Written Statement of

Doug Badger

Senior Fellow, Galen Institute[1]

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Chairman Murphy and Ranking Member DeGette, Members of the Subcommittee on Oversight and Investigation, thank you for this opportunity to appear before you this morning to discuss the Affordable Care Act's cost-sharing reduction program.

Implementation of the cost-sharing reduction program has been irresponsible, unaccountable and, at its heart, unlawful. It is part of a pattern of malfeasance in ACA implementation occasioned by a general miscalculation about the attractiveness of individual qualified health plans (QHPs) to millions of people who lack health insurance coverage.

Those miscalculations – by Administration officials, Washington health policy analysts and, most significantly, some health insurance executives – led to a series of decisions by senior officials at the departments of Treasury and Health and Human Services (HHS) during 2014 that range from the reckless to the illegal.

While it is difficult for Congressional critics and proponents of the law to agree on much, they should agree on this: the executive branch must follow the law, even when it could potentially result in more insurers withdrawing from the program.

[1] The statement reflects the views of Mr. Badger and do not necessarily reflect those of the Galen Institute.

Congress cannot avert its eyes from unlawful behavior. It must address it head-on and seek genuine solutions to the problems that confront issuers of QHPs.

Performance of Individual QHPs

The Administration's unlawful cost-sharing reduction payments can only be properly understood in the context of insurer performance in the individual QHP market.

My colleagues Brian Blase of the Mercatus Center, Edmund Haislmaier at the Heritage Foundation, Seth Chandler of the University of Houston and I have published the first two in a series of papers examining the performance of individual QHPs during the 2014 benefit year.[2]

Ours is the most comprehensive analysis to date of the impact of the ACA on the individual and small group insurance markets in 2014. Using a data set compiled from medical loss ratio forms insurers were required to file with HHS, we provide information on how insurers fared in their first year selling QHPs – plans that satisfy all of the ACA's requirements and are the same or substantially the same as those certified to be sold on the exchanges.

Data in those filings is reported by state at the plan level, broken out by market segment (individual and small group) and by participation in the risk corridor program. Because only QHPs participate in the risk corridor program, we were able to identify the specific financial and

[2] Brian Blase, Doug Badger, and Edmund J. Haislmaier, "The Affordable Care Act in 2014: Significant Insurer Losses Despite Substantial Subsidies," Mercatus Center, George Mason University, April 22, 2016. http://mercatus.org/publication/affordable-care-act-2014-significant-insurer-losses-despite-substantial-subsidies and Brian Blase, Doug Badger, Edmund F. Haislmaier and Seth J. Chandler, "Affordable Care Act in Turmoil: Large Losses in the Individual Market Portend an Uncertain Future," Mercatus Center, George Mason University, June 28, 2016. http://mercatus.org/publication/affordable-care-act-turmoil-large-losses-individual-market-portend-uncertain-future

enrollment data for those plans. We matched this data with information released by HHS on the premium stabilization programs (risk adjustment, reinsurance and risk corridors).

Our first study examined data from 289 issuers of individual QHPs. It found that, despite receiving reinsurance payments that were 40 percent more generous on a per enrollee basis than insurers expected when they set their premiums, these issuers, in the aggregate, suffered substantial losses, as proxied by risk corridor claims. Reinsurance payments to these issuers averaged $833 per enrollee, or nearly 19 percent of premiums. Per enrollee risk corridors claims averaged $273. These claims, even had they been made in full, would not have covered all issuer losses. Put another way, reinsurance and risk corridor corporate subsidies averaging $1,106 per enrollee (nearly 25 percent of premium) were insufficient to make issuers whole in the aggregate.

Performance among individual issuers, of course, varied. Some did reasonably well, with a minority paying risk corridor assessments. But losses in the individual QHP market outpaced gains by a margin of roughly 8:1.[3]

Our second paper examined the relative performance of the 174 issuers that sold QHPs in both the individual and small group markets. Individual QHPs and group QHPs were required to meet the same benefit standards and designs, including the essential health benefits package, cost-sharing limits, and narrow actuarial standards (i.e., bronze, silver, gold, and platinum).[4]

[3] Blase, Badger, et al., "Affordable Care Act in Turmoil, Table 1, footnote (c), p. 13.

[4] 45 C.F.R. § 156.200(b), which incorporates benefit standard requirements set forth in 45 C.F.R. § 156.20. Bronze plans have an actuarial value between 58 percent and 62 percent, silver plans have an actuarial value between 68 percent and 72 percent, gold plans have an actuarial value between 78 percent and 82 percent, and platinum plans have an actuarial value between 88 percent and 92 percent.

They also had to meet regulatory standards relating to network adequacy,[5] rate review,[6] reporting requirements,[7] marketing,[8] and accreditation.[9] The large similarities between individual and group QHPs and the regulations governing allowed for a comparison between issuer performance in the respective markets.

We found that insurers lost nearly three times as much on a per enrollee basis (as proxied by risk corridor claims) selling QHPs to individuals than to groups. These losses occurred despite premium subsidies for millions who bought individual QHPs and tax penalties on millions who refused to enroll.

Nor were the losses staved off by the billions more in corporate subsidies that the government extended to issuers of individual QHPs. The reinsurance subsidy, for example, like individual premium and cost sharing reduction subsidies, were unavailable in the group QHP market. These additional billions in transfer dollars did not prevent issuers from suffering larger losses with their individual plans.

The main reason: individual Obamacare plans attracted people in poorer health, incurring medical claims that averaged 24 percent more per enrollee than for their group QHPs.

[5] 45 C.F.R. § 156.230.
[6] 45 C.F.R. § 156.210.
[7] 45 C.F.R. § 156.220.
[8] 45 C.F.R. § 156.225.
[9] 45 C.F.R. § 156.275.

The differences were far more pronounced between individual QHPs and non-QHPs. The non-QHPs are policies that were exempt from most of the law's requirements; they include "grandfathered" plans that customers originally purchased before the law's 2010 enactment and were allowed to renew in 2014, as well as "grandmothered" plans that regulators allowed to be renewed under the so-called "transition policy." Insurers charged individual QHP customers premiums that averaged 45 percent more than for non-QHPs. Medical claims overwhelmed that steep markup. The average QHP enrollee incurred claims that were 93 percent higher than for enrollees in non-QHPs.

Medical claims consumed 110 percent of premiums for individual QHPs, compared with less than 83 percent for group QHPs and non-QHPs in both the individual and group markets. That unsustainably high ratio for individual QHPs produced heavy losses for insurers in 2014 that individual and reinsurance subsidies could not offset.

Other studies indicate that these losses did not subside after 2014. McKinsey and Company estimates that losses may have more than doubled in 2015, based on its analysis of preliminary data.[10]

The law's architects believed that corporate subsidies would offset the negative effects that massive federal regulation of the individual market would have on insurers. The data suggest that they were wrong.

[10] McKinsey Center for US Health System Reform, "Exchanges Three Years In: Market Variations and Factors Affecting Performance," McKinsey&Company, May 2016. See also Deep Banerjee, Caitlin Weir, and James Sung, "The ACA Risk Corridor Will Not Stabilize the U.S. Health Insurance Marketplace in 2015," *RatingsDirect*, Standard & Poor's Financial Services, November 5, 2015, 2–3.

Corporate subsidies (particularly the reinsurance program) held premiums lower than they otherwise would have been. But premiums were neither low enough to attract uninsured people in reasonably good health nor high enough to cover medical claims incurred by people who did enroll in coverage.

This adverse experience has prompted insurers to raise premiums. Customers who receive large premium and cost-sharing reductions will be shielded from these premium increases; their cost will be borne by taxpayers. But the rate hikes will make individual QHPs even less attractive to reasonably healthy people who don't qualify for substantial subsidies.

The individual QHP "marketplace" will thus likely to continue to consist disproportionately of those who buy coverage with other people's money and those who are reasonably certain that their medical bills will exceed premiums. Such a "market" is incurably dysfunctional.

Insurers and their regulators came to recognize this dysfunctionality during the first half of 2014, leading to a series of regulatory and administrative improvisations that have ranged from the merely negligent to the outright unlawful.

Cost-Sharing Reductions (CSR)

Administration of the cost-sharing reduction subsidy illustrates this spectrum of malfeasance. The program was established by section 1402 of the ACA[11] (as amended by section 1001(b) of HCERA)[12] to reduce cost sharing on essential health benefits (EHB) for an individual with a household income of 400 percent of the Federal Poverty Level (FPL) or below who enrolls in a silver-level qualified health plan (QHP) in the individual market through an exchange.[13] In addition to lower out-of-pocket limits, issuers are required to provide coverage of higher actuarial value to individual QHP enrollees with incomes between 100 and 250 percent of FPL.

CMS is Spending CSR Money Unaccountably

Under the program, CMS makes periodic and timely advance payments equal to plans equal to the estimated value of the cost-sharing reduction to individual enrollees.[14] Although Congress never appropriated money for the program, the Secretary began making these payments to insurers during 2014.

The agency is then required to reconcile these advance payments with the actual cost-sharing incurred by eligible enrollees.[15] Although CMS initially announced it would reconcile 2014 payments in April 2015, it subsequently delayed that reconciliation until April 2016.[16]

[11] 42 U.S.C. 18071.
[12] PL 111-152, 124 Stat 1031f.
[13] CMS, Manual for Reconciliation of the Cost-Sharing Reduction Component of Advance Payments for Benefit Years 2014 and 2015, March 2016.
[14] 42 U.S.C. 18071(c)(3)(A).
[15] CMS, Guidance on Reconciliation, p. 5.
[16] CMS, Timing of Reconciliation of Cost-Sharing Reductions for the 2014 Benefit Year, February 13, 2015. As of this writing, this reconciliation process for 2014 has not been completed.

That delay has meant that billions of dollars have been distributed to health plans without determining whether those amounts are too much or too little.

The HHS Office of Inspector General strongly criticized the agency's handling of these payments in June 2015.[17] The OIG found that "CMS's system of internal controls could not ensure that CMS made correct financial assistance payments during the period January through April 2014."[18] It identified both overpayments and underpayments associated with the CSR program. "Without effective internal controls for ensuring that financial assistance payments are calculated and applied correctly," the audit concluded, "a significant amount (approximately $2.8 billion) of Federal funds are at risk (e.g., there is a risk that funds were authorized for payment to QHP issuers in the incorrect amounts)."[19]

CMS is Spending CSR Money Recklessly

Since the one undeniably positive result of ACA implementation has been an increase in the number of people with health insurance coverage, CMS has thrown caution to the wind in an effort to improve enrollment results.

Its laxity imposes substantial costs on taxpayers, according to the Government Accountability Office. CMS, the agency concluded in a February 2016 report, "foregoes information that could suggest potential program issues or potential vulnerabilities to fraud."[20] Nor has it established a process to resolve "inconsistencies," which GAO defines as "instances where individual

[17] HHS, Office of Inspector General, CMS's Internal Controls Did Not Effectively the Accuracy of Aggregate Financial Assistance Payments Made to Qualified Health Plan Issuers Under the Affordable Care Act, June 2015.
[18] HHS, OIG, p. iii.
[19] HHS, OIG, p. iv.
[20] GAO, CMS Should Act to Strengthen Enrollment Controls and Manage Fraud Risk, GAO-16-29, February 2016, p. 1.

applicant information does not match information from marketplace [i.e., exchange] data sources."[21]

This has resulted, according to GAO, in billions of dollars in government payments to insurance companies on behalf of enrollees with unresolved inconsistencies in 2014. Such problems, which remained unresolved well into 2015, included 431,000 applications involving $1.4 billion in advance premium tax credits and $313 million in cost-sharing reduction subsidies for 2014.[22]

GAO concluded that "CMS is at risk of granting eligibility to, and making subsidy payments on behalf of, individuals who are ineligible to enroll in QHPs." [23]

CMS's incuriosity as to the eligibility of individuals to receive subsidies is so extreme that it has approved subsidies to people who don't exist.

In the same report, GAO disclosed the disturbing results of its undercover testing of the federal health care exchange. The exchange approved subsidized coverage for 11 of 12 fictitious GAO phone or online applicants for 2014.[24] The government paid insurers $30,000 in advanced premium tax credits for these phony beneficiaries and additional money in cost-sharing reduction subsidies.[25]

"The fictitious enrollees," GAO found, "maintained subsidized coverage throughout 2014, even though GAO sent fictitious documents, or no documents, to resolve inconsistencies."[26]

[21] GAO, CMS Should Act, p. 1.
[22] GAO, CMS Should Act, Figure 1, p. 18.
[23] GAO, CMS Should Act, p. 1.
[24] GAO, CMS Should Act, p. 1.
[25] GAO, CMS Should Act, p. 1.
[26] GAO, CMS Should Act, p. 1.

When the agency's leading measure of success is the number of enrollees, fictitious enrollees (whose insurers were paid real money) count every bit as much as real ones.

CMS is Spending CSR Money Unlawfully

The fundamental problem with the agency's CSR spending is neither recklessness nor laxity, but unlawfulness: CMS is spending billions on the CSR program; Congress has not appropriated a dime.

The law could not be more clear. Section 1402 of the Act requires insurers to offer reduced cost-sharing to people with incomes between 100 and 400 percent of the federal poverty level.[27] And although it directs the Secretary to "make periodic and timely payments to the issuer equal to the value of the reductions,"[28] it does not appropriate money for these payments.

Section 1402, unlike the advance premium tax credits authorized under section 36B of the Internal Revenue Code, is not included in the list of permanently "Refunds of internal revenue collections."[29] Nor could it be, since it is not an individual tax credit and, as such, is codified in title 42 of the United States Code, rather than in the Internal Revenue Code.

The Administration understood this. In April 2013, OMB requested "such sums as necessary" for CMS to fund the cost sharing reduction program for fiscal year 2014 and an advance appropriation of an additional $1.4 billion for the first quarter of FY 2015.[30] HHS made a

[27] 42 USC 18071(b).
[28] 42 USC 18071(c)(3)(A).
[29] 31 USC 1324.
[30] FY 2014 Budget of The United States Government, Appendix.

similar request in its FY 2014 Justification of Estimates for Appropriations Committees, referring to the program as "one of five annually-appropriated accounts."[31]

The following month, OMB's Sequestration Preview Report listed the program as subject to a $286 million cut.[32] The 7.2 percent reduction applied only to domestic discretionary program and excluded mandatory spending, such as the advance premium tax credits.

President Obama signed the FY 2014 omnibus appropriations bill in January 2014.[33] In a hearing before Federal District Court Judge Rosemary M. Collyer, the Administration conceded that "there was no 2014 statute appropriating new money" for the cost-sharing reduction program.[34]

It has continued making CSR payments to insurers anyway. The House of Representatives filed suit to enjoin the payments.

Judge Collyer's ruling in *House v. Burwell* was clear.

> "The Affordable Care Act unambiguously appropriates money for Section 1401 premium tax credits but not for Section 1402 reimbursements to insurers. Such an appropriation cannot be inferred. None of Secretaries' extra-textual arguments—whether based on economics, "unintended" results, or legislative history—is persuasive. The Court will enter judgment in favor of the House of Representatives."[35]

[31] CMS, FY 2014 Justifications of Estimates for Appropriations Committees, p. 2.
[32] OMB, Sequestration Preview Report to the President and Congress for FY 2014, p. 23.
[33] PL 113-76.
[34] *House v. Burwell*, U.S. District Court for the District of Columbia, p. 11.
[35] *House v. Burwell*, p. 2.

Judge Collyer stayed her order, pending appeal.

Pattern and Practice

The Administration's unlawful CSR payments are part of a broader pattern and practice of unlawful behavior undertaken to keep insurers from dropping out of the exchanges. This pattern and practice is especially pronounced in its administration of the reinsurance and risk corridor programs.

Reinsurance

Section 1341 of the ACA establishes a transitional reinsurance program with two purposes: 1) to reimburse Treasury for the $5 billion it spent on a temporary program that provided reinsurance payments to corporations and labor unions that provided health benefits to early retirees program [section 1102]; and 2) to compensate issuers of individual QHPs for a portion of medical claims incurred by "high-risk individuals."[36]

CMS has acknowledged this dual purpose and that the Congressional Budget Office considered the $5 billion in collections to be an offset for the early retiree program.[37]

Although the statute requires the program to be state-based and administered, CMS chose to run it as a national program.[38] And although the statute contemplates the identification of 50 to 100 medical conditions to identify "high-risk individuals,"[39] CMS chose instead to reimburse insurers for 100 percent of medical bills between $45,000 and $250,000 incurred by any enrollee in an

[36] 42 USC 18061.
[37] 76 FR 41935.
[38] 42 USC 18061(a).
[39] 42 USC 18061(b)(2).

individual QHP.[40] That decision alone made reinsurance payments to insurers 40 percent more generous on a per enrollee basis than insurers had anticipated when they set their 2014 premiums.[41]

They also chose to institute the equivalent of a tax on virtually every enrollee in a private health plan. The purpose of this collection was to meet the statutory requirement of collecting a total of $25 billion over three years ($12 billion in 2014, $8 billion in 2015 and $5 billion in 2016). Of those amounts, the statute requires that $5 billion be remitted to Treasury ($2 billion in 2014 and 2015, $1 billion in 2016).[42] Insurers would receive the remaining $20 billion ($10 billion for 2014, $6 billion for 2015 and $4 billion for 2016).[43]

CMS soon realized that the collections, like so much else in the ACA, might not go according to plan. On March 11, 2013, they issued a final rule providing that if 2014 collections were to fall short of the $12 billion requirement, payments to Treasury and the plans would be proportionately reduced.[44] They finalized that rule for the 2015 benefit year on March 11, 2014.[45]

By that point, many insurers had begun to recognize their dire condition. Fewer people than expected were buying their product and the customers they were attracting were the ones they least wanted. Nearly half the enrollees were 45 or older. Few young and healthy people were signing up. They turned to CMS for help.

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[40] CMS, "CMS continues to implement premium stabilization programs," June 30, 2015.
[41] Seth Chandler, "How the Obama Administration Raided the Treasury to Pay Off Insurers," *Forbes*, January 18, 2016.
[42] 42 USC 18061(b)(3)(B)(iv).
[43] 42 USC 18061(b)(3)(B)(iii).
[44] 78 FR 15410.
[45] 79 FR 13744.

The agency obliged them ten days later. On March 21, 2014, CMS published a notice of proposed rulemaking that reversed its earlier regulations.[46] If collections fell short, insurers were to get 100 percent of the proceeds until they were made whole. Treasury would get the leftovers.

The agency later that year announced that there would be no 2014 leftovers. Treasury would get nothing, leaving the entire $9.7 billion to be distributed to insurers.[47] For the 2015 benefit year, Treasury would be a bit luckier, collection $500 million of the required $2 billion.[48]

That leaves Treasury $3.5 billion short of the amount the statute requires them to be paid. The likelihood is that the 2016 collections will also fall short, meaning that Treasury will get little or nothing of the $1 billion it is owed. Over the three years, the amount unlawfully diverted from Treasury to the insurance industry will almost certainly fall in the $4.0 - $4.5 billion range.

In a February 2016 letter to this committee, the Congressional Research Service concluded that CMS's actions

> "appear to be in conflict with the plain reading of section 1341(b)(4). Because the statute unambiguously stats that 'each issuer's contribution' contain an amount that reflects 'its proportionate share' of the U.S. Treasury contribution, and that these amounts should be deposited in the General Fund of the U.S. Tresaury, a contrary agency interpretation would not be entitled to deference under *Chevron.*"[49]

[46] 78 FR 15808. Neither the Secretary nor the Acting CMS Administrator has been able to explain this abrupt shift to the committee and has so far refused to turn over subpoenaed documents.
[47] CMS, Summary Report On Transitional Reinsurance Payments And Permanent Risk Adjustment Transfers For The 2014 Benefit Year, June 30, 2015.
[48] CMS, The Transitional Reinsurance Program's Contribution Collections for the 2015 Benefit Year, February 12, 2016.
[49] CRS, February 23, 2016 letter to Committees on Energy and Commerce and Ways and Means, p. 8.

A lengthier legal opinion prepared by Boyden Gray and Associates for the Galen Institute concluded that the "HHS allocation scheme prioritizing payments to reinsurance-eligible issuers over payments to Treasury is unlawful."[50]

Nevertheless, this unlawful behavior persists and Congress has not addressed it.

Risk Corridors

But while the $4.5 billion diversion of funds was a boost to the insurance industry, it soon became clear that it would not be nearly enough to cover their losses from individual QHPs. So they sought another form of assistance: an entitlement to risk corridor payments.

Section 1342 creates a temporary risk corridor program.[51] The statute requires HHS to "establish and administer a program of risk corridors" under which insurers offering individual and small group QHPs "shall participate in a payment adjustment system based on the ratio of allowable costs of the plan to the plan's aggregate premiums."[52] It stipulates that QHP issuers whose allowable costs exceed 103 percent of their targeted amount would be eligible to receive risk corridor payments while those whose costs fell below 97 percent of the target would be required to make risk corridor contributions.[53]

Congress neither authorized nor appropriated funds for the risk corridors program, an indication that it intended the program to be budget neutral. CMS acknowledged in a July 2011 rulemaking that the Congressional Budget Office assumed "collections would equal payment to plans in the

[50] Letter to Galen Institute from Boyden Gray and Associates.
[51] 42 USC 18062.
[52] 42 USC 18062(a).
[53] 42 USC 18062(b).

aggregate."[54] CMS reiterated that budget neutrality assumption in a regulatory impact analysis published in March 2012.[55] Its March 11, 2014 final rule reiterated the agency's intention to "implement the program in a budget neutral manner."[56]

It stated in April 2014 that if risk corridor claims exceeded collections, "all risk corridor payments for that year will be reduced pro rata to the extent of any shortfall."[57] The agency further stipulated that the shortfall would be made up in subsequent years, adding, "We anticipate that risk corridors collections will be sufficient to pay for all risk corridors payments over the life of the three-year program."[58]

As losses piled up during 2014, the agency modified the program to make shortfalls more likely. Specifically, the agency increased the ceiling on administrative costs and the profit floor. Although the adjustments were made to compensate for costs to insurers resulting from the decisions of some states to allow for the renewal of non-ACA-compliant, non-grandfathered individual and group policies, these changes to the risk corridor calculation were made for plans in all states. CMS acknowledged the effect of this in its preamble:

> "These increases to the profit floor and administrative cost ceiling in the risk corridors formula would increase a QHP issuer's risk corridors ratio if claims costs are unexpectedly high, thereby increasing risk corridor payments or decreasing risk corridors charges."[59]

Moreover, insurers and their regulators began to contemplate the possibility that aggregate losses among individual QHP issuers could vastly exceed gains. The Act did not provide for such an

[54] 79 FR 41930 at 41948.
[55] *Health Republic Insurance Company v. U.S.*, government motion to dismiss.
[56] 79 FR 13744 at 13787.
[57] CMS, Risk Corridors And Budget Neutrality, April 2014.
[58] CMS, Risk Corridors And Budget Neutrality, April 2014.
[59] 79 FR 30259-60.

eventuality. It neither automatically appropriated spending nor created an authorization that could serve as the basis for an appropriation.

By May 2014, the agency had begun to hedge on budget neutrality. While it would strive to achieve budget neutrality, the agency argued in a final rule, it was required to make full payments to issuers. It noted that if a shortfall in contributions were to occur, it might have to find other sources of payments, "subject to the availability of appropriations."[60]

In a September 2014 opinion letter to Senator Jeff Sessions (R-AL), the Comptroller General issued an opinion confirming that risk corridor payments required appropriation and identifying the CMS Program Management account as a possible source of risk corridor payments.[61]

In December 2014, Congress appended a provision to the omnibus spending act that prohibited the use of CMS Program Management funds to make payments to insurers under the risk corridor program.[62] Congress renewed that prohibition in the FY 2016 spending bill.[63]

That should have ended the debate. It has not. Several insurers have filed lawsuits against the federal government, seeking to obtain risk corridor payments.[64] In related actions, some states

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[60] Timothy Jost**,** Implementing Health Reform: Final 2015 Exchange And Insurance Market Standards Rule, Health Affairs Blog, May 17, 2014.

[61] Motion to dismiss, p. 9.
[62] PL 113-235.
[63] PL 114-113.
[64] Bob Herman, Another insurer, BCBS of North Carolina, files risk-corridor lawsuit, *Modern Healthcare*, June 2, 2016.

have sued for these funds, seeking additional federal resources to help clean up the mess created by the failure of health insurance co-operatives.[65]

The theory of these lawsuits, in effect, is that the ACA created an entitlement among insurers to risk corridor payments that appropriations restrictions did not eliminate. Moreover, that restriction applies only to CMS and, more particularly, to the agency's program management fund, but not to the Judgment Fund, a permanently appropriated entity administered by the Treasury Department.

That legal argument, as the discussion above suggests, is flawed. The law creates no entitlement to risk corridor payments. Unlike with the CSR program, it does not even authorize an appropriation. Congress has expressly forbidden money to be appropriated. Unless that appropriations restriction is limited, no funds can be expended.

Congress never intended for the risk corridors program to be a new version of TARP – granting the federal government power to shift the costs of bad business decisions by corporations to taxpayers.

The lawsuits will nevertheless move forward. If successful, plaintiffs would seek payments from the Judgment Fund. Such a payment would undermine Congress's constitutional power to appropriate in contravention of long-standing precedent.

In a January 2016 opinion letter to Senator Marco Rubio (R-FL), CRS stated that the Judgment Fund could not be used to circumvent a limitation on appropriations.[66] "Any payment to satisfy

[65] Timothy Jost, Congressional Risk Corridor Payments Spawning Legal Difficulties, Health Affairs Blog, May 24, 2016.
[66] Lawsuits to Recover Payments under the Risk Corridors Program of the Affordable Care Act, CRS letter to Senator Marco Rubio, January 5, 2016.

a judgment secured by plaintiffs seeking recovery of amounts owed under the risk-corridors program," the agency wrote, "would need to wait until such funds were made available by Congress."

Thus, even if a judge were to order HHS to pay insurers, the agency couldn't do so unless Congress appropriated the money.

Congress should not trust the Administration to act in accordance with the law. CMS's willingness to spend unappropriated funds on the CSR program and to divert money from Treasury to insurers through the reinsurance program are evidence enough that it will not respect legal boundaries when it comes to the ACA.

Congress should make a clear statement that money cannot be drawn from the Judgment Fund to satisfy a judgment against the government in any of the risk corridor cases.

Conclusion

The ACA has transformed the regulation of the individual and small group markets. While the small group market appears to be surviving the law's Byzantine regulatory regime, its effect on the individual market has been toxic.

Brian Blase of the Mercatus Institute succinctly summarized the effect of these rules.

> "The ACA largely replaced risk-based insurance in the individual market with income redistribution based on age, income, and health status."[67]

[67] Brian Blase, "The Obamacare Risk Adjustment Trap," Forbes Apothecary blog, July 6, 2016. http://www.forbes.com/sites/theapothecary/2016/07/06/the-obamacare-risk-adjustment-trap/#6ab3a5ed3284

Whatever the merits of redistribution of wealth, it is not possible for government to redistribute health. The rules in their totality instead separate the price of insurance from risk. Since the essence of insurance is the pricing of risk, this decoupling has had adverse effects.

The rules sought to prevent insurers from seeking out people at low risk of incurring medical claims and avoiding high risk consumers. They essentially accomplished this by requiring insurers to overcharge younger and healthier people and to discount premiums for older and less healthy ones. They overachieved. The result is a "market" that attracts high-risk enrollees and repels low-risk ones. Such a "market" is unsustainable.

It was hoped that the payment of billions of dollars in corporate subsidies to insurance companies would nullify the law's effects on insurer balance sheets. They have not. The evidence suggests that insurers continue to suffer outsize losses selling individual QHPs, in contrast to their group QHPs and non-QHPs in the individual and small group markets. Neither reinsurance, risk corridor payments, nor cost-sharing subsidies have offset these losses. The scheduled expiration of the risk corridor and reinsurance programs at the end of this year will further unmask the law's underlying dysfunction.

As the Administration began to realize during 2014 how badly markets were unravelling, it made a series of policy decisions – some of which involved the unlawful payment of corporate subsidies -- to entice insurers to remain in the exchanges. These decisions included:

1. The expenditure of unappropriated money on the CSR program, payments that were made to insurers without proper controls and still remain unreconciled.
2. The diversion of billions of dollars from the Treasury to insurance companies through the reinsurance program.

3. Repeated restructuring of reinsurance attachment points and coinsurance rates, resulting in the government assuming 100 percent of the costs of claims between $45,000 and $250,000.
4. A slow retreat from the agency's prior position on risk corridor budget neutrality, in effort to turn it into a TARP-like fund that used taxpayer funds to mitigate poor corporate business decisions.

This committee has been diligent in calling attention to these actions and Congress has acted to assure that the risk corridor operates as intended. Further action is required to end the unlawful diversion of funds from Treasury through the reinsurance program and to assure that the Judgment Fund is not improperly use to circumvent an appropriations restriction.

Members of both parties have reason to ignore this unlawful allocation of billions of dollars. Some are invested in keeping up appearances of the law's success, while some who seek its repeal are protective of insurers in their districts.

The Administration's behavior raises concerns that transcend the fractious politics of Obamacare. They are institutional and constitutional in nature. Institutional because Congress's core lawmaking function is being effaced. Constitutional because its power of the purse is under legal assault.

In such circumstances, Congress cannot be passive. It must insist that the Administration follow the law.