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PROTECTING AMERICANS FROM ILLEGAL BAILOUTS

AND PLAN CANCELLATIONS

MONDAY, JULY 28, 2014

House of Representatives,

Subcommittee on Health,

Committee on Energy and Commerce,

Washington, D.C.

The subcommittee met, pursuant to call, at 4:00 p.m., in Room 2123, Rayburn House Office Building, Hon. Joseph R. Pitts [chairman of the subcommittee] presiding.

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

Staff Present: Nick Abraham, Legislative Clerk; Sean Bonyun, Communications Director; Leighton Brown, Press Assistant; Noelle

Clemente, Press Secretary; Paul Edattel, Professional Staff Member, Health; Sydne Harwick, Legislative Clerk; Katie Novaria, Professional Staff Member, Health; and Heidi Stirrup, Health Policy Coordinating; Ziky Ababiya, Minority Staff Assistant; Karen Lightfoot, Minority Communications Director and Senior Policy Advisor; Karen Nelson, Minority Deputy Committee Staff Director for Health; and Matt Siegler, Minority Counsel.

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Mr. Pitts. The subcommittee will come to order. The chair will recognize himself for an opening statement. Today's hearing is once again about protecting taxpayers and consumers from the consequences of the Affordable Care Act; namely, a give away of taxpayer dollars to insurers, under the ACA, and another round of planned cancellations in the group market.

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

The risk corridor provision is in effect from 2014 through 2016, if done in a budget-neutral fashion, taxpayers would have little to be worried about when it comes to risk corridors, but while the administration has paid lip service to the risk corridor program being budget neutral, it has also indicated that, quote, "regardless of payments and receipts, HHS will remit payments as required under Section 1342 of the Affordable Care Act," end quote.

Opening the door to what would essentially be a taxpayer-funded bailout of health insurers. Additionally, according to the Congressional Research Service and a plain reading of Section 1342,

the law does not provide an appropriation for these payments. In the absence of a congressional appropriation, any payments are clearly an end-run around Congress and, therefore, illegal. The very idea of risk corridors assumes that there will be winners in the insurance industry whose gains can be shifted to the losers.

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

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

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

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

[The prepared statement of Mr. Pitts follows:]

******** COMMITTEE INSERT ********

Mr. Pallone. Thank you, Mr. Chairman.

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

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

Of course, no one is surprised, since the passage of the ACA, Republicans have reversed course on so many ideas that were once the foundation of their health agenda. Remember that the individual mandate, that was a Republican idea as well. And as we get close to the election, we are going to hear more and more about how the ACA must be repealed and replaced, but I am still waiting for the alternative

and I haven't heard one from the other side of the aisle. Risk corridors specifically are not some made up policy the Democrats decided to use to give a handout to insurance companies. Trust me, no Democrat is interested in bailing out the insurance company. But these policies are in place for legitimate reason and only because they are in the ACA are they controversial and considered in this negative light by the GOP.

And let's recap the importance of risk corridors in order for insurance pools to keep premiums stable and cost low, it is critical to spread out risk. These types of risk-sharing mechanisms are not a new phenomena. They are used in all types of function insurance system. One great example is the use in the Medicare Part D program. In fact, the provisions of the ACA were modelled after the Part D program, which, of course, was authored by the GOP. If Republicans had their way, they would repeal this program and would effectively create chaos in the marketplace.

So, Mr. Chairman, there is a new study, published in the New England Journal of Medicine last week, that estimated that 10.3 million uninsured adults gained healthcare coverage following the first open enrollment period in the health insurance marketplace. The uninsured rate for adults ages 18 to 64 fell from 21 percent in September 2013 to 16.3 percent in April 2014. And these results do not include the more than 3 million young adults who gained health insurance coverage

through their parents' plan. So we have done something pretty remarkable here with the ACA. These millions of people aren't just a number. They are actual people who can now see a doctor. They can now treat an illness that was otherwise going untreated or better yet, they can remain healthy and prevent illness in the future. Women no longer will be charged more men for insurance. Insurance companies must offer robust health coverage, so that when you do get sick or you are hospitalized, you aren't left with thousands of dollars in debt. If Republicans had their way, we would go back to the days when insurance companies could drop someone for a preexisting condition.

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

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

[The prepared statement of Mr. Pallone follows:]

******** COMMITTEE INSERT ********

Mr. Green. Thank you, Mr. Chairman.

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

And I appreciate you yielding me your time.

[The prepared statement of Mr. Green follows:]

******** COMMITTEE INSERT ********

Mr. Pallone. Thank you, Mr. Chairman.

Mr. Pitts. The chair thanks the gentleman.

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

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

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

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

It is clear to me that they don't have any productive ideas of their own to offer. It appears that they have decided to add to their 50 votes to repeal or undermine the ACA. They certainly are working hard to secure their place in history as the least productive Congress in the history of this Nation. I oppose all three of these bills before us today. The first bill, H.R. 3522, says that any group health

insurance plan on the market in 2013 can be sold in perpetuity. They don't have to change it. Now, they wouldn't have to adopt all of the key protections for consumers in the Affordable Care Act, protections that went into place this year, such as ban on annual limits. Insurance companies used to do that. They put a limit at how much you can spend each year, and then after that limit, you pay for it all. Well, they want to go back and continue those plans that have those limits. They want to continue to allow plans that would charge a small business a higher premium because an employee has a preexisting condition.

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

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

The other two bills before us today relate to a premium stabilization program in the ACA, known as risk corridors. This is modelled after a nearly identical program in Medicare Part D that redistributes a portion of profits and losses between insurance companies. This was drafted by the Republicans on this committee as part of their Part D legislation. They and the Bush administration praised it repeatedly. It helped keep Part D premiums stable, and it has saved taxpayers money. But now that it is being used by the plans under the Affordable Care Act, oh, we can't continue these risk corridors. Let's repeal them.

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

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

Mr. Pitts. The gentleman's time is expired. The chairman

thanks the gentleman.

[The prepared statement of Mr. Waxman follows:]

******** COMMITTEE INSERT ********

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

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

Without objection, so ordered.

[The information follows:]

******** COMMITTEE INSERT ********

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

Let me introduce them in the order that they will testify. First, Dr. Stan Veuger, resident scholar, American Enterprise Institute; Dr. John Hoadley, research professor, Georgetown University; and Mr. Edmund Haislmaier, senior research fellow at the Heritage Foundation.

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

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

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

STATEMENT OF STAN VEUGAR

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

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

of the sort of more salient consequences of the legislation that undermine the veracity of that claim.

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

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

First, what I want to note is, by now, I think everyone realizes that in the individual market, millions of people who started out buying insurance there received cancellation notices announcing the ends of their current plans last year, and it may well be as many as 9 million people end up losing the plans they had before the Affordable Care Act passed.

It doesn't stop there, though. A much larger group of Americans enjoy employer-based health insurance, a total of about 170 million people. And many of those plans will change or disappear as well. Of

these plans, there are about -- of these covered workers, about 18 percent were for firms that were smaller than 50 employees and will not be subject to the employer mandate to purchase health insurance if it -- well, when it kicks in, if it ever kicks in. In total, there is about 35 to 40 million covered workers who work for firms with fewer than 100 employees. They are in so-called small groups plans. The remaining 130 do 135 million covered workers work for larger employers, and many of those self-insure.

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

What we do know, as I said, is that there are -- only very few

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

Mr. Pitts. The chair thanks the gentleman.

[The prepared statement of Mr. Veugar follows:]

******** INSERT 1-1 ********

Mr. Pitts. Now the chair recognize Dr. Hoadley 5 minutes for an opening statement.

STATEMENT OF JOHN F. HOADLEY

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

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

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

might attract and of the health status of the enrollees that they did obtain. If the plans did participate, they would likely set higher premiums to reflect these uncertainties.

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

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

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

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

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

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

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

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

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

both in the first years and beyond.

Mr. Pitts. The chair thanks the gentleman.

[The prepared statement of Mr. Hoadley follows:]

******** INSERT 1-2 ********

Mr. Pitts. Now the chair recognizes Mr. Haislmaier, 5 minutes for an opening statement.

STATEMENT OF EDMUND F. HAISLMAIER

Mr. Haislmaier. Thank you, Mr. Chairman.

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

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

The reinsurance provision is essentially designed to address the kind of risk that we might call market selection risk. In other words, you have a choice between markets. This is true of people who are insured and uninsured. I won't go into great length, but suffice it

to say that it is premised on the idea that the way this legislation is designed and works, there is an expectation that more people in poorer health status will gravitate towards this market, and therefore, it taxes the existing market, principally the employer market, and transfers the funds to subsidize the new individual or the expanded individual market on that market selection risk expectation.

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

The third, and the one that is the subject really of your hearing, is the risk corridor program. And the question that I would ask is, well, what is the risk that this is designed to address? Because it was observed that this was designed to hold down premiums. Well, no, it is not really designed to hold down premiums, necessarily. It is not designed to make the market balance out. It is not designed to spread the risk evenly across the market. That is what the other two

are there for. What is this one here for? Well, this is a profit and loss risk. This is saying we don't know, and neither do you, the insurers, what the real price for this product is going to be, and we could be -- and we are paying for most of it, and that was the significance of Part D -- they were paying for three-quarters of it. We and you could be wildly off the mark. So what they do is the government, which is paying three-quarters of it, in effect, has a profit and loss sharing arrangement through risk corridors with the insurers.

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

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

a tolerable rate.

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

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

Mr. Pitts. The chair thanks the gentleman and thanks all of the witnesses for their testimony.

[The prepared statement of Mr. Haislmaier follows:]

******** INSERT 1-3 ********

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

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

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

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

Mr. Haislmaier. Well, I think the administration has taken

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

Mr. Pitts. Thank you.

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

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

The administration sort of mid-range estimate was that, by 2016, 88 percent of all insurance small employer plans will have lost grandfather status, so all of those plans would in principle receive

the same treatment that individual market plans received last year. So they will be canceled. The process would go through the employer, not the individual, so it may be slightly less salient, but the -- it would certainly be the same fate that so many plans in the individual market had. And I find it surprising, honestly, that so many supporters of the law after being caught not being able to live up to the, "if you like your plan, you can keep your plan" promise on the individual side decided to continue with the same story for these plans that will ultimately suffer the same fate.

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

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

Mr. Pitts. My time is expired. The chair now recognizes the

ranking member, Mr. Pallone 5 minutes for questions.

Mr. Pallone. Thank you, Mr. Chairman.

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

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

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

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

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

Dr. Hoadley, the ACA and the Medicare Part D both have risk corridor programs. They seem very similar to me, but again, my Republican friends seem to hate the ACA program and love the Part D program, which seems so inconsistent. They claim that the ACA risk

corridors are a bailout, but the Part D risk corridors have actually made the government money, and they are more generous to insurers than the ACA program is. And of course, the Part D risk corridors are permanent; whereas the ACA risk corridors will only last for 3 years. I mean, all of this, again, to the point that this is something that would not be controversial at all if it wasn't part of the ACA.

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

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

The same system really applies in the ACA. As long as we have

a lot of uncertainty about how the program might operate, there is an interest in protecting, in both directions, protecting the government from errors made in one direction in setting premiums, protect the plans in the other direction if that is the way it works out.

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

Mr. Pitts. The gentleman's time is expired. The chair thanks the gentleman.

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

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

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

I am deeply concerned about it.

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

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

on that market, or is that just a normal level, albeit maybe somewhat elevated, but a normal level of profit and loss risk that private actors bear all the time? And I think that is the latter.

Mr. Lance. Thank you.

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

Dr. Hoadley.

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

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

reinsurance --

Mr. Lance. My own view on that is that this is similar to what existed at a prior time. I suppose that is debatable. But it is only for a limited period of time, and there may be, if I am understanding what you are saying, a volatility for some time. I agree with what Mr. Haislmaier, has said. Obviously, significant legislation is to be debated, and I respect the views of all who are interested in it.

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

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

Mr. Pitts. Without objection, so ordered.

[The information follows:]

******** COMMITTEE INSERT ********

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

Thank you, Mr. Chairman.

Mr. Pitts. The chair thanks the gentleman.

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

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

Dr. Hoadley, I know you have answered about the affordable care market and the senior prescription drug program. The ACA significantly reforms the individual insurance market so that the products insureds are offering in the marketplace are fundamentally different than they were sold before. Insurers can no longer discriminate based on preexisting conditions. They can no longer

charge women more for the same coverage. And they can no longer offer what a lot of us would consider junk coverage that doesn't cover hospitalizations or disappears whenever consumers need it the most.

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

Mr. Hoadley. I mean, one of the things that I think is striking about the notion of a risk corridor, is that if it is not needed, if it turns out that plans are able to estimate their premiums pretty accurately, then no payments will need to be made. If a plan's experience is very similar to what their estimates, then there is no cost in either direction. In the case of the ACA, there is a 3 percent corridor around which plans are at full risk for going higher or lower, and if they stay within that estimate in either program, you know, they will be fine.

I think the other point is that there is a learning process. You could make the argument that the risk corridors for the Part D program aren't needed anymore. We are well into that program, and they could be phased out. So far, CMS has chosen -- there is legislative authority to make a decision for CMS to decide whether or not to extend

that further. For the moment, that has been extended. In the case of the ACA, the decision was in the law, was to have it last just for the 3 years.

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

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

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

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

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

Mr. Green. Okay, I want to reiterate though that over the 50 months since the enactment of the Affordable Care Act, health prices have risen at a slower rate than they have for the last 50 years. M.

R. Chairman, I am going to yield back my time, but I am hoping that we can actually work on legislation. If there are problems with the Affordable Care Act, let's fix it. Let's don't strangle it after we are seeing some of the success after only 50 months of the law.

So I yield back my time.

Mr. Pitts. The chair thanks the gentleman.

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

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

Mr. Haislmaier, under the recently issued regulations, any

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

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

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

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

Mr. Haislmaier. No, I don't -- I mean, I think that is why you have this issue. There isn't anything that I can see in the law that

prevents them, at least in the authorizing statute. There is an appropriations question, which I am not an expert on, but in the authorizing statute, they do not explicitly have to have this budget neutral in the authorizing statute.

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

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

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

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

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

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

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

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

Mr. Bilirakis. Define user fee.

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

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

Mr. Bilirakis. Yeah, I tend to agree.

Thank you, Mr. Chairman, I yield back.

RPTS BAKER

DCMN HOFSTAD

[4:59 p.m.]

Mr. Pitts. The chair thanks the gentleman.

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

Mr. Griffith. Thank you, Mr. Chairman.

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

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

Dr. Cassidy. Thank you, Mr. Griffith.

Several things to go over. First, the legal aspect of it. I noticed that Mr. Pallone mentioned that initially CBO estimated this would return $8 billion to the Treasury and then glossed over the fact that now it is not going to return money to the Treasury, but rather

it will be, quote, "budget-neutral," except as subject to appropriations, we don't know from whence they come. That is a far cry from being $8 billion to the government.

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

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

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

Now, if the other side of the aisle is quite willing to do away

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

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

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

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

Now, in order to provide relief to the individuals losing their health coverage, the House passed the Keep Your Health Plan Act, allowing plans available on the individual market before Obamacare to continue to be offered. The House must now act to provide the same

relief to businesses and employees now by passing my bill, the Employee Health Care Protection Act, which would allow the millions of workers in the group market to keep the health plan they like. I thank the committee for conducting this plan.

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

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

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

Mr. Pitts. The chair thanks the gentleman.

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

Mrs. Blackburn. Thank you, Mr. Chairman.

I want to thank our witnesses for being here.

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

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

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

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

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

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

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

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

Mr. Haislmaier. Well, the consumer does, obviously --

Mrs. Blackburn. Absolutely.

Mr. Haislmaier. -- either directly when they purchase something or indirectly through their tax bill.

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

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

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

Mrs. Blackburn. Yes. I know in Tennessee we had had cost

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

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

Mr. Haislmaier. You are asking me?

Mrs. Blackburn. Yes.

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

I think, really, frankly, the problem here is there are so many ways in this legislation where subsidies are hidden or things are done through the back door, there is so little trust of the administration

in its actually implementing this legislation, that I think a lot of people are, with some degree of legitimacy, concerned that this could become another way for a back-door deal.

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

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

Mrs. Blackburn. Thank you.

Yield back.

Mr. Pitts. The chair thanks the gentlelady.

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

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

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

Dr. Cassidy. So they protect themselves from the risk; you imply

that there is a risk of going into the regulated market. Your testimony emphasizes the increased cost that comes with going into the ACA-regulated market. Fair statement?

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

Dr. Cassidy. There are the taxes, the trillion dollars in taxes --

Mr. Veuger. Yes. For sure.

Dr. Cassidy. -- coming with an individual policy.

Mr. Veuger. Yeah.

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

Mr. Veuger. Will be more limited.

Dr. Cassidy. Yeah.

Mr. Veuger. Yeah. I think that is fair.

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

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

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

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

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

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

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

Dr. Cassidy. Ten billion with a "B."

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

Dr. Cassidy. So it is a $28-billion market, and you have a $10-billion subsidy already going.

Mr. Haislmaier. Right. So, you know, if you make various assumptions about increased costs and increased enrollment, you know, okay, let's say you double that market, you know, you get a $40-billion,

$50-billion market. That is if lots of people sign up and --

Dr. Cassidy. So you have 20 percent of the potential loss --

Mr. Haislmaier. Yes.

Dr. Cassidy. -- already being covered just through the reinsurance --

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

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

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

Mr. Veuger. Uh-huh.

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

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

Dr. Cassidy. Yeah.

Mr. Veuger. So, yeah.

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

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

Dr. Cassidy. Yeah. Okay.

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

Mr. Pitts. The chair thanks the gentleman.

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

Dr. Gingrey. Mr. Chairman, thank you.

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

Dr. Veuger, do you think that it should have been obvious to Members of Congress that many Americans who liked their healthcare plan

would not be able to keep it under the Affordable Care Act?

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

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

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

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

Mr. Veuger. I think it is -- I mean, in a sense, I think it was reasonable for them to do if they really wanted to pass this kind of legislation, which I think -- I don't think it would have passed otherwise. If you are married to the idea of passing it, I think going

through regular order would have kept you from doing that. So, in that sense, it is reasonable.

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

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

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

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

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

the government or make payments to the government. I think it just remains to be seen.

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

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

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

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

So that bill to say that, yes, in the small group market and the individual market, those 2013 policies, the people that like them can keep them, that is a very appropriate legislation. And I hope that

we will pass it in both the House and Senate and hope that President Obama will sign it into law.

And I yield back.

Mr. Pitts. The chair thanks the gentleman.

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

Mrs. Ellmers. Thank you, Mr. Chairman.

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

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

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

Mrs. Ellmers. For people to sign up.

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

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

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

Mrs. Ellmers. Okay, but it is not a mandate. It is --

Mr. Hoadley. Not a mandate.

Mrs. Ellmers. -- a personal choice that every individual, every senior on Medicare can take, correct?

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

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

Mrs. Ellmers. Okay.

Mr. Hoadley. -- and then left the Department with the option of what to do with it thereafter.

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

Mr. Hoadley. Right.

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

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

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

Mr. Hoadley. No, they could not.

Mrs. Ellmers. Okay. Well, I want to point something out to you along that line. Today, the House Oversight and Government Reform

Committee's chairman, Darrell Issa, released a report: "ObamaCare's Taxpayer Bailout of Health Insurers and the White House's Involvement to Increase Bailout Size."

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

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

Mr. Pallone. Mr. Chairman, I haven't seen this report, so I reserve --

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

Mr. Pallone. Well --

Mrs. Ellmers. -- if possible, and --

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

Mrs. Ellmers. Okay.

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

Mrs. Ellmers. Great. Okay, wonderful.

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

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

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

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

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

Mrs. Ellmers. Uh-huh.

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

Mrs. Ellmers. And to that point, you know, we have Medicare Part

D, and we can look back on Medicare Part D and we can watch the way that it played out. We are still, you know, waiting to see how the --

Mr. Haislmaier. We are in mid-process --

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

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

Mrs. Ellmers. Okay. Thank you. Thank you.

Thank you, Mr. Chairman. I yield back.

Mr. Pitts. The chair thanks the gentlelady.

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

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

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

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

Mr. Pallone. Oh, why don't you just -- we will reserve our

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

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

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

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

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

So if you will let us know --

Mr. Pallone. Sure.

Mr. Pitts. -- once you get to see the report, and then, without objection, we will enter it into the record.

[The information follows:]

******** COMMITTEE INSERT ********

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

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

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

[The information follows:]

******** COMMITTEE INSERT ********

Mr. Pitts. Thank you very much for your testimony.

Without objection, the subcommittee is adjourned.

[Whereupon, at 5:27 p.m., the subcommittee was adjourned.]