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PROTECTING AMERICANS FROM ILLEGAL BAILOUTS AND PLAN CANCELLATIONS UNDER THE PRESIDENT'S HEALTH CARE LAW

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE
HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRTEENTH CONGRESS

SECOND SESSION

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[1] The report is available at http://docs.house.gov/meetings/IF/IF14/20140728/102551/HHRG–113–IF14–20140728–SD006.pdf.

PROTECTING AMERICANS FROM ILLEGAL BAILOUTS AND PLAN CANCELLATIONS UNDER THE PRESIDENT'S HEALTH CARE LAW

MONDAY, JULY 28, 2014

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

The subcommittee met, pursuant to call, at 4:01 p.m., in room 2123, Rayburn House Office Building, Hon. Joseph R. Pitts (chairman of the subcommittee) presiding.

Members present: Representatives Pitts, Burgess, Blackburn, Gingrey, Lance, Cassidy, Guthrie, Griffith, Bilirakis, Ellmers, Pallone, Green, Barrow, and Waxman (ex officio).

Staff present: Nick Abraham, Legislative Clerk; Sean Bonyun, Communications Director; Leighton Brown, Press Assistant; Noelle Clemente, Press Secretary; Paul Edattel, Professional Staff Member, Health; Sydne Harwick, Legislative Clerk; Katie Novaria, Professional Staff Member, Health; Heidi Stirrup, Health Policy Coordinator; Ziky Ababiya, Democratic Staff Assistant; Karen Lightfoot, Democratic Communications Director and Senior Policy Advisor; Karen Nelson, Democratic Deputy Committee Staff Director, Health; and Matt Siegler, Democratic Counsel.

Mr. PITTS. The subcommittee will come to order. The Chair will recognize himself for an opening statement.

OPENING STATEMENT OF HON. JOSEPH R. PITTS, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Today's hearing is once again about protecting taxpayers and consumers from the consequences of the Affordable Care Act; namely, a giveaway of taxpayer dollars to insurers, under the ACA, and another round of planned cancellations in the group market.

First, Section 1342 of the Affordable Care Act created what are known as risk corridors, a mechanism that will protect insurance companies from some of the financial losses they face under the Affordable Care Act. It works by decreasing payments to plans whose expenses are below projections, those with healthier than expected enrollees, and redistributing those dollars to plans whose expenses exceed projections, those with sicker than expected enrollees.

The risk corridor provision is in effect from 2014 through 2016, if done in a budget-neutral fashion, taxpayers would have little to

be worried about when it comes to risk corridors, but while the administration has paid lip service to the risk corridor program being budget neutral, it has also indicated that, quote, "regardless of payments and receipts, HHS will remit payments as required under Section 1342 of the Affordable Care Act," end quote.

Opening the door to what would essentially be a taxpayer-funded bailout of health insurers. Additionally, according to the Congressional Research Service and a plain reading of Section 1342, the law does not provide an appropriation for these payments. In the absence of a congressional appropriation, any payments are clearly an end-run around Congress and, therefore, illegal. The very idea of risk corridors assumes that there will be winners in the insurance industry wjhose gains can be shifted to the losers.

However, the President's decision to selectively enforce provisions of the ACA along with higher enrollment of older and sicker individuals than was originally projected, could cause industry-wide losses, putting the taxpayer on the hook for billions of dollars in payments.

The committee will consider legislation today to protect taxpayer dollars from being unlawfully given to health insurance companies under the risk corridor program.

Second, as we have noted in previous hearings, the President promised numerous times that if you liked your healthcare plan, you could keep it. However, millions of Americans experience plan cancellations in the individual market last fall, and millions more will likely lose their employer-sponsored plans in the future. Dr. Cassidy's commonsense bill, H.R. 3522, the Employee Healthcare Protection Act, would permanently grandfather all group plans issued by health insurers that were in existence in 2013, allowing consumers to keep the coverage they like and giving small businesses better options than ACA-compliant plans.

I would like to thank all of our witnesses for being here today to discuss these issues. And I yield back the balance of my time, recognize the ranking member, Mr. Pallone, for 5 minutes for an opening statement.

[The prepared statement of Mr. Pitts follows:]

PREPARED STATEMENT OF HON. JOSEPH R. PITTS

Today's hearing is once again about protecting taxpayers and consumers from the consequences of the Affordable Care Act, namely an unlawful giveaway of taxpayer dollars to insurers under the ACA and another round of plan cancellations in the group market.

First, section 1342 of the Affordable Care Act (ACA) created what are known as "risk corridors," a mechanism that will protect insurance companies from some of the financial losses they face under the Affordable Care Act.

It works by decreasing payments to plans whose expenses are below projections (those with healthier-than-expected enrollees) and redistributing those dollars to plans whose expenses exceed projections (those with sicker-than-expected enrollees).

The risk corridor provision is in effect from 2014 through 2016.

If done in a budget-neutral fashion, taxpayers would have little to be worried about when it comes to risk corridors. But, while the administration has paid lip service to the risk corridor program being budget neutral, it has also indicated that "regardless of payments and receipts, HHS will remit payments as required under section 1342 of the Affordable Care Act," opening the door to what would essentially be a taxpayer-funded bailout of health insurers.

Additionally, according to the Congressional Research Service, and a plain reading of section 1342, the law does not provide an appropriation for these payments. In

the absence of a Congressional appropriation, any payments are clearly an end-run around Congress, and, therefore, illegal.

The very idea of risk corridors assumes that there will be "winners" in the insurance industry, whose gains can be shifted to the "losers." However, the President's decision to selectively enforce provisions of the ACA, along with higher enrollment of older and sicker individuals than was originally projected, could cause industry-wide losses—putting the taxpayer on the hook for billions in payments.

The committee will consider legislation today to protect taxpayers dollars from being unlawfully given to health insurance companies under the risk corridor program.

Second, as we've noted in previous hearings, the President promised numerous times that if you liked your health care plan you could keep it. However, millions of Americans experienced plan cancellations in the individual market last fall, and millions more will likely lose their employer-sponsored plans in the future.

Dr. Cassidy's commonsense bill, H.R. 3522, the Employee Health Care Protection Act, would permanently grandfather all group plans issued by health insurers that were in existence in 2013, allowing consumers to keep the coverage they like and giving small businesses better options than ACA-compliant plans.

I thank all of our witnesses for being here today to discuss these issues, and I yield the balance of my time.

OPENING STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PALLONE. Thank you, Mr. Chairman.

I want to reiterate what I said an hour earlier, and that is that we have, I guess, two bills that are the subject of a hearing today and one of them, H.R. 3522, the Employee Healthcare Protection Act, is already designated or noticed for the full committee markup on Wednesday without even having been marked up in subcommittee. So, once again, I do want to object to the fact—I know this isn't an issue where we can stop the hearing, but I do want to object to the fact that we are proceeding to mark up that bill in full committee without regular order and having a subcommittee markup based on what has been noticed.

But beyond that, today's hearing is nothing more than another episode in a series of Republican attacks on the Affordable Care Act and this time, it is even harder to take seriously the words the GOP have chosen to include in the title include illegal bailouts. It is quite ironic, that, because the provisions of the ACA that are being attacked today are the very same policies Republicans have supported in the past.

Of course, no one is surprised, since the passage of the ACA, Republicans have reversed course on so many ideas that were once the foundation of their health agenda. Remember that the individual mandate, that was a Republican idea as well. And as we get close to the election, we are going to hear more and more about how the ACA must be repealed and replaced, but I am still waiting for the alternative and I haven't heard one from the other side of the aisle. Risk corridors specifically are not some made up policy the Democrats decided to use to give a handout to insurance companies. Trust me, no Democrat is interested in bailing out the insurance company. But these policies are in place for legitimate reason and only because they are in the ACA are they controversial and considered in this negative light by the GOP.

And let's recap the importance of risk corridors in order for insurance pools to keep premiums stable and costs low, it is critical

to spread out risk. These types of risk-sharing mechanisms are not a new phenomena. They are used in all types of function insurance system. One great example is the use in the Medicare Part D program. In fact, the provisions of the ACA were modelled after the Part D program, which, of course, was authored by the GOP. If Republicans had their way, they would repeal this program and would effectively create chaos in the marketplace.

So, Mr. Chairman, there is a new study, published in the New England Journal of Medicine last week, that estimated that 10.3 million uninsured adults gained healthcare coverage following the first open enrollment period in the health insurance marketplace. The uninsured rate for adults ages 18 to 64 fell from 21 percent in September 2013 to 16.3 percent in April 2014. And these results do not include the more than 3 million young adults who gained health insurance coverage through their parents' plan. So we have done something pretty remarkable here with the ACA. These millions of people aren't just a number. They are actual people who can now see a doctor. They can now treat an illness that was otherwise going untreated or better yet, they can remain healthy and prevent illness in the future. Women no longer will be charged more men for insurance. Insurance companies must offer robust health coverage, so that when you do get sick or you are hospitalized, you aren't left with thousands of dollars in debt. If Republicans had their way, we would go back to the days when insurance companies could drop someone for a preexisting condition.

Almost all of the ACA's key reforms and policies are now in place, and the Affordable Care Act is working. It is not perfect, but gutting the law's insurance provisions is not a way to perfect it. It is a way to score political points. So I am going to urge my Republican colleagues one more time to stop their political stunts, stop trying to dismantle the ACA's success, and come together with Democrats to strengthen and improve its historic benefits and protections. Am I going to yield to any of my colleagues, or—did you want some time?

I will yield to the gentleman from Texas, Mr. Green.

OPENING STATEMENT OF HON. GENE GREEN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. GREEN. Thank you, Mr. Chairman.

And thank my ranking member for the time. I was hoping, over the last few months, we had a kind of vacation from efforts to attack the Affordable Care Act, and we were actually legislating and doing things I think our committee could work across party lines. These bills today it seems like it is—we are back to the, you know, how many times do we need to try to repeal the Affordable Care Act? I know it is probably 50 or so. But, you know, maybe it is just election fodder that we need to have. But I don't mind. There is a lot of successes over the last few months because of the Affordable Care Act, and we are seeing it every day. And I would hope us not to throw a roadblock up in front of it.

And I appreciate you yielding me your time.

Mr. PALLONE. Thank you, Mr. Chairman.

Mr. PITTS. The Chair thanks the gentleman.

I now recognize the ranking member of the full committee, Mr. Waxman, 5 minutes for an opening statement.

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

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

We have three bills before us today. We have a hearing on them. But all three bills are intended to undermine the Affordable Care Act. That is exactly what they would do. And I just want to point out that we have had over 50 votes on the House floor to repeal or undermine, effectively repealing, the Affordable Care Act. Don't we have anything better to do?

We were promised by the Republicans that they would come up with a replacement, and they were going to do that in 2011. Then we heard it would come in 2012. Then it was sometime in 2013. Then it was supposed to be early 2014. And then we were assured there would be a vote this summer. Well, then it was the fall. And now we hear we may not see a replacement until 2015 or 2017.

It is clear to me that they don't have any productive ideas of their own to offer. It appears that they have decided to add to their 50 votes to repeal or undermine the ACA. They certainly are working hard to secure their place in history as the least productive Congress in the history of this Nation. I oppose all three of these bills before us today. The first bill, H.R. 3522, says that any group health insurance plan on the market in 2013 can be sold in perpetuity. They don't have to change it. Now, they wouldn't have to adopt all of the key protections for consumers in the Affordable Care Act, protections that went into place this year, such as a ban on annual limits. Insurance companies used to do that. They put a limit at how much you can spend each year, and then after that limit, you pay for it all. Well, they want to go back and continue those plans that have those limits. They want to continue to allow plans that would charge a small business a higher premium because an employee has a preexisting condition.

Those were changes we intended to make and did make in the Affordable Care Act. We said, if you want to keep your plan, you could keep it and we provided for grandfathering in existing individual insurance plans that were for sale when the law passed. And if they liked that coverage, they could keep it, even though that insurance might be inadequate by not covering all of the things that were required under the Affordable Care Act. And earlier this year, the President went a step further and said, well, if a small business had changed plans or purchased a new plan after the law passed, they could keep that new coverage unchanged into 2016.

Now, that is supposed to be going into the affordable care options and choosing an insurance plan that protects the consumers and that is offering a rate consistent with competition by other insurance plans that have to meet all of those protections.

The other two bills before us today relate to a premium stabilization program in the ACA, known as risk corridors. This is modelled after a nearly identical program in Medicare Part D that redistributes a portion of profits and losses between insurance companies.

This was drafted by the Republicans on this committee as part of their Part D legislation. They and the Bush administration praised it repeatedly. It helped keep Part D premiums stable, and it has saved taxpayers money. But now that it is being used by the plans under the Affordable Care Act, oh, we can't continue these risk corridors. Let's repeal them.

Before the administration announced that they would implement the risk corridors in a budget-neutral fashion, the CBO said that program would save taxpayers $8 billion in just 3 years. The provision in the law makes sense. It will keep premiums stable. We should not repeal it or tie the administration's hands in implementing it.

Well, Mr. Chairman, I think what we are seeing is more politics. Maybe it is the stuff that saves you in primaries from the extremists and the so-called Tea Party voters, or whatever. But we ought to do something worthwhile in this committee instead of passing bills that just undermine the ACA. It is working finally. Millions of people now have insurance. We ought to leave it alone. If it ain't broke, don't fix it.

Mr. PITTS. The gentleman's time is expired. The chairman thanks the gentleman.

As usual, all members' written opening statements will be made part of the record.

I ask unanimous consent to insert the following into the record, a memo from the Congressional Research Service to the committee, an article from the L.A. Times, and an article from Bloomberg BNA.

Without objection, so ordered.

[The information follows:]

MEMORANDUM January 23, 2014

To: House Energy and Commerce Committee
Attention: Paul Edattel

From: Edward C. Liu, Legislative Attorney[redacted]

Subject: **Funding of Risk Corridor Payments Under ACA § 1342**

This memorandum responds to your request for an analysis of the following two questions concerning the funding of the risk corridor program under § 1342 of the Patient Protection and Affordable Care Act (ACA):

1. Is an appropriation required for payments to qualified health plans under ACA § 1342(b)(1)?
2. Can the amounts received from qualified health plans under ACA § 1342(b)(2) be used to make payments under § 1342(b)(1)?

This memo provides general background information, and may be used to respond to questions by other Members or Congressional staff.

Overview of Risk Corridors

Risk corridors are a method for constraining financial losses (or gains) because costs are greater (or lesser) than what an insurance company estimated. The corridors allow insurance companies and government to share higher-than-expected costs (or profits). Risk corridors have been employed when there is a change in the market which leaves health insurers unsure about the future costs they face, and how to price (or bid) their products.

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[1] (QHPs) offered to individuals and small businesses.[2] Under § 1342(b)(1), if a plan's allowable costs exceed the total premiums received (less administrative costs), the Secretary is required to pay the plan a percentage of the shortfall in premiums. In contrast, under § 1342(b)(2), if a participating plan's allowable costs are

[1] 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.

[2] 42 U.S.C. § 18062.

less than the total premiums received (less administrative costs), the plan is required to pay to the Secretary a comparable percentage of the excess premiums received.

Is an appropriation required for payments to qualified health plans under ACA § 1342(b)(1)?

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.[3] Under longstanding GAO interpretations, an appropriation must consist of both a direction to pay and a specified source of funds.[4] While the language of ACA § 1342(b)(1) establishes a directive to the Secretary to make such payments, it does not specify a source from which those payments are to be made.[5] Therefore, § 1342 would not appear to constitute an appropriation of funds for the purposes of risk corridor payments under that section.[6]

It is possible that an appropriation that would cover these payments may arise elsewhere. One potential source would be an appropriation enacted as part of the annual appropriations process. Unfortunately, it is too early to be able to predict whether an annual appropriation exists that would cover these payments. This is because the payments under § 1342 would not be made until FY2015 for which we do not yet have a proposed budget from the President or any pending appropriations bills.

Can the amounts received from qualified health plans under ACA § 1342(b)(2) be used to make payments under § 1342(b)(1)?

In some cases, federal expenditures can be financed through a type of permanent, indefinite appropriation known as a revolving fund. Generally, such expenditures have revenue generating activities and the

[3] 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").

[4] *See* GAO, 1 PRINCIPLES OF FEDERAL APPROPRIATIONS LAW 2-17 (2004).

[5] "[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).

[6] 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).

revenue generated from those activities is placed in a revolving fund which can be used to pay for future revenue generating activities.[7]

An agency may not create a revolving fund absent specific authorizing legislation.[8] 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.[9] The necessary elements for a statute to create a revolving fund are:

- It must specify the receipts or collections which the agency is authorized to credit to the fund (user charges, for example).
- It must define the fund's authorized uses, that is, the purpose or purposes for which the funds may be expended.
- It must authorize the agency to use receipts for those purposes without fiscal year limitation. However, as explained above, only receipts and collections that the fund has earned through its operations are available without fiscal year limitation.[10]

Notably for purposes of this memorandum, the amounts received by HHS from plans that have overestimated premiums for a given year are not explicitly designated to be deposited in a revolving account or otherwise made available for outgoing payments under § 1342(b)(1). Therefore, there does not appear to be sufficient statutory language creating a revolving fund that would make amounts received under § 1342(b)(2) available to pay amounts due to eligible plans under § 1342(b)(1).

As with a non-revolving appropriation to cover payments under § 1342(b)(1), a revolving fund can be created in standalone legislation, or in an annual appropriations act.[11] The lack of statutory language creating a revolving fund within § 1342 does not mean that such incoming payments may never be placed in a revolving fund to be used for outgoing payments. Such a revolving fund could be established by Congress at some point in the future, including before the first payments from qualified health plans are due for plan year 2014. Nevertheless, until such time as that legislation is enacted, it does not appear that a revolving fund exists for purposes of receipts and payments under § 1342.

[7] *See* GAO, 3 PRINCIPLES OF FEDERAL APPROPRIATIONS LAW 12-85 (2008).

[8] *Id.* at 12-89 ("[A]gencies have no authority to administratively establish revolving funds.").

[9] 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)).

[10] *See* GAO, 3 PRINCIPLES OF FEDERAL APPROPRIATIONS LAW 12-90 (2008).

[11] *See* GAO, 3 PRINCIPLES OF FEDERAL APPROPRIATIONS LAW 12-89 (2008).

LA Times

Nation

Critics call Obama funding plan for health insurer losses a 'bailout'

By NOAM N. LEVEY MAY 21, 2014, 3:00 AM

Little-noticed adjustment to Affordable Care Act makes billions of extra dollars available to insurers
Republicans point to new provision as evidence of Obamacare 'bailout' for insurers
Obamacare insurance premium increases could affect midterm congressional campaigns

The Obama administration has quietly adjusted key provisions of its signature healthcare law to potentially make billions of additional taxpayer dollars available to the insurance industry if companies providing coverage through the Affordable Care Act lose money.

The move was buried in hundreds of pages of new regulations issued late last week. It comes as part of an intensive administration effort to hold down premium increases for next year, a top priority for the White House as the rates will be announced ahead of this fall's congressional elections.

Administration officials for months have denied charges by opponents that they plan a "bailout" for insurance companies providing coverage under the healthcare law.

They continue to argue that most insurers shouldn't need to substantially increase premiums because safeguards in the healthcare law will protect them over the next several years.

If conservatives want to stop the illegal Obamacare insurance bailout before it starts they must start planning now.- Conn Carroll, an editor of the right-leaning news site Townhall.com

But the change in regulations essentially provides insurers with another backup: If they keep rate increases modest over the next couple of years but lose money, the administration will tap federal funds as needed to cover shortfalls.

Although little noticed so far, the plan was already beginning to fuel a new round of attacks Tuesday from the healthcare law's critics.

"If conservatives want to stop the illegal Obamacare insurance bailout before it starts they must start planning now," wrote Conn Carroll, an editor of the right-leaning news site Townhall.com.

On Capitol Hill, Republicans on the Senate Budget Committee began circulating a memo on the issue and urging colleagues to fight what they are calling "another end-run around Congress."

Obama administration officials said the new regulations would not put taxpayers at risk. "We are confident this three-year program will not create a shortfall," Health and Human Services spokeswoman Erin Shields Britt said in a statement. "However, we want to be clear that in the highly unlikely event of a shortfall, HHS will use appropriations as available to fill it."

The stakes are high for President Obama and the healthcare law.

Although more than 8 million people signed up for health coverage under the law, exceeding expectations, insurance companies in several states have been eyeing significant rate increases for next year amid concerns that their new customers are older and sicker than anticipated.

Insurers around the country have started to file proposed 2015 premiums, just as the midterm campaigns are heating up. Obamacare, as the law is often called, remains a top campaign issue, and big premium increases in states with tightly contested races could prove politically disastrous for Democrats.

If rates go up dramatically, consumers may also turn away from insurance marketplaces in some states, leading to their collapse.

Proposed increases in a few states where insurers have already filed 2015 rates have been relatively low, with several major carriers seeking just single-digit hikes. But insurers in closely watched states, such as Florida, Pennsylvania, North Carolina and Arkansas, are still preparing their filings.

"It's absolutely paramount to keep premiums in check," said Len Nichols, a health economist at George Mason University who has advised officials working on the law.

The state-based marketplaces, which opened last year, allow consumers who do not get health coverage at work to shop among plans that meet basic standards. Sick consumers cannot be turned away, and low- and moderate-income Americans qualify for government subsidies to offset their premiums.

To stabilize this new system, the law set up a complex system of funds, including one known as the Temporary Risk Corridors Program, that collect money from insurers and transfer it from companies with healthier, less expensive consumers to those with sicker, more costly consumers.

This system was supposed to pay for itself, as does a similar one used to shift money between drug plans in the Medicare Part D program.

But insurance industry officials have grown increasingly anxious about the new system's adequacy.

Pressure is most acute on insurers in states where healthy consumers were allowed to remain in old plans that are not sold on the new online marketplaces, an option Obama offered to states amid a political firestorm over plan cancellations last year. The president had promised people would be able to stick with their plans.

The renewal temporarily solved a political problem for the White House, but created a new one. Maintaining these old plans kept many healthy consumers out of the marketplaces, making the pool of new customers less healthy and therefore potentially more expensive for insurers, according to experts.

Premium hikes will likely be modest in much of the country. But probably not everywhere.- Larry Levitt, an insurance expert at the nonprofit Kaiser Family Foundation

In a series of White House meetings over the last several months, Obama and other senior administration officials have sought to persuade insurance company CEOs to nonetheless hold rates in check, arguing that the marketplaces would stabilize over time.

But with proposed 2015 rates beginning to come in, the administration acceded to industry demands for a clear guarantee that more money would be available to cover potential losses.

"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," the regulation published Friday notes. "In that event, HHS will use other sources of funding for the risk corridor payments, subject to the availability of appropriations."

That language allows the administration to tap funds appropriated for other health programs to supplement payments to insurers, according to administration and industry officials.

Among congressional Republicans, the decision has raised concerns. "If the program costs more than it brings in, the secretary would be able to divert money intended for other programs," Republicans on the Senate Budget Committee warned.

Whether the new regulations will be sufficient to control rates remains unclear.

America's Health Insurance Plans, the industry's Washington-based lobbying arm, welcomed the administration's move, saying in a statement that the regulations "provide important clarity about how these insurer-financed programs will work as health plans prepare their rates for 2015."

In a note to investors this week, J.P. Morgan also noted that the new rules "should improve stability of the exchange market."

But some insurers continue to warn of bigger increases. Larry Levitt, an insurance expert at the nonprofit Kaiser Family Foundation, cautioned that some consumers may still be in for sticker shock.

"Premium hikes will likely be modest in much of the country," he said. "But probably not everywhere."

BNA Bloomberg
Health Care
BLOG

Thursday, June 19, 2014

Insurers Expect $1 Billion in Risk Corridor Payments, Committee Finds

by Sara Hansard

The Affordable Care Act includes several provisions to keep premiums stable if health insurers end up with sicker-than-expected enrollees. Congressional Republicans have charged this could lead to a "bailout" of insurers, and they say the Obama administration doesn't have legal authority to make payments under the program without explicit congressional appropriations, something the Republican House may not provide.

At a June 18 hearing of a House Oversight and Government Reform subcommittee, Rep. Jim Jordan (R-Ohio) released data compiled by committee staff showing that insurers covering three-quarters of enrollees in the ACA marketplaces expect to collect payments under the risk corridors program, which the administration initially said would be budget-neutral. "The total taxpayer bailout could in fact well
exceed $1 billion this year alone," said Jordan, chairman of the Economic Growth, Job Creation and Regulatory Affairs Subcommittee.

June 19, the House Energy and Commerce Committee released a June 18 letter from Department of Health and Human Services Secretary Sylvia Burwell saying that the HHS has the authority to collect user fees from insurers that participate in the ACA marketplaces and make payments under the risk corridors program.

Mr. PITTS. On our panel today, we have three witnesses.

Let me introduce them in the order that they will testify. First, Dr. Stan Veuger, Resident Scholar, American Enterprise Institute; Dr. John Hoadley, Research Professor, Georgetown University; and Mr. Edmund Haislmaier, Senior Research Fellow at the Heritage Foundation.

Thank you very much for coming. We appreciate your time very much. Your written statements will be made a part of record. You will each have 5 minutes to summarize your testimony.

And Mr. Veuger, we will start with you. You are recognized for 5 minutes for your opening statement.

STATEMENTS OF STAN VEUGER, RESIDENT SCHOLAR, AMERICAN ENTERPRISE INSTITUTE; JACK HOADLEY, RESEARCH PROFESSOR, GEORGETOWN UNIVERSITY; AND EDMUND F. HAISLMAIER, SENIOR RESEARCH FELLOW, THE HERITAGE FOUNDATION

STATEMENT OF STAN VEUGER

Mr. VEUGER. Mr. Chairman, Mr. Ranking Member, members of the committee, first of all, I would like to thank you for giving me the opportunity today to discuss health insurance plan cancellations and material changes pursuant to the Patient Protection and Affordable Care Act.

When Obamacare became law 4 years ago, a central claim made by proponents of this—informative insurance reform was not just, it would make some better off through redistribution of resources and more stringent regulation, but would do so without harming others, except perhaps through new forms of income and capital taxation. This claim was presented to the public by President Obama, by many other prominent Members of the Democratic party, by the full committee's ranking member just now, in colloquial terms, such as, if you like your plan, you can keep it; if you like your doctor, you can keep him, period. The problem with that promise was that it is not true, and I will discuss a few of the sort of more salient consequences of the legislation that undermine the veracity of that claim.

Upfront in a certain sense, no one has been able to keep its 2010 plan, even if he or she liked it. Health insurance policies are no longer allowed to contain limits on lifetime reimbursements, for example. That may be a popular provision, but of course, it drives up the cost of health insurance policies. To say, in a very narrow sense, the claim "you could keep your plan if you liked it" is completely false.

More central to the discussion today, I think, are plans that have incorporated some of the sort of more popular provisions, you know, a ban on adjusting for preexisting conditions, or the lifetime reimbursements, the annual limits, but it is about mostly the plans that are still being used and paid for.

First, what I want to note is, by now, I think everyone realizes that in the individual market, millions of people who started out buying insurance there received cancellation notices announcing the ends of their current plans last year, and it may well be as

many as 9 million people end up losing the plans they had before the Affordable Care Act passed.

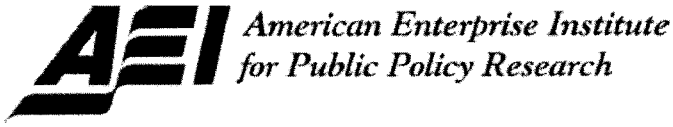
It doesn't stop there, though. A much larger group of Americans enjoy employer-based health insurance, a total of about 170 million people. And many of those plans will change or disappear as well. Of these plans, there are about—of these covered workers, about 18 percent were for firms that were smaller than 50 employees and will not be subject to the employer mandate to purchase health insurance when it kicks in, if it ever kicks in. In total, there is about 35 to 40 million covered workers who work for firms with fewer than 100 employees. They are in so-called small groups plans. The remaining 130 to 135 million covered workers work for larger employers, and many of those self-insure.

All of those plans are affected in different ways by the new Obamacare regulations. The most obvious way in which that happens is very similar to what happened in the individual market. Many fully insured plans that have changed a little bit since the law was passed no longer enjoy grandfather status, and so the firms that used to offer them will now be forced to purchase plans that are subject to new requirements regarding benefits and premiums. The plan covers some 30 million workers in the small group market, about 75 percent of workers in medium-sized firms, and some 20 percent of large firms. In total that is about 45, 50 million people. How large a change is introduced here is hard to assess on an aggregate basis because all of these plans are different, and it is unclear to what extent they will be materially affected by the new requirements.

What we do know, as I said, is that there are—only very few plans are shielded from new rules and regulations due to their grandfathered status. There are other less direct reasons why, even in large firms that self-insure, workers will be affected. For example, even at those firms, the cost of plans will increase due to new taxes like the reinsurance fee, and the Cadillac tax when that arrives. So even though when millions of people receive their cancellation notices from the individual market, the administration claims that that will be it, you know; it is a small, tiny portion of the population, and everyone else is shielded. That is certainly not true, and there will be dozens of millions, if not more, people who will see their plans change whether they like it or not. Thank you.

Mr. PITTS. The Chair thanks the gentleman.

[The prepared statement of Mr. Veuger follows:]



Statement before the Committee on Energy and Commerce
Subcommittee on Health

Even If You Like Your Plan, You May Well Lose Your Plan. And Even If You Like Your Doctor, You May Well Lose Your Doctor.

Stan Veuger
Resident Scholar
American Enterprise Institute
July 28, 2014

The views expressed in this testimony are those of the author alone and do not necessarily represent those of the American Enterprise Institute for Public Policy Research.

The Patient Protection and Affordable Care Act (PPACA), commonly referred to as Obamacare, became law on March 23, 2010, after extensive discussion and argument. A central claim made by proponents of this most transformative social engineering project in decades was that it would not just make some better off through redistribution of resources and more stringent regulation, but that its key components would be Pareto improvements, helping some without harming anyone else. This claim was presented to the public by President Obama and many other prominent members of the Democratic party in more colloquial terms such as "If you like your plan, you can keep it. If you like your doctor, you can keep him. Period."[1]

The problem with this claim is that it does not correspond to some fairly obvious features of the empirical reality surrounding us as shaped by Obamacare. I will discuss a few of the more salient consequences of the legislation that undermine its veracity. I will first discuss changes in the individual market for health insurance that have forced people to forfeit the insurance plans and/or doctors they previously had, and then I will focus on the market for employer-provided health insurance, where existing plans will also be canceled and/or changed materially in the near future.

Note that in a certain sense, no one has been able keep his plan, even if he or she liked it. Health insurance policies are no longer allowed to contain limits on lifetime reimbursements, for example. This ban may be a popular one, but it is certainly not a costless one. In this very narrow sense, then, the claim that you could keep your plan is almost completely false. But more central to the public debate today are plans that have incorporated some of these changes, and are still being used and paid for. How will those be affected by upcoming regulatory changes introduced by the PPACA? How many people will be affected by these changes to their current plans?

It has by now become well-known that millions of people who buy insurance on the individual market have received cancellation notices announcing the end of their current plans. Even professor Jonathan Gruber of the Massachusetts Institute of Technology, one of Obamacare's chief architects, has recognized this fact, indicating that as many as 9 million people may end up losing out due to the new regulations imposed on the individual market relating to, among other plan features, minimal essential benefits and community rating requirements.[2] Professor Gruber also claimed that that would be it: that the overwhelming majority of Americans, those who receive health insurance from their employers or the government (see Table 1), would not be affected.

Table 1 shows that the majority of Americans enjoy employer-based health insurance, a total of 170.9 million people.[3] Despite claims to the contrary, many of the plans providing these workers with health insurance will also undergo significant changes, or even disappear. Of these covered workers, 18.3%

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[1] See, among many other sources: Chait, Jonathan, "'If You Like Your Plan, You Can Keep It.' Well, Not Exactly," New York Magazine, October 29, 2013, http://nymag.com/daily/intelligencer/2013/10/you-like-your-plan-you-can-keep-it-sort-of.html.

[2] Lizza, Ryan, "'Obamacare's Three Per Cent," The New Yorker, October 30, 2013, http://www.newyorker.com/online/blogs/newsdesk/2013/10/obamacares-three-per-cent.html.

[3] DeNavas-Walt, Camen, Proctor, Bernadette D., and Jessica C. Smith, "Income, Poverty, and Health Insurance Coverage in the United States: 2012," U.S. Department of Commerce, Economics and Statistics Administration, U.S. Census Bureau, Current Population Reports, September 2013."

work for firms with fewer than 50 employees that are not subject to the employer mandate to purchase health insurance (see Table 2). In total, about 35-40 million covered workers work for firms with fewer than 100 employees and receive so-called small-employer plans. The remaining 130-135 million covered workers work for larger employers, many of which self-insure instead of purchasing full insurance plans from insurance companies. All of these plans are potentially affected by Obamacare regulations, in a variety of ways.

The most obvious way in which some of these plans will be affected is similar to what has occurred in the individual market. Many fully insured plans that do not have so-called grandfathered status, because they have changed beyond the minimal limits allowed by Obamacare since 2010, are subject to new requirements regarding benefits and premiums. These plans cover some 25-30 million workers in the small-group market, about 75% of medium-sized firms (100-499 workers), which employ some 20 million workers, as well as about 20% of large firms (over 500 workers), which account for millions more.[4] How large the changes introduced here will be is hard to assess on an aggregate basis, but what we do know is that only about a quarter of small-employer plans and a minority of medium and large-employers plans are shielded from such changes thanks to their grandfathered status (see Table 3, mid-range estimates for 2014). Even fewer of these plans will be protected from cancellation by the time the employer mandate tax is implemented, in 2015 and 2016.

There are other, less direct reasons why workers, even at large firms that self-insure, are likely to see changes in their plans. For example, even at these firms, the cost of plans will increase due to new taxes like the reinsurance fee and the Cadillac tax. In a sense, no one will be able to keep the plan he had in 2010. But even if we accept this promise as a non-literal one implying that plans will not undergo material changes, it is clear that there may well be an order of magnitude more people who will see their plans canceled or changed materially than the administration is now willing to admit.

There is a variety of ways to keep this from happening. One way would be to enact H.R. 3522, the "Employee Health Care Protection Act of 2013," which would give insurance companies that offered plans in 2013 to continue to provide coverage under grandfathered protection. Repealing the employer mandate tax – and, to repair some of the damage done in the individual market, the individual mandate tax – would be an effective repair mechanism as well. Repealing the employer mandate tax would have the added benefit of reducing job lock by decoupling health insurance and employment.

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[4] U.S. Department of Health and Human Services "Report to Congress on a Study of the Large-Group Market," March 31, 2011.

Table 1. Coverage Rates by Type of Health Insurance

Coverage Type	2011	2012
Any Private Plan	63.9%	63.9%
Any Private Plan Alone	52.0%	52.0%
Employment-based	55.1%	54.9%
Employment-based Alone	45.1%	44.8%
Direct-purchase	9.8%	9.8%
Direct-purchase Alone	3.6%	3.6%
Any Government Plan	32.2%	32.6%
Any Government Plan Alone	20.4%	20.7%
Medicare	15.2%	15.7%
Medicare Alone	4.9%	5.4%
Medicaid	16.5%	16.4%
Medicaid Alone	11.5%	11.3%
Military Health Care	4.4%	4.4%
Military Health Care Alone	1.3%	1.3%
Uninsured	15.7%	15.4%

From Table 8 in "Income, Poverty, and Health Insurance in the United States: 2012," Census Bureau, September 2013. Rates are for people as of March of the following year.

Table 2. Distribution of Employers, Workers, and Workers Covered by Health Benefits, by Firm Size, 2013

	Employers	Workers	Covered Workers
3-9 Workers	60.8%	8.2%	3.6%
10-24 Workers	24.1%	9.5%	7.8%
25-49 Workers	8.0%	7.3%	6.9%
50-199 Workers	5.6%	13.6%	13.8%
200-999 Workers	1.3%	13.3%	15.2%
1,000-4999 Workers	0.2%	13.0%	15.7%
5,000 or More Workers	0.1%	35.0%	36.8%

Statistics from Exhibit M.2 from the Kaiser Family Foundation's Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2013.

Table 3. Estimates of the Cumulative Percentage of Employer Plans Relinquishing their Grandfathered Status under the ACA

	2011	2012	2013	2014	2015	2016	2017	2018
Low-end estimate								
Small employer plans	20%	36%	49%	59%	67%	74%	79%	83%
Large employer plans	13%	24%	34%	43%	50%	57%	62%	67%
All employer plans	15%	28%	39%	48%	56%	62%	68%	73%
Mid-range estimate								
Small employer plans	30%	51%	66%	76%	83%	88%	92%	94%
Large employer plans	18%	33%	45%	55%	63%	70%	75%	80%
All employer plans	22%	39%	53%	63%	71%	77%	82%	86%
High-end estimate								
Small employer plans	42%	66%	80%	89%	93%	96%	98%	99%
Large employer plans	29%	50%	64%	75%	82%	87%	91%	94%
All employer plans	33%	55%	70%	80%	86%	91%	94%	96%

Estimates and forecasts based on Table 3 in Federal Register Vol. 75, No. 116, Thursday, June 17, 2010 - Rules and Regulations. Small employers are those with 3-99 full-time employees; large employers are those with 100 employees or more.

Mr. PITTS. Now the Chair recognize Dr. Hoadley 5 minutes for an opening statement.

STATEMENT OF JACK HOADLEY

Mr. HOADLEY. Thank you, Mr. Chairman. Thank you, Ranking Member, members of the committee.

My name is Jack Hoadley I am a research professor at Georgetown University's Health Policy Institute, and I do appreciate the opportunity to speak to the committee on issues relating to risk corridors in the Affordable Care Act. There have been two times in recent history when Congress has introduced new health insurance programs.

In 2003, the Medicare Modernization Act created the Medicare Part D prescription drug program. In 2010, the Affordable Care Act created the program of health insurance exchanges that operates as part of a broader initiative to extend health insurance coverage. In both cases, Congress was building a new kind of insurance program not previously in operation. Also, in both cases, policymakers were uncertain about how many plans would choose to participate in the new program and how many Americans would sign up for coverage offered by these plans. Specifically, policymakers were concerned that plans would be less likely to participate when they were unsure of how many enrollees they might attract and of the health status of the enrollees that they did obtain. If the plans did participate, they would likely set higher premiums to reflect these uncertainties.

To address these uncertainties the Congress in both the Medicare Modernization Act and the Affordable Care Act included a set of risk mitigation measures, risk adjustment, reinsurance, and risk corridors, sometimes called the 3Rs. These measures were designed to help the new markets run more predictably, by encouraging entry of insurers in the new insurance markets and stabilizing premiums as the programs got started.

Here is a quick review of the 3Rs. Risk adjustment is a way to adjust payments to plans based on the health status of the individual enrollees of each plan. The idea is to make sure plans and their enrollees are not penalized if enrollees are sicker than average or rewarded if healthier than an average enrollees coming into the program. Effective risk adjustment also deters plans from trying to avoid being chosen by people with more health risk.

Reinsurance is a means of insuring the insurers by providing extra payments of an excessive number of their enrollees incurring usually high cost, such as having more accidents, or more cancer diagnoses than the average plan. As with risk adjustment, the intent is to make sure plans are not penalized or rewarded based on how many high-class people they enroll and reduce incentives to avoid high-cost individuals.

Risk corridors, sometimes referred to as risk sharing, involves creation of a fund so that plans with unusually high gains pay back some of those gains and those with unusually high losses are partially compensated. The idea is to keep premiums affordable and to reduce the risk base by plans during the first years of a program, as the plans learn from experience about how to price themselves accurately.

The risk corridors in both programs are designed on a two-sided basis to limit both health plan losses and gains. If plans underestimate cost, they receive payments from the Government to reduce but not eliminate the loss. If they overestimate cost, they make payments to the Government to reduce, but again, not to eliminate the gain. Thus, all plans maintain a share of the risk for any losses and retain an incentive to set premiums as accurately as possible.

These risk mitigation measures have been in use for Part D for 9 years now. So have they worked in Part D where we have had time to look at the data? The best measure of their success is that participation by both health plans and Medicare beneficiaries is still robust in the program's ninth year and the program is popular with both plans and enrollees. Among the stand-alone Part D plans in 2011, risk adjustment scores range from 72 percent to 146 percent of the average plan score. Without risk adjustment, the plans at the high end would have either suffered significant loses or been forced to charge much higher premiums. The opposite would have been true on the low end.

Reinsurance payments for Part D plans averaged about $40 per member per month in 2012. As such, they helped discourage plans from trying to avoid enrollees with unusually high drug costs.

In contrast to the idea that risk corridors are bailing out plans, the experience of Part D suggests they have actually protected taxpayers. In each of the program's first 7 years, plans made net payments back to the Government as a result of greater profits than expected from their bids as opposed to receiving payments from the Government. In 2012, the most recent year for which data are available, Part D plans paid a total of $1.1 billion back to the Government. And in 2012, three-fourths of all Part D plan sponsors made payments back to the Government. In fact, and perhaps contrary to what some expected, the risk corridors in Part D have been protecting the Government from excessive profits by health plans as opposed to protecting health plans against pricing too low.

The 3Rs continue to operate in Part D. In the Affordable Care Act, two of them risk corridors and reinsurance, are designed as short-term measures that will go away after 2016. Although one could argue that the role of risk corridors in reinsurance could be reduced or eliminated in Part D after 9 years, we can make a good case for the significant role they have played in establishing a functional, sustainable, and robust market. The Part D experience also demonstrates that risk corridors protect the program from uncertainly both in the first years and beyond.

Mr. PITTS. The Chair thanks the gentleman.

[The prepared statement of Mr. Hoadley follows:]

Risk Corridors and Other Risk Mitigation Measures in the Affordable Care Act: Lessons from Medicare Part D

Statement of

Jack Hoadley, Ph.D.

Research Professor

Health Policy Institute, Georgetown University

Before the

Subcommittee on Health

House Committee on Energy and Commerce

July 28, 2014

Good afternoon, Mr. Chairman and Members of the Committee. My name is Jack Hoadley, and I am a Research Professor at Georgetown University's Health Policy Institute. I am a long-time student of health policy, and I have published a wide variety of papers on Medicare, Medicaid, and private health insurance programs. I appreciate the opportunity to speak to the Committee on issues relating to risk corridors in the Affordable Care Act.

Two times in recent history, the Congress has introduced new health insurance programs. In 2003, the Medicare Modernization Act created the Medicare Part D prescription drug program. In 2010, the Affordable Care Act (ACA) created the program of health insurance exchanges as part of a broader initiative to expand health insurance coverage. In both cases, Congress was building a new kind of insurance program not previously in operation. Also in both cases, policymakers were uncertain about how many health plans would choose to participate in the new program and how many Americans would sign up for the coverage offered by these plans. Other uncertainties

included the cost of delivering benefits, the mix of enrollment by health status, and the ongoing stability of the program in the early years. Furthermore, policymakers were concerned that these uncertainties would reinforce each other. Plans would be less likely to participate when they were unsure of how many enrollees they might attract and the health status of these enrollees. If they did participate, they would likely set higher premiums to reflect the uncertainties.

To address these uncertainties, the Congress in both the Medicare Modernization Act and the Affordable Care Act included a set of risk mitigation measures: risk adjustment, reinsurance, and risk corridors – sometimes called the "3 Rs." These measures were designed to help the new markets run more predictably by encouraging entry of insurers in the new insurance markets and stabilizing premiums as the programs got started.

Here is a quick review of the "3 Rs." **Risk adjustment** is a way to adjust payments to plans based on the health status of a plan's enrollees. The idea is to make sure plans and their enrollees are not penalized if their enrollees are sicker than average or rewarded if they are healthier than average coming into the program. Effective risk adjustment also deters plans from trying to avoid being chosen by people with more health risks. Risk adjustment is a permanent part of both Medicare Part D and the ACA's insurance system.

Reinsurance is a means of insuring the insurers by providing extra payments if an excessive number of their enrollees incur unusually high costs, such as having more accidents or more cancer diagnoses than average. As with risk adjustment, the intent is to make sure that plans are not penalized or rewarded based on how many high-cost people they enroll and to reduce incentives to avoid high-cost individuals. In Medicare Part D, plans receive reinsurance payments to cover most of a beneficiary's drug claim costs above a specified annual dollar threshold. These payments are figured into the overall level of federal payments to the drug plans so that overall federal costs are

not increased. In the ACA, money is collected from plans to fund a reinsurance pool. Payments are adjusted to ensure that the program remains budget neutral. The ACA reinsurance program expires after 2016, whereas the law did not call for an end to reinsurance in the Medicare Part D program.

Risk corridors (or **risk sharing**) involve creation of a fund so that plans with unusually high gains pay back some of those gains and those with unusually high losses are partially compensated. The idea is to keep premiums affordable and to reduce the risk faced by plans during the first years of the program as they learn from experience how to price their plans accurately. The risk corridors in both programs are designed on a two-sided basis to limit both health plan losses and health plan gains. If plans underestimate costs, they receive payments from the government to reduce, but not eliminate, the loss. If plans overestimate costs, they make payments to the government to reduce, but not eliminate, the gain. In the ACA risk corridor system, which expires after 2016, health plans retain all gains or losses if claims are within 3 percent of expected spending. If actual claims exceed expectations by more than 3 percent, the federal government reimburses 50 percent of the loss between 3 percent and 8 percent or 80 percent of any loss exceeding 8 percent. Similarly, the health plan pays the federal government 50 percent of gains between 3 percent and 8 percent and 80 percent of any gains over 8 percent. Under this design, all health plans maintain a share of the risk for any losses and thus retain an incentive to set premiums as accurately as possible.[1]

These risk mitigation measures have been in use for Part D for nine years. So how have these measures worked in Part D?[2] The best measure of their success is that participation by both health plans and Medicare beneficiaries is still robust in the program's ninth year, and the program is popular with both plans and enrollees. Although the science of risk adjustment is imperfect, the risk

[1] Cori Uccello, Statement before the House Committee on Oversight and Government Reform, Subcommittee on Economic Growth, Job Creation and Regulatory Affairs, June 18, 2014.
[2] Jack Hoadley, "How the '3 Rs' Contributed to the Success of Medicare Part D," CHIRBlog, January 27, 2014, http://chirblog.org/how-the-3rs-contributed-to-the-success-of-part-d/

adjusters have been refined since the program's start. Among the standalone Part D plans in 2011, risk-adjustment scores ranged from 72 percent to 146 percent of the average plan score. The plans at the high end would either have suffered significant losses or been forced to charge much higher premiums in the absence of risk adjustment. The opposite would have been true on the low end; the plans with the lowest-risk enrollees would have been paid far more than their actual claims costs. Reinsurance payments in 2012 for Part D plans averaged about $40 per member per month; as such, they helped discourage plans from trying to avoid enrollees with unusually high drug costs.

In contrast to the idea that risk corridors are solely a means of bailing out plans, the experience in Part D suggests that they have actually protected taxpayers. In each of the program's first seven years, plans as a whole made net payments back to the government as a result of greater profits than expected from their bids, as opposed to receiving payments from the government. In 2012, the most recent year for which data are available, the plans paid $1.1 billion back to the government. Overall, three-fourths of all Part D plan sponsors, representing a similar share of Part D enrollees, made payments back to the government. In effect, and perhaps contrary to what some have expected, the risk corridors in Part D have been protecting the government from excessive profits by health plans as opposed to protecting health plans against pricing too low.

All of the "3 Rs" continue to operate in Part D. But in the Affordable Care Act, two of them (risk corridors and reinsurance) were designed as short-term measures that will go away after 2016 after the Marketplaces have been in place for three years. Although one could argue that the role of risk corridors and reinsurance could be reduced or eliminated in Part D after nine years, there is a good case that can be made for the role they played in establishing a functional, sustainable and robust market. The Part D experience also demonstrates that risk corridors have protected the program from uncertainty both in its first years and beyond.

Mr. PITTS. Now the Chair recognizes Mr. Haislmaier, 5 minutes for an opening statement.

STATEMENT OF EDMUND F. HAISLMAIER

Mr. HAISLMAIER. Thank you, Mr. Chairman.

My name is Edmund Haislmaier. I am a senior research fellow in health policy at the Heritage Foundation, and thank you for the opportunity to testify before you and the committee today. The comments are my own and not reflecting any institutional position.

As I addressed in my prepared testimony, I think what we need to do is step back for a minute and look at these three programs, and understand that these are different tools for different purposes. If you have a mechanic or a builder who is doing work for you, they are going to have a toolbox full of things, you know, hammer, screw driver, pliers. They will use different tools depending on what the job is. And so I would like to follow up on Dr. Hoadley's comments by simply clarifying for the committee what I see as the different tasks that each of these three are designed to address.

The reinsurance provision is essentially designed to address the kind of risk that we might call market selection risk. In other words, you have a choice between markets. This is true of people who are insured and uninsured. I won't go into great length, but suffice it to say that it is premised on the idea that the way this legislation is designed and works, there is an expectation that more people in poorer health status will gravitate towards this market, and therefore, it taxes the existing market, principally the employer market, and transfers the funds to subsidize the new individual or the expanded individual market on that market selection risk expectation.

The second program, risk adjustment is, as Dr. Hoadley pointed out, really about individual selection risk. I mean, everything could be fine with the market otherwise, but we still don't know when people have the ability to pick and choose a plan, as all of you do, in the Federal employee program, who is going to pick what kind of coverage. There are a lot of things that might influence people's decision, and the concern is, you don't want insurers to try to avoid people who are sicker and whatnot. So there is a risk adjustment mechanism. This is not new. This is, as Dr. Hoadley points out, has been around before elsewhere.

The third, and the one that is the subject really of your hearing, is the risk corridor program. And the question that I would ask is, well, what is the risk that this is designed to address? Because it was observed that this was designed to hold down premiums. Well, no, it is not really designed to hold down premiums, necessarily. It is not designed to make the market balance out. It is not designed to spread the risk evenly across the market. That is what the other two are there for. What is this one here for? Well, this is a profit and loss risk. This is saying we don't know, and neither do you, the insurers, what the real price for this product is going to be, and we could be—and we are paying for most of it, and that was the significance of Part D—they were paying for three-quarters of it. We and you could be wildly off the mark. So what they do is the Government, which is paying three-quarters of it, in effect, has a

profit and loss sharing arrangement through risk corridors with the insurers.

Now, did that make sense in Part D? I think it did. Why? Because it was an entirely new product, providing comprehensive prescription drug coverage on a standalone basis had not been done before. There was no really relevant or suitable example for insurers to work off of, because yes, there was prescription drug coverage in the employer group market but that was integrated. It wasn't standalone, and non-elderly people consume drugs at one-fifth the rate that elderly do. So there was a lot of uncertainty surrounding that.

Now, when we look at this, Dr. Hoadley is right, that was a new program, but my point is, Part D was also a new product. When we look at this, we see that it is a new program, but the product is a very old one. It is just being tweaked. So, at the end of the day, I am not sure that there is really a rationale for this kind of profit and loss sharing, when in fact, it is not hard for the insurers to get within a tolerable rate.

Finally, I would point out that given that the transfer of funds that is going on in the reinsurance program is more than adequate to cover even some very egregious over-underestimation of premiums. If you look at the magnitude of the funds being transferred relative to the size of the market, you are looking at a market that, in 2014, was $28 billion and you are going to dump another $10 billion potentially into it in 2014 in reinsurance programs. That is a huge amount of money relative to the size of the market, even if you assume that the PPACA doubles that market, it is still pretty substantial.

So I think that those programs, the other two programs, are more than adequate for the risks that are in the new program, and that it really isn't necessary to have the risk corridor program. Thank you.

Mr. PITTS. The Chair thanks the gentleman and thanks all of the witnesses for their testimony.

[The prepared statement of Mr. Haislmaier follows:]

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CONGRESSIONAL TESTIMONY

Risk Corridors in the Patient Protection and Affordable Care Act

Testimony before
Committee on Energy and Commerce
Subcommittee on Health
United States House of Representatives

July 28, 2014

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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Mr. PITTS. I will begin the questioning, and recognize myself 5 minutes for that purpose.

Mr. Haislmaier, should taxpayers be concerned that they will be liable for some insurance company losses under the ACA risk corridor program, and please explain?

Mr. HAISLMAIER. Well, the issue, Mr. Chairman, is that, unlike the risk reinsurance program, which is a definitive set amount of money, or the risk transfer program, which is required to operate on a neutral basis, meaning it doesn't spend more than it takes in or it doesn't transfer more than it takes in, this program is not explicitly required to operate on that basis, and therefore, yes, that is a concern that the taxpayers should have.

Mr. PITTS. The Congressional Research Services, American Law Division, issued a memo questioning the ability of the administration to make payments under the risk corridor program for lack of quote, "valid appropriation," end quote. Now, since it is Congress' job to make law and the President's job to implement law, and if the law needs to be changed, it is our job to change it, not his. Given that the administration has tried to rewrite the healthcare law over dozens of times through regulations and Executive Orders, and delays, and so forth, should taxpayers be concerned that the administration will once again ignore the rule of law to prop up the President's healthcare law?

Mr. HAISLMAIER. Well, I think the administration has taken different positions at different times on this particular provision. I believe at one point, they said they would operate on a budget-neutral basis, and then said they wouldn't. So yes, if there is ambiguity then, yes, Mr. Chairman, you know, that is Congress' job to clarify the ambiguity.

Mr. PITTS. Thank you.

Dr. Veuger, at the end of 2013, millions of Americans received notices from health insurers that they would be unable to renew their health coverage under the ACA. Many supporters of the law implied that this problem was restricted only to the individual market and would not affect employer-sponsored coverage. Would you clarify for us whether American workers could be subject to nonrenewals by employer-sponsored plans, often known as plan cancellations, under the Affordable Care Act?

Mr. VEUGER. Thank you, Mr. Chairman, yes. Many American workers will indeed be subject to nonrenewals, as I described with a bit more detail in my written testimony. There will be tens of millions of workers in small group plans that will see those plans being phased out, as very few of them, actually, will continue to have grandfather status by the time the employer mandate kicks in.

The administration sort of mid-range estimate was that, by 2016, 88 percent of all insurance small employer plans will have lost grandfather status, so all of those plans would in principle receive the same treatment that individual market plans received last year. So they will be canceled. The process would go through the employer, not the individual, so it may be slightly less salient, but it would certainly be the same fate that so many plans in the individual market had. And I find it surprising, honestly, that so many supporters of the law after being caught not being able to live up

to the, "if you like your plan, you can keep your plan" promise on the individual side decided to continue with the same story for these plans that will ultimately suffer the same fate.

Mr. PITTS. Some advocates of the ACA said they were surprised about the plan cancellation issue at the end of 2013. Wasn't a central feature of the ACA to impose Federal requirements that many plans simply did not meet? So should anyone have been surprised about the plan cancellation issues on the ACA?

Mr. VEUGER. Certainly not, because, to some extent, beyond a lot of income redistribution, one of the central goals of the legislation was precisely to impose new requirements on as many plans as possible. Some of those requirements are very popular among the general public. Some of the community rating features, for example, much less so. But it was definitely always the intention of the imposed new rules and regulations, and to some extent, it shows how insincere the promise was.

Mr. PITTS. My time is expired. The Chair now recognizes the ranking member, Mr. Pallone 5 minutes for questions.

Mr. PALLONE. Thank you, Mr. Chairman.

I wanted to say at the outset that risk corridors are mechanisms used in all kinds of insurance systems, and this wouldn't even be controversial if it wasn't part of the ACA. So it just bothers me that any time anything that is part of the ACA, no matter how normal it is, it just becomes controversial in an effort by the Republicans to destroy the ACA.

The driving principle behind the risk corridor bills we are considering today is that they will cost taxpayers more or cost taxpayers money. Republicans don't have any evidence though that this will happen, but they figure if they can scream "bailout" enough times, it must just seem true. But the Congressional Budget Office and the experience of Part D show just how silly the claims are. When the Congressional Budget Office looked at risk corridors recently, they said the collections from insurers would be $8 billion greater than payouts from the Government. And that means that the program would save taxpayers $8 billion in just 3 years, and that is not even counting the savings on premiums and premium tax credits. The administration has since made clear that they will implement the program in a budget-neutral fashion, and CBO has since confirmed that the program will be budget neutral.

So I just want to ask Dr. Hoadley, were there concerns that the Medicare Part D risk corridors would cost taxpayers money, and what can you tell us about their actual impact on taxpayers? And what does that tell us about the impact of the ACA risk corridors?

Mr. HOADLEY. The experience in Part D, I think when the law was originally drafted, it was done as a symmetric kind of thing. If the ability of plans to estimate premiums accurately could be wrong in either direction, the experience in fact, as I mentioned in my testimony, is that every single year for which we now have data, which is the first 7 years of the program, plans have actually paid—made payments back to the Government. And I think if you add up all of those figures across the 7 years, we are talking about a total of about $8 billion that have been made from plans back to the Government. So it really has represented a protection to the taxpayer in the way it has played out in Part D.

Mr. PALLONE. And again, you know, that is why I think this Republican bailout argument is just flat wrong, and it is a waste of this committee's time. And the Republicans just don't have the facts on their side.

Dr. Hoadley, the ACA and the Medicare Part D both have risk corridor programs. They seem very similar to me, but again, my Republican friends seem to hate the ACA program and love the Part D program, which seems so inconsistent. They claim that the ACA risk corridors are a bailout, but the Part D risk corridors have actually made the Government money, and they are more generous to insurers than the ACA program is. And of course, the Part D risk corridors are permanent; whereas the ACA risk corridors will only last for 3 years. I mean, all of this, again, to the point that this is something that would not be controversial at all if it wasn't part of the ACA.

Can you say more about the similarities and differences between the ACA and the Part D risk corridors, and are these programs fundamentally different?

Mr. HOADLEY. No, I think you have really highlighted the different ways in which they are similar. The biggest difference probably is that the risk corridor program in the ACA is time limited, and it is only designed to operate for 3 years. And Part D, it was set up for an initial—I think, it was 3 years at a fairly broad corridor, then it was tightened down to be a little bit of a narrower corridor for the next 3 years, and then CMS has had the authority to eliminate the risk corridors after 6 years, but has chosen to keep them in operation; felt that they were still proving a value, and you can kind of see the value even potentially right now with some of the uncertainties around some of the new drugs that are on the market. And it is that kind of uncertainty that those risk corridors are designed to do.

The same system really applies in the ACA. As long as we have a lot of uncertainty about how the program might operate, there is an interest in protecting, in both directions, protecting the Government from errors made in one direction in setting premiums, protect the plans in the other direction if that is the way it works out.

Mr. PALLONE. Yes, the Republicans claim that the ACA risk corridors are not just bad policy; they say they are illegal. And I suppose it is not a surprise, since they are currently wasting taxpayer dollars to sue the President, and they seem to have designs on impeaching him as well. The Department of Health and Human Services has provided the committee with specific answers to questions about its legal authority to implement the risk corridor program. The law authorizes the collection and payment of user fees to and from health insurers to operate the risk corridor program that aligns with OMB and GAO guidance. Bottom line is, the ACA is the law of the land, and this should not be a controversial program, Mr. Chairman.

Mr. PITTS. The gentleman's time is expired. The Chair thanks the gentleman.

I now recognize the gentleman from New Jersey, Mr. Lance 5 minutes for questions.

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

I am the sponsor of the legislation to repeal risk corridors, and I do this because I believe it is bad public policy. And I certainly do not do it as a matter of some sort of intellectual exercise. And I am deeply concerned about it.

Mr. Haislmaier, would you go into a little greater detail as to why you believe there is a difference between this program and the program designed roughly a decade ago for Medicare Part D.

Mr. HAISLMAIER. Well, essentially, the risk corridor program is a deal between the Government and the insurer that says we share the profits and we share the losses. It is, you know, you see commercial deals like that between two parties all the time as a joint venture. The question in my mind is, is that appropriate in each of these cases? I think a stronger argument can be made that that is appropriate in the case of Medicare Part D than can be made here. And I base it on the following: In Medicare Part D, the insurers were being asked to do something they had never done before in a market they didn't understand, with a totally new product. It was not only a new market; it was a new product. The customers had never bought anything like that, et cetera. That is a very different world than the world in which these were applied in the PPACA, where you essentially are making some adjustments to a market that has been around for decades, the individual coverage market, and yes, the Government is adding some subsidies for some people to that. But this really isn't a huge departure from business that the insurers have been in for years. And so the question is, should the taxpayer be at that point involved in profit and loss on that market, or is that just a normal level, albeit maybe somewhat elevated, but a normal level of profit and loss risk that private actors bear all the time? And I think that is the latter.

Mr. LANCE. Thank you.

And certainly, I am willing to give the other panelists time to respond to my question.

Dr. Hoadley.

Mr. HOADLEY. I mean, I would actually argue that the uncertainty in some ways was greater in the Affordable Care Act than in the health insurance marketplaces. In the Medicare Part D program, the insurance was over prescription drugs. People's use of prescription drugs from one time period to the next is rather stable, rather predictable in most cases, whereas the need for a broader health insurance is much more volatile.

This was also a market in the ACA that was with some of the same questions we had in Part D: Who will enroll? Will the number of people we think will enroll, will that actually be the set of people? Will there be pent-up demand? Are there people who have been, in the case of Part D, you know, going without certain prescription drugs who are now going to start taking them? Are there people, in the ACA case, who have been going without treatment now who are going to come in for treatment? It is those kinds of uncertainties that make it hard for an insurance company to set premiums, and the value of having a reinsurance——

Mr. LANCE. My own view on that is that this is similar to what existed at a prior time. I suppose that is debatable. But it is only for a limited period of time, and there may be, if I am understanding what you are saying, a volatility for some time. I agree

with what Mr. Haislmaier, has said. Obviously, significant legislation is to be debated, and I respect the views of all who are interested in it.

I do want to assure the public that my sponsorship of this legislation is based upon my deeply held beliefs that risk corridors should not be permitted in this situation.

Now, regarding the appropriations issue. Medicare Part D includes the risk corridor program, and it includes a source of funds for the program. But as I read the healthcare legislation, that is not the case. And based on a lack of appropriation, it is my legal judgment that the administration cannot make payments to cover insurance company losses under the risk corridor program. This issue is further explained by a recent memorandum compiled by the Congressional Research Service, and I would like to submit it for the record.

Mr. PITTS. Without objection, so ordered.

Mr. LANCE. Thank you. I only have 15 seconds. Let me say that, in December, I asked the Secretary of Health and Human Services whether it was legal to make subsidies to the Federal exchanges as opposed to the State exchanges, and she did not answer the question. That is not the topic of discussion this afternoon, but we have now had a split in the circuits on that significant issue and I trust the Supreme Court of the United States will eventually address this issue. And I would hope that the courts might eventually address the fact that, in my judgment, there is a lack of statutory law to move forward with an appropriation that has not occurred regarding this risk corridor program.

Thank you, Mr. Chairman.

Mr. PITTS. The Chair thanks the gentleman.

I now recognize the gentleman from Texas, Mr. Green, 5 minutes for questions.

Mr. GREEN. Thank you, Mr. Chairman, and thank you for having this hearing.

Dr. Hoadley, I know you have answered about the affordable care market and the senior prescription drug program. The ACA significantly reforms the individual insurance market so that the products insurers are offering in the marketplace are fundamentally different than they were sold before. Insurers can no longer discriminate based on preexisting conditions. They can no longer charge women more for the same coverage. And they can no longer offer what a lot of us would consider junk coverage that doesn't cover hospitalizations or disappears whenever consumers need it the most.

Because of financial assistance the law makes available, tens of millions of new customers are entering the market for the first time, and this means that insurance has significant uncertainty when pricing for a market coverage in the early years of the ACA. Can you go into more detail about that the risk corridors are necessary in Part D and why they are also necessary for the Affordable Care Act?

Mr. HOADLEY. I mean, one of the things that I think is striking about the notion of a risk corridor, is that if it is not needed, if it turns out that plans are able to estimate their premiums pretty accurately, then no payments will need to be made. If a plan's experi-

ence is very similar to what their estimates, then there is no cost in either direction. In the case of the ACA, there is a 3 percent corridor around which plans are at full risk for going higher or lower, and if they stay within that estimate in either program, you know, they will be fine.

I think the other point is that there is a learning process. You could make the argument that the risk corridors for the Part D program aren't needed anymore. We are well into that program, and they could be phased out. So far, CMS has chosen that there is legislative authority to make a decision for CMS to decide whether or not to extend that further. For the moment, that has been extended. In the case of the ACA, the decision was in the law, was to have it last just for the 3 years.

But there really are ways in both programs to try to protect both the taxpayer and the plans against the kind of uncertainty in setting premiums.

Mr. GREEN. I would like to take the remainder of my time to highlight a report on the Medicare's Program Board of Trustees. It was just released today. In 2009, the trustees project that the Hospital Insurance Trust Fund would be unable to pay its bills in 2017, only 3 years from now. However, today's report now puts this date at 2030, 13 years later than that was projected. The report goes on to explain that this improvement is thanks to the part of the reforms in the Affordable Care Act.

While today's report focuses on Medicare, it reflects broader trends in healthcare systems through a much slower growth costs through 2014. Over the 50 months since enactment of the Affordable Care Act, healthcare prices have risen at slower rate than any other comparable period in 50 years. There are many reports about the positive impact this law is having on coverage of the uninsured and underinsured, better benefits and lower growth in healthcare cost.

And in my time left, Dr. Hoadley, would you comment on the ACA and that impact on Medicare?

Mr. HOADLEY. Yes, and I think you have hit the point very accurately. And one of the things that, you know, we can take from that lesson that has come out in today's trustees report is on that lower growth rate, is if that turns out to be true for the broader healthcare system as well, that is one of the reasons why plans may turn out making payments back to the Government under the risk corridor program in the ACA. So there is really a linkage between the savings that we are seeing in healthcare costs generally and the potential to protect the taxpayer by making sure the taxpayer benefits from that lower cost trend rather than that benefit going solely to the plans.

Mr. GREEN. OK, I want to reiterate though that over the 50 months since the enactment of the Affordable Care Act, health prices have risen at a slower rate than they have for the last 50 years. Mr. Chairman, I am going to yield back my time, but I am hoping that we can actually work on legislation. If there are problems with the Affordable Care Act, let's fix it. Let's don't strangle it after we are seeing some of the success after only 50 months of the law.

So I yield back my time.

Mr. PITTS. The Chair thanks the gentleman.

And now recognize the gentleman from Florida, Mr. Bilirakis, 5 minutes for questions.

Mr. BILIRAKIS. Thank you. I appreciate it, Mr. Chairman.

Mr. Haislmaier, under the recently issued regulations, any payment shortfall in year 1 would be made up in year 2 or 3. However, if by year 3, the receipts are less than total payments owed in the risk corridor, the administration has stated, and I quote, "We will establish in new and future guidance or rulemaking how we will calculate risk corridors payments if risk corridors collections do not match risk corridors payments ... in the final year of the program."

Will extra funds come from taxpayer funds, in your opinion? Where is HHS going to find it?

Mr. HAISLMAIER. Well, that is a good question. I don't know where they are going to find the money. It will either come out of—to the extent that they are able to, maybe transferring from some other accounts. There are some revenues that HHS receives directly into the operating account for user fees for like clinical laboratory user fees and things like that. So maybe they can make that. But you would have to ask them. I don't know where they will get the money.

Mr. BILIRAKIS. OK, next question. When the rules for the risk corridor were published in 2011, the administration was willing to pay more in risk corridors than they collected. They have subsequently changed to a budget-neutral position. Is there anything in the law that prevents HHS from reinterpreting risk corridors, yet again, to not keep it budget neutral?

Mr. HAISLMAIER. No, I mean, I think that is why you have this issue. There isn't anything that I can see in the law that prevents them, at least in the authorizing statute. There is an appropriations question, which I am not an expert on, but in the authorizing statute, they do not explicitly have to have this budget neutral in the authorizing statute.

Mr. BILIRAKIS. Thank you. Does the President's healthcare law require HHS to pay the full risk corridor amount owed, regardless of any shortfall, yes or no?

Mr. HAISLMAIER. I am sorry, I don't understand.

Mr. BILIRAKIS. Let me repeat the question. I am sorry. Does the President's healthcare law require HHS to pay the full risk corridor amount owed regardless of any shortfall?

Mr. HAISLMAIER. It could be interpreted that way, yes, sir.

Mr. BILIRAKIS. Does the risk corridor incentivize plans to underbid their premiums as a means to capture insurance market share in your opinion?

Mr. HAISLMAIER. Well, that would be one scenario whereby you could see losses in the program on balance, net losses in the program as if you had significant underbidding. And I think that the concern is that the administration's pressure on carriers to keep premiums down might lead to some of that underbidding, yes.

Mr. BILIRAKIS. The administration has claimed that the risk corridor is nothing more than a user fee. In your opinion, is this program a user fee?

Mr. HAISLMAIER. No, that is something different. A user fee is a different animal, and that is governed by a different statute that is already——

Mr. BILIRAKIS. Define user fee.

Mr. HAISLMAIER. A user fee is a fee charged for some service that the Government provides to the user that is not otherwise generally provided to the public, so the example which you all are probably most familiar with is when companies go before the Food and Drug Administration to get a drug or a device or something approved, you know, they are getting the benefit of that regulatory approval. I mean, it has certain benefits because they can say in court, Hey, it is FDA approved. So they charge a user fee.

There is a general user fee statute on the books, that allows and encourages agencies to do that sort of thing. And that is how the Department of Health and Human Services has come up with funding for the federally facilitated exchange for which there is no operating funding. They are charging a user fee. It at 3.5 percent. But this does not, in my view—I am not an expert on that, but from what I can see, this doesn't seem to fit any of the criteria on the Federal user fee statute.

Mr. BILIRAKIS. Yes, I tend to agree.

Thank you, Mr. Chairman, I yield back.

Mr. PITTS. The Chair thanks the gentleman.

I now recognize the gentleman from Virginia, Mr. Griffith, 5 minutes for questions.

Mr. GRIFFITH. Thank you, Mr. Chairman.

I would say that when we talk about the rates on the Affordable Care Act, they may be growing, the insurance increases may be growing slower, they may be growing faster, we will have to see what happens this fall, but that certainly they are growing, and it is not the reduction that was promised when this bill was passed of $2,500 per family, per average family, in the United States. So it is yet another promise that was made that has not been kept by the Affordable Care Act.

With that, Mr. Chairman, I would like to yield the remainder of my time to Dr. Cassidy of Louisiana.

Mr. CASSIDY. Thank you, Mr. Griffith.

Several things to go over. First, the legal aspect of it. I noticed that Mr. Pallone mentioned that initially CBO estimated this would return $8 billion to the Treasury and then glossed over the fact that now it is not going to return money to the Treasury, but rather it will be, quote, "budget-neutral," except as subject to appropriations, we don't know from whence they come. That is a far cry from being $8 billion to the Government.

And CBO, in their writings, I will note, said that the reason that they initially called it $8 billion—because, Dr. Hoadley, as you mentioned, in the Medicare Part D, there were payments back. But as it turns out, not only is it, I guess, now not going to be money back to the Treasury, but I am told that before Mr. Issa's committee, it is now estimated that insurers are going to request over a billion dollars more than they anticipate paying into the program. So, far from returning $8 billion back, now they are going to require a billion dollars more, and it is not clear where that money comes from.

And as regards the memo, the memo which supposedly HHS justifies with, it is interesting. They say that they are going to call this a fee, but in the President's budget he doesn't call this a fee. Additionally, it is also of interest that never in the legislation is this called a fee but now it is being called a fee, and a fee which goes into a revolving fund which is not being set up.

So there is no subject of a revolving fund in the legislation, nor is there comment of a fee, but now we are being told that it is a fee going into a revolving fund that heretofore did not exist but has been manufactured through a legal opinion of HHS.

Now, if the other side of the aisle is quite willing to do away with Congress' prerogative, prerogative both to appropriate and to designate what shall be a revolving fund, that shall be up to the other side of the aisle to do away with prerogative. I suppose that comes from being loyal to one's President. Shame, shame.

However, I say I will be loyal to the Constitution and support the Lance-Cassidy bill, which requires an appropriation if this is to be the case and requires that there be a specific statutory authority for a revolving fund, which the ACA specifically does not include.

Now, just for that kind of, you know, setting the record straight, if you will, let me just now conclude with another statement, if you will. And, again, going to the bill I am sponsoring, Mr. Veuger—did I pronounce that correctly? "Veuger"? I am sorry. Dr. V, I am sorry, Dr. V.

You know, it is interesting, the President and my congressional colleagues promised many times over the debate of the healthcare law that if you like your health plan you can keep your health plan. This last year, 93,000 Louisianians in the individual markets lost the plan they had specifically because of Obamacare. Clearly the President's promise was, to put it euphemistically, inaccurate.

Now, in order to provide relief to the individuals losing their health coverage, the House passed the Keep Your Health Plan Act, allowing plans available on the individual market before Obamacare to continue to be offered. The House must now act to provide the same relief to businesses and employees now by passing my bill, the Employee Health Care Protection Act, which would allow the millions of workers in the group market to keep the health plan they like. I thank the committee for conducting this plan.

Again, I thank Mr. Lance, my colleague, for working with me to introduce the Lance-Cassidy risk-corridor bill. While it is important to allow risk-mitigation mechanisms for companies in the private market, it is important that we ask the administration to follow the Constitution.

The administration has decided to once more ignore the law as written by Congress and make payments to insurance companies without congressional approval. The Lance-Cassidy bill ensures the risk-corridor program does not become a vehicle for ignoring the Constitution by the administration.

With that, I thank my colleague, and I yield back.

Mr. PITTS. The Chair thanks the gentleman.

I now recognize the vice chairman of the full committee, Ms. Blackburn, 5 minutes for questions.

Mrs. BLACKBURN. Thank you, Mr. Chairman.

I want to thank our witnesses for being here.

And I thank the chairman for making time for us to have this hearing. And I am so pleased that Mr. Lance and Dr. Cassidy have brought this bill forward.

You know, it is amazing to me, as we have lived through the legislative process for Obamacare and then the launch of Obamacare, the failed rollout of Obamacare, and now we get to the implementation and where the cost is going to be.

And as Dr. Cassidy was mentioning, we now are hearing, well, it is not really a tax, this is going to be a fee; well, this fee is going to go to a fund. Well, it seems as if what they are doing is trying to convolute the issue to the point that all people know that their insurance cost is going up but they are not sure who to blame and how to blame.

And I find it so interesting, one of the biggest complaints we get in our district is about insurance costs, access, narrow networks, and everything is costing more. And then people will say, "And now we hear the insurance companies want you to bail them out. Don't you dare bail them out."

So if you were with me in my district, that is what you would hear. And much of it is based on the experience Tennesseeans had with a failed program called TennCare. And I know, Mr. Haislmaier, that you all at Heritage have looked at that program and the failings of TennCare and the reasons it did not work.

And I know it thrills Mr. Pallone that I am sitting here and saying "TennCare." He has probably grown weary of hearing me talk about the failure of that program.

And, by the way, it was a Democrat Governor that took it down because it was too expensive to afford. It was one of the first examples of "too expensive to afford."

So, Mr. Haislmaier, you know, who eventually pays all these taxes and fees? Our regulation taxes, our access fees, who eventually pays all of this?

Mr. HAISLMAIER. Well, the consumer does, obviously——

Mrs. BLACKBURN. Absolutely.

Mr. HAISLMAIER [continuing]. Either directly when they purchase something or indirectly through their tax bill.

Mrs. BLACKBURN. And do you have States that you are researching that are showing that their insurance cost to the consumer is going to be reduced $2,500 a consumer? Are you all finding this anywhere in your research?

Mr. HAISLMAIER. My colleague published a paper, and we are going to be updating it now in 2015 with new data on this.

As expected, the only States where you actually saw any measurable decrease in premiums were States that had already made a worse mess of their market before PPACA was enacted. So New York is the prime example. So when you have actually made things worse, I guess doing this is an improvement. But, by and large, everybody else was seeing increases.

Mrs. BLACKBURN. Yes. I know in Tennessee we had had cost estimates from one of our large insurers of 18 percent. And, as you can imagine, on a weekend in Tennessee, where we are busy with festivals and farmers markets and out and about a good bit, people are not happy with that at all.

Talk for just a minute on the record—Mr. Hoadley mentioned Medicare Part D, and I was here when we did the MMA. And I would like for you to talk for the record just a moment about the difference in the risk corridors for Medicare Part D and for PPACA.

Mr. HAISLMAIER. You are asking me?

Mrs. BLACKBURN. Yes.

Mr. HAISLMAIER. Yes. Well, the mechanism is very similar. The issue that I pointed out is simply whether it was an appropriate thing, whether it was appropriate for the Government to, in effect, be underwriting profit or loss risk in this market, whereas one could make the case that, given that Medicare was a three-quarters Government-funded program, that it was a totally new venture, that the insurers wouldn't doing this if the Government wasn't asking them to do this, that you could make the case that underwriting the profit and loss risk through risk corridors might make some sense there. That is essentially the question.

I think, really, frankly, the problem here is there are so many ways in this legislation where subsidies are hidden or things are done through the back door, there is so little trust of the administration in its actually implementing this legislation, that I think a lot of people are, with some degree of legitimacy, concerned that this could become another way for a back-door deal.

I mean, look at how the legislation sets up additional payments to insurers for reducing the copays and deductibles for specific individuals. And that is not transparent, and it is not accountable. So I can see where the suspicion is coming from.

I think the safest thing to do is you simply make it budget-neutral by statute, because there is ambiguity. And as Dr. Hoadley points out, you know, if it is needed, they will use it, and if it isn't, they won't.

Mrs. BLACKBURN. Thank you.

Yield back.

Mr. PITTS. The Chair thanks the gentlelady.

I now recognize the gentleman from Louisiana, Dr. Cassidy, 5 minutes for questioning.

Mr. CASSIDY. Dr. V., now, go through once more how the ACA treats small businesses and workers differently than those who self-insure.

Mr. VEUGER. Small businesses that insure their employees buy plans from insurance companies, and they have to go into a marketplace and buy them. Larger companies that self-insure, well, as the term suggests, protect themselves from the risk that comes from——

Mr. CASSIDY. So they protect themselves from the risk; you imply that there is a risk of going into the regulated market. Your testimony emphasizes the increased cost that comes with going into the ACA-regulated market. Fair statement?

Mr. VEUGER. Well, there will be cost increases on both sides. If you are self-insuring, there will be cost increases under the Affordable Care Act, as well. There is a reinsurance fee, there is——

Mr. CASSIDY. There are the taxes, the trillion dollars in taxes——

Mr. VEUGER. Yes. For sure.

Mr. CASSIDY [continuing]. Coming with an individual policy.

Mr. VEUGER. Yes.

Mr. CASSIDY. But it seems, it strikes me that, in general, the cost increases under the mandated benefits, et cetera, in the non-ACA market, if you will——

Mr. VEUGER. Will be more limited.

Mr. CASSIDY. Yes.

Mr. VEUGER. Yes. I think that is fair.

Mr. CASSIDY. So, if you will, the cost increases will be greater upon the smaller employer, the one who is not self-insuring.

Mr. VEUGER. I think that is certainly fair to say.

Mr. CASSIDY. So the smaller employer, who typically—let's face it, they are smaller, they are trying to get big—they are the ones getting hammered the most. Isn't that crazy?

Mr. VEUGER. Yes. Perhaps with the exception of microbrews that want to stay small for some reason, I think that is also fair to say.

Mr. CASSIDY. Yes. So, if you will, it is interesting, the CBO recently put out a study saying that they have lowered the cost of coverage because there will be wage reductions under Obamacare so, therefore, fewer will be on subsidies and more will be on Medicaid. You almost wonder if this was by design. Again, you don't have to comment on that. That was CBO reporting that.

Mr. Haislmaier, one more time, can you tell us the amount of money which is available through the reinsurance program relative to the size of the market that is going to be in the exchanges?

Mr. HAISLMAIER. The reinsurance program makes available as much as $10 billion this year. If it is not all used, it can be carried forward——

Mr. CASSIDY. Ten billion with a "B."

Mr. HAISLMAIER. Ten billion with a "B." The 2013, the aggregate premium for the individual major medical market was about $28 billion.

Mr. CASSIDY. So it is a $28 billion market, and you have a $10 billion subsidy already going.

Mr. HAISLMAIER. Right. So, you know, if you make various assumptions about increased costs and increased enrollment, you know, OK, let's say you double that market, you know, you get a $40 billion, $50 billion market. That is if lots of people sign up and——

Mr. CASSIDY. So you have 20 percent of the potential loss——

Mr. HAISLMAIER. Yes.

Mr. CASSIDY [continuing]. Already being covered just through the reinsurance——

Mr. HAISLMAIER. Yes, that is my point, is if you are looking at a situation where there is this uncertainty—as Dr. Hoadley and I and others have pointed out, there is this uncertainty that insurers didn't know how many people and how sick they would be and things like that. My point is simply that there is an appropriation already in there. It is, in effect, designated to that market, because it is going to that individual——

Mr. CASSIDY. And it would actually be allocated in a constitutional fashion as opposed to pushing the envelope.

Dr. V, I am sorry, I messed up. I didn't finish with my conclusion.

Mr. VEUGER. Uh-huh.

Mr. CASSIDY. If we are going to say that the problem with the ACA is that it disproportionally increases cost on smaller firms, the ones that we hope grow to be bigger firms, doesn't it seem a reasonable remedy that we allow them to keep their policy if they like? If it is cheaper for their bottom line, they can stay on the policy which they previously had; if not, they can go onto the regulated market.

Mr. VEUGER. I think there is certainly something to be said for that, especially given the promises that were made to them when this legislation was presented and when it was approved and when it hadn't been rolled out yet.

Mr. CASSIDY. Yes.

Mr. VEUGER. So, yes.

Mr. CASSIDY. So if only to ask the President to keep his word that you can keep your policy if you like it, that would be a reasonable way to go.

Mr. VEUGER. I think that is fair to say.

Mr. CASSIDY. Yes. OK.

Well, I inefficiently asked my questions, so I yield back.

Mr. PITTS. The Chair thanks the gentleman.

I now recognize the gentleman from Georgia, Dr. Gingrey, 5 minutes for questions.

Mr. GINGREY. Mr. Chairman, thank you.

Mr. Chairman, it is my understanding, in regard to some of the questions that the ranking member asked just a few minutes ago, that we actually invited the general counsel of Health and Human Services to be a witness at this hearing, maybe to address some of those issues, but that he declined the invitation to be part of the panel.

Dr. Veuger, do you think that it should have been obvious to Members of Congress that many Americans who liked their healthcare plan would not be able to keep it under the Affordable Care Act?

Mr. VEUGER. Well, so it never really ended up becoming clear to me whether all Members of Congress had read the bill before they voted on it. And I think it is hard to—and, you know, it is a long document. Plus, there are all kinds of related regulations and rules. I would imagine that most of the people most closely involved in drafting the bill would have been aware and partially——

Mr. GINGREY. Yes. Well, listen, let me interrupt you just for a second for a follow-up on that because it is a great segue, your comment.

Under the Democratic majority in 2009 and 2010, there was no subcommittee markup of the House-passed version of PPACA, the Affordable Care Act. There was also no legislative hearing, no subcommittee markup or full committee markup of the Senate bill.

Do you think that it was responsible for Washington Democrats to ignore regular order on something of this magnitude, the Affordable Care Act? And could it have helped Members realize that the law would end up leading to plan cancellations for millions of Americans if we had just followed regular order?

Mr. VEUGER. I think it is—I mean, in a sense, I think it was reasonable for them to do if they really wanted to pass this kind of legislation, which I think—I don't think it would have passed oth-

erwise. If you are married to the idea of passing it, I think going through regular order would have kept you from doing that. So, in that sense, it is reasonable.

Mr. GINGREY. Well, of course, as we all know, you know, the 41st Senator from Massachusetts required them to invoke reconciliation, which was never done before, has never been done before or since, thank God.

So, you know, if we had done things in the right way, whether every Member of Congress had read every single word, every single line, every single page of the 2,700-page bill, I think we would have been more likely to have gotten it right.

Dr. Hoadley, based on the data that insurers have reported, health insurance companies in the exchange expect net payments through the risk-corridor program of a billion dollars from the American taxpayer.

Isn't it true that, while both the Affordable Care Act and Medicare Part D program that you talked about in your testimony contain risk-corridor programs, that it is much more likely that taxpayers will have to pay for some insurance company losses under the Affordable Care Act risk-corridor program as compared to the Medicare Modernization and Prescription Drug Act of 10 years ago?

Mr. HOADLEY. I actually think it is too early to draw any such conclusion. The information that insurers, even themselves, have after just a few months of operation is far too short to really have realistic estimates of whether they are going to get payments back from the Government or make payments to the Government. I think it just remains to be seen.

Mr. GINGREY. Well, you told us in your testimony, I think, that under the Medicare Modernization and Part D, the prescription drug risk-corridor program, that the taxpayers have essentially benefited—did you say to the tune of $8 billion over a 10-year period?

Mr. HOADLEY. Over 7 years—I haven't done the exact arithmetic, but I think it is somewhere in the range of about $8 billion paid back to the Government over 7 years.

Mr. GINGREY. But, as I say, it is predicted and reported by health insurance companies in the exchange, they expect that they will get net payments—that is, from the taxpayer—of at least a billion dollars.

So, you know, I think it is very appropriate. This is a great legislative hearing and opportunity to talk about some of these bills that my colleagues, Representative Cassidy and Lance and others, have in regard to whether we eliminate this risk-corridor program or we modify it. Certainly, we need to do something about assuring that if you like your health insurance plan, you can keep it, period, no exceptions.

So that bill to say that, yes, in the small group market and the individual market, those 2013 policies, the people that like them can keep them, that is a very appropriate legislation. And I hope that we will pass it in both the House and Senate and hope that President Obama will sign it into law.

And I yield back.

Mr. PITTS. The Chair thanks the gentleman.

I now recognize the gentlelady from North Carolina, Mrs. Ellmers, 5 minutes for questions.

Mrs. ELLMERS. Thank you, Mr. Chairman.

Dr. Hoadley, I want to go back to some of your testimony and the exchange you had with one of my colleagues from across the aisle on the differences between Medicare Part D and the Affordable Care Act.

Is the Affordable Care Act something—is it mandatory or not mandatory?

Mr. HOADLEY. For people to sign up for insurance?

Mrs. ELLMERS. For people to sign up.

Mr. HOADLEY. There is an insurance mandate, yes.

Mrs. ELLMERS. It is a mandate. Is Medicare Part D a mandate?

Mr. HOADLEY. It does not have a mandate. It instead has a late-enrollment penalty that creates the incentive for people to sign up.

Mrs. ELLMERS. OK, but it is not a mandate. It is——

Mr. HOADLEY. Not a mandate.

Mrs. ELLMERS [continuing]. A personal choice that every individual, every senior on Medicare can take, correct?

I do want to go back to—also, you had pointed out that initially the risk corridor was temporary. It was a 3-year temporary risk corridor when Medicare Part D was put together. Is that correct?

Mr. HOADLEY. No. Actually, it was set up as a permanent part of the program. It was set at a different width. The amount of potential payments in or out was greater in the first 3 years, stepped back in the second 3 years——

Mrs. ELLMERS. OK.

Mr. HOADLEY [continuing]. And then left the Department with the option of what to do with it thereafter.

Mrs. ELLMERS. And then CMS, at that point, continued it. Is that correct?

Mr. HOADLEY. Right.

Mrs. ELLMERS. So, you know, in your opinion—and, of course, this is your opinion—can you see the same thing happening with the Affordable Care Act, considering that it is at this point supposedly temporary?

Mr. HOADLEY. So, in the Affordable Care Act, it is very specific in the law that it is good for just the 3 years, so there is no option——

Mrs. ELLMERS. But CMS could make that change if they so chose.

Mr. HOADLEY. No, they could not.

Mrs. ELLMERS. OK. Well, I want to point something out to you along that line. Today, the House Oversight and Government Reform Committee's chairman, Darrell Issa, released a report: "ObamaCare's Taxpayer Bailout of Health Insurers and the White House's Involvement to Increase Bailout Size."

The report includes email correspondence showing that senior advisor to President Obama Valerie Jarrett directly intervened in response to an insurance company CEO's threat to increase premiums unless the White House acted to expand Obamacare's taxpayer bailout of insurance companies.

Mr. Chairman, to this I would like to add this exchange, this email, and this report from Oversight and Investigation to our report today.

Mr. PALLONE. Mr. Chairman, I haven't seen this report, so I reserve——

Mrs. ELLMERS. Well, there again, I would like to submit it.

Mr. PALLONE. Well——

Mrs. ELLMERS [continuing]. If possible, and——

Mr. PALLONE. Well, sure, you can. But I would like to reserve, you know, the opportunity to object to it. I would have to see it.

Mrs. ELLMERS. OK.

Mr. PITTS. We will wait until it comes down.

Mrs. ELLMERS. Great. OK, wonderful.

Well, to that, I guess my point is that this is all subject to change based on how the program is going.

And, to that, Mr. Haislmaier, I have a question for you. As far as the risk corridor goes, do you see this as—you know, I know you had mentioned some of the risks because of, you know, back-door deals. You know, we are trying to keep this budget-neutral, as happened with Medicare Part D in a program that worked very well.

Do you see this as just an effort politically to keep premium costs down in order to move forward on this? I mean, could this be, this risk corridor?

Mr. HAISLMAIER. Well, I think that is a very legitimate concern, ma'am. And I think what animates a lot of the concern is, clearly, the administration in many ways has been trying to keep premiums down, and this would be an avenue for them to make up some of that money. That is the concern that is here.

And the way the statute is written, at least for the first 3 years, they could exploit the ambiguity in the statute to do that. So that is, I think, why you are having the hearing here, is to say, well, we have to either get rid of it or make sure that it is clear that that can't be done by being budget-neutral.

Mrs. ELLMERS. Uh-huh.

Mr. HAISLMAIER. Clearly, that potential is there, though. We don't know yet until we see the results for the first year of actual premiums.

Mrs. ELLMERS. And to that point, you know, we have Medicare Part D, and we can look back on Medicare Part D and we can watch the way that it played out. We are still, you know, waiting to see how the——

Mr. HAISLMAIER. We are in mid-process——

Mrs. ELLMERS. Lastly, Mr. Veuger, in the 25 seconds that I have, I guess just a "yes" or a "no" answer. I know we were talking with Dr. Cassidy about, you know, what Members of Congress may or may not have known, whether or not individuals would be able to keep their healthcare plan. Do you believe that the President knew that they would not be able to keep their insurance plan?

Mr. VEUGER. I don't know, but I would hope that he knew.

Mrs. ELLMERS. OK. Thank you. Thank you.

Thank you, Mr. Chairman. I yield back.

Mr. PITTS. The Chair thanks the gentlelady.

Has the staff been able to get the report that you referred to? You have it? Can you—have you given it to the——

Mr. PALLONE. Mr. Chairman, the problem that I have is that my understanding is that Chairman Issa hasn't made these reports public. And so that is one of the reasons I am objecting at this time until we have an opportunity to see it.

Mr. PITTS. Go ahead. Go ahead. It was released today.

Mr. CASSIDY. It was released today. I can forward a copy to Mr. Pallone.

Mr. PALLONE. Oh, why don't you just—we will reserve our objection until we see it. You give it to us, and we will take a look. Until today, he hadn't made them public. I didn't even know he made it public today, but I believe you, but I just haven't seen it.

Mr. PITTS. All right. We will get it to you today. And then, without objection——

Mr. PALLONE. No. We are objecting until we have seen it, Mr. Chairman.

Mr. PITTS. The report is coming. We will hold until the report comes down.

OK. We still don't have the report here. We have 10 days to get it to Mr. Pallone.

So if you will let us know———

Mr. PALLONE. Sure.

Mr. PITTS [continuing]. Once you get to see the report, and then, without objection, we will enter it into the record.

[The information is available at http://docs.house.gov/meetings/IF/IF14/20140728/102551/HHRG–113–IF14–20140728–SD006.pdf.]

Mr. PITTS. All right. I remind Members they have 10 days, 10 business days, to submit questions for the record.

And I am sure the Members will have follow-up questions for the witnesses, so we will submit those to you. We ask that you please respond promptly.

And so Members should submit their questions by the close of business on Monday, August 11th.

Thank you very much for your testimony.

Without objection, the subcommittee is adjourned.

[Whereupon, at 5:26 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

Opening Statement of Chairman Fred Upton
Health Subcommittee Hearing on "Protecting Americans from Illegal Bailouts and Plan Cancellations Under the President's Health Care Law"
July 28, 2014

Today we continue our oversight of the broken health care law and discuss solutions to protect Americans from the president's broken promises.

First, we will discuss potential taxpayer liability and legal concerns surrounding the health law's risk corridor program. This program was designed to limit insurance company losses and profits in the exchange. However, data from some of the nation's largest insurers strongly suggest that the risk corridor program will mostly limit insurance company losses – potentially at the expense of the American taxpayer. Estimates show health insurance companies expect net payments of nearly $1 billion from taxpayers in 2015 alone. These facts raise serious concerns regarding taxpayer liability under this program.

There are also serious questions regarding the legality of payments to insurance companies under this program. Earlier this year, the committee released a legal memorandum from the nonpartisan Congressional Research Service questioning the legal authority of the administration to make such payments. The memo stated that the risk corridor provision of the ACA "would not appear to constitute an appropriation of funds for the purposes of risk corridor payments…."

Without an explicit congressional appropriation, any payment to insurers would constitute an illegal transfer of taxpayer dollars. This troubling legal development comes on top of last week's decision issued in *Halbig v. Burwell* by the D.C. Circuit Court of Appeals. The D.C. Circuit Court rebuked the IRS' decision to spend hundreds of billions of dollars and subject millions of Americans

to the law's individual and employer mandate fines without legal authority. A conflicting ruling a few hours later simply underscores the continuing legal uncertainty brought on by dozens of delays and unilateral rewrites. This law has already disrupted the health care peace of mind of millions of Americans. Americans are rightfully concerned that this administration thinks it can simply ignore its own law.

I would like to thank Mr. Lance and Dr. Cassidy for introducing legislation that would protect our constituents from footing the bill for insurance company losses and stop the administration from circumventing the rule of law.

We will also discuss the serious issue of plan cancellations under the law. Last fall, millions of Americans unexpectedly received notices that their health care plan could not be renewed. Our constituents felt betrayed and misled after having been repeatedly promised by the president for years that, "If you like your health care plan, you can keep it."

While last year's plan cancellations were concentrated in the individual market, millions of American workers also face the prospect of seeing the health care plan they like go away under the Affordable Care Act. Today, we will discuss how this problem may affect Americans who depend on employer-sponsored coverage and we will review legislation introduced by Dr. Cassidy that would help America's workers keep their health plan. This commonsense legislation would help American workers keep their health coverage and offer better choices to small businesses struggling to find affordable choices under the president's health care law.

.....
(Original Signature of Member)

113TH CONGRESS
2D SESSION

H. R. _____

To amend the Patient Protection and Affordable Care Act to repeal the risk corridor program, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

Mr. LANCE introduced the following bill; which was referred to the Committee on _____

A BILL

To amend the Patient Protection and Affordable Care Act to repeal the risk corridor program, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Protecting Americans from Illegal Bailouts Act of 2014".

1 **SEC. 2. REPEAL OF THE RISK CORRIDOR PROGRAM ESTAB-**
2 **LISHED IN PPACA.**

3 (a) IN GENERAL.—Section 1342 of the Patient Pro-
4 tection and Affordable Care Act (42 U.S.C. 18062) is re-
5 pealed.

6 (b) EFFECTIVE DATE.—The amendment made by
7 subsection (a) shall take effect as of the date of the enact-
8 ment of this Act.

I

113TH CONGRESS
1ST SESSION

H. R. 3522

To authorize health insurance issuers to continue to offer for sale current group health insurance coverage in satisfaction of the minimum essential health insurance coverage requirement, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

NOVEMBER 18, 2013

Mr. CASSIDY introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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A BILL

To authorize health insurance issuers to continue to offer for sale current group health insurance coverage in satisfaction of the minimum essential health insurance coverage requirement, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the "Employee Health Care
5 Protection Act of 2013".

1 **SEC. 2. IF YOU LIKE YOUR GROUP HEALTH INSURANCE**
2 **PLAN, YOU CAN KEEP IT.**

3 (a) IN GENERAL.—Notwithstanding any provision of
4 the Patient Protection and Affordable Care Act (including
5 any amendment made by such Act or by the Health Care
6 and Education Reconciliation Act of 2010), a health insur-
7 ance issuer that has in effect health insurance coverage
8 in the group market on any date during 2013 may con-
9 tinue after such date to offer such coverage for sale during
10 and after 2014 in such market outside of an Exchange
11 established under section 1311 or 1321 of such Act (42
12 U.S.C. 18031, 18041).

13 (b) TREATMENT AS GRANDFATHERED HEALTH
14 PLAN IN SATISFACTION OF MINIMUM ESSENTIAL COV-
15 ERAGE.—Health insurance coverage described in sub-
16 section (a) shall be treated as a grandfathered health plan
17 for purposes of the amendment made by section 1501(b)
18 of the Patient Protection and Affordable Care Act.

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113TH CONGRESS
2D SESSION

H. R. 4406

To amend title I of the Patient Protection and Affordable Care Act to impose restrictions on the risk corridor program.

IN THE HOUSE OF REPRESENTATIVES

APRIL 4, 2014

Mr. LANCE introduced the following bill; which was referred to the Committee on Energy and Commerce

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A BILL

To amend title I of the Patient Protection and Affordable Care Act to impose restrictions on the risk corridor program.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Taxpayer Bailout Protection Act".

SEC. 2. RESTRICTIONS ON PPACA RISK CORRIDOR PROGRAM.

Section 1342(b) of the Patient Protection and Affordable Care Act (42 U.S.C. 18062(b)) is amended—

1 (1) in paragraph (1), by striking "The Sec-
2 retary" and inserting "Subject to paragraph (3), the
3 Secretary"; and
4 (2) by adding at the end the following new
5 paragraph:
6 "(3) SAFEGUARD TO PROTECT TAXPAYERS.—
7 "(A) IN GENERAL.—The Secretary shall
8 ensure that the amount of payments to plans
9 under paragraph (1) for a plan year beginning
10 during calendar year 2014, 2015, or 2016 does
11 not exceed the amount of payments to the Sec-
12 retary under paragraph (2) for such plan year.
13 "(B) ADJUSTMENT TO PROTECT TAX-
14 PAYERS.—The Secretary shall proportionately
15 decrease the amount of payments to plans
16 under paragraph (1) in order to ensure that the
17 requirement of subparagraph (A) is satisfied
18 each year.".

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