely.

Mr. DESJARLAIS. This law would not exist today if the Supreme Court had not ruled that Obamacare is indeed a tax. When this bill was originally passed, the taxpayer, the average person out there, did not know they were going to be on the hook for this, did they?

Mr. CHANDLER. Probably not.

Mr. DESJARLAIS. Furthermore, if the system does not work as well as it was supposed to, which we are seeing—in fact, the only thing we have been wrong about to this point about the new healthcare law is that it is even worse than we could have imagined in terms of cost, access and quality of care.

The people basically were sold a bill of goods when this healthcare law was passed. What are the risks of this deteriorating into a single payer system if we cannot afford the bailouts of the insurance companies like we are discussing today?

Mr. CHANDLER. I think the risk is present. I think it is very present because one of the objectives that have been discussed here is that this means insurers will not shun the sick but we are not seeing that. We are still seeing plan design that is causing cancer patients, for example, to have huge out of pocket costs. We are not seeing the market arise like Medicare special needs plans.

The neediest patients are going to be let down by Obamacare and that will perhaps increase the political pressure you are alluding to.

Mr. DESJARLAIS. In my practice of medicine for 20 years before coming to Washington, when we first saw this law, a lot of people were concerned, including myself, that this whole law was simply a funnel into socialized medicine. This hearing today kind of points it more in that direction.

My time has expired. I yield back.

Mr. JORDAN. [presiding] I thank the gentleman.

Mr. Chandler, in one of your responses to Mr. Desjarlais, he talked about the rule changes made are going to result in additional dollars in the risk corridor provision, additional dollars going to insurance companies. You said yes to that.

Can you hazard a guess as to how much that might be?

Mr. CHANDLER. I have not been playing with my computer in the last hour. I cannot give you a point estimate. There are just too many variables involved. However, I think the order of magnitude we are talking about for this year, it would not surprise me to see it between $500 million and $1 billion.

For subsequent years, it gets more difficult to estimate.

Mr. JORDAN. I would just point out, that range, $500 million to $1 billion, is exactly what the committee determined the range was, around $730 million, by talking to the participants, talking to the insurance companies in the exchange.

Mr. CHANDLER. Apparently so.

Mr. JORDAN. I have one last point I would make and then I will recognize the Ranking Member if he has a last point before we got to our next panel.

This comparison with the risk corridor provision and Part D, it seems to me as I look at the two, first, Medicare Part D is a fun-

damentally different program in many ways. There has not been a bailout there and there is a specific appropriation which is not contained in this risk corridor provision we have been talking about. Is that accurate, Mr. Graham, those three points?

Mr. GRAHAM. Yes, sir.

Mr. JORDAN. Mr. Chandler?

Mr. CHANDLER. I am not familiar with how Medicare Part D was funded, so I do not feel competent to answer that question.

Mr. JORDAN. Ms. Uccello?

Ms. UCCELLO. I also do not know how the appropriations worked for that.

Mr. JORDAN. Mr. Haislmaier?

Mr. HAISLMAIER. As to the first part, yes, there has not been a bailout. As to the second, I have not looked closely at the statute recently, so I will pass on that.

Mr. JORDAN. Thank you.

Mr. Cartwright, one last word?

Mr. CARTWRIGHT. Thank you, Mr. Chairman.

I thank Representative Kelly for highlighting the fact that we do have the one actuary here today, Ms. Uccello. Thank you so much for coming and making things plain for us in the non-actuary world.

Mr. Graham, I did not mean to leave you out. One thing you mentioned was you are a Senior Fellow at the National Center for Policy Analysis, a non-profit, non-partisan, public policy research organization.

You said that but in your written material, you said that is an organization that is dedicated to developing and promoting private alternatives to government regulation and control. Is that what it says in your written material?

Mr. GRAHAM. Yes, sir.

Mr. CARTWRIGHT. Professor Chandler, the one question I had for you was in your written material, you explained that you are the principal of a blog and the blog's name is http/acadeathspiral.org. Have I got that right?

Mr. CHANDLER. Yes, you do.

Mr. CARTWRIGHT. Mr. Haislmaier, you are from The Heritage Foundation, am I correct?

Mr. HAISLMAIER. I am the Senior Research Fellow there, yes, sir.

Mr. CARTWRIGHT. Those are all the questions I had.

Thank you, Mr. Chairman.

Mr. JORDAN. I thank our panel for being here today and for your fine answers and testimony.

We will take a short recess and get ready for our next panel.

[Recess.]

Mr. JORDAN. The committee will be back in session.

Dr. Cohen, thank you for joining us. Dr. Mandy Cohen is Acting Deputy Administrator and Director, Center for Consumer Information and Insurance Oversight, Centers for Medicare and Medicaid Services.

Dr. Cohen, you know how this works. I think you caught some of the previous panel. You are recognized now for your five minutes.

STATEMENT OF MANDY COHEN, M.D., ACTING DEPUTY ADMINISTRATOR AND DIRECTOR, CENTER FOR CONSUMER INFORMATION AND INSURANCE OVERSIGHT, CENTERS FOR MEDICARE AND MEDICAID SERVICES

Dr. COHEN. Thank you so much. Good morning, almost afternoon, Chairman Jordan, Ranking Member Cartwright and any of the members who might be listening elsewhere.

I appreciate the opportunity to testify before you today on the Affordable Care Act's Premium Stabilization Program.

Mr. JORDAN. Dr. Cohen, I made a mistake, which happens from time to time. We are supposed to swear you in. Please rise and raise your right hand.

Do you solemnly swear or affirm that the testimony you are about to give will be the truth, the whole truth, and nothing but the truth?

[Witness responds in the affirmative.]

Mr. JORDAN. Let the record reflect Dr. Cohen answered in the affirmative. I am sorry for the interruption. You may continue.

Dr. COHEN. The health insurance market in 2014 looks drastically different than it did in the years before the Affordable Care Act was passed. It has created consumer protections from the worst industry abuses.

Insurers are now prohibited, as you heard earlier, from charging higher premiums to enrollees because of their health problems and from charging women more than men, making prices fairer.

Insurers can no longer refuse to accept consumers because of a preexisting health condition. With limited exception, plans are required to enroll enrollees regardless of health status, age, gender and other factors. They are also prohibited from refusing to renew coverage because an individual becomes sick.

Insurance coverage is there when people need it because plans can no longer impose annual or lifetime dollar limits on essential health benefits. Americans, therefore, no longer have to worry about hitting a prohibitive dollar amount which could force a consumer into bankruptcy or to forego necessary care.

Thanks to the Affordable Care Act, millions of Americans, many for the first time, are able to purchase high quality affordable health coverage, but access to affordable coverage for the uninsured is also beneficial to the millions of Americans who already had health insurance coverage.

When the uninsured receive uncompensated care, the cost is passed along to every American family at a bill of about $1,000 as reflected in higher taxes, higher premiums and higher health care costs. Thus, creating successful, viable insurance marketplaces is in the interest of all Americans, no matter where they get their health insurance.

Because the consumer protections required by the Affordable Care Act dramatically changed the insurance market, Congress also created the premium stabilization programs we have been talking about today.

These programs help ease the transition. The reinsurance, risk adjustment and risk corridors all work together to stabilize premiums for consumers and stabilize the marketplace for insurers by

reducing insurer uncertainty about how the market reforms will play out for them.

For example, the Risk Adjustment Program shifts funds from issuers with healthier populations to issuers with sicker populations, protecting against the potential effects of adverse selection.

The Reinsurance Program, a temporary program, mitigates the cost of those high cost enrollees with pent up medical demand. The Risk Corridor Program, another temporary program, mitigates but does not fully compensate issuers with unexpected high claims costs due to unexpected gains and losses.

Together, these three programs help stabilize premiums for consumes, while allowing insurers time to gain experience competing in a changed health insurance marketplace. The first payments for these programs do not begin until a full year from now.

The Premium Stabilization Program was enacted by Congress to ease insurers entrance into a new and different market and in that new market has been long overdue for Americans. The Affordable Care Act contains several requirements that greatly restrict or end previous insurance practices that were not good for consumers.

Insurers are subject also to new scrutiny and to regulation. They are required to issue insurance coverage to all applicants, regardless of their medical history and age and can no longer rely on annual or lifetime limits to avoid paying for consumers when they get sick.

The medical loss ratio, something we have not talked about yet today, also caps their profits and administrative expenses. Rate review is helping to provide more transparency into these rates these companies charge.

Despite these tough requirements, what we are seeing is that insurers are eager to enter the new marketplace offering competitively priced plans that over 8 million Americans have selected.

On the whole, we are seeing that insurance plans offer stable market plan premiums for the 2015 benefit year. In a recent public report to the financial sector, Wellpoint and Aetna have both expressed confidence in their 2015 pricing environments predicting premium increases in only the single digits. We are also seeing that insurance plans plan to expand into the marketplace for the first time.

Because many people enrolled during the end of open enrollment, at the end of March, with insurance coverage beginning on May 1, insurers likely only had at most six weeks of meaningful claims data to analyze in order to understand where they are in risk order payments.

The first quarter claims are likely to be unrepresentative of claims over the course of the year for the full 2014 benefit year.

Insurers' early projections about 2015 suggest that they are finding the health insurance marketplace to be a competitive new market and that the Affordable Care Act is working as intended to give Americans access to high quality, affordable health insurance coverage.

With that, I thank you and look forward to your questions.

[Prepared statement of Dr. Cohen follows:]

U. S. House Committee on Oversight & Government Reform,
Subcommittee on Economic Growth, Job Creation & Regulatory Affairs
The Affordable Care Act's Premium Stabilization Programs: Reinsurance, Risk Adjustment, and Risk Corridors
June 18, 2014

Chairman Jordan, Ranking Member Cartwright, and members of the Subcommittee, thank you for the opportunity to discuss the premium stabilization programs that Congress created in the Affordable Care Act. The Centers for Medicare & Medicaid Services (CMS) is working to implement these statutory programs to help provide stability in the health insurance market as the Affordable Care Act extends new benefits to consumers.

The Affordable Care Act made many significant reforms in the individual and small group health insurance markets, including ending discrimination based on pre-existing conditions, establishing essential health benefits, and removing annual and lifetime dollar limits on these benefits. These reforms work in tandem with the medical loss ratio, also known as the 80/20 rule, and rate review, to result in significant benefits for consumers, providing many with access to high-quality, affordable health insurance.

The Affordable Care Act also included programs – reinsurance, risk adjustment, and the risk corridors program – to stabilize premiums and the health insurance market. Based on similar, successful programs in the Medicare Part D prescription drug benefit, these programs are designed to reduce uncertainty, which improves the pricing and functioning of the health insurance market. They mitigate the impact of potential adverse selection inside and outside the Marketplace, while stabilizing premiums and encouraging plan participation in the individual and small group markets, including in the Marketplace.

Thanks in part to these programs, the Affordable Care Act will continue to provide consumers with affordable coverage options next year, encouraging issuers to participate in the Marketplace and compete on price and quality. In fact, multiple insurers have expressed confidence in the pricing environment for Marketplace plans, and CMS hopes that additional issuers will seek to participate in the Marketplace in 2015, as several have already said they will.

The reinsurance, risk adjustment, and risk corridors programs help ensure that the Affordable Care Act works as intended, with insurance plans competing on the basis of quality and service and not by seeking to attract the healthiest individuals. Better competition leads to improved coverage so that consumers — whether they are healthy or sick — can pick the best plan for their needs.

Background

CMS is working to implement the premium-stabilization programs as established by the Affordable Care Act. On March 23, 2012, CMS issued the Premium Stabilization Final Rule establishing standards related to reinsurance, risk corridors, and risk adjustment.[1] This Final Rule set a regulatory framework for implementing the three premium stabilization programs and other related policies. CMS provided additional guidance on the structure and administration of the programs in the Notice of Benefit and Payment Parameters for 2014, also known as the 2014 Payment Notice.[2] CMS released further details on the programs in the 2015 Payment Notice.[3]

Transitional Reinsurance Program

Section 1341 of the Affordable Care Act directs that a transitional reinsurance program be established in each state from 2014 through 2016. The reinsurance program is designed to partially reimburse the costs of high-cost enrollees in the individual market and thereby reduce premiums for enrollees in the individual market, to ensure market stability. The transitional reinsurance program is an important element in smoothing risk across the individual health insurance market as the 2014 market reforms go into effect, and sets the foundation for the establishment of the Marketplace. In accordance with section 1341, health insurance issuers and group health plans make contributions. Reinsurance payments are made to individual market issuers that cover high-risk individuals. As established by statute, estimated aggregate contributions for benefit year 2014 will total slightly more than $12 billion – $10 billion to be used for reinsurance payments and $2 billion for the U.S. Treasury. For benefit year 2015,

[1] https://www.federalregister.gov/articles/2012/03/23/2012-6594/patient-protection-and-affordable-care-act-standards-related-to-reinsurance-risk-corridors-and-risk
[2] https://www.federalregister.gov/articles/2013/03/11/2013-04902/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2014
[3] https://www.federalregister.gov/articles/2014/03/11/2014-05052/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2015

estimated aggregate contributions will total a little over $8 billion, with $6 billion to be used for reinsurance payments and $2 billion for the U.S. Treasury. And for benefit year 2016, the target for aggregate contributions will total a little over $5 billion, with $4 billion to be used for reinsurance payments, and $1 billion for the U.S. Treasury. In all three years, a small amount of contributions will go towards reinsurance administrative expenses.

Reinsurance contributions are based on a national per capita contribution rate, which CMS announces in the annual Payment Notice. Reinsurance payments to issuers are based on a portion of costs per enrollee paid once claims costs reach a certain level (attachment point) and until a payment limit (cap) is reached.[4] States have the option to establish a reinsurance program and collect additional reinsurance contributions, regardless of whether they establish a Marketplace. If a state elects not to establish a reinsurance program, the Department of Health & Human Services (HHS) will establish the program and will perform all the reinsurance functions for that state.[5]

Temporary Risk Corridors Program

Section 1342 of the Affordable Care Act provides for a temporary risk corridors program from 2014 through 2016. The risk corridors program applies to qualified health plans (QHPs), both on and off the Marketplace, and certain substantially similar plans in the individual and small group markets. The temporary risk corridors program protects issuers of QHPs from uncertainty in rate setting from 2014 to 2016 by sharing in gains or losses resulting from inaccurate rate setting.

Modeled after a similar, permanent program established in the Medicare Modernization Act of 2003 for Medicare Part D, the temporary risk corridors program protects against uncertainty issuers face when estimating enrollment and costs resulting from the market reforms. The risk corridors program protects against uncertainty in rate-setting in the first three years of the Marketplace by creating a mechanism for sharing risk between the Federal government and issuers of QHPs. As established in statute, plans participating in the program with allowable costs that are at least three percent less than the plan's target amount will remit charges to HHS,

[4] For 2014, the attachment point is $45,000 and the cap is $250,000.
[5] Connecticut is the only state to establish its own reinsurance program, and is operating the program for 2014-2016.

while plans with allowable costs at least three percent higher than the plan's target amount will receive payments from HHS to offset a percentage of those losses. The risk corridors payment or charge amount will be calculated at the issuer level and then pro-rated based on the issuer's percentage of the market enrolled in QHPs, inside or outside the Marketplace, and plans that are substantially the same as a QHP.

We anticipate that risk corridors collections will be sufficient to pay for all risk corridors payments. However, in the unlikely event of a shortfall for the 2015 program year, we recognize that the Affordable Care Act requires us to make full payments to issuers. In that event, we will use other sources of funding for the risk corridors payments, subject to the availability of appropriations (79 Fed. Reg. 30240; May 27, 2014).

Risk Adjustment Program

Section 1343 of the Affordable Care Act provides for a permanent risk adjustment program that applies to non-grandfathered individual and small group plans inside and outside the Marketplace. Risk-adjustment funds are transferred from plans with lower actuarial risk enrollees to plans with higher actuarial risk enrollees (such as individuals with chronic conditions) to protect against the potential effects of adverse selection. This is budget neutral within a market, within a state, meaning this program transfers funds between issuers. The risk adjustment program is designed to reduce the incentive for issuers to avoid the sick and market to only the healthy. Thus, the risk adjustment program is intended to create an environment in which premiums reflect differences in benefits and plan efficiency, not health status of the enrolled population.

States certified to operate their own Marketplace have the option to establish a risk adjustment program. If a state elects not to establish a risk adjustment program, HHS will establish the program and will perform all the risk adjustment functions for that state.

Operationalizing the Premium Stabilization Programs

The 2014 Payment Notice[6] gave further guidance to issuers on how the premium stabilization programs would be implemented and administered in the 2014 plan year, the first year of Marketplace operations.

As a part of this Payment Notice, CMS finalized the reinsurance payment formula and methodology for calculating reinsurance contributions, and set requirements for the submission of reinsurance and risk adjustment data. It established uniform payment parameters for the 2014 benefit year to support fair and equitable access to the reinsurance funds. This approach allocates reinsurance contributions where they are most needed, to reimburse issuers with enrollees with high claims cost in the individual market in 2014, 2015, and 2016. This policy is consistent with the goal of the transitional reinsurance program – to stabilize premiums in the individual market in the initial years of market reform and Marketplace implementation. While each state was given the opportunity to establish and operate its own transitional reinsurance program, as of January 31, 2014, Connecticut is the only state operating a transitional reinsurance program.

In addition, CMS provided further specificity in the 2014 Payment Notice on the treatment of profits and taxes in the calculation of risk corridors, and aligned the calculation of risk corridors data with the applicable single risk pools.

2015 Payment Notice

Earlier this year, the Department issued the 2015 Payment Notice[7] establishing the 2015 reinsurance payment parameters and contribution rate, and additional provisions related to implementing the premium stabilization programs, including certain oversight provisions for these programs.

While the Department has largely finalized the regulatory framework of these programs, we continue to work with all stakeholders to operationalize these programs. It is important to note that the premium stabilization programs work together with other market reforms, such as the

[6] https://www.federalregister.gov/articles/2013/03/11/2013-04902/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2014
[7] http://www.gpo.gov/fdsys/pkg/FR-2014-03-11/pdf/2014-05052.pdf

80/20 rule, to save consumers money on their premiums. We anticipate that the first payments from these programs will occur in the summer of 2015 for the 2014 benefit year. Those payments are timed to align with the data collection and payment calendar for the 80/20 rule for the 2014 benefit year.

The 2015 Payment Notice expands on the provisions of the Premium Stabilization Rule,[8] the 2014 Payment Notice,[9] and the first and second final Program Integrity Rules,[10,11] by establishing HHS's authority to audit state-operated reinsurance programs, contributing entities, and issuers of risk adjustment covered plans and reinsurance eligible plans. It also finalized participation standards for the risk corridors program, and outlined a process for validating risk corridors data submissions and enforcing compliance with the provisions of the risk corridors program.

Conclusion

The Affordable Care Act created the reinsurance, risk corridors, and risk adjustment programs to stabilize premiums and the insurance market in the first years of the new Marketplace. The programs reduce uncertainty for issuers so the market can function more smoothly, encouraging issuers to participate in the Marketplace and offer high-quality, affordable plans, and stabilizing premiums for consumers. CMS believes that these programs are an important part of our efforts to mitigate adverse selection and limit the consequences of uncertainty that could prevent Americans from accessing health insurance. The first payments and transfers from these programs will not likely begin until the summer of 2015. I appreciate the opportunity to discuss the regulatory framework outlined by CMS. I look forward to answering your questions.

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[8] https://www.federalregister.gov/articles/2012/03/23/2012-6594/patient-protection-and-affordable-care-act-standards-related-to-reinsurance-risk-corridors-and-risk

[9] https://www.federalregister.gov/articles/2013/03/11/2013-04902/patient-protection-and-affordable-care-act-hhs-notice-of-benefit-and-payment-parameters-for-2014

[10] http://www.gpo.gov/fdsys/pkg/FR-2013-08-30/pdf/2013-21338.pdf

[11] http://www.gpo.gov/fdsys/pkg/FR-2013-10-30/pdf/2013-25326.pdf

Mr. JORDAN. Thank you so much, Dr. Cohen.

The Chair recognizes the gentleman from North Carolina.

Mr. MEADOWS. Thank you, Mr. Chairman.

Thank you, Dr. Cohen, for being here and testifying.

Let me pick up on a couple of words I guess I heard just now in your testimony. The insurers, in terms of increased premiums, are only going to see increases in premiums in the single digits. Is that what your testimony said?

Dr. COHEN. That is correct.

Mr. MEADOWS. The way I guess the ACA was supposed to reduce health care costs, now we are happy that the increases are only in the single digits, so we need to say that relatively, it is not double digits. That is why we are happy about it?

Dr. COHEN. We are extremely happy. Again, what we are seeing right now are proposed rates in the single digits. That means the process needs to go forward at the State level around rate review. The Departments of Insurance at the State level will certainly scrutinize those.

Mr. MEADOWS. Single digits being low single digits or high single digits?

Dr. COHEN. We are seeing some places where there is even a decrease.

Mr. MEADOWS. I mean overall. Overall, what are you anticipating?

Dr. COHEN. We are looking at single digits. I think time will tell. We are early in the process. We are very happy to see proposed rates that are in the single digits.

Mr. MEADOWS. We are happy that our rates were supposed to go down by $2,500 a family and we are happy they are only going up by single digits?

Dr. COHEN. If you look at what rates were prior to the Affordable Care Act and the rate increases historically, we are very happy.

Mr. MEADOWS. You mentioned competition in your testimony. How do you think we have additional competition? Let me tell you the reason why. My son is looking potentially to start a family, get married, so I said I would like you to go out and get some quotes for medical insurance to make sure you are providing for your family.

The insurer said we cannot really give you quotes, you need to go on healthcare.gov. How do you see that as competitive?

Dr. COHEN. With the health insurance market launching this past year, it is the first time that consumers were able to go to one place and compare apples to apples, the types of insurance products that would be available to them.

Obviously that is the portal where many folks, more than 85 percent of those 8 million Americans, got financial assistance to make premiums even more affordable.

Mr. MEADOWS. But they are not, Dr. Cohen. I am on Obamacare now. My premium is not less than it was, my coverage is not as good in some places and honestly, some of my coverage, I have to buy things that we would never use like maternity coverage just because of our age.

Is that part of what you factored in, that we will have to buy things that we will never use and that is how we pay for this?

Dr. COHEN. As you know, part of the intent of the law is to give access to affordable coverage for millions of Americans and setting a floor for coverage where we have folks who can purchase plans that provide essential benefits for everyone.

Mr. MEADOWS. That does not answer my question. It is a great answer but that was not my question. My question is do Americans have to buy coverage on things they will never use like maternity coverage that we will never use? Do you have to do that in order to make this thing pay?

Dr. COHEN. I think the great thing about the marketplace is the transparency that it brings.

Mr. MEADOWS. I did not ask about transparency, I asked, yes or no, do you have to buy a product that you will never use to make it work, yes or no?

Dr. COHEN. We have ten essential health benefits, maternity is one of those.

Mr. MEADOWS. You have to buy maternity even though you may never have a child?

Dr. COHEN. That is correct.

Mr. MEADOWS. Are there other things that you have to buy that you may never use?

Dr. COHEN. It depends on your personal family situation and your medical situation. As an internist, a primary care doctor, sometimes you do not know what that medical situation will be going forward.

Mr. MEADOWS. Maternity is one that you can probably analyze pretty well for somebody that is in their fifties?

Dr. COHEN. It is a minimal essential benefit that we wanted to make sure all Americans have access to.

Mr. MEADOWS. You wanted to make sure they had a benefit they would not use?

Dr. COHEN. We wanted to make sure that all Americans had access to some essential health benefits.

Mr. MEADOWS. I yield back.

Thank you, Mr. Chairman.

Mr. JORDAN. I thank the gentleman.

I now recognize the gentleman from Pennsylvania.

Mr. CARTWRIGHT. Thank you, Dr. Cohen, for coming here today.

I took note of the fact that you testified you are happy. We frown on that sort of thing here in the Oversight and Government Reform Committee.

Dr. COHEN. Yes.

Mr. CARTWRIGHT. I gather what you are happy about is these things we read about, that health cost increases in this country are the lowest they have been in the last 50 years. Have you seen those things?

Dr. COHEN. Yes.

Mr. CARTWRIGHT. Is that contributing to your sense of happiness, Doctor?

Dr. COHEN. There are many things, but yes, that is one of them.

Mr. CARTWRIGHT. I remember, as an employer, and my friend from North Carolina was also an employer before joining me here in the Congress, paying annual premium increases for our staff of

10, 15, 20 and sometimes 25 percent. Sometimes it was staggering, some of the increases we were paying over the last 15 years.

That is what made me decide we have to do something different with health care in this country. I was not sure what it was but something different has happened.

I thank you for your testimony.

The premise of today's hearing is that the ACA's reinsurance, risk adjustment and risk corridor programs are taxpayer bailout programs for insurance companies. Is this accurate? The Republicans point to recent regulatory changes made by HHS as support for their argument that these programs are going to result in a bailout for insurance companies.

It is my understanding that the Risk Adjustment Program is funded by transfers between insurance companies, is that correct?

Dr. COHEN. That is correct.

Mr. CARTWRIGHT. The Risk Adjustment Program is budget neutral by statute, am I correct in that?

Dr. COHEN. That is correct.

Mr. CARTWRIGHT. Any claims that regulatory changes to the Risk Adjustment Program will result in greater costs to the taxpayer are false, am I correct?

Dr. COHEN. That is correct.

Mr. CARTWRIGHT. The department has announced two sets of changes to the Reinsurance Program centered on lowering the attachment point for enrollees' high cost claims and changing how potential collection shortfalls are addressed.

Dr. Cohen, can you describe the changes the department has made to the Reinsurance Program?

Dr. COHEN. The Reinsurance Program, by law, we are obligated to pay out $10 billion. Again, we modeled this early on and as we had better information around premiums and additional data, we were able to modify both our attachment point and our co-insurance rate on the program in order to make sure that we were fulfilling our statutory obligation of paying out the $10 billion.

Mr. CARTWRIGHT. By statute, the Reinsurance Program is funded solely by contributions from insurance companies, the reinsurance pool amount, am I correct?

Dr. COHEN. That is correct.

Mr. CARTWRIGHT. That is set by statute, right?

Dr. COHEN. Correct.

Mr. CARTWRIGHT. Reinsurance payments cannot exceed what is collected from insurers, right?

Dr. COHEN. That is right.

Mr. CARTWRIGHT. Can you explain the department's changes to the Risk Corridor Program?

Dr. COHEN. The Risk Corridor Program is designed to interact with all of the other programs and protect the insurance companies as they transition to this new marketplace from the uncertainty of pricing.

We have made two changes to the Risk Corridor Program. The first was related to the transitional policy as mentioned before. In States that have chosen to take that transitional policy, we have made an adjustment to the risk corridor formula.

The second applies to all States. That is related to the administration costs and the ongoing cost related to transitioning to the marketplace for the insurers.

Mr. CARTWRIGHT. In April, the Congressional Budget Office, nonpartisan, estimated that the Risk Corridor Program would be budget neutral over its three year life. Then in May, the department stated that it continues to project that risk corridor collections will be sufficient to pay for all risk corridor payments.

Dr. Cohen, do you have any reason to doubt the accuracy of CBO's estimates and HHS' statement?

Dr. COHEN. No. That is where we believe we will be with the program.

Mr. CARTWRIGHT. I am almost finished.

Dr. Cohen, you went to Cornell and then you went to the Yale Medical School. You are an Internal Medicine specialist. You are a physician, right?

Dr. COHEN. Correct.

Mr. CARTWRIGHT. In your opinion, is it accurate to characterize the reinsurance, risk adjustment and risk corridor programs as a "bailout"?

Dr. COHEN. No. Again, these are temporary programs meant to transition folks to the new marketplace. As a physician, making sure that folks have access to affordable, high quality care is really the goal here and mitigating any transition to that has been the goal.

Mr. CARTWRIGHT. Do you call it a bailout?

Dr. COHEN. No.

Mr. CARTWRIGHT. Thank you. I yield back.

Mr. JORDAN. I thank the gentleman.

Doctor, again, thank you for being here.

How many people are in the exchange program today, how many Americans?

Dr. COHEN. Eight million.

Mr. JORDAN. They used to give us a periodic update on the numbers. It seemed for a while it was every hour they were telling us how many folks were enrolling. Now we do not hear from them.

Is there a reason why we do not hear from the Administration on what is happening with how many people are enrolled and what the overall number is? Is it just staying right at 8 million or is there some difference between that number that was announced a while back and what is happening today?

Dr. COHEN. As you know, open enrollment, that period, ended at the end of March. The vast majority of folks cannot enroll at this point until we open enrollment again later this fall.

If folks have a change in life circumstances, they can come in and apply for coverage—if they are graduating from college or lose a job etc. Again, it is a more I think a moment in time where we are outside of the enrollment time period.

Mr. JORDAN. In answer to one of Mr. Cartwright's questions, you mentioned you have confidence in the CBO's April assessment that this was going to be budget neutral, the risk corridor.

Even though just two months prior to that, the CBO estimated it was going to be a windfall for the taxpayers to the tune of about $8 billion. In the previous panel, Mr. Chandler indicated that he

anticipates an actual cost, this is not going to be budget neutral, that it is going to cost the taxpayers. Do you agree with that?

Dr. COHEN. I think we are in a highly speculative time. We are very early on in the year. As mentioned with open enrollment closing at the end of March, I think most of the enrollees are only just starting to use their coverage and thus, we do not really know how the rest of the year is going to pay out.

Mr. JORDAN. What I tried to stress was Mr. Chandler's prediction squares with what insurance companies are telling this committee, that they do anticipate receiving a payment from the taxpayers to the tune of about $700 million. That squared with what Mr. Chandler anticipates as well, somewhere between $500 million and $1 billion. Do you agree with that?

Dr. COHEN. I think we are all in a period of time for estimates. As you saw, there is a lot of differing opinions on those estimates. We believe that the program will ultimately be budget neutral.

Mr. JORDAN. I am talking about now though. Again, we went from $9 billion to zero to now, I think and what people in the program tell us, that they are going to receive money, so it is moving in this direction, not in the right direction for taxpayers.

Let me turn to another subject. If, in fact, it does cost, do you think you have the authority to cover those costs and make those payments?

Dr. COHEN. I am not the lawyer, but my understanding is that our authority to make those payments comes from our ability to levy user fees. I do believe we have that authority.

Mr. JORDAN. How would that work exactly?

Dr. COHEN. Again, not the lawyer, but we just recently provided legal analysis to GAO on this. I would be happy to share that with the committee.

Mr. JORDAN. We look forward to getting that.

Say it costs more than $700 million, is there a point where if the cost is so high, say it is $9 billion or $10 billion, is there any point where you think you do not have the authority, you cannot do the user fees, and you have to actually talk to the Legislative Branch and something has to be worked out with the Legislative Branch before you can proceed?

Dr. COHEN. Again, we believe the program will operate in a budget neutral manner.

Mr. JORDAN. My question is you believe you have the ability to pay, you say you are going to do that via user fees. We think there is a constitutional concern there as outlined primarily by Senator Sessions a little bit ago. You think you can do it and use user fees.

I am asking is there a point where you do not think that works, where this is so big that the amount you have to pay out is at such a level that you cannot do that?

Dr. COHEN. Talking about our legal analysis about user fees, my understanding from our lawyers is that we have the authority to do that.

Mr. JORDAN. I would yield to the gentleman from Florida.

Mr. DESANTIS. I thank the Chair.

Dr. Cohen, in terms of the power of the purse issue, as you look at the text of the 2010 health care law with respect to risk cor-

ridors, in that law, did Congress appropriate a sum to be spent in the Risk Corridor Program?

Dr. COHEN. I do not believe so.

Mr. DESANTIS. I do not believe so either. The way this typically works, according to the Constitution, Article I, Section 9, Clause 7, "No money shall be drawn from the treasury but in consequence of appropriations made by law."

As I read it and you agree with me about what the law said and then as I read the Constitution, that tells me these payments need to be appropriated by Congress. Yet I think the Administration's position is they can simply make these payments without Congress making a single dime's worth of appropriations by law, is that correct?

Dr. COHEN. Again, I believe that we are using our authority to levy user fees to make those payments.

Mr. DESANTIS. User fees on what?

Dr. COHEN. User fees on the insurance companies who need to pay to us or make the collections to us before we pay out.

Mr. DESANTIS. What are they using exactly, to make it a user fee?

Dr. COHEN. We are providing a service to stabilize market premiums.

Mr. DESANTIS. I think at the end of the day, we have the power of the purse. They could have appropriated money for this in there but it sounds to me that there is just a slush fund and somehow that can be put out however CMS sees fit. I do not think that is the way the founding fathers envisioned it working.

Let me ask you this. The New York Times recently reported that HHS is having difficulty verifying the information of about 25 percent of people currently enrolled in the exchanges under Obamacare.

Has the government sent subsidies to insurance companies for anyone that has not been able to verify coverage for it to your knowledge?

Dr. COHEN. The way the statute is written and the way we do eligibility determinations, when someone goes through the healthcare.gov process, they put in several pieces of information, one of which is income, which we immediately verify through our federal data hub. We verify through the IRS and we verify through a private source.

If we cannot immediately verify their income, then they are asked to provide documentation for that income and by statute, are given a presumptive eligibility based on that and have a 90-day window to submit documentation to us.

Mr. DESANTIS. Is the answer no, then, that any subsidy money that has gone to an insurance company for a particular individual, all of those individuals have been verified so there is not an issue of people getting subsidies who, in fact, are not entitled to them?

Dr. COHEN. Again, by statute, if we cannot immediately verify them through the electronic mechanism of healthcare.gov and the federal hub, then they are, by statute allowed a 90-day period in which to submit documentation and are given a presumptive eligibility and allowed to enroll on that plan.

Again, we need that documentation and allow them to continue on in that plan but there is a 90-day period there.

Mr. DESANTIS. The 90-day window has not elapsed for anybody yet?

Dr. COHEN. The statute also contemplated that in the first year of this program, it is going to be new for us, it is going to be new for the consumer and that submitting documentation was going to be a new process and allowed us to have the flexibility to give folks extra time. We have given folks some extra time but that is not limitless.

Mr. DESANTIS. How will the Administration go about actually recouping unlawful subsidy payments received by insurance companies? Assume that as the year goes on, it is clear—the New York Times says 25 percent—you have not been able to verify or have had difficulty, say 10 percent of the people are having subsidies directed to insurance companies and are not eligible for those, how do you get the money back for the taxpayer?

Dr. COHEN. In the law, there is a reconciliation process the IRS is in charge of in terms of making sure we recoup the costs at the end of the year of verifying income at the time.

Mr. DESANTIS. Is the IRS going after the individual?

Dr. COHEN. That is correct. There is a true up with the individual on your tax bill.

Mr. DESANTIS. Wow. When we want emails from the IRS, they are lost but they are going to be going after people for their health insurance.

Let me clarify the 8 million number because I know CMS has stopped putting out the updates. Does the 8 million mean 8 million people who have logged on through the website or does it mean 8 million people who actually have insurance they have paid a premium for?

Dr. COHEN. It means $8 million people who have selected a plan through healthcare.gov.

Mr. DESANTIS. You are not saying that 8 million have actually paid premiums at this point?

Dr. COHEN. We are still trying to understand that number and we will have that later in the year.

Mr. DESANTIS. I have heard different estimates, Mr. Chairman, about the number of people who have paid their first months and there could even be a dropoff after that. I appreciate the 8 million number but in the interest of being honest and transparent to the American people, I think we should explain what that means.

I yield back.

Mr. JORDAN. I thank the gentleman.

That raises the question was the CBO estimate based on 8 million or some other number, do you know, Dr. Cohen?

Dr. COHEN. Sorry, which CBO estimate?

Mr. JORDAN. The CBO estimate that this went from the windfall for the taxpayers to the budget neutral number in April. Was that based on an 8 million person enrollment?

Dr. COHEN. I am not sure how the CBO did their analysis. I only know how we did our own estimates. I would say we were very pleased with going beyond what CBO estimated we would enroll in

the marketplace in terms of the 8 million. Again, we are still early on in the year.

Mr. JORDAN. Do you believe that 8 million is high or do you think it is lower than that based on what Congressman DeSantis just talked about?

Dr. COHEN. The eight million who have enrolled?

Mr. JORDAN. Yes.

Dr. COHEN. Again, those are the number of folks who have chosen a plan.

Mr. JORDAN. I understand.

Dr. COHEN. We have heard from the insurance companies who have given financial reports at various industry conferences that they have seen a high rate of paying their premium and continuing on that plan.

Mr. JORDAN. When will you have a more definitive number?

Dr. COHEN. Later in this year.

Mr. JORDAN. Later meaning when?

Dr. COHEN. I do not know exactly when.

Mr. JORDAN. You said on the user fee issue, you sent a report to GAO. When did you send that report?

Dr. COHEN. I think recently, in the last several weeks, but I can get that for you.

Mr. JORDAN. This is news to the committee, news to the staff, that you have a user fee analysis for how this is constitutional. We would like to see that and we have not.

Dr. COHEN. Certainly.

Mr. JORDAN. Mr. Cartwright?

Mr. CARTWRIGHT. Thank you, Mr. Chairman.

Maybe I can weigh in on that very topic. In May 2014, an analysis by the Congressional Research Service suggested that the Secretary of HHS does have authority to make such payments in the unlikely event they would have to be made and that authority could be derived from appropriations language in the President's budget for fiscal year 2015 giving the Centers for Medicare and Medicaid Services, CMS, the general authority to collect "such sums as may be collected from authorized user fees which shall be credited to this account and remain available until expended."

Are those the user fees you were discussing, Dr. Cohen?

Dr. COHEN. I believe so, but again, I would want the committee to review our legal analysis.

Mr. CARTWRIGHT. I am going to ask, Mr. Chairman, that we make the CRS May 2014 report a part of the record.

Mr. JORDAN. Yes, and you referenced the President's budget. What is that?

Mr. CARTWRIGHT. It says right here, the President's budget for fiscal year 2015 giving the CMS the general authority to collect such sums as may be collected from authorized user fees. I have the CRS report here and ask unanimous consent.

Mr. JORDAN. Without objection, let it be entered in the record.

Mr. JORDAN. The President's budget is not always something that Congress passes. I do not know what binding authority it has. I trust CRS and I will look at it, but I am not following that, frankly. The President proposes all kinds of things that Congress does

not like. Just because he proposes it, does not mean it is constitutional.

Are there further questions for the Doctor?

Dr. Cohen, we want to thank you for being here today. Good luck.

Dr. COHEN. Thank you.

Mr. JORDAN. We are adjourned.

[Whereupon, at 12:20 p.m., the subcommittee was adjourned.]

APPENDIX

Material Submitted for the Hearing Record

DARRELL E. ISSA, CALIFORNIA
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Opening Statement
Rep. Matt Cartwright, Subcommittee Ranking Member

Subcommittee on Economic Growth, Job Creation and Regulatory Affairs
Hearing on "Poised to Profit: How ObamaCare Helps Insurance Companies Even If It Fails Patients"

June 18, 2014

Thank you, Chairman Jordan, and welcome to you, Senator Sessions. It's very good to have you here today. I'm looking forward to a robust discussion.

Today is the 27th hearing our Committee has held on the Affordable Care Act. To date, House Republicans have voted more than fifty times to repeal, de-fund, or otherwise undermine the law. These numbers are truly preposterous and a poor use of the Committee's and the House of Representative's limited resources at a time when our country faces so many immense challenges that are being largely ignored.

I want to start out by highlighting for my Republican colleagues the number that matters most here today. More than 8 million Americans have signed up for health insurance plans through the federal and state exchanges. More than *8 million* Americans can now see a doctor and get the critical health services that every American should have.

Insurance companies are no longer allowed to discriminate against women or people with cancer, diabetes, or other preexisting conditions.

Young people are able to stay on their parents' plans until they are 26, and millions of individuals can finally access free preventative care. We have seen the lowest growth in healthcare costs in 50 years, and billions of dollars in rebate checks have been sent to consumers across the country.

Unfortunately, today's hearing is the latest in a long series of Republican attempts to falsely criticize the Affordable Care Act. The issue before us today involves three risk management provisions in the ACA—reinsurance, risk adjustment, and risk corridors. The Committee previously examined these provisions in a hearing on February 5.

Republicans also fail to mention that they first proposed the reinsurance, risk adjustment, and risk corridor mechanisms in Medicare Part D, where they have been tremendously

successful. They discourage plans from avoiding enrollees with unusually high drug costs, and they help lower premiums for consumers by stabilizing the insurance market. Now in its ninth year, Medicare Part D has robust participation, with 39 million seniors enrolled. I appreciate that the Senator who is here to testify before us today voted in favor of the legislation. As did 41 of his Senate Republican colleagues and 204 House Republicans.

Nonetheless, Republicans continue to inaccurately describe these risk mitigation mechanisms as a "bailout" to health insurance companies. This characterization is just plain wrong. Here are the facts.

Reinsurance, risk adjustment, and risk corridors are programs designed to mitigate risks for insurance companies, stabilize premiums for consumers, and incentivize plans to compete on the basis of *quality* and *efficiency*.

Reinsurance is funded solely by contributions from insurance companies. Risk adjustment is funded by transfers between insurers, making it budget neutral. Under the risk corridor program, the government collects funds from insurers with extreme financial gains and makes payments to those with extreme losses.

Recently, the Department of Health and Human Services announced changes to the reinsurance and risk corridor programs that Republicans claim will result in a taxpayer bailout. This argument is unsound and based on a misunderstanding of how these programs function.

The reinsurance pool amount is set by statute, and payments may not exceed the amounts collected from insurers. In April, the nonpartisan Congressional Budget Office confirmed that the risk corridor program would be budget neutral over the three-year life of the program. None of these facts sounds like a bailout to me.

The Affordable Care Act is the law, already debated for years, passed by Congress, and signed by the President, and it is helping millions of Americans to obtain quality, affordable health insurance. Rather than continuing to look for any conceivable way to attack the law—as my Republican colleagues have done for years—my sincere hope is that we can start examining ways to help the program run more efficiently and effectively as it continues to be implemented.

I would like to thank the witnesses for coming to testify before us today and I look forward to an informative discussion about managing risk in insurance pools.

Thank you Mr. Chairman.

Contact: Jennifer Hoffman, Communications Director, (202) 226-5181.

New Data Shows Affordable Care Act Enrollment Exceeded Insurance Company Projections

Over the past several months, Republican staff on the House Committee on Oversight and Government Reform have been contacting health insurance companies participating in the Affordable Care Act exchanges to request data about initial enrollment projections, as well as actual enrollment since October 1. Although there are problems with the methodology they used (described below), several conclusions can be drawn from the data provided by insurance companies to date.

Overall Enrollment Exceeded Projections

Thirteen insurance companies provided the Oversight Committee with data on projected and actual enrollment. The new data obtained by the Committee shows that actual enrollment exceeded insurance company projections by 4.0%. This result was achieved despite significant challenges with federal and state websites. The data provided by these insurance companies already removed individuals whose plans were canceled because they did not pay first-month premiums.

Projected Enrollment	Actual Enrollment	Difference
3,639,784	3,785,753	+ 4.0%

Enrollment Exceeded Projections for Key Age Group of 18 to 34 Year Olds

Ten insurance companies provided data to the Oversight Committee broken down by age group. The new data from these insurance companies shows that enrollment among adults age 18 to 34 exceeded projections by nearly 11% and represented the single largest proportion of new enrollees at nearly 27%.

Age Group	Projected Enrollment	Actual Enrollment	Difference
18 - 34	817,548 25.9%	906,608 26.7%	+ 10.9 % + 0.8%

The data also shows that enrollment exceeded projections in all age groups except for children and teenagers age 0 to 17.

Enrollment Exceeded Projections in Most States

Twelve insurance companies provided data on projected and actual enrollment broken down by state. Based on this data, enrollment exceeded projections in 17 of the 31 states for which the Committee obtained data. Notably, some of the largest enrollment increases occurred in Republican-controlled states that were hostile to the Affordable Care Act, indicating that there is extremely strong demand in these states for quality, affordable insurance. (States in which data was collected for only one insurance company are listed anonymously to avoid disclosing information unique to that company.)

State	Projected v. Actual Enrollment
(State with Data from One Insurer)	+ 479.2%
(State with Data from One Insurer)	+ 397.8%
Ohio	+ 240.0%
(State with Data from One Insurer)	+ 182.4%
(State with Data from One Insurer)	+ 176.0%
Colorado	+ 124.5%
(State with Data from One Insurer)	+ 112.1%
Delaware	+ 86.5%
Virginia	+ 84.6%
Pennsylvania	+ 62.8%
California	+ 58.7%
(State with Data from One Insurer)	+ 55.8%
(State with Data from One Insurer)	+ 46.8%
Arizona	+ 35.8%
(State with Data from One Insurer)	+ 27.8%
Texas	+ 7.3%
Florida	+ 4.8%
Oklahoma	- 25.9%
Illinois	- 30.2%
(State with Data from One Insurer)	- 35.3%
(State with Data from One Insurer)	- 38.5%
(State with Data from One Insurer)	- 39.5%
District of Columbia	- 42.4%
Oregon	- 42.6%
North Carolina	- 44.8%
Maryland	- 46.4%
Utah	- 49.6%
(State with Data from One Insurer)	- 55.2%
(State with Data from One Insurer)	- 55.4%
(State with Data from One Insurer)	- 61.2%
(State with Data from One Insurer)	- 77.6%

Methodological Problems with Oversight Committee Data Request

- **The Committee did not obtain data from all insurance companies in the exchanges.** The Committee obtained no data from any insurance companies in Alaska, Idaho, Massachusetts, Minnesota, North Dakota, Rhode Island, South Dakota, Vermont, or Wyoming. In other states, the Committee requested data from some, but not all, insurance companies, and as a result obtained data relating to less than 10% of enrollees in those states.

- **The Committee did not collect data on off-exchange enrollments.** Under the Affordable Care Act, insurance companies are required to treat on-exchange and off-exchange enrollments as a single risk pool in each state when setting 2015 premium rates.[1] Off-exchange enrollments are extensive and may skew younger than on-exchange enrollments.[2] CBO estimates that 5 million people enrolled in ACA compliant plans outside of the exchanges.[3] The Blue Cross Blue Shield Association reports that 1.7 million off-exchange customers enrolled between October 1 and March 1.[4] Similarly, Cigna reports that more than 40% of its ACA-compliant enrollments are in plans outside exchanges.[5]

- **Conclusions about risk adjustment, reinsurance, and risk corridor programs are premature.** Insurance companies have limited claims data at this time. As a result, they noted in their submissions to the Committee that any projections regarding revenues from the risk adjustment, reinsurance, and risk corridor programs are preliminary and subject to change between now and 2015, when payments are made.[6]

    - **The risk adjustment program is budget neutral by statute.** Suggestion that regulatory changes will result in greater costs to the taxpayer are inaccurate.

    - **The reinsurance program is fully funded through a fee on insurers.** Set by statute at $10 billion for 2014, $6 billion in 2015, and $4 billion in 2016, payments may not exceed the amounts collected from insurers.[7]

    - **CBO projects that the risk corridor program will be budget neutral.** After considering changes to the risk corridor formula in March, CBO concluded in April: "CBO believes that the Administration has sufficient flexibility to ensure that payments to insurers will approximately equal payments from insurers to the federal government, and thus that the program will have no net budgetary effect over the three years of its operation."[8]

ENDNOTES

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[1] Assistant Secretary for Planning and Evaluation, Department of Health and Human Services, *Health Insurance Marketplace: Summary Enrollment Report for the Initial Annual Open Enrollment Period* (May 1, 2014) (online at http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Apr2014/ib_2014apr_enrollment.pdf).

[2] *New Data from eHealth Price Index Points to Off-Exchange Enrollment Trends as Open Enrollment Draws to a Close*, MarketWatch (Mar. 25, 2014) (online at www.marketwatch.com/story/new-data-from-ehealth-price-index-points-to-off-exchange-enrollment-trends-as-open-enrollment-draws-to-a-close-2014-03-25).

[3] Congressional Budget Office, *Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act* (Apr. 2014) (online at www.cbo.gov/sites/default/files/cbofiles/attachments/45231-ACA_Estimates.pdf).

[4] *The Missing Millions in the Obamacare Enrollment Total*, National Journal (Apr. 3, 2014) (online at www.nationaljournal.com/health-care/the-missing-millions-in-the-obamacare-enrollment-total-20140403).

[5] *Cigna Predicts 116,000 ACA-Compliant Plan Enrollees for Years as Earnings Rise*, Modern Healthcare (May 1, 2014) (online at www.modernhealthcare.com/article/20140501/NEWS/305019985/cigna-makes-little-mention-of-aca-in-reporting-positive-quarter).

[6] *See, e.g.*, Letter from [Name Redacted], Counsel for [Insurance Company Name Redacted], to Chairman Darrell Issa, House Committee on Oversight and Government Reform (May 16, 2014) ("Final calculation of risk corridor payments has not been made and will not be made until the Second Quarter of 2015. At this point, the Company is projecting a very small receivable, on the order of approximately [Amount Redacted], from the risk corridor program. This projection is subject to change.").

[7] Kaiser Family Foundation, *Explaining Health Care Reform: Risk Adjustment, Reinsurance, and Risk Corridors* (Jan. 22, 2014) (online at http://kff.org/health-reform/issue-brief/explaining-health-care-reform-risk-adjustment-reinsurance-and-risk-corridors).

[8] Congressional Budget Office, *Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act* (April 2014) (online at www.cbo.gov/sites/default/files/cbofiles/attachments/45231-ACA_Estimates.pdf#page=22).

ONE HUNDRED THIRTEENTH CONGRESS

Congress of the United States

House of Representatives

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

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WASHINGTON, DC 20515-6143

Opening Statement
Rep. Elijah E. Cummings, Ranking Member

Subcommittee on Economic Growth, Job Creation and Regulatory Affairs
Hearing on "Poised to Profit: How ObamaCare Helps Insurance Companies Even If It Fails Patients"

June 18, 2014 (updated)*

Thank you very much, Mr. Chairman, and let me extend a warm welcome to our colleague, Senator Sessions. This is an important topic, and I look forward to hearing from all of our witnesses today.

For far too long in this country, we have been adding to the ranks of the uninsured. Before the Affordable Care Act, the number of uninsured Americans climbed year after year, amounting to what can only be described as a crisis of public health.

At the peak of this crisis, nearly 50 million people went uninsured. I have always believed that as a nation, we must do better. This is one of the reasons I came to Congress.

I am proud to say that today, we are doing better. More than 8 million people have now enrolled in health insurance through the Affordable Care Act exchanges. Millions more now have access to care through state expansions in the Medicaid program. And young adults across the country now have access to care through their parents' insurance plans.

Today, I would like to place into the record new data that our Committee has obtained on this issue.

Over the past several months, the majority staff of the Committee has been contacting health insurance companies that are participating in the Affordable Care Act exchanges. They have been requesting data about insurance company enrollment projections before the Affordable Care Act went into effect, as well as data about the actual levels of enrollment after October 1.

Although the data has some limitations, several conclusions may be drawn. First, at the highest level, this new data obtained by the Committee shows that actual enrollment exceeded insurance company projections by 4.0%. This result was achieved despite significant challenges with federal and state websites.

Importantly, the data provided by these insurance companies already removed individuals whose plans were canceled because they did not pay first month premiums.

In addition, there has been a lot of concern about whether young people between the ages of 18 and 34 were going to sign up for insurance under the Affordable Care Act. The new data from these insurance companies shows that enrollment among adults in this key age group exceeded insurance company projections by nearly 11%. The data also shows that this age group represented the single largest proportion of new enrollees at nearly 27%.

Insurance companies also provided data broken down by state. This data shows that enrollment exceeded projections in 17 of the 31 states for which the Committee obtained data.

Notably, some of the largest enrollment increases occurred in Republican-controlled states that were hostile to the Affordable Care Act. For example, the data obtained by the Committee shows that actual enrollment exceeded insurance company projections by nearly 5% in Florida.

Now this data is only a sample, which is one of its limitations, but it clearly demonstrates that there is extremely strong demand for quality, affordable health insurance even despite vocal opposition from Republican governors, state legislatures, and insurance commissioners.

Mr. Chairman, I ask unanimous consent that a Fact Sheet that was prepared by my staff setting forth this data be entered into the official hearing record.

Today, we will discuss the reinsurance, risk adjustment, and risk corridors programs under the ACA. These programs are critical mechanisms to help insurance companies transition from a market in which they discriminated against people with preexisting conditions to one in which they must compete on the basis of quality and efficiency.

These programs are key features of the Medicare Part D program, one of President Bush's signature legislative initiatives. They were adopted by a Republican Congress. They have been extremely successful in the Part D program, and they will be successful for the Affordable Care Act.

Thank you again to all our witnesses, and I look forward to your testimony.

Contact: Jennifer Hoffman, Communications Director, (202) 226-5181.

* *Updated on June 19, 2014, with additional data and to correct calculation error in original.*

Statement of Congressman Gerald E. Connolly (VA-11)
Subcommittee on Economic Growth, Job Creation, and Regulatory Affairs
Poised to Profit: How ObamaCare Helps Insurance Companies Even If It Fails Patients
June 18, 2014

Today's hearing – which is this Committee's 27th hearing on the Patient Protection and Affordable Care Act (ACA) – exemplifies the majority's troubling and routine abuse of this Committee's oversight authority to conduct tired political theater that attacks the ACA. Regrettably, while these show hearings may be effective in advancing partisan aims; they do absolutely nothing to strengthen public policy or enhance efforts to provide affordable, quality, health care coverage to millions of uninsured Americans.

Ensuring our Nation develops an effective and efficient healthcare system may be the most important and enduring challenge we face today. This critical issue begs to be addressed in a serious, substantive, and bipartisan manner. Yet time and time again, the Republican majority's blind hatred of the Obama Administration's efforts insure all Americans has led them to waste taxpayer dollars in holding partisan show hearings designed to score political points while pursuing the astonishing goal of preventing American families from obtaining affordable healthcare.

Even with something as simple as today's hearing title, the majority cannot resist imposing a false narrative as fact. Exhibit A. is today's *very* fair and balanced title that reads like it was drafted using a conservative Mad Libs template, "Poised to Profit: How ObamaCare Helps Insurance Companies Even If It Fails Patients." This morning's hearing perfectly encapsulates why so many Americans have grown cynical of Washington and reflexively tune out the so-called "policy debates" surrounding the ACA that amount to little more than regurgitating worn and tired talking points.

The majority's duplicative hearing purports to once again examine three temporary programs established by the ACA that are designed to stabilize premiums and the health insurance marketplace. Often referred to as the "Three Rs" – these programs known as Reinsurance, Risk Adjustment, and Risk Corridors, have a proven track record in mitigating risks for insurance companies, stabilizing premiums for consumers, and incentivizing plans to promote quality.

How do we know this? Over the past nine years, the "Three Rs" have been successfully implemented pursuant to Medicare Part D, which was President George W. Bush's signature legislative initiative, and supported by leading congressional Republicans, including the current Senate Minority Leader, Speaker of the House, House Budget Committee Chairman, and even the Chairman of *this* Committee. Of course, these Members no longer support these programs when in the ACA. Though individuals may accuse the majority of exhibiting stunning inconsistency, with regret, I would note this unexplained 180 degree shift in policy preference is perfectly consistent with the cynical approach to healthcare policy the majority has employed to date, and which has contributed to Americans losing faith in Congress as an institution.

LA Times

Obamacare subsidies on track to cost billions this year, report says

By Noam N. Levey

June 17, 2014, 5:28 PM | Reporting from Washington

The large subsidies for health insurance that helped fuel the successful drive to sign up approximately 8 million Americans for coverage under the Affordable Care Act are on track to cost billions of dollars this year, a new federal report indicates..

Nearly nine in 10 Americans who bought healthcare coverage on the federal government's healthcare marketplaces received government assistance to offset their premiums.

That assistance helped lower premiums for consumers who bought healthcare coverage on federal marketplaces by 76% on average, according to the new report from the Department of Health and Human Services.

Premiums that normally would have cost $346 a month on average instead cost consumers just $82, with the federal government picking up the balance of the bill.

Though the generous subsidies helped consumers, they also come at a price.

The report, though missing data from some states, paints one of the fullest pictures to date of the actual cost of the 2010 healthcare law's coverage expansion.

It suggests that the federal government is on track to spend at least $11 billion on subsidies for consumers who bought healthcare plans on marketplaces run by the federal government, even accounting for the fact that many consumers signed up for coverage in late March and will only receive subsidies for part of the year.

That total does not count the additional cost of providing coverage to millions of additional consumers who bought coverage in states that ran their own marketplaces, including California, Connecticut, Maryland and New York. About a third of the 8 million people who signed up for coverage this year used a state-run marketplace.

Federal officials said subsidy data for these consumers were not available.
If these state consumers received roughly comparable government assistance for their insurance premiums, the total cost of subsidies could top $16.5 billion this year. Making precise estimates is difficult because of expected fluctuations in enrollment over the year.

That total would be approximately in line with projections from the nonpartisan Congressional Budget Office.

The state-based marketplaces -- a centerpiece of the Affordable Care Act -- enable Americans who do not get healthcare coverage at work to select among plans that offer at least a basic set of benefits. The plans cannot turn away sick people.

Consumers who make less than four times the federal poverty level, or about $94,000 a year for a family of four, qualify for subsidies to offset the cost of their premiums in most places.

Obama administration officials Tuesday focused on the availability of affordable coverage for millions more consumers.

"What we're finding is the marketplace is working. Consumers have more choices, and they're paying less for their premiums," Health and Human Services Secretary Sylvia Burwell said in a statement.

Officials who worked on the report refused to speak on the record or discuss the potential effect of the subsidies on the long-term cost of the healthcare law.

Although the law's costs have thus far been lower than projected, some experts question whether the subsidies will be sustainable.

The Congressional Budget Office estimated in April that the annual cost of subsidies will rise to $23 billion next year and $95 billion in 2024, although the budget office continued to project that all the law's costs will be offset by additional revenue it raises and by cuts in other federal healthcare spending.

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MEMORANDUM May 2, 2014

To: Senate Budget Committee
Attention: [redacted]

From: [redacted] Legislative Attorney, x[redacted]

Subject: **ACA Risk Corridor Funding for FY2015**

This memorandum responds to your request for an analysis of legislative language proposed to be included in the President's Budget for FY2015 relating to the risk corridor program established under § 1342 of the Patient Protection and Affordable Care Act (ACA).[1] This memo provides general background information, and may be used to respond to questions by other Members or Congressional staff.

Background

Section § 1342 of the ACA requires the Secretary of Health and Human Services (HHS) to establish and administer a program of risk corridors for 2014, 2015, and 2016 for qualified health plans[2] (QHPs) offered to individuals and small businesses.[3] Under § 1342(b)(1), if an insurer's allowable costs exceed the total premiums received (less administrative costs) for a QHP, the Secretary is required to pay the insurer a percentage of the shortfall in premiums. In contrast, under § 1342(b)(2), if a participating insurer's allowable costs are less than the total premiums received (less administrative costs), the insurer is required to pay to the Secretary a comparable percentage of the excess premiums received.

Authority to conduct the risk corridor program has been delegated by the Secretary of HHS to the Administrator of CMS.[4] The President's Budget for FY2015 proposes that the following language be provided in an annual appropriations act for the Centers for Medicare and Medicaid Services (CMS) for FY2015:

[1] The ACA was signed into law on March 23, 2010 (P.L. 111-148, 124 Stat. 119). A week later, on March 30, 2010, the President signed the Health Care and Education Reconciliation Act (HCERA; P.L. 111-152, 124 Stat. 1029), which amended multiple health care and revenue provisions in ACA. Several other bills that were subsequently enacted made more targeted changes to specific ACA provisions. All references to ACA in this memorandum refer to the law as amended.

[2] Qualified health plans are plans that provide a comprehensive set of health benefits and comply with all applicable ACA market reforms. Exchange plans must be QHPs, with limited exceptions. QHPs may also be offered in the private market outside of exchanges.

[3] 42 U.S.C. § 18062.

[4] 76 Fed. Reg. 53903, 53904 (Aug. 30, 2011).

Program Management

> For carrying out, except as otherwise provided, titles XI, XVIII, XIX, and XXI of the Social Security Act, titles XIII and XXVII of the PHS Act, the Clinical Laboratory Improvement Amendments of 1988, and other responsibilities of the Centers for Medicare and Medicaid Services, not to exceed $4,199,744,000, to be transferred from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, as authorized by section 201(g) of the Social Security Act; together with all funds collected in accordance with section 353 of the PHS Act and section 1857(e)(2) of the Social Security Act, funds retained by the Secretary pursuant to section 302 of the Tax Relief and Health Care Act of 2006; and such sums as may be collected from authorized user fees and the sale of data, which shall be credited to this account and remain available until expended: Provided, That all funds derived in accordance with 31 U.S.C. 9701 from organizations established under title XIII of the PHS Act shall be credited to and available for carrying out the purposes of this appropriation: Provided further, That the Secretary is directed to collect fees in fiscal year 2015 from Medicare Advantage organizations pursuant to section 1857(e)(2) of the Social Security Act and from eligible organizations with risk-sharing contracts under section 1876 of that Act pursuant to section 1876(k)(4)(D) of that Act.[5]

The President's Budget for FY2015 also indicates that the administration proposes to use the funds that would be provided under this language to make risk corridor payments under ACA § 1342.[6]

Analysis

With this historical and legal background, you have asked us to answer the following questions, assuming the proposed legislative language from the President's Budget for FY2015 is enacted:

1. Are the amounts received under the risk corridor program available to make payments under the risk corridor program?
2. If payments exceed receipts under the program, can the other amounts provided in the Program Management account be used to make risk corridor payments?
3. If payments are less than receipts under the program, can the excess be used to fund other activities in the Program Management account?

Availability of Risk Corridor Receipts

As noted above, the risk corridor program directs payments to be made by the Secretary of HHS to certain insurers that have underestimated their premiums for a given plan year through 2016. However, statutory and constitutional provisions prohibit federal agencies from making payments in the absence of a valid appropriation.[7] Under longstanding GAO interpretations, an appropriation must consist of both a direction

[5] OFFICE OF MANAGEMENT AND BUDGET, *Appendix, Budget of the United States Government, FY2015*, at 460, available at [http://www.whitehouse.gov/omb/budget/Appendix].

[6] *Id.*

[7] 31 U.S.C. § 1342 ("An officer or employee of the United States Government or of the District of Columbia government may not ... make or authorize an expenditure or obligation exceeding an amount available in an appropriation or fund for the expenditure or obligation [or] involve either government in a contract or obligation for the payment of money before an appropriation is made unless authorized by law"); U.S. CONST. art. I, § 9, cl. 7 ("No Money shall be drawn from the Treasury, but in Consequence of Appropriations made by Law").

to pay and a specified source of funds.[8] While the language of ACA § 1342(b)(1) establishes a directive to the Secretary to make such payments, it does not appear to clearly specify a source of funds from which those payments are to be made.[9]

Section 1342(b)(2) does require insurers to make payments to the program if they overestimate annual premiums and consequently experience a windfall. These receipts by the government are not explicitly designated to be deposited in a special account or otherwise made available for outgoing payments under the risk corridor program. In the absence of any specific directions, federal law requires such amounts to be deposited in the General Fund of the Treasury, from which they may be further appropriated by Congress.[10]

It is possible that such an appropriation of the amounts received under the risk corridor program could be found in the legislative language proposed as part of the President's Budget for FY2015, which is quoted above. In relevant part, that language provides that:

> For carrying out ... other responsibilities of the Centers for Medicare and Medicaid Services ... such sums as may be collected from authorized user fees ... which shall be credited to this account and remain available until expended.[11]

As noted above, the authority to establish a risk corridor program under ACA § 1342, including the authority to make payments to insurers under that program, has been delegated to CMS.[12] Therefore, if the amounts received by CMS under the risk corridor program can be characterized as authorized user fees, those receipts would appear to be available to make such risk corridor payments during FY2015 under the appropriation created by this language. There are two theories under which CMS might be considered authorized to impose user fees or charges[13] with respect to the risk corridor program. The first potential source of authority is the Independent Offices Appropriation Act (IOAA), which provides federal agencies with the authority to impose user fees or charges when providing a service or thing of value.[14] The second is the text of ACA § 1342 itself which provides that a participating insurer shall pay a percentage of the excess premiums to the Secretary.[15] If either proposition is accepted, then, under the

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[8] *See* GAO, 1 PRINCIPLES OF FEDERAL APPROPRIATIONS LAW 2-17 (2004).

[9] "[I]f ... a participating plan's allowable costs for any plan year are more than [specified thresholds] the Secretary shall pay to the plan an amount equal to [the statutory formula]." 42 U.S.C. § 18062(b)(1). It should also be noted that the question of whether an appropriation is available to make these payments is separate from the question of whether insurance plans meet the eligibility requirements for a payment under § 1342(b)(1). A qualified health plan may have a legal claim to the payments by operation of the statutory formula, but that alone does not constitute an appropriation from which that claim may be paid. *See* GAO, 1 PRINCIPLES OF FEDERAL APPROPRIATIONS LAW 2-17 (2004) (citing Comptroller General Decision B-114808, Aug. 7, 1979). In contrast, the risk corridor payments under the similar Medicare Part D program are funded through a permanent appropriation from the Medicare Prescription Drug Account established in the Federal Supplementary Medical Insurance Trust Fund. 42 U.S.C. § 1860d-16(b)(1)(B).

[10] 31 U.S.C. § 3302(b). *See* GAO, 3 PRINCIPLES OF FEDERAL APPROPRIATIONS LAW 12-93 (2008) (noting that creation of revolving fund is exception to general rule of 31 U.S.C. § 3302(b)).

[11] OFFICE OF MANAGEMENT AND BUDGET, *Appendix, Budget of the United States Government, FY2015*, at 460, available at [http://www.whitehouse.gov/omb/budget/Appendix].

[12] *Supra* footnote 4.

[13] The terms "user fee" and "user charge" are used interchangeably in federal appropriations law. *See* GAO, *A Glossary of Terms Used in the Federal Budget Process*, at 100 (Sept. 2005); and GAO, 3 *Principles of Federal Appropriations Law* 12-143 (Sept. 2008) ("A user fee may be defined as ... "any charge collected from recipients of Government goods, services, or other benefits not shared by the public.").

[14] 31 U.S.C. § 9701.

[15] 42 U.S.C. § 18062(b)(2).

proposed FY2015 language, the amounts received would be appropriately characterized as user fees or charges and those amounts would be available for carrying out the responsibilities of CMS, including the risk corridor program under ACA § 1342.[16]

Availability of Funds to Cover Deficits in Risk Corridor Program

Although, as described above, the amounts collected pursuant to the risk corridor program could be available to make payments to insurers under that program, it is theoretically possible that the amount of payments required to be made under the program will exceed receipts. In the event of such a deficit, there may be questions as to whether the other amounts available in the CMS "Program Management" account could be used as a secondary funding source to make risk corridor payments.

The proposed FY2015 appropriations language for the "Program Management" account identifies several distinct sources of funds:

- $4,199,744,000 transferred from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund as authorized by § 201(g) of the Social Security Act;
- All funds collected in accordance with § 353 of the Public Health Service Act and § 1857(e)(2) of the Social Security Act;
- Funds retained by the Secretary pursuant to section 302 of the Tax Relief and Health Care Act of 2006;
- Such sums as may be collected from authorized user fees and the sale of data, which shall be credited to this account and remain available until expended;
- All funds derived in accordance with 31 U.S.C. § 9701 from organizations established under title XIII of the PHS Act which shall be credited to and available for carrying out the purposes of this appropriation; and
- Fees in fiscal year 2015 from Medicare Advantage organizations pursuant to section 1857(e)(2) of the Social Security Act and from eligible organizations with risk-sharing contracts under section 1876 of that Act pursuant to section 1876(k)(4)(D) of that Act.

Initially, it should be noted that the use of other available funds to make risk corridor payments under ACA § 1342 would likely reduce the amount of available funds that could be used for other purposes. Nevertheless, for some of these categories, the text of the proposed FY2015 legislative language strongly suggests that they may be used for any of the purposes for which the appropriation was made, including payments under ACA § 1342. For example, fees charged under 31 U.S.C. § 9701 to health maintenance organizations under Title XIII of the Public Health Service Act "shall be credited to and available for carrying out the *purposes* of this appropriation."[17]

In other cases, the text of the proposed FY2015 language is silent, but makes reference to other provisions of law that may provide limits on the purposes towards which such funds may be made available. For

[16] Although either the text of § 1342 or the IOAA may provide sufficient justification to levy user charges under the risk corridor program, which authority is used may have implications regarding the available uses for which receipts under the risk corridor program may be used. *See infra* at "Use of Risk Corridor Surplus for Other Purposes."

[17] OFFICE OF MANAGEMENT AND BUDGET, *Appendix, Budget of the United States Government, FY2015*, at 460, available at [http://www.whitehouse.gov/omb/budget/Appendix] (emphasis added).

example, the transfers from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund are made pursuant to § 201(g) of the Social Security Act. In turn, § 201(g) directs the Trust Funds to pay amounts based on estimates of expenditures for various programs authorized under the Social Security Act. Because the proposed FY2015 language makes the transfer of funds subject to § 201(g), it is likely that those transferred funds would be limited to those purposes specified in § 201(g). If so, then these funds would not be available to make risk corridor payments, as that program is not one of the purposes for which § 201(g) authorizes transfers from the relevant trust funds. Similarly, § 353 of the Public Health Service Act;[18] §§ 1857(e)(2) and 1876(k)(4)(D) of the Social Security Act;[19] and § 302 of the Tax Relief and Health Care Act of 2006[20] authorize collection of fees for specific purposes, and thus such fees would also not appear to be available to fund ACA risk corridor payments.

Use of Risk Corridor Surplus for Other Purposes

In the alternative, it is also possible that receipts under the ACA risk corridor program could exceed payments to insurers. In that event, there may be questions regarding whether such surplus funds could be applied towards other purposes for which the CMS "Program Management" account is appropriated.

The particular clause in the proposed FY2015 language under which receipts from the ACA risk corridor program are appropriated to the CMS "Program Management" account simply states that sums "collected from authorized user fees and the sale of data, ... shall be credited to this account and remain available until expended."[21] This language does not appear to impose any restrictions on how the amounts collected as user fees may be used. Similarly, the language in ACA § 1342 which authorizes the charges to insurers who overestimate premiums does not specify or restrict the purposes for which the amounts received may be used.[22]

User fees imposed under the authority provided in the IOAA generally must be fair and based on the costs to the government and the value of the service or thing being provided.[23] The Supreme Court has suggested that if a user fee was structured so that it was being used to fund general government activities unrelated to the service or benefit being provided, this would more closely resemble a tax and would be outside the scope of the authority conferred by the IOAA.[24] This restriction has also been applied to other statutory authorizations to charge user fees that either explicitly reference the IOAA[25] or are *in pari materia* (*i.e.* have a common purpose as the IOAA).[26] Therefore, if the receipts under the ACA risk corridor program were held to be subject to the requirements of the IOAA, it may not be permissible to use a surplus in the risk corridor program to pay for unrelated activities in the CMS "Program Management" account.

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[18] 42 U.S.C. § 263a (relating to certification and inspection of laboratories).

[19] 42 U.S.C. § 1395w-27(e)(2) (relating to enrollment, dissemination of information, and counseling); 42 U.S.C. § 1395mm(k)(4)(D) (same).

[20] 42 U.S.C. § 1395ddd(h)(1)(C) (reserving amounts retained for recovery audit program).

[21] OFFICE OF MANAGEMENT AND BUDGET, *Appendix, Budget of the United States Government, FY2015*, at 460, available at [http://www.whitehouse.gov/omb/budget/Appendix] (emphasis added).

[22] 42 U.S.C. § 18062(b)(2).

[23] 31 U.S.C. § 9701.

[24] Nat'l Cable Television Ass'n v. U.S., 415 U.S. 336 (1974).

[25] Boat Owners Ass'n v. U.S., 834 F. Supp. 7 (D.D.C. 1993).

[26] Yosemite Park & Curry Co. v. United States, 231 Ct. Cl. 393 (Ct. Cl. 1982).

However, there are several factors which may argue against such a conclusion. First, as noted above, ACA § 1342 arguably provides an independent basis aside from the IOAA upon which risk corridor charges can be levied against insurers. Second, § 1342 does not explicitly reference or incorporate the terms of the IOAA. Third, statutes that have been found to be *in pari materia* with the IOAA generally have spoken of reimbursement or recovery of costs, neither of which is present in § 1342.[27] Assuming that the IOAA does not apply, either explicitly or by implication, then the lack of any other restriction in the proposed FY2015 legislative language or the terms of § 1342 itself would suggest that surplus amounts received under the ACA risk corridor program, if any, could be used to fund other activities in the CMS "Program Management" account.

[27] *See, e.g.*, *Id.*; Alyeska Pipeline Service Co. v. United States, 224 Ct. Cl. 240 (Ct. Cl. 1980); First Nat'l Bank v. Smith, 445 F. Supp. 1117 (D. Minn. 1977).