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OBAMACARE: WHY THE NEED FOR AN INSURANCE COMPANY BAILOUT?

HEARING

BEFORE THE

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRTEENTH CONGRESS

SECOND SESSION

FEBRUARY 5, 2014

Serial No. 113–89

Printed for the use of the Committee on Oversight and Government Reform

Available via the World Wide Web: http://www.fdsys.gov
http://www.house.gov/reform

U.S. GOVERNMENT PRINTING OFFICE

87–202 PDF WASHINGTON : 2014

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
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OBAMACARE: WHY THE NEED FOR AN INSURANCE COMPANY BAILOUT?

Wednesday, February 5, 2014

HOUSE OF REPRESENTATIVES
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM
WASHINGTON, D.C.

The committee met, pursuant to call, at 9:35 a.m., in Room 2154, Rayburn Office Building, Hon. Darrell E. Issa [chairman of the committee] presiding.

Present: Representatives Issa, Mica, Turner, Duncan, Jordan, Walberg, Lankford, DesJarlais, Gowdy, Farenthold, Woodall, Massie, Collins, Meadows, Bentivolio, DeSantis, Cummings, Maloney, Norton, Tierney, Connolly, Speier, Kelly, Horsford, and Lujan-Grisham.

Also Present: Mr. Griffin and Mr. McHenry.

Staff present: Ali Ahmad, Professional Staff Member; Brian Blase, Senior Professional Staff Member; Molly Boyl, Deputy General Counsel and Parliamentarian; Joseph A. Brazauskas, Counsel; David Brewer, Senior Counsel; Caitlin Carroll, Press Secretary; Sharon Casey, Senior Assistant Clerk; John Cuaderes, Deputy Staff Director; Brian Daner, Counsel; Adam P. Fromm, Director of Member Services and Committee Operations; Linda Good, Chief Clerk; Meinan Goto, Professional Staff Member; Ryan M. Hambleton, Senior Professional Staff Member; Christopher Hixon, Chief Counsel for Oversight; Mark D. Marin, Deputy Staff Director for Oversight; Aryele Bradford, Press Secretary; Susanne Sachsman Grooms, Deputy Staff Director/Chief Counsel; Jennifer Hoffman, Communications Director; Chris Knauer, Senior Investigator; Una Lee, Counsel; Juan McCullum, Clerk; Dave Rapallo, Staff Director; and Mark Stephenson, Director of Legislation.

Chairman ISSA. The committee will come to order.

I first ask unanimous consent that our colleague from Arkansas, Mr. Tim Griffin, be allowed to participate in today's hearings. Without objection, so ordered.

The Oversight Committee exists to secure two fundamental principles. First, Americans have a right to know that the money Washington takes from them is well spent. And second, Americans deserve an efficient, effective Government that works for them. Our duty on the Oversight and Government Reform Committee is to protect these rights. Our solemn responsibility is to hold Government accountable to taxpayers because taxpayers have a right to know what they get from their Government. Our job is to work tirelessly in partnership with citizen watchdogs to bring the facts

to the American people and bring genuine reform to the Federal bureaucracy. This is our mission.

And today we continue our mission with a hearing as the American people confront ObamaCare. They are faced with a complex web of taxes, subsidies, mandates, regulations, and price controls. Yet, they are receiving little upfront information from the administration.

Our hearing today is one of many that we have had and many more we will have, but it is that important. 18 percent of our economy is in healthcare, and today we are seeing healthcare costs grow and the Affordable Care Act exceed expectations in job loss and in cost.

Four months ago, when ObamaCare opened for business, the administration had to that date refused to release complete enrollment data or how we were going to get it. Today we still do not know how much it has cost, how many people have signed up, what coverage is there because it is, in fact, one of the most opaque government programs to date.

What little enrollment data we have is, in fact, not good news. For the numbers to balance, the administration officials originally claimed that 39 percent of enrollees needed to be young adults. As of January, only 24 percent of enrollees were young adults, and many of those young adults may be highly subsidized. Affordable Care depends on healthy young people buying a plan to subsidize the cost of the aged and the sick. It needs enrollment to balance. It is not something you can force. It is something that must be chosen.

In just the last few days, the administration announced hundreds of millions of dollars will be spent trying to advertise for and recruit those people to sign up for a program that we were told people would flock to because it was good and they needed it. The fact is the Affordable Care Act is not working and the numbers are not working.

Just yesterday, the Congressional Budget Office released figures that showed dramatic adverse effect on total enrollment and a cost of $2 trillion over the next decade, a trillion dollar difference in their estimates. The fact is the act is not performing. CBO is now being forced to recognize, not as the White House would say, that we would—not what the White House would say that people are choosing not to work as much and they have flexibility, but in fact, people who want full-time jobs are finding themselves with less than full-time jobs and often without health care.

Additionally, the GDP of this country, the engine that creates jobs, is likely to slow by as much as 1 percent over the next decade. That is a long-term bad news for our economy.

This does not mean that the goals of the Affordable Care Act are, in fact, to be given up. This committee and all committees of the Congress have an opportunity to seize better choices in how we fashion health care opportunities for the American people. Health care insurance companies make money off of the Affordable Care Act, and the profit is theirs to keep. In fact, although they are not villains, they certainly were an organization—many organizations that were previously vilified, vilified in a big way until it became convenient to get them on board with the Affordable Care Act. The

Affordable Care Act guarantees subsidies and higher enrollment for the health care companies.

Today we will take a number of items, including our first witness who will speak to one of the flaws in the system, which is in fact a guarantee of profit for the health care providers, one that may cause them to price their product in a way that is not in the best interest of competition. This program is called "reinsurance."

A key question we will ask today is what will trigger the bailout provisions and how will it take effect. Under ObamaCare's risk corridor program, if an insurance company cannot cover the losses of its less successful plans, the Treasury will use taxpayer funds to cover up 80 percent of the loss.

Yesterday, the Congressional Budget Office estimated ObamaCare's risk corridor would give Government a gain of $8 billion in profits. It is important to note that that is based on another program in which every year the American people have found themselves overpriced relative to a shrinking cost of prescription drugs. It is not necessarily a valid model. It certainly has one critical difference, which is Medicare Part D was a program which, by definition, was new and did not have a large pool of history. In the case of the Affordable Care Act, most of the carriers are providing exactly the same type of insurance to the exact same pools as they always have.

CBO's projections also concluded that the Affordable Care Act will cost the economy 2.5 million job equivalents. The agency report found the negative impact effects of the law would be substantially larger than had been believed. When they say "substantially larger," let us understand. According to the then-Speaker, Nancy Pelosi, the Affordable Care Act was going to create 4 million jobs. It is now going to cost us 2.5 million jobs.

CBO is a respected, nonpartisan agency on which the ranking member, Mr. Cummings, and I rely daily. But even CBO can only make projections based on information available and on hand, and in fact, the Affordable Care Act continues to migrate. It is well known that at the time the Affordable Care Act was being projected, CBO was much more optimistic as to what would occur. In 2011, CBO estimated, as the law was being implemented, that it could cost 800,000 full-time job equivalents. Again, today they now estimate 2.5. CBO's revised estimate is based on a better understanding of the law. Remember, this is a law that we had to pass before we could find out what was in it. More importantly, out of the 2,400 pages of the original law, we have now mushroomed into over 70,000 pages of regulations and they are still being made.

The law's reinsurance program levels a fee on health insurance consumers to subsidize plans in the exchange, meaning people who already had a plan that they wanted to keep that they may or may not be able to keep are being taxed as part of the Affordable Care Act. Most, if not all, Americans were unaware that they would be taxed for a program even if they had a program they liked, meaning that the programs they are in cost more because of an ObamaCare tax.

The noble aspirations are not enough to make ObamaCare cost-effective or fair, and it is driving up the cost of insurance and driving up the cost of providing health care. Its implementation has

been marked by arbitrary and unilateral delays made by the White House, many of them beyond any fair interpretation of the four squares of the law.

In closing, I think my colleagues are aware that no one on my side of the aisle voted for the Affordable Care Act. We did not believe in element after element after element of it, even though we would have liked to have done a few of the elements of this law. Therefore, we are not neutral observers.

But CBO is a neutral observer, and I believe that the testimony that is going to be given today by our distinguished Senator from Florida, Senator Rubio, who has proposed a bill to repeal the risk corridors in the President's health care law, comes both with a timely proposal and with the recognition that after you guarantee that insurance companies cannot lose money, it is little surprise that when the President makes changes, which will adversely affect the profit projections of insurance companies, you hear not a word. You hear not a word because, in fact, the taxpayer is paying for the arbitrary decisions of the President and, in fact, not the health care providers.

And with that, I recognize the ranking member, Mr. Cummings, for his opening statement.

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

I welcome you, Senator Rubio, to this hearing, and it is certainly good to have you here.

Today's hearing is our committee's 24th—2, 4—24th—on the Affordable Care Act. And after this hearing ends, we will be holding our 25th this afternoon. I am not sure what the line is between oversight and obsession, but our committee has obviously crossed it.

I will begin, as I do, at all of our ACA hearings by highlighting the single most important fact before us today. Millions of Americans are now receiving critical medical care they did not have before. I know that is important to you, Senator Rubio, and it should be important to all of us. People who are sick, trying to get well, people who are well trying to stay well are getting care that they could not receive before.

No more discrimination against people with cancer, diabetes, and other preexisting conditions. That is so important. No more discrimination against women. Free preventative care for millions of people. Billions of dollars in rebate checks sent to consumers across the country in all of our districts and in Florida. And the lowest growth in health care costs in 50 years.

These amazing results are not happening because of Republican efforts. They are happening in spite of them. Republicans have done every single thing they could do in their power to repeal, defund, and eviscerate the Affordable Care Act. And sadly, so sadly, today's hearing is just the latest example.

According to press reports, while House Republicans were at their retreat last week they were desperately searching for something, anything to attach to the debt ceiling legislation. They could not simply pay our Nation's debts. They had to come up with something, anything to politicize the issue.

At first they discussed the Keystone Pipeline, but then they settled on the issue before us today, the so-called Affordable Care Act

bailout of insurance companies. They seized on several provisions in the ACA designed to distribute risk across insurance companies and prevent the artificial inflation of premiums for consumers. Under one of these provisions called the "risk corridor program," the Government collects funds from insurers with large financial gains and uses those funds to make payments to insurers with large losses.

The irony of this Republican attack is that the Republicans first proposed these measures as part of the 2003 law to create the Medicare Part D drug benefit. It was a Republican idea.

Senate Minority Leader Mitch McConnell and House Speaker John Boehner both voted in favor of these provisions, and so did Paul Ryan, the chairman of the Budget Committee, as well as our chairman, Chairman Issa. And at the time, Republican Senator Chuck Grassley described the risk corridor program as one of the, "incentives that the Secretary can use," to get new plans started, "in a strong way." He said "these plans are enabling many beneficiaries to lower their out-of-pocket costs substantially, and that is particularly true for beneficiaries with chronic illnesses." I did not say that. Senator Grassley said that.

The risk corridor program was a good idea during the Bush administration, and it worked. Rather than a bailout for insurance companies, the program has resulted in $7 billion in net gains to taxpayers. But now since these same mechanisms are part of the Affordable Care Act, Republicans argue that they are a bailout for insurance companies.

Senator Rubio, who I have great respect for, calls them—and I "Government favoritism and corporate cronyism at its worst." He claims that we are getting, closer to the reality that billions of dollars in taxpayer money is going to be used to bail out these exchanges." And he introduced legislation to repeal this program.

Just this week, however, the nonpartisan Congressional Budget Office issued a new report that completely obliterates this argument. CBO projects that the ACA risk corridor program will result in net gains to taxpayers of $8 billion over the next 10 years. So where is the bailout? There isn't one.

Just as in the Medicare Part D program, the Affordable Care Act risk corridor program will save taxpayers money, and if we were to adopt legislation to eliminate this program, billions of dollars in savings would simply disappear.

I ask unanimous consent, Mr. Chairman, that the CBO report be entered into the official hearing record.

Chairman ISSA. Without objection, so ordered.

Mr. CUMMINGS. Thank you, Mr. Chairman.

Finally in conclusion, I am surely no advisor to the Republican Party, but if you are trying to create a new image for yourselves, one of truly caring for people facing hardship, why in the world would you eliminate a program that you invented that has been working for nearly a decade and that saves taxpayers billions of dollars? And why would you increase premiums for Americans across the country in the process? This approach makes no sense unless you are putting politics ahead of people.

So for the next week, I would like to make a suggestion. Rather than holding our 26th hearing on yet another false criticism of the

Affordable Care Act, I ask that we turn to more constructive efforts. Let us hold a hearing to help our constituents, not just the constituents from my district, from all of our districts. Let's get ourselves involved in constructive efforts to help our constituents learn about the health care coverage they can now obtain and let us help them enroll. That would benefit them more than anything we will do today.

And with that, Mr. Chairman, I yield back.

Chairman ISSA. I thank the gentleman.

Members may have 7 days to submit opening statements for the record.

Chairman ISSA. We now go to our first panel. After Senator Rubio, we will immediately go to a second panel.

And I would advise all witnesses that it is not customary to interview Members of the House or the Senate afterwards. And I say this because we did have our counterparts from the Senate for a very long back and forth just a few weeks ago, but that was an exception.

Senator Rubio comes today to give testimony specifically on his proposal but, more broadly, on his study of the ongoing implementation of the Affordable Care Act. Senator Rubio, we appreciate your being here. You will be welcomed back for the 26th and the 27th and the 28th hearing, if it becomes necessary, in order to do appropriate oversight of this new law. Senator, you are recognized.

STATEMENT OF HON. MARCO RUBIO, UNITED STATES SENATOR, FLORIDA

Senator RUBIO. Thank you, Chairman Issa and the ranking member, Mr. Cummings, for holding this hearing and for inviting me here today. I am a frequent watcher. I am a loyal viewer of this committee on C–SPAN. So I appreciate the invitation to be here with you today.

My focus of my remarks this morning is going to be on section 1342 of ObamaCare, which I, in partnership with your colleague, Tim Griffin of Arkansas, have introduced legislation to repeal.

Now, section 1342 deals with what has already been described as risk corridors. Now, under normal circumstances, risk corridors are a valid program. They provide insurers insurance against unanticipated major losses caused by anomalies that may occur in a competitive insurance market. This prevents disruption in services, for example, for patients and for customers.

They are budget-neutral, by the way. These risk corridors can actually protect taxpayers from assuming too much of the risk.

The problem with the risk corridor in ObamaCare is that this is not a normal circumstance. First of all, its failures are not anomalies. They are across the board. It is not one or two companies that are miscalculating on ObamaCare's long-term prospects; it is the entire industry that is being affected by its failures.

And, by the way, ObamaCare and its exchanges are not a true competitive insurance market. In fact, it has increasingly become more like a high-risk pool.

The risk of a bailout has always been high. As many of us predicted, these exchanges have not attracted enough young and healthy people to sign up, but the chances of the bailout have in-

creased significantly in the last few months due to several unilateral actions taken by the President and by his administration.

For example, this past November, in response to a public backlash from people who were losing their health plans and providers, President Obama delivered a speech in which he announced his unilateral action to, quote, fix his broken promise that if you like your plan, you can keep your plan. That same day, however, the Department of Health and Human Services issued a press release to go with the President's speech. And in that press release, they added a critical detail that was missing in the President's remarks. And here is what the press release said. "Though this transitional policy was not anticipated by health insurance issuers when rate-setting for 2014, the risk corridor program should help ameliorate unanticipated changes and premium revenue."

Now, what this means is pretty straightforward. The rates being charged by the insurance companies in the exchanges were based on a certain number of young and healthy people signing up, but because that is not happening, companies in the exchange will not be able to offset the costs of insuring older and less healthy individuals. And as a result, the risk corridor will be needed to bail out the companies for their losses.

Now, the administration and the law's supporters deny that this is where we are headed, but the proof already exists that a bailout will be required.

For example, earlier this year, health insurance companies had to file their key disclosure documents with the Securities and Exchange Commission. In it, they had to explain to their shareholders what ObamaCare will mean for their bottom line in the coming year, and here is what it said. It will mean losses. That is why, based on these filings, the credit rating agency Moody's has downgraded the outlook for American health insurers to negative status.

So health insurers are leveling with their shareholders about how ObamaCare's failures will affect their bottom lines, and credit rating agencies are leveling with investors about how ObamaCare's failures affect the health insurance industry.

Now it is time for the President, for Secretary Sebelius, and for ObamaCare supporters to level with taxpayers about the fact that their hard-earned tax dollars will soon be needed to bail out the ObamaCare exchanges.

The supporters of ObamaCare have defended the risk corridors by citing how it has worked for Medicare Part D, but these are two fundamentally different programs. Medicare Part D deals with a defined, a limited and a predictable population of seniors. Insurers knew who was going to sign up, and they had a pretty good idea of how much they were going to cost to insure, and so they could price for it accordingly. But ObamaCare exchanges deal with an open-ended, broad, and unpredictable group of enrollees. No one knew who was going to sign up, how many would sign up, and how much they would cost. But what they are now finding out is that the pool of enrollees that is signing up is smaller, older, and unfortunately sicker than what they had priced for. And soon they will be coming to Washington for their bailout to cover their losses as a result.

Now, the law has a host of other problems. For example, as the chairman has already pointed out, just yesterday the Congressional Budget Office found that ObamaCare will cost millions of Americans their jobs, and it will add trillions in additional deficits. That, by the way, is why a growing number of Americans have come to realize that this law has so many flaws that it cannot be fixed.

Now, I respect the fact that there are some who still hold out hope that ObamaCare will work, just like there were some in Denver this Sunday still holding out hope that the Broncos could come back and win in the fourth quarter. But no matter how you may feel about the law, we should all be able to agree that the American people should not have to pay for another taxpayer-funded bailout.

Refusing to take that possibility off the table is like basically telling the American people that some are so devoted to protecting ObamaCare that they do not care how much it will cost taxpayers.

The bottom line is that it is not right to allow a powerful industry to use its influence here in Washington to protect itself from the consequences of ObamaCare, and it is not right that hard-working Americans are forced to pay for it.

So, Mr. Chairman, Ranking Member, I appreciate the opportunity to testify before you today, and I look forward to coming back. Thank you.

Chairman ISSA. Senator, we thank you for your input. We thank you for your insight in this area, and we thank you for being a loyal watcher.

We will take a short recess and set up for the next panel.

[Recess.]

Chairman ISSA. We now welcome our second panel of witnesses. Mr. John Goodman is President and CEO of the National Center for Policy Analysis and Senior Research Fellow at the Independent Institute. Mr. Douglas Badger is a former Senior White House Adviser for Health Policy to George W. Bush, and Mr. Timothy Jost, is Professor of Law at Washington and Lee University. I want to thank all of you for being here and, pursuant to the committee rules, would ask that you please rise to take the oath and raise your right hands.

[Witnesses sworn.]

Chairman ISSA. Please be seated. Let the record reflect that all individuals answered in the affirmative.

Since we have a full panel and the committee rules call for 5 minutes for opening testimony, I would ask that you observe the lights and stay as close to the 5 minutes, recognizing that your entire opening statements will be placed in the record, along with additional, extraneous materials, should you choose to add it.

And with that, we go to Mr. Goodman.

WITNESS STATEMENTS

STATEMENT OF JOHN C. GOODMAN, PH.D.

Mr. GOODMAN. Mr. Chairman, members of the committee, the people who created the health insurance exchanges were apparently of good intention, but they created perverse incentives for

those at the bottom. And when people act on those perverse incentives, they are doing things that create perverse outcomes.

The insurers are prevented from pricing risk accurately in the health insurance marketplace. As a consequence, people who are relatively healthy are overcharged at the point of enrollment and people who are relatively sick are undercharged. This gives every insurer an incentive to attract the healthy and avoid the sick because they make profits on the healthy and they make losses on the sick.

The way they behave, in the face of this incentive, contrasts markedly with insurers in other markets. All of you have seen casualty insurers advertising on TV. You have seen the actor in front of the town that was wiped out in 2 minutes telling you with Allstate you will be in good hands. You have seen advertisements with car accidents. You have seen the Aflac ads, the Chubb ads. And every one of these ads pictures some bad thing that could happen to you, and the message in these ads is if the bad thing happens, the insurer will be there for you. You are never, ever going to see an ad like this by insurers selling insurance in the exchange. You are never going to see an ad that says if you get cancer, we are going to be the health plan for you, or if you get heart disease, come to us because they are running away from the sick instead of trying to attract them.

Now, the insurers have their benefits regulated down to the smallest items. Yet, they are free to choose their own networks and their own premiums. What they are doing is they are selecting premiums and networks in order to attract the healthy and avoid the sick. They have become convinced that the healthy buy on price and that only sick people look really closely at networks. And so we are getting a race to the bottom on the networks. Blue Cross, for example, of California has only about a third as many doctors in its exchange network as it does in its normal network. We are seeing these networks leave out the best hospitals and the best doctors.

Now, on the buyer side, it makes sense if insurance is guaranteed issue. If it has nothing to do with health condition, why would I not buy on price? And then if I get sick, if I get heart disease, I will look around for a better plan. If I get cancer, I will look around for a better plan. And what we all forget is that if everybody is chasing the healthy person, when I do get cancer, there may not be a plan there that provides decent cancer care.

In the exchange, people who are overcharged will tend to underinsure. People who are undercharged will be inclined to over-insure. People with serious health problems will choose to go on platinum plans. People who are healthy will chose the bronze plan, or more likely, they will simply stay uninsured and wait until they get sick to enroll at all.

To make these conditions even worse, we have outside groups who are allowed to do things that I regard as unconscionable. The Federal risk pool is about to dump all the enrollees in the risk pool into the State exchanges. All of the State-level exchanges are about to end their risk pools and dump high-cost enrollees into the exchange. We have cities and towns throughout the country that have unfunded post-retirement promises, and they are getting

ready to unload on the exchanges. The City of Detroit is sending 10,000 retirees, who are older and therefore more costly, to the exchange. We have businesses thinking about doing the same thing, ending their post-retirement health care plans. We have all the people who are characterized as job lock employees who are working only because of the health insurance, and they will leave their jobs and enter the exchange. And then, as I understand it, hospitals now are allowed under the Affordable Care Act to actually sign people up in the hospital bed with the hospital paying the premium.

In my written testimony, I do not talk about all the things that employers might do, but if you would for me to get into it, I think that there are many things they can do to game the system and we are going to see it happen.

In summary, I think that we have underestimated the costs that are being piled onto the exchange, not overestimating. I think that this is a potential large strain on the taxpayer, and the remarkable thing is this is a small market, less than 10 percent of the private insurance population. It was working reasonably well. And what we have done is unconscionable, bad policy, and bad ethics.

[Prepared statement of Mr. Goodman follows:]

The Economics of the Health Insurance Exchanges

Statement of

John C. Goodman, Ph.D.

President & CEO
National Center for Policy Analysis

and
John R. Graham and Greg Scandlen
Senior Fellows
National Center for Policy Analysis

Committee on Oversight & Government Reform

ObamaCare: Why the Need for an Insurance Company Bailout?

February 5, 2014

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Mr. Chairman and members of the Committee, I am John Goodman, President and CEO of the National Center for Policy Analysis (NCPA), a nonprofit, nonpartisan public policy research organization dedicated to developing and promoting private alternatives to government regulation and control, solving problems by relying on the strength of the competitive, entrepreneurial private sector. My testimony today is based on work I've done with John R. Graham and Greg Scandlen, both colleagues of mine at the NCPA. I welcome the opportunity to share my views and look forward to your questions.

With fewer glitches to deter them, millions of Americans are successfully logging on to the (ObamaCare) health insurance exchange websites.

When they get there, many are discovering some unpleasant surprises: the deductibles are higher than what most people are used to, the networks of doctors and hospitals are skimpier (in some cases much skimpier), lifesaving drugs are often not on the insurers' formularies and, even after the highly touted subsidies are taken into account, the premiums are often higher than what they previously paid.

Why is this happening? Because of perverse incentives faced by buyers and sellers in the exchanges.

Matters are made worse by other aspects of the Affordable Care Act (ACA). Insurance pools outside the exchange are being allowed to dump their oldest, sickest enrollees into the exchanges, virtually guaranteeing that costs for the participating insurers are higher than they need to be. In anticipation of significant losses — at least initially — the ACA provides for federal government subsidies for the next three years, in addition to the types of risk adjustment one would normally expect.

This puts taxpayers at risk for the cost of serious mistakes in the design of the exchanges.

Perverse Incentives for Sellers. Under the health reform law, the benefits insurers must offer are strictly regulated — right down to free contraceptives and inexpensive preventive care. At the same time insurers have been given enormous freedom to set their own premiums and choose their own networks.

The result has been a race to the bottom. In order to keep premiums as low as possible, the insurers are offering very narrow networks, often leaving out the best doctors and the best hospitals. BlueCross of California, for example, only includes one-third the number of doctors in the exchange plan that it includes in the normal BlueCross plan. An exchange plan in Denver includes only one hospital, the one that usually treats Medicaid patients.

Note: Narrow networks can be good or bad. Walmart has selected half a dozen centers of excellence around the country for its employees. These are places carefully chosen for their high quality and low costs. The exchange health plans, by contrast, appear to care only about cost. They are offering low fees — sometimes even lower than what Medicaid pays — and accepting only those providers who will take whatever fee is offered.

Under health reform, insurers are required to charge the same premium, regardless of the applicants' health status; and they are required to accept anyone who applies. This means they must overcharge the healthy and undercharge the sick. It also means they have strong incentives to attract the healthy (on whom they make a profit) and avoid the sick (on whom they incur a loss). Evidence so far suggests that risk corridors, reinsurance and risk adjustment are not compensating for this incentive.

Perverse Incentives for Buyers. In the ObamaCare exchanges, insurers apparently believe that the healthy buy on price — ignoring other features of the plan. By contrast, only people who plan to spend a lot of health care dollars pay close attention to deductibles and which doctors and hospitals are in the insurer's network. Thus, by keeping deductibles high and fees so low that only a minority of physicians will agree to treat the patients, insurers are able to lower their premiums.

A race to the bottom doesn't happen in normal markets. What makes the ObamaCare exchanges different? Answer: the incentives of buyers.

If I am healthy why wouldn't I buy on price? If I later develop cancer, I'll move to a plan that has the best cancer care. If I develop heart disease, I'll find a plan with the best heart doctors. And by law, these plans will be prohibited from charging me more than the premium paid by a healthy enrollee.

Perverse Incentives Outside the Market. If insurers are acting in perverse ways to keep premiums low, why are so many shoppers shocked by how high they are? Answer: no matter how narrow the provider network is, health plans are going to cost more if the entire market enrolls more people with above-average health care costs. And that is what is about to happen.

The federal (ObamaCare) risk pools will soon close their doors and send their enrollees to the state exchanges. This is the program that allows people who were "uninsurable" to purchase insurance for the same premium healthy people pay. All of the state risk pools are planning to do the same. These risk pools were spending billions of dollars subsidizing insurance for high cost patients. Now those subsidies will have to be implicitly borne by the private sector plans through higher premiums charged to everyone else.

To make matters worse, cities and towns across the country with unfunded health care commitments are readying to dump their retirees on the exchanges, nationalizing the costs. Since retirees are above-average age, they have above-average expected costs. The city of Detroit, for example, is planning to unload the costs of 10,000 retirees on the Michigan exchange. Many private employers face the same temptation.

Then there are the "job-lock" employees — people who are working only to get health insurance because they are uninsurable in the individual market. Under ObamaCare, their incentive will be to quit their jobs and head to the exchange.

To add to this burden, the Obama administration has decided hospitals, AIDS clinics and other providers will be able to enroll uninsured patients in the exchange and pay premiums for them in order to get private insurance to pay the bills.

Bottom line: a lot of high-cost patients are about to enroll through the exchanges, causing overall costs for participating plans to be much higher.

Insurance Company Risks. Because health insurers are no longer allowed to ask any questions about an applicant's health, they have no way of knowing whom they are enrolling in terms of past or present illnesses or health conditions. They might attract a group of pretty healthy people or a group of pretty sick people, but they won't know until people start filing claims. So it is impossible to accurately set premiums, at least for the first few years.

Another problem is that some insurers may attract a whole lot of very sick people while others attract mostly healthy people. In a particular state, BlueCross may be known as the best place to go if you have cancer or heart disease, while Aetna may offer attractive discounts on gym memberships. The healthy people will be drawn to Aetna while the really sick people will prefer the Blues. If companies could set premiums to accurately reflect their enrolled population, BlueCross premiums would be outrageously expensive while Aetna premiums would be cheap. The ACA tries to fix these problems in three ways. (See the Table.)

Table 1: Summary of Risk and Market Stabilization Programs in the Affordable Care Act

	Risk Adjustment	Reinsurance	Risk Corridors
What the program does	Redistributes funds from plans with lower-risk enrollees to plans with higher-risk enrollees	Provides payment to plans that enroll higher-cost individuals	Limits losses and gains beyond an allowable range
Why it was enacted	Protects against adverse selection and risk selection in the individual and small group markets, inside and outside the exchanges by spreading financial risk across the markets	Protects against premium increases in the individual market by offsetting the expenses of high-cost individuals	Stabilizes premiums and protects against inaccurate premium setting during initial years of the reform
Who participates	Non-grandfathered individual and small group market plans, both inside and outside of the exchanges	All health insurance issuers and self-insured plans contribute funds; individual market plans subject to new market rules (both inside and outside the exchange) are eligible for payment	Qualified Health Plans (QHPs), which are plans qualified to be offered on a health insurance marketplace (also called exchange)
How it works	Plans' average actuarial risk will be determined based on enrollees' individual risk scores. Plans with lower actuarial risk will make payments to higher risk plans. Payments net to zero.	If an enrollee's costs exceed a certain threshold (called an attachment point), the plan is eligible for payment (up to the reinsurance cap). Payments net to zero	HHS collects funds from plans with lower than expected claims and makes payments to plans with higher than expected claims. Plans with actual claims less than 97% of target amounts pay into the program and plans with claims greater than 103% of target amounts receive funds. Payments do not have to net to zero.
When it goes into effect	2014, onward (Permanent)	2014 – 2016 (Temporary – 3 years)	2014 – 2016 (Temporary – 3 years)

Source: Kaiser Family Foundation

The First of Three Rs: Risk Adjustment. Risk adjustment is a permanent feature of the new exchanges. It involves taking money from insurance plans with healthier enrollees and giving to plans with sicker enrollees. The adjustment is revenue neutral in the sense that the amount paid in exactly equals the amount paid out.

Health and Human Services has developed a risk adjustment model that assigns one or more of 127 "Hierarchical Condition Categories" (HCCs) to each enrollee and gives each enrollee a "risk score," which results in higher or lower adjustments for payments to the health plan. One surprising feature of the risk

adjustment parameters is that an insurer can actually come out ahead by attracting a sicker-than-average population of enrollees.

For example, carriers would expect to have an 8.8 percent loss on males age 60 and above, but the risk adjustments turn that into a gain of 7.3 percent. For males age 25-29, an expected gain of 34.3 percent becomes a loss of 3.2 percent after the risk adjustments. So a company that wants to make money has every incentive to avoid young males and attract the oldest ones, at least as far as this adjustment is concerned. Overall, a Milliman report[1] says that people with "seven conditions would actually produce profit margins in excess of 1,000 percent of premiums."

With this adjustment alone, insurers would be tempted to attract the sick and avoid the healthy. But there is more to the story.

The Second R: Reinsurance. Each year, there will be a special premium tax levied on all insurers (whether participating in exchanges or not) as well as self-insured plans. This tax revenue is supplemented by a little extra from the U.S. Treasury. In total, the reinsurance sums are: $12 billion for 2014, $8 billion for 2015, and $5 billion for 2016. (For more details, but in laypersons' language, see the analysis by the Wakely Consulting Group.[2])

For each of the three years, the U.S. Department of Health & Human Services (HHS) must publish a notice explaining how it will distribute this money. The notice must be published by the end of March the previous year. Last March, HHS issued its notice of payment parameters[3] for 2014. The attachment point for reinsurance is $60,000, with a co-insurance rate of 80 percent capped at $250,000.

For example, if a patient has medical claims of $200,000, the insurer will be compensated $112,000 [($200,000-$60,000) X 80%] by the reinsurance fund. If the patient has medical claims of $500,000, the insurer will claim the maximum of $152,000 [($250,000-$60,000) X 80%]. If reinsurance claims are greater than $12 billion, HHS will prorate the claims. Of course, health insurers also have access to the commercial reinsurance market for claims above $250,000.

Like risk adjustment, the reinsurance program is also revenue neutral — the amount paid in is equal to the amount paid out.

The Third R: Risk Corridors. Under this program, insurers in the exchanges are subsidized for their losses in the following way. If medical costs for a plan are in excess of 103 percent of its target costs, the plan will receive a subsidy equal to 50 percent of its losses between 103 and 108 percent of target. For costs above 108 percent of target, the plan's subsidy will recoup 80 percent of the losses. The converse is that the insurers are taxed on their unexpected gains. Further, the tax thresholds are the mirror image of the subsidy thresholds. So there is a 50 percent tax on the gains for plans with costs below 103 percent and 108 percent of target costs, etc. (See the chart.)

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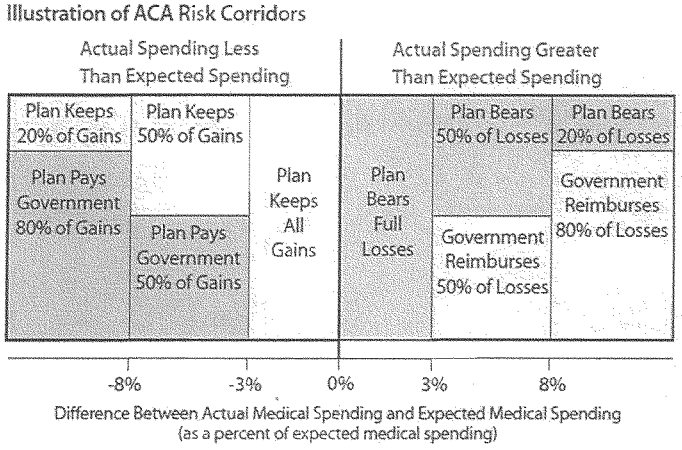
[1] Jason Siegel, Jason Petroske, *When Adverse Selection Isn't: Which Members are Likely to be profitable (Or Not) in Markets Regulated by the ACA, 2013*, Milliman Healthcare Reform Briefing Paper.
[2] Ross Winkelman, Julie Peper, Patrick Holland, Syed Mehmud, James Woolman, *Analysis of HHS Final Rules On Reinsurance, Risk Corridors and Risk Adjustment, 2012*, Robert Wood Johnson Foundation, State Health Reform Assistance Network.
[3] Center for Consumer Information and Insurance Oversight, *Payment Notice Technical Summary, 2013*, Centers for Medicare and Medicaid Services.

Unlike the first two Rs, this adjustment is not revenue neutral. If claims overall are more expensive than the target costs built into the premiums established at the end of 2013, subsidies to those plans that experience losses can exceed the taxes on plans that profit. In fact, there is potentially an unlimited taxpayer liability here — at least for the next three years. (Note, however: in its original analysis, the Congressional Budget Office assumed that the risk corridors would be budget neutral (as noted on pages 10 and 39 of this analysis[4]).

ACA Risk Corridor Program (2014-2016)



(Source: American Academy of Actuaries fact sheet[5])

Comparison to Medicare Part D. Some health economists[6] have noticed that the risk corridors in the ACA exchanges are similar to the risk corridors created in the early years of the Medicare Part D program. In fact, the risk corridors in Part D were actually more protective of the insurance companies than the ACA is. There is one difference, however. The Part D program did not encourage other insurance pools to dump their most costly enrollee into the newly created drug insurance marketplace. In fact employers were actually subsidized for continuing drug insurance programs that were already in place.

Where We Are Now. After one month, there are signs that insurers got their pricing significantly wrong. Because it is so hard to enroll in the ObamaCare exchanges, only the most persistent (that is, those who expect the highest medical claims) spent hours navigating the website to sign up. According to an HHS

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[4] Center for Consumer Information and Insurance Oversight, *Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, Exchange Standards for Employers and Standards Related to Reinsurance, Risk Corridors and Risk Adjustment, 2012*, Centers for Medicare and Medicaid Services.
[5] *Fact Sheet: ACA Risk-Sharing Mechanisms, 2013*, American Academy of Actuaries.
[6] Austin Frakt, *Risk corridors: ACA vs. Part D, in charts, 2014*, The Incidental Economist.

report[7], of those who selected plans from October through December, only one quarter are between the ages of 18 and 34, while one third are between 55 and 64; 55 percent are between the ages of 45 and 54. Priority Health, a Michigan insurer, reported that the average age of new applicants is 51[8], versus 41 in the previous individual market.

It certainly looks like health insurers' ObamaCare exchange adventure will be very expensive. By 2015, they will likely ask the federal government for risk corridor subsidies and those subsidies will be characterized as a "bailout." The administration has no flexibility in this regard. It would be a mistake to blame the insurance industry, however. It would be unreasonable to expect them to lose money on ObamaCare.

The Combined Effect of all Three Rs: A Case Study. Edie Sunby[9] has a rare form of cancer that is almost always fatal. Yet she is alive, thanks to the efforts of doctors in San Diego, at Stanford University and in Texas. Over the past year, UnitedHealthcare spent $1.2 million on her medical expenses. But at the end of last year she was informed that her insurance is being cancelled.

Worse, in the new California exchange, the only plan that will allow her to continue seeing her San Diego doctors will not pay for the doctors at Stanford or in Texas. There is no reimbursement for out-of-network services.

For Edie Sunby, the rules governing the new health insurance exchanges amount to a potential death sentence. She is not alone.

Here is our prediction: unless the Affordable Care Act is radically reformed, the kind of coverage Edie Sunby had will never again be seen in the individual market in this country.

Needed Reform. Wharton school health economist Mark Pauly and his colleagues have studied the individual market in great detail and discovered that despite so much negative rhetoric in the public policy arena this is a market that worked and worked reasonably well[10]. Despite President Obama's repeated reference to insurance plans that cancel your coverage after you get sick, this practice has been illegal for almost 20 years and in most states it was illegal long before that. And despite repeated references to people denied coverage because of a pre-existing condition, estimates are that only 1 percent of the population has this problem[11] persistently. (Remember: only 107,000 people enrolled[12] in the federal government's pre-existing condition risk pool — out of a population of more than 300 million people!) At most, Pauly puts the pre-existing condition problem at 4% of the population.[13]

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[7] *Health Insurance Marketplace: January Enrollment Report for the period: October 1, 2013 – December 28, 2013, 2014,* Department of Health and Human Services.
[8] *Insurers: Early Pool of ACA Exchange Applicants Older than Expected, 2013,* California Healthline.
[9] Edie Littlefield Sundby, *You Also Can't Keep Your Doctor, 2013,* The Wall Street Journal.

[10] Mark Pauly, *Health Reform without Side Effects: Making Markets Work for Individual Health Insurance, 2010,* The Hoover Institution.
[11] Paul Roderick Gregory, *Obama's Pre-existing Conditions Whopper, 2013,* Forbes.
[12] John C. Goodman, *ObamaCare Was Sold To American Voters On Deceptive Terms, 2013,* Forbes.
[13] Mark Pauly, *Health Reform without Side Effects: Making Markets Work for Individual Health Insurance, 2010,* The Hoover Institution.

So we started with a market that was working and working well for 96 to 99 percent of those who entered it and we have completely destroyed that market — ostensibly to help the few people for whom it did not work. We suspect that after the next election members of both parties will want a major return to normalcy. How can that work?

There is a principle that must never be violated. An insurance pool should never be allowed to dump its high cost patients on another pool. Suppose an individual has been paying premiums to insurer A for many years; then he gets sick and transfers to insurer B. Is it fair to let A put all those premium checks in the bank and force B to pay all the medical bills? Of course not. But even more important, if we do that we will create all of the perverse incentives discussed above — plus many more we might have added had time permitted.

The alternative is something we call "health status insurance.[14]" In the above example, the individual would continue paying the same premium to B that he paid to A and B would pay an additional amount to bring the total premium up to a level that equaled the expected cost of the individual's medical care.

Compare this idea to the Medicare Advantage market. Enrollees all pay the same premiums, but when a senior enters an MA plan, Medicare makes an additional payment to make the total amount paid reflect the true expected cost the senior brings to the plan. Because of this system, MA plans do not run away from the sick. In fact, there are special needs plans that specialize in attracting enrollees with high costs (about $60,000 per person on average).

Risk adjustment in Medicare does not work perfectly, however, and because the government runs the procedure, political pressures often interfere. So we recommend risk adjustment within the market rather than by an external government bureau. On this approach, insurer A and insurer B would have to agree among themselves on an appropriate transfer price. Only if they could not agree would the problem be left to an insurance commissioner to resolve.

John C. Goodman is president of the National Center for Policy Analysis, a research fellow with The Independent Institute and author of Priceless: Curing the Healthcare Crisis.[15]

John R. Graham is a Senior Fellow with the National Center for Policy Analysis and with The Independent Institute.

Greg Scandlen is a Senior Fellow with the National Center for Policy Analysis and with the Heartland Institute.

[14] John C. Goodman, *Rational Health Insurance, 2009*, John Goodman's Health Policy Blog.
[15] John C. Goodman, *Priceless: Curing the Healthcare Crisis, 2012*, The Independent Institute.

Chairman ISSA. Mr. Badger?

STATEMENT OF DOUG BADGER

Mr. BADGER. Thank you, Mr. Chairman, Ranking Member Cummings, and distinguished members of the committee. Thank you for inviting me to appear today to discuss the provisions of the health care law that have been characterized as insurance company bailouts.

People generally understand that the health care law includes subsidies for individuals who buy insurance. It should not provide subsidies to corporations that sell it. It has been argued that insurers cannot make a profit without such subsidies. CBO's most recent estimate on risk corridors suggest that in the aggregate issuers in the exchanges will realize premium revenue that substantially exceeds their projected costs. Their expected profitability is attributable to powerful tools contained in the law. These provisions help companies that sells through the exchanges prosper without the need for various corporate welfare provisions.

The law has handed such insurers enormous opportunities to increase their revenues and attract more customers, including healthy ones. It subsidizes the cost of their product. It penalizes people who do not buy their product.

Regulators have required the cancellation of non-grandfathered individual and small group policies and will cancel more later this year, leaving these people with little choice but to obtain insurance coverage through the exchange. It is an enormous Government effort that involves driving business to that segment of health insurers that sells through the exchanges.

Collectively, these provisions should be sufficient to induce millions of people into plans sold through the exchanges without the need for additional Government intervention.

The law's premium stabilization provisions raise concerns because they create the possibility of back-door assistance from taxpayers to insurance companies and the moral hazards that result. The law's risk corridors are among these provisions. CMS's decision to permit risk corridor disbursements in excess of receipts is what I find troubling. It creates the possibility that Government will use public money to mitigate losses incurred by insurers who improperly price their products.

CBO's estimate that risk corridors will save the Government $8 billion over 3 years offers some comfort, but CBO, as we all know, is often wrong and its new estimate is accompanied by a number of caveats. There is simply too much uncertainty surrounding the law's implementation for Congress to rely exclusively on this latest CBO estimate, which is subject to change without notice.

Instead, I believe we should amend the act either to repeal risk corridors or, in the alternative, to stipulate that aggregate risk corridor disbursements cannot exceed receipts. If CBO is correct, then the Government will get its $8 billion in deficit reduction. If it is wrong, taxpayers will be protected against unforeseen spending.

Now, some might argue that even a change this small and, in my view, this prudent should not be taken because insurers were not expecting the change when they established their 2014 premiums last spring. That is not a line of argument that Government has

found terribly persuasive when applied to individuals and small firms. Millions of individuals and small businesses were expecting to renew their coverage. They did not expect to have it canceled, but that did not stop the Government from ordering the cancellations.

More cancellations will come later this year, according to CBO, meaning that people will lose their coverage. That is not their choice but it is their fate. Put on a personal note, my mother-in-law expected to continue to receive care from the area's largest health system. She did not expect her Medicare Advantage plan to drop the system from its network, but that is one consequence of the Medicare cuts in the law.

Millions of Americans have been asked to adjust, adapt, evolve, to endure adverse consequences without complaint and without relief. They are dealing with the unexpected. Congress should ask no less of insurance companies. Insurers should be able to make a profit in Government marketplaces even if Government repeals risk corridors or prohibits expenditures to exceed receipts. The law's combination of mandates, subsidies, cancellations, and tax penalties can be expected to induce or compel millions of people in relatively good health to buy their product. Individual competitors will suffer losses if their costs exceed their revenues. That is not the taxpayers' problem. The Government has established its marketplaces. Let the insurers compete.

[Prepared statement of Mr. Badger follows:]

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

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

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

People generally understand that the health law includes subsidies for individuals who buy insurance. It should not subsidize companies that sell it.

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

I urge Congress to act by repealing the health care law's risk corridor provision, or at least requiring that CMS not disburse more in payments to insurers than it receives from them.

Before proceeding further, I want to make it clear that, while I am taking a position contrary to that advocated by many in the insurance industry, I bear no animus against insurance companies. On the contrary, I believe that they play a vital and essential role in the health care system. On a personal level, I know that when you face large medical bills, only the insurance companies have

your back. My objection is not to the enterprise of private health insurance, but to the reinsurance and risk corridor provisions that inappropriately provide them subsidies at the expense of taxpayers and group health plans.

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

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

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

Policy cancelations are the other stick. Millions of individuals and small firms have been told that it is illegal for them to renew their "non-grandfathered" coverage. Both parties have expressed sympathy for such people, but most were not provided relief. The Administration adopted an aggressive stance on cancelations in order to force millions of people who liked the coverage they had into the exchanges. I won't hazard even a rough estimate of the monetary effect of this policy, but it clearly inures to the benefit of insurers that sell through the exchanges.

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

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

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

Reinsurance is pure corporate welfare, a government-compelled transfer of $20 billion over three years to insurers that participate in the exchanges. Under this provision, these insurers can get

out from under the costliest medical claims. The government will pay 80 percent of medical bills that exceed $45,000 but are less than $250,000 out of a "reinsurance fund."

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

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

information until July 31 of the year **following** the benefit year, meaning that companies won't file their 2014 risk corridor paperwork until July 31, 2015. That should temper concerns about Congress changing the rules at the eleventh hour.

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

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

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

CMS has made it clear that it will make risk corridor payments even if the aggregate amount of losses in which the government "shares" exceeds the profits in which it "shares." CMS has not provided estimates on just how much this "loss-sharing" might cost. An article that appeared in

the October 2013 issue of *Health Watch*, a publication of the Society of Actuaries, says that the costs "could be substantial."

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

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

> We are proposing an adjustment to the risk corridors formula that would help to further mitigate potential QHP [qualified health plan] issuers' unexpected losses that are attributable to the effects of the transition policy. This proposed adjustment may increase the total amount of risk corridors payments that the Federal government will make to QHP issuers, and reduce the amount of risk corridors receipts … We cannot estimate the magnitude of this impact on aggregate risk corridors payments and charges at this time.

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

In effect, the agency has turned the risk corridor program, which should be budget-neutral like the risk adjustment program, into a form of corporate welfare. CBO has recently estimated that, on net, insurer payments into the risk corridor program will exceed disbursements by $8 billion over 3 years. CBO's estimate is accompanied by a number of caveats. There simply is too much uncertainty surrounding the law's implementation to rely exclusively on this latest CBO estimate. Instead, Congress should amend the Act to stipulate that aggregate risk corridor disbursements cannot exceed receipts.

Arguments Against Repealing or Changing The Reinsurance and Risk Corridor Provisions

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

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

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

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

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

exhaust the $10 billion, they would pay it out to the plans anyway by tinkering with the 80 percent number. In other words, the program's parameters still are not finally determined.

These regulatory improvisations suggest that what the law calls reinsurance is instead a subsidy amateurishly disguised as reinsurance – the direct transfer of money from group health plans to exchange plans. There is no plausible comparison to the Part D program and it should be repealed.

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

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

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

Cancelations. The Part D program did not require cancelation of anyone's prescription drug coverage. Indeed, the law provided subsidies to employers to continue their existing coverage,

thus denying prescription drug plans access to millions of potential customers. In addition to the choice of remaining uninsured, seniors could keep the coverage they already had. The lone exception was Medicaid, a change that was made because Congress believed that Medicare should be the primary source of medical and prescription drug coverage for all seniors. Given the frail state of many Medicaid-eligible seniors, including those in nursing homes, this wasn't necessarily a net positive for prescription drug plans.

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

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

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

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

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

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

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

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

It is odd to argue that it is unfair for the government to change its rules governing these provisions. The agency has been changing the rules on these programs repeatedly and they're still not entirely settled. With each regulatory iteration, the provisions become more generous to insurers – there are lower attachment points for reinsurance and a promise to distribute the entire $10 billion even if insurers don't submit enough claims to justify that sum; the agency will "adjust" risk corridor payments to account for the fact that fewer people will have their insurance canceled than previously anticipated.

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

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

Clearly, if that $10 billion were returned to the group health plans and additional assessments scheduled for 2015 and 2016 were repealed, premiums for those enrolled in such plans would be lower than under current law.

The argument that repealing risk corridors would raise premiums is really quite curious. Complexities aside – and the interactions between reinsurance, risk adjustment payments, medical loss ratio requirements and risk corridors are extremely complex -- symmetric risk corridors should be budget neutral. Plans set their premiums to cover anticipated medical claims, administrative costs and profits. Once the government has made its series of calculations, revenues should more or less randomly come in "too" high or "too" low. That is why CBO assumed that risk corridors wouldn't cost the taxpayers money and why the Part D risk corridors have actually marginally reduced the program's costs.

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

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

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

Some also have argued that, if the repeal of risk corridors were to result in a health plan raising its premiums, the government will have to pay bigger subsidies to people who enroll in that plan. That's not entirely true. The most recent report I've seen out of CMS indicates that around 20 percent of those who had selected a plan as of the end of December will not receive subsidies at all. So these premium increases will be passed through to consumers, who can avoid the increase by selecting another plan during open season.

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

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

Medicare Advantage network, but that is one consequence of the Medicare cuts in the health care law.

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

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

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

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

Chairman ISSA. Mr. Jost?

STATEMENT OF TIMOTHY S. JOST

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

The Affordable Care Act's risk corridor program is not a bailout. It is a rational approach to risk sharing in a public/private insurance partnership.

The ACA's premium stabilization programs have arguably already saved consumers and the Federal Government billions of dollars, and as we have heard several times today, the CBO is now projecting that the program will produce $8 billion in revenue for the Federal Government over the next 3 years. A very strange bailout.

But the risk corridor program is moreover a commitment of the Federal Government to private businesses, and breaking this commitment would not only be a breach of contract, it could possibly be an unconstitutional taking. The Federal Government must honor its debts and it must honor its contracts.

The ACA's risk corridors are modeled after the risk corridor program in the Bush administration's Medicare Part D drug plan. The Bush administration used risk corridors and reinsurance to get private insurers to offer a product that they had not offered before and did not know how to price. Insurers that offered Medicare Part D drug plans would price their premiums based on actuarial estimates of what providing the coverage would cost. If actual costs were higher than expected spending, the Government would absorb part of the loss. Conversely, if actual expenses fell below expected spending, the Government would recover excess gains. Additionally, the Bush prescription drug legislation reinsured 80 percent of all drug costs above a catastrophic threshold. These provisions, still in effect today, have been a key to the success of the Part D drug plan. Moreover, the Part D risk corridor program has turned out to be a net moneymaker for the Federal Government in every year it has been in effect.

There is a long history of the Federal Government sharing risks with private insurers. Federal subsidies to the national flood insurance program, which Senator Rubio voted to extend last week, have for 35 years enabled private individuals to purchase flood insurance through the Federal Government. The farm bill passed by this body last week included Federal reinsurance for crop insurance.

The ACA encourages private insurers to offer individual market coverage without underwriting for preexisting conditions through the exchanges. Congress built on the experience of the Medicare drug plan, creating a permanent risk adjustment program and temporary reinsurance and risk corridor programs. The Affordable Care Act risk corridors are, in fact, less generous than the Bush administration's programs, even though the risk that these companies are taking on is much greater, but they are intended for the same reason: to achieve stability for insurers and lower premiums for enrollees. In fact, because insurers did not have to charge a risk premium for this new product, premiums for 2014 came in 16 percent below CBO projections, saving the Federal Government billions of dollars.

A bailout occurs when the Government intervenes to save a business from its own unwise decisions without a legal obligation to do so. With the risk corridor program, however, the Government has encouraged insurers to take a risk by sharing, not assuming the risk. The Federal Government has entered into a contract with insurers to provide coverage through the exchange. Insurers relied on the premium stabilization program in setting their premiums.

But most importantly, removing the backstop of the risk corridor program would put private insurers at higher risk, possibly leading to insolvencies that would need to be covered at great expense by the State and Federal governments. It would lead to fewer participants and higher premiums in 2015. Since the full cost of premiums in the exchange is borne by the Federal Government, once lower and middle income enrollees pay a set percentage of their income, the cost of this program to the Federal Government would increase dramatically.

The risk corridor program is a commitment of the United States Government to private businesses, which it has partnered with to offer a public service. It is modeled after a successful program created by the Bush administration. Just, again, as the United States must not default on its debts for narrow political purposes, it must not breach its promises. Doing so is not only a breach of trust, it is also a foolish and short-sighted public policy.

Thank you.

[Prepared statement of Mr. Jost follows:]

House Committee on Oversight and Government Reform

The Operation of the Affordable Care Act's Risk Corridor Program

Timothy Stoltzfus Jost

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The Affordable Care Act's risk corridor program is a reasonable approach to risk sharing in a public-private insurance partnership. It is not a bailout. The ACA's premium stabilization programs, including its risk corridor provisions, have helped reduce premiums for qualified health plans, saving American consumers and the federal government billions of dollars. The CBO, moreover, estimates that the risk corridor program alone will result in $8 billion in revenues for the federal government.[1] The premium stabilization programs are, moreover, at this point a commitment of the federal government to private businesses. Breaking this commitment would be a breach of contract and possibly an unconstitutional taking. Just as the United States must honor its debts, it must honor its contracts.

The Risk Corridor Concept was an Innovation of the Bush Administration

First, a little history. In 2003, the George W. Bush administration faced a quandary. The administration was under tremendous political pressure to create an outpatient prescription drug benefit in the Medicare program, but was ideologically opposed to doing so through a public insurance program like the existing Medicare Parts A and B. The administration instead wanted to extend coverage through a government-subsidized private insurance program. But prescription drug-only private plans did not exist, therefore private insurers would have to create a new product. Insurers had no actuarial experience in pricing such a product, and the risk would be considerable. Private insurers would be reluctant to take on this risk.

The administration devised a solution that was at the same time both innovative and based on a long-tradition of public-private partnerships in insurance matters—risk corridors. Insurers that decided to offer a Medicare Part D drug plan would price their premiums based on their best actuarial estimates of what providing the coverage would cost. If actual costs exceeded 2.5 percent of expected spending, the government would absorb 75 percent of the excess loss.[2] If actual costs exceeded expected spending by more than 5 percent, the government would cover 80 percent of the excess loss. Conversely, if actual expenses fell below expected spending by more than 2.5 percent, the government would recover 75 percent of excess gains. The government would recover 80 percent of excess gains if actual costs fell more than 5 percent below expected costs. Additionally, the Bush prescription drug legislation offered to reinsure 80 percent of all drug costs above a catastrophic threshold. Since enrollees paid 5 percent of catastrophic costs, insurers were actually only responsible for 15 percent of catastrophic costs.

The rest is history. A Republican Congress created the Part D drug program.[3] With risk corridor and reinsurance protection, private insurers showed up to participate in the Part D program, and they offered initial premiums below those that had been expected. The risk corridors are still in place a decade later, and the program has been widely seen as a success.

Although the risk corridor solution to sharing risk was innovative, there is a long history of the federal government covering risks that private insurers will not assume to make private insurance viable. The National Flood Insurance Program has for 35 years enabled private individuals to purchase flood insurance through the federal government, allowing private insurers to offer homeowners insurance at reasonable rates by excluding the costly risk of flooding.[4] Senator Rubio voted with two thirds of the Senate last week for bipartisan legislation to continue federal subsidies for flood insurance.[5] Similarly, the Terrorism Risk Insurance Act of 2002 allowed commercial insurers to continue to offer coverage for businesses at reasonable rates by reinsuring the risk of terrorist attacks.[6] The farm bill recently passed by this body reaffirms the provision of federal reinsurance for crop insurers.[7] Cost-plus contracts in the defense industry are also similar in nature—the government assumes the risk of cost overruns to incentives private businesses to perform a necessary task for the government.

The Affordable Care Act Premium Stabilization Programs

In 2009 and 2010, a new Congress faced a similar quandary to that presented by Medicare drug coverage. Congress was proposing to create a national program through which private insurers would offer coverage in the individual market without pre-existing condition underwriting through marketplaces known as exchanges. Insurers had little experience with offering health insurance in the individual market without health status underwriting, and were understandably reluctant, as they were with flood, crop, and terrorism coverage and outpatient drug coverage for seniors, to take on the risk by themselves.

The Affordable Care Act, therefore, contained three premium stabilization programs, two temporary and one permanent. The permanent program, risk adjustment, was intended to move revenue from insurers who ended up with a disproportionate share of low cost insureds to insurers who ended up with high cost insureds.[8] This is a zero-sum program that does not receive any federal funding. A three-year reinsurance program, like that in the Part D drug program, provided a backstop for all insurers in the individual market for high-cost cases, funded entirely by a fee imposed on all insurers and self-insured plans.[9]

Finally, a three-year temporary risk corridor program program, would, much like that created by Medicare Part D, assure insurers that offered qualified health plans through the exchanges that the risk that they took on by entering the program would be shared by the federal government.[10] The Affordable Care Act risk corridor program is less generous than the Bush administration's Part D program was in its first years. Risk sharing payments from the federal government do not kick in until expenses exceed expected revenues by 3 percent rather than 2.5 percent, and then only cover half the losses rather

than 75 percent. Risk sharing payments do not increase to 80 percent of losses until costs exceeded expected revenues by 8 percent rather than 5 percent. Conversely, insurers whose actual spending is less than expected spending will contribute less to the program. Regulations specifying the parameters of the premium stabilization programs were finalized in the spring of 2013, and were relied on by insurers in setting their premiums and entering into contracts with the government for marketing their policies for 2014.

The ACA Premium Stabilization Programs Reduce Premiums

The combined premium stabilization programs achieved their goal. In the 36 states served by the federal exchange, the marketplaces are served by an average of 8 insurers offering 53 plans.[11] In part because insurers did not have to charge a risk premium for the risk of underwriting a new product, premiums came in 16 percent below previous Congressional Budget Office projections, saving enrollees an average of $1100 per year.[12] This in turn will save the federal government $190 billion over ten years in premium tax credits.[13] A study released last week by Price Waterhouse Cooper found that ACA exchange premiums cost the same or less than comparable employer coverage.[14]

The CBO did not originally assign a cost to the ACA risk corridor program, presumably because it expected contributions from insurers with below projected costs would balance out pay-outs to insurers with above projected expenses. In fact, however, the Part D drug plan risk corridor program has turned out to be a net money maker for the federal government. In every year since 2006, the federal government has received more from the program than it has paid out, with annual receipts ranging from $100 million to $2.6 billion.[15] For the first two years, at least, far more insurers paid in that received payments. Simulations developed by actuaries for discussion by a National Association of Insurance Commissioner actuarial group last year suggested that the same thing might happen with the ACA risk corridor program.

Whether this will turn out to be true for ACA insurers remains to be seen. The Congressional Budget Office currently projects that the risk corridor program will over three years result in $16 billion in revenue for the federal government, with $8 billion in expenditures, for a revenue gain of $8 billion. It is possible, however, that at least in the first year, the risk corridor program will end up costing more than it brings in. Problems with the website in the first two months of its operation, which continue to exist in some states, have led to below expected early enrollments and stalled enrollment campaigns. Determined efforts to discourage enrollment by opponents of the ACA, including state efforts to impede the work of navigators and assisters, recently declared unconstitutional in Missouri;[16] direct campaigns to persuade young people not to enroll; and continuing efforts by ACA opponents to spread unfounded rumors about insecurity of personal information submitted to the exchange have depressed enrollment. Misinformation and confusion about the program are rampant.

Although enrollment through the exchanges is currently strong, and open enrollment lasts for another two months, it is possible that enrollment will come in below expectations.

Since those most likely to sign up for coverage early are those who need it most, it is possible that the risk pool will be more costly than the pool insurers anticipated, although no one, including insurers, expected a normal risk pool for the first year of the program. Moreover, the political controversy surrounding the non-renewal of non-conforming individual insurance policies for 2014 forced the administration to allow the continuation of 2013 individual policies for another year, changing the composition of the expected risk pool in those states that allowed renewal of 2013 policies.

The Risk Corridor Program is not a Bailout

If risk corridor payments do exceed contributions, this still would not be a bailout by any stretch of the imagination. A bailout occurs when the government intervenes to save a business from financial distress—often caused by the business' own unwise decisions—without a legal obligation to do so. When private businesses run into financial distress because of risky behavior of their own, and the government rescues them, that is a bailout. The problem with bailouts is that they create a moral hazard problem—private businesses are incentivized to take unreasonable risks with the potential for private gain, trusting government to rescue them if they lose instead. The Wall Street bailouts resulted in huge losses for investors, consumers, and the taxpayers, but often rewarded those who took the risks.

This is not how the risk corridor program operates. The government is encouraging insurers to take a risk, but is sharing, not assuming, that risk. The government has by law prospectively encouraged insurers to take a risk by assuming a contractual obligation to share that risk.

The necessity of such a program, and impliedly the hypocrisy of trying to make an election issue out of it, has been recognized by conservatives such as Christopher Holt of the American Action Forum,[17] Yevgeniy Feyman in Avik Roy's column at Forbes,[18] and Avik Roy himself.[19] Feyman recognizes that opposition to these programs is short-sighted, since such programs will no doubt be necessary if Republican premium support proposals ever succeed. Feyman states:

> . . . any conservative reform plan for universal coverage will have to use similar methods of risk adjustment. The point here is simple – if you want insurers to participate more broadly in the individual market, you'll need to offer a carrot to offset the unavoidable uncertainties. And railing against risk corridors now will make them a hard sell further down the road. Risk adjustment mechanisms get you the buy-in of insurers, but they also helps keep premiums at manageable levels while insurers develop enough experience to properly price plans on their own. This helps encourage people to enroll in these plans, which in turn helps insurers develop the necessary pricing experience – resulting in a virtuous cycle.

The direct beneficiaries of the premium stabilization programs are American consumers, who are paying lower insurance premiums because of the program. Taxpayers also benefit because premium tax credit payments are lower if premiums are lower. Indeed,

whatever happens in 2014, in the end the taxpayer will likely come out ahead under the risk corridor program alone, as was true under the Part D program, but time will tell.

Repealing the Risk Corridor Program would be Illegal, Unwise, and Possibly Unconstitutional

Repeal of the risk corridors also would raise questions about the trustworthiness of the federal government. The federal government has entered into a contract with insurers that provide coverage through the exchanges. That contract incorporates the federal laws and regulations governing the exchanges, including the risk corridor program. Insurers relied on the terms of the ACA, including the risk corridor program, in setting their premiums. The government, like a private party, is bound by its contracts.

Indeed, the failure of the United States to honor its commitment to private insurers under the risk corridor program could be an unconstitutional taking, prohibited by the Fifth Amendment, as contractual rights are property rights for purposes of the Fifth Amendment[20] even though the federal courts prefer to find a breach of contract rather than a taking when both are possible claims. Moreover, the Supreme Court has recognized, honoring its contracts is in the "Government's own long-run interest as a reliable contracting partner in the myriad workaday transaction of its agencies."[21] This includes a general implied covenant of good faith and fair dealing as well as the express terms of the contract.[22]

But most importantly, refusing to honor its obligations would be foolish. Removing the back-stop of the risk corridor program would put private insurers at much higher risk, possibly leading to insolvencies that would need to be covered at great expense by the state and federal governments. It would certainly lead to fewer insurers participating in the exchange in 2015, and to higher premiums. Since the full cost of premiums in exchange coverage is borne by the federal government once lower- and middle-income enrollees pay a set percentage of their income, the cost of the program to the federal government would increase dramatically. These are, no doubt, results desired by opponents of the ACA, but are they good for the nation? Moreover, consider the consequences for all federal programs if the United States cannot be trusted to honor its commitments when it contracts with private businesses.

Conclusion

The risk corridor program is not a bailout. It is a contractual commitment of the United States government to private businesses with which it has partnered to offer a public service. It is modeled after a successful program created by the Bush administration. Just as the United States must not default on its debts for narrow political purposes, it must not breach its contracts. Doing so is not only a possible violation of the Constitution, but also foolish and short-sighted public policy.

[1] CBO, The Budget and Economic Outlooks, 2014 to 2024 (2014).
[2] 42 U.S.C. § 1395w-115(d).
[3] 42 U.S.C. §§ 1395w-111 et seq.
[4] 42 U.S.C.§§ 4001 et seq.
[5] http://politics.nytimes.com/congress/votes/113/senate/2/19
6 Pub. L. 107–297, 116 Stat. 2322 as amended by Pub. L. 109-144, 119 Stat. 2660, and Pub. L. 110-160, 121 Stat. 1839.
[7] 7 U.S.C. § 1508.
[8] 42 U.S.C. § 18063
[9] 42 U.S.C. § 18061.
[10] 42 U.S.C. § 18062.
[11] ASPE, Health Insurance Marketplace Premiums for 2014 (2013) http://aspe.hhs.gov/health/reports/2013/MarketplacePremiums/ib_marketplace_premiums.cfm
[12] Ibid.
[13] Topher Spiro and Jonathan Gruber, The Affordable Care Act's Lower than Projected Premiums will Save $190 billion (2013) http://www.americanprogress.org/issues/healthcare/report/2013/10/23/77537/the-affordable-care-acts-lower-than-projected-premiums-will-save-190-billion/
[14] PWC, Health Insurance Premiums: Comparing ACA Exchange Rates to the Employer Market, pwchealth.com/cgi-local/hregister.cgi/reg/pwc-hri-health-insurance-premium.pdf
[15] http://cms.hhs.gov/Medicare/Medicare-Advantage/Plan-Payment/Plan-Payment-Data.html?DLSort=0&DLPage=1&DLSortDir=ascending
[16] St. Louis Effort for Aids v. Huff (W.D. Mo. January 23, 2014), http://media.npr.org/documents/2014/jan/missouriorder.pdf
[17] Reinsurance, Risk Corridors and Bailouts, Oh My! http://www.realclearpolicy.com/articles/2014/01/23/reinsurance_risk_corridors_and_bailouts_oh_my_810.html
[18] Obamacare's Risk Corridors Won't be a Bailout of Insurers (2014) http://www.forbes.com/sites/theapothecary/2014/01/22/obamacares-risk-corridors-wont-be-a-bailout-of-insurers/
[19] http://www.forbes.com/sites/theapothecary/2014/01/10/humana-obamacare-exchange-enrollment-more-adverse-than-previously-expected/
[20] Lynch v. United States, 292 U.S. 571, 579 (1934).
[21] Robert Meltz, When Congressional Legislation Interferes with Existing Contracts: Legal Issues (CRS 2012); United States v Winstar Corporation, 518 U.S. 839, 883 (1996).
[22] Centex Corp. v. United States, 395 F.3d 1283 (Fed.Cir. 2005).

Chairman ISSA. Thank you.

I will now recognize myself for a series of questions, and I have a lot of questions.

Mr. Jost, just so you understand—and you can comment back for the record, but I read the elements of the bill. The insurance companies are entitled to absolutely nothing unless Appropriations appropriates money. So technically we can take the tax, take all $16 billion of the tax, and pay none of the $8 billion. Statutorily we say we do it, but it is subject to appropriations. So I know the President is a constitutional scholar. I would appreciate it if you would answer for the record on your view of it after researching it.

Chairman ISSA. Mr. Goodman, I want to ——

Mr. JOST. Can I respond to that or will I have time later?

Chairman ISSA. No. You helped write the bill. So the fact is that is what the bill says.

Mr. Badger and Goodman, I have got a bunch of questions and very little time. Let me just understand a couple of things that the public needs to understand that are tangential but are part of this.

There is an estimate of $16 billion to be gotten from overpayments, meaning I pay too much because I am in ObamaCare. I pay too much. The Government does not get it rebated when, in fact, I paid too much for my—I think it is a gold plan that we are required to buy. I pay too much. The Government takes that money. They do not let me get the discount for overpayment. Is that correct?

Mr. GOODMAN. I think that is right.

Chairman ISSA. They then—let us just say the Blues, United Health, any of them. They have another one that is a loss leader that they charge too little on. They get my money for the one when they were trying to buy market share. Is that right?

Mr. GOODMAN. That is right.

Chairman ISSA. Now, it could be the reverse. I could be getting the loss leader and somebody else could be paying.

So this whole balancing act includes the assertion that you take from one group of people who pay too much and give it to another, give it back to the companies.

Additionally, are they not taking $63 from every insurer in the way of a tax so that every American is paying $63 to fund exchanges?

Mr. GOODMAN. For the next 3 years, yes.

Chairman ISSA. For the next 3 years. So Americans who are losing the health care plan they wanted, the doctor they wanted, and so on, but have a private plan are paying $63 to run these exchanges. It is just another tax, a hidden tax.

Is there not another $100 billion or so in health insurance taxes that are also being paid that are funding ObamaCare?

Mr. GOODMAN. Yes. Everybody is being taxed, even the Medicare Advantage plans, the Medicaid managed care plans. They are all being taxed.

Chairman ISSA. Okay. So Americans are seeing part of their health care costs going up, in fact, for taxes that are being paid for subsidies like the underwriting here in this bill.

Mr. GOODMAN. Yes.

Chairman ISSA. It is amazing that they passed a bill that could hurt so many people, including the people who already were paying out of their own pocket for their insurance.

Mr. Badger, you were active in Medicare Part D and you saw it. Is it true that Medicare Part D has a substantial difference in what we did or did not know about Medicare Part D versus what we did or did not know about these plans?

Mr. BADGER. Yes.

Chairman ISSA. And in the case of Medicare Part D, it has been giving us revenue. Is that correct?

Mr. BADGER. That is correct.

Chairman ISSA. And is that revenue not essentially from overcharging for Medicare Part D?

Mr. BADGER. It is revenue that derives from the fact that insurers' actual revenues exceeded their costs by more than they expected.

Chairman ISSA. So the source that CBO was scoring—and I am not going to get into as many things as some other members might, but the source of this revenue that we are talking about coming to the Government as a good thing is, in fact, taxing our senior citizens. Whenever there is an overpayment, too much for the insurance, instead of rebating it back to the senior, we are taking it as tax revenue. Right?

Mr. BADGER. The revenue is collected and it is not distributed

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Chairman ISSA. So our seniors are being taxed on their paying too much for Medicare Part D. Right?

Mr. BADGER. It has to calculate that way.

Chairman ISSA. So it is not all that good a program when it goes on in perpetuity. Is it?

Mr. BADGER. A risk corridor program? I would agree. It is not one that goes on in perpetuity.

Chairman ISSA. So if we were going to do a risk corridor program, would it not be fair to make sure that at least the excesses in the reductions are fairly distributed back to the insured rather than going to the Federal Government as just another tax on people trying to buy necessary health insurance?

Mr. BADGER. I had not thought about that approach, Mr. Chairman, but at the very least, I would say that the Government should not pay out more in disbursements to insurance companies than it collects.

Chairman ISSA. You know, being a bleeding heart conservative I guess here, I am trying to figure out why people's necessary health care should be increased in price, called a revenue, so that if CBO is right, what we are really doing is taxing their health care and making it more expensive. And if they are wrong, what we are doing is taking the American people's hard-earned tax dollars to bail out insurance companies. We really lose either way as buyers of insurance. Is that not true, Mr. Goodman?

Mr. GOODMAN. I would say so, yes.

Chairman ISSA. Mr. Jost, the one item I wanted to have you respond for the record. But any of the questions I ask now if you could briefly comment on them. I am certainly happy to hear it.

Mr. JOST. Well, the purpose of the Affordable Care Act was to cover people in ——

Chairman ISSA. No. My questions, please, were all about are we not causing seniors to pay too much, are we not taxing health care. I mean, you helped write this thing, and I am seeing a series of taxes on hard-working Americans to pay for this that hard-working Americans did not know about. If you want to comment on that, that was my question.

Mr. JOST. I actually had nothing to do with writing this legislation.

Chairman ISSA. You have previously testified on a number—I thought you were more involved.

With that, I yield to the gentleman from Maryland for his questions.

Mr. CUMMINGS. Mr. Jost, please—first of all, thank you for clearing up that you did not write the legislation, you were not involved in that. And I want to thank you for your scholarly work.

Now, would you now respond? I think you wanted to respond to something that you did not get a chance to respond to that was asked by the chairman.

Mr. JOST. Yeah. An issue that I thought would come up today—and the chairman just raised it obliquely—was a CRS report that was made public yesterday that was actually passed on to the majority 10 days ago, but it was leaked to the press yesterday and first seen by minority staff and myself, claiming that appropriations are necessary before the risk corridor program can be operationalized. And I would just refer this committee to the case of Salazar v. Ramah Navajo Chapter from the Supreme Court in 2012 in which the Supreme Court said the United States are as much bound by their contracts as are individuals. Although the agency itself cannot disburse funds beyond those appropriated to it, the Government's valid obligations will remain enforceable in the courts.

For better or for worse, the Federal Government—Congress through this statute has made a commitment to the insurers that if you enter this risky market, we will share the risk. We will not free you from the risk because the risk remains shared. Companies that under-price their products will not make a profit, but the Government is sharing the risk to draw them into this market. And at this point, after the insurers have set their rates after they have gone into the market, to turn around and tell them that we are not going to honor the obligation set out in the law I think would be unconscionable.

Mr. CUMMINGS. Let me just ask you a few questions to follow up on that.

Medicare Part D was one of President Bush's signature legislative initiatives. It was supported by Senator Mitch McConnell, John Boehner, Speaker Boehner, Majority Leader Cantor, Budget Chairman Ryan, and Chairman Issa, all of whom voted for the bill. Medicare Part D included risk adjustment, reinsurance, and risk corridor programs. Is that right, Professor?

Mr. JOST. That is correct.

Mr. CUMMINGS. Those are the same programs that Republicans are now calling a bailout now that they are part of the Affordable

Care Act. I do not understand why Republicans were for these provisions before they were against them.

But one real difference is clear. They are obsessed with destroying the Affordable Care Act, and this is just a new proposal to do just that.

Professor Jost, can you explain why these risk mitigation programs were included in Medicare Part D? How did these risk mitigation programs impact the participation of insurers in the cost of premiums? And finally, do the Affordable Care Act risk mitigation programs work in the same way to increase participation of insurers and stabilize the cost of premiums? You got those three questions?

Mr. JOST. Yes.

The problem that the Bush administration faced in 2003 is that it was asking insurers to create a product that they had not previously marketed, a prescription drug plan for senior citizens. The three R's in the Bush drug plan served exactly the same purpose that they do here. They provided reinsurance for catastrophic costs. They provided risk corridors so that if insurers who priced their products inappropriately to begin with could have some comfort that they would not suffer great losses, although they did it differently, but risk adjustment to move profits from the insurers who ended up cherry-picking to those who did not deal with the problem that Dr. Goodman raised. Exactly the same thing happens under the Affordable Care Act.

As the chairman pointed out, there are fees that are imposed on insurers throughout the group market and the individual market to move funds not just to the exchanges but to all individual insurers to reinsure high-cost cases to try to make the individual market work, which it has not in the past. There is risk adjustment so that if insurers cherry-pick, they will have to pay the ones who take on the high losses. And then there are these risk corridors which again are there as kind of a flywheel to stabilize the program.

It was mentioned that risk is going to be higher because of the transition policy announced by the Obama administration. The GAO factored that into account. It said that would decrease the revenue of the Federal Government from the program from $8.5 billion to $8 billion.

Mr. CUMMINGS. And the risk corridor program for the Affordable Care Act is 3 years. Is that right? It has a limit of 3 years?

Mr. JOST. That is correct. It is only 3 years. So is the reinsurance program.

Mr. CUMMINGS. And what about the prescription drug program?

Mr. JOST. That has turned out to be indefinite.

Mr. CUMMINGS. Indefinite?

Mr. JOST. Yes. I mean, it is still in effect. It is actually still making money for the Federal Government.

Mr. CUMMINGS. Very well. That is the same one that Senator Grassley applauded as being so great.

Mr. JOST. That is correct.

Mr. CUMMINGS. Very well.

Mr. FARENTHOLD. [Presiding] Thank you, Mr. Cummings.

Mr. Jost, I was informed by the majority staff Mr. Jost made a comment that they had had this for quite some time, and they indi-

cate our staff just got that yesterday as well. It was originally requested by the Energy and Commerce Committee. Without objection, I would like to enter the report into the record so everyone has access to it.

Mr. JOST. I was informed that no minority staff of any committee had heard it or seen it heretofore.

Mr. FARENTHOLD. Thank you.

At this point we will go to the gentleman from Florida, Mr. Mica.

Mr. MICA. Well, thank you, Mr. Chairman and members of the committee.

First of all, you know, I have the greatest respect. We have had a great working relationship with the ranking member, Mr. Cummings. But I really have to disagree with him on some of his opening comments. I made a few notes.

You know, he gave the soliloquy about how we are covering all of these people. Actually if you look at the facts of the impact of ObamaCare, I have to say this that the facts differ with what the ranking member said in fact. Even if you took the best estimates of 2 million sign up, you have got about 40 million people who we have left behind with health care. Republicans want to find a way to provide health care in a cost-effective manner in which we make affordable health care available, and that was the intent of this. The 2 million they have signed up—Mr. Badger just testified—did you not, Mr. Badger—about how many people—it is just a big cost-shifting scheme that we have got here. You told me Detroit—was it you or Goodman? You said, Detroit, 10,000.

Mr. GOODMAN. Yes.

Mr. MICA. Yes. I am a victim. I did not want to sign up for that. The chairman had—he has got the gold plan. I think I got the bronze plan. I am getting screwed. Excuse the terminology before the committee. I am paying more. My deductibles are three times as much. I am forced on it.

But you are telling me here in the testimony we have heard today we have got cities shifting pension plans. We have got States dumping into the exchange. That is the great success, shifting the cost? Is that what you testified to, Mr. Goodman?

Mr. GOODMAN. Yes, it is.

Mr. MICA. This was predicted to be a train wreck. This is a massive train wreck. You know, you can only put so much—even at Thanksgiving, you can only put so much parsley around the turkey, and you have still got a turkey. This is sinful that we are spending billions of dollars to set up this mess. The Government is the worst in setting anything up, and we have seen that from a technological standpoint. But from a coverage standpoint, of signing up people.

Okay, here is CBO. The chairman started out today—this is the great success. We have displaced 2.5 billion people in work. Did you see this, Mr. Goodman?

Mr. GOODMAN. Yes.

Mr. MICA. I think that is an underestimate because if I was in business—I was in the private sector. The first thing you do—the 29 hours. He has forced already millions of people into part-time employment. Would you agree with that?

Mr. GOODMAN. I would.

Mr. MICA. Yes. They have been doing it. They did it in anticipation. These are full-time jobs—CBO.

Here. I want to put this in the record too. In 2024, there will be 31 million people still uncovered in a decade. That is sinful. That is a shame. And we are trying to cover people in a decade. Did you agree with this, Mr. Goodman or Mr. Badger? Did you see this?

Mr. GOODMAN. Yes.

Mr. MICA. Here is another point. Surprise. Millions of people who liked their insurance plan will lose their plan. They predict—and I have heard it is 5 to 6. They are predicting 6 to 7 fewer million people will have employment-based coverage. This is, again, CBO, not mine. This is not my estimate.

And then a fourth point. I am going to make five of them out of this report. ObamaCare reduces the incentive to find and keep a job. Not my comment. Boy, this is great getting people productive, employed, self-reliant, contributing to society and they are being able to support their family. This is a shame.

And then finally, here people are struggling to put gas in their car, pay their fuel bills, keep their kids in school, trying to make it, and the CBO says their paycheck—wait, listen—will be borne primarily by workers in the form of smaller, after-tax compensation. Do you agree with that, Mr. Goodman, Mr. Badger?

Mr. GOODMAN. I do.

Mr. MICA. This is a disaster for the working people of America and people without health care who need health care who should be covered by health care and then shifting the burden. This is just a big scheme to shift costs that has failed. Is that right, Mr. Goodman?

Mr. GOODMAN. Well, I do not know if I would use those exact words.

Mr. MICA. I would. I did.

Well, you said insurance is a business game. Somebody has to cover the costs. Right now we are shifting the costs. We are dumping the costs on the taxpayers, and it is going to be a lot to pay. And we are shifting the costs on people who had insurance who will lose insurance or see higher premiums. Gentlemen, Mr. Badger, Mr. Goodman, is that not the case?

Mr. GOODMAN. I believe it is.

Mr. BADGER. Yes.

Mr. MICA. Thank you.

I yield back the balance of my time.

Mr. FARENTHOLD. Thank you, Mr. Mica.

We will now go to the gentlelady from the District of Columbia, Ms. Holmes Norton.

Ms. NORTON. Thank you very much, Mr. Chairman.

Just to make it clear about the so-called 2 million jobs being lost, the Affordable Health Care Act has apparently freed 2 million who wanted to retire, wanted to leave the workforce, or perhaps get part-time work or to start their own businesses, but did not do so because there was no other way to keep their health care except to keep the jobs they did not want to hold.

Now, I want to ask about this risk corridor, Mr. Jost. Actually I was totally unfamiliar with the risk corridor until this hearing, and given the way in which it was framed, it seems strange for me

to hear that Democrats were protecting the insurance companies. So I had to look further into it, and I said to staff, go get me how conservatives would justify these risk corridors that they are responsible for getting into Part D. And so they came back with some remarkable commentary that I would like to ask you about. I told them I wanted only to hear about how Republicans, who after all authored this notion, would justify this. And here is one they came back with.

Christopher Holt of the American Action Forum. The risk corridor and reinsurance provisions in the Affordable Health Care Act made policy sense at the time the law was drafted, made policy sense today, and protect consumers. They do not constitute a bailout. It is a refutation of the total theme of this hearing.

Do you agree with that, Mr. Jost?

Mr. JOST. Yes. A number of conservatives ——

Ms. NORTON. If you could withhold statements, Mr. Jost. I just want to clarify where this came from and whether it is still justified by the conservatives who were responsible for it in the first place.

Go ahead, sir.

Mr. JOST. I would just say I assume you are going on, but this has been said by quite a number of conservative commentators, that this makes business sense.

Ms. NORTON. Let us take the consumers. Democrats have not been known for protecting insurance companies. They have been known for beating up—forgive me—on insurance companies for not protecting consumers. How do these provisions protect consumers?

Mr. JOST. Well, the way in which they protect consumers is that if I were an insurer—and I am a consumer representative to the National Association of Insurance Commissioners. I have been on a lot of calls with insurance actuaries discussing the Affordable Care Act. This is a risk that is very hard to price. If I were an insurance company without any of this backstop that was put into the law, I would have priced premiums very high to make sure that I covered my risk. But insurers could look at it now and price their policies at a reasonable rate, in fact 16 percent less than what the CBO had projected, because they knew that if they were off the first year, there was a backstop. Now, second year, third year, we are going to have better estimates, and as in the Medicare Part D plan, premiums are going to be closer to pricing as to what the actual actuarial risk is. But these programs are very important for consumers to make sure that premiums are priced without charging a fortune to cover the risk that is there.

Ms. NORTON. So the ultimate benefit is to the consumer.

Mr. JOST. Absolutely.

Ms. NORTON. So could these risk corridors in your view be characterized as a bailout in any sense of the word?

Mr. JOST. No, not any more than the flood insurance program is a bailout, the crop insurance program is a bailout, the terrorism risk insurance—they are all programs where there are very high risks and actuarial uncertainties that the ——

Ms. NORTON. Let me just quote another. I just cannot get over what conservative commentators have said.

Here is another from the Manhattan Institute. Risk adjustment mechanisms get you the buy-in of insurers, but they also keep premiums at manageable levels while insurers develop experience to properly price on their own. This helps encourage people to enroll in these plans which, in turn, helps insurers develop the necessary pricing experience, resulting in a virtuous cycle.

Professor Jost, do you agree with the Manhattan Institute statements?

Mr. JOST. I think for once they are right.

Ms. NORTON. You said what?

Mr. JOST. For once they are right.

Ms. NORTON. You know, it is interesting, Mr. Chairman, where Republicans and Democrats have adopted the same mechanism and there are things about this bill that I think both Republicans and Democrats need to be fixed, but the very last thing I would focus on is something that Republicans and Democrats have agreed about in the first place.

And I thank you very much, Mr. Chairman, and I yield back the remainder of my time.

Mr. FARENTHOLD. Thank you very much.

We will now recognize the gentleman from Tennessee, Mr. Duncan, for 5 minutes.

Mr. DUNCAN. Well, thank you very much, Mr. Chairman.

Mr. Mica referred to the train wreck quote, and as almost everyone here knows, that quote about ObamaCare being a giant train wreck came not from a Republican, but from Senator Baucus, the chairman of the Senate Finance Committee and one of the health care leaders for the Democratic Party.

And then, of course, Speaker Pelosi famously said we would have to pass this legislation before we could find out what was in it. And every week, the more we find out, the worse it gets including, as the chairman mentioned briefly, the estimate by the Congressional Budget Office that this is going to destroy 2 million jobs over the next 3 years.

But this was sold as being a law to get medical insurance or health care for those who were uninsured. I heard a program last night in which they said that the original estimates of 30 million or a little more maybe being uninsured was really incorrect, that the number was more like 9 million or 10 million who actually did not have it, and some of those were people who were between plans and were choosing not to have coverage.

Dr. Goodman, I would be interested to know if you know what was the accurate figure then. And also, I have two articles in front of me that say that at least two-thirds of the people who have signed up now already had coverage. I did not get to hear your testimony. I was at another committee. Is it accurate that at least two-thirds of the people who have signed up so far already had coverage before this legislation was passed?

Mr. GOODMAN. There are estimates even higher than that, estimates that only 11 percent in one survey were previously uninsured. So that means 89 percent had previous insurance. So we appear not to be doing a very good job at insuring the uninsured.

Mr. DUNCAN. Would not the best way to get people—to get our health care costs under control would be to give individuals more

control over their own medical spending either through the vouchers or tax incentives or other ways?

Mr. GOODMAN. Well, the Affordable Care Act does some of that. The problem is that it does a lot of things that should not be done that I described in my testimony. It is allowing pools with a lot of high-cost sick people to dump into the exchange, to dump into the individual market which previously was a market that worked pretty well, and now it is going to be a very high-cost market.

Mr. DUNCAN. So I am told that Detroit and Chicago and possibly other cities are considering or are in the process of dumping their older, sicker retirees onto ObamaCare. Is that correct?

Mr. BADGER. I believe Detroit has done the deal. That is about 10,000 retirees, and because they are older, they are going to be higher-cost. Chicago is considering it.

But there are lots and lots of cities around the country that have made unfunded promises about post-retirement health care. So there are a lot of potential costs that could be going toward the exchanges.

Mr. DUNCAN. Charles Krauthammer wrote this. He said the whole scheme was risky enough to begin with, but things have gotten worse. The administration has been changing the rules repeatedly. First, it postponed the employer mandate. Then it exempted from the individual mandate people whose policies were canceled by ObamaCare. And for those who did join the exchanges, Health and Human Services Secretary Kathleen Sebelius is strongly encouraging insurers to, during the transition, cover doctors and drugs not included in their clients' plans. The insurers were stunned, told to give free coverage, deprived of their best customers, forced off or stripped down catastrophic plans to over 30 clients contrary to the law. These dictates, complained their spokesman, could destabilize the insurance market. Translation: how are we going to survive this? End result: insolvency.

And I think most of us feel that he is one of the most accurate and intelligent people on the scene today.

Mr. Badger, I was asked by the staff to ask—they think that you may have some disagreement with Mr. Jost about the necessity of these risk corridors or a little different view.

Mr. BADGER. I have a different view. My concern has been regulatory issuances and pronouncements from CMS that had been repeated now throughout the time period that they could make payments to insurance companies out of the risk corridor plan that exceed the amount of money that other insurers have paid in. If the risk corridors are merely, as they are in Part D, and in the risk adjustment program both in Part D and in this law, simply moving money from insurers that are doing well to insurers that are struggling—I have no problem with that.

The problem I have with the way the risk corridors are being applied by CMS is that it allows insurance companies to say to the taxpayer we have a problem, I lost money. And that is the behavior that I think should be of concern to Congress and that it should correct.

Mr. DUNCAN. All right. Thank you. Unfortunately, I have run out of time. Thank you.

Mr. FARENTHOLD. The gentleman's time has expired.

We will now recognize the gentlelady from California, Ms. Speier.

Ms. SPEIER. Mr. Chairman, thank you.

You know, I have a fantasy that I would like to share with you, and it is a fantasy that we would have a new House rule that would require members to wear Pinocchio noses every time they make a statement that is not true because if they had to walk around with Pinocchio noses on, they would be careful about the kinds of statements they make.

Now, the statement that has been made by the leadership of both houses in the last 24 hours is that we knew it was true, it is true. The CBO now says it is true. 2 million jobs will be lost as a result of the Affordable Care Act. And that statement is just false.

The "Washington Post" fact checker gave the claim three Pinocchio noses with a headline that read: "No. CBO Did Not Say ObamaCare Will Kill 2 Million Jobs." The fact checker explains it like this.

First, this is not about jobs. It is about workers and the choices they make.

He further explains, look at it this way. If someone says that they have decided to leave their job for personal reasons—they just decided they wanted to retire early—we would not put them in the category of having lost their jobs.

The "New York Times" editorial board called this a liberating result of the law.

So in other words, the report is about the choices workers can make when they are no longer tethered to an employer because of their health insurance. And there are so many Americans that stay in jobs just because they have to keep their health insurance.

So my question is to you, Professor Jost. Please do your best to clear this up. Can you explain how the Affordable Care Act frees individuals and how it does not kill jobs in this country, but has actually the reverse effect?

Mr. JOST. Like you, I run into people all the time who tell me I would love to quit this job, but I cannot because I have to be here for health insurance.

About 15 years ago, my brother-in-law basically quit his job. He had health insurance through his wife, fortunately, but he went out on his own and started a company that is now a household name that is worth billions of dollars. My wife and her family all were part of that startup.

Ms. SPEIER. What is the name of it?

Mr. JOST. Rosetta Stone.

But he was able to do that because he did not have to worry about health insurance, or at least he was able to go out there on his own without it. There are many, many Americans like that today who would like to go out and fulfill their dream, but they are stuck in their job because of health insurance.

What the Affordable Care Act says, if you are making less than 400 percent of poverty, which includes a lot of entrepreneurs in this country, you can go out and you can fulfill your dream or you can just stop working at 60 because you are tired and you can get health insurance regardless of your health status. That is a very liberating thing, and that is what the CBO recognized yesterday.

In fact, they did say there are concerns about employers cutting back on employment and cutting back on hours. That did not figure into their calculation because they said there are just too many unknowns there. There are reasons why employers might expand their workforce. There are reasons they might cut back.

But the 2.5 million full-time equivalents is people who are stopping work because they have the freedom to do so or reducing their hours.

Ms. SPEIER. Let me ask you a further follow-up question on risk corridors. The risk corridors and reinsurance provisions in the ACA are really the same McConnell-Boehner provisions that were included in the Medicare Prescription Drug Improvement and Modernization Act. I know Mr. Badger is shaking his head no, but the truth is there is reinsurance in both programs. And this reinsurance, unlike the reinsurance in the Part D, is one that exists only to 2017, and there really is no Federal dollars involved.

So my question, Professor Jost, is it is my understanding that the Congressional Budget Office just this week released its revised budget outlook for 2014 to 2024, and it scored the reinsurance program as budget-neutral. Is that correct?

Mr. JOST. It is because under the statute, only the money can be spent that is brought in under the program.

Ms. SPEIER. And is it not also true that in essence there is a transfer of funds between insurers, and thus it has no impact on the Federal budget?

Mr. JOST. That is technically correct, yes. I mean, it is a tax that it has imposed on insurers in the group market primarily to subsidize the individual market for 3 years, in part because of these transfers from the group market to the individual market that have already been discussed.

Ms. SPEIER. And when we talk about Medicare Part D, was there not also reinsurance involved in that program?

Mr. JOST. Yes, there was.

Ms. SPEIER. And how did that work?

Mr. JOST. Well, there still is reinsurance. In fact, the risks borne by Medicare Part D insurers is very, very small, and up until recently it was very small because it was only up to the point you hit the donut hole. At that point, there was essentially reinsurance from Medicare beneficiaries who covered the full cost up until you got to the catastrophic. When you got to catastrophic, the Government picks up 80 percent of the risk. The insurers only picked up 15 percent, and the beneficiary picked up 5.

Ms. SPEIER. Mr. Chairman, thank you. I see my time has expired.

Mr. FARENTHOLD. Thank you very much.

I am up next. One of my least favorite times when I was in the private sector was the time I had to redo the insurance for my employees. I want to kind of step back a little bit and take an overview about this. I will start with you, Dr. Goodman.

The way insurance works is they sell policies to a bunch of people, and hopefully the money that comes in from that covers the losses for the people in that group. So it ends up the healthy people end up subsidizing the 52-year-old, overweight Congressman with

high blood pressure in a high-stress job. Is that basically how insurance works?

Mr. GOODMAN. Well, that is true in every market. But in most insurance markets, the premium that was charged at the point of entry reflects the expected cost then.

Mr. FARENTHOLD. Right. What we had in ObamaCare then was the idea we have got a whole new market and the insurance companies are concerned that they do not know how to price this and what the actuarial risk is, how many unhealthy people versus healthy people. Is that an accurate statement of part of the problem?

Mr. GOODMAN. Yes, and we could be stronger than that. We have built perverse incentives into the structure of the market, and I think that is totally unnecessary.

Mr. FARENTHOLD. All right. So as a result of this, part of the deal that was struck in ObamaCare is we put these risk corridors in so that taxpayers are potentially on the hook in the event that the loss ratio is out of whack. Is that a fair assessment of ObamaCare and what we are talking about today?

Mr. GOODMAN. Sure.

Mr. FARENTHOLD. All right. So let me ask you a question. The President has been under a lot of fire for his statement, if you like your health insurance, you can keep it, and there have actually been some changes made to ObamaCare as a result of that. As a result, the policy offerings have changed. Is that going to run up the cost potentially to insurance companies and increase the amount taxpayers may be on the hook under these corridors?

Mr. GOODMAN. Well, I think the way they have changed some of the rules of the game within the last month or so has increased the riskiness of the products in the market.

Mr. FARENTHOLD. All right. Now, assuming you owned an insurance company, would you have jumped into ObamaCare but for these risk corridors? I mean, would you have said, all right, I am out of the health insurance game or this is too risky, or would you maybe have run your prices way up?

Mr. GOODMAN. Well, you got to understand I do not have a problem with the risk corridor. What I have a problem with are the poor design of the exchange which is then going to put taxpayers at great risk to pay for those design mistakes. It is not insurance company mistakes.

Mr. FARENTHOLD. Mr. Badger, do you want to weigh in?

Mr. BADGER. Yes. Again, I do have concerns with the way risk corridors work in this law as opposed to Part D and particularly with the way CMS said they would work, and that is to say that because of the problems that are created for insurance companies, CMS is going to give them direct subsidies out of taxpayer funds, not out of revenues that come in.

Mr. FARENTHOLD. All right. So let us go to this scenario. Suppose we decide we are not going to do these corridors and we pull them out. The insurance companies are going to be on the hook for these losses. Is there a way they are going to be able to reinvent their policies and stay in business? How do we get out of this without bankrupting the insurance companies and have no insurance mar-

ket at all left and potentially end up with the Government being the only insurer of last resort?

Mr. BADGER. Well, that raises other questions about the law's design that Dr. Goodman has raised.

But I guess the principle I would like to lay out is this. If you cannot make a profit without corporate welfare, you cannot make a profit, and we should not be putting taxpayers in the position of having ——

Mr. FARENTHOLD. But were insurance companies not making a profit before ObamaCare?

Mr. BADGER. Yes, they are. And they may well make a profit in ObamaCare. CBO's announcement yesterday suggests that they will do very well. If they are paying $16 billion in and only taking $8 billion out of the risk corridors—I do not think they are right about that, but if they are, CBO thinks they are going to make a profit.

Mr. FARENTHOLD. Dr. Goodman?

Mr. GOODMAN. There is a better way of doing this. We call it change of health status insurance. But the fundamental principle is the insurance pools do not get to dump their sick people on other insurance pools. If we would just follow that principle, the taxpayer would be far less at risk than they are right now.

Mr. FARENTHOLD. And you think this could be done as a tweak to ObamaCare somewhere? We got such a big, massive law. Our side, I think, wants to be done with it and start over. Can this be done short of starting over and maybe get some of our colleagues on the other side of the aisle to help?

Mr. GOODMAN. Yes, but I would not call it a tweak. It would require a fundamental restructuring of the exchanges, and they would probably, at the State level, have to be instructed to move over time to a rational form of insurance.

Mr. FARENTHOLD. We could talk about this a good bit longer, but I see that my time has expired. Just because I am in the chair does not mean I get to break the rules. So I will move along and recognize Mr. Massie for 5 minutes.

Mr. MASSIE. Thank you, Mr. Chairman.

The chairman makes a good point. I would like to look into it a little bit more.

Senator Rubio made the observation that when the President tried to retroactively make good on his broken promise, his empty promise that if you like your health care plan, you can keep it, by unilaterally forcing insurance companies to grandfather insurance policies that were not included in the Affordable Care Act, he actually increased the likelihood that the bailout provisions of the risk corridor program would be invoked.

And I would like to give everybody on the panel here a chance to answer this. Do you agree with Senator Rubio's assertion that by changing the rules midstream that the President actually increased the probability that the risk corridor would have to be invoked?

Mr. GOODMAN. Well, if all the insurers price their products on the assumption, let us say, by the end of this year, 80 percent of the people in the individual market would be in the exchange and then we change the rules and say, no, if you are healthy and you

are in a plan that you like, you can stay there, yes, of course that increases the cost and the riskiness of the exchange.

Mr. MASSIE. Thank you.

Mr. Badger?

Mr. BADGER. My understanding is that CBO quantified that at about half a billion dollars in payments that would come out of the risk corridor program to insurers.

Mr. MASSIE. Mr. Jost?

Mr. JOST. Yes, and therefore, it reduced the surplus to the Federal Government from $8.5 billion to $8 billion, but yes, that did increase the risk. It was, of course, a response to a political firestorm over the cancellation issue, which I think was largely a bogus issue, but that was the administration's response.

Mr. MASSIE. Well, I am glad to hear that all the witnesses agree that the President actually, by trying to change this law midstream unilaterally without Congress, has increased the risk that taxpayers will be on the hook for the insurance companies' losses.

Mr. Badger, you have stated that—I think you have stated in the past that the reinsurance provision and risk corridor provisions limit insurer competition. Does the risk corridor program, even if it worked as some people say it does by taking a pool of money and distributing it among the insurance companies, even if it worked that way and did not take taxpayer money—does it not just reward unsuccessful competitors with money it confiscates from successful ones?

Mr. BADGER. Well, there is no question that the formula, in effect, works that way so that if your losses exceed your target amount by more than 3 percent, that you would be entitled to payments out of the pool. So if it functions properly, it is a redistribution from insurers who were successful to those who were less successful.

Mr. MASSIE. Let me ask you another question. You have argued that the individual mandate was put into place actually to benefit insurance companies, I believe. Is that correct?

Mr. BADGER. Yes. My point was, unlike Part D where we did not have the IRS penalize seniors who did not sign up for drug coverage, the argument here was that insurers could not succeed unless there were, in addition to subsidies, both penalties on people who did not buy and as well canceling policies that people would have liked to renew. So, yes, the idea is these were all provisions designed to help insurance companies succeed despite some of the distortions that Dr. Goodman has talked about.

Mr. MASSIE. Speaking of distortions, does this risk corridor provision not incentivize the insurance companies to offer artificially low sort of introductory rates because they have a backstop? Would their first rates not be higher without this risk corridor provision?

Mr. BADGER. There is moral hazard. And understand again, unlike Part D, everybody is offering the same benefit package. So the only way to distinguish yourself really in the marketplace, aside from provider networks, is by price. So if we are both selling silver plans, chances are the person with the lower price will get the most enrollees. So, obviously, if you believe that the Government will share in your losses, there is a moral hazard that you will price too

aggressively in order to drive competitors out and gain market share.

Mr. MASSIE. Thank you.

Mr. Goodman, in my remaining time, you mentioned in your opening statements that employers could game the system, I believe. Could you elaborate on that?

Mr. GOODMAN. Well, one of the techniques that they are going to use is they are going to cover preventive care with no lifetime cap, and that gets them out from under the $2,000 fine. But these could be mini-med plans. So if a worker gets sick and goes to the exchange, then the company can be fined $3,000. But if a worker goes to that length, his medical expenses will probably be way in excess of $3,000. So this is a way, just one—and we could talk about others—for employers to move their sickest, most costly employees over to that exchange when they have a health problem.

Mr. MASSIE. And this is one reason that the way this program is set up it is just not going to work. Is it not?

Mr. GOODMAN. Well, there are many, many ways to game the system, and if we do not deal with all of that, we are going to have huge problems in the future.

Mr. MASSIE. Thank you. My time has expired.

Mr. FARENTHOLD. Thank you very much.

We will now recognize the gentleman from Georgia, Mr. Collins.

Mr. COLLINS. Thank you, Mr. Chairman.

I think one of the things that we get lost in many times here is we lose—and I have tried to bring this to light over time—is we lose the human face of what we are talking about. It is easy to come up here and talk about bailouts, risk corridors. Frankly, that does not mean anything.

And frankly, Mr. Jost, just a moment ago, you said that you felt like that the dropping of insurance coverage was a bogus issue. If you would like to come to the 9th District of Georgia, I will be happy to show you people who have lost their coverage who are dealing with this right now. I think that was one of the most callous statements that I have heard today in this hearing, and I think to say a bogus issue on people who are actually losing insurance and having trouble with this plan is not—there has been at least acknowledgement on both sides of the aisle that there is a problem here. And I mean, to say that is just, frankly, to me is just very callous to those who are having to deal with the results of what has become a very bad law.

Mr. JOST. I would be happy to explain the response, if you want me to.

Mr. COLLINS. At this point, I think your response was clear enough, Mr. Jost.

Reclaiming my time. One of the issues that I have seen and one of the issues here dealing with insurance—and again, I think the insurance companies—we can deal with that in this risk corridor issue. We can deal with it from how the system was set up. Mr. Massie made a great point on how we are actually making it worse in some ways.

But mine is overall and dealing with a system in which people are having to deal with. And one is a constituent of mine I talked to yesterday, Rebecca Lambert. She is from Stephens County. It is

a little place up in northeast Georgia, Martin. She runs a small business, Calico Country Store. It is one of those one-stop shops. Up in my part of the world, you get a lot of these. You can buy groceries. You can buy plumbing equipment all in the same place.

She is recently widowed and she is struggling to run the store. And in doing so, all of this for the first time, she pays her bills, she pays her taxes, she works hard. And she was not real thrilled to find out she was going to have to go through ObamaCare and do this to start with. She did not want the dictate of how she had to do it and went ahead. But being a good citizen, she said, okay, I will do it. This is the way I have got to do it because I do not want the penalty. She went ahead and bought insurance because that was the law. She signed up under healthcare.gov. She got a plan, she thought. She received a bill, paid her premium, but has not received any proof of insurance. 5 and a half hours on hold on Friday, 2 and a half hours on hold on Monday, and has not been able to talk to a soul. She is all paid up to her knowledge. She cannot even get someone on the line to confirm she is covered. That means she spent 8 hours over the course of the day trying to figure this out through a program she did not want to be a part of to start with, and at this moment, if she was to walk into a hospital or an emergency room anywhere, she has no proof of insurance that she has. And nobody can talk about it.

With all due respect for what we are doing here—and the chairman has brought out—and there have been concerns on all sides—I am concerned more about the welfare of my constituents and how they are having to deal with this and how they are having to go through it than the bottom line of the insurance or anything else at this point.

Why are we going through this in a way that puts people in positions of not understanding, of yes, losing the coverage that they had, trying to find other coverage, or in the case of many of the State employees in Georgia, paying more or equal for less coverage?

I believe—and I will just say in a good-hearted effort—for those trying to work this, there was an effort to help, but many times in the rush to help, when you only have one, you get tunnel vision. And what is happening is people like my constituent Rebecca are the ones that get lost in the tunnel vision. To help X, we do not realize what we hurt on the outside. That is what is coming up here. And whether it is the risk corridors or covering profits or going back and saying this was capped or not, this is just the problem that we are dealing with when you cannot get confirmation, when you cannot get issues that are going on.

As I have said earlier from the floor of the House, I had a lady who is going through cancer treatment, and she has issues. It is not covered under her new plan. Her cancer treatments were halted until proof could be provided. Are you kidding me? This is what we are dealing with.

So I think really—and not personal to any witness, but to be in a position where we are talking about this and removing it from the people, that is the problem I have here.

I could question you and grill all three of you on many things. My people just want to know why has such a bad system been put on me and forced me to pay higher for less or forced me to change

or forced me to look at insurance companies in a way that I had not looked at before or frustrated with before in a way that is very unreasonable and callous.

With that, that is why we do these oversight hearings. It is time to fix this. It is now time to do it and it needs to be done away with.

With that, Mr. Chairman, I yield back.

Mr. CUMMINGS. Would the gentleman yield?

Mr. COLLINS. Yes.

Mr. CUMMINGS. I just want to give Mr. Jost a chance to just respond to what you said.

Mr. JOST. Well, just very briefly, obviously there were many people and are many people who are losing the coverage that they had. They are all being offered alternative plans. Some of them are more expensive. Some of them have higher cost-sharing. Many of them are less expensive. Many of them have lower cost-sharing. Many of those people are having access to premium tax credits that are making their health care insurance substantially less expensive.

I misspoke. I would have to say that. It is not a bogus political issue. But to call these things cancellations instead of what they were, which was non-renewals of the current policy offering and an offer of an alternative, which happens all the time in the individual insurance market—I think to make it sound like these are people who are suddenly uninsured and have no chance of getting insurance—every one of them can get insurance, and many of them can get it for less than before.

Mr. COLLINS. Mr. Chairman, reclaiming my time on this.

Your first statement basically just summed up your last statement. It was callous. It did happen. And to say that it did not and it happens all the time is again a perpetuation of what we are talking about here, of being very honest with people. And yes, they have cancellations not because the cancellations occurred and they could not get other insurance. It was because the Government told them because of the ACA that these were not going to be renewable policies, and they could not have what they had. They do not have what they had. And to really say that—with all due respect to the ranking member, I appreciate him allowing—this is the problem we are talking about. But your first statement was summed up by your last statement.

And with that, I do yield back.

Mr. FARENTHOLD. Thank you very much.

We will now recognize the gentleman from Michigan, Mr. Walberg, for 5 minutes.

Mr. WALBERG. I thank the chairman, and I thank Mr. Collins for following up on that and pressing that issue because that is a crucial issue that we are addressing here. We are talking about real live people, and certainly we want to meet needs of those, a frankly smaller number right now, that are having better opportunity, and those are the people we could have fixed with a far more simple system dealing with the issue of cost.

Mr. Badger, just to make sure it is clear, is it correct that the reinsurance provision is financed by a fee or a tax on all non-exchange health insurance plans?

Mr. BADGER. Yes, on group health insurance plans. That is correct.

Mr. WALBERG. Is it accurate that the vast majority of individuals with health insurance will be paying higher premiums to finance the reinsurance fund?

Mr. BADGER. Yes.

Mr. WALBERG. So essentially the reinsurance fund is a large transfer from the vast majority of Americans without an ObamaCare insurance plan to the few Americans with an ObamaCare plan.

Mr. BADGER. To their insurers. That is correct.

Mr. WALBERG. To their insurers.

Moving on from that relative to cost, how do risk corridors, as implemented in ObamaCare, impact the pricing of health insurance, Mr. Badger?

Mr. BADGER. Well, I think arguably they should induce insurers to be willing to take on more risk. They also, as I mentioned earlier, provide a moral hazard. If you know that the Government, the taxpayer, will share in your losses and the only way you are allowed to differentiate yourself is by price, you may price more aggressively to gain market share. So there are some perverse incentives that actually would hurt consumers over the longer run.

Mr. WALBERG. So relative to that moral hazard, expand, if you would on the implications of companies under-pricing exchange plans versus non-exchange plans.

Mr. BADGER. Well, you know, to be honest, as the professor has noted, basically non-exchange plans will soon be nonexistent for all intents and purposes. But for those who are selling compliant plans both inside the exchange and outside the exchange, those issuers would participate in the risk corridor program. They do not, however, outside the exchange get subsidies for the coverage.

Mr. WALBERG. Do you think that companies did this in order to drive enrollment into the exchanges and the generous subsidies that are there?

Mr. BADGER. I do believe that the purpose of the policy that required the cancellations, yes, was to move more people into insurance policies sold through the exchanges.

Mr. WALBERG. How do risk corridors, as implemented in ObamaCare, impact the pricing of health insurance?

Mr. BADGER. Well, again, as we talked earlier, there is ——

Mr. WALBERG. I am sorry. I missed it.

Mr. BADGER. No. That is quite all right.

The issue there that we are concerned about is that insurers would price so aggressively to gain market share because of the fact they knew that the taxpayers would be on the hook for some of their losses. And so there could be a price effect in the near term that would be favorable, but it could have long-term negative implications.

Mr. WALBERG. So the longer it goes on, the more negative the implications for the price for the consumer.

Mr. BADGER. Potentially if it affects market share substantially.

Mr. WALBERG. And health care in general.

Mr. BADGER. Yes.

Mr. WALBERG. Thank you.

Mr. Chairman, I yield back.

Mr. FARENTHOLD. Thank you very much.

I see Ms. Maloney has just arrived. Do you have some questions?

Mrs. MALONEY. I do, and I apologize to the chairman and ranking member. I had a conflict.

Mr. FARENTHOLD. That is all right. We will be happy to give you your 5 minutes. We will give you a second to get settled, and we will start the clock as soon as you start.

Mrs. MALONEY. I want to thank all the panelists for joining us today.

And I guess my question is for Professor Jost. It is my understanding that the risk corridor program is a key element of the Affordable Care Act that helps keep premiums in the exchange affordable by reducing uncertainty to insurers. We know if there is uncertainty, the price goes up. Right? So can you explain why insurers face such uncertainty in new programs like the Affordable Care Act and Medicare Part D and how the risk corridors operate to reduce this uncertainty?

Mr. JOST. Yes. Again, the idea here is that insurers have traditionally priced their products based on their assessment of the health of the people that they were insuring. So they charged low rates to healthy people and high rates—or totally excluded, as they do in many instances, people who are unhealthy or exclude their unhealthy conditions. Under the reform law that this body adopted in 2010, they cannot do that anymore. And so that puts them in a situation where it is much harder for them to price their products. So there is this temporary program for 3 years called the risk corridor program, another temporary program for 3 years called the reinsurance program that provides a backstop for them so that they can price their products in a way that is affordable to consumers. And that has been very successful.

Mrs. MALONEY. That is wonderful.

Were the risk corridors successful in getting insurance companies to participate in Part D?

Mr. JOST. Yes.

Mrs. MALONEY. That did work that way. Well, thank you.

I would also like to ask about the effect of risk corridors on premiums. Did the Part D risk corridor help stabilize premiums in the opening years of the program?

Mr. JOST. Yes, and the premiums in the Part D program came in under projections for the first year.

Mrs. MALONEY. And what about the Affordable Care Act? I understand that premiums came in 16 percent below CBO projections. And is this in part attributable to the risk corridor program?

Mr. JOST. Yes, and the CBO recognized that in its report yesterday and it is.

Mrs. MALONEY. Can you explain how the risk corridor program protects enrollees who are signing up for health insurance using the exchanges?

Mr. JOST. Well, the risk corridor program means that insurers projecting their premiums for 2015 and 2016 and deciding whether to enter the exchange or deciding to stay in the exchange understand that for the first 3 years of the program, there is this

flywheel. There is this backstop so that if their prices are off, they will get some help.

Now, again, it is a risk-sharing program. It is not a risk-transfer program. If an insurer under-prices their product too much, they are going to have no profit at all and possibly become insolvent. So they have to be careful. But they can take a little bit of risk there.

Mrs. MALONEY. I also understand that the risk corridor program reduces the risk for insurers participating in the exchanges from both extreme gains and losses. And is that accurate? And would that translate into saving taxpayer funds?

Mr. JOST. That is correct. And also, if their gains are excessive, we still have the medical loss ratio program and there will still be rebates to consumers. So this is not just an open-ended profit for

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Mrs. MALONEY. Can you elaborate how this would benefit taxpayers? How do they benefit from these risk exchanges?

Mr. JOST. Well, the CBO projected yesterday that the risk corridor program will benefit taxpayers to the tune of $8 billion.

Mrs. MALONEY. $8 billion?

Mr. JOST. $8 billion.

Mrs. MALONEY. An $8 billion benefit to taxpayers?

Mr. JOST. Yes. Some bailout.

Mrs. MALONEY. Wow, wow. Well, I think you made a strong case. This in no way sounds like a bailout to me. And these are CBO numbers. Right?

Mr. JOST. That is correct.

Mrs. MALONEY. So these are independent numbers saying that there will be a benefit of $8 billion to taxpayers.

Mr. JOST. That is correct.

Mrs. MALONEY. Thank you very much.

Chairman ISSA. [Presiding] Would the gentlelady yield just for a question?

Mrs. MALONEY. Yes, I will yield to the chairman.

Chairman ISSA. Thank you. I was quick on the draw.

It is a benefit to taxpayers. What I am trying to understand is are not the people who pay the excesses that are then taken off—in other words, the excesses that are being gotten are excessed as payments by taxpayers. I appreciate the gentlelady's point that it has a scored revenue, but in fact, as a taxpayer I am also a ratepayer, and as a ratepayer that is where the money is coming from. So we tax people's health insurance in order to get this $8 billion. Is that not true?

Mrs. MALONEY. I would like Mr. Jost—usually adhering—it is not the panelists that are answering the question, but I would like Mr. Jost to answer this question.

Mr. JOST. Thank you. I would be happy to answer that.

No. The risk corridor program is funded—well, the $8 billion in revenue will be excess profits of the insurers that are refunded to the Federal Government. There is also a second benefit to the Federal Government because the Federal Government is at risk for the premiums through the premium tax credit. So because the premiums came in 15 percent lower than expected, that is also going to save the Federal Government, one estimate, $190 billion over 10

years, although the CBO said that they could not determine the exact amount.

Chairman ISSA. Does anyone else need to answer that for the gentlelady?

Mr. BADGER. Well, just I know it is a very technical question. I am sorry. But, yes, what happens is, I think as Professor Jost has pointed out and I think as the chairman said, the money, that $8 billion, ultimately comes from the people who bought insurance. So it was in their premiums. And under the formula in the law, the insurers' actual cost relative to their premium was lower than they had anticipated, and as a consequence, they have to pay into the fund. What CBO is projecting is that more insurers will pay in than take out. I for one do not believe that, but I think Congress could, in fact, codify that to capture the savings by merely saying that CMS is not allowed to pay out any funds in excess of what they take in, and that would lock in your $8 billion.

Chairman ISSA. Thank you. Thank you all.

We now go to the gentleman ——

Mrs. MALONEY. Mr. Goodman wanted to answer.

Chairman ISSA. If the gentleman could hold for a second. If you need to quickly answer on the gentlelady.

Mr. GOODMAN. Sure. I would just like to say that that estimate is not based on our recent experience, and it is very likely to be wrong. It is unlikely that taxpayers will gain and most likely that they will lose.

Chairman ISSA. Thank you.

The gentleman from North Carolina.

So insurers that lose money will be bailed out to some degree by the taxpayers through the law's premium stabilization program. Would you all agree?

Mr. BADGER. I would agree, yes.

Mr. JOST. Yes, I would agree.

Mr. MCHENRY. Would you agree, Mr. Goodman?

Mr. GOODMAN. Yes.

Mr. JOST. That is the purpose of these programs, yes, to stabilize premiums.

Mr. MCHENRY. But they will be bailed out to some degree—the insurance companies. Right?

Mr. JOST. Well, the insurance companies are sharing risk with the Federal Government.

Mr. MCHENRY. Right, but anyway, I am actually quoting you, Mr. Jost, from your November editorial about this. Insurers that lose money will be bailed out, to some degree, by the taxpayers through the law's premium stabilization programs. I could not have said it better. So this is just another shameful part of ObamaCare.

Look, I serve on the Financial Services Committee.

Mr. Jost, you say that this risk corridor provision is very similar to flood insurance. Right?

Mr. JOST. That is correct.

Mr. MCHENRY. Do you know that the taxpayers are on the hook for over $50 billion in payouts? So the flood insurance program is under water to the tune of $50 billion for a taxpayer bailout.

The example, I think, is perhaps a good one unintentionally. It is again a very problematic feature when the Government gets into the marketplace.

And, look, I understand if you are a health insurer, this is probably a very positive provision for you. So, thus, when the administration makes their—I do not know how many additional changes they have made in the last 2 years above and beyond what they are really able to do under the law. Health insurers are not complaining as much, though, about this ad hoc rulemaking as perhaps they would be if they did not have this bailout provision within the law.

Mr. Badger, is that approximately right? Is that how you would see it?

Mr. BADGER. Well, as I said before, when this announcement was made that at least the Federal Government would not enforce the law requiring cancellations, CMS responded with half a billion dollars in payments to insurance companies out of the risk pool, according to CBO's estimates.

Mr. MCHENRY. Where does the money come from in the risk pools?

Mr. BADGER. Well, out of the risk corridors, it is supposed to come from payments from insurers who make, "excessive profits." So it should be totally internally distributed. Unfortunately, CMS has indicated that they will throw taxpayer money on the table if the receipts are not enough to cover disbursements.

Mr. MCHENRY. Okay. So that I understand this, if I pick a different policy in my exchange and that company is deemed to make excessive profits, where do those excessive profits come from?

Mr. BADGER. Well, the excessive profits obviously come from the premiums.

Mr. MCHENRY. The premiums. So, therefore, I made a bad choice and perhaps I am paying a higher rate than someone else who is in another company that is getting the bailout. Right?

Mr. BADGER. Yes. It is certainly true that the money is supposed to come exclusively from the premiums, although sometimes taxpayers are implicated as well.

Mr. MCHENRY. So if you have three providers in the exchange and you make a choice for one that is maybe the middle-priced one, you might be subsidizing the lower-priced one.

Mr. BADGER. The so-called excess premiums or excess profit based on your premium may well be funneled through to that other insurer, yes.

Mr. MCHENRY. Okay, interesting. So this could be a taxpayer bailout in execution or it could actually be a bailout funded by those that are obligated to buy insurance through the exchange.

Mr. BADGER. Yes. The money either comes from the premiums that people pay or the taxes that people pay.

Mr. MCHENRY. So this is not like the Federal Reserve printing money and making money from nowhere. Right?

Mr. BADGER. No.

Mr. MCHENRY. Now, I asked this because it is a very common question I have got at home from my constituents about this.

Look, the reason why we are talking about this is because of this grave concern about the Government overreach. Look, if you are

health insurer, I see why this is a very positive—if you are in the business of health insurance, it is probably a pretty positive thing because it takes your risk away, and it also means you are a little more compliant with the administration when they make rules changes. So it benefits this administration's ad hoc rulemaking. Right?

Mr. BADGER. There are mutual interests there, yes.

Mr. MCHENRY. Thank you, Mr. Chairman.

Chairman ISSA. I thank you.

We now go to the gentleman from Virginia, Mr. Connolly.

Mr. CONNOLLY. Thank you, Mr. Chairman.

Professor Jost—is it Jost?

Mr. JOST. Jost actually.

Mr. CONNOLLY. Jost, okay.

I do not know if you are aware of the fact that the Chamber of Commerce actually issued a statement warning against the Rubio legislation, the repeal of the risk corridors. And it says—"repeal would make it harder and less likely that companies will offer products to small businesses and individuals in the future and would certainly lead to significantly higher premiums for coverage offered next year without these protections. It would limit choice, increase premiums, and hinder the development of a robust private insurance market."

Mr. Chairman, I would ask that this letter from the Chamber of Commerce be entered into the record at this point.

Chairman ISSA. Without objection, so ordered.

Mr. CONNOLLY. I thank the chair.

Professor Jost, do you agree with the Chamber of Commerce that repeal of the risk corridor might not only raise premiums but would reduce insurer participation in the exchanges?

Mr. JOST. Yes, I think it would.

Mr. CONNOLLY. Could you elaborate a little?

Mr. JOST. Well, again, the purpose of the risk corridors is to stabilize premiums, to share risk between the insurers that agree to participate in the exchanges and the Federal Government so that insurers will be comfortable coming into the exchange and charging reasonable premiums rather than to have to charge a high premium for risk. I mean, this is a very reasonable business decision, which is why the Chamber of Commerce supports it.

Mr. CONNOLLY. Speaking of that, the insurance companies themselves are helping to finance these risk corridors. Is that correct?

Mr. JOST. That is correct. Some insurers chip in when they overprice their products and others receive subsidies when they underprice their products. It is exactly the same way as in Part D.

And by the way, it has been said several times that the taxpayers are not on the hook for Part D. They are. Any overages in the Part D risk corridor program—so far there have not been any—would be paid out of the Medicare Trust Fund.

Mr. CONNOLLY. So the ACA risk corridors actually are sort of modeled on an existing program, the Medicare Part D risk corridors. Is that correct?

Mr. JOST. They are less generous and they are temporary rather than permanent, but they are modeled on that.

Mr. CONNOLLY. But hardly a Government bailout.

Mr. JOST. Right.

Mr. CONNOLLY. So one might even want—to sort of coin an expression Herman Kane made famous in the 2012 Republican primaries, I will do 16–8-8. The insurance companies, if I understand it correctly, Professor, are going to finance this to the tune of $16 billion. The estimated cost by CBO over the next 10 years is half of that, $8 billion, and the Government gets to essentially pocket the remaining $8 billion, thus saving the Federal Government $8 billion. Is that correct?

Mr. JOST. That is correct according to the CBO.

Mr. CONNOLLY. So other than that, these risk corridors seem a terrible idea.

Mr. JOST. Well, once again, it is not only that. It is also the fact that they have helped to lower premiums for individuals which, in turn, has lowered the premium tax credits for the Government, saving billions of dollars in that way as well and billions of dollars to consumers.

Mr. CONNOLLY. To consumers.

Mr. JOST. Yes.

Mr. CONNOLLY. What is the intellectual thinking behind establishing risk corridors?

Mr. JOST. Well, the premium stabilization programs, all three of them—the idea behind them is that you create a market in which private businesses will participate because they know that their risk is going to be shared, at least initially until they can figure out how to price these products and until the market stabilizes. I mean, it has been said many times today that there are only 2 million. Well, there are at least 3 million, probably many more by now. There will probably be 6 million by the end of March. But the CBO still projects 3 years from now there are going to be 25 million. So it is going to take a little while for this market to develop.

Mr. CONNOLLY. And again, not something unique to the ACA. We have done it before.

Mr. JOST. Right.

Mr. CONNOLLY. And it is certainly something welcome in the business community as something that can help smooth the bumps while we figure out, with experience, just how big and elastic the market is going to be.

Mr. JOST. Correct.

Mr. CONNOLLY. Thank you, Professor Jost. Thank you for your testimony.

Chairman ISSA. The gentleman yields back.

We now go to the gentleman from Nevada, Mr. Horsford.

Mr. HORSFORD. Thank you, Mr. Chairman.

I appreciate the panel this morning and this hearing, but one of the areas that I would like to focus on, since I am towards the end of this hearing, is on the significant changes within the Affordable Care Act dealing with preexisting conditions and the fact that insurance companies are no longer able to prohibit denying coverage to individuals with preexisting conditions. They are also prevented from discriminating against individuals with preexisting conditions by charging them higher prices for coverage. And I think that that is an important achievement in the underlying legislation.

But as, Professor Jost, you have talked about, this means that insurers need to be able to provide people with preexisting conditions, who are generally a sicker population, affordable insurance. And one of the purposes of the reinsurance program in the Affordable Care Act is to prevent insurers from pricing their premiums too high at the outset due to an influx of these new enrollees.

And so I would like to read just a quote from the Association of Health Insurance Plans which stated that the reinsurance program will help health plans meet the needs of high-cost enrollees who previously have not had health insurance coverage, while making individual market premiums more affordable for consumers. It went on to say that the Department of Health and Human Services estimates that the reinsurance program will reduce premiums in the individual market in 2014 by 10 to 15 percent compared to what they would have been without this program.

So, Mr. Chairman, without objection, I would like to enter the full statement on behalf of America's health insurance plans into the record.

Chairman ISSA. Without objection.

Mr. HORSFORD. Thank you.

Professor Jost, can you explain how the reinsurance program helps insurers provide affordable insurance to these sicker individuals?

Mr. JOST. Yes. The reinsurance program is a program where if a person who has coverage under the Affordable Care Act in a qualified health plan—in or out of the exchange, but in a qualified health plan—presents claims of more than $45,000 in a particular year, the Federal Government bears 80 percent of the risk of those claims up to $250,000. The insurers is at risk above that amount and also below the $45,000 amount. But that provision was purposely put into the act, and it is projected to reduce the cost of insurance by 10 to 15 percent across the individual market because of the fact, as we are seeing now, many of the people who sign up the earliest are high-cost people. They are people who are coming from the State and Federal high-risk pools. They are people who retirees who have been without coverage. They are older people predominantly, just as in the individual market now. And so this reinsurance program was put there to make insurance affordable to those people.

Mr. HORSFORD. And is the reinsurance program funded solely by contributions from insurance companies?

Mr. JOST. That is correct.

Mr. HORSFORD. So it is not funded by taxpayers.

Mr. JOST. It is not funded by taxpayers. However, I think it would be fair to say that some of those costs are being passed on to consumers.

Mr. HORSFORD. So can you explain briefly why the insurance premium reductions in the individual market in 2014 will decline compared to what they are currently?

Mr. JOST. Because the reinsurance program is funded at $10 billion this year, I forget the exact amounts, but it is cut in about half the following year and then reduced further in the third year and then it goes away. It is basically a program for the first year to cover the costs of this migration to the individual market.

Mr. HORSFORD. Thank you for clarifying.

And, Mr. Chairman, I know it is just you and Mr. Lankford here that are on the other side, and I listened to some of my other colleagues, one that spoke prior to my question. And I just find it remarkable that Republicans are calling this a bailout, a bailout which helps individuals with preexisting conditions, people who were previously unable to obtain coverage and purchase affordable health insurance. So I really think that we need to, again, get away from the rhetoric, look at the facts, and if you want to refer to this as a bailout, then I ask you is it a bailout for people with heart disease. Is it a bailout for those with cancer or diabetes? Is it a bailout to protect our constituents with preexisting conditions from being gouged? Is that what we refer to as a bailout?

You know my circumstance, Mr. Chairman. Last year I had six-way open heart bypass surgery. It is only because of the grace of God that I am here and because I was able to access a health insurance plan similar to one that my constituents are being asked to enroll in. I am in the exchange as well, and it is only because of that that I am not bankrupt.

And so this is important, and we continue to just have these hearings that want to demagogue the issue rather than work to repair it, to make it better or to implement it right.

And I yield back my time.

Chairman ISSA. Will the gentleman yield?

Mr. HORSFORD. I yield back my time. My time has expired.

Chairman ISSA. I thank the gentleman.

We now go to the gentleman from Oklahoma.

Mr. LANKFORD. Thank you, Mr. Chairman.

Mr. Horsford, I do understand, and we are grateful for a very successful surgery for you. But also I have people in my district and in my State that had a cancer doctor last year that they can no longer access this year, and they are in the middle of treatments. I have people that are in my district that have to have two knee replacements, had one knee replaced, and then they go back this year to get the second knee replaced and find out, no, you cannot use this doctor because the plan has changed. And part of the issue that we are faced with seems to be extremely narrow provider networks to try to control the premium costs, and then we have less access to doctors.

So I would ask Mr. Goodman or whoever maybe that wants to be able to address this. What are you seeing in the provider networks to be able to hit some of the target numbers?

Mr. GOODMAN. That we are getting a race to the bottom and that the insurers are putting out fees that are very low and taking all the doctors who would accept the low fees and not taking any others. That often excludes the best doctors and best hospitals.

Mr. LANKFORD. So the best care, the most experienced, the greatest insight as far as treating multiple patients—those individuals now have lost access to those doctors, and they are getting new, young—which, great. I am glad they have been well trained, but they are not getting access to maybe the doctor they had or the one that they prefer.

Mr. GOODMAN. I do not know what all the profiles look like because it is still early. But it is clear that the networks are very nar-

row and you have to pay a lot more to have a network that looks like the old network you were in.

Mr. LANKFORD. Mr. Badger, let me ask you about this concept of picking winners and losers and some of the change that has happened in some of the plans and grandfathering in health plans and some of the transitions and the rollouts and everything else. Do you have a perception that right now we are picking winners and losers as far as insurance companies as well?

Mr. BADGER. Well, we are certainly preferring coverage in the exchange to coverage outside the exchange.

And if I might, I know you are on the clock.

Mr. LANKFORD. We both are.

Mr. BADGER. But it was said earlier that, well, you know, if your plan is canceled, they just did not get it renewed. It happened all the time. Prior to enactment of this law, there was something called HIPPA that was passed by Congress in 1996 that guaranteed renewability in the individual and small group market. The effect of this law, coupled with the regulations, is it became illegal to renew that coverage, and the resulting cancellations were precisely to push people into exchanges.

Mr. LANKFORD. So the question is on some of the rules and what we are dealing with today as well. There seems to be a preference to say if you played ball with the administration and got involved in the exchange, we will make sure you are taken care of. If you did not get involved in one of the exchanges, then you are kind of outside this loop.

Mr. BADGER. Insurers in the exchanges definitely enjoy tremendous advantage under the law with respect to these provisions.

Mr. LANKFORD. This is part of the struggle that we face as a Federal Government, the cronyism and the fact that if you are willing to come into the administration and play by the rules, do it their way, then we are going to make sure that we protect you. Otherwise then, no, you do not have those same protections. So that pushes industry to say, well, we better come to the table or else we will be on the table. And that is a problem in a free market system and in a system where we want there to be the greatest amount of transparency and the least amount of interference from Government.

Mr. Goodman, do you want to comment anything on that?

Mr. GOODMAN. Well, I think all of the sectors were pressured in that very same way. And what I heard was if you do not come to the table, you are going to be the lunch, but it is the same message. So here in this city, a lot of organizations did a poor job of representing people out in the hinterland and cooperated with something that now in retrospect looks like it is very poorly designed.

Mr. LANKFORD. Mr. Badger, the insurance companies have argued that it is unfair to change the rules now, that they already have the parameters set. Please do not change the rules. Do you consider that a fair argument?

Mr. BADGER. It is an understandable argument. The problem is, again, we have had a number of people, certainly people who have benefited by this law, but people who were hoping to renew their

coverage, people that perhaps were able before to see a particular doctor and no longer able—we changed the rules on them.

Mr. LANKFORD. So how many times do you think CMS has changed the rules during this process?

Mr. BADGER. They have changed considerably. In the reinsurance alone, as the professor said, they are still changing the rules. They are not solid as yet.

Mr. LANKFORD. Which again goes back to our same issue. The rules seem to change consistently and there does not seem to be a consistent plan, and the consumer is very much out of control. And for the American people that they just want to be able to choose for themselves and be in control of their own health care, now suddenly even the health care provider that they go to is not in charge of their health care and is not making decisions for them. And they make another phone call, and they are not in charge of it either. And they are trying to find out who is controlling my health care. How far do I have to go to be able to find the person that is making the choice on where I can go, what I am going to pay, what doctor I am going to have access to, what treatment that I am going to have? And it is very distant in this process and it is continuing to frustrate Americans. Agree or disagree with the policy change, Americans just want to have control back of their own health care again and be able to make decisions.

So with that, I yield back.

Chairman ISSA. I thank the gentleman.

Today we covered a number of subjects, some of which our first and second panel were very critical to. Many of the things that were covered were tangential to the hearing today.

On the board, in closing, you have the original projection in 1967 dollars of the cost of Medicare and the actual cost of Medicare. Again, these are 1967 dollars. They are very reduced.

Just yesterday, the CBO similarly is adjusting by threefold the cost of jobs to America and, by seemingly double, another trillion dollars the cost of this plan.

Today much of our discussion centered around a plus or minus $8 billion bailout. Mr. Horsford wanted to know who was being bailed out. The fact is that under this program, whether it was done in the past or not, it guarantees that the health insurance insurers will get their full 3 percent by over-billing, and if they make an error on one of maybe a dozen or two dozen policies and they lose, they will be covered out of the excesses. In no case will the ratepayer—and since ObamaCare has been ruled to be a tax, the taxpayer—who is paying excess monies in for health insurance—in no case does that health insurance payer get his or her money back. These are undeniable truths. ObamaCare is getting much more expensive both in jobs and in cost. ObamaCare's excess monies paid in by people for their health care do not come back to the ratepayer, and in fact, there are a number of embedded taxes.

As we continue to look at the Affordable Care Act, this chair, along with our ranking member, have an obligation to ensure that we do look at the cost drivers of health care and the areas that are, in fact, in need of consideration. This was a small area, although we touched on larger areas.

I want to thank our panel of witnesses for coming prepared.

I will hold the record open for 3 days for additional thoughts that any of our witnesses may have and extraneous material by members on the dais.

Chairman ISSA. Does the ranking member have any closing statements? The gentleman is recognized.

Mr. CUMMINGS. Thank you, Mr. Chairman.

I want to thank the witnesses for being here today.

Clearly, as has been said earlier, it may seem like we are in disagreement today, but the fact is that these risk corridors were something that under Medicare Part D are still in existence and will continue to be and has been for 10 years. And under the Affordable Care Act, you are talking a 3-year limit. Very interesting.

As I listened to Mr. Collins, I am concerned that—he said that he had some constituents who are not able to have the type of insurance policy that they had before. And I think that those kind of issues ought to be addressed. It should be addressed soon, and I am sure they will be. At the same time, I could give him story after story of people who were suffering from cancer, heart disease that had absolutely no way of getting any kind of treatment. Period. Or if they got treatment, it was an emergency room, and it was basically to save their life but there was no follow-up. And so they were basically out there on their own.

You know, Emerson said we should not be pushed around by our problems and our fears, but we should be guided by our hopes and our dreams. And I think one of the major things that we need to concentrate on is how do we take care of all Americans. Why do we leave anybody behind? And when we are basing it on our hopes and dreams, our hopes and dreams should be that we keep people well, and if they get sick, we do everything in our power to help them get well. There are a lot of people who suffer.

You know, it just seems to me that we need to move from just criticism to actually making the repairs that are necessary. Nobody said the law was perfect. This is a very complex law, and it took many, many years to bring this about. A lot of Presidents tried to do it. This President accomplished it. And so hopefully, moving forward, we will be able to do just that.

One of the things that I did want to ask Senator Rubio and did not have a chance to—but I wanted to ask him, you know, you got 850,000 people in Florida who have no insurance. And still, the Governor down there has made a decision that he would not open the door for them to enter into Medicaid, and those are people—many are sick and are in need. Automatically you put 850,000 people—give them insurance, provide them with insurance. That is significant.

So, again, we have got work to do. I think all of us have to pull together and, again, move forward, not based on our fears, not based on our problems, but based on our hopes and our dreams.

Thank you very much.

Chairman ISSA. I thank the ranking member. I thank our witnesses.

We stand adjourned.

[Whereupon, at 11:55 a.m., the committee was adjourned.]

APPENDIX

Material Submitted for the Hearing Record

the FEDERALIST

HEALTH CARE

5 Devastating Obamacare Facts From CBO's Latest Economic Report

By Sean Davis
FEBRUARY 4, 2014

The Congressional Budget Office (CBO) just released its latest analysis of the country's economic and budget outlook, and it's a doozy. If you're a Denver Broncos fan who watched in horror as your team disintegrated during the Super Bowl on Sunday, then you'll have some idea of how Obamacare's proponents will feel as they read this report.
Yes, it's that bad.

It's so bad that there's even a report section entitled, "How Much Will the ACA Reduce Employment in the Longer Term?" (Spoiler alert: a lot). As predicted by its conservative opponents, Obamacare has indeed destroyed jobs, increased spending, and made health care less accessible.

Here are 5 facts from CBO's report that illustrate how the law's effects bear no resemblance whatsoever to its namesake's promises.

1) Obamacare Will Destroy 2.5 Million Jobs By 2024

From the report:

> The reduction in CBO's projections of hours worked represents **a decline in the number of full-time-equivalent workers of about 2.0 million** in 2017, **rising to about 2.5 million** in 2024. Although CBO projects that total employment (and compensation) will increase over the coming decade, that increase will be smaller than it would have been in the absence of the ACA.

Back in 2011, CBO guessed the law would only kill 800,000 jobs. Oops! But what's a couple million jobs between friends, right?

2) In 2024, There Will Still Be 31 Million People In The U.S. Without Health Insurance

Before the Affordable Care Act was passed, its top proponents – including the president himself — made a big deal about how the law would solve the problem of the uninsured. And during a September 2009 speech on the topic before a joint session of Congress, President Obama lamented that "there are now more than 30 million American citizens who cannot get coverage."
Surely that number will be lower more than a decade after the law's passage right?

> Still, according to estimates by CBO and JCT, about **31 million nonelderly residents of the United States are likely to be without health insurance in 2024**, roughly one out of every nine such residents.

Oops again.

3) Surprise! Millions Of People Who Liked Their Health Plan Will Lose Their Health Plan

There's a reason even PolitiFact was forced to acknowledge that the president's "if you like your health care plan" promise was a total lie. From the CBO report:

> CBO and JCT project that, as a result of the ACA, **between 6 million and 7 million fewer people will have employment-based insurance coverage** each year from 2016 through 2024 than would be the case in the absence of the ACA.

So many oopses.

4) Obamacare Reduces The Incentive To Find And Keep A Job

Yes, Virginia, incentives matter:

> [R]educed incentives to work attributable to the Affordable Care Act (ACA)—with most of the impact arising from new subsidies for health insurance purchased through exchanges—will have a larger negative effect on participation toward the end of that period.
>
> [...]
>
> By providing subsidies that decline with rising income (and increase with falling income) and by making some people financially better off, the ACA will create an incentive for some people to work less.
>
> [...]
>
> [M]ore than 2.5 million people are likely to reduce the amount of labor they choose to supply to some degree because of the ACA, even though many of them will not leave the labor force entirely.

5) Your Paycheck Will Be Smaller Thanks To Obamacare

If it walks like a tax increase, and talks like a tax increase, it's probably a tax increase, even if the people who voted for the tax increase promised it wasn't a tax increase:

> In addition, beginning in 2018, the ACA imposes an excise tax on certain high-cost health insurance plans. CBO expects that **the burden of that tax will**, over time, **be borne primarily by workers in the form of smaller after-tax compensation.** Some firms may seek to avoid or limit the amount of the excise tax they pay by switching to less expensive health plans, and in that case workers' wages should rise by a corresponding amount. Those wages will be subject to income and payroll taxes, however, so total tax payments by those workers will be higher than they would have been in the absence of the ACA.**After-tax compensation will thus fall** whether firms pay the excise tax or take steps to avoid it, and the resulting increases in average and marginal tax rates will cause a slight decline in the supply of labor, CBO estimates.

But other than that (and the doc shock, and the premium shock, and the broken website), the law is doing totally awesome, you guys.

AMERICAN ACADEMY *of* ACTUARIES

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

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

Statement of

Cori E. Uccello, MAAA, FSA, FCA, MPP
Senior Health Fellow
American Academy of Actuaries

February 5, 2014

The American Academy of Actuaries is an 18,000-member professional association whose mission is to serve the public and the U.S. actuarial profession. The Academy assists public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

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

The Affordable Care Act (ACA) is expanding access to health insurance coverage by prohibiting insurers from denying coverage, excluding pre-existing conditions, and varying premiums based on an individual's health status. To reduce the adverse selection arising from such requirements, the ACA includes other provisions, such as premium subsidies and an individual mandate, designed to increase overall participation in health insurance plans.

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

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

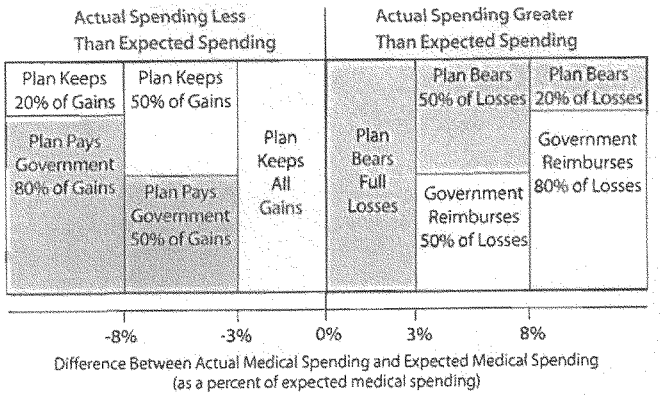
The ACA establishes three risk-sharing mechanisms to mitigate these risks—risk adjustment, reinsurance, and risk corridors. The following testimony will focus on risk corridors, which aim to mitigate pricing uncertainty; however, more information on each of the mechanisms can be found in the American Academy of Actuaries fact sheet on ACA risk-sharing mechanisms.[1]

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

The ACA provides for a temporary risk-corridor program that will be effective from 2014 to 2016 for qualified health plans (QHPs) in the individual and small group markets. This program will mitigate the pricing risk introduced because of very limited data available to

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

Illustration of ACA Risk Corridors



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

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

Committee Insert - CBO Budget & Economic Outlook 2014-2024 – found here:

http://www.cbo.gov/sites/default/files/cbofiles/attachments/45010-Outlook2014_Feb.pdf

Opening Statement of Ranking Member Gerald E. Connolly (VA-11)
Committee on Oversight and Government Reform
ObamaCare: Why the Need for an Insurance Company Bailout?
February 5, 2014

Today's hearing represents yet another tired attack on the Affordable Care Act (ACA) by House Republicans who want to engage in political theater to the exclusion of serious, substantive, and bipartisan work aimed at refining and enhancing the ACA in order to most *effectively* provide every American with affordable, quality health insurance coverage.

Frankly, this morning's hearing is occurring three days too late, as it would have been fitting to be held this past Sunday in honor of its similarity to the film Groundhog Day. I know that having been subject to an endless series of duplicative Republican efforts to repeal the ACA I am beginning to feel like Bill Murray's character who found himself stuck in a time loop that repeats over and over again.

Perhaps it would be most effective to lead off by disposing of the banal question posed by today's *very* fair and balanced hearing title, "Obamacare: Why the Need for an Insurance Company Bailout?" To answer the majority, the simple answer is that there is absolutely no need for an insurance company bailout, and that is why one does not exist in the ACA.

Based on legislation introduced by Senator Marco Rubio, who is testifying before the Committee today, it appears that my colleagues on the other side of the aisle have interpreted risk corridor programs as constituting a so-called "bailout." Putting aside questions over how an insurance industry funded risk mitigation fund could possibly constitute a "bailout" – I would simply note that to any actual health policy expert, risk corridors are hardly a novel invention. Rather they are a common feature of insurance design, and in fact, at the risk of shocking my Republican colleagues who support Medicare Part D – are used by that popular program to this day!

It is telling that Republicans have hypocritically embraced these so-called "bailout" risk corridors in Medicare Part D, while simultaneously demeaning these risk management programs when used by the ACA.

If one uses a reasonable understanding of the term "bailout," which law professor Cheryl Block defines as, "...a form of government assistance or intervention specifically designed or intended to assist enterprises facing financial distress and to prevent enterprise failure," the notion of a health insurance company-funded risk corridor program that provides risk mitigation assistance to a subset of the *very* same health insurance companies that funded the program in the first place constituting a "bailout" of insurance companies is patently absurd.

Of course, it may be possible that the majority is utilizing a special Republican definition of a bailout, which based on their strident and irrational opposition to the President, appears to be any Federal program that President Obama supports. Either way, we have entered a twilight zone where Republicans are seeking to repeal a so-called bailout program that the Congressional Budget Office (CBO) projects will result in net savings of $8 billion for the Federal Government.

(OVER)

That point bears repeating. In analysis released yesterday, CBO projected that the ACA risk corridor program that Senator Rubio describes as a bailout and seeks to repeal, will *save* the Federal Government $8 billion, as a result of insurance companies paying $16 billion into the risk corridor fund, and only $8 billion needing to be paid out over the 2015 to 2024 period.

Now for those keeping score at home, if you are confused about how a so-called bailout could actually save the Federal Government *billions* of dollars in a given year, take solace that you are not alone. Of all the installments of anti-ACA political theater, today's hearing is simply the most astonishing and bizarre, as it focuses on what the Washington Post's health policy reporter coined, "Obamacare's magical, deficit-reducing bailout." Come to think of it, that would have been a more apt and accurate title for this morning's hearing.

I would urge my colleagues to simply call a spade a spade. If you hate the ACA, if you care little about providing affordable, quality health insurance to all Americans, fine. But please spare us the misleading and manipulative messaging that makes a mockery of measured policy debate and as the Roosevelt Institute's Mike Konczal recently observed, appears to be just another effort by Republicans to "blur that definition [of bailout] into all government actions, which in turn is simply used to discredit the state. That easy temptation should be avoid[ed]."

I could not agree more.

-END-

MEMORANDUM January 23, 2014

To: House Energy and Commerce Committee
[redacted]

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).

CHAMBER OF COMMERCE
OF THE
UNITED STATES OF AMERICA

R. BRUCE JOSTEN
EXECUTIVE VICE PRESIDENT
GOVERNMENT AFFAIRS

1615 H STREET, N.W.
WASHINGTON, D.C. 20062-2000
202/463-5310

February 4, 2014

TO THE MEMBERS OF THE UNITED STATES CONGRESS:

The U.S. Chamber of Commerce, the world's largest business federation representing the interests of more than three million businesses of all sizes, sectors, and regions, as well as state and local chambers and industry associations, and dedicated to promoting, protecting, and defending America's free enterprise system, urges you to consider the harm that would be caused by the repeal of the risk mitigation programs as contained in the Patient Protection and Affordable Care Act (PPACA).

Recently, certain policymakers have been examining the purposes of the programs collectively known, as contained in the PPACA, as "the 3 Rs," that is, the risk corridor program, the transitional reinsurance program, and the risk adjustment program. As our business members continue to struggle with the market disruption associated with the implementation of the PPACA, the Chamber urges you to carefully consider the wide-ranging ramifications that any changes to these market stabilization mechanisms may have. If the market is disrupted, it would lead to higher costs and fewer choices for small business owners and the self-employed.

These risk mitigation programs were collectively created to mitigate the financial risk and uncertainty facing private sector businesses as they offer products in the newly restructured small group and individual markets. Facing a host of new rating limitations, mandated coverage requirements, and a likely influx of new consumers, these companies relied on the safeguards that the risk mitigation programs were designed to provide. Businesses chose to offer products in these markets based on the understanding that financial harm or benefit would be moderated both in circumstances where the prices they set far exceeded the costs they incurred and in circumstances where the prices they set fell far short of the costs they incurred.

The purpose of these provisions is to help stabilize the new markets and provide some protection to consumers and businesses enrolled in and offering coverage for the first few years in particular. The provisions were deliberately included in the law to protect businesses offering products in these new markets with no valid historical data in the initial years to guide them in setting the price of products that consumers could buy regardless of pre-existing conditions. Without these provisions, consumers would have seen much higher premiums and far fewer products offered in the individual and small group markets.

Beyond the practical importance of these risk stabilizing provisions, they have also successfully encouraged private sector engagement and participation in other new and/or high risk insurance programs. A little over a decade ago, the legislation enacting Medicare Part D

included similar risk stabilization programs to encourage choice and competition for the first six years of the 2003 stand-alone prescription drug program. Other programs, such as flood insurance, crop insurance, and terrorism risk coverage, similarly rely on these types of mitigating provisions.

Further, according to a newly released Congressional Budget Office (CBO) report, the government will in fact collect more money than it pays out under this program. In an estimate released today, CBO projects that under the new risk corridor program insurers will pay in $16 billion while the government will pay out only $8 billion, resulting in $8 billion in net government revenue.

The problem with repealing these provisions is that it would effectively harpoon the rates that were established based on the very protections these provisions promised. It would change the rules of the game in the middle of the game and cause some private businesses to lose big and others to potentially win big. Repeal would make it harder and less likely that companies will offer products to small businesses and individuals in the future and would certainly lead to significantly higher premiums for coverage offered next year without these protections. It would limit choice, increase premiums, and hinder the development of a robust private insurance market. And as the American Action Forum points out in its February 4, 2014, backgrounder, "[I]t is worth noting that the provisions keeping premiums lower will also reduce federal spending on the exchange subsidies. In the absence of the risk mechanisms, higher health insurance premiums would result in more households qualifying for subsidies and increased cost for those who are subsidized."

Therefore, to protect both consumers and business, the Chamber urges you to consider the extreme harm that eliminating these programs during the most critical phase of implementation would cause. It is crucial that additional reforms strengthen and protect individuals, business, and the health care system at large, not harm it further. Repealing the risk mitigation programs would clearly be a step in the wrong direction.

Sincerely,

R. Bruce Josten

FOR THE RECORD

Statement
on
The Affordable Care Act's Premium Stabilization Programs:
Promoting Competition and Affordability for Consumers

America's Health Insurance Plans
601 Pennsylvania Avenue, NW
South Building, Suite 500
Washington, DC 20004

Submitted to the
House Committee on Oversight and Government Reform

February 5, 2014

I. Introduction

AHIP is the national association representing health insurance plans. Our members provide health and supplemental benefits to more than 200 million Americans through employer-sponsored coverage, the individual insurance market, and public programs such as Medicare and Medicaid. AHIP advocates for public policies that expand access to affordable health care coverage to all Americans through a competitive marketplace that fosters choice, quality, and innovation.

We appreciate the committee's interest in the premium stabilization programs that were established by the Affordable Care Act (ACA) to promote competition and affordability for consumers during the early years of the law's implementation. Our members strongly support these programs as essential tools for helping to create a stable and predictable environment for consumers who are seeking health insurance coverage in the new Exchanges. Similar programs are embedded in the Medicare Part D Prescription Drug Program and the National Flood Insurance Program. These initiatives – just like the ACA's premium stabilization programs – are designed to protect consumers.

Yesterday, the Congressional Budget Office (CBO) issued a report[1] outlining new projections that one of the premium stabilization programs – which establishes risk corridors – will yield net savings to the federal government of $8 billion over the three-year period of 2015-2017. Specifically, CBO projects that the government will collect $16 billion from insurers through the risk corridors, while paying out $8 billion in risk corridor payments. CBO indicates that these projections were informed by an analysis of recent data from the Medicare Part D program and its experience with risk corridors.

We strongly oppose legislative proposals that would repeal any of the ACA's premium stabilization programs. Last year, insurers submitted their qualified health plan (QHP) applications for 2014 based on rules and programs that were in place at the time of the May 3, 2013 deadline, including the premium stabilization programs. Changing the rules in the middle of the year – long after premiums have been set based on rules that were in place nine months ago – would be disruptive for consumers.

[1] "The Budget and Economic Outlook: 2014-2024," Congressional Budget Office, February 2014.

We believe it is particularly important to recognize that the availability of affordable coverage options, an issue of great importance to consumers, is directly supported by the premium stabilization programs. Many of the ACA's provisions – including the new health insurance tax, the Exchange user fees, the essential health benefits requirements, and the minimum actuarial value requirements – are pushing premiums higher.[2] But the premium stabilization programs, as we explain below in our statement, protect consumers by reducing potential short-term volatility in premiums at a time when affordability of coverage is a critically important priority for families.

Our statement focuses on the following topics:

- The success that similar risk mitigation programs have demonstrated in promoting choices and competition in the Medicare Part D prescription drug program.
- An overview of the ACA's premium stabilization programs, and why they are needed to protect consumers and promote competition in the reformed marketplace.
- The specific roles of the risk corridor, reinsurance, and risk adjustment programs.

II. The Precedent of Similar Risk Mitigation Programs in Medicare Part D

The Medicare Part D Prescription Drug Program is an example of another federal health program in which similar risk mitigation strategies have been established by Congress to promote a stable and competitive market. The Medicare Part D program, which gives Medicare beneficiaries the option to enroll in prescription drug plans sponsored by private insurers, includes similar versions of the ACA's risk mitigation programs.

The following are permanent features of the Part D program:

- The Centers for Medicare & Medicaid Services (CMS) administers a risk corridor program in which Part D plan sponsors share risk above and below predetermined payment-to-cost ratio

[2] "Comprehensive Assessment of ACA Factors That Will Affect Individual Market Premiums in 2014," Milliman, Inc., prepared at the request of AHIP, April 25, 2013. This report provides a comprehensive overview of ACA provisions that will impact individual market health insurance premiums. The report highlights how some provisions will increase premiums while others will make coverage more affordable.

thresholds established by law. The risk corridors have broadened over time, meaning that Part D sponsors are more likely to be at full risk than was true during the initial years of the program.

- CMS provides reinsurance payments to Part D plan sponsors when a beneficiary's prescription drug costs reach a catastrophic threshold, providing additional support to sponsors with high-cost enrollees.

- CMS reimburses Part D plan sponsors on a risk-adjusted basis through a system that provides payments to Part D plans that enroll more individuals with complex conditions to more accurately reflect the costs of addressing these beneficiaries' health care needs. A similar system is used to risk-adjust payments to Medicare Advantage plans.

Together, these risk mitigation strategies have been instrumental in creating a new insurance market that has a demonstrated track record of promoting competition, choice, and innovation through Medicare Part D plans that are providing beneficiaries with high quality, affordable prescription drug coverage. The success of the Part D program offers valuable lessons for policymakers about the importance of ensuring that the ACA's premium stabilization programs are permitted to play a similar role in making health insurance coverage affordable for the American people.

III. Overview of the ACA's Premium Stabilization Programs

The ACA established new marketplaces with entirely new market rules, creating uncertainty about who will purchase coverage and what their costs will be, particularly during the initial years of enrollment. To protect consumers and promote competition during the early years of the program, the ACA established three premium stabilization programs, modeled after those in the Medicare Part D program, that include: (1) risk corridors; (2) reinsurance; and (3) risk adjustment. These programs – commonly known as the "3Rs" – are specifically designed to provide greater stability in the marketplace as the new insurance reforms are implemented and as consumers enroll in the new Exchanges.

The "3Rs" include temporary risk corridor and reinsurance programs designed to reduce premium volatility during the first three years of enrollment and a permanent risk adjustment program that spreads costs among health plans to avoid penalizing insurers that enroll people

with higher-than-average costs. Similar premium stabilization programs have been used successfully in other government programs and are a permanent feature of the popular Medicare Part D program that is noted for its successful track record of providing market-based competition for consumers.

The risk corridor program is a temporary risk-sharing arrangement between QHPs participating in the marketplace and the federal government that will help protect consumers from dramatic year-to-year changes in premiums if actual costs vary significantly from projections used in setting premiums. If the amount a health plan collects in premiums exceeds its targeted medical expenses by a certain amount, the plan will make a payment to the federal government. If premiums fall short of this target, the risk corridor program transfers a portion of this shortfall to the health plan.

The temporary reinsurance program is a fully funded initiative that covers a portion of the costs of enrollees in the individual market with very high medical expenses. This program reduces uncertainty in the market and helps mitigate individual market rate increases that might otherwise occur due to enrollment of individuals with very high cost claims.

While the "3Rs" are important programs that help protect consumers during the transition to the new marketplace, those programs will not fully offset the impact on the market if the Exchanges fail to achieve broad participation, particularly among the young and healthy. Health plans set their premiums for 2014 based on the rules and programs that were in place at the time, including premium stabilization programs that help mitigate the impact on consumers of unexpected enrollment in the market. Repealing these programs now – after premiums have been set and after millions of consumers are now enrolled – would cause disruptions in the market and higher premiums for consumers.

IV. The Specific Roles of the Risk Corridor, Reinsurance, and Risk Adjustment Programs

Each of the ACA's premium stabilization programs takes specific steps to address uncertainty in the marketplace and support the law's goals of providing coverage to the young and healthy, as well as the old and unhealthy, without regard to pre-existing conditions. The importance of these programs is reinforced by the following explanation in an issue brief published by the Kaiser

Family Foundation[3] in January 2014: "The ACA's risk adjustment, reinsurance, and risk corridors programs are intended to protect against the negative effects of adverse selection and risk selection, and also work to stabilize premiums, particularly during the initial years of ACA implementation."

Risk Corridor Program

New benefit mandates, regulatory requirements, and the ACA's broad insurance reforms have dramatically transformed the insurance marketplace in 2014. Although health plans have made assumptions about the cost of coverage in this new market, there is still substantial uncertainty about who is purchasing coverage. The risk corridor program will limit volatility in the individual and small group markets, resulting in a more stable marketplace and options for consumers that accurately reflect the cost of coverage.

For each year of the risk corridor program, QHPs and the federal government will share in the risk associated with the uncertainty of the new marketplace. If the amount a health plan collects in premiums exceeds its medical expenses by a certain amount, the health plan will make a payment to the federal government. If premiums fall short of this target, the risk corridor program transfers a portion of this shortfall to the health plan.

Like the reinsurance program, the risk corridor program is a temporary measure designed to ease the transition between the old and new marketplace and help stabilize premiums for consumers. As risk pools in this new market become more predictable over time, the protections provided by risk corridors will become less critical for protecting market stability.

A fact sheet recently published by the American Academy of Actuaries[4] discusses the rationale behind the ACA's risk corridor program:

> "Under the ACA, risk corridors have been established to mitigate the pricing risk that insurers face because they have very limited data to use to estimate who will enroll in plans operating under the new 2014 ACA rules and what their health spending will be... The risk corridors are temporary since they are most appropriate during the first few years of the new program, when less expenditure data are available. As more data become available on health

[3] "Explaining Health Care Reform: Risk Adjustment, Reinsurance, and Risk Corridors," Issue Brief, Kaiser Family Foundation, Jan 22, 2014.

[4] "Fact Sheet: ACA Risk-Sharing Mechanisms," American Academy of Actuaries, 2013.

spending patterns of the newly insured, the ability to set premiums accurately should improve, thereby reducing the need for risk corridors."

Reinsurance Program

The ACA also establishes a temporary reinsurance fund that will be used to pay a portion of the costs for individuals with very high medical expenses. For the 2014 benefit year, the reinsurance program will pay 80 percent of the claims cost for non-grandfathered individual market enrollees between $60,000 and $250,000. All health plans providing major medical insurance will contribute a set amount of money to the reinsurance program for each year of its operation, totaling $10 billion in 2014, $6 billion in 2015, and $4 billion in 2016.

The reinsurance program will help health plans meet the needs of high-cost enrollees who previously have not had health insurance coverage, while making individual market premiums more affordable for consumers. The Department of Health and Human Services (HHS) estimates that the reinsurance program will reduce premiums in the individual market in 2014 by 10 to 15 percent compared to what they would have been without this program.[5]

The American Academy of Actuaries' fact sheet, mentioned in the previous section, provides the following explanation for the ACA's reinsurance program:

> "As the ACA was being drafted, it was recognized that high-cost individuals would have the greatest incentives to enroll in coverage. Therefore, during the first years of the law's implementation, this population could make up a greater share of enrollment than in subsequent years when the individual market risk pool is anticipated to be larger and more representative of the population as a whole... The reinsurance program will offset a portion of the costs of high-cost enrollees in the individual market."

Risk Adjustment Program

The ACA's risk adjustment program is designed to spread risk among health plans to prevent problems associated with adverse selection. Under this program, health plans that enroll disproportionately higher-risk populations (such as individuals with chronic conditions) will receive payments from plans that enroll lower-risk populations. Payments and transfers are only between health plans, and apply only to individual and small group plans both inside and outside of the Exchange.

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[5] 77 FR 73199, December 7, 2012.

By spreading risk across all health plans in a state, risk adjustment promotes market stability while also protecting consumers with complex medical conditions. Preventing adverse selection will lead to a more robust marketplace and more affordable coverage options for consumers.

The importance of the ACA's risk adjustment program is discussed in a health policy brief published by *Health Affairs*[6]. The author of this brief explains:

> "Because the exchanges will feature standardized benefit options and restrict insurers' ability to base premiums on their enrollees' health status, plans that enroll a sicker-than-average enrollee population will be in danger of losing money, while plans that enroll relatively healthier enrollees will probably be overpaid. Ultimately, if too many plans lose money, some could go out of business, and the overall system could be seriously destabilized. To prevent this from happening, the law requires the use of risk adjustment to reallocate premium income among plans to account for differences in their enrollees' aggregate health conditions, and therefore the likely cost of paying for their care."

V. Conclusion

Thank you for considering our perspectives on the value of the ACA's premium stabilization programs as strategies for promoting competition and affordability for consumers. Our members are strongly committed to continuing to work with Congress, the Administration, and other stakeholders to expand access to high quality, affordable coverage options.

[6] "Risk Adjustment in Health Insurance," Rob Cunningham, Health Policy Brief, *Health Affairs*, August 30, 2012.

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