THE PRESIDENT'S HEALTH CARE LAW DOES NOT EQUAL HEALTH CARE ACCESS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE

HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRTEENTH CONGRESS

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C O N T E N T S

WITNESSES

SUBMITTED MATERIAL

THE PRESIDENT'S HEALTH CARE LAW DOES NOT EQUAL HEALTH CARE ACCESS

THURSDAY, JUNE 12, 2014

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

The subcommittee met, pursuant to call, at 9:59 a.m., in room 2123, Rayburn House Office Building, Hon. Joseph R. Pitts (chairman of the subcommittee) presiding.

Members present: Representatives Pitts, Burgess, Shimkus, Murphy, Blackburn, Gingrey, Griffith, Bilirakis, Ellmers, Pallone, Capps, Schakowsky, Green, Barrow, Christensen, Castor, Sarbanes, and Waxman (ex officio).

Also present: Representative McKinley.

Staff present: Clay Alspach, Chief Counsel, Health; Gary Andres, Staff Director; Sean Bonyun, Communications Director; Noelle Clemente, Press Secretary; Paul Edattel, Professional Staff Member, Health; Brad Grantz, Policy Coordinator, Oversight and Investigations; Sydne Harwick, Legislative Clerk; Sean Hayes, Deputy Chief Counsel, Oversight and Investigations; Robert Horne, Professional Staff Member, Health; Katie Novaria, Professional Staff Member, Health; Chris Pope, Fellow, Health; Chris Sarley, Policy Coordinator, Environment and the Economy; Heidi Stirrup, Policy Coordinator, Health; Ziky Ababiya, Democratic Staff Assistant; Debbie Letter, Democratic Staff Assistant; Karen Nelson, Democratic Deputy Committee Staff Director, Health; and Matt Siegler, Democratic Counsel.

Mr. PITTS. Ladies and gentlemen, if you will take your seats. The subcommittee will come to order.

We are going to have votes shortly, so we are going to run a tight gavel this morning.

The Chair will recognize himself for an opening statement.

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

The President's health care law was sold to the American people with a number of promises: If you like your plan, you will be able to keep it; if you like your doctor, you will be able to continue seeing him or her. Advocates of the law made this promise again and again. In fact, President Obama, according to one count, made this promise nearly 37 times.

Yet, as we now know, this promise was simply not true. Last year, millions of Americans had their health plans canceled, were forced to enroll in exchange plans. Americans are also learning another sad truth: Health plans offered in the exchanges are often not providing access—access to doctors, hospitals, and drugs they need.

Why is this occurring? As we will hear today, many of these problems lie at the feet of the Affordable Care Act. The Affordable Care Act includes a number of benefits—mandates—imposed on the plans consumers can buy. The law also adds hundreds of billions of dollars in new taxes that are being passed on to patients. And this leaves insurers with only a few tools to control and manage cost.

As a result, many plans are turning to narrower provider networks and skimpier prescription drug coverage to keep premiums and deductibles in check. Studies show that, compared with typical employer-sponsored plans, Bronze and Silver exchange plans include far fewer doctors, specialists, and hospitals.

One of our witnesses today, Dr. Scott Gottlieb, in an analysis comparing an exchange plan to a comparable private health plan across several States found dramatically narrower networks for critical specialties, such as cardiologists, oncologists, and OB–GYNs, among others.

As CNN Money reported last October, quote, "Many insurers have opted to limit their selection of doctors in some exchange plans to keep premiums and other costs down. And they are also excluding large academic medical centers, which are often pricier because they tackle sicker patients and more complex cases," end quote.

This trend is particularly dangerous for those dealing with serious diseases that may have to go out of network and, therefore, bear significant cost to find a provider to meet their unique needs.

Even those without serious illnesses have found that their doctors they know and like are no longer participating in their new exchange plans. A constituent from Conestoga, Pennsylvania, wrote to me that, after her policy of nearly 30 years was canceled last fall because it was not fully ACA-compliant, she was unable to find a new exchange plan which included her doctors in the network. Her OB–GYN, whom she had been seeing since 1989, and her gastroenterologist are now out of network.

Narrower networks are not the only access problem consumers are running into. And, again, in order to manage cost, some plans are simply not covering the most cutting-edge, expensive treatments and drugs in their formularies. Analysis shows that even when expensive drugs are covered, patients in exchange plans pay much higher cost-sharing for them than their counterparts in traditional employer-sponsored plans.

It is this committee's job to understand the negative consequences patients are facing under the Affordable Care Act. And it is also incumbent for us to begin to examine this problem and develop solutions to protect Americans being hurt by the health care law.

I thank all of our witnesses for being here today. I look forward to getting your perspective on the challenges patients have and will face under the Affordable Care Act.

I will yield to Dr. Burgess.

Mr. BURGESS. No, I think——

Mr. PITTS. OK. I yield back and now recognize the ranking member of the subcommittee, Mr. Pallone, for 5 minutes.

[The prepared statement of Mr. Pitts follows:]

PREPARED STATEMENT OF HON. JOSEPH R. PITTS

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Advocates of the law made this promise again and again. In fact, President Obama, according to one count, made this promise nearly 37 times.

Yet as we now know, this promise was simply not true. Last year, millions of Americans had their health plans cancelled and were forced to enroll in exchange plans.

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Why is this occurring? As we will hear today, many of these problems lie at the feet of the Affordable Care Act.

The ACA includes a number of benefits mandates imposed on the plans consumers can buy. The law also adds hundreds of billions of dollars in new taxes that are being passed on to patients. This leaves insurers with only a few tools to control and manage costs. As a result, many plans are turning to narrow provider networks and skimpier prescription drug coverage to keep premiums and deductibles in check.

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Narrower networks are not the only access problem consumers are running into. Again, in order to manage costs, some plans are simply not covering the most cutting-edge, expensive treatments and drugs in their formularies.

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It is this committee's job to understand the negative consequences patients are facing under the Affordable Care Act. It is also incumbent for us to begin to examine this problem and develop solutions to protect Americans being hurt by the President's health care law. I thank our witnesses for being here today and look forward to getting your perspective on the challenges patients have and will face under the ACA.

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

Mr. PALLONE. As we prepare to have this conversation today, there has to be some perspective. Republicans again will hammer over and over again the same smears against the Affordable Care Act that they have said year after year, and they will say the President and the law have done no good for the country, but the facts beg to differ.

So let's talk about how the law has led to the largest expansion of health insurance coverage in decades. And I am not just saying that; multiple independent surveys and analysis have shown that, because of the ACA, millions more Americans have health insurance coverage this year than they had last year.

Here are some numbers: 8 million have private health insurance through the ACA's new marketplace; 6 million more now have Medicaid coverage; and millions more have purchased health care outside the exchanges.

Mr. Chairman, Massachusetts' uninsured rate is down to essentially zero percent because of the ACA. Minnesota's is down by 40 percent. And my home State New Jersey's rate of uninsured adults has dropped by nearly 40 percent, its lowest level in nearly 25 years. And these are real numbers that matter.

So if Republicans want to talk about how to ensure that this coverage equates to better access, let's have that debate. Let's talk about the ways in which we can strengthen the new marketplaces. Let's talk about real solutions. Unfortunately, the Republicans don't have any. They have no alternative plan that can be put in place through the ACA that would result in the same level of coverage for the millions of people who want health insurance.

If you want to improve upon the law, that is fine. The insurance industry just released a paper yesterday offering ideas to improve the law. But where are the Republicans' solutions? Do you want to guarantee broader doctor networks? Great. Let's discuss the ways in which we can do that. Do you want to mandate broader drug coverage? Wonderful. Let's talk about the best approach to address that.

The law sets key basic standards and then gives States flexibility to address these issues. In fact, we will hear from one of the witnesses today about the flexibility. And so I ask my Republican colleagues, do you want to preempt States?

Meanwhile, insurers, providers, and drug companies engage in private contract negotiations every year to create benefit packages. So are my Republican colleagues saying they would like to interfere in those negotiations?

The truth is, the Republicans aren't saying anything except let's go back to a system that gives companies free range charge to whatever they want without any requirements to actually take care of sick people or help them stay healthy.

We cannot and should not lose sight of the great strides that this law has taken to get health insurance coverage to people who never had it, who couldn't afford it, who were denied it because they had preexisting conditions. Now, millions of Americans have a health plan that ensures quality coverage with guaranteed benefits and a

premium placed on prevention. This is a significant improvement in Americans' access to health care.

So, Mr. Chairman, I am waiting to hear what is the Republican plan to improve access, because the only so-called solution I have seen out of the Grand Old Party is an effort to repeal the law and leave 25 million more Americans uninsured. If we want to improve the new insurance market, let's do so. But, so far, I have not seen any serious effort by the Republicans to improve health coverage for anyone.

I yield the remainder of my time to Mr. Green of Texas.

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

Mr. GREEN. I thank Mr. Pallone for yielding.

The landmark health reform law has enabled 8 million Americans to enroll in exchanges, 6 million to gain coverage through Medicaid and CHIP, and Americans who already have insurance can feel more secure in their coverage, ending some of the worst abuses of insurance companies, providing key new consumer protections and cost savings.

If you want something perfect, don't come to Congress. This law is a result of compromise, and there are so many ways to improve it. If the 24 States that so far refused to expand Medicaid at very modest cost to the States and which was largely offset by savings in cost of services for the uninsured, millions more would be able to access health care.

The Affordable Care Act is so important to pivot from the health-sick system to the true health care system. The law has allowed the uninsured rate for Americans to drop to the lowest level since Gallup and Healthways started tracking this data. And I look forward to seeing it decline further and working toward making improvements in this landmark law.

And, again, I thank my colleague for yielding.

Mr. PITTS. The Chair thanks the gentleman.

I now recognize the vice chairman of the subcommittee, Dr. Burgess, 5 minutes for an opening statement.

OPENING STATEMENT OF HON. MICHAEL C. BURGESS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. BURGESS. Thank you, Mr. Chairman.

And thanks to our witnesses for being here with us today.

Thank you for holding this hearing.

Already been pointed out, we heard it time and time again from the President: If you like your doctor, you can keep your doctor, period; if you like your health plan, you can keep your health plan, period. It sounded great on the stump but is operationally not possible.

The Affordable Care Act cancels the policy that patients wanted, mandates what they must buy instead, and this comes at a cost. The Affordable Care Act overly constricts the health insurance marketplace. It limits choice by imposing hundreds of benefit mandates, leading to higher costs. States like California have imposed even greater restrictions on choice. As a result, they are facing

some of the most limited networks and highest out-of-pocket costs for prescription drugs in the country.

Plans have been canceled. Plans sold on the health care exchanges are leaving people functionally uninsured. Patients are being subjected to higher and higher deductibles and other out-of-pocket costs. They now lack critical access to their doctors and vital prescription medication.

I am very familiar with these problems. I did not accept the deal that was offered to Members of Congress in buying health insurance. None of my constituents could do that. So what I did was went into healthcare.gov and bought on the individual market. My current plan now has a $6,000 deductible. It does not cover medications that I had previously been taking. And I am pretty lucky, I don't have to take many things, but even with that narrow requirement, it could not be met.

This law also negatively impacts those most in need of care. For individuals who do have severe medical needs, pediatric oncology patients, many of the Nation's leading cancer centers and pediatric hospitals are not included in the provider networks or the exchange plans, and access to necessary specialty drugs often comes at a tremendous cost. Analysts have found that the cost of just one dose of some specialty medications could eat up to a third of an enrollee's monthly income, even for so-called high-value plans with lower cost-sharing.

Texas is home to some of the world's best medical centers. The State's cancer centers and transplant centers—M.D. Anderson, Baylor University Medical Center, Texas Children's Hospital—treat patients from all over the country. Yet these centers are generally included in less than half of the plans that are offered in the Texas health insurance exchange.

There is also widespread physician uncertainty about whether having existing contracts with insurers means that they are already included in an exchange plan network. As a doctor, I know this could lead to confusion both for the physician and their patient. So another example of how the Affordable Care Act hurts patients, hurts doctors, and is a strain on our economy.

This committee should continue to hold the President to his word and ensure that patients have the ability to keep their doctor and their choice of insurance. The only way to do this is to rescind or modify burdensome laws and regulations.

I yield the balance of the time to the gentleman from West Virginia, Mr. McKinley.

OPENING STATEMENT OF HON. DAVID B. MCKINLEY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WEST VIRGINIA

Mr. MCKINLEY. Thank you.

And thank you, Mr. Chairman, for holding this hearing on the access to drugs and doctors under Obamacare and allowing me to join the subcommittee today.

The issue of access to good medical care has become a passion of mine. Since introducing the Patients' Access to Treatments Act, I have heard from people all around the country, about people that

are not able to afford medication that they need, even with private insurance, because of a specialty tier.

Now we hear that under the Obama exchanges some plans are not covering specialty and biologic medicines at all. This loophole is blocking Americans with disabling diseases from getting the necessary care that they need. This is unacceptable.

I am looking forward to hearing from the witnesses this morning on this issue that is extremely vital to the most vulnerable citizens in our Nation.

And I yield back my time. Thank you.

Mr. PITTS. The Chair thanks the gentleman and now recognizes the ranking member of the full committee, Mr. Waxman, 5 minutes for an opening statement.

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

Mr. WAXMAN. Thank you, Mr. Chairman.

Today's hearing is about access to health care services in the new health insurance marketplaces. The Affordable Care Act is the single most important step forward on this issue in the last 50 years. It will expand insurance coverage by over 25 million people, it ensures all plans offer real benefits, and it bans discrimination on the basis of preexisting conditions.

Now, I know my Republican colleagues are in a constant struggle to see who can be the most misleading and most opposed to the ACA, but the premise of this hearing is a stretch even for them.

Republicans are trying to claim that the benefit packages and provider networks in ACA plans are actually limiting access to care. But at the same time, they want to take us back to a world where health plans are free to offer policies that do not cover prescription drugs or hospitalization. They want to go back to a world where a child with asthma can be turned down by a health insurance company because of his or her preexisting condition. Do they really think that would improve access?

If a father has a policy that doesn't cover prescription drugs, what type of access does he have? If a mother has a policy that does not cover hospitalizations, what type of access does she have? And if a young girl is barred from insurance because of a preexisting condition, what type of access does she have? And if a working family is denied Medicaid because their State won't take 100 percent Federal dollars and expand coverage, what type of access do they have? The answer is obvious: They have next to no access.

So I really can't take Republicans' criticism too seriously today. What I do take seriously is the need for good provider networks and robust benefit packages in the health insurance marketplaces. That is why we wrote the first nationwide network adequacy standard for the private insurance into the law. It is why we ensured that prescription drugs were 1 of the 10 essential health benefits. And it is why we barred discriminatory insurance benefit designs and included essential community providers in all insurance networks.

Insurers' and providers' and drug companies' private contractual negotiations have always been contentious, and regulators have an important balance to strike between broad access and affordability. These challenges are nothing new. As enrollment and competition in the new marketplaces increase, I am confident that we will see more choice and broader range of benefit packages.

For example, in my own district, one of the most expensive and best-regarded health systems in the Nation was not a major participant in the marketplace last year, but after our State's enrollment dramatically exceeded expectations, they announced they will be in-network next year. That is private competition at work.

As the law moves forward, Democrats will continue to work to step up enforcement of plans that discriminate or improperly limit access and will continue to work to expand choice and improve the benefit packages offered in the marketplaces. And we would welcome the Republicans joining us in trying to accomplish that.

But if Republicans truly share these goals, while we are eager to work with them, Mr. Chairman, what we will not do is go back to the rampant discrimination and dangerous lack of access that we had before reform. And that is what we would have had if any of those votes that passed the House were taken up and passed by the Senate and signed by the President to repeal the Affordable Care Act.

This is a hearing that is all politics and very little substance.

I yield back my time.

Mr. PITTS. The Chair thanks the gentleman.

That concludes the opening statements of the Members. The written statements of all Members will be made part of the record.

I would like to have a UC, seek unanimous consent, to submit three items for the record: a letter from the Association of Mature American Citizens; a sheet of the White House Web site listing "You Can Keep Your Own Insurance;" and a study by the Congressional Research Service entitled, "Private Health Insurance Market Reforms in the Affordable Care Act."

[The information follows:]

Amac
Association of Mature American Citizens
Voice of Americans 50+

June 12th, 2014

The Honorable Joe Pitts
16th District, Pennsylvania
420 Cannon House Office Building
Washington, DC 20515

The Honorable Frank Pallone, Jr.
6th District, New Jersey
237 Cannon House Office Building
Washington, DC 20515

Dear Chairman Pitts and Ranking Member Pallone,

On behalf of the 1.2 million members of AMAC, the Association of Mature American Citizens, I am writing to express our thoughts regarding the Health Subcommittee's upcoming hearing entitled, "The President's Health Care Law Does Not Equal Health Care Access."

AMAC is grateful for the Subcommittee's ongoing examination of access to health care since the passage and the partial implementation of the Affordable Care Act. Too often, our members are relating experiences of diminished provider networks, increased premiums, and health care plans with paltry benefit offerings.

The Affordable Care Act was sold as a means to increase access to health care, but instead, many of our members have seen long-term relationships with their physicians severed as less and less providers are available to care for them. For this reason, AMAC continues to emphasize the importance of a health care system centered on the doctor-patient relationship and the need to empower individuals with more choices when it comes to health care. Additionally, AMAC believes it is equally as important to differentiate between increased coverage and the delivery of high-quality health care.

AMAC commends the Health Subcommittee for addressing the many issues currently facing the U.S. health care system. As the fastest-growing alternative seniors advocacy organization in the country, AMAC appreciates your attention to these important matters and looks forward to engaging with the Subcommittee and to promoting commonsense solutions to these problems in the future.

Sincerely,
Dan Weber
President and Founder of AMAC

Whether or not you have health insurance right now, the reforms we seek will bring stability and security that you don't have today.

This isn't about politics. This is about people's lives. This is about people's businesses. This is about our future.

– *PRESIDENT BARACK OBAMA*

As the passing of health insurance reform draws near, the defenders of the status quo in Washington are growing fierce in their opposition and using misleading information to defeat the chance of real reform. Health insurance reform will protect people against unfair insurance practices; provide quality, affordable insurance to every American; and bring down rising costs for families and businesses — this shouldn't be about Washington politics. It's about American lives, businesses and our future.

It's never been more important to dispel these outlandish rumors and myths. Learn the facts and share them with your friends, family and neighbors.

REALITY CHECK:

You Can Keep Your Own Insurance

Reform isn't about putting government in charge of your health insurance; it's about putting you in charge of your health insurance. If you like your doctor, you can keep your doctor. If you like your health care plan, you can keep your health care plan.

Reform Will Stop "Rationing" — Not Increase It

Reform will not lead to a "government takeover" of health care or "rationing." On the contrary, reform will forbid many forms of rationing that are currently being used by insurance companies.

Reform Will Benefit Small Business — Not Burden It

Health insurance reform will ease the burdens on small businesses and help level the playing field with big firms who pay much less to cover their employees on average.

The "Euthanasia" Distortion on Help for Families

It's a malicious myth that reform would encourage or even require euthanasia for seniors. On the contrary, reform empowers families and provides the option to get resources and accurate information.

Your Medicare is Safe, and Stronger with Reform

Reform would simply eliminate waste and unnecessary subsidies to insurance companies, not cut Medicare benefits.

Reform Won't Add to the Deficit — It Will Bring Down Long Term Costs

President Obama has demanded that health insurance reform not add to the deficit, and has identified hundreds of billions of dollars in savings by eliminating unnecessary subsidies to insurance companies through Medicare. Skyrocketing health care costs pose the biggest threat to our fiscal stability in the long term under the status quo, and reform is imperative to bring down those costs.

Health Insurance Consumer Protections

The security YOU GET from health insurance reform:

- No Discrimination for Pre-Existing Conditions
- No Exorbitant Out-of-Pocket Expenses, Deductibles or Co-Pays
- No Cost-Sharing for Preventive Care
- No Dropping of Coverage for Seriously Ill
- No Gender Discrimination
- No Annual or Lifetime Caps on Coverage
- Extended Coverage for Young Adults
- Guaranteed Insurance Renewal

Learn More and tell us what myths we should address next

Visit **WhiteHouse.gov/realitycheck**

Private Health Insurance Market Reforms in the Affordable Care Act (ACA)

Annie L. Mach
Analyst in Health Care Financing

Bernadette Fernandez
Specialist in Health Care Financing

May 6, 2014

Congressional Research Service
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www.crs.gov
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CRS REPORT
Prepared for Members and
Committees of Congress

Summary

The Affordable Care Act (ACA, P.L. 111-148, as amended) establishes federal requirements that apply to private health insurance. The market reforms affect insurance offered to groups and individuals and impose requirements on sponsors of coverage (e.g., employers). In general, all of ACA's market reforms are currently effective; some became effective shortly after ACA was passed in 2010, while others are effective for plan years that begin on or after January 1, 2014.

While some of the market reforms had previously been enacted in some states, many of the reforms are new at the federal level. Collectively, the reforms create federal minimum requirements with respect to access to coverage, premiums, benefits, cost-sharing, and consumer protections. For example, the requirement to offer health plans on a guaranteed issue basis means that, in general, insurers must accept every applicant for health coverage, as long as the applicant agrees to the terms and conditions of the coverage (e.g., premium). The requirement to offer the essential health benefits means that certain plans have to cover a specified package of benefits.

The applicability of the market reforms across types of plans is not uniform. Some of the reforms apply to all three segments of the private insurance market—nongroup, small group, and large group—while others may apply only to plans offered in the nongroup and small group markets. In the group market, the reforms do not always apply to both fully insured plans (plans offered by state-licensed carriers that are purchased by employers or other sponsors) and self-insured entities (groups that set aside funds to pay for health benefits directly). The applicability of the reforms also depends on whether a plan has "grandfathered" status. Under ACA, an existing health plan in which a person was enrolled on the date of ACA enactment was grandfathered; the plan can maintain its grandfathered status as long as it meets certain requirements. Grandfathered health plans are exempt from the majority of ACA market reforms.

While the applicability of the market reforms is not necessarily uniform across plan types, it is uniform for plans offered inside and outside health insurance exchanges. Every state has an exchange, and individuals and small employers can use the exchanges to shop for and obtain health insurance coverage. The same market reforms apply to a nongroup plan offered through an exchange and a nongroup plan offered in the market outside of an exchange. Some types of plans do not have to comply with any of the market reforms. For example, retiree-only health plans are not required to comply with federal health insurance requirements, including ACA's market reforms.

This report provides background information about the private health insurance market, including market segments and regulation. It then describes each ACA market reform. The reforms are grouped under the following categories: obtaining coverage; keeping coverage; cost of purchasing coverage; covered services; cost-sharing limits; consumer assistance and other health care protections; and plan requirements related to health care providers. The **Appendix** of the report provides details about the types of plans that are required to comply with the different reforms.

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The Affordable Care Act (ACA, P.L. 111-148, as amended) includes reforms of the health insurance market that impose requirements on private health insurance plans.[1] Such reforms relate to the offer, issuance, generosity, and pricing of health plans, among other requirements. Certain reforms also require the participation of public agencies and officials, such as the Secretary of Health and Human Services (HHS), in order to facilitate administrative or operational elements of the insurance market.

This report first provides background information about the private health insurance market and then describes the market reforms included in ACA. The **Appendix** of the report provides additional information about how ACA market reforms apply to different market segments and types of health plans.

Background

Health Insurance Markets

The private health insurance market is often characterized as having three segments—the large group, small group, and individual markets. Insurance sold in the large and small group markets refers to plans offered through a plan sponsor, typically an employer.[2] Prior to ACA, large group plans typically had more than 50 workers, and small group plans had 50 or fewer workers. However, ACA implements specific definitions of large and small groups that affect the provisions discussed in this report. Prior to 2016, states can elect to define "small employers" as those that employ 100 or fewer employees or those that employ 50 or fewer. Beginning in 2016, small employers will be defined as those with 100 or fewer workers. The nongroup, or individual, market refers to insurance policies offered to individuals and families buying insurance on their own (i.e., not through a plan sponsor).

State and Federal Regulation

States are the primary regulators of the business of health insurance, as codified by the 1945 McCarran-Ferguson Act (15 U.S.C. §§1011 et seq.). Each state has a large, unique set of rules that apply to state-licensed insurance carriers and the plans they offer.[3] Such rules are broad in scope and address a variety of issues, such as the legal structure and organization of insurance issuers (e.g., licensing requirements), business practices (e.g., marketing rules), market conduct (e.g., capital and reserve standards), nature of insurance products (e.g., benefit mandates), and consumer protections (e.g., plan disclosure requirements), among others.

[1] For simplicity's sake, the term "plan" is used generically in this report. It applies to different types of health coverage provided to groups (e.g., employees of a single firm) and individuals.

[2] The reference to group markets technically applies to health plans offered by state-licensed insurance carriers and purchased by employers and other plan sponsors. However, health insurance coverage provided through a group may also be sponsored through "self-insurance." Groups that self-insure set aside funds to pay for health benefits directly, and those groups bear the risk for covering medical expenses generated by the individuals covered under the self-insured plan.

[3] State regulation of health insurance applies only to state-licensed entities. Since self-insured plans are financed directly by the plan sponsor, such plans are not subject to state law.

In addition to the state regulation of insurance, the federal government has established federal standards applicable to health coverage and imposes requirements on state-licensed insurance carriers and sponsors of health benefits (e.g., employers). The federal regulation of health coverage is particularly salient with respect to health benefits provided through employment.[4]

ACA follows the model of federalism that has been employed in prior federal health insurance reform efforts (e.g., Health Insurance Portability and Accountability Act of 1996). In other words, while ACA establishes many federal rules, the states have primary responsibility for monitoring compliance with and enforcement of such rules. In addition, states may impose additional requirements on insurance carriers and the health plans they offer, provided that the state requirements neither conflict with federal law nor prevent the implementation of federal market reforms.

ACA Market Reforms

ACA establishes federal requirements that apply to private health insurance. The reforms affect insurance offered to groups and individuals, impose requirements on sponsors of coverage, and, collectively, establish a federal floor with respect to access to coverage, premiums, benefits, cost-sharing, and consumer protections. While such market reforms may be new at the federal level, many of ACA's reforms had already been enacted in some form in some states, with great variation in scope and specificity across the states. In general, all of ACA's market reforms are currently effective.[7] (See the text box, "Transitional Policy," for a discussion about why some plans may not have to comply with applicable ACA market reforms until 2017.)

The applicability of reforms across types of plans is not uniform. Often reforms apply differently to health plans according to the market segment in which the plan is offered

Transitional Policy

On March 5, 2014, the Centers for Medicare and Medicaid Services (CMS) extended a transitional policy that was first described in guidance issued by CMS in November 2013.[5]

Under the transitional policy, health insurance issuers offering non-grandfathered coverage in the nongroup and small group markets may choose to continue coverage that would otherwise be cancelled. Pursuant to the policy, state insurance commissioners may choose whether to enforce compliance with specified ACA market reforms. Presumably, if state insurance commissioners choose not to enforce compliance, then issuers may renew coverage for enrollees who would otherwise receive cancellation notices.

Pursuant to the extended policy, coverage renewed for a plan year between January 1, 2014, and October 1, 2016, does not have to comply with certain ACA market reforms, provided the coverage meets specified conditions.[6]

[4] Federal regulation applies to both traditional insurance and self-insured plans. For more information about federal regulation of health benefits provided through employment, see CRS Report RS22643, *Regulation of Health Benefits Under ERISA: An Outline*.

[5] The March 5, 2014, extension guidance is available at http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/transition-to-compliant-policies-03-06-2015.pdf. The original November 2013 guidance is available at http://www.cms.gov/CCIIO/Resources/Letters/Downloads/commissioner-letter-11-14-2013.PDF.

[6] The market reforms with which the coverage does not have to comply and the conditions the coverage must meet are described in the November 2013 guidance: http://www.cms.gov/CCIIO/Resources/Letters/Downloads/commissioner-letter-11-14-2013.PDF.

[7] The reforms that go into effect in 2014 are generally effective for plan or policy years that begin on or after January 1, 2014. In other words, when a plan or policy is renewed in 2014 it must become compliant with all ACA market reforms that are effective in 2014 (but it does not necessarily have to comply with the reforms on January 1, 2014).

and whether the plan has grandfathered status.[8] However, the reforms do not apply to certain types of plans (this is true of other federal health reforms as well). For example, retiree-only health plans are not required to comply with federal health insurance requirements, including ACA's market reforms.[9] In the text of this report the term "plan" is used generally; for information as to the specific types of plans (i.e., a grandfathered plan in the large group market) to which a reform applies, see the **Appendix**.

In this report, the reforms are grouped under the following categories: obtaining coverage; keeping coverage; cost of purchasing coverage; covered services; cost-sharing limits; consumer assistance and other health care protections; and plan requirements related to health care providers.

Obtaining Coverage

Guaranteed Issue

ACA requires certain types of coverage to be offered on a guaranteed issue basis.[10] In general, "guaranteed issue" in health insurance is the requirement that a plan accept every applicant for health coverage, as long as the applicant agrees to the terms and conditions of the insurance offer (such as the premium). Nongroup plans that must be offered on a guaranteed issue basis are allowed to restrict enrollment to open and special enrollment periods.[11] With regard to plans offered in the group market, in general "guaranteed issue" means that a plan sponsor (e.g., an employer) must be able to purchase a group health plan any time during a year.[12]

Regulations allow plans that would otherwise be required to offer coverage on a guaranteed issue basis to deny coverage to individuals and employers in certain circumstances.[13] Those circumstances include when a plan demonstrates that it does not have the network capacity to deliver services to additional enrollees and when the plan demonstrates that it does not have the financial capacity to offer additional coverage.

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[8] A grandfathered health plan refers to an existing plan in which at least one individual has been enrolled since enactment of ACA (March 23, 2010). To maintain grandfathered status, a plan must avoid certain changes to employer contributions, access to coverage, benefits, and cost-sharing (e.g., any increase in co-insurance requirement). For more information about grandfathered status, see CRS Report R41166, *Grandfathered Health Plans Under the Patient Protection and Affordable Care Act (ACA)*, by Bernadette Fernandez.

[9] The federal exemption for retiree-only health plans is not a new exemption. Retiree-only health plans have been exempt from federal health insurance requirements since enactment of the Health Insurance Portability and Accountability Act of 1996. For additional information about these issues, see the Appendix in CRS Report R41166, *Grandfathered Health Plans Under the Patient Protection and Affordable Care Act (ACA)*, by Bernadette Fernandez.

[10] 42 U.S.C. §300gg-1.

[11] The annual open enrollment periods in the nongroup market are the same inside and outside ACA health insurance exchanges. For policy years beginning on or after January 1, 2014, the open enrollment period is October 1, 2013, through March 31, 2014. The qualifying events for special enrollment periods are defined in §603 of the Employee Retirement Income Security Act (ERISA, P.L. 93-406) and in 45 C.F.R. §155.420(d).

[12] Regulations provide an exception for plans offered in the small group market. The plans may limit enrollment to an annual period from November 15 through December 15 of each year if the plan sponsor does not comply with provisions relating to employer contribution or group participation rules, pursuant to state law.

[13] 45 C.F.R. §147.104(c) and (d).

Nondiscrimination Based on Health Status

ACA prohibits plans from basing eligibility or coverage on health status-related factors.[14] Such factors include health status, medical condition (including both physical and mental illness), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence), disability, and any other health status-related factor determined appropriate by the Secretary of HHS. ACA allows, however, for the offering of premium discounts or rewards based on enrollee participation in wellness programs, in keeping with prior federal law.[15]

Extension of Dependent Coverage

ACA requires that if a plan offers dependent coverage, the plan must make such coverage available to a child under age 26.[16] Plans that offer dependent coverage must make coverage available for both married and unmarried adult children under age 26, but not for the adult child's children or spouse (although a plan may voluntarily choose to cover them).

Prohibition of Discrimination Based on Salary

The sponsors of health plans (e.g., employers) are prohibited from establishing eligibility criteria, for any full-time employee, that are based on the total hourly or annual salary of the employee.[17] Eligibility rules cannot be permitted to discriminate in favor of higher-wage employees. The Departments (HHS, Labor, and Treasury) have determined that compliance with this requirement is not required until after regulations are issued; as of the date of this report, regulations have not been issued.[18]

Waiting Period Limitation

ACA prohibits plans from establishing waiting periods greater than 90 days.[19] A "waiting period" refers to the time period that must pass before coverage for an individual who is eligible to enroll under the terms of the plan can become effective. In general, if an individual can elect coverage that becomes effective within 90 days, the coverage complies with this provision.

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[14] 42 U.S.C. §300gg-4.

[15] The Health Insurance Portability and Accountability Act of 1996 (HIPAA) allows group plans to establish premium discounts or rebates or modify cost-sharing requirements in return for adherence to a wellness program. If a reward is provided based solely on participation in a wellness program, or if it does not provide a reward, the program complies with HIPAA without having to satisfy any additional standards, as long as the program is made available to all similarly situated individuals. If a reward is based on an individual meeting a certain standard relating to a health factor, then the program must meet additional requirements specified in HIPAA regulations. Under ACA, the reward must be capped at 30% of the cost of the employee-only coverage under the plan, but the Secretaries of HHS, Labor, and the Treasury would have the discretion to increase the reward up to 50% of the cost of coverage if the increase is determined to be appropriate.

[16] 42 U.S.C. §300gg-14.

[17] 42 U.S.C. §300gg-16.

[18] Internal Revenue Service (IRS) Notice 2011-1.

[19] 42 U.S.C. §300gg-7.

Keeping Coverage

Guaranteed Renewability

"Guaranteed renewability" in health insurance is the requirement on a plan to renew individual coverage at the option of the policyholder, or renew group coverage at the option of the plan sponsor. Under ACA, most plans offered in the nongroup and small group markets must renew coverage at the option of the enrollee or plan sponsor; however, plans may discontinue coverage under certain circumstances.[20] For example, a plan may discontinue coverage if the individual or plan sponsor fails to pay premiums or if an individual or plan sponsor performs an act that constitutes fraud in connection with the coverage.[21]

Prohibition on Rescissions

The practice of "rescission" refers to the retroactive cancellation of medical coverage after an enrollee has become sick or injured. ACA generally prohibits rescissions, except that rescissions will still be permitted in cases where the covered individual committed fraud or made an intentional misrepresentation of material fact as prohibited by the terms of the plan.[22] A cancellation of coverage in this case requires that a plan provide at least 30 calendar days advanced notice to the enrollee.[23]

Costs Associated with Coverage

Rating Restrictions

ACA imposes adjusted (or modified) community rating rules on the determination of premiums.[24] "Adjusted community rating" rules prohibit plans from pricing health insurance products based on health factors but allow it for other key characteristics such as age. ACA's rating rules restrict premium variation to the four factors described below.

Self-only or family enrollment. In most states, plans can vary premiums based on whether an individual or an individual and any number of his/her dependents enroll in the plan. However, if a state does not permit rating variation for age and tobacco, the state is allowed to require that premiums for family coverage are determined by using state-established uniform family tiers.[25] For example, such a state may allow plans to vary premiums based on self-only coverage, self plus one coverage, and family coverage.

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[20] 42 U.S.C. §300gg-4.

[21] 45 C.F.R. §147.106.

[22] 42 U.S.C. §300gg-12.

[23] 45 C.F.R. §147.128.

[24] 42 U.S.C. §300gg.

[25] As of the date of this report only two states, New York and Vermont, prohibit plans from using tobacco and age to vary rates. Both states allow plans to vary premiums using state-established uniform family tiers.

Geographic rating area. States are allowed to establish one or more geographic rating areas within the state for the purposes of this provision. The rating areas must be based on one of the following geographic boundaries: (1) counties; (2) three-digit zip codes;[26] or (3) metropolitan statistical areas (MSAs) and non-MSAs.[27] If a state does not establish rating areas or if the Centers for Medicare and Medicaid Services (CMS) determines that a state's proposed rating areas are inadequate,[28] then the default is one rating area for each MSA in the state and one rating area comprising all non-MSAs in the state.

Tobacco use. Plans are allowed to charge a tobacco user up to 1.5 times the premium that the plan will charge an individual who does not use tobacco.

Age. Plans can vary premiums by no more than a 3 to 1 ratio for adults aged 21 and older. This means that a plan will not be allowed to charge an older individual more than three times the premium that the plan will charge a 21-year-old. Regulations require that each state use a uniform age rating curve to specify the rates across all adult age bands, and they require each state to set a separate rate for all individuals aged 20 and younger. HHS created an age curve that states may choose to use, but some states have implemented standards other than the federal defaults.[29] **Figure 1** shows the federally established age rating curve. In states that choose to use this curve, a plan cannot set a premium for a child (age 0-20) that is more than 63.5% of a premium for a 21-year-old, and a premium for an individual age 64 and older cannot be more than three times that of a premium for a 21-year-old.

[26] A three-digit zip code refers to the first three digits of a five-digit zip code. A three-digit zip code represents a larger geographical area than a five-digit zip code, as all five-digit zip codes that share the same first three numbers are included in the three-digit zip code.

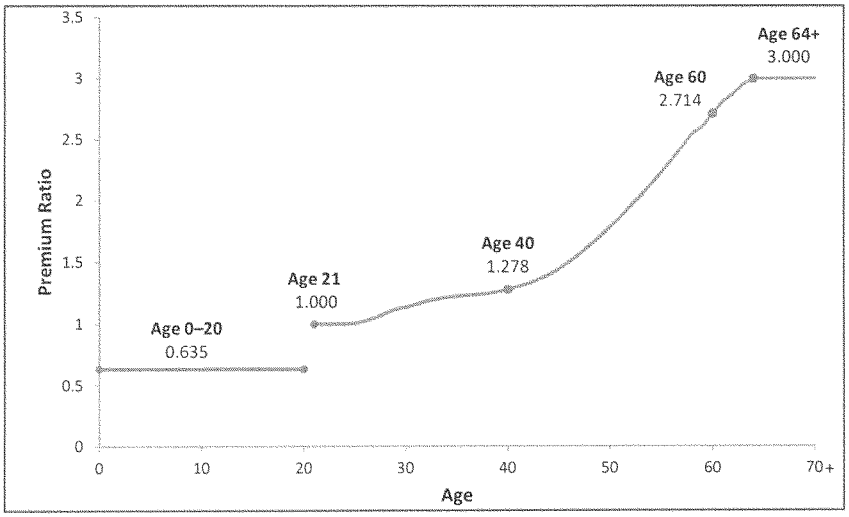
[27] OMB establishes delineations for various statistical areas, including MSAs. The most recent delineations are available at http://www.whitehouse.gov/sites/default/files/omb/bulletins/2013/b-13-01.pdf.

[28] A state's rating areas will be presumed adequate if either of the following conditions are met: the state established the rating areas for the entire state prior to January 1, 2013, or the state establishes the rating areas after January 1, 2013, for the entire states and there are no more rating areas than the number of MSAs in the state plus one. A state that establishes its rating periods after January 1, 2013, may propose a greater number of rating areas to CMS, provided such rating areas are based on the geographic boundaries noted above.

[29] For information about states that have established their own age curves, see http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/state-rating.html.

Figure 1. Age Rating Curve, as Established by HHS

For Plan Years Beginning in 2014



Source: 77 *Federal Register* 70584, November 26, 2012.

Notes: In implementing the ACA's rating restriction requirements, states may use a different uniform age curve, provided it prohibits plans from varying premiums based on age by more than a 3 to 1 ratio.

Rate Review

The intent of the rate review program is to ensure that all proposed health insurance rate increases in the small group and individual markets that meet or exceed a specified threshold are reviewed by a state or CMS to determine whether they are unreasonable.[30] Plans subject to review are required to submit to the HHS and the relevant state a justification for the proposed rate increase prior to implementation of the premium, and HHS will publicly disclose the information.[31]

For the first year of the rate review program (plan years beginning on or after September 1, 2011), a proposed rate increase was considered unreasonable if the increase was 10% or more (over a 12-month period beginning on September 1). Since then, states have had the option to establish state-specific thresholds; the 10% threshold remains in effect in any states that do not establish state-specific thresholds.[32] Note that ACA's rate review process does not establish federal authority to deny implementation of a proposed rate increase. (This is a "sunshine" provision designed to publicly expose rate increases determined to be unreasonable.)

[30] ACA does not apply the rate review requirements to grandfathered health plans.

[31] 42 U.S.C. §300gg-94.

[32] For information on state-specific thresholds, see http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/sst.html.

Single Risk Pool

A health insurance issuer must consider all enrollees in plans offered by the issuer to be members of a single risk pool.[33] More specifically, an issuer must consider all enrollees in nongroup plans offered by the issuer to be members of a single risk pool; the issuer must have a separate risk pool for all enrollees in small group plans offered by the issuer. (However, ACA gives states the option to merge its nongroup and small group markets; if a state does so, an issuer will have a single risk pool for all enrollees in its nongroup and small group plans.)

A risk pool is used to develop rates for coverage. A result of the single risk pool requirement is that issuers must consider the medical claims experience of enrollees in all plans (nongroup and small group separately, or combined) offered by the issuer when developing rates.

Covered Services

Coverage of Essential Health Benefits

ACA requires plans to cover the essential health benefits (EHB).[34] ACA does not explicitly list the benefits that comprise EHBs; rather, it lists 10 broad categories from which benefits and services must be included.[35] ACA requires the Secretary to further define the EHB. In response, the Secretary outlined a process for defining the EHB for at least 2014 and 2015; the Secretary may revisit how the EHB are defined for the 2016 plan year and beyond.

For 2014 and 2015, the Secretary asked each state to select a benchmark plan from four different types of plans.

- the largest plan by enrollment in any of the three largest small group insurance products in the state's small group market;
- any of the largest three state employee health benefit plans by enrollment;
- any of the largest three national Federal Employees Health Benefit (FEHBP) plan options by enrollment; or
- the largest insured commercial non-Medicaid Health Maintenance Organization (HMO) operating in the state.

If the selected benchmark plan did not cover services and benefits from all 10 categories listed in statute, a state is required to supplement the benchmark plan (according to a process outlined by HHS) to ensure that all 10 statutorily required categories are represented. In general, plans that are required to offer the EHB must model their benefits package after the state's selected benchmark plan.[36]

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[33] 42 U.S.C. §18032.

[34] 42 U.S.C. §18022.

[35] The 10 categories are ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

[36] Summaries of each state's selected benchmark plan are available at http://www.cms.gov/CCIIO/Resources/Data-(continued...)

ACA requirement for plans to cover the EHB does not prohibit states from maintaining or establishing state-mandated benefits. In fact, the Secretary of HHS has determined that state-required benefits enacted on or before December 31, 2011, are considered part of the EHB for at least 2014 and 2015. However, any state that requires plans to cover benefits beyond EHBs and what was mandated by state law prior to 2012 must assume the total cost of providing those additional benefits.[37] In other words, states have to defray the cost of any mandated benefits enacted after December 31, 2011.

No Cost-Sharing for Preventive Health Services

Plans are required to provide coverage for certain preventive health services without imposing cost-sharing.[38] The preventive services include the following minimum requirements:[39]

- evidence-based items or services that have in effect a rating of "A" or "B" from the United States Preventive Services Task Force (USPSTF);[40]
- immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC);[41]
- evidence-informed preventive care and screenings (for infants, children, and adolescents) provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA);[42] and
- additional preventive care and screenings for women not described by the USPSTF, as provided in comprehensive guidelines supported by HRSA.[43]

(...continued)

Resources/ehb.html.

[37] Plans offered inside and outside an exchange must cover the EHB; however, states only have to defray the cost of additional benefits for qualified health plans (QHP), which are plans that must meet the certification standards to be offered through an exchange.

[38] 42 U.S.C. §300gg-13.

[39] The complete list of recommendations and guidelines required to be covered under the regulations is available at http://www.healthcare.gov/news/factsheets/2010/07/preventive-services-list.html.

[40] The USPSTF is currently sponsored by the Agency for Healthcare Research and Quality (AHRQ), as an independent panel of private-sector experts in prevention and primary care issues. For more background, see http://www.ahrq.gov/clinic/uspstfab.htm.

[41] The Advisory Committee on Immunization Practices consists of 15 experts in fields associated with immunization who have been selected by the Secretary of HHS to provide advice and guidance to the Secretary and the CDC on the control of vaccine-preventable diseases. The committee develops recommendations for the routine administration of vaccines to children and adults in the civilian population; recommendations include age for vaccine administration, number of doses and dosing interval, and precautions and contraindications. For more information, see http://www.cdc.gov/vaccines/acip/index.html.

[42] HRSA is the primary federal agency within the Department of Health and Human Services for improving access to health care services for people who are uninsured, isolated, or medically vulnerable. For background information, see http://www.hrsa.gov/about/index.html.

[43] HRSA published its guidelines related to women's preventive services in August 2011; the guidelines are found at http://www.hrsa.gov/womensguidelines/. These guidelines include, among other services, coverage for all FDA approved contraceptive methods and sterilization procedures. The requirement to cover these services has been a source of controversy; for more details, see CRS Report WSLG689, *History and Current Status for Enforcement of ACA's Contraceptive Coverage Requirement*, by Cynthia Brougher.

Additional services not recommended by the USPSTF may be offered, but are not required. For the purposes of this provision and others in federal law, ACA negates the November 2009 USPSTF recommendation that women receive routine screening mammograms beginning at age 50. As a result, plans are required to cover screening mammograms beginning at age 40, based on the prior USPSTF recommendation.

A plan that has a network of providers is not required to provide coverage for a recommended preventive service that is delivered by an out-of-network provider, and the plan may impose cost-sharing requirements for a recommended preventive service delivered out-of-network. Additionally, if a recommended preventive service does not specify the frequency, method, treatment, or setting for the service, then the plan can determine coverage limitations by relying on established techniques and relevant evidence.

Coverage of Preexisting Health Conditions

ACA prohibits plans from excluding coverage for preexisting health conditions.[44] In other words, plans may not exclude benefits based on health conditions for any individuals. A "preexisting health condition" is a medical condition that was present before the date of enrollment for health coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date.

Cost-Sharing Limits

Limits for Annual Out-of-Pocket Spending

ACA places annual limits on out-of-pocket spending.[45] The limits apply only to in-network coverage of the essential health benefits (EHB).[46] In 2014, the limits cannot exceed existing limits specified in the tax code applicable to certain high-deductible health plans: $6,350 for self-only coverage and $12,700 for coverage other than self-only.[47]

The Departments (HHS, Labor, and Treasury) have provided that group plans that utilize more than one service provider to administer benefits may allow separate out-of-pocket limits. For example, if a group plan utilizes one service provider to administer major medical coverage and another to administer a separate pharmacy benefit, the major medical coverage may have the maximum out-of-pocket limit ($6,350 or $12,700) and the pharmacy benefit may also have the maximum out-of-pocket limit. This option is available only for the first plan year that begins on or after January 1, 2014, and it is not an option for nongroup plans.[48]

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[44] 42 U.S.C. §300gg-3.

[45] ACA also included deductible limits for plans offered in the small group market—generally prohibiting these plans from having deductibles greater than $2,000 for self-only coverage and $4,000 for any other coverage in 2014. However, the Protecting Access to Medicare Act of 2014 (P.L. 113-93) repealed this provision, thereby removing the limitation on deductibles for plans offered in the small group market.

[46] Certain types of plans—self-insured plans and plans offered in the large group market—must comply with this requirement but do not have to offer the EHBs. HHS has indicated that such plans must use a permissible definition of EHB (including any state-selected EHB benchmark plans) to determine whether they comply with the requirement.

[47] 42 U.S.C. §18022.

[48] For more information, see the Department of Labor's Frequently Asked Questions Part XVIII: http://www.dol.gov/ (continued...)

Minimum Actuarial Value Requirements

ACA requires plans to tailor cost-sharing to comply with one of four levels of actuarial value.[49] Actuarial value (AV) is a summary measure of a plan's generosity, expressed as the percentage of total medical expenses that are estimated to be paid by the issuer for a standard population and set of allowed charges.[50] In other words, AV reflects the relative share of cost-sharing that may be imposed. On average, the lower the AV the greater the cost-sharing for the enrollee.[51]

Each level of plan generosity is designated according to a precious metal and corresponds to a specific actuarial value:

- Bronze: 60% AV
- Silver: 70% AV
- Gold: 80% AV
- Platinum: 90% AV

Prohibition of Lifetime Limits and Annual Limits

Prior to ACA, plans were generally able to set lifetime and annual limits—dollar limits on how much the plan would spend for covered health benefits either during the entire period an individual was enrolled in the plan (lifetime limits) or during a plan year (annual limits).[52] Under ACA, both lifetime and annual limits are prohibited; the limits apply specifically to essential health benefits (EHB).[53] Plans are permitted to place lifetime and annual limits on covered benefits that are not considered EHBs, to the extent that such limits are otherwise permitted by federal and state law.

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ebsa/faqs/faq-aca18.html.

[49] 42 U.S.C. §18022.

[50] While actuarial value (AV) is a useful measure, it is only one component that addresses the value of any given benefit package. AV, by itself, does not address other important features of coverage, such as total (dollar) value, network adequacy, and premiums.

[51] While actuarial value is calculated based on costs for an entire population, it does not mean that every person enrolled in the same plan will have the same expenses, because in any given group some people use relatively little care while others use a great deal. Given that actuarial value reflects cost-sharing, such a measure may be useful to consumers when comparing different health plans.

[52] 42 U.S.C. §300gg-11.

[53] Certain types of plans—grandfathered plans, self-insured plans, and plans offered in the large group market—must comply with these requirements but do not have to offer the EHBs. HHS has indicated that such plans must use a permissible definition of EHB (including any state-selected EHB benchmark plans) to determine whether they comply with the requirements.

Consumer Assistance and Other Patient Protections

Internet Portal to Assist Consumers in Identifying Coverage Options

The Secretary of HHS, in consultation with the states, is required to establish an Internet portal for the public to easily access affordable and comprehensive coverage options.[54] The portal is required to provide, at minimum, information on the following coverage options: health plans offered in the private insurance market; Medicaid and the State Children's Health Insurance Program (CHIP); high risk pools; and small group health plans. The Internet portal, www.healthcare.gov, launched on July 1, 2010.

Summary of Benefits and Coverage

The ACA required the Secretaries (HHS, Labor, and Treasury) to develop standards for plans with respect to providing their enrollees with a summary of benefits and coverage (SBC) and to periodically review and update the standards.[55] **Table 1** summarizes the standards for the SBC.

Table 1. Summary of Benefits and Coverage Document Requirements

Issue Area	Requirements
Prohibitions	• Cannot exceed four pages in length. • Cannot use smaller than 12-point font.
Required description	• Coverage including cost-sharing for each of the essential health benefit categories. • Any exceptions, reductions, and limitations on coverage. • Renewability and continuation provisions. • Whether the plan covers minimum essential benefits. • Other benefits as identified by the Secretary. • Contact information including a phone number and Internet web address for consumer information.
Other requirements	• Must be presented in a culturally and linguistically appropriate manner utilizing language understandable by the average plan enrollee. • Must use uniform definitions of standard insurance and medical terms. • Must have a statement ensuring that not less than 60% of allowed costs are covered by the benefits. • Must have a statement that the document is a summary and should not be consulted to determine the governing contractual provisions.

Source: 42 U.S.C. §300gg-15.

ACA requires that each plan provide a SBC to individuals at the time of application, prior to the time of enrollment or reenrollment, and when the insurance policy is issued. The SBC can be in

[54] 42 U.S.C. §18003.

[55] 42 U.S.C. §300gg-15.

paper or electronic form. Enrollees must be given notice of any material changes in benefits no later than 60 days prior to the date that the modifications would become effective. Any entity that willfully fails to provide the information required is subject to a fine of not more than $1,000 for each such failure, defined as each enrollee that did not receive the required information. ACA also requires that plans provide a uniform glossary of terms commonly used in health insurance coverage (e.g., coinsurance) to enrollees upon request.[56]

Medical Loss Ratio (MLR)

Under ACA, health plans are required to submit to the Secretary of HHS a report concerning the percentage of premium revenue spent on medical claims ("medical loss ratio," or MLR).[57] The MLR calculation includes adjustments for health quality costs, taxes, regulatory fees, and other factors. The law requires plans in the individual and small group markets to meet a minimum MLR of 80%; for large groups, the minimum MLR is 85%.[58] States are permitted to increase the percentages, and the Secretary of HHS may adjust the state percentage for the individual market if it is determined that the application of a minimum MLR of 80% would destabilize the individual market within the state.[59] Health plans whose MLR falls below the specified limit must provide rebates to policyholders on a pro rata basis. Any required rebates must be paid to policyholders by August of that year.[60]

Appeals Process

ACA requires that plans implement an effective appeals process for coverage determinations and claims.[61] The process at a minimum must

- have an internal claims appeals process;
- provide notice to enrollees of available internal and external appeals processes, and the availability of any applicable assistance; and
- allow an enrollee to review their file, present evidence and testimony, and to receive continued coverage pending the outcome.

To comply with the requirements for the *internal* claims appeals process, group plans are expected to initially incorporate the claims and appeals procedures previously established under federal law[62] and will update their processes in accordance with any standards established by the

[56] HHS created the uniform glossary that plans must provide upon request; for more information, see http://www.cms.gov/CCIIO/Programs-and-Initiatives/Consumer-Support-and-Information/Summary-of-Benefits-and-Coverage-and-Uniform-Glossary.html.

[57] 42 U.S.C. §300gg-18. For more information about the MLR, see CRS Report R42735, *Medical Loss Ratio Requirements Under the Patient Protection and Affordable Care Act (ACA): Issues for Congress*, by Suzanne M. Kirchhoff.

[58] Until 2016, ACA allows states to define the small group market as employers who have up to and including 50 employees or up to and including 100 employees; in 2016, the small group market will be defined as employers who have up to and including 100 employees.

[59] To view a list of state requests for an MLR adjustment, see http://cciio.cms.gov/programs/marketreforms/mlr/state-mlr-adj-requests.html.

[60] For rebate information, see http://www.cms.gov/CCIIO/Resources/Data-Resources/mlr.html.

[61] 42 U.S.C. §300gg-19.

[62] Section 503 of ERISA, codified at 29 C.F.R. §2560.530-1, requires that employee benefit plans provide adequate (continued...)

Secretary of Labor. Individual health plans will comply with internal claims and appeals procedures set forth under applicable law and updated by the Secretary of HHS.

In order to comply with the requirements for the *external* appeals process, plans must comply with a state's external review process, provided that process includes, at a minimum, the consumer protections set forth in the Uniform External Review Model Act promulgated by the National Association of Insurance Commissioners (NAIC). If a state's review process does not meet the minimum requirements, the state must implement a process that meets the standards established by the Secretary of HHS, and plans must comply with such a process.[63]

Patient Protections

Plans are subject to three ACA requirements relating to the choice of health care professionals and one ACA requirement relating to benefits for emergency services.[64]

Regarding the choice of health care professionals, a plan that requires or allows an enrollee to designate a participating primary care provider is required to permit the designation of any participating primary care provider who is available to accept the individual. This same provision applies to pediatric care for any child who is a plan participant. A plan that provides coverage for obstetrical or gynecological care cannot require authorization or referral by the plan or any person (including a primary care provider) for a female enrollee who seeks obstetrical or gynecological care from an in-network health care professional who specializes in obstetrics or gynecology.

If the plan covers services in an emergency department of a hospital, the plan is required to cover those services without the need for any prior authorization and without the imposition of coverage limitations, irrespective of the provider's contractual status with the plan. If the emergency services are provided out-of-network, the cost-sharing requirement will be the same as the cost-sharing for an in-network provider.

Nondiscrimination Regarding Clinical Trial Participation

ACA does not allow health plans to

- prohibit "qualified individuals" from participating in an approved clinical trial;
- deny, limit, or place conditions on the coverage of routine patient costs associated with participation in an approved clinical trial; or
- discriminate against "qualified individuals" on the basis of their participation in approved clinical trials.[65]

(...continued)

notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and to afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

[63] Department of Labor, Technical Release No. 2013-01, March 15, 2013.

[64] 42 U.S.C. §300gg-19a.

[65] 42 U.S.C. §300gg-8.

ACA defines qualified individual, for purposes of this provision, as an individual who is eligible to participate in an approved clinical trial for treatment of cancer or other life-threatening disease or condition, and who either has a referring health care provider who has concluded that the individual's participation is appropriate, or who provides medical and scientific information establishing that participation in a clinical trial would be appropriate.

Plan Requirements Related to Health Care Providers

Nondiscrimination Regarding Health Care Providers

ACA imposes nondiscrimination requirements with respect to health care providers.[66] Plans are not allowed to discriminate, with respect to participation under the plan, against any health care provider who is acting within the scope of that provider's license or certification under applicable state law. This provision does not require that a plan contract with any health care provider willing to abide by the plan's terms and conditions, and the provision cannot be read as preventing a plan or the Secretary of HHS from establishing varying reimbursement rates for providers based on quality or performance measures.

Reporting Requirements Regarding Quality of Care

Beginning upon ACA enactment, and concluding no later than two years after enactment, the Secretary of HHS (Secretary) must develop quality reporting requirements for use by specified plans.[67] The Secretary must develop these requirements in consultation with experts in health care quality and other stakeholders. The Secretary is also required to publish regulations governing acceptable provider reimbursement structures not later than two years after ACA enactment. Not later than 180 days after these regulations are promulgated, the U.S. Government Accountability Office (GAO) is required to conduct a study regarding the impact of these activities on the quality and cost of health care. To date, the Secretary has not published the required regulations; therefore, the required GAO report has not been published either.

Once the reporting requirements are implemented, plans will annually submit, to the Secretary and enrollees, a report addressing whether plan benefits and reimbursement structures do the following: (1) improve health outcomes through the use of quality reporting, case management, care coordination, and chronic disease management; (2) implement activities to prevent hospital readmissions and to improve patient safety and reduce medical errors; and (3) implement wellness and health promotion activities. The Secretary is required to make these reports available to the public, and is permitted to impose penalties for noncompliance.

Wellness and health promotion activities include personalized wellness and prevention services, and specifically efforts related to smoking cessation, weight management, stress management, physical fitness, nutrition, heart disease prevention, healthy lifestyle support, and diabetes prevention. These services may be made available by entities (e.g., health care providers) who

[66] 42 U.S.C. §300gg-5.

[67] 42 U.S.C. §300gg-17.

conduct health risk assessments or who provide ongoing face-to-face, telephonic, or web-based intervention efforts for program participants.[68]

[68] With respect to gun rights, a wellness or promotion activity cannot require disclosure or collection of any information in relation to (1) the presence or storage of a lawfully possessed firearm or ammunition in the residence or on the property of an individual, or (2) the lawful use, possession, or storage of a firearm or ammunition by an individual. A health plan issued in accordance with the law is prohibited from increasing premium rates, denying health insurance coverage, and reducing or withholding a discount, rebate, or reward offered for participation in a wellness program on the basis of or on reliance on the lawful ownership, possession, use or storage of a firearm or ammunition.

Appendix. Applicability of Market Reforms to Health Plans

Table A-1. Applicability of ACA's Private Health Insurance Market Reforms to Health Plans

	Grandfathered Plans[a]			New Plans (Non-grandfathered)				
	Group Market[b]			Large Group Market[c]		Small Group Market[d]		
Provision	Fully Insured[e]	Self-Insured[f]	Individual Market[g]	Fully Insured	Self-Insured	Fully Insured	Self-Insured	Individual Market
Obtaining Coverage								
Guaranteed Issue	N.A.	N.A.	N.A.	√	N.A.	√	N.A.	√
Nondiscrimination Based on Health Status	N.A.	N.A.	N.A.	√	√	√	√	√
Extension of Dependent Coverage	√	√	√	√	√	√	√	√
Prohibition of Discrimination Based on Salary	N.A.	N.A.	N.A.	√	N.A.	√	N.A.	N.A.
Waiting Period Limitation	√	√	N.A.	√	√	√	√	N.A.
Keeping Coverage								
Guaranteed Renewability	N.A.	N.A.	N.A.	√	N.A.	√	N.A.	√
Prohibition on Rescissions	√	√	√	√	√	√	√	√
Costs Associated with Coverage								
Rating Restrictions	N.A.	N.A.	N.A.	N.A.	N.A.	√	N.A.	√
Rate Review	N.A.	N.A.	N.A.	N.A.[h]	N.A.	√	N.A.	√
Single Risk Pool	N.A.	N.A.	N.A.	N.A.	N.A.	√	N.A.	√
Covered Services								
Coverage of Essential Health Benefits	N.A.	N.A.	N.A.	N.A.	N.A.	√	N.A.	√
No Cost-sharing for Preventive Health Services	N.A.	N.A.	N.A.	√	√	√	√	√
Coverage of Preexisting Health Conditions	√	√	N.A.	√	√	√	√	√
Cost-Sharing Limits								
Limits for Annual Out-of-pocket Spending	N.A.	N.A.	N.A.	√	√	√	√	√

Provision	Grandfathered Plans[a]			New Plans (Non-grandfathered)				
	Group Market[b]			Large Group Market[c]		Small Group Market[d]		
	Fully Insured[e]	Self-Insured[f]	Individual Market[g]	Fully Insured	Self-Insured	Fully Insured	Self-Insured	Individual Market
Minimum Actuarial Value Requirements	N.A.	N.A.	N.A.	N.A.	N.A.	√	N.A.	√
Prohibition on Lifetime Limits	√	√	√	√	√	√	√	√
Prohibition on Annual Limits	√	√	N.A.	√	√	√	√	√
Consumer Assistance and Other Patient Protections								
Summary of Benefits and Coverage	√	√	√	√	√	√	√	√
Medical Loss Ratio	√	N.A.	√	√	N.A.	√	N.A.	√
Appeals Process	N.A.	N.A.	N.A.	√	√	√	√	√
Patient Protections	N.A.	N.A.	N.A.	√	√	√	√	√
Nondiscrimination Regarding Clinical Trial Participation	N.A.	N.A.	N.A.	√	√	√	√	√
Plan Requirements Related to Health Care Providers								
Nondiscrimination Regarding Health Care Providers	N.A.	N.A.	N.A.	√	√	√	√	√
Reporting Requirements Regarding Quality of Care	N.A.	N.A.	N.A.	√	√	√	√	√

Source: CRS Analysis of ACA and its implementing regulations.

Notes: N.A. indicates that the reform is not applicable to that type of health insurance plan. These market reforms do not apply to retiree-only health coverage (see footnote 9). The reform "Internet Portal to Assist Consumers in Identifying Coverage Options" is not included in this table because the reform does not apply to health plans. There are other health insurance reforms that are currently effective under federal law. This table lists only ACA's market reforms; therefore, it is not intended to be a comprehensive listing of all federal health insurance requirements and standards.

a. A grandfathered plan refers to an existing group health plan or a health insurance plan/policy in which at least one individual is enrolled since March 23, 2010. To maintain grandfathered status, a plan must avoid certain changes to benefits, cost-sharing, employer contributions, and access to coverage.

b. Health insurance can be provided to a group of people that are drawn together by an employer or other organization, such as a trade union. Such groups are generally formed for some purpose other than obtaining insurance, like employment. When insurance is provided to a group, it is referred to as "group coverage" or "group insurance." In the group market, the entity that purchases health insurance on behalf of a group is referred to as the plan "sponsor."

c. Prior to ACA, large groups were defined as groups with more than 50 workers. For plan years beginning before January 1, 2016, a state may elect to keep the previous definition of large groups, or change the definition to include those groups with more than 100 workers, applicable to ACA-created exchanges and market reforms. For plan years beginning on or after January 1, 2016, large groups must be defined as groups with more than 100 workers.

d. Prior to ACA, small groups were defined as groups with 2 to 50 workers, although some states also included self-employed individuals ("groups of one") in the small group market. For plan years beginning before January 1, 2016, a state may elect to keep the previous definition of small groups, or change the definition to include those groups with 100 or fewer workers, applicable to ACA-created exchanges and market reforms. For plan years beginning on or after January 1, 2016, small groups must be defined as groups with 100 or fewer workers.

e. A fully insured health plan is one in which the plan sponsor purchases health coverage from a state-licensed insurance carrier; the carrier assumes the risk of paying the medical claims of the sponsor's enrolled members.

f. Self-insured plans refer to health coverage that is provided directly by the organization seeking coverage for its members (e.g. a firm providing health benefits to its employees). Such organizations set aside funds and pay for health benefits directly. Under self-insurance, the organization bears the risk for covering medical claims.

g. Consumers who are not associated with a group can obtain health coverage by purchasing it directly from an insurance carrier in the individual (or nongroup) health insurance market.

h. The final rule regarding rate review specified that this provision would apply only to nongroup and fully insured, small group coverage, and not to large groups.

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Mr. PITTS. We have one panel with three members today. I will introduce them in the order they speak. First, Dr. Scott Gottlieb, resident fellow of the American Enterprise Institute; second, Dr. William Harvey, chair of the Government Affairs Committee, American College of Rheumatology; and, finally, the Honorable Monica Lindeen, commissioner of the Montana Office of the Commissioner of Securities and Insurance.

Thank you for coming. Your written testimony will be made a part of the record. You will each be given 5 minutes to summarize. There is a little box of lights on the table, so when you see the red light appear, we ask that you please conclude.

At this point, Dr. Gottlieb, you are recognized for 5 minutes for your opening statement.

STATEMENTS OF SCOTT GOTTLIEB, RESIDENT FELLOW, AMERICAN ENTERPRISE INSTITUTE; WILLIAM F. HARVEY, CHAIR, GOVERNMENT AFFAIRS COMMITTEE, AMERICAN COLLEGE OF RHEUMATOLOGY; AND MONICA LINDEEN, COMMISSIONER, SECURITIES AND INSURANCE, OFFICE OF THE MONTANA STATE AUDITOR

STATEMENT OF SCOTT GOTTLIEB

Mr. GOTTLIEB. Chairman Pitts, Ranking Member Pallone, thank you for the opportunity to testify today before the committee. My name the Scott Gottlieb. I am a physician and resident fellow at the American Enterprise Institute, and I previously served at positions at the FDA and CMS.

Americans who sign up for insurance under the ACA are finding many of these plans offer very narrow options when it comes to their choice of doctors and drugs. Some argue these narrow benefit designs aren't unique to the ACA, but this isn't entirely true. The construction of the exchanges preordained the wider adoption of these restrictive networks and formularies and certainly made these constructs politically suitable.

Since many plans have little or no coinsurance outside of their networks and formularies, patients seeking care outside of these arrangements can be saddled with the full cost of these choices. Under many plans, when patients are out of their networks or off their formularies, these costs don't count against deductibles or out-of-pocket maximums.

To get a sense of how restrictive the formularies are and its impact on patients, we looked at drugs used to treat two chronic diseases: rheumatoid arthritis and multiple sclerosis. We examined the drug coverage offered by the lowest-cost Silver plan offered in the most populated county in 10 different States and focused on disease-modifying drugs that are widely prescribed for these patients.

We found that none of the plans provided coverage for all the drugs or covered any of them without significant cost-sharing that would tap out most people's annual deductibles and out-of-pocket limits on spending. The challenge for consumers is that most of the plans have closed formularies where nonformulary drugs aren't covered at all. Moreover, the cap on out-of-pocket spending only applies to costs incurred on drugs included in a plan's formulary.

Among some of our findings, the multiple sclerosis drug Aubagio is left off the formularies of 2 of 10 plans, so patients on these plans could have to pay the full $4,400 monthly retail cost of the medicine, translating to about $53,000 annually. The drug Avonex was left off the formularies of 2 of the 10 plans, potentially saddling patients with the drug's $4,800 monthly cost. That is $57,000 annually. Extavia wasn't included on 2 of the 10 formularies, at a monthly cost of $4,600 or $55,000 annually. Tecfidera was left off 6 of the 10 plans, at a monthly cost to patients of $5,200.

We found similar results when it came to drugs targeted to rheumatoid arthritis. For example, the RA drug Xeljanz was left off the formularies of 4 of the 10 plans, at a monthly cost to patients of $2,400 or about $30,000 annually. Orencia was left off two plans, at $2,600 a month or $32,000 annually. The RA drug Remicade was left off the formulary of three plans, at about $3,500 for a 2-month supply or $21,000 annually.

The high cost of developing innovative medicines translates into high retail prices. This is a challenge for our health care system. But the cost of disease progression and the ensuing disability can far outweigh the cost of effective management with some of these drugs. Many newer medicines are more targeted to these diseases and far more effective.

These findings have been replicated by other analyses. One study by Avalere Health of 22 carriers in 6 States found the number of drugs available in formularies ranged from a low of about 480 to nearly 1,100.

Even if your drug makes it onto the plan's formulary, getting access can still be a costly affair. Another analysis looked at 123 formularies from different Silver plans. More than 20 percent required coinsurance of 40 percent or more for the drugs for one of seven different chronic diseases, and about 30 percent of plans provided no coverage for at least one key drug for multiple sclerosis.

The same challenges are being seen when it comes to networks of doctors that the health plans offer. More than two-thirds of exchange plans have provider networks considered narrow or ultra-narrow in which as many as 70 percent of local health providers aren't included.

Earlier this year, we released our own analysis that consistently found that exchange plans offer just a fraction of the specialists available in the PPO plan offered by the same carrier in the same region.

In the 1990s, consumers firmly rejected the idea of very restrictive health plans and drug formularies when they spurned HMOs in favor of preferred provider organizations. Yet, the ACA seems premised on a view that consumers were making a bad trade when they chose PPOs over HMOs. Each scheme has tradeoffs, but the ACA all but codifies the HMO model into law, forcing consumers into these restrictive arrangements as a way to pay for the ACA's other rules and mandates.

Congress could reform the ACA by permitting any health plan that previously met State eligibility prior to passage of the law to be offered on the exchanges. This would allow for a much wider selection of plans that make different tradeoffs between benefit design and networks. These restricted schemes are an unfortunate

consequence of the way the ACA structured the State exchanges. It is within Congress' power to fix these rules.

Thank you.

Mr. PITTS. The Chair thanks the gentleman.

[The prepared statement of Mr. Gottlieb follows:]

Hearing before the U.S. House of Representatives
Energy & Commerce Committee
Subcommittee on Health

"The President's Health Care Law Does Not Equal Health Care Access"

Scott Gottlieb, MD
Resident Fellow
American Enterprise Institute
June 12, 2014

Americans who sign up for insurance under the Affordable Care Act are finding many of these plans offer very narrow options when it comes to their choice of doctors and drugs.

Some observers argue the insurance business tactics resulting in these narrow benefits are not unique to the ACA plans. But this isn't entirely true.

The rules embedded in the ACA made these very restrictive drug formularies and narrow provider networks almost inevitable, and certainly far more prevalent. It popularized these approaches, and made them politically acceptable. I want to briefly highlight some of the reasons why I believe these outcomes were made inescapable by the way that the rules were crafted under the ACA. I want to briefly describe how these restrictive drug plans and provider networks are taking shape and affecting patients. Finally, I want to make some recommendations on how we can reform the ACA and unwind some of these challenges.

Why did many of the health plans end up with very restrictive networks of doctors, and narrow drug formularies that leave patients exposed to significant out of pocket costs? Simply put, the health plans had to offer full coverage for what were – in many cases -- new and costly mandated benefits, like mental health parity and first-dollar coverage for preventive benefits recommended by the United States Preventive Services Task Force. I don't want to debate the merits of these benefits. There are clearly patients who will benefit substantially from access to these mandated services. But these federally mandated benefits – on top of all of the state insurance mandates that were grandfathered into the exchange-based health plans -- come at a big economic cost. In many cases, that cost was compensated for by skimping when it came to the design of provider networks and the drug formularies.

That's because the mandated benefits were coupled with rules that barred insurers from using many of the traditional tools they employ as a way to manage costs. For example, the health plans couldn't price the coverage to risk, or make full use of co-pays as a way to manage utilization. The major contours of the benefit design were largely established by federal regulation. Premium increases are also tightly controlled. But the health plans were given wide latitude to narrow their provider networks and drug formularies as a way to manage cost and utilization. So the plans made aggressive use of this one allowable tool. It's worth noting that proponents of the ACA who were close to the drafting of the regulations, publicly anticipated that plans would use narrow networks as a way to control costs.

While narrow networks aren't unique to the Affordable Care Act (in 2007, 15% of employer plans had narrow networks) these constructs are far more prevalent in the ACA. The frequency, and indeed, acceptance of these narrow provider networks and restrictive drug formularies matters not only for plans sold in the exchanges, but also health plans offered in other markets. In many respects, the political concessions that were made inside the Affordable Care Act -- to exchange broader access to doctors and drugs in favor of other mandated benefits – will enable these same constructs to take hold in non-ACA insurance markets. The last time that the commercial insurance industry tried to popularize these restrictive provider networks and closed drug formularies, was in the 1990s with the advent of closed HMOs. It led to a backlash that ultimately culminated in the introduction of the Patients Bill of Rights.[1] Not this time. Narrow networks and drug formularies have been rendered politically acceptable as a result of the concessions made in the ACA. As a result, we will start to see these same approaches become far more prevalent in the commercial

insurance market, and even Medicare. Once established in the ACA, insurers will start to use the same formularies and networks to service many of their other lines of business.

Making Narrow Networks Fashionable

That is the lesson from other government programs, where approaches taken as a cost-saving compromise inside one federal health program were eventually adopted market-wide. For example, prior to the creation of the Medicare Part D drug benefit, in 2000, no drug plans had a "specialty" tier for higher-cost, specialty drugs. In 2004, the year Part D was implemented, 3% of private health plans had a specialty tier. The Part D regulations issued by the Centers for Medicare and Medicaid Services adopted this construct. The rules allowed Medicare drug plans to use this fourth drug tier as a way to control their drug spending. Once Part D made this then-novel construct politically acceptable, commercial drug plans started to adopt the same approach across all of their lines of business. By 2013, fully a quarter of drug plans had a fourth or "specialty" tier in their drug plans.

The construction of the exchanges also made it easier for insurers to fashion these restrictive networks and formularies. For example, the ACA allows health plans to bid for consumers on a county-by-county basis. That has led to the creation of networks that are sometimes only countywide. They comprise doctors that are only located only within a narrow, countywide geographic area. These extremely narrow networks are being referred to as "Exclusive Provider Organizations" or EPOs. Since many plans have limited co-insurance outside of their networks (sometimes drugs also aren't covered if they are prescribed by a non-network provider) patients who seek care outside of these narrow provider networks can be saddled with high costs. Under many plans, when patients are out of their networks, these costs don't count against deductibles or out of pocket maximums.

This can apply equally for all consumers, regardless of their income, level of subsidies, or whether they are eligible for cost sharing subsidies. The benefit designs are typically consistent across the different metal plans. When consumers are eligible for bigger subsidies to offset their deductibles, or to lower out of pocket limits, they are still getting the same basic benefit design. If the plan doesn't provide adequate co-insurance (or any coverage at all) outside of a narrow network of providers or a closed drug formulary, then consumers will be saddled with the full costs of their choices whether the plan is bronze or gold.

So far, the restrictive benefits have been more obvious when it comes to providers, in part because the plans are relatively new, and consumers have not maxed out deductibles or tried to tap the drug benefits in big numbers. While the narrow provider networks have been widely discussed, I want to first focus on the drug plans, and new data that we developed that illustrates some of the hardships certain consumers might confront.

The Example of Multiple Sclerosis and Rheumatoid Arthritis

To get a snapshot of how restrictive the drug formularies are, and the impact that this could have on patients, we looked at drugs in two different disease areas – rheumatoid arthritis and multiple sclerosis. We chose to look at these diseases because patients with these conditions often require chronic therapy. Moreover, in recent years, the treatment of each of these diseases has also benefited substantially from the introduction of highly effective therapies.

But many of these new drugs are also very costly. If patients lack adequate drug coverage, they can be saddled with substantial costs. Finally, for each of these diseases (and especially for MS) if patients are controlled on a particular medicine, there is a great reluctance to switch them off their current drug regimen for fear that their disease could flare. The question is whether health plans offered in the ACA are meeting the needs of these patients.

The results are discouraging. Take the example of multiple sclerosis. We looked at lower cost silver health plans offered in 10 different states. For each state, we selected the most populous county in order to maximize the likelihood that we would find competitively priced insurance plans. We chose silver plans because of the availability of cost sharing subsidies (to offset the out of pocket costs) for consumers who select these options. It is my view that the availability of these cost-sharing subsidies often makes the silver plan the best choice for a consumer shopping for coverage under the ACA.[ii] We then looked at how the plans covered ten drugs that are widely prescribed for patients suffering from MS.

None of the plans provided coverage for all of the drugs. None of these plans covered these drugs without significant cost sharing that would burden the patients with thousands of dollars of out of pocket expenses, even after they had exhausted their deductible. One plan provided partial coverage for eight of these medicines, four plans partially covered seven of the drugs, three plans provided partial coverage for six of the ten drugs, one plan only covered five, and a final plan only provided partial coverage for three of these medicines.

The challenge for consumers is that the co-pay structure, and the caps on out of pocket spending, often only applies to costs incurred on drugs that are included on a plan's drug formulary. This is the list of medicines that the health plans have agreed to provide some coverage for. If the drug isn't on this formulary, then a patient could be responsible for its full cost (with little or no co-insurance to help offset that cost). Most of the plans offered under the ACA have "closed" formularies where non-formulary drugs aren't covered.

For costly specialty drugs, this can add up to substantial annual costs. Right now, the use of closed formularies is far more prevalent in the ACA than they are in the existing commercial market. The vast majority of ACA carriers also use similar formularies across their different metal tiers and network type within a given state. So by "buying up" to a higher metal, consumers are not getting a better benefit package in the form of a more inclusive drug formulary. In most cases, consumers are just paying higher premiums to buy down co-pays and deductible. It's worth noting that earlier this year, Express Scripts announced that it intended to remove several drugs for the treatment of Rheumatoid Arthritis from its national formulary. This could be interpreted as another example of constructs that have been rendered political palatable, if not appropriate by the ACA starting to seep into other insurance markets. In the 1990s there was a widespread movement away from closed formularies to tiered formularies that reduced restrictions. In many respects, the ACA has re-embraced and popularized the concept of the closed formulary.

So how does this translate into the actual costs that consumers will face if they need a particular medicine for the treatment of multiple sclerosis. To provide an estimate of what the actual costs could be to some patients, we used the retail prices of these medicines listed on the Walmart pharmacy. We chose this price list because it represented one of the lowest cost retail prices available in the public domain. Some of these drugs are dosed by weight, or

dosed on different intervals depending on a patients severity of symptoms. In these cases, monthly and annual costs were a rough approximation, imputed off an assumption around the proper dosing for a conservatively managed, 70kg patient. We used the terms of the health plan to estimate what the cost for a one month supply of medication would be if the drug was not included on a plan's formulary list. Most formularies were missing at least some key drugs. We focused on cases where a closed formulary excluded a drug. In most of these situations, the patient would be expected to pick up the entire cost of the drug. In most cases, that spending would not count against a person's deductible or out-of-pocket limits.

We didn't focus on cases where the drugs were included on formularies. But it's worth noting that in almost all of these cases, under the contract terms, patients were exposed to significant co-insurance costs if they were prescribed one of these drugs. It's probably reasonable to assume that patients prescribed any one of these drugs would end up reaching their out of pocket limits, even in cases where the medicines were included on the formulary.

Among our findings related to the drugs that were not included on drug formularies: The multiple sclerosis drug Aubagio wasn't included on the closed formularies of two of the ten silver plans that we examined. That means that patients on these plans could have to pay the full $4,420 monthly retail cost of this medicine. That comes out to about $53,000 annually. Avonex wasn't included on the formularies of two of the ten plans, potentially saddling patients with the drug's $4,805 monthly cost ($57,660 annually). Extavia (Interferon beta 1b) wasn't included on two of the ten closed formularies, at a monthly cost of $4,625 ($55,500 annually). Tecfidera wasn't included on the formularies of six of the ten plans at a monthly cost to patients of $5,209 (at a total cost of $62,508 annually).

We found similar findings when it came to drugs targeted to the treatment of rheumatoid arthritis. The RA drug Xeljanz wasn't included on the closed formularies of four of the ten silver plans we examined (with a monthly cost to the patient of $2,485, or $29,820 annually); Orencia wasn't included on the formulary of two plans (monthly cost of $2,673 or $32,076 annually); Kineret wasn't included in two plans (monthly cost $2,978 or $35,736 annually); Remicade was left off the formulary of three plans (about $3,592 for a two-month supply for a 70kg patient, or $21,552 annually); Rituxan was left off of six plans (a course of therapy will cost about $2,868); Actemra was left off four plans (about $1,555 every two weeks for a bi-weekly course of therapy, or $37,320 annually); and Simponi was left off two plans (at a cost of about $2,867 for a one-month 50mg supply for a 70kg patient, or $34,404 annually).

The high cost of developing innovative medicines, which translates into high retail prices for these medicines, is no doubt a challenge for our healthcare system. But for diseases like MS, the unwillingness to cover these costs is not easily understood. The number of patients with these diseases is well defined. Insurance companies can develop actuarial models to predict these costs with precision. Moreover, the cost of disease progression, and the ensuing disability, can far outweigh the cost of effective management with some of these new medicines. One would hope that an insurance scheme would provide comprehensive and deep coverage for rare and debilitating diseases like MS. Yet these plans seem to be tightening up their rules and their coverage precisely for these kinds of dreadful ailments.

In response to these drug formulary issues, and the potential for important drugs to remain completely uncovered, staff at the Centers for Medicare and Medicaid Services (CMS) is

arguing that patients will have the option to appeal formulary decisions — to try and compel a health plan to cover a given drug. But this appeals process can take months. And there is no sure chance of winning. If a drug costs tens of thousands of dollars a year, how many patients will be able to foot that bill out of pocket until they win an appeal? Or take the chance that they could lose the appeal, and be stuck with the full cost of the medication?

These findings have been replicated by other analyses. One study by Avalere Health of 22 carriers in six states looked at the benchmark plans that the ACA coverage would be tied to. It found that the numbers of drugs listed as available on formularies ranged from about 480 to nearly 1,110. Even if your drug makes it onto the ACA plan's formulary, getting access to a medicine can still be a costly affair for patients. In the same study, researchers found that 90% of the lowest-cost bronze plans require patients to pay 40% (on average) for drugs in tiers 3 and 4, compared with 29% co-pays in current commercial plans. Most of the Obamacare silver plans also require patients to pay 40% for the highest-tier drugs.

Another analysis by Avalere, released this week, looked at 123 formularies from different exchange-based plans. It found that more than one-fifth of silver plans require co-insurance of 40% or more for drugs in one of seven different classes that the authors examined (HIV/AIDS, mental health, oncology, diabetes, rheumatoid arthritis, and asthma). The anticipated out of pocket costs were generally greatest when it came to costlier medicines used to treat cancer or chronic diseases like multiple sclerosis. The analysis found that more than 60% of plans placed all of their covered molecularly targeted oncology drugs, their anti-anti-angiogenic oncology drugs (like Avastin), and their drugs for multiple sclerosis in their highest tier, requiring the greatest amount of out of pocket spending by patients. For MS, 50% of plans required co-insurance of 30% or more. In about 30% of cases, the plans provided no coverage at all for an MS drug, which is consistent with our findings.[iii]

Restricting Access to Providers

The same challenges are being seen when it comes to the networks of doctors that the health plans offer. More than two-thirds of health plans on the exchanges have assembled provider networks considered "narrow" or "ultra-narrow," in which as many as 70% of hospitals and other local health providers aren't included (according to a recent study by the consulting firm McKinsey & Co.) Earlier this year, we released similar analysis on these networks. We looked at health plans offered by BlueCross, BlueShield. We focused on a BCBS PPO for six specialist provider categories, and looked at the plans being sold in each state's largest county. We consistently found that exchange plans offered just a fraction of the specialists available in the PPO plan offered by the same carrier and offered in the same region.

Even in cases where plans offer choice among a larger complement of providers, the networks are still granting their exchange plan enrollees access to just a fraction of the providers available in their commercial plans. Statewide in California, Blue Shield of California reports that its exchange customers will be restricted to about 50 percent of its regular physician network offered in its commercial plans. This seems fairly consistent across different plans and different markets. Some plans appear to offer much less. The lack of contracted providers may strain the ability of patients to get non-urgent appointments.

Moreover, it's now been well documented that specialty hospitals like cancer centers and academic medical centers are being excluded from these networks. This is largely because these top tier institutions – which often deliver the highest levels of care – are nonetheless seen as too costly. For routine health matters, this may be of less concern. But if patients develop serious conditions that require expert attention, the out-of-pocket cost of going "out of network" to seek care at a specialty institution is likely to be prohibitively expensive.

These narrow provider networks lower costs, and in that way, help accommodate the other expensive but more routine benefits mandated by the law. Across various markets analyzed by McKinsey, the median increase in the premium for the same product type (e.g. HMO, PPO) offered by the same carrier, in the same metal tier, but utilizing a broad versus narrow hospital network, is 26%. In other words, when a carrier offered a product with both a narrow and an expanded network, the narrow network made the same basic benefit package 26% cheaper than if the same benefits were offered under a plan with a broader network. The same held true when it came to access to hospitals. Plans that offered access to academic medical centers had insurance costs that were 10% higher on average [iv]

Reforming Access to Drugs and Doctors

In the 1990s, consumers firmly rejected the idea of very restrictive health plans when they spurned HMOs in favor of PPOs that offered wider choice, but in some cases reduced benefits. In short, consumers showed through their collective choices that they were willing to trade the first dollar coverage that HMOs offered for a lot of routine care, in favor of greater choice and flexibility when it came to their formularies and networks. Yet the structure of the ACA is premised on a view that consumers were making a bad trade when they showed this widespread preference for PPOs over HMOs. The ACA effectively codifies the HMO model into law – forcing consumers into restrictive networks and formularies as a way to offset the costs of the mandated benefits that ACA plans must offer.

The most meaningful change that Congress could make to the ACA is to curtail this forced migration into HMO style plans, and enable consumers to have a wider set of options. Congress could allow a wider choice in the state-based exchange; to provide consumers a greater choice of PPO style plans. Consumers could select plans with wider formularies and networks in lieu of the benefits that are mandated by the ACA. Congress could reform the ACA by allowing any health plan that previously met state eligibility (prior to the ACA) to be offered on the ACA exchanges and eligible for the cost-sharing subsidies. This would allow a much wider selection of plans that make different tradeoffs between benefit design and networks. For consumers who want more flexible provider networks and broader drug formularies, they would have a greater selection of plans that embodied these constructs.

For now, consumers need to be vigilant when they buy coverage on the exchange. The terms of coverage can be convoluted despite steps to simplify their presentation. Many consumers will be unaware, for example, that their drugs are not covered unless prescribed by an in-network doctor. They may not know that drug co-insurance sometimes doesn't count against their out-of-pocket limits. They won't be aware that drugs that aren't included in a closed formulary may be completely uncovered by the plan. Moreover, in these cases, the money that consumers spend will not count against deductibles and out-of-pocket limits. The ACA could benefit from rules that require greater transparency around these terms. To

these ends, there is activity in the states that bears watching. In California, proposed legislation (SB 1052) would require a health plan to post its formularies on its Internet and include easy-to-understand details on how much each drug will end up costing patients.

The restrictive networks and formularies are an unfortunate consequence of the way that the ACA structured the exchanges. It is within Congress' power to fix these rules.

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[i] McCain-Edwards-Kennedy Patients' Bill of Rights S.1052 2001

[ii] Scott Gottlieb. In Obamacare, Go For Bronze Health Plans -- Buying Platinum Is Often A Waste Of Money. January 24, 2014.
http://www.forbes.com/sites/scottgottlieb/2014/01/24/in-obamacare-go-for-bronze-for-most-consumers-buying-up-to-gold-or-platinum-plans-may-be-waste-of-money/

[iii] Source: Avalere Health PlanScape, data as of October 31, 2013

[iv] McKinsey Center for U.S. Health System Reform. Hospital Networks: Configurations on the Exchanges and their Impact on Premiums. McKinsey & Co. December 14, 2013

Mr. PITTS. Dr. Harvey, you are recognized for 5 minutes for an opening statement.

STATEMENT OF WILLIAM F. HARVEY

Mr. HARVEY. Chairman Pitts, Ranking Member Pallone, thank you for allowing me to speak before you today. My name is Dr. Will Harvey, and I am a practicing rheumatologist at Tufts Medical Center in Boston, Massachusetts.

In addition to my daily duties caring for patients with rheumatic and musculoskeletal disease, I am privileged to chair the Government Affairs Committee of the American College of Rheumatology. As a member of the Coalition for Accessible Treatments, the ACR advocates for, among other things, affordable access to treatments for chronic conditions, including rheumatoid arthritis, multiple sclerosis, lupus, hemophilia, certain cancers, and many more. With these treatments, much of the disability of these diseases may be averted.

But a great tragedy is emerging in our country involving increasing barriers accessing these treatments. Some of these barriers include cuts to provider networks, step and fail-first therapies, co-pay assistance problems, and specialty tiers. I appreciate the opportunity to discuss some of those barriers in more detail with you today.

The first barrier I wish to bring before the committee relates to the practice of co-pays. I have no doubt every member of this committee is familiar with co-pays and their typical structure of generic tiers, name-brand preferred, and name-brand nonpreferred, or Tiers 1 through 3.

Unfortunately, however, we are seeing more and more insurers in plans and exchanges creating a fourth tier for expensive specialty drugs. Data released this week from Avalere shows that for many diseases, including rheumatoid arthritis, 100 percent of the biologic treatments fall within these specialty tiers.

What is more alarming about this fourth tier is that the insurers and plans in the exchanges have often assigned a coinsurance on a percentage basis, ranging from 20 to 50 percent of the total cost of this drug, which, as you just heard, can exceed $20,000 or more a year. This results in patient facing thousands of dollars per year of out-of-pocket costs.

Prior to the ACA, about 23 percent of plans included a fourth tier. Based on this data from Avalere, 91 percent of exchange plans use a fourth tier and 63 percent of them use a coinsurance for that tier.

Because of the cost of coinsurance, many patients are declining treatment. And, in many cases, when patients fail to access these treatments, they become disabled and can no longer remain in the workforce, thus costing the Federal Government more money to cover disability. Arthritis remains one of the top reasons for disability in the United States, at very high cost to the Federal Government.

Here is a stark example sent to me from a colleague in Wisconsin. "I have a young mother," she tells me, "with rheumatoid arthritis who cannot afford biologic treatments because of high co-pays. As a result, she has damage to her joints, and my concern

is that it will affect her ability to remain employed. It has already limited the activities that she can do with her children. I have many other stories," she tells me, "of patients who go without their medications, but this patient is in her 30s, and I have watched her RA erode her joints without being able to help her."

Fortunately, 127 Members of Congress have charted a path forward. H.R. 460, the Patients' Access to Treatments Act, sponsored by Representatives McKinley and Capps, limits the practice of Tier 4 pricing by preventing a percentage-based approach in favor of pegging Tier 4 co-payments to lower tiers. The ACR and the Coalition would like to thank Representatives McKinley and Capps for their heroic leadership in this regard.

It has been noted that a potential consequence of such action is an increase in premiums across all beneficiaries of those plans. We commissioned Avalere to conduct an evidence-based assessment of the likely impact of H.R. 460 on premiums. The results indicated that, if passed, H.R. 460 would only raise premiums in plans with specialty tiers by approximately $3 per year, or 25 cents per month.

There is too much at stake for patients who might stay in the workforce longer, avoid costlier treatments, and remain productive members of our society to let this practice continue.

Another issue I wish to bring before the committee relates to changes in provider networks where insurers have attempted to control costs by dramatically cutting provider networks. We believe this has begun with Medicare Advantage plans across the country, but there is great trepidation amongst all of my colleagues that it will expand dramatically to plans within the ACA.

In conclusion, I have great faith in the institution of Government and that its members will do everything in their power to protect the people of our Nation who suffer from chronic diseases and are burdened with the growing expense of treatments, with less access to the experts who can diagnosis and treat their conditions.

I cannot leave without acknowledging that the ACA has had successes and has been a benefit to many Americans. But the health care system is far from fixed, and much work is still necessary.

The committee should take swift action to, first, maintain adequate provider networks to ensure access to care while ensuring truth in advertising by requiring insurers in exchanges and in the broader marketplace to disclose plan changes to provider networks during open enrollment periods; and, secondly, to prevent excessive cost-sharing by blameless patients with chronic diseases by supporting H.R. 460, the Patients' Access to Treatments Act, which would apply to any private insurer within the ACA exchange.

Thank you again for accepting this testimony. I am happy to address any questions the committee may have.

Mr. PITTS. The Chair thanks the gentleman.

[The prepared statement of Mr. Harvey follows:]

William F. Harvey, MD, MSc, FACR

Chair, Government Affairs Committee

American College of Rheumatology

Testimony – Committee on Energy and Commerce

Subcommittee on Health

Thursday, June 12, 2014

Chairman Pitts, Ranking Member Pallone, Chairman Upton, Ranking Member Waxman and distinguished members of the Health Subcommittee, thank you for allowing me to speak before you today. My name is Dr. William F. Harvey and I am a practicing rheumatologist at Tufts Medical Center in Boston, MA. In addition to my daily duties caring for patients with rheumatic and musculoskeletal disease, I am privileged to chair the Committee on Government Affairs of the American College of Rheumatology (ACR). The ACR represents approximately 9,300 rheumatologists and rheumatology health professionals. As a member of the Coalition for Accessible Treatments (CAT), the ACR advocates for, among other things, affordable access to treatments for chronic conditions including Rheumatoid Arthritis (RA), Multiple Sclerosis (MS), Lupus, hemophilia, certain cancers and many more. I wear on my lapel a bent fork, created by the ACR to remind everyone that when you have arthritis, even simple tasks, like using a fork can be difficult. Recent advances in the treatment of RA and other diseases have created a 'new normal' for patients suffering from rheumatic diseases. With early diagnosis and treatment the disability and disfigurement also symbolized by the bent tines may be prevented. But a great tragedy emerging in our country involves the increasing barriers to accessing these treatments. Some of these barriers include cuts to provider networks, step and fail first therapies, co-pay assistance, and specialty tiers. I appreciate the opportunity to discuss some of these barriers in more detail with you today.

The first barrier I wish to bring before the committee relates to the practice of co-pays. I have no doubt that Members of this Committee are familiar with co-pays. Co-payments, among other purposes, are designed to create a dis-incentive for access by requiring patients to pay a larger amount for more expensive treatments. This type of structure in a setting where myriad choices are available, choosing to forego expensive treatments when cheaper alternatives abound has little consequence. However, for patients suffering from chronic diseases with limited effective therapies, the 'skin in the game' mentality backfires to the detriment of patients, particularly if the co-payment is not affordable. Again, Members of this Committee are likely familiar with the notion that they may pay a co-pay of 20, 40 or 60 dollars for a prescription, depending on whether the medication is generic, brand name preferred, or brand name non-preferred. The dollar amount of the co-pays for each of these 'tiers' has increased steadily over the last decade. Today, costs of many medications far exceed the amounts actuarially set within tiers by insurers. In response, insurers and plans in the exchanges are moving to create a fourth tier of expensive specialty drugs. Biologic therapies for RA and many other diseases, because of their nature and cost, are always included in this specialty tier. Because even among these treatments costs vary considerably, insurers and plans in the exchanges have often assigned a co-insurance on a percentage basis, ranging from 20-50% of the cost of the drug. This results in patients, who did not choose their disease or its expensive, innovative treatments, facing thousands of dollars per annum in out-of-pocket costs. Prior to the ACA, about twenty-three percent of plans included a fourth tier. Based on data from Avalere, 91% of exchange plans use a fourth tier and 63% of exchange plans use a co-insurance for that tier; 65% of silver plans and 75% of bronze plans use co-insurance. [Reference: Avalere PlanScape, Updated November 2013. http://avalerehealth.com/expertise/managed-care/insights/analysis-exchange-formulary-structure-more-similar-to-part-d-than-employer]. Not only do the Silver plans have higher premiums than the Bronze plans, the co-insurance could result in additional and substantial out-of-pocket costs. While this has been a very big problem for patient access both in the Medicare space

and in the private insurance market, it's now much greater a problem in the exchanges and must be addressed. This leads to two distinct phenomena. First, perhaps obviously, is that many patients decline the treatment based on cost. In many cases when patients fail to access these treatments, they become disabled and can no longer remain in the workforce, thus costing the federal government money on disability. Arthritis remains one of the top reasons for disability in the United States, at high cost to the federal government. Additionally, appropriate use of these treatments may prevent hospitalizations, and prevent the need for expensive procedures like joint replacements. Recent data suggests also that treating rheumatoid arthritis patients with certain of these medications reduces the risk of heart disease and its attendant costs [Bili et.al Arthritis Care & Research, Vol 66 (3), p355-363, March 2014]. Here is a stark example sent to me by a colleague in Wisconsin. "I have a young mother with rheumatoid arthritis who cannot afford biologic treatments because of high co-pays and deductibles. As a result, she has had many erosive changes in hands and feet. My concern is that this will affect her employment eventually. It has already limited the activities she can do with her children. She is using a lot of Prednisone to control her symptoms, which I think will also cause long term side effects. I have many other stories where patients go without their medications, but this patient is in her 30's and I have watched RA erode her joints without being able to help her." The second phenomenon relates to truth in advertising. When faced with the prospect of changing their insurance, a patient may look at posted formularies and see that a biologic treatment for rheumatoid arthritis, multiple sclerosis or other chronic disease is "covered", only to learn later that it is covered only in the context of a 20% or more co-insurance payment. For far too many Americans, this level of financial obligation cannot be afforded and is in effect not coverage. I am not here to argue any point about right to specific care, only the notion that a medication should not be listed as covered if its out-of-pocket costs result in such unaffordability as to reasonably regard it as un-covered. Fortunately, 127 members of Congress have charted a path forward. HR 460 (The Patients' Access to Treatments Act), sponsored by Congressman McKinley and

Congresswoman Capps, limits the practice of Tier IV pricing by preventing a percentage-based approach in favor of pegging Tier IV co-payments to the lower tiers. The bill has garnered 127 House co-sponsors and we are actively seeking introduction of a Senate companion bill. The ACR and the coalition would like to thank Representatives McKinley and Capps for their heroic leadership in this regard. We strongly urge this subcommittee to review and mark up this legislation, then pass it on to the Full Committee and the House floor for a vote during this 113th Congress. It has been noted that a potential consequence of such action is an increase in premiums across all beneficiaries of a plan. In order to address this concern, our coalition commissioned the renowned health-care firm Avalere to conduct an evidence-based assessment of the likely impact of HR460 on premiums. Results indicated that if passed, HR 460 would in fact raise premiums in plans with specialty tiers by approximately $3 per year or twenty-five cents per month. It's time for this country, and this Congress, to say to the American people that halting the practice of excessive co-payment and co-insurance is a reasonable step to ensure that patients who have not chosen their disease, nor its innovative treatments, shall not be denied that treatment in order to balance an actuarial chart for $3 dollars per year. There is too much at stake for patients who might stay in the workforce longer, avoid costlier treatments, and remain productive members of our society to let this practice continue.

Another issue I wish to bring before the committee relates to changes in provider networks that are a growing problem. The trend appears to have started with Medicare Advantage plans and there is great trepidation amongst my colleagues that it will expand to plans within the ACA exchanges. Over the last year, insurers have attempted to control costs by dramatically cutting provider networks. This has been a problem across the country, but has been felt acutely in the northeast. This Subcommittee's website cites a recent article in the Boston Globe highlighting these concerns and describing their impact on patients. In particular, the common practice is to change these networks after the conclusion of the open enrollment period. The result is that savvy consumers seeking to select a network with

access to certain specialists or to maintain their current network can select plans which will later not cover the providers they seek. Indeed litigation is pending in several states to limit this practice. Patients should not be limited arbitrarily by insurers to see certain providers without fair notice. The basic free market principles of full and necessary disclosure therefore dictate that insurers should be required to disclose to patients any planned network changes during the open enrollment period. Should plans within the ACA adopt similar practices, the results could be catastrophic. A colleague in Connecticut recently described the story of a patient she saw for many years. When the open enrollment period ended, my colleague was dropped, without warning, from the Medicare Advantage insurer's network. Without recourse until then next open enrollment period, her patient not only had to re-establish care with another provider, but had to drive an additional two hours to reach that provider. Congress should step in to prevent this practice in all insurance plans, including those in ACA exchanges.

Similar to ongoing changes to provider networks, another rampant practice that has been in existence for some time, but has now increased within exchange plans is changes in formulary coverage of medications. While common and relatively inexpensive medications used to treat some chronic diseases such as diabetes and heart disease have many viable alternatives, recent advances in the care of many diseases have few options. Please allow me to describe for you a class of medications known as 'biologics'. In comparison to most medications, like aspirin, with a simple chemical formula discovered and manufactured with relative ease, biologics are treatments derived from or consisting of components of living organisms. Examples include antibodies or proteins designed to react with our immune systems. They require significantly more intensive research and development, as well as production costs. With this innovation comes many of the revolutionary treatments changing the paradigm of care I described in relation to my bent fork. But a consequence of these advancements is their escalating cost. That cost, while arguably justified by the manufacturer, invariably gets passed on to patients and

insurers covering their care. The biologic medications used in the treatment of rheumatoid arthritis may cost as much as $15,000-$30,000 annually and that's just for one medication. Many patients with chronic conditions such as RA are forced to take several medications each month. Additionally, the figure grows with every new pharmaceutical innovation. A great deal of press has been garnered by recent advances in the treatment of hepatitis C which could be three times this cost. A ubiquitous tool employed by all payers, except Medicare, is to negotiate prices for drugs with the manufacturer in exchange for preferred status on that insurer's formulary. The insurer then creates financial dis-incentives, ranging from non-coverage to excessive co-insurance to restrict use of the more expensive, non-formulary alternatives. Step therapy and 'must fail first' policies are the norm amongst payers across the spectrum both within and outside of ACA exchanges. Even when an individual fails the formulary treatment, barriers to accessing non-formulary alternatives are difficult to overcome. As insurers within various tiers of the exchange plans seek to control costs, limiting the formulary remains an effective and often used tool. These changes may occur irrespective of open enrollment periods and we have grave concerns again that a savvy patient will not have the ability to make an informed decision during the open enrollment process. Congress should step in to limit changes to plan formularies outside of open enrollment periods and place reasonable limits around step or fail first policies amongst insurers.

One way to manage the growing burden of co-pay and co-insurance is allowing manufacturers to provide co-pay assistance. The practice typically is undertaken by charitable foundations established by manufacturers to provide co-pay assistance to patients. Based on current law and precedent, Medicare and other federally subsidized insurance recipients are not permitted to use these services. While I am not here to debate that particular point, the fact remains that patients covered in the private marketplace can utilize these options. Legitimate questions have been raised about the applicability of these programs to patients obtaining coverage through exchanges, even if the plan is not directly

subsidized by government. While a recent clarification from CMS has indicated that patients with private plans within exchanges may benefit from this practice, there is still concern about legal challenges to this determination. One unfortunate phenomenon of relying on co-payment assistance from a manufacturer is that the entities providing the support have limited funds. It is not at all uncommon for a patient to receive assistance throughout the year only to have the entity run out of funds by year end. For these patients, cessation of therapy, particularly if it has proven effective, could have dire consequences. Another patient story comes from a man with severe psoriasis for the last 20 years living in Dallas, TX. It took him three months to find a plan that worked for him in the marketplace. Mr. E was frustrated he never got to see the details of the plans available to him and made choosing a plan very difficult. In particular he wanted to find something similar in terms of access to prescriptions. Once he chose a plan, he had to go through the approval process again in order to continue taking his previous biologic and treatment was delayed. For individuals living with psoriatic disease, cycling on and off biologics can impact of the efficacy of the medication and quality of life. Mr. E also depends on co-pay assistance from the manufacturer. If he cannot use the manufacturer assistant program for his biologic in the marketplace, he worries he may no longer be able to afford the medication. Congress should step in to clarify that beneficiaries of any fully private plan, even those within exchanges, may leverage co-pay assistance provided by any source and enforce truth in advertising among exchange plans.

In conclusion, I wish to thank the Chairman and Ranking Member for the opportunity to speak with you today. I have great faith in the institution of government and that its members will do everything in their power to protect the people of our nation who suffer from chronic disease and are burdened with the growing expense of treatment and with access to the experts who can diagnose and treat their condition. I cannot leave without acknowledging that the ACA has had successes and has been a benefit to many Americans, but the healthcare system is far from fixed and much work is still necessary. As we gain further experience with the plans and coverage contained within the auspices of

ACA healthcare exchanges, we need to be cognizant of unintended consequences in need of redress. The committee should take swift action to: 1) maintain truth in advertising by requiring insurers in exchanges and in the broader marketplace to disclose planned changes to provider networks and drug formularies during open enrollment so that patients can make informed decisions about their healthcare coverage; 2) reaffirm the intent of Congress that individuals on private plans offered through healthcare exchanges be permitted to benefit from co-pay and co-insurance assistance offered through pharmaceutical manufacturers; and 3) prevent excessive cost sharing by blameless patients with chronic diseases by supporting HR 460, the Patients' Access to Treatments Act, which would apply to any private insurer within the ACA exchanges.

Thank you again for accepting this testimony and I am happy to address any questions the Committee may have.

Mr. PITTS. I now recognize Commission Lindeen, 5 minutes for an opening statement.

STATEMENT OF MONICA J. LINDEEN

Ms. LINDEEN. Good morning, Chairman Pitts, Ranking Member Pallone, and members of the subcommittee. My name is Monica Lindeen, and I am the commissioner of securities and insurance for the State of Montana. And I also serve as president-elect of the NAIC.

I appreciate the opportunity to appear before the committee to discuss these two important topics that have a great influence over the quality of care that QHP enrollees receive.

While I am limiting my spoken comments today to network adequacy, my written testimony also contains information about drug formularies.

As the ACA has been implemented, insurance commissioners across the country have focused on protecting consumers and markets in their individual States. The issues we deal with are complex, but, through the NAIC, our national organization, we have worked cooperatively to address the challenges.

Insurance companies have long used provider network contracts as a way of controlling costs. Providers agree to lower reimbursements in exchange for the increased traffic of patients seeking lower out-of-pocket costs within the network. But there can be problems. If the networks become too narrow, patients can't get the services they really need. If the regulation becomes too stiff, insurance companies can't organize policies in ways that truly cut health care costs.

These concerns have been ongoing for some time, and network adequacy oversight has been and will continue to be a priority for insurance commissioners around the country.

Given the importance of striking a balance, particularly with respect to tradeoffs between breadths of network and cost and the differences in local geography, demographics, patterns of care, and market conditions, it is important that responsibility for assessing the adequacy of networks remain with the States. State-based regulation works and has proven to effectively protect consumers. Networks are inherently local, and you need local expertise to effectively regulate the markets and preserve patient access to the care they need.

Montana has the tools in place to adequately regulate in-networks, and our network adequacy standards are, in general, more protective than what the ACA requires. My staff reviews the network adequacy of every health plan approved for sale inside the Federal exchange as well as those sold outside the marketplace. Because I conduct the same review inside and outside, I am able to ensure a level playing field in our market.

In Montana, we have not witnessed the sale of private health insurance plans restricted to certain service areas and the very narrow networks do not really exist. The majority of the health plan products offered in Montana are a variation of a PPO product. However, in 2014, two of our three marketplace insurers did offer a narrower network option in two cities. But both of those compa-

nies also offered products in all parts of the State with access to their complete network, including the rural areas.

It is very important for consumers to understand the network features of a plan and how those apply to care provided by specific providers. Most of the network adequacy complaints received by my office this past year were rooted in a lack of transparency about available providers and a lack of understanding about how network restrictions work. Consumers found it difficult to find lists of provider networks when they were shopping for insurance, and this made it very difficult to choose the correct plan. The marketplace and insurance companies need to do better job of providing accurate and easy-to-access network lists.

These are not insurmountable problems, and States are focused on fixing these transparency issues. Over the years, insurers have been experimenting with new types of plan designs, and the head-to-head competition on exchanges has accelerated this trend, as competition on prices become more acute.

While I and my colleagues agree that containing cost and bending the curve is critically important, we must also remember that health care is about more than the bottom line. Some older State statutes may no longer fully accommodate these new plan designs, and so the NAIC has begun working to revise our network adequacy model law, which aims to fully protect consumers while providing regulatory flexibility.

We have spent the last month receiving input from all interested stakeholders before drafting any revisions, which we hope to develop and consider through our open and transparent process and complete by the end of the year. Until that time, we believe CMS should not engage in further rulemaking until the States have time to act.

As I conclude my remarks, let me leave you with this perspective from someone who has been on the ground dealing with implementation. I have traveled across the entire State of Montana in many communities, including all seven of our Indian reservations, a distance greater than from here in DC to Chicago. And even on our Indian reservations, whether they are Republicans or Democrats, the folks in Montana don't want to talk about partisan arguments; they want to talk about solutions that are going to help them find their correct doctor and their correct insurance plan and get the care they need for their families. Trying to help answer those questions is what drives my decisions as a commissioner, not what is happening here in DC.

So thank you for the opportunity to testify.

Mr. PITTS. The Chair thanks the gentlelady.

[The prepared statement of Ms. Lindeen follows:]

Testimony of Monica J. Lindeen
Montana Commissioner of Securities and Insurance

Before the
House Energy and Commerce Subcommittee on Health

June 12, 2014

Good morning Chairman Pitts, Ranking Member Pallone, and Members of the Subcommittee. My name is Monica Lindeen, and I am the Commissioner of Securities and Insurance for the State of Montana. While I am testifying today in that capacity, I also serve as President-Elect of the National Association of Insurance Commissioners (NAIC), which will also inform parts of my testimony. I appreciate the opportunity to appear before the Committee to discuss two important topics that can have a great influence over the quality of care that qualified health plan (QHP) enrollees receive: the breadth of their provider networks and prescription drug formularies.

Network Adequacy

The use of narrow networks by QHPs sold on both State-Based and Federally Facilitated Exchanges has received a great deal of attention since the beginning of the initial open enrollment period last October. Issues related to network adequacy are nothing new, however. Ever since insurers began using networks, there have been concerns regarding their ability to meet consumer needs, and state regulators have been examining network arrangements to ensure

that they provide sufficient access to care for consumers. While the Affordable Care Act (ACA) has probably accelerated the trend in the individual and small group markets by sharpening competition between insurers selling coverage on Exchanges and by eliminating other avenues for cost reduction, such as medical underwriting and preexisting condition exclusions, insurers and employers have been moving towards narrower networks for a number of years. As price competition on Exchanges becomes more acute, however, regulators are seeing many insurers put pressure on providers to accept lower reimbursements and demonstrate the quality of care they provide. Properly done, this can be a way to push competitive market forces down to the provider level and bend the cost and quality curves. Improperly done, it can deprive consumers of promised services to the detriment of the patient's health and financial security. That is why it is very important for consumers, regulators, health care providers that networks are sufficient to deliver the services promised under a health insurance policy. Ultimately, this is also in the long-term interests of insurers, as a repeat of the managed care backlash of the 1990s could deprive them of the ability to use the provider contracting process to reduce costs and improve quality. That is why regulatory oversight of provider networks has been and will continue to be a priority for me and for other Insurance Commissioners around the country.

In Montana, we have not witnessed the sale of private health insurance plans restricted to certain service areas, and "narrow networks" do not really exist. At this point, very few, if any "HMO" type plans are being sold in Montana, since this state is very rural and HMO products in the past have not been popular. HMO point- of- service products are sometimes offered, but those plans are very similar to the PPO products. I have not yet seen the health plan form filings for 2015. The majority of the health plan products offered in Montana are a variation of a "PPO" product. Two of our three Exchange insurers offered a narrower network option in two cities in Montana,

but both of those companies still offered products in all parts of the state, with access to their complete network, even in rural areas.

Many states have network laws that envision only "PPO" or "HMO" type of products. Over the years, insurers have been experimenting with new types of plan designs, such as "tiered networks" or "exclusive provider organizations." The older statutes cannot fully accommodate all of the new plan designs. Consequently, the NAIC is working on a new network adequacy model law (discussed later in this testimony) that will provide regulatory flexibility to allow innovative plan designs, but still protect the consumer's access to necessary healthcare providers.

In assessing the adequacy of an insurer's network, there are three key considerations that regulators must balance: ensuring adequate access to health care providers, maintaining the affordability of coverage, and ensuring that there is sufficient transparency for consumers to make a fully informed decision when deciding between insurance plans.

The primary objective of network adequacy regulation, of course, is to ensure that if an insurer requires enrollees to receive benefits from in-network providers, or provides financial incentives to do so, the network is capable of providing those benefits to enrollees when needed. This includes looking at the availability of hospitals, primary care and specialty providers, pharmacies, and other types of providers to ensure that networks have enough providers throughout their service area to provide benefits, as well as an insurer's procedures for remedying any geographic shortages and allowing out-of-network care when warranted.

This analysis should, however, take into account a number of important factors in order to confirm that the standards put in place fully ensure access to care and are achievable by insurers. These factors include:

General provider availability in a given geographic area. Consideration should be given to the number and types of providers and facilities located in a given area. General availability will vary depending on population, urban density and the provider's willingness to enter into contracts under reasonable terms and conditions. It should also be kept in mind that, as part of the network analysis, network adequacy considerations may have to be modified, depending on a state's specific geographic makeup.

For instance, large parts of Montana are very rural and have no oncologists available for hundreds of miles in any direction. The width of Montana is equal to the distance between Chicago and Washington D.C. Therefore, as the state insurance regulator, I must meet that challenge by proposing rules that provide the most logistical and reasonable method to ensure the population living in those remote areas has in-network access to the type of healthcare they need.

Medical care referral patterns and hospital admission privileges. Network analysis must include a review of the hospital admission privileges of providers as well as typical referral patterns for a given community or area. This information may be obtained from the state's health department. Hospital admission privileges are typically gathered as part of the carrier's provider credentialing process. Analysis must confirm that providers requiring the use of facilities—including hospitals, ambulatory surgical centers or specialty treatment facilities—are able to admit their patients to network facilities. As an example, obstetricians must have admitting privileges to network hospitals for delivery services.

Availability of hospital-based providers. Hospital-based providers—such as radiologists, pathologists and emergency room physicians—may not be part of the same network as the facility, or may not be in any network. Absence from the network may result in inadequate network for these services. This is particularly the case if the hospital providers hold an exclusive contract with the facility. Historically, ensuring adequate coverage of these providers has been a challenge, as there is often little incentive for them to contract with insurers since most patients do not specifically choose the radiologist reading an imaging test or the pathologist conducting the biopsy on a tissue sample.

State insurance regulators may need to take "provider willingness to contract" into consideration when developing network adequacy rules. Historically, certain categories of physician specialists refuse to contract with insurers, especially in parts of the country where there are shortages.

Geography. Geographical barriers may exist that impede access to care, and the analysis should not rely on a simple mileage factor to determine accessibility. Examples of geographical barriers include mountain ranges and rivers or other bodies of water. I am able to examine the geographic barriers and travel patterns unique to my state, which has geographic barriers in every direction. In a more urban state, such as , New Jersey, that may not be the case.

Essential Community Providers. The location and availability of essential community providers as well as mental health and substance abuse providers is not specifically addressed in most existing state laws. However, the final Exchange rules specifically require networks to include an adequate number of these providers.

Federal regulation requires Exchange insurers to cover at least 30 % of essential community providers (ECPs) available in the state. ECPs serve the low income and medically underserved population. Much of Montana's population is rural and therefore "medically underserved." I reviewed the federal ECP list in Montana and found that it did not include many of necessary providers that should have been considered ECPs. I added many more providers to the ECP list. In addition, I have advised all Exchange issuers that they must strive to meet the 80 % standard for ECPs—the same as other healthcare providers. However, I must be flexible, especially when the insurer can show that a particular ECP is refusing to sign a contract. Montana is a huge state that is sparsely populated. The federal "30 %" standard is not in the best interests of Montanans and could result in closest ECP being 400 miles away.

Centers of Excellence. The availability and access to centers of excellence for transplants and other medically intensive services is crucial, as is the availability of critical care services such as advance trauma centers, burn units, etc. If a carrier does not have such providers in their networks, then arrangements must be made by the QHP issuer to ensure access to these specialized services.

Availability for new patients. The availability of provider types as well as their capacity to accept new patients is a critical component of understanding the network. It is also imperative to recognize that different health plans may include the same provider or facility.

Overly rigid network adequacy requirements, however, can lead to premium increases, as insurers lose the ability to meaningfully negotiate with providers over the price of delivered

items and services. By entering into a network agreement with an insurer, providers strike a bargain: accepting lower reimbursement in exchange for the higher volume of patients seeking in-network care. Narrower networks sharpen this bargain even further. Providers must often make greater price concessions to participate, but the insurer's pool of patients is spread over a smaller number of participating providers. According to one analysis of broad- and narrow-network silver level QHPs sold in urban areas across the country, premiums for broad-network plans were 26% higher.[1] For this reason, it is important for regulators to be mindful of the premium impact of requiring insurers to maintain broader networks, especially if a narrower one can still provide sufficient access to all promised services.

It is very important for consumers to understand the network features of a plan during the shopping process and how those features would apply to care provided by specific providers. If an insurer maintains multiple networks, it should be clear to consumers which provider network a given plan makes use of. Similarly, practitioners should have a clear understanding of which networks they are members of in order to prevent confusion and unexpected bills.

In Montana, most of the complaints about network adequacy that we have received since January 1, 2014 involve the consumer's lack of understanding regarding how the plan's network functions and also deficiencies regarding the insurer's provider directory. In Montana, the provider network directories did not function as well as they should have during 2014 open enrollment, and we will continue to work on improving that function. This is why states are focusing on network transparency issues.

Need for continued state control

[1] McKinsey Center for U.S. Health System Reform. *Hospital networks: Configurations on the exchanges and their impact on premiums*. December 14, 2013.

Given the importance of striking the balance that I have mentioned above—particularly with respect to tradeoffs between breadth of network and cost—and the differences in local geography, demographics, patterns of care, and market conditions, it is very important that responsibility for assessing the adequacy of provider networks remain with states that have effective programs in place. It is impossible to come up with a one size fits every state solution.

States have a much more detailed understanding of these competing factors. In particular, they will have a better sense of the general availability of providers to contract within the various parts of their states, which depends greatly upon population, urban density, and willingness to enter into contracts. Based upon its analysis of these factors, a state may need to modify its network adequacy standards, and should have that flexibility.

Because effective network analysis must account for hospital admission privileges and referral patterns in a given community, as well as geographical barriers that will be more well-known to state regulators than to federal regulators in Washington and may impede access to care and can make the application of a simple mileage factor difficult in determining accessibility. Mountain ranges, for example, can be difficult to travel through in certain times of year and can make a seemingly close provider facility difficult to reach.

States are best positioned to balance these competing factors and have the detailed knowledge and understanding of their markets that is needed to make these determinations. On April 30, I and my fellow insurance commissioners sent a letter to President Obama, urging him to keep network adequacy review at the state level, where it can be most thoughtfully performed within the context of the market in which it occurs and to allow the NAIC, in consultation with all

affected stakeholders, to examine and potentially revise its current model act. CMS should not engage in further rulemaking until the states have time to act.

ACA Requirements

The final Exchange regulations promulgated under the ACA require each QHP "maintains a network that is sufficient in number and types of providers, including those that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay."[2] This establishes a minimum network adequacy standard for QHP issuers while also providing sufficient discretion to Exchanges and states to structure network adequacy standards that are consistent with standards applied to plans outside an Exchange and are relevant to local conditions.

In federally facilitated and partnership Exchange states in 2014, the Centers for Medicare and Medicaid Services (CMS) deferred to state reviews, as long as the state had an effective network adequacy program in place under which the state has statutory authority to review insurers' networks, and whether the state's authority allows the state to determine whether those networks are sufficient in number and type of providers to ensure that all services will be accessible without unreasonable delay. If a state did not have an effective program in place, CMS accepted an accreditation that included it accepted an insurer's attestation of adequacy, so long as that insurer was accredited for an existing line of business by an HHS-recognized accrediting entity.

[2] 45 CFR 156.230(a)(2)

In all other cases, CMS collected an access plan for the QHP and monitored accessibility complaints.[3]

Next year, CMS will be collecting full provider lists from all QHPs in FFMs and SPMs as part of the plan management process and will use that data to review the adequacy of their networks. It has also indicated that it intends to use the provider lists and its experience in states where it is making network adequacy determinations to inform possible future rulemaking in this area. While state regulators are encouraged that they have pledged to work in consultation with state regulators conducting network adequacy analyses, they are also wary of federal overreach in this area where state oversight is so important.

In 2013, the legislature amended the Montana preferred provider organization (PPO) network adequacy law, making it overall more protective of consumers. The new law specifies that an insurer who has 80 % of all of the healthcare providers in the state and 90 % of all the health care facilities in the state in their network is "deemed" adequate, although I have the discretion to determine that a lower percentage is also adequate. The trade-off for obtaining these high percentages is that the law now allows the cost-sharing differential between in and out of network services to be much higher. I also review the adequacy percentages for certain provider types, such as mental health professionals and other specialties. My office is currently working on draft administrative rules that will clarify the network adequacy requirements for PPO products. This rule will focus on network transparency for consumers and also issues relating to geographic barriers, the availability of providers in a particular area, as well as their willingness to contract.

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[3] Center for Consumer Information and Insurance Oversight, *Affordable Insurance Exchanges Guidance, Guidance on State Partnership Exchange*

The Montana statutory amendment was not in response to any ACA requirements. The current ACA requirement for network adequacy is a very broad reasonableness standard, as stated above. In general, I would judge the Montana network adequacy standards to be more protective than the ACA standard. My staff reviews the network adequacy of every health plan approved for sale inside the federal Exchange in Montana, as well as those sold outside the Exchange marketplace. Because I conduct the same network adequacy review inside and outside the Exchange, I am able to ensure a level playing field in the Montana health insurance market. I believe that the major medical health insurers approved to sell in Montana, on and off the Exchange, have healthy and adequate provider networks. The draft administrative rules for network adequacy also protect Montanans who need to seek care from specialists by requiring insurers to cover claims as if they are in network, if a specialist is not available within a reasonable distance—or if it is necessary to seek care out of state.

However, the issue of access to healthcare providers is always complex and requires some compromises in order to achieve affordability. Therefore, there will always be consumer complaints on this topic, which regulators like myself must weigh carefully. When there are issues that need to be resolved, I try to work with insurers to solve them when possible, but will take regulatory action when necessary.

National Experience

Over the past several months, my colleagues in other states have run across a number of issues associated with narrow networks in QHPs. A common issue is the inclusion of children's hospitals and academic medical centers in provider networks. Care at these facilities is often more expensive than in other nearby hospitals for similar procedures. Consequently, some

insurers, particularly on Exchanges where price competition is more acute, have sought to reduce their spending by excluding them from their networks. In many cases, insurers have agreed to allow enrollees to use these facilities to access specialized care that is not available from network providers within a reasonable distance without imposing out-of-network cost-sharing. While I and my colleagues agree that containing costs and bending the curve is critically important to the future of health care affordability in this country, we must also be vigilant about cost-cutting measures that negatively impact the quality of care that patients receive.

Another issue is when policies exclude coverage, even on an out-of-network basis, for any care provided out-of-state. Health care delivery markets often cross state lines, and many consumers are used to relying on nearby providers in other states for needed care. While this plan provision may not necessarily be prohibited, regulators have worked very hard to ensure that insurance agents, navigators and others assisting consumers in plan selection make consumers fully aware of these limitations before they purchase the plan so that they will not be surprised with large bills after receiving care. Currently, Montana does not have any health plans that exclude care for out of state services.

In response to these and other issues, a number of states have revised their network adequacy requirements. Washington State has recently revised its regulations to, among other things, require insurers with an insufficient number of in-network providers in an area to allow enrollees to receive needed care from nearby out-of-network providers with out-of-pocket costs that are the same as those for in-network care. This is similar to the proposal in the Montana draft network adequacy rules. This provision is also in the current version of the NAIC model law on network adequacy.

On a national level, state regulators recognize that current state standards may be in need of revision to effectively address the increased use of narrow networks by QHPs and to reflect the ACA's requirements to include providers who specialize in mental health and substance abuse services and Essential Community Providers. The NAIC identified its *Managed Care Plan Network Adequacy Model Act*, which was first adopted in 1996, for revision late last year. The model sets out requirements for health carriers in designing and establishing their networks to assure adequacy, accessibility and quality of health care services for carriers that offer a managed care plan. In 2014, the HHS identified the NAIC model as a floor for states to adopt to meet the ACA's network adequacy requirements.

The NAIC appointed the Network Adequacy Model Review Subgroup in March to review the model and make necessary revisions. The Subgroup began holding weekly open, public conference calls in May and intends to finish its work by the end of this year. Before drafting language to revise the model, the Subgroup is hearing from various stakeholders, including consumers, providers, business groups, accreditors and insurers, on the issues and concerns they are currently seeing related to network adequacy inside and outside the health insurance marketplaces. It has also asked these stakeholders to propose solutions to address the problems they have identified.

Among the issues the Subgroup is likely to address is the definition of what constitutes a "managed care plan" subject to network adequacy standards today, as opposed to what fell under that definition when the model was first adopted in 1996. With the advent of tiered networks and other plan designs used by carriers, the Subgroup anticipates making revisions to clarify that term and its application under the model. Another issue relates to the provision of provider directories to applicants and current enrollees. The current model does address how, and in what

manner, provider directories must be made available to consumers. It is anticipated that the Subgroup will consider revisions to the model that will dictate: 1) when provider directories must be provided to applicants prior to enrollment and current enrollees prior to renewal and other times, such as when the directory is materially updated; 2) the periodic update of each plan's directory – annually, quarterly or more frequently; and 3) in what manner the directory must be made available, such as electronically on the plan's or carrier's website or on paper, at the request of an applicant or current enrollee. Consumer transparency regarding the adequacy and function of a health plan's network was identified by consumer advocates as one of their top concerns.

Formulary Design

A second quality issue that has arisen over the past several months concerns the design of QHP prescription drug formularies. In 2014, because of federal law, all individual and small employer group health plans sold in Montana must offer prescription drug coverage that meets the requirements contained in the Montana essential health benefit benchmark. Under the essential health benefits (EHB) regulations, all non-grandfathered, non-transitional plans in these markets are required to provide coverage for at least as many drugs (but at least one) in each therapeutic category and class as the benchmark plan in the state. In addition, if a particular drug is not covered, there must be a waiver (or appeal) process that requires the insurer to consider the medical necessity of covering particular drugs that are not currently part of their formulary. Prior to January 1, 2014, most small employer group health plans were covering prescription drugs, but not all individual health insurance coverage included prescription drug benefits. Prior to the ACA, Montana law did not require coverage for prescription drugs. Our experience is that health plans sold in 2014 in Montana adequately cover medically necessary drugs.

Drug costs often account for a very large percentage of claim costs in a health plan. Health plans need to have some way to protect consumers from price gouging by large pharmaceutical companies. Most plan designs sold in Montana have a tiered drug plan; (i.e. different cost sharing for generic, brand name and specialty drugs—each tier has a different cost sharing amount).

Some plans also use a cost management approach involving "step therapy," meaning that lower cost or generic drugs must be tried first--before more expensive drugs can be covered. Both of these types of plan designs provide important methods to keep drug costs under control. The use of tiered formularies by both group and individual health plans to encourage greater use of appropriate generic drugs can be extremely effective and has been a major factor in the recent trend towards lower prescription drug spending.

Generally speaking, obtaining prescriptions from an "in-network" pharmacy is not a significant problem for consumers in Montana. There are local pharmacies, as well in mail order pharmacies readily available. All of the prescription drug coverage in Montana, and all states, falls under the "maximum out of pocket" protection provided under the ACA ($6350/individual in 2014)—no waivers from that provision have been allowed in Montana for fully insured health plans. Therefore, even if there is higher cost sharing for specialty or brand name drug tiers in a particular health plan, the maximum out-of-pocket costs for the consumer is capped at $6350, or less depending on the plan design. Many plan designs available for sale in Montana have lower caps on out-of-pocket costs.

We must also be vigilant that plan designs aren't structured to discriminate against those individuals who need coverage most. ACA nondiscrimination requirements prohibit QHPs from

engaging in "marketing practices or benefit designs that have the effect of discouraging the enrollment in such plan by individuals with significant health needs."[4] This requirement serves two purposes. First it seeks to ensure that individuals with serious medical conditions receive equal treatment from insurers and have coverage available that meets their health care needs. Second, it prevents some insurers from attempting to shift the costs incurred by these individuals to their competitors, creating an adverse selection situation.

Recently, the AIDS Institute and the National Health Law Program filed an administrative complaint with the HHS Office of Civil Rights, which administers the nondiscrimination provisions of the ACA and other federal health statutes, including Section 1557 of the Rehabilitation Act, which prohibits discrimination against individuals with disabilities, including those living with HIV/AIDS, in federal programs.[5] In the complaint, they allege that several insurers selling QHPs in Florida have placed all covered drugs used for the treatment of HIV/AIDS, including both brand name and generic drugs, in their highest tier, reserved for non-preferred specialty drugs. Drugs in this tier are subject to the highest level of cost-sharing, with coinsurance ranging from 40-50% after a separate prescription drug deductible are satisfied. These drugs are also subject to prior authorization by the insurer and may only be dispensed in limited quantities. The complainants allege that this constitutes a discriminatory plan design that serves to discourage individuals living with HIV/AIDS from enrolling in these insurers' plans. Unfortunately, these types of issues are going to be difficult to spot in the initial plan approval process given the resources state and federal regulators have at their disposal and the fact that nearly half of the issuers selling QHPs on that state's Exchange used this sort of plan design. This is a good example, however, of how issues can come to regulators' attention through back-

[4] ACA 1311(c)(1)(A)
[5] 42 USC 156.125(a)

end complaints. A number of states have already taken action to prevent similar problems. The state of Maryland has enacted legislation that would limit cost-sharing for specialty drugs to $150 for a 30-day supply,[6] and the Illinois Insurance Commissioner issued a bulletin on May 23 reminding insurers in the state of the prohibition on discrimination against individuals with health conditions, including HIV/AIDS.[7] In that bulletin, he also signaled his intent to closely examine plans' compliance with this provision, including by looking at plans' medical management techniques and preauthorization requirements.

In Montana, my staff has received complaints from consumer groups alleging that certain companies have imposed excessive coinsurance in the "specialty" drug tier. We are currently investigating those allegations. I may be able to disapprove those prescription drug plan designs on the grounds of discrimination because only people in certain disease groups (such as M.S. and rheumatoid arthritis) would need to purchase drugs in that tier. State insurance Commissioners are reacting to these complaints and taking steps to protect consumers during the health plan approval process.

Once again, I would like to thank the Subcommittee for holding this hearing to look at this important topic. The use of networks and prescription drug formularies to reduce costs is one way that insurers can compete with one another inside and outside of Exchanges and bring down premiums, but we must be vigilant that it does not come at the expense of patient access to care. Thank you again for the opportunity to testify today. I look forward to your questions.

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[6] Maryland Senate Bill 874

[7] Illinois Department of Insurance. *Company Bulletin CB2014-08: Discrimination and Qualified Health Plan(QHP) Certification or Recertification for 2015 Plan Year*, May 23, 2014. Located at http://insurance.illinois.gov/cb/2014/CB2014-08.pdf

Mr. PITTS. That concludes the opening statements of the witnesses. We will now go to questions and answers. I will begin the questioning and recognize myself for 5 minutes.

At the outset, I want to point out one thing I find deeply troubling. It is now widely acknowledged that the President's promise that if you like your doctor you can keep your doctor under the Affordable Care Act is simply not true for many patients around the country. Given this fact, I think it is unacceptable that the administration continues to give Americans the false impression that this promise is somehow true.

To this day, the White House Web site includes a section entitled "Health Insurance Reform Reality Check." And on the Web site, the promise appears, "If you like your doctor, you can keep your doctor." The Americans don't expect their elected leaders to agree with them on everything, but they do expect and deserve the truth. So I would urge the White House to either take this page down from their Web site or correct the record immediately.

Dr. Gottlieb, many patients with coverage through the ACA's health care exchanges are sadly finding out that they may not have real access to their doctor or medicines that they rely on because of narrower networks, restrictive drug formularies, or a complete lack of coverage for a specific provider or drug.

Can you further explain how these patient access issues are being driven by the design of the President's health care law?

Mr. GOTTLIEB. Well, I think it was a combination of things. The first thing was the costly mandates that the law imposed on what the plans needed to cover, things like mental-health parity, first-dollar coverage for a lot of preventative services. There is no question there are going to be consumers who benefit from those mandated benefits, and I am not debating the merits of that, but they are expensive.

Coupled with that, the law outlawed or restricted a lot of the traditional tools that insurance companies used to control costs. And things like underwriting risk, things like using co-pays to steer patients aggressively, adjusting premiums—and so what they were left with was the ability to go after the networks and go after the formularies. And since that was the only tool they had left to try to adjust the plans to meet the cost requirements in an environment where they had a lot of mandates imposed on them, they went after them very aggressively.

There were a lot of folks, prior to passage of ACA, in this town, smart folks on both the right and left, who knew that the networks were going to be narrow in these plans and anticipated that and saw it as a—you know, proponents of the law saw it as a necessary compromise to accommodate the mandates. But I think that, in fact, was the reality of what happened.

Mr. PITTS. Dr. Harvey, in your testimony, you note a study from Avalere showing a dramatic expansion in the use of specialty tiers for prescription drugs in exchange plans relative to coverage before the ACA.

Can you elaborate a little more on how this trend has grown and what it means for the patients you serve?

Mr. HARVEY. Certainly.

It has grown dramatically. It seems to have started, to some extent, in the Medicare Advantage plans but has, as you noted, become much more common in the ACA exchange plans.

The impact on patients is profound. Every day, in my practice, I see patients who tell me they cannot afford their medications because of this expensive co-pay. And it is a tragedy, as Congressman McKinley said, unacceptable, that in this country we can have the tools to prevent disability without them being affordable to patients.

Mr. PITTS. Commissioner Lindeen, at the beginning of your written testimony, you state that the President's health care law, quote, "has probably accelerated the trend," end quote, toward narrower networks for patients in the individual and small-group market because the law limits underwriting by insurers.

Are there other benefit requirements in the ACA that you believe could be contributing to the trend of narrow networks? Are there other requirements—for example, the requirement that consumers buy coverage that includes essential health benefits and that meet minimum actuarial value?

Ms. LINDEEN. Thank you for the question.

You know, network adequacies and the narrowing of those networks is really nothing new. This has been going on for years, and I think that, obviously, the ACA has accelerated that process.

And it is market competition at work that is occurring, literally. And while the head-to-head competition in the exchanges are accelerating that trend of narrow networks, it can also be a very effective way of actually reducing the cost of health care. But that doesn't have to, you know, reduce the amount of quality also. And that is why it is really important that we are regulating these networks and making sure that we are not compromising quality.

We also know that, you know, as they are working on these contracts, that they are actually going to—just to the marketplace. We have already gotten a lot of companies who have talked about the fact that they are getting more contracts in place for this coming year. And so I think that we are going to—they are responding to what they are hearing from patients and responding to what they are hearing from you folks, as well. So we are going to see this continue to change and improve for the consumer.

Mr. PITTS. The Chair thanks the gentlelady.

I now recognize the ranking member, Mr. Pallone, 5 minutes for questions.

Mr. PALLONE. Thank you, Mr. Chairman.

I do have this—I ask unanimous consent to include this written statement for the record from Claire McAndrew from Families USA.

Mr. PITTS. Without objection, so ordered.

[The information follows:]

Written Statement for the Record
By Claire McAndrew, Families USA
U.S. House of Representatives
Committee on Energy and Commerce
"The President's Health Care Law Does Not Equal Health Care Access"
Thursday, June 12, 2014

Since 1982, Families USA has worked to promote access to affordable, high-quality health coverage and care for all Americans. With the enactment of the Patient Protection and Affordable Care Act in 2010 and its subsequent implementation, monumental progress toward that goal has been achieved. The Affordable Care Act provides access to health care provider networks for millions who previously had no access to health coverage at all, while taking initial steps to address long-standing network adequacy problems.

This statement will:

- Review the difficulties consumers faced in accessing care before the passage of the Affordable Care Act;
- Discuss new federal protections for network adequacy put in place by the Affordable Care Act;
- Suggest policy solutions for improving network adequacy and provider network information.

Before the Affordable Care Act, Millions Were Locked out of the Health Care System

The Affordable Care Act guarantees access to health coverage and care for millions of Americans. But before the law was in place, millions went without insurance and without needed medical services. This was because health insurance company practices shut them out of coverage or because coverage was too expensive.

Individuals whose employers did not offer affordable health insurance had to shop for coverage in the individual market, where in most states they could be denied coverage because of a pre-existing condition. For customers who were healthy enough to receive an offer of coverage, they frequently faced an additional hurdle: the prohibitive cost of many plans in the individual market. Low-income adults have had even more difficulties obtaining coverage. Many states did not provide Medicaid coverage to childless adults, even when they had little or no income. As envisioned by the Affordable Care Act, about half of the states have expanded Medicaid coverage to everyone below 138 percent of the federal poverty level. But in many of the remaining states, people living in poverty do not qualify for any health coverage.

Prior to the Affordable Care Act, the covered benefits of plans in the individual market were also often insufficient. In 2013, nearly 40 percent of individual market plans did not cover evaluation and treatment of mental health conditions, and more than 45 percent did not cover substance use disorder services. Additionally, more than 65 percent of individual market plans did not cover maternity and newborn care and nearly 20 percent did not cover prescription drugs.[i] Even when pre-Affordable Care Act individual market health plans covered needed services, the costs consumers would incur to obtain these services could be enormous. Individual market insurers in most states commonly offered plans with annual deductibles of $10,000 or more for individuals and $20,000 or more for couples, and these plans often had no out-of-pocket spending caps.[ii]

Individual market consumers also struggled to find providers who could meet their needs once enrolled in coverage. Insurers' provider directories have been notoriously inaccurate for decades,[iii] with little accountability required of the plans to ensure their accuracy and little recourse for consumers in most states who rely on inaccurate provider listings. Networks themselves have long been inadequate,[iv] with consumers often having to travel too far or wait too long for an appointment with a provider for necessary care. In the worst-case situations, consumers have been unable to find an in-network provider who can meet their needs at all.

The Affordable Care Act Improves Access to Coverage and Care for Americans

Under the Affordable Care Act, all Americans, including vulnerable sick and low-income individuals, are experiencing improved access to health coverage and care. Since the start of the first Affordable Care Act enrollment period in October 2013, the uninsured rate has decreased rapidly. The most recent Gallup-Healthways Well-Being Index ("Gallup Poll") release indicates an uninsured rate of 13.4 percent for the second quarter of 2014, down from an uninsured rate of 17.1 percent during the fourth quarter of 2013.[v] This significant decrease in the rate of uninsurance would not have occurred without the Affordable Care Act's premium tax credits, prohibitions on discriminatory insurance practices against people with pre-existing conditions, and expansion of Medicaid.

Once enrolled in coverage, Affordable Care Act protections now guarantee that insurers cannot unfairly rescind consumers' insurance when they get sick, or place annual or lifetime limits on their coverage. The Essential Health Benefits package that is part of the Affordable Care Act guarantees consumers access to critical services that before were often left out of individual market insurance plans, such as prescription drugs and mental health care. Gone, too, are the days of deductibles reaching $10,000 or more. Plans must now have out-of-pocket spending caps for consumers that guarantee that individuals will not pay more than $6,350 a year for not just deductibles, but for all cost-sharing, including copayments and co-insurance.

The Affordable Care Act Includes First-Ever Federal Network Adequacy Protections

Before the enactment of the Affordable Care Act, consumers had no federal protections pertaining to provider networks or provider directories in the individual or small group private insurance markets. For the first time, the Affordable Care Act puts *federal* protections in place guaranteeing that consumers in marketplace plans have a right to provider networks that are sufficient in the "number and types of providers, including providers that specialize in mental health and substance abuse services, to assure all services will be accessible without unreasonable delay." Under the law, marketplace plans must also include in their networks essential community providers, like federally qualified health centers (FQHCs), Ryan White HIV/AIDS providers, and community hospitals, which serve predominantly low-income, medically underserved individuals. And, the Affordable Care Act creates the first-ever federal consumer rights to accurate provider directories in private insurance plans. Rules under the law state that in the marketplaces, plans must make information about which providers are in their networks and which are taking new patients available to consumers.

Having these federal rights in place is an important step. However, problems persist. Consumers continue to struggle to 1) get accurate information about which providers are in health plans' networks, and 2) find in-network primary care providers, specialists, and other providers and facilities to meet their needs. Fortunately, policymakers can help address these longstanding problems.

Making Consumers' Rights to Adequate Provider Networks and Directories Real

Consumers have long reported problems finding in-network health care providers and accurate information about their plans' networks. Through first-person accounts logged in our consumer story bank, Families USA has heard concerns about inadequate networks long before the implementation of the Affordable Care Act. But media coverage of the topic is increasing, as recent news reports[vi] assert that some marketplace plan networks are narrower than the networks available through plans sold in previous years.

Policymakers must take a holistic perspective when contemplating how to improve network adequacy. It is too simplistic to define a provider network as either "broad" or "narrow." Instead, policymakers, regulators, and health care consumers should consider whether in a given network, consumers can get the right care, in a timely manner, without having to travel unreasonably far. A plan does not necessarily have to have all health care providers or hospitals in its area in-network to provide this access to consumers. But if a health plan has too few providers or facilities in its network to guarantee these rights, consumers will face barriers to

care. There are some policy changes that lawmakers who are truly interested in improving access to care should consider.

Plans Should Meet Specific Standards for Provider Directory Accuracy and Network Adequacy

Across the country, some states have laws and regulations in place that outline requirements for health plans to ensure that they provide accurate provider directories to consumers and that their provider networks are adequate to meet consumers' needs. Congress could consider enacting federal standards requiring all health plans to provide accurate information to consumers and provide adequate networks.

Congress could develop federal provider network standards that:

- Define the maximum travel time or distance that plan enrollees should have to go to reach an in-network provider;
- Define the maximum amount of time plan enrollees should have to wait to get an appointment with an in-network provider;
- Describe the necessary ratio of providers to plan enrollees to adequately serve the population's medical needs;
- Outline the different types of providers that must be included in each plan's network;
- Define the share of essential community providers in an area that must be included in a plan's network;
- Define the frequency with which plans must update their provider directories;
- Require a plan make it easy for the public to report directory inaccuracies and that the plan investigate these reports and modify directories accordingly in a timely manner.

Families USA has always been concerned with the predicaments faced by consumers who cannot obtain accurate information about the providers in their health insurance plans' networks or who cannot find a provider in-network to meet their needs. This problem existed long before the implementation of the Affordable Care Act, which in fact expands access to health care for millions who had previously no access to care at all. Policymakers genuinely concerned with provider network problems should act to implement standards to ensure that, regardless of whether plans have broad or narrower networks, all health plan networks can provide to consumers the right care, at the right time, without consumers having to travel unreasonably far. Families USA would welcome the opportunity to work with members of the

Committee to craft these standards and appreciates the opportunity to provide input on this important consumer issue.

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[i] http://www.healthpocket.com/healthcare-research/infostat/few-existing-health-plans-meet-new-aca-essential-health-benefit-standards/#.U5IGOSJ5IfE

[ii] http://www.gao.gov/assets/660/656121.pdf

[iii] http://www.commonwealthfund.org/usr_doc/731_shelton_physician_directory_information.pdf; http://www.ag.ny.gov/press-release/health-plan-correct-inaccurate-physician-directories; http://www.oag.state.ny.us/sites/default/files/pdfs/bureaus/health_care/settlements/MultiPlan_10-006.pdf;

[iv] http://www.texmed.org/Template.aspx?id=4228; http://www.mentalhealthpromotion.net/resources/untreated-and-undertreated-mental-health-problems-how-are-they-hurting-your-business.pdf

[v] http://www.gallup.com/poll/170882/uninsured-rate-holds-steady.aspx

[vi] http://www.latimes.com/business/healthcare/la-fi-healthcare-watch-20140601-story.html

Mr. PALLONE. Thank you.

As I said in my opening statement, if Republicans were serious about improving health care access, I would be very pleased that we are having this hearing. The ACA takes unprecedented steps to expand access to health care services, but I agree that if any American lacks access to the care they need, we have more work to do.

But I can't sit idly by and listen to Republicans claim they want to expand health care access and then in the same breath claim that they want to repeal the ACA. I think that is just ridiculous.

So, Commissioner Lindeen, the ACA has led to dramatic increases in health insurance coverage. It has opened up affordable coverage to millions who were previously priced out because of preexisting conditions. Over the next few years, it is projected to reduce the number of uninsured Americans by 26 million.

Can you help us get some clarity on a simple point? Does having health insurance increase people's access to health care services? Or put another way, would the 25 million Americans getting covered because of the ACA have better access if the Republicans got their way and they became uninsured?

Ms. LINDEEN. Congressman, thank you.

Let me just say this, that in my experience as the insurance commissioner in Montana and having had the conversations that I have had with thousands and thousands of folks across my State, there has been an increase in coverage for Montanans. And I am certain that that probably is happening in every State.

And I can also guarantee you that there are folks who didn't have coverage previously that have it now. There was one woman I know of, for instance, in Montana who was born with this heart condition and so she had never had insurance in her life because, number one, she couldn't afford it and because of the preexisting condition. She had incredible expenses throughout her life as a result, and then her husband passed away, and she had more of a burden on her in terms of finances. And then she was diagnosed with uterine cancer. She made the decision to actually forego any treatment because she knew that it was going to bankrupt her and her family. I mean, that is a tough decision to make.

Well, as it turned out, the ACA passed about the same time that this occurred, and, as a result, she was actually able to get for the first time in her life access to care that she could afford and is alive today.

And I think that is what we need to remember, is that this is really life and death to many, many people across this country. This is about making sure that they are taking care of themselves and their families.

And really, frankly, the public is tired of hearing the arguments in Congress. What they want is for us, and for all of us, to solve the issues. And I can tell you that insurance commissioners across this country in every single State, who are Republicans and Democrats, put aside their partisan beliefs every day to try to do what is best for their consumers. And all we ask is that you folks do the same.

Mr. PALLONE. I appreciate that. Thank you. And as I have said, if Republicans are serious about improving the ACA to expand access, then I am eager to work with them.

But the ACA includes unprecedented nationwide network adequacy requirements; it requires plans contract with essential community providers that work in underserved communities and offer key services; it bars plans from imposing extra cost-sharing on out-of-network emergency care; and it requires plans to cover essential health benefits, which means that they must have a range of providers in-network.

So I just wanted to ask you, Commissioner, States have a great deal of flexibility in setting their own standards and enforcing those requirements; isn't that correct?

Ms. LINDEEN. Yes, they do. We in our States have always had a great deal of ability to set standards. Obviously, we feel like the ACA, in many cases, set a floor and then we can then go above that floor if necessary.

You know, in terms of—and if I could, in terms of the essential health benefits, you know, insurance is really about spreading risk. OK? And it is important for things like maternity coverage to be included in order to help spread that risk. Because if you don't, what happens then is you have folks who can't even afford to get coverage for maternity care, which was happening in some States prior to the Affordable Care Act.

Montana is an exception to the rule. We have had unisex insurance law on our books for over 20 years, and so we have been spreading the cost all this time. And, as a result, every woman in the State of Montana has had the ability to have that kind of care, and affordable care, in order to have coverage for pregnancy.

Mr. PALLONE. All right. Thanks so much.

Mr. PITTS. The Chair thanks the gentleman and now recognizes the vice chair of the full committee, Ms. Blackburn, 5 minutes for questions.

Mrs. BLACKBURN. Thank you, Mr. Chairman. And I am delighted we are having the hearing today and having this discussion.

I find it so interesting that my colleagues across the aisle continue to say we have no options to replace Obamacare because, indeed, we do. Indeed, Mr. Scalise and Dr. Roe and I wrote the President on December 10th of last year asking if we could come and discuss with him the American Health Care Reform Act, which would be a replacement. It includes such popular ideas as across-State-line purchase of health insurance, portability, equalizing tax treatment, looking at tort reform.

So we have plenty of options. What we need is people who are willing to listen that there just might be a better way to administer health care than going through a Government-run program.

Now, when we talk about repealing Obamacare, we are talking about getting rid of Government control of health care. The reason we do this is because history tells us and what we see playing out in front of us shows us it does not work. Look at what is happening with the VA.

And, of course, we all know from some of the Democrat leadership that the stated goal of Obamacare is to have it push us to a single-payer system.

So, with that in mind, I would just say—and, Commissioner, to you, thank you for joining us, but I have to tell you, in Tennessee, we had an experiment with Hillarycare, the test case for

Hillarycare, which became the template for Obamacare. Now, ours was called TennCare. And what we saw is it was an expensive—far too expensive to afford. It was consuming every new dollar that came into our State.

So what did a Democrat Governor do? And putting aside his partisanship, what he did was to take the program down to—took several hundred thousand people off the program because we could not afford this. It became 35.3 percent of the State budget.

We know it does not work. Access to the queue and access to the care is not the same thing.

I heard from a woman who had Obamacare. She was excited to get it. She went to her primary care physician, thought she had all these essential benefits. Needs a test, goes over to the medical lab. Guess what? Doesn't pay for the test. Guess what? She didn't have $1,200 to pay for it. So, see, access to the queue and access to the care are a couple of different things.

I have heard from an eye surgeon over at Vanderbilt, and he has a surgery that deals with blindness for those that have diabetes. He is looking at narrowing networks for Medicare and incredibly narrow networks, the process not even covered through Obamacare. And so we are seeing this problem with access to the care that is needed.

And I have to tell you, after living through the issues with TennCare in my State, I think it is just awful that we would give false hopes and false promise to people that really want to access health care and have that available for their families.

And that is what we are seeing play out with Obamacare. That is why you continue to have waivers. It is why you continue to have people seeking to opt out. It is why the administration continues to go around Congress and give different parts of the law different treatment. Not supposed to do that, but they do it anyway because they are dealing with the program that doesn't work.

Dr. Gottlieb, let me come to you. I am so concerned about these narrowing networks and what we saw in TennCare, what we have seen in Medicare with the narrowing network, such as what I mentioned with the eye surgeon there in my district. And I would like to know your thoughts on if you believe that the same central cost-controlling behaviors are going to happen as we move forward with Obamacare and why you think that is going to happen and the effect that is going to have on access to specialty care.

Mr. GOTTLIEB. Well, it is happening, and it is happening because I think it is one of the primary cost-control tools that the insurance companies have left to them under the existing rules.

I also think that the compromises that were made in the Affordable Care Act made this politically palatable, if not fashionable, to have these kinds of networks. If we think back to the 1990s, the last time there was a broad movement towards more restrictive kinds of plans, the HMO-style plans, we saw introduction of the patients' bill of rights and a real political backlash. I think that the environment now prevents that backlash from happening, and so you are going to see more insurance companies take advantage of these tools.

And I fully expect that you are going to see these narrow networks start to roll out into other aspects of the market—the com-

mercial market, the Medicare Advantage market. This isn't going to just be confined to the Affordable Care Act marketplace.

Mrs. BLACKBURN. I yield back.

Mr. PITTS. The gentlelady's time has expired.

The Chair recognizes the gentlelady from Virgin Islands, Dr. Christensen, 5 minutes.

Mrs. CHRISTENSEN. Thank you, Mr. Chair.

And I have to agree with Dr. Lindeen that it is time to stop arguing and just, you know, move ahead. Too many people are benefiting right now from the Affordable Care Act, and, yes, there might be things that we could tweak a little bit, and we have always been willing to do that, but it is time to stop the arguing and take care of the needs of the American people.

The Affordable Care Act is a very important step towards eliminating health disparities. Minorities are far more likely to lack insurance, far more likely to lack access to a regular source of care, less likely to receive key preventative benefits. The ACA's coverage expansion and its focus on prevention is already having a huge impact, positive impact, on minority communities.

Provider networks and prescription drug coverage are key to this impact. The law's requirement that all health plans contract with essential community providers that work with the underserved population is critically important. And I am hoping that, you know, some of the doctors that I have worked with in the National Medical Association and the Hispanic Medical Association are being seen as essential community providers in these networks.

The essential health benefits and cost-sharing protections are huge steps forward to make sure necessary treatments are available and affordable to the newly insured. Commissioner Lindeen, how do these provisions and other aspects of the ACA help the underserved communities in your State?

Ms. LINDEEN. I appreciate the question.

You know, we have a very rural State, as you can imagine, and a large proportion of the population actually falls in that area of low-income, including seven Indian reservations, where there is, you know——

Mrs. CHRISTENSEN. Yes.

Ms. LINDEEN [continuing]. Obviously, limited employment opportunities.

And I can tell you that I had a study commissioned by an independent group with, actually, one of the grants as a result of the ACA. I guess it has been almost 4 years ago now. And we, through that process, were able to come up with a number of about 170,000 Montanans who were not only uninsured but actually fell into, in many cases, these—the same type of—were the same type of people that you are talking about.

As a result of the ACA and the new marketplace, I can tell you that, in this first enrollment period, we have been able to get coverage for a good number of them, tens of thousands of that 170,000.

Unfortunately, about 70,000 of those individuals still fall into that Medicaid gap. We have not expanded Medicaid in the State of Montana. And so it is kind of a difficult situation we find ourselves in, where, you know, these 70,000 folks, at least in my State, really

have no option—affordable option. I mean, they are the working poor.

Mrs. CHRISTENSEN. Yes.

Ms. LINDEEN. But we have seen, definitely, thousands of folks who have been able to get access as a result.

Mrs. CHRISTENSEN. Yes. If we could have all of the States expand Medicaid, we would cover probably 95 percent of the people—of minorities and the poor. So we continue to work and hope that the States will accept Medicaid expansion that have not thus far.

But these are important steps forward. We all need to remain vigilant to make sure that the law is implemented so that it achieves the goals of eliminating health disparities. For example, the law bans insurers from designing their health plans in a discriminatory manner. They cannot set up drug formularies or choose their providers in a way that discriminates against any group or individual with serious health needs.

Commissioner, how are you looking at potential discrimination in the marketplace? And how should we think about this issue going forward?

Ms. LINDEEN. Well, I would say that, I mean, I think it is a really important issue that I think every one of the commissioners is very concerned about.

Obviously—let's just talk about the tiered drug formularies for a second. I mean, it has really proven to be effective in terms of helping to bring down costs and really steer consumers toward generic drugs. But, at the same time, we are also, you know, wary of the fact that we want to ensure that these are being structured in a way that do not keep patients that have these certain medical conditions from actually accessing their drugs. That is in violation of the ACA, it is in violation of State laws.

And so, if there are any nondiscrimination—or any discrimination occurring, I mean, we will actually investigate that and take measures to make sure that that doesn't occur in the future.

Mrs. CHRISTENSEN. Thank you.

Mr. PITTS. The gentlelady's time has expired.

The Chair recognizes the vice chair of the subcommittee, Dr. Burgess, for 5 minutes of questioning.

Mr. BURGESS. Thank you, Mr. Chairman.

Dr. Gottlieb, again, thank you for being at our committee. You are always good to respond when we request, and we appreciate it.

An article that was published in Forbes in December, it's titled, "No, you can't keep your drugs either," are you familiar with that article?

Mr. GOTTLIEB. Yes.

Mr. BURGESS. Well, in the article—I mean, I have got to tell you a lot of people are not familiar with what a formulary is or what a formulary does, but I suspect even more are not familiar with what a closed formulary is or does.

Could you tell us in a few words what that is?

Mr. GOTTLIEB. Well, a lot of these formularies are closed formularies, particularly when you look at the Bronze and the Silver Plans.

And what it basically means in most cases is that, if a drug isn't on the list of the plan's formulary, it is not covered at all, there

is no co-insurance, and whatever you would spend on purchasing the drug wouldn't count against your out-of-pocket limits or your deductible.

Mr. BURGESS. And that, you know, is such a key point. Again, as I referenced in my opening statement, I bumped up against this myself, not with something that was terribly esoteric.

But at the same time I thought, "Well, I am a free American. I will just buy the darn drug myself, but I will charge it against my deductible." And I was informed that that—you know, "You are just spending your money. You are not covering your deductible."

Now, of course, the out-of-pocket limits were suspended the first year in the individual market for individuals under one of the President's unilateral decisions on enforcement activity under the Affordable Care Act. So that really doesn't even play.

But the concept of a closed formulary is one that I don't think people are aware of. They need to become aware of it. And, again, like me, they may bump up against it without knowing that that restriction actually exists.

Mr. GOTTLIEB. I will just add it is very hard to figure out. When we looked at these plans, we had a very difficult time figuring out if these were closed formularies or not. We spent days on it. And I had a very talented research assistant working with me and we had to actually call the plan and even then it was difficult to get that information. So consumers might not know until it is too late whether they are in one of these.

Mr. BURGESS. Correct. It is too late because they are already into their coverage year. Presumably, they could change plans next year.

But, unfortunately, we don't know whether there will be access to plans that will not—I mean, I think closed formularies are here to stay. I mean, I think it is just one of those things.

I practiced in the 1990s. I remember what it was like with HMOs. But a lot of those practices, even though they have been modified and mitigated with time, they are still with us.

You are still calling a 1–800 number to get approval for your patient who doesn't—if you don't follow the step therapy for asthma, for example. You have got to do it exactly the way the insurance company says or the product is not covered.

Another piece that I have here of yours is also from Forbes, and this one was published in March, so just a few weeks ago: Hard Data on Trouble You Will Have Finding Doctors in the Affordable Care Act. And then you have a table.

That is some pretty striking information that you revealed there as well. I mean, again, we go back to, if you like your doctor, you can keep your doctor, unless your doctor happens to be a cardiologist in Connecticut, for example, where 177 of the 400 cardiologists are no longer available to you.

Have I interpreted that correctly?

Mr. GOTTLIEB. You have. And the other thing—you know, we talk about the sort of popularization of the closed formularies.

The other thing that I think is going to be popularized is something called the exclusive provider organization, which might be a new acronym for a lot of folks, where you are dealing with a network of physicians that literally are countywide.

And once you go outside your network, again, if you are in a closed network, whatever you spend with a physician outside that network won't count against your out-of-pocket limits, potentially

Mr. BURGESS. And, you know, I am just like anybody else. When I went and priced this stuff on healthcare.gov—or when I went and shopped on healthcare.gov, I was only shopping on price.

I think that is what most people do, not anticipating they are ever really going to need their health insurance. But the reality is you can get some serious restrictions and some boundaries on the type of medical care you are able to get under these policies.

Ms. Lindeen, let me ask you a question, and this is a little bit off topic. But since you are the insurance commissioner on the panel, we are all familiar with medical loss ratio and the fact that any insurance company can only have 15 percent of its expenses on the administrative side.

What happens when an insurance company buys a doctor group? Do those administrative costs then just get automatically transferred to the clinical side because a doctor group has been purchased now by a health plan?

Ms. LINDEEN. I have to tell you that I am not an expert on how that works, but I would be definitely willing to go back and get you that information.

Mr. BURGESS. I think that is something we are likely to see more and more of. I think it is a loophole, if you will, in the way the—one of the many loopholes in the way the law was drafted. But I would appreciate your researching that and getting back to the committee on that issue.

Ms. LINDEEN. Absolutely. It is my pleasure.

Mr. BURGESS. Thank you.

I yield back, Mr. Chairman.

Mr. PITTS. The Chair thanks the gentleman.

Now recognize the gentleman from Texas, Mr. Green, for 5 minutes of questions.

Mr. GREEN. Thank you, Mr. Chairman, Ranking Member. I appreciate you having the hearing today.

I want to start by saying, while health insurance does not necessarily equal health care access, having coverage, whether it is through the employer, Medicare, Medicaid, CHIP, or exchanges, the essential first step is to have access to health care.

And I was a State legislator for 20 years—I tell people before I lost my mind and came to Congress—in Texas and worked on access and worked on expansion of Medicaid when we had to come up with a third of the money for Medicaid in Texas. Under the Affordable Care Act, it would be 100 percent for a few years and no more than 10 percent.

So I understand—but my first question is if the witnesses could give us some specific changes or reforms in the Affordable Care Act, or Obamacare, if you will send them to the committee, things that you would see that—something we could do, because, hopefully, we will get to that point some day in our committee, saying, "What can we do to make it better?"

My frustration is that, in Texas, we didn't expand Medicaid. If we had, 92 percent of all eligible uninsured Texans, or 4.5 million,

would qualify for premium tax credits, Medicaid or the CHIP program.

Commissioner Lindeen, some of my colleagues make the argument that having Medicaid coverage is worse than being uninsured. What do you say to that? Have you heard that having Medicaid coverage is worse than being uninsured?

Ms. LINDEEN. No. I have not heard that. I am just being honest. Honestly, I have not.

Mr. GREEN. OK. What would be your response to it? You know, granted, Medicaid is not a major plan, but it still gives access to a health care system.

Ms. LINDEEN. Yes. I mean, I would argue that, if you talk to somebody who actually is uninsured and does not have access to Medicaid, who is in that gap and who has some serious health needs, I would definitely ask them that question.

Mr. GREEN. It is estimated that States' unwillingness to—or inability to expand Medicaid is leaving 5 million uninsured who could otherwise have coverage.

What would Medicaid expansion mean to families and the uninsured in your State?

Ms. LINDEEN. Well, it would mean the world. I mean, obviously, medical bills are one of the number one reasons for bankruptcy.

And I can tell you that those folks who fall in that gap, if they find themselves in the situation where they are going to have to try to get care and it is going to be expenses that they can't afford, I mean, that is where they are going to end up. They are going to end up bankrupt.

Mr. GREEN. Well, I don't have a wealthy district.

Ms. LINDEEN. I don't either.

Mr. GREEN. In study after study, Medicaid has been shown to improve access, increase individuals' reported health, and provide significant financial security.

A recent study even demonstrated that Medicaid coverage can improve educational advancement in helping lift people up the economic ladder.

And I have to admit, even in Houston, Texas, the Greater Houston Partnership was our main chamber of commerce. They encouraged our State legislature during the last session to expand Medicaid.

Hopefully, when the legislature goes in session in January, they will realize that, you know, that is the cheapest way we can cover folks in Texas.

Because in Texas—in the military, they would call it a target-rich environment. We have the highest percentage of uninsured. We also have the highest number of uninsured.

So Medicaid expansion would help for those qualified for Medicaid, but it would also allow, like you said, for those near-poor Medicaid to be qualified under the Affordable Care Act for the subsidies.

And, of course, Medicaid expansion is funded by the Federal Government and, like you said, most Medicaid is two-thirds Federal funding, a third State funding, although each State has a different percentage, as I found out. Many States are seeing a big influx in funds and are likely to save money over the long term.

Commissioner, when you look at the total picture, is Medicaid expansion worthwhile for States like yours?

Ms. LINDEEN. I can tell you that we also commissioned an independent study to look at the effect of Medicaid expansion on the State of Montana, and the positive economic impact to the State was incredible in terms of the hundreds of millions of dollars that it would bring into the State, as well as the thousands of jobs it would create, not only just any kind of job, but good-paying jobs, mostly in the medical community.

We, too, had obviously legislation that came before our legislature this past year, and I was amazed at the folks who came and testified in favor. It wasn't just the hospitals and the providers, but it was business people.

We had one gentleman who works for an investment company who came in front of the legislature and said, "Listen, if I was a Fortune 500 company standing before you today and saying that, if you were to accept these Federal dollars and it was going to help create all these jobs for my company and my company would come to your State as a result, you would fall all over yourselves to pass it." But because it is not a Fortune 500 company, they refused.

Mr. GREEN. Thank you, Mr. Chairman.

Mr. PITTS. The Chair thanks the gentleman and now recognize the gentleman from Illinois, Mr. Shimkus, for 5 minutes of questions.

Mr. SHIMKUS. Thank you very much.

Great to have the panel.

And, Commissioner, just—it is our job to do oversight. So preaching the partisan aspects of Washington, DC, we need to continue to do oversight on this law, and that is our job. So I just put that on the table because I have a problem with your tone.

Having said that, what is the population of the State of Montana?

Ms. LINDEEN. First of all, let me apologize if my tone——

Mr. SHIMKUS. No. That's fine. I am running out of time. I only have 5 minutes. So——

Ms. LINDEEN. About a million people.

Mr. SHIMKUS. And in your testimony you mentioned that the ACA is sharpening the competition between insurers.

Can you tell us how many insurers are in the State of Montana.

Ms. LINDEEN. Well, we have hundreds of insurers licensed to do business. But in terms of the numbers that are in the marketplace—the new Federal marketplace, we had three this year.

Mr. SHIMKUS. Three.

Ms. LINDEEN. I know we had one more——

Mr. SHIMKUS. So some of us would question whether that is vibrant competition. Three is better than two. Two is better than one. We would rather have more versus less and a vibrant market that has a lot of choices for the consumer.

Let me go to another question to the panel as a whole.

Recent stories indicate that emergency room access is increasing. Why do we think that is?

If we pass a national health care law which is supposed to provide people health care coverage to access primary care doctors, internists, and to make sure that hospitals aren't—ER rooms are not

being overutilized, why is there an increase in emergency room usage?

Mr. HARVEY. So my wife is an emergency room physician. So we have a lot of dinner table conversations about this.

I think a couple of issues. One is that people who are now covered—or who believe they have coverage don't necessarily understand the fact that treatment in an emergency room comes at much greater cost than treatment in other settings.

Secondly——

Mr. SHIMKUS. But if they have got care, why are they going to the emergency room?

Mr. HARVEY. Well, I think the second point is that there are access issues to physicians not because of any coverage, per se, but because there is a shortage of primary care in particular, but many specialty physicians as well, that has been uncovered by the fact that there are many more people now with coverage demanding the services.

Mr. SHIMKUS. Could the—Dr. Gottlieb?

Mr. GOTTLIEB. I was just going to say I practice at a hospital. So I admit from the emergency room. I think a couple of things that I would just point out.

The first is that coverage doesn't necessarily equal access and coverage doesn't change whether or not a person is a good consumer of health care services.

And what you typically see—or often see is someone will get coverage. They will be newly on Medicaid or Medicare or private coverage and their patterns won't change at all as a result of the coverage. So just giving someone health care coverage really doesn't guarantee that they are going to get care.

And the other thing is that a lot of folks end up in schemes where they are underinsured. And so they still don't have access to doctors who return phone calls after hours, the ability to schedule appointments the day of when a problem arises. And so they still end up in the emergency room.

That is typically what I see when I see newly insured people who are ending up in the emergency room even though they have insurance for the first time.

Mr. SHIMKUS. Is there a co-pay with a lot of these plans, a high co-pay——

Mr. GOTTLIEB. A deductible issue.

Mr. SHIMKUS. The deductible. That is what I mean. The deductible is at. They can't afford the deductible.

Let me ask another question. Is emergency room care more expensive or less expensive than going to a urgent care or a primary care doctor?

Mr. GOTTLIEB. Well, it is far more expensive and it is far less efficient.

Mr. SHIMKUS. And everybody would agree that. Right?

Even, Commissioner, you would agree with that.

Is this driving up the cost of health care or lowering the cost of health care, this issue about emergency room usage?

Mr. GOTTLIEB. Well, we are going to see health care costs go up if we see more people end up in emergency rooms. There is no

question about that. We need to do more to try to make care accessible to people and not just hand them an insurance card.

Mr. SHIMKUS. Thank you.

And my time is expiring. And I will just end on this.

My friends tout 8 million have signed up, actually, Medicaid expansion. I always say there is a sliver of people that have been helped, but I will tell you there have been more people harmed by paying more in their health insurance and getting less coverage.

The Wall Street Journal has said 10 million people have lost their insurance. Part of that 8 million or 10 million who have lost their insurance and—have to buy new insurance, just like us. We had insurance coverage.

So when you count how many have been added to the insurance roles, you better make sure you are counting the people that have lost their insurance under this new law.

And I yield back my time.

Mrs. ELLMERS [presiding]. The gentleman yields back.

The Chair now recognizes Ms. Castor from Florida.

Ms. CASTOR. Well, thank you very much.

I want to thank the chairman and the ranking member for organizing this hearing on access to health care.

I don't think anyone can ignore the fact now that the Affordable Care Act has been the largest expansion for families across America and their access to the doctor's office in our lifetime.

And in the State of Florida, it was very surprising. We had a very high rate of uninsured, and we thought, gosh, we are going through all these political fights with what the ACA means. And, in the end, I think these families spoke very loudly.

We thought we would maybe have 500,000 sign up on the Federal exchange or 600,000 would be really great. We had about a million Floridians sign up on the Federal exchange. That is the population of Montana. They are breathing easier now because they have access to the doctor's office.

Is it going to be perfect? No. Part of the problem was they had so many choices. They had the Bronze Plan, the Silver Plan, the Gold Plan, with all sorts of different networks where they might want to go with a more affordable option.

And I think this is going to change over time, but we have empowered the consumer to make that choice by going online and examining all of the networks. And their health needs are going to change over time; so, their choices are going to evolve.

I think one of the most fundamental of changes in the law is now no one can be discriminated against in America from getting health insurance. Think about your family members, your neighbors, that had a preexisting condition, cancer, diabetes. They can't be barred from coverage anymore.

So when we are talking about access, that is really a fundamental—it is the fundamental change of the ACA, along with affordability and a meaningful policy. A lot of people wouldn't pay for an insurance policy because it wasn't worth very much, but now the law requires these essential health benefits.

And what hasn't been talked about a lot, it requires that networks in these plans have to be adequate. Now, it is not going to be perfect for everyone.

And I really appreciate it, Commissioner, that the State insurance commissioners are going to have great responsibility in ensuring the adequacy of networks and that there aren't any discriminatory issues.

We had one issue in Florida that has always confounded me, though. Last year during all the political fights the Florida legislature and Governor actually passed a law that said the Florida insurance commissioners no longer have the ability to negotiate rates—health insurance rates.

Have you heard of that being done anywhere else across the country, that they restricted the power of the insurance commissioners?

Ms. LINDEEN. Yes. Actually, there are all sorts of levels of authority for insurance commissioners across this country in terms of the ability to review or even approve rates.

I in Montana, in fact, have never had—this office never had the ability to review rates until this past year. We finally convinced the legislature to allow me to review them.

I can't, like, deny the rate increase, but what I can do over the course of that 60-day time period while I am reviewing the rate is actually look at whether or not it is an appropriate rate and reasonable.

And if I find issues, I can go back to the company and I can negotiate it down. And it has already been working.

Ms. CASTOR. So is that a benefit to the consumer?

Ms. LINDEEN. Oh. It is a huge benefit. We——

Ms. CASTOR. That is why I can't understand why a State would take the action to actually say, "Oh, don't go and review the health insurance rates." That is going to be an access problem.

And I appreciate your emphasis on solving the issues together. We have had the Medicaid discussion. In Florida, they haven't expanded Medicaid. That is about the population of Montana, again.

So when you are talking about what is an important way to expand access, we have got to bring our tax dollars back home to put them to work covering people, helping the hospitals.

I think another one is the ACA also had provisions to improve the health care workforce. And I know a number of us are very concerned about primary care: Are we going to have the providers out there?

HHS has not done a good job with following through and, frankly, the Congress hasn't given them the money to go and look at the workforce issues.

My Republican friend and colleague Joe Heck and I have a bill called the CARE Act, the Creating Access to Residency Education—I know a number of members here have been concerned about that—that would allow States, insurance companies, local communities, hospitals to put up matching funds for residency positions.

But do you see the primary care situation as one of the problems going forward with access?

Mr. GOTTLIEB. Look, I think that we are going to face a relative shortage of doctors in certain insurance schemes. I have written that I don't think we are going to face a shortage of doctors overall in this country.

I think, depending on what insurance scheme you are in, it could very much feel like you are facing a doctor shortage.

I see a future where I think physician productivity will continue to increase. I think we are going to see more—greater access to non-physician providers, like nurse practitioners, and that is going to alleviate some of the burden.

So I am not a believer that we are going to see a physician shortage as a result of Affordable Care Act or for anything. I think that we will see relative shortages in certain insurance schemes.

Mrs. ELLMERS. The gentlelady's time has expired.

The Chair now recognizes Dr. Gingrey from Georgia for 5 minutes.

Mr. GINGREY. I thank the Chair.

And I just wanted to comment on what the gentlewoman from Florida just said in regard to access. But at what cost? And I think that is the most important thing for us to keep in mind. You improve access by the Affordable Care Act.

In his opening remarks, the ranking member said that it's counterintuitive—and I am paraphrasing here—but counterintuitive for Republicans to say that they want to expand access and coverage for the uninsured, yet remain opposed to the Affordable Care Act, suggesting that there is nothing out there except the—no way to do this except the Affordable Care Act.

And that is categorically untrue. In fact, the vice chairman of the committee, the gentlewoman from Tennessee, pointed that out earlier in a bill that came out of the Republican Study Committee that is a fantastic way to approach this. So we definitely have ideas and have plans.

Commissioner Lindeen, I want to make sure. I may have misunderstood you in your opening statement. Did you say that, even before the Affordable Care Act, that in Montana you had mandated coverage for OB/GYN for all policies that were sold in your State?

Ms. LINDEEN. Yes.

Mr. GINGREY. Would that be mandated for a 55-uear-old bachelor who had had a vasectomy? If he wanted to get a health insurance policy in the State of Montana, it would have to include obstetrical coverage?

Ms. LINDEEN. As I said, insurance is about spreading the risk. And in Montana we have a constitutional law that says that you cannot discriminate based on gender. And so that is applied as well to our insurance and health insurance.

Mr. GINGREY. Well, that may be spreading the risk, but I will tell you that that is insane. And that is what the problem here is in regards to the Affordable Care Act.

All of these mandates, all this mandated coverage, comes at a tremendous price, at a tremendous price. And this is only going to get worse. It is only going to get worse.

Chairman Pitts said at the outset—and I am going to repeat this because I think people need to understand and listen.

He was talking about the suggestion that, if you like your doctor, you can keep your doctor; if you like your hospital, you can keep your hospital; if you like your medication, you can keep your medication; and, gee, you know, the price is—it couldn't be better.

And this is just not true; yet, some of my Democratic colleagues have decided in perpetration of this falsehood to keep this information on their Web site. In fact, he talked about the—I think the ranking member's Web site.

It is time to speak the truth so the American people know. It is time for Washington Democrats to take these statements down because we know that they are patently false, and the American people deserve better.

Now, let me go to Dr. Gottlieb and specifically ask you a question, Doctor.

In Forbes recently, you provided data by physician specialty on the number of providers included in ACA exchange plans versus a typical private health insurance plan.

Can you tell this committee about your findings, particularly as they relate to women's lack of access to OB/GYNs in exchange plans relative to any other private form of coverage.

Mr. GOTTLIEB. So we looked at PPO plans—preferred provider organizations—offered by the same category in the same market relative to what they were offering on the exchange. And, on average, I think the statistic was we found that they had about 50 percent fewer physicians in their exchange-based plans.

It varied across market, but we found some plans with real inadequacies where, you know, a plan didn't include a single Mohs surgeon.

We found a plan in a county in Florida of about a quarter of a million people that had about a dozen pediatricians on the network.

And we found a plan in San Diego that had fewer than 10 urologists for a very big—the whole of San Diego County.

So we found some plans that had some significant deficiencies with certain kinds of physicians. And the Mohs surgeon is relevant because the plans——

Mr. GINGREY. Dr. Gottlieb, I am going to stop you on that. I want to get one last point in.

And, Madam Chairman, I would like to submit for the record an ABC News article of just yesterday where the chairman of the Senate Appropriations Committee cancelled a hearing because of a fear that Republicans would have amendments to the Affordable Care Act that would bring down costs that Democratic members didn't want to vote on.

So I would like to ask unanimous consent to submit this article from ABC News yesterday.

Mr. PITTS. Without objection.

[The information follows:]

abcNEWS

Mikulski Postpones Vote on Health Spending Bill

Senate panel chairwoman postpones vote on bill funding 'Obamacare' in face of GOP challenges

By ANDREW TAYLOR

The Associated Press

WASHINGTON

The chairwoman of the Senate committee responsible for a bill funding implementation of "Obamacare" has canceled a vote on the measure after Republicans signaled they would force a series of politically painful votes on endangered committee Democrats.

Wednesday's move by Appropriations Committee Chairwoman Barbara Mikulski, D-Md., came after several committee Democrats expressed reservations about voting on amendments related to President Barack Obama's health care law.

The measure in question is a $158 billion measure funding the departments of Labor, Health and Human Services, and Education. The bill's author, Sen. Tom Harkin, D-Iowa, had said Tuesday that the Appropriations Committee would debate and approve the measure on Thursday. But the session was never scheduled by Mikulski, whose spokesman said the schedule was "under review."

The move has angered the sometimes prickly Harkin, who is leaving the Senate at the end of the year. Harkin has authored or co-authored the health legislation for decades and is invested in seeing it become law. He is particularly proud of increases for health research at the National Institutes of Health.

Several Appropriations Democrats, including Mark Pryor of Arkansas, Mary Landrieu of Louisiana and Mark Begich of Alaska, are at risk of losing re-election bids this fall.

Separately, Mikulski announced that the full Senate next week will take up a hybrid measure funding the departments of Commerce, Justice, Transportation, Housing and Urban Development, and Agriculture.

Mr. GINGREY. I yield back.

Mrs. ELLMERS. Thank you. The gentleman yields back.

And I will say they are going to call votes soon; so, we are going to try to get as many questions in as possible within this time frame.

So, with that, I would like to recognize Ms. Capps for 5 minutes.

Mrs. CAPPS. Thank you very much.

And thank you to the panelists for your testimony today.

I have a question for the Commissioner from Montana. I went to high school in Kalispell; so, what you had to say about health care in Montana is important to me.

The Affordable Care Act rollout, in my opinion, was even more impactful than expected. Over 8 million Americans signed up for health insurance, many of whom had been living for years without the security of coverage.

But, as you noted—and rightly so—the law is not perfect. It is not perfect in California, where I live, either. It is clear that more could be done to ensure robust provider networks and broader access.

To be clear, in many cases, the insurance companies, not the ACA, have been making these decisions. But this is something I have been working on in my district, an issue that I think does deserve more attention.

There are some tools available through the ACA that would address this issue right now.

Commissioner Lindeen, what enforcement authorities do you use within the ACA in order to ensure that networks stay wide and people stay covered?

Ms. LINDEEN. All right. Well, let me tell you that what we like to do is we really like to look at ensuring access, affordability and transparency, making sure that there are enough providers available based on all sorts of different types of factors.

And those include everything from looking at general provider availability, medical referral patterns, hospital-based providers and whether or not—and, of course, that can be affected by their willingness to actually contract——

Mrs. CAPPS. Right.

Ms. LINDEEN [continuing]. The geography that exists within the State, ECPs, and, also, making sure that there is, you know, just reasonable access to all these specialists. And we want to make sure that there is good transparency for consumers to make informed decisions as well.

Mrs. CAPPS. That is great.

Have you done anything that has been working to broaden the networks that you could share with us, to just expand the networks that you do have?

Ms. LINDEEN. I can't think of anything really specific off the top of my head, but I will go back and look and get back to you.

Mrs. CAPPS. It seems to be an area that now could use some additional support. And I want to put on record that I hope there is ways that we can give you more tools or work with you in our individual States to make those networks more available.

But, additionally, as you mentioned, there have been allegations of excessive co-insurance in the specialty drug tier. We know that

specialty tiers are a real problem for the patients who need those treatments.

They may not only save lives, they can improve the quality of life of the patient, often helping them to stay off disability rolls and remain engaged in work, with their families and in their communities.

But specialty tiers are not a function of the ACA. They have existed for many years, so much so that some States banned them long before the ACA became law.

That is why I have been pleased to join with my colleague, Mr. McKinley, to introduce legislation to address this and put these specialty drugs back in line with other prescription drug costs, putting these treatments back in research for those who need it most.

And a similar problem exists in Medicare and for cancer patients who are prescribed orally administered chemotherapy drugs, but only have coverage for traditional chemotherapy. These issues are real, but they were not created by the ACA, I believe, and to insinuate them as such is disingenuous.

But if we all now agree that this is a problem, I hope we can also agree that we should fix it. I want us to be able to vote on H.R. 460, the Patients' Access to Treatment Act. I believe we should have a hearing on H.R. 1801, the Cancer Drug Coverage Parity Act.

We can address these issues right now by passing these pieces of legislation. So I hope there is a time when we can have you back and we can tackle these and other pressing health issues that we face without getting into the political gamesmanship like we are seeing much of this hearing focused on today in kind of a biased way.

Strengthening this law, which we know we need to do, will not be accomplished while we continue a kind of drumbeat for repeal or going back to the broken system of the past. I know you are in positions where you see these real needs and that we need to address on a regular basis.

Thank you. And I appreciate again.

I am going to yield back.

Mrs. ELLMERS. Thank you to the gentlelady for yielding back.

I now recognize Mr. Griffith for 5 minutes. If you might be able to squeeze——

Mr. GRIFFITH. I will squeeze as quick as I can.

Mrs. ELLMERS. OK. Thank you.

Mr. GRIFFITH. Let me just say that, when you are talking about things like rheumatoid arthritis—and I have a family member who has that—and you are talking about access to care, particularly in my region, we are being limited. There is no gamesmanship being played. The real concern is about what is happening with the Affordable Care Act.

And I bring this up because—and if we can pull that map up of my district—I was recently told by not one, but two, of the folks who are in this business—and if you can look—they are getting it up there—I am the green part down there.

And you can see why this is a particular problem. Because what happened in rural Virginia and my part of the State is that, in many of these areas, we only have one company that is under the

shop plan or one company under the individual plan. Some places have two. There are not a lot of opportunities.

And what my brokers are telling me is that they are having to go to their small customers in the shop plan—those are people with small businesses—and all that is available is an HMO and that HMO limits them—look at that map—it limits those people from going to health care providers within the Commonwealth of Virginia or one county out.

Now, if you are in the Galax or Martinsville area and even some folks in the Roanoke Valley, up a little bit further on the border with North Carolina, you are used to going to either Duke or Bowman Gray. Can't do it with the new plans. You are outside.

Bristol, Virginia-Tennessee, for those of you who don't know, it's a wonderful city. The main street of the town is the State line. If you live on the Virginia side of the line, you can't go to the Children's Hospital in Johnson City under these new plans—under the Affordable Care Act's shop plan. You can't do it.

That happens to be the tri-cities area. Bristol, Kingsport, Johnson City have worked really hard so that they have the availability in a relatively rural area to have one of everything.

And while you can certainly get your children treated at other hospitals, the hospital where the money has been spent to have for those high-risk people is in Johnson City.

So if you are living in Bristol, Virginia, on the wrong side of main street—State Street, but the main side of the main commercial area, you can't go to that hospital. This is not games. We are not playing any games.

Are you seeing that that's a problem in other States or is it just because my district borders so many other States and you can actually get to other States' teaching hospitals quicker than you can get to UVA for many of my constituents?

Is that just a problem because I have an oddly shaped district or is that a problem for other States, Dr. Gottlieb?

Mr. GOTTLIEB. Well, it seems like a particular problem there, but this is not that uncommon. The Affordable Care Act allows county-level bidding by the health plans. So sometimes you are seeing only countywide networks as a result.

Mr. GRIFFITH. So it is a problem not only from State to State, but also within counties. I can see where that would be a serious problem.

Are we seeing, also, a narrowing on the ages? I need to ask that question. Are we seeing that they are narrowing services?

For example, if you are an 84-year-old woman whose father died of colon cancer—yes, I am speaking of a constituent—you normally would be getting your inspection—your colonoscopy again, are there any limitations because of the age? Are you seeing any of that?

Mr. GOTTLIEB. I haven't seen age-based restrictions that go outside of normal medicine convention in terms of when things are recommended in these plans. Certainly that would be a Medicare—more of a Medicare scenario, too.

Mr. GRIFFITH. Yes. I appreciate that.

That being said and because they have already called for votes and some others want to ask questions, Madam Chair, I will yield back.

Mrs. ELLMERS. Thank you to the gentleman.

The Chair now recognizes Mr. Bilirakis from Florida for 5 minutes. But if I could—if you could, I would love to be able to—oh. I take that back. I am sorry to Mr. Sarbanes. I apologize.

Mr. SARBANES. Thank you, Madam Chair. I will try to keep my questions under 5 minutes.

There is no question that the Affordable Care Act represents disruptive change—OK?—but disruptive, I think, in a very positive way, on balance.

It disrupts the situation where there were millions of people who were discriminated against based on preexisting conditions.

It disrupts the situation where millions of young people were having problems affording the coverage—health care coverage.

It disrupts the situation where millions of seniors were falling into the donut hole and not being able to cover that with the out-of-pocket expenses that it represented; so, we are beginning to close that donut hole.

And it disrupts most significantly a situation where one out of seven Americans were being left out of health insurance coverage to the detriment of those individuals and their families but, really, to the detriment of the productivity of our country.

So it is disruptive change and, whenever you have disruptive change, it is going to take a while to sort of get everything in place, get it all rationalized, get the system working as well as the expectations are that we bring to bear.

So, you know, we need to be vigilant, but we also need to understand that it is going to take some time to get all of these pieces in place.

And, frankly, if you look at what the Affordable Care Act itself says about its expectations of the way provider networks will function, you know, it has provisions that require plans to create networks that are, quote, sufficient in numbers and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay.

It requires plans to contract with, quote, essential community providers, as that term is understood, that primarily serve low-income and medically underserved individuals. It requires plans to equalize cost-sharing for emergency services, et cetera.

These are requirements that are baked into the law, and it is going to have the effect over time of addressing this—sort of the startup bumps that we have in terms of restructuring these provider networks.

I mean, it used to be the case that you could keep your cost down. You could say, "Hey, you can go to any provider you want," but the benefits that were available to cover that were pretty minimal in certain situations.

So was that really a good insurance plan? Just looking at the provider network and the expanse of it, you might have said, "That is terrific," but you look at other features of it, not so much.

So I just wanted to ask the Commissioner: Do you have confidence that the tools that you possess, as an insurance commissioner, are going to be adequate, particularly given these requirements of the Affordable Care Act that you can cite and use and enforce to ensure over time that you will be able to put in place provider networks that can provide the coverage and the access that people deserve?

Ms. LINDEEN. I think that, as long as commissioners at the State level are given the flexibility to do that and do their job and be able to enforce those provisions as well—I think that is going to be a huge help.

But one of the biggest issues that we face is the transparency issue in making sure that consumers really are informed about what is actually in these networks and making good informed decisions for themselves. Because the more informed they are, the more that they are going to impress upon the companies in terms of competition and forcing them to make good decisions that are in the best interests of the patients as well so that they will get them what they need, so to speak.

But at the same time, the other thing that is really frustrating, I think, not only for the regulator and for the consumer and even for the company, is sometimes, with all due respect, this unwillingness to contract by providers. And I think that that is an issue that we are all going to have to deal with.

But, overall, I think that giving States the flexibility to actually do our job and do it based on the fact that we know our market's better than anyone else is really going to be helpful.

Mr. SARBANES. Thank you.

I yield back.

Mrs. ELLMERS. Thank you to the gentleman.

And now I yield time to Mr. Bilirakis. I do want to say that there are less than 4 minutes left in the vote on the floor.

Mr. BILIRAKIS. I will be as quick as I possibly can. I will ask just one question.

Mrs. ELLMERS. Thank you.

Mr. BILIRAKIS. I won't make any comments on the ACA. I will go directly into my questions.

Mr. Gottlieb, you have written extensively about the narrow networks. The Leukemia & Lymphoma Society commissioned a report about the narrow networks in the ACA.

According to their data, for the State of Florida, my home State, only 1 of 12 had coverage at the Moffitt Cancer Center in Tampa, Florida, the only NCI-designated cancer center in the State.

All Children's Florida hospital, Jackson Memorial, Mayo Clinic, Miami Children's Hospital, Moffitt, Nemours in Jacksonville, Sylvester in Miami, and Shands in Gainesville—only 4 ACA plans out of 12 covered any one of these hospitals, any one of these hospitals.

Mr. Gottlieb, it doesn't seem like it is very accessible. It seems to me that the people most disadvantaged by the law are the sick, the patients with serious, chronic, and complex medical conditions.

Are these narrow networks and closed formularies disadvantaging the sick and the most vulnerable, in your opinion?

Mr. GOTTLIEB. Well, I think, unfortunately, they will. You are absolutely right. I am on the policy board of the Leukemia & Lymphoma Society. You are absolutely right.

The academic cancer centers have been actively excluded from these plans largely because they are more expensive. And people who have rare cancers will not be able to get care there, and other people who might have more common cancers, but just want a second opinion, won't be able to get it.

Mr. BILIRAKIS. Extremely unfortunate.

I yield back.

Mrs. ELLMERS. Thank you to the gentleman.

I now yield time to Mr. McKinley. And, if you can, try to keep it close. Thank you.

Mr. MCKINLEY. Thank you, Madam Chairman.

Dr. Harvey, if I can direct this to you in the very short time period—I have got a question as to how you would handle this scenario that we are facing in West Virginia.

Recently I met a 15-year-old girl from West Virginia. She is suffering the early symptoms of juvenile arthritis—rheumatoid arthritis. But thanks to biologic medicine and the drug she has been on, she has been able to participate and actually has become a track star.

I am curious. If her family is ever faced with a scenario that they have to go into an exchange—and in West Virginia we only have one compared to—in Montana you have three. We have one.

But her family's income is $50,000. So it is probable and likely that they can afford to go to the cheapest plan within that exchange. So they are either going to be faced with not having biologic coverage or being forced to go to something that is more expensive that they can't afford, either.

So in either case, she is either out $12,000—by paying a higher premium—or the family has to pay maybe $75,000 to $100,000 a year. What would you advise?

Mr. HARVEY. Well, it is a very difficult problem. I think the main option, actually, is to provide cheaper medications, which are usually far more toxic, actually, and there are attendant costs associated with that. There aren't very many other solutions.

The main solution that presents itself is your bill, sir. And I think—you know, I wear a fork on my lapel that has bent tines, and it is meant to symbolize the deformities that people with arthritis can develop, but, also, the simple tasks that they are prevented from doing.

And you all can help us unbend those tines by providing support for people so they can afford their co-pays.

Mr. MCKINLEY. Thank you. I appreciate your support for 460. I think we do have to move on that. Thank you very much.

I yield back the time.

Mrs. ELLMERS. Thank you to the gentleman.

In the interest of time, I will submit my questions for a written response.

I would like to remind the Members that they have 10 business days just to submit questions for the record.

And I ask the witnesses to respond to the questions promptly.

Members should submit their questions by the close of business Thursday, June 26.

Without objection, this subcommittee is adjourned.

[Whereupon, at 11:41 a.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

Opening Statement of Chairman Fred Upton
Health Subcommittee Hearing on "The President's Health Care Law Does Not Equal Health Care Access"
June 12, 2014

"If you like your doctor, you will be able to keep your doctor, period. If you like your health care plan, you'll be able to keep your health care plan, period. No one will take it away, no matter what." The second promise of that oft repeated phrase earned the president the "Lie of the Year" last year from a leading fact checker. Now, more and more Americans are learning that the first promise about keeping one's trusted doctor has also failed to hold true.

Sadly, even those who wrote this law knew that its mandates and structure would not allow the president to keep these promises, no matter how often Mr. Obama repeated them. In fact, one of the law's chief architects later elaborated on this failed promise saying, "if you want to pay more for an insurance company that covers your doctor, you can do that." But this is not what the American people were promised.

My colleagues and I have heard from countless constituents who have lost their health care plans or lost their trusted doctors. Folks are finding out the hard way that the health care coverage offered under the president's health care law falls far short of what they were promised.

Analyses have shown that, in order to comply with the law's many taxes and mandates, provider networks have necessarily been limited. But, it is the sickest Americans who are being hurt the most. Patients with cancer, HIV/AIDS, multiple sclerosis, and autoimmune diseases who are purchasing silver plans through the health care exchanges are facing

coinsurance rates often as high as 40 percent of the cost of their drug. On average, patients are paying 130 percent more in out-of-pocket costs for medicines in silver plans on the health care exchanges when compared to employer-sponsored coverage.

The president's health care law has disrupted health care coverage and destroyed health care choices for millions of Americans. The president and his allies have tried to put an end to any conversation about this health care law, but as the American people continue to be faced with its harsh realities, we will continue to do our part and hold the administration accountable for its broken promises and protect the American people from this law's costly consequences.

FRED UPTON, MICHIGAN
CHAIRMAN

HENRY A. WAXMAN, CALIFORNIA
RANKING MEMBER

ONE HUNDRED THIRTEENTH CONGRESS

Congress of the United States

House of Representatives

COMMITTEE ON ENERGY AND COMMERCE

2125 RAYBURN HOUSE OFFICE BUILDING
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Majority (202) 225–2927
Minority (202) 225–3641

July 1, 2014

Dr. Scott Gottlieb
Resident Fellow
American Enterprise Institute
1150 17th Street, N.W.
Washington, D.C. 20036

Dear Dr. Gottlieb:

Thank you for appearing before the Subcommittee on Health on Thursday, June 12, 2014, to testify at the hearing entitled "The President's Health Care Law Does Not Equal Health Care Access."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

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To facilitate the printing of the hearing record, please respond to these questions and requests with a transmittal letter by the close of business on Wednesday, July 16, 2014. Your responses should be mailed to Sydne Harwick, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C. 20515 and e-mailed in Word format to **Sydne.Harwick@mail.house.gov**.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Joseph R. Pitts
Chairman
Subcommittee on Health

cc: The Honorable Frank Pallone, Jr., Ranking Member, Subcommittee on Health

Attachments

Questions for the Record
Dr. Scott Gottlieb

Rep Michael C. Burgess

1. There are a number of methods/tools available to the insurance industry that could help keep rates competitive and low without shifting a large proportion of the burden to physicians. One would be to offer consumers plan designs that provide transparency around issues of price and relative value, and structured insurance products that leave more choices with consumers based on these considerations. The insurance industry has talked about value-based designs for many years, but at each juncture has been largely unable to implement these designs, or otherwise simply prefer to pursue the more restrictive schemes. This is probably a consequence of administrative ease, and the relative complexity of providing greater transparency around price and outcomes and structuring insurance designs to empower consumers to make choices based on these considerations.

2. I believe the physician networks will continue to erode in 2015. More states are pursuing regulations that will exert greater scrutiny to the adequacy of the networks. This may force some plans to expand networks in certain areas. But we will see networks contract in others areas, and will also see more physicians drop out of these schemes. On balance, I wouldn't expect the networks to look any better in 2015, and in some areas (for example, access to specialists) could be appreciably worse. In the first year some insurers were offering PPO style options on the exchanges. I would expect to see more narrow network plans supplant the handful of more flexible arrangements that were available as the insurers become more adept at managing selection on the exchanges, and more experienced in dealing with the low pricing and costly regulation that is imposed on them.

3. I believe on balance these networks will remain very restrictive. Insurers can expand them in ways that are noticeable to consumers and the political class without affecting the real issues of access and adequacy. For example, they can expand the number of doctors they enroll in a single institution but still restrict patients to that institution. Have consumers really benefited from greater choice in such a scenario? They may have access to more of the doctors in a local hospital, but they are still confined to that facility to receive all their care.

4. In year one, there weren't any reliable criteria applied. On the whole, insures sent contracts to providers, and networks were formed on the basis of those doctors that opted in. We will see more insurers force providers to take exchange coverage by making it a condition of participation in the insurer's other lines of business. Physicians will lose discretion as a consequence of the consolidating insurance market. This is one way insurers are going to gain leverage as the providers themselves consolidate, mostly around hospitals. In the post-ACA marketplace, the ongoing goal of providers and insurers is to gain market heft to exert this sort of leverage. On the whole the contracting is not accounting for patient severity risk,

and providers don't have any more insight into the capitated arrangements to gauge this risk than they possessed when wholesale capitation was pursued in the 1990s. This is one of the principal reasons why capitation failed. The providers, including hospitals, had poor insight into the risk they were assuming under these contracts, and had no reliable way to price the capitation arrangements.

Rep Gus Bilirakis

1. The tools available to patients were wholly inadequate. Patients had better selection tools when Medicare Part D was rolled out, and that plan was implemented during a time when the information technology was far less advanced. Consumers were able to compare Part D plans based on the drugs they used. The IT for enabling these kinds of capabilities is widely available. While we should expect to see more plans have better tools during the 2015 enrollment season, the fact is that the health plans are not incented to provide this sort of transparency. The incentives are directed toward imposing restrictions on access. The most significant complexity will surround the drug plans that accompany these ACA plans. There are so many terms and conditions; consumers will continue to have a hard time evaluating what their liability is under different clinical scenarios.

2. The restrictive rules are a consequence of three principal forces at work in the exchanges: first insurance market changes restricted how plans could use other cost-saving tools (high deductibles and cost sharing to steer utilization, underwriting based on risk, etc) to lower costs; second regulations imposed costly federal requirements on what benefits had to be included in coverage; and finally, insurers were restricted from raising premiums beyond a certain threshold in order to adequately price their products to the new costs that regulations imposed. The end result is that the ACA plans are largely the same within each insurer's particular line. The only thing that typically varies is the co-pay structure. The benefit design is the same. The single most significant reform to enable greater choice would be to lift all of the federal regulations and allow states to regulate the plans based on rules that pre-dated the ACA, and enable any plan that previously met sate eligibility requirements to be sold in the new exchanges. This would enable greater choice in some state exchanges. We will certainly see these narrow designs rolled out in the commercial marketplace. The ACA popularized these designs, and insures will import these same constructs into their other product lines now that these cost-saving approaches have been deemed acceptable by our political class. The inevitable outcome here is that the restrictive plans will ignite calls for still greater regulation, and we will be engaged in a cycle of more federal rules, and rising costs.

Rep Renee Ellmers

1. The essential benefit mandate has increased the costs of these plans, and created a market where consumers don't have a real choice of benefit design. All of the plans have conformed to the federal rules and are, for practical purposes, the same benefit design. Insurers are no longer competing on the basis of the underlying benefit. The

idea was to push competition to cost alone. What it's done is push insurers to adopt escalating tactics to cheapen the cost of delivering this mandated benefit by hollowing out the provider networks. This is similar to how Medicaid plans operate.

2. There is ample evidence that the consolidation of care, and especially oncology services, into hospital-based settings increases costs. 340B is contributing to this consolidation by giving hospitals a lucrative incentive to buy oncology practices. As I noted in a previous op ed article for Forbes, hospitals are buying private oncology practices so that they can book more drug purchases at the 340B discount rates. More than 400 practices have been acquired since the passage of the ACA. Between 2005 and 2011, the amount of chemotherapy infused in doctor offices fell from 87- to 67 percent according to an analysis of Medicare billing data done on behalf of community oncology groups. When cancer care to shifts to hospital clinics it's not only less comfortable for patients, but also more costly. Owing to hospital inefficiency, a patient treated in a hospital clinic costs $6,500 more than the same person treated in a private medical office. The cost of infusing the drugs alone rises by 55 percent. This doesn't account for the drop in provider productivity that we know ensues when providers shift from an outpatient to an owned arrangement.

3. The protected classes were implemented as a way to protect certain vulnerable patients from formulary designs that would inadvertently, or deliberately, exclude them by denying coverage for certain pivotal drugs. While such regulation can add to the costs, and decrease competition, the fact is that patients are being put at a significant hardship by regulations that encourage these restrictive designs. It may be that the only way to protect patients from the adversities created by the ACA is to implement such regulations. This is another example how ACA regulations are creating market failures that beget still more regulation to protect patients from the pernicious effects of the initial rules. This is how a regulatory arms race ensues, which regulators at CMS always one step behind that consumers are facing.

Rep Gene Green

1. I believe the single most significant reform that we can make, to encourage more choice and competition, would be to peel back the federal mandates and revert to state regulation of the insurance products. This would enable, in many states, more competition in the exchanges around benefit design, and give consumers a wider choice of affordable options. The consequence of the federal regulation has coalesced the market around a single template for benefits, with competition on price alone. It has created a race to the bottom on cost of goods where insurers are focusing on how to cheapen the mandated benefit by squeezing providers and networks. While price competition is important, we should also encourage competition based on the quality and breadth of the benefits, and give consumers a wider choice. In a viable risk pool, we shouldn't require that everyone buy the exact same benefit package as the only way to spread risk and costs. There is nothing inherently wrong with state-level exchanges as a way to pool consumers and facilitate purchasing. There is nothing inherently wrong with providing subsidies, in

the form of tax credits, to help consumers who are priced out of affordable coverage. The most pernicious flaw in the ACA is the top-down, federal regulation that limits the choices that consumers have, and in so doing, ends up driving up costs and forcing plans to compete on an increasingly narrow set of variables.

FRED UPTON, MICHIGAN
CHAIRMAN

HENRY A. WAXMAN, CALIFORNIA
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Minority (202) 225-3641

July 1, 2014

Dr. William F. Harvey
Assistant Professor of Medicine
Clinical Director, Division of Rheumatology
Tufts Medical Center
800 Washington Street, Box 406
Boston, MA 02111

Dear Dr. Harvey:

Thank you for appearing before the Subcommittee on Health on Thursday, June 12, 2014, to testify at the hearing entitled "The President's Health Care Law Does Not Equal Health Care Access."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

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Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Joseph R. Pitts
Chairman
Subcommittee on Health

cc: The Honorable Frank Pallone, Jr., Ranking Member, Subcommittee on Health

Attachments

AMERICAN COLLEGE OF RHEUMATOLOGY
EDUCATION • TREATMENT • RESEARCH

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July 16, 2014

The Honorable Joseph Pitts
U.S. House of Representatives
Chairman, Energy and Commerce Subcommittee on Health
2125 Rayburn House Office Building
Washington, DC 20515

RE: Response to Questions for the Record, Committee on Energy and Commerce, Subcommittee on Health; Hearing Held June 12, 2014

Dear Chairman Pitts,

Thank you for the opportunity to appear before the Subcommittee on Health to testify at the hearing entitled "The President's Health Care Law Does Not Equal Health Care Access." Attached, please find my responses to additional questions that were submitted for the record after the hearing.

Please do not hesitate to contact me or the American College of Rheumatology should you have any follow-up inquiries. Thank you for the chance to provide these additional responses.

Sincerely,

William F. Harvey, MD, MSc
Chair, Government Affairs Committee
American College of Rheumatology

Attachment 1 – Additional Questions for the Record

The Honorable Renee Ellmers

Everyone knows that we are facing a shortage of primary care doctors, but many do not realize that the shortage extends to cognitive providers like rheumatologists and neurologists. It is my understanding that Obamacare provides a bonus to primary care providers but fails to include other physicians that bill the identical evaluation and management codes. This impacts really sick patients, those with severe arthritis or even diseases like MS. How is that impacting the recruitment of cognitive physicians to specialties like yours?

The country is indeed facing a shortage of many kinds of doctors. My fellow witness Dr. Gottlieb made a comment in response to a question indicating he did not foresee shortages of physicians. I strongly disagree with that statement. This was a trend existing before the Affordable Care Act (ACA) due primarily to the aging of the baby-boomer generation of Americans who have increasing health needs combined with an aging physician population who are nearing retirement. In my view this has been accelerated by the ACA due to people with newly acquired coverage entering the healthcare system over a relatively short time period. Where I practice in Massachusetts, we have had a coverage mandate for several years and what we have seen with increasing frequency are primary care doctors who are not taking new patients. Emergency rooms and urgent care clinics are overwhelmed by patients who cannot get to see their primary care doctor in a timely manner for urgent issues. Patients needing appointments with specialists are seeing increasing wait times even in a place like Boston where there are more doctors per capita than anywhere in the country. These shortages therefore not only affect those seeking urgent or primary care, but also the sickest patients requiring complex care by specialist physicians.

The Affordable Care Act, as well as other historical initiatives, has sought to address this problem by providing additional payments to providers in primary care. Another approach has been to structure new payment models around a primary care practice (i.e. ACOs and PCHM). Both of these strategies rely on defining which practitioners are eligible for that bump, or to lead these medical homes and in virtually every instance, that eligibility has been based on being board certified in family medicine, internal medicine or pediatrics. This is done on an inaccurate assumption that primary care doctors are the ones principally providing the primary care and care coordination that patients need and that help control costs. A major problem arises however when you consider that many patients with complex medical conditions receive the majority of their care from a provider traditionally designated as a specialist.

Here is a stark example. I have a panel of patients with rheumatoid arthritis or lupus. They see me 4 or 6 (or more) times a year for management of their disease. I screen their cholesterol, measure their blood pressure, send them to a cardiologist if they need it, coordinate their rehabilitation, etc. They see their primary care doctor less often. Their primary care provider and I bill the same evaluation and management code in the fee-for-service system for an office visit, yet for the same billing level, their primary care doctor is

paid 10% more than I am because they are a primary care doctor and I am a specialist. Under the PCMH model, the primary care doctor is receiving a large sum to coordinate care, yet the specialist is the one providing those services.

The fact is that rheumatologists, infections disease specialists, endocrinologists and neurologists, to name a few specialists, are the principal care providers and care coordinators for many of their patients with rheumatoid arthritis, HIV, diabetes and Multiple sclerosis. All of these providers, as well as primary care doctors, are facing critical shortages. Therefore differential reimbursement aimed at reducing physician shortages needs more parity. The ACR and a coalition of other cognitive specialists, including endocrinology, infectious diseases and neurology advocate for an alternate methodology. If the goal of incentive payments to certain doctors is to fairly reimburse them for invaluable services as well as to encourage entry into their fields of practice, then recipients of any bonus should be defined solely on the basis of what services they are providing rather than the type of doctor they are. That simple shift in philosophy, paying people for what they do, rather than what they call themselves, will introduce this needed parity.

The differential reimbursements have a major impact on recruitment. New physicians will always make a choice about what type of medicine they practice after considering what field they are passionate about. But in an era of increasing student debt and decreasing reimbursements, financial considerations are intruding on that decision more and more. This is at the expense of patients who need doctors of all types to care for them. Congress can take a major step in this regard by a) adequately valuing evaluation and management services in general and b) creating parity within bonus programs designed to incentivize areas of medicine with practitioner shortages by determining eligible providers based on services provided, rather than specialty designation.

Attachment 2 – Member Requests for the Record

The Honorable Gene Green

Would you provide the committee with some specific changes or reforms you would recommend making to the ACA to improve the law?

I view health care reform in this country as a living organism; an evolving creature with constant need for feeding, maintenance, evaluation and modification. The Affordable Care Act represents the largest body of aggregate reforms to our system in decades. Incumbent in the evolving nature of health care is the ability to adapt the system to new understandings and new challenges. I appreciate the opportunity to enumerate some for you.

In preface to those comments, I would emphasize the principal point that patients need access to health care. The doorway to access has at least three pillars, which include access to providers, access to treatments, and access to coverage for services. In my view, unless all three are adequately addressed, access will be incomplete. During the hearing, there was significant debate about the impact of the ACA on various definitions of access, mostly around these three facets. Put another way, a patient needs to see their doctor, their doctor needs treatments to offer, and the patient or the system needs to be able to pay for both.

Patient Access to Care

Repeal the Independent Payment Advisory Board – While the ACR understands the expanding costs of health care and that steps must be taken to control those costs, we do not believe that the IPAB as created in the ACA is the correct solution. Neither Congress, providers, nor patients would have adequate oversight of this body. Well-intentioned policies enacted to control costs often have unintended consequences. These are often first felt by patients and their doctors, and without adequate oversight the IPAB may bring harm to patients. The ACR believes that patients and their doctors should be the primary driver of medical decision making with other safeguards to help control costs.

Repeal the Sustainable Growth Rate payment formula – Though not included in the ACA, the ongoing issues and uncertainty surrounding the sustainable growth rate formula is driving physicians away from seeing Medicare patients, thus limiting access. We encourage Congress to pass a permanent, bicameral, bipartisan repeal of the SGR.

Tort reform – The practice of defensive medicine results in increased cost to the system in a myriad of ways, including unnecessary or duplicative testing. The ACR believes Congress should pursue meaningful tort reform that respects the right of patients to recover damages while protecting well intentioned and competent physicians. These reforms may include caps on non-economic damages, standards for expert witnesses, rigid statutes of limitation, limitations on contingency fees, elimination of joint and several liability, and creating alternative means of dispute resolution.

Extend and expand the Primary Care 'bump' – Due to the increasing physician shortage in this country, primary care providers, who provide coordination of care and evaluation and

management services to their patients, are afforded a bonus payment within the ACA. These providers include family medicine, internal medicine and pediatrics. This was done in part to address the shortages of primary care doctors by increasing their reimbursement. Many other specialists however provide the principal care of their patients and coordinate their care – typically, for patients with complex medical conditions. Examples include rheumatologists for patients with rheumatoid arthritis, infectious disease specialists for patients with HIV and neurologists for patients with multiple sclerosis. Each of these specialties also faces critical workforce shortages. The ACR strongly supports realignment of payment differentials on the basis of services provided (evaluation and management and care coordination vs. procedures) regardless of their specialty designation.

Prohibit overly restrictive provider networks – The ACR understands that both the federal government and the private payment sectors will need to look for innovative solutions to control costs. However, overly restrictive provider networks, intended to control costs, are restricting access to care. These include some geographic restrictions on crossing state lines for care, even when services are cheaper and closer in a neighboring state. They also include changing of provider networks after open enrollment periods end. Informed consumers shopping in the marketplace should be able to tell if the doctor they wish to see is included in that payer's network for the entire year until the next open enrollment. The restrictive provider networks also create an access problem in which they do not include adequate numbers of certain types of physicians within a payer network.

Patient Access to Treatment

Prohibit overly restrictive drug formularies – Again, the ACR understands the need to control costs; however formulary restrictions are resulting in restricted access to treatment. Additionally, payers should be restricted from changing drug formularies outside of open enrollment periods. Informed consumers shopping in the marketplace should be able to tell if the medication they may need is included in that payer's formulary for the entire year until the next open enrollment.

Prohibit excessive cost sharing – As noted in my testimony, an increasingly common practice for payers is to charge co-insurance for specialty drugs often at 30-40% or several thousand dollars per month. This practice existed before the ACA but has accelerated in the marketplaces. Charging vulnerable patients excessive co-pays is an unnecessary step. Data shows tiny premium increases, $3 per beneficiary across a plan, would obviate the need for this practice, and restore access to treatments for patients with rheumatoid arthritis, multiple sclerosis, HIV, hemophilia, among many other chronic, disabling, and life-threatening diseases. Enacting HR 460, the Patient Access to Treatment Act would accomplish this.

Address the rising costs of prescription medications – The ACR, through its Rheumatology Research Foundation is the primary non-profit funder of arthritis research after the NIH. We understand very well the expense associated with research and development. The funding distributed by ACR pales in comparison to that expended by industry to support its research and development. The pharmaceutical and device industries are for-profit and fairly deserve to derive that profit by charging for their treatments. It is undeniable however that the rising costs associated with this research and development places a greater burden on the healthcare system and on patients who struggle to pay for the cost-sharing of their treatments. Meaningful

discourse and reform must take place to reduce the cost of medications, and this could include modifications to discount and negotiating programs, and reforms to the drug and device approval process that balance patient safety with cost of bringing a device to market.

Drug shortages – several key drug shortages have impacted the care of patients in this country. The ACR supports providing the FDA with the tools necessary to minimize drug shortages, including creating redundancies in drug supply changes and robust monitoring of drug production levels for key therapeutics.

Medicare reform – There are significant problems with Medicaid and Medicare beyond those listed above. These include adequate reimbursement for Part B drugs infused in an office setting. It also includes adequate reimbursement for preventative services. For example, bone density testing is now reimbursed at a level below the cost of purchasing, maintaining and operating the machine. Reduced access to testing results in more osteoporotic fractures in the elderly and more cost to the system by having the testing done only in hospital settings. Reimbursement was addressed in the ACA, but the provision expired in 2011 and should be renewed.

Dr. Gottlieb made an additional remark that lamented that the ACA has hamstrung many tools which payers have historically used to control costs, resulting in new measures which some find objectionable or which may limit access. As a practitioner, I encounter every day a new loophole or hoop which must be navigated to obtain access for patients to drugs or other doctors or diagnostic testing. While I believe that Dr. Gottlieb is in fact correct - that many of the tools such as charging more for patients with pre-existing conditions- have been eliminated by the ACA, I have no doubt that payers are intelligent enough to discover new ways to control costs. In fact, as stated previously, that innovation both in the private sector and in government managed payment is essential to move the cost needle in a more favorable direction and I encourage it. As those innovations happen however, we must, as a society, take care that there are not unintended consequences disproportionately affecting certain patient populations or certain segments of our society. Many of the items related enumerated above, such as excessive cost sharing for specialty drugs, go too far in that regard and need to be addressed. Again I thank the committee for the opportunity to discuss these critical issues.

FRED UPTON, MICHIGAN
CHAIRMAN

HENRY A. WAXMAN, CALIFORNIA
RANKING MEMBER

ONE HUNDRED THIRTEENTH CONGRESS

Congress of the United States

House of Representatives

COMMITTEE ON ENERGY AND COMMERCE

2125 RAYBURN HOUSE OFFICE BUILDING
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Majority (202) 225-2927
Minority (202) 225-3641

July 1, 2014

The Honorable Monica J. Lindeen
Commissioner
Montana Securities and Insurance
840 Helena Avenue
Helena, MT 59601

Dear Commissioner Lindeen:

Thank you for appearing before the Subcommittee on Health on Thursday, June 12, 2014, to testify at the hearing entitled "The President's Health Care Law Does Not Equal Health Care Access."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

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Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,

Joseph R. Pitts
Chairman
Subcommittee on Health

cc: The Honorable Frank Pallone, Jr., Ranking Member, Subcommittee on Health

Attachments

COMMISSIONER OF SECURITIES & INSURANCE

MONICA J. LINDEEN
COMMISSIONER

OFFICE OF THE MONTANA
STATE AUDITOR

July 16, 2014

Representative Joseph R. Pitts
Congress of the United States
House of Representatives
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515-6115

Dear Representative Pitts,

Thank you again for inviting me to testify at the subcommittees hearing on June 12, 2014. I appreciated the opportunity.

Please find my written responses to committee member's written questions below:

From the Honorable Michael C. Burgess:

1. *In plan year 2014, Montana had three carriers in your exchange. As you look at plans that will be offered in 2015, how are you ensuring that plans have an adequate number of physicians in each specialty, or subspecialty? And what do you consider "reasonable access" for non-urgent care?*

Ensuring that Montanan's have reasonable access to specialists and non-urgent care:

In 2013, the Montana legislature amended existing statutes regarding network adequacy for PPO plans. The new law sets the following standard: insurers who have contracted with 80% of healthcare providers in the state and 90% of hospitals and other facilities are "deemed" to have an adequate network. Below that threshold, the insurance commissioner may determine a network to be adequate. All of the major health insurers in this state are at, near or well above the 80% threshold for physicians and the same for the 90% threshold for facilities. In 2015, we expect to have 4 insurers operating in the FFM. We have numerous other insurers in the employer group market, all of whom are also held to this standard.

Montana also has rigorous standards for HMO network adequacy; however, there are few, if any, HMO plans offered in Montana at this time.

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840 Helena Ave., Helena MT 59601 Website: www.csi.mt.gov E-Mail: csi@mt.gov

Access to specialists

My staff is currently working on administrative rules that provide additional protections for consumers and also further defines and refines the review my office performs regarding network adequacy. For instance, one of the proposed rules specifies that if a particular network does not have a specialist available within a reasonable distance, the insurer must pay the claim as if it were in-network.

Reasonable access

Montana is a very rural state, with large distances and a sparse population. Therefore, when reviewing networks for adequacy, I must consider geographic barriers, typical travel patterns and availability of healthcare providers in certain areas. Therefore, determining "reasonable access" for non-urgent care is not a simple process. However, my staff and I take the issue of provider access very seriously and work hard to ensure the best possible access to care for Montana consumers, including access to care out-of-state when necessary.

Another important component of access and network adequacy is consumer education. In all of our consumer outreach efforts and in the extensive training that my staff has done with agents and other assisters, we stress the importance of evaluating the insurer's network and the consumer's medical needs BEFORE they choose a plan. Our network adequacy review now includes a review of the insurer's provider directory in order to ensure that it is complete, transparent, and easy to understand and access.

2. *Are you seeing plans narrow their networks further for plan year 2015?*

No. All of the plans sold on the FFM in Montana are offered in all parts of the State. Two insurers offer a more restricted network option in two cities only--the only two cities that have two hospital systems. These narrower network plans offer lower premiums and richer benefit packages. However, there are plenty of other options available in those two cities that have no network restrictions.

3. *One issue that has been raised to me is that it does not appear insurance plans differentiate subspecialties when evaluating a specialty area. For example, in Dermatology CMS recognized six sub-specialties, one of which is Mohs surgery, which is used to treat skin cancer. How do you ensure enough subspecialties providers are in a network and how do certify they are adequately trained to provide the subspecialty service?*

It is true that "subspecialties" are not really part of the adequacy analysis in Montana at this point in time and most insurance plans only identify "specialists." However, I am not sure how many "subspecialists" are even practicing medicine in the state of Montana. Some of this type of care would be sought "out of state," which is why we educate consumers on the need to evaluate how a particular health plan will reimburse for services received out- of-state. Also, the rule discussed above concerning reasonable access to specialist care would include subspecialists. If access to a subspecialist is medically necessary and one is not reasonably accessible "in network," the plan would have to reimburse the same as if the care was provided "in network."

The issue of adequate training for subspecialty services would be addressed during the credentialing process, which is part of the provider contract. State insurance regulators do not generally have control over the contracts between health care providers and insurers.

4. *There is a trend for insurance companies to acquire hospitals and clinics to provide medical services for their enrollees. How would such an arrangement affect MLR calculations?*

Staff-model HMOs and other insurers that own or control entities that directly provide health care services to plan enrollees typically will maintain the part of the company that provides health care as a separate legal entity which it reimburses for medical care provided, often on a capitated basis. This reimbursement, whether capitated or fee-for service, would cover the health care provider's direct costs of patient care and any administrative and overhead expenses associated with the provision of that care, just as it would if it were coming from an unrelated payer. All of these reimbursements, which include the provider's administrative expenses, would be included in the numerator of the MLR calculations as claims costs. To the extent, however, that the provider is billing the insurer for administrative functions performed on its behalf of the insurer that are unrelated to direct patient care, those expenses do not qualify as medical care and would be excluded from the numerator. This would be the case regardless of whether the provider is owned by the insurer or is an unaffiliated provider providing services under a contractual arrangement, however.

Question from the Hon. Jim Matheson:

1. *You come from a large rural state, much like mine. I am concerned about accounts I have read about the narrowing of provider networks that is occurring*

and how that might impact patients access to care. While this would likely be more acute in states like ours, I know that it is not just limited to rural states.

When you think specifically about the unique needs of rare disease patients and the challenges associated with accessing care, particularly specialists, you can understand that this could be a big problem for these patients. What are you doing in your capacity as Insurance Commissioner to ensure that these patients are not left out in the cold when so few treatment options are available to them from the start?

Montana has not yet seen a proliferation of "narrow" networks and the rules I am proposing would limit that as an option for health plan issuers. In addition, the proposed rule addresses the issues of reasonable access to specialists, as discussed in the answers above.

The unique needs of rare disease patients living in Montana often must be addressed by seeking care from out-of-state specialists and facilities. All of our health insurers have out of state networks; however, some of those out-of-state networks meet the needs of certain patients better than others. Individuals with special medical needs must be savvy health insurance shoppers. As mentioned above, my staff and I address that issue through consumer education and training of enrollment assisters and producers. We stress the need for consumers to research insurers' provider networks, in-state and out-of-state, before deciding which health plan to purchase. We also emphasize research on the insurer's drug formulary. We often partner with consumer advocacy groups, such as the cancer association to deliver that education and training. My consumer education efforts include a website dedicated to health insurance issues.

In addition, when there is a dispute about coverage for a particular medical procedure, we assist consumers with appeals and other types of claim resolution issues every day, and usually very successfully.

1. *(From the Hon. Michael Burgess): What happens when an insurer buys a doctors group? Do administrative costs get transfer to the clinical side?*

Please refer to the answer to Question 4 above.

1. *(From the Hon. Lois Capps): Have you done anything that has been working to broaden the networks that you could share?*

Representative Joseph R. Pitts

Please refer to the discussion above about Montana's amended PPO network adequacy laws, the current network adequacy reviews conducted by my office and the discussion on the administrative rules on network adequacy that I am proposing.

1. *(From the Hon. Gene Green): Would you provide the committee with some specific changes or reforms you would recommend making to the ACA to improve the law?*

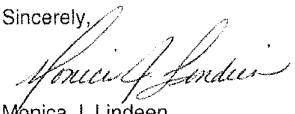
a) Change or eliminate the "affordability" test for employer coverage.

b) Modify the employer responsibility requirement; for instance, allow employers to offer coverage to dependents, but don't require the offer to bar access to tax credits on the exchange if dependents choose individual coverage instead of the employer's health plan.

c) Allow individual policyholders who don't qualify for tax credits to receive tax deductions, similar to what they would receive under a cafeteria plan in an employer group health plan.

Please feel free to contact me, if you have further questions on these topics.

Sincerely,



Monica J. Lindeen
Commissioner of Securities and Insurance

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