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HEALTH INSURANCE EXCHANGES AND ONGOING STATE IMPLEMENTATION OF THE AFFORDABLE CARE ACT

HEARING

OF THE

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

UNITED STATES SENATE

ONE HUNDRED TWELFTH CONGRESS

FIRST SESSION

ON

EXAMINING HEALTH INSURANCE EXCHANGES AND ONGOING STATE IMPLEMENTATION OF THE "PATIENT PROTECTION AND AFFORDABLE CARE ACT"

MARCH 17, 2011

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C O N T E N T S

STATEMENTS

THURSDAY, MARCH 17, 2011

HEALTH INSURANCE EXCHANGES AND ONGOING STATE IMPLEMENTATION OF THE AFFORDABLE CARE ACT

THURSDAY, MARCH 17, 2011

U.S. SENATE,
COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS,
Washington, DC.

The committee met, pursuant to notice, at 10 a.m. in Room SD–430, Dirksen Senate Office Building, Hon. Tom Harkin, chairman of the committee, presiding.

Present: Senators Harkin, Mikulski, Merkley, Franken, Bennet, Blumenthal, Enzi, Burr, Alexander, and Hatch.

OPENING STATEMENT OF SENATOR HARKIN

The CHAIRMAN. Good morning. The committee on Health, Education, Labor, and Pensions will come to order.

A year ago on March 23 President Obama signed into law what I believe will be remembered as the most forward thinking and humane reform of our health care system since Medicare.

When the Affordable Care Act became law I said, and I quote: "We have made America a more compassionate and more just society."

I believe this with even greater conviction a year later. Over the last year, States, in partnership with the Department of Health and Human Services, have moved ahead decisively to implement the law. The results have been striking.

Since last fall, the law has protected consumers against the worst insurance company abuses and strengthened the coverage they already have. These protections are tremendously important to the physical and financial health of American families.

As Emily Schlichting, a University of Nebraska student who suffers from a rare autoimmune condition, said at this committee's January hearing on this subject:

> "I believe that allowing young people to stay under their parent's insurance gives us new freedom to work toward our goals without going uncovered. But even more important than that is the fact that the Patient's Bill of Rights makes it so that I cannot be denied insurance simply because I have a disease I can't control. Young people are the future of this country and we are the most affected by reform. We're the generation that is most uninsured. We need the Affordable Care Act because it is literally an investment in the future of this country."

That was Emily Schlichting, a University of Nebraska student.

The law also makes an historic long-term down payment in prevention, wellness, and quality of care, provisions for which I fought very hard. The Prevention and Public Health Funds supports vital programs like the Communities Putting Prevention to Work Program, which, to cite just one example, has funded my State, Iowa's efforts to implement a plan to reduce tobacco use and improve public health.

The new law makes vital investments in our Nation's health care workforce to ensure that the health needs of all Americans, rural, urban, old, and young will be met by a medical provider; for example, the State of North Carolina has received more than $9 million under this act to train and prepare the primary care workforce.

The new law strengthens Medicare for future generations of seniors and engages the challenge of cost control by transforming the way we pay for health care rewarding quality rather than quantity. It brings new transparency and accountability to the health insurance market, giving States new resources to review premiums and deny unreasonable hikes.

The State of Tennessee, for example, has received a $1 million grant and is using it to expand and improve its rate review process.

By controlling Federal health care costs and transforming how we deliver care, the Affordable Care Act, according to the Congressional Budget Office, reduces the deficit by $210 billion the first decade and by more than $1 trillion in the second decade. That's according to CBO.

At the heart of the new reform law is a long-overdue promise to all Americans: If you work hard, play by the rules and pay your fair share, you will never go to sleep worried that you can't afford to see a doctor or pay your family's medical bills.

The Affordable Care Act will, for the first time, give 94 percent of Americans access to affordable health coverage that can never be taken away.

Now, the primary mechanism for these changes is a new insurance marketplace in every State called the exchange. Modeled on successful prior State efforts, the exchange is a one-stop shop for health coverage. It will provide access to coverage to millions of individuals and small businesses currently locked out of the market.

Individuals with certain income limits and small businesses will receive tax credits to make premiums affordable; and people eligible for Medicaid will be enrolled automatically in the exchanges.

Small businesses, whose premiums have increased 85 percent on average just in the last decade, will be able to give their employees unprecedented choices among plans.

Overall, as I said, over 30 million Americans who would otherwise be insured, who would live with the oppressive fear of being one illness away from bankruptcy, or not knowing if they can afford a doctor's visit for their child, will have comprehensive, affordable insurance coverage, thanks to this law.

This hearing will show that, as usual, the States are already way ahead of the debate in Washington, working full steam ahead to lay the foundations for the insurance exchanges. By providing funding and the legal authority to establish exchanges, the Affordable Care Act empowers States, more than ever before, to serve their citizens' unique needs.

Far from being a top-down approach, the law gives States flexibility to determine which plans will be offered in the exchange. We have a good lineup of witnesses today to talk about these exchanges, what's happening in the States; and I look forward to their testimony today.

I want to thank my Ranking Member, Senator Mike Enzi for all of his involvement in these efforts. And, I will now recognize him for his opening statement.

OPENING STATEMENT OF SENATOR ENZI

Senator ENZI. Thank you, Mr. Chairman. Today's hearing will look at insurance exchanges established by the new Health Care Law and the related requirement for States to set up these exchanges. Like several provisions in the new Health Care Law the idea of a health exchange started with a kernel of common sense and it attempted to address a real problem in the market.

It's often difficult for consumers to be able to find the information they need to compare prices and understand the benefits offered by many insurers. By providing a place where consumers can compare prices and benefits, exchanges could provide valuable assistance to consumers and help them get lower prices for their insurance. That's what States like Utah have done in setting up their insurance exchanges.

Exchanges, however, cannot fix the fundamental problems with the new Health Care Law. The new exchanges will still be required to offer only qualified health plans which comply with all of the new Federal mandates. That's Washington telling you the minimum amount of insurance that's good for you.

Government bureaucrats will still determine all of the benefits that must be covered. They will also specify how much plans can charge in co-payments and deductibles.

In short, bureaucrats will design the insurance plans that everyone must buy because the authors of the new law believe that government knows what's best for all of us.

Exchanges will also offer health insurance to small employers. I believe that we should be doing everything that we can to help lower costs for small employers. Exchanges will not actually lower employer's costs, however, because of all of the provisions in the new law.

We've already seen how the new law will apply, sweeping new mandates to most employer health care plans. According to the Administration's own estimates, up to 80 percent of small businesses will have to change their plans to comply with new requirements imposed by the law. The bottom line is that these changes will increase the cost of these plans to employers and their workers.

Exchanges will also not be able to prevent health insurance premiums from increasing. During the debate on the new law, the Republicans predicted that the new mandates, taxes, and regulations would increase insurance premiums. We're just now beginning to see those predictions proven true.

The *New York Times* recently reported that groups of more than 20 were experiencing premium increases of around 20 percent while smaller groups were seeing increases of 40 to 60 percent or more.

Exchanges cannot fix the fundamental flaws in the new law. At its core the new law will mean that insurance premiums will increase, millions of Americans will lose the coverage they have, and American workers will see their jobs eliminated or their wages reduced as a direct consequence of the new law. We can and should do better.

The Health Care Law needs to be repealed and replaced with provisions that will actually lower costs, help the employers and allow Americans to keep the plans they want rather than being forced to buy the plan the government bureaucrats thinks best fits their needs.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Enzi.

Our first witness is Mr. Steve Larsen. I would like to ask him to come up to the witness table.

Before I formally introduce Mr. Larsen, we're joined here today by one of our distinguished long-term members of this committee, Senator Hatch. I know he has other obligations that he has to do this morning, but he wanted to introduce a witness for the second panel which I will yield to him to do at this moment.

Senator Hatch.

STATEMENT OF SENATOR HATCH

Senator HATCH. Thank you so much, Mr. Chairman, and Senator Enzi as well, for allowing me to take a moment to introduce my good friend, Representative Dave Clark. As you all are aware, Utah has been a leader in developing innovative State-based approaches to reforming the health care system.

But Dave's ideas would not have become a reality without the hard work of my good friend. And he's an excellent Legislator, and he's very dedicated and has done a terrific job in Utah. He first served as co-chair of the State's health system reform task force to develop ideas that reduce costs and provide a competitive marketplace for insurance companies to sell insurance to individuals and small businesses.

To make these ideas a reality, Representative Clark, then serving as Utah's Speaker of the House, shepherded the legislation through the Utah House of Representatives.

Once the law was passed, he worked tirelessly to ensure the exchange and other reforms were implemented as intended, and Utah became one of two States that had an exchange; Massachusetts being the other.

As our State became an example to other States, Representative Clark offered his assistance to others, and was welcomed under various national platforms to teach others about our State's success.

Today, I'm proud to welcome him a second time to the health care committee to share with us his views about the Utah exchange and how it fits into the requirements under the new overhaul law. I'm very concerned about the impact this law will have on Utah's ability to continue to implement health insurance reforms in a manner that fits within the State's goals.

For example, if Utah were to apply to have their exchange certified today, Secretary Sebelius would have to deny their applica-

tion because of the onerous and costly mandates the law places on State-based exchanges.

The Utah exchange is a true free-enterprise marketplace, but unfortunately, the freedom it affords does not adhere to the President's health care agenda.

I hope Representative Clark's insight and knowledge will help to persuade some of my colleagues that PPACA was short-sighted in its one-size-fits-all approach.

Representative Clark, I want to thank you for making the long trip back here and for joining us today. My colleagues welcome you and I welcome you, and we're eager to learn more about Utah's perspective on health reform; and I don't know of a better person in the country that would be able to explain that than you.

So, I'm grateful to have you here.

Forgive me for having to go to a markup, but I'm going to try and get back if I can. If I can't, I know you're going to let everybody know how important this is to Utah, and I think, to the Nation. Thanks so much.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Hatch, very much.

I'd like to start by welcoming Mr. Steve Larsen, director of the Center for Consumer Information and Insurance Oversight at the Centers for Medicare and Medicaid Services.

In this capacity, Mr. Larsen is responsible for implementing many provisions of the Affordable Care Act, including insurance market reforms, the Medical Loss Ratio Provision and working with States to set up insurance exchanges. He has a distinguished insurance background. He has held a number of senior positions with AmeriGroup, a managed health care company, and has worked in the Medicaid Managed Care field.

He's also a long-time public servant. He spent 6 years as Maryland's Insurance Commissioner and was a member of the State's Hospital Rate Setting Board.

So, again, Mr. Larsen, thank you for joining us today, and your statement will be made a part of the record in its entirety. If you could sum it up in several minutes, we would be most appreciative.

Director Larsen.

STATEMENT OF DIRECTOR STEVEN B. LARSEN, J.D., DEPUTY ADMINISTRATOR AND DIRECTOR, CENTER FOR CONSUMER INFORMATION AND INSURANCE OVERSIGHT, (CCIIO) CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS)

Mr. LARSEN. Thank you, Chairman Harkin, Ranking Member Enzi, and members of the committee.

Thank you for the chance to appear before you this morning, and, as you said, my full testimony has been submitted for the record.

At this time last year Congress passed, and the President passed into law the Affordable Care Act which will expand coverage to over 30 million Americans and ensure individuals have coverage when they need it most.

Just 1 year after the Affordable Care Act became law, people are enjoying, today, new protections and new coverage options.

In 12 months we've implemented important, private market reforms, including eliminating pre-existing condition exclusions for children, prohibiting insurance companies from rescinding coverage just because a consumer may have made an error on the application form, ending lifetime dollar limits, and enabling many young people to stay on their parent's health plan up to age 26.

In 2011 we estimate that more than 1.2 million young adults can maintain coverage through their parent's health plan because of this new policy. The Affordable Care Act also established new programs to expand and support coverage options as a bridge to 2014 when the exchanges are fully operational. These include the preexisting condition insurance plan, the PCIP Plan, and the Early Retiree Reinsurance Program.

Through the PCIP Plan thousands of Americans who were denied access to coverage before the ACA now have this valuable and needed coverage. Enrollment in the PCIP Program has increased by 50 percent in the last few months, and we expect it to grow.

The Early Retiree Reinsurance Program provides much-needed financial relief for employers, and has benefited nearly 4.5 million early retirees and their families, and more than 5,000 employers, including many State and local governments, have been accepted into the program from all 50 States and the District.

Another new program this year was the Consumer Assistance Program that's provided nearly $30 million in new resources to help States and territories establish or enhance consumer assistance offices.

In this past year we've also made funds available to strengthen States and territories' ability to review proposed rate increases by private health insurance companies.

And, starting this year, insurers must spend at least 80 to 85 percent of premium dollars, depending on the market, on health care and quality improvement efforts for their policy holders. This will encourage efficiency and ensure policy holders receive value for their premiums.

The NAIC worked for nearly 6 months to develop uniform definitions and methodologies; and their process was an excellent one that included extensive input from stake holders. And, we certified and adopted the NAIC recommendations.

We've also provided States with the flexibility on the MLR provisions to apply for a multiyear adjustment to the extent that there was a risk that application of that standard would destabilize the individual market there. All of these new programs and protections serve as a bridge to 2014 when the State-based health insurance exchanges will improve access to affordable quality insurance options for Americans who previously had no health insurance or had inadequate coverage. The exchanges increase transparency, lower administrative costs, and will make purchasing health insurance coverage easier by providing families, individuals, and small businesses with one-stop shopping.

Although the exchanges are not required to be operational until 2014, work is already underway across the country to conduct the necessary research and planning.

Forty-nine States and DC, received exchange planning grants to help assess their needs and plan their exchanges.

CCIIO has also awarded seven, what we call, early innovator grants to support States in developing an array of innovative models for the IT Systems for the exchanges.

Our hope is that these States can help serve as a model for other States and encourage efficiency and avoid duplication of effort.

The Affordable Care Act empowers States to implement the law in a way that accommodates their markets and their needs; and States are already taking their first steps toward 2014.

As we celebrate our accomplishments in the past year while working toward the establishment of the exchanges in 2014, we are committed to working with the States, and the District, and the territories to make sure that they have the flexibility and support they need as we work together to give Americans more freedom in their health care choices.

Thank you for the opportunity to discuss the work that CCIIO and HHS has been doing to implement the Affordable Care Act. And, I'd be happy to answer your questions.

[The prepared statement of Mr. Larsen follows:]

PREPARED STATEMENT OF STEVEN B. LARSEN, J.D.

Chairman Harkin, Ranking Member Enzi, and members of the committee, thank you for the opportunity to discuss the Health Insurance Exchanges and the efforts to implement the Affordable Care Act. I serve as Deputy Administrator and Director of the Center for Consumer Information & Insurance Oversight (CCIIO) within the Centers for Medicare & Medicaid Services (CMS). Since taking on this role, I have been involved in CCIIO's implementation of many of the provisions of the Affordable Care Act, including overseeing private health insurance reforms, assisting States to implement Health Insurance Exchanges (Exchanges), and ensuring that consumers have access to information about their rights and coverage options. Prior to becoming the Director of CCIIO, I served as the Director of the Office of Oversight within CCIIO, which is charged with working with the States to ensure compliance with the new insurance market rules, such as the prohibitions on rescissions and pre-existing condition exclusions for children, as well as ensuring consumer value for premium payments through the medical loss ratio (MLR) standards and the enforcement of the new restrictions on annual dollar limits on benefits.

As a former State Insurance Commissioner, I understand the key role that States play in the regulation of insurance and insurance markets. I have seen first-hand the importance of holding insurance companies accountable, and understand the need to make quality, affordable coverage more accessible to all health care consumers. I have also served as an executive in a for-profit, publicly traded managed care company, and understand the need for competitive and robust markets as well reasonable regulations. The Affordable Care Act appropriately balances these objectives.

At this time last year, Congress passed and the President signed into law the Affordable Care Act, which expands access to affordable, quality coverage to over 30 million Americans and strengthens consumer protections to ensure individuals have coverage when they need it most. Immediate reforms include a critical foundation of patients' rights in the private health insurance market that help put Americans in charge of their own health care. Over the past year, we have already implemented historic private market reforms including eliminating pre-existing condition exclusions of children, prohibiting insurance companies from rescinding coverage absent fraud or intentional misrepresentation of material fact and from imposing lifetime dollar limits on coverage, and enabling many dependent young adult children to stay on their parent's insurance plan up to age 26. The Affordable Care Act also established new programs to expand and support coverage options, including the Pre-Existing Condition Insurance Plan (PCIP) and the Early Retiree Reinsurance Program (ERRP).

Beginning in 2014, State-based health insurance Exchanges will improve access to affordable, quality insurance options for Americans who previously had no health insurance coverage or inadequate coverage. The Exchanges will make purchasing private health insurance coverage easier by providing individuals, families, and small businesses with "one-stop shopping" where they will be able to compare a range of plans. Eligible individuals will also have new premium tax credits and cost-

sharing reductions available to them to make coverage more affordable. By increasing competition between insurance companies and allowing individuals and small businesses to band together to purchase insurance, Exchanges will help to lower health care costs for consumers.

Although the Exchanges are not required to be operational until 2014, work is already underway to conduct the necessary research and planning. More than $296 million in grants has been made available to States and Territories to plan their Exchanges. This funding includes "Early Innovator" awards to support select States in developing an array of innovative models for the Exchanges' information technology systems as well as "Planning and Establishment" grants that provide resources for States and Territories to research and design the governance and operations of their Exchanges. Kansas, is one State that received a grant to develop IT infrastructure that will support health insurance Exchanges, not just in Kansas, but across the country. As a winner of an "Early Innovator" grant award, Kansas is creating state-of-the-art information technology systems that will support a consumer-friendly insurance marketplace. Other States that have received early innovator grants are represented on this committee, including Maryland and Oregon. In addition, Rhode Island, Vermont, and Connecticut are part of a multi-State consortium that also received funding. All of these States have committed to ensuring that the technology they develop is reusable and transferable to other States.

The Affordable Care Act empowers States to implement the law in a way that respects their unique situation and needs. States are already taking their first steps toward 2014. For example, on September 30, 2010, California enacted first-in-the-nation legislation to implement a health insurance Exchange under the Affordable Care Act. Additionally, Maryland's Health Reform Coordinating Council has already carried out research to understand the State's health insurance marketplace and health expenditures. Meanwhile, Colorado is holding regular community forums on issues around developing an Exchange, as well as conducting economic analyses of the State's health insurance market. CCIIO and States are well on their way toward giving consumers more control, quality choices, and better protections when buying insurance.

Today, millions of Americans are already benefiting from the Affordable Care Act. Many parents across the country are able to protect their dependent young adult children by allowing them to stay on a parent's plan until they are 26 years old. We estimate that, in 2011, more than 1.2 million young adults will be able to maintain insurance coverage through their parent's health plans because of this new policy. This is an important protection for these young adults and a huge relief for their parents.

We estimate that more than 31 million Americans will benefit from the preventive services provision of the Affordable Care Act, which requires that important early detection services like mammograms and colonoscopies be available to Americans enrolling in new plans without expensive co-pays or deductibles. Furthermore, insurers are no longer permitted to rescind insurance policies simply because a consumer made an inadvertent error on a form. These changes are putting consumers back in charge of their health care and getting insurers out from between patients and their doctors.

Consumers can also use an important new tool to gain access to an unprecedented amount of information about insurance options and public programs available to them by zip code. In 8 months, *www.HealthCare.gov* has had more than 4 million visitors and the number of insurance options listed continues to grow rapidly. Visitors can get information in plain English—and Spanish—about the coverage options available to them, their protections, and their rights as health care consumers.

As mentioned previously, States play a crucial role in the implementation of the Affordable Care Act. Since enactment, we have worked actively with the Governors, insurance commissioners, Medicaid directors, and other stakeholders to implement programs that are helping consumers and businesses with coverage. It has been our priority to work collaboratively with our State partners as the provisions of the Affordable Care Act go into effect.

States were critical to our efforts to write regulations implementing the new medical loss ratio provisions of the act. The National Association of Insurance Commissioners (NAIC) worked for nearly 6 months to develop uniform definitions and methodologies for calculating a MLR. Their process included significant input from the public, States, and other key stakeholders, and was approved unanimously by the NAIC Commissioners. HHS certified and adopted the NAIC recommendations and the reaction from consumers and insurers has been very positive. Starting this year, insurers must spend at least 80 or 85 percent of premium dollars, depending on the market, on health care and quality improvement efforts instead of CEO bonuses, profits, or marketing. And those that do not meet this standard will be required to

reduce their rates or provide rebates to their customers. In addition, the Department recognizes State flexibility. The law allows for a temporary adjustment to the individual market MLR standard if the State requests it and demonstrates that the 80 percent MLR standard may destabilize their individual insurance market.

This MLR provision ensures consumers receive value for their premium dollars and encourages insurers to invest in the health of their policyholders, while maintaining insurance market stability. There are signs that this provision has already helped to moderate premium increases.

Rising insurance costs have made it difficult for American employers to provide quality, affordable coverage for their workers and retirees while also remaining competitive in the global economy. The ERRP mentioned earlier serves as one bridge to the new Exchanges that will become available in 2014. Many Americans who retire before they are eligible for Medicare and without employer-sponsored insurance see their life savings disappear because of the high cost of insurance in the individual market. Millions more see their insurance disappear, leaving them vulnerable to high costs and poor quality care. The ERRP provides much-needed financial relief for employers so early retirees and their families can continue to have quality, affordable insurance. More than 5,000 employers—including many State and local governments—have been accepted into the program from all 50 States and the District of Columbia.

The Pre-Existing Condition Insurance Plan program is another bridge to 2014, when all Americans, regardless of health status, will have access to affordable coverage. PCIP provides a lifeline to uninsured Americans who private insurers have refused to insure because of a pre-existing condition. These Americans can now receive health coverage without limitation on benefits or higher premiums because of their condition. Thousands of Americans who were locked out of accessible private insurance coverage before the passage of the law now have this valuable and needed coverage. I'm pleased that enrollment has increased by 50 percent in the last few months, and we expect it to grow. The Department is actively working with States, consumer groups, chronic disease organizations, health care providers, social workers, other Federal agencies, and the insurance industry to promote the program, including holding meetings with State officials, consumer groups, and others.

As part of a comprehensive outreach strategy for PCIP, we have had regional meetings with local grassroots and provider organizations to get the word out about the PCIP & CAP programs. To date, eight regional launch meetings have been held with key referral sources and other local leaders in Jefferson City, MO, Providence, RI, New York, NY, Columbia, SC, Austin, TX, Cheyenne, WY, Sacramento, CA, and Wilmington, DE. Tomorrow we have another meeting scheduled in Indianapolis, IN.

Consumer Assistance Program grants provided nearly $30 million in new resources to help States and Territories establish or enhance consumer assistance offices or ombudsman programs. States have been using grants to educate consumers about their health coverage options and new rights under the Affordable Care Act, and assist them in taking advantage of new protections. For example, North Carolina will use grant funds to expand the services they provide to consumers and create a new independent Consumer Assistance Program as well as interpretation and translation services to better help consumers obtain culturally and linguistically appropriate services and resources. Montana recently reported that as a result of the CAP grant, they are now able to assist non-Federal governmental health and church plan members with issues related to their coverage, including denial of covered benefits. The program has begun a consumer education and outreach tour to different communities, particularly in rural areas, to address questions, take complaints, and provide consumer guides.

Finally, the Affordable Care Act should result in more protections from unreasonable rate increases. The law provides $250 million to strengthen States and Territories' ability to review proposals by private health insurance companies to raise their rates. Since enactment, $45 million has been distributed to 44 States and the District of Columbia, and, in February, $205 million in additional funding was made available to States, the District of Columbia, and Territories to continue such efforts. States are using these funds based on the needs in their States. Arkansas developed a "Rate Review Center" that will serve as a clearinghouse for information related to premium rate review. The Arkansas Insurance Department also introduced detailed legislation that would strengthen their authority to review rate increases and protect the State's insurance consumers. Colorado hired actuarial staff and implemented programs to increase transparency for consumers with its grant dollars. We are committed to continuing to work with States, the District of Columbia, and Territories, who are the primary regulator of insurance rates and solvency.

WORKING WITH STATES TOWARDS 2014

We understand the importance of State-based leadership and tailored policy execution during the implementation of the Affordable Care Act. That is why we keep an open dialogue between the Administration, Governors, and States to make sure they have the flexibility and support they need as we work together to give Americans more freedom in their health care choices. Building on this commitment, we, along with the Department of the Treasury, proposed new rules outlining the steps States may pursue in order to receive a State Innovation Waiver under the Affordable Care Act.

State Innovation Waivers will give States the power and flexibility to innovate and find the health care solutions that work for them. These Waivers will allow States to implement policies that differ from the Affordable Care Act as long as the new policies cover as many people as affordably and comprehensively as the Affordable Care Act does, without increasing the deficit. Although current law doesn't allow these waivers to begin until 2017, the President supports legislation that would accelerate implementation of this policy to 2014.

For the past year, States and the Federal Government have worked together to reform the health insurance market through flexible policies designed to address States' unique situations, ensuring a smooth transition from last year's broken health insurance market to this year's improved market. That partnership will continue and strengthen as we work together towards 2014.

MOVING FORWARD

We are proud of all that we have accomplished over the past year and look forward to 2014 when Americans will have access to more affordable, comprehensive health insurance plans. In the meantime, I look forward to continuing to work on our bridge toward 2014, year after year, strengthening CCIIO's partnership with Congress, the States, consumers, and other stakeholders across the country. Thank you for the opportunity to discuss the work that CCIIO has been doing to implement the Affordable Care Act.

The CHAIRMAN. Thank you very much, Director Larsen. And, we'll start a round of 5-minute questions.

Director Larsen, am I correct that the Institute of Medicine is making recommendations on what should be included in the essential benefits package, and they're doing public hearings nationwide; is that true?

Mr. LARSEN. The Institute of Medicine is part of the process along with the surveys of employer benefits, yes sir.

The CHAIRMAN. Also, I understand that the Federal Government is working with governors and States to get their input on the essential benefits package, and that this has not really been determined yet, has it?

Mr. LARSEN. No, it hasn't, and the process will be a very inclusive one to get a feedback from all the affected stakeholders.

The CHAIRMAN. Again, how would you feel about a statement which said that this minimum benefits package would be overly burdensome on States?

Mr. LARSEN. Our objective is to work closely with the affected parties and the stakeholders. It hasn't been determined yet exactly what the essential benefits would be. And, again, it's the Secretary's goal to make sure that it's a package of benefits that will be right for the exchanges and the coverage that are offered under the exchanges.

The CHAIRMAN. I know that my staff and I think staff from the Ranking Member's Office have also testified in front of the Institute of Medicine, to ensure that all viewpoints are being considered by the panel. The idea behind this was to go out to the States and get all their input; that's why we're working with the States, to find out what should be in an essential benefits package that basi-

cally most or all the States would agree with; that the Institute of Medicine and not a bureaucracy, but the Institute of Medicine would consider to be beneficial, would be the minimum benefits package, but that has not been determined yet, and you say we're casting a wide net to get all of the input that we possibly can before that is established.

You noted in your testimony the different ways that this is going to benefit States. I'd like to focus on just one area, Mr. Larsen, and that is small business.

They face very significant challenges in finding insurance options for their workers. I just met with some from Iowa the other day. They just don't have the negotiating leverage of big businesses; they're far less likely than large firms to offer health insurance to workers. Only 49 percent of firms with less than 10 workers offer coverage in 2008. That was down from 58 percent just several years ago. In contrast, 99 percent of firms with more than 200 workers offered coverage.

The small businesses also pay an average of 18 percent more for the same plan because they just don't have the purchasing power.

How will the insurance exchanges relieve this burden on small business owners? What can small business people who employ 20, 30, 40 people, what can they look forward to in terms of this set of the exchanges; how will it benefit them?

Mr. LARSEN. One of the big advantages is that it is—that as you mentioned, that allows through the Exchanges that it be essentially the bargaining power of the small businesses to combine and become closer to what large employers experience today; and we know large employers have lower administrative expenses associated with their plans, and lower premiums; and so this brings small businesses much closer to that type of situation.

The exchanges simplify the administrative processes; they bring more people in the insurance pool; they increase essentially, the bargaining power of small businesses; and then, of course, there are the enhanced tax credits for small businesses under 25 employees. So, the small group market has historically—and this has gone on for decades—has been broken and difficult to navigate; and this is a huge improvement from where we are today.

The CHAIRMAN. Now, there are tax credits involved in this bill for small businesses; I think it starts at 35 percent, I think, and goes up to——

Mr. LARSEN. Fifty.

The CHAIRMAN [continuing]. Fifty percent. And, so, a lot of these small businesses that are employing 10 or 11 or 12 people, that are really mom and pop businesses in this country. I don't think many of them know that they have the tax credit available to them. That is a fact, though, isn't it?

Mr. LARSEN. It is; and we're going to continue to work on making sure that people are aware of that.

The CHAIRMAN. Director Larsen, thank you very much, and I'll yield to Senator Enzi for questions.

Senator ENZI. Thank you very much, Mr. Chairman.

Mr. Larsen, when did the Department plan to issue the proposed rule on exchanges?

Mr. LARSEN. I think we've said colloquially that our goal is to get that out sometime this spring, and we are, I can tell you, working diligently trying to get that out so the States have as much notice as they need to get to continue their work.

Senator ENZI. That will be a little difficult for them without the rule being in place.

Now, if the State decides it's not going to impose the three-to-one age rating structures the new law requires, does that mean the State will be prohibited from establishing a recognized exchange?

Mr. LARSEN. Yes. We're still working through the exact mechanics of what will and won't be required of the State exchanges. Obviously, the statute lays out some minimum basic requirements.

Senator ENZI. That makes it sound even tougher to get one of these done.

Now, in the law there's this little-known provision that says that Massachusetts is going to be presumed to meet the standards listed.

Will Utah or any other States be presumed to meet those standards?

Mr. LARSEN. I don't think that we've made a determination in about which particular exchanges would pass the presumption test; so we would look forward to working with States that have exchanges in place now, like Utah, Massachusetts.

Senator ENZI. Materials on your Web site mention that States have to achieve certification of their exchanges.

Can you elaborate a little bit on that?

Mr. LARSEN. The exchanges go into law, essentially on January 1, 2014; and so if you back up from that date, the statute provides that by January 2013 we would know whether States are ready to proceed with essentially their goals; so there is a certification qualification requirement that HHS will conduct in advance of January 2014.

Senator ENZI. But, they have to do that so far—all their work without the rule.

Does the Department support uniform initial open enrollment periods outside of the exchange that are the same as the uniform initial open enrollment periods inside the exchange?

Mr. LARSEN. Do we support the same open enrollment periods in and outside the exchange?

Senator ENZI. Yes.

Mr. LARSEN. I'd have to answer by saying our goal is to provide as much flexibility to the States as we can. The way the States structure their rules in and outside the exchange is something that we hope that they can determine to the extent possible; so again, I don't think we've made a determination about exactly which insurance rules would have to apply inside the exchange and outside the exchange. But our goal, always, in all of these provisions that you're talking about is, to the extent that we can, provide a flexibility to the States to make those determinations.

Senator ENZI. But we won't know until the regulations come out.

Of these 90,000 children that the Department estimates will benefit from the new law, how many live in 1 of the 19 States where there are no carriers selling the new child only health plans so there won't be anything on the exchange; how can parents of these

children consider terminating the children's existing policy if they live in 1 of the 19 States in which there are no new child policies available? How will that work?

Mr. LARSEN. If I'm understanding your question, there's issues today with respect to the availability in some States of that coverage, and then what happens in 2014.

It's unfortunate, frankly, that so many carriers have declined to continue to offer these types of policies even though we've given them really, all the tools that they need to continue to offer child-only policies, including the ability to rate these policies up if they need to be rated up; the ability to run open enrollment periods, for example. We've given States maximum flexibility to try and keep those carriers in the market and the fact is that they—it appears that they just don't want to offer insurance to kids that are sick.

That will change in 2014, and there will be coverage available to kids, because you won't be able to apply the pre-existing condition exclusions.

Senator ENZI. I think one of the difficulties, actuarially for the companies, is trying to figure out how much to charge for somebody that can purchase their insurance on the way to the emergency room.

In insurance commissioner Praeger's testimony, she mentions her concerns with multi-State plans or, what I prefer to call, the government-run plans. She mentions that multi-State plans are allowed to operate under rules that are significantly different from those that govern their competitors. We're concerned that they could cherry-pick the best risks and that their enrollees could unwittingly be left without important consumer protections provided by State law. They must play by the same rules as other carriers that are similarly situated, or consumers could be harmed. That's her statement.

Do you support requiring multi-State plans and consumer-operated and oriented plans, the co-ops, to abide by all the same Federal and State rules all the other insurance companies have to abide by; and what actions will your department take to ensure that that's the case?

Mr. LARSEN. What I can say is, having spent 6 years regulating the companies in Maryland, I can share Commissioner Praeger's concern that we set up a system that has a level playing field and doesn't encourage adverse selection or in other ways disadvantage some of the market participants.

As we move forward fashioning the particulars through their role-making process, I think that's certainly an area that we share her attention to and will work closely with the States to make sure that we set up the flexibility for them to deal with those types of issues.

Senator ENZI. Have any of the entities or health plans been issued waivers exempting them from any of the requirements included in the PPACA other than the waivers that have been issued exempting plans from meeting the annual benefit limits; and does HHS intend to issue waivers exempting any entities from other requirements?

Mr. LARSEN. The statute and in the MLR provisions, for examples, specifically provide the Secretary with the authority to waive

the MLR standards in a State, on a state-by-state basis if application of that standard would destabilize the individual market. For example, we do have, I think, four States that have applied. We recently announced that we granted the State of Maine's request for a multiyear adjustment in that particular market; and we're going to continue to review the applications that we have in now.

And, when we put the reg out, we laid out exactly what the criteria would be for evaluating the waivers.

Senator ENZI. This is the reg that's about to come out.

I've used up all my time, but I have a whole host of other questions, but I'll submit those.

The CHAIRMAN. Thank you. Thank you very much, Commissioner.

Senator Franken.

STATEMENT OF SENATOR FRANKEN

Senator FRANKEN. Thank you, Mr. Chairman.

Thank you, Mr. Larsen.

Mr. Larsen, experts have been talking about the massive inefficiencies in health insurance markets for a long time. When I looked at Minnesota's markets, as we were debating health reform, it struck me that insurers in Minnesota were offering high value products, where most of the premiums were going to actual health care; but it wasn't that way in every State, and in some States was as low as 50 percent for individual policies that were small group policies—40 percent or even 30 percent; and this calculation of how much goes to actual health care is called the medical loss ratio, as you know.

Based on this championing the provision to require that at least 80 percent of premiums for individual and small groups, and 85 percent for large group markets go to actual health care and not marketing, not administrative costs, not profits or CEO salaries—and I think this is one of the most important things that we did to make insurance companies more accountable and transparent and require that they spend their premium dollars on actual health care services—and I was thrilled to see in your prepared testimony that you said, "there are signs that this provision"—MLR—"has already helped to moderate premium increases." Can you walk us through some of the examples of how you've seen the MLR provision help to moderate premium increases?

Mr. LARSEN. Sure. I think there's a couple. First of all, at least one of the public companies, a major player in the marketplace, has announced repeatedly that they have been moderating the rate at which their rate increases would be proposed in light of the MLR targets.

They have consciously made a decision that in order to hit the targets, they're going to have to slow the rate of the premium growth.

We also know, based on conversations with insurance commissioners around the country, that companies are making rate filings based on hitting the targets, which means that they have to structure their rate filing to provide a higher level of benefits to their policy holders. We're seeing that play out across the country, and among larger and smaller companies, and we think that's great.

Senator FRANKEN. And, you expect going forward, that as insurers will have to pay rebates to customers if they don't meet the MLR requirements, that there will be——

Mr. LARSEN. They will, and there has been a lot of attention on the rebates. Our goal is actually not to get companies to have to pay rebates, and I think in the first fiscal round, there may be companies that are subject to rebates, but ultimately you want the premium to be fair in the first place.

Senator FRANKEN. OK, and so, basically, this means insurers will be forced to—going forward—to reduce their overheard costs.

Mr. LARSEN. I wouldn't say that they'll be incentivized to reduce their overhead costs.

Senator FRANKEN. OK, incentivized.

I'm sorry.

I understand that six States have submitted applications to HHS asking to be exempted from medical loss ratio requirements; these waivers or adjustments, as they're officially referred to, are only supposed to be granted in cases where the new requirements would, "destabilize the health insurance market."

Now, I understand that for the States that have just a couple of major health plans, the waivers may be worth considering, like in Maine; and they have been done there.

But, for most States, medical loss ratio will keep insurance companies from spending such a higher percentage of premium dollars on, again, administrative costs, marketing and profits. The MLR ratio is, I think, one of the most potent tools in health reform that could, in the long-term, help stem skyrocketing premium increases; so it's important that it not be watered down through unnecessary waivers, I believe.

What criteria is HHS using to evaluate MLR waiver requests from States; and what is your process for reviewing these requests?

Mr. LARSEN. When we published the criteria for evaluation in the regulation in December and its a number of different issues, for example, is there a major insurance carrier that would potentially leave the market if the 80 percent were applied.

And then the next question would be, how many people are associated with the potentially exiting carriers; the big market share or small market share. In the State of Maine, as you mentioned, it was unusual that the potentially departing carrier had over 35 percent of the market.

Then, the question is, what other coverage options would be available to people if the carrier exited? And, so we look at whether there's a guaranteed issue in the State or a high-risk pool, or whether the commissioner has the ability to place this business with other carriers.

We really walk through all of the regulatory criteria. It's a, I think, a rigorous but reasonable process, and we want to run it fairly and consistently; and what we know is every State is different. So, every State is going to have different considerations applied.

Senator FRANKEN. Thank you very much. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Franken.

Senator Bennet.

STATEMENT OF SENATOR BENNET

Senator BENNET. Thank you, Mr. Chairman. I want to thank you very much for holding this hearing. I'm proud that in Colorado we've already had 11 hearings in our State to talk about how to set up the exchanges; and, in fact, just this week, or last week, the House Majority Leader in the State of Colorado is a Republican and the Democratic State Senator are pairing up to work on a bipartisan piece of legislation to begin to implement the exchanges. So, we care deeply about it.

In an article we see in the Denver Post where a Republican legislator in our State said, "most people viewed exchanges as the most free-market part of Obama Care," as she referred to it—I call it health care reform—but this part of the puzzle is getting a lot of high praise in our State, and I wonder, Mr. Larsen, first of all, whether that's an accurate characterization. Is this a free-market approach on the exchanges? You have a lot of experience both in the private and the public sector when it comes to health care reform.

I wonder if you'd talk a little bit about the free-market qualities of this; and, also, the balance that needs to be struck between making sure we've got common-sense regulation, and a free market on the other hand.

Mr. LARSEN. I agree. I think it is very much a free market approach. Certainly the exchanges rely on the participation of the private insurers and co-ops as they get set up in those States. It is very much reliant on setting up a marketplace.

And, one of the big advantages is the one-stop shopping transparency component. I mean, that's how marketplace works, when you know what your options are, and you can evaluate options and differences between options; and that's the core of what the exchange is.

Senator BENNET. If you were in a town hall in my State and somebody were asking you, Mr. Larsen, what would this look like in 2014 if we had a fully functioning exchange versus what would it look like if we didn't have an exchange.

I've got three little kids at home; and if I were a small business owner or somebody employed by a smaller business, what difference does all this make to me?

Mr. LARSEN. In so many other areas today, technology and the Internet has allowed us to have more accessible understandable choices, whether it's buying airplane tickets or trading stock; that technology and those choices have not expanded to health insurance markets.

With an exchange you can go to one place, one site, enter basic information and get an array of choices, learn more about the plans, enroll, determine where you're eligible. That's what the future is. That's what the exchanges are going to do in 2014.

Senator BENNET. Then, what effect can that transparency have on costs, do you think?

Mr. LARSEN. I think that's one of the challenges today, that there is no real price transparency; it's very difficult. You can look at one plan, and you know what one plan is. So, when insurers know that they're going to have to stack their prices up against other plans

in the marketplace, I think that everyone would agree that that can have a leveling effect and require plans to become more efficient.

If they want to sell, they're going to have to compete on price, and on quality, which is going to be another component of the exchanges.

Senator BENNET. As the States begin to set up functioning exchanges, if more than one State wanted to get together and provide that exchange together, would they be able to do that?

Mr. LARSEN. Yes, and our goal is, and will be always, to give the States the maximum flexibility; so there may be regions of the country where a regional exchange makes sense. And, if they can get together to do that, they should do that.

Senator BENNET. The States themselves would decide, not the Federal Government, but the States would decide to come together, in those instances, you could have a marketplace that extended across State lines for insurance.

Mr. LARSEN. That's right.

Senator BENNET. And, that's the purpose of the law; right?

Mr. LARSEN. That's right.

Senator BENNET. I wanted also, feedback on the Chairman's question earlier—and maybe this is a little bit away from exchanges, but based on your experience as insurance commissioner and insurers, I continue to hear from the small businesses in my State that they are just being crushed by rising health care costs; and I wonder, while we have you here, if you would be willing to give us the benefit of your acquired wisdom of what we could do, and what you are already trying to do to bring these costs back in line, because it is strangling our ability to create jobs and keep our doors open.

Mr. LARSEN. It's a challenge today. It's been a challenge, really, for the last 20 years. I think that premiums for small businesses have been a challenge for a long time.

One of the things the exchanges do, is they reduce the administrative costs significantly. I know—and I think the Chairman pointed this out—that if you look at the administrative costs for large groups versus small groups, versus individual groups, that it's low and it goes up higher with each, inversely proportional to the size.

Exchanges at a minimum, have to lower the administrative costs associated with selling to small businesses.

The ACA generally, has a number of provisions that are going to be kicking in, but will take time; and it should be fully functional by 2014 that help reduce costs, including patient safety initiatives, and getting more people in the insurance pool. The MLR standard that we talked about, incentivizes health plans to be more efficient and to spend more on quality, which actually reduces its costs for their policy holders.

There's a number of provisions that are in play, but will take some time to get there, until 2014.

Senator BENNET. My time is up, Mr. Chairman.

Thank you again, for holding the hearing.

The CHAIRMAN. Thank you very much, Senator Bennet.

Senator Burr.

STATEMENT OF SENATOR BURR

Senator BURR. Mr. Larsen, does the act reduce the cost of health care in America?

Mr. LARSEN. Yes, it does.

Senator BURR. Why, then, does CBO have such a difficult time agreeing with you on that?

Mr. LARSEN. I think they opine that it didn't reduce the overall cost——

Senator BURR. How about the actuary at CMS?

Mr. LARSEN. Mr. Foster.

Senator BURR. Yes.

Mr. LARSEN. Yes. I'm not actually familiar with his most recent opinion.

Senator BURR. It was my understanding that the IOM recommendations would go to the Secretary and she would use that as counsel to make the final determinations, but that it was her decision.

And, I heard you answer Senator Harkin, and you agreed that IOM would be defining the essential health benefits package. Isn't it true the Secretary is going to define it?

Mr. LARSEN. Yes, and I apologize if I left the impression that IOM defines it. That's not right. In fact, there's kind of a multistage process associated with essential benefits.

IOM is providing some advice that the Department of Labor is conducting a survey to determine what the typical benefits are that are provided in employer plans across the country.

Senator BURR. If this plan's so good, why are so many people asking for waivers? We've got companies asking for waivers; we've got States asking for waivers. It seems like the odd man out is the entity that doesn't ask for a waiver by 2014.

Mr. LARSEN. In fact if you look at the types of plans that are getting waivers, for example the annual limits waiver, it's gotten a lot of attention in the press. It's only a very small percentage of the market, about 2 percent employer-based——

Senator BURR. Does that mean there's going to be no more waivers?

Mr. LARSEN. No, I'm not saying there aren't going to be any more waivers. I'm just saying it's a very, very small percentage——

Senator BURR. Last week——

Mr. LARSEN [continuing]. Of mini-med policies.

Senator BURR [continuing]. Last week the Administration issued proposed rules outlining the steps States might pursue in order to receive a State innovation waiver.

Mr. LARSEN. That's right.

Senator BURR. Which is basically a waiver process for allowing policies that differ from the law, provided that the requirements of the law are met; is that an accurate depiction?

Mr. LARSEN. I would describe it this way: There are some basic provisions that need to be satisfied in order to qualify——

Senator BURR. Let's talk about some of those.

Mr. LARSEN. OK.

Senator BURR. Isn't it true that in order to apply for waivers, States must demonstrate that the State's plan will provide a cov-

erage that is at least as comprehensive as the coverage that would have been provided under the Health Care Law, including the essential health benefit requirements which haven't even been determined yet?

Mr. LARSEN. That's right. One of the requirements is, in order to accomplish the objectives of the Affordable Care Act, if there's a different way to get there——

Senator BURR. So, you can't make a determination as to their request for waiver, because we don't know what the essential health benefit is yet.

Mr. LARSEN. The proposed rule that we put out on the State innovation waiver is a proposed rule and——

Senator BURR. So, we can't——

Mr. LARSEN [continuing]. The objective——

Senator BURR [continuing]. Approve or deny those waivers even though we haven't set a definition for the essential health benefit?

Mr. LARSEN. I would answer this way: That we're not accepting applications for a waiver because that rule is a proposed rule. We want to get feedback from the States, frankly, about how that rule in its final form, should be constructed. So, the purpose of putting that rule out in the last week or two was, in fact, to display it and get a feedback from interested parties and stakeholders in States about how, exactly, that process should work.

Senator BURR. Let's talk about feedback. You said you've done everything possible to allow insurers to continue to sell child-only plans. Now, I don't believe that's accurate.

Insurance companies told me and told you what needed to be done to allow them to continue selling those plans, but you didn't do it.

Insurers have said that if you impose a uniform, open enrollment period, they can start selling child-only plans tomorrow. Let me ask you: Will you implement that change?

Mr. LARSEN. We'd be happy to talk to the issuers that you're talking about. We've provided insurers the ability to set up open enrollment plans, and the States. Again, another example of State flexibility. If the State wants to set up an open enrollment plan, we urge them to do that. We hope that they will.

That's really what counts, is that the State's going to set up.

We're not necessarily saying that one size is going to fit everybody across the country, but if a State wants to set up an open enrollment plan period, we hope that they will, if they need to do that to keep the market open.

Senator BURR. But, will you implement a uniform, open enrollment period?

Mr. LARSEN. We're certainly happy to talk to these issuers.

Senator BURR. Is this the first time you've heard about that?

Mr. LARSEN. I've heard that they would like to hear the States set up open enrollment programs, we want the coverage to be available. We think there are lots of options out there. We think it's unfortunate that carriers have declined to insure sick kids; but nonetheless, we're happy to work with them if there's a way to make it work for them.

Senator BURR. Thank you, Mr. Chairman,

The CHAIRMAN. Senator Merkley.

STATEMENT OF SENATOR MERKLEY

Senator MERKLEY. Thank you, Mr. Chair.

And thank you for your testimony.

I want to start with Mr. Larsen's comments that exchanges provide greater information to consumers; one-stop shopping where consumers will be able to compare a range of plans. It's my understanding that each entity is setting up their own structure, but are there certain qualities that you really expect to see? For example, will an individual, regardless of where they live in the country, be able to go to the local exchange and say, "Well, out of these eight plans, I want to compare these two side-by-side," and the software will show how they differ in key features.

Mr. LARSEN. That's exactly the objective, to bring up the array of plans, and then you can—as you can today, on some sites—click two boxes and say, "Compare these two plans; what are the benefits, what are the prices."

Senator MERKLEY. I found that very useful when I went to the Federal benefits plan, when I came into office. With two children, being able to compare them side-by-side was important. So, that is a required feature for each exchange? There could be different formats, so I assume that States are going to——

Mr. LARSEN. If I am understanding you, I don't think we want to be exactly prescriptive, but there is a provision that there be a comparison among the plans, so consumers have the ability; and we'll be working through exactly what that entails.

Senator MERKLEY. One of the challenges in health care unlike, say in life insurance, is that a plan has to set up contracts with providers, a very complex undertaking. It's been anticipated that by making it easier to reach consumers through an exchange, it will encourage new companies to come into particular markets. Where there might be three providers, now, maybe we'll have five—maybe we'll have seven. Do you have a sense of whether that's likely to unfold and provide greater access and more choices to consumers? Do you expect exchanges to encourage more competition, attract more companies in a particular insurance market?

Mr. LARSEN. Yes, we do. And, I think that's exactly what a marketplace is. It's a place where sellers know that the buyers are going to be—and in this place when you have a single point of entry, essentially, for buyers, we hope and expect that there are going to be more sellers in that marketplace to respond to the critical mass of buyers coming in one place.

Senator MERKLEY. What kind of evidence do we have, if any, or is it just too soon to see if that's really going to materialize as we're hoping?

Mr. LARSEN. I think we're progressing toward—I mean obviously, there's some States today that have exchanges that I think are both successful, and we can build on those successes; whether it's a Utah model or a Massachusetts model, improve upon them, learn from them. So, by the time we get to 2014 we'll have really refined what the best practices are, but still give States the flexibility to meet their particular local circumstances.

Senator MERKLEY. But for those States that have set up exchanges, did we see that impact? Can we cite statistics that more providers came into those markets?

Mr. LARSEN. Certainly we've seen, for example in the Utah exchange where there's been a progressively increasing number of small businesses that are accessing the exchange there. I'm sure the next witness can talk about, exactly the number of health plans that are participating, but I think it's been successful.

Senator MERKLEY. I hold a town hall in every county in my State each year, 36 counties, and when I talk about the different features of the plan and then ask people if they think it's a step forward or a step backwards, people love the idea of the exchange. They like the idea of more competition, more choices, and being able to compare plans side-by-side. In many ways, it parallels what people were asking for, for a long time. It's more choices and the ability to compare plans that often State employees have in different areas, or Federal employees have.

There's a deadline coming up at the end of 2012, kind of a milestone in setting up exchanges. Could you describe what States have to do to meet that milestone?

Mr. LARSEN. There's a number of provisions, and we are going to put the regulation out there very soon, meaning this spring, that will provide some additional guidance for the States, but if you back up from the date of January 2014 to January 2013 when we would want to know whether the exchange is ready to go live; and even then we would work with States. Our goal is ultimately, to do everything we can to make sure the State is ready, and that there's a State exchange. We want to be operating as few exchanges as possible, as HHS, and have the most number of States.

So, back up from the January 2014, January 1, 2013, and then between now and January 2013 is where there's going to be ongoing activity as there is today in all States.

Senator MERKLEY. So, I think one of the concrete goals was to have States pass enacting legislation. What happens if a State hasn't done it by then, but then does it in March of the following year?

Mr. LARSEN. March 2012?

Senator MERKLEY. March 2013.

Mr. LARSEN. 2013? I can't say for sure in a particular circumstance what would happen. I could only tell you that our overriding objective will be to make sure that: a State wants to run an exchange and it is ready to run an exchange, and that they're going to run their exchange.

We will work with the States to make sure that they can do that.

Senator MERKLEY. Thank you. Working with the States in this matter is going to be critical to the success of the exchanges—a very valuable tool that will increase competition and make it easier for citizens to find a health care plan that suits their circumstances.

Thank you.

The CHAIRMAN. Thank you, Senator Merkley.

I see the Senator from Utah has returned. I didn't know if Senator Hatch wanted to ask questions of this witness.

Senator HATCH. No, I don't have any questions. Thanks, Mr. Chairman.

The CHAIRMAN. Thanks, Senator Hatch.

Senator Mikulski.

STATEMENT OF SENATOR MIKULSKI

Senator MIKULSKI. Mr. Chairman, I'm going to waive my questions. They've actually been asked by Senators Burr, Bennet and Merkley. I thank you for that.

I just want to note to the committee, this is a banner year for Maryland, and Mr. Larsen has served three Maryland Democratic governors. For Governor O'Malley, as Insurance Commissioner, Mr. Larsen was actually on the ground with the governor trying to provide expanded access to the people of Maryland, and also headed up our Public Service Commission.

He's not like an egghead sitting over CMS; not that there's eggheads over at CMS, but I think the people of America feel that sometimes we govern from 35,000 feet, and our head is in a cloud and our feet are not on the ground. I believe that Mr. Larsen brings that expertise to advise not only CMS, but to work with the States.

We're glad to have you. We noted your testimony and your questions and answers. And, later we'll be hearing from Dr. Josh Sharfstein, the head of the State of Maryland's Health Department.

But, anyway, good to see you again, Steve.

Mr. LARSEN. Thank you, Senator.

The CHAIRMAN. Senator Alexander.

STATEMENT OF SENATOR ALEXANDER

Senator ALEXANDER. Thanks, Mr. Chairman.

Dr. Larsen, thank you for being here. You mentioned that the Administration supports maximum flexibility for States. As a former governor, I welcome that attitude. Does that mean that you would support the request of a large number of the governors that we pass legislation that would give them flexibility in determining relief from the maintenance of effort provision in the health care law?

Mr. LARSEN. I have to defer on the Medicaid questions, because Medicaid is really not my area of expertise over at CMS, if that's OK.

Senator ALEXANDER. Medicaid is not your area of expertise?

Mr. LARSEN. No, sir.

Senator ALEXANDER. It's an important part of the law. Let me offer my own thought on that. We really set up two big cliffs over which States are going to fall; one is the stimulus legislation put a lot more money into Medicaid saying that runs out after a couple of years. It said that until the money ran out, there is a requirement that States not cut any spending continue. So, while States are going through this recession and having to reduce costs, they had to reduce everything else except Medicaid, so that raised college tuition and a variety of other things because of a Federal rule.

Then, we have the unfunded mandate that's in the Health Care Law that our former governor, a Democrat, Governor Bredesen, has estimated will cost our State 1.1-plus billion dollars over 5 years.

Now, what governors have asked—and these include governors of both parties, is basically that the States be given flexibility in this Maintenance of Effort Law; and Senator Hatch, who is here today, is leading an effort to develop legislation that would permit that to happen. And, I'm very hopeful the Administration will favorably consider that.

Another area I would like to ask you about—we're talking about exchanges—I met a few months ago with the heads of the largest restaurant companies in America. They describe themselves as the second largest employer in America. They employ largely lower income people. They were talking about the effect of the Health Care Law upon their companies, and their employees; and I want to describe what they said and see if you've heard a similar thing.

No. 1: They're going to reduce the number of employees based upon the costs that they anticipate from the Health Care Law. One, for example, said that he was operating his restaurants at an average of 90 employees, but as a result of the Health Care Law and his costs he was going to aim to reduce to 70. That's a loss of jobs.

A second was, they were all—several were actively considering whether they would simply not continue to offer health care, because it would be cheaper for them to pay a penalty and allow their employees to go into exchanges.

I'm wondering if in either of those two cases you've heard that from large employers, and if so, what you've done to deal with it.

Mr. LARSEN. Certainly when it comes to a lot of the restaurant owners and small businesses, I mean exchanges are going to be set up and hopefully work to their benefit, not to increase costs, but to lower costs.

We'd be happy to meet with the folks that you met with. The exchanges are for their benefit in addition to those in the individual market; and so, it would be unfortunate if they had a perception that costs are going to increase under the exchanges, rather than become more affordable.

Senator ALEXANDER. You mean to their benefit because their employees might find health care in the exchanges; is that what you're saying?

Mr. LARSEN. Yes, for small businesses, you have tax credits available to them, and then you have the bargaining power of the exchanges for other, larger, if you will, small businesses.

Senator ALEXANDER. What we're talking about is large numbers of employees who have health care restaurant company who would be—who the restaurant company would simply say, "Well, sorry, it cost us too much now; plus there are these exchanges over here, so go on over to the exchange and get your health care."

And, wouldn't that contravene the President's assurance that Americans would be able to keep the health care they have if thousands of American businesses stop providing health care because they can allow their employees to go over to the exchanges and get the health care that they——

Mr. LARSEN. We certainly hope that that doesn't happen, and we're willing to work with those employers for that—to understand the advantages of maintaining an employer-based coverage system but allowing their employees to access coverage through the exchanges.

Senator ALEXANDER. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Alexander.

And, Director Larsen, thank you very much for your appearance. Thanks for your brave work over at CMS.

And we'll now move to our second panel.

Mr. LARSEN. Thank you very much.

The CHAIRMAN. Our second panel, to begin with, I would welcome Kansas insurance commissioner Sandy Praeger. Now in her third term, Commissioner Praeger oversees implementation of the Affordable Care Act insurance reforms. Under her leadership Kansas was awarded an Early Innovator Grant to implement a State-run health insurance exchange. As the Kansas Insurance Commissioner, she's also an active member of the National Association of Insurance Commissioners. She served one term as the Association's president, and now chairs its Health Insurance and Managed Care Committee; and, I will yield to Senator Mikulski for an introduction.

Senator MIKULSKI. Yes. I just want to bring to the committee's attention that we have another Marylander testifying today; Dr. Josh Sharfstein, who was appointed recently by Governor O'Malley as the Secretary of the Maryland Department of Health and Mental Hygiene. Dr. Sharfstein has a distinguished background. He worked on Capitol Hill with the Energy and Commerce Committee, which means he's battle tested and knows how Congress works. He headed up the Baltimore City Health Department where he really was quite an innovator, in terms of particularly improving the health outcomes of children, and was even named Public Official of the Year by Governing Magazine. The Obama administration tapped him to be the No. 2 person at FDA, ensuring the food safety and the safety of our pharmaceuticals in this country, but Maryland has always been his home—not only the home of his zip code, but the home of his heart brought him back.

And, what we're going to hear today is someone who really started life as a pediatrician, and then through government and public policy, really looked at how we can provide health care for our most needy.

We're very proud in Maryland that we receive 6.2 million from HHS as one of the seven States to actually get the health exchanges underway; and we'll be one of the States to lead the way in innovation.

We'll look to Dr. Sharfstein to tell us how Maryland's doing and the lessons learned for perhaps the rest of the country for affordable, expanded access care.

Thank you very much, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Mikulski. And, we welcome you, Dr. Sharfstein and Commissioner Praeger and our Speaker, Mr. Clark. Both Speaker Clark and Commissioner Praeger have testified before this committee before; and if you have Dr. Sharfstein, it was before my watch, and you're not that old.

We welcome you all here to this committee.

All of your statements will be made a part of the record in their entirety.

And, we'll just go from left to right.

We'll start with Ms. Praeger. And if you could just sum up your testimony in several minutes—the clock will be at 5, but if you go over a little bit, don't mind that. When it starts getting close to 10 minutes, I might get a little nervous, but if you go over a few minutes, that's no big deal.

Ms. PRAEGER. Thank you.

The CHAIRMAN. Commissioner Praeger, welcome.

STATEMENT OF SANDY PRAEGER, KANSAS INSURANCE COMMISSIONER, LAWRENCE, KS

Ms. PRAEGER. Thank you, Senator. Thank you, Mr. Chairman. I appreciate that, and I will try to respect the clock.

But good morning to you and to Ranking Member Senator Enzi, and the distinguished members of the committee.

My name is Sandy Praeger, and I appreciate this opportunity to testify on behalf of the NAIC; and I thank you for recognizing the important role played by State regulators and for ensuring that by implementing this law, we do have a seat at the table. Over the past year, one of the main focuses of my department and other State departments of insurance has been to lay the groundwork for implementation and enforcement of the immediate reforms that took effect for plan years beginning on or after September 23, 2010. While the Affordable Care Act defers to State regulation as a default position, in order to enforce these protections State regulators must be granted the authority to do so under State law. While some States have blanket language in their insurance codes requiring insurers to abide by all applicable Federal requirements and empowering regulators to enforce them, most do not.

States have been reviewing their statutes to determine which changes they must make, particularly in the area of external appeals processes and rate review. Some States are taking a wait-and-see attitude pending the resolution of the legal challenges.

While we at the State level have done our very best to ensure that implementation of these provisions is accompanied by as little disruption as possible, some challenges have arisen over the past year.

Ensuring child-only coverages available in the State is one of them. Preserving State programs that require or encourage insurers to offer more limited benefit packages that are more affordable to certain populations—a few States do that. And, avoiding disruptions due to medical loss ratio—these have been all high priorities for State regulators. The majority of our current efforts are directed toward planning and establishment of State Health Insurance Exchanges. Kansas, along with 48 other States, the District and U.S. territories, were awarded a $1 million Exchange Planning Grant, which we are currently using to conduct an analysis of our health insurance marketplace and the work that would be necessary to develop and operate an Exchange in our State. We are now beginning to apply for an Establishment Grant that will allow Kansas to begin extensive work to put the exchange into place.

The State of Kansas was also fortunate to receive an Early Innovator Grant and the funds that we received under this grant will be used to develop the technology that enable a single door, an end-to-end solution by extending the new Kansas Medicaid and Children's Health Insurance Program, an eligibility system and integrating it with the Kansas Health Insurance Exchange.

We will then make this technology available to other interested States; and we've already had some of those discussions.

Most States are engaged in the process of developing legislation to authorize the creation of an Exchange and putting in place the administrative structure that will do the bulk of this Exchange implementation work. In order to guide this process, the NAIC has developed the American Health Benefit Exchange Model Act, which provides a basic framework for the States to use when developing their authorizing legislation. In establishing a State-based exchange, States face several key obstacles. Foremost among these is time. States are working hard to stay on target to allow consumers to purchase coverage by late 2013; and that will require becoming effective when the ball drops in Times Square for ringing in 2014.

Timely guidance from HHS, of course, is critical to this process, and to our success. In particular, guidance on the contents of the essential health benefits package, will be a crucial piece that will impact the availability and the affordability of coverage, and the cost of subsidies. And we need that guidance ASAP.

States must make sure that they have sufficient resources to develop and establish Exchanges. Federal establishment grants are absolutely essential in this regard. States don't have an abundance of extra resources right now, as you all know.

And, then finally, I'd like to briefly discuss some of the more general implementation challenges that we are working on.

Adverse selection is a major concern in any health reform effort. Perhaps the largest open question regarding adverse selection will be the effectiveness of the individual mandate. If the healthier risk stays out of the market until they're sick, rates will rise.

State regulators are also concerned that changes to the small group health plans—their grandfathered status could exacerbate the risk of adverse selection and complicate State enforcement of the law's market reforms.

Another problem area could arise if multi-State plans and consumer operated and oriented plans, which will be sold alongside other plans in the Health Insurance Exchanges; if they are allowed to operate under rules that are significantly different from those that govern their competitors, again, potentially adverse selection. They must play by the same rules as the other carriers that are similarly situated or consumers could be harmed. Solvency issues are really important there.

In addition, if large numbers of carriers exit the marketplace, particularly prior to 2014, competition will suffer and availability of coverage may become a concern.

Thus far we have not seen empirical data indicating a major market exit, though we will remain watchful for problems that might arise.

And, as I have noted in my previous testimony before this committee, the success of this entire enterprise depends upon bringing

health care costs under control. Health insurance premiums are largely a reflection of the underlying cost of care and levels of utilization. While the Affordable Care Act contains numerous provisions designed to start moving the system toward lower costs and higher quality care, it is not yet clear to us how effective those measures will be. Again, I thank you for the opportunity to testify here today. I appreciate the committee's recognition of the States' crucial role in implementing this law and I reiterate our offer of assistance going forward, and I look forward to your questions.

[The prepared statement of Ms. Praeger follows:]

PREPARED STATEMENT OF SANDY PRAEGER

SUMMARY

Over the past year, one of the main focuses of my department and other State departments of insurance has been to lay the groundwork for implementation and enforcement of the immediate reforms that took effect for plan years beginning on or after September 23, 2010. While some States have blanket language in their insurance codes requiring insurers to abide by all applicable Federal requirements and empowering regulators to enforce them, most do not. Early State efforts have been centered on the form review process, with regulators verifying that the forms meet all applicable requirements.

As reforms have been implemented, some challenges have arisen. Ensuring child-only coverage is available in the State; preserving State programs that require or encourage insurers to offer more limited benefit packages that are more affordable to certain populations; and avoiding disruptions due to the medical loss ratio have been high priorities for State regulators.

The majority of our current efforts are directed towards planning and establishment of State Health Insurance Exchanges. Most States are engaged in the process of developing legislation to authorize the creation of an Exchange. Despite the flexibility afforded States in the creation of Exchanges, significant challenges remain.

Foremost among these is time. January 1, 2014 is less than 3 years away, and States must have made sufficient progress towards establishing an Exchange by January 2013 for the Secretary to certify that they will meet the deadline. In addition, the contents of the essential health benefits package will be a crucial piece of information and it may not be available until the end of this year. States must also make sure that they have sufficient resources to develop and establish Exchanges—Federal establishment grants are absolutely essential in this regard.

One of the more daunting challenges that we will face in getting an Exchange up and running will be the development of critical information technology systems and infrastructure. Kansas has received an Early Innovator Grant to perform some of this work, and we look forward to sharing it with other States as they move forward in establishing their Exchanges.

Adverse selection is a major concern in any health reform effort. Perhaps the largest open question regarding adverse selection will be the effectiveness of the individual mandate. There is also concern that the expansion of the small group market to include businesses with 51–100.

Another potential problem area could arise if Multi-State Plans or the Consumer Operated and Oriented Plans are allowed to operate under rules that are significantly different from those that govern their competitors.

In addition, if large numbers of carriers exit the marketplace, particularly prior to 2014, competition will suffer and availability of coverage may become a concern.

Finally, as I have noted in my previous testimony before this committee, the success of this entire enterprise depends upon bringing health care costs under control. It is not yet clear to us how effective these reforms will be in addressing this crucial issue.

INTRODUCTION

Good morning Chairman Harkin, Ranking Member Enzi, and distinguished members of the committee. My name is Sandy Praeger, and I am the elected Insurance Commissioner for the State of Kansas, chair of the Health Insurance and Managed Care Committee of the National Association of Insurance Commissioners (NAIC), and co-chair of the NAIC's Health Insurance Exchanges Subgroup. I thank you for

holding this hearing on implementation of the Patient Protection and Affordable Care Act (PPACA) and for your invitation to appear today on behalf of the NAIC. The NAIC represents the chief insurance regulators of all 50 States, the District of Columbia, and five U.S. territories, whose primary roles are protecting consumers and promoting vibrant and competitive insurance markets.

The last time I appeared before this committee, on November 3, 2009, health reform had not yet been enacted, and I offered the assistance of State regulators through the NAIC as you weighed and debated the difficult issues inherent in trying to achieve the goal of extending health insurance coverage to those with preexisting conditions while controlling costs and improving quality. Today, I would like to thank you for recognizing the important role played by State regulators and for ensuring that when it came to implementation of this law, we would have a seat at the table. I would also like to renew our offer of assistance, both to the Administration in implementing PPACA, and to this and other committees as you fulfill your oversight responsibilities.

STATE ACTIVITIES IN YEAR ONE

Over the past year, one of the main focuses of my department and other State Departments of Insurance has been to lay the groundwork for implementation and enforcement of the immediate reforms that took effect for plan years beginning on or after September 23, 2010. These provisions include:

- Prohibition of lifetime benefit limits;
- Restrictions on annual benefit limits;
- Prohibition of rescissions;
- Coverage of preventive services without cost-sharing;
- Extension of dependent coverage up to age 26;
- Internal and external review;
- Prohibition of preexisting condition exclusions for children; and
- Disclosure of justifications for premium increases.

While PPACA defers to State regulation as a default position, in order to enforce these protections State regulators must be granted the authority to do so under State law. While some States have blanket language in their insurance codes requiring insurers to abide by all applicable Federal requirements and empowering regulators to enforce them, most do not. Consequently, one of the first tasks facing the States after enactment of PPACA was securing this authority. In order to assist the States in this task, the NAIC developed model language for adoption by State legislatures that meets the Federal minimum standards and provides State regulators with the authority they need to enforce the provisions. Most States have been reviewing their statutes to determine which changes they must make, particularly with respect to the external appeals process and rate review requirements. Some States are taking a wait-and-see attitude pending resolution of the challenge to the constitutionality of the law.

For enforcement purposes, early State efforts have been centered on the form review process. Health insurers are required to file the contract, or "form," of each policy that they sell with State regulators, who then review the form to ensure that it meets all requirements of State law and regulation. As these forms are filed, regulators have been verifying that every policy sold in the State meets all applicable early implementation provisions. This process has been expedited through the use of a regulatory checklist, developed by the NAIC, that each insurer must complete identifying where in each policy the relevant language complying with PPACA is located. Even with this assistance, conducting the form review necessary to implement these provisions was a Herculean task for the dedicated regulators in my department and in those of every State around the country, as we worked to ensure that health insurance policies sold or renewed reflect the applicable provisions required by the law. In addition, State regulators are monitoring consumer complaints to ensure that insurers are living up to the amended terms of their policies and are providing the benefits that they have promised to policyholders, and taking action where necessary.

EARLY IMPLEMENTATION CHALLENGES

While we at the State level have done our very best to ensure that implementation of these provisions is accompanied by as little disruption as possible, some unintended consequences have arisen over the past year, posing some challenges for regulators.

The first of these challenges arose in response to the provision prohibiting the application of preexisting condition exclusions to children under the age of 19. Because preexisting condition exclusions were redefined to include denials of coverage, this

provision has, in effect, required guaranteed issue of coverage for children. In response, some or all insurers in most States ceased new sales of individual market policies only to children, creating a situation where a parent whose employer does not offer family coverage is unable to purchase coverage for his or her children. In most cases, insurers continue to issue coverage to children as part of a family policy.

States have attempted to deal with this issue in two ways. First, they have issued regulations creating open enrollment periods in an effort to limit the ability of consumers to wait until children become sick before purchasing coverage for them. On October 13, HHS issued guidance clarifying that—subject to State law—insurers could limit their sales of child-only individual market plans to these open-enrollment periods. The second strategy that some States have adopted has been to require, through legislation, regulations, or sub-regulatory guidance, that carriers in the individual market continue offering child-only coverage. These strategies have been met with varying degrees of success in different States. State regulators remain vigilant with respect to the availability of child-only coverage and will continue to search for ways to implement this provision in a way that minimizes disruption of the marketplace.

A second challenge involves restrictions on annual limits. There was initially some concern among State policymakers that the law's restrictions against low annual limits on benefits might interfere with State programs that either require or encourage insurers to offer more limited benefit packages that are more affordable to Americans who are currently priced out of the insurance market. Until 2014, when subsidies are made available to those under 400 percent of the Federal poverty level, the loss of these programs could have the unintended consequence of increasing the numbers of the uninsured in those States. We were glad to see the creation of a process for States to apply for waivers that will allow these programs to continue until subsidies are available. Four States have applied for—and been granted—waivers for these types of programs.

It is critically important, however, that we maintain an environment that promotes coordinated and collaborative enforcement of the annual limits provision. The information available to State regulators regarding annual limits waivers has so far been limited to the name of the insurer, the policy's effective date, and the number of affected enrollees. To effectively enforce this provision, however, we will need more granular information about the waivers that will tell us which policies sold by these insurers have been granted waivers, and look forward to working with HHS to resolve this issue.

A third concern involves the Federal medical loss ratio (MLR) and rebate program. Many States have been working with HHS to pursue adjustments to the MLR requirements in their individual markets, as allowed under the law. Last week we were pleased to see that the State of Maine was granted a 2-year adjustment, with a possible third year extension, to the MLR for its individual market. While we understand the need for the review process to be grounded upon solid data, several States have expressed frustration over the amount and relevance of specific data requested as part of the application process. State Insurance Departments are already stretched by the implementation process, and gathering large amounts of data that are not readily available and that does not necessarily provide meaningful insight causes additional strain.

A final issue is education of the public. In addition to the hard work that regulators have been engaged in to implement this legislation in a way that minimizes market disruptions, we have been engaged in an ongoing effort to educate the residents in the States about the changes that are going into place. Even before we started implementing this law, health insurance was a complicated and daunting topic for the vast majority of consumers. All States and territories have dedicated resources to educate and assist consumers and carriers as the law is implemented. Passage of PPACA and the subsequent implementation process have made consumer education all the more critical. Thirty-five States, the District of Columbia, and four U.S. territories have been awarded consumer assistance grants from HHS to educate consumers and to address their inquiries and complaints, though again, there has been some concern about the volume, type and relevance of the data required under the grant.

NEXT STEPS FOR STATES

The majority of our current efforts are directed towards planning and establishment of State Health Insurance Exchanges. Kansas, along with 48 other States, the District of Columbia, and all of the U.S. territories, were awarded a $1 million Exchange Planning Grant at the end of September, which we are using to conduct an analysis of our health insurance marketplace and the work that would be necessary

to develop and operate an Exchange in our State. We are now beginning the process of preparing to apply for an Establishment Grant that will allow Kansas to begin doing more extensive work to actually put the Exchange into place.

The State of Kansas was also fortunate to receive an Early Innovator Grant that will support some of the information technology work that must be done to get our Exchange up and running. Funds that we receive under this grant will be used to develop technology that will enable a single-door, end-to-end solution by extending the new Kansas Medicaid/CHIP eligibility system and integrating it with the Kansas Health Insurance Exchange. Under the terms of this grant, we will make this technology available to other interested States and are in preliminary discussions with the State of Missouri to partner on an Exchange and other aspects of this initiative. Depending on the interest of other States, we may also explore the possibility of creating a "cloud" solution for other States to have their own version of one or more of these healthcare applications.

Most States are engaged in the process of developing legislation to authorize the creation of an Exchange and putting in place the administrative structure that will do the bulk of the Exchange implementation work. In order to guide this process, the NAIC has developed the American Health Benefit Exchange Model Act, which provides a basic framework for States to use when developing authorizing legislation. It was our goal in drafting this model to preserve the flexibility for each State to develop an Exchange that is tailored to its needs and preferences while meeting the minimum Federal guidelines. For this reason, while it identifies many of the areas where States may customize the model, it does not prescribe what a State should do. To fill the gap, State regulators, through the NAIC, are developing a series of white papers to provide State policymakers with additional information about some of these choices and associated issues. These papers will cover such topics as Exchange governance and financing; adverse selection threats; the importance of maintaining the role of agents, and exploring that in relation to the role of Navigators; additional Exchange functions; and interactions between the Exchange and a State's Medicaid and CHIP programs. We expect to finalize the first round of these papers by the end of this month.

As I mentioned, there is a fair amount of flexibility in PPACA when it comes to Exchange development, something that we advocated while this law was developed. Taking advantage of this flexibility, the first question most States are first considering is what policy goals they would like their Exchange to accomplish. Many States are looking to create a transparent marketplace to simplify the process of purchasing insurance coverage while providing consumers with the information they need to make informed comparisons between various options. This is the so-called "Utah model." Other States are considering using the Exchange to selectively contract with health insurance carriers in order to negotiate directly on behalf of consumers—the "Massachusetts model." This decision will help determine many of the other questions that States must answer in establishing their Exchanges.

There is also flexibility for States in the governance structure that they choose to establish. They have the option of housing the Exchange in an existing State agency (most likely the Insurance Department or Medicaid agency), a new agency, a quasi-governmental body, or a nonprofit entity established by the State. Each of these options has advantages and disadvantages associated with it, and one or another of them may be more appropriate to realize the specific policy goals set by the State.

Finally, there are additional functions that a State may wish the Exchange to perform for consumers. Some States may wish to require insurers participating in the Exchange to provide additional information to consumers about various aspects of their operations or benefits, while others may want to leverage creation of the Exchange to create an all-payer claims database that will provide valuable data on patterns of coverage and health care utilization in the State. Still others may choose to require insurers to offer additional levels of coverage beyond the gold and silver plans required by PPACA as a condition of participation. It should be noted that States will have the option of adding new functions in future years; they do not need to be included by January 2014.

CHALLENGES IN ESTABLISHING EXCHANGES

Despite all of this flexibility, significant challenges remain. Foremost among these is time. January 1, 2014 is less than 3 years away, and States must have made sufficient progress towards establishing an Exchange by January 2013 for the Secretary to certify that they will meet the deadline. While that may seem like a lot of time, it is not, and States are working hard to stay on target to allow consumers to purchase coverage by late 2013 that will become effective when the ball drops

in Times Square ringing in 2014. While we have received some guidance from HHS that has been useful in taking some initial steps, the sooner we receive more detailed regulatory guidance the easier our tasks will be. I understand that this will be forthcoming in the next few months, and our members look forward to receiving it.

Guidance on the contents of the essential health benefits package, which will most likely be arriving in the first half of next year, will be a crucial piece of information for many States looking at benefit requirements for qualified health plans sold in the Exchanges. This information will be very important for carriers as they prepare to incorporate benefits into the coverage they sell and as they plan to offer coverage in the Exchanges. It will greatly impact premiums and the cost of subsidies.

States must make sure that they have sufficient resources to develop and establish Exchanges. Federal establishment grants are absolutely essential in this regard. Without them, in our current fiscal climate, it is unlikely that we would be able to put these programs into place and would be forced to allow the Federal Government to operate them for us. We are working hard to be good stewards of the Federal funds we receive and to use them as efficiently as possible, but there will likely be some additional costs that States must cover on their own, and after 2014 each Exchange must be self-sustaining.

One of the more daunting challenges that we will face in getting an Exchange up and running will be the development of critical information technology systems and infrastructure. These systems will have to interact with State Medicaid eligibility systems, many of which are decades old and will require a substantial investment to work with the newer Exchange systems, as well as Federal systems at the Departments of Health and Human Services, Treasury, Homeland Security, the Internal Revenue Service, and the Social Security Administration. As I mentioned earlier, Kansas has received an Early Innovator Grant to perform some of this work, and we look forward to sharing it with other States as they move forward in establishing their Exchanges.

GENERAL IMPLEMENTATION CHALLENGES

Finally, I would like to briefly discuss some of the more general implementation challenges that we are working on. Adverse selection is a major concern in any health reform effort. While Congress was attentive to this issue in designing PPACA, there are still some potential sources of adverse selection that we are watching very closely. Perhaps the largest open question regarding adverse selection will be the effectiveness of the individual mandate. There is also concern that the expansion of the small group market to include businesses with 51–100 employees could encourage a significant portion of these businesses to self-insure if they have a younger and healthier workforce and do not wish to subsidize businesses with older and sicker employees through an insurance risk pool. If their level of claims begins to rise, they could then return to the fully insured small group market in order to share this increased level of risk with others. This dynamic could cause the cost of coverage for small employers to rise.

We are concerned that changes to the regulations governing a health insurance plan's grandfathered status could exacerbate the risk of adverse selection and complicate State enforcement of PPACA's market reforms. These changes will allow a group health plan to maintain its grandfathered status even though it has purchased a new health insurance policy. Again, we expect that businesses with younger and healthier workforces will disproportionately take advantage of this option, as the current rules are more advantageous to them than those that will take effect in 2014. Because PPACA prohibits grandfathered plans from being pooled together with non-grandfathered plans, this could exacerbate any adverse selection that occurs in the small group market. State regulators are concerned that allowing a group health plan to maintain its grandfathered status after purchasing new coverage will create a secondary market for grandfathered coverage that could encourage fraud and will make it difficult for State regulators to easily determine whether or not a plan is exempt from PPACA reforms.

A third potential problem area could arise if Multi-State Plans, which will be sold alongside other plans in the Health Insurance Exchanges, are allowed to operate under rules that are significantly different from those that govern their competitors. If they are, we are concerned that they could cherry-pick the best risks and that their enrollees could unwittingly be left without important consumer protections provided by State law. We have had some initial discussions with the Office of Personnel Management, which is very much aware of this potential pitfall and is working to address it. We will, however, continue to watch this issue very closely. State regulators have testified before the Consumer Operated and Oriented Plan (CO-OP)

Advisory Board against reducing solvency and consumer protection requirements on these new plans. They must play by the same rules as other carriers that are similarly situated or consumers could be harmed.

Fourth, any time major changes to health insurance markets are implemented we watch carefully for market disruption and do our best to minimize that disruption. If large numbers of carriers exit the marketplace, particularly prior to 2014, competition will suffer and availability of coverage may become a concern. Thus far we have not seen empirical data indicating a major market exit, though we will remain watchful for problems that might arise.

Finally, as I have noted in my previous testimony before this committee, the success of this entire enterprise depends upon bringing health care costs under control. Health insurance premiums are largely a reflection of the underlying cost of care and levels of utilization. While PPACA contains numerous provisions designed to start moving the system towards lower costs and higher quality care, it is not yet clear to us how effective those measures will be. Continued attention by this committee and policymakers at the local, State, and Federal levels will be necessary to tackle this formidable challenge.

Thank you again for the opportunity to testify here today. I appreciate the committee's recognition of the States' crucial role in implementing this law and reiterate my offer of assistance going forward. I look forward to any questions you might have.

The CHAIRMAN. Thank you very much, Ms. Praeger.

Dr. Sharfstein.

STATEMENT OF JOSHUA M. SHARFSTEIN, M.D., SECRETARY, MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE, BALTIMORE, MD

Dr. SHARFSTEIN. Good morning Chairman Harkin, Ranking Member Enzi, Senator Mikulski, Senator Hatch, Senator Alexander.

Thank you for this opportunity to discuss Maryland's implementation of the Affordable Care Act.

Our Governor, Martin O'Malley, has stated, with public and private innovation, Maryland is implementing the Affordable Care Act to strengthen coverage, improve health, and support our competitiveness in the global economy.

In my testimony, I will provide some background on Maryland's health care and health insurance system, describe the State's implementation of the Affordable Care Act to date and the key reform efforts underway, and discuss the next steps for the Health Benefit Exchange in Maryland.

To understand the impact of health care reform in Maryland, it is helpful to have a little bit of background of the State's health care system. Our system includes Insurance Regulatory Oversight, including review of rates where they are permitted. Our current review is not a public process and is not as robust as we would like it; and we're using a grant from the Affordable Care Act to make it more public and to strengthen it.

We have a small business market that's community rated, which means that small businesses can get insurance based on factors such as age of their employees and not the health status of their employees.

We have nearly 400,000 individuals working for more than 47,000 small businesses in this market right now.

Our individual market is not guaranteed issue. That means if somebody has pre-existing conditions they can be excluded from the individual market. We have about 160,000 Marylanders in the individual market.

We gave a high-risk pool that was created in 2002. It has more than 20,000 Marylanders in it; and we have the Nation's only all-payer hospital rate setting system.

Our State sets hospital rates so that all payers, public and private, pay the same fees at the same hospital. This has given us some unique opportunities I'll talk about later.

In the last few years Maryland has expanded access to health care in several important ways and expanded access to dental care.

Despite this progress, about 13 percent of Maryland residents remain uninsured, representing more than 700,000 people. In addition, there are significant increases in the cost of coverage that threaten employer-based system of care.

A Commonwealth Fund study found that the average premium for family coverage for private sector employers rose nearly 50 percent from 2003 to 2009 in the State of Maryland.

Let me switch to the implementation of the Affordable Care Act to date. A number of provisions have taken effect nationally and are having a tangible, positive impact in Maryland. These include allowing young adults to stay on their parents' insurance until age 26; seniors in Maryland are receiving additional assistance to close the donut hole, which is basically closed when you combine the Federal and the State assistance; children can access health insurance without being declined for pre-existing conditions—and we have two plans offering child-only policies in the State; insurers have to abide by the new medical loss ratio requirements; and small employers can access new tax credits for coverage. And just a couple days ago I was at a great press conference with small business leaders and insurance brokers, and we announced in Maryland that any small business can text with their phone the word health to 877877 and someone will call them back and talk to them about tax credits. We have a Web site and a radio campaign as well.

In addition, we have received support, as I mentioned, to strengthen our high-risk pool and our review of insurance rates.

In terms of other reform efforts in Maryland the morning after President Obama signed the Affordable Care Act into law, Governor O'Malley established a Health Care Reform Coordinating Council to oversee State implementation. This Council has held more than 30 public meetings and received hundreds of comments from physicians, hospitals, payers, unions, public and mental health advocates, brokers, patients, and lawmakers.

As part of its work, the Council asked a nonpartisan healthcare think tank at the University of Maryland in Baltimore County to provide an independent analysis of reform's impact on our State budget. This analysis found that successful implementation will result in a net savings of about $853 million to the Maryland State budget over the next 10 years.

The analysis also found that after the first decade these savings begin to decline, underscoring the imperative that the State make progress on bending the cost curve.

As part of its preparation implementation, the Council reviewed a number of innovative efforts already underway to control costs in Maryland. These are detailed in my testimony and I'm not going to go into detail; but I will say we have some terrific public, private

initiatives on quality such as a hand hygiene initiative. We have an effort to reduce preventable hospital complications where the hospitals with the most complications pay money to the hospitals with the least. We rank them, and you can go to the Web site and see.

We have some of the most interesting payment reform efforts where our goal is pay for value and not volume of hospital care using our all-payer rate system. We are establishing patients at our medical homes to incentivize efficient care. We're expanding health information technology with more than 400 primary physicians already signed up in a State health information exchange underway.

And, we're integrating the health care system in our public health planning to really focus on prevention.

Each of these efforts will support effective implementation of the Affordable Care Act and the long-term sustainability of our health care system.

Maryland has also set in motion key steps that will lead to a successful program for health benefit exchange for individuals and small businesses.

Our goal is a transparent and competitive market.

And, let me just say, we want the companies to compete to provide high quality cost-effective care to people in Maryland. We don't want them to compete against each other on who can cut out which benefits. We don't want families to have to decide or have to choose between my child's health condition and my mom's health condition.

That's why the Essential Benefits Package is a very important part of reform. If there's not consistency in what's offered, then the plans will compete on the wrong things; they will compete on what they can offer, making horrible choices for families, instead of doing a good job to serve people who really need care.

The Administration has introduced legislation in the State's General Assembly that lays the foundation for the development of the Exchange by establishing its governance structure and setting forth the core duties and functions mandated by the Affordable Care Act. When enacted, it will establish the Exchange as a public corporation, governed by a board with three State officials and six nongovernmental members.

We have a number of key projects set out in legislation for the coming year, including analyzing a number of the tasks of the Exchange that are left to State discretion, including whether we should have one exchange or two for individual and small businesses; how we will hire navigators.

The role of insurance producers play a critical role in our State. There are a lot of interesting things to be done this year. We will also, with our innovative grant, be developing some essential technical components of the Exchange.

I'm going to conclude by saying that Maryland is implementing the Affordable Care Act.

Recently, our Lt. Governor delivered a keynote address in which he said that we see this as a law—we see this law as an opportunity to change the face of our health care system, to better support the vitality and strength of our families, businesses, and com-

munities, to expand wellness and prevention, to reduce hospital readmissions and preventable complications, to expand health information technology, and to address health disparities and chronic disease.

He concluded that Maryland intends to seize the moment and use the tools provided by the Affordable Care Act to build a better future for our State.

Thank you, and I look forward to your questions.

[The prepared statement of Dr. Sharfstein follows:]

PREPARED STATEMENT OF JOSHUA M. SHARFSTEIN, M.D.

SUMMARY

BACKGROUND

Maryland's health care system includes an individual market, a small business market, a high-risk pool, insurance regulatory oversight, and a unique all-payer system for hospital rates. In recent years, the State has expanded access to health insurance through tax credits, public programs, and insurance changes.

Nonetheless, about 13 percent of Maryland residents remain uninsured, and significant increases in the cost of coverage continue to threaten employer-based health insurance in the State.

Maryland intends to use the tools provided by the Affordable Care Act to address challenges in access, cost, and quality.

IMPLEMENTATION OF THE AFFORDABLE CARE ACT

Maryland has seen the successful implementation of a number of Affordable Care Act provisions, including provisions benefiting young adults, seniors, children, and small businesses.

The morning after President Obama signed the ACA into law, Governor Martin O'Malley established the Health Care Reform Coordinating Council. The Council has held more than 30 public meetings and received hundreds of comments from physicians, hospitals, payers, unions, public and mental health advocates, brokers, patients, and lawmakers.

As part of its work, Council asked a non-partisan healthcare think tank to provide an independent analysis of reform's impact on our State budget. This analysis estimated that successful implementation will result in net savings of $853 million by 2020.

The Council reviewed a number of innovative efforts already underway to control costs in Maryland, including implementing public-private initiatives on quality, reducing preventable hospital complications, implementing payment reform, establishing patient-centered medical homes, expanding health information technology, and integrating the health care system in public health planning. Each of these efforts will support effective implementation of the Affordable Care Act and the long-term sustainability of our health care system.

THE HEALTH BENEFIT EXCHANGE

Maryland has set in motion key steps that will lead to a successful program for individuals and small businesses. The O'Malley Administration has introduced legislation in the State's General Assembly that lays the foundation for development of Maryland's Exchange by establishing its governance structure and setting forth the core duties and functions mandated by the Affordable Care Act. Maryland is also working to develop some of the essential technical components of the exchange.

MARYLAND'S IMPLEMENTATION OF THE AFFORDABLE CARE ACT

Good morning Chairman Harkin, Ranking Member Enzi and members of the committee. Thank you for this opportunity to discuss Maryland's implementation of the Affordable Care Act.

Governor Martin O'Malley has stated,

> "With public and private innovation, Maryland is implementing the Affordable Care Act to strengthen coverage, improve health, and support our competitiveness in the global economy."

In my testimony, I will provide some background on Maryland's health care and health insurance system, describe the State's implementation of the Affordable Care Act to date and the key reform efforts underway, and discuss the next steps for Maryland's Health Benefit Exchange.

MARYLAND'S HEALTH CARE SYSTEM

To understand the impact of health care reform in Maryland, it is helpful to understand some important elements of the State's health care system. These include:

• *Insurance Regulatory Oversight.* When a carrier proposes to sell a health insurance policy in Maryland, the policy form and the proposed rates must first be filed with the Maryland Insurance Administration and then approved by the Insurance Commissioner. Although the standard varies slightly for nonprofit health service plans, HMOs and insurers, generally premium rates may not be excessive, inadequate or unfairly discriminatory.

• *The small business market.* In 1993, Maryland's small group market reforms required the Maryland Health Care Commission to develop a comprehensive, standardized set of benefits with cost sharing. Plans are guaranteed issue with community rating modified for age, family composition, and geographic location; riders may be purchased that increase the benefits or reduce the cost sharing. The State provides premium tax credits to small employers with fewer than 20 employees and average wage of less than $50,000 who have not offered insurance in the past year. Private third-party administrators work closely with insurers to offer additional benefits to small employers. The market now provides coverage to nearly 400,000 individuals working for more than 47,000 small businesses.[1]

• *The individual market.* Maryland's individual market is not guaranteed issue, so insurers are permitted to deny coverage to applicants with preexisting conditions. Approximately 160,000 Marylanders obtain health insurance through this market.

• *The high-risk pool.* In 2002, Maryland established a high-risk pool, the Maryland Health Insurance Plan (MHIP), funded by a hospital assessment. MHIP now covers approximately 20,000 residents who cannot obtain coverage through the individual market because of a preexisting medical condition. MHIP Plus provides additional premium subsidies for low income residents.[2]

• *The all-payer hospital rate setting system* Maryland is the only State in the country that sets hospital rates so that all payers, public and private, pay the same fees at the same hospital. The independent Health Services Cost Review Commission determines the rates at each hospital based on how much uncompensated care the hospital provides, the local labor market, and other factors. This "all-payer" approach allows the State to create incentives for cost savings, rather than cost shifting. It is an important reason why the cost of a Maryland hospital admission has moved from 26 percent above the national average in 1976 to more than 3 percent below the national average by 2009.[3]

Maryland has also expanded access to health care in several different ways over the last 5 years. In July 2006, Maryland established a Medicaid waiver program that provides primary care access and prescription drug benefits to low-income individuals. In 2007, the State expanded Medicaid coverage to parents and strengthened the package of benefits in our waiver program. Maryland also allowed young, dependent adults up to age 25 to stay on their parents' insurance and took action to close the donut hole for seniors.

After a young boy tragically died in Prince George's County from a tooth infection, Maryland took a number of steps to expand access to timely dental care. Significant improvement has followed, and last year, Maryland was one of just six States in the Nation to receive an A grade for oral health from the Pew Charitable Trusts.[4]

Despite this progress, approximately 13 percent of Maryland residents remain uninsured, representing more than 700,000 people.[5] In addition, significant increases in the cost of coverage continue to threaten employer-based health insurance. A Commonwealth Fund report found that the average premium for family coverage of-

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[1] See *http://mhcc.maryland.gov/smallgroup/smallemployer.html* for additional information on Maryland's small group market.

[2] See *http://www.marylandhealthinsuranceplan.state.md.us/* for more information on the Maryland Health Insurance Plan.

[3] See *http://www.hscrc.state.md.us/* for more information on the Health Services Cost Review Commission.

[4] Pew Charitable Trusts. *The Cost of Delay: State Dental Policies Fail One in Five Children.* February 2010. *http://www.pewtrusts.org/uploadedFiles/Cost__of__Delay__web.pdf.*

[5] Maryland Health Care Commission. Coverage in Maryland through 2009. January 2011. *http://mhcc.maryland.gov/health__insurance/insurance__coverage/insurance__report__2009__20110120.pdf.*

fered by private sector employers in Maryland rose from $9,217 in 2003 to $13,833 in 2009, an increase of 50 percent.[6]

Maryland intends to use the tools provided by the Affordable Care Act to address challenges in access, cost, and quality.

IMPLEMENTATION OF THE AFFORDABLE CARE ACT TO DATE

To date, a number of provisions of the Affordable Care Act have taken effect nationally and are having a tangible, positive impact on the health and well-being of Maryland citizens. These include:

- Young adults can stay on their parents' insurance until age 26;
- Seniors can receive additional assistance in closing the donut hole;
- Children can access health insurance without being declined for preexisting conditions;
- Insurers must abide by new medical loss ratio requirements, standardizing the amount of premium dollars that must be spent on health care;[7] and
- Small employers can access new tax credits for coverage.

In addition, Maryland has received additional support under the Affordable Care Act to strengthen the review of insurance rates, provide additional support for MHIP, and implement public health programs to prevent illness.

REFORM EFFORTS UNDERWAY IN MARYLAND

The morning after President Obama signed the ACA into law, Governor Martin O'Malley established the Health Care Reform Coordinating Council to oversee State implementation of the Affordable Care Act.

Through the end of last year, the Council held more than 30 public meetings and received hundreds of comments from physicians, hospitals, payers, unions, public and mental health advocates, brokers, patients, and lawmakers. The Council presented a report in January with 16 recommendations reflecting this public input. The recommendations cover the full range of topics critical to effective implementation of the ACA, such as entry into coverage, the safety net, and the health care workforce. The Council and a new Governor's Office of Health Care Reform will continue coordination and oversight of the State's implementation of these recommendations. I have attached this report to my testimony.

As part of its work, Council asked a non-partisan healthcare think tank at the University of Maryland in Baltimore County to provide an independent analysis of reform's impact on our State budget. This analysis found that successful implementation will result in estimated net savings of $853 million over the next 10 years. The major components of Maryland's savings include an increase in Federal assistance for key populations, revenue from phasing out Maryland's high-risk pool, an increase in revenue from existing premium assessments on commercial insurance products, and partial reductions in State funding for safety net programs.

The analysis also found that after the first decade, these savings begin to decline, underscoring the critical imperative that the State make progress on bending the cost curve.

As part of its assessment in preparation for ACA implementation, the Council reviewed a number of innovative efforts already underway to control costs in Maryland. These include:

Implementing public-private initiatives on quality. The Maryland Health Quality and Cost Council, a public-private partnership led by the Lt. Governor, has developed statewide initiatives on hand hygiene, blood wastage, hospital-acquired infections, and workplace health.[8]

Reducing preventable hospital complications. Maryland is using the only all-payer hospital rate system in the country to collect reliable data on every hospital admission, which it can then use to create payment incentives to reduce preventable complications. In fiscal year 2010, the rate-setting Commission identified nearly 50,000

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[6] The Commonwealth Fund. *State Trends in Premiums and Deductibles, 2003–09.* Dec. 2, 2010. *http://www.commonwealthfund.org//media/Files/Publications/Issue%20Brief/2010/Dec/1456_Schoen_state_trends_premiums_deductibles_20032009_ib_v2.pdf.*

[7] Maryland's existing MLR for the commercial group market was similar to the standard in the Affordable Care Act, and the MLR for the individual market was less than the Affordable Care Act standard. Maryland did not request a waiver because the data did not support a conclusion that the new medical loss ratio target in Maryland would disrupt the individual market. To date, no carrier has indicated its intent to withdraw, and the acting Insurance Commissioner believes the market is adjusting to the new medical loss ratio.

[8] See *http://dhmh.maryland.gov/mhqcc/* for more information on the Maryland Health Quality and Cost Council.

potentially preventable complications that cost our system approximately $522 million. Ranking hospitals by rates of complications, the Commission then redistributed $4 million from the hospitals with more preventable complications to those that had fewer. Since this process began, rates of preventable complications have declined substantially across the board—approximately 12 percent from 2009 to 2010 for an annual cost savings of $62.5 million.[9]

Implementing payment reform. Maryland is also using the State's unique all-payer rate setting system to pay for value, rather than volume. For example, we are expanding the bundle of payments to hospitals to include both admissions and re-admissions over a 30-day period. Twenty five of the State's forty-six hospitals are choosing this payment structure, which will provide incentives to reduce unnecessary re-hospitalizations. An additional 10 community hospitals with annual revenues of approximately $1.4 billion have volunteered to operate under global budgets, which provide incentive to reduce unnecessary admissions, re-admissions, and emergency department visits. In response to this incentive, one hospital is expanding its outpatient program for diabetes by hiring another endocrinologist. Another is planning to create multidisciplinary teams to plan for discharge and post-discharge care. As hospitals innovate, we will capture their best practices and share them throughout our system.

Establishing patient-centered medical homes. Maryland passed legislation in 2010 to create a pilot program involving multiple payers, 60 practices, more than 340 providers and 250,000 patients. Under the program, which is overseen by the Maryland Health Care Commission, primary care doctors receive extra funding to support comprehensive care for patients and share in the savings from better coordinated and higher quality care. The State's largest private insurer, CareFirst, is also launching a major medical home project across the State.

Expanding health information technology. Maryland has established a Health Information Exchange to allow for the exchange of information between community providers and hospitals across the State. An independent nonprofit called the Chesapeake Regional Information System for our Patients (CRISP) is facilitating physicians' access to health information technology. More than 400 primary care doctors have already joined.

Integrating the health care system in public health planning. Maryland is developing a State Health Improvement Plan around specific health outcomes. Critical to this plan will be efforts to prevent unnecessary illness and cost. Beginning this summer, regional planning will bring together public and private efforts to address key health challenges and disparities across the State.

Each of these efforts will support effective implementation of the Affordable Care Act and the long-term sustainability of our health care system.

NEXT STEPS FOR MARYLAND'S HEALTH BENEFIT EXCHANGE

The Health Benefit Exchange provides a mechanism for organizing the health insurance marketplace to help consumers and small businesses shop for coverage in a way that permits easy comparison of available plan options based on price, benefits, and quality. It also provides access to Federal subsidies and tax credits. Maryland has set in motion key steps that will lead to a successful program for individuals and small businesses.

The Administration has introduced legislation in the State's General Assembly that lays the foundation for development of Maryland's Exchange by establishing its governance structure and setting forth the core duties and functions mandated by the Affordable Care Act. When enacted, it will establish the Exchange as a public corporation, governed by a board with three State officials and six nongovernmental members. Over the next year, the Exchange will hire initial staff and analyze key strategic decisions for Maryland's Exchange, including whether to create a separate exchange for the small group market; whether to engage in selective contracting; and how to design the navigator program. The Exchange will also evaluate how to build upon existing resources in the State, including insurance producers, third party administrators, health care advocates, and other relevant entities, to execute the required functions of the Exchange. The Exchange will make recommendations on these issues and others by early 2012.

Last month, Maryland was awarded an Innovator Grant of $6.2 million to develop several of the essential technical components for the Exchange, including the automatic confirmation of income and citizenship eligibility. The goal is to develop a seamless portal for individuals, small businesses and others to access coverage. Our

[9] See *http://www.hscrc.state.md.us/init_qi_MHAC.cfm* for more information on efforts to reduce preventable complications in Maryland hospitals.

proposal is based upon a successful eligibility pilot program currently underway in the State, and our goal is to develop an IT solution that will be compatible with a wide range of legacy eligibility systems. States including Arizona, Indiana, California, West Virginia, and Oregon provided letters of support for this application and will be collaborating with us as this effort moves forward.

CONCLUSION

Maryland is implementing the Affordable Care Act. Recently, Lt. Governor Anthony Brown delivered a keynote address in which he stated that the law provides the

> "opportunity to change the face of our health care system to better support the vitality and strength of our families, businesses, and communities . . . to expand wellness and prevention . . . to reduce hospital re-admissions and preventable complications . . . to expand health information technology . . . and to address health disparities and chronic disease."

He concluded: "Maryland intends to seize the moment and use the tools provided by the Affordable Care Act to build a better future for our State."

The CHAIRMAN. Thank you, Dr. Sharfstein.

Speaker Clark, welcome back to the committee. Please proceed.

STATEMENT OF THE HON. DAVID CLARK, UTAH STATE REPRESENTATIVE

Mr. CLARK. Thank you very much, Senator Harkin, Senator Enzi and my own Senator, Senator Hatch, and other Honorable Members of the distinguished committee.

Two years ago, I appeared before you to report how Utah's health reform efforts might inform the national health care debate. Since then, Utah has been moving forward to develop health insurance exchanges that is part of an overall strategy to inject elements of consumerism, information, choice, and accountability into health care, all with the goal of improving health status by increasing the availability of high-quality, affordable health insurance. I would like to report on these efforts and suggest some additional lessons that might be considered as implementation of the Affordable Care Act unfolds. As you know, Utah created the second of only two operating exchanges in the Nation.

We are indebted to our friends in Massachusetts who created the first exchange and were willing to teach us from their experience. I commend Congress for attempting to learn from both States. I am confident, however, that there is still much to learn from all 50 States and the Federal Government's work to implement the ACA.

We are moving into unchartered territory. Next week will mark 1 full year since the Affordable Care Act was signed into law. During the past week—excuse me—during the past year, States, led by officials from both sides of the aisle, have implored Members of Congress and the Administration to allow significant State flexibility on issues ranging from public programs to the State health insurance exchanges. Although the language of the ACA is quite prescriptive, it does not specify everything. My plea to you today is for help to ensure that as the ACA is implemented, that the U.S. Department of Health and Human Services uses a light touch and resists the temptation to fill too many of the missing details. Those missing details provide policy space for flexibility—State flexibility, the kind of flexibility that will allow an innovation so very necessary to accomplish the legislation's laudable, but complex goals. Urging States to experiment on competing approaches to solve the Nation's coverage problems, building on considerable State innova-

tion already underway, is far more likely to lead to real improvement than the one-size-fits-all approach currently in the ACA.

For instance, prior to the advent of PPACA, Utah undertook a number of efforts aimed at reforming the health care system to better respond to our State's unique business and demographic needs.

As we gathered data to develop an accurate picture of our uninsured population, we found that most of our uninsured population were employed and most work for small businesses, many of which did not offer health insurance benefits. Like most States, the vast majority of Utah's businesses are small businesses, and only about 44 percent of those small businesses were offering health insurance coverage. In addition, a great number of the uninsured were the young immortals, those between the ages of 18 and 34, who are employed and generally in good health but who tend to view traditional health insurance coverage as either unnecessary or too costly. It was clear to us early on that in order to reduce the uninsured population we needed to find a way to make insurance coverage more accessible and attractive to small employers and employees of small business, and even to the so-called young immortals.

To that end, we pursued changes in our insurance market that would provide more cost predictability for businesses, thereby creating an incentive for employers currently offering benefits to continue to do so, as well as creating a way for employees who are not offered insurance coverage to access group plans. As part of our health system reform efforts, Utah's small businesses now have an option of using a defined contribution model for their health benefit offerings.

Health care, as a defined benefit, left businesses with unpredictable and ever-escalating costs. Through access to Utah's new defined contribution market, employers can manage and contain their health benefit expenditures. With the creation of the Utah Health Exchange, Utah employees also benefit from expanded access, choice, and control over their health care options.

Rather than the traditional one-size-fits-all approach inherent in a defined benefit model, employees can now use the defined contribution model from their employers to shop for health insurance tailored to their individual needs and circumstances.

After the planning phase of 2009, and the demonstration pilot phase in 2010, the Utah Health Exchange is now fully operational. It's worth noting that all groups participating in the pilot chose to renew coverage in the exchange in 2011. In addition, when the Utah Exchange was fully launched in September 2010, 31 additional employer groups enrolled for coverage effective January 1, 2010. Seventeen additional employer groups enrolled in February. We now have approximately 83 employer groups that are getting coverage through the Utah Health Exchange, bringing the total number of individuals covered in the Utah Health Exchange to more than 2,500 in our first 4 months of effective coverage in full launch.

We are now running a fully-functional exchange for the small employer market after a 15-month pilot and various adjustments. Since the pilot was opened at the end of last year, small employer group enrollment and employers of covered life has grown on an average of 43 percent per month.

What does the Utah Health Exchange offer that hasn't been offered before? First, in the Exchange, employees participating—employers have an opportunity to select from the many health plans rather than just the one, two, or three that employers may have previously offered or perhaps not offered at all.

Currently, we have over 100 insurance plans that are offered to small employers in the exchange.

Second, the defined contribution arrangement. The Exchange allows health insurance benefits to provide through a defined contribution model rather than a defined benefit model, much as is now done in many of the retirement plans throughout the Nation.

Employers participating in the Exchange will have to continue funding premiums at levels sufficient to meet existing employees' participation requirements.

And third, we will continue to develop the Exchange, to incorporate some of the features required under ACA; availability of information necessary for consumers to evaluate the performance of insurers in their plans, and the links to public programs.

The Exchange will allow consumers to aggregate premium contributions from multiple employers. This includes contributions from multiple employers of an individual and employers from multiple individuals within a household.

Bear in mind that participation in the Utah exchange is 100 percent voluntary both by the insurance carriers and the employers. It involved no new mandates, no new regulatory features, and no new assessments against carriers for funding purposes.

Perhaps most significantly—let me stress—our figures indicate that 20 percent of the businesses participating in our defined contribution market through the Utah Health Exchange were not previously offering coverage; thus we can safely assume that many of these now covered through the exchange were previously counted among our uninsured population.

An intrinsic flaw of the ACA is that it fails to unleash the potential of States to innovate in designing reforms that respond to their own unique circumstances.

Recently, in a response to the unyielding call from States for increased flexibility, Senator Ron Wyden and Senator Scott Brown introduced Senate bill 3958, otherwise known as the Wyden-Brown. The bill would accelerate, from 2017 to 2014, the date when States will apply to the Secretary of Health and Human Services for a waiver as detailed in Section 1332 of the ACA.

If successful, a State would remain eligible to receive Federal dollars that would otherwise go to premiums or co-payment subsidies for plans in the insurance exchanges as well as tax credits for small businesses, but, instead, use that money to help fund alternative approaches to reaching coverage objectives within ACA.

Under the provision, States would have to demonstrate to the Secretary that, under the State alternative, at least as many individuals would be covered as under ACA, that the coverage was at least as good as was required under the ACA, and affordable to individuals. In addition, the State proposed alternative would have to be budget-neutral for the Federal Government. While I applaud the efforts of Senators Wyden and Brown, I must point out that the

bill is woefully insufficient in terms of granting States meaningful flexibility.

First of all, let me be clear, States were never invited to the table to give input on health care reform as this legislation is being fleshed out. It is frankly difficult for me to imagine that HHS would reverse its course and grant waivers to enhance or repeal any number of ACA provisions under the current Administration.

The Secretary has ultimate waiver authority and it's unrealistic, I think, to expect HHS to grant waivers for alternatives for which they disapprove.

Second, States must still guarantee generous and expensive levels of benefits that go well beyond basic benefits. And since the Secretary defined what constitutes, "at least as comprehensive" is, a State has no guarantee that the waiver would be granted, even if plans for the State-proposed alternative have the same actuarial value as specified in the ACA.

I think it's worth remembering that we are, indeed, the United States of America, and rarely in history have States been more united than they have been now in this message to Washington. One-way flexibility is, really, no flexibility at all.

Congress and the Administration needs to pay more attention than just lip service to that flexibility.

Third, States would be unable to include other health programs into their waiver request. For instance, provisions associated with Medicaid and the SCHIP would not be waived under Wyden-Brown; therefore, State-based alternatives to the enormous Medicaid expansion prescribed in ACA, a particular source of anguish for governors and legislators alike not addressed under Wyden-Brown bill.

And, finally, Wyden-Brown pits theoretical success against actual achievement. Estimates are, at best, educated guesses; and even the most educated guesses can be off. For instance, the initial estimates from the Congressional Budget Office indicated the cost to States for the Medicaid expansion would be about $20 billion.

Recently, however, the Joint Congressional Report prepared by the Senate Finance Committee and the Senate Energy and Commerce Committee estimated that to be six times higher, closer to $118 billion. We can only assume that the estimates regarding the number of people covered under the ACA and the level of affordability promises are not guaranteed, and thus, should not be used as a standard by which State alternatives are measured.

The Wyden-Brown legislation falls short and thus not allow States sufficient flexibility to make meaningful changes, nor will it neutralize serious opposition for various parts of the ACA. To accomplish both through a waiver approach, the States must be allowed to include State-funded Federal programs such as Medicaid and SCHIP as part of the waiver.

This would, of course, require Congress to grant States the option of exempting States from certain plans, including those proposing changes in Medicaid from certain statutory provisions of existing programs. It would also require——

The CHAIRMAN. Mr. Speaker, I want to be respectful, but can we wrap it up?

Mr. CLARK. May I just have 2 minutes, and I promise to be done.

Rather than trying to impose a national solution, Congress should give strong encouragement to the States to take the lead, allowing them to advance alternative proposals and renewed States that achieve the goal of improved health care coverage. That is not a partisan issue or an ideological debate; rather, it is about how best and most efficiently to serve the diverse populations and the different geographies that are about designing State-specific solutions to address State-specific challenges.

In Utah, we have chosen a path of business consumer-oriented health system reform which responds to Utah's needs, and we are making significant progress.

Congress and the Administration should recognize this and remove the barriers to increase success for the States.

To reiterate the point I wish to make today, that in order for true reform to occur the Federal Government must maximize the policy space available for innovation.

Let me make an analogy in closing. Like successful gardening, successful innovation requires fertile soil. The fertile soil of innovation is mutual understanding and cooperation among the stakeholders, free of the weeds of restrictive regulations that choke new and untried ideas.

It is the kind of soil that has to be cultivated and protected. It doesn't appear by itself. If Congress and HHS are not extremely careful, the seeds of Federal policymaking sown under the ACA will rather quickly fill in what little space is available left to States and choke the innovations that are envisioned by the ACA, and which history suggests are much more likely to occur only as a result of experimentation on the State level.

These innovations include payment and delivery reform, innovations like episode of care payments, accountable care organizations, and etc.

The Federal Government, like a wise gardener, should be patient and focus on developing the proper conditions for State-level innovation. It cannot force innovation to grow. Innovation takes cooperation, and cooperation takes time.

Taking the gardening analogy a bit further, the ACA in recognition that the traditional heirloom varieties of health care delivery are no longer sufficient to meet the needs of our country. In their place must be developed new, hybrid varieties that will yield more outcomes at lower cost for people.

Wisdom indicates that States will be given enough time to rise to the opportunities, and enough flexibility will experiment and will develop these hybrids.

In closing, there are many issues related to the development of exchanges that must be addressed within the next 2 years: Determination of essential benefits packages, establishing risk adjustment and other mechanisms to address the potential of adverse selection, standards for plan participation, determination of initial and ongoing individual eligibility, administration of subsidies, coordination with public coverage programs, governance, and etc.

And each of these issues should be addressed with the idea that perhaps we won't get it 100 percent right the first time. We are moving into unchartered territory that requires the humility and

restraint to allow one another space to incrementally innovate and learn from our experiences.

If HHH rushes in, rather than allowing ACA to evolve over time with significant State experimentation and feedback, we run the very real risk that many of the misaligned financial incentives that account so much for inappropriate consumption today will be locked in further and will be that much more difficult to fix in the future.

Thank you. I appreciate your patience. Thank you.

[The prepared statement of Mr. Clark follows:]

PREPARED STATEMENT OF REPRESENTATIVE DAVID CLARK

SUMMARY

Prior to PPACA, in 2009–10, Utah created the Utah Health Exchange—to make insurance coverage more accessible and attractive to small businesses and employees of small business. Utah small businesses can now manage and contain health benefit expenditures through a new defined contribution market, and Utah employees, many of whom were previously uninsured, now benefit from expanded access, choice, and control over their health care options.

The Utah Health Exchange currently gives Utah small business employees more than 100 plan choices, all of which retain the pre-tax and guaranteed-issue advantages of traditional small group insurance. Demonstrated and piloted over 15 months in 2009–10 the Utah Health Exchange is now fully operational with approximately 83 employer groups getting coverage through the Utah Health Exchange. As of April 1, the total number of individuals covered in the Utah Health Exchange reached 2,500 in the first 4 months of effective coverage. Since it was piloted last year, small employer groups enrollment and covered lives has grown on average by about 43 percent per month. Utah's exchange is 100 percent voluntary by both the insurance carriers and the employers. Unlike PPACA, it involved no new mandates, no new regulatory features, and no new assessments against carriers for funding purposes.

Because States were never invited to the table to give input on health care reform as that legislation was being fleshed out, an intrinsic flaw of the PPACA is that it fails to unleash the potential of States to innovate in designing reforms that respond to their own unique circumstances, like Utah's Health Exchange. In response to the unyielding call from States for increased flexibility, Senators Ron Wyden (D–OR) and Scott Brown (R–MA) have now introduced Senate bill 3958, otherwise known as Wyden-Brown, that would accelerate, from 2017 to 2014, the date when States may apply to the Secretary of Health and Human Services (HHS) for a waiver as detailed in section 1332 of the PPACA.

The Wyden-Brown legislation falls short by not allowing States sufficient flexibility to make meaningful changes: (1) States must still guarantee a generous and expensive level of benefits that go well beyond basic benefits. (2) States have no guarantee a waiver would be granted, even if plans in the State-proposed alternative have the same actuarial value as those specified in the PPACA, since the Secretary defines what constitutes "at least as comprehensive" is. (3) The States would be unable to include other costly health programs into their waiver request. Therefore, State-based alternatives to the enormous Medicaid expansion prescribed under PPACA (a particular source of anguish for governors and legislators alike) could not be addressed under Wyden-Brown.

In Utah, we have chosen a path of business- and consumer-oriented health system reform which responds to Utah's needs and we are making significant progress. Congress and the Obama administration should recognize this and remove the barriers to increase success for all States.

Senator Harkin, Senator Enzi, and other Honorable Members of this distinguished committee.

Two years ago, I appeared before you to report how Utah's health reform efforts might inform the national health care debate. Since then, Utah has been moving forward to develop a health insurance exchange that is part of an overall strategy to inject elements of consumerism—information, choice, and accountability—into health care, all with the goal of improving health status by increasing the availability of high-quality, affordable health insurance. I would like to report quickly on

this effort and suggest some additional lessons you might consider as implementation of the Affordable Care Act unfolds.

As you know, Utah created the second of only two operating exchanges in the Nation. We are indebted to our friends in Massachusetts who created the first exchange and were willing to teach us from their experience. I commend Congress for attempting to learn from both States. I am confident, however, that there is still much to learn as all 50 States and the Federal Government work to implement the ACA. We are moving into unchartered territory.

Next week will mark 1 full year since the Patient Protection and Affordable Care Act (PPACA) was signed into law.[1] During the past year, States, led by officials from both sides of the aisle, have implored Members of Congress and the Obama administration to allow significant State flexibility on issues ranging from public programs to State health insurance exchanges.

Although the language of the ACA is quite prescriptive, it does not specify everything. My plea to you today is for help to ensure that as the ACA is implemented, the U.S. Department of Health and Human Services uses a light touch and resists the temptation to fill in too many of the missing details. Those missing details provide policy space for flexibility—the kind of flexibility that will allow for the iterative innovation so very necessary to accomplish the legislation's laudable, but complex goals.

Urging States to experiment with competing approaches to solve the Nation's coverage problems, building on the considerable State innovation already under way, is far more likely to lead to real improvement than the one-size-fits-all approach represented by PPACA.

For instance, prior to the advent of PPACA, Utah undertook a number of efforts aimed at reforming the health care system to better respond to our State's unique business and demographic needs. As we gathered data to develop an accurate picture of our uninsured population, we found that most of our uninsured population were employed and most work for small businesses, many of which did not offer health insurance benefits. Like most States, the vast majority of Utah's businesses are small businesses and, only about 44 percent of those small businesses were offering health insurance coverage. In addition, a great number of our uninsured were "young immortals"—those between the ages of 18–34 who are employed and in general good health but who tend to view traditional health insurance coverage to be either unnecessary or too costly.

It was clear to us early on that, in order to reduce our uninsured population, we needed to find a way to make insurance coverage more accessible and attractive to small employers and employees of small business, even the so-called young immortals. To that end, we pursued changes to our insurance market that would provide more cost predictability for businesses, thereby creating an incentive for those employers currently offering benefits to continue doing so. As well as creating a way for employees who are not offered coverage to access group plans.

As part of our health system reform efforts, Utah small businesses now have the option of using a defined contribution model for their health benefit offerings. A defined health benefit left businesses with unpredictable and ever-escalating costs. Through access to Utah's new defined contribution market, employers can manage and contain their health benefit expenditures. With the creation of the Utah Health Exchange, Utah employees also benefit from expanded access, choice, and control over their health care options. Rather than the traditional one-size-fits-all approach inherent in the defined benefit model, employees can now use the defined contribution from their employers to shop for health insurance tailored to their individual needs and circumstances. The Utah Health Exchange currently gives Utah small business employees more than 100 plan choices, all of which retain the pre-tax and guaranteed-issue advantages of traditional small group insurance.

After the planning phase in 2009, the demonstration pilot phase in 2010, the Utah Health Exchange is now fully operational. It is worth noting that *all* the groups who participated in the pilot chose to renew renewed coverage in the exchange for 2011. In addition, when the Utah Health Exchange was fully launched in September 2010, 31 additional employer groups enrolled for coverage effective January 1, 2010, 17 additional employer groups enrolled for coverage beginning February 1, and approximately 83 employer groups were getting coverage through the Utah Health Exchange as of April 1, bringing the total number of individuals covered in the Utah Health Exchange to more than 2,500 in the first 4 months of effective coverage following the full launch. We are now running a fully functional exchange for the small employer market after a 15-month pilot and various adjust-

[1] The Patient Protection and Affordable Care Act (PPACA) was signed into law on March 23, 2010.

ments. Since the pilot was opened at the end of last year to all small employer groups enrollment of employers and covered lives has grown on average by about 43 percent per month.

What does the Utah Health Exchange offer that hasn't been offered before?

First, choice. In the Exchange, employees of participating employers have the opportunity to select from many health plans rather than the one, two, or three plans their employers may have previously offered or perhaps not offered at all. Currently, over 100 plans are offered to small employer groups in the Exchange.

Second, a defined contribution arrangement. The Exchange allows health insurance benefits to be provided through a defined contribution model rather than a defined benefit model, much as is now done with many retirement benefits. Employers participating in the Exchange will have to continue funding premiums at levels sufficient to meet existing employee participation requirements.

And third, as we continue to develop the Exchange, it will incorporate some of the features required under the ACA—availability of information necessary for consumers to evaluate the performance of insurers and their plans, and links to public programs.

The Exchange will also allow consumers to aggregate premium contributions from multiple employers. This includes contributions from multiple employers of an individual and employers of multiple individuals within a household.

Bear in mind that participation in Utah's exchange is 100 percent voluntary by both the insurance carriers and the employers. It involved no new mandates, no new regulatory features, and no new assessments against carriers for funding purposes. Perhaps most significantly, our figures indicate that 20 percent of businesses participating in our defined contribution market through the Utah Health Exchange were not previously offering coverage, thus we can safely assume that many of those now covered through the exchange were previously counted among our uninsured population

An intrinsic flaw of the PPACA is that it fails to unleash the potential of States to innovate in designing reforms that respond to their own unique circumstances. Recently, in a response to the unyielding call from States for increased flexibility, Senators Ron Wyden (D–OR) and Scott Brown (R–MA) introduced Senate bill 3958, otherwise known as Wyden-Brown. That bill would accelerate, from 2017 to 2014, the date when States may apply to the Secretary of Health and Human Services (HHS) for a waiver as detailed in Section 1332 of the PPACA. If successful, a State would remain eligible to receive Federal dollars that would otherwise go to premium and copayment subsidies for plans in the insurance exchanges as well as tax credits for small businesses but, instead, use that money to help fund alternative approaches to reaching the coverage objectives of the PPACA.

Under this provision, the State would have to demonstrate to the Secretary that, under the State alternative, at least as many individuals would be covered as under PPACA, that the coverage was at least as good as that required under the PPACA, and as affordable for individuals. In addition, the State proposed alternative would have to be budget-neutral for the Federal Government.

While I applaud the efforts of Senators Wyden and Brown, I must point out that the bill is woefully insufficient in terms of granting States meaningful flexibility.

First of all, let me be clear, States were never invited to the table to give input on health care reform as that legislation was being fleshed out. Thus, assuming President Obama is re-elected in 2012, it is frankly difficult for me to imagine that HHS would reverse its course and grant waivers that, in essence, repeal a number of PPACA provisions the current Administration vigorously supports. The Secretary has ultimate waiver authority and it is unrealistic to expect HHS to grant waivers for alternatives of which they disapprove.

Second, States must still guarantee a generous and expensive level of benefits that go well beyond basic benefits. And since the Secretary defines what constitutes "at least as comprehensive" is, a State has no guarantee a waiver would be granted, even if plans in the State-proposed alternative have the same actuarial value as those specified in the PPACA. One way flexibility is, essentially, no flexibility at all. Bear in mind that States, unlike the Federal Government, must balance their budgets each year.

Third, States would be unable to include other health programs into their waiver request. For instance, provisions associated with Medicaid and the State Children's Health Insurance Program (SCHIP) could not be waived under Wyden-Brown; therefore, State-based alternatives to the enormous Medicaid expansion prescribed under PPACA (a particular source of anguish for governors and legislators alike) could not be addressed under Wyden-Brown.

Finally, Wyden-Brown pits theoretical success against actual achievement. Estimates are, at best, educated guesses; and even the most educated of guesses, can

be off. For instance, initial estimates from the Congressional Budget Office indicated the cost to the States for the Medicaid expansion would be about $20 billion. Recently, however, a Joint Congressional Report prepared by the Senate Finance Committee and the House Energy and Commerce Committee[2] estimated that cost at closer to $118 billion. We can only assume the estimates regarding the number of people covered under PPACA and the level of affordability promised are not guaranteed and thus, should not be used as a standard against which State alternatives are measured.

The Wyden-Brown legislation falls short and thus will not allow States sufficient flexibility to make meaningful changes, nor will it neutralize serious State opposition to various parts of the PPACA. To accomplish both through a waiver approach, the States must be allowed to include State-Federal programs such as Medicaid and SCHIP as part of the waiver. This would, of course, require Congress to grant States the option of exempting State reform plans (including those proposing changes to Medicaid) from certain statutory provisions of existing programs. It would also require that HHS not be allowed to reject a waiver simply because it did not square with the partisan goals or ideological leanings of whatever administration happens to occupy the White House.

Rather than trying to impose a national solution, Congress should give strong encouragement to the States to take the lead, allowing them to advance alternative proposals and reward States that achieve the goal of improved health care coverage. This is not a partisan issue or an ideological debate; rather, it is about how to best and most efficiently serve diverse populations and different geographies and about designing State-specific solutions to address State-specific challenges.

In Utah, we have chosen a path of business- and consumer-oriented health system reform which responds to Utah's needs and we are making significant progress. Congress and the Obama administration should recognize this and remove the barriers to increase success for all States.

To reiterate to the point I wish to make today—that in order for true reform to occur the Federal Government must maximize the policy space available for innovation, let me use an analogy.

Like successful gardening, successful innovation requires fertile soil. The fertile soil of innovation is mutual understanding and cooperation among stakeholders, free of the weeds of restrictive regulations that choke new or untried ideas. This kind of soil has to be cultivated and protected, it doesn't appear by itself. If Congress and HHS are not extremely careful, the seeds of Federal policymaking sown under the ACA will rather quickly fill in what little policy space has been left to States and choke the innovations envisioned by the ACA and which history suggests are most likely to occur only as the result of experimentation at the State level. These innovations include payment and delivery reform innovations like episode of care payments, accountable care organizations, etc. The Federal Government, like a wise gardener, should be patient and focus on developing the proper conditions for State-level innovation. It cannot force innovation to grow. Innovation takes cooperation, and cooperation takes time.

Taking the gardening analogy just a bit further, the ACA is recognition that the traditional, heirloom varieties of health care delivery are no longer sufficient for the needs of our country. In their place must be developed new, hybrid varieties that will yield better outcomes at lower cost to more people. Wisdom dictates that States be given enough time to rise to their opportunities, and enough flexibility to experiment in developing these hybrids.

In closing, there are many issues related to the development of exchanges that must be addressed over the next 2 years—determination of essential benefits packages, establishing risk adjustment and other mechanisms to address the potential for adverse selection, standards for plan participation, determination of initial and ongoing individual eligibility, administration of subsidies, coordination with public coverage programs, governance, etc. Each of these issues should be addressed with the idea that we won't get it 100 percent right the first time. We are moving into unchartered territory that requires the humility and restraint to allow one another space to incrementally innovate and learn from our experiences. If HHS rushes to figure out too many details up front, rather than allowing ACA to evolve over time with significant State experimentation and feedback, we run the very real risk that many of the misaligned financial incentives that account for so much inappropriate

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[2] Joint Congressional Report by Senate Finance Committee, Orrin Hatch (R–Utah), Ranking Member and House Energy and Commerce Committee, Fred Upton (R–Michigan), Chairman. Medicaid Expansion in the New Health law: Cost to the States. March 1, 2011. *<http://energycommerce.house.gov/media/file/PDFs/030111MedicaidReport.pdf>*.

consumption today will only be locked in further and will be that much more difficult to fix in the future.

Thank you.

The CHAIRMAN. Thank you, Speaker Clark for a 15-minute presentation. Thank you.

Speaker Clark, I'll start with you. First of all, you have said in your statement that there were no State inputs into the development of the Affordable Care Act. On the other hand, you were here 2 years ago to testify on that.

I also make the point that Senate and House Committees heard testimony from a total of 20 State representatives; there were 11 congressional hearings that included State representatives during the health reform preparation; so, Speaker Clark, you yourself testified here 2 years ago before we developed this legislation. As I said, we had a lot of State input into the development of this.

I want to move ahead to the exchanges, though. I would congratulate you and Utah on setting up your exchange. It seems like, again, this was one of the ways that we believe in developing the Affordable Care Act that we could secure coverage for more people, and involve small businesses. You mentioned the number of small businesses had gone up—I forget the percentage—quite a bit, in your State. Is it not also true that this year, small businesses were given tax credits of the Affordable Care Act, to enroll their people in health insurance plans, and that's true in Utah, is it not?

Mr. CLARK. That is true.

The CHAIRMAN. So, they got tax credits, and I can assume that also encouraged them to sign up on the exchange.

Mr. CLARK. I would support that statement.

The CHAIRMAN. I thank you very much. Now, let me ask you one question, though: I'd like to know how—Utah got $1 million grant to expand and improve its exchange; what was that used for? How did you implement that, or how did Utah implement that money?

Mr. CLARK. We are still in the process of implementing that. Let me give you just a little genealogy: I mentioned in my opening remarks I'm very thankful for the partnership that Massachusetts shared—having their exchange up and running.

We went back and they were very gracious to tell us what they would do again, if they had to do it over, and what they would never do again if they had to do it over, and it was very helpful in building our exchange.

The diversity of how our exchange functions after that, though, are quite stark. They spent $25 million in creating and developing theirs; we spent $600,000 in developing and creating our particular exchange. Ours is actually more of a farmers' market entitled for people to bring their wares, and folks to come who are interested in purchasing.

We've organized our market and used the money that we had here to get an online system that will have side-by-side comparisons of up to four plans; can go as detailed as folks like, in allowing businesses and employers to shop on that online farmers' market. We think that's important in bringing competitive forces available to that site.

As I mentioned, there is no—in our $600,000 that we spent in creating our—there is no off-the-shelf exchange that you go buy.

We had to create what we could, and not having much in the way of a type of checkbook that Massachusetts has from a State level, we had to try and do this a little bit on the cheap. We looked around to try and find innovative ways within the private market that would come and partner with us and put our exchange together.

We found a company in Chicago to help do some of the organization and underwriting and the coordination of that. We found a company, actually, right in our Salt Lake Valley to help us with the financial portion of this; and were critical in putting those things together.

The robustness of ours, as we begin to expand, we need to find—and that's what this $1 million is looking to do, is to try and help us organize from where we have our beginning stages to those next steps.

The CHAIRMAN. That's what you're doing with the $1 million is expanding the exchanges?

Mr. CLARK. Yes. We've built our exchange under our—as I mentioned—with our own, and now this is trying to see what we can do to try and expand the program and make it more functional and operational.

As we grow, we're going to need to do that.

The CHAIRMAN. I wanted to get to Commissioner Praeger. I wanted to ask a question.

You mentioned a number of insurance companies now in your exchange. Did Utah mandate any essential benefits package?

Mr. CLARK. We have a defined statute in essential benefit package, but we did not mandate that. What we did was require the insurance companies that want voluntarily to come to our exchange, and we have about 80 percent of the marketplace that comes to that. We've told them, we want you to bring your five most common plans that you offer. And, we did define three different tiers of plans. We modified this last legislative session into two that you must show on here so we have some actuarial comparisons that you can compare price to price to dollar amount.

Beyond that, the companies have volunteered and brought well in excess of probably another 80 plans, plus, that they would like to sell on the exchange.

The CHAIRMAN. But—again, the State did not mandate an essential benefits package for anyone coming on the exchange; is that right?

Mr. CLARK. No.

The CHAIRMAN. No. I just wanted to make that clear. I did not know.

Senator Enzi.

Senator ENZI. Thank you, Mr. Chairman.

Ms. Praeger, you mentioned a concern that I think is a very viable concern about the effect that the multi-State plans and the co-ops could have on driving business out of the State; do you think there is any possibility that those in-State companies—and what would be the effect if those in-State companies were given the same privilege as the multi-State plans and the co-ops?

Ms. PRAEGER. Senator Enzi, as you know from the work you did several years ago—on looking at common, small-group plans across

the States—it's very difficult to look at State legislatures and say we're going to standardize these plans, and, oh, by the way, the benefits that you've put in place may not be there because we want a level playing field.

You need a level playing field. The plans, if they are going to be offered across the States, are going to end up States wanting to enter into compacts, interstate compacts, then they will have to come to the table; and the law allows for that kind of flexibility. They will have to come to the table and determine the level of benefits, but also the rest of the market rules.

If you begin to segment the market and allow some plans to compete with one set of rules, and other plans to compete with another set of rules, you do get market segmentation which encourages adverse risk, which really could create problems.

That's the way we've advocated level playing fields, same rules across the States.

Senator ENZI. I wanted to be sure that was emphasized a little bit more. I think it's something that's been lost in the discussion.

Now you also mentioned a big concern that if a large number of carriers exit the marketplace, particularly prior to 2014 competition will suffer and availability of coverage will be a concern.

Have you seen carriers leave the market place in Kansas or other States?

Ms. PRAEGER. We have not yet. We, of course, just will continue to monitor that.

The concern would be that if carriers do exit, and people lose their coverage, and right now, they have coverage, they can keep it, even if they have pre-existing conditions; with the guaranteed renewability, but if they lose their coverage and you don't have guaranteed issue, then they potentially would not have any place to go, except our State high-risk pool until 2014; and then we have a guaranteed issue and no pre-existing condition exclusions.

But we have not seen a problem, at least in my State yet, and I think nationally, so far we've not experienced dramatic changes in markets.

Senator ENZI. That may change as we get this Federal benefits package.

Mr. Clark, as Senator Harkin pointed out, you testified 2 years ago before the new law was enacted; and based on what you've seen in the new law, do you think the authors of the law actually listened to what you said when you were here, and did that incorporate your views into the law?

Mr. CLARK. I'm frustrated.

Senator ENZI. Thank you. I am too. I kept hearing the President say, if anybody had any ideas please give them to him. I've got a raft of ideas that I've had there, most of which don't show up in the law at all.

Earlier, we heard testimony from Mr. Larsen that this exchange is going to be a free market. Is a free market something where people have to meet a minimum standard before they can be in it, or they can be in it and have asterisks to say that they're missing something?

It seems to me like if you exclude people, you don't truly have a free market.

Mr. CLARK. I think that's a very accurate statement. I very much appreciate the guidance.

While the rule has not been written, HHS has issued a guidance statement that said that both Utah and Massachusetts are kind of bookends of this process, and States should look at those. Our process, we elected very early on. Rather than having the State select winners and losers in the insurance program or the brokers that are selling, and which programs the State negotiates with, we would allow an existing system. Because we have high quality and fairly low costs in Utah, a system already working, that we would allow the market in the existing distribution systems just to be the model by which we would use regular market forces and not impose governmental forces in that market.

Senator ENZI. Wyoming, of course, borders on Utah, and, a whole lot of people, particularly in southeastern Wyoming get their health care in Utah. Is there any provision where they can get their insurance through your exchange instead of through Wyoming?

Mr. CLARK. We have not ventured into crossing State lines yet in Utah, or exchanges. As I mentioned, we've used the old carpenter rule, you measure the board twice and cut once. We've tried to do this very demonstration I mentioned.

We have a good system in the State of Utah. We didn't want to have an adverse impact of that.

If I might just mention one thing about the essential benefit package, I do have some concerns while you're talking about market forces.

The geography of the essential benefit packages and the Department of Labor doing a nationwide survey, if they aggregate all of those into those areas of us that have a good working system, I'm deeply concerned. There are 60 different mandates in the different States that are required of insurance companies. Not every single State has 60. Some are in the single digits; some are in the twenties and thirties in those mandates.

As you begin looking at trying to find what the essential benefit package is and you work on averages, there are those of us that have low mandate States that feel like we're functioning well, we'll be required to raise up our essential benefits. Every time you have a mandate, you're going to add an additional cost to this program.

We've asked, in the main testimony in front of the Institute of Health, to allow HHS to do a three-tier program. Do one state-by-state; determine what the essential benefits or the average plan is of each State, and then try and let that be the essential benefit for that State. If there are areas over and above, the HHS would like to be involved in, allow States optionally, based upon sound science, to accept each one of those mandates, still within the framework that the Federal Government says it would offer assistance for.

And, then a third tier would be States from beyond that. Let States decide whether they want to pay that themselves and not be involved in looking at any additional subsidies for those mandates.

Senator ENZI. Thank you. I've got some more questions that deal with mandates too, and I hope all of you—and I'm sorry, Mr.

Sharfstein that I didn't get to questions. I have questions, and I'll be submitting those so we can get some——

The CHAIRMAN. I intend to have another round. I have some more questions.

Senator ENZI. I have to go to a meeting.

The CHAIRMAN. Oh, I'm sorry.

Senator Franken.

Senator FRANKEN. Thank you, Mr. Chairman.

I'm sorry I wasn't here for your oral testimony. I read it last night. But, Senator Blumenthal and I were in a judiciary committee.

Dr. Sharfstein, I know that efforts are underway in Maryland as they are in Minnesota and all over the country, to implement and oversee the medical loss ratio. As you oversee this process, how do you see the medical loss ratio bringing higher value care to residents of Maryland?

Dr. SHARFSTEIN. Thank you. Maryland has slightly different rules for medical loss ratio than the Federal rules, and I'm in the small group market, and talking to our acting insurance commissioner, she felt that they're pretty much equivalent to the Federal rules. So, it's a pretty smooth transition there without really much expected in that market.

In the individual market the Federal rules are a little bit tighter, and so she's been monitoring this issue, and her view is that the companies are making the adjustment and that things are going well, that we'll have just an increased medical loss ratio in the individual insurance market, which means more of the premium dollar will be spent on medical care in Maryland.

Senator FRANKEN. So, that would, in your opinion, bring higher value care?

Dr. SHARFSTEIN. Correct.

Senator FRANKEN. I have a question for everyone, which is, the witness in the first panel talked about adverse selection.

This is open to anyone. How do you avoid adverse selection if some policies in the exchanges don't all have the same basic essential benefits?

Dr. SHARFSTEIN. I'm happy to start with that. One of the things that I said earlier is that we want the plan in the exchange to compete on how to provide the best care in the most cost-effective way. We don't want them to compete on the basis of how to pluck off the healthier people or, which services to cover so the families have to decide between the condition the child has and the condition the mother has, for example.

So, we think that having a standard of benefits is very important, for what I think we can describe as a fair playing field so that the competition is really happening on the right things.

Senator FRANKEN. Ms. Praeger.

Ms. PRAEGER. Yes. And, I would agree. I think having a level set of benefits will have four benefit options, potentially. Two have to be offered; the other two are not required to be offered on the exchange, so that will help.

But then there is also a provision that if a company gets adversely selected for whatever reason, and they end up with greater health care costs in their plan, there is a provision allowed for

rules yet to be developed for risk adjustment. So, those companies with higher risk will get some sharing of resources from companies that have less risk.

That also helps provide almost a community rating kind of a system, sort of modified by community rating, but it does allow for some risk sharing among the plans so that——

Senator FRANKEN. OK. Yes.

Mr. CLARK. There are two things we've done in the State of Utah to try and avoid that. One, there's still going to be a robust market outside the exchange, and there should be, so what you want to do is to make sure that the policies that are offered in the exchange are not different from those outside the exchange, so that one advantage is one over the other. There needs to be a commonality.

That took prescribed legislation—we learned from experience, opening, that that isn't going to happen, that they will advantage one or the other, so we came back, through our experience.

The second thing that we've done is that we had a risk adjuster board that is comprised of our insurance commissioner, some appointees from legislative side providing the officer appointments, and from the actual insurance companies that participate. They devise the rules by which that risk, if it does occur, how it will be distributed and how there is a true up after the end for financial consideration.

Our risk adjuster board has already tried to perceive all of the problems—its the players in the market using the tools by which they minimize that risk in their regular markets using that inside the exchange itself; in the advent that they do find there is adverse selection.

Senator FRANKEN. Thank you. Thank you, Mr. Chairman.

The CHAIRMAN. Senator Blumenthal.

STATEMENT OF SENATOR BLUMENTHAL

Senator BLUMENTHAL. Thank you, Mr. Chairman. I want to express my appreciation to you for holding this hearing on this occasion, on the 1-year anniversary to the Health Care Reform Law.

My first question—and I want to join in apologizing. We are often required to be in three places at one time, and can't possibly be, as I know you are required to be in a lot of places at one time. My apologies for being late, but, I did review your testimony.

I would like to ask Dr. Sharfstein: In your testimony, your conclusion is that health care reform will result in estimated savings of about $853 million over the next 10 years in the State of Maryland.

I wonder if you could provide some more details about this analysis, especially, more specifically, what provisions will provide the biggest cost savings and how they'll do it.

Dr. SHARFSTEIN. Sir, I can actually submit to the committee the independent analysis that reached that conclusion.

Senator BLUMENTHAL. That would be helpful.

Dr. SHARFSTEIN. It goes through a whole bunch of factors. It's a net savings. There's some things that increase cost and some things that decrease cost; and to give you an example, we have an uncompensated care system in Maryland, and you get savings because you no longer have to pay for uncompensated care.

That's one example. But there are a whole range of factors.

Senator BLUMENTHAL. That must be a major one, judging by the costs of uncompensated care.

Dr. SHARFSTEIN. Yes. It depends from—this analysis isn't a cookie cutter from State to State.

They looked a lot at the uniqueness of the Maryland system in developing the analysis.

But it was an independent look. It's about a 23-page report with a whole financial model. Parts of the model that were sort of found consistent by the Urban Institute, who had a similar type of thing for the effect of health care reform among coverage in Maryland.

Senator BLUMENTHAL. Are there any other major categories where you have cost savings that you could give us now?

Dr. SHARFSTEIN. Sure. The savings include and enhance the MAT rate for the CHIP Program, the fact that we won't have the high-risk pool to pay for anymore; a rate stabilization offset in Medicaid; certain programs that we won't have to pay for in the State for people with breast and cervical cancer, because they'll be able to get insurance; and the senior prescription drug assistance program, our expenses will be down because the health care coverage covers more medications for seniors. So, there are a whole range of savings to the State.

Having been a couple months on the job so far, I've met with people across the State and met with different groups involved in the health care, businesses, the Chamber of Commerce; people really see a lot of potential for this law. And, we're really focused in Maryland on accomplishing an effective implementation.

Senator BLUMENTHAL. May I ask the other witnesses—based on that sort of rough-cut summary of the areas where there will be savings in Maryland—whether similar savings would be realized in your States in those same categories?

Ms. PRAEGER. I think those general categories, yes. The uncompensated care, the high-risk pools, which will no longer be needed, and there's a re-insurance mechanism to help transition those folks into private coverage—Medicaid match. The numbers would be different in Kansas versus Maryland, but those general categories, I think we would probably see savings as well.

Mr. CLARK. In Utah we started our health care system reform 4 years ago, hoping to accomplish what those numbers are. I will tell you the numbers are elusive, and there are additions and there are subtractions as you go through that process. But, we are committed to try and find those that make sense.

Senator BLUMENTHAL. I have another area of questioning, which I'd like to raise and that concerns the enrollment in exchanges. Perhaps you could tell us, each of you, what is being done in your State to assure that consumers have the opportunity to receive the best plan, or to put it another way, to receive the best information to enable their choices to enroll in the best plan for them through the exchanges.

Ms. PRAEGER. Kansas is one of the States, and I think most States, or many States, receive the grants to assist us with our consumer outreach, in developing an ombudsman office, which we've established in our department.

We were given that flexibility. But I think it will be a very important component of implementing, especially implementing exchanges and getting the education out there. We'll have to work with a whole variety of entities.

We've put together a steering committee to help our process and we have the State Chamber of Commerce involved; we have provider groups; we have consumer groups; we have a whole range of individuals that will help us fan out and get the information out. But, it will require a lot of coordination and a lot of partners.

Dr. SHARFSTEIN. I would just say, in Maryland there's legislation to establish the exchange, and part of that is a system of advisory committees, and the exchange would look to the business community, consumer advocates and others to help us think through what would be the most meaningful way for information to be presented in the exchange.

There are a series of studies we'll have to do this year; and I'm sure that would be one of the topics covered. Our purpose is not going to be, I dream about the money that's going to be, it's going to be what matters to people in the world like that.

Mr. CLARK. All of the above, and the fact that we have a practical thing. We have an online site—Utah exchange, and folks can go online. It's about a 2-minute process for a business to sign up, for employees to go on and shop.

We tried to make this very user-friendly. We're using the existing distribution systems of brokers and agents in the State of Utah to sell this. And, all of the things I've mentioned here about partnering up with the local business communities, chambers, United Way, all of that distribution system to try and do this as effectively as we can, because we don't have a lot of extra money. We don't have a marketing budget in this program.

Senator BLUMENTHAL. Thank you. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Blumenthal.

Senator Hatch.

Senator HATCH. Thank you, Mr. Chairman. I appreciate that. Representative Clark, I understand that my friend, the Chairman, made a point that you were invited to testify to provide input—in other words, the States' input. Little did the States know that when they were being invited to dinner by the White House on Obama Care, they were on the menu.

Have they adopted any of the suggestions that you have made?

Mr. CLARK. I will say that the door has been mostly open when we've said these are things that we've experienced and want to learn, since the enactment of this with HHS, but we've seen not a lot of acceptance or flexibility in this process.

My only hope and prayer is that——

Senator HATCH. Did you say a lot of flexibility or a lot of inflexibility?

Mr. CLARK. We're asking for flexibility. We've not seen a lot.

Senator HATCH. Yes, well, it's interesting because Utah seems like it's running pretty well in health care; and you think the exchange has great potential and gradually will continue to build in numbers?

Mr. CLARK. I do. We've just begun our full-scale launch at the beginning of this year, and we can anticipate that there will be, not

just thousands, but tens of thousands by the end of the year, and exponentially over the next few years, as this information is shared and businesses are coming on line.

What's most exciting is that 20 percent of the people that are currently in the exchange, their companies did not offer insurance prior to having this tool in the tool chest.

Those are folks that we think have been uninsured, but they are effectively moving off the uninsured rolls.

Senator HATCH. If I interpret your statement correctly, it is under the principles of federalism you have 50 States, and it would be good to have 50-state input; and, the 50 different States all have different demographics; all have different problems; all have different approaches if they were allowed to do this.

Mr. CLARK. Just in comparison, because of the two exchanges, one in Massachusetts and one in Utah, 70 percent of the lives in Massachusetts are insured under Fortune 500 companies; larger risk of base models, that have an economy scale unprecedented that you don't see in our market.

We have a dominance—Minnesota is the only other State that has more part-time employees as a percentage of their workforce than Utah.

We are a State of small business; 80,000, two with 50 employees, small businesses, and we don't have the economy of skill. We have a different demographic and a different need, and our small businesses need the tools to meet those on a cost-effective measure.

We hope that the exchange has demonstrated it has that power to do that, and we'd like to be able to continue to go on the path.

Senator HATCH. You mentioned these young people who feel like they're not going to have to worry about health care, and therefore—either it's too expensive for them or they just don't want to buy it. If you had your way and there was a way of taking care of them, how would you do that?

Mr. CLARK. One of the things you need to do is try and look at the cost associated with it. One of the things that the ACA does is a 3 to 1 ratio. That means that the most expensive is only three tiers between the most expensive and the cheapest. So, you're asking the young folks to pay more of the cost of those of us that are the older folks category in covering that health care.

Instead of say, distributing that into a 5 to 1 ratio, you allow that process to have a more effective cost for those at the younger end of that, particularly, when financially, it's also sometimes an impediment for them at that level.

The structure of this is looking adversely, I think, to bring the young immortals into the system.

Senator HATCH. There might be some advantages in having a high deductible policy that are especially attuned to younger people who are basically healthy.

Mr. CLARK. I think very much so, to be able to have those as a tool in the tool chest is very important.

It also brings, another important concept: Two things that we've done in the State of Utah is—everything that we've done, we've had a litmus test of two items. One of them is trying to put market forces into place, and the second one is to have the individual be more accountable for their own health care and health care costs.

As long as I take my insurance from my employer, I have very little—if you think about it for a moment, all of your personal insurance, whether it be your auto insurance, your home insurance, if you have business insurance or life insurance, you own that insurance. The only insurance in your life you do not own is your health insurance. Somebody else owns it, and the incentive, according to that, are opposite of what they ought to be, to bring more individual accountability, whether it be through a health savings, high deductible plans, bringing—where I now have some say in the expenditure of those dollars, and had some accountability with those we think is bringing some of those market forces and individual accountability into the system and will improve it.

Senator HATCH. You really believe that the current—the so-called Affordable Care Act is going to be able to save money over the long run?

Mr. CLARK. I'm trying to race through a number of possibilities, and I'm more concerned about in the long run. We're already seeing what the first impacts of this is that the premiums are escalating at a higher rate than they were prior to this; so I'm not—well, it talks about predictable savings. Our experience right now on the ground is going in the opposite direction, and I don't see anything that's going to turn that ship around.

Senator HATCH. Some of my colleagues blame the insurance companies for that.

Mr. CLARK. I think as you have companies that try and manage risk, as you put more risk into the system, they're going to try to price accordingly.

Senator HATCH. Well, my time is up, Mr. Chairman.

Thank you.

The CHAIRMAN. Thank you, Senator Hatch.

Senator MIKULSKI. Thank you, very much, Mr. Chairman.

First of all, thanks to the entire panel. This was very informative, and very instructive.

I have a question for Dr. Sharfstein. I have several for all of you, but in the interest of time——

Dr. Sharfstein, let me go to the original idea of setting up exchanges, which was that it was going to be like a shopping mall so that small business people like my father (who was a small grocer, who didn't have access—he had to pay to buy insurance on the individual market)—that this was going to be like a shopping mall, where the good old people could go—small businesses, etc.—to see where they could get the best deal; and the best deal is defined either by price for them, or the best deal in terms of benefit package that suited the needs of their particular situation, or if you were an individual. So, if you were a sole proprietor like a florist, to a mid-sized business where you might own three dry cleaners.

Could you tell us now, as you've worked now to get an exchange set up, do you believe that as we're moving ahead, setting these exchanges up, that the original intent is going to work out the way you think? Or do I have a wrong understanding of how these exchanges would work, which is essentially, it would be a gateway, a portal for people who couldn't negotiate on their own—for the small market people, to really get good deals or best deals, depending on how you define it, for yourself or your employees?

Dr. SHARFSTEIN. Thank you. I do think that it will work out in—much like you just described. I think if you think of it, the analogy would be, maybe before the Internet how it would be if you wanted to buy something, you might have to call around to a bunch of places, you wouldn't—if you drove out there, they might not have any, and it was just a huge amount of time and effort to maybe try and buy a piece of equipment.

And, now on the Internet, you can go to sites and you can get the ratings; you can get the prices; you can very efficiently decide where the right place to buy something is.

The goal is for an exchange to be very consumer-friendly. I've heard the phrase that it should delight the consumer. People should be on the Web site and really be able to navigate and to understand what the different plans are and how they compare against each other.

So, that's very much our goal.

Senator MIKULSKI. Ms. Praeger, do you feel the same?

Ms. PRAEGER. I do. We probably couldn't have developed exchanges even 10 years ago. First of all, there wouldn't have been the confidence in purchasing on an Internet. There's the privacy issues that I think we've all grown accustomed to, going to the Internet to get information. I do believe that the exchange can be a good marketplace for people to get information, compare prices, compare quality of plans, and I think, perhaps for the first time, we'll have an individual market that can actually function, because you won't have pre-existing condition exclusions in the individual market, which has made it virtually impossible for some people to buy coverage. They're either not offered it, or it's priced so high that it's not affordable.

While there are many things that we want to continue to work with HHS on, in implementing, we certainly are grateful for the flexibility that States have in setting up their own exchange, and want to make sure that what we set up is easy for people to use and functions from an individual market standpoint as well as a small group.

Senator MIKULSKI. The policy goal is a good one.

Now, the Federal Government, Dr. Sharfstein, has given Maryland $6.2 million to set it up. What are you going to do with the money?

Dr. SHARFSTEIN. We have a $1 million planning grant, which we're going to use to hire some of the initial staff, do some of the assessments around the key technological and other issues in order to get the exchange started. We got a $6 million grant to establish some of the technological building blocks of the exchange, particularly around verifying whether people are eligible for different subsidies or for Medicaid.

We will be working with other States and a lot with the various components of Maryland State Government to move forward, both in the governance of the exchange and on the technical side.

Senator MIKULSKI. Am I right to say that we're looking—you talked a lot about cost savings—at universal access to get rid of or eliminate the high-risk pool? But, one of the things I noted that you're going to move—and something so important to Senator Harkin and to me, to move from volume-based medicine to value-based.

But, also you're implementing significant quality initiatives like the hand washing that came out of the famous Pronovost checklist and some of the recommendations from the Institute of Medicine.

Did you feel that it's not only market forces that will be able to contain and even lower costs, but these other significant, what we would call, public health initiatives, like quality initiatives, and also more efficient and better management of chronic illness?

Dr. SHARFSTEIN. Absolutely, and Dr. Pronovost at Johns Hopkins——

Senator MIKULSKI. In other words, the market and its disciplines, which are significant, are only one of the tools for cost containment in discipline.

Dr. SHARFSTEIN. Right. I think that's absolutely true. I view the Affordable Care Act as a set of tools for States that can combine with the State's own efforts. I don't think the Affordable Care Act gets the States off the hook. We have to do these kinds of public health initiatives.

We have to figure out how to change the way that health care is paid for and change the incentives; we have to do quality initiatives like the ones that are going on, and with the Affordable Care Act, it gives us some extra tools to do that that are very helpful, and it also creates more of a system so we can apply the tools we have across the whole system and have the tools we already have be more effective.

I think when I go around Maryland, one of my key messages is, we will succeed only insofar as we keep health care affordable, and the Affordable Care Act is an important set of tools for us, but we've got to keep moving forward on a whole bunch of other things to succeed.

Senator MIKULSKI. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Mikulski.

I must admit, I'm a little bit confused now. On the one hand, I've just heard from my friend, Senator Hatch—and he's been a friend of mine for 30-some years—say, Mr. Clark, something about the lack of flexibility; but then I read Commissioner Praeger's testimony and I read that there is a fair amount of flexibility.

Commissioner Praeger, I'm just reading your testimony; you said there's a fair amount of flexibility when it comes to exchange development, something that we advocated when this law was being developed—I assume we being the National Association of Insurance Commissioners.

Again, those are State people, so we did have input from the States.

You said, taking advantage of flexibility—most State's first concern is what policy goals they would like their exchange to accomplish.

You go on to say, many States are looking to create a transparent marketplace, to simplify the process of purchasing insurance coverage while providing consumers with the information they need to make informed comparisons between various options.

This is the so-called Utah model.

Other States are considering using the exchange to selectively contract with health insurance carriers in order to negotiate directly on behalf of consumers—the Massachusetts model.

This decision will help determine many of the other questions the States must answer in establishing their exchanges. Then you go on to say, there's a whole flexibility for States in the governance structure, that they choose to establish; they can house it in the existing State agency, a new agency, a quasi-governmental body, a nonprofit established by the State.

There's a lot of flexibility in how they're housed, the way they're run—and then you go on to list other ones.

I had here the flexibility for State-run exchanges, just a list of them.

States will determine which insurers are permitted to offer products in the exchanges; States can choose benefit rules that meet the needs of their citizens; consumer-driven health plans and health savings accounts will be available; States have discretion over Medicaid coverage; there's new funding to establish exchanges and modernize eligibility systems that's available. We talked about that. And, reliable, independent cost estimates are available.

It seems to me that when you said, Commissioner Praeger, it provides great flexibility for States when it comes to building the insurance way, you said a fair amount of flexibility. They can make the exchanges a sort of Expedia.com that's open to all comers or States can give the exchange more power to negotiate, as I just mentioned.

What are the factors that Kansas is considering in making this decision? You've got all this flexibility.

What are you considering in Kansas?

Ms. PRAEGER. We have a committee process that we've established through our department as the awardee of the Innovator Grant—the early Innovator Grant, and so we're seeking a lot of input on governance. This will be a legislative decision, but are we going to recommend that the governance be within an existing State agency, a new, stand-alone State agency, a separate nonprofit?

During this process we want to look at the pros and cons of those various approaches. Do we look more like a Utah model? Do we look more like a Massachusetts model? I think probably we will look more like a Utah model, where all plans that want to be on the exchange will be able to be on the exchange as long as they meet the minimum standards that will be required.

I think another critical decision is going to be, do we have a market outside the exchange versus the one inside the exchange? Probably we will, but I think that's another decision point that we'll have to make; and if we do, then how do we make sure that the playing field is level?

One of the key issues there is that the exchanges will be funded through transaction fees. That adds an additional fee, buying on the exchange; so how do you make sure that you have similar cost on plans outside the exchange so you don't create a disadvantage by that transaction fee on the exchange. So, there are lots of issues like that that we will sort through, seeking as much input as we

can from as many folks as we can in Kansas to make it work for Kansans.

The CHAIRMAN. But this is your decision, the State of Kansas makes those decisions.

Ms. PRAEGER. Yes.

The CHAIRMAN. We don't.

Ms. PRAEGER. Yes.

The CHAIRMAN. I just wanted to make that point, that I think there's a great deal of flexibility out there for the States to design and develop these.

Now, Speaker Clark, when you testified before the committee in 2009—I looked over your testimony—you said that one of the obstacles to State flexibility and health reform was Federal restrictions on—and I quote from your testimony—"wellness initiatives or personal responsibility elements."

That hits home with me, because I have been one of the strongest advocates for years here on wellness and prevention. I've worked closely with Senator Hatch on that in the past. It's been one of my top legislative projects, and that was the part that I had worked on, on the Affordable Care Act.

The Affordable Care Act includes programs that gives States, communities and employers the kind of flexibility that you mentioned, I believe. That act created the community transformation grant program which supports State and community initiatives that used evidence-based techniques to prevent heart attacks, throat cancer and other conditions by directly addressing behavior; like preventing tobacco use and preventing obesity.

The act also authorizes a $200 million grant program to give employees of small businesses access to comprehensive workplace wellness programs. Now, the grants are available to employers of fewer than 100 employees who don't have the resources to create a program of their own.

Studies have shown that workplace wellness programs can be anything from nutrition counseling, to smoking cessation, to in-house gyms. They typically cost about $20 to $200 per employee for small businesses, but they have a proven rate of return ranging from $2 to $10 for every dollar spent in the first 18 months.

So, we have that in the bill.

Again, Senator Hatch asked you, and you said you were frustrated. I suppose all of us are frustrated by some parts of the bill. There are some parts of the bill that frustrate me, too. It's like any piece of legislation that passes around here. I was Chairman of the Agriculture Committee for a long time and passed two agricultural bills. I often said, I don't like every bit of it, but that's what compromise is about. That's what trying to get together and trying to work things through to build a compromise is.

You might be frustrated by some parts. I certainly hope the part on wellness and prevention—I hope you're not frustrated by that.

And do those programs at least partially address your concerns?

Mr. CLARK. I think those are outstanding programs. In fact, I think the cheapest quality of health care is health in itself.

I think the low-cost portion of that is to try to keep all of us healthy, and to try and devise programs that pay for quality outcomes, as I mentioned earlier, rather than just activities, I think

is something we're all engaged in, and have some commonality with.

I agree with that.

The CHAIRMAN. I appreciate that, because we worked very hard to put a lot of wellness and prevention provisions in and to set up the prevention trust fund and everything, which is moving ahead quite aggressively now. Again, the whole idea was to, as you say, keep people healthy than to treat them later on when they've got chronic diseases and illnesses.

Also, as Chairman of this committee, anytime that the accusation or the implication rears its head that somehow we did not take into account disparate views, and that somehow minority views were not accommodated, I only have to respond with facts.

In this committee markup we met for 13 days for 56 hours; no amendment was ruled out of order. Anyone that had an amendment offered an amendment. There were 210 total Republican amendments offered in this committee on this bill. We either accepted or adopted through votes 161 of those amendments—161 out of 197.

Did we take them all? No, obviously not, but that's the legislative process. You're a legislator, Speaker Clark, and I have a great deal of respect for legislators, especially those who have been elected by their peers, to be Speaker—to be a leader.

I'm not going to ask anyone to respond to this. I just wanted to make a statement that these are the facts. That is the data. And people didn't get what they wanted in the bill. I understand that.

I didn't get what I wanted in the bill, either. There were some things I wanted in the bill. I happen to be a strong proponent of the public option. I didn't get it, did I? Such is life. But, that doesn't mean the whole bill is bad simply because I disagree with that. I think there's enough in the bill.

I just wanted to make that point, that minority views were heard; amendments were adopted—not all of them, of course, but that's to be expected in any legislative process.

Let's see, was there anything else we wanted to cover here.

Do any of you have anything else that you wanted to add to the record that I might not have asked or anybody else didn't ask or bring up? Is there anything else, Commissioner Praeger?

Ms. PRAEGER. I always try to—and I pointed it out in my testimony—I just think this is a step in the right direction in terms of getting everybody. It's not perfect, I think we all know that. There are still issues that are going to have to be resolved.

The CHAIRMAN. That's right.

Ms. PRAEGER. But really, the critical issue that needs to be developed, worked on going forward, and I know you know this too, is the ability to rein in health care costs, and I'm a firm believer that you can improve quality and lower costs; they go hand in hand.

And, I think that when we take the ability for companies to manage risk or avoid risk by medical underwriting, we take that away, then the way they manage their profitability is by making sure the right care is delivered; because then they have a vested interest in providing the best quality care.

The CHAIRMAN. I'm in agreement.

Ms. PRAEGER. And, we've not had that in our health care system.

The CHAIRMAN. That's exactly right, and I hope that's where we're headed.

Ms. PRAEGER. I hope so, too.

The CHAIRMAN. I also hope that you'll look at all of the prevention and wellness provisions we have in the bill, and put Kansas on the map in being a leader in that area, too.

Ms. PRAEGER. Absolutely.

The CHAIRMAN. Utah is doing it, and I would complement you on that, because I've known about the health system in Utah for a long time, and they've been very good on wellness and prevention for quite a while.

Yes, Representative Clark.

Mr. CLARK. I will just briefly talk about—maybe I could just identify some of the frustration that we've talked about here.

I accept everything that you've said and think that that portion of the bill is rightfully stepped. Here we have one of only two functioning exchanges, but one was a grandfather and one was excluded. That begins some frustration with this legislation, rather than accepting an already functioning exchange.

Massachusetts is in and Utah has to prove its worth on the exchange.

The next portion of this deals with the Medicaid requirements, and here we are in the State of Utah that's saying, "all right, you're going to be mandated to have about 50 percent increase in eligibility in your system."

I've been in the legislature 10 years. When I began my general fund portion for the entitlement programs under Medicaid in the State of Utah, it represented 9 percent of our budget. Today it represents 23 percent and growing.

The CHAIRMAN. This is Medicaid?

Mr. CLARK. This is the Medicaid portion of it. It is growing at three times the rate of any other portion of our budget; and it's anticipated at the end of this decade that it will be, if not very close to or fully into the 40 percent of our overall general fund portion of our budget.

That creates a lot of concern for us in trying to be able to manage this process. The portion of this we are not able to try, because of some of the mandates, and the requirements that come from the program, we're being forced in this process to spend much, much more money. I don't care to debate the value of whether covering more people with Medicaid is valuable or not; but just the fiscal responsibility and the frustration associated with that is fairly strong.

I can go through half a dozen steps like that, but that's fairly frustrated down this path. We appreciate the openness and the invitation to come and talk about what things we think that we have done in Utah that are valuable. We are sharing those right now under our exchange with 22 other States.

Now, the Senator from Colorado that was here earlier, I would love to have told him about the house member under the majority leadership that came over and spent time with me and in Utah, and from the executive office about what they are doing.

Oklahoma today is considering legislation that is mirroring what Utah has done.

There are a number of States, as we go across the country, that are electing portions of much like we did. We learned from Massachusetts. We didn't use a Massachusetts model, but we learned from there and we're happy to share our experiences and hopefully, save folks from making the same mistakes that, perhaps, we have made, but learning from what we've done right to make sure that they go down those paths to begin with.

The CHAIRMAN. Thank you.

Dr. Sharfstein.

Dr. SHARFSTEIN. Thank you. I first want to thank colleagues from Utah and Kansas. There's a lot that we're working on together to make this work.

Governor O'Malley recently wrote that he thinks the Affordable Care Act—he thinks about how he hears the heartache of parents wondering whether they can afford essential medical care for themselves or their children; and he watches as rising costs erode the competitiveness of innovative companies and small businesses; and I think in Maryland we're trying to keep our eye on those prizes—getting care, essential care to people who need it, reducing the costs and improving our competitiveness.

We believe the Affordable Care Act provides a very important set of tools to States that we can flexibly adapt our circumstances to accomplish those goals.

The CHAIRMAN. Thank you very much.

I just want to respond on one thing on Medicaid. My State of Iowa, also the same thing. All States have the same problem with Medicaid. The more I looked at it, in order to get Medicaid, you have to fall below a certain income threshold. If you look at the number of people who have fallen below the poverty line in the last 10, 15 years, you'll see what's happening in Medicaid. We've got more poor people in this country. That's what is driving Medicaid. We're not expanding it. The poor are expanding it, because they're falling below the poverty line.

I suppose someone could say, "well, maybe we ought to redraw the lines." I suppose if you wanted to, you could get rid of all the poor people in this country by saying that anybody that makes over $1,000 a year isn't poor. I don't know what you're accomplishing by doing that.

We have established poverty guidelines that have been pretty consistent for all my time here, but they take into account how much you need for a family of four for food, clothing, housing, rent, transportation, that type of thing and then what's the basic you need—I think it's around $22,000 a year for a family of four. I'd like to see some of us live on that around here for a family of four.

When I look at these Medicaid rolls, yes, they're going up, because we've got a lot of poor people. And, we've got a lot of people unemployed. I don't know what the unemployment figures are in the States. I don't know. But, we're not as bad as some States, but we do have a higher rate of unemployment than we've had in the past in Iowa; and that means more people on Medicaid.

If somehow we can re-energize and re-invigorate the middle-class in this country, get people making a little more money and put people back to work, Medicaid rolls will come down.

When I hear about all the problems with Medicaid—and it is a burden—I'm not saying it's not a burden on State budgets. It's a burden on our Federal budget too, but that's just because we've got a lot of poor people.

With that, I thank you all very much. If some of you came a great distance, I thank you for coming back again. I thought you added greatly to our deliberations here.

I will just say one other thing: Commissioner Praeger said it very well. This is just my own personal view as the Chairman of this committee, I think we've made great strides in moving ahead on the Affordable Care Act. I believe efforts to repeal it are ill-advised, and trying to fight last year's or last couple years' battles. So, I personally am going to resist every effort to repeal this bill.

What I will not resist, however, are attempts to change it or modify it, or make it work better. Anybody that's got suggestions on how to make this thing work so that we cover 30 million people that are uninsured—make it work so that we do reduce the cost of health care, make it work so that we focus more on health and keeping people healthy rather than just treating them when they get sick—any kind of suggestion; how to make the exchanges work better, believe me, we're open, and we'll look at those, and like any law, I've said many times, that the Affordable Care Act is not the Ten Commandments written in stone for all eternity. It is a law. It's a law developed by imperfect human beings, but I think it's a law that moves us in the right direction; and as any law, it's open to change, and open to modification.

I don't want anyone to think that this can't be changed. Of course it can be changed to make it work better, to meet the goals and the objectives that we've set out.

I just wanted to make that very clear.

Thank you all very much. The committee will stand adjourned, and the record will remain open for 10 days from today for statements and questions to be submitted into the record.

Thank you all very much.

[Additional material follows.]

ADDITIONAL MATERIAL

PREPARED STATEMENT OF GARY R. HERBERT, GOVERNOR, STATE OF UTAH

Good morning. I am Gary R. Herbert, Governor of the State of Utah.

I would like to thank Congressman Upton and the other members of the committee for your invitation to testify.

Let me begin by stating that I am a firm believer in the principles of federalism embodied in the 10th amendment.

States are not powerless agents of Federal authority. I believe that—as Governor of the great State of Utah—I should take every opportunity to assert the *rightful* authority of our State to advance Utah solutions to Utah problems.

A balance of powers between the States and the Federal Government is not only right and proper, but essential if we are ever to find solutions to the complex problems we face.

Justice Louis Brandeis famously described States as laboratories which can engage in ". . . novel social and economic experiments without risk to the rest of the country."

In Utah, we began our health system reform efforts 5 years ago, long before the Patient Protection and Affordable Care Act arrived on the scene. The lessons we've learned in our novel experiments in health system reform can serve as a guide to other States as they begin their own reform efforts. In fact, we have already been contacted by officials in numerous other States asking us to share our experiences with them.

The Federal Government has taken the opposite approach. The Federal Government decreed the one-size-fits-all law of the land, and has left to the States the details of how to shoehorn the Affordable Care Act's voluminous dictates and mandates into their agencies and budgets.

The Governors who are responsible for so much of the implementation of the Affordable Care Act were never invited to the table when it was being proposed by the Obama administration or debated in Congress. I find that unconscionable.

Utah has repeatedly demonstrated we can find Utah solutions to Utah problems, particularly in the area of health care. Our health system reform efforts have been targeted to respond to Utah's unique business and demographic needs.

Unlike many other States, a majority of Utah's uninsured population are employed. Most work for small businesses which do not offer health insurance benefits. Over 80 percent of Utah's businesses are small businesses, and less than 50 percent of Utah small businesses were offering health insurance coverage as of 2009. In order to reduce our uninsured population, we needed to make insurance coverage accessible to our State's small employers.

Utah also has the youngest population in the country. Many of our uninsured are so-called "young immortals," persons between the ages of 18–34 who are generally healthy and employed but who have deemed traditional health insurance coverage to be either unnecessary or too expensive. In order to reduce our uninsured population, we also needed to expand choice in our small group market.

In Utah, we have chosen a path of business- and consumer-oriented health system reform which responds to Utah's needs.

Years ago, most U.S. businesses made the switch from a defined benefit to a defined contribution model for their employee retirement benefits offerings. Incidentally, Utah is leading the Nation by having moved our State employees toward a defined contribution retirement benefit, as well.

As part of our health system reform efforts, Utah small businesses now have the option of using a defined contribution model for their health benefit offerings. A defined health benefit left businesses with unpredictable and ever-escalating costs. Through access to Utah's new defined contribution market, employers can manage and contain their health benefit expenditures.

With the creation of the Utah Health Exchange, Utah employees also benefit from expanded access, choice, and control over their health care options. Rather than the traditional one-size-fits-all approach inherent in the defined benefit model, employees can now use the defined contribution from their employers to shop for health insurance tailored to their individual needs and circumstances. The Utah Health Exchange currently gives Utah small business employees more than 100 plan choices, all of which retain the pre-tax and guaranteed-issue advantages of traditional small group insurance.

After the planned pilot phase, the Utah Health Exchange is now fully operational. In just the first month, we have already helped more than 1,000 employees get health insurance *they* have chosen. Each month, enrollment continues to climb. Our figures show that 20 percent of businesses participating in our defined contribution

market through the Utah Health Exchange are offering health benefits for the first time.

We have used market principles to create a Utah solution to Utah's problems.

Governor Patrick and I hold the distinction of presiding over the only States in the Nation with functional health insurance exchanges at this time.

The Commonwealth Connector in Massachusetts was designed to serve a business community and citizen population vastly different from what we have in Utah. Hence, our exchanges are constructed in vastly different ways.

The Federal Government simply should not be in the business of telling Utah, Massachusetts, Mississippi, or any other State how to run their current or future exchanges, or even force them to have an exchange.

The Affordable Care Act not only mandates exchanges for every State, but it gives the States little leeway in constructing exchanges that work for diverse needs and populations. Worse, the Affordable Care Act feigns a posture of giving flexibility to the States, while it's requirement are, in reality, quite rigid.

Just as Henry Ford offered his customers a choice of any color car they wanted as long as that color was black, the Affordable Care Act allows States flexibility in constructing their exchanges as long as they do it the way Washington tells them. Minimum Essential Benefit mandates, obligatory quality improvement activities for carriers, compulsory Federal subsidy determination mechanisms; these are just some of the examples of the lack of flexibility of the new national health care program.

The next major problem in need of market forces is the State's Medicaid program. Medicaid is poised to wreak havoc on the State's budget for years to come, threatening our ability to fund critical services, such as transportation and education.

Even before the Affordable Care Act, Medicaid was already a large and growing part of the Utah State budget. Medicaid's share of the overall general fund has been growing and is projected to grow even larger, creating real problems for the State. In the 1990s, it was as low as 9 percent. In Fiscal Year 2010 it was 18 percent. By fiscal year 2020, it is estimated to exceed 30 percent, *without* federally mandated expansion.

In this recession, Medicaid enrollment has skyrocketed. In December 2007, enrollment stood at 158,267 individuals. In December 2010, enrollment stood at 230,812 individuals, a 46 percent increase in 3 years.

The Affordable Care Act accelerates growth in Medicaid and compounds the budget pressure. The act prohibits the normal State tools to control costs. It requires Maintenance of Effort, meaning the State must participate at federally dictated levels. The act limits cost-sharing. The act confiscates State pharmacy savings.

Perhaps worst of all, the Affordable Care Act dramatically expands Medicaid eligibility in 2014. Enrollment is projected to grow approximately 50 percent under the mandated expansion. The act only pays for *part* of new costs, meaning States must cover the rest. In Utah, these new costs are estimated to be as high as $1.2 billion over 10 years.

I have come to Washington to present solutions to help ease the burden on our State.

First, I call on the Obama administration to support an expedited appeals process to the Supreme Court for the healthcare litigation which has been decided by the lower courts. Along with 28 of my fellow Governors, I have sent a letter to the President asking for his support.

Second, I would ask that Congress exercise its authority to find legislative solutions to the onerous mandates imposed on the States by the Affordable Care Act.

Third, we have proposed specific solutions for reform. This will require that the Center for Medicare & Medicaid Services (CMS) support the waiver requests that we have or will be submitting. Our message is simple: To have any hope of success, Utah needs flexibility to make this mandated model work in our unique State for our unique demographics and needs.

Our reforms fall into four distinct areas: administrative simplification, provider incentives, patient accountability, and expand premium subsidy options.

The first example is in the area of *administrative simplification*. CMS sent us a memo that essentially requires us to use paper to communicate with enrollees in the program. In our efforts to be more innovative and efficient, we developed an approach which uses electronic technology to communicate with our clients, reducing costs by as much as $6 million a year.

If CMS allows Utah the flexibility we need to be efficient—in this one area alone—we estimate that all the States adopting this technology could save more than *$600 million per year*. This seems like a no-brainer. However, CMS has been slow to respond. Utah's simple request for this issue has been sitting with CMS since last July.

The second example highlights the need to *change incentives for providers*. We are also trying to get waiver approval for a comprehensive reform to the way we reimburse providers for Medicaid services. We should pay for *value*, rather than volume.

We are developing a home-grown solution to this problem. We want to contract with Accountable Care Organizations (ACOs) to move toward a more provider-based care model. These contracts will better align financial incentives for providers to keep people healthy instead of just providing services.

If we are allowed to proceed, this model will be a tipping point for the Utah market, and we expect to shortly see private insurance companies follow suit, benefiting and strengthening our overall health care system.

In conclusion, I emphasize again that real health care reform will rise from the States, not be imposed by the Federal Government.

From the days of our pioneer forefathers, Utahns have been finding Utah solutions to Utah problems. I am here today to assert our right and responsibility to continue to do so.

ADDENDUM 1.—THE UTAH HEALTH EXCHANGE—A BRIEF OVERVIEW

The overarching philosophy of Utah's approach to health reform is that the invisible hand of the marketplace, rather than the heavy hand of government is the most effective means whereby reform may take place. The Utah Health Exchange is part of Utah's overall health system reform effort and is designed to enhance consumer choice and the ability of the private sector to meet consumer needs.

The Exchange formally opened in August 2009 for the individual/family product market as well as a limited launch for the small group market. A full launch of the small group market and a pilot version for the large group market took place in September 2010.

WHAT IS THE EXCHANGE?

The exchange is an Internet-based information portal. It connects consumers to information they need to make an informed choice, and in many cases allows them to execute that choice electronically.

WHY DO WE NEED AN EXCHANGE?

Utah's approach to health system reform is to move toward a consumer-based system, where individuals are responsible for their health, health care, and health care financing. A major step in that direction is the development of a workable defined contribution system.

The Exchange is a critical component in moving towards a consumer-based system. For example, in order for a defined contribution system to function efficiently, consumers need a single shopping point where they can evaluate their options and execute an informed purchasing decision. For a consumer-based market to succeed, brokers, agents, employers, and individuals must have access to reliable information to allow consumers to make side-by-side comparisons of their options.

WHAT IS THE OVERALL GOAL OF THE EXCHANGE?

The overall goal of the Exchange is to serve as the technology backbone to enable the implementation of consumer-based health system reforms.

HOW DOES THE EXCHANGE ACCOMPLISH THAT GOAL?

To accomplish this goal, the Exchange has three core functions:

1. Provide consumers with helpful information about their health care and health care financing.
2. Provide a mechanism for consumers to compare and choose a health insurance policy that meets their families' needs.
3. Provide a standardized electronic application and enrollment system.

DOESN'T THIS EXIST ALREADY IN THE PRIVATE SECTOR?

It could be argued that the information that a consumer needs exists in the present system, however, in Utah we are missing two key elements. In order for consumerism to really take hold, we need to create a system where the information is available in a standardized format that allows comparisons and is located at a single shopping point.

WHY DID UTAH CHOOSE TO GO WITH AN EXCHANGE MODEL?

Utah's approach to health system reform relies on the fundamental principles of personal responsibility, private markets, and competition. To promote competition in the health care system, consumers need three things—accurate and relevant information, real choice, and the opportunity to benefit from making good choices. The exchange model enhances private competition in the health care system by providing all three elements of increased competition.

In addition to the benefits to the consumer, the exchange model also offers relief to employers who will no longer need to bear the full burden of running a health plan for their employees.

WHAT IS UNIQUE ABOUT UTAH'S APPROACH?

Utah's approach to developing an exchange is unique in that it builds on existing technology instead of starting from scratch. This allows the State to incorporate and build on private solutions. Utah's approach is also designed to support the existing roles of entities in the health system, including insurers, producers, and health care providers.

WHAT IS A DEFINED CONTRIBUTION MARKET?

When it comes to employment-based health insurance, Utah recognizes that the traditional approach to purchasing a group plan is not consistent with our underlying philosophies of health system reform. In 2009, Utah created a new defined contribution market for health insurance. In this market, employees choose their own insurance company, network, and benefit structure and employers simply decide how much to contribute toward the employee's policy. It is apparent that while this market greatly enhances consumer choice and competition among insurers, it is also a more complicated system with many more people needing information than in the traditional group market.

WHAT FUNCTIONS CAN THE EXCHANGE ACTUALLY DO NOW?

At present, the Exchange is ready and able to support the new defined contribution market for Utah's small employers. The Exchange serves as the technology backbone that makes such an innovative market possible. The Exchange has the capacity to handle employer enrollment, communicating information to insurers about risk, compiling and displaying price information to employees, executing the employees' enrollment in their choice of plan, and facilitating the collection and distribution of premiums. The end result is that employees have the necessary information and purchasing power to make an informed health insurance choice.

In addition to supporting the defined contribution market, the exchange also supports consumer choice in the traditional individual market. In this regard, the primary role of the Exchange is to connect consumers with private companies that can help them identify and purchase the product they need. On the Exchange, consumers are given three options to shop for and buy a policy—use a private online shopping service, buy direct from a participating insurer, or search for an agent to get in-person assistance. Currently, there are four private online shopping services, five insurers and hundreds of agents available through the Exchange.

WHERE WILL THE EXCHANGE TAKE US IN THE FUTURE?

It is important to remember that a robust Exchange will be more than just a place to "apply for health insurance." While the initial focus of setting up the Exchange has been to establish a stable defined contribution market, this is just the first stepping stone in the process toward a consumer-oriented system.

In order to facilitate consumer choice in the long run, it is clear that the Exchange must provide information that is relevant to not only health care financing but also quality and transparency of the health care system. The Exchange will also evolve into a tool for patients to make better decisions about their health and health care by providing access to information about cost and quality and health and wellness.

The value of the Exchange is the sum of all its parts and each "part" is essential to the long term success of the Exchange and to the success of Health System Reform.

ADDENDUM 2.—MEDICAID ELECTRONIC NOTIFICATION PROPOSAL

Program and Goals—The Department of Workforce Services (DWS) is an integrated, one-stop service delivery agency that administers workforce programs, labor exchange, unemployment insurance, and eligibility for multiple social service pro-

grams—Medicaid, CHIP, SNAP, TANF, and Child Care. Through administrative modernization, DWS expects to reduce administrative costs by $9.2 million over the next 18 months.

Electronic Notification—The core of this effort is to move to a more automated, self-directed eligibility model using the new "myCase" system. Under the proposed system, customers will have easier and real-time access to services and case information, cycle times for determination will decrease and result in greater program integrity. The administrative savings come from three cost centers: (1) Electronic correspondence—the cost of a paper-based notice is currently $.52, which could be virtually eliminated, (2) Staffing—a more automated system will allow more determinations per worker, and (3) Reduced telephony costs.

Summary of myCase—myCase is an electronic customer interface launched in November 2010. Currently, it is being used by over 50,000 customers and growing rapidly. Over 160,000 notices have been read online, with 2.5 million page views. Utah would like to be a national leader in the development of this eligibility model and its application to Medicaid.

Federal Reaction—FNS (who oversees the Food Stamps program, SNAP) has been supportive at the national regional level. DWS appreciates their support with both system development and the potential need for support on additional waivers and policy interpretations. Unfortunately, we have struggled to get permission from CMS for full implementation of electronic correspondence for Medicaid clients.

TIMELINES

- July 1, 2010 waiver request sent to FNS.
- July 12, 2010 electronic correspondence request letter sent to Department of Health (DOH) to be sent to the Regional CMS office.
- Received waiver approval from FNS—December 7, 2010.
- Received conditional support from CMS on December 14, 2010. The condition of the support would require DWS to send a paper notification with all eligibility decisions (resulting in no cost savings).
- Drafted response for CMS as a rebuttal on the conditions. DOH received the DWS rebuttal and sent the response on to regional CMS office.
- December 17, 2010, DOH notified DWS that there should be no further action taken on the request until the CMS Office of General Counsel reviewed and made a decision.
- December 17, 2010—present, CMS (both the regional and national offices) have requested clarification and answers to questions, but there has been no word yet on a final decision from their Office of General Counsel.
- We have informed FNS that until we hear back from CMS, our electronic correspondence implementation is on hold.
- February 15, 2011—Representatives from DWS and DOH participated in a joint call with CMS regional and national officials to review progress, address concerns, and request an expedited decision.
- At present, there has still been no response on this issue.

On February 26 we are slated to release new functionality into myCase. This latest release will include the electronic correspondence "opt in" for customers. We've postponed the release date three times and postponing it again would impact our costs, training, and roll out of other critical functionality. Each month the release is postponed hampers Utah's ability to reduce costs and deliver quality services to our customers in a 24/7 online environment. Our timeline is aggressive and we need an efficient process to meet these milestones.

We would like to work with CMS to quickly resolve the electronic correspondence issue and to develop a better process to expedite future potential waivers or permissions.

ADDENDUM 3.—UTAH MEDICAID REFORM PROPOSAL

Rising Medicaid costs threaten the stability of the budget—In the 1990s, Medicaid expenses accounted for 9 percent of Utah's State budget. Currently, they account for 18 percent of the State budget and are projected to be well over 30 percent within the next 10 years. Enrollment has increased 46 percent from December 2007 to December 2010.

Obamacare will just make this worse—In 2014, Utah Medicaid will be required to add another 100,000 people to the program, a 50 percent increase in enrollment. Enhanced Federal funding for this group will run out within 10 years, costing the State an additional $1.2 billion.

Obamacare also takes away the key tools that States could have used to address the rising costs. It contains a maintenance-of-effort provision which prohibits us

from rolling back some of the expansions to optional populations put in place during better economic times. It freezes cost-sharing arrangements with patients to the old levels, such as $3 co-pays for pharmacy and $6 for inappropriate use of the emergency room. It also confiscates all of the savings that we have generated through our preferred drug list program, costing us $6.3 million a year starting in 2010.

Proposed reforms—To get the costs under control and prevent a total collapse of the State budget, we have to change the way the program works. Utah is considering a proposal that would "fix" the bad incentives in Medicaid and restore some hope of cost control.

The basics of the proposal are:

• Replace existing managed care contracts with Accountable Care Organization (ACO) contracts—Providers would be paid on a capitated basis in a way that brings the doctor and the patient into the mix (as opposed to the old HMO model where we pitted doctors against insurers.)

• Require contracted ACOs to meet performance standards, including using Medical Homes.

• Increase Patient Responsibility—Create a sliding scale copayment schedule for patients based on their income.

• Budget management strategy—Peg the growth in Medicaid payments to the growth in State revenues. Use a Medicaid Rainy Day fund in good years to save up for the bad years.

• Expanding the Premium Subsidy Option—Allow Medicaid clients the option of taking a subsidy to purchase insurance through work or the Utah Health Exchange instead of being on Medicaid.

We may be able to do some of this under our existing waiver authority; however, we need the Federal Government to give us some additional flexibility in order to make these reforms successful. If we can test this model, there is a chance that we could provide insights that would help every State improve their Medicaid program, saving hundreds of billions of dollars in State budgets alone, not to mention the savings to the Federal Government.

It's not just Medicaid—We are proposing reforms to our Medicaid program that are part of a larger effort to address problems with the system. Most insurers recognize the fundamental problem of paying for volume instead of value. If Medicaid takes the lead on changing the way providers are paid, private insurers will follow, lowering overall costs systemwide.

ADDENDUM 4.—THE UTAH HEALTH EXCHANGE: A LOOK IN THE REARVIEW MIRROR (BY NORMAN K. THURSTON, PH.D.)

Preface—Governor Jon Huntsman, Jr. was inaugurated in 2005 and stated that one of his priorities was to make health insurance available to more Utahns. Dr. David Sundwall, the executive director of the State Health Department was tasked to find staff resources to create a solution and I was asked to work on this project to help inform stakeholders and frame the debate.

Our first step was to organize a day-long health summit held at the University of Utah in May 2005. National experts were invited to inform policymakers and stakeholders about the latest national ideas on various health and insurance-related problems. The goal of the summit was to form a consensus on which direction the Governor should take. One of the presentations was on a plan for a new health care connector being negotiated in Massachusetts with a Republican governor and a Democratic legislature. We quickly realized that our approach would need to be different, but it might be possible to create a low-cost, Utah-based version that would focus on markets and private solutions and exclude the expansion of government programs.

With the support of many staff, legislators and governors, we have designed a revolutionary approach to health system reform in Utah. In this document I intend to give a reflection on the development and implementation of the Utah Health Exchange, a critical component of our overall plan for health system reform. I hope to highlight both the thinking behind our approach and the lessons learned.

GENESIS—IDENTIFYING THE UNDERLYING PROBLEM

While the focus of health system reform in Utah has grown to include several critical areas that are intended to bring more value into the system, at the outset the goal was to decrease the number of people without health insurance.

To help understand the problem, we analyzed detailed surveys of the uninsured and realized some commonalities. Most of the uninsured in Utah are in households

with at least one working adult, who is often employed by a small business or if they are employed by a large business, they are part-time workers.

That raised the next question. Why do so few small businesses offer health insurance? Estimates indicated that in 2005 less than 40 percent of small businesses in Utah were offering health insurance as a benefit. A study of businesses in Utah showed us that the No. 1 reason they choose not to offer a health benefit was the unpredictability of costs. Most small businesses are entrepreneurial and need to be able to project both revenues and costs in 3 to 5 years in order to make plans to achieve their profitability goals.

To address these specific issues, we set out to create a new approach to the employee health benefit that would entice more employers to offer it and slow the decline in employers no longer offering coverage.

Some of the critical aspects of the design of this new system include:

• Generate predictability of costs for the employer—Small employers need to be able to forecast with a fair degree of certainty what their labor costs will be. We needed a system that gives the employer the ability to predict costs more effectively than the current system allows.

• Preserve the tax benefit to both the employee and employer—The current tax code creates a huge disparity in treatment of health insurance that is purchased through an employer's group plan versus a policy purchased by an employee on their own. We needed to create a system that continues to allow both the employer and the employee to pay for health insurance with pre-tax dollars. This tax benefit could be as much as 45 percent of the cost of health insurance, considering State and Federal income tax, payroll tax, and the phase-out of the earned income tax credit.

• Bringing the consumer back into the equation—One of the most powerful forces for change is an informed consumer. Traditionally, the employee has been excluded from critical conversations about benefits and prices for group health insurance. To bring competition, discipline, and innovation into the process, we need to give more of the control to the employee.

CHANGING THE UNDERLYING HEALTH INSURANCE MARKETS

With these preliminary goals in mind, the first key element in setting up the new system was to develop an entirely new health insurance market in the State of Utah. At the time, we had four main private-sector markets—individual/family market, small group market, large group commercial, and self-insured. Our intent was to create a new defined contribution market that is modeled after the defined contribution approach to retirement benefits. The defined contribution approach to retirement addressed the same problem that employers had with predictability regarding their retirement benefits.

In this new market, employers would designate a contribution amount for each employee to use toward the purchase of health insurance. The employee would then be allowed to select from plans offered by participating insurers in the same way that they have control over how their defined retirement contributions are invested. In addition to giving the employer control over their benefit costs, this also has the advantage of giving the employee full control over their health plan. They can choose the plan that best suits their needs. The employee also now has skin in the game, in the sense that if they choose a more expensive plan, they pay the difference, but they also perceive the savings from choosing a less expensive plan.

As soon as we started designing this new system, we recognized that the two biggest challenges in creating this new choice-oriented market would be the potential for adverse selection and the need for a technology tool to help consumers evaluate their options and make good choices.

Adverse selection is primarily a problem for the carriers, so we brought them together and gave them an opportunity to identify a solution for potential selection issues.

Their solution was to design and implement one or more risk adjustment mechanisms to ensure that the funds that flow to each carrier inside the Exchange more closely match the assignment of the risk. It turns out to be also a good move strategically. As we researched risk adjustment experiments, we found that in most cases where they failed, the blame was placed on the entity that developed the risk adjuster. It is easy for an insurer to walk away from a failing risk adjuster that is designed by someone else. It's a lot harder for them to make that case when they themselves have designed it. In our system, if the risk adjuster needs to be modified or updated, the carriers have the ability to make those changes.

On the second issue, facilitating consumer choice, we looked to the consumer experience in other industries that have similar challenges. The easiest example to un-

derstand is the travel industry. Over the past 20 years, consumers have been given a significantly greater opportunity to use the Internet to make travel plans and execute them online.

We found that there are several private companies that have developed technologies to help consumers navigate the complex decisionmaking process and get the outcome that best meets their needs. In our presentations, we often pointed to Travelocity as being a prime example of a pioneer in the world of web-based consumer support. We set out to find a solution for employees choosing health plans that replicated the Travelocity service concept.

USING TECHNOLOGY TO FACILITATE HEALTH SYSTEM REFORM

As we contemplated moving forward with this new market, it became apparent that we would want to develop an Internet portal that could serve as the technology backbone for implementing health system reform in the State of Utah. This concept grew into the Utah Health Exchange.[1]

In addition to providing a web-based solution for the new defined contribution market, the portal could also provide technology solutions for other aspects of health system reform. Specifically, if we were going to the trouble of developing a consumer choice module for employees in the defined contribution market, we could also make that same functionality available to individuals buying policies on the open market or employers shopping for traditional group policies. Similarly, this would create a great opportunity and need for us to provide consumers with solid information on cost and quality. Eventually, this core portal could be expanded to support other aspects of health system reform.

As we considered how to structure the portal, we decided to take a modular approach. Initial development would eventually concentrate on three modules:

1. The Consumer Information Module;
2. The Individual Market Shopping Tool; and
3. The Defined Contribution Module.

After taking a realistic assessment of our capabilities and limited staff resources we decided to focus on the most critical component of the portal first—providing a workable solution for small employers. Because of that, the Defined Contribution Module was given the highest priority.

We set a goal of having something ready for a few employers to test by the fall of 2009. To make that happen as quickly as possible, we used an RFP process to identify existing private market technology solutions that could be applied to this module. Through that process, we found that the consumer comparison and choice technology that we needed already existed in the private market place.

In the insurance industry, just like the travel industry, there are several firms that have already developed tools to support health plan choice that could be adapted to meet our goals and needs. At the end of the process, we awarded contracts to two private companies, bswift, and HealthEquity, to work together to form the core technology for Defined Contribution Module. The area of expertise of bswift's is in facilitating consumer choice and HealthEquity brings the tools needed to handle the flow of funds. As a bonus outcome from the RFP process we also identified ehealthinsurance.com as a partner for developing the Individual Market Shopping Tool.

With these three private partners on board, in the summer of 2009, we launched the portal and christened it the Utah Health Exchange (often referred to as the UHE or the Exchange). In its initial form, the Exchange was launched with both the Defined Contribution Module and the Individual Shopping Module.

Development of the Consumer Information Module has begun, but is still not ready for prime time. When it is complete, the Consumer Information Module will be a technology resource to provide consumers with more transparency about the entire health care system, including health care providers as well as insurers. It will be able to display information on cost and quality in a way that helps the consumer make decisions and choices.

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[1] It should be remembered that an Exchange is a technology solution that is designed to facilitate the underlying health system reforms. In national discussions, people occasionally ascribe additional roles for exchanges, including such things as operating public programs, regulating markets, or even negotiating with carriers. While any of those goals could be a part of a State's underlying health reform, they should be thought of separately from the technology component, which is the real Exchange.

THE INDIVIDUAL MARKET SHOPPING TOOL

The Individual Market Shopping Tool is the easiest component of the Exchange to explain. Once word got out that ehealthinsurance.com would be our partner in this module, several other private entities with similar capabilities approached us with a desire to get involved. Since it was our purpose all along to foster competition in the private market, we had no justification to exclude any qualified partner.

As it stands today, individuals coming to the Exchange to buy a policy can shop in three different ways:

1. Online Comparison Shopping—They can choose one of five companies that offer side-by-side comparison shopping Web sites.
2. Online Buy Direct Shopping—They can also buy direct from one of the five insurance company Web sites that offer individual policies for sale through the Internet.
3. Find a Broker—The Exchange also has a tool that allows individuals to find a store-front insurance producer nearby where they can get help in person.

It is important to note that the plans offered through this module are the same plans available through the individual market. Given that our individual market functions relatively well, there was no need for insurers or regulators to create new rules or restrictions on policies that could be offered.[2]

While this adds significant value for consumers by facilitating their interaction with private partners, it is not a cure-all. Products purchased through this module do not have the tax advantages of employer-sponsored plans. In the Utah individual market, these plans are not guaranteed issue plans, so consumers can be denied coverage. In that case, they are informed of their eligibility to participate in the Federal or State high-risk pools.

It's also critical to point out that these private partners do not charge the State for their services and did not receive any State development funds. They earn commissions just as they would through their normal line of business and do not increase the cost to consumers.

While this solution works very well for our current needs, we have to consider that as it stands today, the Affordable Care Act also contains several provisions that will create a significant disruption in our individual market and our Exchange approach might need some additional functionality to meet guidelines. We are currently evaluating the impact on our market and developing a contingency plan.

THE DEFINED CONTRIBUTION MODULE

The Defined Contribution Module is the most well-known and publicized module of the Exchange. This module was launched with a very aggressive timeline. We needed to have small employer beta test up and running by late summer of 2009, with a full launch for small employers in the fall of 2010. We were also asked to conduct a pilot program for large groups in 2011 to see if we could be ready to handle all large groups by the fall of 2011.

The limited launch that ran from the fall of 2009 through the full calendar year of 2010 resulted in a test group of 11 employers offering their employees a defined contribution health benefit. Having a relatively small number of participants was exactly what we needed to be able to test the technology and work out any bugs. We learned a lot in the process.

We have identified seven essential functions that need to be in place for a Defined Contribution Module to work.

1. Creation of Application Packets—The Exchange must be able to accept employer information electronically and create a basic application packet that can be sent to the insurance carriers for evaluation and acceptance. This packet needs to include employees' basic health information collected on an electronic version of the State's uniform health questionnaire.
2. Risk Assessment/Underwriting/Rate Setting—Once the employer packet is approved for participation in a defined contribution plan, the technology must facilitate communication with the insurance carriers in the underwriting and rate setting process. Rates received from the carriers must be posted so that employers and employees see the correct prices based on their group's risk. (In Utah, we use the same underwriting rules as in the traditional small group market, plus or minus 30 percent rate bands.) Once the pricing information is loaded, employers have any oppor-

[2] I should note one exception—as part of the health reform legislation, we raised the bar for carriers to deny coverage in the individual market. Under the new rules, individuals under 225 percent of average risk cannot be denied coverage.

tunity to review the rates and set the defined contribution amounts for the employees.

3. Employee Shopping and Choice—Employees must be given an opportunity to come into the system, evaluate their options, and make their plan choice. While every component is critical, this is the one that makes or breaks the effectiveness of the Exchange. Our goal is to provide the consumer with the tools they need to evaluate their options and make an informed choice. The current technology allows employees to filter or sort based on type of plan, benefits structure, insurance carrier, the inclusion of a particular provider, price, and other elements. This is critical, because with over 140 possible plan choices, it can be an overwhelming experience to evaluate so much information and make a good choice. It is our belief that this is where technology makes the biggest difference.

4. Enrollment—Once the employee choices have all been executed, the technology must be able to create an enrollment file that documents which employees and dependents are enrolled in which plans. This information is then transmitted to the carriers so they can create accounts, print cards, and be ready to process and pay claims for their respective enrollees.

5. Eligibility Reporting—The system also needs to have the capacity to enroll new hires and make changes at other times, such as special qualifying events or terminations and communicate those changes to the carrier and report current and accurate eligibility information to inform other processes in the system, such as financial payments.

6. Financial Transactions—The system must make an accounting for the premium dollars. In this new market, there are more destinations for those dollars than in the traditional group plan. Most importantly, the premium dollars have to be risk-adjusted and forwarded to the corresponding carriers.

7. Customer Service/Support—The last function to cover is a process for customer service and user support. Ideally, most employee needs would be served by their employer's producer, who would be fully aware of the functions of the Exchange and is licensed to make recommendations about plan choice. However, the Exchange needs to have the ability to provide information and support to all users. We are currently in the process of evaluating and redefining our approach to filling this role, but it is becoming apparent that this is more of a policy decision than a technology issue.

As mentioned earlier, one of the critical elements to make this new defined contribution market work is the ability to apply an effective risk adjuster and our approach was to turn that over to the participating carriers. In statute, we created the Utah Defined Contribution Risk Adjuster Board as the formal process for that to happen. This board is composed of carrier representatives, government representatives, and a representative from the business community.

The duty of the board is to develop a plan of operations governing the defined contribution market that addresses problems related to risk and protects the market from adverse selection. Since the details of the operation of this market are fairly dynamic as we continue to learn and adjust, I have left out many of the specifics. However, the current version of the plan of operations would have most of those details.

Similarly, the staff operating the Exchange frequently needs input on difficult operational and implementation issues. To provide additional support in a less formal setting, the Utah Health Exchange Advisory Board was created, composed of representatives from insurers, producers, community organizations, and government.

CRITICAL LEARNING FROM THE DEFINED CONTRIBUTION MODULE LAUNCHES

We used the learning from the limited launch to improve the technology in preparation for a full launch in the fall of 2010. We have also learned a few important things in this full launch that have required us to plan additional improvements.

Perhaps the most important thing we have learned is that it is difficult to put together and manage all of the information needed in an employer application. In the traditional market, this is typically done by producers using a paper-based approach. When this is translated into an electronic format, there is still a tremendous need for the producer to be heavily involved in scrubbing the various components to ensure that everything is ready for submission.

Here are some of the other current issues and learning points from the launches:

1. Employee census—Businesses, especially small ones, are dynamic environments. During the course of a few weeks involved in processing the application, employees are hired, terminated, and become eligible or ineligible for benefits. The insurer has to know that they are basing their underwriting on the complete set of

employees that are to be insured, yet this is a moving target. This is no different than what happens in the traditional small group market, but it is certainly something to take into account.

2. Employer Support—At the end of the process, many employers want assurance that the prices their employees will see in the Exchange are competitive with rates in the traditional market. In Utah, by statute, the plans inside the Exchange cannot be priced higher than the same plans outside the Exchange. However, this can be difficult to verify. Due to the nature of the Exchange, it's not easy to perform an apples-to-apples comparison with plans offered outside the Exchange. First of all, the exact plan that they may be considering outside the Exchange may not be one of the choices inside the Exchange. In addition, for reasons already mentioned about changing employee census, the rate quotes may not have been generated using the same employees. Finally, there is no way to predict what the employees will choose when given the choice.

3. Retrospective Risk Adjustment—In addition to the prospective risk adjuster, carriers may wish to do some back-end or retrospective risk adjustment. One of the challenges will be that claims information for employees in any given group could be housed across multiple carriers who may not be excited about sharing that information with each other. Fortunately, all of our participating carriers are also required to submit data to our All Payer Claims Database (APCD). So there is a single data source that has access to all of the claims related to Exchange participants. It stands to reason that the APCD could be a very useful tool in conducting retrospective risk adjustment for groups insured through the Exchange.

4. Engage Producers—The producers are the primary sales force for the defined contribution market. Rather than confronting and marginalizing them, it is better for everyone involved to engage them as early as possible in the process. An informed producer is likely to see how this new approach can benefit some or all of their existing clients as well as providing them a new sales tool to reach out to those small businesses that don't currently offer a benefit. Producers are also very helpful in guiding the development of the technology tools, ensuring that the process flows as intended, and watching out for errors or deviations in the system.

5. Premium Parity—In order to avoid a scenario where the defined contribution market is overloaded with high-risk employers, it is essential that premiums for like products be the same inside and outside the Exchange. Initially, we did not have this requirement in the limited launch, and it became immediately apparent that this would be a problem. One of the specific areas of concern has to do with restrictions on renewal rates. In Utah, incumbent carriers face statutory limits on premium increases at renewal. When currently covered small employers look at the Exchange, carriers should not get a free pass to rate them up beyond these limits. In our current approach, if an employer is currently insured with a participating carrier, all carriers are restricted from assessing a risk factor higher than their renewal risk factor from their incumbent carrier.

6. Engage Insurers—When all is said and done, the insurers have every incentive to make this work. It represents an opportunity to increase enrollment, which will reduce cost-shifting as well as providing additional premium. To the extent that there are concerns about risk, it is the insurers who have the proper motivation to address them. With this in mind, we have given a fair amount of latitude to the insurers to bring their expertise to the table to help in the design and development of the system.

7. Private Solutions—We now realize that it was very effective for us to contract with companies that have existing technology solutions that could be applied to the needs of the Exchange. However, we have also learned that this partnership works best when the application of the technology is close to the core competency of the partner. It's better to engage additional partners whose core competencies meet the need at hand instead of trying to apply technologies beyond what they are intended to do.

8. Do a Beta-test—Maybe this is the most obvious thing that we only thought about once we were into the process. It is essential to a successful development to continually test the system during development. A beta-test with real participants was very informative and made a huge impact on our eventual outcome.

COUNSEL FOR OTHER STATES

Can this be done faster using Utah as a template? I am convinced that this is the case. Based on our experience, we know what legislative action is required, and we also know what critical functions need to be in place for the Defined Contribution Module to work. This isn't to say that it would take time to develop those functions, but we now know that most (if not all) of them are already developed in

the private market. If States can be clear about their needs, it should be straightforward to build.

What adaptations should States anticipate? It was not easy to develop the data interfaces and communications between the exchange tools and the insurers. While insurers that are participating in our Exchange understand how to deal with that now, new insurers will need some time to get up to speed.

PREPARED STATEMENT OF THE AMERICAN ACADEMY OF FAMILY PHYSICIANS

American Academy of Family Physicians (AAFP), representing 97,600 members nationwide, is pleased to submit this statement for the record to the Senate HELP Committee regarding the first year of the *Affordable Care Act* (ACA). The AAFP supported this legislation for many reasons, not the least of which is its goal of achieving health coverage for nearly everyone in this country. In addition, the ACA implemented numerous strategies for improving health care delivery and making affordable, high-quality care more available.

BACKGROUND

Members of the AAFP have a great deal of experience in delivering health care: family physicians treat one out of four patients in the United States. In fact, more than 215 million office visits are made to family physicians each year; 59 million more than any other medical specialty.

Family medicine is dedicated to treating the whole person, providing preventive care, coordinating care for multiple illnesses, promoting mental health and supporting better health behavior. Because of their focus on prevention and care coordination, family physicians help prevent many illnesses, treat early those illnesses that do occur and, when necessary, refer patients to the right specialist and advocate for them in this fragmented and complex health care system.

As the only medical specialty society devoted entirely to primary care, the AAFP is engaged in virtually all health care issues, including health care coverage, cost and quality, Medicare, Medicaid and CHIP, health information technology, funding for family medicine training, graduate medical education, the affordability, availability and safety of prescription drugs, primary care research and medical liability reform.

Family physicians have long worked with policymakers from both sides of the political aisle to advance health care policies that promote primary care. We are committed to continuing this work with the 112th Congress. Since Congress is focused on either repealing, replacing or maintaining the *Affordable Care Act*, below are our comprehensive comments regarding all aspects of the law. The first section will refer to issues under the jurisdiction of the committee, but we also will include portions that refer to other primary care issues in the health law.

RELIABLE, HIGH QUALITY AND AFFORDABLE COVERAGE

For over 20 years, AAFP has been working to broaden health insurance coverage as the first step toward assuring that everyone has timely and effective access to the health care services they need. As the *Affordable Care Act* evolved over the 2 years it was debated, we were encouraged that several of the provisions of our *Health Care for All* policy remained in the various drafts of the legislation. For example, we supported building on the current employer-based system of providing coverage, while improving the insurance market to create better access to coverage for small businesses and individuals who are neglected in the current market. In our view, this always has included protecting insured individuals from losing coverage or being singled out for premium increases due to changes in health status, so that families with insurance are able to keep it. As long as these broad insurance reforms are part of a private market, a requirement for personal responsibility is probably necessary to avoid the problem of individuals waiting to buy insurance until health care costs arise.

As part of the personal responsibility requirements, we have recommended subsidies or other mechanisms that will help low-income or high-risk individuals with the cost of coverage. We have agreed that subsidies also should be available for small businesses to enable them to offer health insurance to their employees. Finally, we have supported the rights of all consumers to be provided with adequate and comparable information that will enable them to choose the health insurance product that best meets their needs. Each of these important reforms is included in the *Affordable Care Act*.

HIGH QUALITY, EFFICIENT DELIVERY SYSTEM

System reforms must empower physicians to improve health care quality and effectively use finite resources. Quality measurement programs simply cannot identify and penalize physicians and other providers whose results appear to fall below the top level of performance. Such programs will not yield the systemwide improvements needed to assure high-quality health care for all patients.

The AAFP supports the ACA's Patient Centered Outcomes Research Institute for clinical comparative effectiveness research. The new institute will provide physicians and patients with useful information about various diagnostic tools and treatment options, and we strongly believe that such research will contribute to better individual health care decisions.

Family physicians provide care to individuals throughout their lives, including patients with numerous chronic illnesses. As a result of this broad scope of practice, it is not surprising that our members deal constantly with gaps in medical knowledge. As practicing family physicians, our members may feel as though they spend more time "practicing in the gaps," than practicing medicine that is supported by randomized clinical trials.

Given the complexities of clinical care and the multitude of treatment options available for many conditions, as a nation, we cannot expect, afford or in many cases ethically conduct, all the randomized clinical trials that would be needed to fill in the existing gaps in knowledge. As a result of this practical consideration, the AAFP is a strong supporter of ongoing development and support of comparative effectiveness research.

The AAFP also supports efforts in the ACA to expand and accelerate the development of meaningful quality measures and reliable data sources to build an evidence base for high-quality care. Broad adoption of truly connected and interoperable health information systems will help achieve quality improvement goals, but we need to continue to invest to develop an infrastructure to support this plan. Infrastructure needs are particularly acute in smaller physician practices.

INCREASED FOCUS ON WELLNESS AND PREVENTION

The ACA created an important innovation in health care with the establishment of the Prevention and Public Health Trust Fund. The basic goal understanding of this fund is that improvements in the overall health status in the Nation will serve to rein in costs and improve productivity. This fund also is supplemented with an investment in research to fill gaps in knowledge about the most effective health promotion strategies. These sorts of public investments are needed in education, community projects, and other initiatives that promote healthy lifestyles. As decisions are made about this program, AAFP believes that special emphasis should be placed on collecting data and developing strategies to eliminate regional, racial, ethnic, and gender health disparities. In addition, public investments and insurance plans also should support early access to care for mental health and substance abuse disorders.

PRIMARY CARE WORKFORCE

The ACA made a significant step toward effective understanding of our health care workforce requirements by establishing the National Health Care Workforce Commission to:

• Disseminate information on promising health care professional retention practices;

• Communicate information on policies and practices that impact recruitment, education and training, and retention of the health care workforce;

• Work with Federal, State and local agencies to review current and projected health care workforce supply and demand and make recommendations to Congress and the Administration regarding health care workforce priorities, goals and policies;

• Perform duties, including conducting reviews, making reports, making recommendations, conducting assessments and data collection and dissemination activities, related to the State Health Care Workforce Development Grant program; and

• Study effective methods for financing education and training for health care careers.

Beginning in 2011, the Commission must submit to Congress and the Administration by October 1 of each year a report containing the results of reviews and recommendations concerning related policies. Beginning in 2011, the Commission must submit to Congress and the Administration by April 1 of each year a report that

contains a review and recommendations related to at least one high priority area, which may include:

- Integrated health care workforce planning;
- Requirements for health care workers in the enhanced information technology and management workplace;
- Aligning Medicare and Medicaid graduate medical education policies with national workforce goals;
- Eliminating barriers to entering and staying in primary care; and
- Educating and training, projected demands and integration with the health delivery system of the nursing workforce, oral health care workforce, mental and behavioral health care workforce, allied health and public health care workforce; emergency medical service workforce capacity; and a comparison of the geographic distribution of health care providers with identified workforce needs of States and regions.

To carry out its duties, the Commission is authorized to use existing information collected and assessed by its own staff or under arrangements, carry out or award grants or contracts for research and development where existing information is inadequate, and adopt procedures permitting interested parties to submit information for the Commission to use for reports and recommendations.

The AAFP supports the establishment of this commission. It is clear that impartial and informed decisions on how to promote the needed health care workforce are imminent. This commission is necessary to provide unbiased, informed and appropriate data and recommendations for how the Federal Government can best allocate its physician-training resources to achieve the best results. To perform this long-needed function, the commission will need to be sufficiently funded.

SMALL PHYSICIAN PRACTICES AND PATIENT-CENTERED MEDICAL HOMES

While the ACA takes important steps to recognize the high value of primary care services and the critical role such services play in a high-functioning health system, we have some concerns that health reform might not accommodate privately owned small and medium physician practices.

As many as 25 percent of family physicians serve their patients in either a solo or 2-physician practice. These practices flourish all over the country, in rural communities and in city neighborhoods. They provide up-to-date medical care and, with the use of information and communication systems, ensure that their patients find the community resources that will allow them to manage their chronic diseases, and prevent them in the first place.

High-quality health care can be (and is being) delivered to patients, often in rural and underserved areas, by family physicians practicing alone or with a few other physician and health professional colleagues. Claims that health reform will (or must) lead to "vertical organization of providers and accelerate physician employment by hospitals and aggregation into larger physician groups" are without merit and contradicted by the experience of AAFP members.

The Patient-Centered Medical Homes (PCMHs) and the Accountable Care Organizations (ACOs) are potential examples of these larger physician groups. However, AAFP believes that, properly constructed, an ACO can serve as a vehicle for disparate small physician groups to share some assets and support some community resources needed to coordinate care and help prevent disease. We believe that a PCMH need not be a large physician practice. Indeed, physicians in solo, small or medium-sized practices provide the important team-based primary care and preventive health services and chronic disease management called for in the health care reform law.

As we implement the *Affordable Care Act*, it is important to keep in mind that we should transform the practice of health delivery to reduce duplication and fragmentation of service and focus on coordinating care. However, we should not eliminate the variety of practices that make health care delivery most effective in different settings. We will continue to need small and medium-sized practices and we should give these physicians the assistance they need to participate fully in our Nation's renewed emphasis on primary care. It is for these and other reasons that the AAFP is eager to review the proposed regulations from HHS to implement the shared savings program under the ACA.

PAYMENT AND DELIVERY SYSTEM REFORMS

We believe that the *Affordable Care Act* begins to make much-needed investments in value-based payment methodologies that improve chronic disease management and care coordination, including but not limited to the Patient Centered Medical Home. In addition, the ACA includes pilot tests of other innovative approaches cre-

ating joint incentives for providers to coordinate and improve care and achieve cost efficiencies—such as accountable care organizations, gain-sharing, and payment bundles—to assess their feasibility for widespread implementation. However, current regulatory restrictions and antitrust laws that inhibit physicians, particularly those in smaller practices, from pursuing clinical integration strategies aimed at quality improvement and care coordination need to be identified and remedied. We understand that HHS and the Justice Department are attempting to reconcile the ACA's cost-saving reforms that require collaboration with the restrictions of the antitrust laws and regulations. The AAFP has long called for this important and long overdue action.

REDUCED COSTS

The ACA recognizes the importance of preventive health care and refocused health care delivery in containing costs. In addition, there are several other provisions that will help save money both for the health system and for individual patients and payors. These provisions recognize that both private and public health insurance programs must be sustainable and that steps need to be taken to control costs. For example, the goal of the Center for Innovation in CMS is to demonstrate cost savings to the system, while the provisions in the ACA ultimately eliminate the Medicare prescription drug "doughnut hole," and reduce and eliminate cost sharing for preventive health services, helps save money for patients. The AAFP believes these provisions are crucial to the value of the ACA.

The ACA includes a controversial and unusual feature called the Independent Payment Advisory Board (IPAB), which will recommend reductions in Medicare health system costs to meet specified targets. While the AAFP has some concern about the process for implementing IPAB recommendations, we have felt that if the Board were constructed to include at least one representative of primary care physicians and one consumer representative, then there would be potential to help reduce some of the mis-valued payment codes and other high system costs. In addition, we believe it is necessary to include a public comment period for the Board's recommendations before Congress is required to act and that the Board's review authority should extend to the entire range of health system entities, including hospitals that contribute to cost increases. Without re-thinking how the IPAB operates, the scope of its authority and how it is constructed, this likely will be a missed opportunity for health system improvement.

MEDICARE PAYMENT

There are two ACA provisions related to payment that are important, not simply because they pay primary care differently than specialty care but also because they begin to acknowledge and recognize the value that primary care brings to the health care system. Beginning January 1, 2011, qualified primary care physicians—defined as those in family medicine, internal medicine, geriatric medicine and pediatric medicine—began receiving a 10-percent bonus for Medicare services.

To qualify for the bonus, 60 percent of their Medicare allowed charges must be for primary care services as defined by evaluation and management (E/M) codes for office visits, nursing home visits and home visits. AAFP believes the 60-percent threshold is too high. As originally defined, the threshold would have had a particularly negative affect on rural primary care physicians because they are the ones who, by virtue of the fact that there are not as many specialist physicians nearby, provide more comprehensive care for their patients. This can skew the ratio of primary care to total services and would disqualify them for the bonus. Fortunately, the Centers for Medicare and Medicaid Services (CMS) through rulemaking, was able to make needed adjustments to mitigate the unintended consequence and up to 80 percent of family physicians will qualify for this bonus payment.

AAFP is concerned that this is just a 5-year program, scheduled to end January 1, 2016, and that it applies only to payments for primary care services, not to all Medicare services that primary care physicians provide. We also believe that it needs to be significantly higher than 10 percent to achieve the goal of attracting sufficient numbers of medical students into primary care, as emphasized in the recent report of the Council of Graduate Medical Education (COGME). So we believe a lesson learned from year one is the recognition that this bonus must be increased and made permanent in order to have the desired effect. Nevertheless, it was important that ACA recognized that the current physician payment mechanism undervalues primary care and needs to be fixed.

MEDICAID PAYMENT PARITY

The second payment program in the law also is a time-limited one. In 2013 and 2014, Medicaid payments for primary care and some preventive health care services will be increased in many States so that they are equal to Medicare payments. As a result, family physicians who care for Medicaid patients will, for 2 years, see significantly better payments in many States. This is another signal that primary care will ensure better health and better cost control.

Medicaid provider payments are a frequent target of State-level budget cuts during an economic downturn, which is the same condition that drives increased demand in the program. Payments that not only have not kept pace with inflation, but have actually decreased substantially, have forced many physicians to close their practices to Medicaid patients. Family physicians have a strong commitment to serving the Nation's most vulnerable patients, but payment in Medicaid must be adequate to cover the cost of providing essential primary care services. Thus, this ACA provision for payment at least equal to Medicare's is an incredibly important signal to the health care community that provider payments are inadequate.

SUSTAINABLE GROWTH RATE FORMULA

Another issue is the congressional decision not to include in the ACA a provision to resolve the problem with the sustainable growth rate formula that affects Medicare payments. Despite the modest bonus for primary care and the recognition throughout the law of the importance of and high value of primary care, our members are sobered by approaching 29.5 percent cut in Medicare reimbursement for all physicians scheduled to take effect January 1, 2012.

AAFP urges Congress to act expeditiously to permanently fix this flawed Medicare payment formula. Among the approaches that could be considered is an intermediate-term (e.g., 3-year) patch that includes a positive differential payment of at least 1 percent for primary care services. Congress considered such a payment system as a replacement for the SGR early in the debate on health care reform, but it was dropped. We encourage consideration of a payment scheme that includes some mechanism to reduce the large and unproductive disparity in payment between primary care and other health care.

We also eventually seek a permanent formula that incorporates lessons learned from other provisions of the ACA that begin to steer Medicare payment away from relying solely on traditional fee-for-service by incorporating a blended payment system that supports care management and quality improvement, in addition to a reliable formula that supports the fee-for-service portion of the payment to physicians.

MISVALUED CODES UNDER THE MEDICARE PHYSICIAN FEE SCHEDULE

Family physicians, and other primary care physicians and providers, have been concerned with how CMS determines specific payments for medical services. The AAFP appreciates the provision of the ACA that requires HHS to periodically identify physician services as being potentially mis-valued and make appropriate adjustments to the relative values of such services under the Medicare physician fee schedule. Codes would be identified based on certain factors, including codes with the fastest growth. Adjustments to mis-valued procedures would be subject to budget-neutrality requirements.

MEDICAID MAINTENANCE OF EFFORT REQUIREMENTS

The AAFP believes that all patients should have health care coverage through a primary care-based system built around the patient-centered medical home. In the patient-centered medical home model, patients receive health care from a physician leading a medical team that coordinates the preventive, acute and chronic health care needs of patients. This comprehensive approach uses the best available evidence and most appropriate technology. The maintenance of efforts provisions contained in the *Affordable Care Act* require States to maintain eligibility levels for Medicaid and CHIP.

Relaxing or eliminating the MOE provisions would move the U.S. health care system further from that goal. As written, the law's provisions allow States to trim enrollment of certain adult patients. In February 2011, the Centers for Medicare and Medicaid Services (CMS) issued a State Medicaid Director letter clearly outlining the application of the MOE provisions.

The MOE provisions make cutting provider payments more attractive to State budget writers. A core reason for the maintenance of effort provisions is to preserve access. Family physicians, who are on the front lines of serving Medicaid patients, need to know the payment rates their practices receive are stable. To create busi-

ness stability and certainty for family physicians, Congress should extend the MOE provision to include Medicaid payment rates.

The goal of the MOE provisions is to protect the most vulnerable patients currently enrolled in Medicaid and CHIP: low-income pregnant women, children, the disabled and the elderly. Loosening maintenance of effort requirements for these populations will force them to seek more expensive, less efficient care through emergency departments—care for which the States and Federal Government ultimately pay for anyway. These provisions help America's most needy individuals get continuous, high-quality and more cost-efficient care. A recent study of Patient-Centered Medical Home (PCMH) pilot programs from around the country demonstrated over 30 percent less ER use by patients with a PCMH versus the control group and a 50 percent reduction in overall cost growth.

MEDICAID AND PCMH

The Patient-Centered Medical Home model established in the legislation is incorporated into a new Medicaid State option that will help States implement and evaluate this model of coordinated care. While AAFP applauds the 90-percent match provided by the ACA to the States to assist in the establishment of this new Medicaid PCMH option, it does have a restriction that AAFP thinks is not helpful. The PCMH options will include only the so-called high-need patients, such as those with two or more chronic conditions. While the PCMH has demonstrated extraordinary results in both saving costs and improving health by preventing high-cost chronic conditions, restricting the number of patients in a practice who can be included in the PCMH is unfeasible.

Providing different types of care for patients is impractical and possibly even unethical for any physician's practice. Limiting patient eligibility makes the cost of transformation for the practice much higher on a per-unit cost. Physicians are reluctant to invest in a total transformation of their practices into patient-centered medical homes for only a portion of their patient panel. Instead, they are going to become a patient-centered medical home for all of their patients. But if they are only eligible to receive enhanced payment for a small portion of their patients, then the PCMH does not meet the cost test, and it is unlikely that they will undergo this fairly costly and certainly time-consuming transformation.

TEACHING HEALTH CENTERS DEVELOPMENT GRANTS

The ACA directs the HHS Secretary to establish a grant program to support new or expanded primary care residency programs at teaching health centers and authorizes $25 million for fiscal year 2010, $50 million for fiscal years 2011 and 2012. The law also provides $230 million to cover the expenses of qualifying teaching health centers related to training primary care residents in certain expanded or new programs. This is a critically valuable provision that could help identify the residency programs that bring residents to non-hospital sites for training in primary care.

STATE MEDICAL TORT LITIGATION ALTERNATIVES DEMONSTRATION

The ACA authorizes $50 million in demonstration grants to States to test alternatives to civil tort litigation. These models will be required to emphasize patient safety, the disclosure of health care errors, and the early resolution of disputes. Patients will be able to opt-out of these alternatives at any time.

HHS will provide technical assistance through guidance on non-economic damages, including the consideration of individual facts and circumstances in determining appropriate payment, guidance on identifying avoidable injuries, and guidance on disclosure to patients of health care errors and adverse events.

While the ACA included these demonstration grants, it does not completely nor adequately address the problems associated with medical liability in this country. The *Help Efficient, Accessible, Low-cost, Timely Healthcare (HEALTH) Act* (HR 5), introduced in the 112th Congress, includes significant reforms that will help repair our Nation's medical liability system, reduce the growth of health care costs, and preserve patients' access to medical care.

Many experts agree that the current tort system in the United States leads to an increase in health care costs. The proven reforms contained in the HEALTH Act, including the $150,000 cap on non-economic damages, would help reduce costs, while ensuring that patients who have been injured due to negligence receive just compensation. This bill provides a balance of reforms by promoting speedier resolutions to disputes, maintaining access to courts, maximizing patient recovery of damage awards with unlimited compensation for economic damages, while limiting non-

economic damages to a quarter million dollars. In addition, the HEALTH Act protects effective State medical liability reform laws.

AAFP believes this reform is necessary to produce the comprehensive changes to our Nation's health care delivery system. It is time for this legislation which will repair the current litigious climate that continues to increase health care costs and compromise patients' access to care.

ESTABLISHMENT OF CENTER FOR MEDICARE AND MEDICAID INNOVATION WITHIN CMS

The law creates the Center for Medicare and Medicaid Innovation within CMS to research, develop, test, and expand innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care furnished to individuals. This new Center is designed to experiment with the PCMH model and to use it more broadly as soon as it begins showing savings or improved quality. While the CMMI is still in its developmental stages, it is the AAFP's desire that the center will soon be able to begin meaningful and comprehensive implementation of the PCMH demonstrations. This Center is an extremely important tool to make our Nation's health care delivery more efficient and more effective. It is vital that this Center retain its flexibility and scope. The AAFP believes it has the potential for being a powerful force for evidence-based, effective health care delivery.

SUMMARY

For more than 20 years, the AAFP has supported health care coverage for everyone. No one in this country should delay or forego needed care because of cost. Instead, we must:

• provide health care rather than focusing only on sick care—we must constrain total spending by helping patients avoid preventable illness, efficiently managing the care of people who have chronic illness and improving the quality of that care; and we must provide health care coverage to people who cannot afford it or who have been turned away due to pre-existing conditions;

• address the factors that drive up costs and lower quality: the fragmentation of care; the duplication of tests and services; and the disregard for chronic disease management, prevention and wellness care in favor of medical intervention; and

• build up the primary care physician workforce to meet the needs of everyone who needs care.

The ACA makes important strides in these directions by advancing models such as the patient-centered medical home, in which a qualified physician's practice provides and coordinates continuous and comprehensive care and preventive services, and coordinates health services when illness requires a larger team. We look forward to working with you on these important provisions.

OFFICE OF THE GOVERNOR,
STATE OF UTAH,
December 22, 2010.

Hon. KATHLEEN SEBELIUS, *Secretary,*
U.S. Department of Health and Human Services,
Washington, DC 20201.

DEAR SECRETARY SEBELIUS: After considerable technical analysis and internal discussion among State leaders, we have decided that Utah will not submit an application for the Health Exchange Early Innovator Grant.

As mentioned in the grant announcement, this funding opportunity was for "States that lead the race to develop IT systems for State exchanges." It would seem this grant opportunity was custom-made for Utah, given our advanced progress in implementing a health exchange. Utah's exchange is the only functioning market-based health insurance exchange in the country. From a technical perspective, there is no other State as qualified as Utah. In addition, as the grant announcement suggests, Utah is very committed to pursuing a multi-State partnership with like-minded States in order to develop a solution that is modular and adaptable to the local conditions in each State.

However, I am deeply concerned about the timing of the grant announcement and the deadline for grant submission because they seriously impede our ability to create multi-State partnerships. The grant announcement was made at the end of October, just a few days before 29 new governors were elected and the December 22, 2010 deadline effectively precludes any input from these new governors in the development of this proposal.

It is my understanding that the deadline is not statutory, but was chosen arbitrarily. Several States, including Utah asked for flexibility on the deadline to allow us a better opportunity to organize a multi-State response. My staff spoke to several other States who were seriously interested in jointly pursuing a grant with Utah. However, they all withdrew because they saw the December 22 deadline as impossible for them to meet.

As you are well aware, Utah was working on a State-designed solution for health system reform long before the election of the current Administration. Our efforts pre-date the provisions of the Affordable Care Act by several years. We are continuing the process of designing and implementing additional functionality in our current system. While it would definitely be helpful to have additional resources to implement these updates to our system and improve our exchange, the unrealistic timeline and its negative impact on States makes it impossible for us to develop the necessary relationships with other States. This issue was compounded by the fact that we could not get a firm answer from HHS staff as to what constituted a multi-State partnership under the terms of the grant.

For the time being, Utah will continue to develop our exchange on our own timetable. If HHS sincerely wants to foster multi-State partnerships, States need much more flexibility in the funding process. I strongly encourage you to direct your staff to work with us and our partner States to develop a funding process and timeframe that is more realistic. At a bare minimum, the deadline for this grant application should be postponed until July 2011.

Furthermore the current timeline for State-designed reforms to be implemented is unrealistic for most States. States trying to create exchanges will need at least an extra 3 years beyond the current January 2014 deadline to have a reasonable chance at developing a successful exchange. It is arbitrary and capricious to cut short those State efforts and replace them with a Federal solution without giving them a realistic opportunity to succeed.

Thank you for your attention to these very important matters. Please feel free to contact me directly or you may contact members of my staff at 801–538–1000 if you would like to discuss this further.

Sincerely,

GARY R. HERBERT,
Governor.

UTAH STATE LEGISLATURE,
SALT LAKE CITY, UTAH 84114,
January 13, 2011.

COMMITTEE ON DEFINING AND REVISING AN ESSENTIAL
HEALTH BENEFITS PACKAGE FOR QUALIFIED HEALTH PLANS,
Institute of Medicine of the National Academies.

Subject: State Perspectives on Essential Benefits

COMMITTEE CHAIR BALL AND MEMBERS OF THE COMMITTEE: Thank-you for inviting me to offer some thoughts today on the development of the essential benefits package under the Patient Protection and Affordable Care Act. My name is Jim Dunnigan. Since 2003, I have served as a member of the Utah House of Representatives. Over the past several years I have been actively involved in the debate and development of Utah health reform. I am also an insurance broker by profession and an active consumer of medical services. Today I wish to make several points that reflect my background and experience and that I believe are representative of the attitudes and opinions of many State legislators across this Nation, and their constituents. I am not before you today to debate the merits of the ACA or its proposed repeal, and so I will limit my comments to what I hope can be done to make implementation of the essential benefits package as smooth as possible.

I. PRESERVE STATE FLEXIBILITY

My message today is that the Federal Secretary of Health and Human Services should implement the essential benefits provisions of the ACA in a way that preserves maximum flexibility in benefit design across States. I will explain *how* this could be done and then explain *why* this is so important.

First, I don't think there's a question in anyone's mind that the scope of benefits offered in the essential benefits package will be a significant factor in the cost of qualified health plans that must be offered under the ACA, both inside and outside exchanges. Besides specifying general categories to be included in the package, the ACA states that, "The Secretary shall ensure that the scope of the . . . benefits are

equal to the scope of benefits provided under a typical employer plan. . . .” The problem for States is that what’s typical in one State may not be typical in another. For example, in addition to benefits already mandated by Congress, legislatures across this country have required plans within their States to incorporate to one degree or another some 60 additional benefits. Which benefits are included by each State is a matter of local politics and not necessarily a reflection of evidence-based value. To avoid imposing the political choices of each State on 49 others, the Secretary should allow what’s “typical” to be determined on a State-by-State basis. Or, in the case of a multi-State exchange, on a multi-State basis; and in the case of a sub-State exchange, on an exchange-level basis.

To this end, I recommend that the IOM encourage, and the Secretary of Health and Human Services request, that the Department of Labor structure its ACA-required survey of employer benefits in a way that allows a “typical employer plan” to be determined on a State-level basis, and in any cases where States are known to have very distinct regional differences in benefit offerings, on a sub-State basis. Failure to structure the Labor survey in this manner will almost certainly bias development of the essential benefits package toward a one-size-fits-all package that is less generous than typical employer plans in some States and more generous than typical employer plans in others.

In this same spirit of flexibility and recognition of State differences, I recommend that the Secretary of Health and Human Services allow States, through their exchanges, to spell out the definitional details of the general benefit categories listed in section 1302. However, if in the end the Secretary believes she just can’t leave the details up to the States, I recommend that she create a three-tier approach to essential benefits:

- Tier 1 benefits would be limited to those provided under a typical employer plan offered within the geographic boundaries of an exchange.
- Tier 2 benefits would be designated by the Secretary of Health and Human Services and would include benefits that go beyond what employers typically offer within the boundaries of the exchange. Ideally, these would be benefits with strong evidence about delivery and value. States would elect, on a State-by-State basis, whether to adopt Tier 2 benefits as part of an essential benefits package.
- Tier 3 benefits would include any other benefits a State may wish to include in the essential benefits package.

Exchange subsidies for Tier 1 and Tier 2 benefits would be fully funded by the Federal Government. Subsidies for Tier 3 benefits would be funded by the respective States.

II. RECOGNIZE THE IMPACT ON STATE BUDGETS

I realize the IOM would like to gather specific evidence on the health and cost impacts of including or excluding particular services from an essential benefits package. I am not prepared to present that kind of information today, but would recommend that the Institute reach out to State insurance commissioners and health department directors across the country to learn what work has already been done at the State level. I am prepared, though, to discuss some of the impacts an essential benefits package—or perhaps 50 different essential benefits packages—could have on States.

States are fiscal partners with the Federal Government. On average, we fund 43 percent of Medicaid. Each State Medicaid program is unique and reflects the fiscal capacity and political preferences of the sponsoring State. Under the ACA, new expansion populations in each State will be required to have coverage that includes essential benefits. The level of these benefits will have a direct impact on each State’s budget. As the funding responsibility for the newly eligibles shifts from the Federal Government to the States (beginning in 2017), each State will have to either raise additional revenue, if it can, or—more likely—divert funding that would otherwise go to other important services like transportation, corrections, and education. This is not a new phenomenon. Medicaid has been competing with, and sometimes crowding out, other essential government services since its inception. But the degree to which legislatures will have to either raise new revenue or reduce funding for other essential services will depend in large measure on the definition of essential benefits.

One additional concern about Medicaid is the impact over time the essential benefits package may have on other parts of Medicaid. Even if essential benefits start out leaner than benefits provided to nonexpansion populations, essential benefits will drive up the cost to States in traditional populations if, as the benefits are revised, they become the basis for increasing benefits to traditional populations.

States also contribute significantly to the purchase of insurance for their own employees and the employees of State-funded entities, e.g., school districts and institutions of higher education. In my own State, we pick up 95 percent of the cost of a State employee's health plan. If an essential benefits package mandates that we now cover new benefits, those benefits will be a direct cost to the State. To respond, we must increase revenue (not likely, particularly in the current economic environment), decrease funding for State programs, or decrease employee compensation.

One final concern related to State budgets: States realize that if employers who currently cover Medicaid-eligible employees stop offering coverage, those employees will end up on Medicaid. States will become liable for people previously covered in the private market. I don't think anyone really knows how much this will occur, but the likelihood increases to the extent essential benefits requirements exceed coverage already offered. And the benefit levels typically offered by employers are almost certain to be exceeded in some States if the Secretary establishes a national one-size-fits-all essential benefits package.

III. CONCLUSION

All of this suggests that what is or is not considered an essential benefit under the ACA is of real significance to States. Essential benefits will drive the costs of at least a portion of the Medicaid program, public employee health plans, other plans funded by States, and private employer plans. For this reason, flexibility across States to minimize the imposition of significant additional plan costs is essential.

In closing, I'd like to make one final observation.

Utah is a low-cost, high-quality health care State. This is true even after adjusting for demographics. Other regions of the country, as was pointed out repeatedly during the Federal health care debate, have also achieved similar status. This has only been possible because of provider-developed innovations. We should avoid—as much as allowable under ACA—prescriptive directives about benefits, cost sharing, and other plan design features that would have the effect of suppressing such innovation and further locking in the misaligned financial incentives that account for so much of the overutilization, underutilization, and mis-utilization of health care that drives up costs in the current system.

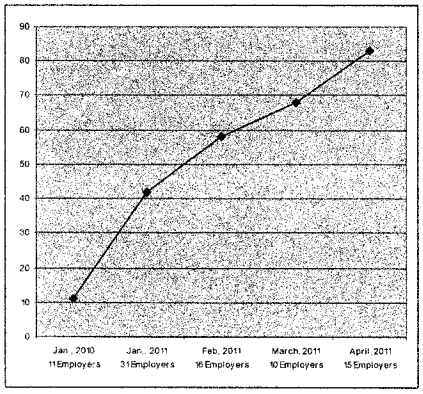
Thank you.

JAMES A. DUNNIGAN,
Utah House of Representatives.

Utah Health Exchange - Summary of Activities
Small Employer Groups
March 7, 2011

Employer Participation Continues to Grow

Total number of employer groups in the Exchange Effective April, 2011: 83



- All eleven 2010 "pilot groups renewed for 2011.
- **January 2011**: Thirty-one additional employer groups enrolled for January, bringing the count to forty-two.
- **February 2011**: Sixteen additional employer groups enrolled for a February 1st benefit effective date, bringing the count to fifty-eight.
- **March 2011**: Ten additional employer groups enrolled for a March 1st benefit effective date, bringing the count to sixty-eight.
- **April 2011**: Fifteen additional employer groups enrolled for a April 1st benefit effective date, bringing the count to eighty-three.
- **May 2011**: Forty employer groups have applied for a May 1st benefit effective date and are currently either in the underwriting process, the defined contribution process, or in open enrollment.
- **June 2011:** Forty-six additional groups have submitted their employer application for a June benefit effective date and are presently completing employee health applications.

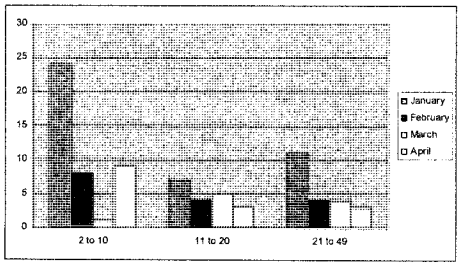
Profile of Participating Employers

Group size matrix:

- Average group size: 13 employees
- Largest group size: 49
- Smallest group size: 2

Breakout of participating employers by group size:

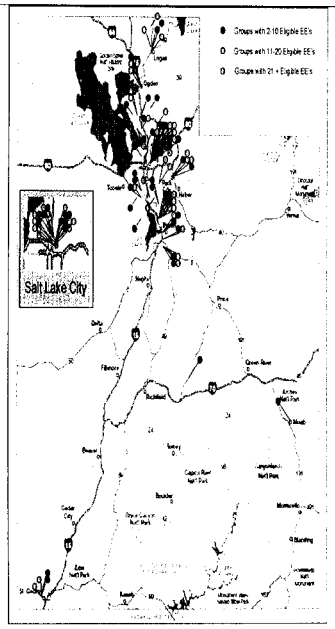
- 42 groups with 2-10 eligible employees
- 19 groups with 11-20 eligible employees
- 22 groups with 21+ eligible employees



Distribution of Participating Employer Groups

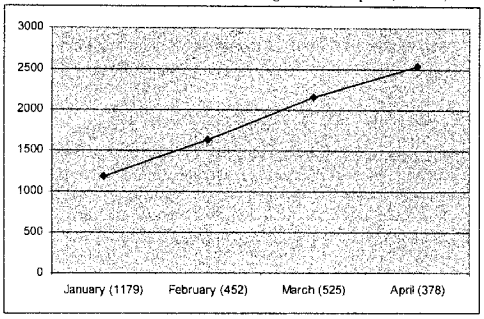
Location map of each group currently enrolled in the Utah Health Exchange.
Total number of employer groups enrolled in the Exchange by city.

- Alpine – 2
- Centerville – 1
- Clearfield – 2
- Draper – 1
- Eagle Mountain – 1
- Emery – 1
- Herriman – 1
- Layton – 3
- Logan – 4
- Midvale – 2
- Moab – 1
- Morgan – 1
- Mtn. Green – 1
- Murray – 1
- Ogden – 4
- Orem – 9
- Park City – 5
- Provo – 3
- Richmond – 1
- Riverdale – 1
- Roy – 1
- SLC – 20
- South Jordan – 2
- Spanish Fork – 4
- Springville – 2
- St. George – 4
- Syracuse – 1
- West Bountiful – 1
- West Jordan – 2
- West Valley – 1



Total Number of Covered Lives in the UHE

Total number of covered lives in the Exchange Effective April 1, 2011: 2,534



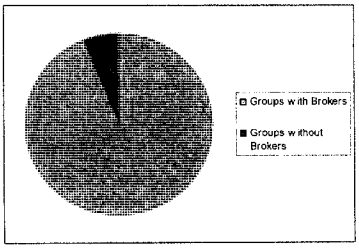
- **January 1 Effective Date Totals:**
  Covered lives: 1179
  Employees covered: 456
  Dependents covered: 723
- **February 1 Effective Date Totals:**
  Covered lives: 452
  Employees covered: 165
  Dependents covered: 287
- **March 1 Effective Date Totals:**
  Covered lives: 525
  Employees covered: 181
  Dependents Covered 344
- **April 1 Effective Date Totals:**
  Covered lives: 378
  Employees covered: 165
  Dependents covered: 213.

Ratio of Groups with Brokers

Broker/No Broker Count

- **January 2010**: 11 groups with a broker
- **January 2011**: 28 New Groups with a broker & 3 groups without a broker
- **February 2011**: 16 new groups with a broker & 0 groups without a broker.
- **March 2011**: 10 new groups with a broker & 0 without a broker
- **April 2011**: 13 new groups with a broker & 2 without a broker.

78 of the 83 groups currently on the Utah Health Exchange have a broker



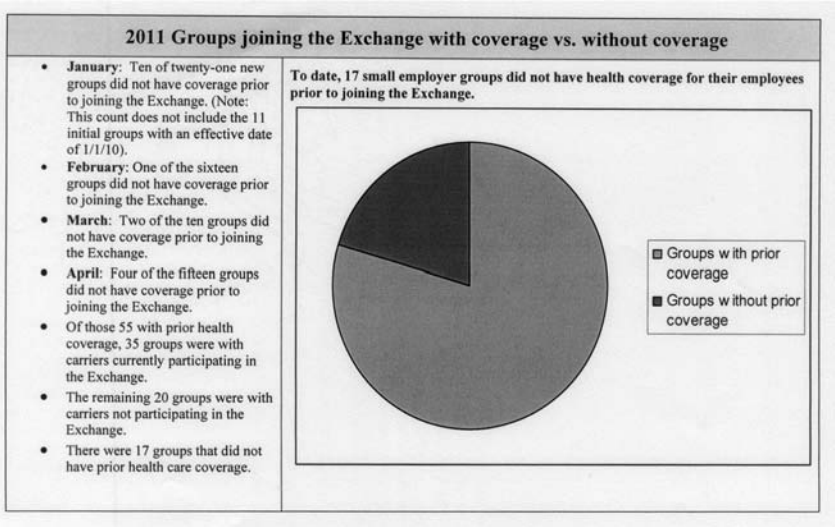
Defined Contribution by Participating Employers

- Average employer defined contribution amount: $360
- Largest employer defined contribution amount: $1,683
- Smallest employer defined contribution amount: $0

Business Types

Business types & number of groups enrolled in the Exchange

- LLC = 30
- S-Corp = 22
- C-Corp = 24
- P-Corp = 3
- Non-Profit = 3
- General Partnership = 1



[Whereupon, at 12:30 p.m., the hearing was adjourned.]

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