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STABILIZING PREMIUMS AND HELPING INDIVIDUALS IN THE INDIVIDUAL INSURANCE MARKET FOR 2018: STATE INSURANCE COMMISSIONERS

HEARING

OF THE

COMMITTEE ON HEALTH, EDUCATION, LABOR, AND PENSIONS

UNITED STATES SENATE

ONE HUNDRED FIFTEENTH CONGRESS

FIRST SESSION

ON

EXAMINING STABILIZING PREMIUMS AND HELPING INDIVIDUALS ON THE INDIVIDUAL INSURANCE MARKET FOR 2018, FOCUSING ON STATE INSURANCE COMMISSIONERS

SEPTEMBER 6, 2017

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STABILIZING PREMIUMS AND HELPING INDIVIDUALS ON THE INDIVIDUAL INSURANCE MARKET FOR 2018: STATE INSURANCE COMMISSIONERS

WEDNESDAY, SEPTEMBER, 6, 2017

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

The committee met, pursuant to notice, at 10:05 a.m. in room SH–216, Hart Senate Office Building, Hon. Lamar Alexander, chairman of the committee, presiding.

Present: Senators Alexander, Murray, Enzi, Burr, Isakson, Paul, Collins, Cassidy, Young, Roberts, Murkowski, Scott, Sanders, Casey, Franken, Bennet, Whitehouse, Baldwin, Murphy, Warren, Kaine, and Hassan.

OPENING STATEMENT OF SENATOR ALEXANDER

The CHAIRMAN. The Senate Committee on Health, Education, Labor, and Pensions will please come to order.

This morning, we are holding our first hearing on stabilizing premiums and ensuring access to insurance in the individual health insurance market for 2018.

We have five State insurance commissioners. Thank you for coming from long distances, some of you, to be with us to give your testimony on how to enable the 18 million Americans in the individual insurance market.

To give an idea of how many people are interested in this, Senator Murray and I invited senators who were not on our committee—which about a quarter of the senate is on this committee—to come to a coffee with the five commissioners that we have just completed for an hour. We had 31 senators there. That is a remarkable level of interest.

Senator Murray and I will each have an opening statement and then we will introduce our five witnesses. After their testimony, senators will have an opportunity to ask witnesses questions and we will do it in 5 minute rounds.

As I mentioned, this committee includes 23 United States senators, nearly one-quarter of the members of the senate. It includes senators with the widest divergence of views. It has a republican majority of only one.

Yet, working together during the last 2 years, we have been able to agree on big steps on big issues about which we have big differences of opinion such as fixing No Child Left Behind, which

President Obama called a Christmas miracle; 21st Century Cures Act, which Senator McConnell, the Majority Leader, said was the most important piece of legislation that passed Congress last year; the first overhaul of mental health laws in a decade; and in early August, after 2 years of work—and I want to thank the staff for that 2 years of work especially—we passed new agreements to help speed safe drugs and devices into medicine cabinets and provide $9 billion in funding for the Food and Drug Administration.

I congratulate Senator Murray and democratic, as well as republican, members of the committee for those accomplishments. This is the way Americans expect the U.S. Senate to work.

Those were big steps. This hearing is about taking one small step, a small step on a big issue which has been locked in partisan stalemate for 7 years, health insurance. It is a step Congress needs to take by the end of this month.

This step is not so small to 18 million Americans—the songwriters, the self-employed farmers—those who do not get their health insurance from the Government or on the job. These 18 million buy their health insurance in the individual market, and about half of them have zero Government support to help buy that insurance.

Eighteen million is only 6 percent of those who have health insurance in America. That is the individual market. Nearly 300 million Americans have health insurance. Eighteen million buy it in the individual market. That is 6 percent of all the insured and 9 million of those 18 million have no Government help to buy their insurance. They are the ones most hurt by higher premiums, and higher co-pays, and deductibles.

Let us take a hypothetical Tennessean, a 35 year old making $48,000 a year in Lynchburg would receive no tax benefit to cover her $7,100 per year premiums. She has an estimated take home pay of $39,000 after taxes, which means almost a fifth of her take home pay is spent on health insurance premiums, and this does not include deductibles or co-pays.

Next year, the Tennessee Department of Insurance says premiums are going to go up by an average of 21 to 42 percent. That is an increase for her of between $1,500 and $3,000 more in premiums next year, and that does not include increases in deductibles and co-pays.

She ought not to have to pay one fifth of her income for health insurance.

Tennessee's Insurance Commissioner, who is here today, has described the State's individual market as, "Very near collapse." At the end of September last year, Blue Cross, our largest insurer, pulled out of the individual market in Knoxville, Nashville, and Memphis. Not just for Tennesseans with Affordable Care Act subsidies, but for everybody.

That could happen again at the end of this September if Congress does not act. And if it happens again, up to 350,000 Tennesseans and millions of Americans could literally be left with zero options to buy insurance in the individual market.

Last year, only 4 percent of American counties had one insurance company on the exchange. This year 36 percent have one insurer on the exchange. For 2018, one-half of the counties will have one

insurer only on the exchange. In Tennessee, it is 78 of our 95 counties.

If we do act, we can limit increases in premiums next year, 2018. We can continue support for co-pays and deductibles for many low-income families. We can make certain that health insurance is available in every county and lay the groundwork for future premiums decreases.

I would suggest we do this by taking two actions, although there may be others that come from these hearings.

One, is appropriate cost-sharing payments through the end of 2018 to help with co-pays and deductibles for many low-income Americans.

Two, amend the Section 1332 Waiver already in the Affordable Care Act so States can have more flexibility to devise ways to provide coverage with more choices and lower costs.

On the first, cost sharing payments are extra subsidies—or discounts, really—for many low-income individuals who receive premium subsidies under the law. They help these individuals pay for out of pocket costs like co-pays and deductibles, but their overall effect is to lower premiums in this individual market.

On the second, the Section 1332 Waivers, as I said, are already written into the Affordable Care Act. Under some circumstances, they allow a State flexibility from certain elements of the law, such as Essential Health Benefits. But they do not in any way reduce the patient protections most of us support, including protections for those with preexisting conditions, and ensuring those under 26 may remain on their parents' insurance and have no annual or lifetime limits.

Right now, 23 States have begun steps to apply for a Section 1332 Waiver; 7 States have applied; 2 States, Alaska and Hawaii, have received the 1332 Waivers so far.

To get a result, democrats will have to agree to something—more flexibility for States—that some may be reluctant to support. Republicans will have to agree to something—additional funding through the Affordable Care Act—that some may be reluctant to support.

That is called a compromise, a much smaller but similar agreement to the compromise that created this U.S. Senate in 1789. When the Founders created a Senate with two members from each State and a House of Representatives based on population; that was a compromise.

This is a compromise that we ought to be able to accept. Temporary cost sharing payments were included in both the Senate and the House republican bills to repeal and replace major parts of the Affordable Care Act. The Section 1332 Waiver is already in the Affordable Care Act, it just has not been very appealing to States because it is a difficult tool to use. We hope to hear more about that from our witnesses today.

If we were able to take the big steps I mentioned earlier—fixing No Child Left Behind and passing the 21st Century Cures Act—we ought to be able to take this small, limited, bipartisan step on health insurance. If we do not, millions of Americans will be hurt.

Timing is a challenge. So I propose that we try to come to a consensus by the end of next week when our hearings are complete so

that Congress can act on what we recommend before the end of September. Otherwise, we will not be able to affect insurance rates and the availability of insurance for next year. That is because the Department of Health and Human Services requires insurance companies to submit their final rates by September 20, and the Department plans to put those rates on healthcare.gov by September 27.

I believe we can do it here because we are plowing very familiar ground. Our goal is a small step and so many Americans will be hurt if we fail.

If we do not do it, it will not be possible for republicans to make political hay blaming democrats, or democrats to make political hay blaming republicans. The blame will be on every one of us, and deservedly so.

Let me conclude with a word about process. We will have four hearings. We are hearing from State insurance commissioners today. We are hearing from five State Governors tomorrow. We will hear from various experts on State flexibility next Tuesday, and a variety of helpful perspectives next Thursday, including representatives from doctors, hospitals, insurers, patients, and insurance commissioners.

This is what we call a bipartisan hearing. Most of our hearings are. That means that Senator Murray and I have agreed on the hearings, on each topic, and on who the witnesses will be.

This committee has a clear jurisdiction over the rules that govern the individual insurance market, which is what we are discussing today. We have jurisdiction over private insurance, over the exchanges created by the Affordable Care Act, and over the Cost Sharing Reduction payments.

The purpose of the hearings is to provide a forum and create an environment for reaching a consensus that we can act on quickly during the month of September.

Note that we do have neither jurisdiction over taxes, including the Affordable Care Act tax credit subsidy, nor over Medicaid nor over Medicare. Those belong to the Finance Committee although there are at least nine members of that committee on this committee.

There has been such great interest in this effort that senators who are not members of our committee are being invited to coffee before each of the four hearings. As I said, 31 senators came to the one today. Senator Murray and I have invited them to do that and to participate in this process.

My goal is to get a result on a small, bipartisan, and balanced stabilization bill. Where it makes sense, we will work with other committees and members to get that result.

Health insurance has been a very partisan topic for a very long time, but the bottom line is 18 million Americans need our help, and I hope we can stay focused on getting a result.

Senator Murray.

OPENING STATEMENT OF SENATOR MURRAY

Senator MURRAY. Thank you very much, Chairman Alexander.

I do want to start by expressing my appreciation for your leadership in holding these hearings. It is refreshing to have an oppor-

tunity for frank and bipartisan discussions on the healthcare system, and is consistent, as you said, with longstanding tradition of working across the aisle on this committee. Thank you very much.

I am also very grateful to each of the State insurance commissioners who have come a long way to join us today. Your perspective is incredibly valuable in this discussion. I am looking forward to hearing from each of you.

I particularly want to acknowledge Commissioner Mike Kreidler, who came all the way from Washington State today. Good to have you here as well.

We are beginning these conversations at an important moment for patients and families. There is a lot of work that needs to be done to undo the damage this Administration has caused within the healthcare system because this Administration is still trying to create Trumpcare by sabotage.

Our healthcare system is more stable than President Trump's tweets would have you believe, but it is weaker as a direct result of some steps that have been taken.

Unfortunately, the President has undermined outreach and consumer assistance efforts, and put forward Executive Orders seemingly designed to inject uncertainty into the markets.

Just last week, this Administration cut funding for outreach by 90 percent and funding for consumer assistance by over 40 percent. Another pressing example is the threats to cutoff payments to reduce coverage costs for low-income people.

Should these out of pocket cost reductions be discontinued, independent analysis suggests that premiums could be an average of 20 percent higher next year for the most popular plans on the exchanges. There will be even more uncertainty in the markets, and patients and families likely will have fewer options when they go to pick their plans.

That is unacceptable and it is avoidable.

Congress can act right away to confirm once and for all that out-of-pocket cost reductions will continue, and we have a very narrow window to do that, as the chairman said, before insurers finalize their plans for 2018 later this month.

I am very glad that there are members on both sides of the aisle who agree that we do need to take this step, and I believe it is critical we work toward a multiyear solution in order to provide the kind of certainty that will have the most impact on families' premiums and choices in the marketplaces.

It takes plans months to develop their rates. If we do not find a multiyear solution, we are just going to be back in this room trying to patch the same problem a few months from now. And that is simply not what certainty looks like.

This kind of discussion around strengthening our healthcare system is exactly what democrats have hoped for over the last few years. We have put forward a number of ideas that would help stabilize markets and lower costs in the near term.

As I have said before, as we work together, I am more than ready to consider additional ideas from the other side of the aisle to make our healthcare system work better for our families and for patients.

But to be clear, that means moving forward, not backward, on affordability, on coverage, and quality of care. Families have rejected the damaging approach taken in Trumpcare, which would have raised families' costs and gutted critical protections like those for preexisting conditions and Congress should listen.

I think we are all aware that threading this needle will not be easy. But I do believe an agreement that protects patients and families from higher costs and uncertainty, and maintains the guardrails in our current health system is possible.

This kind of agreement would not only make a real difference for the patients and families that we serve, but it could provide a bipartisan foundation for future work. I have said many times before this work did not end when the Affordable Care Act passed. It is certainly true today.

There is much more we need to do to strengthen the healthcare system, to lower costs, to expand coverage, and improve quality of care. These are the issues we should be able to work together on in a bipartisan way.

I hope with today's conversation, we can continue to turn the page away from Trumpcare and partisanship that we have seen way too much of, and instead, start working on healthcare policies to help our patients and families afford the care that they need because that is the goal that we should all be focused on.

I am so glad we have seen the interest on both sides of the aisle for coming together and working to find common ground on these issues.

I want to, again, thank all of the commissioners and all of our colleagues who are joining us today.

I will turn it back over to Chairman Alexander.

The CHAIRMAN. Thank you, Senator Murray.

Our first witness is Julie Mix McPeak. She is Commissioner of Tennessee's Department of Commerce and President elect of the National Association of Insurance Commissioners. She has testified here before. Welcome, Commissioner McPeak.

Our second witness is Mike Kreidler. Senator Murray has already welcomed him and acknowledged him. He is Washington's eighth Insurance Commissioner, the State of Washington's, and the country's, longest-serving commissioner.

I will ask Senator Murkowski to introduce the next witness.

STATEMENT OF SENATOR MURKOWSKI

Senator MURKOWSKI. Thank you, Mr. Chairman.

It is a pleasure to introduce to the committee an individual who has been before us before. Director Lori Wing-Heier is Alaska's Director of Insurance. She has been in that position since 2014 and has done an exceptional job.

We recognize not only her service there, but she is also the Chair of the American Indian and Alaska Native Liaison Committee on the Association of Insurance Commissioners.

As you have noted, Alaska is one of two States that has received a 1332 Waiver, and it has been under the guidance of Director Wing-Heier that we have seen that come about.

I thank her, not only for being here today, but for her leadership and her persistence in working, not only with the Obama adminis-

tration, but with the Trump administration in getting that final sign off.

The CHAIRMAN. Thank you, Senator Murkowski.

Senator Casey, would you like to introduce the next witness?

STATEMENT OF SENATOR CASEY

Senator CASEY. Yes. Thank you, Mr. Chairman.

I am pleased to introduce Teresa Miller who is Pennsylvania's Acting Secretary of Human Services and former Pennsylvania Insurance Commissioner. Secretary Miller served as Insurance Commissioner from 2015 through August of this year, when she was nominated by Governor Wolf to serve as Secretary of Human Services.

In her role as Insurance Commissioner, she has been a vocal supporter of Pennsylvania's health insurance marketplace, demonstrating a deep understanding of the insurance industry while advocating for polices in the best interests of Pennsylvanians.

I congratulate her on being nominated to serve as Secretary of Human Services and happy to welcome her to the HELP Committee today.

Secretary Miller, thank you for your testimony today. We are grateful you are here.

The CHAIRMAN. Thank you, Senator Casey.

Our fifth witness is John Doak. We welcome you back Mr. Doak. You were here before to help us understand the issues.

He is Commissioner for Oklahoma's Department of Insurance. He is well known for hosting healthcare innovation summits within his State, which seek to offer cutting edge solutions to the country's healthcare challenges.

As you already know from the meeting we have had earlier, there is a lot of interest here among senators. So if you could please summarize your remarks in about 5 minutes, we will then turn to a series of questions from senators.

To follow that up, let us begin with you, Ms. McPeak.

STATEMENT OF JULIE MIX McPEAK, J.D., COMMISSIONER, TENNESSEE DEPARTMENT OF COMMERCE AND INSURANCE, NASHVILLE, TN

Ms. MCPEAK. Thank you. Good morning, Chairman Alexander, Ranking Member Murray, and members of the committee.

I am Julie McPeak, Commissioner of the Tennessee Department of Commerce and Insurance.

Today, I plan to highlight Tennessee's history with the ACA and discuss some immediate solutions that Congress can consider to stabilize the individual insurance market.

Before I get started, I would like to thank you for holding today's hearing and for inviting so many of my State regulator colleagues.

In an interview last year, I characterized Tennessee's individual health insurance market as very near collapse. In the 12 months since, thankfully, our market has not collapsed, but our market is not any more stable and probably less so.

Tennessee in 2017 has continued to see health insurance carriers flee the market due to the tremendous uncertainties surrounding the 2018 plan year, as well as year-over-year of substantial losses.

As of today, and subject to change until QHP agreements are signed later this month, Tennessee consumers across the State will have at least one option for coverage, but only one in the clear majority of our State.

While we feel very fortunate that Tennesseans will have an opportunity for coverage, I do not think that many people believe that having a single choice in 78 of 95 counties represents ideal market competition.

To summarize, Tennessee's experience over the last 4 years, our consumers have seen premium prices skyrocket while their plan choices have diminished. Tennessee had around a dozen carriers offering individual health insurance coverage in 2010, reduced to only three companies offering ACA-compliant plans in 2018. Tennessee's current ACA trajectory, quite simply, is not sustainable.

Today's hearing could not be timelier as we are approaching a September 20 deadline for final determinations on 2018 rate filings. Tennessee's carriers filed rates assuming the CSRs are not funded, with each carrier attributing approximately 14 percent of their average rate increase to CSR uncertainty.

According to CMS data, approximately 120,000 Tennesseans are enrolled in CSR plans representing almost 60 percent of our FFM market. The CSR funding issue is the single most critical issue you can address to help stabilize insurance markets in 2018. To be clear, this issue is not an insurer bailout.

CSR funding ensures that some of our most vulnerable consumers receive assistance for co-pays and deductibles that are required to be paid under Federal law. It has the effect of reducing proposed premium increases and has a direct impact on the amount of subsidy assistance provided by the Federal Government.

In fact, as you know, last month the CBO reported the Federal deficits would increase by $6 billion in 2018 if CSR funding is terminated.

But on the other hand, should the Federal Government agree to fund CSRs and CMS works with the State, in Tennessee, we could see proposed increases for 2018 be reduced.

Beyond CSRs, Congress should also establish a reinsurance mechanism that would stop losses for individual claims at a specified amount to increase market participation by carriers. For the most immediate impact, this backstop mechanism must be Federal as it would be impossible for many States to develop such a program for the 2018 plan year.

States should have the option and flexibility to set up their own programs to reflect our unique dynamics and market conditions, but the Federal Government should set up a default mechanism to stabilize markets during any transition to a State-run program.

Following these immediate measures—CSR funding and reinsurance—Congress must address broader ACA reforms, such as benefit design, rating restrictions, and the underlying cost of healthcare.

As the cost of healthcare services increase, so too must the cost of health insurance. This causal relationship is simple to understand, yet it is too often not discussed in conversations of health insurance reform.

Health insurance rate requests are subject to review by State insurance departments and in FFM States by the Federal Government.

In Tennessee, the rate review process is an entirely public one. As soon as a rate is filed, it is publicly accessible to anyone interested. Rates are filed and approved on a plan year basis that prohibits rate changes during the year, and provides consumers' notice before a rate increase for the following year.

These parallel protections are nonexistent in the pharmaceutical industry and this level of transparency is lacking in determining appropriate costs for medical services. These issues cannot remain to be unaddressed in our focus on health insurance rates and accessibility.

In conclusion, consumers around this country need, and deserve, access to quality health insurance coverage at affordable rates. Working together, we can get back to a place of vibrant, competitive markets where insurers look to expand, rather than contract, their operations.

Congress should focus on two critical elements to make that possible: CSRs and reinsurance. After addressing these issues, Congress should focus its attention on a broader conversation of our Nation's health and strategies to improve health outcomes while reconsidering tenets of the ACA that have led to challenge and potentially unsustainable markets across much of the country.

Thank you again for your time. I look forward to answering your questions.

[The prepared statement of Ms. McPeak follows:]

PREPARED STATEMENT OF JULIE MIX MCPEAK, J.D.

SUMMARY

Highlight

The ACA as it stands today is not sustainable in Tennessee. Our market remains "very near collapse." Congress and the Administration have a tight window to enact bipartisan legislation that can provide immediate relief and stability for 2018 as Members continue to work together on longer-term solutions.

Tennessee Experience

Tennessee's individual health insurance marketplace is no stronger today than it was a year ago. In fact, in 2017 we continued to see carriers with significant market presence flee the market due, in large part, to the tremendous uncertainty surrounding the 2018 plan year as well as to substantial losses in recent years. Today, Tennesseans in 73 of 95 counties only have one FFM option. That number will increase to 78 counties in 2018. Tennesseans have also seen their premium prices increase substantially since 2014, and those rate requests have been fully justified by medical claims. Tennessee has gone from having premiums among the lowest in the country in 2014 to among the highest for 2018. We have three carriers remaining in the marketplace selling ACA-compliant plans, and carriers have introduced narrower networks.

Immediate Stabilization

Congress can strengthen insurance markets by fully funding CSR payments through the 2018 plan year and by establishing a reinsurance mechanism. CSR funding ensures that some of our most vulnerable consumers receive assistance for copays and deductibles and has the effect of reducing proposed premium increases that would otherwise increase the amount of advance premium tax credit assistance provided by the Federal Government if done expeditiously. Reinsurance will effectively stop losses for individual claims at a specified amount, providing more stability to the claims evaluation and projection process. The program should provide an immediate Federal backstop and then flexibility for States to set up their own

programs in the future and ultimately reduce premiums and bring carriers into the market.

Health Care Costs

Health insurance helps consumers shoulder the costs of health care services. As the costs of health care services increase, so too must the costs of insurance. This causal relationship is simple to understand, yet is too often not discussed in conversations of health insurance reform.

Future

Congress must first focus on these critical stabilization measures. After addressing immediate stabilization measures, Congress should focus its attention on a broader conversation of our Nation's health and health insurance systems and the long-term sustainability of these systems.

INTRODUCTION

Good morning Chairman Alexander, Ranking Member Murray, and members of the committee. Thank you for inviting me to testify this morning. I enjoyed meeting with this committee in February and I look forward to today's conversation.

As you know, I am Julie Mix McPeak. I am commissioner of the Tennessee Department of Commerce and Insurance (TDCI) where I also serve as the State's Fire Marshal. In addition to my responsibilities at home, I also serve as president-elect of the National Association of Insurance Commissioners (NAIC), as an executive committee member of the International Association of Insurance Supervisors (IAIS), and as a member of the Federal Advisory Committee on Insurance (FACI). I have spent most of my career in insurance regulation, previously serving as the executive director of the Kentucky Office of Insurance, and have a strong affinity for the country's State-based system of insurance oversight.

My testimony today will highlight Tennessee's history with the Affordable Care Act (ACA) before discussing some immediate and longer-term solutions that Congress and/or the Administration can consider to stabilize the individual insurance market. Before I get started, I would like to thank you for holding today's hearing and for inviting so many State insurance regulators as we have all spent a significant number of days working in our States and working together to ensure stability in the health insurance markets of this Nation.

TENNESSEE'S INDIVIDUAL MARKET

In an interview last year discussing 2017 filings and rates, I characterized Tennessee's individual health insurance marketplace as "very near collapse." In the 12 months since, our marketplace has not collapsed. Unfortunately, however, our market is not any more stable than it was late last year.

Tennessee in 2017 has continued to see health insurance carriers flee the market due, in large part, to the tremendous uncertainty surrounding the 2018 plan year as well as to substantial losses in recent years. Humana Insurance Company and TRH Health Insurance Company announced this year that they would not write ACA-compliant plans on or off of the federally Facilitated Marketplace (FFM) in 2018. While we added one new insurance carrier, Oscar Insurance Company of Texas, that company will only be writing in one of the State's eight rate and service areas—the Nashville region and its surrounding counties.

BlueCross BlueShield of Tennessee (BCBST) has tentatively agreed to offer coverage in the Knoxville region and its surrounding counties. This is noteworthy because it means that, as of today, and subject to change until Qualified Health Plan (QHP) agreements are signed later this month, Tennessee consumers across the State will have at least one option through the FFM. While we feel very fortunate that all Tennesseans will have such an opportunity, I do not think that many people would argue that having a single choice in 78 of 95 counties and a total of three (3) insurance carriers offering ACA-compliant coverage in the State represents ideal marketplace competition.

Tennesseans will face substantial rate increases for yet another year. BCBST and Cigna filed rate increases that averaged 21 percent and 42 percent for the 2018 plan year, respectively. Those increases may be offset for the 88 percent of our FFM enrollees that receive advance premium tax credits (APTC), but for the other 12 percent of FFM enrollees and for the 37,478 individuals who purchase insurance off the exchange, these premium increases are substantial. And they are in addition to substantial rate increases absorbed by these populations over the last several years.

Tennessee began the ACA experience in 2014 with some of the lowest rates in the country. In fact, our rates ranked the second-lowest in 2014 and the fifth-lowest in 2015. During those same 2 years, Tennessee had the highest and second-highest risk scores in the Nation, according to metrics developed and reported by the U.S. Department of Health and Human Services (HHS). Tennessee is also among the many States that had a Co-Op experience that did not end in success. Our Co-Op provided coverage through the end of 2015, but due to a multitude of factors was ultimately placed into Supervision by my Department. We have been working with HHS since that time and hope to soon complete the company's wind-down and we fully expect that the company will be able to repay the Federal Government a small portion of the Federal moneys allocated for its startup and solvency purposes.

To summarize Tennessee's individual market experience over the last 4 years, our consumers have seen premium prices skyrocket while their choices have dropped substantially. Tennessee had around a dozen carriers offering individual health insurance coverage in 2010, and looking to 2018, the State has a total of three companies offering ACA-compliant plans (though consumers in much of the State will only have one choice), and one company that sells non-compliant, underwritten plans. The companies' experiences and the State's population health, which we are working as a State to improve, have justified the rate increases. While we recognize that premiums for ACA-compliant plans were going to be pricier than non-ACA-compliant plans available before 2014 due to their more robust benefit offerings, policies that increase in price significantly year-over-year has been a tremendous affordability challenge for Tennessee's citizens.

Tennessee's current ACA trajectory, quite simply, is not sustainable into the extended future. We are thankful that consumers in all counties of Tennessee appear to have an FFM coverage option for 2018, and we are hopeful that that remains the case, but for how much longer, as we are running out of carriers? I appreciate today's hearing designed to create solutions to immediately inject some level of stability into the market and I encourage you to continue discussions to more broadly address America's health insurance and healthcare challenges.

TIMELINE & CSRS

Today's hearing could not be more timely as we are rapidly approaching a September 20 deadline for States and the Centers for Medicare & Medicaid Services (CMS) to make final determinations on 2018 rate filings. This deadline was pushed back by CMS on August 10 from an original August 16 due date with a recognition that cost-sharing reduction (CSR) questions added a layer of complexity to the rate review process. The States have addressed CSR uncertainty in a variety of ways, including by requiring carriers to file two sets of rates: one set of rates that assumes CSRs are not funded and the other set of rates that assumes CSRs are funded by the Federal Government for the 2018 plan year.

Tennessee's marketplace carriers filed one set of rates assuming the CSRs are not funded. We asked carriers to identify the percentage of their rate request that is due specifically to uncertainty surrounding CSR funding. BCBST reported that 14 percent of its overall 21 percent average rate increase is due to CSR uncertainty, while Cigna reported its impact at 14.1 percent of its overall 42 percent average rate request. According to CMS data, approximately 120,000 Tennesseans are enrolled in CSR plans, representing almost 60 percent of our FFM market.

There is still potentially time for the Congress and Administration to provide stability to health insurance markets across the country by agreeing to fund CSR payments at least through the 2018 plan year. Such a stability measure could result in an immediate reduction in proposed premium rates for 2018 following coordination between the States and CMS.

The CSR funding issue is the single most critical issue that you can address to help stabilize insurance markets for 2018 and potentially bring down costs. And to be clear, this issue is not an "insurer bailout." CSR funding ensures that some of our most vulnerable consumers receive assistance for copays and deductibles that are required to be paid under Federal law AND has the effect of reducing proposed premium increases that would otherwise increase the amount of APTC assistance provided by the Federal Government. In fact, as you know, last month the Congressional Budget Office (CBO) reported that Federal deficits would increase by $6 billion in 2018 if CSR funding is terminated.

Should the Federal Government refuse to fund CSRs, premium rates will increase at rates that are otherwise unnecessary based on medical trend, inflation, and other cost considerations. This increase will impact the second-lowest silver plan rates, which in turn will increase the amount of available subsidy to FFM consumers. On the other hand, should the Federal Government agree to fund CSRs, and CMS

works with the States, we could see proposed increases for 2018 be reduced by substantial margins. Those reductions could also result in the Federal Government paying out less in APTC than they would pay should currently filed rates be approved. Please act now to fully fund CSRs and provide that necessary certainty to our insurance markets.

INDIVIDUAL MARKET REFORMS

Reinsurance/Stop-Loss Mechanism

In addition to providing certainty regarding CSRs, the Federal Government can take additional action to stabilize markets. To stabilize markets, we need to grow risk pools with healthy individuals. To attract new, healthier risk to the market, we need to calm rates and backstop losses relative to the most expensive claims. Along these lines, Congress should consider establishing, at the very least, a short-term reinsurance mechanism that would effectively stop losses for individual claims at a specified amount. For a most immediate impact, this backstop mechanism must be Federal as it would be impossible for many States to develop such a program for the 2018 plan year and a significant challenge for States to implement a mechanism for 2019 and perhaps 2020. States should have the option and full flexibility to set up their own programs to reflect their unique dynamics and market conditions, but the Federal Government should set up a default mechanism to stabilize markets during any transition to a State-run system.

In Tennessee, TDCI recently issued a data call to our health insurance carriers to better understand the frequency of high cost claims. We requested claim cost numbers in specified increments beginning at $50,000 claims and extending beyond $5 million. Preliminarily, and on the aggregate as we issued this data call under our confidential market conduct authority, we have identified that between 85 percent and 95 percent of claims incurred and reported in 2015 and 2016 respectively, fell between the $50,000 and $200,000 range. We are continuing to review the data.

Rate Bands

When I was here in February, I highlighted providing more flexibility related to rate bands as one area that Congress and/or the Administration could address in trying to bring younger, healthier individuals into the individual insurance marketplaces. In Tennessee, the majority of our FFM population is 45 years of age or older. We need younger, healthier risk to enter the market and balance the currently insured business that, as HHS has indicated, has resulted in a higher risk score than almost every other State's insured population.

As you know, the ACA has a 3:1 age band that requires premiums to differ based on age by no more than a 3:1 ratio. I said in my February statement:

> Providing more flexibility to insurance regulators and carriers in how individuals are rated, even while keeping prohibitions against discrimination based on preexisting conditions, may help stabilize insurance markets. Ratios closer to 5:1 or 6:1 would provide more rate flexibility in the market and when coupled with EHB flexibility may have the ultimate impact of growing the individual insurance pool in Tennessee.

I stand by that statement today and would add that a 5:1 or 6:1 ratio should be a ceiling rather than a requirement. Before the ACA, we saw rates that often provided a 5:1 age ratio in Tennessee. These rates were actuarially justified and allowed for more variability in rates for younger consumers. Should the ACA be amended to provide more flexibility, it is possible, if not highly likely, that younger consumers who today want to purchase insurance but decide to instead pay the individual mandate penalty due to higher prices would come back into the markets to give themselves a sense of comfort that insurance provides should they need medical services.

Yes, greater flexibility in age rating would mean lower prices for younger consumers. Yes, it could also mean higher prices for older consumers; but that's not necessarily the case and it is a situation that Congress could simultaneously address by adjusting APTC formulas. However, there is simply no denying that a bigger risk pool with a greater percentage of low risks will outperform a smaller risk pool with concentrated high risk. We should do what we can to grow our risk pools for the benefit of the many, including by expanding the range of individuals qualifying for an APTC to apply to those individuals falling below 100 percent of the Federal Poverty Level (FPL) who may not otherwise have access to affordable insurance coverage as well as by opening up access to catastrophic plans to everyone, rather than for only individuals aged 30 and younger or those who can otherwise qualify under special circumstances.

HEALTHCARE COSTS

Health insurance helps consumers shoulder the costs of health care services. As the costs of health care services increase, so too must the costs of health insurance. This causal relationship is simple to understand, yet is too often not discussed in conversations of health insurance reform. While recognizing that today's focus is on immediate strategies to stabilize health insurance markets, I would be remiss if I did not urge the committee to also begin a conversation about health insurance cost drivers, and specifically the costs of health care services.

Health insurance rate requests are subject to review by State insurance departments and in FFM States, the Federal Government. Health insurance rates are among the most highly regulated financial products in the country as they must be related to risk and are prohibited from being excessive or inadequate or discriminatory. In addition, Federal law specifies "loss ratios" for health insurance products that require carriers to provide rebates to consumers if the carriers spend too much of their premium revenue on administrative costs. In Tennessee, the rate review process is an entirely public one. As soon as a rate is filed through the Department's electronic system, it is publicly accessible to anyone interested. Objections to the filings, and questions from the Department, are also publicly accessible, as are responses from the companies. Insurance consumers go on *healthcare.gov* to view a menu of policy options, complete with monthly premium prices. Rates are filed and approved on a plan year basis that prohibits rate changes during a year and provides consumers notice before a rate increase for the following year. Are there parallels to these protections applicable to the pharmaceutical industry? Is this level of transparency achieved in determining appropriate costs for medical services?

Medical and particularly pharmaceutical costs and transparency, balance and surprise billing, and air ambulance costs, services, and billing, contribute to the cost of health insurance. As we continue our conversation on stabilizing health insurance markets, I would encourage you not to lose sight of key cost drivers and to look for incentives and wellness programs that may help improve the overall health of our shared constituents.

CONCLUSION

Thank you for the opportunity to visit again with this committee. Health insurance markets remain "near collapse" in several States and are certainly challenged in many others. But insurance regulators are a resilient group, and we stand ready to work with you to provide immediate and long-term stability to our markets.

Consumers around this country need and deserve access to quality health insurance coverage at affordable rates. Working together we can get back to a place of vibrant, competitive markets where insurers look to expand, rather than contract, their operations. The Congress should first focus on two critical elements to make that possible: CSRs and Reinsurance. Fully funding CSRs will provide immediate certainty to our markets, and very possibly bring requested rate increases down, and a Federal backstop for high-dollar claims will calm troubled markets. After addressing these issues, the Congress should focus its attention on a broader conversation of our Nation's health and strategies to improve health outcomes while reconsidering tenets of the ACA that have led to challenged and potentially unsustainable markets across much of the country.

Thank you again for this conversation. I look forward to your questions.

The CHAIRMAN. Thank you, Ms. McPeak.

Mr. Kreidler.

STATEMENT OF MIKE KREIDLER, O.D., WASHINGTON STATE INSURANCE COMMISSIONER, OLYMPIA, WA

Mr. KREIDLER. Good morning, Mr. Chairman, and Ranking Member Murray, and members of the committee.

My name is Mike Kreidler and I am the Insurance Commissioner for the State of Washington. I want to thank you for your bipartisan commitment to address the challenges that we, as insurance commissioners, are facing, but also you are facing in the coming months.

This is especially true for the individuals and families who buy their own health insurance, some 330,000 people in the State of

Washington. The health of that market is really the canary in the coal mine. If there is a problem in the individual market, it is a problem for all of us.

This is made up, as you pointed out, Chairman Alexander, of early retirees, self-employed people who work for employers who do not offer health insurance. The individual market is clearly a very critical safety net. They are relying on us to find a path forward that offers a great deal more certainty than what we have right now.

Washington State has fully embraced the Affordable Care Act from the very beginning. We have a very stable market since 2014. Our uninsured rate has plummeted from 15 percent down to under 6 percent in the State of Washington, but this year, there has been a serious jolt to the system.

Initially, we had two counties in the State of Washington that did not have any health insurers. We solved that problem, thankfully, but I am nervous about what is going to happen next year. Because of the growing uncertainty and actions by the Administration, our individual health insurance markets are in serious peril.

The proposed average rate increases that we have seen for 2018 are 23 percent. In years past, it has been under 10 percent. Nine rural counties have only one insurer. One major insurer largely pulled back in our State completely from western Washington where most of the people live.

The next 2 weeks are going to be very telling. Insurers will be making their final decisions as to whether they are going to participate in the health insurance marketplace or not. Congress must act quickly to address these growing uncertainties.

You must permanently fund the Cost Sharing Reduction payments. That is something that is going to help a great deal in our marketplace. It affects some 72,000 people in the State of Washington. For a low-income family in the State of Washington, the deductible is the difference of being $1,200 with the CSRs or $14,000.

I urge you to create a Federal reinsurance program this year. Doing this would show your commitment to stabilizing the market. It worked very well in the State of Washington for the first 3 years that we had a reinsurance program. We would like to see it continue and go forward.

It is another way of reassuring the insurance market and insurance carriers. It does not help them financially, but it gives them predictability and helps us hold down the rates.

Make sure that you maintain the coverage and affordability guardrails in the 1332 Waivers. We are willing to play by the rules. What we do not want to see is Essential Health Benefits and the guarantees on out of pocket costs eroded away. Those are consumer protections that nobody wants to see leave the marketplace.

In closing, let me say that you must take bold action now to shore up these markets. Millions of hardworking families and individuals are counting on us. In Washington State, we have firsthand experience with what can happen when violating basic insurance principles are allowed to occur, and they are occurring right now.

We tried this in the 1990s and we saw the individual market in the State of Washington totally collapse. Believe me, that is something no one wants to go through.

Let me be a harbinger here and say this. It can and will happen if you do not take action now. That is how critical it is out there in that insurance market and to make sure we do not have that kind of collapse we saw in Washington happen for the whole country in the individual market. Lives depend on it. Our lives rest on your bipartisan efforts.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Kreidler follows:]

PREPARED STATEMENT OF MIKE KREIDLER, O.D.

SUMMARY

Washington State's individual market insures 330,000 people. Most of these people are self-employed, early retirees, or work for employers who don't offer coverage.

This is a vulnerable population of individuals who have no negotiating power, and the market is increasingly unstable, especially in today's regulatory climate.

Washington State successfully implemented health reform, and until this year, has had a stable individual health insurance market with many insurers and lower-than-average rates.

This year was a jolt to our system. We're seeing higher proposed rates, fewer plans being offered, and a major insurer pulling back from Western Washington.

All of these actions are a direct result of growing instability in the individual market and the lack of predictability for insurers.

To stem this trend, Congress must take swift, bipartisan action in three areas:

- Permanently fund cost-sharing reduction subsidies.
- Create a Federal reinsurance program.
- Maintain coverage and affordability guardrails of 1332 waivers.

Washington State has firsthand experience with the dangers of ignoring signs of instability in its insurance market.

We passed reform in the 1990s that ignored basic insurance principles and saw a total collapse of our individual market in only a few years.

Let our experience be your warning. This can and will happen on a national level if Congress does not take appropriate action now.

Chairman Alexander, Ranking Member Murray and committee members, thank you for the opportunity to testify today regarding the challenges facing our individual health insurance market and possible solutions to address those challenges. I welcome the commitment of the Health, Education, Labor, and Pensions Committee to work on a bipartisan basis to address this critical issue.

In Washington State, approximately 330,000 people (or about 5 percent of our population) purchase their own individual health insurance coverage. Most work for employers who don't offer health insurance, are self-employed or are early retirees. People who buy individual insurance often have no other option for coverage; the individual market is their safety net.

As Washington State's insurance commissioner, it is my responsibility to do everything in my power to ensure that these Washingtonians have access to a stable insurance market. But I cannot do it alone—my success depends upon a strong partnership with the Federal Government. Now, this month, critical Federal actions are needed to stabilize the individual health insurance market in Washington State, and in the country. This burden rests on you.

It is with the well-being of my State's residents clearly in mind that I offer my testimony today.

Following enactment of the Federal Affordable Care Act (ACA), Washington State launched a bipartisan effort that fully embraced all aspects of the new law. We acted quickly to establish our own State-based marketplace, the Washington Health Benefit Exchange (Exchange), and to implement Medicaid expansion. I strongly believe that these early decisions are why we have cut our uninsured rate by 60 percent. Today, the percentage of people in our State without health insurance is at a record low of about 6 percent.

There are several additional reasons for our success. We are fortunate to have "home grown" local insurers who have made a strong commitment to our State. We have the benefit of being a lower health care cost State—our use of hospital services is among the lowest in the Nation. And in 2014, I, along with 22 other States and the District of Columbia, made the difficult decision to not allow legacy or non-ACA-

compliant plans to continue to be offered in the individual market so that our individual market risk pool could be as large and as healthy as possible.

As a result, since 2014, Washington State has enjoyed a stable and competitive individual health insurance market. Before this year, we have experienced an average annual premium increase of near or below 10 percent. For 2017, we had 13 health insurers offering 154 plans in our individual health insurance market.

Let me be clear, the Affordable Care Act is not perfect even in Washington State. I am concerned about bringing as many healthy, young people into coverage as possible. And, like other States, we have seen a recent trend to narrower health plan networks. Deductibles and cost-sharing are growing, presenting real affordability challenges for some consumers. We share the national challenge of rising pharmaceutical costs. Yet, despite all this, the ACA has had a major positive impact on our overall market, providing life-saving benefits to many of our most vulnerable citizens.

This year, our progress forward is threatened by uncertainty around the fate of the ACA, including continued payment of cost-sharing reductions, weakened enforcement of the individual mandate, and Federal investment in outreach and marketing to promote enrollment in health coverage.

For plan year 2018, this uncertainty has caused a serious disruption to our individual health insurance market in these ways:

- Insurers have proposed rate increases averaging 23 percent.
- After evaluating proposed filings in June, we discovered two "bare" counties without any individual plans offered for sale. Working closely with our health insurers to see who was willing to step up to this challenge, we ultimately achieved statewide coverage.
- We anticipate having nine rural counties with only one insurer offering coverage on the Exchange.
- One major insurer left all counties in Western Washington, the most populous part of our State.
- Eleven insurers filed 74 plans for the 2018 individual health insurance market.
- The number of proposed health plans offered through our Exchange dropped substantially. Two insurers will no longer offer bronze plans on the Exchange.

These 2018 filings cause me grave concern for the fundamental stability of our individual insurance market.

The next 2 weeks will be telling, as insurers decide whether to follow up on their proposed filings for 2018 and commit to actual participation in the Exchange and in all of the counties they have proposed to serve. Congress must act quickly to address the uncertainty in the individual health insurance market. Clear opportunities are readily available to substantially strengthen it.

COST-SHARING REDUCTIONS

First, and foremost, Congress should bring certainty to cost-sharing reduction payments by making a permanent appropriation for them. Cost-sharing reductions are not insurance company bail-outs; they benefit lower-income people and families by directly reducing their health care costs. For those who struggle to meet basic needs such as food and housing, cost-sharing reduction payments will make a difference in whether they decide to purchase insurance. These payments also make a difference in whether they can afford to see a doctor, even when they do have insurance. The reduced cost burden will literally make the difference between their seeking care or not.

To illustrate this impact, I offer the following chart showing cost-sharing reductions by income level for various services. Consider a 40-year-old man living in Pierce County, Washington earning wages at 150 percent of the Federal poverty level, around $23,000 per year. Suppose he chooses to buy a silver plan with the lowest premium. With cost-sharing reduction payments, his annual deductible is $2,000. Without them, it increases to $7,050. With cost-sharing reduction payments, he can visit his primary care provider without having to make a copayment.

40-Year-Old Non-Smoker in Pierce County Selecting the Lowest Cost Silver Plan*

Income	Deductible	Primary care visit to treat an illness or injury copay	Specialist visit copay	Urgent care centers or facilities copay
150% FPL	$600	No charge	$5	$50
200% FPL	$2,000	No charge	$5	$50
250% FPL	$5,250	$15	$40	$75

40-Year-Old Non-Smoker in Pierce County Selecting the Lowest Cost Silver Plan*—Continued

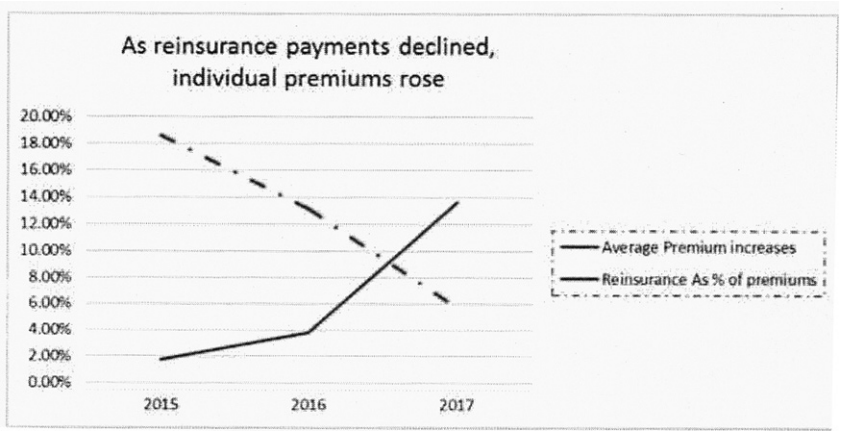
Income	Deductible	Primary care visit to treat an illness or injury copay	Specialist visit copay	Urgent care centers or facilities copay
400% FPL	$7,050	$30	$60	$100

*Ambetter Balanced Care 4 (2017).

Here and around the Nation, States have been spending countless hours during the last several months trying to find an approach to rate setting in 2018 that does the least harm to consumers if cost-sharing reduction payments are suddenly curtailed. I can assure you there is no solution that doesn't hurt consumers, especially those who do not receive advance premium tax credits.

FEDERAL REINSURANCE PROGRAM

Congress should enact a Federal reinsurance program with a minimum duration of 3 years. This level of clear and sustained commitment by the Federal Government is necessary, and will significantly help stabilize the individual health insurance market. In Washington State between 2014–16, we experienced the benefit of a Federal reinsurance program. We have concrete evidence of the impact that a reinsurance program can have on premiums and insurers' willingness to participate in this market.



Some have asked whether enactment of a Federal reinsurance program in late 2017 can impact rates in 2018. Health insurance rates for plans that will be sold in late fall open enrollment are filed in the spring and approved by late summer. At this time in the year, 2018 rates have been filed and approved, and a Federal reinsurance program enacted now would not change them.

However, it would have a strong effect on insurer participation in the 2018 market. As I stated earlier, insurers have filed proposed rates but have not yet committed to participate in the Exchange and the counties they have identified. If insurers know that a Federal reinsurance program will be in place for calendar year 2019 and beyond, there will be greater confidence and certainty related to market participation in calendar year 2018. Insurers will be motivated to participate in the market. And in calendar year 2019, a Federal reinsurance program would positively affect both premium rates and participation. Insurer confidence means more insurers participate in the market, which means more competition among insurers on price and quality of care. Fostering healthy competition among insurers is good for consumers.

In the short term, a Federal reinsurance program modeled on a Federal transitional reinsurance program would provide the most stability. Insurers are familiar with the program and can adapt quickly to its implementation. They will have certainty regarding the level of Federal funding available and the likely payment parameters, given their previous experience with the program. This experience will translate directly to lower premiums beyond plan year 2018.

If Congress has an interest in offering States more flexibility in the Administration of market stability funding, I strongly urge you to choose a funding allocation approach that fairly distributes funds across States, without regard to the approach selected. States can be valuable laboratories of innovation, and even-handed funding will ensure the widest array of methods. I remind you that implementation of a flexible option will require considerable lead time; States will need time for stakeholder discussions to determine the appropriate use of funding, to enact State legislation authorizing policy and spending authority, and to implement program parameters. States will also have to take into account the long lead time necessary for insurers to incorporate new options into their planned filings.

Like several other States, Washington is currently exploring reinsurance as a policy option to help stabilize our individual insurance market for 2019. We will determine, given the number of insurers in our market and our lower premium costs, whether use of a 1332 waiver would be viable in our State. Any program that we develop—if viable and if the necessary State funding is available—would supplement and enhance a Federal reinsurance program.

1332 WAIVER APPROVAL PROCESS

As an elected insurance commissioner, I believe that coverage and affordability guardrails in the current 1332 waiver statute set an appropriate national coverage benchmark. These guardrails ensure that a 1332 waiver will not result in reductions in the number of people covered, the scope of their benefits, or affordability. By creating a level playing field, they promote competition among insurers based upon quality and choice in a more stable market. They also promote improved population health.

I do agree that flexibility and efficiency could be improved in the 1332 waiver approval process. I believe that a 10-year economic analysis is not necessary. In addition, given that proposed insurance plans and rates are filed more than 6 months in advance of the plan year, the current 9-month period for the Centers for Medicare and Medicaid Services (CMS) to determine completeness and to review an application creates too much delay for the States. This is compounded for those States, like Washington, that have a part-time legislature.

It is my understanding that CMS is working to develop an expedited process for review of 1332 waiver applications, and I strongly support those efforts.

FEDERAL INVESTMENTS IN OUTREACH AND ENROLLMENT MARKETING

A key to a stable individual health insurance market is maximizing the number of people enrolled, especially those who are young and healthy. As noted earlier in my testimony, Washington State has its own Exchange. Yet the effectiveness of our own outreach and marketing is greatly magnified by the Federal Government's outreach and enrollment activities.

In the past, we have enjoyed an effective collaborative effort with the Federal Exchange in the months leading up to the start of open enrollment. Yet this year, that activity among the Administration, other States and major stakeholder groups is not occurring. These informative discussions included sharing of best practices, leveraging community infrastructure, developing consistent enrollment messaging, and sharing plans for marketing and advertising buys.

Pre-open enrollment emails and outreach support reports, newsletters and social media announcements suitable for sharing with our partners or socializing on our media channels are no longer being prepared. These resources support the larger message at a national level of the importance of having insurance, and for many of our most vulnerable—those who have English as a second language or live in harder-to-reach rural areas—they are a critical source of information.

Federal marketing and advertising of open enrollment on broadcast, print and social media channels is a critical element of outreach nationally. These ads provide essential open enrollment messages that keep the need for finding, selecting and enrolling in health insurance front and foremost during the busy holiday season. For many people, these ads may be the only time they may see information on open enrollment. Removing this key part of the strategic engagement strategy is damaging not only to the Federal marketplaces but to all marketplaces nationwide and, ultimately, come at the highest price for our consumers.

WASHINGTON STATE'S PAST INDIVIDUAL MARKET FAILURE

In Washington State, we know firsthand the consequences of an unstable individual market. Following passage and partial repeal of health reform legislation in the 1990s, our individual health insurance market went into a death spiral. By

1998, we had no individual health insurance options in the State other than a costly high-risk pool.

The failure of our individual market was caused by three factors:

- Health insurance rules requiring guaranteed issue and prohibiting pre-existing condition exclusion periods of more than 3 months.
- Repeal of an individual mandate.
- Lack of premium and cost-sharing subsidies to make coverage affordable.

I make my recommendations to you today to ensure that other States do not experience the same market failure that we did in Washington. Millions of people—hard-working families and individuals—are relying upon us to ensure that the individual health insurance market will be there for them now and in the future. Yet uncertainty related to payment of cost-sharing reductions, high premiums, and weakened enforcement of the individual mandate have placed our individual health insurance markets at serious risk. There are three concrete steps that Congress must take to address this crisis:

1. Fund cost-sharing reductions for at least 3 years.
2. Establish a Federal reinsurance program with a duration of at least 3 years.
3. Invest in enrollment outreach and education.

Thank you for this opportunity to share my recommendations with you.

The CHAIRMAN. Thank you, Mr. Kreidler.

Ms. Wing-Heier.

STATEMENT OF LORI K. WING-HEIER, DIRECTOR, ALASKA DIVISION OF INSURANCE, ANCHORAGE, AK

Ms. WING-HEIER. Thank you for the opportunity to testify today about the health insurance market in Alaska and the need for congressional action to help the people in the individual insurance market in 2018 and beyond.

Alaska has amongst the highest cost of healthcare in the Nation due to low population density and limited healthcare provider or facility competition in much of the State. While the individual mandate reduced the number of uninsured Alaskans, an unintended consequence was that the high cost of the individual health insurance premiums increased even further.

Premiums in the individual market in Alaska have increased by 203 percent since 2013. On average, an Alaskan in 2013 was paying a monthly premium of $344 per month and in 2017, that premium is $1,041 per month.

To stabilize this volatile market, the Division of Insurance worked with Governor Bill Walker to create the Alaska Reinsurance Program. The 29th Alaska State Legislature passed the Governor's bill in 2016 with overwhelming bipartisan support.

The Alaska Reinsurance Program is intended to provide stability to the individual health insurance market, mitigating rate increases by removing high cost claims. As planned, this had an immediate impact on rates.

Prior to enacting the Reinsurance Program, indications were that the rate filing from the single insurer in Alaska would be close to 40 percent in 2017. After enactment, the rate increase was a moderate 7.3 percent.

An independent actuarial analysis estimates the Reinsurance Program will increase enrollment in the individual market by 1,650 individuals. Modeling also indicates that the program may attract healthier members to the individual market further reducing premiums.

After enacting the Reinsurance Program, Alaska then applied, and was subsequently approved, for a Federal ACA Section 1332 State Innovation Waiver.

Alaska waived the requirement of a single risk pool and proposed that the Federal Government provide pass through funding for a period of 5 years to secure the State's Reinsurance Program. The pass through funding is based on the savings generated as a reduction in the Advanced Premium Tax Credits.

It is estimated that the Alaska Reinsurance Program will save the Federal Government $51.6 million in Advanced Premium Tax Credits in 2018 relative to what would have been the tax liability had the Program not been put into place.

After the Federal pass through funds are accounted for, the State will be responsible for providing approximately 15 percent of the $55 million Program cost necessary to stabilize the individual market.

As you consider congressional action to stabilize premiums across the country in 2018, we offer the following perspectives.

We would urge Congress to not disrupt the health insurance market, but instead, focus immediately on stabilization. Any decision made after the filings are approved could cause unintended, unfavorable disruption to insurance markets. Uncertainty destabilizes the market.

Committing to funding Cost Sharing Reduction payments through at least 2019 will keep premium rates from increasing at an even higher rate.

We support collaborative reforms developed in consultation with State regulators that strengthen markets with a goal of health insurance not only being accessible, but affordable. Programs that allow States to address the unique needs of their citizens, such as the Section 1332 Waivers, are vital to the long-term stability of health insurance markets.

Further deliberation on health insurance taxes is needed. In particular, citizens of States like Alaska that already face extremely high healthcare costs may be unfairly penalized by the Cadillac Tax.

Additionally, exempting insurers from health insurance tax in counties or States served by one insurer may be an effective way to increase the choice or competition that will benefit citizens, but should be considered for all States as a moratorium.

Please consider continuing and funding the Navigator and Assister Programs. In rural areas of Alaska, insurance brokers and consultants are hard to find. These programs reduce the number of uninsured citizens and maximize market participation. Media and public announcements are vital to open enrollment being successful.

A review of regulations may reveal some that are unnecessarily burdensome and costly to both medical providers and insurers.

We are also interested in coordinated efforts with healthcare providers to address the underlying drivers of healthcare spending.

Even under the extreme tight considerations you face to address 2018 premiums, please make your decision in a bipartisan manner after thorough analysis.

We are here to assist you in any way we can and I look forward to your questions.

Thank you.

[The prepared statement of Ms. Wing-Heier follows:]

PREPARED STATEMENT OF LORI K. WING-HEIER

SUMMARY

An unintended consequence of the Affordable Care Act was that the already extremely high cost of health insurance in Alaska increased even further. Premiums in the individual market in Alaska have increased by 203 percent since 2013, the year before the ACA was enacted.

To address the critical situation and stabilize the volatile market, the Division of Insurance worked with Governor Bill Walker to develop the Alaska Reinsurance Program, which the 29th Alaska Legislature subsequently passed with overwhelming bipartisan support in 2016. The Alaska Reinsurance Program provides stability to the individual health insurance market, mitigating rate increases by removing high cost claims from the individual market. The program had an immediate impact on rates.

- Prior to the enactment of the program, indications were that the rate filing from the single insurer in Alaska's individual market would include an increase of close to 40 percent. After the enactment, the 2017 individual rates had an average increase of just over 7 percent.
- Independent actuarial analysis estimates the reinsurance program will increase enrollment in the individual market by nearly 1,650 individuals relative to what enrollment would be absent the program. Modeling also indicates that the program may attract healthier members to the individual market, further reducing premiums.

To solidify the Alaska Reinsurance Program, the State was awarded an ACA Section 1332 State Innovation Waiver. Alaska waived the requirement of a single risk pool and will receive Federal pass-through funds for 5 years. The funding is based on the savings generated as a result of the estimated $51.6 million reduction in the Advanced Premium Tax Credits liability to the Federal Government in 2018, relative to what it would have been absent the reinsurance program.

As you consider congressional action to stabilize premiums across the country in 2018 and beyond, we offer the following considerations from the perspective of the Alaska health insurance markets,

- We urge Congress not to disrupt health insurance markets, but instead to focus on stabilization.
- Any decisions made after the filings are approved next week could cause unintended, unfavorable disruptions to insurance markets.
- Committing to funding Cost Sharing Reduction payments through at least 2019 will keep premium rates from increasing at an even higher rate.
- Until a viable alternative is proposed on the national level or via State waivers, the individual and employer mandates are necessary in the short term to keep markets stable.
- We support collaborative reforms, developed in consultation with State regulators, that strengthen markets with a goal of health insurance not only being accessible but affordable.
- Programs that allow States to accommodate the unique needs of their residents, such as the Section 1332 State Innovation Waiver, are vital to the long-term stability of markets.
- Further deliberation on the health insurance tax is needed.
- A review of regulations may reveal some that are unnecessarily burdensome and costly to both medical providers and insurers.
- We are also interested in coordinated efforts with health care providers to address the underlying drivers of health care spending, considering all aspects including pharmaceuticals, air ambulance, inpatient, and outpatient.

Even under the extreme time constraints you face to address 2018 premiums, please make your decisions in a bipartisan manner after thorough analysis. My fellow insurance directors/commissioners and I are here to assist you in any way we can to inform the difficult decisions before you.

ALASKA'S INDIVIDUAL HEALTH CARE INSURANCE MARKET

The cost of health care is very high in Alaska, and access is limited compared to other States, particularly for specialty services. Low population density and limited healthcare provider and facility competition in much of Alaska are primary contributors to Alaska's high health care costs. With a population of 738,432 spread across 570,641 square miles, Alaska has a small population and is the largest and one of the most geographically isolated States in the Nation.

Access to care has long been a challenge in Alaska due to its large geographic size, rural population, and insufficient health care provider competition. Because of these challenges, common managed care practices such as legislated network adequacy levels, closed network plans, and the development of Health Maintenance Organizations have not been successful. Alaska has among the highest cost of health care in the Nation; correspondingly, Alaska also leads the States in the cost of health care insurance and workers' compensation insurance.

As intended, the Affordable Care Act's individual mandate increased health care insurance enrollment in Alaska. Prior to the ACA's enactment in 2014, Alaska's uninsured population was estimated at approximately 134,000 residents, mostly non elderly adults. After 2 years of expanded ACA enrollment opportunities, the number of uninsured residents in Alaska was estimated to be approximately 100,000 people.

However, the unintended consequence was that the already high cost of health insurance in Alaska increased even further. Many Alaskans who do not qualify for the Advanced Premium Tax Credits or subsidies are unable to afford plans offered in the individual market. According to data from the Division of Insurance and the Department of Health and Human Services, as reported by the Office of the Assistant Secretary for Planning and Evaluation in May 2017, premiums in the individual market in Alaska have increased by 203 percent since 2013, the year before the ACA was enacted. On average, the increase means that an Alaskan in the individual market who was paying a monthly premium of $344 per month in 2013 is paying $1,041 per month in 2017.

The high costs do not only affect those in the individual market. Participants in group markets are not eligible to receive the subsidies or tax credits available to those in the individual market. Even though many Alaskans are covered by employer' sponsored plans, employer contributions typically only apply to the employee's premiums; costs to dependents are still prohibitive.

Therefore, many Alaska families in the group market are unable to afford employer-sponsored insurance.

The Alaska Reinsurance Program Stabilizes Rates

To address the critical situation and stabilize the volatile market, last year the Division of Insurance worked with Governor Bill Walker to develop the Alaska Reinsurance Program (ARP).

The legislation (HB 374) received overwhelming bipartisan support from the 29th Alaska Legislature.

The ARP is intended to provide stability to the individual health insurance market, mitigating rate increases by removing high cost claims from the individual health market. By removing high cost conditions from the risk pool, the benefits of the ARP are shared by the entire individual health insurance market regardless of income, age, race and ethnic group, or any other demographic characteristic.

As anticipated, the program had an immediate impact on the rates in the individual market. Prior to the enactment of the ARP, indications were that the rate filing from the single insurer in Alaska's individual market would include an increase of close to 40 percent. After the enactment of the ARP, however, the 2017 individual rates had a moderate average increase of just over 7 percent. Still, it should be noted that Alaskans who had to switch insurers because their carrier left the market in 2017 experienced increases of over 35 percent from what they were paying in 2016.

Actuarial modeling indicates that the ARP will continue to help reduce the rates necessary for insurers in the Alaska individual market and thus the premium amounts charged to Alaskans. The slowing of the growth of rate increases (and potential for rate decreases) due to the ARP may also draw additional Alaskans into the market. Independent analysis estimates the ARP will increase enrollment in the individual market by nearly 1,650 individuals relative to what enrollment would be absent the program. Modeling also indicates that the ARP may attract healthier members to the individual market, further reducing premium rates.

Additionally, there is potential that the ARP will encourage competition in the State's insurance market. In 2014, Alaska had three national insurers and one regional insurer participating in the individual market. In 2015, two insurers de-

parted the Alaska market, cutting the number of insurers in half. In 2016, the insurer covering approximately two-thirds of those enrolled in the individual market also exited the market, leaving only one insurer to serve Alaska's individual market in 2017. There is optimism that in subsequent years there may be interest from other insurers to provide health care plans if the market remains stabilized. If additional companies move into the Alaska individual market, consumers will benefit from natural market forces.

State Funding of the Alaska Reinsurance Program

Historically, like many other States, Alaska had a high-risk pool to provide access to health insurance to those who were unable to purchase insurance in the commercial market because of pre-existing conditions. Unlike many other States, however, Alaska did not dissolve the pool when the ACA was enacted because there were a few hundred people that purchased Medicare supplement policies, which are not sold in Alaska by a commercial insurer. The Alaska Comprehensive Health Insurance Association (ACHIA) is financed by an assessment on health insurers in the market and the State of Alaska.

HB 374 amended current statute, expanding the responsibilities of ACHIA to include the ARP. The ARP legislation also appropriated $55 million from various premium taxes to stabilize the health insurance market in 2017. Before being appropriated, these taxes would have been forwarded to the State's general fund and used for other obligations of the State, including matters such as education, economic development, infrastructure, and public safety.

Alaska is using the funds to reimburse the one insurer in the individual market for incurred claims from high-risk residents. The high-risk residents are defined as people who have been diagnosed with one or more of the covered conditions identified in regulation. The insurer still administers the claims; ACHIA receives the State funding, audits the claim requests, and upon acceptance of the claims, disburses the funds to the insurer on a periodic basis.

Due to the State of Alaska's ongoing fiscal concerns, the State legislature gave no assurances that the ARP would be funded beyond 2017, putting the sustainability of the ARP and the stabilization of Alaska's individual health insurance market in jeopardy if longer term sources of funding were not identified.

Federal Support of the Alaska Reinsurance Program

In early January of 2017, Alaska submitted an application to the Department of Health and Human Services (Centers for Medicare and Medicaid Services) and the Department of Treasury (Internal Revenue Service) for a Section 1332 State Innovation Waiver. As authorized under the ACA, an innovation waiver allows State-by-State amendments within specific parameters. For instance, coverage must be at least as comprehensive and affordable as what existed prior to the waiver, the number of State residents covered must be comparable to the baseline without a waiver, and the scenario must not increase the Federal deficit.

Alaska's application waived the requirement of a single risk pool and proposed that the Federal Government provide pass-through funds for a period of 5 years to stabilize the ARP. The pass-through funding is based on the savings generated as a result of a reduction in the Advanced Premium Tax Credits (APTC). It is estimated that the ARP will save the Federal Government $51.6 million in APTC in 2018, relative to what the tax liability would have been absent the program.

Premium tax credits associated with the ACA will continue to be paid based on Federal methodology, but the growth of such payments is slowed by the ARP. Independent actuarial analysis showed that the amount in APTC paid by the Federal Government to Alaskans was significantly reduced when the ARP went into effect in 2017:

Calendar year	Baseline–No ARP	APTC with ARP	Difference
2017	$185,716,278	$185,716,278	$00
2018	$233,898,461	$182,260,689	$51,637,772
2019	$258,351,449	$202,372,542	$55,978,906
2020	$279,343,570	$219,162,267	$60,181,304
2021	$312,617,789	$247,210,983	$65,406,805
2022	$342,289,634	$272,477,673	$69,811,961

There was also difference in APTC paid during calendar year 2017, but the waiver is not applicable until 2018; the ARP is wholly funded by the State of Alaska in 2017.

In July, Governor Walker was notified that Alaska's waiver had been approved. Director Seema Verma's letter to the Governor indicated that the State will receive an estimated $322,652,234 to fund the ARP over the next 5 years:

Calendar year	Estimated funding
2018	$48,362,287
2019	$61,536,998
2020	$65,716,251
2021	$71,177,767
2022	$75,858,931
Total	$322,652,234

After the Federal pass-through funds are accounted for, the State will be responsible for providing approximately 15 percent of the funding needed to stabilize the individual market through the ARP. In 2018, Federal funds will cover $48,362,287 and State funds will cover $6,637,713 of the $55 million program costs.

Actuarial modeling shows that, at least in part due to the ARP, Alaska's 2018 premiums are expected to decrease by approximately 20 percent. While the premium decrease may not directly affect those currently receiving tax credits, Alaskans who do not receive Federal tax credits will benefit from the premium reductions. Additionally, if Federal funding of the Cost Sharing Reduction payments continues, the decrease could be as high as 25 percent, bringing the cost in the individual market back to within reach of many Alaskans.

The State will continue to pursue programs that would benefit Alaskans both in the individual and small group markets, possibly including a second Section 1332 State Innovation Waiver.

NEED FOR CONGRESSIONAL AND ADMINISTRATIVE ACTION

The ACA was a well-intended piece of Federal legislation that brought insurance to millions of Americans. The expectation was that as provisions of the ACA alleviated insurance underwriting restrictions that previously made it impossible for many people with pre-existing conditions to obtain insurance, millions of uninsured Americans with chronic or severe illnesses would become eligible for health insurance. Through mechanisms such as the Advanced Premium Tax Credits and Cost Sharing Reduction payments, low and moderate-income individuals who would otherwise not be able to pay monthly premiums would also be able to obtain health insurance. The insurance markets would be stabilized by the 3Rs-risk adjustment, reinsurance, and the risk corridor.

The idea was that millions would enroll and that the premiums generated would support the expenses of the whole. However, this well-intended fundamental concept failed in most States, forcing insurers to either withdraw from entire counties/States or increase the premiums in the individual market to a point that ACA plans were not affordable to consumers. The 3Rs had mixed impact on the markets and have not stabilized the ACA as they were intended to do, which has also led to some of the turbulence the health insurance markets are now facing.

As you consider congressional action to stabilize insurance premiums across the country in 2018 and beyond, I offer the following considerations from the perspective of the Alaska health insurance markets,

- We urge Congress not to disrupt health insurance markets, but instead to focus immediately on stabilization.
  - Rate filings are to be approved next week. Any decisions made after the filings are approved could cause unintended, unfavorable disruptions to insurance markets.
  - Uncertainty destabilizes the market. Committing to funding Cost Sharing Reduction payments through at least 2019 will keep premium rates from increasing at an even higher rate.
  - The individual and employer mandates keep the markets stable. Eliminating the mandates would most likely result in fewer individuals participating in the market, resulting in a smaller health care pool and higher costs to all enrollees. Until a viable alternative is proposed on the national level or via State waivers, the mandates are necessary in the short term to keep markets stable.

• We support collaborative reforms, developed in consultation with State regulators, that strengthen markets with a goal of insurance not only being accessible but affordable.

• Amendments to the ACA must be carefully vetted with State regulators to examine whether expectations of the States are reasonable and how the structure of potential programs may adversely impact States. Program costs should not be shifted to the States, creating undue financial burdens.

• Programs that allow States to accommodate the unique needs of their residents, such as the Section 1332 State Innovation Waiver, are vital to the long-term stability of health insurance markets.

• Further deliberation on the health insurance tax is needed. In particular, citizens of States like Alaska that already face extremely high health care costs may be unfairly penalized by the current structure of the Cadillac tax. Additionally, exempting insurers from the health insurance tax in counties/States served by only one insurer may also be an effective way to increase choice/competition that will benefit citizens.

• Consider continuing the navigator and assister programs. In rural areas of Alaska, insurance brokers are not always available. These programs reduce the number of uninsured citizens and maximize market participation.

• A review of regulations may reveal some that are unnecessarily burdensome and costly to both medical providers and insurers.

• We are also interested in coordinated efforts with health care providers to address the underlying drivers of health care spending, considering all aspects including pharmaceuticals, air ambulance, in-patient, and outpatient. Last year, Alaska established a health care authority feasibility study to begin to look at cost controls. With the support of the Federal Government, a similar national effort could go a long way toward addressing the underlying market dynamics that are driving unsustainable increases in health care costs.

We are down to days to address the number of insurers, the cost, and the subsidies for 2018. Even under such extreme time constraints, as you consider congressional action to stabilize premiums to help people in the individual insurance markets, please make your decisions in a bipartisan manner after thorough analysis. Any decision that you make, large or small, will affect access to health care insurance, an extremely important and deeply personal subject to all Americans.

My fellow insurance directors/commissioners and I are here to assist you in any way we can to help inform the difficult decisions before you.

Thank you.

The CHAIRMAN. Thank you, Ms. Wing-Heier.

Ms. Miller, welcome.

STATEMENT OF TERESA MILLER, J.D., INSURANCE COMMISSIONER OF PENNSYLVANIA, HARRISBURG, PA

Ms. MILLER. Good morning, Chairman Alexander, Ranking Member Murray, and members of the committee.

I am honored to be here today and want to applaud the committee for hosting such an important conversation at such a critical point in time.

I am not going to sit here this morning and tell you that the ACA is perfect. I think we all know that it is not. But the narrative that the ACA is failing and imploding is just false and ignores the coverage requirements that the law put in place.

Millions of Americans have benefited from the ACA. The employer markets, where the majority of people get their insurance, have actually seen a moderation of costs since passage of the ACA.

Pennsylvania's uninsured rate is now the lowest it has ever been thanks to improvements in the individual market and Governor Wolf's expansion of Medicaid in 2015.

Pennsylvania has about 426,000 people on the individual marketplace and about 80 percent of these enrollees receive subsidies to help them pay their premiums and more than half benefit from Cost Sharing Reductions to help them pay their out of pocket costs

like co-pays and deductibles. So for most individuals in this market, the ACA is working well.

The ACA has resulted in millions of Pennsylvanians no longer being denied coverage due to a preexisting condition, or facing financially devastating annual or lifetime limits, and benefiting from quality, comprehensive coverage because of preventative care and Essential Health Benefit requirements.

Pennsylvania's market has experienced difficulties, but our individual market is not collapsing. Our individual market insurers filed for an average increase of 8.8 percent for 2018, assuming no changes to the ACA.

I am pleased to report that our insurers are finally seeing improved experience with this market and that is reflected in their rate increases. But I am also very concerned that that stability is on fragile ground because of the ongoing uncertainty surrounding the future of the ACA and, in particular, payments for Cost Sharing Reductions.

I cannot stress enough how difficult this uncertainty is on our markets. These payments have a significant impact on rates and failing to make a long-term commitment will do nothing but drive up costs for consumers. This will further hurt the 1 to 2 percent of Pennsylvanians, roughly 125,000 people, who do not receive subsidies because those who do will be shielded mostly from these premium increases if their insurer stayed in the market, that is.

Ultimately, rates have to be finalized based on finite assumptions. Pennsylvania consumers will be left to bear the burden of premium increases or lessen choices necessitated by continued uncertainty.

Congress should allocate money for these payments through at least 2019 to give insurers the predictability they so desperately need.

We also must make sure that we are properly encouraging enrollment in the individual market. The health of any insurance market depends on the strength of its risk pool and reduced enrollment strains the risk pool and contributes to rising costs for all of those in it. I worry steps the Trump administration has taken could further erode the risk pool.

Just last week, we found out the extent of cuts to outreach and enrollment efforts funded by the Federal Government. Health and Human Services will spend just $10 million advertising 2018 open enrollment compared to the $100 million spent for 2017.

In addition to this, funding granted to health insurance Navigator organizations to help people enroll was almost halved from the levels given under the previous administration.

Reducing outreach efforts at the Federal level, combined with a shortened enrollment period for 2018, will do nothing but leave more people without coverage and could raise rates for people left in the market.

In Pennsylvania, we are implementing our own outreach program. We are working alongside insurers, healthcare providers, consumer advocates, and other stakeholders to reach our common goal of increasing covered Pennsylvanians.

Encouraging enrollment helps everyone. People have access to coverage, insurers have a more robust risk pool, and providers are

more likely to receive compensation for care they provide. Over time, a more robust risk pool should also result in lower premiums for consumers.

As we work toward providing stability in the market, we should consider all options to moderate the premium increases caused by market instability.

A $15 billion reinsurance program in the context of a careful, bipartisan approach to improving our healthcare system would be a great place to start, especially if the individual mandate were preserved and outreach was boosted to increase enrollment.

The ACA's Reinsurance Program successfully moderated premiums while it was in place and a reintroduction of a long-term reinsurance program could be an effective way to scale back the premium increases that we currently see.

Finally, I do think we need to have a serious national conversation about healthcare costs in this country. These costs are constantly growing and even if we bring stability to our markets, we must still address healthcare costs if we want to ensure that our current system is sustainable in the long-term. This is a national issue and even as States work to address rising costs in our own markets, we are not going to be able to fix this completely on our own.

While the healthcare reform debate has been, without question, partisan the goals that we are trying to achieve are not and neither is recognizing the real problems that exist in our system. We all want Americans to have access to the care they need and be able to afford that care. We all want them to have choices and that means supporting a competitive health insurance marketplace that provides that choice.

I am grateful for your leadership, Chairman Alexander, and I am so thankful that we are finally moving in the direction of working together to find real solutions to ensure all consumers have access to quality, affordable care.

Thank you.

[The prepared statement of Ms. Miller follows:]

PREPARED STATEMENT OF TERESA MILLER, J.D.

SUMMARY

As we discuss the importance of stabilizing the individual market, we must recognize the impact the Affordable Care Act (ACA) has on Pennsylvanians. Before the ACA, people often couldn't get health insurance due to a pre-existing condition. If they did they often paid significantly more, and these polices did not always cover their pre-existing condition. Individuals faced financially devastating annual and lifetime limits, and women could see higher premiums than men and not have contraception or maternity care covered. Critical services like mental health and substance use disorder treatments were often difficult if not impossible to find coverage for.

Governor Wolf has been an active participant in a group of Governors working to ensure Congress's approach to health care reform is bipartisan and strengthens our Nation's health insurance system. Additionally, the Governors urge Congress to take steps to make coverage more affordable and stable in the interim. Governor Wolf and I applaud the committee's efforts to work toward a solution on this important issue. Because of the ACA, more than 1.1 million Pennsylvanians have accessed comprehensive coverage through the ACA. We need to buildupon this foundation and make targeted, common sense changes that will improve the ACA.

Pennsylvania's market is on a path to stability and will not implode unless the Federal Government takes adverse action. If cost-sharing reductions payments are not made, this stability will be jeopardized. These payments have a significant im-

pact on insurers' rates, and failing to make a long-term commitment will increase prices for consumers in the individual market. Making these payments is the simplest way to "fix" the ACA that I can offer. It will very soon be too late to avoid rate increases for 2018, so Congress must act quickly.

Improvements to the ACA's 1332 State innovation waivers and how they are obtained could be made, but greater State flexibility should not come at the cost of the baseline coverage improvements that the ACA has made. Doing so would only create more plans that offer very little coverage and have high out-of-pocket costs when care is accessed.

Both ACA replacement proposals considered by the U.S. House and Senate did contain reinsurance programs for 2018. A $15 billion reinsurance program in the context of a careful, bipartisan approach to improving our health care system would be something I would view favorably, especially if the individual mandate were preserved and outreach was boosted to improve enrollment in individual market plans. The ACA's reinsurance program successfully moderated premiums while it was in place and the reintroduction of a long-term reinsurance program could be an effective way to scale back the premiums we currently see.

The health of any insurance market depends on the strength of its risk pool, and reduced enrollment strains the risk pool and contributes to rising costs for those in it. I worry about some steps the Trump administration has taken that could further erode the risk pool, such as shortening the open enrollment period and making substantial cuts to funds used to advertise the open enrollment period and support enrollment efforts coordinated by health insurance navigators. In Pennsylvania, we are working alongside stakeholders to increase covered Pennsylvanians and inform them of important changes to this year's open enrollment period so people are covered, insurers have a robust risk pool, and providers are more likely to receive compensation for care provided.

While the health reform debate has without question been partisan, the goals we are trying to achieve are not, and recognizing the real problems that exist in our health care system should not be either. I am hopeful that we can move away from proposals that would jeopardize the health and financial security of millions of Americans, and focus on solving real problems with common sense solutions like these.

Good morning Chairman Alexander, Ranking Member Murray, and members of the U.S. Senate Committee on Health, Education, Labor, and Pensions. Thank you for the opportunity to be here today to speak about an issue that is so critical for residents of the Commonwealth of Pennsylvania.

I am pleased to have been recently chosen by Governor Wolf to serve as acting secretary for the Pennsylvania Department of Human Services after having been insurance commissioner since shortly after Governor Wolf took office in 2015.

Governor Wolf has been an active participant in a group of Governors working to ensure Congress's approach to health care reform is completed in a bipartisan manner that strengthens our Nation's health insurance system. Additionally, the Governors urge Congress to take steps to make coverage more affordable and stable in the interim.

Both Governor Wolf and I applaud the committee's efforts to work toward a solution on this important issue. As we begin to talk about the importance of stabilizing our individual health insurance markets under the Affordable Care Act (ACA), we should first recognize the impact that the ACA itself has had on Pennsylvanians and why it is imperative that we fix the law rather than undoing the progress we have made. Before the ACA, sick people often couldn't get health insurance due to a pre-existing condition. If they were able to get coverage, they often paid significantly more for it than someone without a pre-existing condition. In some cases, these individuals would be offered a policy, but it would not include coverage for their pre-existing condition. Individuals with chronic medical issues or anyone who underwent a costly procedure like a transplant could face financially devastating annual and lifetime limits. Women could see higher monthly premiums than men and perhaps not have contraception or maternity care covered. Other critical services like mental health and substance use disorder treatment services and prescription drugs were often difficult if not impossible to find coverage for. Most importantly, more than 10 percent of Pennsylvanians and 16 percent of Americans nationwide went uninsured.

Since the ACA's passage, the national uninsured rate has fallen to 8.6 percent and Pennsylvania's uninsured rate has dropped to 6.4 percent—the lowest it's ever been. More than 1.1 million Pennsylvanians have accessed coverage through the ACA, and that coverage is much more comprehensive than what was previously

available. There are 12.7 million Pennsylvanians, and more than 40 percent of them—5.4 million—have pre-existing conditions and cannot be denied health insurance coverage due to the ACA. Today, 4.5 million Pennsylvanians no longer have to worry about large bills due to annual or lifetime limits on benefits, and 6.1 million Pennsylvanians benefit from access to free preventive care services. In addition to this, more than 175,000 Pennsylvanians have also been able to access substance use disorder treatment services through their exchange and Medicaid expansion coverage. These services are critical as our commonwealth and other States around the country strive to combat the overwhelming impact of the opioid epidemic.

The positive impact of the Governor's efforts to expand Medicaid and help Pennsylvanians access treatment services for substance use disorder have become even more evident to me as I've taken the helm at the Department of Human Services. These are expansions that are making a significant difference in people's lives.

While the ACA has not been perfect, it is critical that we level set and talk about the issues that exist and who those issues really impact. The ACA has had minimal impact on the Medicare program and enhanced the already very popular Medicaid program by expanding access to millions more around the country. Further, since the passage of the ACA, the employer markets, where small and large businesses can purchase insurance products for their employees, have been stable and even seen costs grow at a slower pace than before the ACA. The individual market, where we see problems, is a very small market relative to these others, covering only about 5 percent of Pennsylvanians. However, this market is very important because it is where individuals and families who do not have access to coverage through their employer or public programs go to purchase insurance.

This market is heavily subsidized because of the ACA. About 80 percent of Pennsylvanians who purchase their coverage through the exchange receive tax credits to help pay their premiums. Because of the way the tax credits are structured based on income, these consumers do not feel the full impact of premium increases. Currently more than half of Pennsylvania consumers who enroll in the exchanges are also eligible for cost-sharing reductions, additional financial assistance that helps them pay for their out-of-pocket costs like deductibles and co-pays. The payments the Federal Government makes to insurers to cover the costs of this additional financial assistance are in jeopardy because President Trump has not committed to making them longer than a month-to-month basis. I am seriously concerned about the destabilizing effect failing to commit to these payments could have on both Pennsylvania's market and others around the country and how this will impact premiums for people in the individual market, but I will address this at length later in this testimony.

I believe we need to buildupon the foundation of the health care system we have and make targeted, common sense changes that will improve the ACA and make it work better for the people it is not working perfectly for today. We still have a serious affordability problem in the individual market, especially for the 1–2 percent of Pennsylvanians who rely on the individual market for coverage but are not eligible for financial assistance and those facing rising deductibles. Their concerns are legitimate and must be addressed, but starting over or moving backwards will not better serve Pennsylvanians or Americans throughout the Nation. I applaud this committee's efforts to work together to strengthen this law so it may better serve everyone rather than undoing the good it has accomplished around the country. With that context, I would like to offer Pennsylvania's thoughts on the issues we currently face and what reasonable bipartisan solutions that would improve the ACA for all could look like.

GUARANTEEING PAYMENTS FOR COST-SHARING REDUCTIONS

While the individual market is facing issues, in some States more than in others, I can tell you that Pennsylvania's market is on a path to stability and will not implode unless the Federal Government takes adverse action. Our market saw some issues last year and lost two carriers, but I worked closely with our remaining insurers to ensure that we did not have any bare counties for 2017. For 2018, our individual market insurers filed for a statewide average increase of just 8.8 percent, assuming no changes come from the Federal level. An analysis on the drivers of 2018 premium increases puts our requests at or below what we would expect based on trends in annual medical costs and a Federal tax on health insurance plans that comes into effect for the 2018 plan year. I am very happy that our insurers are finally seeing improved experience with this market and that is reflected in the rate increases they filed, but I am very concerned that this stability is on fragile ground because of all the uncertainty here in Washington.

When rates were initially filed, I asked our insurers to provide information on what they would need to request if cost-sharing reduction payments were not made or if the individual mandate was not enforced. The differences are stark. If cost-sharing reductions are not paid, they estimated that they would need to request a statewide average increase of 20.3 percent. If the individual mandate is not enforced, they said they would seek an estimated 23.3 percent increase. If both changes occur, our insurers estimated that they would seek an estimated increase of 36.3 percent, assuming they continue to participate in the market at all. I'd be lying if I said these numbers didn't worry me, especially as we prepare to finalize rates. At this point, we have no more certainty on cost-sharing reductions than we had in April when I, along with executives from all five of Pennsylvania's on-exchange insurers, first wrote to Secretary Tom Price on this issue.

What's most frustrating about the situation we are in is that it is entirely avoidable. I have sent multiple letters to Secretary Price asking the administration to not take steps to undermine the progress we have made and the pathway to stability that we put our market on. I reiterated this urgent need for stability in an answer to a request for information on how to stabilize the individual market issued by the Centers for Medicare and Medicaid Services in June. Governor Wolf and a bipartisan group of Governors have asked congressional leaders to address stability, too. And, yet here we are, 2 weeks out from when States need to send final rates for 2018 to the Department of Health and Human Services (HHS)—a deadline that was already extended—and the Trump administration still refuses to make anything longer than a month-to-month commitment on these payments.

I cannot stress enough how difficult this uncertainty is on our insurers. These payments have a significant impact on their rates, and failing to make a long-term commitment will do nothing but drive up prices for consumers in the individual market. This will further hurt the 1 to 2 percent of Pennsylvanians—roughly 125,000 people—who do not receive subsidies as those who do receive subsidies would be shielded from most of the increases—if their insurer stayed in the market at all. At the end of the day, rates have to be finalized based on finite assumptions and insurers will sign contracts to participate on the exchange or they won't participate at all. Pennsylvania consumers will be left to bear the burden of premium increases or lessened choices necessitated by this instability.

Failing to make payments for cost-sharing reductions does not serve any goal aside from trying to make markets fail. According to the Congressional Budget Office's analysis on the matter, doing so would result in higher premiums, more counties without individual market coverage options for 2018, and would increase the Federal deficit by $194 billion through 2026 due to the payment of additional premium subsidies because of higher premiums. The Congressional Budget Office further estimates that premiums would rise an additional 20 percent in 2018. This will undoubtedly create more problems, especially for individual market consumers who are not eligible for financial assistance.

If the Trump administration is not going to do the right thing for consumers and stabilize the law, Congress should allocate funds to ensure payments for cost-sharing reductions continue for 2018. Making these payments is the simplest way to "fix" the ACA that I can offer. I fear that it will very soon be too late to avoid rate increases for 2018, so Congress must act quickly.

SUPPORTING OPPORTUNITIES FOR STATE INNOVATION

Under Section 1332 of ACA, States have the opportunity to obtain waivers on portions of the law as long as they do not increase the Federal deficit, reduce affordability or quality of coverage sold in the State, or have a negative quantitative impact on the State's insured population. States currently must offer a public notice and comment period, hold public hearings, and pass legislation outlining the State's intent to pursue and implement a Section 1332 waiver. Governor Wolf and I join the sentiments outlined in the bipartisan plan presented by Governors Hickenlooper and Kasich to streamline the waiver process in order to improve State flexibility.

Changes that permit States to easily buildupon waivers obtained and successfully implemented by other States, coordinating the waiver submission and approval process, and easing the process of applying for waiver extensions would be viewed favorably. We would value the ability to pursue a waiver without requiring action from our State's legislature. If States are making small, targeted changes to stabilize the market like what is needed now, the current process can be too long and cumbersome when you consider a State's budget cycle and legislative process. An extensive process should be in place if States were to make significant changes to the structure of their market, but streamlining the current process would allow States to use Section 1332 waivers to make incremental changes as issues arise.

The Wolf Administration would also look favorably on the opportunity to combine multiple waivers into a coordinated effort and consider deficit neutrality across the comprehensive plan.

However, we strongly believe that the baseline coverage improvements that must be maintained during the waiver process must be preserved. Eliminating these provisions—often called "guardrails" would likely result in a race to the bottom. Insurance companies would sell plans that offer less comprehensive coverage at a lower monthly cost, leaving consumers vulnerable to large out-of-pocket costs when care is accessed—something we all do at some point. These protections exist to ensure that Americans around the country have access to equitable, quality coverage regardless of the State in which they reside. The baseline protections contained in the ACA and the coverage improvements that have resulted should not be jeopardized as we consider opportunities for greater State flexibility.

PRESERVING THE INDIVIDUAL MANDATE

Since the ACA was passed, the individual mandate has historically been an unpopular feature of the law. However, it is imperative to making sure the law functions as it was intended.

The ACA included a "three-legged stool"—the individual mandate, non-discrimination requirements for people with pre-existing conditions, and subsidies and cost-sharing reductions that helps insurers balance the added risk of individuals with pre-existing conditions while avoiding the risk of adverse selection where people only enter the market when they are sick and need care. Proposals to replace the ACA have eliminated the mandate in exchange for a continuous coverage requirement. Because purchasing insurance would no longer be mandatory under a continuous coverage requirement, the people who seek coverage during the open enrollment period will likely be a less healthy population and the risk pool would deteriorate, thus driving up premiums for those who need coverage the most.

I know that the individual mandate is not popular, but we must have adequate incentives to encourage people to purchase coverage and bring healthy people into the market. Over time, this should help stabilize and even lower premiums for everyone as more young and healthy people enter the market and help offset the cost of sicker enrollees.

ADEQUATE FUNDING FOR RISK STABILIZATION PROGRAMS

When the ACA was passed, it contained three premium stabilization programs to help insurers experiencing higher than anticipated claims as they adjusted to the new market. Two of these programs—risk corridors and reinsurance—were designed to be temporary and have expired, but many insurers around the country, including those in Pennsylvania, are still owed significant risk corridor payments. Last year, Highmark, one of the Pennsylvania insurers, sued HHS for these payments, and the Pennsylvania Insurance Department filed an amicus brief in support of their suit because insurance companies who entered this market under a set of expectations should be made whole for payments they were anticipating. Many of these insurers experienced significant losses in the first few years, and making these payments would be a good way for the Federal Government to demonstrate good faith and a long-term commitment to the success of this market.

Both ACA replacement proposals considered by the U.S. House and Senate contained reinsurance programs for 2018. Implementing a reinsurance program would be another effective way to demonstrate a long-term commitment to the health of this market for insurers and consumers who rely on this market for coverage.

A $15 billion reinsurance program in the context of a careful, bipartisan approach to improving our health care system would be something I would view favorably, especially if the individual mandate were preserved and outreach was boosted to improve enrollment in individual market plans. The ACA's reinsurance program successfully moderated premiums while it was in place and the reintroduction of a long-term reinsurance program could be an effective way to scale back the premiums we currently see. Increasing participation in the individual market would create a more stable, healthy risk pool, while the reinsurance program would help off-set the costs of enrollees with abnormally high claims costs. Together, these steps would moderate premiums for all while retaining the critical protections and robust benefits required by the ACA.

CONTINUING ENROLLMENT OUTREACH PROGRAMS

Encouraging people to enroll in this market through active outreach programs is extremely important to ensuring the market's success. The health of any insurance market depends on the strength of its risk pool, and reduced enrollment strains the

risk pool and contributes to rising costs for those in it. I worry about some steps the Trump administration has taken that could further erode the risk pool, such as shortening the open enrollment period and ending HHS's contracts to support outreach and enrollment efforts for the marketplace. In total, the Trump administration intends to spend $10 million nationwide on advertising for 2018 open enrollment compared to $100 million spent last year. The Administration also recently announced that funding granted to health insurance navigator organizations to help people enroll was almost halved from levels given under the previous Administration. I worry that these decisions will result in fewer people enrolling and relatively fewer healthy people enrolling, exacerbating the issues that already exist in the risk pool.

Pennsylvanians are accustomed to having 3 months to enroll in coverage. In the past, December 15 has been an important deadline because it was previously the last day to enroll in coverage that was effective January 1, but enrollment still continued for the remaining 6 weeks of open enrollment. During 2017 open enrollment, more than 130,000 Pennsylvanians enrolled in coverage after the initial December 15 deadline. That is roughly one third of our market. I am extremely concerned that a shortened open enrollment period coupled with low outreach from the Federal Government will catch consumers off guard and result in people who want or need coverage being left out of the market because they missed the enrollment window.

In Pennsylvania, we are working to ensure that our marketplace population and potential enrollees understand this change through our own insurance outreach program. We are working alongside insurers, health care providers, consumer advocates, and other stakeholders to reach our common goal of increasing covered Pennsylvanians and informing them of important changes to this year's open enrollment period. Encouraging enrollment helps everyone—people have access to coverage, insurers have a more robust risk pool, and providers are more likely to receive compensation for care provided. Overtime, a more robust risk pool should result in lower premiums for consumers. I hope the Trump administration ultimately sees the value in this outreach too, but for now Pennsylvania will work to fill the gap created by the Administration.

ADDRESSING UNDERLYING COSTS OF HEALTH CARE

Stabilizing the individual market is an important first step to addressing cost concerns we hear from consumers, but we still need to get to the root of what really drives insurance costs: the cost of health care. To put it simply, insurance is expensive because the health care it pays for is expensive. Unfortunately, it gets more and more expensive every year, which means premiums will continue to rise every year even if there are no detrimental changes to the market.

We need to have a serious national conversation about how we can moderate the unsustainable growth in health care costs, especially in areas experiencing astronomical growth in cost like we currently see with pharmaceutical costs. There is no silver bullet to reduce the cost of health care and the conversation is not easy, but it is essential as we look to the future and the long-term viability of our health care system. We continue to look for solutions to these problems at the State level, but these are national problems that I believe merit national solutions. So, I am hoping all of you and your colleagues in Congress will work alongside the States in tackling this complex and multifaceted issue.

THE NEED FOR BIPARTISANSHIP

While the health reform debate has without question been partisan, the goals we are trying to achieve are not, and recognizing the real problems that exist in our health care system should not be either. I am very thankful that we are finally moving in the direction of working together, and I am optimistic that the ideas shared today will be a strong foundation moving forward. We all want Americans to have access to the care they need and be able to afford that care. We also want them to have choices, and that means supporting a competitive health insurance marketplace that can provide that choice. Let's start by recognizing where consumers may not have that access or affordability, and let's understand where we are not supporting the competitive market we need. Then, taking a lead from Governor Wolf and the group of bipartisan Governors, let's look for solutions that can solve those problems, both in the short-term and in the long-term.

As my testimony outlines, I believe some of those short-term strategies must be to provide clarity and stability of the rules in the market by appropriating funds to ensure payment of cost-sharing reductions and robustly enforcing the individual mandate while enhancing outreach and enrollment efforts to get more healthy people into the market and improve the risk pool. A reinsurance program could also

contribute to stability and the moderation of premiums and show insurers that the government wants to work with them for the benefit of consumers—your constituents—to make this market an attractive place to do business. In the long-term, it is imperative that we begin to look for ways to moderate the growth of health care costs to ensure our health care system is sustainable and will meet the needs of those that need it now as well as those that will need to rely on it in the future. I am hopeful that we can move away from drastic proposals that would jeopardize the health and financial security of millions of Americans, and focus on solving real problems with common sense solutions like these.

Again, thank you for allowing me to speak with you today. I would be happy to take any questions that you might have.

The CHAIRMAN. Thank you, Ms. Miller.

Mr. Doak, welcome.

STATEMENT OF JOHN D. DOAK, COMMISSIONER, OKLAHOMA DEPARTMENT OF INSURANCE, TULSA, OK

Mr. DOAK. Thank you, Senator. Good morning, Chairman Alexander and Ranking Member Murray.

One of the things, before we get started today, our hearts and prayers are with those folks that are in the line of the hurricanes. We want to keep them in our prayers today. We would ask for speedy consideration of the Flood Reauthorization Act with all that on our minds.

Good morning. I appreciate the opportunity to testify today to provide an Oklahoma perspective on stabilizing the individual health insurance market for 2018.

For years, Oklahoma has been dealing with the negative consequences of Obamacare. I have been warning about spiking rates, narrowing networks, rising deductibles, general market instability for too long. My warnings have been ignored at the Federal level. I look forward to seeing how Congress will finally address these problems in time for carriers to meet their 2018 deadlines.

The implementation of Obamacare in Oklahoma has been a failure. It has created severe market disruptions without meaningful reductions in the number of uninsured in our State.

In 2014, our citizens chose plans from five different carriers on the federally facilitated marketplace. Those carriers sustained heavy losses and by 2017, that number had dropped to only one carrier. What is happening now cannot be sustained and we can expect eventually Oklahomans will have no market and no options.

Not only do Oklahomans have one marketplace carrier to choose from this year, but over the past 4 years, rates in our marketplace have increased by 130 percent. Studies estimate that approximately 30,000 individuals, who do not quality for premium assistance, exited the non-group market in Oklahoma between 2016 and 2017. Small business owners and self-employed individuals, who are the backbone of Oklahoma's economy, are suffering.

As premiums have spiked, enrollees have experienced deductible shock and cannot afford the coverage. Many people in Oklahoma, where the average per capita income is just above $25,000 annually, are being forced to pay higher premiums for a policy they cannot afford to actually use.

Further, as carriers have sustained large losses in the marketplace, they have responded by narrowing their provider networks. It turns out, you cannot always keep your doctor.

Many other States are facing similar issues. Unfortunately, all recent efforts to repeal and amend Obamacare have failed and States like mine have been left holding the bag.

I am encouraged by the Trump administration's priorities, particularly in encouraging State flexibility and autonomy. In Oklahoma, Obamacare gives us no other options at this point.

Oklahoma has submitted a 1332 Waiver application under the Obamacare framework. This application focuses on the creation of a market stabilization program using Federal pass through funding and State-based assessments. This would create a reinsurance program for carriers operating in the marketplace.

This initial plan is estimated to reduce premiums and increase enrollment in the marketplace in 2018. Subsequent Waivers will regain State control over other Obamacare requirements. However, I am not convinced that Obamacare Waivers are going to be the solution to our problem.

What we really need is an innovative, long-term solution that truly returns powers back to the States to implement ideas tailored to fit each State's specific needs in health insurance.

That is why I have been encouraged that proposals that are out there, like ones from Senators Graham and Cassidy, which would repeal the individual and employer mandates, and allocate block grant dollars to the State. This is the kind of leadership and flexibility to the long-term stability of our markets.

If some States want to keep their regulations from Obamacare, that is great if that works for them. But that is not working for Oklahoma and we should have the opportunity to do something different, or else we face an uncertain and difficult future on this current flawed path.

In conclusion, former senator, Dr. Tom Coburn, recently said, "If you want to fix healthcare, fix the markets." I do not think government will ever fix healthcare. Only markets will.

For more information, please see my written testimony, which includes letters I sent in January to House Majority Leader McCarthy and Chairman Alexander. These letters outline several other innovative solutions to our insurance problems.

Thank you very much, Mr. Chairman.

[The prepared statement of Mr. Doak follows:]

PREPARED STATEMENT OF JOHN D. DOAK

SUMMARY

Insurance commissioners across the country have been dealing with the consequences of the Affordable Care Act (ACA) on State markets since its inception: rising rates, constricting networks, rising deductibles, fewer consumer choices, and market instability. What we have now in our individual market is the consequence of encumbering a functional market with the burdens of becoming a Federal tax distribution system.

The consequences of the ACA on Oklahoma's individual market have been severe. We have seen a reduction in competition down to only one carrier on the marketplace, drastic rate increases, constricting networks, higher deductibles, and market instability. These problems were not caused by uncertainty about cost sharing reduction (CSR) payments, but have all occurred while CSR payments have been made to insurers.

The construction of the ACA intentionally left States like mine with limited ability to affect any real and lasting changes to these Federal programs. However, I am encouraged by the shift in priorities from a new Presidential administration and a

focus on State flexibility and autonomy. We are continuing to look for solutions while we await a more comprehensive change at the Federal level.

Over the last few years I have worked on several State initiatives in an effort to improve our health insurance markets. In 2012, the Oklahoma Legislature passed a bill allowing small employers to purchase group health insurance through an employer association. In 2017, the Oklahoma legislature passed a bill creating a framework in which insurers licensed in other States, such as those sharing geographic borders and communities with Oklahoma, can sell health insurance policies across State lines. These types of State innovations should be encouraged by Congress, not preempted.

For the last year, Oklahoma's 1332 Waiver Task Force has been working to formulate a number of recommendations for modernizing Oklahoma's health insurance market. The first waiver application submitted on August 16, 2017, focuses on the establishment of the Oklahoma Individual Health Insurance Market Stabilization Program, which proposes to utilize Federal pass-through funding and State-based assessments to create a reinsurance program for carriers operating on the FFM. I remain unconvinced that this Program is a long-term solution to Oklahoma's health insurance problems.

While I would advocate for greater State flexibility and a return of authority over health insurance regulation to the States, there are many things that Congress can do within its existing authority to help us, including: repeal all fees and taxes that increase the price of health insurance; repeal the individual and employer mandates and replace them with a meaningful continuous coverage premium discount or a surcharge and waiting period for interrupted coverage; eliminate the use of Navigators in the distribution of health insurance; allow States to define what qualifies as a short-term medical plan not subject to the requirements of the ACA; and adopt a series of proposals intended to reduce the cost of health care and give individuals more control over their health care dollars, including expanding the use of HSA's, addressing the cost of prescription drugs, and supporting transparency in pricing for the delivery of medical services.

INTRODUCTION

Chairman Alexander, Ranking Member Murray, and members of the committee, thank you for the invitation to testify today. My name is John Doak, and I am the elected Insurance Commissioner for the State of Oklahoma. On behalf of my State, I appreciate the opportunity to provide you with information regarding Oklahoma's experience with the Affordable Care Act (ACA) as well as my recommendations for the future of individual insurance markets.

Insurance commissioners across the country have been dealing with the consequences of the ACA on State markets since its inception: rising rates, narrowing networks, rising deductibles, fewer consumer choices, and market instability. Since my election in 2010, I have opposed the type of top-down Federal intrusion into our health insurance markets we have experienced with the ACA because this system removes the traditional understanding of health insurance as a transfer of risk. What we have now in our individual market is the consequence of encumbering a functional market with the burdens of becoming a Federal tax distribution system.

OKLAHOMA'S EXPERIENCE

The consequences of the ACA on Oklahoma's individual market have been severe. During the first 4 years of federally facilitated marketplace (FFM) activity, Oklahomans have seen a drastic decrease in competition, leaving them fewer choices each year. In 2014, Oklahoma consumers seeking coverage on the FFM could choose plans from five carriers. This number dropped to four in 2015, two in 2016, including a new entrant to the market, then finally to one in 2017. While the one carrier remaining has indicated its continued commitment to the market in 2018, the lack of competition limits plan options for consumers.

Oklahoma's FFM enrollees have also faced numerous significant rate increases for their dwindling plan options. The last carrier left standing endured over $300 million in losses for its first 3 years of FFM business leading to a 76 percent average rate increase for 2017 qualified health plan (QHP) enrollees. Over the past 4 years, rates have increased for Oklahomans on the FFM by 130 percent and approximately 30,000 Oklahomans exited the non-group market because of unaffordability. These increases are especially harmful for individuals with QHPs who make too much money to qualify for Advanced Premium Tax Credits (APTCs) or Cost Sharing Reductions (CSRs), or who purchase an individual policy off the FFM. These people—

often small business owners or self-employed individuals—are bearing the brunt of these increases.

These rising premiums impact consumer decisions about other policy provisions, like deductibles. As premiums have risen, enrollees have been pushed to accept higher deductible levels in order to offset the cost of coverage. These higher deductibles have frustrated the intention of health insurance for many customers who cannot afford to pay the out-of-pocket costs for their health care.

Further, as carriers have suffered losses on FFM business they have responded by narrowing their provider networks, which can result in a disruption in the primary care relationship for many consumers. In some instances, all of the specialists involved in a procedure may not be in the same network, resulting in surprise bills for the consumer. This uncertainty only adds to the affordability and accessibility problem the consumer already faces.

The question is frequently asked whether Congress should expressly fund cost sharing reduction (CSR) payments to insurers. It should be noted that the instability in Oklahoma's market, the spike in premiums, the rise in deductible levels, and the constriction of networks have all occurred while CSR payments were being made to insurers. While the nonpayment of CSRs would exacerbate Oklahoma's numerous individual market problems, CSRs are not the source of those problems. Oklahoma's market instability is the result of the ACA's foundational flaw: it is a top-down Federal Government intervention into health insurance regulation that distorts natural, cost-controlling market forces and stifles innovation in a sector in need of new ideas.

OKLAHOMA'S RESPONSE

The construction of the ACA intentionally left States like mine with limited ability to affect any real and lasting changes to these Federal programs. However, I am encouraged by the new outlook and shift in priorities from a new Presidential administration. It is clear that President Trump and Health and Human Services Secretary Price want to provide each State more flexibility and autonomy to develop solutions to fit its particular needs. In Oklahoma, we are continuing to look for solutions while we await more comprehensive change at the Federal level.

In the last few years I have worked on several State initiatives in an effort to improve our health insurance markets. In 2012, the Oklahoma Legislature passed Senate Bill 1621, which allows small employers to purchase group insurance through an employer association. The bill requires associations to meet the requirements of a "bona fide" association. In 2017, the Oklahoma Legislature passed Senate Bill 478, which creates a framework in which insurers licensed in other States, such as those sharing geographic borders and communities with Oklahoma, can sell health insurance policies across State lines. Allowing for increased State control over the benefits required in health insurance plans through broader legislative changes could lead to greater competition and stability in the individual marketplace. These types of State innovations should be encouraged by Congress, not preempted.

This April, I held a Healthcare Innovation Summit during which presenters at the cutting edge of their fields discussed price transparency and medical care value, innovative insurance product design, health insurance underwriting, Project ECHO, digital delivery models, and government participation in the health insurance and health care markets, along with other current issues. These discussions are available online to watch any time and I encourage the committee to review these discussions as a part of your study on these issues.[1]

Other agencies and groups in Oklahoma are looking for solutions as well. For the last year, Oklahoma's 1332 Waiver Task Force has been working to formulate a number of recommendations for modernizing Oklahoma's health insurance market.[2] The first waiver application submitted on August 16, 2017, focuses on the establishment of the Oklahoma Individual Health Insurance Market Stabilization Program ("the Program").[3] The Program proposes to utilize Federal pass-through funding and State-based assessments to create a reinsurance program for carriers operating on the FFM. The impact of the Program is unclear at this point, and several groups have expressed their interest in submitting legal challenges to stop its implementa-

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[1] A video recording of the Healthcare Innovation Summit is available online at *https://www.youtube.com/user/okinsurance411*.

[2] A copy of the Task Force's concept paper can be found at *https://www.ok.gov/health/documents/1332%20Waiver%20Concept%20Paper.pdf*.

[3] The 1332 waiver application can be found at *https://www.ok.gov/health2/documents/1332%20State%20Innovation%20Waiver%20Final.pdf*.

tion. I remain unconvinced that this Program is a long-term solution to Oklahoma's health insurance problems.

If the initial 1332 waiver is approved, the Task Force's focus will shift to developing the next 1332 waiver to pursue its additional recommendations. While well-intentioned, the Task Force's proposals will always remain constrained by the overarching regulatory scheme constructed by the ACA. States would only be able to exercise the authority they once held through a system controlled by the Federal Government. As I have stated repeatedly in my time as Insurance Commissioner, this is authority that should have been left to the States all along. What we really need is an innovative, long-term solution that returns power back to the States to implement ideas tailored to fit each State's specific needs. I have been greatly encouraged by the recent proposals I have seen from Senators Graham and Cassidy, which would allocate block grant funding to States to be used as each State sees fit.

RECOMMENDATIONS FOR CONGRESS

While I would advocate for greater State flexibility and a return of authority over health insurance regulation to the States, there are many things that Congress can do within its existing authority to help us. On January 18, 2017, I sent a letter to House Majority Leader Kevin McCarthy outlining my recommendations for reforming this sector.[4] An identical letter was sent to Chairman Alexander's office and shared with every Representative and Senator from Oklahoma. I won't reiterate every recommendation I made in the letter, but I would like to emphasize a few key points.

First, Congress should repeal all fees and taxes that increase the price of health insurance, including the Patient-Centered Outcomes Research Institute (PCORI) fees, the Health Insurance Tax (HIT), and FFM user fees. Second, Congress should repeal the individual and employer mandates and replace them with a meaningful continuous coverage premium discount or a surcharge and waiting period for interrupted coverage. Third, Congress should eliminate the use of Navigators in the distribution of health insurance because the program has disrupted the longstanding vital role of agents and brokers in the marketing and sale of health insurance. Fourth, Congress should allow States to define what qualifies as a short term medical plan not subject to the requirements of the ACA.

Finally, Congress should look beyond health insurance and adopt a series of proposals that would help reduce the cost of health care and give individuals more control over their health care dollars. We should expand the use of health savings accounts to allow people to choose more affordable high-deductible health plans, work to address the skyrocketing cost of prescription drugs in America, and support transparency in pricing for the delivery of medical services like the model instituted by the Surgery Center of Oklahoma so that market forces can work as intended.

CONCLUSION

Oklahoma is facing the collapse of our individual health insurance market. We are down to only one carrier on our FFM and we have seen a rise in premiums of 130 percent over the last 4 years. While many in my State are taking steps within the existing regulatory framework to hopefully stop some of the damage the ACA has caused, we still need help in the form of regulatory rollback and clarity to establish a more solid long-term footing. In addition, Congress should take steps to encourage price transparency in the delivery of medical services and to reign in the high cost of prescription drugs. It is time for serious leaders to make serious decisions to help out the people of every State as we move into 2018. I appreciate the committee's focus on this important issue and I thank you for the opportunity to present this testimony.

The CHAIRMAN. Thank you, Mr. Doak. And thanks to each of you.

We will now begin a round of 5 minute questions. We will begin with Senator Enzi.

Senator ENZI. Thank you, Mr. Chairman.

[4] A copy of this letter can be found at *https://www.ok.gov/oid/documents/McCarthy percent20Letter%20Draft%20Final%20clean.pdf.*

STATEMENT OF SENATOR ENZI

I want to thank the panel for, not only what you have said, but what is in your testimony. It will be helpful to us in a number of solutions.

I will begin with Ms. Wing-Heier. I know that Alaska has been faced with some dramatic premium increases in the country and potential loss of carriers on the exchange. You set up that Reinsurance Program to address premiums and working through that Section 1332 Waiver now that also includes several market reforms.

Can you talk about what you are seeing from the Waiver, and what you might look for, and what some of the impediments might have been to getting the Waiver?

Ms. WING-HEIER. The Waiver process is somewhat onerous in the fact that there is not a defined application to submit.

So the States that are applying are hoping that they are providing the data requested by CMS including the actuarial analysis, the economic impact, and proving that they are staying within the guardrails to be given the Waiver.

After that is done, the part that is stifling States right now is the 6-month waiting period before they receive final approval.

The first part of the Waiver, as far as the application, the actuarial analysis, and such can be done in a period of a couple of months. But then you wait—after CMS has given the first approval—for up to 6 months to know if you will receive final approval, your funding, or the ability to go forward with any State innovation that you may find would benefit the citizens in your State.

I will tell you that CMS was very helpful to us, but it still was a rather lengthy process.

Senator ENZI. So you can probably provide us with some suggestions as you just did for simplifying that process.

Ms. WING-HEIER. We submitted and worked with CMS on some reforms that we thought would help. I do not believe they have been adopted. I am quite sure they have not been adopted. But we did submit some comments to CMS on things that could improve the Waiver process.

Senator ENZI. Thank you.

Mr. Doak, Oklahoma faces some similar challenges to Wyoming. We are practically neighbors. We have only one insurer offering individual coverage on the exchange.

Can you talk about the challenge that it creates with one carrier holding all the risk? I know that Wyoming's Blue Cross sustained some real losses last year—and I might talk about those later—in their first year as the only carrier offering coverage.

What changes would you suggest that could encourage more competition in the individual market for States like Oklahoma and Wyoming? I know you had some of that in your testimony, if you could share that with us.

Mr. DOAK. Yes, sir, Senator. Thank you very much for that question. We do share some of the similarities with your State. Our Blue Cross had a huge amount of losses, much like yours.

One of the things I think that we can do is as long as we are under the current framework that we are operating under, under

Obamacare, the 1332 Waiver—and funding the CSRs—is the right way, the path to go ahead unless we make other, dramatic changes in the future. In my letter as you have stated, I see many options for Oklahomans in the future to be able to——

Small businesses in Oklahoma are really bearing the brunt of many of these unintended consequences. I think the associational health plan bills, other types of vehicles that can be used.

I, for one, believe that buying across State lines is a possibility. But again, also offering maybe more catastrophic type plans, as we talked about earlier this morning, for Oklahomans to be able to have choices for what types of carriers, and services, and deductibles they have.

The more choices we can give consumers, in my opinion, is the right thing to do for my State and others.

Senator ENZI. Thank you.

I noticed that Ms. McPeak mentioned a stop loss of a specific amount. Mr. Kreidler mentioned a Federal stop loss. And unusual market changes were mentioned by virtually all of you.

I know in Wyoming, we had a carrier that found out that two boys each had a $30,000 prescription each year, but that was bought out by the primary company. The generic went away and it went to $1.3 million each. They had a $2.6 million hit from just one family.

I appreciate your comments on that and my time is about to expire here. I will be asking in writing for some suggestions from you on ways to do that stop loss, a specified amount, and how the Federal Government ought to have a role in it, and what the States' role should be.

Senator ENZI. Thank you.

The CHAIRMAN. Thank you, Senator Enzi, and thank you for staying within 5 minutes and setting a good example. We have lots of senators here today.

Senator Casey.

Senator CASEY. Mr. Chairman, thank you. I want to thank the chairman and Ranking Member Murray for making this hearing possible and the subsequent hearings, as well as the roundtables.

When I was going across Pennsylvania in August, I was in 32 of our 67 counties, and when I could announce that we were having bipartisan healthcare hearings, there was an audible sigh of relief. So we are grateful for the opportunity.

Secretary Miller, I wanted to ask you in particular that we have, I think, a broad consensus emerging, at least, about the importance of the Cost Sharing Reduction payments, the so-called CSRs. I think more discussion now, as well, about 1332, the Waiver.

You said in your testimony that you felt that the 1332 Waiver process could be streamlined to minimize administrative burden—I am paraphrasing here—while also protecting the guardrails of the Waiver program.

Can you walk through that? In particular, the concerns you have about maintaining those so-called guardrails. Explain that.

Ms. MILLER. Thank you, Senator Casey.

I think from Pennsylvania's perspective, as we think about potentially looking at a 1332 Waiver, the current process is very cumbersome. We would have to pass legislation. We would have to go

through public hearings and then go through the process that, I think, Alaska is familiar with in terms of working with CMS. So it is a long process to get there.

I think the more we could streamline that process, the better off it would be. I think if States have the opportunity to submit a letter from their Governor—as opposed to having to pass legislation to move forward on a 1332 Waiver—that would be very helpful in allowing us to respond to market changes and trying to make sure our markets are stable going forward.

I do not mean to sound greedy, but if we could have some planning funding available to help us really think through how this would work, I think, that would also be very helpful.

Also, having flexibility around the 1332 Waivers and 1115 Waivers, the Medicaid waivers, to think about those in conjunction with the terms of the budget neutrality requirements, as opposed to looking at them individually for those requirements. But I think as we move forward trying to make——

The CHAIRMAN. Could you explain what you mean by that, please?

Ms. MILLER. Sure. The 1332 Waivers and the 1115 Waivers, each have requirements for budget neutrality. I think for States, if we want to be even more innovative, being able to think about those Waivers together instead of having to think about them separately, and having the overall budget neutrality requirement looked at as a pool. From just a strict, "Is this budget neutral together?" would be very helpful and would allow States to be more innovative in thinking about that.

To your point, Senator Casey, I do think that the baseline coverage requirements are really important in ensuring that whatever we do does not result in fewer people covered or does not erode the coverage.

I think a lot of us up here hear from consumers on a regular basis about high deductibles and concerns about other out of pocket costs that maybe they do not expect when they go to use their care.

I think we want to keep those baseline coverage requirements intact as much as possible, but the more we can streamline that process, make it easier for States to respond to market dynamics, that would be helpful.

Senator CASEY. The other thing I wanted to ask you about is what happens to folks in the age category of 50 to 64?

We know, for example, that the rate of uninsured adults ages 50 to 64 dropped by some 47 percent from 11.6 to 6.1 percent between December 2013 and March 2015. Obviously, good news there of a huge drop by almost 50 percent.

In the context of your experience in Pennsylvania, how has Pennsylvania stabilized its marketplace while also protecting older Pennsylvanians who are not yet eligible for Medicare, meaning that 50 to 64 age category?

How have we done in terms of accessing more affordable care?

Ms. MILLER. I think the current system protects older Americans and older Pennsylvanians. I think the 3-to-1 age band that we currently have in the ACA helps makes sure that older Pennsylvanians can afford that coverage.

I think a lot of us, as we think about stabilizing these markets, are really focused on getting more young and healthy people into the risk pool. And I think if we can find ways to do that that are not on the backs of older Americans, that is the way to do it.

I think a lot of us have talked about expanding enrollment, funding, advertising, and funding Navigators so that we have assistance getting people enrolled. All of those are ways that we can boost enrollment without doing it on the backs of older people.

Senator CASEY. Great. Thank you, Mr. Chairman.

The CHAIRMAN. You have some time, if you have another question here?

Senator CASEY. I am good.

The CHAIRMAN. Thank you.

Senator Paul.

STATEMENT OF SENATOR PAUL

Senator PAUL. I think the Chairman has done a good job at focusing on the problem and so has the panel. We have problems in the individual market and it is 6 percent of the marketplace.

I think, though, that we have ignored where they are and what is working in the insurance market. If there are parts of the insurance market that are working, maybe we should look at those and try to figure out how we get more people into the parts of the marketplace that are working and how we get them out of the marketplace that is not working.

Six percent of the people are in the individual marketplace, 36 percent of the people are in the large group self-insured marketplace. This is the ERISA marketplace and I think you can make the argument that it works better than anything else.

It probably has the lowest increase in rates over time. People are protected. They have large groups. They can have leverage to get cheaper prices. They have a pool of people that they are a group of, where they are protected against one person getting sick.

I would argue that the worst place, an impossible place in the whole world to be is in the individual market. You should not want to be there.

My question is a more fundamental question: can you fix it? And is it morally or ethically right to take money from the taxpayer and give it to insurance companies to subsidize people in the individual market?

Maybe we ought to give people an exit. Let us let people get out of the individual market.

Mr. Doak has talked a little bit about this with the health associations in his State. I would go a step further.

There are 2 million fast food restaurants in our country. About 15 million people work in the fast food industry. These are our lower wage, working class citizens. These are the people who are struggling. These are the people who are still not even insured under Obamacare. These are the people we should want to help.

Let us let them become part of the ERISA plans. Let us have nationwide health associations.

What if one person was negotiating for 15 million people, fast food restaurant workers? You are bound to get a better price. It is

the phenomenon of Wal-Mart. Wal-Mart gets a better price because they are a bigger purchaser of things.

Let us legalize that. It would cost the taxpayer nothing. Let us just say, "People can associate with other people and buy insurance." Get the heck out of the individual market.

I would prefer there be no individual market. I think it is an artificial construction of attaching insurance to your taxes. When we did that, we created the individual market and then we have Big Insurance come to Washington with their hands out.

They made $6 billion a year in profit before Obamacare. They now make $15 billion a year. CSRs are money you are giving to the insurance companies. All this money is being given to Big Insurance. Do not give it to them.

Let the individuals get into the group marketplace and guess who pays for that? It comes out of the $15 billion in profit they make in the group market.

What a scam. They come here and they make billions of dollars in the group market, but then they whine that they cannot make it in the individual market. They cherry pick. They love the group market, and they stay in it, and they say, "We are not going to sell in the individual market."

Let us equalize the individual and give them the power to negotiate with the insurance company. It does not cost anything. All we are doing is legalizing collective bargaining for consumers. We should like it on this side of the aisle.

While Senator Sanders and I do not often agree on things, if there are a few people left that are uninsurable or have a preexisting condition, I would rather buy them healthcare than give money to the insurance companies.

It makes no sense to try to buy insurance for people who cost $1 million a year who we already know what is wrong with them. Put $1 million in for somebody and buy them healthcare. Do not buy them insurance.

You can do all these fancy reinsurance things and all these backstops. They do not work. We are subsidizing an individual market that does not work. It just is nonfunctional. You can never get there.

People say it is too expensive. New cars are too expensive. Why do we not subsidize it? You can have a stabilization fund for new cars, for iPads, for iPhones, college education; anything that costs too much. We can just put a bunch of taxpayer money in and say we are going to make it lower by giving money to the people who provide these things; people who make the iPhones, people who supply college.

I think we ought to look at it a different way. Let us do not try to fix the individual market. Let us try to give people an exit ramp to get out of the individual market completely. For those who cannot or who do not that we have to provide healthcare for, why do we not look at actually buying healthcare for them rather than buying insurance for them?

Mr. Doak, if you want to respond. If you have any numbers on what your health associations have done and whether or not it has put a little bit of a dent in helping people from the individual market get into the group market, I would appreciate it. Thank you.

Mr. DOAK. Yes, sir. Thank you.

At this current time, the Oklahoma health, we have the legislation in place at the State level, but there are some frameworks around the bona fide, the actual definition of an association which, I think, needs a closer scrutiny to be to open up.

I do agree with you that associational healthcare plan bills, while I may differ from my colleagues respectfully, but I do think that there is, that could be a very viable market for folks to band together. Whether they are, as you mentioned, folks in the restaurant business, or whether they are from the flower industry, wherever that might be to band together to purchase coverage. We know that there are folks that can facilitate that in the marketplace.

I do agree with you on that, Senator.

Senator PAUL. Thank you.

The CHAIRMAN. Thank you, Senator Paul.

Senator Franken.

STATEMENT OF SENATOR FRANKEN

Senator FRANKEN. Before I begin, I want to thank you, Chairman Alexander, and I want to thank the Ranking Member, Senator Murray, for holding this series of hearings on the individual insurance market reforms.

Healthcare is such an important personal issue that affects millions of Americans. That is why I am heartened that we are having these bipartisan hearings to discuss common sense reforms that will stabilize markets and lower healthcare costs for consumers.

I just wanted to spend a moment on the correct pronunciation of insurance, which is insurance not in-surance.

[Laughter.]

Thank you.

Whether the commissioners here today pronounced it correctly, I think you all agree that we should have reinsurance or reinsurance. I believe that all but Mr. Doak who, by the way, mispronounced it, spoke explicitly on the importance of continuing the cost sharing and all of those who talked about cost sharing for multiple years.

Mr. Doak, are you for continuing the cost sharing?

Mr. DOAK. Is that Franken or Frank-en?

[Laughter.]

Senator FRANKEN. I cannot mispronounce Doak.

Mr. DOAK. That is good. That is good, sir.

My position is that under the current Obamacare network, we must continue under the current framework we are working under unless it is changed. We do need to continue the cost sharing agreements.

Senator FRANKEN. Right.

Mr. DOAK. So I think we have consensus.

Senator FRANKEN. Good. We all have consensus on this panel of actual people—who are the heads of insurance in their States—that we should continue cost sharing and that we should do reinsurance.

Commissioner McPeak, it is nice to see you again. As you know, Minnesota has applied for a 1332 Waiver to set up a Federal-State

reinsurance program to help reduce health insurance premiums. My hope is that the Administration will approve this Waiver quickly.

As documented in a "New York Times" article that ran this past weekend, my State insurance program has bipartisan support and passed in the State legislature, bipartisan support. If approved, it would reduce health insurance premiums by about 20 percent.

As the article notes, this reduction would help all Minnesotans buying health insurance on the exchange, not just those with the most costly healthcare needs. Other States like Mr. Doak's Oklahoma are considering similar proposals.

Senator Alexander, I would like to ask unanimous consent that this article from "*The New York Times*" be submitted for the record.

[The New York Times article referenced above may be found at *https://www.nytimes/2017/09/02/us/politics/minnesota-healthcare-reinsurance.html*.]

The CHAIRMAN. It will be.

Senator FRANKEN. Commissioner McPeak, in your testimony you talked about the importance of a Federal reinsurance program.

What advantages does a Federal reinsurance program offer compared to a State-based approach?

Ms. MCPEAK. Thank you for the question and I will try to pronounce insurance correctly, but I am from the south, so I do not have any guarantees there.

[Laughter.]

I will say the Federal reinsurance program has a benefit for States like mine. It may not have the ability to upfront the seed money to get our own program started, even in a 1332 Waiver process.

Then, to use the Waiver process to create our own State fund would require the legislative approval that can sometimes be very difficult to obtain, even when your legislature in the State is in session, which ours is not again until the first of the year 2018.

I see the additional benefit of the reinsurance program, not only to reduce premiums for consumers, but I think that it would add market competition. It would entice insurers back into the market because it would provide the economic certainty about a stop loss attachment point for a reinsurance program, so insurers could better estimate the risk of entering the market.

Senator FRANKEN. Would anyone else care to—Ms. Wing-Heier, I know that Alaska has a reinsurance program. You have had the 1332 Waiver.

Would anyone care to talk to the wisdom of a permanent Federal reinsurance program like the one that was established under Medicare Part D?

Mr. Kreidler, I see you nodding. I like people nodding when I say something.

Mr. KREIDLER. Certainty is one of the things that we are really looking for, for 1332. Tell us if our application is going to be accepted. Do tell us whether it meets the criteria. Speed is what we are really interested in.

In answering it, we are exploring it right now as one of our options in the State of Washington. We are also looking at a public

option particularly in counties where there are not any other insurers that we could make available, either through our public employees, or expansion of the Medicaid program, or we have a high risk pool; some other way of being able to guarantee it.

But when it comes to the 1332, because of the 6-month waiting period that we have right now in filing the application, because we have to go back to the legislature, it really compresses.

We are trying to make a difference and see if we can make a change for 2019. We will not be able to do it for 2018, but we are pretty confident in our State that things are going to be stable for 2018. We are really worried about what is going to happen in 2019.

Getting the CSRs funded will help in 2018 because it starts to restore their confidence. But give us some certainty on the 1332 Waivers.

We do not want to see our backs turned to the issues of the Essential Health Benefits or the protections on out of pocket expenses.

Senator FRANKEN. The guardrails that——

Mr. KREIDLER. The guardrails.

Senator FRANKEN [continuing]. Ms. Wing-Heier talked about this morning.

Mr. KREIDLER. Exactly. And you have heard that from other commissioners too. We are concerned about the guardrails, that they are not eroded away. Thank you.

Senator FRANKEN. I am out of time.

I just want to say one thing, which is all of these things—cost sharing, reinsurance—have virtual cycle that bring down the costs of premiums and ultimately bring healthier people in. So does enforcing the mandates. So does more advertising and more people to help you navigate.

That is what I am for.

The CHAIRMAN. Thank you, Senator Franken.

Senator Collins.

STATEMENT OF SENATOR COLLINS

Senator COLLINS. Thank you, Mr. Chairman.

Commissioner McPeak, it is good to see you back again. I want to followup on the reinsurance issue as well.

Since the soaring costs of premiums in the individual market is a major concern of mine, and I would say of all of us, we heard today of the success of the reinsurance pool that Alaska has set up.

Similarly Maine, between 2012 and 2013, had a reinsurance pool that was successful in lowering rates in the individual market by 20 percent, on average. I think if you look at the experience of those two States alone, it shows the benefit of reinsurance pools.

As a practical matter, however, many States are simply not in a position to immediately stand up a reinsurance or a high risk pool. Therefore, I have two questions for you.

One, do you see a role for the Federal Government in the short term in either establishing a high risk pool or assisting States in doing so?

Second, the analysis that I have seen by Milliman has suggested that the cost to replicate the kind of reinsurance pool that Maine had would be about $15 billion annually.

Does the NAIC agree with that and could you comment on both of those issues?

Ms. MCPEAK. Certainly. Thank you for the question.

I do believe that the reinsurance mechanism, or a high risk pool, either one, has the effect of removing from the risk pool the highest cost claims, which provides certainty to the insurers. It helps them actually price products for those other individuals in the risk pool. It should bring premiums down remarkably.

Plus, as I said, I think it would also entice insurers to write in areas where you have very limited options because you have an idea of what your ultimate risk might be for writing in that area.

As for the Milliman report, I do not know that we have provided any analysis on that figure. Fifteen billion dollars does seem like that would be a good place to start to set up a Federal mechanism until States could get on their feet to have their own system, which might be a reinsurance program or it could be a high risk pool, depending on the individual State needs.

I think in Tennessee, we would be more interested in creating a reinsurance program. But as you mentioned, we do not have the ability to set that up immediately and certainly not to affect the 2018 rates.

Senator COLLINS. Thank you.

Ms. Wing-Heier, thank you for being here and sharing your experience. One of the keys to driving down rates in the individual market is to broaden the market and to get as many people as we can enrolled. Let me ask you about two ideas and one comes from conversations that I have had with insurance experts in the State of Maine.

Right now under the Affordable Care Act, if you are over age 29, you cannot purchase the Copper Plan and get the subsidies that would be available even if your income would warrant that subsidy. And if you do not qualify for the subsidy, you are also prohibited from buying the Copper Plan unless you are under age 29.

Should we change that, is my first question to you?

Ms. WING-HEIER. We believe that being able to have a catastrophic or a Copper Plan available for a younger population is beneficial to growing the market; getting the healthier individuals in.

We also think that it should probably be combined with a Health Savings Account. It will be somewhat of a learning experience for the younger population, the healthier population, to come in, and purchase insurance that they are not now doing mostly because of the prohibitive cost.

So we are in support of finding, if you call it the Copper Plan or a catastrophic plan, bundled with an HSA for the younger population.

Senator COLLINS. That is a great combination because then the HSA can be used to help pay the out of pocket costs.

Ms. McPeak, I have only 8 seconds left, so you may have to answer this for the record. But another idea, which Senator Cassidy and I proposed many months ago, was auto-enrollment instead of an individual mandate where someone could opt out. But we know from the experience with 401(k) plans that if people are automatically enrolled, they are likely to stay enrolled.

Do you have any thoughts on that as a way to help broaden the individual market?

Ms. MCPEAK. I will just say very briefly. I do think that auto-enrollment could assist people in staying enrolled.

The issue is if we have more than one carrier, which I hope that we return to that competitive environment some day, I would like to have the ability for consumers to choose because there are such detrimental options with provider networks and drug formularies that I would want to have some ability to make sure that you are enrolled in a plan that works for your family.

Senator COLLINS. Thank you.

The CHAIRMAN. Thank you, Senator Collins.

Senator Bennet.

STATEMENT OF SENATOR BENNET

Senator BENNET. Thank you, Mr. Chairman.

I also want to thank you and Patty Murray, the ranking member, for holding this hearing. It is long overdue that we begin to approach this in a bipartisan way. I was so pleased to see so many senators at the session this morning that you held. It suggests very strong bipartisan interest in trying to figure out how to fix this.

I also think it is important to underscore something you said at the beginning of the hearing, Mr. Chairman, because it is an important perspective for people to have. We are talking about 6 percent of the folks that are insured in America. If we can solve these issues for that 6 percent in a bipartisan way, that would be a very important book of business for us to take care of, but it is not the end of what needs to be done.

When I hear from people in my State whether they support the Affordable Care Act or whether they oppose the Affordable Care Act, they are deeply dissatisfied with the way their lives intersect with America's healthcare system.

I think it is because they know they are being forced to make choices that people in other industrialized countries do not have to make about healthcare, about their business, about the predictability of being able to go to a doctor. A lot of that has to do with the underlying costs in our healthcare system and a lack of transparency in our healthcare system that we still have not found a meaningful way to address.

My hope, more than a plea, is that once we get this piece of work done that we will continue to work in a bipartisan way to try to deal with the root causes of what this panel is talking about today, which is that we spend too much money on our healthcare without getting the result that we should have reason to expect.

The question that I would like to ask the panel is that to me the most solid critique of the Affordable Care Act, as opposed to our healthcare system generally, is when people say to me, "Michael, you are forcing me to buy something, insurance, that costs too much because there is no competition in my area." This is very often in rural parts of the State, in mountainous parts of the State. "The deductible is so high that it is of no use to my family."

I think that is a legitimate criticism of the Affordable Care Act. I was somebody who supported the Affordable Care Act, but I am willing to take criticism.

The question is, how do we solve that problem? How do we introduce more competition into these rural areas than we have to drive the price down?

Mr. Kreidler, maybe I will start with you just because you were saying that Washington State was considering the possibility of a public option for some of these counties. I would be interested in other thoughts that other folks on the panel have as well.

I understand the backdrop of reinsurance and all of that. We probably do not need to revisit all of that. But just specifically talk about what has happened in rural areas.

Mr. KREIDLER. Thank you, Senator Bennet.

Something to remember is that rural counties were a problem before the Affordable Care Act. They have been historically a challenge for every State.

We have nine counties right now that have only one insurer in them and they are all rural counties.

Mr. BENNET. We have 14 and it is the same.

Mr. KREIDLER. Yes. I think what we can wind up doing is offering some incentives for carriers to go out there, but then there is always the potential of looking toward a public option. That is what we are considering right now in the State of Washington on a very broad group of insurers and providers.

Our health insurance exchange is working very closely with us and we are doing a joint effort here as to how we can analyze the various options. The 1332 Waiver is one of them. I do not know if it will work for the State of Washington.

But we do have the opportunity here to take a look at a public option that might exist for those counties so that we are offering them something, which is, right now, not acceptable to be in a position either with very limited competition or no competition.

Senator BENNET. Do you need the 1332 Waiver to do the public option or are those two separate ideas?

Mr. KREIDLER. These are two separate ideas.

Senator BENNET. Thank you. I have 1 minute left if there is anybody else who would like to answer.

Ms. MILLER. I would just say there was a bipartisan group of Governors that sent a letter to Congress last week and in that letter, they have some recommendations around offering choices in underserved counties.

One of the proposals, which I thought was interesting, was allowing residents in underserved counties to have access to or to buy into the Federal Employees Health Benefits Program.

I think ideas like that would be great places to start.

Senator BENNET. Ms. McPeak, do you have something quickly?

Ms. MCPEAK. Thank you.

I would just like to suggest that if we could provide some flexibility to States to provide maybe a less robust schedule of benefits still within the EHB categories, but providing first dollar coverage for things like preventative care, but on a lesser scale than what is currently in the market in the Silver Plan.

That could really attract a lot of folks into the market with a more affordable option because we hear the same thing that you do is that, "I am forced to buy something that, at the end of the day, I really cannot use to access healthcare."

Senator BENNET. I am out of time, but I just would respond to that by saying also that it is really important for Americans not to be forced to buy lousy insurance. Insurance that no one else in the industrialized world has to settle for. It needs to be real, but I appreciate the desire for flexibility.

Thank you, Mr. Chairman.

The CHAIRMAN. Thanks, Senator Bennet.

Senator Murkowski.

Senator MURKOWSKI. Thank you, Mr. Chairman.

I want to follow-up with some of the comments that Senator Bennet has just made, also, to thank the chairman and the ranking member for this very important beginning of a good, constructive dialog.

Speaking to the issue of how we deal with those in our rural areas and, of course, Alaska is always the Poster Child when it comes to real rural.

When we are talking about our individual market, it is a group of 18,000 people. We cannot construct a market off of 18,000 people. In Alaska, we have been looking at where could they fit?

I was actually pleased to read the letters from the Governors in suggesting that maybe it might be a workable idea to have residents in underserved counties to buy into the Federal Employees Health Benefits Program. I do not know if that is the place.

[Applause.]

I do not know if it is the State employees program. I do not know if it is the other programs that we have out there.

We have a big V.A. population in Alaska. We have a big population of our Native people that are served through IHS. So trying to construct something for 18,000 people, to me, just does not seem like a measure that works.

Another proposal that has been out there a lot, and Mr. Doak, you raised the opportunity for purchasing across State lines and Ms. Wing-Heier, I would ask you to address that as a viable alternative for us in Alaska.

As people have asked me, I have said, "We are not attractive to anybody. We are high cost. We are high risk. Why does anyone want to adopt Alaska into their pool?"

But is that something that has merit, even for a State like ours?

Ms. WING-HEIER. It could possibly have merits. There is some concern with consumer protections in selling across State lines, which we have discussed.

But Alaska is unique in the fact that when insurers look at us, as we are right now, I do not know that it is going to matter if we are joined with a Wyoming or an Idaho. I mean, we have looked at possibly doing a co-op or an arrangement with other western, rural States to see if we could come up with the numbers that 18,000 here, 20,000 there, if we could develop our own co-op, so to speak, of enrollees.

But we still have not come up with the numbers and right now our experience has been so bad that you are exactly right when we have talked. No one has wanted us because of our cost of healthcare and what that translates, then, into insurance. We would be bringing the rest of the market down and that is not a position that we want to be in.

It is just the fact of living in Alaska. Very rural, limited facilities in very rural areas that are hard to access. There is no magic answer for us.

But selling across State lines is certainly something we could explore, but right when we have talked prior to insurers and when we have talked to other States, we have not been an attractive risk.

Senator MURKOWSKI. Let me ask about the issue of cost sharing. It has been raised by everyone. I think we recognize that uncertainty within the market is deadly. You cannot move with accuracy.

There have been some that have suggested, I believe it was the chairman in his remarks, said that we need to extend the cost share subsidies through 2018. Another date that has been out there is 2019. I think the Governors, in fact, ask for extension at least through 2019.

If we were to do it just through 2018, does that provide sufficient certainty, or does it need to be a longer year, 2019, or even beyond to give the certainty? Right now, we are going month-to-month and we know that that does not work.

Can you all speak to that?

Ms. WING-HEIER. I believe it has to be at least 2 years. I think that right now there is enough consternation in the market that the insurers looking to remain are looking for more than a 1-year commitment.

Senator MURKOWSKI. I am seeing two head nods; at least 2019?

Mr. KREIDLER. Senator, I would say it even needs to go further than that because insurers right now are already planning the 2019. So we are, so to speak, 2 years out already.

In order to give them that predictability, you have to give them a little bit more certainty going into the future that it is going to be there so that they do not bolt and leave the market. That is the biggest concern that I have is that somebody will yell, "Fire!" in a crowded theater and they will all leave.

We have seen it happen in Washington State in the 1990s and it should not be replicated for the rest of the country.

Senator MURKOWSKI. Thank you, Mr. Chairman.

The CHAIRMAN. Thanks, Senator Murkowski.

Senator Baldwin.

STATEMENT OF SENATOR BALDWIN

Senator BALDWIN. Thank you, Mr. Chairman.

I want to underscore what many of my colleagues have already said that I am deeply grateful for your bipartisan leadership, both of you.

I really believe we can find common ground to stabilize the health insurance markets, to improve coverage, and to reduce costs for the constituents we represent.

Yet, while this committee is working together to achieve this goal, the Administration continues to play dangerous political games that are destabilizing the market and causing premiums to rise.

Wisconsin insurers are requesting between 10 and 46 percent premium increases. They are pointing to President Trump's failure

to provide certainty in the markets and the threats to end the Cost Sharing Reduction payments as they announce these plans.

I would also note, in addition, it has gotten a little bit less attention, although some of you did raise it in your testimony. The 90 percent reduction in funding for enrollment programs that get the word out, especially to young people and healthy people to help with the enrollment process.

The cuts to the Navigator programs that in my State have provided such useful assistance to those enrolling; the shorter enrollment period; all of these add up. Beyond that then the issue of whether the individual mandate will be enforced at all.

I want to focus a little bit more deeply on some of those today and invite my republican and, frankly, my democratic HELP colleagues to partner as we explore policies to enhance enrollment, again, particularly among young and healthy people.

Mr. Kreidler, why is it critical to market stability and affordability, particularly in this upcoming 2018 enrollment period, to boost the coverage of younger and healthier individuals? What do we need to do in this stabilization effort that we are talking about on a bipartisan basis to achieve that right now?

Mr. KREIDLER. Yes, Senator. It is critically important that you have good risk along with bad risk in the insurance pool.

If you only have bad risk, no one can afford the insurance. You have to have good risk. Typically, the younger individual is going to represent better risk in the overall market as opposed to somebody who is older. One part of that is certainly doing that kind of outreach effort.

We are a State exchange. I think I am the only one who does have a State exchange here at the table. So I am not in the position of really having to rely on the Federal Government. But there are a lot of help to come because of the marketing approaches that they have taken at the national level. We are in the slipstream. We pick up benefits even though we have our own State exchange.

I would certainly encourage that we continue to have a very strong outreach that it allows us to really get the message out to individuals. There are problems with individuals to sign up for it if they are younger and healthier.

We need to make sure that they get health insurance. They need to listen to mom on these issues and that, "Health insurance is something you should not be ignoring." To the extent that that message is being delivered, it becomes much more effective.

Senator BALDWIN. That is great.

Ms. Miller and Mr. Doak, for both of you, I would like to hear your comments on this because, as noted, Washington has a State exchange. You are working in a different context.

Ms. MILLER. Thank you.

I think from Pennsylvania's perspective, we are very concerned about the decrease in funding for advertising for the exchange, which we rely on, for the decrease in funding around the Navigators, and the critical assistance they provide to get people enrolled. All of those things, I think, we are very concerned about the mandate and the enforcement of that mandate. That has an impact on premiums.

Even if we get Cost Sharing Reduction payments paid into the future, which is critical, I think there is still a lot of concern. We hear from our insurers in Pennsylvania that because we are not sure how effective that mandate is going to be going forward because of all the conversations about eliminating it, I think we are going to see that uncertainty built into our rates going forward. So that is a major concern for us.

Senator BALDWIN. Thank you.

Mr. DOAK. Senator, I would just like to make a comment regarding a couple of your earlier statements.

We are here because many things have failed. We have had increases in Oklahoma even while we have had cost sharing in place.

Your other comment about Navigators is I would ask for the full senate committee to do an audit of the Navigator program to find out are they doing the job that they are supposed to be doing? Where are the checks and balances there for the millions of dollars that have been spent in that area? Has it achieved the outcomes that you thought it did? Navigators are not incentivized regarding healthcare.

I fallback to the position of that always should have been handled by licensed agents and brokers in the United States and, in particular, in Oklahoma because I have been in every county of Oklahoma, all 77 counties. There is an insurance agent on every corner that is readily available and they are the insurance professionals that should be helping folks.

I think that the Navigator program needs some oversight. That is one of the things we are going to be looking at in Oklahoma is, where those dollars were spent and were they worthwhile?

The CHAIRMAN. Thank you, Senator Baldwin.

Senator Cassidy.

STATEMENT OF SENATOR CASSIDY

Senator CASSIDY. I had the privilege of being with you this morning, so some of what I say will be built upon that.

I am going to set a context, and layout three questions, and ask you all to respond very quickly and concisely to that which you pick.

We spoke this morning, Ms. Miller, regarding the individual mandate. Jonathan Gruber, the so-called architect of Obamacare, has an article both in the "New England Journal of Medicine" and the "NBER," which says that the individual mandate really does not do anything. It is actually Governors. If a Governor gets engaged, my gosh, things happen, but the individual mandate? Minimal effect.

Then, as I have learned about this, Maine and Alaska have done great things, innovative things as regards the reinsurance program which, in turn, have lowered costs and a potential to increase coverage.

I say that and here is the first of my three questions. In the Cassidy-Collins plan, in the Graham-Cassidy-Heller plan, we want to give States flexible block grants allowing States to do what they wish to do. That is an overview, and my colleague from Maine may say, "Well, wait a second. There is a nuance here," and she is absolutely right.

But the reality is we allow States to innovate. That is No. 1. Commissioner, you had said earlier, that you want to make sure the money is there. As much as possible, we know the money for Obamacare is there, but maybe not because I can tell you it is already a little bit threatened.

Let us just assume the money is going to be there. Would you prefer a flexible block grant? Could you do more with it? You have to spend it on healthcare.

Second, I am concerned about Oklahoma. My State, Louisiana's ability to afford a 10 percent match on the Medicaid expansion, that 10 percent match on the Medicaid expansion is going to be huge in my State, $310 million. We are an oil State. Revenue is down. We are sucking wind right now. Can we afford that?

Third, even aside from expansion versus non-expansion, there are some States that have dramatically increased costs of care relative to others. Washington State has done such a good job in controlling costs; others not so good. How do we compensate for that?

Should we attempt to equalize the payment that goes to States or should we prejudice toward high cost States, frankly, as opposed to those which manage costs well?

Take your pick. You have 2 minutes 45 seconds. Try and be concise.

Ms. MCPEAK. I will begin. I will say that your comments on the individual mandate really reflect the experience in Tennessee. I do not know that it has driven a lot of our consumer behavior.

We see a lot of our individuals being willing to risk the penalty for not having ACA-compliant coverage, actually accessing other products available in the market, both non-ACA compliant plans or other cost sharing mechanisms which would still require a penalty to be paid if the mandate were enforced.

I also ask our insurers to break out a provision on 2018 rate increase requests attributable to non-enforcement of mandate and it was negligible. It was about 5 percent increase where the CSR uncertainty was about 14 percent.

Senator CASSIDY. So really, it is the State getting engaged.

To my other points, what do you all think about it?

Mr. DOAK. Senator, I might just respond to your comment about the cost of the expansion is that there is, and I was trying to find some notes, and we will get it sent to you.

Former Oklahoma Governor Frank Keating wrote a really good article on the ultimate cost to the State of Oklahoma, which is something that needs to be taken into account.

On your other point, I am 100 percent in favor of all the funds coming to the State of Oklahoma, giving the State of Oklahoma, our legislature, our Governor, and the people of Oklahoma the ability to put together the best plan.

If California wants to come up with universal healthcare, let California do that. If Washington, my friend from Washington, if they want a different type of policy.

I think the laboratory of democracy and the success we could all learn from each other, but get those moneys back to the State where we can take care of Oklahomans.

Senator CASSIDY. Amen, brother. Anyone else?

Mr. KREIDLER. Senator, I would certainly hope that the block grants would not vary from one State to another just because——

Senator CASSIDY. On a per beneficiary basis; you would have to do it per enrollee. Correct?

Mr. KREIDLER. We do a good job in the State of Washington holding down spending on healthcare better than most States. It is really not appropriate that we should wind up being essentially punished for doing a good job.

Senator CASSIDY. Equity across States, you think would be important?

Mr. KREIDLER. Equity and make sure that it is guaranteed going forward so that we do not wind up seeing a diminishment as opposed to an entitlement program, as we have to today.

Senator CASSIDY. Ladies, I have 20 seconds left. Any comments?

Ms. WING-HEIER. I would add that in the block grants, we would ask that you take into consideration the cost of healthcare and the rural-ness of Alaska because of our cost of healthcare and the diminished facilities that we have just due to what Alaska is.

Senator CASSIDY. Simple answer: we do.

I yield back. Thank you.

The CHAIRMAN. Thank you, Senator Cassidy.

Senator Murphy, good entrance.

STATEMENT OF SENATOR MURPHY

Senator MURPHY. My timing is never going to get better than that.

The CHAIRMAN. That is right.

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

Ms. McPeak, I wanted to ask you to expand a little bit on your opening comments, in which you talked about predicting last year that your marketplaces were on the verge of collapse, and as you testified today, they have not collapsed during that time.

I guess it speaks to a worry that I have about how the rhetoric gets overheated with respect to the stability of these exchanges and the overall stability of the Affordable Care Act.

I am so appreciative of the process that both Senator Alexander and Senator Murray have begun. I acknowledge the fact that we need to make some changes. Changes the democrats want and changes the republicans want in order to provide some certainty.

Maybe you can talk a little bit about what happened over the last year. You said you were on the verge of collapse. You did not collapse. What does that say about how these marketplaces are, and have been holding together?

Just tell us a little bit about that story.

Ms. MCPEAK. Thank you.

Certainly, I am very grateful that the market, in fact, in Tennessee has not collapsed. But I would still say that we are on the verge of being in a very difficult situation and probably still on the verge of collapse.

What we have experienced is carriers fleeing the market year over year. We did have one of our nine rating areas that did not have any options when Humana decided to withdraw from the exchange earlier this year.

We did, in fact, receive coverage for that area through one of our other carriers. But still, 78 of 95 counties having one option on the exchange is not a place where I like to be. We need to have a competitive environment so that our consumers actually have choice and we can do something to address premium rates.

When you have one insurer that is threatening to pull out of rating areas, it is very, very difficult to really challenge the rate increase requests that we are receiving on a lot of different factors. The worse possible situation would be for a carrier to flee the market and our consumers not have any choice in the market.

We are still very much concerned about that possibility until the QHP contracts are signed at the end of this month by the carriers.

Senator MURPHY. Thank you. Yes, I just think it is a caution for everybody to be a little careful about how fast we declare that the sky is falling. Here the popular phrase is "death spiral." And yet, during the period of time that we have been debating the bill, there have been less and fewer bare counties rather than more. So I appreciate that explanation.

Mr. Kreidler, I wanted to talk to you about the importance of advertising and marketing. I think Senator Baldwin raised this question. You are an interesting State because you have pretty much every type of population that exists: rural communities, suburban communities, communities with easy access to information resources, places where it is a little bit hard to get the word out.

There is a study out of Kentucky that looks at what happened when the marketing efforts effectively stopped. You had a democratic Governor who is doing robust marketing and then the new republican Governor has effectively shut down funding for ACA advertising.

What happened there was that there were 450,000 fewer page views per week on the website for the State marketplace. There were 20,000 fewer unique visitors per week to the website. And guess what? ACA enrollment fell by 100,000 people to 94,000 people in 2016 to now 81,000 people.

So there seems to be a pretty direct correlation between telling people that these options exist and people actually going and taking a look at the information that would lead them to get coverage. That speaks to what is happening right now with a 90 percent reduction in Federal funding.

I just would love to hear you talk about how you communicate effectively and how instrumental those communications are in making effective marketplaces that insurers want to be a part of.

Mr. KREIDLER. Senator, actually we saw an increase in the number of people who were signing up through our health insurance exchange even while the Federal exchanges were showing a slight decrease, we were actually showing an increase.

I think part of that is we do have a very active website through our health insurance exchange. It makes it very convenient and easy for people to go there and shop. It was not as robust an increase as we had anticipated.

That really is because of the effect that you have when they are doing it on a national basis, the kind of sharing of information and strategies going forward. That really assists us a great deal and

helps to address the issues around language, which are a particular issue for many of us.

I think that is where we can really make a difference from the standpoint of getting people to sign up for health insurance if you have that kind of outreach out there. It helps to offset the enforcement of the individual mandate, though I would argue quite strongly that you need an individual mandate that is effective. If it is not the one we have now, then you have to come up with something that is comparable.

Senator MURPHY. I support the Chairman's goal of getting a narrow package that can pass quickly.

But I hope that we do include in our discussion this dramatic reduction in advertising and marketing funding which, I think, does have a fairly, just positive effect on the health of these exchanges.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Murphy.

Senator Burr.

STATEMENT OF SENATOR BURR

Senator BURR. I have listened intently to this discussion and I am reminded, as we talk about how to bring healthcare costs down, that each State is unique, but healthcare cost reduction is a function of a change in outcomes. Change outcomes, you change the cost of healthcare. So let us not lose focus on what the most important thing is.

Ms. Miller, I have to admit that I was moved by a statement you made that everybody should be able to buy into FEHBP that cannot fit in a box. I came from the private sector, and my experience in Government is my healthcare went up and my benefit went down.

Then the ACA came and I am now a participant in the DC exchange. My premium costs went up, my deductible went up, and my benefits went down. I would love to buy into FEHBP as a Member of Congress again, wholeheartedly.

I am not sure that is the answer, though, for a population that is scattered, most of it rural, most of it without the delivery system that is needed to change the health outcome.

This is not just about coverage. This is about placing them in some type of delivery system. I am going to start at this end and I am going to go up to Mr. Doak.

All I want to know, yes or no, are you supportive of your State having control over how your healthcare plan looks in your State? In other words, you have a 1332 Waiver, or a 1215 Waiver, you can decide exactly how it is going to look. We will figure out the financing.

Yes or no, Ms. McPeak?

Ms. MCPEAK. Absolutely. I think Tennessee can better mange our health outcomes for our consumers.

Senator BURR. Mr. Kreidler.

Mr. KREIDLER. I would very much like to see, the answer would be yes, but let us make sure we protect consumers and not take away their protections.

Senator BURR. You would have full control over that, so you would be the one to be held responsible.

Ms. Wing-Heier.

Ms. WING-HEIER. One State size does not fit all and Alaska needs to be in control of its health insurance program for its residents.

Senator BURR. Ms. Miller.

Ms. MILLER. As long as we are not talking about reduced Federal funding and requiring States to come up with that funding, which Pennsylvania could not do, then yes. I think we are in a great position to regulate our markets.

Senator BURR. All right. So we have agreement that one of the things we should look at is to empower States to design their healthcare, to structure their healthcare system to meet the unique delivery system capabilities within their States.

I think we have made tremendous progress.

The CHAIRMAN. What about Mr. Doak?

Senator BURR. He already answered that they were supportive of it. That is what I played off of.

Ms. McPeak, in order to solve the healthcare crisis facing our country today, we need to think of ways to leverage all of the new tools provided through innovation in healthcare.

The insurers have access to tremendous amounts of data on the individuals enrolled in their plans in a way that was not imaginable just a decade ago. With this new information, healthcare insurers have the opportunity to design plans that incentivize the best possible health outcomes for their customers.

As an insurance commissioner, have you had an opportunity to review plan designs for your State?

Ms. MCPEAK. No. Unfortunately in the individual market, the carriers are limited by the ACA to the plan design and underwriting factors in the law.

Senator BURR. Do you believe that should be also a function of the commissioner in the State?

Ms. MCPEAK. Absolutely, I do.

Senator BURR. Is that, in your estimation, a way to leverage healthcare data to offer more health insurance?

Ms. MCPEAK. I do and actual benefits that are accessible and usable by our consumers.

Senator BURR. Do you believe you have the tools you need to review innovative plan designs working to keep pace with the new capabilities of healthcare data?

Ms. MCPEAK. I believe we do because we review those plans and rates for the employer markets and small group market already today.

Senator BURR. I am reminded that we are headed for a decade of disruption, where technology is going to impact every sector of our economy; probably healthcare as big, if not bigger, than anywhere else.

Some of the challenges we are trying to build into our construction of policy today will be trumped—for the lack of a better word—by our capabilities of connecting an individual in a rural or noncovered area where there is not a hospital, not a doctor.

But because every American has this device that there is going to be software that enables them to send their own vitals that are

needed to a lab that will give them a reading without a hospital, without a doctor, without a nurse.

How do we take advantage of this incredible innovation if, in fact, we have constructed in concrete what insurers can and cannot do?

Mr. Doak.

Mr. DOAK. Yes, sir. Great question and you are absolutely right with the mobile phone devices the innovation is definitely taking on.

One of the things, we just held an Innovation Summit in Tulsa in partnership with Oklahoma State University and the University of New Mexico. They presented on a Project ECHO which actually has dramatically helped and assisted rural outcomes across the country.

I think when you take a look at this program, it is in my report, and see what they are doing and the partnerships that they are doing. They are able to drive great healthcare sent through programs to rural America. The innovation is happening at such a quick level that you are absolutely right.

I think that is why the NAIC, and the leadership under President Ted Nickel from Wisconsin, formed the Innovation Committee that we really have to stay ahead of the curve. So you are on the right track, sir.

Senator BURR. Mr. Chairman, could I ask all of the witnesses to provide, in writing for the committee, thoughts that they might have on offering multiyear access to plans?

In other words, for individuals in the individual market, not signing up for 1 year, but signing up for 5 years or longer. So that we can truly see the benefits of the investment by the insurer to get people healthy, to keep them healthy, and to eliminate the risk that drives up these premiums so drastically.

Senator BURR. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Burr. That would be very helpful if you could do that.

Senator Hassan.

STATEMENT OF SENATOR HASSAN

Senator HASSAN. Thank you, Mr. Chairman and Ranking Member Murray for holding this hearing and the hearings we are going to have.

I know I share with what Senator Casey said. People around New Hampshire, when I said we were going to have bipartisan hearings and listen to experts who actually deal with the nitty-gritty of how health insurance and healthcare works, there was a real sigh of relief. So I am very grateful for the hearings.

I am very grateful for a panel that pronounces insurance in all different ways because I am the daughter of a southerner and a New Englander. You sound like my family to me.

[Laughter.]

I also think it is really important that you are all here because it is essential that we really drilldown to how things actually work as opposed to just talking about big concepts.

One of the concerns I have from when we talk about letting people buy into ERISA or employer sponsored plans is, that sounds

great, but most people have their employer subsidize the plans. Remember when we enacted COBRA, so people who terminated their employment could still buy their plan, a lot of people could not afford it once the employer subsidy went away.

It is really important as we have these discussions that we hear from all of you about how things work.

To that point, Secretary Miller, I would like to just start with you. Right now, about 5 percent of people who buy health insurance coverage in the individual market represent almost 60 percent of healthcare claims' costs.

We have talked about reinsurance. We have talked about the importance of what a Federal reinsurance plan could have as kind of the biggest bang for the buck idea.

I wanted to ask you a little bit about how the temporary reinsurance program that the ACA had at the beginning of the program, how did it successfully moderate premiums in your State?

Ms. MILLER. Senator, in Pennsylvania in the last year of the program, we saw between a 4 and 7 percent increase because of the end of the program. In other words, it moderated premiums by 4 to 7 percent and that is when we saw an increase happen between 2016 and 2017 was when that program went away.

Senator HASSAN. Thank you.

That brings me to another question which is for Commissioner Wing-Heier. When you talked about using the 1332 Waiver to establish Alaska's reinsurance program, as I understand it, the 1332 Waiver program initially was not really to help States establish reinsurance. It was to help them innovate within the insurance market in their State in ways that could really help move us forward, and gain efficiencies, and really tailor the insurance programs to the State.

The question I have is if we had a Federal reinsurance program, could the States then turn to 1332 Waivers to do some of the other work that we all need to do and that States need to do to tailor their insurance to their State?

Ms. WING-HEIER. You most certainly could. The flexibility should be great within the Waivers. It should be only limited by the innovation that the State can come up with.

At the time, Alaska was down to one insurer, as we still are.

Senator HASSAN. Yes.

Ms. WING-HEIER. And we felt that we were in enough of a crisis mode that we took the appropriate action at the appropriate time.

Our legislature agreed to fund for 2 years the reinsurance program, which led us to then apply for the Section 1332 Waiver, which will allow us for a 5-year funding mechanism for this.

We will certainly be looking at other waivers in the future to benefit our citizens and to make sure that our program is uniquely designed for Alaskans and our conditions.

Senator HASSAN. And I applaud you all for doing what you did. I just think if we had the Federal reinsurance program, like the first one we had as a part of the ACA for the first 2 years, then you all could be doing that second stage of work that you are approaching now.

Secretary Miller, I want to come back to another issue. I know that your State is grappling with the opioid addiction crisis as so

many of our States are, and as you may know, New Hampshire has been particularly heavy hit by it. I know that you have been both an insurance commissioner and now, as I understand it, you are Acting Secretary of Health and Human Services.

So if the Administration decided to cutoff the Cost Sharing Reduction payments, how would that affect access to coverage for people who are suffering from opioid addiction?

Ms. MILLER. Senator, I think Pennsylvania, as all States right now, we are grappling with this issue and it is having such a huge impact on our communities.

We need to stabilize this market so consumers have options in terms of quality coverage. The Essential Health Benefits and that requirement ensures that people have access to that coverage if they have ACA-compliant coverage.

So we need to stabilize this market, keep insurers in it, and by doing that, we will have more competition.

The problem right now is that it is not a very attractive market to be in because of all the uncertainty and that is hurting the competition.

That is why this conversation we are having today is so important because if we can stabilize this market, we can increase the competition, make sure consumers have options that include that quality coverage that has that treatment available for people who are struggling with addiction.

Senator HASSAN. Thank you very much.

And thank you, Mr. Chair.

The CHAIRMAN. Thank you, Senator Hassan.

I am going to go ahead and ask my 5 minutes of questions now because I want to ask the whole panel about reinsurance, as all of you have mentioned it.

I have two questions. I will ask them and then let you just answer them.

One is, how can we make it easier for you to use the 1332 Waiver to set up a State reinsurance program as Alaska and Minnesota have done?

As I understand it, Ms. Wing-Heier, you are not getting any more Federal money than you did before. You are just using it better because you are able to use some of the Federal money to pay for 85 percent of the reinsurance program. The State pays for 15 percent and you lower premiums 20 percent with basically the same amount of Federal dollars.

Is that basically right?

Ms. WING-HEIER. That is correct. Our innovation waiver was based on the fact that the reinsurance program reduced the liability of the Federal Government to pay the advanced premium tax credits——

The CHAIRMAN. Right.

Ms. WING-HEIER [continuing]. That would have been paid.

The CHAIRMAN. Then here are my two questions.

If we need reinsurance, why can States not do it? They are the same taxpayers. Let us take Maine, for example. Not a rich State.

Maine set up a reinsurance program, $4 per month applied to all policies and insurance plans, plus insurance seeded 90 percent of

the premiums of the risk given to the pool, and paid the first $7,500 in claims.

The Federal Government has a $20 trillion debt. The Federal Government is paying an average, according to the Congressional Budget Office, of $4,200 for each individual in the individual market who qualifies for a subsidy.

If a reinsurance program is such a good idea—and Alaska was able to set one up using some State funds and Minnesota was using some State funds—why do States not do it? All it takes is money. State budgets are balanced. The Federal Government is $20 trillion in debt, already contributing a lot.

All of you could put a $4 tax on every policy, create enough money to take the sickest people out of your individual market and lower premiums for everybody else.

So my questions are: why do you not do it? No. 1.

What can we do to make it easier for you to use Section 1332 to pay for it? And if the answer is, "Well, our legislature will not approve any more money," that is not a very good answer to those of us in this legislature who have a $20 trillion debt.

Who wants to answer that?

Ms. WING-HEIER. The States that I have talked to like the concept of the reinsurance waiver and the application. But the requirement for Alaska was that we seeded the program for the first year.

We do hear from States that they cannot get the funds from their legislature for that first year to show that there is an impact to the rates that would bring down the rates so that there is the money in the premium tax credits.

It is a chicken and an egg. That they want to see the results of the premiums coming down so there is that savings in the premium tax credits to then put the pass through funding back to the State.

The CHAIRMAN. But there is nothing to keep you from raising taxes or putting a charge on every policy in Alaska to help pay for your insurance fund. Right?

Ms. WING-HEIER. That is true, but I would tell you that in the State of Alaska, we would have a hard time putting that tax through strictly because we are such a small market.

The CHAIRMAN. Yes.

Ms. WING-HEIER. We would be taxing the market we are trying to help.

The CHAIRMAN. Yes.

Ms. WING-HEIER. The 18,000 that we are trying to help.

The CHAIRMAN. Who else has an answer?

Why cannot States do it and what can we do to help you use 1332 to set up your own reinsurance fund, at least initially?

Mr. KREIDLER. Senator, what you can do is certainly make it an easier process than we have right now so that when you file for a waiver that you have a quicker turnaround time; that you get definitive answers on much shorter notice.

We also heard the description here of saving us from having to wait until our legislature is in session before we have to return to them. The States like Washington and Oklahoma where we are elected as Insurance Commissioners turn it over to the insurance

commissioners to make that decision and the other States can leave it to the Governors to make the call.

We are not asking to increase the national debt at the Federal level when it comes to 1332. What we are asking for is to make it more predictable as to whether it is going to work or not.

In the end, even though you might wind up having some impact on the Federal budget, it is one that is going to have to meet the budget neutrality standard and I am in favor of that. I think that is not unreasonable to have that standard apply when it comes to these 1332's.

We are not asking for more money. Just make the process work a little bit smoother than what we have right now. It is with some certainty.

The CHAIRMAN. Thank you.

Mr. DOAK. Senator Alexander.

The CHAIRMAN. Yes, and then we will stop there.

Mr. DOAK. I agree with my other elected colleague from Washington is that let the States make more of their decision.

In Oklahoma, it is going to be a $2.15 charge for folks in the self-insured market to come up with approximately $325 million, which is going to have the reinsurance program pick up everything from 15 to 400,000. It is a fee. It is a tax disguised as a fee, basically, on Oklahomans.

It is up to Oklahomans to decide how they should put this together and how we should actually come up with that money with a State that is having a very challenging time as you are probably going to hear from some of the other Governors' tomorrow. That is kind of where we are in Oklahoma.

The CHAIRMAN. Thank you, Mr. Doak. My time is up.

Senator Kaine.

STATEMENT OF SENATOR KAINE

Senator KAINE. Thank you, Mr. Chair.

Again, to the chair and ranking member, I am so happy we are here in this set of hearings hearing from the people who are affected about what is good, what is bad, and what needs to be fixed about our healthcare system.

I would like to make sure everybody knows what you do. You are expert witnesses. You are in the box and you are giving us some recommendations, and there is some significant consistency between you, whether you work for democratic or republican administrations.

I am correct that each of you, Ms. Miller until your recent promotion, each of you are the chief insurance regulator of your State.

Is that correct?

[All nod affirmatively.]

Senator KAINE. Are all of you active in the National Association of Insurance Commissioners?

[All nod affirmatively.]

Senator KAINE. And you are the incoming president of that. Is that not right?

Ms. MCPEAK. That is correct.

Senator KAINE. The NAIC has a mission statement. Each of you, I know, have different State laws, so there is some peculiarities about your States.

But the NAIC says,

> "The mission of the NAIC is to assist State insurance regulators, individually and collectively, in serving the public interest and achieving the following fundamental insurance regulatory goals in a responsive, efficient, and cost-effective manner consistent with the wishes of its members."
>
> "The five goals of the NAIC: protect the public interest, promote competitive markets, facilitate the fair and equitable treatment of insurance consumers, promote the reliability, solvency, and financial solidity of insurance institutions," and five, "Support and improve State regulation of insurance."

Recognizing that each of your States have your own legal peculiarities, is that a mission that you generally accept in the work that you do as the chief insurance regulator in your own States?

[All nod affirmatively.]

Senator KAINE. Let me then ask this, and Ms. McPeak, you presaged this a little bit in your testimony.

All of you support—Mr. Doak with a qualification—all of you support the CSR payments continuing. You said if we choose not to alter the current structure that would be necessary.

All of you support, to some degree or another, State or Federal reinsurance. There are other areas of commonality.

None of what you are proposing to us today, though, is because you are trying to bailout insurance companies. Correct?

Ms. MCPEAK. That is correct.

Senator KAINE. Because I have heard colleagues in this body, the other body, and outsiders say things like, "CSR payments that is bailing out insurance companies." Or reinsurance, "That is bailing out insurance companies."

But as the chief insurance regulator in your State, who has pledged to basically follow these goals, you are not here to bailout insurance companies. Correct?

Ms. MCPEAK. That is correct.

Senator KAINE. Let me talk about one of these, reinsurance, because both the CSR and reinsurance things have been talked about as if they are insurance company bailouts. I am going to use my PowerPoint to see if I understand what reinsurance does.

In a health market or any market, because we use reinsurance at the Federal level for crop insurance, flood insurance, Medicare Part D. We used it for the Affordable Care Act.

But healthcare, families have different costs. Some have low medical claims, some have medium medical claims, some have really high medical claims.

If an insurance company has to write a premium to cover all that, they are going write a premium up here. If you can provide a backstop on the high cost claims, they do not have to write the premium here; they can write the premium down here.

Generally, reinsurance is a tool that you are all familiar with that, for the low- or moderate-costs, or the normal claimant, can have a significant effect in reducing premiums.

Is that not correct?

[All nod affirmatively.]

Senator KAINE. Then when you get to the high claim side, by providing reinsurance, what you are doing is you are providing a backstop, Senator Enzi called it a stop loss, a backstop and that has the effect of providing people protection. But it also, by providing a backstop, keeps insurers in the market that might otherwise vacate the market.

Is not one of the reasons that many insurers are vacating the individual market is because they are worried about these high cost claims? Is that not one of the main reasons they are vacating the market?

Ms. MCPEAK. Yes, Senator, if I could respond.

You are exactly correct. And in addition to that, when you have very limited carriers in a market like the majority of my State, if you are the one carrier writing in that market and you know that you have guaranteed issue, guaranteed renewability, and no ability to capitate risk because of no lifetime maximums, you have to rate everyone high because you are taking all comers and it is guaranteed renewability.

If you are able to say this is the backstop and this is the ultimate level of risk that you would have for writing in this market, it does entice additional insurers to write in that market because they can better estimate the risk.

Senator KAINE. And so the backstop ends up having a double benefit. It encourages insurers to stay in the market, but it also allows them to do a premium that does not have to take into account all of the super high cost claims. But that premium, then, is more favorable to the average person.

By reducing premiums on most, because so many folks get the advanced premium tax credits, the subsidies, when you bring the premiums down on most, you also reduce the Federal premium payment, which has a countervailing effect.

Reinsurance costs something, but it also brings down the Federal Government's obligation by reducing the advanced premium tax credit.

Is that not correct?

[All nod affirmatively.]

Senator KAINE. That is what you are using in your State to try to use that reduced Federal obligation down the road as one mechanism for paying for what Alaska is doing with its State reinsurance program.

Correct?

Ms. WING-HEIER. Yes, sir.

Senator KAINE. Senator Carper and I have a reinsurance bill in that would basically go with what we did with the first 3 years of the Affordable Care Act and put a reinsurance provision back in. That we think would accomplish all of those goals.

It would reduce premiums for the overwhelming majority of individuals in the individual market. It would provide a backstop that would keep insurers in. And by reducing premiums, it would also reduce the Federal obligation to pay the advanced premium tax credit, which would have a countervailing effect in reducing the cost of a reinsurance program.

I know that may not be the immediate issue on the table, I understand. But I am happy to hear that, to some degree, this is a concept that these witnesses support.

Thank you, Mr. Chair.

The CHAIRMAN. Thank you, Senator Kaine.

Next we have Senator Young, then Senator Murray, then Senator Roberts, then Senator Warren.

STATEMENT OF SENATOR YOUNG

Senator YOUNG. I want to thank our panelists for being here today.

I think each of you recognize that if we do not control the cost of healthcare delivery in this country, we are going to continue to see an increase in the cost of health insurance, whether that is at the consumer level, or among taxpayers, or some combination thereof. A number of you spoke to that in your testimony, and I thank you for bringing that important topic up.

I would like to focus a couple of questions on that area for each of you.

What do you think the primary drivers of healthcare cost increases are based on your professional experience? And, what are your ideas for actually bending the cost curve down as we head into the future?

I will start with Ms. McPeak because I know in your testimony, you spoke to the importance of incentivizing preventative care. Perhaps you could fill in some details on that.

Ms. MCPEAK. Thank you, Senator.

Our experience is that our claims costs in Tennessee are extremely high. Those are real dollars going out for real healthcare services that are being provided.

The majority of those seem to be going to prescription drugs and also to co-morbidities, real claims and issues that need to be addressed for our population. Bending the curve down is certainly something that can be affected through preventative care and wellness initiatives.

Certainly, an examination of the reimbursement costs to see is there a discrepancy that is reasonable from area to area in my State and then also from Tennessee to surrounding States.

Senator YOUNG. What is the best way, to your mind, to incentivize preventative care?

Preventative care can be quite broad. Right? From a gym membership, to seeing your primary care physicians, what have you. It is a better wellness program for your life.

Ms. MCPEAK. We would certainly appreciate the ability to manage those outcomes for Tennesseans.

We have used some of those programs on our TennCare side that have been pretty effective for disease management, for health coaching, smoking cessation, and then certainly the physical movement and wellness attributable to the fitness activities.

Senator YOUNG. Thank you.

I am going to go down to Mr. Doak because in your testimony, you spoke to the importance of price transparency, empowering the consumer based on the information of services provided and the perceived value of those services.

Is a lack of transparency to your mind a primary driver of healthcare costs and thus health insurance premiums? And if so, how do we improve the functioning of the market so that there is a more transparent market?

Mr. DOAK. Great question. Thank you, Senator.

One of the answers is—as I mentioned in my earlier discussion that was very near and dear to former Oklahoma Senator Coburn—talking about price transparency. We have seen that.

I would ask the committee as we said earlier this morning to possibly invite the CEO of the Oklahoma Surgical Center here to testify on behalf of what he has been able to do with transparency in Oklahoma City and where some of those things are going.

The more transparent we can be with our costs all through healthcare is that you are going to provide and empower consumers to be able to see the outcomes that Senator Burr was talking about relative to the cost expenditures. There are various places around the State of Oklahoma that are doing that very well.

That is a true opportunity.

Senator YOUNG. But you do not have particular recommendations here at the Federal level regarding obstacles we could remove or regulations we could put in place so that it would facilitate more transparency?

Mr. DOAK. I think that is something worthwhile to consider. I am a bit hesitant to have anything further done here in Washington. I would rather see it done at the local and State level, quite frankly.

Senator YOUNG. Oftentimes a health instinct from my perspective.

I am going to give others an opportunity to speak to this issue.

Mr. KREIDLER. Senator, I would certainly put a high emphasis on pharmaceutical drugs.

That is the one area where—if you remove the shackles that are on the States right now as to what they wind up doing and contracting, either through their Medicaid program or other programs that they have at the State level—we can have a very strong impact, particularly if we joined together with likeminded States to take on that same approach toward bargaining when it comes to these drugs.

That is the No. 1 driver in the individual market and we see it with our filings. It is on the cost of pharmaceuticals.

Senator YOUNG. I am pretty much out of time here. So I will give others an opportunity to respond to that question in writing.

I would just say in pharmaceutical costs, we want to make sure that we do not absorb an opportunity cost to future research and development, lives saved, and approved into the future by adopting some of the suggestions you have put forward.

Thank you.

The CHAIRMAN. Thank you, Senator Young.

Senator Murray.

Senator MURRAY. Thank you very much.

This has been really great. A lot of senators are participating and I think they all really appreciate all of your testimony. Thank you for being here.

Commissioner Kreidler, I wanted to ask you. In your testimony, you talked about the Cost Sharing Reductions are the difference between whether a 40 year old in Tacoma earning $23,000 per year has a $2,000 deductible or a $7,000 deductible.

Consumers have really come, I think, to rely on these measures to lower their own healthcare costs. The same way that employer contributions help keep costs down for people who get insurance through their jobs.

Something changed this year. President Trump has made patients, and families, and insurance companies, and State regulators play this guessing game about whether or not those payments are actually going to be made.

We know that failing to make those payments is going to spike premiums for the most popular plans in the marketplace by 20 percent, leading an increase to the Federal deficit of $200 billion. So this is really an important issue.

I wanted to ask you, what did you have to change about the way you review and approve insurance premiums this year because of that guessing game?

Mr. KREIDLER. Senator, it is one where we have to sit down with the health insurers and really press them on it.

But the point has been made that if you get down to just one carrier in a particular county, you do not have a lot of bargaining flexibility. They are in the position of saying, "Well, if you do not give me the rate increases I want, then we are looking toward the highway," and then you do not have an insurer there. We are under a lot of pressure.

Stabilizing the market is No. 1. You have to stabilize that market. The CSRs are No. 1 from the standpoint of what you can do immediately. It can have a direct impact and get away from this idea of funding on a month-by-month or even a year-to-year basis.

It really has to be multiyear with some real predictability in the market.

Senator MURRAY. So my additional question to you is we have heard 1 year, 2 years. Tell me what the difference between, if we just did a 1-year, what a difference that would make rather than a 2-year?

Mr. KREIDLER. Clearly, 1 year is a whole lot better than month to month. But even 2 years is very tough because of the range of which the insurers are planning right now as to what the rate increases are.

Any degree of increase in predictability that goes beyond this situation we have right now of being so tentative right now with just month to month is going to help. The longer we can give it, the better it will be to help stabilize.

Senator MURRAY. The more certainty, the lower the costs of the care?

Mr. KREIDLER. Absolutely, absolutely.

Senator MURRAY. All right.

I wanted to ask you, Commissioner Wing-Heier, because I noticed when Senator Baldwin asked about the Navigators and the money there that I think you testified that it is really needed in many remote parts of Alaska, and used across the country in really important ways.

The budget for Navigators has been cut by 40 percent. Tell me what impact that is going to have on you in Alaska.

Ms. WING-HEIER. We are very concerned it will have a major impact in our enrollment.

I know that Commissioner Doak testified that he does have insurance brokers and consultants throughout much of his State. We do not.

In most of Alaska, outside of Fairbanks, Anchorage, Juneau, and other cities, there is not an insurance broker or consultant to be found. We rely on the clinics and the Navigator programs to explain benefits and enrollment to the people living in rural Alaska.

This will be devastating to our population to know what their options are, to understand basic things from the dates of enrollment.

There is also a part that is very cultural in Alaska in the fact that we have a variety of languages. And the Navigators cross that bridge in being able to speak the Inupiaq language or the Native languages of Alaska and other languages. They provide that service.

We do not have that very readily in the insurance community, unfortunately.

Senator MURRAY. Right.

Commissioner Kreidler, quickly, our State is looking at a 1332 Waiver.

When applying for that kind of waiver, States have to show that they are going to cover the same number of people, the same types of services, and the same amount of out of pocket costs for consumers. Those are the guardrails in the Waiver.

Can you talk really quickly about how important those guardrails are as you look at the Waiver?

Mr. KREIDLER. Senator, we have changed the environment that we have right now with healthcare delivery through insurance because of the ACA. We are now competing on quality and service because we have the standardize benefits, the Essential Health Benefits; limitations on out of pocket expenses. It has changed the dynamic of the game tremendously.

If we want to go forward and have the insurers in there, we have to participate. It is absolutely critical that we wind up making sure that those guardrails are not eroded away. But to focus on what can really make a difference.

For one, stabilize and then second, be in a position to allow the insurance companies to innovate without being punished with the reinsurance program to back them up.

Senator MURRAY. OK.

Mr. Chairman, I do want to submit four letters for the record. They are actually signed by hundreds of leading patients' disease, physician, provider insurance, and business organizations. They are requesting multiple years of certainty for out of pocket reductions, and Federal investment in risk mitigation programs like reinsurance we have heard so much about, and preserving the protections for preexisting conditions including the Essential Health Benefits.

I would like to put them in the record for today.

The CHAIRMAN. Thank you. They will be.

[The information referred to can be found in additional material.]

Thank you, Senator Murray.
Senator Roberts.

STATEMENT OF SENATOR ROBERTS

Senator ROBERTS. Yes, thank you, Mr. Chairman.

Thank you to all the witnesses for taking time, your very valuable time out of your schedule to come and visit with us.

As rates are filled and not filled by some plans, obviously exiting the marketplace like we have seen in Kansas City, an action that serves absolutely nobody. So thank you for holding this hearing.

I think it is important we focus on permanent or longer term reforms so we can help slow the growth of premiums and maintain or increase insurance options for consumers, as opposed to simply patching or providing an influx of cash to these markets which has been touched on by the witnesses.

I know many are focused on the uncertainty surrounding the Cost Sharing Reduction subsidies, but I think it is important to note that, at least in Kansas, we have had insurers leaving the exchange market before this Administration, or the court ruling on this matter, and with the CSRs in place. Premiums still doubled in Kansas since Obamacare has been in place. And I think that is only one piece to the puzzle with regards to ASR's.

Tighter age rating bands can be an answer. I know that is controversial. The health insurance or HIT tax, that is just a tax that is passed onto the consumer or the patient. Other mandates that you have talked about all add to the premium increases.

We had 60,000 families paying $13 million in penalties in 2014. $6 billion, I think, was the figure with regards to the Nation as a whole.

So as premiums continue to increase, we had something in the recent reform proposals that did not pass, obviously, considered by the House and Senate. They took two different approaches to encourage, not mandate, folks to maintain continuous coverage.

From your position as insurance commissioners, which do you see as more effective, as well as which would be easier to operationalize a penalty on premiums for lack of continuous coverage, or a waiting period for enrollees upon returning to enroll in coverage, or anything else you might suggest?

We will start with Ms. McPeak.

Ms. MCPEAK. Thank you.

I have a preference for the waiting period over the premium penalty for not maintaining continuous coverage because there is an administrative issue for our insurers that have been participating in the exchange market with individuals coming in and out of coverage, and really trying to catch up with premium payments through grace periods.

From my perspective, a waiting period would be more effective to incentivize consumers to maintain continuous coverage.

Senator ROBERTS. Appreciate it.

Sir.

Mr. KREIDLER. Thank you, Senator.

I think one of the things that has really been challenging for the States is not all States have truly embraced the Affordable Care Act.

The expansion of the Medicaid program had a very profound, positive impact; the creation of our own exchange, so we were more in control of our own destiny. Establishing network adequacy standards that reflected our values in the State of Washington is something that we did.

Most States did not take those actions and as a consequence, they have seen more in the way of rate increases.

Our rate increases have not gone up until this last year. We were under 10 percent per year, and now we have seen a marked increase.

Stabilizing the market is going to be the thing that is really going to make a difference from our standpoint.

Senator ROBERTS. Right. I appreciate that.

Next, please.

Ms. WING-HEIER. It is a tough call because you hate to see anyone be without insurance, but we have the special enrollment periods for a reason. And that, in itself, brings you into your waiting period because you cannot, in all circumstances, just go and enroll if you missed open enrollment. There are very few criteria that allow you to enroll if you miss open enrollment.

Alaska would probably be looking more at the penalty.

Senator ROBERTS. Yes, ma'am.

Ms. MILLER. I think we all want to do everything we can to make sure our risk pools are as robust as possible. I have not seen an alternative to the individual mandate that would be as good an option to make sure that we have the young and healthy.

I am not saying that the mandate has been perfect by any stretch, but I have not seen an alternative that would do as well as that in terms of keeping the young and healthy in.

Senator ROBERTS. Oklahoma.

Mr. DOAK. I am not in favor of a mandate, you might be surprised, but I think that there are other ways to reach plan design, to reach this group that does not have insurance. Avail themselves of more creative plan design relative to catastrophic plans for the young, invincible, to move them into possibly using Health Savings Accounts, as Director Wing-Heier mentioned. But I think there are ways.

I am not sold on this marketing campaign that a few of the senators talked about either. Insurance companies have been marketing at every football game we watch. Possibly if they incentivized agents and brokers to sell this type of product, they might have a better result than use Navigators.

Senator ROBERTS. Is that football game when Oklahoma comes to Kansas State?

Mr. DOAK. Yes, sir.

Senator ROBERTS. I appreciate that.

I have a real quick question and I am out of time. I apologize for this.

How would increasing the age rating curve to 5-to-1 or maybe 4-to-1 as opposed to 3-to-1, that would be an intermediate change, if you so choose with regards to the individual or trying to get more younger people into the plan.

Are you for it, against, against it, what? Yes or no. We can start with Oklahoma and rundown real quick.

The CHAIRMAN. We are out of time, so if you could be quick about it and then submit it.

Senator ROBERTS. They could submit it for the record, Mr. Chairman. I appreciate that. Thank you.

The CHAIRMAN. You can make a short answer. That is OK.

Mr. DOAK. What was the question, sir?

Senator ROBERTS. The question is on the rating band, the exchange market does not have enough of the young.

Mr. DOAK. Yes, I would be in favor of changes.

Ms. MILLER. I would have some concerns about increasing the rating band.

Ms. WING-HEIER. We have concerns with increasing the rating band strictly because our rates for the older population, the three, are so high right now. We would price them out of ever being able to afford it.

Senator ROBERTS. We say "more mature" in the senate. But go ahead.

[Laughter.]

Mr. KREIDLER. Washington likes 3-to-1. We have in statute 3.75-to-1 currently before the ACA. So we were not far off of 3-to-1 to even begin with.

Ms. MCPEAK. I would be in favor of expansion to 5-to-1 to bring the younger, healthier into the risk pool with more affordable premiums.

Senator ROBERT. Thank you.

The CHAIRMAN. Thank you, Senator Roberts.

Senator Warren.

STATEMENT OF SENATOR WARREN

Senator WARREN. Thank you, Mr. Chairman.

And thank you, Mr. Chairman, for holding this hearing. Thank you, ranking member. I think it is important that we are having a bipartisan conversation about how to improve healthcare instead of destroy healthcare in America.

At the same time that we are having this conversation, President Trump is actively working to sabotage our healthcare system. He is using a lot of different tactics, but two of them include reducing Federal help to keep out of pocket costs low, and cutting 90 percent of the advertising efforts so that people know about affordable health insurance.

We have talked some about this, so let me just see if I can do this first part quickly. I just want to ask about the first one, withholding the Federal dollars that keep costs lower.

Commissioner McPeak, are American families better off or worse off if the President refuses to make cost reduction payments?

Ms. MCPEAK. If those payments are not funded, the American consumer is worse off, certainly. Not only the individuals that are eligible for those reduced co-payments and deductible amounts, but the individuals that would have to pay the increased premium dollars from the carriers associated with that lack of funding.

Senator WARREN. OK.

Commissioner Kreidler, if the Government cuts advertising, fewer people will sign up for health insurance. But how does that affect the costs for the people who do sign up for health insurance?

Mr. KREIDLER. You want to encourage the people that are probably the least likely to sign up, to enroll because they are more likely to be healthier individuals that are now protected. They do not become the free riders in our system that relies on uncompensated care to care of them. It adds cost to the system.

The more accountable you make healthcare, the better it is for all of us.

Senator WARREN. Very strong points on both of these.

The President has been perfectly clear about what he is doing, sabotaging healthcare and driving up costs for families. It is petty and it is going to hurt millions of people. If he will not stop on his own, then Congress should stop him.

But for me, that is just the beginning of what we need to do to really improve health insurance in this country.

Secretary Miller, did the ACA put in place any sort of restrictions on how high an insurance company can raise its premiums in a given year?

Ms. MILLER. Senator, I think aside from the fact that in many States, we approved those rates.

Senator WARREN. I am going to ask you about the States. I am asking about the ACA.

Ms. MILLER. There are no restrictions in the ACA.

Senator WARREN. That is right. The ACA makes no restrictions at all. Right? But some States impose tough rules to protect consumers and they insist that the insurance companies have their rates approved by the insurance commissioner before those rates can go into effect.

Let me ask, Secretary Miller, in the past years before all the chaos that has come to the markets lately, did you let insurers in Pennsylvania charge whatever they wanted for their plans?

Ms. MILLER. I did not, Senator.

Senator WARREN. You did not?

Commissioner Kreidler, I understand that in Washington State, like Pennsylvania, insurance companies have to get permission ahead of time.

Do insurers always come up with reasonable premiums the first time around?

Mr. KREIDLER. No, they do not.

Senator WARREN. Someone laughed out loud during that. Go ahead.

Mr. KREIDLER. We have applied a very vigorous review; in fact, we are among those States that are the most vigorous. In fact, we are recognized by the Federal Government as being a State that can do that hard review. I think several of us are in that position.

Senator WARREN. Hard review and I think you have some data on how much you pushed down one of the most recent premium requests.

Mr. KREIDLER. We do and I cannot remember exactly which one that was.

Senator WARREN. Maybe a 30 percent drop in average rates.

Mr. KREIDLER. It was something like that, yes.

Senator WARREN. All right. Good, good.

I should say it the other way. Yes, a 30 percent drop in average rates.

The reason I raise this is because letting insurance companies charge whatever they want opens up price gouging. Rate review programs among the various States have saved consumers about $1.5 billion in premium costs in just 2015 alone, in a single year. Unfortunately, not every State is stepping up on this and the difference is huge.

From 2010 to 2013, just that short time period, premium increases in States with the weakest review programs were 10 percent higher than in States with the strongest review programs. That is a lot of money that a lot of families paid out. For me, it just shows the kind of work that we need to do.

Right now, Medicare restricts premium increases for most beneficiaries, but the ACA does not. Medicare has high standards for the Medicare Advantage plans, while the ACA in many cases has lower standards. Medicare and Medicaid plans cover everybody who qualifies. ACA plans can pick and choose who they get in the game with.

Let us be blunt. We can either make these markets work better for consumers or we can let insurance companies hold people hostage in order to maximize their own profits.

In my view, if we were really serious about trying to make these markets work, we need to talk about the kind of rules that make them work best for consumers.

Thank you, Mr. Chairman.

[Applause.]

The CHAIRMAN. Thank you, Senator Warren.

Senator Whitehouse.

STATEMENT OF SENATOR WHITEHOUSE

Senator WHITEHOUSE. Thank you, Chairman.

Let me first, as a former Insurance Commissioner in my State, welcome our distinguished panel.

Again, thank the chairman and the ranking member for trusting this committee to do a fair and thoughtful bipartisan process. We did it in education with great success to a unanimous, significant bill out of this committee, and I am confident that we can do something very worthwhile here.

I want to open by pointing out that our health insurance commissioner in Rhode Island has written that,

> "The ACA has worked in Rhode Island and we have a remarkable story to tell." I am quoting a letter from this January.
>
> "Rhode Island has enjoyed market stability, and has avoided dramatic increases in premiums seen in other States. Over the last 3 years premium increases in the individual and small group markets have been relatively modest. For plan year 2017, average premium changes in the individual market will range from a 5.9 percent decrease to a 5.9 percent increase based on issuer. In the small group market, average premium changes in 2017 will range from a decrease of 3.1 percent to an increase of 3.6 percent based on issuer."

To my colleagues, please follow the Hippocratic Oath and do no harm to those of us who have States where this is all working very well.

The last point I will make before I go to questions is that I hope that the bipartisan process that we are embarked on here, with respect to shoring up the markets, can continue and be extended into other areas. Patient safety and medical errors remains a huge issue with tens of thousands of American casualties every year.

There is nothing republican or democrat about ending hospital-acquired infections. The wild variations in care and outcomes are issues that we can address. It ought to be bipartisan to find the best States and the best practices, and encourage those.

There is nothing republican or democrat about high administrative overhead and continuing feuding between insurers and providers over payment.

The care that patients want at the end of life ought to be something we can make sure that they actually get. There ought to be no partisan difference about honoring a patient's and a family's wishes as they near the end of life.

Finally, payment reform so that doctors are compensated for keeping people healthy rather than starved on that front and compensated only when they do late stage procedures once somebody's health is already compromised; another great area for bipartisan action.

I hope that we will continue on those fronts.

My questions are primarily going to be to Director Wing-Heier. I appreciate you coming all the way from Alaska. That is pretty impressive. I want to ask you about the 1332 Waiver process through which you created your reinsurance program.

You created it, not based on hitting a financial number, a dollar number in claims and then having the reinsurance kick in. You created it based on the diagnosis, based on conditions.

Correct?

Ms. WING-HEIER. Yes, sir. We did.

Senator WHITEHOUSE. Why did you make that choice and how did you choose the conditions?

Ms. WING-HEIER. We did what we call a "data call" and had all the insurers that were in the market the first 2 years submit their claims.

We submitted those, that data to an independent actuary, who then we had segregate the claims from the highest to the lowest based on the condition, so we could see what we were dealing with. What was causing the market for our rate increases to be roughly 40 percent for 2 years in a row?

We then made the determination that if we removed the top 10, the top 20, the top 30, we could put a correlation to how that would impact the market as far as how our rates would stabilize or, hopefully, decrease.

Senator WHITEHOUSE. Why pick conditions rather than, say, stop loss at $100,000 per claim or some other more numerical figure?

Ms. WING-HEIER. We are looking at the biggest impact we could have to stabilize a market that was losing its——

We were down to one insurer. We needed to stabilize the market to the greatest extent we could. Removing the entire claim or the

entire person from a very small pool had the biggest impact or the biggest bang for our buck on our rates.

Senator WHITEHOUSE. What happens year to year as somebody goes into a new enrollment period or perhaps shifts their carrier? Does the new carrier know that your reinsurance for that individual because they have the requisite diagnosis will follow them, or do they have to stay with their—how does it work in terms of future enrollments?

Ms. WING-HEIER. No. If we had a second carrier, based on the condition, that person would be seeded the first of every year or the first time they treated and continuing the diagnosis, be it a chronic condition or a new condition.

Senator WHITEHOUSE. So the reimbursement, the reinsurance for the carrier follows the individual year to year for as long as the diagnosis or condition remains in place. Correct?

Ms. WING-HEIER. As long as they are treating.

Senator WHITEHOUSE. Did you consider setting up a risk pool rather than a reimbursement system for those individuals?

Ms. WING-HEIER. Yes, we did.

Senator WHITEHOUSE. Why did you choose the reimbursement system rather than the risk pool?

Ms. WING-HEIER. We chose the reimbursement system, again, to have the biggest impact on a very small market: 20,000 people.

Senator WHITEHOUSE. So the administrative problem of setting up a separate risk pool would have been a problem for a small number of patients like that?

Ms. WING-HEIER. We feel that we had a pool to begin with and with the 20,000 that were in it at the time was not succeeding. So to create a pool within a pool, we needed to get those high cost claimants out of the pool.

Senator WHITEHOUSE. Right.

Ms. WING-HEIER. So that the entire individual market, we could reduce the rates and people could afford the premiums.

Senator WHITEHOUSE. Got it.

My time is running out here, but I would like to ask a question to each of you. This will be a question for the record given the timing.

But if an insurance company came to you, to your organization, proposing to sell health insurance in your State, I would like to know what steps, particularly setting up a provider network you would expect or require of that insurer?

And conversely, to turn the question to the other side, what concerns would you have about an insurer showing up in your State purporting to offer health insurance who was not prepared to create a provider network and go through whatever other steps you would require?

With that, I am out, but I would be really interested in your answer to those questions.

Thank you.

The CHAIRMAN. Very good questions. Thank you, Senator Whitehouse.

This has been a very good discussion, both the hour before we started and this.

I want to ask Senator Murray if she has concluding remarks.

Senator Franken, do you have some concluding remarks?

Senator FRANKEN. I was going to ask a question about prescription drugs, but I see you want to conclude, and I respect that.

The CHAIRMAN. No, go ahead, if you would like.

Senator FRANKEN. I just want to ask a rhetorical question about the cuts by HHS in advertising for the exchanges.

Mr. Doak said that insurance companies advertise at every football game that we watch. Are those insurance companies just stupid or maybe insurance advertising works. That is the rhetorical question.

I think there is a reason those insurance companies advertise.

Mr. DOAK. I guess the question is, are they funded by the Federal Government. Does that make sense or not?

Senator FRANKEN. I think the issue is, does advertising work? If you are cutting it by 90 percent, you are probably cutting the effectiveness of the advertising, whoever pays for it.

Mr. DOAK. We have thousands and millions of licensed agents and brokers all across the United States, Senator, that have been doing a great job in the health insurance market before Obamacare and could be doing the same after.

Senator FRANKEN. I really meant it as a rhetorical question, which I said.

The CHAIRMAN. Good luck with that.

Senator FRANKEN. But good luck with that is right.

The point is that they advertise for a reason whether or not they sell it through brokers or not. Advertising does work and that is why they advertise.

I had a question on pharmaceuticals, but I really do not want to eat up time. Although, I would like to thank the chairman as we had a hearing on pharmaceuticals.

I think, as you all have said in one way or another, that the pharmaceutical spikes in the last 3 years or so has been one of the things responsible for the premiums going up.

I would love to hear your thoughts on how we can get those under control, and maybe we can do that in a written answer so that the chairman and the ranking member can include it.

One other thing, my favorite moment in the hearing so far was Senator Whitehouse thanking Ms. Wing-Heier for the hardship of coming from Alaska.

My favorite moment was seeing Senator Murkowski's expression when he did that.

[Laughter.]

The CHAIRMAN. Thank you, Senator Franken.

Senator Murray, do you have any concluding remarks?

Senator MURRAY. You are easily entertained, Senator Franken.

I want to thank all of our witnesses today. This has been an extremely important first step. I know we have three more hearings. We do have a very short timeframe within which to do this and we need to seize this opportunity.

Mr. Chairman, I know my side looks forward to working with you and I appreciate the opportunity today.

The CHAIRMAN. Thanks, Senator Murray.

And I thank the witnesses too. You have been very patient. You have given us a lot of time.

I thank the senators. We have had maybe half the senate involved this morning in this discussion. That is pretty unusual and mostly on our best behavior. That is pretty unusual too. We welcome that.

I would like to conclude with these remarks; one, just these facts from CMS on the Navigator program. I am not sure what the right amount of money is for the Navigator program.

According to CMS, in 2016, Navigators received $62 million of Federal money to enroll 81,000 people; less than 1 percent of the total enrollees. Seventeen Navigators enrolled less than 100 people each at an average cost of nearly $5,000 per enrollee. The top 10 most costly Navigators spent a total of $2.7 million to enroll 314 people in the Affordable Care Act. One grantee received $200,000 and enrolled one person. Only 22 percent of all Navigators achieved their own performance goals.

Maybe it is an area that needs some oversight.

Let me go to a point that several senators have made including Senator Franken and several others. I have been thinking this especially.

For 7 years, we have been stuck in this partisan stalemate on health insurance with most of the argument—not all of it, but most of it—about the 6 percent of Americans who buy their insurance on the individual market.

When we really should have been spending more time on the fundamental problems with the American healthcare system that have caused it to grow from consuming 9 percent of the Gross Domestic Product in 1980, about 40 years ago, to nearly 18 percent in 2015, and a predicted 20 percent in 2025.

At the same time, as was mentioned, we have the phenomena of 5 percent of those who receive healthcare consume 60 percent of the costs. So we should be doing more on the larger question about addressing healthcare costs. There is no question about that.

Looking at what we pay to visit the doctor or how to get a test at the hospital, that is the transparency Mr. Doak talked about.

What we spend on prescription drugs, several of you talked about that.

How much excessive paperwork and administrative burdens increase our costs.

What more can be done to encourage wellness? That is really the low hanging fruit in the whole issue of health costs.

What can be done to prevent more serious illness and disease, and the high costs that come from being ill?

We should be looking at the real ways to bring down the cost of healthcare, which is the best way to reduce the cost of health insurance.

What I have heard today, just to summarize, has been very helpful. It has been a focused hearing on a narrow part of the market where we have most of the problems; the 6 percent, the people with insurance.

What we asked you to do was to focus on what could we do, especially this month, that might affect 2018. I heard three things mostly: reinsurance, Cost Sharing Reductions, and more flexibility from 1332.

Reinsurance. One way to do reinsurance, of course, is the way Minnesota and Alaska did it, which is to use some of the Federal money you are already getting to do that. I am not suggesting that is the long-term solution. Senator Kaine has proposed a long-term solution.

Reinsurance has broad support among republicans, I know. This is not a very complicated idea. It is just take this very narrow market, which is an odd market, a small market, and recognize that some people are very sick and we need to find, create a fund to pay for the costs of some of those people in order to lower the premiums for everybody else. That is what we are talking about.

There are a variety of ways to do that, Federal tax dollars, State tax dollars. You can do what Maine did and charge everybody something on their premium. There are various ways to do that.

But clearly, reinsurance is one part of the solution to a long-term fix for the individual market.

Now, for the short term, for something we might sit down in 10 days and say, "OK. We can agree on this much," and try to ask the House and the Senate, and the President, and all to do it in time to have an effect on 2018. Maybe what I have heard is, "Adjust 1332 in any way that makes it easier for you to create your own short-term reinsurance next year." That may be hard.

Several suggestions for improving 1332 that ought not to be too controversial; I mean, the 6-month waiting period.

No one mentioned the "me too" application. That is if Washington puts something in that is approved, why can Tennessee not come right along behind it and say, "We want to do what Washington did with one change?" That ought to speed things up.

The idea of letting the process go ahead with just the application of the Governor, or as you have suggested the insurance commissioner and not wait for the legislature to have to pass a law, since some State's legislatures only meet every 2 years.

Alaska submitted a list of reforms that we will take a look at. I thank you for mentioning those.

Planning funds, Ms. Miller mentioned that. That would seem an odd thing to have to do for a bankrupt Federal Government to give money to a balanced budget State Government for planning funds, but I understand the problem of quick providing of funds so that you can make your application for a longer term plan.

Then I was intrigued with the suggestion, I have heard it often, of what can we do about the budget neutrality requirement? And make sure that that does not keep you from doing what you would do to make a long-term plan.

Is there any way to include the savings that you have in Medicaid with what you are doing in the individual market; the two different Waivers that the Federal Government has?

I know that New Hampshire has tried to do some things in that area. And even though the democratic Governors and the republican Governors both support it, they are not able to do it, according to both the Obama and Trump administrations.

That is a short list of some things that might make some real difference in the 23 States that have actually started the process of applying for a 1332 Waiver.

I am hopeful that maybe some combination of continuing cost sharing for a period of time—and we can discuss what that time is—and significant changes in flexibility for States, probably mostly through amendments to Section 1332 since it is already in the Act, might provide a basis for action we could take this month.

Then if we act, we will count on the House of Representatives and the President to take advantage of that and my hope is that they would.

That would not end the process. That would only be step one, then we would go pretty quickly to step two on a long-term, strong, vibrant individual market and other changes that need to be made in the Affordable Care Act.

I hope we can begin to spend most of our time on the larger issue of healthcare costs.

If you have other comments that you would like to give to us, we would like to have them in writing pretty quickly because we are moving pretty quickly.

The record will be open for 10 days for comments and questions.

The CHAIRMAN. Tomorrow, our committee will meet again to hear from five Governors to further discuss marketplace stability and how to advance many of the topics mentioned today.

We have two more hearings next week. Then we will see where we are and see what we think we can accomplish.

Thank you for being here.

The committee will stand adjourned.

[Additional Material follows.]

ADDITIONAL MATERIAL

SEPTEMBER 5, 2017.

Hon. LAMAR ALEXANDER, *Chairman*,
Hon. PATTY MURRAY, *Ranking Member*,
Senate HELP Committee,
U.S. Senate,
Washington, DC 20510.

DEAR CHAIRMAN ALEXANDER AND RANKING MEMBER MURRAY: As providers of healthcare and coverage to hundreds of millions of Americans, we commend the HELP Committee's leadership in efforts to develop policy solutions to stabilize and strengthen the individual health insurance marketplace. These bipartisan discussions come at a pivotal time for the marketplace given the timing of final participation decisions by health plans for 2018.

As the Senate HELP Committee considers legislation to stabilize the health care coverage and choices for the 20 million Americans who rely on the individual market, we urge the committee to ensure that cost-sharing reduction (CSR) benefits are continuously funded *for at least 2 years* (2018–19).

CSR benefits help those who need it most: low-and moderate-income Americans with incomes under 250 percent of the Federal poverty level. Nearly 60 percent of exchange-plan enrollees rely on CSR benefits, which translates into comprehensive coverage and access for nearly 6 million individuals and families. The CSR program makes it more affordable for patients to receive needed medical care and services by reducing deductibles, copayments, and out-of-pocket maximums. As a result, providers can better serve the needs of their communities and employers do not needlessly face higher costs to provide coverage to their employees.

Persistent uncertainty about CSR funding is a significant driver of current market instability—pushing premiums higher and resulting in fewer choices for individual market consumers. According to the most recent analysis by the Congressional Budget Office, eliminating CSR benefits would—

- Increase average premiums for benchmark silver plans by 20 percent in 2018 and by 25 percent in 2020.
- Increase the Federal budget deficit by $194 billion over the next 10 years (2017–26).
- Lead to fewer plan choices for consumers and greatly increase the risk that some consumers would be left with no insurance options in certain States and geographic areas.

We urge the committee to include continuous funding for CSR benefits for at least the next 2 years (2018–19) as part of bipartisan legislation to stabilize the individual market. Without 2 years of CSR funding, uncertainty will persist and the Congress will need to address these same issues early next year. In addition, without a break in funding for the CSRs, we expect that this provision would not contribute to the Federal deficit. By committing to CSR funding for 2 years, it would go a long way to bring much needed stability to the individual market and promote access to more affordable coverage and choices for millions of Americans.

Sincerely,

America's Health Insurance Plans; American Academy of Family Physicians; American Benefits Council; American Hospital Association; American Medical Association; Blue Cross Blue Shield Association; Federation of American Hospitals; U.S. Chamber of Commerce.

SEPTEMBER 5, 2017.

Hon. MITCH MCCONNELL, *Majority Leader*,
Hon. CHUCK SCHUMER, *Democratic Leader*,
U.S. Senate,
Washington, DC 20510.

Hon. PAUL RYAN, *Speaker of the House*,
Hon. NANCY PELOSI, *Democratic Leader*,
U.S. House of Representatives,
Washington, DC 20515.

DEAR LEADER MCCONNELL, SPEAKER RYAN, LEADER SCHUMER, and LEADER PELOSI: The undersigned organizations representing consumers, patients, and

health care providers share the strong belief that everyone in this Nation deserves high-quality, affordable health coverage and care. We stand committed to building on the historic progress of the Affordable Care Act (ACA) and working with you to secure meaningful and affordable health coverage for all.

Continued uncertainty about funding for cost-sharing-reduction payments, evidence of administrative attempts to undermine the law, and concerns about future congressional attempts to repeal the ACA pose a significant threat to the stability of marketplaces and the broader individual market. It is now time for Congress to move past attempts to repeal the ACA and cut the Medicaid program and turn its attention toward bipartisan policies that would safeguard the stability of health insurance markets for 2018 and beyond. Specifically, we urge Congress to take swift action in three main areas:

(1) **Guarantee funding for cost-sharing reductions (CSRs)**. We urge Congress to immediately enact legislation that clarifies there is a permanent, mandatory appropriation that ensures full funding of CSRs, eliminating all questions raised by pending litigation. CSRs provide critical financial protection for nearly 6 million people who obtain private coverage on health insurance marketplaces.[1] If CSRs end, premiums would rise by an estimated 19 percent, and reduced plan participation could leave many consumers without any coverage options.[2] Quick action that guarantees ongoing CSR funding is critical to ensuring a stable individual market.

(2) **Restore premium stabilization programs**. We urge Congress to immediately appropriate ongoing funding for a premium stabilization program that shields individual insurance markets from the volatility of high-cost claims. The potential impact of such a program is illustrated by the 10 to 14 percent drop in premiums that resulted from transitional reinsurance under the Affordable Care Act.[3] An ongoing, fully funded premium stabilization program would also encourage insurers to offer marketplace coverage.

(3) **Ensure continued funding for outreach and enrollment assistance**. We urge Congress to continue to appropriate adequate funding for Federal Navigators and outreach, culturally and linguistically appropriate education, and marketing activities through the Department of Health and Human Services. This funding helps consumers—particularly young and healthy people who will help balance the risk pool—learn about and enroll into available coverage.

Thank you for considering our requests. We urge you to protect the Medicaid program and preserve the coverage gains made under the ACA as you turn your attention to market stabilization efforts. We stand ready to work with you to address these urgent concerns in the short term and, in the long term, to enact policies ensuring that everyone in our Nation has high-quality, affordable health coverage and care.

Sincerely,

Families USA; Academy of Nutrition and Dietetics; ADAP Advocacy Association (aaa+); The AIDS Institute; AIDS United; Alliance for Retired Americans; American Academy of Pediatrics; American Association on Health & Disability; American Federation of State, County and Municipal Employees; American Federation of Teachers; American Muslim Health Professionals; American Nurses Association; American Public Health Association; The Arc of the United States; Asian & Pacific Islander American Health Forum; Association of University Centers for Disabilities; Autistic Self Advocacy Network; Bazelon Center for Mental Health Law; Black Women's Health Imperative; Cancer Support Community; Center for American Progress; Center for Law and Social Policy; Center for Medicare Advocacy, Inc.; Center for Popular Democracy; Center for Public Representation; ChangeLab Solutions; Children's Defense Fund; Coalition on Human Needs; Community Access National Network (CANN); Community Catalyst; Congregation of Our Lady of Charity of the Good Shepherd, US Provinces; Consortium for Citizens with Disabilities; Consumers

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[1] Centers for Medicare and Medicaid Services, *2017 Effectuated Enrollment Snapshot*, (Washington, DC: Department of Health and Human Services, Centers for Medicare and Medicaid Services, June 6, 2017), available online at *https://downloads.cms.gov/files/effectuated-enrollment-snapshot-report-06-12-17.pdf*.

[2] Larry Levitt, Cynthia Cox, and Gary Claxton, *The Effects of Ending the Affordable Care Act's Cost-Sharing Reduction Payments*, (Washington, DC: Kaiser Family Foundation, April 25, 2017), available online at *http://www.kff.org/health-reform/issue-brief/the-effects-of-ending-the-affordable-care-acts-cost-sharing-reduction-payments/*.

[3] Letter to Senate Majority Leader Mitch McConnell and Senate Minority Leader Chuck Schumer Re: The Better Care Reconciliation Act of 2017 (BCRA), from Karen Bender, Chairperson of Individual and Small Group Market Committee, and Michael Nordstrom, Chairperson of Medicaid, American Academy of Actuaries, June 30, 2017 *http://actuary.org/files/publications/BCRA__Comment__Letter__063017.pdf*.

Union; CPD Action; Disability Rights Education and Defense Fund; Doctors for America; Easterseals; Epilepsy Foundation Family Voices; Farmworker Justice; Foundation for Healthy Generations; Friends Committee on National Legislation; The Greenlining Institute; Health Care for America Now (HCAN); Hepatitis B Foundation; Hep B United; HIV Medicine Association; Hogg Foundation for Mental Health; International Union, United Automobile, Aerospace & Agricultural Implement Workers of America, UAW; Justice in Aging; Lakeshore Foundation; Leadership Conference on Civil and Human Rights; League of Women Voters of the United States; Medicare Rights Center; The Michael J. Fox Foundation for Parkinson's Research; NAACP; NASTAD; National Advocacy Center of the Sisters of the Good Shepherd; National Alliance on Mental Illness; National Association for Health and Fitness; National Association of Area Agencies on Aging (n4a); National Association of Perinatal Social Workers (NAPSW); National Association of Social Workers; National Center for Lesbian Rights; National Center for Transgender Equality; National Consumers League; National Council of Jewish Women; National Council for Behavioral Health; National Disability Institute; National Disability Rights Network; National Family Planning & Reproductive Health Association; National Health Law Program; National Latina Institute for Reproductive Health; National LGBTQ Task Force; National Partnership for Women & Families; National Patient Advocate Foundation; National Respite Coalition; National Viral Hepatitis Roundtable; National Women's Health Network; NETWORK Lobby for Catholic Social Justice; Organizing for America; Out2Enroll; Planned Parenthood Federation of America; Public Citizen; Raising Women's Voices for the Health Care We Need; Religious Institute; RESULTS; Sargent Shriver National Center for Poverty Law; Service Employees International Union (SEIU); Society for Public Health Education; TASH; Third Way; Trust for America's Health; UnidosUS; Union for Reform Judaism; United Church of Christ, Justice & Witness Ministries; United Methodist Church—General Board of Church and Society URGE: Unite for Reproductive & Gender Equity; YWCA ZERO TO THREE.

MENTAL HEALTH LIAISON GROUP [1]

SEPTEMBER 1, 2017.

Hon. LAMAR ALEXANDER, *Chairman*,
Senate Health, Education, Labor, and Pensions Committee,
455 Dirksen Senate Office Bldg.,
Washington, DC 20510.

Hon. PATTY MURRAY, *Ranking Member*,
Senate Health, Education, Labor, and Pensions Committee,
154 Russell Senate Office Bldg.,
Washington, DC 20510.

Re: Stabilizing the Individual Health Insurance Marketplace

DEAR CHAIRMAN ALEXANDER AND RANKING MEMBER MURRAY: Thank you for leading a bipartisan effort to reform our health care system. With the HELP Committee's hearings on stabilizing the individual health insurance marketplace under the Affordable Care Act (ACA) scheduled for September, the Mental Health Liaison Group (MHLG) writes to offer our thoughts on issues associated with market stabilization that would likely have an impact on coverage of mental health and substance use disorder prevention and treatment services through marketplace plans. The MHLG is a coalition of more than 60 national organizations representing consumers, family members, mental health and substance use treatment providers, State behavioral health agencies, advocates, payers, and other stakeholders committed to strengthening Americans' access to mental health and substance use services and programs.

Particularly in light of the ongoing national opioid addiction epidemic, MHLG believes that ensuring the whole health of all Americans requires maintenance of coverage for mental health and substance use disorder benefits at parity with existing medical/surgical benefits in all marketplace plans. Maintenance of those benefits has little meaning without affordable and ready access to the plans providing that coverage. Ensuring affordable and ready access requires retention of the ACA's pro-

[1] National Organizations Representing Consumers, Family Members, Advocates, Professionals, and Providers c/o Laurel Stine, JD, American Psychological Association at *lstine@apa.org*. Angela Kimball, National Alliance on Mental Illness at *akimball@nami.org*., and Debbie Plotnick, MSS, MLSP, Mental Health America at *dplotnick@mentalhealthamerica.net*.

hibition against denying coverage based on a pre-existing condition, as well as the ACA's prohibitions against annual and life-time limits on coverage.

We oppose eliminating or reducing the cost-sharing reduction payments (CSRs) made to insurers to keep co-payments and co-insurance requirements low for plan members. Congress should fund the CSRs on a permanent basis to ensure insurers do not withdraw from markets, leaving low-income enrollees who are sicker or older—particularly those with mental illness and/or substance use disorders—without affordable coverage. So many individuals with serious mental illness and substance use disorders have limited-incomes that eliminating premium assistance and cost-sharing subsidies, thereby rendering coverage largely unaffordable, would—in essence—eliminate coverage for these essential services for many.

We also strongly believe, as we know you do, that Congress must act immediately to ensure that plans are available in each State-designated marketplace for the 2018 benefit year. Furthermore, mental health and substance use disorder benefit coverage must be preserved in marketplace plans, and should not be subject to State waivers of coverage or other existing ACA limitations under an expanded § 1332 waiver authority. We do not believe that individuals with a serious mental illness or substance use disorders should be denied coverage based on the State in which they reside, as would be the case should coverage vary from State-to-State under the proposed expanded waiver authority.

As a threshold matter, MHLG believes that mental health and substance use disorder benefit coverage must be preserved in all marketplace plans, and should not be subject to State waivers of ACA regulations or other existing ACA limitations under an expanded § 1332 waiver authority. We do not believe that individuals with a serious mental illness or substance use disorders should be denied coverage based on the State in which they reside.

In addition, the permitted range of premiums and deductibles—including the limits on age-banding of premiums—must remain as they currently exist so that plans cannot impose premiums so high for the provision of mental health and substance use disorder services that they become unaffordable to the individuals who most need them. We oppose reducing the Federal premium tax credits which lower income, non-Medicaid enrolled insureds have received from the Federal Government to maintain insurance coverage and which have, until now, averaged 72 percent of the cost of premiums.

We do not believe the answer to keeping coverage costs low is the short-term funding of a temporary Federal fund for State grants targeted toward subsidizing plan coverage for individuals with serious mental illness and/or a substance use disorder, as was contained in H.R. 1628. Such a fund would, within only a few years, be totally inadequate in meeting need for the populations that Congress worked to serve with the passage of the 21st Century Cures Act and the Comprehensive Addiction and Recovery Act (CARA) of 2016.

Moreover, it is important to remember that untreated serious mental illness and substance use disorders intensify and increase the number of comorbid medical conditions in individuals with those conditions, increasing total individual insurance coverage costs in the long-run. Those proliferating comorbid conditions and costs also have the potential to increase costs in the Medicaid program for individuals whose catastrophic health events leave them at income levels making them eligible for Medicaid.

MHLG recognizes that the individual personal responsibility coverage mandate is unpopular among some. However, the 30 percent premium surcharge that would have replaced the individual mandate under H.R. 1628 for failure to maintain continuous coverage is not an appropriate solution, as it would have a disproportionate impact on the lowest income enrollees who would have been struggling to maintain premium payments for coverage. It would be particularly destructive for those enrollees whose serious mental illness or substance use disorders often render them cognitively impaired and thus less capable of maintaining premium payment schedules until they recover, when the sizable surcharge would leave them unable to pick up coverage. Similarly, the waiting period for coverage after a failure to maintain continuous coverage included within the Senate amendments to H.R. 1628 would be particularly harmful for individuals struggling with addiction or serious mental illness who are left with no way to address those issues in the absence of access to insurance coverage.

We urge you to continue to protect these vulnerable Americans' access to and coverage of vital mental health and substance use disorder treatment and prevention services, and to not reverse the recent progress made with the enactment of key

mental health and substance use disorder prevention and treatment reforms under the 21st Century Cures Act and CARA.

Sincerely,

American Art Therapy Association; American Association of Child & Adolescent Psychiatry; American Association for Marriage and Family Therapy; American Association for Geriatric Psychiatry; American Association for Psychoanalysis in Clinical Social Work; American Association on Health and Disability; American Dance Therapy Association; American Foundation for Suicide Prevention; American Group Psychotherapy Association; American Mental Health Counselors Association; American Nurses Association; American Psychiatric Association; American Psychoanalytic Association (APsaA); American Psychological Association; American Society of Addiction Medicine; Anxiety and Depression Association of America; Association for Ambulatory Behavioral Healthcare; Bazelon Center for Mental Health Law; Campaign for Trauma-Informed Policy and Practice; Children and Adults with Attention-Deficit Hyperactivity Disorder (CHADD); Clinical Social Work Association; Clinical Social Work Guild 49-OPEIU; Depression and Bipolar Support Alliance; Eating Disorders Coalition; EMDR International Association; Global Alliance for Behavioral Health and Social Justice; International Certification & Reciprocity Consortium (IC&RC); Mental Health America; National Association for Children's Behavioral Health; The National Association of County Behavioral Health and Developmental Disability Directors (NACBHDD); The National Association for Rural Mental Health (NARMH); National Association of Social Workers; National Association of State Mental Health Program Directors (NASMHPD); National Alliance on the Mental Illness (NAMI); National Council for Behavioral Health; National Disability Rights Network; National Federation of Families for Children's Mental Health; National Health Care for the Homeless Council; National League for Nursing; National MS Society; National Register of Health Service Psychologists; No Health Without Mental Health (NHMH); Psychiatric Rehabilitation Association and Foundation; Residential Eating Disorders Consortium (REDC); School Social Work Association of America; Treatment Communities of America; Trinity Health of Livonia, Michigan; Young Invincibles.

AUGUST 10, 2017.

Hon. PATTY MURRAY, *Ranking Member*,
Senate HELP Committee,
154 Russell Senate Office Building,
Washington, DC 20510.

DEAR RANKING MEMBER MURRAY: In March, our organizations, representing some of the Nation's leading patient and provider advocacy groups, joined together to define a set of principles representing the essential components of any patient-focused health care reform plan.[1] These principles are specifically designed to protect the health and well-being of the millions of individuals we represent and their unique health care needs. The bills recently considered by the House and Senate contained provisions that would have had substantial and irreversible negative impacts on patients and their families, providers, communities, and economies. As Congress continues its efforts to reform the health care system, we urge policymakers to consider these principles and work in a bipartisan manner to craft proposals that improve access to care for our patients and strengthen the Nation's health system in the near and long term.

Today, millions of Americans, including many who are low-income or live with pre-existing health conditions, rely on health care coverage received through the Affordable Care Act (ACA). Our organizations have long said the ACA is by no means perfect, but it made important gains in access to coverage. It is clear that steps must be taken to both stabilize the individual health insurance marketplace and bring down premiums and other out-of-pocket costs. These changes are critical to maintain and expand access to quality and affordable insurance for low- and middle-income families across the Nation.

To this end, we believe that the current law can be strengthened by focusing on the following critical issues:

Cost-Sharing Reductions (*CSR*)

A top priority that must be addressed immediately is ensuring continued funding for the ACA cost-sharing reductions. In the absence of expedited Congressional ac-

[1] Health Care Reform Principles: *http://www.heart.org/idc/groups/heart-public/@wcm/@adv/documents/downloadable/ucm__495416.pdf.*

tion, additional insurers could exit markets very soon, leaving patients without coverage options while forcing premium increases of at least 19 percent both on and off the marketplace exchanges.[2]

Supporting Coverage in Counties Without Insurers

Congress should identify ways to ensure insurer participation on the exchanges in bare counties. For instance, leveraging the Federal Employee Health Benefits Program (FEHBP), which offers private insurance coverage to Federal employees in every county in the country, could help with this issue. Requiring private insurers who participate in FEHBP to issue insurance on the exchanges could be required as a condition for continued participation at the national level. Alternatively, waiving the insurer tax for issuers in counties without options could also be an appropriate stopgap measure.

Risk Reinsurance

Other key stabilization concepts Congress might consider include development of risk reinsurance proposals, akin to the program implemented in Alaska. Reinsurance reduces the risk to insurers of covering high-cost patients thus creating stability in the markets. This protects Americans from significant premium increases by offsetting the costs of sicker and more costly enrollees. We would also urge Congress to consider other innovative and financially sustainable risk mitigation proposals at either the State or Federal level.

Outreach

It remains imperative that the administration and Congress devote adequate resources to State health insurance marketplace outreach and enrollment to ensure all eligible Americans have the opportunity to sign up for health insurance coverage. We know States that devote robust resources to marketing, outreach, and enrollment assistance programs experience higher rates of enrollment than those that do not.[3] A focus on enrollment also helps ensure that more low-cost individuals obtain insurance on the State health insurance exchanges to help offset the costs of older, sicker patients. We would urge these activities also be coupled with actions to streamline the application and enrollment process.

Tax Credits

As members of both parties have noted, affordability remains a barrier for many Americans to purchase adequate insurance. While we recognize the challenge of increasing program costs, we would support increasing financial support for individuals and families by expanding income eligibility for health insurance tax credits. Many middle-income families struggle to afford coverage with increasing premiums, deductibles, and copays.

Long-Term Costs

While we agree that affordability at the individual and family levels is a serious hurdle to securing coverage, we would also encourage Congress to examine other major factors that contribute to the rising cost of health care, including the rising costs of many treatments. Much but not all of our Nation's health care spending is on the treatment of chronic disease, much of which can be prevented through evidence-based efforts. We urge you and your colleagues to work together to evaluate the root causes of these growing costs and address them directly.

Finally, while we remain ready to work on efforts to reduce unnecessary health care spending and costs and to improve the health insurance marketplace, this should not be done at the expense of ensuring access to quality care for all patients, including those who rely on the Medicaid program. Our organizations remain committed to retaining important patient protections including the ban on pre-existing conditions exclusions and premium rating, guaranteed issue, the prohibition on annual and lifetime benefit caps and continued coverage of critical essential health benefits. Essential health benefits must also continue as a Federal benefit and must include preventive benefits that help maintain and improve the health and wellness of millions of Americans. Finally, we urge Congress to maintain and support important health care safety net programs, such as Medicaid and the related Medicaid expansion.

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[2] C. Cox., What's the near-Term Outlook for the Affordable Care Act? (Kaiser Family Foundation, Aug. 2017). *http://www.kff.org/health-reform/issue-brief/whats-the-near-term-outlook-for-the-affordable-care-act/*.

[3] J. Wishner, I. Hill, S. Benatar et al., Factors that Contributed to High Marketplace Enrollment Rates in Five States in 2015 (Urban Institute, Oct. 2015). See also S.R. Collins, M. Gunja, M.

We look forward to working with Congress to ensure all Americans have access to affordable and adequate health care coverage.

Sincerely,

ALS Association; American Diabetes Association; American Heart Association; American Lung Association; Arthritis Foundation; Cystic Fibrosis Foundation; Family Voices; March of Dimes; Muscular Dystrophy Association; National Health Council; National MS Society; National Organization for Rare Diseases; United Way Worldwide; Women Heart: The National Coalition for Women with Heart Disease.

RESPONSE BY MIKE KREIDLER O.D., TO QUESTIONS OF SENATOR ALEXANDER, SENATOR BURR, SENATOR YOUNG, SENATOR ROBERTS, SENATOR WHITEHOUSE AND SENATOR FRANKEN

STATE OF WASHINGTON,
OFFICE OF INSURANCE COMMISSIONER,
OLYMPIA, WA 98501,
September 15, 2017.

Hon. LAMAR ALEXANDER, *Chairman*,
530 Hart Senate Office Building,
Committee on Health, Education, Labor, and Pensions,
U.S. Senate,
Washington, DC 20510.

DEAR CHAIRMAN ALEXANDER: Thank you for the opportunity to testify before the U.S. Senate Health, Education, Labor, and Pensions (HELP) Committee last week. It was an honor to participate in the first of your bipartisan hearings on health care reform. I appreciate the Senator's efforts to understand the priorities of State insurance regulators and to learn from our experience on the front line of the individual insurance market.

During the hearing, several members of the HELP Committee posed important questions to me from the dais. Please consider this letter, containing those questions and my answers, as a supplement to the hearing record.

I believe we can turn this market around and continue the successes we have enjoyed in Washington State. I have real hope that your committed efforts will result in bringing about the immediate relief all five insurance commissioners were unified in requesting: funding of the cost-sharing reduction payments through 2018, at the very least.

I'm happy to offer you any assistance that I can to develop long-lasting solutions for a stable insurance market this year, and beyond.

Sincerely,

MIKE KREIDLER,
Insurance Commissioner.

SENATOR ALEXANDER

Question. How can we use the 1332 waiver to allow States to benefit from reinsurance?

Answer. The benefit of a reinsurance program can be a solid reduction in premiums paid by the consumer. For example, in Washington State, the Federal transitional reinsurance program resulted in an 8–10 percent drop in average premiums (from 2014 through 2016, the years the program existed). A State reinsurance program should have the same effect, but the cost of funding it is prohibitive for many States. The 1332 waiver is a good mechanism to assist with the necessary funding, diverting realized Federal savings from advanced premium tax credits (APTC's) into dollars to support a State reinsurance program.

There are some challenges in pursuing a 1332 waiver. One is the length of time and the cost associated with the application process. And State legislators must make a commitment to fund the State reinsurance program without a specific Federal dollar commitment; this can be a political challenge, and a timing challenge for States with part-time legislatures.

The success of a State reinsurance program funded by a 1332 waiver is based upon predicted APTC savings. Alaska's 1332 waiver was very successful, in part because their premiums were very high, and they had only one insurer participating in the market. Here in Washington, we have an efficient health system with seven insurers in our State-based Exchange, and our premiums are significantly lower. We are actively working with a contractor now to analyze insurer data to predict the

potential premium impact of a reinsurance program. But without significant premium savings resulting in significant Federal funds, it is unlikely our State can independently implement the program.

SENATOR BURR

Question. What opportunity is there to stabilize the market with the purchase of multi-year plans?

Answer. Multi-year health insurance contracts are not currently permitted in any State, and there are significant obstacles to this option. Consumers would have to be willing to give up an annual choice of plan, and would likely require portability across State lines. Insurers might object to the possibility of decreased competition, if the cost of switching plans is too high, and could find it difficult to reliably predict future costs within the contract time period. Plans would have to be built with incentives for healthy consumers to stick to them.

Because of these obstacles, I would not consider multi-year health insurance contracts to be a meaningful stabilization strategy for the 2018, 2019 or 2020 plan year.

SENATOR YOUNG

Question. How can States increase transparency?

Answer. This year, Washington State will bring online an All-Payer Healthcare Claims database that will systematically collect all medical, pharmacy and dental claims from private and public payers, with data from all settings of care that permit the systematic analysis of health care delivery. This system will help patients, providers and hospitals make informed choices about care, and it will promote competition based on quality and cost.

However, a recent U.S. Supreme Court decision, *Gobeille* v. *Liberty Mutual Insurance Company*, found that ERISA preempts State attempts to require self-funded plans to submit data to a State's database. Congress could address that issue in Federal law; the result would be a significant increase in the data Washington could collect, to the benefit of consumers, providers and hospitals.

SENATOR ROBERTS

Question. Do you support increasing the 1:3 age band and why?

Answer. In 1995, our State set the mandated age ratio at 3.75:1. This level reflects what we believe was a fair balance of affordability for young and older enrollees. Upon passage of the Federal Affordable Care Act (ACA), we adopted the mandated average of 3:1. I would support a return to our State band of 3.75:1, but would not advocate for adoption of a broader band at this time.

Prior to the ACA, most States has a 5:1 age band ratio. A major concern with narrowing the band to 3:1 was the impact on younger purchasers—if the cost rises too high, young healthy people are more likely to stay out of the market. In our State, the impact on premiums for young people younger people was less evident (shifting only .75 percent). And the impact of the rise in premium was cushioned by the temporary Federal reinsurance program that dropped Washington State rates by 8 to 10 percent. Younger enrollees, many of whom have lower incomes, also received significant support in the form of APTCs and cost-sharing subsidies. But even under these favorable conditions, the enrollment of younger people was less than we had hoped.

Widening the age band might lead to incremental differences in premiums for younger enrollees, but I'm not convinced it will make the difference in bringing them into the insurance market Congress should focus on keeping and enforcing the individual mandate, and increasing penalties as contemplated by the ACA for those who stay out of the market, until the decision to enroll becomes the clearly better financial choice.

SENATOR WHITEHOUSE

Question. What standards would a new insurer need to meet to do business in Washington State? How would you feel about an insurer who wanted to do business but couldn't meet those standards?

Answer. Washington has a business-friendly climate with a Top–10 ranking among States in a recent Forbes magazine survey of "The Best States for Business." Our regulatory environment is fair and reasonable, and we use the National Association of Insurance Commissioners (NAIC) Uniform Certificate of Authority Application (UCAA) forms to review and process applications from insurance companies quickly.

We are committed to a thorough review of potential health insurers to ensure that companies can provide the level of quality and commitment we want for our residents. In addition to the UCAA requirements, Washington State law requires that we request documentation of net worth, geographic areas and population groups to be served, schedules of proposed rates and charges, and detailed descriptions of almost every business process—from the enrollee complaint system to the health care delivery system—to ensure that services will meet State law requirements and will be of professional quality.

Washington is an active rate review State; once a health insurer is admitted in our State to sell to Washington consumers, we review *all* filed plans and rates to be sure they are actuarially justified and meet our State requirements.

Washington has a long history of strong consumer protections, and many of our requirements are not found in the laws of other States. I would not allow an insurer to do business here that did not meet our requirements, and the prospect of lowering the high standards for quality and service we receive from our currently admitted insurers would be a big concern.

SENATOR FRANKEN

Question. What can we do to bring prescription drug costs under control?

Answer. The skyrocketing cost of prescription drugs directly impacts people who purchase insurance, by driving up premiums and hitting their out-of-pocket expenses in co-insurance.

One of the most important things we could do is prohibit "pay for delay" deals between dealers of name brand and generic drugs. Generics are important to cut costs, and consumers want them. We should not permit drug companies to keep them off the market.

We should also demand increased transparency from drug companies. Purchasers should be able to understand the true cost of drug research and development. Consumers should be able to see prices, including those charged to Medicare and other countries. The current pharmacy supply chain, from manufacturer to pharmacist, should be clearly documented, so we can find potential savings from transactional costs.

RESPONSE BY MIKE KREIDLER, O.D. TO QUESTIONS OF SENATOR WHITEHOUSE

STATE OF WASHINGTON,
OFFICE OF INSURANCE COMMISSIONER,
TUMWATER, WA 98501,
October 11, 2017.

Hon. SHELDON WHITEHOUSE,
530 Hart Senate Office Building,
U.S. Senate,
Washington, DC 20510.

Re: U.S. Senate Health, Education, Labor, and Pensions Committee Hearing—*Stabilizing Premiums and Helping Individuals in the Individual Insurance Market for 2018: State Insurance Commissioners*

DEAR SENATOR WHITEHOUSE: Thank you for the opportunity to respond to questions you posed during the U.S. Senate Health, Education, Labor, and Pensions Committee hearing on September 6, 2017.

I am pleased and heartened by the bipartisan efforts to improve health care delivery and insurance market stability in our States. Washington, in particular, has long embraced efforts to find innovative ways to deliver quality health care through stable insurance markets.

I appreciated the opportunity to share our State's history regarding the individual insurance market; your questions raise other areas where I hope Washington's experience can be of assistance.

Attached are your questions with my responses. I hope these prove to be helpful to you. I would be happy to provide additional information, should you need it.

Sincerely,

MIKE KREIDLER,
Insurance Commissioner.

Question 1. Following the HELP Committee's work to stabilize the individual market, I hope the committee will move on to other efforts to address cost and im-

prove quality in our health care system. I believe the following areas are ripe for bipartisan collaboration:

a. Improving patient safety by preventing medical errors and healthcare-acquired infections;

b. Addressing the dramatic variations in care quality and outcomes across States;

c. Identifying ways to reduce administrative overhead and dispute, specifically the bureaucratic warfare between insurance companies and providers over reimbursement;

d. Ensuring that a patient's wishes are honored at the end of his or her life; and

e. Advancing payment reform to encourage prevention and primary care.

Which of these areas should be a priority for the HELP Committee going forward? What strategies would you suggest to lower costs and improve quality in these areas? Is there innovative work in your States and communities that you would like to highlight?

Answer 1. Each of the areas you have identified have the potential to lower costs and improve quality. We have done significant work in Washington State to improve patient safety and the payment system, and to reduce administrative overhead and reimbursement disputes. Below are illustrations of some programs that have provided good results for our State.

IMPROVE PATIENT SAFETY

Washington has adopted several programs into law that require reporting of incidents to allow State oversight and intervention.

Adverse Health Events and Incident Reporting System. Washington State law (Chapter 70.56 RCW) requires healthcare facilities to report to the Washington State Department of Health whenever they confirm an adverse event, as defined by the National Quality Forum. Facilities required to report include psychiatric hospitals, State correctional medical facilities, ambulatory surgical facilities, and child birthing centers. Facilities that report an adverse event are required to conduct a root cause analysis and identify corrective actions. This requirement is intended to address prevention of such events in the future.

Healthcare Associated Infections Program. This program requires hospitals to report infection information to the Washington State Department of Health, which annually produces an interactive map and reports comparing hospital infection rates for central line-associated bloodstream infections, surgical site infections and ventilator-associated pneumonia. (See *www.doh.wa.gov,* Healthcare Association Infections).

PAYMENT REFORM

We recognize the need for an objective comparative standard for medical service pricing. In January 2018, Washington State will implement an All Payer Claims database. (See *Health Care—Price Transparency Health Care*). The database will assist consumers in making informed choices about health care, promote improvements in health care performance, and enable purchasers to increase their value-based purchasing activities. Reports will include claims data from Medicaid, Medicare, State employee health benefits, our State's workers' compensation medical program, and commercial health insurers regulated by my office.

At this point, submission of claims data from self-funded employer-sponsored group health plans and Taft-Hartley plans is voluntary, based on the U.S. Supreme Court's ruling that ERISA's preemption clause prevents States from requiring self-funded group health plans to submit claims data to State all-payer claims databases. (See *Gobeille* v. *Liberty Mutual*). In the interests of transparency and payment reform, a bipartisan discussion on the possibility of mandating self-funded group health plans participation in State databases would be very welcome.

We also recognize that, as a major purchaser, the State can be a positive force for system change. Currently, our State Medicaid program and our State employee health benefit program are integrating strategies to implement value-based purchasing and behavioral health integration goals. Our "Healthier Washington Initiative" has goals of building healthier communities through a collaborative regional approach, integrating physical and behavioral health services and financing to focus on the whole person, and improving how we pay for services by rewarding quality over quantity. (See *Healthier Washington—Washington State Health Care Authority*).

The initiative is taking a multi-payer approach. We have developed a common performance measure set and are working to implement value-based payment reforms. Washington State participates in the CMS Medicare/Medicaid dual-eligible demonstration and has implemented a Medicaid State plan health home program

as a key component of our duals demonstration participation. (*Washington—Centers for Medicare & Medicaid Services*). Evaluation results for the first 2 years of the demonstration show Medicare savings of $67 million.

Last, as you know, Washington is a full rate review State, meaning that we closely review proposed health insurance premium rates to ensure that the premiums charged reflect the benefits that are provided under a health plan. We have seen continued increases in underlying health care costs, particularly with respect to prescription drug expenditures. Any bipartisan discussions related to prescription drug pricing would be a high priority.

REDUCE ADMINISTRATIVE OVERHEAD AND REIMBURSEMENT DISPUTES

We have also focused on establishing uniform and streamlined administrative processes for the health care and insurance community, aimed at reducing the potential for error, and improving care quality and outcomes. My office partners in this effort with an organization called OneHealthPort, a Washington cooperative owned by health plans and health care providers. The goal of OneHealthPort is to reduce administrative burdens by making information exchange more efficient, with fewer errors, and to develop and recommend best practices for providers and health plans. This year, my office adopted rules, for example, to standardize processes across insurers for prior authorization.

This year, I am re-introducing a bill designed to protect consumers from payment disputes between insurers and providers who are out of network. When consumers receive care from an out-of-network provider in an emergency or in an in-network facility, they can receive a bill from the provider for any balance due over what the insurer has paid. This "surprise bill" happens frequently, and the average bill is under $1,000.00. The solution is passing a law to take the consumer out of the middle, and establishing a predictable payment rate for the provider along with a fair and objective resolution process.

Question 2. If an insurance company came to you proposing to sell health insurance in your State, what steps, such as setting up a provider network, would you expect or require that insurer to take before you authorize the insurer to sell health insurance policies in your State?

Answer 2. We would expect all insurance companies to meet our stringent requirements. Washington State has a strong history of consumer protection reflected in the requirements that insurers must meet to be admitted to sell health insurance in our State. We have adopted the National Association of Insurance Commissioners' (NAIC) Uniform Certificate of Authority Application. We go beyond the NAIC's requirements in two critical ways central to consumer protection: requirements for financial solvency and provider network adequacy.

Washington State's financial solvency requirements set minimum net worth requirements for health insurers that must be met in order to sell insurance in our State. For example, health care service contractors (e.g. our Blue Cross and Blue Shield insurers) must have a minimum net worth equal to the greater of 3 million dollars, or 2 percent of the annual premium earned on the first $150 million of premium earned and 1 percent of premiums earned in excess of $150 million (RCW 48.44.037). The insurer must maintain this minimum solvency standard (RCW 48.44.039). A similar requirement applies to health maintenance organizations (RCW 48.46.235–.247).

Equally important, Washington State has strong provider network adequacy standards. As I am sure you are aware, in the face of rising underlying health care costs, especially for prescription drugs, and the uncertainty facing the individual health insurance market overall, we have seen a trend of insurers moving away from preferred provider organization health plans with broad provider networks to exclusive provider organization or HMO plans. By design, these health plans offer a somewhat narrower network of providers in an effort to offer more affordable premiums and cost-sharing. A consequence of that movement is that our network adequacy rules have become even more critical.

My agency has promulgated regulations that address both qualitative and quantitative standards for provider network adequacy. The qualitative standard is as follows:

1. An insurer must maintain each provider network for each health plan in a manner that is sufficient in numbers and types of providers and facilities to assure that, to the extent feasible based on the number and type of providers and facilities in the service area, all health plan services provided to enrollees will be accessible in a timely manner appropriate for the enrollee's condition. An insurer must demonstrate that, for each health plan's defined service area, a comprehensive range of

primary, specialty, institutional, and ancillary services are readily available without unreasonable delay to all enrollees, and that emergency services are accessible 24 hours per day, 7 days per week without unreasonable delay.

2. Each enrollee must have adequate choice among health care providers, including those providers which must be included in the network under Washington Administrative Code (WAC) 284–170–270, and for qualified health plans and qualified stand-alone dental plans, under WAC 284–170–310.

Our quantitative standards include minimum distance and appointment time standards for primary care providers, as well as appointment time standards for urgent appointments and specialty services (WAC 284–170–200(13)). Washington State also has a strong mental health parity statute. To ensure its robust implementation, we have adopted clear standards regarding the types of behavioral health services that must be included in provider networks (WAC 284–170–200(11)).

Question 3. What concerns would you have about an insurance company coming to your State that was not prepared to create a provider network or complete any other steps you may require?

Answer 3. I would have extremely strong concerns regarding an insurance company coming to Washington State that was not prepared to create a provider network or complete other steps required for an insurance company to do business in our State. As described above, the Washington State Legislature and my office have defined minimum standards beyond those included in the NAIC uniform application. Those requirements were established to protect consumers in our State. While I respect the right of other States to set their own standards for insurers that do business in their States, our ability to maintain strong consumer protection standards is critical.

RESPONSE BY LORI K. WING-HEIER TO QUESTIONS OF SENATOR ALEXANDER

DEPARTMENT OF COMMERCE,
COMMUNITY, AND ECONOMIC DEVELOPMENT,
DIVISION OF INSURANCE,
JUNEAU, AK 99811–0805,
October 10, 2017.

Hon. LAMAR ALEXANDER, *Chairman*,
Senate Committee on Health, Education, Labor, and Pensions,
U.S. Senate,
Washington, DC 20510–4704.

Re: U.S. Senate, Committee on Health, Education, Labor, and Pensions "Stabilizing Premiums and Helping Individuals in the Individual Insurance Market for 2018: State Insurance Commissioners"

DEAR SENATOR ALEXANDER: Following my testimony on September 6, 2017, in the referenced committee hearing, Senator Sheldon Whitehouse posed several questions for the record to me. The questions and my responses for the record are listed below:

Question 1. Following the HELP Committee's work to stabilize the individual market, I hope the committee will move on to other efforts to address cost and improve quality in our health care system.

I believe the following areas are ripe for bipartisan collaboration:

a. Improving patient safety by preventing medical errors and healthcare-acquired infections;

b. Addressing the dramatic variations in care quality and outcomes across States;

c. Identifying ways to reduce administrative overhead and dispute, specifically the bureaucratic warfare between insurance companies and providers over reimbursement;

d. Ensuring that a patient's wishes are honored at the end of his or her life; and

e. Advancing payment reform to encourage prevention and primary care.

Which of these areas should be a priority for the HELP Committee going forward? What strategies would you suggest to lower costs and improve quality in these areas? Is there innovative work in your States and communities that you would like to highlight?

Answer 1. Improving patient safety and quality care are important health care priorities, but the Alaska Division of Insurance's regulatory authority does not generally encompass items a, b or d.

Addressing the underlying cost of health care insurance coverage is key to meaningful reform. Alaska experiences a lack of provider competition in many regions; therefore, insurance companies have little to no leverage when negotiating contracts. The goal of insurance companies in connection with these pricing contracts is to keep the premium levels in check so that coverage is more affordable and competitive. Through medical loss ratio standards, health care insurers are closely monitored to ensure that pricing for services is based on the actual cost of care and that profit margins are maintained at reasonable levels. However, health care medical service providers and health care providers engaged in manufacturing and distribution of pharmaceutical and other health care equipment do not have a similar form of cost control oversight in private markets. Establishing standards to streamline reimbursement between insurance companies and providers through more transparent pricing structures coupled with limitations to curb price gouging and excessive profits could help to control costs and greatly improve the affordability of health care insurance coverage.

Regarding patient's wishes at the end of life, we would refer you to La Crosse Wisconsin for their efforts. [1]

The common theme for preventive care is that reimbursements are not focused on the dialog between a primary care provider and their patient. Other items that are not health related but can later produce costly medical expenses, especially behavioral health, include social determinants.

Question 2. If an insurance company came to you proposing to sell health insurance in your State, what steps, such as setting up a provider network, would you expect or require that insurer to take before you authorize the insurer to sell health insurance policies in your State?

Answer 2. The first step would require the health care insurer to apply for a certificate of authority under AS 21.09.110. In addition to financial statements necessary to evaluate the company's solvency and financial history, the company would be required to file policy forms and rate approval request and receive prior approval from the Alaska Division of Insurance before selling health insurance policies in Alaska.

Question 3. What concerns would you have about an insurance company coming to your State that was not prepared to create a provider network or complete any other steps you may require?

Answer 3. The division's primary concern is to protect consumers by ensuring an insurance company's financial solvency to pay claims.

Question 4. As you know, Alaska chose to base the eligibility criteria for its reinsurance program on a list of 33 specific medical conditions rather than a dollar amount based on claims. You stated during the hearing that using conditions to determine eligibility for the reinsurance program would make the "biggest impact" to stabilize the market. Why did eligibility based on conditions lead to a "bigger impact" than setting up a reinsurance program based on by a dollar amount?

Answer 4. By establishing qualification based on 33 known significant medical conditions, Alaska was able to define an objective measure based upon market experience and projected risk. The focus has centered upon chronic conditions since they are costs that are expected to continue year after year. Random accidents that result in significant medical costs do not necessarily belong in a separate risk pool.

Question 5. You stated that setting up a reinsurance program was better suited for stabilizing Alaska's individual market than a high-risk pool. What aspects of a reinsurance program make it more effective than a high-risk pool in Alaska's case?

Answer 5. Alaska's high risk pool administrator, Alaska Comprehensive Health Insurance Association, previously handled condition-based eligibility, so this was an easier transition than a dollar-level based reinsurance program.

Question 6. How, if at all, does Alaska plan to reevaluate eligibility for its reinsurance program? Will the State review the effectiveness of its conditions list at insulating individual market from the highest cost patients? Is there a mechanism by which the conditions list can be modified in the future?

Answer 6. Yes, the Division plans on reviewing the conditions as experience develops. The modifications would be made through State regulation.

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[1] *http://www.npr.org/sections/money/2014/03/0S/286126451/living-wills-are-the-talk of-the-town-in-la-crosse-wis.*

Question 7. Does Alaska's reinsurance program absorb 100 percent of the claims cost for an eligible individual-market enrollee once that enrollee has been ceded to the reinsurance program? Is there a cap on the reimbursement provided to insurers for the claims of eligible enrollees?

Answer 7. Yes, that's correct, the Alaska reinsurance program (ARP) will receive 100 percent of the claims for an individual who has one of the eligible medical conditions. There is no cap on individual reimbursement. The total reimbursement to insurers is based on the trended contribution from 2017 per actuarial modeling. SSSM trended approximately 10 percent per year is the expected allocation for the reinsurance program.

Question 8. From a patient's perspective, are there any differences in benefits and/or cost-sharing for those in the reinsurance program and those who are not?

Answer 8. No, the ARP consumers will not have any difference from non-ARP individuals.

I am grateful for the bipartisan efforts of the Senate Committee on Health, Education, Labor, and Pensions to establish solutions to help stabilize individual health care insurance markets and ensure access to quality, affordable health care. Thank you for the opportunity to contribute ideas for consideration as you work to find solutions for so many Americans.

RESPONSE BY JULIE MIX MCPEAK TO QUESTIONS OF SENATOR WHITEHOUSE

Question 1. Following the HELP Committee's work to stabilize the individual market, I hope the committee will move on to other efforts to address cost and improve quality in our health care system.

I believe the following areas are ripe for bipartisan collaboration:

a. Improving patient safety by preventing medical errors and healthcare-acquired infections;

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c. Identifying ways to reduce administrative overhead and dispute, specifically the bureaucratic warfare between insurance companies and providers over reimbursement;

d. Ensuring that a patient's wishes are honored at the end of his or her life; and

e. Advancing payment reform to encourage prevention and primary care.

Which of these areas should be a priority for the HELP Committee going forward? What strategies would you suggest to lower costs and improve quality in these areas? Is there innovative work in your States and communities that you would like to highlight?

Answer 1. As I mentioned in my written testimony, a direct causal relationship exists between the costs of health care services and the costs of health insurance. After, hopefully, approving Cost Sharing Reduction (CSR) funding to stabilize individual markets, the HELP Committee should address both the short-term as well as long-term factors contributing to our current health care landscape. As my Governor stated in his testimony before the HELP Committee on September 7,

> "ultimately making health care more affordable involves looking at a variety of factors which contribute to the high cost of health care, including exploring incentive programs which focus on the quality of patient care."

Additionally, the committee could explore strategies to contain rising pharmaceutical costs as well as review ways in which transparency of costs could contribute to reductions in health care costs. The HELP Committee could look at ways to incent wellness and prevention initiatives or transparency measures surrounding health care costs.

Addressing items b and e above, Tennessee has been among the Nation's chief innovators in establishing an episode-based payment structure in our Medicaid program that is expanding into the commercial market. The episodes of care model rewards high-quality care and reduces ineffective and/or inappropriate care by aligning provider payment incentives with successful patient outcomes. Payment methodologies which aim to group health care services into episodes, if implemented appropriately with timely and adequate disclosures of metrics to physicians, have the potential to reduce costs and improve patient outcomes. Of course, as mentioned earlier, incenting consumers to make healthier choices could also have a positive impact on the health of our constituencies.

Question 2. If an insurance company came to you proposing to sell health insurance in your State, what steps, such as setting up a provider network, would you expect or require that insurer to take before you authorize the insurer to sell health insurance policies in your State?

Answer 2. The most important factor that we, as insurance regulators, review when considering company applications is the solvency of the company; i.e. whether the company has sufficient resources to pay claims. Upon receipt of an application for licensure, the Department reviews the suitability and experience of company management, company risk controls, and the information technology capabilities of the company to ensure that the internal operations can support the complexity of its business. This process, which would lead to the issuance of a license, is distinct from the review of policy forms and rates but can be performed simultaneously. It is important to note, however, that a company may not write any health insurance business until its plans and rates have been approved by the Department.

The Department reviews proposed policies for compliance with State and Federal law during the rate review process. The review of forms also confirms that a carrier has adequate provider networks; typically, that those networks have gone through the adequacy review process of a national accrediting body. At the same time, we work with actuaries to review rates to ensure that they are not excessive, insufficient, or unfairly discriminatory.

Fortunately, Tennessee has experience this year with a company that came to the Department proposing to sell health insurance on the federally facilitated marketplace. While their coverage area is limited to one service area, this still was a bit of welcome news, as our consumers had previously witnessed carriers withdraw from offering health insurance policies throughout our State.

Question 3 What concerns would you have about an insurance company coming to your State that was not prepared to create a provider network or complete any other steps you may require?

Answer 3. The Department would not license a company that we did not believe would have sufficient resources to pay claims. Further, we do not approve policy forms or rates until filings satisfactorily meet State and Federal requirements, including network adequacy provisions. In theory, a company could be licensed by the Department but not authorized to write insurance. The company must meet both financial standards and regulatory requirements before it can offer health policies to consumers. This Department is dedicated to the protection of Tennessee's insurance consumers, and we expect and require insurance carriers to be able to meet their promises to policyholders.

RESPONSE BY TERESA MILLER, J.D., TO QUESTIONS OF SENATOR WHITEHOUSE

Question 1. Following the HELP Committee's work to stabilize the individual market, I hope the committee will move on to other efforts to address cost and improve quality in our health care system.

I believe the following areas are ripe for bipartisan collaboration:

a. Improving patient safety by preventing medical errors and healthcare-acquired infections;

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d. Ensuring that a patient's wishes are honored at the end of his or her life; and

e. Advancing payment reform to encourage prevention and primary care.

Which of these areas should be a priority for the HELP Committee going forward? What strategies would you suggest to lower costs and improve quality in these areas? Is there innovative work in your States and communities that you would like to highlight?

Answer 1. I wholeheartedly agree with you that we need to have a true national dialog about health care costs, and how we can rein in the unsustainable growth of those costs without sacrificing quality and innovation. While some of the solutions may be national and others may be better implemented by States themselves, this is certainly an area where I believe we can work across the aisle and seek bipartisan solutions. With that in mind, I want to highlight some of the steps already being taken by States, and particularly by Pennsylvania with these critical goals in mind:

Several states have enacted and operationalized all-payer claims database (APCD) laws. These databases are designed to inform cost containment and quality improvement efforts by providing service-level information such as charges and payments, the provider(s) receiving payment, clinical diagnosis and procedure codes, and patient demographics.

Governor Wolf included an APCD as part of his fiscal year 2017–18 proposed budget, and Pennsylvania's General Assembly is currently considering APCD legislation, which has achieved support from republicans and democrats alike. Policy-

makers, payers, providers, and patients could all use APCD data to better drive, deliver, and seek out value in the healthcare system. The committee could consider supporting the States in this effort to increase cost and quality data transparency through support of funding for States to establish APCDs and by addressing Federal impediments to cost transparency, in particular by working with the Department of Labor to ensure that States have access to data from self-insured plans, which cover approximately a third Pennsylvanians.

Reimbursement and provider contracting remains a critical part of building an adequate network. One area of interest for many States, including Pennsylvania, is reimbursement for services received by an out-of-network provider, particularly in cases of "surprise billing." A handful of States have enacted legislation related to out-of-network reimbursement, and, in Pennsylvania, we have been working with interested parties to determine how best to address the issue. In fact, a proposal to resolve surprise billing has now been introduced in both chambers of the Pennsylvania legislature with bipartisan sponsorship.

Pennsylvania's Department of Human Services is also working to move our healthcare system away from predominantly focused fee-for-service payment arrangements and more toward alternative payment arrangements that are focused on value and outcomes. These are arrangements that incentivize the healthcare system and our providers to deliver on the triple aim: better care, better health, and lower costs. As just one example, we have established targets for our Medicaid managed care organizations to increase their use of value-based payments, and are working to establish similar targets in our other program areas.

Pennsylvania's Department of Health is also leading an innovative initiative in collaboration with Medicare, Medicaid, and private insurers to transform the way that rural hospitals are paid for care. Participating hospitals will be paid using all-payer global budgets, which are set annually, rather than on a fee-for-service basis. This will provide stable financing for rural hospitals, a critical community asset, while allowing them to transform care delivery to increase their focus on prevention and care management.

Support from the Centers for Medicare and Medicaid Innovation (CMMI) has been vital in this initiative, and Pennsylvania looks forward to continuing the partnership with CMMI.

Question 2. If an insurance company came to you proposing to sell health insurance in your State, what steps, such as setting up a provider network, would you expect or require that insurer to take before you authorize the insurer to sell health insurance policies in your State?

Answer 2. Companies must obtain a license from the Insurance Department to do business in the State and have their provider networks certified by the Department of Health as adequate. The licensure process is critical in protecting consumers and serving the greater public interest. Health insurance companies, along with other regulated entities, must provide information such as biographical data, a business plan, capital and surplus requirements, and proof of adequate networks to be licensed to sell insurance in Pennsylvania. We also review certain policy forms and rates prior to the sale of the policy. While we recognize that these requirements represent an administrative burden, we endeavor to streamline the process for insurers by coordinating our regulatory oversight with those of other States through use of NAIC models, best practices, and established national standards. To that end, the requirements of a health insurance company seeking to sell insurance in Pennsylvania will experience, and be able to leverage, processes that are similar to the States in which they already sell insurance.

Question 3. What concerns would you have about an insurance company coming to your State that was not prepared to create a provider network or complete any other steps you may require?

Answer 3. The steps we require for companies to sell health insurance are important to ensure consumers are protected and will ultimately have their claims paid. It's not easy to be a health insurer, particularly balancing solvency (and profits) with consumer service and affordability. Establishing provider networks is, without question, the biggest obstacle for insurers who want to do business in a new State. It's not easy working with all the hospitals, doctors, clinics and other health care providers to ensure consumers will have access to quality care and the doctors they want. But, it's critically important for consumers who will be purchasing insurance that they have access to services they need. Access to these networks, however, comes at a price, and better negotiated rates in provider contracts means better premium rates for consumers. This requires that companies strike a balance with providers such that providers are given adequate and fair reimbursement (including ac-

knowledgement of volume discounts, actual cost of care, etc.), and that consumers have access to affordable care from a network that is able to meet their needs.

We have heard a lot about a proposal that would allow insurers to sell health insurance "across State lines." Proponents claim such a proposal would increase competition and reduce costs for consumers. While these are laudable goals, this proposal simply ignores the fundamental nature of how health insurance works. It assumes the barrier to entry for companies wanting to expand their footprint into new States is the license they need to obtain from the insurance department. As noted above, through established national standards and shared best practices, many State insurance regulators have streamlined the process to be licensed. However, if you ask health insurance companies why they don't expand their footprints (including companies who only do business in limited areas within a State), they will tell you how difficult it is to establish the provider networks needed to offer quality coverage.

[Whereupon, at 12:55 p.m., the hearing was adjourned.]