# RISING HEALTH INSURANCE PREMIUMS UNDER THE AFFORDABLE CARE ACT

## HEARING

BEFORE THE

## COMMITTEE ON WAYS AND MEANS
## U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTEENTH CONGRESS

SECOND SESSION

JULY 12, 2016

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# RISING HEALTH INSURANCE PREMIUMS UNDER THE AFFORDABLE CARE ACT

**TUESDAY, JULY 12, 2016**

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
*Washington, DC.*

The Committee met, pursuant to call, at 10:10 a.m., in Room 1100, Longworth House Office Building, the Honorable Kevin Brady [Chairman of the Committee] presiding.

[The advisory announcing the hearing follows:]

WAYS AND MEANS
CHAIRMAN KEVIN BRADY

**Chairman Brady Announces Hearing on Rising Health Insurance Premiums Under the Affordable Care Act**

House Committee on Ways and Means Chairman Kevin Brady (R-TX) announced today that the Committee on Ways and Means will hold a hearing on the rising costs of health insurance premiums under the Affordable Care Act (ACA). The hearing will begin immediately following the official Committee photo, which will be taken on Tuesday, July 12, 2016 at 10:00 AM in Room 1100 Longworth House Office Building.

Oral testimony at the hearing will be from the invited witnesses only. However, any individual or organization may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

**Details for Submission of Written Comments:**

Please Note: Any person(s) and/or organization(s) wishing to submit written comments for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, http://waysandmeans.house.gov, select "Hearings." Select the hearing for which you would like to make a submission, and click on the link entitled, "Click here to provide a submission for the record." Once you have followed the online instructions, submit all requested information. ATTACH your submission as a Word document, in compliance with the formatting requirements listed below, **by the close of business on Tuesday, July 26, 2016**. For questions, or if you encounter technical problems, please call (202) 225-3625 or (202) 225-2610.

**Formatting Requirements:**

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

All submissions and supplementary materials must be submitted in a single document via email, provided in Word format and must not exceed a total of 10 pages. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears. The name, company, address, telephone, and fax numbers of each witness must be included in the body of the email. Please exclude any personal identifiable information in the attached submission.

Failure to follow the formatting requirements may result in the exclusion of a submission. All submissions for the record are final.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202-225-1721 or 202-226-3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

**Note:** All Committee advisories and news releases are available at http://www.waysandmeans.house.gov/.

Chairman BRADY. The committee will come to order.

Welcome to the Ways and Means Committee hearing on the rising cost of health insurance premiums under the Affordable Care Act.

Over 6 years have passed since President Obama and Democrats in Congress drafted the Affordable Care Act behind closed doors and forced it into our homes, our workplaces, and doctors' offices. Since then, the law has been one broken promise after another, starting with the promise in its very title "affordable."

Millions of Americans have seen the cost of health care increase to astonishing levels, while quality, choice, and access have hit new lows. Meanwhile, the White House refuses to acknowledge that Obamacare is simply failing ahead of schedule and that the pain it has inflicted so far may be nothing compared to what lies ahead for millions of Americans and their families.

So we are holding this congressional hearing today to make clear that Obamacare's broken promises have real impacts on real people. And because we care deeply about providing Americans with access to high quality affordable health care, House Republicans have released a detailed credible plan for repealing the ACA and bringing patient focus care back to the American people. The truth about this law, it has never expanded access to affordable high-quality health care of an individual's choosing and it never will.

Estimates show that increases in 2017 could be double what we see this year, and in several States, these costs could spike by more than 50 percent with no end in sight. A 50 percent increase is outrageous. Americans simply cannot afford to pay 50 percent more for their premiums. One reason costs are skyrocketing, enrollment is far lower and far more expensive to cover than projected. That is why, in addition to raising premiums, many insurers have shrunk their provider network, so for individuals and families to

purchase coverage, it costs more, and with that more expensive coverage, they get fewer choices and less access to doctors and providers who best meet their needs.

Even after raising premiums and narrowing provider networks, many insurers are still struggling to shoulder the cost of doing business in the Affordable Care Act's mandate-ridden marketplaces. Every month we learn of more insurers who decided to leave the flawed Obamacare exchanges altogether. In April, United Health Group announced that it would be forced to exit many of the exchanges it was participating in because it couldn't sustain the crushing losses. After United leaves, 1.8 million Americans will have only two insurers to choose from, and over a million will only have one.

And some Americans, including thousands in my home State of Texas, may not have any insurers to choose from at all. In fact, BlueCross/BlueShield of Minnesota has announced their exit from the State after suffering more than a half a billion dollars in losses over just 3 years.

I, like many of my colleagues, have heard countless stories from families who are deciding it is just not worth paying the high prices to get Washington-approved coverage. Instead they are choosing to pay a stiff tax penalty rather than buy a plan they can't afford and don't want. And it is not just a few Americans. In States like New York, Iowa, Colorado, Arkansas, Minnesota, and South Dakota, more than three out of four people eligible to purchase exchange plans have found a way not to be covered in Obamacare.

I have no doubt we will hear today about families getting health insurance under Obamacare, but the reality for many of my constituents is that now they have to worry year to year about access to the right plan, access to the same team of specialists, and changes to their out-of-pocket costs. What is the point of expanding coverage if you can't afford or get access to care?

Over the past year, I have received letters from Texas families that are caught in the middle of the downward pressures of Obamacare's regulations and mandates. For example, especially hospitals my constituents rely on are being squeezed out of network. I would like to enter into the record two Houston Chronicle articles highlighting the struggles of families to get the specialized treatment they need. This is a direct result of Obamacare's mandates and rigid rules.

Americans have had enough of the Obamacare experiment and government-run health care. That is why we are dedicated to repealing this flawed law in advancing patient focused solutions that truly expand choice and access to high quality affordable health care.

I want to thank all the witnesses for being here today. I look forward to hearing your thoughts on how we can work to make our healthcare system work better for the American people.

People across our country all want the certainty of knowing they will have access to the care they need when they need it most. This is what Americans deserve, and it is what our committee will keep fighting to deliver. I now yield to the distinguished Ranking Mem-

ber from Michigan, Mr. Levin, for the purposes of an opening statement.

Mr. LEVIN. Thank you, Mr. Chairman. Essentially what we have heard is the campaign message of the Republican party against ACA, and that is the purpose of this hearing today, essentially bringing the campaign attack of the Republican party within the halls of Congress, and we look forward to that debate.

We had a situation, 50 million people in this country without any healthcare coverage. We had skyrocketing costs of health care, we had skyrocketing increases in premiums, and essentially what was decided after 50 years of inaction, we decided to do something about it, and what we decided to do was experiment with a combined program of expanding Medicaid and other government-based programs with the private sector of the United States of America.

We expanded Medicaid, and in Texas, because of the action of the leadership there, well over a million people did not benefit from the expansion of Medicaid in your State, Mr. Chairman. While in the State of Michigan, a Republican governor decided to take advantage of the expansion of Medicaid and brought real healthcare coverage to hundreds of thousands of people in this country in the State who needed it.

The Republicans have never come up with a comprehensive substitute for ACA. Instead, attack after attack, repeal effort, after repeal effort, and the number now is what, well over 60, and so you essentially can mark up today as whatever the number is, the next effort in the Republican party to attack and to try to undo the healthcare structure that has brought coverage to millions of people in this country and also brought down premiums.

So the experiment, as I said, was with combining public and private sector. It is controversial, even at times within the Democratic party. The Republicans essentially wanted to have a totally private system in this country, including to privatize Medicaid, privatize everything, and now, essentially, this hearing is being held to attack what is happening in the private portion of healthcare reform. Ignoring the millions of people in this country who have benefitted from the expansion of health care, millions, millions.

So this debate, this hearing is nothing more than another part of the political debate in this presidential year. And we understand the need to address issues relating to premiums. Mr. Lee will give some background on this, and we will continue to address this issue.

The Republican party has failed to take steps that would have been able to address the issue of premium cost where they are going higher, up higher in some States than in most others. They fail to do this, and so therefore, they essentially now are attacking some of the results of their own making.

So take this for what it is worth, we welcome you. We don't say that you gentleman here today are part of the political process. You have a distinguished background, but you should understand, the hearing today is part of the political debate of this year, and we Democrats welcome the opportunity to tackle this issue as to how, after 50 years, we began to address this issue while the Republican party, for all these years, has been bankrupt and remains bankrupt as to how they would undertake a major change that would benefit

millions of people who today can go to sleep knowing that they will have healthcare coverage. I yield back.

Chairman BRADY. Without objection, all the members' opening statements will be made part of the record.

Today's witness panel includes four experts, Joel White is president of the Council for Affordable Health Coverage; Christopher Condeluci is a principal of CC Law & Policy, PLLC; Tom Harte is president of Landmark Benefits representing the National Association of Health Underwriters; Mr. Peter Lee is executive director of Covered California.

The committee has received your written statements, and they will all be made part of the formal hearing record. You each have 5 minutes to deliver your oral remarks. We will begin today with Mr. White. You may begin when you are ready.

**STATEMENT OF JOEL WHITE, PRESIDENT, COUNCIL FOR AFFORDABLE HEALTH COVERAGE**

Mr. WHITE. Chairman Brady, Ranking Member Levin, Members of the Committee, I appreciate the opportunity to testify today. My name is Joel White. I am the president of the Council for Affordable Health Coverage, which is a broad based alliance with a singular focus, and that is, bringing down the cost of health care for all Americans.

Our membership reflects a broad range of interests, organizations representing patients and consumers, small and large employers, insurers, and physician organizations. We are concerned that healthcare costs are too high and are rising too fast. In fact, costs continue to outpace GDP, the economy, and premiums are increasing about three times as fast as wages. As a result, by 2030, the typical American family will spend more than half their income on health care.

As we all know, the ACA made massive changes to health markets, some positive and some negative. It created new consumer protections, corrected market imbalances, and reduced the number of uninsured Americans to historic lows. Yet overreach by the ACA has also contributed to high and growing health insurance premiums marked by average double-digit price increases both this year and next.

For example, this year, average premiums for both bronze and silver plans, which represent 92 percent of the market, increased by double-digit rates. Next year, the requested weighted medium premium will increase 19.2 percent based on rates already filed. This ranges from a high of 56 percent in Tennessee to a low of 3.6 percent in Rhode Island.

In addition, cost sharing, including copayments, coinsurance, deductibles, and the use of these strategies and formularies is increasing faster than premiums. For example, in 2016, the average silver plan had a $3,000-plus deductible. That reflects an increase of about 20 percent from 2015. The factors impacting premium rates and cost sharing increases include rising medical costs, mandated benefits and regulatory changes, and a risk pool that is smaller, older, and sicker than originally projected.

Despite the broad array of available plans on exchanges and a tax for being uninsured, many of those who have been expected to

sign up for coverage, even those eligible for subsidies, have not done so. Why? I think simply the point is people don't want exchange plans at the prices they are being offered. They are too expensive and have too significant cost-sharing requirements. In fact, a study that CAHC released last month shows participation rates vary with the generosity of subsidies.

Eighty-one percent of those receiving a full premium subsidy signed up for a plan. Just 2 percent of the nonsubsidy eligible population enrolled in exchange coverage this year.

As a result, enrollment is only about half of what CBO originally projected. ACA risk pools are thus smaller and sicker. So while many Americans with significant health needs or lower incomes have greater access to coverage now, the reality is that for millions of others, health coverage is less affordable and more out of reach than when the ACA was created 6 years ago.

The fact, this fact should spur Congress to enact bipartisan reforms to help stabilize and improve markets, making healthcare more affordable and accessible for all Americans. Increasing premium subsidies to encourage enrollment is not the answer in my opinion. This approach will shift costs, not contain them. Remarkably, some are even proposing fewer choices and less competition through public options and standardized benefit designs.

The fact is, we have tried the top down approach that relies on mandates and penalties, and costs have increased unsustainably as a result. CAHC believes that it is time to try market-based solutions that expand choice and competition to lower costs. One of most effective ways to lower premiums on the exchanges is by broadening and improving the risk pool. Greater participation rates in exchanges would lower average costs by spreading risk across a bigger population.

In my written statement, I outline 13 policy proposals to help achieve these goals. Briefly, these approaches would create competition across public and private exchanges, allow subsidy portability so consumers can use their support for plans they want and need, allow more flexibility for plans and employers, address medical cost growth, and promote transparency for plans and providers. I look forward to responding to any questions you may have. Thank you, Mr. Chairman.

[The prepared statement of Mr. White follows:]

COUNCIL FOR AFFORDABLE
**HEALTH COVERAGE**

**Testimony of Joel C. White**
**President, Council for Affordable Health Coverage**

Committee on Ways and Means
Hearing on Rising Health Insurance Premiums
Under the Affordable Care Act

July 12, 2016

Chairman Brady, Ranking Member Levin, and Members of the Committee, I appreciate the opportunity to testify today regarding premiums for health insurance plans offered on the Affordable Care Act's (ACA) exchanges. My name is Joel White, and I am the President of the Council for Affordable Health Coverage, also known as CAHC, which is a broad-based alliance with a singular focus: bringing down the cost of health care for all Americans. Our membership reflects a broad range of interests—organizations representing patient groups, consumers, small and large employers, insurers, and physician organizations. We run several solutions-oriented campaigns to promote affordability, including efforts to improve health care transparency, reform health markets, and improve patient adherence to medications. All told, our members total more than 75 distinct organizations representing tens of millions of people with an interest in lower health costs and more affordable coverage.

My testimony to the Committee will focus on rate increases for individual market plans offered on ACA's exchanges and their impact on enrollment and other factors.

**Introduction**

CAHC is concerned health costs are too high and rising too fast. In fact, costs continue to rise faster than the economy, while premiums are increasing about three times faster than wages. As a result, by 2030 the typical family will spend more than 50 percent of their income on health care. [1]

The ACA made massive changes to health markets – some positive and some negative. It created new consumer protections, corrected market imbalances, and reduced the number of uninsured Americans to historic lows. Yet, overreach by the ACA has also contributed to high and growing health insurance premiums, marked by average double digit price increases on exchange plans both this year and next. The result is an unbalanced and expensive market that is driving away many of the healthy consumers the exchanges need to attract in order to hold coverage costs down over the long term. While many Americans with significant health needs or lower incomes have greater access to coverage now, the reality is that for millions of others, health coverage is less affordable and more out of reach than when the ACA was enacted six years ago. Recent rate filings indicate this trend will continue and may worsen in the years to come. This fact should spur Congress to enact bipartisan reforms to help stabilize and improve markets, making health care more affordable and accessible for all Americans.

**Background on ACA's Requirements and Exchanges**

A basic overview of the ACA's exchanges is appropriate as background on how costs and coverage are playing out in the market. The ACA established new insurance exchanges in every state, where consumers can shop for, compare, and purchase private health insurance plans. Consumers can choose between several uniform tiers of health plans, ranked from Bronze to Platinum, that offer different levels of benefits at varying costs. Plans must cover certain "essential health benefits (EHB)," including emergency services, hospitalization, preventive services, and prescription drugs. Certain other reforms apply, including a ban on pre-existing condition exclusions, guaranteed issue and renewability, and minimum medical loss ratios.

[1] "2015 Milliman Medical Index." Milliman, May 2015. http://www.milliman.com/uploadedFiles/insight/Periodicals/mmi/2015-MMI.pdf

Community and age rating rules limit premium variation to age, family size, geographic location, and tobacco use; premiums are subsidized for lower income consumers. Specifically, the ACA ties federal premium subsidies to income on a sliding scale for people earning up to 400 percent of the federal poverty level (FPL)—$47,520 for an individual and $97,200 for a family of four in 2016. Cost-sharing subsidies are also available for people earning less than 250 percent of the FPL. Rates are subject to review and approval in the small group and individual market. The table below outlines the various applicable requirements by market.

**Major Federal Regulations Impacting Premiums**

| | Large Group | | Small Group | | |
|---|---|---|---|---|---|
| | Fully Insured | Self-Insured | Fully Insured | Self-Insured | Non-Group |
| **Individual Mandate** | X | X | X | X | X |
| **Employer Mandate** | X | X | | | |
| **Regulations Governing Insurance Benefits** | | | | | |
| **Essential Health Benefits** | | | X | | X |
| **Prohibition on excluding pre-existing conditions** | X | X | X | X | X |
| **Minimum Actuarial Value (generally 60 percent)[a]** | X | X | X | | X |
| **Regulations Governing Insurance Offers and Pricing** | | | | | |
| **Guaranteed issue and renewability[b]** | | | X | | X |
| **Modified community rating[c]** | | | X | | X |
| **Rate review required** | | | X | | X |
| **Risk Adjustment** | | | X | | X |
| **Minimum Medical Loss Ratios** | X | | X | | X |

***Source: Congressional Budget Office, Affordable Care Act (P.L 111-148)***

***A fully insured plan is one in which the insurer bears the risk; that is, the insurer incurs the added costs if expenditures are higher than expected and keeps the savings if expenditures are lower than expected. A self-insured plan is one in which an employer pays for the claims incurred by enrollees and bears all or most of the risk that those claims will be higher than expected.***

***a. Large employers may be penalized under the employer mandate if they offer coverage that has an actuarial value of less than 60 percent.***

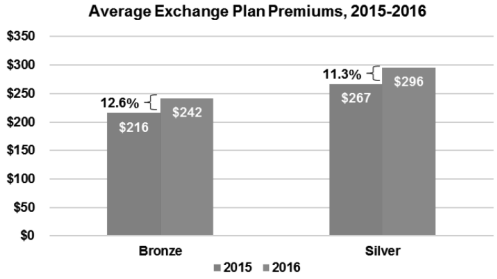
***b. For the fully insured large-group market, guaranteed renewability applies; guaranteed issue does not.***

***c. For large employers and for small ones that self-insure, the total premium or cost per enrollee may vary because of differences in the average health of each firm's enrollees. However, an individual employee's eligibility to enroll in a plan and that employee's required premium payment generally cannot vary on the basis of health.***

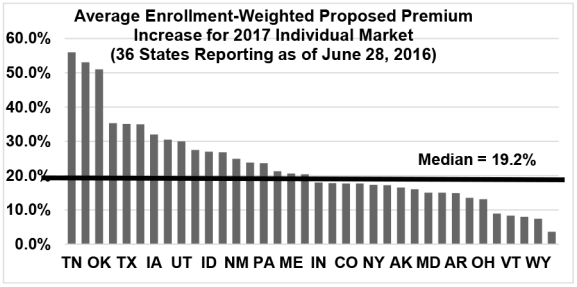
**What We Are Seeing Now**

*Premiums*

In 2016, average premiums for both Bronze and Silver plans saw double digit growth.[2] The most significant factors in this growth are the underlying increase in medical costs, the reduction of reinsurance program funds, and the size and changing composition of the risk pool.[3]




Based on rate filings for 2017, consumers can expect another year of double digit increases, on average. The median premium increase for 2017 is 19.2 percent based on average enrollment-weighted proposed rates already filed. [4] Notably, Blue Cross Blue Shield issued a report last March pointing out that participants in its exchange plans cost 19 percent more to insure than expected. This being the case, it was only a matter of time before these higher costs were reflected in the price of policies offered on the exchanges.




[2] "Silver Premiums by State." Robert Wood Johnson Foundation, Dec 2015. http://www.rwjf.org/content/dam/files/rwjf-web-files/Research/2015/Table%201_Silver%20Premiums.pdf

[3] For an in-depth discussion of these issues, please see Drivers of 2016 Health Insurance Premium Changes, American Academy of Actuaries, August 2015 accessed at http://actuary.org/files/Drivers_2016_Premiums_080515.pdf

[4] "Presenting the ACA Signups 2017 Requested Rate Hike Challenge." ACA Signups, 22 Jun 2016. http://acasignups.net/16/05/24/presenting-aca-signups-2017-requested-rate-hike-challenge

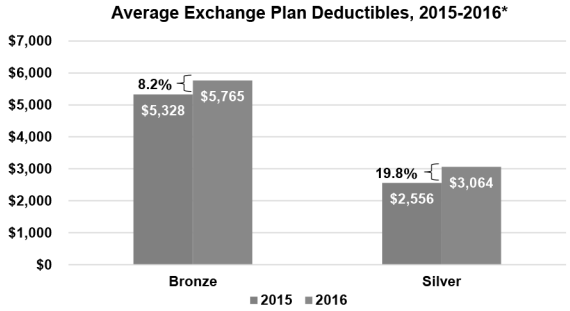
Given that these are applications for increases that are subject to approval, the allowed increases may be less than those shown in the chart (above). Nonetheless consumers should still expect a double digit premium increase in 2017 because of the same factors affecting 2016 rates – rising medical costs, expiration of the reinsurance program, and a risk pool that is older and sicker than originally projected. Statutory changes recently enacted by Congress that will help lower premiums for 2017 include changes to the definition of the small group market and a moratorium on the health insurance tax in 2017.

*Future Rates Across Markets*

The Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT) recently projected premium rate increases for employment-based plans and non-group insurance and found that premiums for the second lowest cost Silver plan will grow, on average, by 8 percent annually between 2016 and 2018, and by 6 percent annually between 2016 and 2025. By way of comparison, CBO and JCT project employment-based rates to increase by an average of 5 to 6 percent per year during 2016 to 2025.[5]

*Cost-Sharing*

Cost-sharing, including co-payments, co-insurance, deductibles, and their use on formularies, particularly specialty tiers, is increasing faster than average premiums. For example, in 2016, the average Silver plan had a $3,000+ deductible, reflecting an increase of almost 20 percent over 2015. [6]




Most plans use a mix of pricing strategies involving cost-sharing. For example, most have a combined medical and prescription drug deductible while using both copayments and coinsurance for services and drugs. The Commonwealth Fund examined cost-sharing for exchange plans and found:

[5] Congressional Budget Office, Private Health Insurance Premiums and Federal Policy; February 2016, available at https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/51130-Health_Insurance_Premiums_OneCol.pdf

[6] *"Patient Cost-Sharing in Marketplace Plans, 2016." Kaiser Family Foundation, 13 Nov 2015. http://kff.org/health-costs/issue-brief/patient-cost-sharing-in-marketplace-plans-2016/*

- Average copays, deductibles, and out-of-pocket limits remain considerably higher under Bronze and Silver plans than under employer plans;
- Cost sharing is similar between Gold plans on the exchanges and employer plans; and
- Exchange plans are more likely than employer plans to subject prescription drugs to a deductible, but less likely to do so for primary care provider visits.

For 2016, only one category of cost-sharing decreased on exchange plans. Copays for generic drugs fell by 3 percent. Out-of-pocket limits, general annual deductibles, and copayments for non-preferred brand drugs rose by 7 percent, 10 percent and 14 percent respectively.

A survey from the Kaiser Family Foundation found that families are struggling to meet these obligations. Only about half of households have enough liquid financial assets to meet higher range deductibles ($2,500 for an individual and $5,000 for a family).[7] Higher deductibles and cost-sharing are not necessarily a bad thing, as they can lead to greater awareness of health costs and lead to more judicious use of health services. Congress created a number of mechanisms such as Health Savings Accounts (HSAs) to ensure that consumers enrolled in such plans would continue to have access to needed services. Unfortunately, the majority of high deductible health plans on the exchanges are not coupled with HSAs, including new standardized plans that will be offered next year.

Given historical trends since the enactment of the ACA and absent data that suggests otherwise, CAHC believes these historical trends will continue in 2017 and beyond.

**Why are Exchange Premiums and Cost Sharing Increasing?**

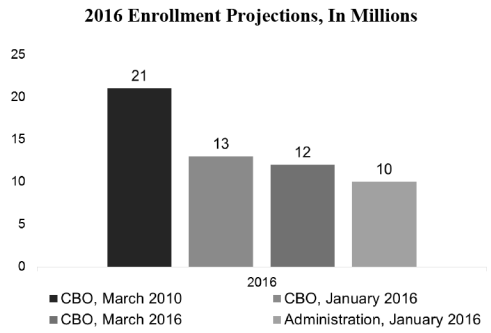
I believe the primary reason premiums and cost-sharing are increasing is that the risk pool is unbalanced and smaller than originally expected; additional reasons include:

1.
2. Rising medical costs, including the impacts of diminished insurer and provider competition;
3. The expiration of premium stabilization programs; and
4. Statutory and regulatory requirements on health plans and employers.

*Composition of the Risk Pool*

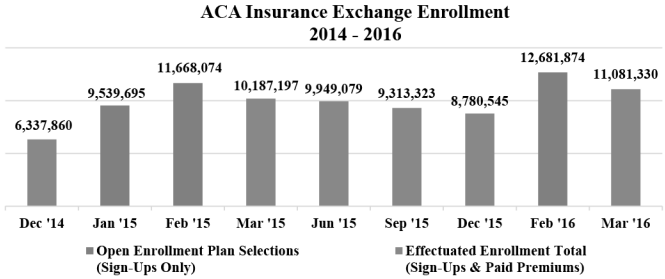
The ACA is widely credited with reducing the number of uninsured to historic lows, but this achievement is mainly the result of the Medicaid expansion, not because products on the exchanges attract the needed number of consumers for a sustainable risk pool.[8] Despite the broad array of available health plans and a tax for being uninsured, many of those who had been expected to sign up for coverage – even those eligible for subsidies – have not done so. In fact, enrollment is only about half of what the CBO projected when the law was first passed. [9]

[7] Claxton, G., Rae, M., and Panchal, N. (2015, March 11). Consumer access and patient cost sharing. Kaiser Family Foundation. Accessed at http://kff.org/health-costs/issue-brief/consumer-assets-and-patient-cost-sharing/
[8] "Trends in Health Insurance Enrollment, 2013-2015." RAND Corporation, 6 May 2015. http://www.rand.org/pubs/external_publications/EP50692.html
[9] "Exchange Enrollment: An Opportunity for Reform." Council for Affordable Health Coverage, Avalere Analysis, 7 Jun 2016. http://cahc.net/wp-content/uploads/2016/07/CAHC-IssueBrief_ExchangeEnrollment_061616.pdf




*Source: "Exchange Enrollment: An Opportunity for Reform." Council for Affordable Health Coverage, Avalere Analysis, 7 Jun 2016.*

CMS reports that as of March 31, 2016 approximately 11.1 million (11,081,330) people had "effectuated coverage" – meaning they paid their premiums and had an active policy as of that date – through the insurance exchanges.[10] It is unclear, however, how many will continue to pay premiums and maintain enrollment through the year. In previous years, non-payment of premiums, failure to provide documentation and transitioning to other coverage (such as Medicaid or an employer plan), led to attrition in the market. The chart below shows exchange enrollment over time.

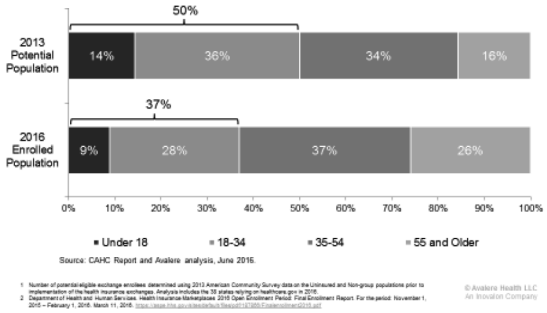



This is problematic because without robust enrollment, the risk pool is unbalanced. In a guaranteed issue market, cost is inversely proportional to enrollment. As more people enroll, average costs decrease, reflecting the relative health status of additional enrollees. The opposite seems to be happening on exchange plans. According to a CAHC analysis of exchange enrollment in 2016, participants tend to be older with greater risk, more females, and more ethnically homogenous than

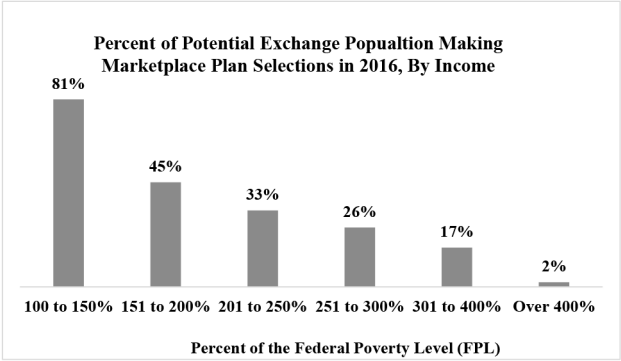
[10] "March 31, 2016 Effectuated Enrollment Snapshot." Centers for Medicare and Medicaid Services, 30 Jun 2016. https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-06-30.html

the eligible population. For example, 50 percent of the potential exchange population was under the age of 35, but less than 40 percent enrollees are actually in that age bracket.

*2013 Potential Exchange Population vs. 2016 Enrolled Population, by Age*



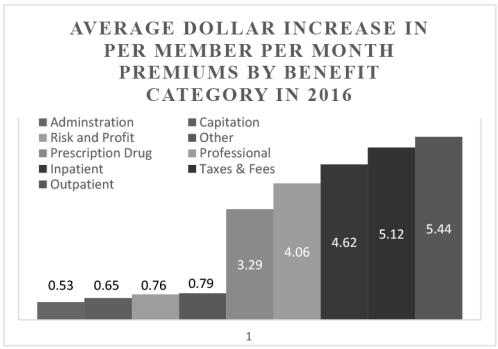

A prominent feature of the market is the extent to which participation rates vary with the generosity of the subsidies; only two percent of the non-subsidy eligible population have enrolled in exchange coverage as of 2016. (These higher income participants may consist disproportionately of individuals with high medical costs).



One of the most effective ways to lower premiums on the exchanges is by broadening and improving the risk pool. Greater participation rates in exchanges would lower average costs by spreading risk across a larger population. What we see on exchanges now is a smaller pool, and the pool itself is riskier. According to actuaries CAHC has consulted, premiums and cost-sharing are greater than expected and are rising more rapidly as a result. The higher rates already filed this year leads us to believe enrollment – and the health of the risk pool – will not improve measurably in 2017, and may in fact worsen. The vast majority of insurers on the exchanges continue to lose money because of this trend. This is evident in the large number of CO-OPs that have folded over the past two years. While some of the larger companies may be able to sustain such losses for a short time, this is not sustainable over the long-term and does not bode well for the future viability of exchange markets.

*Rising Medical Costs*

All plans sold in the individual and small group market are required to submit actuarially-certified justifications for premium increases, including the portion of the premium increase attributable to each unique benefit category. Avalere conducted an analysis of rate filings and found that the health insurance premium increases in 2016 largely mirror insurer spending on health services and products. The majority of health costs are for hospital services (32 percent), physician and clinical services (20 percent), and prescription drugs (10 percent). This percentage distribution is projected to remain consistent over the next ten years, with hospital services eating up a slightly larger share of the health care dollar over time. PricewaterhouseCoopers' Health Research Institute projects the 2017 medical cost trend to be the same as the current year – a 6.5 percent growth rate.[11] Because hospital (inpatient and outpatient) and physician costs make up roughly two-thirds of each health dollar, premium increases largely track cost increases in those sectors. The chart below outlines the average dollar increase in per-member per-month premiums by benefit category in 2016 in both the individual and small group markets.[12]




[11] PwC Health Research Institute, Medical Cost Trend: Behind the Numbers 2017 accessed at http://www.pwc.com/us/en/health-industries/health-research-institute/behind-the-numbers.html

[12] Avalere, Health Insurance Premium Increases Largely Mirror Spending, November 16, 2015, accessed at http://avalere.com/expertise/managed-care/insights/health-insurance-premium-increases-largely-mirror-spending

Importantly, taxes and fees cost more than inpatient spending, illustrating the extent to which government policy is contributing to premium cost increases. This is one area Congress can directly reduce inflationary pressures in the insurance market.

Of course, as insurers and providers vie for business and negotiate the best reimbursement, cost trend and premium rates will be greater or less as a result. About 80 percent of Americans live in highly concentrated medical markets, where too much pricing power limits insurer ability to effectively negotiate rates, which generally leads to higher premiums and cost-sharing for individuals and businesses. This fact, coupled with the problems in the enrolled risk pool, has contributed to plan losses for many insurers participating in exchanges. In fact, several insurers have or plan to exit markets or, indeed, have gone out of business altogether. According to the Kaiser Family Foundation, 664 counties (out of 3,007) may have just one exchange issuer in 2017, up from 225 counties last year.[13]

*Sunset of Reinsurance Program*

The ACA reinsurance program provides payments to plans for claims within specified dollar limits, partially offsetting the costs of high-cost enrollees and helping to mitigate risk exposure. The Centers for Medicare and Medicaid Services (CMS) has announced it will pay out about 50 cents on the dollar for claims between $90,000 and $250,000 in 2016. Reinsurance payments to insurers end in 2017, and premiums are expected to increase by four to seven percent as a result.[14]

*Statutory and Regulatory Changes*

While the law largely standardizes plan offerings and seeks to address the real or perceived abuses of the past, mandates and requirements of the law are driving up costs.

- CBO has estimated that the essential health benefits, actuarial value, and guaranteed issue requirements alone drive up costs by 27 to 30 percent.
- Expiration of the reinsurance program will drive up premiums an estimated four to seven percent, while the re-imposition of the health insurance tax may increase premiums by another one to three percent.
- Premium and cost-sharing subsidies and cost-sharing mandates in standardized plans hide costs from consumers and shift costs, but do nothing to actually reduce them, and may even lower consumer cost sensitivity in ways that increase systemic costs and premiums overall.

In implementing the law, regulatory activity related to the ACA that negatively impact costs has been robust. For example, the following list of recent regulations will likely further limit consumer choice and increase costs and premiums now and in the future:

- CMS recently issued a proposed regulation restricting the duration of short-term medical plans to 90 days with an inability to renew such plans. Many consumers enroll in such plans to cover gaps in coverage that last longer than 90 days for a wide variety of reasons.

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[13] Kasier Family Foundation. Following some withdrawals, more counties could have one ACA marketplace insurer in 2017. Accessed from http://kff.org/health-reform/slide/following-withdrawals-by-some-marketplace-insurers-more-counties-could-have-one-exchange-insurer-in-2017/

[14] Please see Drivers of 2017 Health Insurance Premium Changes, American Academy of Actuaries, June 2016, http://www.actuary.org/content/drivers-2017-health-insurance-premium-changes-0

Restricting the sale and renewal of these plans could marginally increase enrollment in exchanges, but eliminates an option that some consumers may rely on for continued and consistent coverage.

- The Internal Revenue Service has limited choices for small businesses by defining Health Reimbursement Arrangements (HRAs) as group health plans, subjecting the accounts to all of ACA's market reforms. Businesses that offer these accounts without pairing them with major medical policies will be subject to a $100 per-day, per-employee fine. HRAs can help small employers who cannot afford to provide full health benefits to their employees with assistance in the purchase of qualified health coverage, which could lead to greater enrollment (particularly of non-subsidy eligible) individuals and families on the exchanges. The House recently and overwhelmingly passed legislation sponsored by Congressmen Charles Boustany and Mike Thompson to correct this problem. CAHC applauds you for taking this step.
- Perhaps most troubling is a new policy introduced in the 2017 Notice of Benefit and Payment Parameters, which will introduce standardized plan designs that could lead to reduced plan offerings and higher premiums and cost-sharing for some consumers. The cost-sharing required for some treatments and services would largely make them completely inaccessible and unaffordable for lower income individuals. For example, the standard option design is particularly troublesome for Bronze Plans. Due to the proposed constraints on benefit design for pre-deductible coverage and formulary and network tiering, insurers will be left with few mechanisms to both hold down costs and meet statutory actuarial value requirements. Particularly concerning is the fact that there are only two tiers for formulary drugs – either generic or non-generic – with 50 percent coinsurance for all non-generic drugs, which is highly atypical in today's marketplace. None of the standard benefit options afford consumers the option of using HSAs, even though these plans have extremely high deductibles and cost sharing for many services.

It should be noted that not all changes proposed by CMS are negative. The Agency has committed to restricting the use of Special Enrollment Periods (SEPs), which were supposed to be for life-changing events or special circumstances, but have been used practically to game the system in many instances. CAHC believes that with proper enforcement, this change can improve the risk pool and premiums in the future.

Finally, and despite popular media and party-line narratives from both sides, Congress has enacted 24 changes to the Affordable Care Act since its enactment, most of them in a bipartisan manner. Some of these changes have positively impacted premium rates, including:

- The Protecting Affordable Coverage for Employees Act (on October 7, 2015), which staved off a premium increase of about 18 percent for three million workers in the small group market.
- Congress created flexibility for small businesses by repealing the cap on deductibles for small group plans, saving $1.2 billion over 10 years.
- Last year, Congress enacted a moratorium on collection of the Health Insurance Tax, which will lower premiums by one to three percent in 2017.

These laws were strongly supported by CAHC, but Congress can and should do much more.

**Solutions**

Fortunately, many of the problems outlined in this testimony are solvable or at least can be remediated, but they will require leadership and, we believe, bipartisanship. CAHC encourages you to enact reforms that will help improve the risk pool, better manage and target care for enrollees, and attract healthier enrollees in both the on- and off-exchange markets. We call on you to introduce and/or move legislation that promotes affordability through reductions in medical cost trend and expanded choices and competition in the marketplace. These include:

- **Improving Consumerism:** Both Republicans and Democrats support the concept of health insurance exchanges. To date, taxpayers have spent about $5 billion on decades old technology that offers only limited views of the information consumers want and need to make smart coverage decisions. CAHC believes this has harmed enrollment both on and off exchanges, which needlessly drives up health premiums. We believe Congress should pass reforms to improve the exchanges and limit taxpayer liabilities. Specifically, Congress should:

    1. Create next generation exchanges that allow for subsidy portability. Consumers would be able to use premium and cost sharing subsidies to purchase plans that comply with federal and state law on both public and private exchanges. The federal and state governments would retain the subsidy eligibility verification and payments to health plans functions. Such a reform would incentivize the private sector to create new and better tools and marketing platforms to reach more consumers annually – including consumers who are currently slipping through the cracks, such as those with higher incomes, individuals under 35, males, and Hispanics.

    2. Enact health care transparency improvements, which could save up to $100 billion annually by empowering consumers to choose efficient and effective providers while giving providers information on costs before treatment. Exchanges must also do better in presenting plan choices to consumers, including covered drugs and their cost sharing, provider directories, and out-of-pocket cost calculators.

    3. Reform SEPs and the grace period for non-payment of premiums. CMS has destabilized the risk pools in its frequent and unnecessary use of special enrollment periods. Open enrollment periods should be meaningful and the government should not encourage, sanction, or turn a blind eye to those who may game the system through non-payment of premiums.

- **Create Additional Flexibility.** As mentioned, the major cost drivers for exchange plans beyond the general costs of health care and risk pools are the mandates surrounding EHB, AV, and rating rules. Flexibility in these areas would create more competition that reduces costs:

    1. Allow AV flexibility, and new metal levels, such as Copper plans as a lower AV option (50 percent) for consumers who could not afford any plan. Congress could allow for the sale of Copper plans and/or expand catastrophic-only policies to those older than 30. Either option would expand enrollment.

2. Provide States with greater control over rating rules. The Energy and Commerce Committee held a hearing on draft legislation to provide plans and states with the flexibility to revert the decision over age rating to states or default to a 5:1 ratio rather than the current 3:1 if no changes are made. This would lower premiums for younger enrollees, which would help improve the risk pool and lower premiums for all consumers in the long-run.

3. Encourage the use of consumer-driven health products, such as Health Savings Accounts (HSA). Currently, CMS does not highlight HSA-compatible plans on Healthcare.gov, despite repeated requests to do so. Additionally, the new standardized benefit plans that will be featured on Healthcare.gov, have high deductibles but are not eligible for HSAs. As we have seen, deductibles and cost-sharing are rising at even higher levels than premiums in the individual market. Consumers should be allowed to avail themselves to current tax code support in paying for high cost sharing found on exchanges.

4. Allow for and incentivize the creation of specialized plans that target and improve care for patients with high-cost conditions such as diabetes, mental health, and other illnesses. Because the exchange population has greater medical needs than the general population, specialized plans can help insurers keep enrollees with higher cost conditions healthier, lowering costs and premiums in a unified risk pool. Current non-discrimination rules may make it difficult for plans to offer such coverage. Additionally, these types of plans are not available to consumers in states such as California that prohibit variation from rigid standardized benefit designs. CAHC is also extremely concerned that CMS' introduction of standardized plans will make it more difficult for enrollees to be aware of and access these innovative plans.

- **Address Medical Cost Trend Drivers.** One of the biggest mistakes of the ACA was to incorrectly assume that the market failures present in the health system and the difficulty many individuals and families had with accessing care was due to insurance design and practice rather than medical cost drivers. Addressing the largest components of medical costs, such as hospital inpatient and outpatient, is key to getting our arms around cost growth. Congress should work to lower cost trend by:

    1. Addressing uncompetitive markets. Consolidation is leading to highly concentrated markets across the country and in every congressional district, which, in turn, dramatically drives up the price of health services and the overall cost of care. This is translating into inflated government spending, higher premiums, and inefficient cost shifting. These factors are creating strong head winds in our labor markets, making retaining and hiring workers more difficult and creating a drag on our economy and household finances. Congress should avoid enacting policies and/or correct those that will likely lead to greater consolidation, particularly in the provider market, which drives

up premiums by preventing effective price negotiations. Congress should also oversee and counteract regulations that have similar effects.

2. Repealing aspects of the law that directly pass through costs to consumers. The medical device, drug, and health insurance taxes should all be repealed because these costs are passed onto the consumer in the form of higher premiums and greater cost sharing.

3. Reforming the laws holding back the proliferation of value-based reimbursements for prescription drugs. We have seen a strong and promising push to move away from a system that pays for volume of medical cost and treatment toward one that pays for value. We believe this should include prescription drugs.

4. Increasing competition in prescription drug markets. With more than 4,000 products awaiting a decision, the Food and Drug Administration's current backlog of generic products is not acceptable. We see time and again when there is expanded competition, there are lower prices.

5. Enacting policies that help patients access and adhere to needed therapies. Policies that improve medication adherence can help patients avoid hospitalizations and emergency room visits, providing $300 billion in potential system-wide savings.

6. Making the Medicare Access and CHIP Reauthorization Act's alternative payment model (APM) pathway more viable for more health care providers. More APMs should have positive spill-over effects into both the individual and group markets.

**Conclusion**

With the proposed premiums filed for the 2017 market, CAHC is very concerned about diminished affordability and lower enrollment on exchange plans next year. Even with subsidies, many of those enrolled may remain functionally uninsured due to increasing cost sharing. Shopping for different plans will not fix this problem as newly selected plans will likely have lower premiums, but more expensive cost sharing.

Only by addressing the underlying conditions that are producing high and growing premiums and cost sharing obligations will affordability become a reality for most people. Already, the typical family spends 30 percent of their income on health care. If current trends continue, that family will spend more than 50 percent of their income on care within 14 years. Congress can help families avoid this future, but you must be ready and willing to act.

Thank you for the opportunity to testify today, and I am happy to answer any questions.

Chairman BRADY. Thank you. Mr. Condeluci, you are recognized.

**STATEMENT OF CHRISTOPHER CONDELUCI, PRINCIPAL, CC LAW & PUBLIC POLICY PLLC**

Mr. CONDELUCI. Thank you, Chairman Brady, Ranking Member Levin, and Members of the Committee for the opportunity to speak with you today. My name is Chris Condeluci——

Chairman BRADY. Mr. Condeluci, could you pull that microphone down just a little bit closer.

Mr. CONDELUCI. Yes, sir.

Chairman BRADY. Perfect.

Mr. CONDELUCI. My name is Chris Condeluci. I am the sole shareholder of CC Law & Policy, a legal and policy practice that focuses on issues relating to the Patient Protection Affordable Care Act, the ACA. Prior to starting my own practice, I served as counsel to the Senate Finance Committee where I participated in drafting portions of the ACA, including the ACA exchanges, the State insurance market reforms, and all of the taxes under the new law.

In my practice, I provide legal counsel to stakeholders ranging from employers to insurance carriers to the ACA exchanges and private exchanges. I also provide policy analysis on the implementation of the ACA.

It is important to emphasize at the onset of my testimony that there is no one single event or ACA implementation decision that has contributed to increased premium rates. Instead, there are a number of contributing factors that, when added up in the aggregate, can objectively be viewed as the causes for the rise in premiums. These factors include but are not limited to, first, the statutory requirements under the ACA itself. In particular, the new minimum insurance standards in addition to the adjusted community premium rating rules.

These statutory requirements constrain an insurance carrier's ability to develop plan designs for a specific niche of consumers in the market; for example, young and healthy consumers who may want coverage of a limited number of medical services at a very low price tag, along with high risk individuals with specific chronic illnesses like diabetes or health disease—or heart disease, excuse me. These statutory requirements also push premiums higher, discouraging younger healthier individuals from entering the risk pool.

Second, two ACA implementation decisions that have been made by the Obama administration. In particular, the administration's transitional policy, which segmented the risk pool in certain markets and which has prevented healthier risks from entered the ACA's newly reformed risk pools. This also includes HHS' and other State-based exchanges limited enforcement of the eligibility criteria for enrollment during certain special enrollment periods.

Third, the failure of the individual mandate penalty tax having its intended effect of encouraging younger healthier individuals to purchase insurance coverage. These factors, when aggregated together, are resulting in an unbalanced risk pool, and the consequences of an unbalanced risk pool are increased premiums.

What does it mean to have an unbalanced risk pool? In short, an unbalanced risk pool arises when the pool is made up of a number of less healthy, heavy medical utilizers, and a smaller number of younger healthier individuals. Is the ACA's newly reformed individual market unbalanced? Data from HHS indicates that only 28 percent of individual market exchange plan enrollees are between the age of 18 and 34.

Actuaries have suggested that 40 percent of exchange enrollees in this age cohort are needed to ensure a balanced risk pool. The IRS has also indicated that 45 percent of the 7.9 million people who paid the individual mandate penalty tax in 2014 were under age 35.

Objective analysts have also observed that less healthy heavy medical utilizers have been attracted to the exchanges, and much of the increased medical claims in 2014 and 2015 came from individuals who have enrolled during certain special enrollment periods.

One logical solution to balancing out the risk pools attracting more younger and healthier individuals into the market; however, due to the manner in which the ACA constrains insurance carriers in developing plan designs that may appeal to younger and healthier individuals, these consumers are less likely to enter the market.

In addition, the three to one age variant now required when developing premium rates increases premiums for younger healthier individuals, which discourages these good health risks from obtaining coverage.

Another solution is allowing the individual mandate penalty tax to achieve its intended result. Unfortunately, to date, objective analysts have not found that the individual mandate is causing younger healthier individuals to purchase an individual market plan, evidenced by the HHS and IRS data that I referenced earlier. And while the individual mandate penalty tax increased by 600 percent in just 3 years, the penalty tax will only be indexed to CPI in 2017 and the 2.5 percent of income threshold will remain constant. It is unlikely that the slow growing penalty tax will have a substantive impact in future years.

If younger and healthier individuals do not enter the market, the risk pool will remain unbalanced, which will cause insurance carriers to continually increase premiums. Although I have laid out some of the factors that have led to an unbalanced risk pool in the individual market, which have contributed to premium increases, these are solvable problems.

I look forward to working with the witnesses who appear in front of you today as well as you, Mr. Chairman, Mr. Levin, and all the Members of the Committee. Thank you for your time. I look forward to answering any questions you may have.

[The prepared statement of Mr. Condeluci follows:]


# Testimony Before the Ways & Means Committee of the U.S. House of Representatives

Hearing on Rising Health Insurance Premiums Under the Affordable Care Act

**Christopher E. Condeluci, Esq.**
**Principal and Sole Shareholder**
**CC Law & Policy PLLC**

**July 12, 2016**

Thank you Chairman Brady, Ranking Member Levin, and members of the Committee for the opportunity to speak with you today. My name is Chris Condeluci. I am the sole shareholder of CC Law & Policy, a legal and policy practice that focuses on issues relating to the Patient Protection and Affordable Care Act ("ACA"). Prior to starting my own practice, I served as Counsel to the Senate Finance Committee. During my time on the Finance Committee, I participated in drafting portions of the ACA, including the ACA Exchanges, the State insurance market reforms, and all of the taxes under the law.

In my current practice, I provide legal counsel on the statutory and regulatory requirements impacting stakeholders ranging from employers and insurance carriers to the ACA Exchanges and private exchanges. I also provide policy analysis relating to the manner in which the ACA is being implemented by the Obama Administration. This includes observing and analyzing the evolution of the newly reformed "individual" and "small group" health insurance markets, and the impact the ACA is having on large fully-insured and self-insured "group health plans."

**Organization of Testimony**

My written testimony is organized into four parts. First, I talk generally about some of the factors contributing to rising health insurance premiums under the ACA, and also the results that are produced from these factors. Second, I provide technical explanations of (1) the statutory rules and (2) the implementation decisions that I believe are the factors that are responsible for the current state of the insurance markets and the premium increases in the individual market. Third, I talk about the ACA's "risk stabilization" programs (often times referred to as the "3 Rs"), and explain how these programs are contributing to the most recent premium increases. And finally, I discuss various issues relating to employer-sponsored insurance.

## Part I – Factors and Results

### A. Factors Contributing to Premium Increases

It is important emphasize at the onset of my testimony that there is no one single event – or ACA implementation decision – that has contributed to rising health care costs and premium rates. Instead, there are a number of contributing factors that when added up in the aggregate, can objectively be viewed as the causes for the premium increases consumers are experiencing in the individual market. These factors include:

(1) The statutory requirements under the ACA itself – in particular, the minimum insurance standards that insurance policies sold in the individual and small group markets must now meet, in addition to the "adjusted community" premium rating rules.

   (a) These statutory requirements limit an insurance carrier's ability to develop plan designs that are attractive to younger, healthier individuals; and
   (b) The new minimum insurance standards – in addition to the 3 to 1 age variant now required when developing premium rates – push premium rates higher.

(2) Two ACA implementation decisions that have been made by the Obama Administration.

(a) The Administration's "transitional policy," which allowed individuals and employees of small employers to remain covered under a non-ACA-compliant plan past January 1, 2014 (the effective date of the ACA's insurance market reforms); and
(b) Limited enforcement of the eligibility criteria for enrollment during certain "special enrollment periods."

(3) The failure of the "individual mandate" penalty tax having its intended effect of encouraging younger, healthier individuals to purchase health insurance coverage.

**B. The Results Produced From These Factors**

It is also important to establish why premium rates are going up in the individual market. In other words, it is important to understand what results the factors discussed above (and described more fully below) are producing. In short, these factors are resulting in an "unbalanced risk pool." And, the consequences of an unbalanced risk pool are increased premiums.

*An Unbalanced Risk Pool In the Individual Market*

In the case of the individual market, an objective analyst will tell you that the current individual market risk pool is unbalanced (i.e., the risk pool is made of a greater number of less healthy, high-medical utilizers and a smaller number of younger, healthier individuals). For example, data from the Department of Health and Human Services ("HHS") indicates that only 28% of Americans enrolled in an individual market plan offered through an ACA Exchange are between the age of 18 and 34.[1] Actuaries have suggested that 40% of Exchange enrollees in this age cohort are needed to ensure a balanced risk pool.

In addition, insurance carriers have indicated that a larger percentage of high-risk individuals have entered the market than was originally anticipated, due in large part to enrollment during special enrollment periods. Specifically, insurance carriers participating in the ACA Exchanges have contended – and HHS has acknowledged – that an increasing number of people (1) have enrolled in an Exchange plan during a special enrollment period, (2) they have utilized a significant amount of medical services, then (3) these individuals ultimately dropped their insurance coverage shortly after receiving the medical care, which resulted in (4) these individuals failing to pay in enough premiums over the course of a full year to cover the medical claims they incurred. In my opinion, the drafters of the ACA never expected people would "game the system" this way, and the drafters actually expected HHS would enforce the eligibility criteria for special enrollment enrollees in a manner similar to the employer market, where eligibility must be proven before enrollment can be effectuated. But, this is a reality that has contributed to an unbalanced risk pool, and one of the root causes for the significant losses experienced by a majority of the insurance carriers participating in the new marketplaces.

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[1] *Health Insurance Marketplaces 2016 Open Enrollment Period: Final Enrollment Report*, March 11, 2016, page 3 at https://aspe.hhs.gov/sites/default/files/pdf/187866/Finalenrollment2016.pdf.

Importantly, when faced with an unbalanced risk pool, insurance carriers have historically increased premiums to cover the abnormally high medical claims that are not adequately offset by the premium revenue (and lower medical claims) generated from younger, healthier individuals. As premiums increase, however, insurance coverage becomes less attractive to younger, healthier individuals, as well as individuals (1) who are not eligible for a premium subsidy under the ACA and (2) who are paying the full cost of a plan's premiums out of their own pocket (and who tend to be younger and/or healthier). As a result, these individuals are less likely to enroll in a health plan, which effectively results in a stagnant risk pool of less healthy enrollees.

*Attracting Younger and Healthier Individuals Into the Individual Market Risk Pool?*

One logical solution to balancing out the individual market risk pool is attracting more younger and healthy individuals into the market. However, due to the manner in which the ACA constrains insurance carriers in developing plan designs that may appeal to younger and healthier individuals, these consumers are less likely to enter the individual market. In addition, the 3 to 1 age variant now required when developing premium rates increases premiums for younger, healthier individuals, which discourages these "good health risks" from obtaining coverage. If younger and healthier individuals do not enter the market, the risk pool will remain unbalanced, which will cause insurance carriers to continually increase premiums year-over-year. These increased costs will likely make individual market plans – even subsidized coverage made available through the ACA Exchanges – unappealing to younger and healthier individuals, thus serving as an additional deterrent to entering the risk pool. This circular pattern may continue for years to come, never abating.

*Is the Individual Mandate Penalty Tax Working?*

Another solution is allowing the individual mandate penalty tax to achieve its intended result, which is encouraging more Americans to obtain health insurance coverage, which will result in a greater number of individuals entering the ACA's newly reformed risk pool. If a greater number of younger, healthier individuals entered the insurance markets, this will result in more healthy risks entering the risk pool.

Unfortunately, to date, objective analysts have *not* found that the individual mandate is causing younger, healthier individuals to, for example, purchase an individual market plan through an ACA Exchange (evidenced by HHS's data discussed above). And, while the individual mandate penalty has increased by 600% in just three years,[2] the individual mandate penalty will only be indexed to the Consumer Price Index ("CPI") beginning in 2017 and beyond. This effectively means that the penalty tax will no longer increase significantly year-over-year. If the penalty tax is currently *not* having the intended effect of encouraging younger, healthier individuals to purchase health coverage now, it is unlikely that a slow-growing individual mandate penalty tax will have a substantive impact in future years, especially in the face of continued premium increases.

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[2] In 2014, the individual mandate penalty tax was equal to the greater of (1) $95 or (2) 1% of an individual's (or a family's) household income. In 2015, the tax increased to the greater of (1) $325 or (2) 2% of an individual's (or a family's) household income, and in 2016, the penalty tax increases to the greater of (1) $695 or (2) 2.5% of an individual's (or a family's) household income.

## Part II – Technical Explanations of Factors and Results

### A. The ACA and the New Minimum Insurance Standards

Based on my experience during the debate and development of the ACA, I believe there were two main drivers for enacting the new health care reform law: (1) Expanding health insurance coverage to as many Americans as possible and (2) Requiring that insurance policies provide an adequate level of health care coverage. To meet this latter policy goal, the drafters of the ACA required insurance policies sold in the individual and small group markets to meet certain minimum standards beginning in 2014. These minimum standards include (1) the "essential health benefits" ("EHBs") requirement, (2) the cost-sharing limitations (otherwise referred to as the "out-of-pocket maximum limitations"), and (3) the "actuarial value" ("AV") requirement. The ACA's insurance market reforms also included two additional requirements that were intended to make the individual and small group health insurance markets much more functional markets. They include (1) the new "adjusted community" premium rating rules and (2) the "single risk pool" requirement. See **APPENDIX A** for a more detailed description of the ACA's minimum insurance standards and the premium rating and single risk pool requirements.

*The ACA Minimum Insurance Standards and New Premium Rating Rules Push Premiums Higher*

An objective argument can be made that the ACA's minimum insurance standards and other requirements such as the "adjusted community" premium rating rules are direct causes for premium increases under the ACA. For example, with respect to the "adjusted community" premium rating rules, the Congressional Budget Office ("CBO") estimates that this new requirement tends to raise premiums for two reasons:

- First, prohibiting insurance carriers from varying premiums based on "health status" lowers premiums for high-risk individuals, but these actions raise premiums for people with lower health risks. The result: Higher-risk individuals are encouraged to obtain health insurance coverage, while lower-risk individuals are discouraged from obtaining such coverage, producing an unbalanced risk pool of enrollees (which, as stated above, has historically resulted in higher premiums).

- Second, the 3 to 1 limit on varying premiums by age increases premiums for younger individuals and decreases premiums for older individuals because older individual's health costs exceed younger individual's by a larger degree than a 3 to 1 ratio. For example, CBO cites a study that shows that health care spending for a 64 year old is about 4.8 times as high as spending for a 21 year old.[3] Based on this, CBO explains that the 3 to 1 limit effectively encourages older people to enroll, while discouraging younger people from obtaining coverage, which again, results in an unbalanced risk pool and increased premiums.

[3] *Health Care Costs – From Birth to Death*, Society of Actuaries, June 2013, page 44 at http://tinyurl.com/q5z2zb9.

CBO also estimates that the EHB and AV requirements – along with the requirement to offer health insurance coverage to individuals with a pre-existing condition (i.e., "guarantee issue") – increases premiums in the individual market by 27% to 30% relative to pre-ACA prices.

Arguments have been made that the ACA's minimum insurance standards have effectively increased the adequacy of health insurance relative to pre-ACA health plans, and that the added cost of providing more comprehensive health coverage is outweighed by the fact that policyholders now have greater protections than they had previously. This argument has merit if you place a greater emphasis on the fact that the ACA's insurance market reforms provide more comprehensive health coverage than pre-ACA plans. However, when examining how and why premiums are increasing under the ACA, there is direct evidence that covering additional benefits and medical services carries with it increased costs.

*The ACA Minimum Insurance Standards Limit an Insurance Carrier's Ability to Develop Attractive Plans Designs, So the Young and Healthy Are Not Enrolling*

The ACA essentially "standardized" the types of health plans that may be offered in the individual and small group markets by requiring plans to cover the EHBs and satisfy the AV requirements. For many individuals, however, the EHBs include benefits and services they do not want or need. But, these individuals are required to pay for these services regardless, which simply increases the cost of the coverage in the eyes of these individuals, thereby making the notion of purchasing insurance unappealing (and therefore, these individuals never enter the risk pool). Younger, healthier individuals are often the type of health care consumers finding ACA-compliant plans (and coverage of the EHBs) unattractive, contributing once again to an unbalanced risk pool in the individual market.

The AV requirement is also prescriptive in relation to the amount of the cost that is shared between the insurance policy and the underlying insured. Interestingly, however, there is generally no significant issue with the percentages of the cost that must now be shared between the health plan and the insured. The issue stems from the fact that the AV requirement is inextricably linked with the EHB requirement. That is, the AV of a health plan is calculated based on the provision of the EHBs to a standard population. As a result, to satisfy the AV requirement, the health plan must cover all of the EHBs at the specified cost-sharing levels (e.g., 60% for a "bronze" plan or 70% for a "silver" plan). As stated above, for many individuals, the EHBs include benefits and services they do not want or need, yet to be ACA-compliant, a health plan must cover these benefits and medical services at the specified cost-sharing levels to satisfy the AV requirement.

Accordingly, an objective argument can be made that standardized plans constrain an insurance carrier's ability to develop plan designs for a specific "niche" of consumers in the market (e.g., young and healthy consumers who may only looking for coverage of a limited number of medical services with a very low price-tag, along with high-risk individuals with a specific chronic disease like diabetes or heart disease). If insurance carriers could tailor plans for these particular populations, arguments can be made that more younger, healthier individuals may enter the risk pool, and the carriers could better manage the high-utilizers, which could keep premiums low across-the-board.

**B. Implementation Decisions Made By the Administration Has Also Contributed to Increased Premium Rates**

There are two specific implementation decisions made by this Administration that can be attributed to the recent premium increases in the individual market: (1) The Administration's "transitional policy" and (2) The limited enforcement of the eligibility criteria for enrollment during certain special enrollment periods.

*The Administration's "Transitional Policy"*

On November 14, 2013, HHS announced what is commonly referred to as the "transitional policy." According to HHS's "transitional policy," a State could allow the health insurance carriers operating within the State to continue to offer individual and small group market health plans that do not comply with the ACA's new insurance market reforms (e.g., the EHBs and AV requirements, the "adjusted community" premium rating rules, and the single risk pool requirement). On March 5, 2014, HHS extended this "transitional policy," allowing ACA non-compliant individual and small group market health plans to remain in force all the way through October 1, 2017. And on February 29, 2016, HHS extended this "transitional policy" yet again, but the Department indicated that the policy would expire on December 31, 2017.

It is important to emphasize that the policyholders covered under a non-ACA-compliant health plan were placed into their own risk pool. In other words, because these health plans were not subject to the ACA market reforms, insurance regulators were required to impose the insurance laws in effect prior to the ACA's effective date, thus requiring these plans to be separated out from the ACA-compliant plans (so individuals covered under a non-ACA-compliant plan did not enter the newly reformed ACA risk pool). Many analysts believe that individuals covered under non-ACA-compliant plans tend to be healthier. Thus, as a result of the "transitional policy," healthier individuals did not enter the ACA's risk pool as less healthy/high-utilizers were purchasing insurance through, for example, the ACA Exchanges. This contributed to an unbalanced risk pool.

*Eligibility Determination Process for Enrollment During a "Special Enrollment Period"*

Under the ACA, individuals are able to enroll in an individual market health plan outside of the annual "open enrollment" period (i.e., during a "special enrollment period") if such individuals experienced a "life changing event" (like getting married, having or adopting a baby, or aging off of a health plan, just to name few). The ACA and HHS regulations also set forth a number of other reasons for enrollment during a special enrollment period, including a permanent move, gaining citizenship, and losing health coverage under, for example, an employer-sponsored plan or Medicaid.

In cases where individuals sought to enroll in a health plan offered through an Exchange, the Exchange did not require the individual to provide proof (e.g., some sort of documentation) that he or she experienced a life changing event or otherwise qualified for a special enrollment right under HHS regulations. This lack of enforcement during the eligibility determination process opened the door for "gaming of the system," where people waited until they got sick before they enrolled. Specifically, the insurance industry has provided evidence that people were willing to the take the risk and refrain from enrolling in health coverage during the annual open enrollment period, only to attempt to enroll in a health plan if they got sick after the open

enrollment period ended. In many cases, these individuals subsequently incurred significant medical bills, and then dropped their coverage, leaving the carriers with higher than expected medical claims and little premium revenue to cover those claims.

HHS – and other Exchanges like the California Exchange – now require documentation proving that an individual is indeed eligible to enroll during a special enrollment period. But, the tightening of the special enrollment eligibility process comes *after* the disruption that has contributed to an unbalanced individual market risk pool.

**C. Individual Mandate**

CBO estimates that the individual mandate penalty tax will reduce premiums in the individual market by roughly 20%. CBO bases this estimate on the agency's belief that the penalty tax encourages healthier people to obtain insurance, which, according to CBO, lowers average spending on health care among the insured population, thus lowering premiums for all individual market policyholders. CBO further states that while the penalty tax may be smaller than the amount of premiums an individual would otherwise pay for health insurance coverage, the tax nevertheless increases the cost of remaining uninsured, which means that more people will gain financially by obtaining coverage. CBO also suggests that some people will obtain coverage not for financial reasons, but simply because the mandate exists.

Despite CBO's estimates, objective data informs us that the individual mandate penalty tax is *not* encouraging younger, healthier people to obtain insurance. For example, the Internal Revenue Service has indicated that 45% of the 7.9 million people who paid the individual mandate penalty tax in 2014 were under age 35.[4] As a result, health care spending is *not* decreasing among the insured population, as CBO suggests it would. Instead, health care spending is increasing. And, such increased spending is placing inflationary pressure on premiums, pushing them higher. In addition, this increased health care spending – in the form of significant medical claims incurred by individual market policyholders – is producing financial losses for insurance carriers offering health plans in the individual market, thereby requiring these carriers to increase premiums to make up for their losses.

All told, the expectation that premiums would decrease on account of the individual mandate penalty tax is not materializing. Instead, it appears that the exact opposite is occurring. That is, the individual mandate is not encouraging younger, healthier individuals to enter the risk pool, which is actually resulting in an unbalanced risk pool and higher premiums.

## Part III – The "Risk Stabilization" Programs

The drafters of the ACA knew that the individual insurance market reforms would cause significant disruption. For this reason, the drafters created the reinsurance, risk corridor, and risk adjustment programs (the "3 Rs") to help stabilize the markets while insurance carriers figured out (1) how to insure the influx of less healthy, high-utilizers and (2) how to deal with, among other reforms, the new "guarantee issue" and "adjusted community" premium rating requirements. The drafters were told by actuaries that it would probably take three years for the individual market to stabilize. And based on this information, the drafters limited the

[4] See *Strengthening the Marketplace by Covering Young Adults*, June 21, 2016 at https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-06-21.html.

reinsurance and risk corridor programs to three year programs (i.e., they will sunset as of December 31, 2016). The risk adjustment program, on the other hand, is a permanent program.

**A. The Expiration of the Reinsurance Program Will Increase Premiums**

To date, it appears that the reinsurance program has been the most successful of the 3 Rs, paying out $7.9 billion in 2014 and $7.8 billion in 2015 to insurance carriers offering health plans in the individual market. HHS also estimated that the reinsurance program would reduce premiums by 10% to 15% in 2014 and 5% to 6% in 2015 relative to the expected cost of premiums without the availability of reinsurance payments.[5] The reinsurance program, however, is expiring at the end of 2016, which means expected premium costs in 2017 will not experience a reduction like in years past. And, insurance carriers will no longer be able to factor payments under the reinsurance program into the development of their premium rates, which effectively means premium rates will be adjusted higher.

**B. The Risk Adjustment Program Is Actually Causing Premiums to Increase**

The permanent risk adjustment program is intended to provide payments to insurance carriers that disproportionately attract high-risk populations, and also collect payments (known as a "risk adjustment charge") from insurance carriers that insure lower-risk, younger/healthier lives. While the program was expected to moderate premiums in the individual health insurance market by essentially reimbursing carriers that experienced abnormally high medical claims incurred by its high-risk population, the program is actually causing premiums to increase. For example, some carriers have opted against developing low premiums for fear of attracting younger, healthier individuals who end up producing a risk adjustment charge for the carrier. In other words, carriers are trying to avoid lower-risk lives by pricing their plans higher.

In addition, those carriers that have experienced a risk adjustment charge – and those carriers that estimate that they will have a risk adjustment charge in a future coverage year – are specifically increasing their premiums to make sure that they can generate enough premium revenue to cover the payment obligations (the built-in increase is sometimes as high as 15%). State Insurance Commissioners are even suggesting to certain insurance carriers that they should increase their rates to make sure they can pay their risk adjustment charge without dipping into reserves. Alternatively, State Insurance Commissioners are shutting down carriers whose financial solvency is impaired by the payment obligations under the risk adjustment program. This reduces competition within the State, which has historically impacted premiums in a negative way.

## Part IV – Issues Relating to Employer-Sponsored Insurance

**A. Increased Costs Under the ACA**

*Small Group Health Plans*

No one can dispute that – prior to the ACA – premium increases in the small group health insurance market were significant year-over-year. As a way to manage the continual premium

[5] 78 Fed. Reg. 15410, 15413 (March 11, 2013) and 79 Fed. Reg. 13744, 13826 (March 11, 2014).

increases, small employers routinely switched insurance carriers, shopping around for the best price. This "churn" added abnormally high administrative costs to an already volatile market.

Unfortunately, the ACA did little to address the premium increases in the small group market. Actually, it appears that the ACA has contributed to the recent rise in premium rates for many small employers. These increases are a direct result of the requirement that small group health plans cover the EHBs and meet the AV requirement. Another key driver to premium increases in the small group market can be attributed to the "adjusted community" premium rating rules. It is true that those small employers with an older workforce actually benefit from the new premium rating rules (based on the 3 to 1 age variation), and as a result, these employers may see a decrease in their premium rates. But, a greater percentage of small employers are adversely impacted by these new rules (in particular, because of the 3 to 1 age variation).

*Large Group Fully-Insured and Self-Insured Group Health Plans*

During the health care reform debate, the drafters of the ACA accepted the argument that large group fully-insured and self-insured group health plans (of any size) provided an adequate level of health care coverage. In other words, the drafters subscribed to the belief that these employer plans would by definition meet many of the ACA's minimum insurance standards (discussed above and in more detail in APPENDIX A), and as a result, the drafters exempted large group fully-insured and self-insured group health plans (of any size) from these new requirements.

However, the ACA did require employer plans to meet certain new coverage requirements, including covering an adult child up to age 26, paying for certain preventive services without cost-sharing, prohibiting annual and lifetime limits on benefits that would otherwise qualify as EHBs, and complying with specific out-of-pocket maximum limitations. While these new requirements did not increase the cost of an employer plan significantly, actuaries have found that the cost of an employer plan increased by 4% to 8% on account of the ACA.

**B. The "Exclusion" for Employer-Sponsored Insurance**

As the Committee knows, employer and certain employee contributions used to pay for health insurance coverage are not considered taxable income to an employee for income and FICA tax purposes. These contributions are shielded from tax under what experts call the "exclusion." For decades, both liberal and conservative economists have suggested that Congress should place a limitation on the exclusion. The drafters of the ACA did just that by enacting the Excise Tax on High-Cost Employer-Sponsored Health Coverage (otherwise known as the "Cadillac Tax").

CBO projects that the Cadillac Tax will reduce premiums by 10% in 2020 and between 10% to 15% by 2025. CBO justifies these reductions by suggesting that the exclusion increases premiums by 10% to 15% because this tax preference encourages employees to spend more on health care services, thus raising premiums for employer-sponsored plans. CBO explains that the presence of the Cadillac Tax will force employers and employees to respond by seeking plans with lower premiums, which will reduce health care spending and premiums overall.

There is significant political pressure to repeal the Cadillac Tax. But, there appears to be continued interest among members of Congress on both sides of the aisle to continue to limit the exclusion in the event the Cadillac Tax is removed. If Congress pursues some sort of limitation on the exclusion – in an effort to achieve the premium reductions that CBO estimates will be produced under the Cadillac Tax – I believe any new limitation must be structured with *precision*, so as to address many of the flaws of the current exclusion generally, and the Cadillac Tax specifically.

The current exclusion is "regressive." To address this flaw, the value of the tax benefit for mid- to upper-income employees could be limited to 28% of the cost of the insurance coverage that is under the threshold of any limitation on the exclusion. For employees in lower tax brackets, an additional "exemption for health insurance" – similar to the current "dependent exemption" – could be offered, which would further reduce a lower-income employee's tax liability, if any.

As former Counsel to the Senate Finance Committee, I understand that the goal for limiting the exclusion is to reduce offers of "comprehensive" health coverage (like 100% pay-all plans and plans with no- or low-cost-sharing). Typically, the dollar value of a health plan is a proxy for its "richness." However, the dollar value for a comprehensive plan providing "rich" benefits in Arkansas may equal the same dollar value for a less comprehensive, high-deductible health plan ("HDHP") in California. To address these differences, the dollar value of any new limitation placed on the exclusion *must* vary by geography.

Alternatively, limiting the exclusion could be based on the greater of a dollar value or the "actuarial value" of the plan. An AV metric (which is a measure of how much the insurance pays for medical expenses) would effectively impose a tax on the comprehensive plan in Arkansas, while shielding the HDHP in California from any tax.

Policymakers often use the Tax Code to encourage behavior. Congress should continue to encourage employees to save their own money in Flexible Spending Arrangements ("FSAs") and Health Savings Accounts ("HSAs") on a tax-free basis to help pay for out-of-pocket medical costs. In doing so, Congress should *not* count employee contributions to both FSAs and HSAs toward any limitation on the exclusion. Providing such an exception is necessary in light of recent data showing that employee out-of-pocket costs have increased six times faster than wages have increased over the past ten years.

Finally, unlike the Cadillac Tax, any new limitation on the exclusion *cannot* be indexed to the CPI. An equitable index rate would be "medical inflation."

## APPENDIX A

*The "Essential Health Benefits" Requirement*

The "essential health benefits" ("EHBs") are a list of ten (10) specified medical services that must be covered under individual and small group market plans.[6] The Department of Health and Human Services ("HHS") issued regulations implementing the EHB requirement, effectively permitting States to designate an "essential health benefits"-benchmark plan that may also include State benefit mandates that were in existence as of December 31, 2011.

*The Cost-Sharing Limitations*

The cost-sharing limitations require that amounts paid under a health plan in the form of cost-sharing (e.g., co-insurance, co-payments, and deductibles) cannot exceed the maximum out-of-pocket limits for a high-deductible health plan ("HDHP") defined under the health savings account ("HSA") rules for 2014. These amounts – otherwise referred to as the "out-of-pocket maximum limitations" – are indexed each year to what is known as the "premium adjustment percentage," which is a measure of premium increases over a specified period of time. Specifically, the overall out-of-pocket maximum limits will increase each year by the percentage by which premiums in the preceding year exceed the average premiums for a "benchmark" plan in 2013. In 2015, the premium adjustment percentage was 4.3%, increasing the out-of-pocket maximums to $6,600 for single and $13,200 for family coverage. In 2016, the premium adjustment percentage was 8.3%, increasing the out-of-pocket maximums to $6,850 for single and $13,700 for family coverage, and in 2017, the premium adjustment percentage is 13.2%, increasing the out-of-pocket maximums to $7,150 for single and $14,300 for family coverage.

*The AV Requirement*

According to the AV requirement, individual and small group market health plans must offer varying "levels of coverage" designed to provide benefits that are actuarially equivalent to a specified percentage of the full actuarial value of the benefits provided under the plan. In layman's terms, the AV requirement provides that the insurance coverage must pay for a specified percentage of the cost of a particular benefit or medical service covered under the plan, and the individual policyholder is responsible for paying the remainder of the cost. For example, in the case of a "silver" plan (which is required to have a 70% AV, plus or minus 2%), the insurance coverage will pay 70% of the cost of a covered benefit and the remaining 30% of the cost must be paid by the plan participant out of his or her own pocket (through some combination of deductibles, co-pays, and/or co-insurance).

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[6] These ten (10) specified medical services include: 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.

*The "Adjusted Community" Premium Rating Rules*

As discussed in the body of the testimony, the drafters of the ACA endeavored to make the individual and small group insurance markets much more functional markets. To achieve this policy goal, the drafters prohibited insurance carriers from under-writing an insurance policy based on the health status of an insured. Premium rates can only vary by age (by a 3 to 1 ratio), by tobacco (by a 1.5 to 1 ratio), by geography, and by family size. These new requirements apply equally to the individual and small group markets.

*The "Single Risk Pool" Requirement*

The drafters of the ACA also sought to expand the risk pools in the individual and small group markets. Specifically, the drafters developed the "single risk pool" requirement. Under the single risk pool requirement, the health risks of all individuals purchasing insurance in the individual market must be pooled together. Similarly, all of the health risks of employees of small employers purchasing coverage under a small group health plan must be pooled together.

However, there is a very important caveat to this single risk pool requirement in both the individual and small group markets. Specifically, the health risks pooled together in the respective markets will be pooled within the insurance carrier that is under-writing the particular health insurance policy. In other words, while the health risks in the respective markets are required to be pooled together in a single risk pool, those risks are pooled together on a carrier-by-carrier basis.

Another important caveat is this: While the drafters of the ACA sought to create the Exchanges to serve as a marketplace through which health insurance in the individual and small group markets could be sold, the drafters also wanted to preserve the market that existed "outside" of the Exchange. As a result, according to the ACA, consumers are currently permitted to purchase a health plan through the Exchange, and they are also permitted to purchase a health plan outside of the Exchange. Based on this, one would think that there are two separate risk pools in the individual and small group markets. But, in order to make the insurance markets work properly, there is actually only one risk pool that includes the health risks of individuals/employees purchasing a health plan both *inside* and *outside* of the Exchange.

> **Example**: If Person A purchases an individual market plan through the Exchange from Carrier XYZ, and Person B purchases an individual market plan outside of the Exchange also from Carrier XYZ, the health risks of Person A and Person B are pooled together in Carrier's XYZ risk pool. If, however, Person B purchased an individual market plan from Carrier QRS, then Person B would *not* be pooled together with Person A.

The small group market single risk pool requirement works the same way.

Chairman BRADY. Thank you. Mr. Harte, you are recognized.

**STATEMENT OF TOM HARTE, PRESIDENT, LANDMARK BENEFITS, NH**

Mr. HARTE. Good morning. Thank you, Chairman Brady, Ranking Member Levin, and distinguished members of this committee.

As I mentioned earlier by the chairman, my name is Tom Harte, and my company is Landmark Benefits. I am an employee benefits broker. I own a small business. I deal with hundreds of employers throughout the year on their health insurance benefits, hundreds of individuals trying to access health insurance, so I come here today with a very unique perspective, with conversation I have with my clients every day, every year with regard to the continued challenges that they have with access to health care as well as access to affordable plans.

I am also here representing the National Association of Health Underwriters, which represents well over 100,000 employee benefit professionals like myself that are in the trenches every single day trying to find these affordable solutions.

Before I jump into some of my comments with regard to the challenges that I am seeing, I want to also share with you some of the successes that we have seen over the past 12 months, that are welcome from me on the frontline of marketplace, things like passing the PACE Act. In New Hampshire, that made a big difference. By allowing our State the opportunity to determine what size group is best for our insureds, but also avoiding, as Mr. Condeluci referred to, the rate grids and three to one ratios by allowing my insurance commissioner to determine what is the best size group for my State, that has significantly helped us with was with rate grade overload.

Also, the moratorium on the medical device tax, the suspension of the health insurance tax, as well has the delay of the Cadillac tax, those are all very welcome from the clients that I represent every day.

Ranking Member Levin, you also talked about the uninsured rate. We love the fact that more people are getting insured. We love the fact that healthcare trend is coming down. Those are all welcome signs to us in the industry.

But at the same time, when I talk to my clients, what I thought it would be helpful for you is if I went to some of the renewals that we are experiencing over the past couple of months in 2016, my renewals for my clients in the past couple of months that we looked at have ranged anywhere from just over 11 percent to just shy of 30 percent. Now, these are small businesses like mine. I have 20 employees, but some of the clients that I represent have thousands of employees. Those 30 percent rate increases are not just for a select group of small businesses. They are also affecting large businesses that we represent in the New England area.

In addition to that, when I look at my clients and where their health plans have been over the past few years, I have seen plans transform themselves. And in my written testimony, you will see that some clients 10 years ago had $1,000 deductible and today they have a $5,000 deductible. So when I look at healthcare trend, and again, I welcomed healthcare trend to continue to come down,

healthcare trend does not necessarily represent the renewals that I am delivering to my clients.

So if the healthcare trend is, let's just say it is 8 percent, because there is different arguments out there with healthcare trend, that doesn't take into account utilization, demographic trends, pooling charges, risk adjustments, and many of the fees that my clients are paying through the passage of these premiums.

In addition to that, every single client I sit down with, they are having a reduction in benefits not by their own decision. They are seeing primary care office copays go from $25 to $50, specials copays go from $50 to $100. Some are paying $500 a month for a 30-day prescription at a retail pharmacy, and that is unacceptable. So what has happened is, with our uninsured rate falling, we are seeing a greater issue of the underinsured.

Now, what I mean by that—and again, in my written testimony, I provided you several graphs, but I wanted to do, and I did this over the weekend for you, was to show you the growth in deductibles for some of my clients. Now, I took one of my account managers at my company and I took their book of business, and I said: Over the course of a 9-year period, what has happened to the deductibles for these particular clients.

So I picked them at random, and what I saw was from 2006 to 2015, over a 9-year period, the deductibles for those clients increased by 479 percent. Over a 5-year period, they have increased by 329 percent. Over a 3-year period, 137 percent. So I am submitting to you that a lot of the employees that we insure every single day could not afford, 9 years ago, $1,000 deductible, and today, they certainly can't afford a $6,300 deductible. And I have to submit to you also that many of our larger clients have moved to these higher deductibles, putting their employees in a place where they can't afford to access basic general health care.

What I will say to you last, and that is one of the greatest problems that I have in the health insurance industry is a lack of transparency. Now, I am fortunate. On my iPhone, I have access to an app that will show me how much it costs to have access to health care from one facility to the next. But what will alarm you is that when you look at the statistics, and you can look at my home State of the New Hampshire, and all I did was a 30-mile radius from my hometown of Windham, New Hampshire, and I found that an MRI of the spine has a 436 percent difference from the least expensive facility to the most expensive facility. And I can name for you several different medical procedures that have similar differentials in healthcare costs, but one of the challenges that we need to focus is transparency in health care. Thank you.

[The prepared statement of Mr. Harte follows:]

**Written Statement for the Record of**
**Thomas M. Harte, President of Landmark Benefits**
**Representing the National Association of Health Underwriters**
**before the United States House Committee on Ways and Means**
**Hearing on Rising Health Insurance Premiums Under the Affordable Care Act**
**July 12, 2016**

Chairman Brady, Ranking Member Levin, members of this distinguished committee: Good morning and thank you for the opportunity to share some of the continued challenges of healthcare reform on individual and group consumers and offer some considerations that will support the Affordable Care Act's objective of improving the accessibility and affordability of health insurance.

My name is Tom Harte and I am the president of Landmark Benefits located in Hampstead, New Hampshire. My company provides health insurance benefits to over 300 corporate clients and the majority are small to medium-sized businesses.

I am proud to be here today on behalf of my professional association, the National Association of Health Underwriters (NAHU), which represents approximately 100,000 employee benefit professionals. Last year, I completed six years of service as a member of our national Board of Trustees, including serving as the NAHU's national president.

Before I respond to the primary issues for the consideration of the subcommittee, I want to share with you some of the successes within the market over the past year:

- The passing of PACE (signed October 7, 2015), which allowed states to determine if increasing the definition of small group in their state to 100 was in the best interest of their small businesses, was instrumental in fostering stability in local markets across the country and avoiding "rate grid overload" for businesses between 50 and 100 employees.
- Congress passed legislation that delayed or suspended several burdensome taxes embedded within the ACA to address affordability in the market:
    - Moratorium on Medical Device Tax of 2.3%
    - Delay of the 40% Excise Tax to 2020 (thresholds of $10,200/$27,500)
    - Health insurance tax suspension for 2017.

At the same time, it is important to share with you that health insurance consumers continue to be faced with significant premium increases. Although some individuals and employers have received premium decreases, the majority are receiving double-digit premium increases. Within the past couple of months, my company delivered rate increases to employers between 11.47% and 29.96%.

| Client Location | Enrolled | Deductible | Rate Adj. |
|---|---|---|---|
| Manchester, NH | 65 | $5,000 | 29.96% |
| Nashua, NH | 46 | $5,000 | 29.96% |
| Kittery, ME - SHOP | 12 | $2,600 HDHP | 12.61% |
| Lowell, MA | 2 | $2,000 | 29.22% |
| Derry, NH | 86 | $5,000 | 18.45% |
| Salem, NH | 10 | $500 | 11.47% |
| Cambridge, MA | 19 | $2,000 | 17.73% |
| Methuen, MA | 8 | $2,000 | 15.47% |
| Chelmsford, MA | 3 | $2,000 | 19.01% |

While healthcare trend in small groups has recently decreased, it is important to understand that this trend continues to be considerably higher than most other consumer or business products and services, and continues to outpace employee wage growth. Additionally, this trend does not consider other factors impacting health plan premiums:

- Utilization,
- Taxes,
- Risk Adjustment,
- Fees,
- Pooling charges, and
- Demographic adjustments

I would like to bring you into the companies that I represent in New England and share their experiences, which are common among individuals and employers across the country. Bottom line, health insurance consumers are growing more and more concerned with the exponential growth of health plan premiums while experiencing a reduction in benefits.

**REDUCTION IN BENEFITS**

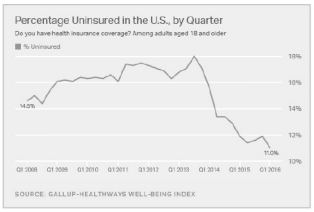
It is important to understand that most small employers have been faced with mandatory health plan changes. For example:

- Primary care office copays are increasing from $25 to $30 or $40.
- Specialist office copays are increasing from $50 to $60 or $80.
- Prescription drug copays are increasing dramatically, with shares increasing up to a monthly maximum of $500 for a 30-day supply.

Bottom line: In order to address the affordability of health insurance, health plans are eliminating plan benefits for small businesses that would result in more affordable health plan premiums.

**UNDERINSURED/ELEVATED DEDUCTIBLES**

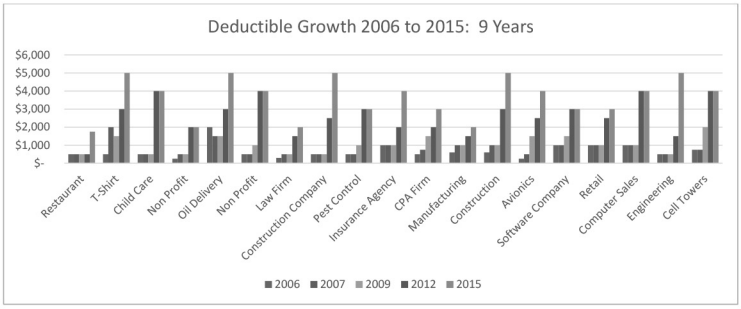
The recent success of the adult uninsured rate to 11.0% (Gallup) does not take into consideration those individuals that we consider "underinsured." These are people who have insurance but are not able to afford a catastrophic healthcare event due to the high plan deductible. For example, most employers are increasing plan deductibles to as high as $6,300; however, most employees can't afford a deductible event of $1,000, let alone $6,300.




According to the Kaiser Family Foundation, from 2009 to 2014, plan deductibles have increased by 47%. This increase in out-of-pocket expense before coverage is deterring many individuals from seeking necessary healthcare services. This delay of care will further exacerbate medical conditions, requiring more expensive care at a later date. (http://kff.org/health-costs/press-release/employer-sponsored-family-health-premiums-rise-3-percent-in-2014/ )

| Deductible Expenses | X > $1,000 | X > $2,000 |
|---|---|---|
| **2006** | 10% of employers | 3% of employers |
| **2014** | 40% | 18% |

From my professional experience with the clients that I represent in New England, the following chart represents a random selection of small business clients and their deductible growth since calendar year 2006.




*The supporting data can be found in Appendix 1.*

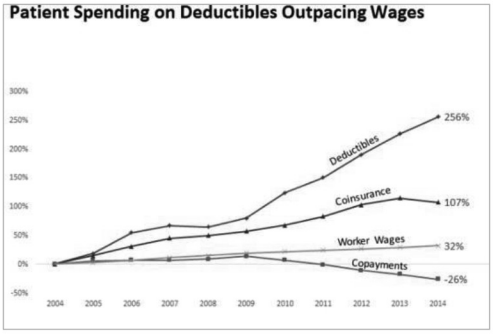
More specifically, this chart demonstrates significant deductible growth for our clients with the following representing the average increase in deductibles:

- From 2006 to 2015: 479.57% over 9 years
- From 2007 to 2015: 404.21% over 8 years
- From 2009 to 2015: 329.00% over 5 years
- From 2012 to 2015: 137.38% over 3 years

Furthermore, according to the Wall Street Journal's national estimates on the acceleration of deductible expenses, from 2004 to 2014 deductibles increased by 256% during the same time that employee wages only increased by 32%.

**FACTORS DRIVING HEALTHCARE COSTS**

I would like to address factors driving healthcare costs and health insurance policies that have affected premiums for small businesses since the two are connected. The cost of premiums are high, and rising, because the cost of healthcare continues to increase. The leading causes of increased healthcare costs, and therefore increased premiums, are increased utilization and government regulation.




**UTILIZATION**

In 2014, utilization increased in virtually every metric, with more physician visits, hospitalizations and prescriptions than in 2013. Higher utilization of services accounted for 43% of the increase, fueled by factors such as:

- Increased consumer demand
- New and more intensive medical treatments
- Defensive medicine
- Aging population
- Prescription drug cost
- Unhealthy lifestyles.

As American consumers return to increasing use of healthcare services, including many newly insured individuals under the ACA, utilization has increased significantly.


**TRANSPARENCY**
It is very surprising for most to learn that there is a significant price difference for healthcare services within our local communities. The good news is access to healthcare costs information has improved for some, but the access across the country is very limited. I have an APP on my phone from MyMedicalShopper that demonstrates the alarming difference in cost within 30 miles of my home in New Hampshire:

- MRI of lumbar spine without Dye: least $485.00 / most $2,114 (436%)
- Colonoscopy: $458 to $3,031 (661%)
- Mammography: $186 to $701 (376%)
- Chest X-Ray: $58 $347 (598%)

At NAHU we have always recognized that "**health insurance is expensive because healthcare is expensive**" but we need to have solutions that will address the significant waste in the healthcare system. Without addressing the cost of healthcare and at the current trend, premiums will double again in the next 6 years.

**HIGH-COST CLAIMANTS**
The conventional wisdom in the health insurance industry is that 5% of our members represent 50% of the total utilization of healthcare costs. For employers that continue to be generous to their employees by offering a health plan, these high-cost claimants are a major contributor to premium increases above healthcare trend. A few weeks ago, I was sitting with a client and reviewed one of their claimants who has kidney disease. Over the past 12 months, the total claims for this employee are nearly $1 million.

**MEDICAL LOSS RATIO**
Finally, as defined by the ACA's Medical Loss Ratio rules, health plans must limit their administrative expenses to 15% to 20% of health plan premiums and the remainder of 80% to 85% of the premium must be paid for healthcare expenses. As a result, it would benefit businesses of all sizes to focus our collective efforts on the costs that represent 80% to 85% of healthcare premiums, not the 10% to 15%. This will include prescription drug costs, high-cost claimants, transparency and much more.

**COMPLIANCE**
The ACA has imposed significant compliance burdens on employers, employees, individuals and local and state governments. Many of these compliance burdens discourage employer-sponsored coverage by adding onerous requirements and responsibilities that must be performed on behalf of employees. For small employers, many of the ACA's arbitrary provisions, such as narrow rating bands, limits on composite rating, new levels of minimum coverage and employer reporting requirements, have resulted in higher costs. However, the compliance burden does not end with employers, as individuals, providers, state and local governments, and all other elements of the healthcare delivery and financing system must meet the requirements of the law.

**EMPLOYER REPORTING**
Further, final regulations concerning employer reporting are overwhelmingly burdensome for employers. I can testify that some of my employer clients have spent hundreds of hours in preparation, coordination and deployment of these burdensome reporting demands. Additionally, the cost for reporting with either a payroll company or third-party administrator is excessive at best. Many of our clients were left without a solution with their payroll provider, prohibiting their access to employer reporting and were found scrambling for a solution prior to the reporting deadlines.

**EMPLOYER SPONSORED COVERAGE**
Employer-sponsored coverage is the bedrock of private insurance coverage in the United States. According to the Bureau of Labor Statistics, about 175 million Americans have employer-sponsored coverage and are statistically more likely to maintain coverage year after year. Providing coverage through employers or other group arrangements offers controlled entry and exit in the health insurance market, which ensures the spreading of risk, federally guaranteed consumer protections like portability rights, the ease of group purchasing and enrollment, and the economies of scale of group purchasing power. In addition, it is a means for employers to provide equitable contributions for their employees.

**EMPLOYER EXCLUSION**
The employer exclusion is used to reference the tax benefit that excludes employer-provided contributions toward an employee's health insurance from that employee's compensation for income and payroll tax purposes. This exclusion makes employer-provided health coverage an attractive form of compensation for workers. According to a new poll from Accenture, three-quarters of workers see health benefits as a "*vital reason*" for continuing to work for their employers, and one-third would quit if their employers stopped offering insurance. A similar percentage said they wouldn't work as hard if their benefits disappeared

Several recent health insurance and tax-reform proposals have suggested eliminating or capping the tax exclusion provided to individuals who have employer-provided group coverage and perhaps substituting it for some other tax preference. Capping the exclusion for employees would degrade the benefit and serve as a tax increase for middle-class Americans. Eliminating the exclusion would mean that most of the advantages of employer-provided coverage would no longer exist:

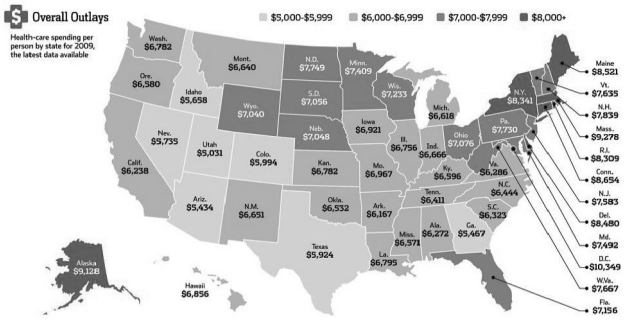
- No longer would there be a potent means for spreading risk among healthy and unhealthy individuals; employers and individuals would lose many group purchasing efficiencies;
- Workers would be less likely to have their employer as an advocate in coverage disputes;
- Employers would be less likely to involve themselves in matters of quality assessment and innovation; and
- Employers could suffer in terms of worker productivity and labor costs because employer-sponsored insurance leads far more workers to purchase health insurance than they would on their own.

Some employers would not meet participation requirements for group coverage so the entire workforce would lose employer-sponsored coverage. This shift might seem minor, but it could compel employers to stop providing health insurance, according to the Congressional Budget Office and the Joint Committee on Taxation. Companies will expect their employees to secure affordable coverage in the individual market. For many people, particularly older and lower-income workers, that may be impossible, even with the implementation of the ACA.

One plan would eliminate the tax exclusion for employer-provided health insurance, preventing companies from purchasing coverage with pre-tax dollars, and instead provide individuals with a tax deduction of $7,500 a year for buying insurance. Families would receive a deduction worth $20,500. These types of tax deductions would encourage young, healthy workers to forgo employer-sponsored insurance because they could purchase cheaper plans elsewhere. Employers would be left with an older, sicker risk pool, thus higher costs – if they can get group coverage at all. As costs escalate, even the most generous employers may quit offering health insurance altogether. De-linking coverage from employment like this would make health insurance more expensive and less accessible, thereby contradicting the objectives of the Affordable Care Act.

## Around the Nation

A breakdown of health-care spending state by state




Adding to the threat to employer-sponsored insurance is the increase in cost to the employers. In a recent

survey, almost 90 percent of businesses reported that their costs had increased because of the law. Employers are responding by laying off workers, making full-timers part-time so the mandate doesn't apply or dropping coverage altogether. In all three cases, the result is fewer people with employer coverage

Getting businesses out of the healthcare business would be a mistake. We urge you to maintain the system that has worked for Americans for decades, and preserve employer-sponsored health coverage through the continuation of the employer exclusion.

**INDIVIDUAL MARKET**

Since the implementation of the ACA, members of Congress, health insurance companies, brokers and the American public have struggled with the continued increases in the cost of health insurance and the erosion of plan choices. Yes, the ACA has produced many beneficiaries through subsidies and tax credits; however, now six years beyond the passage of ACA, the consequences are significant:

- Premium Increases:
  - Wall Street Journal, May 4, 2016, "Health Insurers Struggle to Offset New Costs":
    - *"Providence Health Plan, currently the largest insurer for people buying coverage through the **Oregon** health exchange, is seeking an average increase of 29.6%."*
    - *"In **Virginia**, where premium increases had been relatively modest to date, Anthem Inc. is asking for an average increase of 15.8%."*
  - Carolina Coast Online, June 29, 2016, "The Obamacare Albatross":
    - *"In **Tennessee**, after losing $300 million in ObamaCare's first two years and on track to lose another $100 million this year, on top of the 36% increase it got last year, BCBS wants a 62% increase in premium."*
  - The Baltimore Sun, May 13, 2016, *"Health Insurers Seek Rate Increases in Maryland as United Healthcare Quits Market"*
    - *"The unanticipated costs of providing health care to customers on the state's online exchange has prompted large insurers to seek rate increases of up to 30 percent while one insurer decided not to offer individual plans at all."*
- Risk Adjustment Program:
  - Forbes, July 6, 2016:
    - *"A **Maryland** insurer, Evergreen Health Cooperative, has filed a lawsuit against the Obama administration claiming that the formula used to determine risk adjustment amounts is arbitrary and unlawful."*
    - *"**Illinois** acting insurance director has ordered the Land of Lincoln Health Cooperative not to make its 2015 risk adjustment payment because doing so will cause the insurer, which has 40,0000 enrollees, to collapse."*
    - *"**New Mexico** Insurance Superintendent John Franchini calls the*


*implementation of the risk adjustment program 'completely backwards.' "*
- *"**New York** State Department of Financial Services asked the Obama administration for 'immediate changes' to the program, and yesterday Connecticut shut down its health care cooperative because of their new risk adjustment obligation."*

- Access to Plans:
  - CNN Money, April 19, 2016: "UnitedHealthcare to Exit Most Obamacare Exchanges":
    - *UnitedHealthcare, the biggest health insurer in the United States, said Tuesday that it plans to exit most of the Affordable Care Act state exchanges where it currently operates by 2017."*
    - *"It shouldn't come as a huge surprise. UnitedHealth had previously said that it lost $475 million on the ACA exchanges last year and could lose another $500 million this year."*
  - The Arizona Republic, June 20, 2016, "Blue Cross, Health Net Drop Affordable Care Act Marketplace Plans"::
    - "*Blue Cross Blue Shield of **Arizona** and Health Net, will drop Affordable Care Act plans next year in Maricopa and Pinal counties, forcing tens of thousands of consumers to switch plans next year."*
  - The Daily Signal, June 29, 2016, "Middle-Class **Minnesotans** Will Soon Have Fewer Healthcare Choices Because of Obamacare":
    - *"Minnesota's largest health insurer is minimizing its individual plan offerings, so much so that all family and individual preferred provider organization, or PPO, plans no longer will be in effect after Dec. 31. Restricting its presence in the individual market solely to Blue Plus HMO."*
  - The Post and Courier, July 2, 2016, "Healthcare Experts Question Future of Obamacare Marketplace in South Carolina":
    - "*With insurers struggling to make money and access to plans severely limited, top **South Carolina** health officials warn the Obamacare health insurance marketplace is on the verge of collapse."*
  - Alaska Dispatch News, May 2, 2016, "*Moda Health to Leave Alaska's Individual Insurance Market in 2017*"
    - "*Moda Health will exit **Alaska's** individual insurance market next year, the company announced Monday, leaving only one health insurance provider in the state's market that, so far, has been defined by drastic annual rate increases for consumers and big losses for insurance companies."*
  - Healthcare Dive, May 20, 2016, "*UnitedHealth to Leave NJ, Humana Exits CO*"
    - "*Both Humana and UnitedHealth are leaving the Colorado exchange."*


**RECOMMENDATIONS GOING FORWARD**

We all have an interest in having a functioning, viable health insurance marketplace for small employers. While the ACA has brought many changes and market resources to consumers and employers, I am concerned about policies threatening the small group's viability that could lead to its erosion. The membership of the National Association of Health Underwriters feels that the following policy changes would have a significant impact on improving the cost and coverage options available today for our nation's employers and their employees:

- To address the affordability of health insurance we need:
  - Continuation of the employer exclusion
  - Complete repeal or further delays of the Excise tax beyond 2020
  - Complete repeal or continued suspension of the health insurance tax
  - Complete repeal or continued moratorium on medical device tax
  - Legislation that allows states to increase the law's age rating bands from the current 3:1 spread to bands that more closely resemble the natural breakdown of age and meet the needs of a particular state. If a state does not set its own bands, the default should be 5:1
  - We need to focus on the portion of health insurance premiums that represents 80% to 85% of premium – more specifically, healthcare expenses.
- To address the accessibility of health insurance we need:
  - To remove agent and broker commissions from the medical loss ratio calculation in the small and individual health insurance markets will ensure small business access to an employee benefit professional.
- To address the simplification of health insurance we need:
  - A repeal or simplification of the employer mandate OR establish a threshold at 101 or more employees
  - Allow employers to set the definition of a full-time employee as one that works 40 or more hours a week for health coverage purposes.

In closing, I would like to thank Chairman Brady and all of the members of the committee for the amazing opportunity to share information about the opportunities and challenges small business owners like me and my clients are having in today's health insurance marketplace. If you have any questions or need more information, please do not hesitate to contact me at either (603) 329-4535 or tharte@landmarkbenefits.com.


Appendix 1: Deductible Growth, 2006 to 2015

| | 2006 | 2007 | 2009 | 2012 | 2015 |
|---|---|---|---|---|---|
| **Restaurant** | $ 500 | $ 500 | $ 500 | $ 500 | $ 1,750 |
| **T-Shirt** | $ 500 | $ 2,000 | $ 1,500 | $ 3,000 | $ 5,000 |
| **Child Care** | $ 500 | $ 500 | $ 500 | $ 4,000 | $ 4,000 |
| **Non Profit** | $ 250 | $ 500 | $ 500 | $ 2,000 | $ 2,000 |
| **Oil Delivery** | $ 2,000 | $ 1,500 | $ 1,500 | $ 3,000 | $ 5,000 |
| **Non Profit** | $ 500 | $ 500 | $ 1,000 | $ 4,000 | $ 4,000 |
| **Law Firm** | $ 300 | $ 500 | $ 500 | $ 1,500 | $ 2,000 |
| **Construction Company** | $ 500 | $ 500 | $ 500 | $ 2,500 | $ 5,000 |
| **Pest Control** | $ 500 | $ 500 | $ 1,000 | $ 3,000 | $ 3,000 |
| **Insurance Agency** | $ 1,000 | $ 1,000 | $ 1,000 | $ 2,000 | $ 4,000 |
| **CPA Firm** | $ 500 | $ 750 | $ 1,500 | $ 2,000 | $ 3,000 |
| **Manufacturing** | $ 600 | $ 1,000 | $ 1,000 | $ 1,500 | $ 2,000 |
| **Construction** | $ 600 | $ 1,000 | $ 1,000 | $ 3,000 | $ 5,000 |
| **Avionics** | $ 250 | $ 500 | $ 1,500 | $ 2,500 | $ 4,000 |
| **Software Company** | $ 1,000 | $ 1,000 | $ 1,500 | $ 3,000 | $ 3,000 |
| **Retail** | $ 1,000 | $ 1,000 | $ 1,000 | $ 2,500 | $ 3,000 |
| **Computer Sales** | $ 1,000 | $ 1,000 | $ 1,000 | $ 4,000 | $ 4,000 |
| **Engineering** | $ 500 | $ 500 | $ 500 | $ 1,500 | $ 5,000 |
| **Cell Towers** | $ 750 | $ 750 | $ 2,000 | $ 4,000 | $ 4,000 |

Chairman BRADY. Thank you. Thank you. Mr. Lee, you are recognized.

**STATEMENT OF PETER LEE, EXECUTIVE DIRECTOR, COVERED CALIFORNIA**

Mr. LEE. Good morning, Chairman Brady, Ranking Member Levin, and distinguished Members of the Committee. It is a pleasure to be with you today.

My name is Peter Lee, and I am the executive director of Covered California, the State of California's marketplace implementing the Affordable Care Act.

And what I would like to speak to briefly, and it is in more detail in my written remarks is first how the Affordable Care Act is working today; second, taking a look at what are the prospects for health insurance premiums in 2017; and third, some of the tools we are using in California to bring competition and affordability to California's consumers.

So first, the Affordable Care Act is working on many levels. Nationally, the share of Americans of all ages who are uninsured has fallen to the lowest level in history. 9.1 percent at the end of 2015. In California, 8.1 percent.

In addition, Americans have reported that they are spending less of their money, less struggling to meet their healthcare expenses than ever before. Now, this means 16 percent of Americans say they have trouble meeting healthcare bills. That is still a lot of Americans having trouble, but it is lower than it has ever been.

As we look ahead, it is important to remember that before the Affordable Care Act, consumers in the individual market regularly saw double-digit rate increases, saw increases that we just heard employers are seeing today, up to 30 percent. But in the old days, consumers couldn't change, couldn't shop, couldn't move plans. They now can.

The Affordable Care Act has slowed rate increases, creating competitive markets that are giving consumers the power to shop for better value.

Now, in California, last year, our rate increase was, on average, 4 percent. But if consumers shop to find the lowest cost plan available to them in their area at the same level, they would have reduced their cost by 4-and-a-half percent. That is the power of a marketplace working.

In addition, through the expansion caused by the Affordable Care Act, of 10 million people having subsidies, those are generally healthy people lowering costs to all Americans because they are now part of the risk pool, as you have heard many of the speakers speak to the importance of the risk pool.

So 2017, let's look ahead. It is going to be a transition year, and I think that it is important to know the main factors for that. First, the temporary reinsurance program is going away. That has been a program that has helped keep premiums low the last few years. It will have a 1 year impact. Experts estimate between 4 and 7 percent one time, and then that goes away.

Second, plans have had trouble pricing, and you have heard this from a number of the witnesses already, in particular, States that did not transition to a common risk pool, plans did not know how

to price, to get pricing right is difficult, and there is a number of plans that are adjusting this year, but by the end of next year, those transitional plans are going to be gone, all one risk pool.

Third, a number of plans have struggled with understanding this special enrollment people coming in. We have seen that issue being unforeseen by plans. We have also seen new guidelines and processes, both Federal and State level that should mitigate those problems in the future.

Trends are going up because healthcare costs are going up, and a key part of that, especially drug costs and pharmaceutical costs.

But finally, what is keeping rates down is competition. Competition drives pricing. Let me speak to you briefly about what we are doing in California to make sure that consumers are the drivers of the healthcare marketplace.

First, in California, we actually actively solicit health plans to participate in our marketplace, but we don't take everyone. They have to agree to play and try to improve healthcare delivery. They need to offer standard patient-centered designs, that make sure when consumers have a deductible, that deductible doesn't stand in front of a consumer in getting their primary care, which is never the case in our standard benefit designs.

It also means, those patient-centered designs, consumers can truly shop for what they really care about, which is the networks, the prices, and which doctors are in those networks. That is what consumers care about. They are able to shop in California, and that shopping is driving plans to put better prices on the table.

Now, I would note that, in California, we actually have from the most recent study from CMS, the lowest risk score, meaning we have the healthiest risk mix in the Nation. Risk mix is a core part of what we all have to be doing. That requires extensive marketing like we are doing, working with insurance agencies we have been doing, and having the subsidies that bring people to the table. But also, we have to be changing the underlying cost of health care.

The fundamental issue we have is health care is too expensive in America. Covered California has as part of our contracts with our health plans, requirements that they do things like make sure a consumer has a doctor within 60 days. That is a new requirement starting this next year. Making sure that they are paying differently to align with that work to actually improve the quality of care, which is the real driver of health care.

Our job is not done. I look forward to taking your questions now, but I also look forward to the work that we are all doing to improve on the Affordable Care Act. Thank you very much.

[The prepared statement of Mr. Lee follows:]


**United States House of Representatives**
**Committee on Ways and Means**
**"Hearing on Rising Health Insurance Premiums Under the Affordable Care Act"**
**July 12, 2016**

**Written Testimony Submitted by:**
**Peter V. Lee**
**Executive Director**
**Covered California**

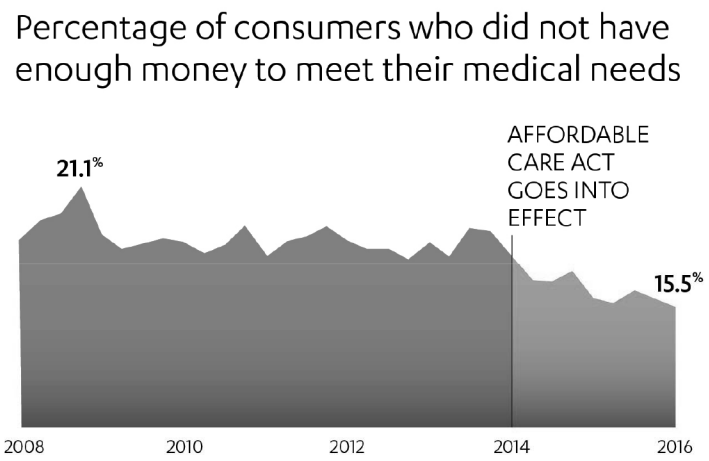
Good morning, Chairman Brady, Ranking Member Levin and distinguished members of the committee. My name is Peter V. Lee, and I serve as the executive director of Covered California. It is an honor for me to be here in Washington, D.C., before this committee, to speak with you about how the Affordable Care Act is working across the nation, specifically in California, and taking a look at the facts about potential changes to health insurance premiums in 2017.

Let me begin by saying that the federal Patient Protection and Affordable Care Act created a historic new era of health care that is working for millions of people in our country on numerous different levels. At the end of the most recent open-enrollment period, the Centers for Medicaid and Medicare Services (CMS) announced that 20 million people had been covered either through a Qualified Health Plan on a marketplace or through expanded Medicaid.[1]

Nationally the Centers for Disease Control and Prevention reported that the share of Americans of all ages who are uninsured had fallen to 9.1 percent by the end of 2015[2], down from 14.4 percent at the end of 2013. Last month, the Gallup-Healthways Well-Being Index reported that the number of Americans who reported not having enough

[1] Health and Human Services - http://www.hhs.gov/about/news/2016/03/03/20-million-people-have-gained-health-insurance-coverage-because-affordable-care-act-new-estimates
[2] Centers for Disease Control and Prevention - http://www.cdc.gov/nchs/data/nhis/earlyrelease/insur201605.pdf

money in the past 12 months to pay for necessary health care and/or medicines for themselves or their families had fallen to its lowest level on record.[3]




Source: Gallup-Healthways Well-Being Index

While these figures are impressive and provide a clear demonstration that the Affordable Care Act is working on many fronts, they also underscore the high cost of medical care continues to mean many Americans are struggling to afford the care they need. There are, however, several other important impacts on consumers across the nation and things we need to consider when looking at future rate changes.

Prior to the Affordable Care Act, consumers in the individual market regularly saw double-digit rate increases on an annual basis. According to the U.S. Department of Health and Human Services (HHS):

> *"Before the enactment of the Affordable Care Act, annual premium increases in the individual market were highly variable and increases often averaged 10*

[3] Gallup-Healthways Well-Being Index: http://www.gallup.com/poll/192914/healthcare-insecurity-record-low.aspx?g_source=CATEGORY_WELLBEING&g_medium=topic&g_campaign=tiles

> *percent or more at the state-level. From 2008 to 2010, the average annual rates of premium increases in the individual market ranged from 9.9 percent to 11.7 percent. In 2010, many increases were in the range of 9 percent to 15 percent, but a full quarter of issuers increased premiums by 15 percent or more. The average annual state-level increase was 10 percent or higher."*[4]

The HHS report revealed that once the Affordable Care Act was enacted, the new law had an immediate impact on the average rate changes in the individual market, which has saved consumers millions of dollars in health care premiums:

> *"Average rate increases in the individual market moderated to 7.0 percent in 2011 and 7.1 percent in 2012. The average rate increase was 10.3 percent in 2013, but would have been 8.7 percent if the high increases in one outlier state were excluded. This report shows that rate increases have remained moderate since 2013. The average rate increase in the individual market was 2.4 percent in 2014 and 6.9 percent in 2015."*

In addition to the double-digit rate changes prior to the Affordable Care Act, it's important to note that many consumers were essentially trapped into paying whatever increased costs were passed on by their health plan, because the health care system did not provide them with the protections, tools and transparency they needed to make well-informed choices about their coverage and they did not have the true power consumers need — the power to shop for a better value.

All that has changed now. Consumers are no longer locked into their health plan. Thanks to the Affordable Care Act, consumers have the ability to shop for the plan that best fits their needs and their pocketbooks. Data from CMS shows that of the 5.6 million people who actively renewed their coverage through the federal marketplace for 2016, 43 percent or 2.4 million people switched plans.[5]

This is key because the Affordable Care Act created a competitive market where the consumer is now in the driver's seat. Not only must insurers take all consumers, regardless of health status, the new reality is that consumers who face rate changes, which can vary from very little to substantial, can shop around for the best deal. The Affordable Care Act is designed to make the consumer the winner because they have the power to choose and they are receiving a product that is there when they need care.

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[4] U.S. Department of Health and Human Services - https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/Rate-Review-Annual-Report_508.pdf
[5] Centers for Medicare and Medicaid Services - https://blog.cms.gov/2016/02/05/open-enrollment-trends-selected-healthcare-gov-statistics-prior-to-the-final-enrollment-deadline/

When we talk about rate changes, we need to focus on this reality. Insurance carriers who raise their rates do so at their own peril and risk losing customers because the consumer is now in control. The Affordable Care Act created a competitive market, where there will be winners and losers among insurers, depending on how those companies price their products.

To put the power of choice into context, in 2016 the average rate increase for Covered California consumers who decided to stay in their prior plan was about 4 percent, while renewing consumers could reduce the cost of their existing premium by an average of 4.5 percent if they shopped around and switched to the lowest-cost plan in the same metal tier. A total of 14 percent of Covered California's returning consumers ultimately made the decision to switch plans prior to the 2016 coverage year. We attribute the reason that this figure is so much lower than the national average to the fact that California's rate change for 2016 was substantially lower than those seen in most states across the nation. But the same dynamic is in play throughout the nation — consumers now have the freedom to choose and are shopping to get the best value.

Giving consumers the ability to understand their plans and options, which they could not have prior to the Affordable Care Act, is bringing market forces to bear and promoting choice and competition. This is a competitive market that works, and consumers are holding our health insurance carriers accountable for their rates by carefully examining their costs and choices.

**2017 Will Be a Transition Year for the Individual Market**

Looking ahead to the next year, we have known for some time that 2017 will be a transitional year for premium rates across the nation. There are four primary factors behind why rates may see significant adjustments than those we have seen in recent years:

- *The end of the federal reinsurance program*

The main factor driving these rate changes is the end of the temporary federal reinsurance program, which was designed to help keep rates down during the first three years of the exchanges. The program assessed a fee on all health insurance payers and distributed the proceeds to carriers with non-group enrollees who had enrollees with high medical expenses.

The reinsurance program succeeded in moderating health premiums and keeping rate increases lower than they would have been otherwise, which has helped attract more consumers to help build a healthy risk mix, while also stabilizing the marketplace by

providing a measure of certainty for health insurance carriers. The impact on rates has been most important for the millions of Americans who benefit from the competitive market for individual insurance, but do not benefit from the premium tax credit that has made health insurance affordable for the first time to so many. An independent analysis from the American Academy of Actuaries estimates the end of this program will cause a one-time adjustment that will add between 4 and 7 percent to this year's rate change.[6]

In addition to the end of the reinsurance program, 2016 also marks the last year of the risk corridor program, although most experts believe this will have little impact on most plans. The third of the "Three R's" — risk adjustment — will continue as a permanent program and provides a critical tool to move health plans away from believing the path to profitability is avoiding less healthy consumers. Finally, for 2017, insurance companies will have a one-year moratorium on the health insurer fee as a result of legislation approved by Congress at the end of 2015, which will have a one-year positive impact on premiums of about 1 to 3 percent.[7]

- *Adjustments for mispricing*

While pricing has not been a major issue in California, it has had an impact across the nation. We must remember that the Affordable Care Act brought millions of new consumers into the health insurance industry and carriers did not have any data on these new consumers. Consequently, insurers were forced to provide their best estimates when setting rates. While some carriers got it right and have been able to keep rates stable, others have experienced a wide fluctuation in cost. This problem has been particularly problematic in those states that did not transition the individual market to one common risk pool in 2014 — and will be finishing that transition in 2017 and 2018.

In addition, carriers now have two full years of data on the costs and health status of consumers who signed up for coverage during a special-enrollment period (SEP). Some carriers have identified concerns about whether some who have enrolled during SEP may not actually be eligible, causing unforeseen impacts to their health care costs. These issues will be mitigated in the future thanks to new guidelines and processes being implemented at both the federal and state level. New policies will ensure that only consumers eligible for SEP are allowed to sign up for coverage outside of the regular open-enrollment period.

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[6] American Academy of Actuaries - http://www.actuary.org/files/publications/IB.Drivers5.15.pdf
[7] American Academy of Actuaries - http://www.actuary.org/content/drivers-2017-health-insurance-premium-changes-0

- *Rising trend in health care costs*

Unlike the two items above, which are expected to be either one-time adjustments or corrected by newly implemented policies, the rising trend of health care costs remains a constant driving factor in health care premiums. "Trend" refers to the carrier's estimate of how health care costs will change in the coming year. Gary Claxton and Larry Levitt of The Henry J. Kaiser Family Foundation recently stated that while trend has been relatively low in recent years:

> *"Insurers have been warning that cost pressures are increasing and there has been some suggestion that trend may be a little higher in 2017 than last year. From looking at a handful of early rate filings, low end projections are in the 3 to 5 percent range while some insurers are projecting trend of 7 to over 9 percent."*[8]

Part of that "trend" is the ongoing increase in the cost of specialty drugs. A new report by Health Affairs shows that:

> *"The proportion of specialty prescription drugs (defined as those reimbursed at $600 or more per thirty-day fill) nearly quadrupled. Over this time period, fills for specialty drugs increased by 198 percent and spending for the drugs increased by 292 percent."*[9]

In addition, a recent report by Express Scripts[10] found that, "despite being used by only 1 to 2 percent of the population, specialty medications accounted for 37 percent of U.S. drug spend in 2015 and are projected to reach 50 percent by 2018. Spending on specialty medications increased 17.8 percent in 2015."

It's important to note that the high cost of "trend" and specialty drugs is not an "Affordable Care Act problem", rather it is a "health care in America problem", and one we believe needs focused attention by purchasers, health plans, consumers and policy makers.

- *Competition matters*

Finally, in order for rates to remain moderate, exchanges need a competitive market where carriers are forced to jockey for consumers by offering the best combination of price, network and products. A number of markets around the nation did not have

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[8] Kaiser Family Foundation - http://kff.org/private-insurance/perspective/what-to-look-for-in-2017-aca-marketplace-premium-changes/#footnote-187632-5
[9] Health Affairs - http://content.healthaffairs.org/content/35/7/1241.abstract
[10] Express Scripts - http://lab.express-scripts.com/lab/drug-trend-report

competition prior to the Affordable Care Act — either among insurers or among health care providers — and they are still struggling today to increase choice in their markets. In California, we have more plans competing for consumers, they want to be in our market and they are aggressively pricing their products to attract as many consumers as possible. Exchanges that can address this issue by increasing choice will benefit consumers, because competition drives pricing.

**Covered California is Using all the Tools of the Affordable Care Act**

There is no question that the Affordable Care Act is having a positive impact on millions of Americans. There is also no question that implementing a law as big and as complex as this will take years and will not occur without variation across the nation, bumps along the way and lessons learned that can and should be used to improve upon the law going forward. This landmark legislation is about building a market that works for consumers and changing health care costs over the long-term. Let me tell you about where Covered California stands now and how we are seeking to use the tools of the Affordable Care Act and our state's enacting legislation to truly make a competitive market and build for a long-term future of health care affordability.

➢ *California Embraced the Affordable Care Act*

Following the passage of the federal Patient Protection and Affordable Care Act in 2010, California's then Governor Arnold Schwarzenegger and our Legislature created the California Health Benefit Exchange, the first state exchange under the new law. Since then, under the leadership of Governor Jerry Brown and a new Legislature, California adopted the Affordable Care Act's provisions to expand the state's Medi-Cal program.

Covered California's Board also adopted a policy that would be the driving force behind our creation of a competitive marketplace. While many other state exchanges and the federal marketplace sell any carrier that is compliant with the Affordable Care Act, Covered California actively works to create a market for consumers and carriers must compete to be a part of our exchange.

➢ *Building a Competitive Market*

Covered California puts every health insurance company that wants to be a part of the exchange through a rigorous review. Our health insurance carriers must meet high standards of quality, affordability and accountability as they compete in the marketplace. We do not take all-comers and if a carrier does not meet these standards, we will turn them away.

After choosing which plans will participate in the exchange, Covered California vigorously negotiates the premiums they can charge. For the 2015 individual market, Covered California negotiated a weighted average change of 4.2 percent. Covered California does not negotiate by table-pounding, but rather by providing good data on the risk mix of who is enrolled and working the health plans to garner maximum enrollment. In 2015, we provided data that proved Covered California enrollees were healthier and presented less risk to insurance companies than anticipated, which helped drive down the cost of health premiums. Covered California enrollees saved an estimated $100 million in premiums because of this innovative use of information.

In 2016, the average weighted change was just 4 percent, but as I noted earlier, consumers could reduce the cost of their existing premium in 2016 by an average of 4.5 percent if they shopped around and switched to the lowest-cost plan in the same metal tier. Again, we used data that proved we had a good risk mix to negotiate a better deal with the health insurance companies and save consumers approximately $200 million in premiums.

Providing data has been an important component to helping health plans “price-right,” but just as important has been the consumer-centric market dynamic, which means health plans know that they will lose enrollment if they price too high and the market discipline of knowing they will lose money if they price too low. We want “Goldilocks pricing” — health plans having the lowest possible price that will support covering all the medical costs that will be incurred by those enrolled in the individual market.

Covered California is currently wrapping up negotiations for its 2017 rates. As we have seen across the nation, and for the reasons listed previously, we expect our rates to be higher than we saw in our first two years. At the end of this week we will finish our negotiations and our health plans will submit their rates to regulators — and then be subject to regulatory review, as is the case across the nation. We will announce these preliminary results next week.

It is important to remember that the rates and benefits Covered California negotiates apply to the coverage our health insurance carriers offer in the off-exchange individual market as well. This means that an estimated 900,000 Californians, who are not in Covered California, receive the benefit of our work to expand the insurance pool, negotiating with health plans and our patient-centered benefit designs.

Our negotiated rates also help the tens of millions of Californians with employer-based coverage in two ways. First, by lowering the number of uninsured — we are reducing the cost shift to employers and their employees from hospitals and other providers

needing to make up their uncompensated care in commercial premiums. Second, all Californians now know that if they lose employer-based coverage, they will have affordable insurance available to them.

Currently we have 12 plans serving the state, including some of the biggest names in the health insurance industry, along with well-known regional entities and carriers that focus on California's Medi-Cal population. Covered California has 19 rating regions across the state and many of those regions are bigger than other states in the country. Currently each region has between three and six plans serving consumers.

- *Patient-Centered Benefit Design*

Covered California also has put consumers first by developing a patient-centered benefit design, which standardizes what our health plans offer to provide comparable set of designs that are all geared around promoting ways for consumers to get the right care at the right time. By working with health plans, clinicians, consumer advocates and others to both design and continually update these plans, California has made it far easier for consumers to compare plans both inside Covered California and in the broader individual and small group markets, without having to navigate incomprehensible variations in designs.

The plans are specifically designed to reduce the number of services that are subject to a deductible, thus increasing a consumer's access to care. For example, every outpatient service in our Silver, Gold and Platinum plans can be accessed without being subject to the consumer's deductible. That includes primary care visits, specialist visits, lab tests, X-rays and imaging. Some of our enhanced, subsidized Silver plans have little or no deductible and very low co-pays, such as a $3 office visit. Even our most affordable plans in the Bronze tier promote care, allows consumers to see their doctor or a specialist three times before being subject to the deductible. With all of the discussion about "high deductibles" — Covered California has sought to turn the attention to look beyond just the size of the deductible, but also to what is or is not subject to the deductible.

By offering standardized products, Covered California is providing consumers better options, even if these options are fewer in number. Looking across the nation, in most areas health plans have decided to offer four different "silver products" and about one-third of the silver products offered nationally in 2016 require consumers to meet their deductible prior to having any doctor visit fully covered. Many of those products with the cheapest premiums mean you do not get any coverage unless you have satisfied a deductible of several thousand dollars. We believe that is a recipe for promoting a bad

risk mix — since many consumers will not see the value of their health insurance and will be more likely to drop coverage.

Other ways Covered Californian seeks to be both innovative and patient-centered can be seen in our coverage of specialty drugs. We are the first health exchange in the country to institute a specialty drug cap to partially protect our enrollees from these rising costs. We wanted to make sure that our consumers have access to the medications they need, including those used to treat HIV, AIDS, Diabetes and Hepatitis C. The vast majority of Covered California consumers have had their specialty drugs capped at $250 per month, per prescription. Overall, the caps will range from $150 to $500, and because of Covered California's patient-centered benefit design, they must be offered by every health plan in the individual market, and in all plans offered by the exchange.

All of these benefits are designed to bring health care within reach and to make sure that a Covered California plan is not just an insurance card, but something that opens the door to health care and helps consumers get the services they need and deserve.

By requiring all carriers to have patient-centered benefit designs for each metal tier, carriers are required to compete with one another based on premium, network, quality, and consumer tools and service. For 2017, the Federally Facilitated Marketplace is encouraging plans it offers to provide at least one common patient-centered design for their consumers. This will help consumers more easily compare plans to make it easier for them to see what services are subject to a deductible and which ones are not.

Getting benefit designs right, however, is not just an issue for state and federal marketplaces and its significance goes beyond "just" encouraging consumers to get care when they need it. Earlier this year I co-authored an article with Dr. Elliott Fisher from Dartmouth College, where we urged state-based marketplaces, the employer-sponsored insurance market and health insurance companies to take action and move towards these patient-centered plan designs as needed complements to payment changes, seeking to promote better care coordination and effective primary care.

Covered California's competitive marketplace and patient-centered design model helped it receive the highest overall grade from the National Health Council in its "State Progress Reports" which examined which exchanges were "beneficial for patients." The report stated Covered California:

> *"Has led other states in its efforts to improve the comparability of exchange plans. Key protections in the state include the standardized benefit designs across all metal levels, including the cost-sharing reduction versions of Silver*

*plans that are available to people with limited income. The state does not allow any non-standard plans in the exchange, which is unique among states with standardized plans. These requirements mean that all people enrolled in the same metal level plan in the state encounter the same cost sharing for the same benefits; in effect, it levels the playing field."*[11]

- *Expanded Medicaid*

California expanded its version of Medicaid, known as Medi-Cal. This critical decision opened the door to no-cost or low-cost health insurance for millions of low-income Californians.

- *Unified Risk Pool*

Covered California also made the tough decision to eliminate transition plans in our first year. While this move was unpopular in some circles, it was the right thing to do for the majority of our consumers because it unified our pool of consumers and gave our carriers more certainty as we embarked on this new era.

Taken all together, Covered California has created a cycle of sustainability by building a competitive market where consumers have a wide choice of carriers with plans that promote care by removing financial barriers and benefits that attract consumers.

**Covered California is Working and Building a Competitive Market**

Since we opened our doors in January of 2014 more than 2.5 million people have signed up for health care coverage through Covered California. These are people who either had no health insurance previously because they could not afford the coverage or were refused coverage because of a pre-existing condition, or they may have found themselves without coverage because of a change in their jobs or life conditions.

The latest data from the Centers for Disease Control and Prevention shows that since Covered California began offering coverage in 2014, the uninsured rate in the state for all ages has been cut by more than half, from 17 percent at the end of 2013 to 8.1 percent by the end of 2015. This 52 percent drop puts California's uninsured rate at the lowest level on record.

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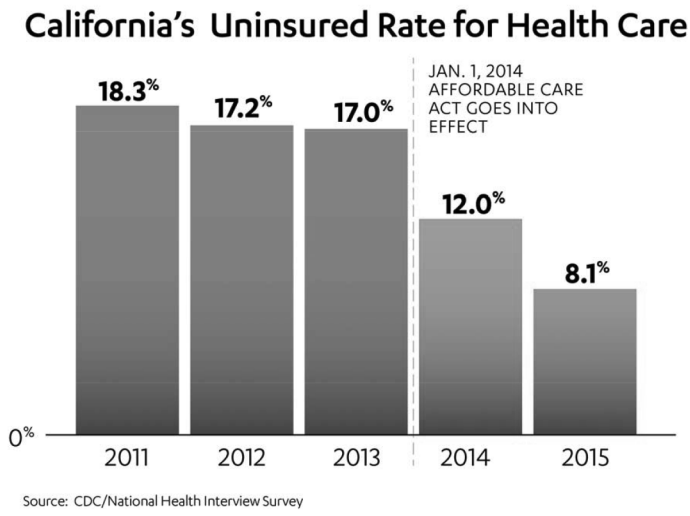
[11] National Health Council - http://www.nationalhealthcouncil.org/sites/default/files/Enhancing-State-Health-Insurance-Markets.pdf




**Covered California Continues to Enroll a Healthy and Diverse Mix of Consumers**

Covered California's success is firmly rooted in the hundreds of thousands of consumers we have helped obtain quality and affordable health care coverage, who have enrolled because they understand the benefits of their coverage, who get tax credits that bring health care within reach and are the product of a broad multi-faceted marketing, outreach and education campaigns across California. As of May 2016, Covered California had 1.4 million consumers actively enrolled in a plan participating in our health exchange.

The mix of consumers we have continues to be young, healthy and diverse. During our third open-enrollment period (OE3), from Nov. 1, 2015 to Jan. 31, 2016, more than 439,000 people signed up for coverage and Covered California saw strong enrollment in many key demographics, particularly among Latinos, African-Americans and Asian/Pacific Islander consumers.

The breakdown below shows how Covered California hit nearly all of the marks estimated by the University of California's statistical model (CalSIM 1.91) of California's subsidy-eligible population.

| | Open Enrollment 3 | CalSIM 1.91 |
|---|---|---|
| Latino | 36% | 38% |
| Caucasian | 34% | 34% |
| Asian/Pacific Islander | 20% | 21% |
| African-American | 4% | 5% |

Covered California's enrollees also got younger during our third open-enrollment period. The percentage of consumers between the ages of 18 and 34 who signed up for coverage was 29 percent during our first open enrollment period, 34 percent in our second open-enrollment period and 38 percent during our most recent open-enrollment period.

Even more importantly, a new CMS report showed that California had the lowest average risk liability score in the country, 19 percent lower than the national average, which means Covered California's enrollees are among our nation's healthiest. [12]

This healthy risk mix is an essential key to helping keep rate changes moderate. As we noted previously, data on California's healthy risk mix played a significant role in helping Covered California negotiate the best premium rates for its consumers and save a total of more than $300 million dollars in premiums over the past two years.

The healthy risk mix is not an accident. The risk mix and its impact on rates for all Californians is the product of Covered California making significant investments in marketing, outreach, consumer enrollment experiences and customer service over the past four years. We are just now starting our 2016-17 fiscal year which will be the first in which we will not be spending any of the federal establishment funds that were so important to our launch. This coming year, we have a $320 million budget, which includes almost $100 million for marketing and outreach, with additional substantial investments in improving our customer service and our website.

Covered California will continue to conduct extensive marketing, in multiple languages, in all corners of our state, on television, radio, print, and digital platforms to effectively reach potential consumers and support the retention of those consumers. This includes

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[12] Centers for Medicare and Medicaid Services - https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/index.html

conveying the value of coverage, supporting informed choice, enrollment and education, as well as working with the agent community and consumer groups to promote enrollment and helping consumers use their care once they get covered.

For this year, we will fund our budget from our assessment on health plans and spending a portion of the over $278 million reserve we have built up since 2014. In our next fiscal year, we project to be break-even and to continue operating with a prudent surplus and a strong balance sheet.

Our assessment on health plans is based on 4 percent of premium for “on-exchange enrollment,” which because of the large off-exchange enrollment in our products — at the exact same price — means that the actual increase to premiums is about 2 percent. Based on work done by Price Waterhouse Coopers, we estimate that compared to the cost of acquiring individuals prior to the Affordable Care Act, Covered California has been part of reducing the “load” on premium from about 7.8 percent to about 5.8 percent — a reduction of 2 percent. But as important as this reduction is, even more important is the need to make continued ongoing investments to assure enrollment.

Covered California has surveyed consumers who have left the exchange and the vast majority transitioned to another source of coverage — with the biggest portion moving to employer-based coverage. Our marketplace, along with the federal and other state-based marketplaces, is serving as the glue that helps make the employer-based, individual and public insurance offerings work. This reality, however, means that the need to do robust marketing and enrollment is ongoing. With about half of our enrollees turning over each year to get another form of coverage, continued efforts are critical to maintaining a healthy risk pool and providing that safe and affordable way station for millions of Americans.

**Reducing Health Care Costs by Improving the Delivery System**

While assuring a good risk mix is an imperative for any marketplace, moving forward, Covered California is also focusing with the plans it contracts with on the underlying issues driving health care premiums that are the cost and use of health care. Premiums are a reflection of what health care costs and how it is delivered.

Right now the U.S. spends more on healthcare per capita than any other nation.[13] Instead of moving forward, insurance providers are cutting back, reducing benefits and increasing the share that consumers and employees must pay.

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[13] Organisation for Economic Cooperation and Development - http://www.oecd-ilibrary.org/social-issues-migration-health/total-expenditure-on-health-per-capita-2014-1_hlthxp-cap-table-2014-1-en

The Affordable Care Act provides new tools to meaningfully change our expensive, fragmented and confusing health care system by providing new ways to make our health care system work better for everyone. Increasingly, Medicare and other purchasers are looking at actively promoting changes in how we organize and pay for care to put patients at the center of our healthcare system.

In order to improve how health care is delivered, and ensure that patients receive quality care at a good value, Covered California's Board recently approved significant new changes to its contracts with health insurers. The new contracts, which will cover the years 2017-2019, are specifically designed to achieve the "triple aim" of better quality, healthier consumers and lower costs by rewarding quality over quantity.

Specifically, the new contract includes the following initiatives:

- Plans will ensure all consumers either select or are provisionally assigned a primary care clinician within 60 days of effectuation into their plan, so they have an established source of care that can help them navigate the health care system.
- Covered California will encourage plans to promote enrollment in advanced models of primary care, including patient-centered medical homes and integrated health care models, such as Accountable Care Organizations.
- Plans will exchange data with providers so that physicians can be notified if their patients are hospitalized and can track trends and improve performance on chronic conditions, such as hypertension or diabetes.
- Plans will be required to track health disparities among all their patients receiving care, identify trends in those disparities and reduce the disparities, beginning with four major conditions: diabetes, hypertension, asthma and depression.
- Plans will develop programs to proactively identify and manage at-risk enrollees, with requirements to improve in targeted areas.
- Plans will be required to help consumers be active participants in their health care by providing tools to help consumers better understand their diagnoses and treatment options and understand their share of costs for medical services — based on the contracted costs of their plan.

Covered California is committed to working to reduce the burden on clinicians, while we align our efforts with those of other public and private purchasers to promote improvements in how care is delivered.

**Conclusion**

In closing, the Affordable Care Act is working and we at Covered California have built a sustainable and competitive marketplace. In addition to our 1.4 million consumers, approximately 900,000 Californians who do not get subsidies, benefit from the lower rates, protections and the more consumer-centric competitive marketplace that we foster.

We are seeing lives changed by the security they now have and the quality care they have received. We are also seeing lives changed by the fact that all Californians know they are no longer a pink-slip away from going without health insurance.

Thank you for having me here this morning. Our job is not done, but in California and across the nation we are seeing the building blocks being put in place that are creating competitive marketplaces and promoting fundamental changes to the health care system as we work to improve the lives of millions of people. We are grateful for your support and I look forward to answering your questions and doing whatever we can at Covered California to help implement this new era of health care in our state and across the country.


# United States House of Representatives

Before the House of Representatives
Ways & Means Committee

Peter V. Lee
Executive Director
Covered California
July 12, 2016

## The Affordable Care Act is Working

**Rate Increases for 2017 are a One-Time Adjustment**

- The end of the federal reinsurance program
- Adjustment for mispricing
- Rising trend in health care costs (such as cost of specialty drugs)
- Competition matters

Health Insurance Marketplace Premium Changes for 2015-16 in HealthCare.gov States*

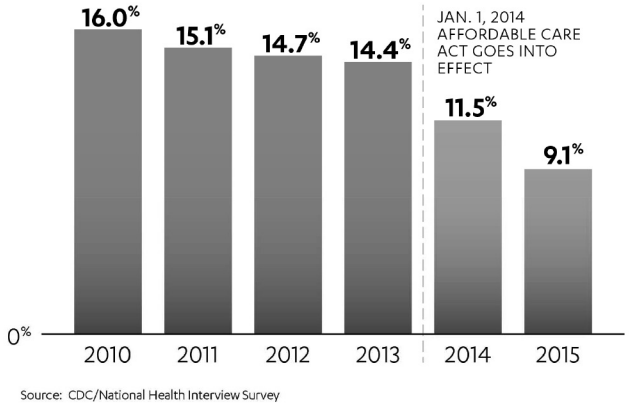
| | 2015 Avg. Monthly Premium | 2016 Avg. Monthly Premium | Increase in Average Monthly Premium | |
|---|---|---|---|---|
| **Full** monthly premium among all plan selections | $356 | $386 | $30 | 8% |
| **Net** monthly premium among plan selections with premium tax credits | $102 | $106 | $4 | 4% |

* Source: Office of the Assistant Secretary for Planning and Evaluation, U.S. Dept. of Health and Human Services

1

## Uninsured Rate at Historic Lows — Nationally

National Uninsured Rate for Health Care




Source: CDC/National Health Interview Survey

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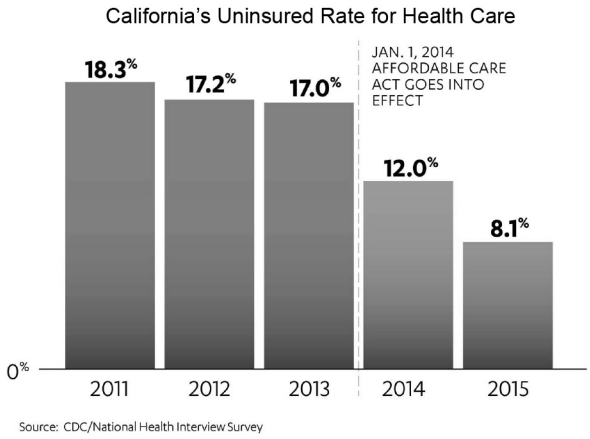
## Uninsured Rate at Historic Lows in California

Since the Affordable Care Act, uninsured rate has been cut by half




Source: CDC/National Health Interview Survey

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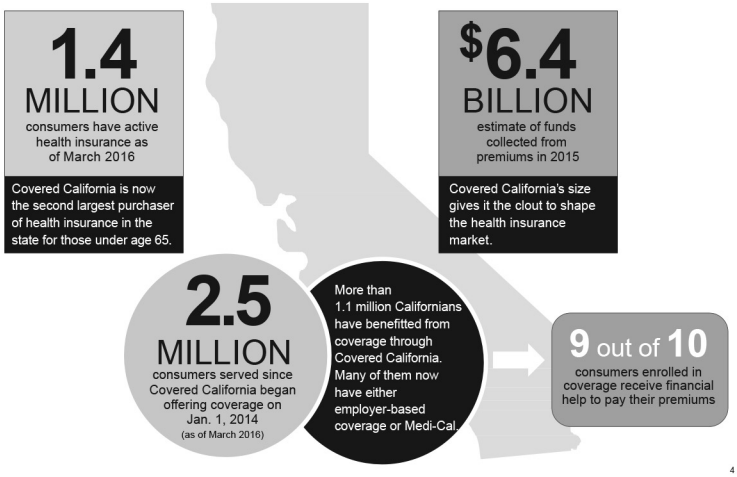
## Covered California is Big and Having Big Impacts

It is now one of the largest purchasers of health insurance in California and the nation.

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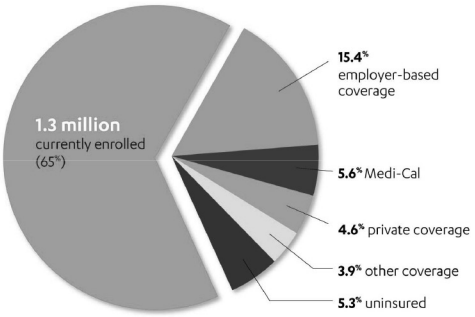
COVERED CALIFORNIA

## More Than Two and a Half Million Consumers Served

The majority of those served have continuous coverage and of those who have left Covered California, the vast majority (85 percent) continue to have health insurance.




- Prior to 2014, Covered California forecasted that about one-third of enrollees would leave coverage on an annual basis.
- In the period from January 2014 through September 2015, more than two million Californians have had coverage for some period of time with approximately 700,000 of those no longer active in June 2015.
- As of June 2015, the actual rate of disenrollment is about 33 percent.
- Based on a recently completed Covered California survey of members who left ("disenrolled"), the vast majority (85 percent) left for employer-based, Medi-Cal, Medicare, or other coverage.

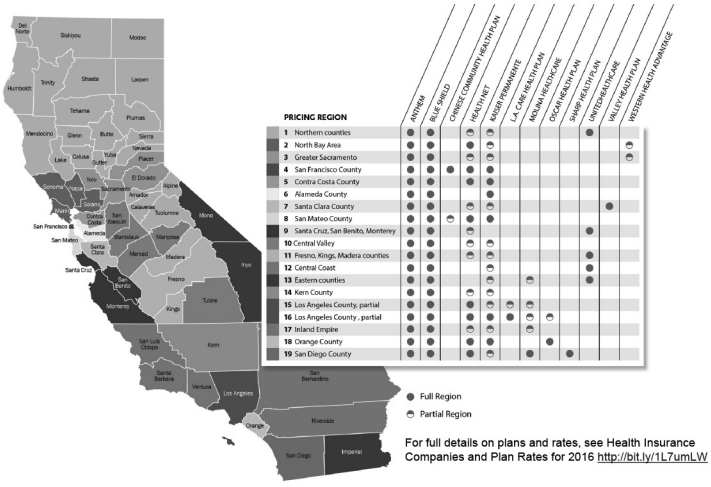
Estimated from Covered California enrollment data and 2015 member survey (n=3,373)

5

COVERED CALIFORNIA

## Covered California is Creating a Competitive Market

Broad Choice and Many Local Options



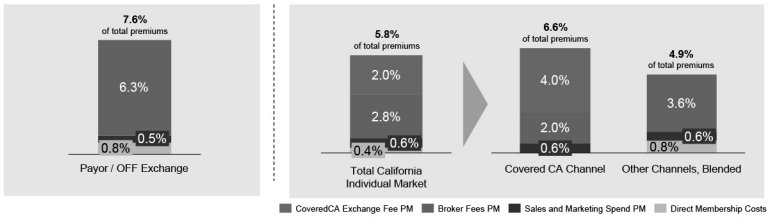

For full details on plans and rates, see Health Insurance Companies and Plan Rates for 2016 http://bit.ly/1L7umLW

6

## In California, Individual Market Acquisition Costs Have Dropped Significantly as a Percent of Total Premiums — Helping Lower Overall Premiums While Driving More Enrollment

**Pre ACA Member Acquisition (National View)**
7.6% of Total Premiums Spent on Member Acquisition

**Post ACA Member Acquisition (California View)**
5.8% of Total Premiums Spent on Member Acquisition




Sources: Kaiser Family Foundation, Covered California, Price Waterhouse Coopers analysis, June, 2016.

Note: Independent of acquisition costs, health plans have had changes to there costs that may be either reduce or increase costs – for instance, eliminating costs related to conducting medical underwriting or adding costs for data exchanges with state or federal marketplaces. Under any circumstance, in the post-Affordable Care Act period health plans total non-health related expenses are limited by the Medical Loss Ratio standards.



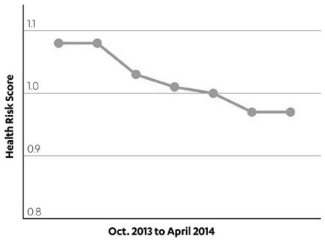
## Affective Outreach, Partnerships and Policies Create a Healthy Risk Mix that Benefits the Entire Individual Market

**Good Risk in California**

- In 2015 California had the healthiest risk mix in the nation, about 19% lower than the national average. This is the second year in a row that California had the best risk mix.
- In 2014 health insurance companies in California had consistently strong financial performance, contributing more than half of all risk corridor "excess" profits ($182 million).

**The Percent of Enrollment of 18 to 34 Year Olds Continues To Grow**

| 2014 | 2015 | 2016 |
|---|---|---|
| 29% | 34% | 38% |




Through our innovative data analysis, we were able to prove to our health insurance companies that the risk scores were decreasing over time, allowing Covered California to negotiate better prices.

Sources: Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2015 Benefit Year, and Health Services Research. "Sorting Out the Health Risk in California's State-Based Marketplace." Andrew B. Bindman, Dennis Hulett, Todd P. Gilmer, and John Bertko.

## Covered California 2016 Patient-Centered Benefit Designs

In California, patient-centered benefit designs allow apples-to-apples plan comparisons and seek to **encourage** utilization of the right care at the right time with many services that are not subject to a deductible. ***Benefits below shown in blue are not subject to a deductible.***

**MEDICAL COST SHARES BY METAL TIER**

| Coverage Category | Bronze | Silver | Gold | Platinum |
|---|---|---|---|---|
| | Covers **60%** average annual cost | Covers **70%** average annual cost | Covers **80%** average annual cost | Covers **90%** average annual cost |
| Annual Wellness Exam | $0 | $0 | $0 | $0 |
| Primary Care Visit | $70* | $45 | $35 | $20 |
| Specialty Care Visit | $90* | $70 | $55 | $40 |
| Urgent Care Visit | $120* | $90 | $60 | $40 |
| Emergency Room Facility | Full cost until out-of-pocket maximum is met | $250 once medical deductible is met | $250 | $150 |
| Laboratory Tests | $40 | $35 | $35 | $20 |
| X-Ray and Diagnostics | Full cost until out-of-pocket maximum is met | $65 | $50 | $40 |
| Deductible | Individual: $6,000 medical $500 drug<br>Family: $12,000 medical $1,000 drug | Individual: $2,250 medical $250 drug<br>Family: $4,500 medical $500 drug | N/A | N/A |
| Annual Out-of-Pocket Maximum | $6,500 individual and $13,000 family | $6,250 individual and $12,500 family | $6,220 individual and $12,400 family | $4,000 individual and $8,000 family |

***Benefits shown in blue are not subject to a deductible.***

**Copay is for any combination of the first three visits. After three visits, they will be at full cost until the out-of-pocket maximum is met.*

**DRUG COST SHARES — 30 DAY SUPPLY**

| | | | | |
|---|---|---|---|---|
| Generic Drugs (Tier 1) | up to $500, after deductible is met | $15 or less | $15 or less | $5 or less |
| Preferred Drugs (Tier 2) | up to $500, after deductible is met | $50 after drug deductible | $50 or less | $15 or less |
| Non-preferred Drugs (Tier 3) | up to $500, after deductible is met | $70 after drug deductible | $70 or less | $25 or less |
| Specialty Drugs (Tier 4) | up to $500, after deductible is met | 20% up to $250 after drug deductible | 20% up to $250 | 10% up to $250 |

**MEDICAL COST SHARES BY INCOME**

| Coverage Category | Enhanced Silver 94 | Enhanced Silver 87 | Enhanced Silver 73 |
|---|---|---|---|
| Eligibility Based on Income and Premium Assistance | Covers **94%** average annual cost | Covers **87%** average annual cost | Covers **73%** average annual cost |
| Single Income Ranges | up to $17,655 (≤150% FPL) | $17,656 to $23,450 (>150% to ≤200% FPL) | $23,451 to $29,425 (>200% to ≤250% FPL) |
| Annual Wellness Exam | $0 | $0 | $0 |
| Primary Care Visit | $5 | $15 | $40 |
| Specialist Visit | $8 | $25 | $55 |
| Urgent Care Visit | $6 | $30 | $80 |
| Laboratory Tests | $8 | $15 | $35 |
| X-Rays and Diagnostics | $8 | $25 | $50 |
| Imaging | $50 | $100 | $250 |
| Deductible | Individual: $75 medical<br>Family: $150 medical | Individual: $350 medical $50 drug<br>Family: $1,100 medical $100 drug | Ind.: $1,900 medical $250 drug<br>Family: $3,800 medical $500 drug |
| Annual Out-of-Pocket Maximum | $2,250 individual and $4,500 family | $2,250 individual and $4,500 family | $5,450 individual and $10,900 family |

**DRUG COST SHARES — 30 DAY SUPPLY**

| | | | |
|---|---|---|---|
| Generic Drugs (Tier 1) | $3 or less | $5 or less | $15 or less |
| Preferred Drugs (Tier 2) | $10 or less | $20 after drug deductible | $45 after drug deductible |
| Non-preferred Drugs (Tier 3) | $15 or less | $35 after drug deductible | $70 after drug deductible |
| Specialty Drugs (Tier 4) | 10% up to $150 | 15% up to $150 after drug deductible | 20% up to $250 after drug deductible |

***Benefits shown in blue are not subject to any deductible.***

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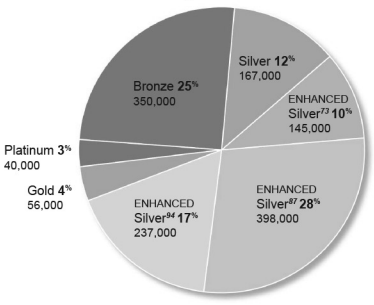
## Covered California Enrollees Able to Choose Both Low Premium and Low Out-of-Pocket Designs

More than 68 percent of Covered California subsidy-eligible enrollees selected a Silver plan, which have NO deductibles for any out-patient services and 56 percent of all subsidy-eligible enrollees qualified for an "Enhanced Silver" plan, which means even lower out-of-pocket costs when accessing services.

**2016 Subsidized Enrollment**
by Metal Tier




*A few notes on monthly premium costs:*

73 percent pay less than $150 per month per individual.

More than 192,000 enrollees pay less than $25 per month per individual.

For consumers enrolled in an Enhanced Silver 94 plan, more than half pay less than $50.

*In addition, these individuals pay only $3 for doctor visits.*

Covered California's Patient-Centered Benefit Design:

- Bronze — three office visits and lab work, not subject to deductible.
- Silver, Gold, Platinum — no deductibles on **any** outpatient services.

Source: Covered California enrollment data as of April 1, 2016, including only subsidized enrollees who have paid for coverage.

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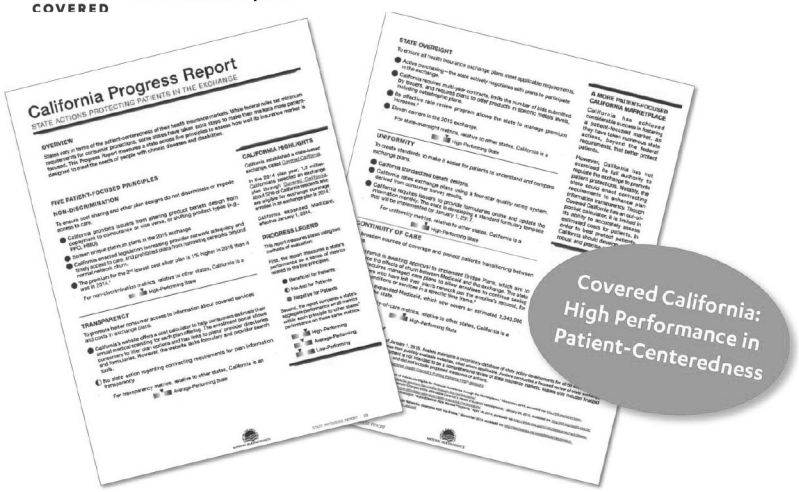
## Enhancing the Patient Centeredness of State Health Insurance Markets — State Progress Reports

Health Council, July 2015




**Link to full Report:** http://www.nationalhealthcouncil.org/sites/default/files/Enhancing-State-Health-Insurance-Markets.pdf

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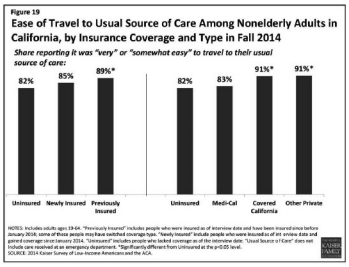
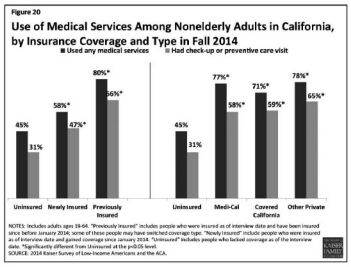
## Health Care Access is Improving Dramatically for both Covered California and Medi-Cal Enrollees

A Kaiser Family Foundation independent survey of consumer released in May 2015 reported on services through the Fall of 2014.

- **91 percent** of Covered California enrollees reported it was "very" or "somewhat easy" to travel to their usual source of care, which matches the Other Private markets (Figure 19).
- **59 percent** of Covered California enrollees had a check-up or preventive care visit by the Fall of 2014, which is nearly twice the rate for preventive visits amongst the uninsured (Figure 20). This is not significantly statistically different from other private market, and if extrapolated over time, this means more than 800,000 preventive visits have been provided through Covered California since Jan. 2014.




Source: Henry J. Kaiser Family Foundation. 2015. "Coverage Expansions and the Remaining Uninsured: A Look at California During Year One of ACA Implementation". Menlo Park, CA.

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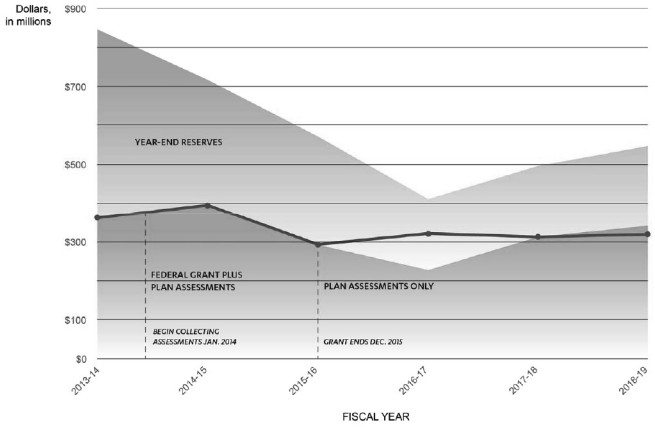
## Covered California's Strong Balance Sheet and Financial Management Assures Long-Term Viability

Covered California has a business model that guarantees ongoing support. For fiscal year 2016-17, Covered California's budget includes $320.9 million and unrestricted reserves of more than $278 million.

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## Promoting Affordability Over the Long Term — Covered California is Pushing Improvements in the Delivery of Care

Covered California contract requirements to promote the triple aim of improving health, delivering better care and lowering costs for all Californians include:

**Promoting innovative ways for patients to receive coordinated care, as well as have immediate access to primary care clinicians**

- All Covered California enrollees (HMO and PPO) must have a primary care clinician.
- Plans must promote enrollment in patient-centered medical homes and in integrated healthcare models/Accountable Care Organizations.

**Reducing health disparities and promoting health equity**

- Plans must "track, trend and improve" care across racial/ethnic populations and gender with a specific focus on diabetes, asthma, hypertension and depression.

**Changing payment to move from volume to value**

- Plans must adopt and expand payment strategies that make a business case for physicians and hospitals.

**Assuring high-quality contracted networks**

- Covered California requires plans to select networks on cost and quality and in future years, will require exclusion of "high cost" and "low quality" outliers — allowing health insurance companies to keep outlier providers, but detailing plans for improvement.

Note: for detailed information about improvements in the delivery of care, Covered California requires health insurance companies to abide by Attachment 7 of the model contract. To view Attachment 7, go to http://hbex.coveredca.com/stakeholders/plan-management/

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Chairman BRADY. Thank you all for your excellent testimony. We will now proceed to the question and answer session, and I will begin.

I know it is sort of common to just claim Republicans are fighting against Obamacare, but in our view, we are fighting for patients and local businesses who have been hurt by this law. I have a constituent in Huntsville who purchased coverage for his family on the Federal exchange. He wrote to me: My health insurance costs $989 a month. That is almost a 1,000 percent increase in healthcare costs. So much for being affordable, but what can we do?

Another constituent from the Woodlands where I live writes: The second year in a row, BlueCross/BlueShield is canceling my policy. Further, for 2016, no insurance carrier in Texas is offering individual PPO policies. So much for choice. My insurance premiums for the closest of coverage to what I have now, going up $200 a month after going up $900 a month in 2015. So much for insurance rates going down. So much for more choice.

Now, look, many of my constituents are worse off now than they were before this law was passed. Certainly those who like their healthcare plan, many of them couldn't keep to them at all. Mr. White, some of the work your organizations have been done, I think it is worth highlighting, when the ACA was being debated, we were told by CBO that over 20 million people would want to enroll in the individual exchanges. That has not proven to be true at all. It is less than half of that number who actually enrolled.

We also were told young healthy people are signing up at much lower levels than expected. As you pointed out, only 37 percent of people, of those who enrolled, were under the age of 34.

So why are so few people enrolling in these plans? And in New York, one out of five that could get help in those exchanges are in the exchange, one out of five are in there.

Mr. WHITE. I believe it is a combination of factors, but we believe the primary factor is cost. These are just not producing the value for people in ways that they want to sign up for these plans. They are very high deductibles, very high cost-sharing amounts, and coupled with the premium, I mean, in your example, the $900 a month, that individual is spending more than $10,000, right, a year on the premium, probably with a significant deductible. Some of what we are seeing in the marketplace is 5, 6, 7, $10,000 deductibles. So if you are paying $10,000 on the premium and a $10,000 deductibles, you wonder does that actually make sense, or would I just pay the individual mandate tax penalty and self-insure us, in effect.

Chairman BRADY. Yeah. Thank you. Mr. Condeluci, do you think—are you surprised enrollment was so much lower than predicted? Do you see any change?

Mr. CONDELUCI. I think there are two reasons for the lower than anticipated enrollment. One is the transitional policy that I cited, as Mr. Lee spoke about. In short, the transitional policy allowed not only individuals in the individual market but employees of small employers to stay on nonACA compliant plans.

So while the Congressional Budget Office, for example, expected a number of smaller employers to drop coverage, those small employers did not drop coverage and send their individuals to the in-

dividual market exchange market due to the fact that they could stay on their nonACA compliant plan.

Now, not every State has adopted this transitional policy, but for my count, there are about 35 to 40 States that have indeed adopted a transitional policy both in the individual market as well as the small group market. So I think that is one of the reasons why you are not seeing as much enrollment.

The other is, we touched on it, I spoke about it in my testimony, is the younger and healthier folks are not finding insurance appealing, and the minimum insurance standards and the adjusted community rating rules, while consumer protections that were arguably needed in the marketplace are carrying with them higher costs. It is just the nature of how it works. If you have a health plan that is covering more benefits for medical services, that is going to become more expensive. So the carriers, in an effort to try to develop premium rates that are reasonable, had to increase the cost sharing, so shift more costs onto the policyholder, as well as narrow the networks by pushing out some of the providers or reducing the provider payments for those doctors and hospitals that are in that network. And those actions are making insurance unattractive, in addition to the cost increases that you might see.

The last point is, I do recognize that the premium subsidy for those folks who are subsidy eligible, between 100 percent of the Federal poverty level and 400 percent of the poverty level, do get a premium subsidy if they are purchasing an individual market plan through an exchange, and that does blunt much of the premium increases.

But younger folks are still paying a percentage of income out of their own pocket for a policy. That is what the statute requires, and that also is not enough to convince a younger, healthier individual to purchase a plan when you are balancing that or balancing that up against a fairly low individual mandate penalty tax.

Chairman BRADY. Thank you. Mr. Harte, you looked at trends with your real world people that you are trying to cover in their plans. So do you see anything changing? I mean, do you see costs continuing to increase? Do you see networks continuing to narrow going forward?

Mr. HARTE. Even if we just looked at medical trend and just said that premium increases were a direct correlation to medical trend at 8 percent, that means that health insurance premiums will double in about 7—I am sorry, 9 years. That is unacceptable. So I have always preached from the choir. I have talked so much about it. Health insurance is expensive because health care is expensive.

Now, within the ACA, medical loss ratio is built in there, and it was a safeguard from insurance companies, from taking and collecting too much in premium and not paying enough out in health care. So when I talk to folks all over the country, I say, well, why don't we start focussing in on, as ACA determined, the 80 to 85 percent of premium dollars that go to pay for health care.

So when I talk about transparency or when I talk about wellness initiatives and other ways to reduce the cost of health care, that is the real solutions for us to start considering in having a long-term impact on employer solutions.

So in answer to your question, Chairman Brady, I don't see any light at the end of the tunnel based upon current regulations, current legislation, current environments, and on all the issues that this panel has talked about today with losing carriers and increased premiums, I, myself, see my clients continue to be faced with double-digit rate increases for the next 5 years.

Chairman BRADY. Yeah. Well, we were promised that families would have lower premiums by $2,500 a year. I haven't found one family in my district do that. When medical trend costs are 8 percent but some States are facing 50 percent increases in premiums, there is a deeper problem here, in my view.

So I now recognize the distinguished Ranking Member from Michigan, Mr. Levin, for your questions.

Mr. LEVIN. Now, Mr. Chairman, remember that 85 percent of the people in the marketplace are receiving some assistance to obtain health care. So for them, their premiums are lower than it otherwise would be.

Mr. Condeluci, you are shaking your head yes. I mean, look at the whole picture. Look at the whole picture. You don't want to do that, including in Texas. And you said the number of people in the marketplace is less than expected. There were various estimates. But how many people are in the marketplace who otherwise would not be? We are talking about what, 10 million? And the majority sat here for years in the majority and never did anything at all to address the disgraceful fact in this country, 50 million people going to sleep every night without any healthcare coverage in terms of insurance.

And how much were premiums going up before ACA, Mr. Harte? How much were they going up annually, before ACA?

Mr. HARTE. Before ACA, double digits every year.

Mr. LEVIN. Okay. So you just do that over your 5-year period. So you had premium increases before ACA, double digit, they were something like 14, 15 percent a year on average, right?

Mr. HARTE. Yeah.

Mr. LEVIN. And yet the Republican majority sat here doing nothing. So let's, Mr. Lee, talk a bit about the risk pool issue, because we all knew it was a factor, and in fact, when we had whatever you want to call it, the penalty or the provision, there was debate as to where it would set to try to stimulate people to be covered.

We also should remember, in terms of younger people, how many people are now covered through their parents' insurance who were not covered before. Anybody know, on the panel, the number of people covered as a result of that? Mr. Lee.

Mr. LEE. I believe about 2-and-a-half million? Under 26-year-olds are on their parents' policies.

Mr. LEVIN. So Mr. Lee, you want to comment on this issue in terms of the risk pool and others, because my guess is, at least in terms of some of you, you might be willing to sit down and discuss how we make ACA work even better. I am not sure how much you are part and parcel reel of this repeal or rip up ACA effort by the majority here. So let's talk for just a minute. I have just under 2 minutes.

Mr. Lee, how do we address the issue of more and more younger people coming in? There has been some discussion, eliminate the minimum standards. I don't think you want to do that entirely. Right, Mr. Condeluci, you don't want to do that?

Mr. CONDELUCI. Yes, sir. I am not suggesting that you eliminate the minimum insurance standards, but from at least my perspective, my opinion, of course, those minimum standards are a bit constraining. The essential health benefits, for example, and the actuary value requirement, which is tied to the essential health benefits, essentially require plans to cover benefits and services that many policyholders don't want or need, depending on the type of individual, but those individuals still have to pay for those services.

Mr. LEVIN. Okay. So as we continue to improve ACA, we will discuss that. Mr. Lee, you want to comment?

Mr. LEE. Yeah, a couple of things. One is it is really important for, in the marketplace, where we are providing subsidies, as you know, to California, about 90 percent of the people that enroll, it is about affordability, and we are still new in this venture of educating and doing outreach.

We spend, in California $100,000,000 to do marketing and outreach. We are selling insurance. Because even with the subsidy, people are making a choice to use some of their hard-earned dollars to buy insurance.

And the issue about the penalty has come up, but I want to be clear. We have done a lot of market testing, surveying, the big issue is can people afford it on a day-to-day basis, and the penalty is part of the equation, but I think the issue about affordability is critical, the issue about doing effective marketing and outreach is vital.

In California, last year, 38 percent of our enrollment was in that targeted age range. It takes time to change from a culture of people just coping and thinking they cannot get coverage to having a culture of coverage, and that is what we are moving into, and it is going to take ongoing effort.

Mr. LEVIN. Thank you.

Chairman BRADY. Thank you. All time is expired.

Mr. Johnson, you are recognized.

Mr. JOHNSON. Thank you, Mr. Chairman. You know, thanks to Obamacare, my constituents are facing rapidly rising health insurance premiums, as well as, problems accessing care.

Earlier this year, NBC 5 in Dallas ran a story about a Plano couple by the name of Cris and William Lyle who bought health insurance through healthcare.gov. Their plan cost $435 a month, but here is the thing. The Lyles had a problem finding a doctor according—and that is happening again today. According to the news piece, they reached out to about 20 doctors, but not one of these docs took their insurance. Ultimately they were able to find a doctor, and they were also concerned about finding a specialist.

Mr. Condeluci and Mr. White, the Lyle story is becoming all too common as health insurers are narrowing their networks in an attempt to keep costs down. In fact, a recent study found that over half the plans on the exchanges were narrow network plans like HMOs.

So first with you, Mr. Condeluci, doesn't that make it harder for consumers, such as the Lyles, to actually see the doctors they want and get the care they need in a timely manner?

Mr. CONDELUCI. I will answer your question, sir, and say yes, generally speaking. The other kind of caveat to that is, you know, some folks don't mind, let's say, handcuffing themselves to a particular provider or a particular health system. So in that case, maybe that consumer is okay with having a narrow network which does carry with it lower cost. But there are other policyholders, and as we all know, everyone has different needs, different desires, different aversion to risk, and those individuals might not want to handcuff themselves to just that particular health system or healthcare provider, and that limits the choice for that particular individual, which then, I would argue, makes insurance unappealing. If you add the added cost, as we have discussed, and just as a followup to Mr. Levin's question, with these minimum standards, again, they carry with it increased cost.

There are new premium rating rules that actually increase cost for younger healthier individuals. It is those type of new minimum standards, while very good consumer protections, are a bit constraining that if they were loosened up, could allow an insurance carrier to let's say offer more broad networks at a reasonable price point as opposed to being forced into the position to narrowing that network in order to lower cost to offer it to consumers.

Mr. JOHNSON. Mr. White, do you agree with that?

Mr. WHITE. I do agree with that. I think this is a logical response to the constraints of the law. The Affordable Care Act basically says you have got to cover all these benefits, you have got to offer it within these metal tiers, and you can't use the premium rating tools that you would normally use pre-ACA. And so there are only a few places that the insurers could go to compete based on a premium price point, and that was largely on a cost-sharing side and then on the narrow network side.

And so they tried to use those tools to negotiate rates through the narrow networks, and that was an important tactic, I think, early on in the ACA.

What we are seeing now is fewer PPOs on the exchanges, so there are more narrow networks definitely emerging, and then off exchange, we are seeing a lot more broader networks, a lot more access to specialists and other types of providers.

So this is a logical response to the law. It is unfortunate, but you know, we believe it can be addressed through additional flexibility on the exchanges.

Mr. JOHNSON. Is it true, in your opinion, that some people may only have access to one insurer or access to a plan with limited networks?

Mr. WHITE. Yes, sir. What we are expecting, according to a Kaiser analysis, is about 650 counties, maybe more, with only one plan. One plan is not a choice of plans, and so that is very concerning. As competition decreases, we see premium rates increase.

Mr. JOHNSON. Is that getting better or worse?

Mr. WHITE. Excuse me, sir?

Mr. JOHNSON. Is it getting better or worse?

Mr. WHITE. That is a worsening development. We are seeing these counties with one plans emerge, largely in rural areas, and is not good for consumers. It is not good for competition. It is its not good ultimately for costs for subsidies, and for the U.S. Treasury.

Mr. JOHNSON. Thank you, sir.

Chairman BRADY. Thank you. Mr. Rangel, you are recognized.

Mr. RANGEL. Thank you so much, Mr. Chairman, and thank you for calling this hearing.

I was wondering why we were having this, but then I recognize we are about to have our national conventions, and so I assume this is to sharpen up our skills for the convention.

First of all, if there is a problem with the Affordable Care Act as it relates to premiums, it would just seem to me, it would make a lot of sense to have the administration here to explain why we have this problem, but since you saw to select three witnesses that are not a part of the administration, let's find out who they are.

Now, Mr. White, you used to work for the leadership in the Senate, the Republican leadership doing what? Mr. White, did you work for the House, the Senate or——

Mr. WHITE. I worked for this committee for 6 years, sir.

Mr. RANGEL. Under whose—what committee?

Mr. WHITE. The Ways and Means Committee.

Mr. RANGEL. Who was the chairman?

Mr. WHITE. Chairman Bill Thomas, from 2001 to 2007.

Mr. RANGEL. Okay. Now, what did you do before you came to work for the Ways and Means Committee?

Mr. WHITE. Before that, I worked for 2 years with Congressman Jim Greenwood from Pennsylvania, and before that, I worked for Congressman Chris Shays for 4 years from Connecticut.

Mr. RANGEL. All Republicans, right?

Mr. WHITE. All Republicans, correct.

Mr. RANGEL. Okay. Now, you are in charge of a—president and counsel for Affordable Health Coverage?

Mr. WHITE. Yes, sir.

Mr. RANGEL. Is that a for-profit organization?

Mr. WHITE. It is a nonprofit 501(c)(6).

Mr. RANGEL. And how long did it take before you left the Congress that you head up this organization?

Mr. WHITE. I left in January of 2007, and I became president of CAHC in December of 2008, so that was——

Mr. RANGEL. So it wasn't you went from the Congress to this organization.

Mr. WHITE. Right.

Mr. RANGEL. Now, Mr. Condeluci, is your outfit a for-profit or not-for-profit?

Mr. CONDELUCI. I run my own practice, sir, which is a for-profit legal and policy practice.

Mr. RANGEL. What did you do before you ran this outfit?

Mr. CONDELUCI. Prior to that, I was an attorney with a law firm, and prior to that, I was counsel to the Senate Finance Committee. Prior to that——

Mr. RANGEL. How long were you with the Senate Finance Committee?

Mr. CONDELUCI. April of 2007 to September of 2010.

Mr. RANGEL. Who was the chairman?

Mr. CONDELUCI. Chairman Baucus was—or Max Baucus was the chairman at the time. I was on the Republican professional staff, and at the time, Senator Grassley was the Ranking Member.

Mr. RANGEL. So okay. You worked for Republicans. How long was it before you left the Congress that you joined the PLLC in Washington?

Mr. CONDELUCI. When I left the committee in September 2010, I went back to the law firm to practice law.

Mr. RANGEL. How long was it before you went from the time I am talking about leaving the Congress and——

Mr. CONDELUCI. I started my CC Law & Policy practice in——

Mr. RANGEL. How long was it?

Mr. CONDELUCI [continuing]. September of 2014, so 6 years.

Mr. RANGEL. Thank you. Mr. Harte, you were president of some National Association of Health Underwriters.

Mr. HARTE. That is correct.

Mr. RANGEL. Is that insurance agents?

Mr. HARTE. Yes.

Mr. RANGEL. Brokers?

Mr. HARTE. Yes.

Mr. RANGEL. So you represent the insurance business, right?

Mr. HARTE. We like to say that we represent the American consumer for health insurance, but our membership is predominantly agents, brokers, and consultants who represent corporations.

Mr. RANGEL. But you were lauded for what you were doing for the brokers and insurance company when you got elected, right? I mean, for——

Mr. HARTE. I believe I received recognition for addressing the escalating cost of health care. That is what I am known for is dealing with health insurance premiums.

Mr. RANGEL. Well, anyway, with all due respect to you gentlemen, I really don't see how we can get to the core of the problem we face as a Congress and as a Nation.

Mr. Chairman, it would seem to me that these are qualified people respecting their constituency, but our constituency are not insurance agencies, they are not employers, it is the people that are trying to gain access to health care. If for any reason we find higher premiums than we expected, I really don't expect these gentlemen to have the answers to the problems.

The answer has to be with who made the mistakes and how can we correct it, and it would seem to me it is done by law and not by those people that are engaged in for-profit for good reason and mature-ish reasons, efforts. So I am ready for Philadelphia, I hope you are ready for Cleveland, but I just don't see what relationship this hearing has for improving the quality of care for American citizens. Thank you. I yield back whatever balance of the time I have remaining.

Chairman BRADY. Thank you for establishing the credentials of our witnesses, and God forbid we hear from real people about real problems in health care because they are serious ones.

Mr. Tiberi, you are recognized.

Mr. TIBERI. Thank you, Mr. Chairman. And thank you for having this hearing today. You know, if I am back home watching, I can't imagine what our constituents think.

It would have taken us back to when we were the majority and then in the minority, and you all passed the Affordable Care Act, I sat down there, and we talked about those 40 to 50 million people who didn't have health care, we talked about the fact that they access the most expensive coverage by walking into an emergency room, and that the Affordable Care Act was going to help them. We also talked about, or the President talked about if you like what you have you can keep it, okay. And I sometimes get frustrated because I know in my heart that when the Affordable Care Act was passed, it was done with good intentions. I really believe that.

But I also know and have seen that a lot of Americans actually like the health care they have—they had and now don't, and we simply have a difficult time communicating with each other to recognize the challenges of what the new law created to try to help the 40 to 50 million people who didn't have health care.

The irony is, as chairman of the health subcommittee in visiting hospitals in is my district, there are still people who are accessing the emergency room as their primary care, which is the most expensive care.

We have a building boom of emergency room departments freestanding in America today, which is a whole other discussion. But I want to associate myself with the chairman's remarks because real people are experiencing problems in their health care who didn't have problems before. You have created new problems because of the health care bill, all maybe unintentionally, by the way.

Let me tell you about Mr. and Mrs. Dean Wagner of Westerville, Ohio. They worked their entire lives. They both retired, and since the Affordable Care Act has passed, they have experienced 75 percent—75 percent increase in premiums, 75 percent. Ms. Dianne Smothers in Johnstown, Ohio sacrificed higher premiums in order to keep the doctor she wanted to keep, and then she finds out that her doctor was suddenly canceled with no warning when a coop in my district, and now a majority of coops have failed, coops created by the Affordable Care Act. When that coop failed, she and her husband's out-of-pocket expenses were $16,500 more than they had ever been before the Affordable Care Act had passed. These are regular middle class folks.

Unfortunately, for the Wagners and the Smothers, they are not the only constituents that I have talked to who have contacted my office that are facing outrageous premium increases, outrageous out-of-pocket expenses like they have never experienced before, and now going to a doctor that they didn't want to go to because they can't go to the doctor they had, which they were promised over and over again.

Mr. White and Mr. Condeluci, I wanted to ask you about a specific failure of the ACA that has been reported widely now. The coop program. I was here when that was discussed, and it was a nod to the public option for some Democrats who wanted the public option. I believe 8 of the 23 that began remain, and one of those, as I said, was InHealth that failed in Ohio. 22,000 lives were covered, and these people were left devastated.

So instead what was supposed to happen with these coops was to create competition. It seems that the coops badly mispriced premiums, artificially creating a lower market, underpricing the market, and in doing so artificially, did it hold down premiums initially? Meaning, you know, there was a lot of ballyhoo about premiums didn't go up immediately. Is that because the coops provided this artificial floor?

Mr. WHITE. I will take the first shot at this, I guess.

So according to the Government Accountability Office, they did a report, they looked at the premium rates and basically said that in about half the rating areas the premium rates were substantially below market rates. So they were coming in with a below market rate. Of course, they had significant taxpayer support in establishing the coops and getting off the ground, but were trying to attract enrollment through those lower premium rates.

And I think what happened was the premium rate, the experience, cost experience, quickly outpaced the premiums that they were charging, and the vast majority of the coops, as you know, have since failed. And the insurers that remain in the markets had to pick up and cover those folks who lost their coverage through the coops. Significant problem in Ohio, Iowa, other areas, as the committee knows.

Chairman BRADY. Thank you. Dr. McDermott, you are recognized.

Mr. MCDERMOTT. Thank you, Mr. Chairman. I always love to come to these propaganda hearings before the elections, and it is obvious we are trying to hold the insurance companies harmless here. Premiums go up because of the Affordable Care Act, that is why they go up.

But I lived for 45 years with a father who was an insurance underwriter, so I know a little bit about what goes on.

Mr. MCDERMOTT. And if you look at why the premiums go up, it is either because the company misjudged and made a bad rate to charge people or the costs of the medical profession have gone up uncontrollably.

Mr. Lee, what percentage of those two things do you think is bringing the premiums up? Is it misjudgment by the insurance companies or is it that medicine is jacking up the costs?

Mr. LEE. I think it varies by locale. I think in much of the country, it is because the plans, whether co-ops or for-profit or nonprofit plans, got their risk mix wrong, and they underpriced and are now jacking it up to catch up on the real costs.

But underlying this, and we have heard this from all the witnesses, the driver of healthcare costs is the underlying cost of what it costs to deliver health care to Americans. And that is one of things I think the Affordable Care Act provides some tools for, but we need to be focusing on.

In California, we have not seen consumers whipsawed by big price changes. They have been pretty constant. But costs are still going up and we need to address those with tools of transparency and others.

Mr. MCDERMOTT. Let me take an example, because we hear a lot of examples given up here. They give these horror stories of Mr. Johnson or Mrs. Williams or whatever and her problem.

Let's take Texas. Now, if you were an insurance company in Texas and you were trying to set the rates for Texas, and you had 1,314,000 people uncovered by insurance in your market who have access to the emergency rooms, and they go in, they get sick, and they get taken care of and their costs are unpaid for by any insurance company, how does an insurance company factor in that number of people? I mean, the Governor of Texas said: I don't care about those people. I am not going to take Medicaid for them. They are floating around in Texas.

How does the insurance company take that into account?

Mr. LEE. Again, how insurance companies I believe take that into account is by what they are going to get charged by providers. And what happens with uncompensated care is hospitals or doctors make it up on the other side. So those costs for the uncompensated care is right now being paid in Texas by employers, by individuals, et cetera, where those costs are being spread.

Where you have expanded coverage, like in California and the 35 other States or more that have expanded Medicaid, is every American is benefiting by having coverage, because you aren't then having the cost shift, which it is called, of everyone, employer-based, people, individuals, picking up the costs of the uncovered, which hospitals pass that through to the health insurance companies and their rates.

Chairman BRADY. Mr. Lee, you might be confused. Dr. McDermott asked about those who would be covered by Medicaid. They aren't in the exchanges. Why would an insurer plug that in if they are covered by Medicaid?

Mr. MCDERMOTT. Reclaiming my time, Mr. Chairman.

Mr. LEE. My point is, as I was understanding the example of Texas of a million people that do not have coverage, when they show up at an ER at a hospital, they are uncompensated care, and that cost is passed on to insurance companies or employer-based coverage, et cetera.

Chairman BRADY. But you agree those who aren't covered on Medicaid are not in the exchanges, they are not factored in.

Mr. LEE. Absolutely right. Absolutely right. That is what I understood the question to be. Did I get the question wrong?

Chairman BRADY. We will give you some more time, Dr. McDermott.

Mr. MCDERMOTT. I think the chairman has really put a sharp point on it. The Governor of Texas decided he didn't want health care coverage for 1.2 million or 1,314,000 people. So they still get sick, and their costs are factored into the system, and the insurance company jacks up the prices to cover for what isn't paid for in other places.

Chairman BRADY. That is not accurate, Dr. McDermott.

Mr. MCDERMOTT. I mean, hospitals do that. They add a couple of dollars on the room rate to cover for their unaccounted costs.

Now, I have another question, though. We have in the Part D, we had risk corridors to control the costs for the drug companies or the people who were putting out the drug coverage. We had it also in the ACA. In the Part D, it is still working. In Part A they have cut it out. It seems to me that we have undermined the ACA by cutting out that money in those risk corridors.

I yield back the balance of my time.

Chairman BRADY. I just want to clarify, those who are in Medicaid are not in the exchanges, they are not factored in the insurance premiums. Now, the more than a million Texans who decided to pay the tax rather than go to a plan they don't want and can't afford, that is another story.

Mr. LEVIN. Can he answer that since you took the time?

Chairman BRADY. Sure. Are those who are covered in Medicaid factored into the insurance exchanges?

Mr. LEVIN. Of course they are factored in.

Mr. LEE. The cost of uninsured are basically borne by everyone, both in marketplaces and in employer-based coverage, because the hospitals pick up those costs and others can——

Chairman BRADY. We are not taking about employer-based. We are talking about the exchanges and the insurance premiums. They are not covered in that package? Are they reflected in the Medicaid rates?

Mr. LEE. The uninsured that have uncompensated care, hospitals, other providers, build that into their rates that are charged to people in marketplaces or in employer-based care, and that is a factor in terms of raising costs.

Chairman BRADY. You are confusing the Medicaid populations with the insurance agents.

Mr. LEVIN. No, he is not. You are the one who is confused, Mr. Chairman.

Chairman BRADY. Mr. Reichert, you are recognized.

Mr. REICHERT. Thank you, Mr. Chairman.

So let's deal in some facts. ObamaCare has proven time and time that promises made were not kept. The President promised affordability, yet the law continues to drive up premiums and deductible costs.

We need to look no further than my home State for evidence. Insurers in Washington have requested an average of 13.5 percent increase. That is for individual plans for next year, with at least one insurer requesting increases of almost 20 percent.

The President promised Americans that if they liked their plan they could keep it, if they liked their doctor they could keep their doctor. Well, that turned out not to be true.

And I was in a meeting 6 years ago, as were a lot of the Republicans, when the President was asked to come and speak to us, and he was asked the question: Can you keep your health plan? Can you keep your doctor? And he said: Well, you know, there might have been some language snuck into the bill that runs contrary to that promise. The President said that.

Premera Blue Cross and LifeWise Health Plan of Washington, a subsidiary of Premera, announced that they will completely withdraw from Washington Health Benefit Exchange in 12 counties in Washington State. The result is thousands of my constituents will lose their health plan and be forced into another whether they like it or not or they will be taxed for failing to sign up for a healthcare plan.

So my question is for Mr. White. What do you think is causing insurers to exit the market? And how do you think that will impact

the choice and access to care for constituents like mine, especially in rural communities?

Mr. WHITE. I think your experience is not unlike other State experiences in terms of the double-digit premium increases and the exit of certain insurers from the marketplace. I think the insurers are leaving the marketplaces because they are losing money. And probably the most prominent example of that is United Health Group. But there are other insurers in the marketplace who are looking at various geographic-based markets and saying: We can't afford to stay there.

Now, Congressman McDermott made the comparison to Part D and having risk corridors and risk adjustment and reinsurance, and I would note, in the Part D market, where the model is based on a competitive model, there are 800 or so plans available nationwide. In the average marketplace you have approximately a choice of about 34 plans. The ACA experience is opposite that. It is marked by fewer plan choices, plans exiting markets, and premiums that are not stable but are going up significantly.

Mr. REICHERT. So you said there were 600 counties in the country that will be down to one choice?

Mr. WHITE. According to a Kaiser Family Foundation analysis.

Mr. REICHERT. Three of those will be in the district that I represent. What is the answer to——

Mr. WHITE. Well, it raises interesting questions, right? Like the subsidy is supposed to be tied to the second-lowest-cost Silver plan under the law. And if there is only one plan, what is that second-lowest-cost option? The other thing is that having a choice of one is no real choice at all, right?

So in my opinion, flexing up the market, allowing some competition in the exchanges, and perhaps allowing consumers to take their subsidy, make it portable, and allow them to leave the ACA exchanges to buy a plan off exchange, I think Chairman Brady has called this concept like a subsidy backpack, but being able to carry that outside to really use that subsidy and that assistance off the exchange we think is a very important reform that would generate competition and hopefully encourage more insurers to get back in the market.

Mr. REICHERT. Current law doesn't allow that to happen.

Mr. WHITE. Current law does not allow the subsidy to be used off exchange. There is some flexibility——

Mr. REICHERT. I am sorry. The ACA, then, is in violation of its own law which requires that you have at least two choices. Is that what I heard you say?

Mr. WHITE. I would defer to maybe Chris or, you know, a legal opinion on that. But it creates some interesting questions, let's say, in the various marketplaces.

Mr. CONDELUCI. Sir, in the exchanges, if a carrier is participating, the statute does require the carrier to offer a Silver-level plan, as well as a Gold-level plan. So that is just a requirement that a carrier wanting to participate in the exchange has to meet.

But when it comes to other carriers being a part of that market, there is not that similar requirement. Carrier Chris might say: Hey, I am fine, I will offer a Silver and a Gold. Carrier Joel might

go: You know what? I don't want to enter the market for a myriad of reasons.

So that, I hope, is an explanation of that.

Mr. REICHERT. All right. Thank you. I yield back.

Chairman BRADY. Thank you.

Mr. Lewis, you are recognized.

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

Mr. Lee, 20 million people have been covered by the Affordable Care Act and we have a historically low number of uninsured Americans. How does reducing the number of uninsured impact premiums in the employer-sponsored insurance market?

Mr. LEE. The relationship there is that providers, in particular hospitals, will take uncompensated care and build that into the rates they charge individuals or people that have employer-based coverage. And so that raises the cost of insurance, whether it is in an individual market or in employer-based coverage. So the expansion of coverage that we have seen through both exchange coverage and through the Medicaid expansion has been a factor in lowering what premiums would have been otherwise.

Mr. LEWIS. Mr. Lee, could you tell us what is the impact of competition on insurance rates in your State, the State of California?

Mr. LEE. Yeah. We think competition is vitally important. I think everyone up here on this panel would agree with that, is that for the 90 percent of Americans that have three plans or more to choose from—and in California it is far more than 90 percent—plan competition is what drives premiums. The plans know that consumers want the lowest price plan, and they will shop for that. And that is the main driver of keeping costs down.

And so I think everything we can do to foster a competitive marketplace and to give consumers an ability to make informed decisions between plans is vital. In California, we have had both of those. We have had a vibrant competition across the vast majority of the State. And consumers know when they are choosing plan A versus plan B it is not because of some quirk on deductibles. It is because of a different network. So they know what they are buying. We think that has contributed to our good risk mix.

Mr. LEWIS. Mr. Lee, in my district, in the city of Atlanta, HIV infection rates are very concerning. From your testimony, it seemed that you have experience in reducing healthcare and insurance costs to consumers. What action or policies can make it easier for people, especially those living with HIV and AIDS, to access and afford the medication they need?

Mr. LEE. Well, I think one of the most important things the Affordable Care Act has done is change the rules of the game for insurance companies to not be about avoiding sick people, but now getting people who are sick the care they need when they need it.

Part of what we have done in California is have in our patient-centered benefit designs limits on cost of high-cost specialty drugs, which are a major concern into the drive in expense, but we want people that have to get specialty drugs to not have their copay be a barrier between them and getting those drugs.

So we both require for people with HIV a mix of drugs at lower formulary tiers, but also for the most expensive drugs, that may

cost $60,000 a year, that a consumer would only have $250 a month they would need to spend for their share of the costs.

And this is part of the balancing act we need to wrestle with as a Nation, is we need to be addressing the rising costs of pharmaceuticals, the rising cost of specialty drugs. But let's not do that in ways that don't give lifesaving drugs to consumers because of their high cost. And that is a balancing act we have struck in our patient-centered designs in California.

Mr. LEWIS. And, Mr. Lee, I for one want to thank you for all of your great and good work, and for your vision in helping to provide health care, not just for the people of California, but for the people of our Nation.

I yield back, Mr. Chairman.

Chairman BRADY. Thank you.

Dr. Boustany, you are recognized.

Mr. BOUSTANY. Thank you, Mr. Chairman.

Mr. White, I am going to step back and ask some very, very basic questions. Do you believe we have a functioning market in health care today? Is it a functional market?

Mr. WHITE. I believe there are a lot of warts in the market. It functions for some people and I think it doesn't work for a lot——

Mr. BOUSTANY. Okay. So it is a poorly functioning market.

Mr. WHITE. Poorly functioning would be the phrase I would use.

Mr. BOUSTANY. Poorly functioning market.

I noted that the President just within the last 24 hours, I believe, admitted that it is a poorly functioning market as a result of this law, ObamaCare, when he called for a renewed effort to put forth a public option and to raise subsidies. I think that is a pretty tacit admission that the market is failing. Is that correct?

Mr. WHITE. I think it highlights some of those warts. And I think other people have suggested that we need to expand cost-sharing subsidies to fill in these very large cost-sharing requirements on the exchanges. And that also is a recognition that these things are growing like crazy.

Mr. BOUSTANY. And just a moment ago you referenced the fact that we are seeing significant consolidation in the insurance marketplace, which means fewer choices, correct?

Mr. WHITE. It may mean fewer choices. It may not. So what we are seeing in the exchanges right now is there are choices of plans available in most markets. I think the average is somewhere around six or seven. It may be different in California.

So there are still choices. What I am suggesting is that there is consolidation on both the insurer side and the provider side——

Mr. BOUSTANY. Correct.

Mr. WHITE [continuing]. And that those raise trend on medical costs questions in different directions.

Mr. BOUSTANY. Exactly. And if you have a functioning market, there are certain characteristics that are required—information, transparency about provider quality, about cost, about insurance coverage. I see contraction in what is going on there as a result of fewer choices, less information. We still don't have the kind of information we need to really have a good functioning market, both on the provider side and on the insurance side.

And then information choice and control ultimately. Shouldn't the consumer decide and have the information to be able to make decisions to have a really truly functioning market?

Mr. WHITE. Yeah. I think information is the lifeblood of a functioning marketplace. We don't see those on exchanges today. In December of 2015, we did a report card on exchanges and graded the exchanges from A to F. We looked at all the State exchanges in healthcare.gov, and healthcare.gov was solidly at a C level, which hopefully they will improve next year. But they are not providing basic information on is the provider in the network, is the drug on the formulary, how much is the patient facing out of pocket for that formulary drug, is there is a smart plan sorting tool, et cetera, et cetera, et cetera.

So we need better information on the exchanges. For example, with these very high deductibles, can we say the plan is HSA qualified or not. We need better information on the providers as well. Are they high quality? Are they efficient? Can I pay lower costs if I go to provider Chris versus provider Boustany.

Mr. BOUSTANY. So the trend lines in all these areas are very disturbing, in my mind, as a physician who has been around health care for quite a long time. And if you agree that coverage, for whatever it is worth or whatever it is, is the gateway to the service, high-quality health care, and I think the focus needs to be on quality, then we have a poorly functioning market that is rapidly failing. And I think the President's admission just in the last 24 hours sort of verifies that in my mind.

We have to take substantive steps to change this. Less choice, less information, less control. This is disastrous for health care. I think it is truly pathetic. I am really upset. I am angry about what is happening to my beloved profession, medicine. And at the same time, as a patient, the husband of a patient, the father of patients, I am really worried about what this is doing.

And we are seeing the costs going up. And of course what the President is proposing is higher taxpayer liability on top of this, on type of higher premiums, higher copays, out-of-pocket expenses.

We are going in the wrong direction. This is a failure. And we better recognize it as such and take steps.

Mr. WHITE. I agree, Congressman. We have presented 13 different policy options in our testimony to you today. We want to work with both sides of the aisle to see if we can make some improvements here, because the market is not working the way it should.

Mr. BOUSTANY. Thank you. I yield back.

Chairman BRADY. Thank you.

Mr. Neal, you are recognized.

Mr. NEAL. Thank you, Mr. Chairman.

Just quickly a response to my friend, Dr. Boustany. I think there is general agreement from all the panelists here that conventional economics don't work when applied to health care. People age, people get sick, and sometimes they get sick in a catastrophic manner, and the rest of the system, in terms of implied shared risk, is what is supposed to absorb some of those costs. That is the whole notion of the ACA.

And I think that one of things that is left out conveniently in the argument is the ACA was really a compromise in the sense that you were going to try to keep the private sector alive to discipline price. That was the idea. And I think just to discuss that with the suggestion that somehow that it is a poorly functioning market, how would we have described it before the ACA? An efficiently functioning market?

I mean, the reason that we have Medicare and Medicaid is because conventional economics don't apply to health care. People simply get old and they get sicker as they get older. That is part of the challenge that we face.

But in any event, Mr. Lee, when Massachusetts implemented our State-level healthcare reform plan, or as we fondly called it those days, RomneyCare, we recognized that that consumer education and outreach were key to the success of the program. Community assistance programs made this work. It was not just getting consumers in the door, but having them find value in the insurance product and to use the healthcare system in a new, thoughtful way.

The State partnered with the Red Sox, as one example, to educate residents about the new law and to entice them into enrollment. Then the State partnered with issuers and local organizations to educate newly covered individuals about how to use coverage and access services with the new plan for insurance.

Just before you talk about how California has done this, Mr. Lee, in terms of educating its citizens, in Massachusetts it really was Governor Romney, the whole notion of the Heritage Foundation's mandate. I mean, David John's picture is at the end of that photograph. Governor Romney signs the legislation. Ted Kennedy is standing behind him. But it was the business community in Massachusetts that put the plan together with Governor Romney.

So perhaps in the 2½ minutes you have in response to my question, Mr. Lee, could you talk about what California has done to educate citizens about these opportunities?

Mr. LEE. Thank you very much. I just do need to underscore your initial comment, if I may, about the prior market failures in health care. Because before the Affordable Care Act, remember, the individual market was one where insurance companies could and did turn people away regularly. And once you were in, you couldn't shop and choose. It is absolutely an imperfect market today, but I think it is a vastly improved one that needs to be built upon.

And California did a lot of learning from Massachusetts, actually, and I think we learned from other States, we learned from the Federal marketplace. We are seeing across the Nation efforts to make sure we get everyone enrolled.

And a couple of examples I would give are, first, in California there are more than 500 storefronts, huge stores with our logo, Covered California, on it. Those aren't State stores. Those are stores run by insurance agents who are members of CAHU, I mean the California Association of Health Underwriters. These are individual small-business people who are members of their community saying: We want to use this platform to sell insurance, to make insurance available.

Because it is about not just signing people up for insurance. It is then helping them understand how to use it. And I think that

question is spot on, because what we have seen from many of the people coming into exchanges across the Nation is getting in is only the first step.

And this is why we in California believe patient-centered designs are so important. If you have not had insurance before or you are a young healthy guy and you show up at the doctor and say, "Sorry, you have got $3,000 you have got to spend before you get this as a covered benefit," are you going to leave coverage? Absolutely.

Patient-centered design is part of the education to say, when you get sick, you go see a primary care doc, it is a covered benefit right out of the gate. And that is part of the reason we have patient-centered designs, because we think educating people about how to use insurance is also having an insurance design that works for all consumers.

Mr. NEAL. Thank you, Mr. Lee.

Thank you, Mr. Chairman.

Chairman BRADY. Thank you.

Mr. Roskam, you are recognized.

Mr. ROSKAM. Thank you, Mr. Chairman.

A quick word about today, a quick look back, and then a question.

Mr. McDermott suggested that this is a hearing today about holding the insurance companies harmless. That hearing was last week when the administration came before the Oversight Subcommittee and essentially was arguing for subsidies through the Cost Sharing Reduction Program for the insurance companies. So the administration was here advocating for insurance subsidies last week.

A word about maybe why we don't need to hear from the administration on every problem and that we can hear from four fresh voices is this. Last week at the same subcommittee meeting on Thursday, we heard from the administration. Mr. Mazur, the Treasury assistant secretary for tax policy, said this about a very controversial thing that they are doing. He said this: If Congress doesn't want the money appropriated, they could pass a law that specifically says don't appropriate the money from that account.

So that is the wisdom and constitutional insight. Of course that runs completely counter to the explicit language of the Constitution that says: "No money shall be drawn from the Treasury but in consequence of appropriations made by law."

So, look, the administration has a very big microphone, and they can fend for themselves.

A quick look back. 2008, the country had made up its mind, I think, after President Obama was elected, around two things as it relates to health care. The first was that health care was too expensive. And the second thing, we were scandalized, basically, as a country with the fact that preexisting conditions precluded people from having access to an insurance pool. That, I think, was the opportunity. That is where the national consensus was, to move forward on that basis. I think it would have been the smart move all the way around. And I think the nature of the discussion that we would be having to day would be fundamentally different.

But the administration made a different decision. It is their prerogative. But they decided to go basically all in on the Affordable Care Act. And that is where the problem happened.

Now, this business never works when an expectation is created here and the result is here. So the chaffing, the level of anxiety, and the feeling that people have right now is like: Oh, no, no, everyone said this was going to be great. So when Mr. Lewis is talking, for example, about HIV problems in the inner city of Atlanta, no, it was basically ObamaCare was the remedy, this was all going to be great.

And I think, Mr. Lee, part of the challenge now is you talked about something like a culture of coverage. Even a culture of coverage is a suggestion that somehow this gets better the longer we wait. So I am not encouraged by that.

And I want to get to the coverage question. I actually have a question for Mr. Harte. So there is an illusion here, and I think the illusion is that coverage is the goal. Well, coverage is simply: I will do this. You can get a library card that says: Here is a library care. But you walk in to try and check books out of the library and there is no books.

Can you speak to this notion of coverage versus access and give us some word about how we should be evaluating the concept of coverage as opposed to actual access to health care? Mr. Harte, do you have an insight on that?

Mr. HARTE. Absolutely. You will all define access completely differently. Some of you may say access is about being able to have access to a health insurance plan. And as Mr. White has indicated, in several States we have lost a lot of health insurance companies and co-ops are failing. So a lot of your constituents across the country are losing access to those plans.

Some may also say: I don't have access to my doctor, for many reasons. Number one, maybe it is just too expensive, maybe access to an MRI, they simply can't afford it, or, as we have talked about earlier, these bifurcated networks.

So I live in New Hampshire and all of the health insurance plans on the marketplace are limited networks. All of my health care is being done in Boston. All of my surgical procedures are done at Mass General or Brigham and Women's. I do not have access to care in Boston under a marketplace plan. And that is a huge problem if you want to cross the border and get into Massachusetts or, quite frankly, in any other state where you may want to have access to better care.

So in answer to your question, access to health insurance plans is a huge challenge. Access to affordable plans, access to affordable health care, and access to your own doctor is a continued problem in the post-ACA world.

Chairman BRADY. Thank you.

Mr. Doggett, you are recognized.

Mr. DOGGETT. Thank you so much, Mr. Chairman.

And to each of our witnesses, I believe that there are many factors contributing to these hikes and surges in health insurance premiums, and one of the major factors is the failure of this House and this Congress to do anything but engage in obstructionist tactics concerning the Affordable Care Act.

Whenever there is the discussion of the slightest improvement—how can we make the Affordable Care Act work more efficiently, how can we make it more fair, how can it be better—there is nothing but repeal, repeal, repeal. And that has some effect on the administration, because instead of noting an area where there is a shortcoming and a need for legislative action, the administration is placed on a defensive posture with now over 60 attempts to repeal.

And of course the original cry in this committee when it acted back in January of the new Congress coming into effect was that it would repeal and replace. But it never offered any replacement in a meaningful way to address these needs. So that failure, that obstructionism certainly has an impact on premiums.

The second aspect of this that has already been referred to that I have seen personally is the impact of the indifference of the State of Texas and a number of other States to the needs of its poorest citizens; in all, 1.3 million Texans. And this indifference and this refusal to take 100 cents on a Federal dollar to pay for the expansion of healthcare coverage has been a subject that has been raised by business leaders, by hospitals, by elected officials, all saying how important it is to achieve the full promise of the Affordable Care Act by including those citizens who would be covered through Medicaid.

I have looked personally in the eyes of families who have come in San Antonio in order to sign up for the Affordable Care Act and to have to tell them: I am sorry, you are too poor to achieve access to the Affordable Care Act. You cannot sign up in the exchange. Your remedy is through Medicaid, which they have been denied.

And anyone who thinks that denying health insurance coverage in the hope of getting for the first time a family doctor to these families means that they do not have an impact on health insurance premiums is ignoring reality. Yes, actually, in many cases these folks do not receive the healthcare coverage they need. And so eventually, when things get so bad, they are forced into the emergency room.

We had estimates before the Affordable Care Act that the impact of the unpaid-for care of the poor was hiking insurance premiums for the family that has an insurance policy by over $1,000 a family. That has an impact for employer-provided care, but it absolutely has an impact on the premiums being paid through the exchanges. They are not excluded from the impact of the cost of covering the uninsured poor people, many of whom I have seen personally denied the opportunity we thought would be forthcoming, and paying for it both in pain and in the cost to health insurance premiums.

There is another factor, Mr. Lee, we haven't touched on that I think is really significant, you refer to it in your testimony, and that is the impact of pharmaceutical prices and price gouging by pharmaceutical manufacturers. This committee, just as with improvements to the Affordable Care Act, has refused to even conduct a hearing about this problem and it has been ignored.

You referred to the discussion of Express Scripts on the impact on specialty drugs. But they have also reported that in 2015 alone, that increases in the average price of brand name drugs were at about 16.2 percent. That is consistent with other reports of organizations, like Kaiser Family Foundation, that prescription drug

costs now amount to 19 percent of health spending by employer health insurance plans. On brand name drugs, we don't have the transparency or the competition that you have suggested is a problem with some health insurance markets.

Do you believe, Mr. Lee, that pharmaceutical prices are contributing to premium increases and that more transparency and competition here would help us address premium increases?

Mr. LEE. There is absolutely no doubt that a significant factor in California and across the Nation of rising healthcare costs have been pharmaceutical costs increasing at a far higher rate than underlying medical trend, in particular, the cost of specialty drugs, which in 2015 rose by about 18 percent. But we are seeing this in our discussion with our health plans in California. They are highlighting the fact that those costs are a major driver. And for many consumers, it is a very opaque market. Transparency would be a huge boon for consumers.

Mr. DOGGETT. Thank you.

Chairman BRADY. Thank you.

Dr. Price, you are recognized.

Mr. PRICE. Thank you, Mr. Chairman.

Look, let's be clear. The reason that we are here today is not because of all these wonderful stories that the other side tells. The reason that we are here today is because the American people are hurting because of the healthcare program that the Federal Government put in place.

Twenty-six percent of the American people say they have been harmed by this law. If we had any other law where one out of every four Americans said they had been harmed by it, we would be having hearing after hearing after hearing and bill after bill after bill to fix it. Four out of 10 Americans say that they have a positive view of this law. That means 6 out of 10 say: No, help us.

Now why is that? Our job as policymakers is to figure out the why. And let me suggest that the why is because this law violates the principles that every American holds dear when it comes to health care. We all want a system that is accessible for everybody. We want a system that is affordable for everybody. We want a system of the highest quality. We want a system where patients have choices. The fact of the matter is that this law violates those principles, regardless of what your ideological stripe is.

Mr. White, you said that the current law has made health care less affordable and more out of reach than before. Affordability, accessibility, significantly harmed.

Mr. WHITE. Yes, sir.

Mr. PRICE. This hearing is about increased premium costs.

Mr. Harte, you were asked a question about what the premium increases were before ObamaCare, and you said that there were double-digit increases every single year. So what was ObamaCare supposed to do? What was the ACA supposed to do? Stop that, right? That is what the President said. Costs won't be going up, they will be going down.

The fact of the matter is that the administration spent over $1 trillion on a broken Medicaid system and on subsidies that are forcing people to buy insurance that they don't want, raiding Medicaid

for $800 billion, increasing taxes by a trillion dollars. And what do we have? We have double-digit inflation in premiums.

And it is not just premiums. The deductibles are out of site. Mr. Harte, you identified that. I was stunned by your figures. Four hundred and eighty percent increase over the past 9 years in deductibles, 140 percent over just the past 3 years, which means people have coverage, but they don't have care.

I used to practice orthopedic surgery. My former colleagues call me and they are distraught because of the patients who come into their office, they recommend something that needs to be done, and the patient says: I am sorry, Doc, I can't afford that, my deductible is thousands of dollars. This is a system that is not working for the American people.

A fellow in my district, Mickey Roberts, 59 years old. In 2013, his premium was 500 bucks a month—500 bucks a month. Now it is 1,200 bucks a month. Example after example after example. I have a cancer survivor who can't get a screening MRI following her cancer because you have non-medical people making medical decisions. That is part of ObamaCare.

Families harmed. Family of five in my district whose premiums just 3 years ago, premiums were 330 bucks a month. Now they are 1,365 bucks a month. I have another family whose premiums have increased 30 percent over the past 2 years. Deductible went from 6,500 to 12,500. And now their health insurance costs are higher than their mortgage. The highest cost that they have in their family budget is their health insurance. This is craziness.

So what we invite our friends on the other side of the aisle to do is to please recognize that there are people that are hurting, and that they need help, which is why what we have tried to do is to put forward positive solutions. Our friends say we don't have a plan. We have put forward A Better Way, a better way to address the challenges that we face in all sorts of areas, not the least of which is health care. And in health care, a better way means that patients and families and doctors are making medical decisions and nobody else.

Mr. Lee, you highlighted this cost shifting that you talked about. Cost shifting ended decades ago. There is no cost shifting anymore. I am a third-generation physician. The fact of the matter is that cost shifting doesn't exist. The government is setting the prices. Physicians, hospitals, they aren't able to pick the prices that they charge. In fact, what they are being paid today for Medicaid and Medicaid services oftentimes doesn't even cover the cost of the service being provided.

This is a system that is broken, and it needs to be fixed. And I urge my colleagues on the other side of the aisle to join us in A Better Way.

Chairman BRADY. Thank you.

Mr. Larson, you are recognized.

Mr. LARSON. Well, thank you, Mr. Chairman.

And certainly I want to thank our witnesses here today, because I really did appreciate the comments that you made, the thoroughness, and a number of the good ideas that you are suggesting. But you, of course, know that you are part of theater. You are not part

of getting anything done. This is all about messaging. It has nothing to do with solving the problems that the American people face.

This matter has been taken before the public in 2010, in 2012, in 2014, and it again will be front and center in 2016. Fifty-eight times or more in the Congress this act has been repealed by the House of Representatives. There is no substitute, there is no alternative, there is no score that has been given to any meaningful program that would address the issues as you have thoughtfully outlined or as California is diligently doing, because this is a farce, it is a play that we have all become a part of. Where is the solution?

Yeah, there are a lot of things that are wrong about the Affordable Care Act that need correcting, and when thoughtful people put their minds together and are able to address these issues, you can make these changes. But there has been no serious attempt to make any change other than to message against this bill and its flaws, its warts and blemishes, instead of looking at the constructs of the bill, as Mr. Neal outlined, and how they can be successfully managed, as they are in California and as they were by the business community in Massachusetts, as they are being done in Connecticut.

Instead, we are like this great ostrich with our head in the sand here, prevailing upon you to come before the committee so that we can try to convince the public that people are hurting out there. And they are. But this Congress isn't doing anything about it.

It is no different than leaving Congress this week without doing anything about gun violence. It is happening all around us. It is happening at a devastating rate. It is happening in a way that we should be ashamed of ourselves. We will message on it, but we won't take a vote, we won't sit down and constructively work towards coming up with a solution for the American people.

And that is what the American people are fed up with. That is why the American people believe that there is a wall that is going to be built and the Mexicans are going to pay for it. And that is why people believe in these promises that are never going to come to fruition.

It is long overdue that we, as Americans, roll up our sleeves and sit down. This committee is fully capable and talented on both sides of this aisle of resolving these issues in a nanosecond by coming together and working through these concerns. But it is more convenient to have a message that you can pound home in a campaign. Very successfully done in 2010. A Presidential campaign was waged on it in 2012. And ever since 2010, 2012, 2014, and now in 2016, the American people have been told this is a God-awful plan, but they haven't had one solution from the other side.

I apologize to you for being here today, not because you haven't provided thoughtful information, you have, but you must understand by now that you are just part of theater.

I yield back.

Chairman BRADY. Mr. Smith, you are recognized.

Mr. SMITH OF NEBRASKA. Thank you, Mr. Chairman.

Thank you to our panel as well.

Listening to all of the various comments here, it is quite interesting. It is frustrating. I hear some of the messaging from my col-

league who spoke just previous to my remarks here. These are serious issues. I don't have to tell any of you that.

I get frustrated when we hear that competition is alive and well from Mr. Lee, and that is not what I hear from my constituents. I hear from constituents, for example, one of them, one of my constituents who has lost her coverage three times. And they had a plan that they wished they could have kept, and of course they were promised they could keep it. I won't belabor that point too much, Mr. Lee, but that is one of those promises that is very frustrating.

I know you worked for Secretary Sebelius. Is that accurate? And we hear various numbers of individuals who are now covered with insurance who didn't previously have insurance. That makes me wonder how accurate those numbers are when I hear from constituents who have lost their plans, who had a plan, obviously. And so maybe the constituent who lost her coverage three times, has she been counted three different times as though the plan is wildly successful because she signed up for three different plans on three different occasions, and not by her own choosing?

But I worry that there are fewer choices for consumers out there rather than more choices. I worry that there is less competition. I worry that we have the risk corridor issue that is out there. The assumptions were that there would be a balance between plans losing money and plans making money. That hasn't taken place obviously. The co-ops, I mean, the Nebraska, Iowa CoOpportunity Health was the first co-op to collapse, 120,000 people. I wonder how many times those people have been counted in these numbers we hear tossed around in terms of the number of individuals covered.

We have also seen how many insurers are choosing to pull out of various markets, not just the failure of co-ops, but various markets that insurers are pulling out of.

Mr. White and Mr. Condeluci, how were the bill's drafters and HHS so wrong about the risk corridor program?

Mr. CONDELUCI. I will jump in to say, when the drafters were drafting the ACA it was well established that the individual market pre-ACA was dysfunctional. So the drafters endeavored to incorporate minimum standards, a guarantee issue which allows access to folks with preexisting conditions, to make the market a much more functional market.

Sadly, as I think has been established by the witnesses here and the discussion today, it is not a functional market. It is functioning, but it is not a functional market, even post-ACA.

But to your question, and the reason why I bring up the drafters, is due to the reforms, the drafters knew that there would be significant disruption in the individual market. So as a result, they created the stabilization programs, the risk corridor, risk adjustment, and reinsurance program.

Risk corridor, the drafters did expect, and I believe, as did HHS expect, that there would indeed be the same amount of carriers asking for a risk corridor payment or making a request for a risk corridor payment due to their losses associated with insuring higher risk individuals, which would be balanced out by carriers that would be insuring younger, healthier individuals. And due to the

fact that, as we have established, younger and healthier individuals have not entered the risk pool, the insurance carriers had suffered the losses, and more significant losses compared to insuring those better risks.

Mr. SMITH OF NEBRASKA. Okay. Shifting gears just a little bit because of the interest of time here, we now know that the President is calling for a public option. Secretary Clinton is now calling for a public option.

With the wild failure of the co-ops within ObamaCare occurring, I mean, is there any reason we would believe that somehow that would be a better situation? I struggle to think that it would be. I mean, with the Federal backstop that was out there spending gobs of money, taxpayer dollars, to try to prop up these plans, I just fear that we would see a different kind of failure within a public option.

My time has expired. I regret that. But if you would care to respond in writing, perhaps, I would be happy to hear each of your perspectives. We have folks on both sides of the issue here. I would love to hear more in terms of what your perspectives are moving forward. Thank you.

Chairman BRADY. Thank you.

Mr. Pascrell, you are recognized.

Mr. PASCRELL. Thank you, Mr. Chairman.

A couple of points before I ask the question. A, we can't blame, and I don't think any of you are, every problem in healthcare costs on the ACA, I think we have to make that very clear, like we came from a perfect system to an imperfect system. In fact, as I recall, your history shows that regardless of what party you are affiliated with, which is immaterial to me right now, that you were all advocating some changes because the system was broken. It was broken. So that is A.

B, in order to change anything here, whether you are talking about trade, whether you are talking about anything, you need bipartisan support to make a lasting change. We have done that in Medicare, we have done that in Social Security, and we have done it in Medicaid, with very different parties at the helm at the White House. It can be done.

I didn't hear from any of you, through the chair, that we should dump the ACA. Am I mishearing? Before I go on to my next question, is anyone here on the panel advocating getting rid of the ACA altogether as it now is?

Mr. CONDELUCI. From my perspective, sir, no.

Mr. WHITE. We are not.

Mr. HARTE. I am not.

Mr. LEE. No.

Mr. PASCRELL. Let's make that clear, Mr. Chairman. Let's make it clear. Very important. Very significant. You not only have good panelists, you have honest panelists. They are dangerous. No question about it.

Mr. CONDELUCI. If you will indulge me, sir, there are some caveats.

Mr. PASCRELL. Of course. You want to have some changes and so do I.

Now, some of you emphasized the unbalanced risk pool. Major problem. How do you get those 18 to 35s into the pool? You can't arrest them and put them into the pool. We need to do something about that. California has, and we will get to that in a second.

So the unbalanced risk. This is something we need to take a look at very, very, very closely. All of you have mentioned other things that are contributing to the cost. There are no two ways about it. How do you track younger, healthier individuals?

And the last point I would make before I ask the question is, the uninsured rate—Mr. Harte, you mentioned this—the uninsured rate is falling, but there is an increase in deductibles. That, you said, was one of the main reasons—many of you said this—what those deductibles were before the ACA, what the deductibles percentage-wise are now. We need to take a look at that. There is no question. Transparency, you talked about it also.

So I would like to add just one thing, by the way, to the cost, and that is we have a growing emphasis in this society on consolidation and merging. In fact, there was a report out last December about how that is contributing to the higher cost of health care.

So now we have 250 million people that are covered either by their employer, by the ACA, Medicaid, whatever. Have 250,000.

And I want to ask this quick question. Are we simply talking about then, if 85 percent of the people are covered in the ACA, these 20 million people, they get subsidies, are we basically talking about the 15 percent that don't get subsidies? Is that how I understood all of you saying?

Mr. CONDELUCI. I would offer this, sir, that in the individual market there are about 20 million people. Right now there are about 11.1 million who are enrolled through an exchange, and 85 percent of that 11.1 million are receiving subsidies. So that is 9 million people receiving subsidies.

So you take, let's say, the 9 million people who are not in the exchange, and you can make an argument that that is a population that is experiencing these premium increases without any subsidization, and you hear the stories that you have heard.

Mr. PASCRELL. I would be happy, and my last question is this. Mr. Lee, my time has run out, what I'd like you to discuss, you can't do it now, some of the tactics that Covered California has used to limit out-of-pocket costs. I find them to be very interesting. Perhaps you could share them with your colleagues here and the rest of us in dealing with a very important issue. This is important for everybody.

And, Mr. Chairman, let me conclude by asking how in God's name do we have a panel without the HHS Secretary.

Chairman BRADY. Thank you. Ms. Burwell has been invited a number of times to discuss the Affordable Care Act with us, including the shifting of money illegally to fund health insurance companies, which the hearing was last week.

All time has expired.

We will be going to two to one to make sure we can cover all the members here.

So, Mrs. Black, you are recognized.

Mrs. BLACK. Thank you, Mr. Chairman. I appreciate your having this very important hearing.

The issue of rising premium costs is something that, unfortunately, our constituents are facing every day. I certainly hear it constantly in my district. And across America folks are being forced to choose between paying more for less coverage in smaller networks or just foregoing health insurance altogether. Again, this is what I am hearing in my district continuously.

And it is hard for me to believe that my colleagues across the aisle aren't hearing a very similar story. And if they are not hearing any of this, I am really curious about what is going on in their State that is causing them not to hear from their constituents that the Affordable Care Act has impacted the quality of care, the accessibility, the sustainability of health insurance in this country.

So in my home State of Tennessee, premium rates in the marketplace are expected to increase by 62 percent—62 percent in 2017. So for anybody to say, "Well, costs aren't going up, they are being contained," it just amazes me. I expect the Obama administration would tout this as a nonissue, however, since 80 percent of the marketplace enrollees in Tennessee are eligible for subsidies.

But I have to ask, is this how we want our health care system to work, with costs rising astronomically for this mediocre care that is being given, where you can't choose your doctor, you can't choose your facility, you can't choose your specialty? ObamaCare is forcing more and more Americans to accept the government subsidies to afford even the most basic coverage.

Now, I want to read to you very quickly a letter that I just received this week, which is not uncommon to get this kind of letter.

"Hello, Mrs. Black. I am 32 years old. I am a married mother of three. I have no preexisting conditions, I don't smoke, and I live a very healthy lifestyle. Why, then, with the Affordable Care Act, is my insurance company canceling my great low deductible, low premium multibenefit plan next year and forcing me to choose a plan that offers less coverage, triple the deductible, triple out-of-pocket expenses, with a much higher premium?

"Now it will be less expensive for me to pay a yearly tax fine, and I will have to give up my insurance that I have had for 7 years that I am happy with. I am well aware of the so-called tax credit available to people such as myself, but I have paid for my own insurance for many years without the government's help, and if my premiums were to remain reasonable, I wouldn't need a tax credit."

So my question is, is it the role of the government to force people out of the health insurance that they like and that they can afford and they have used for years into a plan that would require taxpayer-funded subsidies to afford the most basic coverage? Shouldn't we be removing those barriers and mandates to encourage people to actually control their own health care and allow the open markets to keep the plans competitive and affordable and accessible?

Mr. White, I would like to start with you. I know I only have 2 minutes left. So if you could address those.

And then, Mr. Condeluci, and then, Mr. Harte, if you would address those, I would appreciate it.

Mr. WHITE. Yeah, I think the scenario that you outlined in that letter is exactly the scenario that a lot of people are facing in deciding whether or not to enroll in the exchanges. And a lot of those

people are saying: No, it doesn't make sense for me financially or otherwise, with or without subsidies.

So CHAC is advocating for market-based reforms that improve flexibility, that create additional options for consumers, using those subsidies on and off the exchanges to create a market for competing for those lives.

Mrs. BLACK. And it will allow people to get what they want and what they need as opposed to what the government is telling them they want or need.

How about you, Mr. Condeluci?

Mr. CONDELUCI. As I have suggested, the minimum insurance standards, the adjusted community rating rules, the new rules that came in to make the individual market a much more functional market are driving up costs. That is just the nature of how these reforms have impacted the insurance market.

I would suggest that insurance carriers be allowed additional flexibility to come up with more creative plan designs, creative plan designs that could be targeted to different cohorts of the population. As I indicated earlier, obviously the young and healthy, but, in addition, folks that have chronic illnesses, like diabetes, heart disease.

If carriers were able to better manage that care, that helps folks across the board from an insurance perspective, but the drafters of the ACA wanting to, let's say, require that everyone have an adequate level of coverage, has, I don't want to use the word "overreached," but it just has increased cost.

And if you pull that back, I am not suggesting that we get rid of the minimum standards or guaranteed issue, for example, which I am a fan of, if you loosen them up, I believe you can reduce premiums.

Mrs. BLACK. Mr. Harte, you have 15 seconds. I apologize.

Mr. HARTE. Thank you.

All I will say to you is, we have to look through a prism of are the decisions that we are making going to make health insurance more affordable? I don't know if it makes you comfortable or uncomfortable, but I deal with the issues of plan changes every single day, and I have to share those changes with thousands of people every year. So you are not alone, and that is what we need to focus on.

Mrs. BLACK. Thank you, Mr. Chairman. I yield back.

Chairman BRADY. Thank you.

Mr. Kelly, you are recognized.

Mr. KELLY. Thank you, Chairman.

Thank you all for being here.

I come from the private sector, and I was not here whenever the healthcare law was debated and then passed, but I can tell you as a person who actually provides insurance for the people that I work with, we have seen premiums—this is for a family, a mom and dad with a couple children—it has gone from about $800 a month to $1,150 a month. That is the premium.

Now, maybe you all can explain this, because I am just looking at this as a business model right now. When you take in $1 in premium and pay out $1.20 in claims, that is not a sustainable business model. So I think, rather than going after the insurance com-

panies and saying, "Hey, you guys are trying to make money," I mean, if you don't make money, you go out of business, I kind of get that from my life experience, but the copays and the deductibles are also part of health care.

So when I talk to people—and with ours right now it is $3,000 in deductibles before insurance kicks in—they have heavy copays. And if you go to the emergency room, that is another charge on top of it. So most of the folks I talk to back home are saying: Yes, I do have insurance, but I don't have coverage until I go past a certain point.

Now, I am understanding some of the people that I represent, some of their increases are going to be 38 to 40 percent. That is what they are going to ask for it. They are not going to get that, but they are going to get something. And then the question comes down to, well, that is not as big of a problem on the premiums because there are going to be subsidies that are going to take care of that.

So Mr. White, Mr. Condeluci, Mr. Harte, Mr. Lee, who is going to pay for the subsidies?

Mr. WHITE. Taxpayers will. And that is the problem, right? We are shifting costs, we are not lowering them. We need some strategies to lower the costs.

The other issue I would say on the deductibles is that only half of Americans have enough liquid assets to meet higher deductibles, according to the Kaiser Family Foundation.

Now, the problem with the ACA exchanges is that in many instances they are masking the availability of account-based plans like health savings accounts. If people knew and were informed that HSAs could help them fill in deductibles on a tax-preferred basis, we might get some help in meeting some of those deductibles.

Unfortunately, we are also seeing some policies come out in the regulatory front that are discouraging the use of HSAs on the exchanges, either healthcare.gov or at the State level.

And so there are tax tools that we can use to help fill in these deductibles. They are just not being employed very effectively.

Mr. KELLY. Mr. Condeluci.

Mr. CONDELUCI. Briefly, the premium subsidies, as we all know, shield some of the policyholders from the premium increases, and that has been established——

Mr. KELLY. If I can interrupt you one second, though. But the subsidy doesn't change the actual cost.

Mr. CONDELUCI. It does not.

Mr. KELLY. I think that is the problem, we get into this idea that somehow the subsidy is going to make it okay. Because at the end of the day, somebody still has to pick up the tab on it.

Mr. CONDELUCI. Right.

Mr. KELLY. The answer is hardworking American taxpayers.

Listen, oftentimes our hearts are willing but our wallets are weak. We are putting such a heavy burden on the private sector right now and the people that provide this, believe me, because I am one of them. I provide that for the people I work with.

See, the sustainable business model is the thing I think we are turning away from. It is not that we don't want to make sure that people have health care.

By the way, we are not talking about sick Republicans, sick Democrats, sick Independents, or sick Libertarians. We are talking about sick Americans that need help. I want to make sure that we don't make it a thing about our parties, but about our people.

So the sustainability of it is where we have to go on this, and that is where I am seeing the disconnect.

Mr. CONDELUCI. Because as the premiums go up, the government shields those premium increases in the form of higher government spending, which is in the form of the premium subsidy, that is. So there is a tension between increased premiums, how the subsidy works, and how they shield consumers from those premium increases.

It is not the consumer that has generally experienced that premium increase, instead it is the government, and at a point you might have an unsustainable situation from a spending perspective.

Mr. KELLY. We keep using the term "the government." The government doesn't pick up the tab on anything. The government collects money from hardworking American taxpayers and redeploys it where the government thinks it should go.

So we take the decision out of the individual's hands of how they are going to purchase products, and we say this is how you are going to do it, and if it is too steep, we will subsidize it without saying: By the way, you are going to pay for the subsidy.

Mr. Harte, if you could just weigh in. I am almost out of time. But this is critical people understand. This is an unsustainable business model. It has nothing to do with wanting to provide people with health care. It is to the point that it is going to reach that we can't do it and taxpayers can't be burdened every time we want to do something.

Mr. HARTE. They simply can't afford it. You are absolutely right. Those subsidies are coming from my business, from my employees, from your employees, and everyone across the country to pay for these taxes.

But you are actually pretty lucky. For someone in your company to have a $3,000 deductible and a $1,100 premium, that is pretty good. Where I come from, where healthcare costs are soaring, we have to pay three times that. We have families who are paying over the Cadillac tax limit already for an average health insurance plan. So you are right, I am concerned just like you, very concerned.

Mr. KELLY. Thank you.

Chairman BRADY. Thank you.

Mr. CONDELUCI. To clarify, Mr. Chairman, my reference to government was taxpayers.

Chairman BRADY. Thank you.

Dr. Davis, you are recognized.

Mr. DAVIS. Thank you very much, Mr. Chairman. And I certainly want to thank our witnesses for being here today.

Mr. Lee, opponents of the Affordable Care Act have been trying any tactic that they can think of to discredit the law or to make

consumers look unfavorably on it. One of the red herrings opponents have used is try to make consumers think that the law is unaffordable due to premium increases. It is my recollection that premiums were going up, increasing before the Affordable Care Act. Is that not true?

Mr. LEE. That is definitely true.

Mr. DAVIS. Now we have, with the ACA, what I would call a pretty significant improvement. For example, consumers are guaranteed critical protections when they purchase insurance, limits on rating based on age, requirements insurers must spend a certain amount on care. And also State officials have stronger tools to review unreasonable rate increases, along with transparency, so that the public knows which insurers are jacking up prices and why.

Could you comment on this environment?

Mr. LEE. Yeah. The main comment is that it is absolutely the case that the post-Affordable Care Act insurance marketplace is a reformed but still imperfect marketplace, but it is in a marketplace now where insurers have to compete on price to get consumers who cannot be turned away. It is a different marketplace, and there is transparency. And many consumers—not all—have many choices that they can exercise to make that marketplace work.

It is also the case, if I may, that many of the problems we are hearing about are not Affordable Care Act problems. They are health care in America problems. Issues of rising healthcare costs, as we heard from Mr. Harte, of rising costs of up to 30 percent on people's employer-based care. This is the range of what small businesses, large businesses, individuals are facing that we all need to get our arms around.

Mr. DAVIS. While we laud the California experience, Illinois hasn't done too badly itself, the State that I come from. What caused California to be able to accomplish what we all know and believe it has accomplished?

Mr. LEE. I think, well, first, I want to be very clear, there have been a number of States that have been very effective in implementing the Affordable Care Act. You can look at the State of Connecticut, you can look at Illinois, you can look at Washington. There are a lot of States.

The thing that they have in common is—and I know this is a hard thing to say in this environment—but they put politics to the side. And in California, our working has been with Republican members of our State legislature, have been with every single district elected office, it is with people who have said this is the law now, let's make it work.

And so the issue of having effective outreach and education. I have said this a couple of times, but health insurance doesn't sell itself. And we are out there spending a lot of money because people that need to sign up for health insurance say: Maybe I don't want to.

The ones we need to convince most are the ones who need it the least who will benefit the risk pool, which requires ongoing, very significant marketing, outreach, partnerships with agents, et cetera. And that is something that the States that have been most successful have consistently leaned in on those outreach efforts.

Because those people that get subsidies, which in California is about a million, and there are about a million people in the individual market without subsidies, those nonsubsidized people benefit from the people who get subsidies because they are part of the better risk pool, they are part of keeping premiums down for everybody.

So it really is a win-win when we get subsidized people in to help keep the premiums down for those even that don't have subsidies.

Mr. DAVIS. Thank you very much. And I think that was part of the intent from the beginning that many people discount. I think the reality is that it is working much better than many people would have us believe.

I thank you, Mr. Chairman, and yield back the balance of my time.

Chairman BRADY. Thank you, Doctor.

Mr. Renacci, you are recognized.

Mr. RENACCI. Thank you, Mr. Chairman.

And I want to thank the witnesses for being here with us here today and presenting the information. This hearing is really extremely important, and I appreciate your expertise.

I, like one of my earlier colleagues, believe that when those that voted for the Affordable Care Act, they sincerely believed they were helping. Let's face it, I am sure that was their thought process when they voted for it. But it is disingenuous today to ignore the fact that there are problems.

Unfortunately, since the passage of the Affordable Care Act the access to affordable care has significantly dropped. There is no denying that since the ACA premiums are rising, deductibles are rising, and many people can no longer afford their healthcare plans. And we are hearing the proposed rate filings for 2017 on the Federal marketplace are projected to increase a median of 19 percent.

I go back in my district and I have meetings with employees. Every time I meet with an employer, I want to meet with the employees. I ask the same question: Are you happy with the Affordable Care Act? Are costs okay? How are things going? I am going to have to bring some of my colleagues from the other side with me because I get very few people put up their hand and say they like it.

Now, some people do. I am not going to lie and say it is not 100 percent. But it is a very, very small portion of the people in the crowd, and I am talking about hundreds and hundreds of people. So I always ask them a question: Tell me what tissues are. Tell me what the problems are. I try and learn from it.

Look, no law passed is going to be 100 percent perfect. But I go back to my colleague last year, John Carney. He tried to pass H.R. 4414, which was a fix to the Affordable Care Act, and we got that passed. The sad thing was that the majority of Democrats, over 133 Democrats, even came to the floor and said: We can't change anything because if we change it, we are going to open up the doors to changing more things.

So 133 people even voted against a simple change, ignoring the fact that there are problems, and those are the things we have to fix. Just last month, in my home State of over Ohio, we had the 13th co-op, InHealth Mutual, announced it was going out of busi-

ness. This was 1 of 23 co-ops created under the ACA, had received 129 million in taxpayer funds, had left nearly 22,000 Ohioans with fewer choices and, unfortunately, once again, searching for new health insurance.

So again, we know there are problems out there. We can say we don't, we can talk about how great the Affordable Care Act, it has problems, and we have to start looking at those problems.

I have had people in my district, Brian from Westlake, saying he has lost his choices. I have another constituent, Scott from Dalton, saying his plan jumped from $314 in 2013 to $920 in 2016. He simply couldn't afford to continue with this plan and he had to go to a higher deductible. I had another individual, John, a registered Democrat from Brewster, who said he now calls the ACA the Unaffordable Care Act. So these are real people, real lives, real things affected.

But the saddest story I ever had was a woman walking up to me at a restaurant saying: Congressman, I just had my hours reduced to 29 hours, and now my premiums are going up and I have a deductible I can't afford. Help me. That was the saddest moment when it came to the Affordable Care Act—help me—and that is what we need to do.

So I want to talk a little bit about this deductible, because we have talked about premiums. Nobody can argue that premiums are going up. They are going up. Everybody knows that. They are going up again this year. But we are getting people insurance, and I have an individual in my district who has fully subsidized insurance, but came to me and said: Congressman, thank you for allowing me to get insurance.

I said: Well, I wasn't part of the vote for the Affordable Care Act. But she says: I can't use it anyway because I have a $6,000 deductible that I now can't use. The insurance is worthless for me. I need surgery, and I can't get it done because I can't afford that.

Mr. White, can you talk a little bit about the deductibility, how this deductibility is affecting people and the size of it and how that hurts people getting health insurance?

Mr. WHITE. It is massive, and it is not just the deductibles. So the deductibles are increasing on average by about 20 percent, or they increased 20 percent this year. So the average Silver plan has about a $3,000 deductible, the average Bronze plan has about a $6,000 deductible, but $10,000, $12,000 deductibles are not uncommon.

And the reason these deductibles are at that level is that it allows the insurer to lower the price point, the premium rate that they sell on the exchange. A lot of consumers will shop for a plan based on the premium, not necessarily the deductible.

Mr. RENACCI. So you would agree that, because of the Affordable Care Act and because premiums are going up, the only way to reduce the premiums is to raise the deductible, which in the end, who pays? The American people.

Mr. WHITE. The consumer, absolutely. And it is not good, because, as you indicated, when you have these massive deductibles, you are not accessing care. So you are not getting maybe the diabetes care, the coach management, the preventive care, the well baby

care, the things that you really need to stay out of the hospital, out of expensive settings. It is unsustainable over the long term.

Mr. RENACCI. Thank you, Mr. Chairman. I yield back.

Chairman BRADY. Thank you.

A vote has been called. We would like to finish with Mr. Meehan and Mr. Holding.

Mr. Meehan, you are recognized.

Mr. MEEHAN. Thank you, Mr. Chairman.

I just want to say at the outset, just to comment, I know some of the commentary from the other side of the aisle regarding that part of the problem is that insurers are miscalculating. We sat here last week and listened to the design of a plan in which over $7 billion was illegally transferred to the insurance companies and still not capable of holding down these costs. That was what the record demonstrated.

But I want to follow up on Mr. Renacci's questions with the panel because it is really going to the issue. We hear a lot about people saying we have more people insured. What I am seeing in mid district are the underinsured. These are people who are working, who have been watching the explosion of the various factors. You named them. It is the copays, the higher premiums.

And the biggest problem is, just like many seniors now split their medications by taking half and do away with the effect, we are having people that won't use health care at certain times, and situations are getting worse.

Mr. White, I went back through the written testimony of each of you. I was very impressed with lots of it. You had some things to say about the special enrollment periods influencing this, Mr. White. And can you tell me about what you see as the reforms in the special enrollment periods quickly, if you can, and whether what the administration is currently doing is going to be sufficient to impact that?

Mr. WHITE. I am not sure what the administration is doing is sufficient. I think what needs to be done is that you need to clamp down on some of the abuses that are taking place because of the special enrollment periods. People are jumping into and out of these risk pools, gaming the system in effect, and the enforcement is not rigorous enough to prevent that type of gaming.

So having prospective eligibility is probably—let me put it this way. I think you don't automatically get the person in the plan until you can verify that they actually meet the requirements of the special enrollment period, and then you can make their coverage retroactive to cover the claims expenses. You don't just do that at the outset, though.

Mr. MEEHAN. You think it was a rush, so to speak, just to get numbers, but they are not appropriately overseeing the entrance into the program?

Mr. WHITE. Yeah. It was a big problem. I think there were 40-some-odd special enrollment periods. One insurer that we work with quite a bit in our coalition said it, added about 3 percent to the premium that they have got to carry into next year. So this is a real impact on people.

Mr. MEEHAN. Thank you.

And, Mr. Harte, you spent some time, you laid out a number of things, but again, I go back to the issue of the uninsured. And this was the point that was being made, I think so eloquently, by my colleague Mr. Renacci.

I am watching in Pennsylvania, 21 percent reported that deductibles and 18 percent reported that premiums were their greatest financial challenge. So we are seeing that these are the things that are impacting people. The rate of uninsured is going down, but the costs associated with those that have it is skyrocketing.

So what combination of reform should be advanced to address the challenges of individuals and families with insurance? They have insurance, but they can't afford health care. What would you recommend?

Mr. HARTE. So if I can first say, my clients, when I sit down with them and they are faced with a 29 percent rate increase, as I testified to earlier, my job with that client is to say: What can we do to cut costs?

So the first thing we have to look at is: Okay, you have a $3,000 deductible today, how much can we save to go to a $4,000 deductible? And that is about 10 percent. And then we say: What is it going to take you to go to a $5,000 deductible? It might be another 5 percent.

And then we start looking at the prescription drug costs, and the traditional drug plan would be $10 for generic and $25 or $40 for brand name. Today, the health insurance companies have moved away from that entire equation, especially for small employers, and told the employees that they insure: Well, you are now going to pay a percentage of the brand name prescription cost.

Now, this is New England, okay, but it is happening all over the country. Now they are having to pay 30, 40, 50 percent of the monthly cost of that prescription up to a monthly cost share of $500. That is significant.

So when you talk about the underinsured, we are not just talking about access to doctor's office visits or primary care, specialty care, physical therapy, emergency rooms, hospitalization, it is the entire healthcare equation that people are underinsured.

So the question is, what can we do, that is your final question. As I said earlier, health insurance is expensive because health care is expensive. And as much as we talk about the Affordable Care Act and that the issue is all about health insurance or health insurance companies, it is really a financing mechanism.

When you look at health insurance, we are taking 80 to 85 percent of that money and paying for healthcare expenses. So the reason why health insurance premiums continue to escalate at such an alarming rate is because healthcare costs continue to soar out of control.

Mr. MEEHAN. Thank you, Mr. Harte.

Thank you.

Chairman BRADY. Thank you.

Mr. Holding, you are recognized.

Mr. HOLDING. Thank you, Mr. Chairman.

First, I would like to give a little state of play in North Carolina. Our largest insurer in the State has been approved for an average

rate increase of 25 percent in 2015 and 34 percent in 2016 and 18 percent in 2017. But even with these consistent double-digit rate increases, BlueCross BlueShield, the insurer I reference, has lost over $400 million in the last 2 years.

And even though they have been given these rate increases, yeah, it doesn't ensure that they are going to stay and continue to offer plans throughout North Carolina. And we are looking at a potential situation where 60 out of our 100 counties might be left without a single ACA plan offered.

I would like to pick up where Mr. Smith from Kansas left off. You hear this argument that, well, the public option, if that is put in place, it cures all these problems.

Mr. White, could you address the public option and whether or not it would cure the ills that we see with the ACA as it exists today?

Mr. WHITE. I think the public option is a bad option. I think that it is government coming in to promote competition in a market in which they have basically evaporated competition.

So this is a problem that was caused by government inflexibility that made insurers leave the market. They are losing money. We are seeing it in co-ops. We are seeing it in North Carolina. We are seeing it in other markets across the country.

So the proposed solution is let's have the government run a plan in that marketplace so that people have choices. Well, they had choices before, right? So how do we flex up the market, how do we create a competitive environment so that the insurers will want to go back in? Tennessee had a very significant experience in this in the Medicaid market.

I mean, like, this isn't necessarily rocket science. We ought to let the market operate in a way that fosters competition and an environment to offer products.

Mr. HOLDING. Thank you.

Mr. Chairman, in the interest of time, I will yield back so that we are not late for our vote.

Chairman BRADY. You are kind, Mr. Holding. Thank you very much.

I would like to thank our witnesses for appearing before us today. Please be advised, members have 2 weeks to submit written questions to be answered later in writing, and those questions and your answers will be made part of the formal hearing record.

With that, the committee stands adjourned. Thank you.

[Whereupon, at 12:32 p.m., the committee was adjourned.]

| | Results |
|---|---|
| 1. | UnCovered;Families losing kind of care they need as insurers narrow plans;Couple part of growing struggle to keep costly treatments; *The Houston Chronicle*, January 24, 2016 Sunday, A; Pg. 1, (2227 words), By Jenny Deam |

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The Houston Chronicle

January 24, 2016 Sunday
3 STAR EDITION

## UnCovered;Families losing kind of care they need as insurers narrow plans;Couple part of growing struggle to keep costly treatments;

**BYLINE:** By Jenny Deam

**SECTION:** A; Pg. 1

**LENGTH:** 2227 words

UnCovered

First of an occasional series on the health care crisis in America.

>> News from the Medical Center and beyond: HoustonChronicle.com/Prognosis

The boy and his dad sit in the glow of the nursery lamp, their shadows wide as they rock together in the big chair. Bedtime is coming. But first there is the machine.

A switch is flipped and the medical contraption roars to life with an insistent whine. It looks like a Shop-Vac whose ribbed hose snaps into a special vest slipped over footie pajamas. The power of the machine makes every inch of 11-month-old Jack Faught shake in the hope of loosening mucus in his airways.

For a half hour his chubby cheeks quiver, as do little fingers. Even his eyelashes vibrate. It is the third treatment of the day. Through it all, he never cries.

"It's all he knows," says Austin Faught, pressing his face close to his son.

Since last spring, first-time parents Austin and Kyra Faught have stumbled, fallen and risen again after learning their child has cystic fibrosis, a lifelong disease that damages the lungs and pancreas. Left untreated, it could kill their son. If poorly treated, his life could be shortened. Their vision of parenthood forever changed, they threw themselves into battle against his sickness.

Three weeks ago, a new fight landed at their doorstep, one that came with just as many tears and sleepless nights, waged not with medicine but phone calls and fax machines. It was with their insurance company as they begged to let Jack stay at Texas Children's Hospital, home to Houston's only accredited cystic fibrosis center and the team of specialists who were helping to keep him alive.

Their story is part of a larger one being played out across Houston and the nation as the insurance industry reacts to its changing landscape by moving customers into narrower plans. At a time when millions of lower-income Americans are enjoying insurance coverage, some for the first time, an untold number of middle-class families are discovering that the kind of health care they want and need is slipping from their grasp.

On the final day of 2015, tens of thousands of Blue Cross and Blue Shield of Texas health insurance customers, including the Faughts, saw previous plans expire. Those with serious illnesses had been fretting for weeks over what such a change would mean, especially as word seeped out that the city's top hospitals would no longer be covered.

The couple learned as soon as the calendar turned. At $967 per month, their new health maintenance organization plan is virtually identical in price to their former plan, known as a preferred provider organization, or PPO.

The replacement HMO prohibited in-network access to Texas Children's Hospital.

At least 1,000 other children who have been treated there may have lost access when they lost their insurance plan - double what administrators first feared.

"When Jack was first diagnosed, we were devastated. The one thing that got us through was knowing that we were within minutes of one of the best medical centers in the country and specifically one of the best cystic fibrosis centers. To have that taken away ..." Kyra's soft voice trails as she struggles to find the word. "It's a horrible feeling."

There is no cure for cystic fibrosis, only vigilance. And hope.

Each day, in addition to hooking Jack to the machine to unblock mucus, his parents crush two dozen enzyme tablets, hiding them in bowls of applesauce and yogurt to help his body absorb nutrients so he can grow.

There are the squirts of liquid antibiotics squeezed into his mouth three times a day to derail infection and the inhaler mask that nearly swallows his tiny face to help him breathe. A 32-ounce bottle of hand sanitizer sits by the front door right next to the open Bible.

'Unsustainable' plans

It might seem as if this all began last October when Kyra, 30, quit her job at an oil and gas company to become an independent contractor, making both her and 33-year-old Austin, a real estate developer, self-employed. By leaving, she lost her employer-based insurance plan with Blue Cross Blue Shield that had kept Jack's medical needs well covered.

But in truth, the Faughts' collision course with the insurance industry was in motion months, if not years, before.

When the Affordable Care Act passed in 2010, it came with the fundamental pillar that people with pre-existing conditions or complex medical issues must be covered. This was especially important for the self-employed in the individual market who had previously faced cancellations or no coverage at all if deemed too much risk.

Insurance companies said they supported the law, standing to gain millions of new customers. But soon there were complaints that they underestimated the scope of the ACA's mandate to cover those who went to the doctor often or needed expensive care. Premiums had to rise - often by double-digit percentages - and plans changed with the expensive providers jettisoned to compensate for shortfalls, insurers said.

In the summer of 2015, Blue Cross Blue Shield of Texas, the state's largest insurer, announced it was eliminating all of its 367,000 PPO plans statewide, including 88,000 in the Houston area. Company executives called the plans "unsustainable" and announced a $400 million loss even as its nonprofit parent company in Chicago had amassed a $9.9 billion surplus in profits.

The insurer declined to comment on the Faughts' case without written permission from the family. But Edna Perez-Vega, senior manager for media and public relations, said on Friday that even if given such permission, any comment would have to be cleared by their legal department and would not be available for this story. She also declined to make any executive available for an interview.

PPO plans are typically more expensive and favored by those wanting broader access. By comparison, HMOs are often considered "gatekeepers" requiring pre-authorization to stray outside the network.

When the 2016 individual enrollment period opened Nov. 1, there were no PPO plans by any major insurer in the Houston area either on or off the federally mandated exchange. Humana and Cigna also eliminated the option. (Humana re-entered the market in mid-December offering a PPO plan off the federal exchange).

The Faughts knew none of this. Kyra verified online that she could buy a plan covering Jack's care when she quit her job. The couple signed up for a Blue Cross Blue Shield individual PPO at $1,010 per month with an effective date of Nov. 1. On Nov. 4, they got an email saying their plan would be eliminated at year's end.

Worried, Kyra immediately called the insurer and asked what would happen to Jack if they enrolled in the replacement HMO plan. She says she was reassured that because the baby was "already in the system" the switch to HMO coverage "was just paperwork," Kyra says she was told.

But it was far from that easy.

Desperate for a referral

On Jan. 4, the first Monday of the new year, with an appointment with Jack's care team in two days, Kyra again called her insurer to check coverage. It was the first time she heard they needed a referral from an in-network primary care provider. Since his doctors affiliated with Texas Children's Hospital were now out-of-network, she had to quickly find someone new.

The first doctor given to her had a disconnected phone. The receptionist at the second doctor's office said he had not shown up for work in months. The Faughts got a recommendation for a third doctor, this one at a crowded pediatric clinic.

Children with cystic fibrosis are at great risk for infection. Austin was so alarmed by the swarm of sick kids at the clinic, he swabbed the examining table with his own sanitizing wipes. While he says the doctor was professional, she did not seem versed in cystic fibrosis care. His first instinct was to grab his child and flee, but he needed the referral.

Kyra figures she spent at least 15 hours on the phone with her insurer that first week of January. She pleaded, she swore, she cried so hard she could not breathe, all the while being passed from one person to the next trying to get Jack's referral in time for his tests. "I felt like they were stalling or just making stuff up," she says. They had to cancel the appointment.

That night, Austin wrote to the CEO at Health Care Service Corp.: "My wife and I understand that we are dealing with politics and business here. However, this situation is far more important to us and Jack than politics and business. ... The unilateral decision by BCBS to disrupt Jack's continuity of care is having a devastating effect on our family."

They have never received a reply.

The first denial by Blue Cross Blue Shield came by phone the next day. Austin felt woozy. "How can you do this?" he shouted into the phone. He was told they would be getting an explanation in writing.

That came by fax at 6 p.m. on Jan. 11. It said Jack's treatment at Texas Children's Hospital was not necessary because "covered services were available through a participating provider." The decision was made by an unnamed insurance company doctor whose specialty was obstetrics and gynecology.

Dr. Michelle Mann, a pediatric pulmonologist who leads Jack's care team, entered the fray in a "peer to peer" consultation with an insurance company doctor she declined to name. She says she painstakingly laid out Jack's treatment and why cystic fibrosis protocol must be followed. Nationally, there are 120 care centers accredited by the Cystic Fibrosis Foundation. Houston has one.

"She wanted to know why he couldn't just be seen by a pediatrician," Mann said last week in an interview.

Ultimately, the insurance company doctor agreed there was no comparable care and approved treatment out of network. Mann can't remember the doctor's exact words but felt certain the approval covered the entire year. That night, the Faughts wanted to celebrate but feared it was too good to be true.

It was.

On Jan. 18, the couple got a call from their insurer: The approval was good only until Feb. 5. For further care, they would have to go through it all again.

"We recognize health-related issues can be stressful for families and we work as quickly as possible to help all of our members with their questions or concerns about their coverage," said Vega-Perez at Blue Cross Blue Shield.

She added that a system is in place to help customers who want to challenge a denial, including being assigned a case manager or having their physician speak with a company-hired doctor.

Vega-Perez declined to disclose how often denials are overturned or specify who the doctors are who make company medical determinations.

She said the insurance market has "evolved significantly," which has led to "adjustments." But she stressed that "based on our customers' experience with tailored and managed networks of doctors and hospitals, we know that quality care is very much possible at a lower cost."

Finally fed up, last week the Faughts signed up for a Humana PPO plan at $967 a month with a $6,450 deductible that includes Texas Children's Hospital. Already, Austin worries that with all of the former Blue Cross Blue Shield customers flocking to Humana's plan, it, too, will vanish next year.

Doctors alerted

The story of Jack and his family has spread through the halls of Texas Children's Hospital, making its ways to the executive offices. Randy Steward, the hospital's director of managed care contracting, finds it disturbing.

"What this shows is not every patient is going to fit into their box," he says of insurance company rules. He calls their exceptions to in-network coverage "a short list," including pregnancy, hospice, chemotherapy and radiation, dialysis or proof there is no other comparable care within 75 miles.

But what of those he calls the "square pegs who fall out of the round hole"? For example, children born prematurely can need lifelong care, often under the guidance of three of four specialists, he says.

Physicians at the hospital's clinics have been alerted to reach those who may have lost coverage to help with appeals.

"It's the 20th of January. I might know more the 20th of February," he said last week. "I'm more worried about the family in March who finds out for the first time their child has cancer."

He sees the Faughts as exceptions. He wonders about the families who "may not have day after day to sit on the phone to fight with the insurance company."

The couple believes the barriers thrown at them were intentional, designed to wear them down.

"I felt all along the way that we are going way beyond what Blue Cross expects people to do," says Austin.

He and his wife hope to begin advocacy work for other families of cystic fibrosis children.

Thirteen days ago, Jack took his first step. In three weeks, he will turn 1. There will be a party, and baseballs will be involved. Austin played college ball and was drafted by the Texas Rangers before an injury derailed his athletic career. He dreams of passing his passion on to his son. Kyra dreams of being that mom cheering from the stands.

Jack's doctor says it is possible.

A generation ago, a child with cystic fibrosis rarely lived to enter kindergarten. Today, with diligent care, they can enter middle age. In Jack's lifetime, there could be a cure.

The Faughts know all those statistics by heart. It's what gets them through the hard times.

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**CORRECTION:**

**GRAPHIC:** Marie D. De Jesús / Houston Chronicle Austin Faught, 33, gives saline in a nebulizer to his son, Jack, who wears a vest that helps his body loosen up the mucus inside his lungs. The 11-month-old has to go through the treatment more than once a day. Jack has cystic fibrosis, a lifelong disease that damages the lungs and pancreas. There is no cure. Marie D. De Jesús / Houston Chronicle Austin and Kyra Faught enjoy time with their 11-month-old son, Jack. The couple spent long hours on the phone fighting Blue Cross Blue Shield of Texas so they could continue Jack's treatment for cystic fibrosis at Texas Children's Hospital.

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| | Results |
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| 1. | Cancer patients losing options;Health exchange plans don't cover M.D. Anderson; *The Houston Chronicle,* November 1, 2015 Sunday, A; Pg. 1, (1438 words), By Jenny Deam |

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The Houston Chronicle

November 1, 2015 Sunday
3 STAR EDITION

# Cancer patients losing options;Health exchange plans don't cover M.D. Anderson;

**BYLINE:** By Jenny Deam

**SECTION:** A; Pg. 1

**LENGTH:** 1438 words

>> Get news from the Medical Center and beyond: HoustonChronicle.com/Prognosis

>> Breast cancer rising among black women Page A24

As the health insurance enrollment season opens Sunday, it's what missing from the list of options that frightens Martha Gardenier most.

The 59-year-old self-employed certified public accountant from The Woodlands area has a rare bone marrow disease that two years ago took a deadly turn, progressing to a form of leukemia so dire a doctor told her she should begin end-of-life care. But a Hail Mary plan put her in an experimental trial at Houston's medical crown jewel, the University of Texas M.D. Anderson Cancer Center. Against improbable odds, the treatment worked, dialing back her cancer from Grade 3 to Grade 1.

"Every day is a new miracle," she said, her honeyed drawl filled with awe.

Then came the Sept. 25 letter from her insurance carrier, Blue Cross Blue Shield of Texas, which said her Preferred Provider Organization (PPO) individual plan - one she picked specifically because, although expensive, it covered M.D. Anderson - was being dropped effective Dec. 31.

As many as 2,000 other patients at M.D. Anderson also may be cut off from coverage with the loss of such PPO plans either through the Affordable Care Act's federal exchange or, in the Gardeniers' case, bought privately in the individual market, said Dr. Lewis E. Foxhall, vice president of health policy at the cancer center.

In fact, in 2016 there no longer are any plans by any carrier for the Houston area on the federal exchange that cover M.D. Anderson, although the hospital may be able to accommodate some patients on a case-by-case basis.

"They look at it as a business decision," Foxhall said last week. "We look at it as a coverage issue, and coverage here can mean life or death."

Blue Cross Blue Shield announced on its website in July that it was dropping all PPOs in the state because the policies no longer made financial sense for the company. The Gardeniers had no idea until the letter arrived, the cancellation noted in boldface letters.

Coverage unclear

On Oct. 20 the Gardeniers got a follow-up letter saying Blue Cross Blue Shield had "selected" another plan for them and all they had to do was "continue to pay your monthly premium on time." The new plan is part of a Health Maintenance Organization, the coverage boundaries of which remain unclear.

Preliminarily, it appears M.D. Anderson now will be considered "out of network" on Gardenier's HMO plan, and the company will pay only 50 percent of covered costs instead of the previous 70 percent, an M.D. Anderson spokesman said. In the world of cancer treatment, such a difference can be financially crippling for patients.

One of Gardenier's medications, part of the cocktail of drugs she'll take for the rest of her life, is $10,000 a month. The second one costs $5,000 per month. It is not clear how medications would be covered under the HMO.

"This is my life we're talking about," she said, her dismay and disgust colliding as she wonders why saving it has become an actuarial calculation.

Last week, a preview of the 61 health care plans for 2016 through the federally mandated exchange showed no PPOs plans being offered in the Houston area. For 2015, there were 19. Only HMOs or the rarer Exclusive Provider Organization, which allows members only to use doctors and hospitals within its network with no out-of-network benefits, are now listed.

Additionally, it appears no PPOs will be offered by major insurers in the individual market in the Houston area, insurance brokers said.

Plan typically sought

The loss of individual-market plan PPOs will affect tens of thousands of people in the region who, like the Gardeniers, buy their insurance privately rather than through an employer. Before the Affordable Care Act, it was the way most people who did not have employer insurance got coverage.

These individual plans remain the only option for many people not on a group plan, such as the self-employed, or for those who are ineligible for subsidies to lower premium costs on the federal exchange.

A PPO plan, although more expensive for customers, is typically sought by people looking for a wider range of physicians and hospitals. This can be especially important for those with complex medical needs.

While still being offered in many employer plans for 2016, the sudden disappearance in Houston of PPOs both on and off the exchange has stunned consumers and insurance brokers alike.

"It's pretty stark and shocking," said Jason W Bohmann, a Houston insurance broker whose clients include the Gardeniers. "It rips me up. I want to provide choices to my clients."

A cruel irony at play?

Gardenier was covered in the early part of her treatment at M.D. Anderson by Aetna. But in December 2014 she learned during a routine call to its customer service that the insurer was dropping the cancer center for the coming year. She panicked.

Then her broker steered the couple to a Blue Cross Blue Shield PPO plan in the individual market.

She never considered the federal exchange for coverage.

"We'll just do it ourselves," she and her husband thought, even as the premiums and out-of-pocket costs began draining their retirement savings.

"Are you sure?" she asked Blue Cross Blue Shield. "We want to get it in writing that you cover M.D. Anderson."

She signed up quickly, paying $886 per month for her plan and $658 per month more for her husband's. She thought she could relax and concentrate on getting better.

Dr. Dan McCoy, divisional senior vice president and chief medical officer at Blue Cross Blue Shield of Texas, told the Houston Chronicle editorial board in October it was a difficult decision to drop PPOs and that it was not made lightly. He previously has said the company paid out $400 million more in claims than it collected in premiums.

The company posted a message on its website last summer.

"Since the Affordable Care Act began, the market has changed. We found the individual PPO plan was no longer sustainable at the cost it was being offered," the statement read in part.

One of the most puzzling issues this enrollment season is why there is such an absence of PPO coverage in Houston.

Such plans are being offered by other carriers in Texas cities, both on the exchange and in the individual market.

Michael Ledgerwood, president of the Houston Association of Health Underwriters, wonders if there is a cruel irony at play for patients in a city with a global reputation for cutting-edge medical care.

"Being in Houston is good and bad. We have all of these wonderful medical facilities. People come from all over the world to be treated in Houston. But that kind of care comes with a very high price," Ledgerwood said.

'Distressing' to watch

"It's very distressing to see this happening," said Foxhall at M.D. Anderson. He, too, wonders if the kind of expensive care offered here may be spooking insurers.

In the first year of the exchange, several companies offered plans that covered M.D. Anderson. Last year it was only Blue Cross Blue Shield PPO. Now that is gone, too.

"We're in the process of trying to reach out to those patients that lost coverage to see what we can do to help," he said.

Bohmann, the Gardeniers' insurance broker, may have come up with a strategy to save their coverage.

Since they both are CPAs and work together out of their home, they might qualify to get a PPO policy as part of a group plan. The premium would be $2,411 a month.

Blue Cross Blue Shield would not address the Gardeniers' case directly. But in a late-week email to the Chronicle, the company said it "has programs in place to help members if they are impacted by the PPO discontinuance in the individual market. If a member is seeing a health care provider who will no longer be an in-network provider for their plan in 2016, we offer other quality network provider choices for our members and will work with them to provide transition assistance address."

Trying to 'fool people'

That infuriates Gardenier, who said insurance companies think cancer care is interchangeable. She once believed that herself - before she was written off by one doctor as beyond saving.

"My assumption was, I live in Houston. All cancer specialists and hematologists would be aware of all the latest research and would be about the same," she said. "That is the point insurance companies are trying to fool people with, that all treatment is equal."

But without the unique treatment she received at M.D. Anderson, Gardenier has no doubt she would have never met a cherished milestone.

"I got to hold my fifth grandbaby last summer," she said.

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**GRAPHIC:** Gary Coronado / Houston Chronicle Martha Gardenier has been battling a rare form of cancer for more than a decade. Now, she is concerned about losing coverage at the University of Texas M.D. Anderson Cancer Center after her insurance provider stopped offering the plan she uses.

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## Member Questions for the Record

### Congressman Dold's QFRS

**Are narrow networks the future of individual health insurance plans?**

In my opinion, yes, narrow network plans are the future of individual health insurance plans.

It is important to understand that the ACA's minimum insurance standards constrain an insurance carrier's ability to develop a plan design with a reasonable price point. This is because the "essential health benefits" and the "actuarial value" requirements, among others, increase the underlying cost of coverage. The only way carriers have been able to reduce the costs of their plans is by narrowing the plans' provider networks and increasing the cost-sharing under the plans.

Recent studies have found that narrow network plans constituted nearly half (50%) of all Exchange plans in the first two years of the ACA. And, for the reasons discussed above, I expect that the prevalence of narrow network plans in the individual market will only increase.

**How do narrow network plans impact consumers and what can Congress to do mitigate these impacts?**

In truth, I am a fan of narrow network plans. BUT ONLY if the person purchasing the narrow network plan thoroughly understands what they are getting themselves into. For example, if a person purchasing a narrow network plan fully understands that they are trading access to care for lower premiums, then the purchaser should have the freedom to make this choice. There may be instances where a person is comfortable limiting their access to care to a finite set of medical providers because they want to pay less for their health plan.

However, where problems arise is when a purchaser does not understand that by purchasing a lower costing, narrow network plan they may NOT have access to their preferred doctors and medical providers. And, the problem is exacerbated when the purchaser accesses medical services at a doctor/provider that is out-of-network (and incurs significant out-of-network charges that are not covered by insurance).

In the first two years of the ACA, a significant number of individuals who purchased a health plan through the ACA Exchanges were oblivious to the fact that they were purchasing a narrow network plan. When these individuals finally realized that their preferred doctor was not in their newly purchased plan's network, they felt they were misled by the Exchanges and proponents of the new law. In other cases, individuals only found out about their narrow network plan when they received an exorbitant medical bill for out-of-network medical services.

HHS and State regulators have tried to take steps to help consumers better understand what medical providers are in a particular plan's networks. These steps have included requiring insurance carriers to update their plans' provider networks monthly. But, I would argue that more should be done. Congress may consider developing some sort of "labeling" system that could inform a consumer whether the plan they are choosing has a narrow network or a broader network. Congress may also consider requiring insurance carriers – as a condition to

participating in the Exchanges – to provide education tools on their web sites that can easily explain what a narrow network plan is, and the trade-off between giving up access for care and paying a lower price for a health plan. The ACA Exchanges should also be required to provide education tools on their web site (e.g., a pop-up video can be deployed on the Exchange's web site).

**Based on increases in out-of-pocket costs, are we seeing situations where an individual or family has insurance, but cannot afford to use it?**

In my opinion, yes. As discussed above, insurance carriers were forced to adopt a strategy of narrowing networks and increasing deductibles, co-payments, and co-insurance to keep premiums low. As a result, low-cost plans now have sky-high deductibles. In many cases, individuals do not want to pay the "individual mandate" penalty tax. So, they seek out the lowest cost option, which again, is a health plan with extremely high cost-sharing. In the end, they have health insurance, but because of the significant out-of-pocket exposure before the insurance coverage kicks in, they effectively do not have meaningful health coverage.

**With insurance costs so high, will some people, especially those who are young and healthy, decide that paying all their health costs out-of-pocket along with the individual mandate penalty is more cost effective than purchasing insurance?**

Yes, we are already seeing this play out in practice. For example, we know that younger and healthier individuals are not purchasing insurance, evidenced by the fact that only 28% of the current Exchange enrollees are between the ages of 18 and 34. This fact is also supported by IRS indicating that 45% of the 7.9 million taxpayers who paid the individual mandate penalty tax in 2014 were under age 35. It is clear that younger and healthier individuals are foregoing health insurance, opting to pay for their own health costs out-of-their-own-pocket, and choosing to pay the penalty tax.

We are also seeing individuals choosing to purchase short-term health plans or limited benefit-type plans (e.g., indemnity coverage) instead of an ACA-compliant major medical plan. These individuals are attracted to the lower costs associated with short-term health plans and indemnity coverage, and even after they pay the individual mandate penalty (because short-term plans and indemnity coverage do not qualify as "minimum essential coverage"), their total out-of-pocket spending is lower than the amount they would otherwise pay for an ACA-compliant major medical plan.

**How does the collapse of a CO-OP impact its enrollees and contracted providers?**

In the case of CO-OP plan-holders, these individuals must now find other coverage. This disruption places a burden on these individuals, who must now find a health plan with a similar plan design and a similar provider network. In some cases, any new plan that the CO-OP plan-holders may enroll in may not include the same doctors and medical providers in the plan's network.

In the case of contracted providers, depending on whether the defunct CO-OP is insolvent or whether the CO-OP is simply being "unwound" by a State Insurance Commissioner, contracted providers may be treated differently. For example, if the CO-OP is insolvent, the CO-OP may not be able to pay outstanding claims to a contracted provider. As a result, these providers will have to seek payment from the State Guaranty Fund or they may simply have to treat the outstanding claims as "bad debt." Where a CO-OP is being "unwound," however, the CO-OP is typically able to make good on all of its outstanding claims with its contracted providers. But, those payments may be delayed until the State Insurance Commissioner has a full accounting of the CO-OPs assets and liabilities.

**What impact will the collapse of a CO-OP have on the markets overall, and more specifically on competition between the remaining providers in individual counties?**

As you know, the CO-OPs were put into the law in an effort to increase competition in the individual health insurance market. In the first two years of the ACA, we actually saw fairly robust competition in many State insurance markets, and especially in markets where CO-OPs were offering health coverage.

With the departure of a CO-OP in a particular market, competition will surely be impacted. And, less competition could push premiums higher. Any increase in premiums could be mitigated by a new insurance carrier entering a market where a CO-OP is departing. But, if no new carriers enter the market as a CO-OP departs, then premiums could be adversely impacted.

For those carriers that remain in the market (and that ultimately end up insuring the displaced CO-OP plan-holders), these carriers may inherit a disproportionate amount of unhealthy lives (in cases where the defunct CO-OP insured higher-risk individuals, who are now displaced). This will have an adverse impact on the remaining carriers' risk pool.

## Congressman Noem's QFRs

**Some claim that similar or worse rate increases occurred prior to the ACA. Is this accurate?**

In general, claims that premium rate increases were similar prior to the ACA are true. However, I believe it is a stretch to suggest that rate increases were worse.

For example, rate increases of 40%, 50%, or even 60% for the vast majority of policyholders in the pre-ACA individual market were rare. Typical premium increases pre-ACA ranged from 10% to 20%, depending on the market, and also depending on the health of a particular policyholder. In my opinion, trying to compare pre-ACA premium increases to post-ACA premiums increases is trying to compare apples with oranges.

What do I mean? As you may know, pre-ACA, insurance companies were permitted to develop the premiums for a particular policyholder based on the policyholder's health. So for example, let's say in Year 1 both Policyholder A and Policyholder B were quoted the same premium amount. But, in Year 2 Policyholder B developed a medical condition while Policyholder A remained healthy. In this case, Policyholder B might see their premiums increase by 20%+ because the insurance company providing coverage could change the premiums based on Policyholder B's health status. Policyholder A, on the other hand (who remained healthy), may only see a 7% premium increase, which simply reflected the increase medical trend for the year.

The ACA prohibited insurance companies from developing premiums based on health status. Under the ACA, premiums may only vary by age (by a 3 to 1 ratio), tobacco use (by a 1 to 1.5 ratio), geography, and type of health plan (single vs. family). So in essence, in the post-ACA market, every policyholder's premiums are the same, with some variation based on the factors enumerated above. Because every policyholder's premiums are generally the same, the premium increases in the post-ACA market affect *every* policyholder, not just individual policyholders.

Using our example above, in a post-ACA market, when Policyholder B developed a medical condition in Year 2 (while Policyholder A remained healthy), the premium increases for Policyholder A will essentially be the same as for Policyholder B. This means that if insurance companies increased premiums by 20%+ for a particular year, BOTH Policyholder A and Policyholder B would see the same 20%+ increase in their premiums.

**What tools are being developed to help benefits managers and patients make informed healthcare decisions regarding site of service?**

There a number of small "start-up" companies that are trying to provide employees and individual market policyholders with better transparency of medical prices (e.g., Amino, Pokitdok, and GoodRx, just to name a few). There are also companies that have been working on trying to increase transparency for a number of years now (e.g., Healthcare Bluebook, which you mentioned, as well as Castlight).

These transparency tools are primarily utilized by self-insured employers (i.e., an employer that offers health coverage to their employees where the employer is acting like an insurance company and paying the employees' medical claims). A number of "private" health insurance exchanges also offer these types of transparency tools to employees of those employers partnering with the private exchange to offer health coverage.

Unfortunately, these transparency tools are NOT being utilized by the ACA Exchanges (both the State-based Exchanges and the Federal Exchange, run by HHS). A strong argument can be made that the ACA Exchanges should leverage the private sector technology that is available to help individual market policyholders become better consumers of health care. Incorporating these types of transparency tools will also improve the "consumer shopping experience," and help an individual market policyholder find a health plan that best fits their needs.

Much more needs to be done to make these transparency tools available to a broader population of health care consumers, both in the employer-sponsored market as well as the individual market.

Committee on Ways and Means
Hearing on Rising Health Insurance Premiums Under the Affordable Care Act
Responses to Questions Posed By the Committee Members to Joel White, President, CAHC
July 12, 2016

***From Representative Smith of Missouri:***

Mr. White, in your written testimony, you mentioned a recent proposed policy from CMS that will continue this trend. CMS has decided to prohibit the sale of short-term medical plans that last longer than 90 days – and will not allow a consumer to renew a policy after this 90-day window.

As was detailed in an article from the Wall Street Journal in April, the sale of these types of policies has skyrocketed since the exchanges opened in 2013 with sales increasing by 150 percent in the last 3 years. The majority of people who purchased these policies said they bought them these policies because they are much more affordable than those seen on the exchanges. It is clear there is a strong demand and market need for more affordable, limited policies like these – but the government is taking away choice and dictating what can and should be purchased.

**Mr. White, why do you think CMS issued this proposed policy? Don't you think there are better solutions to improve the risk pool and ensure that more Americans have affordable, accessible coverage?**

**Joel White:**
The proposed rule would establish new benefit requirements for hospital indemnity or other fixed indemnity coverage (subsequently referred to as "fixed indemnity"), specified disease or illness insurance, and short-term, limited-duration insurance (subsequently referred to as "short-term medical insurance"), which we believe will significantly limit coverage options for consumers. It appears that in an effort to shore up the ACA insurance exchange risk pools, the Administration seeks to regulate these products in a way that will drive more consumers into the exchange market. The Agencies, however, have not provided empirical data to show either how the proposed rule would impact the number of enrollees in the exchanges, or how it might impact plan choice and costs for consumers.

We believe that with regard to fixed indemnity coverage and specified disease insurance, the proposed rule's regulatory actions have no basis in statute and run counter to Congressional intent. Congress specifically created and protected these plans in statute under the 1996 Health Insurance Portability and Accountability Act. The law requires only that such plans:

1) Are provided under a separate policy; and
2) Offer independent, non-coordinated benefits (with any other plan the individual may have) with respect to an "event."

When the ACA was passed in 2010, Congress incorporated 42 U.S.C § 201 of the Public Health Service Act's (PHSA) definition of "excepted benefits," and chose not to make any changes to these plans or apply any of the ACA's new rules to these plans.

The Administration's proposed rule would require all fixed indemnity plans to provide benefits on a per-day or other per-period basis, rather than on a per-service basis, and to provide a dollar benefit amount without regard to the type of items or services received. These additional limitations violate clear statutory language for fixed indemnity excepted benefits. In addition, the D.C. Circuit Court of Appeals ruled in Central United Life Ins. V. Burwell, No. 15-5310 (D.C. Cir. 2016) that additional regulatory restrictions on these types of products is counter to the statute.

If the Agencies' proposals are finalized, nearly all fixed indemnity policies on the market today would be prohibited and roughly 49 million enrollees could lose access to their current benefits as a result. We believe that this section of the proposed rule should be withdrawn.

Similar to limits on fixed indemnity plans, the Agencies propose to amend the current definition of "short-term, limited duration insurance" to restrict this form of coverage as well. Like fixed indemnity products, Congress exempted short-term plans from many Public Health Service Act requirements and regulations, including the offering of essential health benefits.

These short-term medical plans have an expiration date (taking into account any extensions that may be elected by the policyholder without the issuer's consent) that is less than 12 months after the original effective date of the contract. The proposed rule seeks to significantly reduce the permissible contract expiration date from the current length to a term of within three months of the effective date of coverage. The Agencies believe that, in some instances, individuals are purchasing this coverage as their primary form of health coverage and that issuers are renewing this coverage beyond 12 months. The Agencies further note that this coverage option is "adversely impacting the risk pool for ACA-compliant coverage" through the insurance exchanges, in part because healthier individuals may be more likely to enroll in this type of coverage.

While the Agencies may believe the argument that fixed indemnity and short term liability policies are negatively impacting the risk pools (the Agencies provide no data to back up this claim), the fact remains that the statute precludes the proposed regulation because the ACA itself requires the maintenance of a private market outside of the insurance exchanges. There is no legal justification for the Agencies' actions, no matter how pure the Agencies' motives.

Congress, not the Administration, decided these products should be an option for consumers. The Agencies have sought regulatory changes to these plans not contemplated or authorized by Congress and that would restrict these plans as a choice for consumers. If the Administration does not withdraw these regulations, Congress should intervene to ensure that consumers continue to have access to these plans.

***From Representative Dold of Illinois:***

My constituents in the north suburbs of Chicago are lucky to have access to some of the best teaching hospitals in the country, and many see doctors in multiple provider systems. Yet, for the 2016 plan year, the vast majority of the plans available on the exchanges in my district have very narrow networks, forcing my constituents to pay higher premiums and deductibles for the few plans that allow them to keep the doctors they like and trust.

**Are narrow networks the future of individual health insurance plans? How do narrow networks impact consumers and what can Congress do to mitigate these impacts?**

**Joel White:**
Some background information may help in answering this question, as this issue is complex and has a long history in U.S. health care.

Health insurance plans with limited provider networks are becoming more common. This is partly in response to the ACA's limits on benefit design (essential health benefits and actuarial value) and rating rules (age and underwriting changes, for example). In order to compete on price (premium), many plans on exchanges narrowed their provider networks to hold down costs. This means they have aggressively negotiated price concessions to obtain lower premiums, or excluded providers from networks.

John Wennberg of Dartmouth Health Atlas calculates that 60 percent of care received by Medicare beneficiaries is "supply sensitive," meaning its provision is motivated primarily by the capacity of the local health system rather than patient need. For example, patients are likely to have longer stays in hospitals that have empty beds or extra tests when testing facilities are underutilized. Frequently, this added intensity comes without statistical evidence of better health outcomes. Another 24 percent of care, says Wennberg, is "preference sensitive"—and often the result of poor communication. Surveys show that, when given an informed choice, a significant percentage of us will opt for the less invasive, less costly alternative.

In the early part of the decade, private health insurers set out to tackle input costs through "tight" managed care systems in the form of health maintenance organizations (HMOs). HMOs achieved their savings through three means: 1) by directing patients to exclusive "narrow" networks of providers, HMOs induced providers to bid against one another on price; 2) pre-authorization of specialty services allowed "gatekeepers"—typically, primary care physicians—to winnow out waste; and 3) sharing risk with providers to give health systems an organic (self-organizing) business case for efficiency.

Although the managed care revolution lost momentum in the late-1990s amid fears that insurance clerks were denying clinically beneficial care, tens of millions of Americans still participate in capitated payment systems or HMOs. Meanwhile, employers and insurers again are experimenting with "narrow" provider networks.

Limited networks of providers can be valuable if they bargain down costs or raise efficiency or some combination of the two. This creates real value for consumers, but may create new barriers to accessing care. Narrow networks therefore are likely essential to transitioning payers and providers and others from payment and delivery mechanisms that reward volume to ones that support value (think of ACOs). Consumers, too, are rewarded for participating in narrow networks through lower premiums. Balancing the lower cost against networks that may potentially be too narrow is the challenge, and not something well suited to regulatory or legislative efforts as each consumer's preferences are different.

We recognize that HHS is considering providing a rating of the breadth of each plan's relative network coverage on HealthCare.gov by rating plans as "Basic," "Standard," or "Broad." This rating would solely be based on the calculation of the number of hospitals, adult primary care providers, and pediatric care providers that are accessible within specified time and distance standards. CAHC considers this proposal to be highly problematic and contradictory to HHS' goal of moving from volume-based reimbursement to a value-based system. Such a rating would provide consumers with no information about the quality of networks and providers. This would also discourage plans from creating innovative network designs, such as alternative payment models within the private market. If HHS moves forward with this approach, Congress should require a rating method that would inform consumers about network quality and innovation rather than breadth alone.

It is also critical that insurance exchanges utilize integrated provider directories that allow consumers to easily determine which plans cover their preferred doctors. Furthermore, exchanges should take further measures, in conjunction with plans, providers, and regulators, to ensure that plan information presented to consumers is accurate, consistent across multiple sources, and updated on at least a monthly basis. Congress should require these attributes across all exchanges.

Finally, Congress should also reward Medicare beneficiaries who participate in the Medicare Shared Savings Program by allowing a rebate on premiums or reduced cost sharing as an incentive to participate more directly in their care and in engaging with their providers.

When discussing health insurance affordability, we must go beyond premiums to also look at deductibles and other out-of-pocket costs. Nationally, in 2016 the average deductible for a bronze plan increased about 10% over 2015 to about $5,700 for an individual. The average deductible for a silver plan increased 6% to about $3,100. These costs are on top of premiums that are often hundreds of dollars per month.

**Based on these increases in out-of-pocket costs, are we seeing situations where an individual or family has insurance, but cannot afford to use it? With insurance costs so high, will some people, especially those who are young and healthy, decide that paying all**

**their health costs out-of-pocket along with the individual mandate penalty is more cost effective than purchasing insurance?**

**Joel White:**
The simple answer to the first question is we do not know conclusively. We have collected anecdotal evidence that some consumers with high cost sharing are not accessing care. Other recent research in *Health Affairs* examines what happened with those covered by an exchange plan or through Medicaid. The researchers found that uninsured people who gained private coverage filled, on average, 28 percent more prescriptions and had 29 percent less out-of-pocket spending per prescription in 2014 compared to 2013. Those who gained Medicaid coverage had larger increases in fill rates (79 percent) and reductions in out-of-pocket spending per prescription (58 percent).

It remains, however, that both premiums and out-of-pocket costs are increasing at double digit rates, putting care more out of reach for many.

Earlier this year, CAHC issued a report on exchange enrollment, which found that the number of individuals enrolled in exchanges is lower than originally projected.[1] While enrollment in exchange plans has grown each year -- from 6.3 million enrollees in 2014, to 8.8 million in 2015, and a projected 10.1 million in 2016 – enrollment is about half than was originally projected by the ACA (21 million versus 10 million).

Further, our research found that while over half the exchange enrollees were projected to be under 34 years of age, just 37 percent of that age cohort actually enrolled. So younger, healthier individuals have not enrolled as expected.

A variety of relevant factors are at play:

1. The individual mandate penalty is not having the behavioral impact CBO and others expected. Mandates and restrictions on plans drive up the cost of coverage. Our conclusion is that this cost is simply too great to cause many to enroll, unless an individual is subsidized. In fact, our research shows just 2 percent of the unsubsidized population eligible for exchange coverage has actually enrolled. Future behavioral economic research may uncover a significant cost-benefit analysis between the threat of the penalty for being uninsured, the premiums and cost sharing of exchange plans, and the likelihood of actually paying the penalty.

2. HHS has granted "hardship exemptions" to the mandate that may have numbed millennials and other young Americans to the threat of paying the mandate. In addition, many Americans may still be unaware of the mandate's requirement to purchase coverage.

3. The ACA discourages enrollment of young adults in exchange plans through the allowance to remain on a parent's plan through age 26, age rating, and the

[1] "Exchange Enrollment: An Opportunity for Reform." Council for Affordable Health Coverage, 7 Jun 2016. http://cahc.net/wp-content/uploads/2016/07/CAHC-IssueBrief_ExchangeEnrollment_061616.pdf

unavailability of subsidized catastrophic coverage (which is only available until age 30). And, exchange coverage may simply be too expensive to afford without a premium or cost-sharing subsidy for many young adults.

Some have simply decided that, after comparing the cost of health insurance premiums, deductibles, and other cost-sharing amounts, the cost is not worth the product or the penalty for being uninsured (which is the greater of $695 or 2.5 percent of household income in 2016). These individuals may be more financially comfortable paying for medical costs and services -- such as doctor appointments, lab tests, and prescription drugs -- out of their own pocket and only when necessary.

We believe the answer to these challenges is not to increase subsidies, which simply shift costs onto taxpayers, but to rather lower underlying medical costs, as I indicated in my testimony.

We believe Congress should fund research into how access to care has changed under the ACA law for those with and without exchange plans. Recent research from the Agency for Healthcare Research and Quality lacks granularity, and, we believe, research from HHS appears to be biased.

On July 14, 2016, Illinois' Consumer Operated and Oriented Plan (CO-OP), Land of Lincoln Mutual Health Insurance Company, announced it will be liquidating on September 30, 2016. Land of Lincoln is the fifteenth of the original 23 CO-OPs to collapse. 49,000 beneficiaries in Illinois now have to purchase a new insurance plan for the remainder of 2016, or risk paying a fine.

**How does the collapse of a CO-OP impact its enrollees and contracted providers? What impact will the collapse of the CO-OPs have on the markets overall, and more specifically on competition between the remaining providers in individual counties?**

**Joel White:**
It is unfortunate that thousands of Illinois beneficiaries could be penalized under the ACA because the law's own failed CO-OP program prevented their compliance with the individual mandate.

CO-OPs were the creation of politicians and a compromise between those who support a public option in health markets and those who thought that policy would disrupt markets and create problems for consumers. The former group, according to them, sought only to create a level playing field between newly created CO-OPs and existing insurers.

Given that the Land of Lincoln and 15 other CO-OPs have collapsed and the remaining seven CO-OPs appear to be on precarious financial footing, it is important to ensure taxpayers are provided with detailed information about the CO-OPs and their challenges, and how taxpayer dollars were and are being spent.

In general, market experience and how the law was implemented are two of the many factors playing a role in the financial demise of CO-OPs. Some CO-OPs offered coverage with premium rates far below their competitors, but they quickly saw medical costs outpace premium revenue. Required solvency reserves quickly dwindled. Other CO-OPs had little enrollment their first year and offered lower premiums in their second year of existence.

According to the Government Accountability Office, the average premiums for CO-OP plans in 2014 were lower than those for other issuers in more than half of the rating areas for states in which they participated.[2] In general, it seems to me that the CO-OPs had substantial start-up costs and little experiential data upon which to set premiums.

The primary factors in developing appropriate premiums are projected claims and the underlying medical costs of the insured population. So, if a health insurance plan attracts a disproportionate share of individuals with higher than expected premiums, then premiums will be higher in order to reflect those costs.

Under the ACA, three risk management programs were created: a temporary reinsurance program; a temporary risk corridors program; and a risk adjustment program that requires carriers with healthier enrollees to subsidize carriers with sicker populations. In some cases, it appears that CO-OPs may have enrolled a disproportionate number of enrollees who are healthier than the market average, ultimately triggering risk adjustment payments from CO-OPs to other plans.

According to media reports, the Land of Lincoln's demise is largely due to a requirement to pay $31.8 million to other insurers, which came on the heels of a loss of more than $90 million in 2015. The Land of Lincoln filed a lawsuit in the U.S. Court of Federal Claims claiming that the federal government had shortchanged its risk corridor payments.

It is clear that CO-OPs have faced numerous administrative, financial, and management problems. In areas in which a CO-OP collapses, enrollees are faced with the unexpected responsibility of finding other coverage or going without and facing a possible tax penalty. Health care providers, including hospitals and physicians, are also negatively impacted.

When a CO-OP fails and there is a shortfall of funds necessary to meet the obligations to policyholders, the state guaranty associations are activated. This means that insurers doing business in that state are assessed a share of the amount required to meet all covered claims. This will increase premiums for all other consumers as these costs are passed on. Provider claims for medical services provided to CO-OP members may not be paid in full and in a timely manner. In general, while the market should be able to absorb CO-OP enrollees and consumers should have access to other coverage, premiums are more expensive because of losses and higher market rates.

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[2] "Private Health Insurance: Premiums and Enrollment for New Nonprofit Health Issuers Varied Significantly in 2014." GAO-15-304. April 2015. http://www.gao.gov/assets/670/669945.pdf

As CAHC and the Galen Institute wrote to the Committee 11 months ago, we believe there are a number of oversight issues that remain. We suggest Congress should repeal the CO-OP law or significantly reform it to create a level playing field. Specifically, we suggest that Congress:

- Require HHS and the CO-OPs to provide a strict accounting of all taxpayer funds spent and the status of any remaining funds;
- Require the return of any unused funds from failed CO-OPs to the Department of Treasury and any real property purchased to be returned to the General Services Administration;
- Continue to examine the role of various stakeholders involved in the funding and operations of CO-OPs and their level of accountability for the program, including the role of:
    - CMS and CCIO, including: (1) the criteria and evaluation process used to determine the approval and application of CO-OP loan and solvency grant funds; (2) any correlation between the amount of solvency loans and a CO-OPs total enrollment; and (3) any audits employed to safeguard taxpayers and consumers
    - IRS, particularly in the review and approval of CO-OP tax returns, which require information on: (1) the amount of reserves required by each State in which the CO-OP is licensed; and (2) the amount of reserves on-hand, as well as any information on concerning any tax penalties assessed to individuals who lose health insurance coverage due to a failed CO-OP;
    - States insurance departments, particularly when it comes to: (1) reviewing and approving CO-OP premium rates and determining whether such rates are adequate to pay projected claims and expenses; and (2) monitoring CO-OPs for capacity and rapid customer growth.

- Continue to examine the role of State Guaranty Associations and the process that is required for their activation; as well as the ramifications of CO-OP insolvency on state revenues, solvent insurance carriers and taxpayers in terms of cost-shifting.

We hope these reforms will protect consumers from an ill designed and poorly executed CO-OP program that is creating significant problems and may be raising costs for all players in the marketplace.

***From Representative Nunes of California:***

Mr. White, California has imposed additional requirements beyond federal laws – and we saw a 13 percent increase in premiums this year, while many of our rural counties only have one or two insurance plans available.

**Do you believe there is a direct cause and effect here? If more flexibility were allowed, would we see more competition and lower costs?**

**Joel White:**
Yes, there is a direct cause and effect. Overreach by the ACA has contributed to high and growing health insurance premiums. Double digit price increases this year and next, and unbalanced risk pools that are lowering participation and competition in health markets typify the exchanges. These are caused, in part, by rising medical costs, statutory and regulatory mandates on health plans and employers, and regulatory inflexibility by rule makers.

In fact, CBO estimated in 2009 that the essential health benefits, actuarial value, and guaranteed issue requirements would increase premiums in the individual market by 27 to 30 percent.[3]

In implementing the law, regulatory activity related to the ACA that negatively impacts costs has been robust. For example, California has been a loud and vocal proponent of standardized benefit designs, which will further restrict consumer choices by requiring plans to curtail diversity in plan offerings. We believe this will lead to higher cost sharing for some consumers. For example, standardized plan designs currently proposed for HealthCare.gov include only two tiers for formulary drugs – either generic or non-generic – with 50 percent coinsurance for all non-generic drugs, which is highly atypical in today's marketplace. None of the standard benefit options afford consumers the option of using HSAs, even though consumers could benefit from additional tools to meet the plan deductibles and cost sharing requirements. Put simply, requiring standardized plans would restrict choice, drive up cost sharing and likely increase premiums.

Congress should prevent HHS from imposing standardized plans on HealthCare.gov as yet another cost increasing regulatory step.

***From Representative Black of Tennessee:***

Mr. White, HealthCare.gov does not currently indicate what plans are eligible for HSAs on the exchange even though many have very high deductibles.

[3] "An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act." Congressional Budget Office, 30 Nov 2009. https://www.cbo.gov/sites/default/files/111th-congress-2009-2010/reports/11-30-premiums.pdf

**Can you tell me why this is particularly problematic in light of the new standard benefit design plans that will be offered in 2017?**

**Joel White:**
HealthCare.gov does not currently indicate which plans meet the requirements as HSA qualified plans. Because deductibles and other cost sharing are large and increasing rapidly, and because HSAs provide current law tax benefits to help consumers meet cost sharing obligations, HealthCare.gov and the state-based exchange websites should clearly identify plans with HSA benefits as part of the listed information on the exchange plan display pages.

This is important because the standard plan options proposed for 2017 will be displayed in a manner that makes them more prominent than other plan options, which makes them more likely to be selected by consumers. Standard plans do not meet HSA rules and cannot be paired with an HSA account. Consumers selecting the standard plan options will thus have no additional resources to meet significant cost sharing requirements.

CAHC believes the HHS proposal to introduce standard plan options into the federally-facilitated exchanges would reduce consumer choice and do little to enhance the plan selection process. Rather than implementing standard options to simplify the plan selection process for consumers, HHS should be actively working to provide consumers with access to the best consumer support tools to help narrow appropriate choices.

CAHC urges Congress to implement reforms to create the next generation of health insurance exchanges to help create exchanges that are true markets for buying health insurance. Reforms include:

(1) **Private Shopping Websites**. These websites would compete directly with public websites for consumers based on the user experience and key-decision support tools, such as: out-of-pocket cost calculators; smart plan finder tools to prioritize and quickly highlight best-fit options; integrated, searchable provider networks and drug directories; and easy-to-understand cost information for common services and procedures.

(2) **A Modern Eligibility Process:** The federal government would contract with a private vendor(s) to set-up a "Paypal"-like system for the payment of premium subsidies. This would allow subsidies to become portable so that low-income consumers could purchase coverage from any exchange website, public or private.

(3) **Simplified Small Employer Shopping:** Private shopping websites would allow small employers to purchase traditional small group coverage. Time-saving features could be offered, such as the ability to upload demographic files that would allow employers to only input data once and be able to obtain health insurance pricing across multiple insurers.

(4) **A Revamped State Certification Process:** Each state would certify that at least one website: allows for the purchase of health insurance; shows the pricing of all insurers that offer individual market and small group coverage in the state; and offers a "Paypal"-like system for subsidies.

Mr. White, I have long been a champion of value-based insurance design that can help patients maintain access and treatment regimens for their chronic conditions. At the same time, I also want to promote consumer directed health plans to make consumers more aware of how they spend their health dollars. I am concerned that the high deductible health plans and also plans that have high deductibles, but aren't qualified for HSA use may potentially be dangerous to consumers who have on-going, serious health needs.

**Do you think coupling a VBID type of structure with an HSA-eligible plan would help to lower costs while also helping patients adhere to treatment regimens for their chronic conditions? Why?**

**Joel White:**
Given that chronic disease conditions account for about 86 percent of health care spending, chronic disease management tools, including value-based insurance design, are essential to lower long-term health care costs.[4]

As we continue to witness the shift from payment and delivery mechanisms that reward volume to ones that support value, I believe the federal government should provide greater incentives and flexibility to improve how care is delivered, including the use of VBID practices coupled with High-Deductible Health Plans (HDHPs).

We need to explore ways to better align out-of-pocket costs with the value of services. And, we should consider benefit designs that engage consumers and encourage access to high-value and appropriate care.

Your legislation (H.R. 5652, the Access to Better Care Act) is a great step in the right direction. By allowing HSA-eligible HDHPs to provide first-dollar coverage for targeted preventive services that are clinically proven to have good health outcomes and prevent chronic disease progression, the bill would improve health, create greater efficiencies, and reduce medical expenses, such as hospitalizations.

***From Representative Noem of South Dakota:***

In your testimony, you referenced a report from the Council for Affordable Health Coverage showing that fewer than 40 percent of Exchange plan enrollees are under 35, despite the fact that 50 percent of the potential Exchange population is in that age bracket. Additionally, males and Hispanics are enrolled at much lower rates than anticipated. Despite spending billions of dollars

[4] "Chronic Disease Prevention and Health Promotion." Centers for Disease Control and Prevention. http://www.cdc.gov/chronicdisease/

to expand insurance coverage, Americans are still falling through the cracks.

**How does the government's monopoly on the Exchanges and subsidy portability play into this problem? Can costs be brought down by bringing in some younger, healthier people? How can the private sector be leveraged to address these problems?**

Younger people simply are not signing up for coverage as anticipated. Part of this is due to the law's attributes:

- Adult children are encouraged to remain on their parents' plan until age 26;
- Age rating shifts resources from young to old; and
- Younger people typically have lower incomes which may translate into a smaller individual mandate penalty.

Health insurance exchanges were created to facilitate consumer choice of health plans for individuals, families, and small businesses via on-line portals that should appeal to younger, technologically savvy consumers. The exchanges built to-date, however, suffer from use of decades old solutions and e-commerce strategies long abandoned by the private sector. While the ACA exchanges have upped their e-commerce game since 2014, most still lag behind the state of the art. In 2016 open enrollment season, only three exchange websites (out of 14 total including HealthCare.gov) allowed consumers to quickly search and identify plans that cover their prescribed medications. Only six allowed consumers to identify those plans with their favorite doctors covered in-network. Only seven had easily accessible out-of-pocket cost calculators designed to compute expected annual outlays.

Exchange web sites can and should be improved by opening up exchanges to market competition, primarily by contracting out non-essential functions and by allowing consumers to take their subsidy with them to off-exchange products. Consumers would be empowered to use their premium and cost-sharing subsidies to purchase plans through any certified exchange or plan vendor, including both public and private exchanges. We believe such reforms would incentivize the private sector to create new and better tools and marketing platforms to reach more consumers annually—including consumers who are currently slipping through the cracks, such as those with higher incomes, healthier and younger individuals under age 35, males, and Hispanics.

CAHC urges Congress to implement reforms to create the next generation of health insurance exchanges to help create exchanges that are true markets for buying health insurance. The model would consist of four parts:

1. **Private Shopping Websites**. These websites would compete directly with public websites for consumers based on the user experience and key-decision support tools, such as: out-of-pocket cost calculators; smart plan finder tools to prioritize and quickly highlight best-fit options; integrated, searchable provider networks and drug directories; and easy-to-understand cost information for common services and procedures.

2. **A Modern Subsidy Process:** The federal government would contract with at least one private vendor to set-up a "Paypal"-like system for the payment of premium subsidies. This would allow subsidies to become portable so that low-income consumers could purchase coverage from any exchange website, public or private.

3. **Simplified Small Employer Shopping:** Private shopping websites would allow small employers to purchase traditional small group coverage. Time-saving features could be offered, such as the ability to upload demographic files that would allow employers to only input data once and be able to obtain health insurance pricing across multiple insurers.

4. **A Revamped State Certification Process:** Each state would certify that at least one website: allows for the purchase of health insurance; shows the pricing of all insurers that offer individual market and small group coverage in the state; and offers a "Paypal"-like system for subsidies.

Congress should create a working exchange market by bringing more market forces to bear on public exchanges and by allowing consumers to vote with their feet and their subsidies.

We have seen huge rate increases across the nation since full ACA implementation, and South Dakota is no different.

**Some claim that similar or worse rate increases occurred prior to ACA. Is this accurate? How do average individual out-of-pocket costs (including premiums) compare in the pre- and post-ACA marketplace?**

**Joel White:**
Premiums and cost sharing were growing more slowly prior to the ACA. According to CBO, the CMS Actuary and a survey from eHealthInsurance, pre-ACA and in general, premium increases averaged in the single digit range in both the non-group and group markets. In general, ACA exchange plan premiums have grown at more than double digit rates[5]. This is not surprising considering the benefit mandates and rating rules imposed on

[5] "Private Health Insurance Premiums and Federal Policy." Congressional Budget Office, Feb 2016. https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/51130-Health_Insurance_Premiums_OneCol.pdf

plans. Coverage, in general, is likely more robust than in pre-ACA plans.

These general statements are made with significant caveats. It is difficult to find perfect data points capturing nationwide average premiums and deductibles in the pre-ACA individual insurance market. One cannot accurately compare pre-ACA plans with post-ACA plans because the same mandates (essential health benefits, guaranteed issue, etc.) did not apply before implementation of the exchanges in 2014.

Nonetheless, several government agencies and private sector entities have provided data for comparison sake. For example:

- CBO found that average premium per enrollee in non-group coverage grew by 6.1 percent between 2010 and 2011 and by 2.6 percent between 2011 and 2012.[6]
- CBO also estimates that average premiums for single or family coverage grew by more than 7 percent each year between 2001 and 2005. The annual rate of growth has exceeded 7 percent only once since then, however—for family premiums in 2011—and has stood at roughly 4 percent since 2012.[7]
- The Kaiser Family Foundation reports that the average U.S. individual market plan premium was $235.27 in 2013.[8] In 2014, 2015, and 2016, HHS reports that the average insurance exchange plan premium across all metal levels before premium tax credits was $346,[9] $356, and $386,[10] respectively.
- The CMS Office of the Actuary estimates that the average premium per enrollee in all private markets grew from about $2,320 in 2000 to about $5,080 in 2013, indicating an average annual growth rate of 6.2 percent.

Similarly, cost sharing requirements have increased substantially in both the on- and off-exchange markets, and for individuals, small and large firms. For example, the average deductible for single coverage in small firms (3-199 workers) is higher than the average deductible in large firms, $1,836 vs. $1,105. The average general annual deductible for single coverage has increased significantly over time (see graph below). The average deductible of $1,318 is similar to last year, but is significantly higher than $917 in 2010 (an increase of 30 percent).[11]

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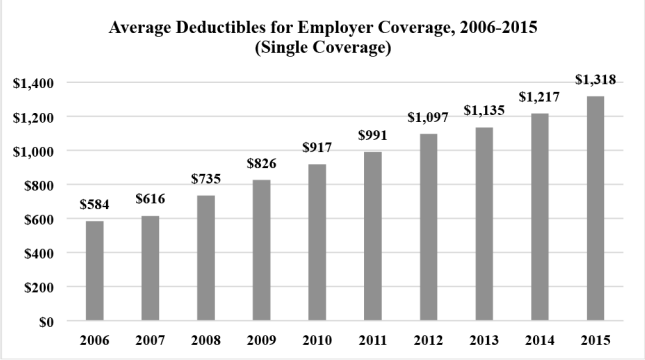
[6] Ibid
[7] Ibid
[8] "Average Monthly Premiums Per Person in the Individual Market." Kaiser Family Foundation, 2013. http://kff.org/other/state-indicator/individual-premiums/
[9] "Premium Affordability, Competition, and Choice in the Health Insurance Marketplace, 2014." HHS, 18 Jun 2014. https://aspe.hhs.gov/sites/default/files/pdf/76896/2014MktPlacePremBrf.pdf
[10] "Health Insurance Marketplace Premiums After Shopping, Switching, and Premium Tax Credits, 2015-2016." HHS, 12 Apr 2016. https://aspe.hhs.gov/sites/default/files/pdf/198636/MarketplaceRate.pdf
[11] "2015 Employer Health Benefits Survey." Kaiser Family Foundation, 22 Sep 2015.




Source: "2015 Employer Health Benefits Survey." Kaiser Family Foundation, 22 Sep 2015.

The average aggregate deductibles for family coverage are $2,758 for HMOs, $2,012 for PPOs, $2,467 for POS plans, and $4,332 for HDHP/SOs. made massive changes to health markets – some positive and some negative.

Compared to exchange plans, these deductibles are both smaller and growing at lower rates. Bronze and silver deductibles for 2016 are $5,765 and $3,064 and growing by 8.2 and 19.8 percent respectively from 2015.[12]

Importantly, premium and cost sharing obligations are growing faster than wages and inflation on average. As costs outstrip an individual's ability to pay, coverage becomes less affordable. This is a major reason why many feel left behind in the current economy as productivity (and wages) fails to keep up with health cost growth. By 2030 we estimate more than half of a family's income will be spent on health care, a bleak and unappealing, but avoidable future.

This fact should spur Congress to enact bipartisan reforms to help stabilize and improve markets, making health care more affordable and accessible for all Americans. Flexibility in these areas would create more competition that reduces costs.

Many consumers lack the tools necessary to shop around and compare prices for common medical services, one of the issues preventing them from making informed decisions about their care. This is especially true for decisions related to the most appropriate site of care for a given service. A recent review of commercial medical claims data by Healthcare Bluebook found that the availability of Ambulatory Surgical Centers (ASCs) reduced costs by more than $38 billion annually, including a reduction in cost to the patient in the form of lower deductibles and coinsurance payments. To me, this study suggests that it is possible that consumers who are

[12] "Patient Cost-Sharing in Marketplace Plans, 2016." Kaiser Family Foundation, 13 Nov 2015. http://kff.org/health-costs/issue-brief/patient-cost-sharing-in-marketplace-plans-2016/

better informed about the appropriate site of service for a given procedure may choose the most cost-effective option, thereby lowering cost.

**What tools are being developed to help benefits managers and patients make informed healthcare decisions regarding site of service?**

**Joel White:**
Rising health care costs are raising the stakes for consumers in selecting the right health plan and provider to meet their needs. As a result, consumerism in health care is rapidly evolving, supported by improved tools via data and information technology, new plan designs, and the growing role of online comparison shopping in our everyday lives.

To improve enrollment and get a handle on costs, policy makers in Congress and the Administration should create incentives and provide data for consumers to make better choices. Effective management of federal and state programs increasingly means decision makers must keep up with the latest tools, trends, and capabilities.[13]

Demand for these tools is robust and growing across demographic groups. Millennials in particular are more prone to expect "instant gratification," with online information available at their fingertips 24/7 through mobile devices. Unlike previous generations, millennials tend to be more cost-conscious and value on-the-go convenience, with 41 percent likely to request a cost estimate prior to treatment and 71 percent likely to use a mobile app to manage their health care, review records, and schedule appointments.[14]

While the reasons may vary, the need for more information is a constant across all generations. We need greater transparency in the health care system so that all Americans can make more informed decisions that improve health outcomes and lower costs.

There are obvious signs that the health care system and federal government have been too slow to adapt to the changing dynamics and growing demand for transparency in health care. Several issues continue to frustrate federal data policy that would contribute to better data, better tools, and better markets for consumers making decisions about their health care and coverage. For example, federal health programs still allow for information blocking by Electronic Health Record vendors and consumers are often misled with confusing jargon and apples-to-oranges comparisons.

At the same time, the private sector is taking collective action towards refining price claims data and making those data broadly available in a consumer-friendly format, for example, such as through the Health Care Cost Initiative's Online Price Transparency Platform, Guroo.com, supported by Aetna, Humana, and UnitedHealthcare.[15]

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[13] "Promoting Transparency and Clear Choices in Health Care." Health Affairs Blog, 9 Jun 2015. http://healthaffairs.org/blog/2015/06/09/promoting-transparency-and-clear-choices-in-health-care/
[14] "Here's how millennials could change health care." USA Today, 7 Feb 2016. http://www.usatoday.com/story/news/politics/elections/2016/02/07/heres-how-millennials-could-change-health-care/79818756/
[15] "Major US Health Plans Agree to Give Consumers Free Access to Timely Information About Health Care Prices to Foster Greater Transparency." Health Care Cost Institute, 14 May 2014. http://www.healthcostinstitute.org/news-and-events/major-us-health-plans-agree-give-consumers-free-access-timely-information-about-heal

To build on these efforts and help address limitations in federal policy towards health care transparency, Congress should:

- **Provide for Hospital Price Disclosure:** Require hospitals to disclose average payment for insured and uninsured patients for the most common inpatient and outpatient procedures via a searchable website for consumers.
- **Provide for Medicare Site-of-Service Price Disclosure:** Require HHS to disclose online the estimated costs to the government and to beneficiaries for comparable Medicare services provided in HOPDs, ASCs and physician offices.
- **Protect Consumers from Surprise Out-of-Network Billing:** Require providers and facilities to provide specific notice to consumers in advance of an elective procedure if certain providers involved are not covered under the consumer's in-network plan cost sharing.
- **Improve and Disclose Quality Reporting Data:** Ensure that HHS adheres to Congressional intent under MACRA to strengthen health care quality measurement and reporting by increasing its relevance for patients and decreasing its burden on providers.
- **Make More and Better Data Available to Consumers and Entrepreneurs:** Require HHS to increase the availability of health care data, such as claims data for Medicaid and CHIP, in standardized formats for developers, researchers, and consumers.
- **Streamline Exchange Enrollment Websites:** Require HHS to continue improving the consumer-facing features and tools on HealthCare.gov for the upcoming plan years. Such tools should include searchable formularies with out-of-pocket cost disclosure, OOP cost calculators, integrated provider directories, and other tools to help consumers more clearly understand the cost and benefit tradeoffs of plan choices.
- **Ensure Exchanges Disclose Whether Plans are HSA Qualified.** Exchanges should also disclose the current law tax benefits available through HSA plans.
- **Improve Medicare's Web Sites:** Plan Finder and the Medicare Compare web sites are needlessly complex. Congress should require and fund upgrades to the functions, including plan comparison tools, and contract out web site management to e-commerce experts.

**Submissions for the Record**

AMERICAN ACADEMY *of* ACTUARIES

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**Testimony of**
**Karen Bender, MAAA, ASA, FCA**
**Chairperson, Individual and Small Group Markets Committee**
**American Academy of Actuaries**

**and**

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

**Submitted for the Record**

**U.S. House Ways and Means Committee Hearing**
**Titled "Rising Health Insurance Premiums under the Affordable Care Act"**
**July 12, 2016**

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Chairman Brady, Ranking Member Levin, and distinguished Members of the Committee:

On behalf of the American Academy of Actuaries'[1] Individual and Small Group Markets Committee, we appreciate the opportunity to provide this written testimony for your committee's July 12 hearing, "Rising Health Insurance Premiums under the Affordable Care Act." The 2017 health insurance premium rate filing process is underway. Our testimony outlines factors underlying premium rate setting generally and highlights the major drivers behind why 2017 premiums could differ from those in 2016. It focuses primarily on the individual market, but some factors that are unique to the small group market are highlighted as well.

**Premiums Reflect Many Factors**

Actuaries develop proposed premiums based on projected medical claims and administrative costs for pools of individuals or groups with insurance. Factors that affect proposed premiums include:

***Who is covered—the composition of the risk pool***. Pooling risks allows the costs of the less healthy to be subsidized by the healthy. In general, the larger the risk pool, the more predictable

[1] The American Academy of Actuaries is an 18,500+ member professional association whose mission is to serve the public and the U.S. actuarial profession. For more than 50 years, the Academy has assisted public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

and stable premiums can be. But the composition of the risk pool is also important. Although the Affordable Care Act (ACA) now prohibits insurers from charging different premiums to individuals based on their health status, premium levels reflect the health status of the risk pool as a whole. If a risk pool disproportionately attracts those with higher expected claims, premiums will be higher on average. If a risk pool disproportionately avoids those with higher expected claims or can offset the costs of those with higher claims by enrolling a large share of lower-cost individuals, premiums will be lower.

***Projected medical costs***. Most premium dollars go to medical claims, which reflect unit costs (e.g., the price for a given health care service), utilization, the mix and intensity of services, and plan design. Unit costs and utilization can vary by geographic area and from one health plan to another depending on the ability and leverage of the insurer to negotiate fees with health care providers.

***Other premium components***. Premiums must cover administrative costs, including those related to insurance product development, sales and enrollment, claims processing, customer service, and regulatory compliance. They also must cover taxes, assessments, and fees, as well as profit (or, for not-for-profit insurers, a contribution to surplus).

***Laws and regulations***. Laws and regulations, including the presence of risk-sharing programs, can affect the composition of risk pools, projected medical spending, and the amount of taxes, assessments, and fees that need to be included in premiums.

**Major Drivers of 2017 Premium Changes**

***Underlying growth in health care costs***. The increase in costs of medical services and prescription drugs—referred to as medical trend—is based on not only the increase in per-unit costs of services, but also changes in health care utilization and changes in the mix of services. Medical trend is expected to rise slightly faster than in previous years but remain low relative to historical levels. Some uncertainty remains regarding the causes of the recent low medical trends and whether they will continue. Structural changes to the health care payment and delivery system might be contributing to slower medical spending growth—such as a greater focus on cost-effective care.

Costs for prescription drugs continue to increase and are anticipated to again outpace the costs for other medical services. More high-cost specialty drugs are expected to come to market (e.g., new drugs to treat cancer). Some drugs (e.g., Crestor, Benicar, Symbicort) are coming or have recently come off patent and will over time reduce drug costs; however, price decreases aren't necessarily immediate because generic competition for drugs coming off patent is often limited or slow to be adopted. The impact could be further mitigated if patients are moved by their physicians to newer, higher-cost alternative drugs.

***Sunset of reinsurance program funds***. The ACA transitional reinsurance program provides payments to plans in the individual health insurance market, with payments declining over the three years of the program, from 2014 to 2016. The year 2017 will be the first year in which there is no reinsurance in the individual market supported by contributions from health plans

under the ACA.[2] By offsetting a portion of claims, the reinsurance program lowered premiums, and each year the gradual reduction in reinsurance funding resulted in a corresponding increase in premiums. The final impact of the program on premiums will occur in 2017, when projected claims are expected to increase by 4 to 7 percent due to the reinsurance program ending in 2016.

***Changes in the risk pool composition and insurer assumptions***. The ACA requires that insurers use a single risk pool when developing premiums. Therefore, as in previous years since the ACA's enactment, premiums for 2017 will reflect insurer expectations of medical spending for enrollees both inside and outside of the marketplace (i.e., exchanges). Health insurance premiums are set at the state level (with regional variations allowed within a state) and are based on state- and insurer-specific experience regarding enrollment volume and composition. Changes in premiums between 2016 and 2017 will reflect expected changes in the risk profiles of the enrollee population, as well as any changes in insurer assumptions based on whether experience to date differs from that expected in assumptions underlying prior premiums.

Although enrollment in the marketplaces has increased somewhat over time, it is uncertain the extent to which the enrollee risk profile has changed as a result. According to the Department of Health and Human Services, marketplace enrollment at the end of the open enrollment period increased from 8.0 million in 2014 to 11.7 million in 2015 and 12.7 million in 2016.[3] Average health costs for a given population in a guaranteed issue environment generally can be viewed as inversely proportional to enrollment as a percentage of the eligible population. Higher individual market participation rates will tend to be associated with lower average costs, and lower participation rates with higher average costs. This is because those previously uninsured individuals with greater health care needs are more likely to enroll and to enroll sooner than those with lesser needs. Higher take-up rates typically reflect a larger share of healthy individuals enrolling. The Kaiser Family Foundation estimates that 2016 enrollment represents 46 percent of the potential enrollment.[4]

Premiums for 2017 will reflect insurer expectations for enrollment changes from 2016 to 2017 as well as any adjustments to assumptions if 2016 enrollment differed from expected. Insurers that expected higher enrollment in 2016 than what actually occurred might need to adjust their assumed average costs upward for 2017; those that expected lower-than-actual enrollment might need to adjust their average costs downward. In addition, there will be downward pressure on premiums if insurers expect significantly increased enrollment in the market as a whole in 2017.

Insurers have more information now than they did last year regarding the risk profile of the enrollee population and are using that information to adjust their 2017 assumptions accordingly. Because the ACA risk adjustment program shifts funds among insurers depending on the relative

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[2] Funding for the reinsurance program came from contributions required by the ACA from all health plans, including not only plans in the individual market, but also those in the small and large group markets, as well as self-insured plans. These contributions were used to make payments to ACA-compliant plans in the individual market.

[3] See enrollment reports for 2014, 2015, and 2016; Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. Enrollment figures are understated because they do not include off-marketplace enrollment in ACA-compliant plans, and overstated because they reflect plan selection only, with or without payment of premium.

[4] Larry Levitt, Gary Claxton, Anthony Damico, and Cynthia Cox, "Assessing ACA Marketplace Enrollment," Kaiser Family Foundation, March 4, 2016.

health status of an insurer's population to that of the entire market, premiums need to reflect not only an insurer's expected claims, but also any expected risk adjustment receipts or transfers. In other words, premiums should reflect the risk profile of the entire state risk pool, not just the insurer's expected enrollment. When filing premiums for 2016, insurers had information on their enrollee demographics and health spending in 2014 and 2015, but lacked information regarding the risk profile of the market as a whole. Since that time, the Centers for Medicare and Medicaid Services (CMS) released information regarding payments and receipts under the risk adjustment, reinsurance, and risk corridor programs for the 2014 plan year, as well as interim risk adjustment information for 2015. These data provide insurers more information regarding how their enrollee risk profiles compared to those of the whole market. Analysis of the risk adjustment data suggests that some insurers may have set premiums low relative to the market-wide risk profile.[5] In addition, the risk corridor results reveal that for many insurers, 2014 premiums were too low relative to actual claims. Some of this understatement was likely due to the implementation of the transitional policy that allowed individuals to keep their prior non-ACA-compliant coverage. Risk profile assumptions for 2017 premiums will reflect these results to the extent that they have not already been factored into prior premium increases.

As mentioned above, subsequent to 2014 premiums being finalized, states were allowed to adopt a transitional policy that allowed non-ACA-compliant plans to be renewed in 2014. The policy was subsequently extended until the end of 2017. A majority of states allowed insurers to renew non-ACA-compliant policies and most, but not all, have allowed the extension through 2017. In states with the transition policy, ACA-compliant plans exhibited less favorable experience because lower-cost individuals were more likely to retain their prior policies. Insurers already knew about the transition policy when developing their 2015 premiums, so any related premium increases likely have already been incorporated. To the extent they have not, or if the impact of the transitional policy is expected to change over time, assumptions for 2017 premiums will be revised accordingly.

Although more information is now available to insurers regarding their own enrollment and claims experience as well as the market-level experience, some uncertainty remains. The individual market undergoes considerable enrollment turnover as individuals move among different plans within the individual market or among individual market coverage and other coverage (e.g., employer coverage, Medicaid).[6] This turnover limits the ability to use 2014 and 2015 experience data to project risk profiles in 2017. Furthermore, CMS emphasized that the 2015 interim risk adjustment results are preliminary, incomplete, and could change materially when the final risk adjustment process is performed later in the year. In addition, experience for insurers with limited market share in 2015 might not be indicative of future experience as they may be more subject to random fluctuations or selection bias.

***Health insurer fee***. The health insurance provider (HIP) fee was enacted through the ACA. The HIP fee is scheduled to collect $11.3 billion in 2016, and insurers built this cost into their premiums. The Consolidated Appropriations Act of 2016 included a moratorium on the collection of the health insurer provider fee in 2017. Insurers will remove the cost of this fee in

[5] For more details, see the Academy's analysis, *Insights on the ACA Risk Adjustment Program*.
[6] According to Avalere, only one-third of individual market exchange enrollees in 2016 were in the same plan from 2015.

their 2017 premiums, resulting in a reduction in expected premiums by about 1 to 3 percent, depending on the size of the insurer and their profit/not-for-profit status.

***Repeal of expansion of the small group market***. In the current small group health insurance market, small employers are those employing up to 50 employees. The ACA as originally enacted called for the expansion of the definition of small employers to include those with up to 100 employees for plan years beginning in 2016. Insurers set their 2016 premiums based on an expectation that this expansion would occur. However, in October 2015, the Protecting Affordable Coverage for Employees Act was signed into law, resulting in the definition of small employers remaining at 50 or fewer employees except in states that elect to extend the definition to include employers with up to 100 employees. To date, California, Colorado, New York, and Vermont have chosen the higher number. All other states remain at 50.

For states remaining at 50, the impact on 2017 premium changes depends on whether and how the 2016 premiums were adjusted based on the expectation of groups sized 51-100 entering the market. Some insurers did not expect the experience of groups sized 51-100 to differ significantly from smaller groups and therefore did not materially adjust their 2016 premiums for this expansion.[7] In that case, there would be little or no impact on 2017 premium increases. Others expected higher levels of claims for groups sized 51-100 choosing to purchase ACA-compliant plans, in part because the healthier groups would have an incentive to forgo ACA-compliant plans and self-insure instead. Groups sized 51-100 are rated in part based on their own experience. Those with poor experience would have higher-than-average premiums while healthier groups would have lower premiums. Because small group, ACA-compliant plans are not rated based on experience, the healthier groups would have faced premium increases had they purchased ACA-compliant plans. These potential premium increases might have caused many of the healthier groups to self-insure, while groups with poor experience would be more attracted to ACA plans. The removal of this adjustment in 2017 will exert a slight downward pressure on premiums for insurers that adjusted 2016 small group premiums upward based on this expectation.[8]

For insurers in the four states that elected to include employers with up to 100 employees in the small group market, there would be no impact on 2017 premiums unless the insurer's assumptions as to the impact of the expansion on experience have changed. Such a change in assumptions may be unlikely because they will have had very little 2016 experience at the time 2017 premiums are filed.

***Changes in provider networks***. Since the ACA marketplaces became operational in 2014, many insurers have been shifting to narrower provider networks to help keep premiums affordable. Narrower networks can give insurers more leverage to negotiate lower provider payment rates, and they also can be used to direct enrollees to more cost-effective and high-quality providers.

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[7] In states where it was available, the transition policy allowing small groups to retain non-ACA-compliant coverage was expected to mitigate the impact of the expansion of the small group definition on 2016 premium changes.

[8] Some insurers that initially adjusted 2016 premiums based on the expectation of covering groups sized 51-100 removed that adjustment for small group policies issued or renewed in the second and later quarters of 2016. In that situation, only groups renewing coverage in the first quarter of 2017 will see a difference in premiums as a result of the adjustment being removed.

Not only do broader network plans tend to have higher provider reimbursement rates, but health plan experience for 2014 and 2015 suggests that preferred provider organization (PPO) plans and those with broader network choice have had worse experience than narrower network plans. That has led to some health plans eliminating PPO plans on the marketplaces rather than raise premiums further.

These developments have created a mix of complex forces related to changes in provider networks and their effect on 2017 premiums. The elimination by some companies of plans with broad provider networks may put additional upward pressure on premium increases for remaining broad network plans in the market if the insured moving from plans that were terminated are less healthy than the current membership of the persisting broad network plans and if risk adjustment transfers do not fully offset the increase in morbidity or utilization. It is possible premiums could be reduced if the transferred membership is relatively healthier than the current membership and the risk adjustment transfer does not offset this improved health status change.

The elimination of broad network plans might put some upward pressure on the premiums of narrow network plans because those enrollees who contributed adverse experience to the richer network plans will likely need to move to a narrower network plan for their coverage if alternative broad network plans are not available or affordable.

Additionally, CMS has increased its focus on the makeup of provider networks to ensure that they provide adequate access and do not penalize consumers for using non-network providers of which they had no choice or knowledge (e.g., hospital-based specialists, radiologist, pathology labs, still-listed physicians who actually left the network). Any changes to the composition of existing narrow networks or revisions to the adjudication process of claims related to use of non-network providers in order to meet these expectations could result in upward pressure on premiums.

**Other Drivers**

***Benefit package changes***. Changes to benefit packages (e.g., through changes in cost-sharing requirements or benefits covered) can affect claim costs and therefore premiums. This can occur even if a plan's metal level[9] remains unchanged. In particular, changes in benefits or cost-sharing requirements may have been needed to comply with the metal-level determinations using the actuarial value (AV) calculator, which was recalibrated for 2017. Other changes in benefit packages could be made based on market or other considerations. Such changes could put upward or downward pressure on premiums, depending on the particular change. Other plan design features, such as drug formularies and care management protocols, also could affect premium changes.

[9] ACA plans are categorized into four metal tiers (bronze, silver, gold, and platinum), based on the relative level of plan generosity. Actuarial value is used to measure plan generosity, and is based on the average share of medical expenses that a plan will cover, as opposed to being paid out of pocket by the consumer. In turn, actuarial value is measured using the AV calculator released by the CMS.

***Risk margin changes***. Insurers build risk margins into their premiums to reflect the level of uncertainty regarding the costs of providing coverage. These margins provide a cushion should costs be greater than projected. Greater levels of uncertainty typically result in higher risk margins and higher premiums. Changes to the level of uncertainty regarding claim costs or other aspects of ACA provisions can cause changes to the risk margins.

The ACA risk corridor program sunsets at the end of 2016. The program was intended to minimize the risk margins built into premiums by having the federal government share in the plan losses and gains beyond a 3 percent corridor. Because of legislative changes enacted after the initial passage of ACA that required the program to be budget neutral, it is unclear how effective the program was in reducing 2016 premium risk margins. However, any reductions that were reflected in 2016 premiums due to this program will be eliminated in 2017 pricing, likely resulting in slightly higher premiums.

***Market competition***. Market forces and product positioning also can affect premium levels and premium increases. Insurers might withstand short-term losses in order to achieve long-term goals. Due to the ACA's uniform rating rules and transparency requirements, premiums are much easier to compare than before the ACA, and in previous years some insurers lowered their premiums after they were able to see competitors' premiums. However, underpricing in any one year could drive premium increases higher in future years because, in the long run, premiums need to adequately cover claims and expenses. Health insurers are increasingly focused on local competition, offering coverage only in geographic regions in which they are believe they have a competitive advantage. As such, there may be more price competition in those regions where many health plans are offered, and less price competition where fewer health plans participate.

***Changes in provider competition and reimbursement structures***. Consolidation of health care providers has been ongoing in many local markets, largely for the purpose of increasing providers' negotiating power. This trend is likely to continue. Any increased negotiating power among providers could put upward pressure on premiums. On the other hand, mergers of health care plans can have the opposite effect if they increase health plans' negotiating leverage with providers. It is also notable that insurers are pursuing changes in provider reimbursement structures that move from paying providers based on volume to paying based on value. For example, accountable care organization structures offer incentives to provide cost-effective and high-quality care. Such efforts could put downward pressure on premiums, at least in the short term.

***Changes in administrative costs***. Changes in administrative costs will also affect premiums. For instance, changes can result from increased costs associated with ACA implementation or from spreading fixed costs over a different enrollment base than projected. Moreover, as the ACA reforms have gone into effect, the important role that brokers can play has been acknowledged, and reductions in commissions that may have been expected generally have not been realized. However, some plans have decided to eliminate or dramatically reduce commissions for marketplace sales, at least outside of the open enrollment period. This may help reduce premiums, not only because of the lower administrative costs, but also due to the expectation that there may be less adverse selection during the year. On the other hand, some health plans are finding that increased regulatory requirements associated with the administration of provisions in

the ACA are increasing their administrative costs. These costs all need to be reflected in premiums. Depending on the circumstances in any particular state, these changes in marketing and administrative costs can put upward or downward pressure on premiums. However, the ACA's medical loss ratio requirements limit the share of premiums attributable to administrative costs and margins.

***Changes in geographic factors***. Within a state, federal rules allow health insurance premiums to vary across geographic regions established by the state. Insurers can use different geographic factors to reflect provider cost and medical management differences among regions, but are not allowed to vary premiums based on differences in health status (which should be accounted for by the single state risk pool construct and risk adjustment process). An insurer might change its geographic factors due to changes in negotiated provider charges and/or in medical management of some regions compared to others. A decision to increase or decrease the number of regions in which the health plan intends to offer coverage in 2017 within a state could also result in a change in its geographic factors. Another key reason for changes in geographic factors could be new provider contracts that reflect different relative costs. A realignment of these differences could result in changes across the rating regions within a state.

**Summary**

The 2017 health insurance premium rate filing process is underway and how 2017 premiums differ from those in 2016 will depend on many factors. Key drivers include the underlying growth in health costs and the sunset of the reinsurance program, each of which will increase premiums relative to 2017. Another key driver is changes to the risk pool composition and insurer assumptions from 2016. Insurers have more information than they did previously regarding the risk profile of the enrollee population and will revise their assumptions for 2017 accordingly. However, some uncertainty remains, as a market equilibrium in terms of enrollment levels and risk profiles likely has not yet been reached. The one-year moratorium on the health insurer fee will reduce premiums relative to 2016.

Other factors potentially contributing to premium changes include the repeal of the expansion of the small group definition and modifications to provider networks. In addition, changes to provider reimbursement structures, benefit packages, risk margins, administrative costs, and geographic region factors can affect premium changes. Insurers also incorporate market competition considerations when determining 2017 premiums.

Premium changes faced by individual consumers will also reflect increases in age, and any changes in geographic location, family status, or benefit design. In addition, if a consumer's particular plan was discontinued, the premium change will reflect the increase or decrease resulting from being moved into a different plan, which could be at a different metal level. Average premium change information released by insurers or states could reflect the movement of consumers to different plans due to their prior plan being discontinued.

**PREMIUM CHANGES FROM A CONSUMER PERSPECTIVE**

Premium changes are often the most visible and discussed aspect with respect to the ACA impact on health insurance. However, premium changes can be measured using different approaches, making it difficult to compare premium changes among health insurers, among plans offered by an insurer, or among consumers.

In addition, the average premium change within a specific insurer may not represent the premium change experienced by a particular consumer. The ACA requires that premiums vary only by age, tobacco use, geographic location, family status, and benefit design. Premium changes from a consumer perspective can then result from underlying medical trends and other aggregate premium factors, as well as changes in these consumer-specific factors. The following situations could result in a premium change a consumer experiences differing from the average premium change reflected in a premium rate filing.

**Changes in Age**
All insurers are required to use a prescribed age rating curve (either the federal default curve or a state-established curve) when determining how to vary premiums by age. In other words, premium variations by age are the same regardless of insurer. Most individual consumers will experience a premium increase each year, due to aging one year. Such a change (on the order of 2 to 3 percent per year for individuals older than 24) is rarely included in insurer-level premium change calculations because it does not represent a change in the underlying factors. But it is a change a consumer would experience.

**Tobacco Status**
In most states, insurers are allowed to charge smokers more than similar nonsmokers, and this surcharge can vary by state and by age. In other words, older smokers can face higher surcharges than younger smokers (or vice versa). In plans that vary the surcharge by age, consumers who smoke will see a premium change due to the change in the tobacco use surcharge. In addition, consumers who have either started or stopped using tobacco products could see a premium change.

**Changes in Geographic Location**
All states require the use of rating areas prescribed by the CMS. Insurers are not allowed to change the rating areas but are allowed to change how premiums vary across areas due to differences in relative provider charge levels and differing levels of medical management. Such a change may or may not be included in the average aggregate premium change from the insurer's perspective, but it is a change a consumer would experience depending on where they live. If a consumer moves from one rating area to another, that also may result in a premium change.

**Changes in Benefit Design**
A plan's benefit design encompasses both the benefits covered as well as the associated cost-sharing requirements (e.g., deductibles, coinsurance, copayments). Consumers who switch to a new benefit design or are re-enrolled in a different plan due to discontinuance of a plan could experience a premium change due to the benefit design change. If an insurer discontinues offering plans at a metal level, such as platinum or bronze, consumers in those plans may be re-enrolled in the next higher or lower metal level plan, which could significantly impact the premium. Insurers also might change covered benefits or cost sharing (subject to uniform modification provisions of guaranteed renewability) in order to offset medical trend or maintain the metal level.

**Family Status**
The ACA allows premiums to vary by family size. Family premiums reflect the premiums for each covered adult plus the premiums for each of the three oldest covered children younger than 21. Therefore, consumers with family coverage who experience a change in family composition could face a premium change.

**Subsidy Eligibility**
The ACA provides premium subsidies in the individual market based upon household income. Changes in income alone can result in upward or downward changes in the net premiums that any specific consumer may have to pay, even if there is no change in the underlying premiums. A change in available plans offered in the market also could affect the subsidy an individual receives.

HealthPocket

**MAJOR CONSUMER HARM HIDDEN IN PROPOSED SHORT-TERM HEALTH INSURANCE RULE**

EXECUTIVE SUMMARY

Updated July 11, 2016

HealthPocket, Inc. "("HealthPocket") is a leading health insurance comparison firm and consumer advocate. We have published dozens of research papers on the American health insurance market that have been widely cited by top news organizations. This Executive Summary sets forth our comments on the Proposed Rule by the IRS (ID: IRS-2016-0021-0001) restricting short-term health insurance that, if implemented without modification, will curtail an affordable health insurance solution for millions of Americans and poses considerable harm to several vulnerable populations in the U.S. Full comments will be provided in a white paper to be published in early July 2016.

Short-Term Health Insurance

Short-term health insurance (STH) is limited duration health insurance coverage similar to other categories of health insurance. STH is "major medical insurance" for people under age 65 and provides benefits that address core medical needs such as doctor and specialist visits, lab tests, x-rays, emergency care, and hospitalization.

STH coverage is associated with broad healthcare provider networks supplying access to top doctors and hospitals at negotiated rates. Additionally, provider access is often unrestricted in STH plans so even if an out-of-network doctor is used the plan will still pay reimbursement for covered medical services. This network breadth and flexibility stand in contrast to the growing trend of narrow networks where no reimbursement is provided to out-of-network doctors except in the case of medical emergencies.

Like healthcare sharing ministries and grandfathered health plans (both legally permitted outside Affordable Care Act ("ACA") health plan requirements), STH plans apply medical underwriting to applicants and reject a small portion based on pre-existing health consideration. Nearly nine-out-of-ten applicants are approved for coverage based on a study of tens of thousands of applicants.

STH coverage lasts from one to 11 months. Most STH plans offer a lifetime maximum benefit of at least $1 million. In comparison, healthcare sharing ministries may have a $250,000 limit per incident maximum benefit. For appreciation of the true scale of the STH lifetime maximum, the projected cost of healthcare for a twenty-year period among the more costly Medicare population (ages 65 to 85) is estimated to be $433,900.

There are no fixed open enrollment periods for STH so an uninsured consumer can apply at any time. Due to buyers' need for immediate coverage, STH insurance typically becomes effective within 24 hours of application submittal and approval as opposed to weeks for other forms of insurance. STH also contains several consumer protections in

case an enrollee is dissatisfied with this insurance. These protections include the ability to cancel the policy for any reason as well as a 10-day "free look" period where premiums can be recovered if the enrollee decides to discontinue coverage.

The Proposed Rule

The Proposed Rule incorrectly characterizes STH as being less than meaningful coverage despite, and without reference to, STH's benefits, provider network, and cost-sharing characteristics. The Rule additionally speculates that STH is negatively affecting the ACA risk pool. The Rule further requires that STH marketing include a notice informing consumers that STH is not a qualifying health plan under the ACA and that purchasers may owe an additional tax. The Proposed Rule goes into effect January 1, 2017.

The Proposed Rule's Unintended Harm to Consumers

Though well-intentioned, the Rule's lack of understanding of STH buyer circumstances sets the stage for considerable consumer harm if the Rule is implemented without modification. The market for STH includes many consumers who are ineligible for health insurance subsidies and who would not be able to afford health insurance without STH. The reduction of STH options is more likely to push these consumers into the ranks of the uninsured rather than into ACA health plans. These consumers include:

- *Low-income consumers in the 'Medicaid Gap'* – Nearly 3 million adults fall into the "Medicaid Gap" where their income is too high for Medicaid eligibility but below the minimum threshold for an ACA subsidy.
- *Uninsured consumers outside the Annual Enrollment Period for ACA*--The broadest group that would be adversely affected by the proposed Rule are the uninsured outside the annual enrollment period. HHS is well aware that millions each year miss the ACA annual enrollment period and subsequently do not qualify for a special enrollment period. In the absence of STH, the earliest this population can obtain active coverage is January 1 of the following year. Reducing STH coverage to less than three months legally mandates a period where such consumers cannot obtain ACA coverage and cannot obtain alternative health insurance coverage. Consequently, for a consumer in February who missed the ACA enrollment deadline, he or she can enroll in coverage for only three months and then face considerable financial risk from medical bills for the remaining seven months until new ACA coverage can become effective.
- *The Unsubsidized At Risk for Going Uninsured* – A portion of the STH market is compromised of Americans who are ineligible for premium subsidies and cannot afford coverage outside of the low-cost STH market. A recent survey found that most Americans can afford no more than $100 for health insurance but the average unsubsidized ACA premium is $364.
- *People without Legal Residence* – According to the Pew Research Center, there are over 11 million unauthorized residents in the U.S. This group is legally prohibited from accessing subsidies for health insurance as well as buying insurance on the exchanges.

- *Rural People Needing Access Quality Local Doctors & Hospitals* –Across 650 moslty rural counties in the U.S., ACA plans will include only one carrier in 2017. STH represents the only affordable medical coverage that provides access to preferred local doctors and hospitals. Broad networked ACA plans may be completely unavailable in these rural regions or only available at premiums well beyond affordability.

Unrealistic Implementation Date

Between the comment period and implementation, the Proposed Rule would be finalized no earlier than October, but implemented January 1, 2017. Such short notice will send STH consumers, insurance companies and state departments of insurance scrambling to determine their best course of action. In the unrealistically short period of three months, insurance companies and state departments of insurance would need to perform the design, pricing, filing, review, and approval of new STH plans.

Recommendations

The proposed Rule should be revised to make the maximum coverage period of STH coincide with the maximum period that a consumer can be locked out of the ACA market after the conclusion of the annual enrollment period. The public interest is best served by maximizing the population with health insurance including instances where individuals cannot take advantage of ACA coverage due to subsidy ineligibility or enrollment period timing. Anything short of this would be legally mandating a period of uninsurance for multiple populations within the U.S.

With respect to the effective date for the proposed Rule, adequate time should be provided for insurance company review, health plan redesign, submittal to state regulators, and regulator approval. This implementation period should be no less than 6 months from the date the final rule is issued.

The aforementioned modifications to the proposed Rule would ensure that new requirements are both achievable without disrupting a market that has been in existence for over thirty years or increasing the number of uninsured within the U.S.

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