STRENGTHENING OUR HEALTHCARE SYSTEM: LEGISLATION TO LOWER CONSUMER COSTS AND EXPAND ACCESS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE
HOUSE OF REPRESENTATIVES

ONE HUNDRED SIXTEENTH CONGRESS

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C O N T E N T S

WITNESSES

SUBMITTED MATERIAL

STRENGTHENING OUR HEALTHCARE SYSTEM: LEGISLATION TO LOWER CONSUMER COSTS AND EXPAND ACCESS

WEDNESDAY, MARCH 6, 2019

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

The subcommittee met, pursuant to call, at 10:00 a.m., in the John D. Dingell Room 2123, Rayburn House Office Building, Hon. Anna G. Eshoo (chairwoman of the subcommittee) presiding.

Members present: Representatives Eshoo, Butterfield, Matsui, Castor, Luján, Schrader, Kennedy, Cárdenas, Ruiz, Dingell, Kuster, Kelly, Barragán, Blunt Rochester, Rush, Pallone (ex officio), Burgess (subcommittee ranking member), Upton, Shimkus, Guthrie, Griffith, Bilirakis, Long, Bucshon, Brooks, Carter, Gianforte, and Walden (ex officio).

Also present: Representatives Peters and Soto.

Staff present: Jacquelyn Bolen, Health Counsel; Jeff Carroll, Staff Director; Tiffany Guarascio, Deputy Staff Director; Zach Kahan, Outreach and Member Service Coordinator; Saha Khaterzai, Professional Staff Member; Una Lee, Chief Health Counsel; Samantha Satchell, Professional Staff Member; Andrew Souvall, Director of Communications, Outreach, and Member Services; Sydney Terry, Policy Coordinator; C. J. Young, Press Secretary; Mike Bloomquist, Minority Staff Director; Adam Buckalew, Minority Director of Coalitions and Deputy Chief Counsel, Health; Margaret Tucker Fogarty, Minority Staff Assistant; and J. P. Paluskiewicz, Minority Chief Counsel, Health.

Ms. ESHOO. Good morning, everyone. Welcome to the witnesses. The Chair now recognizes herself for 5 minutes for an opening statement.

OPENING STATEMENT OF HON. ANNA G. ESHOO, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Today is the second legislative hearing of the Health Subcommittee in the 116th Congress. We are going to examine legislation today to drive down costs and increase options in the private insurance markets created by the Affordable Care Act.

Democrats made a promise to the American people to lower their healthcare costs and undo the Trump administration sabotage of the ACA. Today we are continuing to deliver on that promise by

examining legislation that creates a reinsurance program for all States, funds States that did not initially set up State-based insurance marketplaces to set up these State-run private exchanges, and restore funding for patient navigators.

If an individual is not enrolled in Medicare or Medicaid, does not get their insurance through their employer, or is a small business owner or self-employed, the legislation we are considering today will help bring down the cost of health insurance. The bill gives States the funding and flexibility to improve the private marketplaces created by the ACA and increase choices for Americans who purchase their health insurance from these exchanges.

Representatives Angie Craig and Scott Peters have written a bill which provides funding for State-based reinsurance programs and establish a Federal reinsurance program similar to the one established in the Affordable Care Act that expired in 2016, so all Americans can benefit from lower premiums in the individual marketplace. Reinsurance programs add money to the health insurance market created by the ACA to cover the costs of patients with high medical costs such as those with preexisting conditions.

This will drive down costs for middle-class Americans who don't receive the ACA tax credit. By providing payments that enroll high cost patients, many of whom have preexisting conditions, reinsurance protects against premium increases and will bring down the cost of health insurance coverage for those who buy their insurance from ACA exchanges. For anyone who cannot afford health insurance on the private market today, this bill will bring premiums down next year and help individuals afford high quality, comprehensive coverage.

We will also examine the bipartisan SAVE Act introduced by Representatives Andy Kim and Brian Fitzpatrick which provides funding to States to set up State-based insurance marketplaces like the original ACA did. I am very proud of Covered California that is California's State-based insurance market. I think it is the gold standard for these programs and currently has enrolled 1½ million Californians. That is a lot of human beings that have coverage today that never had coverage before. If a State originally chose not to establish their own State-based marketplace when the ACA became law, this bill gives those States the funding they need to establish a marketplace that meets their needs while maintaining the minimum benefits established by the ACA.

Lastly, we will consider Representative Castor's ENROLL Act. It provides funding for navigators who assist small businesses or self-employed individuals with guidance and information to determine the best health insurance option for their needs.

[The prepared statement of Ms. Eshoo follows:]

PREPARED STATEMENT OF HON. ANNA G. ESHOO

Good morning everyone, welcome to the witnesses. The Chair now recognizes herself for 5 minutes for an opening statement. Today is the second legislative hearing of the health subcommittee in the 116th Congress. We're going to examine legislation today to drive down costs and increase options in the private insurance markets created by the Affordable Care Act.

Democrats made a promise to the American people to lower their healthcare costs and undo the Trump administration's sabotage of the ACA.

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Representatives Angie Craig and Scott Peters have written a bill which provides funding for State-based reinsurance programs and establishes a Federal insurance program similar to the one established in the Affordable Care Act that expired in 2016 so all Americans can benefit from the lower premiums in the individual marketplace.

Reinsurance programs add money to the health insurance market created by the ACA to cover the cost of patients with high medical costs such has those with preexisting conditions. This will drive down costs for middle-class Americans who don't receive the ACA tax credit.

By providing payments that enroll high cost patients, many of whom have preexisting conditions, reinsurance protects against premium increases and will bring down the cost of health insurance coverage for those who buy their insurance from ACA exchanges.

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Lastly, we will consider Representative Castor's ENROLL Act. It provides funding for navigators who assist small businesses or self-employed individuals with guidance and information to determine the best health insurance option for their needs.

I promised that I would yield a minute of my time to Congressman Ben Ray Luján. I'm happy to yield to the gentlemen from New Mexico for the remaining time.

Ms. ESHOO. I promised that I would yield a minute of my time to Congressman Ben Ray Luján. Is Ben Ray here? Yes, he is. So I am happy to yield to the gentleman from New Mexico for the remaining time.

Mr. LUJÁN. Thank you, Madam Chair. Democrats made a commitment to the American people that we would lower their healthcare costs, and with their support we are now in the majority. It is the expectation of the American people that we move forward in a bipartisan way to address this major issue. Ms. Craig's and Mr. Peters' bill is strong. In fact, the bill is modeled after the reinsurance program that made its debut in the Republican repeal effort.

Now what I am concerned about is what we will hear today is that congressional Republicans are more focused on interjecting an abortion fight into an unrelated debate, that they are making sure families can't see their doctors. I do not understand that, but what I do know is the Democrats are going to forge ahead in our goal to lower healthcare costs for the American people.

I am ready and willing to work with my colleagues across the aisle when they want to join forward in this progress. I thank the Chair and I yield back.

Ms. ESHOO. I thank the gentleman.

The Chair now recognizes Dr. Burgess, the ranking member of the subcommittee, for 5 minutes for his opening statement.

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

Mr. BURGESS. Well, thank you for the recognition and thanks to our witnesses. Today we are convened to discuss, according to the title of this hearing, legislation to lower consumer costs and expand access to healthcare. Legislation that my friends on the other side of the dais have put forth today is once again disappointing. I do believe there are some areas where we could have worked together, particularly on the area of reinsurance, but there was no effort to work in a bipartisan way on that issue.

Republicans have supported reinsurance when coupled with additional structural reforms to improve healthcare markets and have led efforts to establish a patient and State stability fund to provide States with the funding and the flexibility that they need to successfully set up and implement cost reduction programs.

While I see that much of this language may be similar to that which we have supported before, there are some critical provisions that are missing from the text. The benefits of a smart and thorough reinsurance policy would allow States to repair markets damaged by the Affordable Care Act while honoring federalism. Unfortunately, the bill before us today is particularly restrictive and does not provide States with adequate flexibility to use those funds. It also fails to include critical and longstanding Hyde protections.

I have introduced H.R. 1510. It includes a responsible reinsurance policy that enables States to use funds for a wide variety of initiatives from helping high-risk individuals to enrolling in coverage to promoting access to preventive services, providing maternity coverage and newborn care. It is important to mention that this bill would also provide Hyde protections.

Next, I would like to turn to the issue of navigators. As a physician, as a Member of Congress, and just your average simple country doctor, I like to base my decisions on evidence-based research. I found it interesting as I read the Democrats' memo that they are trying to sell us this legislation to increase funding for navigators without outlining the impact that navigators have had in enrolling individuals.

Navigators are not a new phenomenon. We have sufficient data to show that they have been only minimally effective, spending 36 million in 2018, prior to that 63 million, all to enroll less than 1 percent of the fee-for-service market. However, CMS data shows that agents and brokers have helped 42 percent of fee-for-service enrollment plan for 2018, substantially more cost effective than navigators. The agents and brokers cost $2.40 per enrollee.

The final bill before us today would provide $200 million to create State exchanges, which is another effort that has proven to be astonishingly efficient in wasting taxpayer dollars. Seventeen States have spent a total of four and a half billion dollars to estab-

lish exchanges, many of which have failed. The Subcommittee on Oversight under Chairman Upton found that the CMS was not confident that the remaining State-based exchanges would be sustainable in the long term. Additionally, it found that only one State had complied with the Affordable Care Act's requirement that all State-based exchanges publicly publish costs related to its operations.

Again it is disappointing that not only none of these bills adequately address the affordability of health insurance, I am disappointed that there was only a minimal attempt to work on the reinsurance and no attempt to even discuss the other two bills. Bipartisanship means asking for my input, not just my vote.

If you had asked for my input, I would have suggested that we look at language like I have introduced in H.R. 1510, a bill that includes reinsurance coupled with structural reforms to the Affordable Care Act, gives States more choice on how to repair their markets that have been damaged by Obamacare, and the legislation is, in fact, fully offset by stopping bad actors from gaming the system, and includes language that affirms the longstanding consensus that taxpayers should not foot the bill for abortions.

I thank the gentlelady for the time and I yield back.

[The prepared statement of Mr. Burgess follows:]

PREPARED STATEMENT OF HON. MICHAEL C. BURGESS

Thank you, Chairwoman Eshoo. Today, we are convened to discuss, according to the title of this hearing, "legislation to lower consumer costs and expand access" to healthcare. Alas, the legislation that my friends on the other side of the dais have put before us today is once again disappointing. I do believe that there are some areas here where we could have worked together, particularly on the issue of reinsurance, but there was little effort to work in a bipartisan way on this issue.

Republicans have strongly supported reinsurance when coupled with additional structural reforms to improve healthcare markets and have led efforts to establish a patient and State stability fund to provide States with the funding and flexibility they need to successfully set up and implement cost-reduction programs. While I see that much of this language may be similar to that which we have supported before, there are some critical provisions that are missing from the text.

The benefits of a smart and thorough reinsurance policy would allow States to repair markets damaged by the Affordable Care Act, while honoring federalism. Unfortunately, the bill before us today is particularly restrictive and does not provide States with adequate flexibility to use the funds. The bill also fails to include critical and long-standing life protections that exist in current law.

I have introduced a bill that includes a responsible reinsurance policy that enables States to use funds for a wide range of initiatives, from helping high-risk individuals enroll in coverage, to promoting access to preventive services, to providing maternity coverage and newborn care. It is important to mention that my bill also includes Hyde protections.

Next, I would like to turn to the issue of navigators. As a physician, a Member of Congress, and as your average Joe consumer, I like to base my decisions on evidence-based research. I found it interesting as I read the Democrats' memo, that they are trying to sell us this legislation to increase funding for navigators, without outlining the impact that navigators have had in enrolling individuals. Navigators are not a new phenomenon, and we have sufficient data to show that they have been minimally effective.

The Centers for Medicare and Medicaid found that during the plan year 2018 open enrollment period, navigators received $36 million, but enrolled less than 1 percent of the fee-for-ervice enrollment population. In 2017, when navigators received a larger sum of grant funding, $63 million, they still only enrolled less than 1 percent. CMS data show that agents and brokers helped with 42 percent of the fee-for-service enrollment for plan year 2018. This was substantially more cost effective than navigators, as agents and brokers only cost $2.40 per enrollee. Why buy a faulty product when there's a better one on the market? Especially when, under

this bill, an individual would be essentially forced into an ACA plan as navigators not required to be knowledgeable on alternative forms of coverage, such as short-term limited duration and association health plans.

The final bill before us today would provide $200 million to create State exchanges, which is another effort that has previously been proven to be a remarkable waste of taxpayer dollars. Seventeen States spent a total of $4.5 billion to establish exchanges, many of which failed. The Subcommittee on Oversight and Investigations released a detailed report in 2016 that found that CMS was not confident that the remaining State-based exchanges will be sustainable in the long term. Additionally, it found that only one State had complied with the Affordable Care Act's requirement that all State-based exchanges publicly publish costs related to its operations.

Again, I find it disappointing that not only do any of these bills adequately address the affordability of health insurance. I am also disappointed that our friends on the other side of the aisle made only one attempt to work on reinsurance and no attempts to even discuss the other two bills. Bipartisanship means asking for my input, not my vote. I yield back.

Ms. ESHOO. I thank the ranking member.

Now it is my pleasure to recognize the chairman of the full committee, Mr. Pallone, for 5 minutes.

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

Mr. PALLONE. Thank you, Madam Chair. The bills we are considering today reflect Democrats' continued commitment to deliver on our promise to make healthcare more affordable and accessible to all Americans and to reverse the Trump administration's sabotage of the Affordable Care Act. This legislative hearing comes several weeks after we held another legislative hearing on bills that were important first steps in lowering healthcare costs and protecting consumers with preexisting conditions.

Today we will be discussing three more bills that will reduce consumers' costs and improve access to care. And one way to ensure that people have access to healthcare is to provide them the support and information they need to make the right decision. So we will be discussing a bill introduced by Ms. Castor that would reverse the Trump administration's harmful cuts to the navigator program.

The Trump administration has gutted funding for the navigator program by over 80 percent, leaving huge swathes of the country without access to fair and unbiased enrollment help. We should restore this critical funding and ensure that navigators can provide fair and impartial information on people's enrollment and financial assistance options.

We also have to look at providing States another round of funding to establish State-based marketplaces. The SAVE Act was introduced by Representatives Andy Kim and Brian Fitzpatrick. As you may recall, some State legislatures who wanted to establish State-based marketplaces were unable to do so due to the opposition of the Republican Governors. In my State of New Jersey, former Governor Chris Christie, in 2012, vetoed a bill to establish a State-based marketplace for the residents of New Jersey.

While all States have been negatively affected by the Trump administration's sabotage of the ACA, State-based marketplaces have been better able to weather these storms. In 2018, premiums in these marketplaces were 17 percent lower than in the Federally

Facilitated Marketplace, and enrollment in these States has outpaced enrollment in the Federally Facilitated Marketplace States. The State-based exchanges framework also gives States the opportunity to tailor the program to meet the needs of their State residents, and the bill provides us another opportunity to make healthcare more affordable.

And, finally, we will consider a bill introduced by Ms. Craig and Mr. Peters to provide 10 billion in reinsurance funding for States that set up their own reinsurance programs. States may also use this funding to provide financial assistance to help lower premiums and out-of-pocket costs for consumers and beyond the ACA's subsidies. Reinsurance pays for the costs of people with serious medical conditions whose healthcare costs are significantly higher than the average person. This support helps reduce premiums through the individual market, making healthcare more affordable.

Seven States have successfully implemented State-based reinsurance programs through the 1332 waiver program, including my State of New Jersey. These programs have significantly lowered premiums and have had widespread bipartisan support. Now the bill that we are considering today would build upon the success of these programs, but the funding would come from the Federal Government.

I believe that that is the right approach. A sustained Federal commitment is needed in order to lower costs for all 50 States and the District of Columbia. Like with the Part D program, reinsurance should be a permanent part of the individual market and it should be a federally financed responsibility.

Now the bills that Ms. Craig and Mr. Peters have introduced are modeled after the reinsurance program that all the Republicans on this committee supported in the repeal bill of last year. We all agree that Congress must take action to reduce costs for middle-class consumers and we all agree that reinsurance is a good thing. And that is why I was disappointed that we were unable to get to bipartisan agreement on reinsurance.

My colleagues on the other side of the aisle have made it clear that they will not support any reinsurance bill without Hyde language. There is no reason, in my opinion, to drag Republicans' anti-choice politics into this discussion. There is bipartisan consensus that reinsurance is effective in bringing down costs for middle-class consumers. A number of States under Republican leadership such as Maine, Maryland, and Wisconsin, happily took Federal money for reinsurance without raising the issue of Hyde and we should take this opportunity to allow States to make healthcare more affordable for their residents.

[The prepared statement of Mr. Pallone follows:]

PREPARED STATEMENT OF HON. FRANK PALLONE, JR.

The bills we are considering today reflect Democrats' continued commitment to delivering on our promise to make healthcare more affordable and accessible for all Americans, and to reverse the Trump administration's sabotage of our healthcare system. This legislative hearing comes several weeks after we held another legislative hearing on bills that were important first steps in lowering healthcare costs and protecting consumers with preexisting conditions. Today, we will be discussing three more bills that will reduce consumers' costs and improve access to care.

One way to ensure that people have access to healthcare is to provide them the support and information they need to make the right decision. We will be discussing a bill introduced by Ms. Castor that would reverse the Trump administration's harmful cuts to the navigator program. The Trump administration has gutted funding for the navigator program by over 80 percent, leaving huge swathes of the country without access to fair and unbiased enrollment help. We should restore this critical funding and ensure that navigators can provide fair and impartial information on people's enrollment and financial assistance options.

We should also look at providing States another round of funding to establish State-based marketplaces. The SAVE Act was introduced by Representatives Andy Kim and Brian Fitzpatrick. As you may recall, some State legislatures who wanted to establish State-based marketplaces were unable to, due to the opposition of their Republican Governors. In my State of New Jersey, former Governor Chris Christie in 2012 vetoed a bill to establish a State-based marketplace for the residents of New Jersey.

While all States have been negatively affected by the Trump administration's sabotage, State-based marketplaces have been better able to weather these storms. In 2018, premiums in these marketplaces were 17 percent lower than in the Federally Facilitated Marketplace, and enrollment in these States has outpaced enrollment in the Federally Facilitated Marketplace States.

The State-based exchange framework also gives States the opportunity to tailor the program to meet the needs of their State residents. This bill provides us another opportunity to make healthcare more affordable.

Finally, we will consider a bill introduced by Ms. Craig and Mr. Peters to provide $10 billion in reinsurance funding for States to set up their own reinsurance programs. States may also use this funding to provide financial assistance to help lower premiums and out-of-pocket costs for consumers, above and beyond the ACA's subsidies.

Reinsurance pays for the costs of people with serious medical conditions whose healthcare costs are significantly higher than the average person. This support helps reduce premiums throughout the individual market, making healthcare more affordable. Seven States have successfully implemented State-based reinsurance programs through the 1332 waiver program, including the State of New Jersey. These programs have significantly lowered premiums and have had widespread bipartisan support.

The bill that we are considering today would build upon the success of these programs, but the funding would come from the Federal Government. I believe that this is the right approach. A sustained Federal commitment is needed in order to lower costs for residents of all 50 States and the District of Columbia. Like with the Medicare Part D program, reinsurance should be a permanent part of the individual market, and it should be a Federal financial responsibility.

The bill that Ms. Craig and Mr. Peters have introduced is modeled after the reinsurance program that all the Republicans on this committee supported in the repeal bill of last year. We all agree that Congress must take action to reduce costs for middle-class consumers and we all agree that reinsurance is a good thing.

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There is no reason to drag Republican's anti-choice politics into this discussion. There is bipartisan consensus that reinsurance is effective in bringing down costs for middle-class consumers. A number of States under Republican leadership, such as Maine, Maryland, and Wisconsin happily took Federal money for reinsurance without raising the issue of Hyde. We should take this opportunity to allow States to make healthcare more affordable for their residents.

I look forward to the discussion today and I yield back.

Mr. PALLONE. So I want to yield now, the minute or so left, to Mr. Peters, if I could, Madam Chair.

Mr. PETERS. Thank you, Mr. Chairman or Chairman Pallone for yielding me time and thanks to Chairwoman Eshoo and Ranking Member Burgess for holding this hearing today.

I am grateful to the committee for their consideration of H.R. 1425, the State Health Care Premium Reduction Act, a bill that I recently introduced with Representative Angie Craig. I would also

like to thank Reps Schrader, Underwood and Kuster for their early support of the bill.

Let's be honest. Stabilizing the individual marketplace may not be a bipartisan priority, but lowering healthcare insurance premiums and reducing out-of-pocket costs for working Americans certainly is. And it is widely acknowledged by both Republicans and Democrats that one of the best ways to lower premiums is to provide adequate Federal funding to create State reinsurance programs.

H.R. 1425 creates a dedicated stability fund that States can use to lower premiums and out-of-pocket costs for all individuals by defraying the costs of high-cost enrollees. Our bill is expected to lower premiums for individuals by approximately 10 percent. So Representative Craig and I look forward to working with both our Republican and Democratic colleagues to provide millions of Americans with swift relief from the rising costs of healthcare, and I thank you for the time.

Ms. ESHOO. I think I would now like to introduce the witnesses that are here today and welcome them and thank them for being willing to share their expertise with us.

First, Mr. Peter Lee. I am going to move off of script and say to everyone that Mr. Lee comes from one of the most distinguished families in California and our country. I am going to go way back many, many years. I think it was your—was it your grandfather that founded—he was Dr. Lee—founded the Palo Alto Medical Clinic? He had five sons, all M.D.s, at least—and a daughter—well, you are ahead of me—a daughter that was also a doctor.

And out of those five sons, one served in two administrations in the healthcare arena. So Mr. Lee comes to us not only with great genes, but with having implemented the ACA in California. We are really honored to have you here today and thank you for your commitment, unswerving commitment that has traveled through more than one generation of your family. You are a gift to the country.

Mr. Wieske, welcome to you. He is the Vice President for State Affairs at the Council for Affordable Health Coverage.

Ms. Audrey Morse Gasteier, who is the Chief of Policy and Strategy for the Massachusetts Health Connector, again, thank you.

I am going to recognize each witness for 5 minutes for their opening statement. There is a lighting system. The light will be green when it first comes on, then it will be followed by yellow, then you will have 1 minute remaining, so we ask you to stay within the 5 minutes.

So I am going to begin with the distinguished Mr. Lee.

STATEMENTS OF PETER V. LEE, EXECUTIVE DIRECTOR, COVERED CALIFORNIA; J. P. WIESKE, VICE PRESIDENT, STATE AFFAIRS, COUNCIL FOR AFFORDABLE HEALTH COVERAGE; AND AUDREY MORSE GASTEIER, CHIEF OF POLICY AND STRATEGY, MASSACHUSETTS HEALTH CONNECTOR

STATEMENT OF PETER V. LEE

Mr. LEE. Good morning, Chairwoman Eshoo, Ranking Member Burgess, and distinguished members of the subcommittee. I do want to note that as you see I am Mr. Lee, not Doctor, so clearly

the gene pool dilutes over time, but I want to very much appreciate your remarks about my family. I serve as the executive director of Covered California and am honored to participate in this hearing to help inform your deliberations.

Remarkable progress has been made throughout the country with the Affordable Care Act, but recent Federal policy actions are having significant negative effects on millions of Americans. I welcome the fact that today's hearing is about building out and improving the Affordable Care Act which is what we need to focus on.

Well, Covered California, for 6 years, has effectively used all the tools of the Affordable Care Act to improve affordability for coverage, promote competition, give choice to consumers, and drive improvements in the delivery system. We have made investments in marketing, in outreach, in navigators, and the results show that we have a 20 percent healthier enrolled population which means our premiums are 20 percent healthier than in the Federal marketplace would have if they had our risk mix.

We made remarkable progress in California and across the Nation, but recent Federal policy actions are posing challenges such as the Federal elimination of the individual mandate penalty, promotion of limited benefit plans, and significant reductions in marketing and outreach that don't affect California, but affect 39 States relying on the Federal marketplace. These policies are having the direct effect of raising premiums and pricing millions of Americans out of coverage.

Today, California, Massachusetts, and Washington exchanges released an analysis showing a very different story of what happens in States like ours that lean in to support consumers, compared, sadly, to what has happened in consumers served by the Federal marketplace. The findings in that report are stark.

Since 2014, Federal marketplace States have had a cumulative premium increase of over 85 percent. In our three States the increase has been less than half of that. This means that if the Federal Government had spent roughly—because of that the Federal Government spent roughly $35 billion—$35 billion more in premium tax credits than it would have if their premium increases had matched ours. But the biggest impact has been felt by millions of middle-class Americans who get no financial help who have been priced out of coverage.

This analysis shows the importance of the mandate penalty also. California and Washington have leaned in to promote insurance. We have good risk mixes. But this last year we saw significant drops in new enrollment. The State of Massachusetts, who you will hear from more today, saw a 31 percent increase in their new enrollment. That is because they had a mandate that predated the Affordable Care Act that is in place today. Their consumers know about it. So while recent Federal actions are taking us backwards, I am encouraged that today's hearing focuses on ways to move forward and build on the Affordable Care Act.

The first proposal relates to reinsurance to help stabilize markets. Reinsurance can have a profound effect on coverage affordability particularly for middle-class Americans who don't qualify for premium subsidies. It would directly benefit them by lowering premiums and creating greater carrier participation that provides

market stability to encourage health plans to play. We have 11 carriers in California. Many parts of America have one or two. Reinsurance helps bring plans to the market.

Now I would note, State-based reinsurance programs may work for some, but it is not a viable strategy for the vast majority of States. Most States will not come up with State funds to invest in the risk of uncertain Federal pass-throughs. H.R. 1425 would not only fund reinsurance but would allow States the option of investing in targeted ways in their States to reduce costs for their consumers. This proposal provides State flexibility, State choice, and would lower premiums across the board.

H.R. 1385 would fund States that seek to establish their own marketplaces. Now, Covered California benefited from establishment funds. We got a lot of money to get started. We have paid that off many times over by reducing premiums for Californians. Other States need funds to get set up.

The final legislation is to support navigator funding. As you consider this, I would look back at not only the dramatic cuts that we have seen federally, but California has a robust navigator program. That program we have funded at about $6.5 million for each of the last 4 years. But you need to consider this program in concert with our broad, $100 million investments in marketing and outreach and our support for over 12,000 licensed insurance agents. All of those should be done. All of those are necessary tools to keep robust enrollment, to keep premiums down by having a healthy risk mix.

So I would close by noting that we really are at a pivotal time in healthcare. To the extent Federal policy discussions can now turn to building on, repairing, fixing, and having the Affordable Care Act work better, we are at a good place for California and for the Nation. I look forward to your questions. Thank you very much.

[The prepared statement of Mr. Lee follows:]

COVERED CALIFORNIA

United States House of Representatives
Committee on Energy and Commerce Subcommittee on Health
"Hearing on Strengthening Our Health Care System: Legislation to Lower Consumer Costs and Expand Access:
March 6, 2019

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

Good morning Chairwoman Eshoo, Ranking Member Burgess, and distinguished members of the Subcommittee on Health. My name is Peter V. Lee and I serve as the Executive Director of Covered California – California's state-based health insurance marketplace for the individual and small group markets. I am honored to participate in today's hearing. The information and perspectives I will provide are based on six years of experience operating a robust and successful state-based marketplace as well as over twenty years working to make sure the health care better meets the needs of America's consumers. I hope to help inform your deliberations on the measures before you in committee today.

Remarkable Progress Has Been Made Under the Affordable Care Act – But Federal Policy Actions Are Having Significant Negative Impacts on Millions of Consumers in States Across the Nation

Our nation has made historic progress under the Affordable Care Act with millions of Americans across the country gaining access to coverage they can count on through the expansion of Medicaid and health insurance marketplaces since 2014. As a result, rates of uninsured have dramatically decreased and the promise of better access to health care and financial security has been realized by millions of American consumers.

In our state, Covered California has steadily worked to leverage its role in the market to maintain and improve affordability of coverage, promote competition and choice for consumers, and foster improvements in quality and delivery system reform. We have served over 3.5 million California consumers since opening our doors in 2014, by maintaining a very competitive market with 11 contracted health insurance carriers that actively compete based on price and service, developed patient-centered benefit designs that promote value and access to care, and fostered one of the healthiest risk pools in the nation. California's rate of uninsured has been reduced from 17.2 percent in 2013 to an historic low of 7.2 percent in 2017 by using the tools provided under the

Affordable Care Act, including establishing Covered California and the expansion of Medi-Cal, California's Medicaid program. When you count only those currently eligible for coverage — not including individuals who are ineligible for coverage due to their immigration status — California's eligible uninsured rate is roughly 3 percent.

Covered California has also used all of the tools of the Affordable Care Act to build a strong and sustainable individual market that helps keep health care premiums as low as possible. Covered California's eleven contracted qualified health plans (QHPs) vie for consumers based on price and quality. Our significant investments in marketing and outreach have led to strong, steady enrollment and one of the healthiest risk scores in the nation. As a result, individual market health care premiums in California are estimated to be about 20 percent lower than the national average with Covered California's five-year average rate increase below eight percent.

Despite this remarkable progress, we know that there is more work to be done – not only in California, but across the nation. Affordability remains a paramount issue for consumers, especially middle-class Americans who do not qualify for federal financial assistance and must bear the full weight of premiums on their own. These challenges are exacerbated by recent federal policy actions – including the federal elimination of the individual mandate penalty, promotion of short-term, limited duration insurance, and the reduction in marketing and outreach by the federally facilitated marketplace (FFM) – which have chipped away at the integrity of the Affordable Care Act in much of the nation.

These federal actions have contributed to an ongoing decline of enrollment in the FFM. From 2016 to 2018, states served by the FFM experienced a 39 percent decline in new enrollments, decreasing from 4 million to 2.5 million. For the 2019 plan year, the FFM experienced a 16 percent decrease in the number of new enrollees, on top of the 39 percent decrease from the prior years. In contrast, California saw a vey modest 9 percent drop in new enrollment between between 2016 to 2018. However, despite maintaining a competitive market, steady enrollment, and a healthy risk mix, California is feeling the effects of these federal policy changes. Earlier this month, Covered California released its "2019 Open Enrollment Early Observations and Analysis," demonstrating that the federal removal of the individual mandate penalty appears to have had a substantial impact in California which experienced a 23.7 percent decrease in new enrollment for the 2019 benefit year.

Additionally, today, Covered California, the Massachusetts Health Connector, and the Washington Health Benefit Exchange released a joint analysis entitled "Exploring the Impact of State and Federal Actions on Enrollment in the Individual Market: A Comparison of the Federal Marketplace and California, Massachusetts, and Washington." This report highlights the stark difference between the experiences of consumers who live in states that have been committed to using the tools of the Affordable Care Act and those who are now relying on the the federally facilitated marketplace. Since 2014, the cumulative premium increase that consumers in states served by the federally-facilitated marketplace have risen by 85 percent; while in our three states the increase has been less than half of that increase. Not only does this mean that the federal government is paying literally tens of billions more in premium

support through Advanced Premium Tax Credits than they would have if they'd kept increases to the level of our states — which we estimate to be roughly $35 billion dollars over the past five years — but the biggest impacts are felt by millions of middle class Americans who get no financial help to pay for coverage and have been priced out of coverage due to these federal policies.

The analysis demonstrates the critical role that the federal mandate penalty plays in promoting stability and reducing costs. California and Washington – both of which have used state-specific solutions to build health insurance exchanges that work and maintain very good risk mixes — saw their new enrollment drop significantly in 2019. Conversely, Massachusetts, which has maintained the state-level mandate penalty that they enacted in 2006, and leaned in to expand outreach and promotion for 2019, actually saw increases of over 30 percent in new enrollment for the 2019 benefit year.

In light of the challenges before us, we stand at a time of opportunity. While the Affordable Care Act has provided a staunch framework that has has helped millions of Americans gain access to health coverage and care, American consumers stand to gain from policy efforts to build on the law as it stands today. In his first act as California's governor, Governor Gavin Newsom sent a letter to Congressional leadership that outlined the ways that the Affordable Care Act can and should be improved. States like California, Washington, Massachusetts and many others are working to preserve the gains made and mitigate the impacts of recent federal policy actions in ways that aim to help consumers retain access to affordable, quality coverage.

While Covered California does not take positions on legislation, we do seek to inform the policy discussions with analysis and a real-world perspective informed by our five years of operation. It is in this context that I appreciate the opportunity to provide these comments and welcome a hearing that is looking ahead at how to build on a law that is working well AND needs to be improved.

Woven throughout this testimony are examples of the work states like ours are doing to promote stability and affordability in our marketplaces that can serve as a roadmap for federal policy in both the short- and long-term. In this vein, the legislative proposals before the committee today appear to reflect an effort to build on the Affordable Care Act. Reinsurance, the Navigator program, and the work of state-based marketplaces have each played a vital role in the successful implementation of the Affordable Care Act. I am pleased to provide comment on the policies at the heart of each of these proposals.

A Federal Reinsurance Program Can Effectively Help Stabilize Markets and Lower Premiums for Consumers

One of the most effective ways to help stabilize individual markets throughout the nation is to provide adequate federal funding through reinsurance. By covering a portion of medical costs for enrollees who experience extremely high medical claims, a reinsurance program lowers plan costs thus lowering premiums for all plans sold in the individual market. As a result, reinsurance can have a profound effect on the affordability of coverage, particularly for middle class Americans who do not now

receive federal financial premium assistance because they are above the "cliff" at 400 percent of poverty level and who stand to directly benefit from lowered gross premiums. Additionally, reinsurance gives carriers additional pricing certainty which can help foster carrier participation and more competition in the market.

The Affordable Care Act included a temporary federal Transitional Reinsurance Program for the individual market in years 2014-2016. By providing funding to carriers to offset high cost claims prevalent in a sicker risk mix, the federal reinsurance program fostered carrier participation in the early years of the Affordable Care Act and reduced premiums by more than 10 percent per year (with state and regional variance in the amount of premium reduction experienced). However, the federal Transitional Reinsurance Program expired at the end of the 2016 plan year resulting in higher rates for 2017 in California and other states across the nation. For example, in California the expiration of the federal reinsurance program resulted in a one-time rate increase of approximately 4 to 6 percent as carriers priced for the loss of federal reinsurance funding.

In the absence of a federal reinsurance program, seven states have implemented state-based reinsurance programs to stabilize premium increases in their individual markets using the federal Section 1332 "state innovation" waiver process. Through the 1332 waiver process, states finance the reinsurance program using state funds, with some of the state funding then offset by federal "pass-through" funding based on federal savings generated by premium reductions achieved through reinsurance.

While state-based reinsurance programs may provide a potential means for some states to stabilize markets and reduce premiums, they are absolutely not a viable strategy for many states. State-based reinsurance programs require a significant financial investment by states, and the amount of federal pass-through funding made available to offset that state investment can vary greatly. In February 2019, State Value Health Strategies released a report entitled "State Reinsurance Programs and 1332 Waivers: Considerations for States," which highlights the significant variance in the amounts of federal pass-through funding received by each of the states with federally approved 1332 waivers. The percentage of the state-based reinsurance program covered by federal pass-through funds ranges from a low of 31 percent in Minnesota to a high of 100 percent in Alaska.

While each state is unique in terms of its own market dynamics and ability to invest state funds into a state-based reinsurance program, not having clear and predictable sense of how much federal pass-through funding may be available can put states at financial risk of having to support a significant proportion of the program with state funds. As such, state-based reinsurance programs at best only provide for a patchwork of premium relief across states and full reliance upon state-based reinsurance does not present either a comprehensive, sustainable or equitable solution to affordability and stability issues throughout the nation.

Fostering and encouraging state-based solutions is vital and states that want to pursue a 1332 waiver for state-based insurance should have that option. However, the reinstitution of a federal reinsurance program would be available to all states, regardless

of whether they have the funding or other capability to support a state-based program. This would ensure that all Americans can benefit from the premium reductions and market stability resulting from reinsurance.

Implementing a new federal reinsurance program with sufficient federal funding could greatly reduce premiums in the individual market, both on- and off-exchange. For a specified nominal amount of funding such as $10 billion for 2020, the net cost to the federal government would likely be only about $3 billion since premium reductions due to reinsurance would reduce federal expenditures on premium subsidies by approximately 70 percent of the reinsurance spend. Additionally, because the federal mechanism for calculating reinsurance payments (referred to as the "EDGE server") remains in place and could likely be "turned on" for reinsurance in a matter of months.

A federal reinsurance program makes sense for the individual market. With recent federal policy changes such as the removal of the individual mandate penalty, a 90 percent reduction in marketing and outreach by the FFM, and the promotion of short-term, limited duration insurance and association health plans, the risk mix of the individual market has deteriorated, contributing to higher premiums, especially for the middle class.

In addition, consideration of federal reinsurance for the individual market is warranted because the individual market is unlike that for employer-sponsored insurance (ESI) for either large or small employers. In contrast to the ESI market, many consumers in the individual market may have some income but are unable to work full-time due to some chronic condition. Based on risk adjustment data published by the Centers for Medicare and Medicaid Services for 2015 through 2017, it appears that enrollees in the individual market are approximately 19 percent higher risk than enrollees in the small group market, and the risk difference increased over the three-year period. This is evidence that a longer-term reinsurance program for the individual market is needed to keep premiums more affordable for consumers who do not have ESI and who do not qualify for other government programs.

Federal policymakers are in a position to help stabilize markets across the country by adopting a federal reinsurance program. Federal reinsurance has been the subject of bipartisan efforts to stabilize markets, and has been proven to be an effective tool to keep coverage affordable and foster carrier participation, and thus competition. The legislation before the committee today, H.R. 1425, would provide, starting in 2020, $10 billion annually to states to either establish a state reinsurance program or provide financial assistance to reduce out-of-pocket costs for individuals buying coverage through the exchange. It also would establish a federal reinsurance program in states that do not apply for federal funding, thus offering a federal reinsurance fallback. While Covered California does not promote or take positions on legislation, as a matter of policy, this proposed legislation appears to provide states with the flexibility and choice to leverage federal funds in a way that would best serve their consumers in the most cost-effective way.

While H.R. 1425 would not require a Section 1332 Waiver for implementation by states, I would like to add, however, that to the general extent funding to states is based on the use of the Section 1332 Waivers, there are structural improvements that could be made to that Waiver process to truly foster state innovation and allow states to meet their consumers' needs in alignment with the goals of the Affordable Care Act. Under current law, the structure of the waiver requires "budget neutrality" for the federal government over a 10-year period – meaning that total funding under a waiver cannot exceed total funding projected to be spent in the absence of a waiver. This limits the potential for innovation under the waiver. Changes to budget neutrality requirements under Section 1332 that would allow states to use per-member federal costs as a basis for waiver funding would mean that rather than having coverage expansions count "against" state efforts that lower the per-person costs of subsidies as they currently do under the existing budget neutrality construct, budget neutrality would be calculated on a per enrollee basis, not total spending. Given that the work in our state through Covered California has resulted in lower per-member costs to the federal government, and thus significant federal savings, making a change such as this would enable states like California to better innovate and enact policies that would meet the goals of the Affordable Care Act to expand coverage in a cost-effective way.

State-Based Exchanges are Proving Grounds for Marketplaces Done Right

Today, the Committee will deliberate on H.R. 1385 which would provide states with $200 million in federal funds to establish state-based marketplaces. Given that Covered California is a well-established state-based marketplace, this proposal would not impact our state. However, I would like to take this opportunity to highlight the valuable and innovative role that state-based marketplaces can play in helping reduce the rate of uninsured, fostering competition, maintaining a healthy risk mix, helping make premiums more affordable, and driving improvements in quality and delivery system reform.

I'll begin with an oft-stated adage that bears repeating: "all health care is local." State-based marketplaces have the advantage of knowing and understanding their markets and consumers in ways that can optimize performance and lead to good outcomes with regard to enrollment, affordability, and risk mix. Covered California, as well as many other state-based marketplaces, have leveraged the tools of the Affordable Care Act to build strong and sustainable individual markets that have helped drive down health care premiums. In California alone, the result is a competitive marketplace in which a stable group of carriers vie for consumers based on price and quality. Covered California's significant investments in marketing and outreach — which equate to about 1.1 percent of the on-exchange premium and is funded out of our assessment on health plans — have led to more than one million actively enrolled consumers and one of the lowest risk scores in the nation. As a result, individual market health care premiums in California are about 20 percent lower than the national average.

In addition to California, other state-based marketplaces have set models for how successful exchanges work. State-based exchanges have lower risk scores on average than the FFM. [1] As outlined in our comparative analysis of California, Massachusetts

and Washington exchanges to the FFM, each of our three states has used state-specific solutions to build health insurance exchanges that work, including:

- Active outreach and marketing.
- State policies that ensure a stable and competitive individual marketplace.
- To varying extents, playing active roles in the certification of QHPs to ensure quality and affordable products.
- Having common patient-centered benefit designs and improved choice architecture to simplify the purchase experience and have consumers focus on price and quality.

The result has been that these three states have been successful at restraining growth in the average benchmark premium, holding average annual increases to less than 7 percent since opening in 2014. During the same period, the FFM average benchmark premiums have grown at an average rate of over 13 percent.[2] In 2019, average benchmark premiums in the FFM are now 85 percent higher than they were in 2014, while the weighted average increase across the three states was 39 percent. Had the FFM experienced the lower premium growth seen in California, Massachusetts, and Washington, the federal government could have seen saved as much as $14 billion in 2018, or cumulative savings of approximately $35 billion, based on reduced expenditures on federal premium subsidies. Additionally, lowered premiums through the FFM could have provided direct savings to millions of Americans who do not receive any subsidies making them less likely to have been priced out of coverage.

Recent changes to federal policy appear to have impacted new enrollment in our three State-based marketplaces. While the FFM has seen new enrollments drop considerably from 2016 to 2018 – a 40 percent drop from 4.0 million to 2.5 million – our marketplaces held steady given the state-based efforts that have driven new enrollment and kept markets stable despite changing policies at the federal level. However, for the 2019 open enrollment, it appears that the loss of the individual mandate penalty has been a significant driver of lower numbers of new enrollment for California and Washington. Both states with healthy risk mixes - saw their new sign-ups drop off significantly, 24 percent and and 50 percent, respectively. The FFM also experienced a 16 percent decline on top of the 40 percent cumulative decline from 2016 to 2018. In contrast, Massachusetts saw a 31 percent *increase* in the number of new sign-ups. A major distinction between Massachusetts and California, Washington, and the FFM is

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[1] Health Affairs (July 2018). National vs. California Comparison: Detailed Data Help Explain the Risk Differences Which Drive Covered California's Success.
https://www.healthaffairs.org/do/10.1377/hblog20180710.459445/full/

[2] Analysis of enrollment weighted average benchmark premiums reported by Kaiser Family Foundation (2014-2019): https://www.kff.org/health-reform/state-indicator/marketplace-average-benchmark-premiums/

that it had in place since 2006 its own state individual mandate penalty and also adds additional states subsidies for enrollees. The state of Massachusetts invested more in outreach and marketing for the 2019 plan year and — building on a "culture of coverage" where residents know they need to get coverage — residents of the state are the winners.

In California, Governor Newsom and the California State Legislature are actively considering taking action to protect the Affordable Care Act from erosion by federal action by proposing to implement a state-level individual mandate penalty. At the same time, they are also showing notable leadership by proposing additional subsidies to low- and middle-income Californians – including groundbreaking proposals to provide financial assistance to individuals with household incomes up to 600 percent of the federal poverty level. If enacted, this policy would make California the first in the nation to address the subsidy "cliff" by providing financial help to those members of the all-too-often forgotten middle class who currently bear the full cost of coverage all on their own.

Covered California has helped inform these state policy efforts by developing policy options that can improve affordability and expand upon the progress we have made in our state. On February 1, 2019, Covered California released a report entitled, "Options to Improve Affordability in California's Individual Health Insurance Market," which outlined modeling and analysis of the impacts of various state-based policies to improve affordability including a state individual mandate penalty, premium and cost-sharing subsidies, and reinsurance. I will note that while California and other states are charting a path forward with these efforts, in many instances these types of policies are better done at the federal level — as reflected in Governor Newsom's letter to Congress. When we completed this report for the Governor and California's legislature, we also sent it via a letter to Congressional leadership sharing our work with the hope that it may serve as a roadmap for federal policymakers to the extent Congress presses forward on health care policy in both the short- and long-term for the benefit of all Americans.

Finally, in light of your consideration of the policy merits of H.R. 1385, I'd like to take this opportunity to share some of the core elements specific to Covered California that serve as examples of a marketplace done right:

- ***Curating a competitive marketplace that promotes affordability and value for consumers***
  Covered California actively negotiates with its contracted QHPs in an effort to keep premiums affordable, ensure access to care by consumers, and promote competition among carriers that fosters choice and value for consumers. Covered California's patient-centered benefit designs, which are designed to encourage access to care – including access to outpatient services outside of deductibles – promote enrollment and retention, and result in Covered California QHPs competing on price, provider networks, and service, all to the benefit of consumers.

- ***Advancing improvements in quality and delivery system reform***
  Since its inception, Covered California has set forth standards and requirements for quality improvement and delivery system reform in its contracts with its

qualified health plans with the goal of lowering costs and making sure consumers get the right care, at the right time and in the right setting. These requirements, which exceed those set by the Affordable Care Act, aim to address underlying costs of health care and promote better quality. For example, our qualified health plans are required to work toward improving health outcomes and patient safety, prevent hospital readmissions and reduce medical errors and health disparities. Covered California is currently in the process of revising its quality improvement and delivery system requirements for QHPs. We recently issued a report entitled, "Covered California's Efforts to Lower Costs While Ensuring Consumers Get the Right Care at the Right Time," which provides an early look at the results of Covered California's work to improve care and promote better quality while reducing costs. I would be happy to provide a copy to the committee which could help inform congressional discussions about how to address rising costs of health care and delivery system reform.

- ***Investing in marketing and outreach***
  While the federal government has significantly reduced its marketing investments, Covered California has continuously made major investments in marketing and outreach leading to steady enrollment, one of the healthiest risk mixes in the country, and lower premiums. In its landmark report, "Marketing Matters: Lessons from California to Promote Stability and Lower Costs in National and State Individual Insurance Markets," Covered California outlines that selling health insurance is uniquely challenging and that while sick people are motivated to buy health insurance, healthier people need to be reminded, nudged and encouraged. Marketing is necessary to overcome innate biases that discourage consumers from purchasing something that does not provide immediate returns. A recent analysis, "National vs. California Comparison: Detailed Data Help Explain the Risk Differences Which Drive Covered California's Success," cites Covered California's high marketing and outreach spending and efforts as being associated with its better risk scores and a contributing factor to its success in stabilizing the individual market both on- and off-exchange.

While there are many opportunities for the federally-facilitated marketplace to use existing evidence and itself implement these policies, there is evidence indicating that state-based exchanges perform well when they leverage tools and resources in innovative ways to reach and serve consumers. The state-based marketplaces that are in existence today benefited from receiving federal "establishment funds" to help start up in the early years of ACA implementation. Federal establishment funds expired, and today no state-based marketplace receives federal funds in order to operate. However, it is not clear that states would have made the early investments required to create the new state-based marketplaces that have taken shape over the past eight years, had it not been for early federal support.

Many states may be very interested in receiving federal support to inform their decisions about whether or not to establish their own state-based marketplaces that would serve in the best interest of their residents and leverage their own innovations to provide affordable and sustainable options for health care. In addition, the bill gives states until

2024 to implement a self-sustaining state-based marketplace — essentially allowing them the opportunity to build from lessons learned from other states. To the extent that the federal government can continue to foster the laboratory of the states through state-based marketplaces, providing states with support that gives them the latitude to develop and establish their own state-based marketplace has the potential of going a long way in boosting consumer enrollment in the health insurance marketplace.

Navigator Funding and Program Requirements

As the committee deliberates H.R. 1386 which would fund the Navigator program for the FFM $100 million per year, among other provisions, I would refer back to California's experience which shows that a stable individual insurance market does not just happen on its own – investments in marketing, outreach, and enrollment assistance play a vital role in maintaining enrollment and attracting healthy risk which in turn can lower premiums, encourage carrier participation, and foster stable markets. Under the Affordable Care Act, Navigator programs provide outreach, education, and enrollment assistance to consumers eligible for marketplace coverage and are funded by marketplaces. Navigator grantees play an important role in the constellation of service channels facilitating marketplace enrollment, particularly among traditionally "underserved" populations.

In 2017, CMS reduced funding for Navigator programs serving states in the FFM by 43 percent, from $63 million awarded in 2016 to $36.1 million for 2017. On a state-by-state basis, the funding reduction ranged from 0 percent to 96 percent from the amounts Navigator grantees were expecting for the 2017-18 program year.[3] CMS also reduced all other marketing expenditures by 90 percent, from $100 million in advertising in 2017 to $10 million for 2018. On September 12, 2018, CMS released funding awards for Navigators serving consumers in the FFM which reduced funding to $10 million. Compared to 2016, federal Navigator funding for the 2018-19 program year reflects an 84 percent reduction. The number of Navigator grantees serving the FFM states was 104 in 2016 compared to 40 for the 2018-19 year.

In California, we have a Navigator program that complements and supplements the work of over 12,000 certified licensed agents. Our competitive grant program for Navigators has selected organizations rooted in communities throughout the state serving distinct and diverse populations, many of which require one-on-one assistance delivered in culturally and linguistically appropriate ways. As such, Covered California's investments in the Navigator program have generally held steady between 2016 to today. In 2016, funding for the Navigator program in California was $7.1 million. For 2018-19, Covered California allocates approximately $6.5 million (reflecting approximately 0.08 percent of the premium dollar) to 102 grantees (42 lead Navigator entities and 60 subcontractors). In 2018, approximately 2.5 percent of Covered California enrollees, roughly 40,000 consumers, were enrolled in Covered California through Navigators, with about 3.5 percent (about 60,000) being enrolled through our uncompensated but supported Certified Application Entities.

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[3] Kaiser Family Foundation. September 2018. *Data Note: Further Reductions for Navigator Funding in Marketplace States.* https://www.kff.org/health-reform/issue-brief/data-note-further-reductions-in-navigator-funding-for-federal-marketplace-states/

Navigators are part of a comprehensive investment by marketplaces and others in consumer acquisition. In addition to Navigator programs, Covered California makes significant investments in marketing and advertising; digital advertising and engagement; earned media, quality customer service through our Service Centers; support for licensed and certified agents and brokers; patient-centered benefit designs that provide value; and many efforts to provide a positive consumer experience. In addition, Covered California's QHPs make investments to attract and retain enrollment through competitive pricing, marketing, agent commissions and others.

As the committee evaluates the goals and merits of increased Navigator funding, it should consider the valuable role Navigators play in providing outreach, education and enrollment assistance to consumers in need. The committee should also consider how the Navigator program fits with within the comprehensive efforts across marketplaces, agents and brokers, carriers, and others promoting coverage and providing enrollment assistance as it determines the level of federal funds for the program.

Additionally, the proposed legislation would impose new requirements related to Navigators, both those serving the FFM states as well as state-based marketplaces. One such proposed provision would prohibit the U.S. Department of Health and Human Services (HHS) from taking into account a Navigator entity's capacity to provide information related to association health plans or short-term, limited duration insurance in awarding grants. In California, a new law[4] taking effect this year bans the sale of short-term, limited duration insurance in the state, so our Navigator grantees would not be allowed to enroll individuals into such plans. However, with federal policies promoting the sale of short-term, limited duration insurance and association health plans as cheaper alternatives to the comprehensive coverage consumers can purchase through the marketplace, this provision appears to be timely and relevant to others states throughout the nation.

Short-term, limited duration insurance does not need to comply with the consumer protections of the Affordable Care Act, allowing these policies to deny coverage based on pre-existing conditions or other factors. Additionally, contrary to the comprehensive coverage guaranteed to be issued under the Affordable Care Act, this type of insurance generally covers a limited set of services and can include annual and benefit limits. The promotion of this type of coverage can not only leave consumers who purchase it vulnerable to health and financial risk when they need care, it can also have negative impacts to individual markets where they are sold. These products lead to the siphoning of healthy individuals out of the marketplace as they may take the risk of buying cheaper coverage with limited benefits. This will leave sicker enrollees who need the protection of comprehensive coverage in the marketplace, which creates adverse selection and can drive up premiums for everyone.

While it is unclear to what degree Navigator entities would promote short-term, limited duration insurance or association health plans given their general commitment to the

[4] Senate Bill 910 (Hernandez, Chapter 687, Statutes of 2018), commencing January 1, 2019, prohibits a health insurer from issuing, selling, renewing, or offering a short-term limited duration health insurance policy, as defined, for health care coverage in California.
http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201720180SB910

goals of the Affordable Care Act, this issue merits consideration as you deliberate on this legislation.

Conclusion

I will close my testimony by stating that, as a nation, we are at a pivotal time in health care. This subcommittee and all members of Congress will be faced with challenging decisions that will have real and significant impacts on the lives of Americans throughout the country. Having served as the only Executive Director for Covered California, I have been witness to both the remarkable achievements made thus far, as well as challenges overcome as our state-based marketplace moved from being start-up to now being a robust, financially solid, successful exchange serving millions. Despite some of the contentions around the passage of the Affordable Care Act, it is fair to say that the Affordable Care Act is the most significant health care-related legislation since the establishment of Medicare and Medicaid in 1965. Like Medicare, the Affordable Care Act was not perfect upon enactment. Also like Medicare — which has been revised many times — it can and should be reviewed, revised and improved. To the extent that federal policy discussions can shift toward building on the progress of the Affordable Care Act, we are hopeful that the work of Covered California and other state-based marketplaces can serve as a roadmap for the nation.

Again, I would like to thank the committee for inviting me to testify on this set of timely and relevant proposals. I am honored to represent Covered California, and always aim to help inform the health policy dialogue at both state and federal levels. To that end, I encourage you to use Covered California as a resource, and do not hesitate to reach out to us if we may provide you with any information or lessons learned that can assist you as you consider health care proposals that come before you in Congress.

Peter V. Lee
Executive Director
Covered California

Ms. ESHOO. Thank you, Mr. Lee, excellent testimony.

Now I would like to recognize Mr. Wieske for his 5 minutes of testimony. Welcome and thank you.

STATEMENT OF J. P. WIESKE

Mr. WIESKE. Thank you, Chairman Eshoo and Ranking Member Burgess, for the opportunity to testify on the issues surrounding the Affordable Care Act and more specifically the individual health insurance market through the proposed legislation regarding exchanges, reinsurance, and navigators.

When I spoke before the committee in February of 2017, I focused on the nature of the individual market. Since that time, little has changed. It has remained a very small market, less than 5 percent of almost every State's population, dwarfed by employer coverage, Medicaid, and Medicare. In 2019, we have seen a drop from the very sharp rate increases, but premium rates remain too high. Of course the subsidized insurance market consumers have largely been insulated from those rate increases. In some cases, consumers even have the option of choosing no premium Bronze plans due to the issue of silver loading, a process by which a State allows insurers to apply cost-sharing reduction expenses exclusively to on-exchange plans.

The question before the committee is the same as it was in 2017. The ACA has done many good things for consumers, but it has also created new problems. So how can we fix this market? I think you can see from my written testimony that we support the same goals. We need to stabilize the insurance market. We need more outreach. We need more States' flexibility and State ownership of the ACA.

Please allow me a brief aside. Last November I attended an InsureTech conference. It was filled with innovators from across the globe looking at insurance problems. And I was struck by one——

Ms. ESHOO. Excuse me. What was that conference? I didn't get——

Mr. WIESKE. An InsureTech conference.

Ms. ESHOO. InsureTech?

Mr. WIESKE. InsureTech conference, correct.

Ms. ESHOO. I see.

Mr. WIESKE. InsureTech conference, and I was struck by one presentation in particular. It was from an entrepreneur who had figured out how to provide crop insurance to rural Africa through their nonsmartphones. What was fascinating about this is that this innovator had found a way, is unlikely to make any effort and make any money off his effort, but that wasn't the goal. The goal was to provide financial stability to rural farmers in Africa. A financially stable farmer is better able to provide for his family and for his neighbors. The solution did not come from government. It came from a private company looking to solve a problem. Similarly, the goal of reinsurance, exchanges, and navigators is not just to provide money for those programs, but to stabilize the market, encourage consumers to make an informed decision in purchasing health insurance coverage.

While I still hope you read my eight pages of testimony, I can encapsulate it this way. CHC has long supported reinsurance and

ACA 1332 waivers to improve the markets, including Collins-Nelson and Alexander-Murray efforts in the Senate who recognize that reinsurance doesn't reduce costs directly, it shifts who pays. We addressed the long, hard work of improving risk pools and lowering costs in a letter we recently sent to Senator Alexander which we would be happy to make available to members of the committee.

Navigators, again our experience in Wisconsin was that navigator approach didn't have a huge impact. In my written statement I recommend both closer engagement with traditional brokers and agents as well as new technologies to help consumers find coverage. Finally, we recommend going beyond State exchanges to allow private exchanges and web-based alternatives and direct enrollment to connect people with coverage. Again thank you for the opportunity to testify and I will be happy to answer any questions.

[The prepared statement of Mr. Wieske follows:]

COUNCIL FOR AFFORDABLE
HEALTH COVERAGE

Testimony of J.P. Wieske
Council for Affordable Health Coverage

Committee on Energy and Commerce, Subcommittee on Health
Hearing on "Strengthening Our Health Care System: Legislation to Lower Consumer Costs and Expand Access"

March 6, 2019

Introduction

Chairwoman Eshoo, Ranking Member Burgess and Members of the Subcommittee, I appreciate the opportunity to testify today on the issue of lowering consumer costs and expanding access, and for continuing the dialogue surrounding the status of the individual health insurance market.

I am J.P. Wieske, Vice President of State Affairs at the Council for Affordable Health Coverage, also known as CAHC, which is a broad-based alliance with a singular focus: bringing down the cost of health care for all Americans. I testified before this committee in my prior role as Deputy Commissioner of Insurance for the State of Wisconsin in February of 2017. In that role, I was involved with a number of health insurance issues including serving on Wisconsin's high-risk pool board, working with the state legislature, and assisting with operationalizing the Affordable Care Act (ACA). I would also note that in my former role, I have had some leadership experience on state issues serving as Chair of the National Association of Insurance Commissioner's Regulatory Framework Task Force, Chair of the Pharmaey Benefit Manager Subgroup, Chair of the Network Adequacy Subgroup, and Chair of the Health Care Regulatory Alternatives Workgroup. It should be made clear that my views do not reflect the views of the state of Wisconsin nor the National Association of Insurance Commissioners.

CAHC's membership reflects a broad range of interests—organizations representing patient groups, consumers, small and large employers, insurers and health plans, biopharmaceutical manufacturers, and physician organizations. CAHC is concerned health costs are too high and rising too fast. In fact, costs continue to rise faster than the economy, while premiums are increasing about four times faster than wages. As a result, by 2030 the typical family will spend more than 40 percent of their income on health care.[1] We support many reforms to promote affordability, including efforts to reform health markets, improve health care transparency, promote value-based care, and strengthen patient adherence to medications.

My testimony will address the following topics:

1. The Individual Market Generally
2. Reinsurance / 1332 Waivers
3. Navigators / Outreach
4. State Based Exchanges

The Individual Health Insurance Market

In essence, the individual market functions as a residual market by providing coverage to anyone not eligible for anything else. This creates a unique set of needs. Some consumers need coverage only

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

temporarily between employment-based coverage. Some are temporarily too sick to work. Others are entrepreneurs who are working independently and starting their own business. This is a market that needs to serve this diverse population.

The ACA made massive changes to health markets. It created new consumer protections, corrected market imbalances, and reduced the number of uninsured Americans to historic lows. Yet there are high and growing health insurance premiums, marked by average double-digit price increases on exchange plans both this year and next. 2018 data from eHealth shows the average cost of an individual (Obamacare) health insurance plan has increased 123% since 2013. During that same period of time, average monthly premiums for families increased 174%. The result is an unbalanced and expensive market that is driving away many of the healthy consumers the exchanges need to attract in order to hold coverage costs down over the long term. This fact should spur Congress to enact bipartisan reforms to help stabilize and improve markets, making health care more affordable and accessible for all Americans.

Based on my experience in Wisconsin, it's clear that the ACA created winners and losers among enrollees in the individual health insurance market. Before, HIPAA provided guaranteed issue coverage and guaranteed renewability for those that maintained coverage, but there were no subsidies and premiums could rise sharply as enrollees aged. People whose applications for coverage were denied used the state's subsidized high-risk pool, which in Wisconsin was good coverage at fairly reasonable prices.

In the pre-ACA market, only employers and their employees were subsidized through tax-favored treatment. Most employees can pay for their benefits pre-tax through Section 125 / Cafeteria plans. Consumers in the individual market did not receive that help. And make no mistake, consumers in the individual market are the most vulnerable.

Now, most individual market consumers in Wisconsin are receiving subsidies for their coverage, which has made it more affordable. Unfortunately, because the overall risk pool in the individual market has worsened – with not enough younger and healthier enrollees to offset the costs of those older and sicker – the cost of coverage for those without subsidies has become even more unaffordable.

I realize Wisconsin may have been a special case. Before the ACA, Wisconsin had a high functioning risk pool that subsidized the premiums of those with health conditions and provided comprehensive insurance coverage for care from any medical provider in the state. Not all state high risk pools functioned so well and neither did some markets. HIPAA may have provided guaranteed issue and guaranteed renewability to individuals maintaining continuous coverage, but in some states, insurers were allowed to significantly raise premiums for individuals whose medical expenses were expected to be high.

Taken as a whole, when we compare the pre-ACA and post-ACA individual market, it is clear that we have solved for some problems while inadvertently creating others, and as a result, there is still

work to do. With the shared aim of lowering costs and increasing access to our health care system, I hope that the details I will offer on Wisconsin's individual market will shed light on the potential impact of proposed legislative changes considered here today.

What Happened in Wisconsin?

Prior to the ACA, in states like Wisconsin, relatively young and low-risk individuals enrolled in the individual market, and the sick were subsidized through broad based subsidies like those offered in a high-risk pool.

Since my experience has primarily been in the state of Wisconsin, I will highlight the issues I observed in my prior role as Deputy Insurance Commissioner for Wisconsin. As a reminder, I do not speak for the state of Wisconsin in any capacity.

When we worked to operationalize the ACA for Wisconsin residents, our main goal was to ensure Wisconsin consumers were protected from any negative consequences. We had planned to create our own version of an exchange that would have been a one-stop portal for folks eligible for Medicaid and subsidized ACA coverage. We worked extensively with stakeholders and the high-risk pool to create a new risk mitigation program under federal law and provide a glide path for high-risk pool members. We had planned to build on the Office of Commissioner of Insurance's regulatory authority to ensure compliance with law in the same way we had done with HIPAA.

Without question, the first open enrollment during the early implementation of the ACA in 2013 ranged from problematic to completely dysfunctional. While there were a number of discreet factors that contributed to that outcome, a common thread was the lack of state control and flexibility at a time when states were trying to interpret the new law and regulations, and develop and implement action plans, all while operating with extremely short timeframes. Learning from that experience, it is imperative that in the context of any fixes to the ACA that states need more flexibility not less. States know what will work in their state. What works in Wisconsin will not necessarily work in

Michigan, Texas, or California. As with the old Medicaid adage, if you have seen one state insurance market, you have seen one state insurance market.

I can only extrapolate from my experience in Wisconsin. I know some of my former colleagues faced similar issues while others did not.

In the reports issued around the reinsurance program in Wisconsin, we highlighted the problems:

- higher rates
- higher cost sharing, and
- fewer insurers in the market.

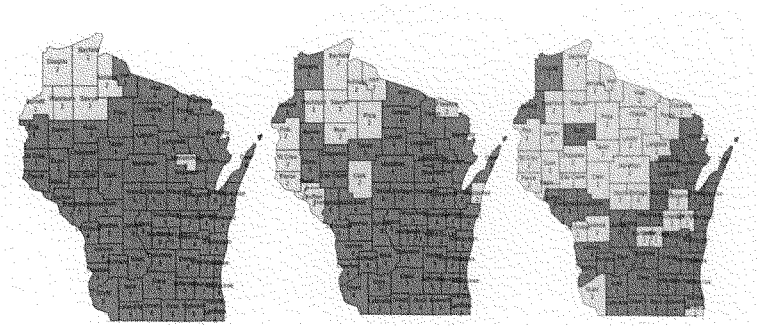
Insurers who offered coverage in the individual market just a few years ago – and indeed are still active in the small group market – have left the individual health insurance market. It is easy to see why: Wisconsin insurers lost more $500 million in the individual market since the start of the ACA. Loss ratios have exceeded 100% after the various temporary risk mitigation programs ended. Premiums had a huge jump with the ACA, and despite lower rates in Wisconsin in 2019, insurance is still mostly unaffordable for those not receiving a subsidy.

In short, the post-ACA market has its own issues. Premiums are too high. Consumers have fewer choices with higher cost-sharing and narrower networks. Insurers operating in the market have lost significant amounts of capital which negatively impacts their other lines of business, and raises costs for all consumers.

Reinsurance

Our primary effort was to pass the reinsurance program known as the Healthcare Stability Plan. At roughly this time in 2017, it was likely that two health plans were functionally dropping out of the ACA market. This would leave the state with just one insurer in a number of areas including my hometown of Green Bay, Wisconsin. For this section of the state, it meant the only insurer providing

coverage was Common Ground, the state's federal co-op. The maps below highlight the issue as we entered the rate and form filing period.



2016 2017 2018

Green: 3 or More Insurers
Yellow: 2 Insurers
Red: 1 Insurer
Source: Wisconsin Office of the Commissioner of Insurance (OCI)

The health insurers remaining in the market raised significant concerns about whether or not they could take on as much risk as required by the new market. Even more considered dropping out because of the risk. While Wisconsin had numerous insurers in the market, most of them covered only a relatively small region and in some counties were facing taking all of the risk. Most businesses seek the kind of monopoly status these insurers had, but in the individual market they were concerned that capturing the market could drive them to insolvency.

The goal at this point was to create a solution to make coverage both more affordable and bring back new entrants. While alternatives to reinsurance were considered, the restrictions surrounding the 1332 waiver process made it untenable to impact the 2019 plan year through more innovative reforms.

Ultimately, a solution was crafted to create a $200 million reinsurance program covering claims between $50,000 and $250,000, with the ability to make adjustments in future years. The shared savings model under the ACA's 1332 process limited the state's liability to about $72 million dollars

while the federal government – through the savings on the ACA subsidies it would otherwise have to pay – would cover the remaining about $128 million. This reflects a 64% pass through rate.

The net result was positive for Wisconsin consumers. Wisconsin received numerous inquiries about market re-entry, and ultimately insurers entered new markets in several areas. This was especially true in the Green Bay area. More importantly, it led to lower premiums across the state. Reinsurance reduced premium rates by a little more than 10 percent from where the rates would have been. Ultimately, rates were lower by roughly 4.2% from the 2018 rates.

While the program met its goal, it is important to note that reinsurance is not a panacea. It is another way to provide a government subsidy. It doesn't change the fundamentals of the risk pool nor make the market healthier. It also doesn't attract the young and healthy back into the market. Long term, the same reinsurance money will have diminishing returns; in other words, it will require more money to continue to provide the same savings. It is also important to note that it will have little effect on those consumers already receiving subsidies – between 100-400% of poverty in Wisconsin's case.

One other important lesson from reinsurance is that the program has to build in appropriate incentives. Insurers must retain some of the risk in reinsurance or there will be no incentive to properly manage the program. While states need access to additional funding, it is important for individual states to consider costs and impact in designing the program. A poorly designed program without a state stake could lead to perverse market impacts including a negative impact on other market segments.

Navigators

There is no question that people continue to need assistance in purchasing coverage, and while Navigators have provided some assistance, the claim that loss of navigator funds is alone responsible for the drop in 2019 enrollment is misguided. A fair analysis may find a number of factors contributed, including a robust economy with very low unemployment which should lead to higher rates of employment-based insurance coverage.

The loss of agents in the individual health insurance market has created many problems and navigators are just not a substitute for driving enrollment. Wisconsin licensed over 100,000 agents, both domestic and from outside the state. Unfortunately, federal policies like overly restrictive medical loss ratio rules, have encouraged insurers to move away from using agents. Access to agents provides consumers with value before and after their purchase of insurance and they have long played a role in assisting consumers in understanding their policies not just at time of sale, but when the consumer has a claim. An agent typically also has a longer-term relationship with their client,

and assisting them in changing plans from year to year is done with an understanding of their personal history.

The federal navigator program is a program that operates largely outside of the current health insurance system. Even before the reduction in funding, we saw fewer and fewer navigators and navigator entities. Anecdotally, many navigators are appropriately referring clients to agents or brokerage firms to actually effectuate coverage. In many cases, the navigator program is centered around large population centers with limited availability to the rural community. It is in these areas where it is particularly important for an insurance advisor to deeply understand issues like network adequacy, carrier reputation, and many other local concerns.

In short, a stronger emphasis on Navigators alone as an enrollment solution may not provide the value some seek or expect.

It is also important to find consumers where they want to shop. Younger consumers who have largely abandoned the individual market shop online for most things. They are generally not interested in face-to-face interactions. Any legislation should provide states and the federal government more flexibility in connecting consumers with insurers and brokerage firms that are using technology to link consumers with products. If we truly want to increase outreach opportunities, we need to allow the industry to innovate.

State Exchange Funding

Health exchanges are a fundamentally sound idea. They reflect the proposition that informed consumers can stimulate system-wide improvements in the cost and quality of health care as they have in other realms. The exchanges are designed to facilitate online comparison shopping for health insurance plans by providing a transparent review of complicated price and coverage details. CAHC has conducted an annual survey to assess the e-commerce competency of the public exchanges created after the enactment of the ACA. The subjects of our study include the 12 exchanges run by individual states and the District of Columbia, as well as the federal health exchange, Healthcare.gov, which provides services in 38 states.

Our independent review offers an unbiased look at all of the exchanges — each a monopoly serving a captive market within their respective state. In some cases, it appears that certain state-run exchanges are subject to chronically weak legislative oversight and the structural flaws inherent in monopolies that are well-documented (including insensitivity to customer needs and lagging innovation). Total reliance on public exchanges and enrollment efforts have proven to be insufficient

to offer consumers consistently functioning sites that both inform and ease the plan selection process.

- More than half the exchanges (7) received a D or F —all of them state-based. There was one A, four Bs and one C. The average exchange website scored 71 out of a possible 100 on our composite index, and had 3 best-in-class shows.

- Healthcare.gov, the federally-facilitated exchange that serves 38 states, ranked fourth in our index, scoring 81 out of a possible 100. The federal exchange had four best-in class showings. Key minuses included a rudimentary cost calculator—one based on a default order that prioritizes premiums alone rather than more important indicators of consumer value, such as expected annual out-of-pocket costs. These deficiencies can present a misleading view if the expected costs and benefits of plans to consumers.

- Variation in exchange composite scores indicate the consumer experience is uneven across the country, with an F (a 48) at the low end and a high of 92. This may reflect the varying levels of commitment (both political and financial) to public exchanges.

Despite the more than $5 billion spent to establish and maintain public exchanges, most have been operating below the state of the art in consumer accessibility and decision-support tools even though these tools are often found in the private sector. As a result, consumers are not receiving the benefits of available technologies to support sound decision-making, and fewer consumers enroll.

The number of unique requirements, constraints, and embedded processes that government entities must navigate is significant, and slows the government's ability to respond and adapt quickly. This structure is intentionally designed to guide federal agencies broadly, but is not made to facilitate quick, dynamic responses that technologically demands and requires. As a result, with respect to exchanges, government-run programs simply cannot keep up with market demand. We believe competition is better for consumers. In no other sector does the government compete with private industry to the disadvantage of the consumer, and we believe that consumers, the government, and industry will all be better served if we work together to improve the consumer experience in the individual market.

As I highlighted in the opening section, Wisconsin was an early grant recipient to create a state-based exchange. The grant funds were used to explore options, but ultimately found that the rules surrounding creation of an exchange were overly prescriptive and burdensome. A regulator in another state described the exchange rulemaking process as akin to buying a car: while states were allowed to decide what color fabric was in the interior, they were not allowed to choose the make, model or any other details of the car. Nothing in the intervening years has made the process

significantly more flexible, and it is unlikely the $200 million is enough to entice new state-based entities.

As an alternative, our report suggested some common-sense solutions to improve the market.

1. Over the next three years, transition to a privately-operated exchange model and eliminate funding for activates unrelated to the federal data hub in the HealthCare.gov program;

2. During scheduled downtime, HHS should direct all traffic to private enrollment web sites;

3. Transition an increasing number of APTC eligible enrollees into privately operated exchanges, starting with at least 10 percent in the enhanced direct enrollment pathway in 2019;

4. Congress should enable all beneficiaries to use their premium tax credits off the public exchanges, to also be used in the privately-operated exchange model when fully implemented; and

5. Reduce or eliminate the 3.5 percent premium tax that funds public exchanges.

Conclusion

CAHC is very concerned about diminished affordability since enactment of the ACA, and the lower enrollment on exchange plans may be a warning sign of a market in the midst of a death spiral. Even with subsidies, many of those enrolled may remain functionally uninsured due to increasing cost sharing. Increasing subsidies, enacting new reinsurance programs and setting up new government-run monopoly web sites will not fix the underlying problems in the market.

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

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

Ms. ESHOO. We thank you, especially for not attempting to read eight pages of testimony into the record.

Now I would like to recognize Ms. Audrey Morse Gasteier. Am I pronouncing your name correctly?

Ms. GASTEIER. Gasteier, that is right.

Ms. ESHOO. Thank you very much for being here and you are recognized for 5 minutes.

STATEMENT OF AUDREY MORSE GASTEIER

Ms. GASTEIER. Thank you. Good morning, Chairwoman Eshoo and Ranking Member Dr. Burgess, and members of the subcommittee. My name is Audrey Gasteier and I serve as Chief of Policy and Strategy at the Massachusetts Health Connector. Thank you for the opportunity to testify today and share perspectives for Massachusetts on expanding coverage and lowering costs.

Massachusetts has a unique history of bipartisan health insurance expansion efforts spanning several decades. The advantage of time has given us perspective on what health reform and State marketplaces can look like when given stable regulatory environments and tools to promote affordability and enrollment. This historical view may be useful as the subcommittee builds upon the initial years of ACA implementation.

Today Massachusetts enjoys a strong health insurance market and the Health Connector is a high functioning and competitive marketplace with nine carriers and 280,000 enrollees. Three key building blocks have been critical to our market's success. First, one of our most effective tools for promoting affordability is our ConnectorCare program for individuals earning up to three times the poverty level.

ConnectorCare provides additional State subsidies in addition to ACA subsidies. Enrollees have access to zero or low-dollar premiums, zero or low-dollar copays, and no deductibles. This level of affordability assistance helps retain widespread enrollment among a population that would otherwise be at higher risk of uninsurance.

Second, for decades our market has featured the basic protections consumers have come to expect following the ACA, such as protections for people with preexisting conditions, guaranteed issue and renewability, community rating and strong standards for minimum medical loss ratios. In addition, our State has its own market rules and coverage standards and engages in robust market monitoring which together results in little room for noncompliant plans, keeping our risk pool stable and our residents in coverage that is there for them when they need it.

Further, since 2007, the Commonwealth has had its own individual mandate ensuring that people do not buy coverage only when they expect to need it, driving up premiums for everyone else. Third, the Health Connector has seen firsthand the powerful role that outreach and consumer assistance play in drawing residents into coverage. Outreach is an integral part of successful coverage expansion and an essential component of stable risk pools by drawing healthier risk into the marketplace, improving affordability for all.

The Health Connector runs a robust navigator program partnering with 16 organizations with longstanding, trusted pres-

ence in their communities. These three building blocks of reform have resulted in a number of successes for our residents. Specifically, Massachusetts has achieved nearly universal coverage with 97 percent of our residents now covered.

The Massachusetts Health Connector had the lowest average premiums of any marketplace in the country in 2018 at $385 per member per month before any subsidy was applied. We note for the subcommittee that these lowest-in-the-Nation premiums are situated within a State market with robust benefit requirements and protective cost-sharing limits, clarifying that cost savings need not come at the expense of consumer protections.

Further, we note that Massachusetts' overall healthcare system is one with relatively high medical costs, illuminating that the marketplace model has the potential of bending the curve for consumers even while the State and Nation still have work to do in bringing down the underlying healthcare costs that drive premiums. We support this subcommittee's interest in ensuring that States have resources and tools to foster stability and affordability.

We support the proposed State options for further advancing affordability for consumers whether they are low and moderate income, and affordability would be achieved through a State wrap program designed to meet State and local needs or a reinsurance program that could lower premiums across the commercial market helping unsubsidized enrollees as well. Each State's affordability challenges are likely to be unique and it is important for States to have flexibility to address the needs of their populations and market conditions above and beyond the baseline protections of the ACA.

With respect to the navigator proposal, the Connector's experience suggests that a robust navigator program is a vital component of ensuring coverage for the populations that need the most help getting insured and that the work they do contributes to the overall stability of the commercial market risk pool.

Lastly, the Health Connector recognizes the subcommittee's interest in supporting States that are interested in establishing new State-based marketplaces. The successes Massachusetts has experienced would simply not be possible without a State-based marketplace. Working side by side, day in and day out with market participants, State-based marketplaces can successfully bring the promises of health reform and coverage expansion to life.

Thank you again for the opportunity to speak with you today and your interest in hearing about our experiences in Massachusetts. I look forward to working with you and welcome your questions.

[The prepared statement of Ms. Gasteier follows:]

Testimony of Audrey Morse Gasteier
Chief of Policy and Strategy, Massachusetts Health Connector

Hearing on "Strengthening Our Health Care System: Legislation to Lower Consumer Costs and Expand Access"

U.S. House of Representatives
Committee on Energy and Commerce Subcommittee on Health
March 6, 2019

Good morning, Chairwoman Eshoo and Ranking Member Burgess, and members of the Health Subcommittee of the Committee on Energy and Commerce, and thank you for the opportunity to testify today.

My name is Audrey Morse Gasteier and I serve as Chief of Policy and Strategy at the Massachusetts Health Connector. I appreciate the opportunity to share perspectives from Massachusetts as they relate to policy proposals designed to expand health coverage and lower costs. Massachusetts believes strongly in health care coverage for all of its residents, and has a unique history of bipartisan, innovative health insurance expansion efforts spanning several decades.

The advantage of time (and the lessons that come with an extended runway and the opportunity to iterate) has given us some perspectives on what health reform and local insurance markets and state marketplaces can look like when: (1) given time and stable regulatory environments in which to mature and thrive and (2) equipped with a strong set of tools to promote affordability and enrollment in strong and comprehensive health coverage. This historical view may be useful as the Subcommittee builds upon the initial years of Affordable Care Act (ACA) implementation.

Background

In 2006, Massachusetts enacted health reform legislation that has since resulted in the highest rate of health coverage in the nation – currently over 97 percent. The Massachusetts approach to health reform and coverage expansion embodied a bipartisan spirit of shared responsibility for coverage, with a broad coalition of consumers, employers, insurers, providers, state policymakers, and federal partners working together to achieve near-universal coverage. This initiative leveraged both public and commercial coverage options, and ensured that our residents' health and financial stability would be protected by a strong health coverage system.

Our health reform effort included an array of policy and programmatic components, many of which later went on to be incorporated into the ACA.

Our guiding principles for reform include: (1) promoting coverage of a strong set of benefits and services; (2) building on commercial carrier coverage; (3) ensuring fair competition among insurance carriers; (4) providing affordability supports for coverage, particularly for low- and moderate income residents; and (5) instituting mechanisms to protect consumers.

Specifically, our reform law created a state-based marketplace, the Health Connector, a competitive marketplace for individuals and small businesses to shop for high-quality health coverage. The Health Connector has been a programmatic and policy-making cornerstone of our 13-year reform history. Since its inception, the Health Connector has administered a unique state-designed program that provides subsidies for low- and moderate-income individuals to help them afford coverage— in a program originally called Commonwealth Care, later renamed ConnectorCare after the implementation of the ACA. Further, the Health Connector operates a curated, competitive marketplace platform for unsubsidized individuals and small businesses to shop for commercial coverage. The Health Connector also governs the Commonwealth's state-level requirement that adult residents carry coverage that meets minimum standards.

A few years after these reforms took effect, Massachusetts implemented the additional reforms of the ACA, and has also since enacted legislation to promote health care quality and cost-containment.

Today, the Commonwealth enjoys a strong health insurance market and the Health Connector is a stable, high-functioning, and competitive ACA-compliant marketplace, with nine carriers selling 57 plans to individuals and 70 plans to small businesses for plan year 2019. Competition among carriers is strong and the Health Connector's 280,000 enrollees have access to meaningful choice. The vast majority of our membership reports satisfaction with their experience with the Health Connector and, since its creation in 2006, the Health Connector has worked to steadily grow its membership. Its nongroup enrollment now comprises roughly 80 percent of the entire Massachusetts nongroup market.

While every state's health insurance market and needs are unique, we hope to offer perspectives and experiences that might help inform the Subcommittee about evidence-based ways to allow health insurance markets and marketplaces to thrive and to ensure even stronger access to high-value coverage in stable markets. Our 13-year experience of market-based health reform and running a state-based marketplace offers some indications about what works and what is possible, all while recognizing we are still learning and the work of ensuring access to affordable coverage must continue.

Three Building Blocks of Our Successful Coverage Expansion and Market Environment

There are three key building blocks that have been particularly critical to our market's success on affordability, access, and stability.

(1) Flexible State Investments to Make Coverage More Affordable and Accessible to Low- and Moderate-Income Households

One of the Massachusetts Health Connector's most unique and effective tools for promoting access and affordability is its ConnectorCare program for individuals with income up to 300 percent of the Federal Poverty Level (FPL), sometimes referred to as a "state wrap" program. ConnectorCare provides additional state subsidies to individuals enrolling in lower-cost Silver tier plans by providing both premium and cost-sharing subsidies in addition to ACA subsidies.[1] Depending on income, enrollees have access to zero- or low-dollar premium plans, zero- or low-dollar co-pays, and no deductibles or co-insurance. This program currently covers approximately 200,000 individuals, or about three-quarters of total nongroup enrollment in the Health Connector. Our experience is that this level of affordability assistance is critical to residents at these income levels, who do not have access to employer-sponsored insurance and are earning low wages that have not kept pace with health care costs, and helps draw and retain widespread enrollment among a population that would otherwise be at higher risk of uninsurance.

In addition to directly assisting Massachusetts residents who would otherwise struggle to afford health coverage, the program also benefits the broader commercial market for unsubsidized individuals and small groups. The Health Connector has designed the ConnectorCare program to foster competition among participating carriers, which compete to be the lowest cost plan and thereby enroll a larger share of the program's enrollment. These competitive dynamics pull down the pre-subsidy base cost of premiums, which are then available to unsubsidized enrollees and even small businesses, which are situated in the same commercial market risk pool as our nongroup market.

(2) State-Based Approaches to Keeping Markets and Risk Pools Healthy and Stable

Massachusetts has long taken a proactive approach to ensuring the health and stability of its health insurance market and risk pool. It has accomplished this through an array of carefully calibrated regulatory approaches that respond to local market conditions and policy objectives, ensuring a stable insurance landscape and promoting core consumer protections.

To promote a fair and competitive health coverage market, Massachusetts has taken a number of steps over the years to strengthen its market and protect against consumer risks, including:

- Prohibiting insurance carriers from denying coverage to residents with pre-existing health conditions;

[1] As an example, a 42 year old living in Worcester, Massachusetts who is earning $20,000 per year (168.35% FPL) would have access to coverage based on a $288 "full cost" silver plan, with an APTC subsidy of $192 bringing their premium down to $96 per month. ConnectorCare, however, adds an additional state premium wrap subsidy of $53, further lowering this individual's monthly contribution to $43.

- Requiring guaranteed issue, guaranteed renewability, and community rating;
- Setting rigorous standards for health plan minimum medical loss ratios (MLR) that are higher than those required by the ACA; and
- Merging the nongroup and small-group markets; and further expanding the insurance risk pools by adding the population of residents with subsidized coverage purchased through the Health Connector to our commercial "merged market."

Further, an array of state laws and regulations around market behavior and comprehensive coverage standards have resulted in little room for non-compliant plans, keeping our market's risk pool stable and broad, and our residents in coverage that is there for them when they need it.

In addition, since 2007, the Commonwealth has had its own "individual mandate," requiring individuals to maintain coverage that meets minimum creditable coverage standards; this ensures that people do not buy health insurance only when they expect to need it and then later drop out of coverage, driving up premiums for everyone else. Our individual mandate has helped foster a market environment where consumers, issuers, and providers are protected.

These localized approaches to stewarding our state insurance market – through policy-making, regulation, and market engagement – have been driven at the state level, which allows for us to continue to react to local market conditions and needs.

(3) Robust In-Person Outreach and Education for Enrollment in Health Coverage

Since our earliest coverage expansion efforts, the Health Connector has seen first-hand the powerful role of outreach and consumer assistance for drawing residents into health coverage through the marketplace. Outreach is an integral part of successful coverage expansion and is also an essential component of keeping risk pools stable, by drawing often healthier risk into the marketplace, improving market stability and affordability for all. The Health Connector runs a robust Navigator program partnering with 16 organizations composed of a mix of community-based nonprofits, public health organizations, fishing industry organizations, and community health centers. To be responsive to the nature of the populations in need of the most assistance to join and stay in coverage, the Health Connector's Navigator grantees offer assistance in 21 languages. Approximately one-third of Massachusetts residents who have been assisted by Navigators speak a language other than English; about 12 percent speak a language other than English or Spanish.

Through deep local community ties, Navigators help bring new people into the ranks of the insured because they can assist people where they live, work, and go to school. During the Open Enrollment period for 2019 coverage, Navigators held over 400 informational events to educate Massachusetts residents about their health care coverage options. Navigators also help keep people in coverage. During 2018, Navigators fielded nearly 30,000 renewal questions, over one-third of which came in during 2019 Open Enrollment.

Although Massachusetts has had a coverage rate near 97 percent for the last several years, maintaining and improving this high level of coverage requires ongoing and consistent work to educate individuals about coverage. Because the nature and purpose of marketplaces is to provide coverage to people who may be coming and going between other types of coverage, the population that needs assistance is always churning. As such, outreach will always be an ongoing component of a healthy, high-functioning marketplace.

In addition to broad-based marketplace awareness initiatives, the Health Connector analyzes data from the U.S. Census Bureau and other national data sources, as well as state-based sources of data on insurance trends, demographics, economic trends, and other population data to develop maximally effective outreach interventions. The Health Connector and our Navigator partners then craft and execute data-driven strategies in "target communities": cities and towns with the highest percentages of uninsured residents, such as Springfield, Lawrence, and Lowell. We conduct marketing and advertising in seven languages and a variety of print, radio, and television formats, as well as digital advertising and in-person events, with particular intensity in these target communities. The results of this on-the-ground, data-driven work are clear: During the 2019 Open Enrollment period that just concluded, 46 percent of new members came from these identified target communities, compared to 35 percent during 2018 Open Enrollment, when we hadn't yet begun intensive targeted outreach.

Results

The building blocks of reform I have detailed above have resulted in a number of successes for the Commonwealth's health coverage landscape and residents, including:

1. The lowest average marketplace premiums in the nation. In 2018, the Massachusetts Health Connector had the lowest average premiums of any marketplace in the country, at $385 per month (before any subsidy was applied). These premiums are likely the result of a high degree of competition fostered by the design of the ConnectorCare program, the power of comparison-shopping when price sensitive consumers can compare standardized benefits in an apples-to-apples fashion, a high number of carriers (most of whom are local non-profits), state-based insurance market stability policies, and assertive outreach and assistance to consumers. These low premiums benefit not only the Massachusetts residents enrolled with the Health Connector, but the broader commercial market as well.

We note for the Subcommittee that these lowest-in-the-nation marketplace premiums are situated within a state market that has very robust and protective benefit requirements and cost sharing limits, clarifying that cost savings and affordability need not come at the expense of consumer protections. Further, we note that Massachusetts's overall health care system is one with relatively high medical costs, illuminating that the marketplace model has the potential of bending the curve

for consumers even while the state and nation still have work to do in bringing down the underlying health care costs that drive premiums.

2. The highest rate of insurance coverage in the nation. Massachusetts has achieved nearly universal coverage, with over 97 percent of its residents in health coverage. The Health Connector continues to use data to better understand and reach individuals without coverage and communities at relatively greater risk of uninsurance, and we see recent evidence of further inroads in the remaining uninsured. The Health Connector serves 280,000 individuals and has one of the highest enrollments as a share of a state population of any marketplace.

3. This Open Enrollment, the Health Connector had the highest year-over-year marketplace enrollment growth in the nation. Over 60,000 new individuals signed up for 2019 Health Connector coverage this Open Enrollment, which ran from November 1st to January 23rd, longer than the federal Open Enrollment period and consistent with the state's Open Enrollment dates in recent years. This extra time, combined with affordable premiums and data-driven community-level outreach initiatives, helped Massachusetts lead the nation in marketplace enrollment this Open Enrollment.

4. Better physical, mental, and financial health for state residents. In 2017, the Urban Institute found Massachusetts ranked fourth among states for the lowest share of residents with past due medical debt, and Becker's Hospital Review named Massachusetts the second-healthiest state for the last two years. Along with strong insurance coverage, Massachusetts' healthy designation is driven by low obesity rates, the lowest teen birth rate in the country, low infant mortality rates and high percentages of well-baby checks and vaccinations.

Conclusion and Suggestions for the Subcommittee

Based on the experience of Massachusetts, the combination of state-level control and flexibility, outreach, and funds to support enhanced affordability are the key building blocks that have led to historic gains in health coverage and a vibrant, competitive, and stable health insurance market that promotes health care access and protects people from financial ruin. We support this Subcommittee's interest in looking at evidence of what works in state insurance markets and marketplaces and its interest in ensuring that states have resources and tools to foster stable health insurance markets, make coverage more affordable through reinsurance or state wrap programs as they see fit to best address their local market conditions, and ensure that consumers have ready access to reliable in-person outreach and assistance.

With respect to the proposal to make funds available to states to stand up a federally or state-administered reinsurance program or reduce cost sharing burdens, we support the combination of resources devoted to state options for further advancing affordability for consumers— whether they are low- and moderate-income and affordability would be achieved through a state-wrap program

designed by the state to meet local needs, or a reinsurance program that could lower premiums across the commercial market, helping unsubsidized enrollees as well. Each state's affordability challenges are likely to be unique, and it is important for states to have the flexibility to address the needs of their populations and market conditions. Although Massachusetts has the lowest average premiums of any marketplace in the country, unsubsidized individuals and small businesses continue to see challenges with affordability, and we support serious consideration of options for reinsurance programs, which are proven, powerful tools to promote affordability in those market segments. We need to identify opportunities to address small business affordability in our state, ranging from new initiatives through the Health Connector's small business platform to working on flexibility to preserve certain historical market approaches to small groups that are unique to Massachusetts's particular merged market structure.

With respect to the Navigator proposal, the Health Connector's experience suggests that a robust Navigator program is a vital component of ensuring access to coverage for the populations that need the most help getting into the ranks of the insured, and that the work they do contributes to the overall stability of the commercial market risk pool. In our program, we believe it is vital to work with organizations that are based in their communities, operate as non-profits, are expert in high-need populations, and are prepared to educate individuals about Qualified Health Plans and the importance of comprehensive coverage, as well as adapt to locally-identified emerging needs, like educating consumers about being on guard against scam health insurance products.

Lastly, the Health Connector recognizes the Subcommittee's interest in supporting states that are interested in establishing new state-based marketplaces to address local population and market needs. The successes and lessons described above from the Massachusetts experience would simply not be possible without a state-based marketplace. A state-based marketplace, reacting to local policy and market needs, working side-by-side, day-in-and-day-out with market participants, can successfully bring the promises of health reform and coverage expansion to life. Our effective outreach apparatus, a state-wrap program, an approach to proactively ensuring market conditions that promote fair, stable, comprehensive coverage for all – through an individual mandate and market oversight – are strongly rooted in the ability for the state to run a state-based marketplace geared to Massachusetts-specific market needs.

The Health Connector deeply values the working relationship it has with its 12 peer state-based marketplaces, learning from and leaning on each other in ways big and small, on everything from reacting to federal rule-making to considerations for managing call centers to best practices for working with local broker communities. Although our states' markets, stakeholders, political environments, and sizes may vary, we share a common commitment to being there for the residents of our states who need high-quality coverage and to using the marketplace model, which holds much promise for individuals and small businesses alike, to make health insurance markets work better. The state-based marketplaces' performance this Open Enrollment, including Massachusetts's

success, underscores the difference that is possible with state flexibility made possible through the state-based marketplace model.

Thank you for the opportunity to speak with you today and your interest in hearing about our experiences expanding and improving health coverage in Massachusetts. I look forward to working with you and welcome any questions you may have.

Ms. ESHOO. Thank you very much.

Congratulations to each one of you. You did really well with your allocation of 5 minutes.

My question of the three of you is we are considering the three bills today, 1386, 1425, and the SAVE Act. Do you all support the three bills? Do you think that they are going to make a difference to reduce costs and allow for more choice and more people being enrolled and being insured with good health insurance policies?

Mr. Lee?

Mr. LEE. Covered California doesn't take positions on legislation and so I am speaking more to the substance of what is in the bills that may take different forms. I noted in my testimony reinsurance is a valuable tool, reduces premiums and also directly addresses the issue that the individual market will always be more expensive than the rest of the market. Bringing those costs down through reinsurance is a good vehicle.

I noted also that navigators provide a vital piece of a broader whole for market——

Ms. ESHOO. I do. I think we all agree to that. Yes. I have learned that people know exactly what their premium costs, but they don't know always what they are buying.

Mr. LEE. Right.

Ms. ESHOO. And so navigators are so important to assist people and answer the questions that they have.

Mr. Wieske?

Mr. WIESKE. I think I have some concerns with the navigator piece. I mean I think we have seen some value.

Ms. ESHOO. Why?

Mr. WIESKE. We have seen some limited value in the State of Wisconsin related to navigators, so, you know, I think as a program there is some value there. I think it has been much more effective to use agents. I think our understanding is most of the navigators, a lot of the navigators and certified application counselors in the State of Wisconsin actually refer a lot of clients to agents.

Ms. ESHOO. What about the rest of the country? You are naming Wisconsin. What about the rest of the country?

Mr. WIESKE. My impression from other States is that there are some concerns with the navigator program in other States as well.

Ms. ESHOO. But it is in and around whether they are licensed agents. Is that what you are referring to?

Mr. WIESKE. Correct, licensed insurance agents.

Ms. ESHOO. Thank you.

Ms. Morse Gasteier?

Ms. GASTEIER. Like Mr. Lee, we don't take positions on specific legislation, but the tools and the concepts I think promoted here are ones that we recognize in our own experience that the availability of navigators' in-person assistance, being a State-based marketplace, and tools like reinsurance are very powerful and evidence-based.

Ms. ESHOO. I want to just take a moment and recognize all the white coats that are in the hearing room today. Welcome to you and thank you for your professionalism and what you do for people across the country. I don't know where you are from, but I have

no doubt that wherever you are from that you do magnificent work, so thank you. We all want to thank you for that.

What of the three of you believe would be the most effective tool in order to create affordability for those that are in the private market and to afford a good health insurance policy? What are the most effective tools? I know you don't want to take a position on legislation, but just maybe spend a minute each telling us what you think is the most effective tool.

Mr. LEE. So then I will start and——

Ms. ESHOO. The middle class has taken a hit. There is no question in my mind about that. And that is not acceptable for any of us.

Mr. LEE. I think that you are absolutely right, Chairwoman, that middle-class people who make more than 400 percent of poverty, but that doesn't mean they are rich, have been hit hardest. They don't get Federal subsidies. So the two things that could be done, well, there is three things, I think, could be done. Number one is reinsurance. That lowers premiums for everybody. It saves the Federal Government money, but it saves money for people that over 400 percent of poverty. Second, targeted subsidies. Governor Newsom in California has proposed providing State subsidies and tell the Federal Government act to get rid of the cliff for people that make from four to six hundred percent of poverty.

Ms. ESHOO. Thank you.

Mr. LEE. We have people in northern California in your district who are being forced to spend 30 percent of their income to afford insurance. They can't afford it. So directed subsidy—and the third thing is market and outreach. Health insurance must be sold. You need to remind people, cajole, nudge, those three elements are needed; would make a vital difference.

Ms. ESHOO. Mr. Wieske?

Thank you, Mr. Lee.

Mr. WIESKE. I would just add onto the discussion that I think there needs to be some movement to fundamentally improve the risk pool. I think California has indicated they have a good risk pool, Wisconsin on the other hand does not. The average age is much higher than the average ages across the——

Ms. ESHOO. Are you from Wisconsin?

Mr. WIESKE. I am from Wisconsin, yes.

Ms. ESHOO. I see.

Mr. WIESKE. So that is——

Ms. ESHOO. What was my first clue? All right.

Mr. WIESKE. So, and across the country it varies State to State, but it can be very expensive. So changing the dynamics of that risk pool to get more younger folks in is a sort of key.

Ms. ESHOO. Healthy people, good mix.

Ms. Morse Gasteier?

Ms. GASTEIER. Thank you. I would agree on reinsurance and keeping risk pools stable and broad and not allowing for the proliferation of plans that will siphon healthier people out of the risk pool. And I think the flip side of that is outreach to the people who because they are price-sensitive and maybe younger, people who don't anticipate having health needs, whether you have tools that promote continuous enrollment or whether you are doing very

proactive outreach to those populations to bring them in, I think those can be very powerful tools.

In Massachusetts we have also found that applying additional subsidies to lower-income individuals can, in fact, incentivize very competitive dynamics for carriers that also bring down costs for unsubsidized enrollees as well, although there is more work to do there.

Ms. ESHOO. Thank you very much.

The Chair now recognizes the ranking member, Dr. Burgess, for his 5 minutes of questioning.

Mr. BURGESS. Thank you, Chairwoman.

And I would also just like to make a general statement to all of the physicians who are in the audience. This is the committee who brought you Cures for the 21st Century, so those tools that you are going to have at your disposal that no generation of doctors has ever known, this is the committee that helped you achieve that goal. This is also the committee that brought you the Affordable Care Act, so there is obviously some good along with the bad. But you all are smart and young and you have got good computers, and I trust that you will help us figure this out.

Mr. Lee, let me just ask you on the individual mandates since you referenced it, we had another panel of witnesses here earlier that Mr. Tom Miller from AEI who suggested that zeroing out the penalty for the individual mandate was as a practical matter no significance because no one really paid the penalty in the individual mandate.

Do you have a sense of the number of people who paid the individual mandate penalty in California and what the dollars collected were?

Mr. LEE. In California, because of the removal of the penalty, we think we have dropped coverage by about 300,000.

Mr. BURGESS. Prior to the——

Mr. LEE. The penalty, paid penalty in the last year we know was about $500 million. So there were people that paid it that did not take insurance, but also it provided that economic nudge to about 300,000 people that the market has dropped and because of that I note last year our premiums went up about 9 percent. Half of that increase was health plans pricing for a sicker population because of the drop of people because of the mandate.

Mr. BURGESS. $500 million and they still have no money to put to their healthcare and they still get stuck with silver loading.

Mr. Wieske, you have—and it is really a shame you couldn't read the entirety of your statement into the record. I may just take the time to do that myself. But there is one line here that really caught my attention. And in your discussion of navigators you talk about a number of factors that have contributed including a robust economy, very low unemployment, which should lead to higher rates of employer-based insurance coverage.

In the last 2 years we have seen a significant increase in the number of people employed, people coming out of the ranks of long-term unemployed to perhaps having the availability of employer-sponsored insurance. I have not gotten, been able to get the Congressional Budget Office to give us coverage numbers for what

would be the result of that increase in employment. Do you have a sense of that?

Mr. WIESKE. So I don't. Unfortunately there is a significant lag in looking at coverage issues, and with the time and the CBO it is usually about a 2-year lag, so it will take some time to figure out.

Mr. BURGESS. So as if—and I have a number of questions and I will have to ask for written responses. Also in your written responses, if you have an inclination as to where we might look for that information outside of the CBO if there is any outside group that might have looked at that, I think that would be helpful information for the committee to consider.

Let me, because I am going to run out of time, let me ask you, Mr. Wieske—and I appreciate your testimony here in February of 2017. Many people forget that we actually had hearings before we did our healthcare bill, and your testimony on the experience you had on risk pools in Wisconsin was very helpful in crafting that part of the bill that dealt with reinsurance, that plus the Health Affairs article that dealt with the hybrid plans in the State of Maine, the risk pools reinsurance hybrid that came about in that State.

So yesterday—this phenomenon of silver loading, I mean I get more complaints. Yes, I get people who are concerned about preexisting conditions, but the overwhelming number of complaints I get in my office are people who are outside the subsidy window, phenomenon of silver loading that affects them. In my district, a teacher and a policeman with two children are both in the individual market because of the way insurance is structured in our State for those professions, and they don't get any help. They get no subsidy. So the cost of the benchmark silver plan increases—"What, me worry? I have a subsidy, so my premium didn't go up"—but that teacher and policeman now are really, really strapped.

So are there ways that this Congress and this administration can increase the options for those Americans?

Mr. WIESKE. So the silver-loading issue is caused by the cautionary reduction subsidy. It is not paying the cautionary reduction subsidy. There is no budget, Federal budget number that was attached, no appropriation, and so that would affect the silver loading from that standpoint that, if that were funded, then States would not be required to do silver loading.

Mr. BURGESS. Let me just ask unanimous consent to include for the record the article from the Kaiser Family Foundation and yesterday's Washington Post, the Daily 202, which referenced how risk pools and reinsurance may actually help this situation, and again urge members to look at H.R. 1510 as a vehicle to achieve that, and I will yield back.

Ms. ESHOO. I thank the ranking member.

Is Mr. Pallone—no, not here.

I now have the pleasure of recognizing the gentlewoman from California, Ms. Matsui.

Ms. MATSUI. Thank you very much, Chairwoman Eshoo and Ranking Member Burgess, for holding this important hearing, and to our three witnesses for being here with us today. And I am par-

ticularly happy to welcome Mr. Lee, who is from my home State of California and who I see an awful lot in Sacramento.

I was struck by a few things that all our witnesses agree upon. We all agree that the ACA has resulted in numerous positive changes for Americans, consumer protections, expanded access to coverage, and historic lows in the number of uninsured Americans. We also agree there is an opportunity to build on the law, the remaining gaps in coverage, affordability challenges for consumers, and market challenges for insurers.

As we heard from Mr. Lee, California has made a significant investment in marketing outreach and enrollment assistance for consumers. A key component of this investment was funding the California navigators program, which plays an important role in enrolling populations especially underserved populations in health insurance. A new law taking effect this year in California bans the sale of short-term, limited-duration insurance in the State. Last month our committee held a hearing on these types of junk insurance plans and learned how consumers can be duped into buying these products without knowing they don't cover preexisting conditions or certain essential health benefits.

Mr. Lee, does California's navigator program help Californians enroll in these types of junk insurance plans?

Mr. LEE. Thank you for the question. Absolutely it does not. They cannot. The short-term plans, actually, in California are not allowed as a matter of law and we make sure that our navigators and our certified agents are promoting policies that actually provide good essential benefits.

Ms. MATSUI. So you don't at all advocate, great.

Like California, we have heard about the success of Massachusetts at achieving nearly universal coverage. As we heard from Ms. Morse Gasteier——

Ms. GASTEIER. Gasteier.

Ms. MATSUI [continuing]. This happened through strategic investments, outreach, and policy. Ms. Morse Gasteier, in your testimony you note that the Massachusetts Health Connector uses data to better understand and reach individuals without coverage and communities at greater risk of uninsurance. Can you elaborate on how you reach these populations and help them enroll in affordable coverage?

Ms. GASTEIER. Thank you for the question. We do, we use both national U.S. Census Bureau and local sources of data to understand population and demographic dynamics around populations that have a higher risk of uninsurance and then we use that data to actually select our navigators that we include in our program. We work with 16 navigators and they are strategically selected to help us make inroads in those particular populations. Not just because of their physical presence and their sort of trusted role in the community, but because they have particular tools to overcome the barriers that we think people in those specific populations may be facing, whether it is language barriers or accessibility to in-person assistance.

Ms. MATSUI. That is wonderful. I am pleased that Covered California—and we have Mr. Lee here joining us to share in the State's success story. As we heard today, Covered California has been on

the front lines of implementing the ACA, serving over 3.4 million Californians since 2014, lowering our eligible uninsured rate to 3 percent, and working to keep our premiums about 20 percent lower than the national average.

Mr. Lee, what are the unique characteristics of Covered California that allowed you to steadily increase enrollment and keep costs low and maintain competition?

Mr. LEE. Well, first I would note we aren't unique. We were thrilled to do this report jointly with the State of Washington, the State of Massachusetts, other States that have leaned in, have used all the tools——

Ms. MATSUI. Right.

Mr. LEE [continuing]. Specific to their State. But I would note it has been number one, focusing on market and outreach. Number two, having common patient-centered benefit designs that when people sign up for our plans whether they pick Kaiser, Blue Shield, or Anthem, they have the same knowledge that when they go to see a doctor there won't be a deductible they need to pay before they see the doctor. That means consumers see the value of insurance.

That, and finally I would note we actually focus on the underlying cost of care. We have contractual requirements with our 11 health plans to have them look at the delivery system making sure people get the right care at the right time. Those factors together we think are part of our formula for building what we hope will be success for over the long term.

Ms. MATSUI. Thank you.

Ms. Morse Gasteier, your State has also taken a proactive approach going back to before the ACA. What lessons can you continue to apply from Massachusetts to the Federal marketplace?

Ms. GASTEIER. So I would say that we focused again on trying to bring in healthy, low-risk people into the marketplace by doing data-driven outreach to them and also really work to have a very stable regulatory environment where we keep our eyes on the road in terms of keeping the markets stable. We work really closely with our carriers which is something that we are able to do as a State-based marketplace in being in very close contact with them.

And I would just say more broadly in Massachusetts we have had sort of a bipartisan cross-stakeholder support for our health reform and that has continued through the 13-year experience of our coverage expansion efforts which has been critical.

Ms. MATSUI. Well, thank you very much and——

Ms. ESHOO. I thank the gentlewoman. I now would like to recognize the gentleman from Michigan, and a gentleman he is. He is a former chairman of the full committee, Fred Upton.

Mr. UPTON. Well, thank you, Madam Chair. It is a delight to be here, obviously, and I appreciate the testimony from our witnesses.

Mr. Wieske, I would like to go back to your very beginning of your statement talking about how States could have more flexibility, and to date I would note that 14 States have submitted waivers under section 1332. Eight of the States have active waivers, seven of which are for State reinsurance programs. And I would have to say that it is my understanding that these waivers are budget-neutral to the Federal Government. Is that correct?

Mr. WIESKE. That is correct, sir. It is a requirement of the 1332.

Mr. UPTON. And it is also true that States have demonstrated that they can take steps under section 1332 to stabilize their markets without new Federal money? In fact, the pass-through funding or savings generated from those market stabilization programs can be reinvested onto the program further reducing premiums. Is that correct as well?

Mr. WIESKE. Correct. We use the program in the State of Wisconsin to do exactly that.

Mr. UPTON. Yes. Now, Dr. Burgess—I am sorry he left, but I know he is coming back—yesterday introduced legislation that would provide additional Federal resources for States to establish market stabilization programs. And it is my understanding that that would then incentivize additional premium reductions across the country; is that right?

Mr. WIESKE. Yes. I think coming from Wisconsin and seeing it on the front lines, I think States need a lot of flexibility and having a one-size-fits-all program has never sort of worked.

Mr. UPTON. I would note that CBO previously projected that one of the most effective ways to stretch premium reductions is to have a State option with a Federal fallback, which is in a sense what Dr. Burgess said does, or a Federal default allowing for States to innovate as they see fit.

Would you agree that States should be given choice instead of control when it comes to repairing their markets' damage?

Mr. WIESKE. Yes. I think in my experience in Wisconsin as deputy commissioner there, I think it was important for us to have a lot of flexibility and I think a lot of the problems that we face in the ACA would have been made better if we would have had more flexibility in how we implemented it.

Mr. UPTON. In your experience in Wisconsin, what other States would you highlight are on that same path?

Mr. WIESKE. So our reinsurance program was copied from Minnesota's almost whole cloth. We made some changes which was moved off of Alaska's. So I think in a lot of cases States are talking to each other. And we talked when I was there, still there, we talked to a number of States about our program as we were going through the development.

So I think through the NAIC, National Association of Insurance Commissioners, and other pieces, there is a lot of discussion among States to sort of get commonality and to figure out what the best approaches are and the best approaches are not necessarily the same State to State.

Mr. UPTON. Great.

Yield back, thank you. Thank you, Madam Chair.

Ms. ESHOO. I thank the gentleman. I now would like to recognize the gentlewoman from Florida, Ms. Castor.

Ms. CASTOR. Thank you, Chairwoman Eshoo, for scheduling this hearing on how we lower healthcare costs for our neighbors and provide meaningful coverage for American families.

I want to start by thanking our hardworking, nonprofit partners who have fought with us for affordable healthcare over the years and to ensure that independent, unbiased navigators are available to American families, especially Rob Restuccia, the longtime execu-

tive director of Community Catalyst, who died over the weekend from pancreatic cancer. Rob was a champion of empowering consumers to fight for better healthcare and he will be missed.

And I want to thank the witnesses. After reading your testimony I was really struck by how difficult it has been for American families to keep up. The Trump administration has really socked it to them. We were making such good progress on lowering the uninsured rate and lowering healthcare costs and now, you know, it is like death by a thousand cuts.

Removing the individual mandate and promoting junk insurance plans, a tax on the insurance pool, whittling away the protections for preexisting conditions just have really socked it to consumers in their wallet and we want to get back to doing everything we can to lower healthcare costs for them. The Trump administration also has slashed funding for our independent, unbiased navigators who are very effective. Yes, they work in concert with agents and brokers, but you need them both on the field. There is just no substitute for that independent, unbiased advice.

So my bill, H.R. 1386, Expand Navigators' Resources for Outreach, Learning, and Longevity, the ENROLL Act, will secure vital services for navigators so that they can continue serving our neighbors. And I want to thank my colleague Congresswoman Blunt Rochester along with Representatives Wilson, Crist, and Murphy for being original cosponsors on this important bill.

Families across the country have been aided by unbiased navigators to help them determine the best health insurance option for them. Unfortunately, the Trump administration attacked this crucial initiative by slashing it by over 80 percent since 2016, as well as big cuts to outreach and advertising efforts.

So my ENROLL Act will guarantee that navigators remain on task to ensure that our neighbors understand the financial assistance and coverage options available to them. Specifically, the ENROLL Act will fund the navigator initiative in the Federal ACA marketplace at $100 million per year. It will require HHS to ensure that grants are awarded to organizations with demonstrated capacity to carry out the duties of a navigator. It would reinstate the requirement that there be at least two entities at each State; that they have a physical presence in the State. Oftentimes, navigators determine that the more appropriate and affordable option might be the Children's Health Insurance Program or it might be Medicaid, so it would clarify that navigators can provide that advice on enrollment.

In Florida we are very fortunate that the University of South Florida has been the lead navigator and has worked with other nonprofit partners all across the State and their efforts have paid great dividends to families across my State. We continue to lead in the number of enrollees in the healthcare marketplace.

But they have told me this year that those dramatic cuts had a very serious impact. That they were not able to get out especially into rural areas to make sure that families understood what their options were and had the ability to sign up. This directly impacts affordability for everyone.

And, Ms. Gasteier, could you speak to the importance of a broad-based insurance pool to lowering costs and the role that navigators play in that?

Ms. GASTEIER. Thank you for the question. We believe in Massachusetts that we all do better when everybody is in the same market and the same risk pool with strong comprehensive standards sort of holding up that market so that people know that the coverage they have they can count on. And we see outreach as an effective, proven method for drawing in people who might otherwise think that they can go out without coverage who may tend to be younger people.

And so we have found that those efforts are very important both for those people so they are protected, even though they may not expect something to happen to them and that we think that that has been part of why we have been able to keep our premiums so stable in Massachusetts.

Ms. CASTOR. And, Mr. Lee, do you agree with that?

Mr. LEE. Very strongly and including in particular your note that it is not just navigators, it is navigators with agents. Twelve thousand agents in California, but we have 100 nonprofit groups we directly fund to fill in the gaps. We target them to serve areas that are not well served by agents.

Ms. CASTOR. And that investment helps everyone by lowering costs; is that correct?

Mr. LEE. Absolutely. We have lower costs in California because of the effective outreach, and again we use navigators to target where agents aren't effectively reaching. So it is not an either-or, agents in California get paid $130 million in commission payments. It is a lot of money. We pay our navigator program about 6.5 million. And so, yes, they enroll fewer than agents, great, but we target them to outreach to Spanish-speaking communities, African American communities, LGBTQ communities, rural communities. So that is the role that navigators—to pick up the gaps that agents and other outreach isn't addressing effectively otherwise.

Ms. CASTOR. Thank you very much. I yield back.

Ms. ESHOO. We thank the gentlewoman for her legislation.

I now would like to recognize Mr. Shimkus, the gentleman from Illinois and a good friend and my E911 partner and——

Mr. SHIMKUS. Yes, ma'am.

Ms. ESHOO [continuing]. Away we go.

Mr. SHIMKUS. Thank you, Madam Chairman. This is a great hearing, and I appreciate you all being here.

Mr. Lee, I want to—and the way I like to do it, I like to breeze through the testimony, but I like to hear the questions and answers and I scribble a lot of notes and questions taken off of—so you mentioned that because the individual mandate was not enforced, 300,000—is that the right—300,000 dropped off.

And then I think I heard through the other questions is that California, and I think my colleague Ms. Matsui mentioned California has a law that says you can't have other than the standard ACA-type plans. So these 300,000 have no option then, is that—I am trying to figure where they—are they covered somewhat?

I mean, a lot of States have options. I have been through the whole debate. I was here when we passed. A lot of folks liked the

plan they had, the Congress and the President decided to change that. So then they got thrown into plans that they didn't like that was so too costly and the premiums were high and the deductibles were ridiculously high. And they just begged for me—and I have four from just recently in October and November and December—to just go back to the plan they had in the past, a lot of my constituents.

So I am trying to figure out where is the—does these 300,000 have no coverage?

Mr. LEE. Our understanding is the vast majority go to be what we call bare. They go without insurance. And again, this happens also in the employer market. About 20 percent of the people who——

Mr. SHIMKUS. Yes, I got that. But wouldn't something be better than nothing?

Mr. LEE. In many cases not, because the issue about that something, often that something, a short-term plan may mean that if they get cancer it is not covered. So often it is faux coverage. The point of encouraging people to sign up for coverage that matters is to encourage people to get coverage that will be there for them when they get sick.

Mr. SHIMKUS. Right. And we had a hearing earlier as was identified and I brought up associated health plans as an option with either associations—I mean California is a big State, Illinois still a relatively big State. If our farm bureau decides to either State-wise to develop a covered pool in associated health plans that has the same requirements as outlined under the ACA, does California support association-type health plans?

Mr. LEE. Again I don't speak for the State of California. What we have done in California as a State though is try to make sure that the insurance offerings will be there when people need them. And so examples of, there are products today in California that are under sharing ministries that mean you buy it and there is a $250,000 lifetime cap per incident.

Mr. SHIMKUS. Right, OK. Fine, I got that.

Mr. LEE. And so that is part of the——

Mr. SHIMKUS. I want to get to another couple questions, but I would just from my experience in my district is many people lost insurance that they liked and was thrown into insurance that they couldn't afford and they couldn't use. And I want to go to Morse Gasteier for a second, because you mentioned how Massachusetts really changed the Affordable Care Act in one interesting provision.

When we had this debate in the legislation, what was mandated was if you get sick you can immediately buy. And I think I heard either in your testimony or in response to a question you said we have changed that. How have you changed that and what did you do?

Ms. GASTEIER. Thank you for the question. I am not sure we have changed anything. We had our own individual mandate already in Massachusetts prior to the Affordable Care Act so there was——

Mr. SHIMKUS. Can people—I think one of the problems was people were if they got sick today they could go buy insurance, which

when you are talking about pools and people buying in that escalates costs.

Ms. GASTEIER. It does. So we have always used open enrollment periods to try to make sure that people are not sort of, quote unquote, jumping and dumping and coming in and out of coverage just when they get sick or think they may need an expense. And we have found that having tools like that in the market where there is sort of an expectation that everybody is always in the pool has helped keep——

Mr. SHIMKUS. So I may have misunderstood that response to your question.

Ms. GASTEIER. That is fine.

Mr. SHIMKUS. So then I apologize. That is what I wanted to ask.

Mr. Wieske, this silver loading—no. I don't want to ask that question. I want to ask, do you have empirical data on the benefits or the lack of benefits that you have seen in that navigator population? I am a big dealer and broker, folks. I understand spreading it out. But, really, the question is cost-benefit analysis and are they really delivering for what versus kind of what we hear?

Mr. WIESKE. There may be a difference between States that have an exchange and can control their navigator programs and States that don't. What we saw as a problem in Wisconsin is we never knew what was going on with navigators despite requirements for licenses, despite requirements for CAC licenses and registration of assisters.

We had numerous occasions where we had to investigate navigators who we later found out in some cases were and in other cases were not navigators, were holding this out. So it was a little bit confusing for us despite the fact that we had some regulatory authority.

Mr. SHIMKUS. Thank you, Madam Chairman, appreciate the time.

Ms. ESHOO. Thank you, Mr. Shimkus.

I have to excuse myself from the hearing for a bit, but certainly all the doctors in the audience will be pleased to know that we have M.D.s on both sides of the aisle. And so Dr. Raul Ruiz is going to take this chair.

Mr. RUIZ [presiding]. And with that I would like to recognize Congressman Schrader from Oregon for 5 minutes.

Mr. SCHRADER. Thank you very much, Mr. Chairman. I appreciate the hearing today. It is a great hearing, actually, indicative of hopefully where this Congress is going to go in terms of fixing some of the problems, a few of the problems with the ACA and recognize that it serves a great deal of value for a lot of folks.

And I am a proud cosponsor of 1425. It is probably the single most important thing we can do to help stabilize the individual marketplace which, based on the Republicans' work in the last Congress, would be a goal of theirs as well as a goal of Democrats, so a nice area of bipartisanship.

I wanted to also note that earlier this week I led a letter with 76 other of my colleagues from the New Democrat Coalition—Chairman Pallone, Chairman Scott, and Chairman Neal—making it a priority for this Congress to bring down costs and make sure

that healthcare is affordable to everybody through the Affordable Care Act, which as I said went a long way to getting us there.

So I would like to ask consent, unanimous consent, that we can enter that letter into the record.

Mr. RUIZ. So ordered.

[The information appears at the conclusion of the hearing.]

Mr. SCHRADER. OK. Thank you, Mr. Ruiz, Dr. Ruiz.

I would also like to note for the record that Blue Cross Blue Shield is also a big supporter of 1425 because they recognize the value of reinsurance also.

I guess a basic question for Mr. Lee, a number of States pointed out by the ranking member and others have established their own reinsurance programs through the 1332 waivers, which I think is a great thing, everyone has testified, and I think everyone here acknowledges is a great opportunity for States to innovate, you know, not a one-size-fits-all.

But there are probably some limitations and some opportunities that a Federal reinsurance program or high risk pool type of thing could offer. Could you talk a little bit about how that might relate to what some of the States who are already doing some reinsurance programs and how it might help them?

Mr. LEE. Yes, I would be happy to, thank you. So first, as you note, seven States have done the State-based reinsurance, but they range in what the Federal Government has matched to a low of 30 percent, meaning the State had to come up with 70 percent of the dollars, other States got a hundred percent, others 70. And most States are struggling with their own State budgets, so that is one uncertainty.

The other thing I would flag is the 1332 provisions, as was noted earlier must be deficit-neutral. Now I understand the importance of deficit neutrality, but that actually means a State that uses a program and enrolls more people is hit because enrolling more people will affect the deficit. The goal of the Affordable Care Act should be to get more people covered.

And that is one of the reforms I think that isn't on the table, but in thinking about to use a 1332 waiver mechanism that in essence punishes a State for getting more people insured is a bad mechanism. So those are two problems.

The other is—and I want to really appreciate the thoughtfulness in your legislation—is some States will say reinsurance, reinsurance if we use California by the formulas in your bill would reduce premiums by about 7 percent. That is a lot. But it might be better invested to target those people just from four to six hundred and your allowing a State the flexibility to do that I think gives State flexibility, which is exactly what many States like California would look to do.

Mr. SCHRADER. Thank you very much for the response, and I agree. I mean, there is a nice synergy here between the Federal Government supporting some of these programs in a thoughtful way and enabling the States to use it in a flexible manner that best serves their needs. That was the genesis of the work that the New Democrats did with their solutions over politics in the last Congress. It is the genesis of the bipartisan legislation came out of the Problem Solvers Caucus. It included reinsurance, had the cost

sharing subsidies, and expanded exactly what you are talking about, the 1332 waivers.

But it kept the essential benefits package that you guys have also acknowledged is critical so that consumers aren't being deceived. And the more people you get into the marketplace, the more the risk is shared, the less cost shifting that goes onto these individual marketplace people that are suffering, if you will, under these premium/deductible increases while other people are benefiting.

The last comment I would make real quick is to the Hyde language. I mean I really hope that my colleagues on the other side of the aisle are willing to move past that. I would point out that in our previous legislation, whether it was the ACA or the Problem Solvers one, we did not try and get rid of the Hyde Amendment, you know, that has been a longstanding agreement, or by both sides of the aisle. We recognize people have different faith-based concepts and support that.

I think it is a little unfortunate that some of our colleagues on the other side of the aisle are trying to, you know, prevent States from using their own funds or nonprofits' funds or individuals' funds in the arena of family choice. That is unfair. That is an expansion of the Hyde Amendment that I think makes fixing the Affordable Care Act and fixing the marketplace, getting at the preexisting condition thing a real problem. And I yield back. Thank you.

Mr. RUIZ. Next is Congressman Guthrie.

Mr. GUTHRIE. Thank you very much. Thanks, Chairman, for yielding. I appreciate the opportunity and all of you to be here today.

I want to focus on the background of the State-based marketplaces. The State-based marketplace grants were awarded between 2010 and 2015 in compliance with the law. No planning or establishment grants could be awarded after December 31st, 2014. I think we all agree with that. In all, CMS awarded over 5½ billion to 49 States, the District of Columbia, and four territories for the purpose of planning and establishing health insurance exchanges.

The available money was unlimited, the amount of money was unlimited, and in definite authorization and appropriation the 5½ billion included grants for exchange planning, exchange establishment, early innovators and administrative supplements to any of these grants. Every State except Alaska applied for these grants.

Florida and Louisiana were awarded planning grants but later returned their entire grants. Other States returned some of the money they received but kept some. For 2018 planning year, 34 States had Federally Facilitated Marketplaces, 12 States had State-based marketplaces, and 5 States had State-based marketplaces using the Federal platform.

So in all, 17 States have 12 based marketplaces or State-based marketplace that uses the Federal platform. Those 17 States accounted for roughly 4.5 billion of the 5½ billion, but only 12 States had their own State-based marketplace. So in summary, of the 5½ billion dollars awarded in grants, 12 States have exchanges.

So, Mr. Wieske, when you with Wisconsin's insurance department—and this gets—I think you talked about some innovative

things you wanted to do when Congressman Upton asked you questions. But my question is, when you were with Wisconsin's insurance department, if you were given a slice, your slice of the 5.5 billion without all the mandates that came with it, what creative and efficient ways would you choose to utilize Federal dollars?

Mr. WIESKE. We actually started going down that path at one point and we actually are one of the States that returned the money. What we found was there was some lack of flexibility in the ability for us to design the exchange and it was going to be very expensive. And let me be more specific. We were looking for a single-door entry into both our Medicaid and our State system. We were looking a variety of other pieces to make it easier for consumers. Unfortunately, the requirements that the Federal Government had in place made it impossible for us to continue and we ended up dropping off of that.

So I think at that time we were looking at a single-door entry, I just didn't think we under the Federal rules think it was possible. On top of that, the cost of doing it for a smaller population in a State like Wisconsin where there is about 200,000 people enrolled in the exchange, if you look at $20 million a year to spend that is $100 a person, $100 a person to be able to afford the exchange. That is a very expensive fee on top of what the overall costs were. So the risks were very high for us as well.

Mr. GUTHRIE. Thanks. When we were debating the Affordable Care Act and repeal and replacement of it, Wisconsin came to the forefront in preexisting condition coverage and a lot of debate here was talked about what Wisconsin did and how people who had, particularly cancer survivors and so forth, had better coverage under the Wisconsin pre-ACA model than after the mandate, after the ACA. Would you kind of talk about what you guys did for preexisting conditions?

Mr. WIESKE. Yes. I think the important message here, I think, from a State perspective is that States have an interest in insuring their residents as well. I think both, you know, everybody here at the table understands that and believes that. And Wisconsin actually had a very comprehensive high-risk pool. You could see any doctor in the State. We subsidized that high-risk pool. It was expensive, make no mistake. It was more expensive than standard coverage because we didn't subsidize it, so there should have been pieces that—there were pieces that could have been improved upon.

But I think we still have some folks who have an interest in going back to that. However, moving forward, you know, it is clear that the ACA has provided some subsidies for folks who had affordability issues in that market as well. So, you know, Wisconsin could have done a bit more if they had more flexibility.

Mr. GUTHRIE. Thank you.

And, Ms. Morse Gasteier, you talked about continuous coverage and tools for ensuring continuous coverage. I understand the open enrollment gives an incentive. Is there other tools that you would suggest? I mean just in open enrollment if I have guaranteed issue and I don't sign up and then I get sick, then I can buy health insurance coverage when open enrollment comes again. I get you are

in it for the interim. Is there other tools that you would suggest to be able to do?

Ms. GASTEIER. Thank you for the question. I think we take the allure of affordability very seriously in Massachusetts and have tried to construct a very competitive marketplace that in addition to those tools incentivizing people to keep continuous coverage we see as drawing people into the ranks of the insured through our exchange which covers 280,000 people now. And I have noted some of the policy features of the way we have approached our subsidized program also has benefits for unsubsidized individuals as well who also have access to these lowest-in-the-Nation premiums.

So we see all those tools as working together, those incentives through our individual mandate to incentivize coverage as well as making sure affordability is of paramount significance and presence for people in our market.

Mr. GUTHRIE. Well, thank you. My time has expired and I yield back.

Mr. RUIZ. Thank you.

Representative Kuster, you have 5 minutes.

Ms. KUSTER. Thank you very much. And thank you to our panel for being with us. I want to start by associating myself with the remarks of Representative Schrader. I think we do have options to shore up the Affordable Care Act and they are bipartisan and we should work together to get that done. I am very concerned about the efforts of this administration to sabotage the Affordable Care Act, and I do agree that some of our colleagues on the other side of the aisle are trying to throw, really, a monkey wrench in terms of the status quo of the Hyde Amendment and trying to disrupt our ability to provide health insurance for all Americans.

I want to talk about H.R. 1425, the reinsurance bill, and I am a proud supporter cosponsor with my colleagues Angie Craig and Scott Peters. Why would a State—and I will direct this, Mr. Lee, at you—why would a State seek to develop its own reinsurance program if there was a Federal reinsurance? That is a place to start.

Mr. LEE. A really good question, I think, that a State wouldn't. If the mechanism was reinsurance they would probably go with a Federal administration. The issue is if proportionately a State could get the same amount of funds that would have been used for reinsurance and instead target it in a different way, States might do that.

I gave the example of our Governor Newsom has said we want to bring back a penalty and expand subsidies, targeting people right above the cliff. We have working middle-class Americans; I am sure, in New Hampshire as well in California that really need help. Reinsurance lowers costs for everybody, saves the Federal Government a lot of money, but it may make a State, for a particular State to say we want to target particular populations, but it would not make sense to me. I can't imagine a State that would take the money and just do reinsurance.

Ms. KUSTER. And I agree with you we want to target that. I was visiting with a hospital the other day that has dropped the uninsured population showing up at their hospital from 9 percent down to 3 percent, but it is how to get at that 3 percent, the working low-income people and younger people, honestly.

You mentioned the increased riskiness of the individual market making reinsurance a tool to control costs. Is there a point at which the market becomes too risky for even reinsurance to work—and again back to the sabotage by this administration—making these markets unstable?

Mr. LEE. I think there is. I am not sure what it is, but you look at it again—Massachusetts, California, Washington, other States with State-based marketplaces—we have maintained enrollment over the last years. Federal marketplace States have seen mammoth drops in new enrollment. Many of those States have seen premiums rise so high that people without subsidies are largely only sick people because healthy people have been priced out entirely.

Reinsurance would help. I don't think in many of those States it would help enough. A 7 percent reduction in premiums when those States have seen an 85 percent premium increase in the last 5 years is good, but is it enough, probably not. And so I think one of the challenges, it is reinsurance is a tool, but it needs to be part of a broader issue of doing outreach, doing outreach, a whole range of things that in much of the Nation is not currently happening.

Ms. KUSTER. And I want to get out the sabotage again because they have created a catch-22. This administration is sabotaging the Affordable Care Act and then turning around and saying rates have gone up. But you mentioned the proliferation of junk health plans and other efforts by the Trump administration to sabotage.

Are you concerned that the efforts of this administration over the last year may push these markets past a tipping point, and again tying into your comment about how reinsurance can be helpful?

Mr. LEE. Well, I think absolutely encouraging healthy people to buy products that look cheap but might not be there for them when they get sick both is risky for those individuals that buy the products and damages the risk pool, raises costs for everybody. I do think—I am not sure what a tipping point is, because while we continue to have the subsidies people that get subsidies will always have a market. The only problem is without doing marketing they won't even know it is there.

Ms. KUSTER. And I do have legislation around the 1332 waivers that to try to keep us from reaching that point.

Ms. Morse Gasteier, as a New Hampshire neighbor to Massachusetts I am especially interested, why didn't Massachusetts seek a 1332 waiver for reinsurance?

Ms. GASTEIER. It is something we have looked at. Massachusetts, you know, looks at different options for flexibility and if we find opportunities that can help our market in terms of affordability and stability, you know, we are interested in those so long as they don't, you know, deteriorate any of the important market conditions or consumer protections that we have long held as critically important.

Our market right now is largely stable. We will continue to look at opportunities for reinsurance. But as Mr. Lee noted, it does require at present a lot of State resources to invest in these 1332 waivers. So it is something we will continue to look at, but to date hasn't struck us as compelling for our market.

Ms. KUSTER. Well, and hopefully if we can get this bipartisan legislation passed you will have that option, so thank you.

I yield back, Mr. Chair.

Mr. RUIZ. Thank you.

Now Representative Griffith, you have 5 minutes.

Mr. GRIFFITH. Thank you very much, Mr. Chairman. I do appreciate it. This committee had significant concerns about and accordingly extensively studied the navigators program in the previous administration. And I would like to introduce into the record the following letters sent by the committee in 2013: an April 12, 2013 letter to Secretary of HHS Kathleen Sebelius; a June 28, 2013 letter to then-Secretary of HHS Kathleen Sebelius; an August 29, 2013 letter sent to 51 grant recipients in 11 States that received 61 percent of navigator dollars at the time and a list of those grant recipients who received the letter; and a September 20th, 2013, letter to then-Deputy Administrator and Director of the Center for Consumer Information and Insurance Oversight, CCIIO, at CMS, Gary Cohen.

May that be admitted, without objection?

Mr. RUIZ. So ordered.

[The information appears at the conclusion of the hearing.]

Mr. GRIFFITH. During plan year 2017, navigators received more than $62 million in grants and enrolled only 81,426 individuals, less than 1 percent of the total enrollees but at a cost of over $750 per person. By contrast, agents and brokers assisted with 42 percent of federally facilitated exchange enrollment for the plan year 2018, which cost the FFE only $2.40 per person or per enrollee to provide technical and training assistance.

So, Mr. Wieske, I have questions about whether we should, you know, be putting more good money after bad results. H.R. 1386 would redirect a hundred million annually to the failed navigator program. Based on your experience in Wisconsin, can you speak to whether the navigator program was a good investment for taxpayers there?

Mr. WIESKE. Look, what we saw in the State is if you look at the other lines of insurance they have moved away from sort of the face-to-face. They have moved into different methods to get customers. And while navigators have some value, certainly, in certain populations, I don't think we had a feeling that they had a strong presence in our rural communities that were also largely uninsured and in other spots. So, you know, we felt that agents were much more effective and that there were other methods to encourage enrollment.

Mr. GRIFFITH. Thank you. During your time as deputy insurance commissioner of Wisconsin, did Wisconsin experience any fraud, waste, or abuse within the navigator program?

Mr. WIESKE. So we had a number of cases that we had to investigate. Mostly people who were posing as navigators who were not, in fact, navigators, that had problems. We didn't actually have any problems, we had a——

Mr. GRIFFITH. So you didn't have any problems with the real navigators, it was with the fake navigators.

Mr. WIESKE. Real navigators. We had problems with fake navigators, correct.

Mr. GRIFFITH. All right. And based on your experience with the navigator program, do you believe that redirecting a hundred mil-

lion annually to the navigator program as H.R. 1386 intends to do would be a wise investment for the taxpayer?

Mr. WIESKE. I think we are hoping to encourage more flexibility in the way consumers can sign up for coverage, should get them where they actually buy coverage today.

Mr. GRIFFITH. All right, I appreciate that. I did think it was interesting to note that several of my colleagues have talked about the cost of the insurance. Mr. Lee spoke about 85 percent in most of the Federal markets, the price has gone up in the States that have their own markets that is less than half of that, about 39 percent, in his written testimony, and that this really affects the middle-class family, the average family that are above that 400 percent of poverty level rate.

What is interesting about that is that when this plan was being discussed, and it is one of the things that we have to look at when we are looking at the new promises to lower rates, people of my district were promised—that the President came to the district when he was campaigning and said he was going to reduce the average cost of healthcare for the average family by $2,500 a year.

And now we are talking about if we pass new bills we might get a 7 percent reduction in an 85 percent increase. Clearly we are not anywhere near the goals that this plan promised and we are experiencing—and my constituents complain all the time. And so I appreciate you mentioning that, Mr. Lee. You know, their copays have gone up, their out-of-pockets have gone up, and their insurance premiums have gone up and they have just been hit hard and it is a whole lot more expensive than what they were facing before Obamacare.

Hopefully we can find some bipartisan resolutions to bring down these costs, but I don't think that it can ever get to that point where the families actually see, average American family sees a reduction under Obamacare, as he promised at Virginia High School in my district, a $2,500 decrease. I yield back.

Mr. RUIZ. Ms. Kelly, you have 5 minutes.

Ms. KELLY. Thank you, Mr. Chair, and thank you all for your testimony today. Since the Affordable Care Act's passage, approximately 20 million Americans have gained health coverage through the laws' various coverage protections. An additional nine million low- and moderate-income Americans receive health insurance subsidies that help them pay for healthcare. In 2019, more than 7 in 10 consumers on the ACA marketplaces can get coverage for $75 or less per month after tax credits. These tax credits make healthcare affordable for millions of Americans.

Ms. Morse Gasteier, thank you for your testimony today. You discussed Massachusetts' subsidy program known as ConnectorCare which supplements ACA subsidies and helps your State's residents pay for healthcare. You briefly mentioned how the program benefits consumers who are not eligible for subsidies. Can you describe how the program helps lower premiums for all enrollees in your State?

Ms. GASTEIER. Absolutely. Thank you for the question.

So our program ConnectorCare provides subsidies, extra State subsidies on top of Affordable Care Act subsidies and further brings down the cost of premiums and cost sharing for individuals

up to 300 percent of the Federal poverty level. And those products that become available through that program are built on top of a commercial silver market tier plan. And what the structure of the program does is it strongly incentivizes participating carriers to lower premiums to compete to be in that program because they show up to as the lowest cost plan and they get a lot of enrollment by being very cost-competitive. The benefit for unsubsidized individuals is those low-base silver plans then become available to unsubsidized enrollees as well.

And in Massachusetts we also have small businesses in the same risk pool, so small businesses also benefit from those lower premiums that carriers are competing to get the attention of price competitive shoppers with. So that is one of the ways the program itself is helpful both to those low-income enrollees who are enrolled in the program as well as middle-class unsubsidized enrollees as well and small businesses too.

Ms. KELLY. Thank you. For other States that are looking at this, what are some of the challenges that they might face?

Ms. GASTEIER. So of course coming up with the funding to create those State wrap dollars is critical, so I would think if another State were pursuing something like this that would be sort of priority one for them to determine how to finance that. We, I think are very advantaged by being a State-based marketplace. In administering something like this we are able to aggregate all the different funding streams, the Federal subsidies, the State subsidies, the enrollee contributions and we are able to do that by doing premium aggregation which is a benefit of being a State-based exchange.

And so States that are pursuing things like this would need to think about the mechanics of how it all works together and we would certainly be happy to provide technical assistance to any State interested in that. But I would say resources are the top order issue for a State pursuing something like this.

Ms. KELLY. And just share how you did come up with the resources and just—OK.

Ms. GASTEIER. Absolutely. So it was a number of different funding sources that the State identified and this was all a part of our original State reform effort back in 2006. So we worked with our Medicaid program and Federal partnership with CMS. There are a number of State-based revenue streams that come into a trust fund that our Connector administers. And so that has kind of gone back to 2006 and then we restructured the program in 2014 to complement the Affordable Care Act.

Ms. KELLY. Thank you. And I want to thank you and I commend you for all the work you are doing to help make healthcare affordable for your State's residences. A lack of funding is certainly challenging for States which are interested in setting up similar programs, but hopefully you will get some phone calls.

Ms. GASTEIER. Thank you.

Ms. KELLY. Thank you and I yield back.

Mr. RUIZ. Thank you.

Mrs. Brooks, you are up for 5 minutes.

Mrs. BROOKS. Thank you, Mr. Chairman.

Mr. Wieske, in your testimony you mentioned that many insurers who were offered coverage in the individual market just a few years ago have left. Can you discuss further why, from your studies, why these insurers are finding business in the individual market untenable?

Mr. WIESKE. Yes, I think in the State of Wisconsin they lost roughly $500 million in the individual market and that made it absolutely unaffordable for them to provide coverage. I think we saw a market that just became—it was interesting. In my home city of Green Bay, the second-least-cost silver went up 105 percent from 2016 and 2017. And that became—2017 to 2018—that became an untenable sort of solution. And the concern I think that the insurers had was that the market had deteriorated so far that they didn't want all of the risk even in a given region. So it was just unaffordable for them to continue to maintain coverage.

Mrs. BROOKS. Can you elaborate on ways in which the section 1332 waivers have actually increased access to care that have those approved waivers?

Mr. WIESKE. And I will say, you know, in my home State, since I worked on it directly in my former role, so we had a $200 million reinsurance program that we went through in a bipartisan effort through the legislature and got it passed. That reduced the premiums by 11 percent over where they would otherwise have been, a net 5 percent decrease year over year, so not just a decrease of the increase, but an actual decrease year over year on average. And we believe that that expanded coverage in the State of Wisconsin from where it otherwise would have been.

Mrs. BROOKS. Can you talk a little bit about what else the Federal Government might be able to do to increase enrollment in health insurance aside from spending more money on marketing and navigators? How else can we be bringing people into—because we all want people to have access to health insurance and understand their options, but what else might we be doing?

Mr. WIESKE. Sure. And in my prior role I think, you know, we dealt with life insurers and health and P&C insurers. And if you look at those other lines of insurance they are becoming increasingly active in other spaces to provide coverage and becoming increasingly active in their consumer's life to provide broader opportunities. There are even groups that are having individuals in shopping malls to download apps in order to buy coverage. And people are purchasing their entire coverage on an app, through their phone, and getting everything delivered.

That seems to be, you know, while there is some availability, and there is some availability in the health space, that doesn't seem to be as much widely available in the individual market as it is in other lines of insurance and in employer coverage. So I think a lot more flexibility on the State level for States to be able to do some different things and to have different options, because States operate very differently and look very differently. Massachusetts is very different than Wisconsin and California is very different than Wisconsin as well.

Mrs. BROOKS. I am curious, Mr. Lee, excuse me. Do you have any other ideas of how we might be increasing enrollment in healthcare?

Mr. LEE. Yes. First, I would note that we in California have 11 carriers, have had since day 1. Massachusetts, I believe, eight; Washington nine. So the experience of many States that have not done marketing things that have worse risk pool is unstable for plans. We want a market that works for consumers which means plans competing, so that is number one, competition works.

Number two, I would note, and I mentioned it earlier in my testimony having patient-centered benefit designs. In California, our standard benefit designs mean there isn't a $2,000 deductible between patients and their primary care doctor. That means even healthier people don't say it is not worth me having insurance. They see value.

The third thing I would note is subsidies. Healthcare as many of us have noted is too expensive in America. And even at what Massachusetts has done, below 400 expanding subsidies, above 400 percent subsidies—California, we issued a report to our legislature on how to improve affordability. A lot of it is subsidies, it is reinsurance with a penalty, but it is too expensive. People need financial help and I would encourage the committee to look at this report as options.

Mrs. BROOKS. Thank you. I yield back.

Mr. RUIZ. Thank you. The Chair now recognizes himself for 5 minutes.

Thank you all for your testimony. Since day 1 the Trump administration has taken actions that have increased premiums and out-of-pocket costs for Americans. I am just going to list a few here since there has been so many administrative actions to change, repeal, and sabotage the ACA.

In 2017, the Trump administration stopped the cost-sharing payments that helped reduce out-of-pocket costs for low- and middle-income Americans. This act alone increased premiums by 20 percent. Health insurance companies and CEOs said that it would, the action was taken, and they did. While subsidized consumers are largely protected from these premium increases, unfortunately many unsubsidized middle-class consumers bear the brunt of this and have of these premium increases.

Last year, the administration expanded these junk plans, harming Americans who need comprehensive coverage and get their health insurance through the ACA. They offer these very inexpensive premiums, relatively speaking, but they don't cover much so deductibles are very high and a lot of out-of-pocket costs are incurred by the patients. In States that opt not to regulate these plans, consumers will see their premiums increase and their options dwindle.

The administration issued new 1332 guidance that would allow States to raise healthcare costs for individuals with preexisting conditions and undermine the consumer protections for people with preexisting conditions. The administration sabotages raising the cost of healthcare for hardworking Americans.

Mr. Lee, I understand that 2018 premiums in California increased by double what it would have otherwise been because the Trump administration terminated these cost-sharing payments. Is that correct and can you elaborate?

Mr. LEE. Absolutely, it is correct. But I think it is really important to note that stopping direct cost-sharing payments meant that States across the Nation did what is called silver loading, but it is actually a CSR surcharge. Plans have to pay for that benefit. What we did in California is direct our plans to not put that surcharge on the off-exchange product. So in California and many States, unsubsidized individuals did not have to pay that 12 percent surcharge that plans had to put on to cover their costs of that program which is required.

Mr. RUIZ. Did other States that couldn't do that were those costs then given to the consumers?

Mr. LEE. In many States they had policies to protect off-exchange individuals, other States did not. Some of the concerns that we have with the potential of Federal policy to ban silver loading is it would shift the cost of paying for a required program on unsubsidized Americans and lower coverage, raise costs for everybody.

Mr. RUIZ. Can you discuss how these actions by the Trump administration has impacted access to affordable healthcare particularly for Americans who are not eligible for the ACA subsidies?

Mr. LEE. Well, again the——

Mr. RUIZ. Do you have any numbers in terms of people who——

Mr. LEE. I don't have numbers, and again there is a number of policies that have had big effects, the CSR rollback and caused confusion, many States have worked around that. Bigger issues in Federal marketplace States are not doing marketing and promoting plans that don't offer coverage that encourage healthy people to buy a product that they think is a good deal that isn't.

Mr. RUIZ. Yes.

Mr. LEE. It is going to cost them later. It costs all of us in the near term.

Mr. RUIZ. Ms. Gasteier, can you describe the impact of the Trump administration's termination of these cost-sharing payments on your State's residents' access to affordable coverage?

Ms. GASTEIER. Yes. So similar to California, we did everything we could to try to avoid that outcome where the Trump administration stopped making those CSR payments which they announced right before the beginning of open enrollment 2018. But we had worked with our Division of Insurance to prepare for a plan B in the event that they did that. Similar to other States, we permitted carriers to add that load of CSR value onto the silver tier plans only on exchange and then we worked with the population of impacted, unsubsidized people to make sure they understood they had other options.

But it was incredibly disruptive to our market, of course, and Massachusetts actually stepped in to cover the cost exposure of our carriers in the last quarter of 2017.

Mr. RUIZ. One of the things that I want to make clear is that oftentimes these cost-sharing reduction payments get characterized as industry bailouts. They are not industry bailouts, because they are point of care only when needed by people who only meet certain criteria to help them pay for their care. So it is not a health insurance bailout, especially when health insurance companies are making record profits during this entire time.

I yield back the time and next speaker is Mr. Carter from Georgia.

Mr. CARTER. Thank you, Mr. Chairman. And thank all of you for being here, we appreciate your attendance.

Mr. Wieske, I am going to start with you. You testified before this committee, I believe, before the subcommittee in February of 2017 and talked about how States could improve our healthcare system and the role that they could play in improving it. Beyond reinsurance, what are some ways that you think we could use stability funds to help patients in the exchange marketplace?

Mr. WIESKE. Yes, I think from the perspective that I came from then and the perspective that I come from now, I think there are ways to design more affordable benefit options for consumers to add some flexibility. I think there are ways to provide some risk sharing. I think if you look at some of the issues that we have seen with younger folks who are not signing up for coverage, you know, we may have 13 carriers in the State of Wisconsin, but they are regional and in some cases we are seeing no younger folks signing up because of value propositions.

Redesigning those sort of subsidies, I think re-looking at the way we, you know, the cost-sharing reduction subsidy issue related to whether or not you use, you know, payments or whether or not you use an account-based solution that would provide some value to consumer, I think there are ways to sort of, you know, for States to become laboratories of democracy and experiment and find out what the best solution would be similar to the way Massachusetts started.

Mr. CARTER. OK. Well, thank you for that. Let's move on to the State-based exchanges bill, the one that we are discussing here. And correct me if I am wrong, but I believe that you of the 12 State-based exchanges that you said that only half of them received, that over half of them received a D or an F grade; is that correct?

Mr. WIESKE. Yes. I think we had some issues with the level of information that is available through the exchanges. And this is part of the reason why we support looking at some private competitive versions in the State and new ways to enroll. That, you know, what we are looking at now is different than what we looked at in 2014 and time has moved on for a lot of the ways consumers shop.

Mr. CARTER. And I believe you said that almost three-fourths of them were worse, or scored worse than the Federal exchanges.

Mr. WIESKE. Yes. And we are seeing that you know, States are certainly making efforts to improve, but it is a very expensive process and it is very intensive. And the people who are bearing the cost of those in a lot of cases, either the State through general tax revenue or more likely it is through the consumers who are purchasing coverage through the exchange for access to that Web site.

Mr. CARTER. OK. All right, let's move on to talk about the navigators. In 2017, we spent 62½ million dollars on navigator grants and it yielded us only a 1 percent increase in ACA enrollment out of those grants? That doesn't seem like it is a very efficient use of money to me.

Mr. WIESKE. Again what we have seen in other lines of insurance and in other places that there are different ways for people to get

access to coverage, so it is not just that. So I think navigators are important, a small important piece of that to do outreach for underserved consumers, but consumers are buying their coverage in different ways. And a 22-year-old, 27-year-old is not going to go into a navigator in the same way other folks are.

Mr. CARTER. Right. And the same thing in rural areas. Am I correct?

Mr. WIESKE. Correct. Correct.

Mr. CARTER. So that is really something we need to be concentrating on, younger people as well as our rural areas.

Mr. WIESKE. Mm-hmm.

Mr. CARTER. Well, thank you for that. I appreciate it.

Mr. Chairman, and I realize you are sitting in for the chairman, so but I do have to get this on record. And that is here we are in our third hearing in the subcommittee that has the broadest jurisdiction over healthcare of any subcommittee in Congress, and yet already the Oversight and Reform Committee has had a drug pricing hearing. The Ways and Means Committee has had a drug pricing hearing and they are on their second one this week. The Senate Finance Committee has had two hearings. And this week, the Senate Committee on Aging is having two hearings on drug pricing.

Now this committee, the Energy and Commerce Committee, has a record of working in a bipartisan fashion. We have come up with Cures. We have come up with 21st Century Cures. We have come up with a number of different things in a bipartisan fashion. Can you give me an idea or at least relate to the chairman an idea of when we are going to start talking about drug pricing that impacts all——

Mr. RUIZ. Yes, sir. Yes, sir.

Mr. CARTER [continuing]. Americans and it is a bipartisan issue?

Mr. RUIZ. Yes, sir. Yes, sir. And I recognize you are the one pharmacist in our committee.

Mr. CARTER. Yes, sir.

Mr. RUIZ. So I appreciate your concern. It reminds me of a scene in "The Karate Kid" where the Master told the Karate Kid, patience, Daniel-San, patience.

Drug pricing will be a priority in this committee. In fact, the first hearing is going to be next week and we are going to tackle this issue straight on and you are going to be gleaming with happiness when we do.

Mr. CARTER. Thank you, Mr. Chairman. I yield back, Daniel-San.

Mr. RUIZ. Great.

Next, Ms. Blunt Rochester, please.

Ms. BLUNT ROCHESTER. Thank you, Mr. Chairman, and thank you to the panel.

Over the past 2 years, the Trump administration's funding cuts have prevented marketplace navigators from providing counsel to consumers looking to enroll in health insurance plans that work best for them. In Delaware, only one navigator organization received Federal funding for 2019 open enrollment, making it even harder for Delaware families to sign up for coverage. Navigators help communities in my State learn about their coverage options and enroll in affordable healthcare.

According to the Kaiser Family Foundation study, 40 percent of uninsured Americans are unaware of the marketplaces and over 75 percent of consumers sought help from navigators because they either lacked confidence to apply on their own or needed help understanding their plan choices. For many of the 24,000 Delawareans participating in the individual marketplace, enrollment specialists are a trusted source they can rely on when making deeply personal decisions about their health insurance plan.

Ms. Gasteier, I understand that uninsured Americans are less likely to be aware of the availability of coverage or even that subsidies can help them pay for coverage. Is that true?

Ms. GASTEIER. That is correct. We found that in Massachusetts and we work with our navigators to make sure that we have in-person resources available to educate people about how affordable options can be for them and people are often surprised when they find out what they qualify for.

Ms. BLUNT ROCHESTER. And can you describe how gutting this funding for the program, the navigator program, impacts enrollment, because we just heard from Mr. Carter that it was only a 1 percent increase in enrollment. Can you talk a little bit about that?

Ms. GASTEIER. Absolutely. So that doesn't square with what our experience has been in Massachusetts where our navigators provide immense in-person support in the communities that need the most help getting into coverage.

So just as an example, our navigators this past open enrollment period held 400 informational events around the State educating people about their options, and we find that the uninsured population even in a well-covered State like Massachusetts is always churning. It is a new group of people that need assistance and so their in-person presence in those communities where they are sort of trusted leaders for many other services are really key.

I would also like to note that navigators do more than just get people into coverage once and then walk away. They provide year-round support to people who need to make updates to their income information, add a baby, had a life change, and we find that that assistance for particularly low-income populations is key to not just getting into coverage but staying covered as well.

Ms. BLUNT ROCHESTER. You know, I was going to ask you, you brought up the term "churning," and I saw that in your testimony and was going to ask you if you could expand a little bit on the concept of churning, the population churning.

Ms. GASTEIER. Absolutely. So we find in Massachusetts, again even with a less than 3 percent uninsurance rate, the uninsured population is a mix of some people who are chronically uninsured, but also people who have gaps of 6 months, 12 months in between other kinds of coverage who kind of fall through the cracks. And that could be because somebody loses a job and loses job-based coverage, somebody who moves to Massachusetts from another State and doesn't really know kind of where to go for help.

And so we try to kind of catch people, you know, people who may be weighing a COBRA option if they are leaving a job, or people who may be in between some other kind of life circumstance, getting a divorce, et cetera. And we find that that kind of active pres-

ence to make sure that the new people coming into the ranks of the uninsured we are there to catch them right away.

Ms. BLUNT ROCHESTER. Excellent. And my last question was really another thing I noticed in your testimony was about the diversity of your State, but also all of the players that are involved in helping to do the outreach. You mentioned everything from focusing on 21 different languages to the different community-based organizations, 16 of which—can you talk a little bit about that as well?

Ms. GASTEIER. Absolutely. So like most States, Massachusetts is diverse and we have very dense urban population areas as well as rural areas in the western part of our State and our navigators are spread out to be present in places where we know there is a higher risk of uninsurance. And, for example, in urban areas we find language access and awareness about affordability programs is a key thing for those navigators to work on. In our rural areas we will work with navigators to make sure they are sending people out into the community.

So in our more rural Greenfield area, for example, the Franklin County Community Health Center will send their folks out to drive 20, 30 minutes to meet people at food pantries and farms and make sure they are providing the kind of assistance people in those less populated areas need.

Ms. BLUNT ROCHESTER. Thank you so much. I yield back.

And well, before I yield back I did want to say I am a proud cosponsor of this bill and thank Ms. Castor for that and also the support on the MORE Health Education Act. Thank you.

Mr. RUIZ. Thank you.

Now, Mr. Long, you have 5 minutes.

Mr. LONG. Thank you, Mr. Chairman. I appreciate also my friend Larry Bucshon, here, next to me who yielded his place in order. I was a little late and missed the gavel. I was actually cleaning up a spill out in the hallway and somebody said did you spill something? And I said no, but I am cleaning it up so somebody else doesn't fall. So, you know, no good deed goes unpunished, so I was late for the gavel.

Mr. Wieske, if memory serves, when we were talking about implementing the Affordable Care Act and talking about navigators, it is in the back of mind it seems like navigators were not allowed to be navigators if they had any background in the insurance field. And to me that would be kind of like taking your car to a mechanic, but oh, you have to pick a mechanic that has never worked on a car before.

So that being said, you said that the loss of agents in the individual health insurance market has created many problems and that navigators are just not a substitute for driving enrollment. Could you talk about the differences in how agents and brokers operate compared to navigators both before and after consumers purchase their insurance and why are not navigators a substitute for agents?

Mr. WIESKE. Yes. When we looked at creating our own navigator program, which by the way in Wisconsin we are going to call badgigators, we saw the same issue that you saw that there was

some limited ability for folks with ongoing industry background to be able to be a navigator, so that created a concern.

I think in the individual market we have seen insurers stop paying commissions to a lot of agents in Wisconsin. Again that reflects at $500 million of lost revenue as they have exited the market. We may have 13 carriers but they are regional in nature. They are all small carriers, so those expenses are very high. That makes it difficult for the folks in the community to be able to access sort of coverage and expertise. And the expertise that we require a navigator to have in Wisconsin in their license is nowhere near what we require what an agent is required to have.

Mr. LONG. You also note that the Federal navigator program operates largely outside of the current healthcare system and in many cases the navigator program is centered around large population centers which we kind of talked about earlier in not serving the rural areas. What effect does this have for those rural communities and how important is the role of agents and brokers in advising consumers out in these rural areas? I represent a lot of rural areas in Missouri.

Mr. WIESKE. We had two sort of issues. We had navigators come in who were under a navigator grant that we had no idea existed and were papering a local community with, papering a local community and we were never told, they were never registered. They turned out to be licensed through a different entity so they were OK, we had some concerns with that.

I think rurally, I think in places like Rhinelander, Wisconsin where my wife is from, there is just not as much availability. There is just not as many people. They have to drive hours just to get to a dermatologist, let alone anything else. But that is an issue in those reasons that they are primarily served by their local insurance agents.

Mr. LONG. And could you talk about how the medical loss ratio is affecting agents and brokers? Is it inhibiting agents' and brokers' ability to operate?

Mr. WIESKE. Yes. I think again in Wisconsin prior to us doing the $200 million reinsurance program, our insurers had loss ratios in excess of a hundred percent after the various government programs provided reinsurance back to them. That means that you know, the medical loss ratio, those losses made it unaffordable for them. They had to cut expenses somewhere and largely they have cut it out of agents.

And I think in other States where you are cutting it closer to the 80 percent, we have seen agents, you know, the loss of agents serving individual consumers, you know, across the country.

Mr. LONG. And do you think that instead of focusing solely on navigators, which enroll less than 1 percent of the total enrollees for the plan in the year 2017, we should be considering amending the medical loss ratio provisions to ensure greater access to agents and brokers in order to drive enrollment?

Mr. WIESKE. Yes, I think that would, you know, from our perspective I think that would provide some value. And I think on top of it, I think allowing some flexibility in enhanced direct enrollment and some private exchanges, some other folks who are

incentivized to find people who are uncovered and have some incentives to get there.

It is certainly, you know, different approaches work in different States so what works in California and Massachusetts may not work in Wisconsin. But I think incentivizing States to have a different approach would make some sense.

Mr. LONG. OK, thank you. And once again I would like to thank my friend Larry Bucshon for giving me his slot here. And, Mr. Chairman, I yield back.

Mr. RUIZ. Thank you.

Mr. Cárdenas, you have 5 minutes.

Mr. CÁRDENAS. Thank you very much, Mr. Chairman. I would like to thank all of you for testifying today and thank you for bringing your expertise and your perspectives on this very important issue. Since the ACA's passage I would like to remind America that 20 million Americans have gained coverage that otherwise didn't have it before then. The uninsured rate fell from a high of 18 percent in this country to 11 percent at the end of 2016.

What is unfortunate is that this Trump administration has been actively undermining the law and attacking Americans' access to healthcare. For example, the administration cut their advertising enrollment budget from $100 million to $10 million, then they gutted funding for the navigator program by 80 percent. This program helps American families learn about the coverage options that are available to them.

As anyone can tell you, understanding different healthcare plans can be difficult and, thankfully, under the Affordable Care Act we have these navigators, these medical professionals who can guide people over the phone on the different options they have to protect their families is very important. This program is critical for people who might have difficulty understanding the difficult options or who might be short on time, for example, single patients working multiple jobs, families already struggling with their finances, and Americans who don't speak English as their first language.

English was not my first language but English is now my most dominant language. I have gone to college, I have an electrical engineering degree. But going through the coverages before the Affordable Care Act when I used to provide healthcare for my employees was always complicated and difficult. Now that I have my own coverage as a public servant, it is still very difficult to navigate through that.

So let me make that very, very clear. The Affordable Care Act did not make healthcare complicated in America, it was already complicated. The good thing about it is, it is still complicated. However, 20 more million Americans now have healthcare that otherwise didn't have it.

I grew up when I was born under healthcare when my father was a union worker. Later on he became a self-employed gardener. I was number 11, child number 11, and shortly thereafter he went off to be a private business owner and that is when healthcare coverage was unaffordable to them. Now people in my district like my father who are gardeners now have access to healthcare and these navigators are very, very important.

So with that, Mr. Lee, can you describe how navigators help Californians access affordable coverage? Can you give us a good example that is working well in California?

Mr. LEE. I absolutely can. I think that—I want to note that we use agents, licensed agents, 12,000. They cost a lot, 1.7 percent of premium goes to paying agents. That is a lot. It is over $130 million. We have a $6.7 million navigator program where we target communities that don't have as many agents serving them, in particular Spanish-speaking communities.

We do a lot of studies and looking at the fact that agents are less apt to be serving Spanish-speaking people, so we specifically contract with entities that serve Spanish-speaking communities. Similarly, we have seen agents are less apt to serve African Americans. We target grants to navigators anchored in the Crenshaw district, anchored in parts of the community that are otherwise underserved.

So it is very much a complement to a broad program and it is not just to be scored by enrollment, scored by doing outreach. The outreach function as you heard from Ms. Morse Gasteier is part of getting the word out that is particularly important in Federal marketplace States that as you noted have abandoned doing marketing. We in California spend $60 million on marketing and advertising. The Federal Government now spends 10 for 39 States. That money means people know to find navigators, know to find agents, so it is a complementary program.

Mr. CÁRDENAS. So basically navigators are helping people potentially save money, also end up getting coverage that is more applicable to their situation and their family, and then on top of that does it translate into Americans having better access to healthcare when a navigator helps an individual get to that point?

Mr. LEE. So we study this closely, people that use navigators or agents make better decisions. They are more apt to choose a health plan that is right for them than those that do online only. Whether a web broker or whether other, getting help means they make a better choice. It also means more people enroll, they are healthier which lowers costs for everybody. So it really is one of those things, investing and helping people understand insurance and get insurance and use insurance means they get access to care when they need it, better, and lowers costs for everybody.

Mr. CÁRDENAS. Are navigators needed in rural areas?

Mr. LEE. Absolutely.

Mr. CÁRDENAS. Are navigators, when available, are they utilized at high rates in rural areas?

Mr. LEE. By high rates—we actually are going to be, we are reupping our navigator program in California to fund more navigators. In some rural areas we don't have enough. So it is one of the issues we do that we base on analysis and target where the needs are.

Mr. CÁRDENAS. Thank you very much, Mr. Chairman. I yield back my time.

Ms. ESHOO [presiding]. I thank the gentleman from California, excellent questioning. And it really, I think, brings together a highly diverse State and one that may not be diverse, and how navigators work it is instructive.

I now would like to recognize 5 minutes for questioning, the gentleman from Indiana, Mr. Bucshon.

Mr. BUCSHON. Thank you.

Mr. Wieske, H.R. 1386 seeks to significantly increase the funding for the navigator program. In the 2016 and 2017 enrollment year in Indiana, the total amount of grant funds for navigators was $1,635,961. Three entities in the State were awarded grants. The total estimate for the number of individuals who would be enrolled in the ACA the estimate was 3,314, but in reality only 606 people were enrolled for a cost of nearly $2,700; to be exact, $2,699.61 per enrollee. If the grant recipients had met their goals, the per enrollee cost would have been $493.65.

So do you know of any requirements that grant recipients attain their enrollment goals or penalties for nonattainment?

Mr. WIESKE. I am not aware of any.

Mr. BUCSHON. OK, neither am I. Do you think there should be a per-enrollee cap and that assuming we have navigators and that any unspent funds should be returned to the government?

Mr. WIESKE. So, you know, I think the funds, to be honest, are spent at the time that they are granted. The awards come very, very late. It is very difficult for the navigator entities to be able to plan ahead based on when they have received those grants. And so there have been issues and this goes back, all the way back to 2014. So, you know, if they are not spending the money, yes, they should.

But I think, by and large, they are almost required to spend it the day they get it. And I think, you know, in Wisconsin we had less than 50 navigators registered, I think, year to year in any given year.

Mr. BUCSHON. Yes, I mean I have strong concerns that it seems like there is really an incentive to enroll fewer people because there is no penalty and the legislation doesn't seem to, this legislation doesn't seem to address the problem. I mean it seems to me that $2,700 per enrollee is quite a lot when you were expected to be less than $500 per enrollee. And it seems like we need to maybe have some guardrails in that program.

Mr. WIESKE. I think what we hope as an organization is that there are more opportunities for other entities to be able to enroll, that some of them are much more effective especially with distinct populations.

Mr. BUCSHON. OK.

Mr. WIESKE. And so we are hoping for more enhanced direct enrollment and more private exchanges, more other options, more flexibility for the individual plans to be able to sign people up and make it easier from a path perspective instead of making it harder, especially through the Federal exchange.

Mr. BUCSHON. Thank you.

Mr. Lee, California has spent roughly a hundred million dollars every year for the last 3 years, I think it was 99; that I mean this year it is estimated at 111.5 million on advertising. Three years ago, how many people were in Obamacare, enrolled in Obamacare in California?

Mr. LEE. In the individual market, about 2.4 million.

Mr. BUCSHON. OK. And how about after 3 years of a hundred million in marketing, what is the number?

Mr. LEE. About the same because 40 percent of the people leave our market every year. So we have to market with a hundred million because people leave job-based coverage and you have got to bring them in. So this is like any product, if we stop marketing we would dwindle away. And by staying constant we have kept that risk pool which again is 20 percent healthier than the Federal marketplace which translates directly into 20 percent lower cost, so our 1 percent of premium goes to marketing.

Mr. BUCSHON. OK, so I get that.

Mr. LEE. OK.

Mr. BUCSHON. So, but the national experience hasn't been the same with a large amount of marketing. It really didn't change the overall enrollment nationally, which is your experience in California. Three years, a hundred million dollars, and you have the same number of people. They may not be the same people, I get that. But that seems like a lot of money. That is your decision, I am fine with that.

Do you think there is anyone in America that doesn't know that they have an option to get healthcare on the exchanges, on Obamacare?

Mr. LEE. Sadly, yes. I know that even in California, where with our advertising the average Californian sees or hears us 59 times during open enrollment, even in California.

Mr. BUCSHON. Well, the question was, is do you think there is anyone in the United States that doesn't know that if they don't have healthcare they can't get it on the exchange under the ACA?

Mr. LEE. Yep. There are absolutely many Americans in California and across the Nation that don't know that, that are——

Mr. BUCSHON. Yes, I would be interested in you submitting that estimate to the committee, because I would argue that I don't know anyone that I come across that doesn't know that after all the years and the debate on the national level about Obamacare both pro and con that doesn't know that if they don't have health coverage—you know, it is one of those things where, you know, it is not like McDonald's.

You drive by McDonald's and you say, hey, I am hungry, I am going to stop and get something, right? It seems like healthcare is more of a destination restaurant where you decide, hey, I am hungry and I am going to go to this restaurant specifically, you are not driving by. And I think to many, in many respects, that maybe you don't agree with that, that you know, people understand that they can get healthcare through the exchanges and it is a decision they are making not to or to do it. I just——

Mr. LEE. I would be happy to——

Mr. BUCSHON. That is why I want to say, at the national level, I just don't see it is justified to spend millions and millions of dollars marketing something that everybody knows about.

Thank you, I yield back.

Ms. ESHOO. I thank the gentleman.

Just as an aside, there are millions of people in the country that don't know that the ACA and Obamacare are one and the same. So, hard to believe, but it is still the case.

I now would like to recognize the chairman of the full committee, Mr. Pallone, for 5 minutes of questioning.

Mr. PALLONE. Thank you, Madam Chair. In his testimony, Mr. Wieske recommends that we dismantle the Federal and the State-based marketplaces where of course millions of Americans receive health coverage. So I wanted to get a response to that from Mr. Lee and Ms. Gasteier.

Mr. Lee, can you comment on Mr. Wieske's recommendations that we shut down the marketplaces and privatize it instead, and then I am going to ask Ms. Gasteier to answer the same question.

Mr. LEE. Certainly. So Covered California partners closely with hundreds of licensed agents, many of which are web-based entities, web-based brokers. We believe there is a vital role for them in the private sector. But we are also deeply concerned that private entities have one purpose, to earn money based on commissions paid differentially by different insurance companies and different insurance products.

We in the public sector have one purpose, to lower health costs for Americans or specifically to California. Web-based brokers are—I have known them well—are good, bad, and ugly. There are some great ones. There are some really lousy ones. And some of their tools are good, some are terrible. But they have a very different motivation.

Our job in the public sector is to help millions of Americans get public dollars to lower healthcare costs and to make healthcare more affordable. Web-based brokers are seeking to get a best return, and I will note some agents might get 20 percent for one product, 2 percent for another. I would be quite nervous about what is going to happen to consumers. We put them first all the time.

Mr. PALLONE. And, Ms. Gasteier?

Ms. GASTEIER. Similar. We find that having a publicly run exchange is really critical for the integrity that people know they will find when they come and shop for products on our shelf. We offer a curated, competitive marketplace experience for people that people know when they come and get coverage from the Health Connector in Massachusetts or healthcare.gov they are getting safe, trustworthy coverage. And that they can make apples to apples comparisons, that is helpful for everybody in terms of affordability and understanding their options.

I would also say part of the exchange's responsibility is to administer taxpayer dollars in the way of subsidies and so we think there is an important role for the public oversight component of being a public entity and doing that and ensuring that there is program integrity to these important functions.

Mr. PALLONE. I appreciate that because, I mean, obviously, as you said, the Federal and State-based marketplaces have to certify plans to ensure that only the products that offer comprehensive coverage are available for sale and the exchanges verify eligibility to ensure that low- and moderate-income Americans who qualify for financial assistance receive the ACA subsidies.

But let me ask Mr. Lee kind of in the same vein, can you discuss the risk to consumers if the marketplaces are privatized?

Mr. LEE. Well, first, we do look very closely at every health plan that wants to be in our marketplace. They have to be clear they have good networks, the right benefits and, sadly, healthcare is one of the areas that has actually failed consumers. Web-based brokers can sell not just qualified health plans, but in many States that offer skimpy benefits and they may get better commissions, those could be looking right next to products that are there and meaningful. Consumers don't know and may not know.

And again the danger of the incentive for one agent or broker is very different than a group like ours which is publicly accountable. We bring together consumer advocates, doctors, and others to say what are the right benefit designs, how do we position plans so that consumers can choose right. I would be very concerned about many consumers being steered wrong if we just threw it to the market.

Mr. PALLONE. I mean, I agree, you know, many people, you know, from what I can see end up buying these junk plans and then have no idea of the lack of coverage.

Ms. Gasteier, similarly, can you discuss the risk of shifting this responsibility to private insurance companies given billions of dollars, you know, in subsidies that are at stake?

Ms. GASTEIER. Sure. So I think again it comes back to exchanges play a really important role in being a source of trusted, comprehensive coverage where people know what they are getting is not going to be something that exposes them to costs if they get sick or that there is sort of tricks in the coverage itself in terms of what is sold to people. And so in having a place that is publicly accountable where we are engaging with carriers, consumer advocates, providers, and others to design products that are safe and trustworthy for people, there for them when they need it, is really a critical component of the public role for exchanges and we found that to be very effective in Massachusetts.

And again similar to California, we have placed a real premium on standardizing benefits so that we can ensure that people when they shop and compare their options really understand what they are getting and what the differences may or may not be, but that everything there is safe and reliable.

Mr. PALLONE. And I agree. I mean I am very concerned that, you know, we have billions of dollars in Federal subsidies and, you know, they could be at risk from fraud, abuse, and waste. That is my concern.

Thank you, Madam Chair.

Ms. ESHOO. I thank the chairman.

I now would like to recognize the gentleman from Montana, Mr. Gianforte.

Mr. GIANFORTE. Thank you, Madam Chair, and thank you for the panel being here today. Time and time again I hear from Montanans about the rising cost of healthcare in our State. For many in Montana, Obamacare has been unaffordable. Watching their premiums and deductibles continue to grow, while their benefits shrink has been a frustrating and in some cases a devastating experience for them. Thankfully, the Trump administration has proposed real solutions to halt the rise in healthcare costs. Improving access to short-term, limited duration insurance plans, eliminating

the individual mandate penalty, and expanding association healthcare plans is giving choice back in control to Montanans and putting them back in charge of their healthcare needs.

Unfortunately, the ENROLL Act is not innovative and is a prime example of policies that misunderstand the needs of rural communities. Our rural hospitals in Montana are hurting. And across this country since 2010, 98 rural hospitals have been closed and almost 700 are vulnerable to closure. Our communities depend on these vital institutions. When a hospital closes in a rural community, not only do we lose access to care, but the community is less sustainable. The region loses jobs and financial viability.

We need to be working to make sure that people not only have coverage but also have access to care. A navigator won't be around to help when a farmer needs emergency medical services and their local hospital has closed. We need to ensure that our rural providers are stable and available in case of emergencies and I look forward to working together to continue encouraging innovation, affordability, and access to care for all.

Mr. Wieske, I would like to direct a couple of questions to you. In your testimony you say that navigators are typically centered around large population centers with limited availability in rural communities. Can you speak as to why the navigator program is less effective in rural areas and frontier communities like Montana?

Mr. WIESKE. I mean it is a matter of economics. I mean the population is not there and the ability to drive the number of people you can see in a given time frame in a rural community is, you know, the distances as you know are significant and so the effectiveness is an issue.

Mr. GIANFORTE. OK. In our business we are constantly looking for ways for continual improvement. When we found a program in our business that wasn't working we would stop focusing resources on that program and look to invest elsewhere.

Mr. Wieske, do you believe that there should be a shift in our resources away from navigators to other areas that provide better outcomes for Americans?

Mr. WIESKE. I do think there are other ways that we can provide better access in rural communities in the same way that you are seeing other insurance lines, you are seeing medical care and other things delivered in different ways in those rural communities in order to give them access, so.

Mr. GIANFORTE. So there might be better ways to use the money——

Mr. WIESKE. Yes.

Mr. GIANFORTE [continuing]. In rural areas in particular. OK.

And then, Mr. Wieske, you also talked in your testimony about transparency in the navigator program. And I constantly hear from Montanans that they want—they are frustrated with the lack of transparency, generally, in our healthcare system. What changes could we make from your experience to make this program more transparent?

Mr. WIESKE. I think for, you know, I think one of the issues that we have seen is that this is something that States should be primarily responsible. I think California and Massachusetts certainly

highlighted the way they deal with the navigator program. I think if States are responsible for the navigator program directly, I think that will make it a much more effective program because they understand how the State works, where the needs are, work with the Medicaid department, work with the insurance department in order to make that work better.

Mr. GIANFORTE. So as we look at public policy, we should really have a design requirement around more local control at the State level. You would agree with that?

Mr. WIESKE. Yes.

Mr. GIANFORTE. OK. Thank you so much.

And with that I yield back—yes, I would.

Mr. BURGESS. You know, you have reminded me that one of the principal failures of the Affordable Care Act was when we allowed Speaker Boehner, Leader Reid, President Obama, to remove Members of Congress from being forced to go into the exchanges. That was a mistake.

I did not accept the subsidies that all Members of Congress get for going in the DC exchange. I went through healthcare.gov, one of the most miserable experiences I have ever been through in my life, but it would be important for Members of Congress to experience what our constituents were feeling as they faced the very dire prospects of healthcare.gov not working on its rollout, and then of course the very expensive and unsubsidized premiums that we faced in the individual market.

And I am just like anybody else, I bought on price. I bought a Bronze plan. I had a $6,800 deductible, never understood why I couldn't couple that with a Health Savings Account. It was difficult to do that. We could have made it easy and that would have been easier had we all been required to go through what we were putting our constituents through.

I thank the gentleman for yielding and yield back to him.

Mr. GIANFORTE. And, Madam Chair, I yield back.

Ms. ESHOO. I thank the gentleman.

I think, Dr. Burgess, you made a big mistake by not enrolling because it is terrific. It works beautifully for me. It has gone beyond my expectations because of its coverage.

Mr. BURGESS. But if I——

Ms. ESHOO. No.

Now I would like to recognize the gentleman from Florida. I did see him, where is he? There, way down there.

Mr. Soto, you have 5 minutes to question.

Mr. SOTO. Thank you, Madam Chairwoman. And, first, I am from Florida, home of the largest Federal exchange for the ACA in the Nation, with over 1.7 million Floridians. We had an increase this year. One of the big reasons that the ACA has been so successful in Florida is because we don't have a lot of folks with access to employer-based health insurance. So, for large States like us, this was made to help. My wife and I are on the insurance plans from the DC exchange. She recently had surgery which was pretty much covered, so it has been a good experience for the Soto family.

I want to go through each of the five ways that President Trump has sabotaged the Affordable Care Act and get an idea from our witnesses whether it increased or decreased access and what it

would relate to costs. So starting just brief answers with each of our witnesses going through first the five ways, one is, it eliminated cost sharing; two, ending high-risk corridors; three, cutting enrollment dollars and marketing dollars in half; four, eliminating the individual mandate; and five, eliminating mandatory Medicaid expansion.

So let's start with the first of these five plagues on Obamacare, the eliminating of the cost-share subsidies.

Mr. Lee, did this increase access or decrease access by eliminating the subsidies?

Mr. LEE. I think on the margins it decreased access. But the fact of silver loading meant some consumers with subsidy actually had more money to work with so it is actually a trade-off. It definitely cost the Federal Government more money. It caused confusion that I think in many markets led health plans to pull out of their markets, so it is a market-by-market issue.

Mr. SOTO. So, but you would say overall it decreased access?

Mr. LEE. Overall, decreased.

Mr. SOTO. Ms. Gasteier, did it increase or decrease access or costs?

Ms. GASTEIER. It reduced access for the unsubsidized middle-class population.

Mr. SOTO. And, Mr. Wieske, did it increase or decrease?

Mr. WIESKE. It increased costs and created some instabilities.

Mr. SOTO. What about on ending the high-risk corridors, Mr. Lee? How did that affect access and costs?

Mr. LEE. That I think also ended up having—well, I am actually, I am not sure.

Mr. SOTO. OK. You are not sure.

Mr. LEE. So I will pass.

Mr. SOTO. What about Ms. Gasteier? How did it affect access or costs?

Ms. GASTEIER. I would say all of the reductions or disruption to any of the three Rs—risk corridors, reinsurance, and risk adjustment—have been, have reduced access and stability just in general to the extent that each of those programs have either been ended or they have hit turbulence in various ways.

Mr. SOTO. And, Mr. Wieske?

Mr. WIESKE. I think with the three Rs, I think the decision early on to federalize them and not to go State by State created significant issues in the market outside of it, which predates most of the issues surrounding it.

Mr. SOTO. What about cutting marketing dollars and enrollment time, Mr. Lee? How did that affect access and costs?

Mr. LEE. Dramatically reduced access, dramatically has increased premiums across much of the Nation except for those States that have State-based marketplaces that continue to do marketing.

Mr. SOTO. And, Ms. Gasteier, how did that affect costs and access?

Ms. GASTEIER. I would presume elsewhere it has reduced access. Like California, Massachusetts has been able to stay level with respect to its investment in outreach and marketing so has stayed the same.

Mr. SOTO. Mr. Wieske?

Mr. WIESKE. We just didn't see that effect, that negative effect.

Mr. SOTO. OK. What about eliminating the individual mandate? Mr. Lee, how did that affect access and cost?

Mr. LEE. It has raised premiums across both California and the Nation and decreased enrollment. Many fewer, hundreds of thousands of fewer Californians have insurance because of that.

Mr. SOTO. Ms. Gasteier?

Ms. GASTEIER. We have stayed insulated from those impacts in Massachusetts because we have our own individual mandate, but we imagine if we didn't have a tool like that either State- or federally based it would reduce access.

Mr. SOTO. Mr. Wieske?

Mr. WIESKE. Specifically in Wisconsin, our rates were so high that we are not convinced that it had a significant impact on enrollment.

Mr. SOTO. OK. And, finally, not requiring Medicaid expansion, I realize the courts helped in that, how did that affect access and costs?

Mr. LEE. Well, I think that in States like Florida, the reason you have a big exchange is you have many, many Floridians who do not benefit from the Medicaid program, and I think Californians benefit. I think there are millions of Americans not benefiting from that coverage expansion.

Mr. SOTO. Ms. Gasteier?

Ms. GASTEIER. Similar, I think the Affordable Care Act put puzzle pieces in place with the assumption that Medicaid expansion would catch a particular population of people and ensure that they had guaranteed coverage, so obviously Massachusetts has taken advantage of that to great effect. And so I would expect that that has dramatically reduced coverage elsewhere where that has not been mandatory.

Mr. SOTO. Mr. Wieske?

Mr. WIESKE. And we haven't seen a negative impact from that in where I was in Wisconsin. We saw a positive impact.

Mr. SOTO. Thank you.

Mr. WIESKE. And we had a unique approach.

Mr. SOTO. Thank you. My time has expired.

Ms. ESHOO. I thank the gentleman for his excellent questions.

Now I have the pleasure of recognizing Mr. Bilirakis from Florida to question for 5 minutes. And I would like to note that for those that may not know, his father preceded him in Congress and was the chairman of this subcommittee, a wonderful chairman and still a wonderful friend. So you have 5 minutes to question, Mr. Bilirakis.

Mr. BILIRAKIS. Thank you. I appreciate that. Thank you so very much. It is an honor to serve on this committee and to serve under you as the chairwoman, and also the ranking member. I won't forget that.

So anyway, thank you very much and thank you for your testimony. I appreciate it very much.

Mr. Wieske, in your testimony you talked about how in Wisconsin the insurance markets were damaged by the exchanges. The number of insurance companies withdrew from the market and

premiums kept moving up. That problem isn't isolated just to Wisconsin. In Florida we have less participation in the exchange today than 2014 and the majority of counties only have one insurance carrier. As a matter of fact, the county that I represent, I represent three counties, one of the counties only has one insurance and it is a carrier and it is—I think the population is close to 500,000.

Last year, Wisconsin received a 1332 State innovation waiver to reestablish a reinsurance program and other States have applied or received a waiver for reinsurance in other programs. Are 1332 waivers still available for States to use? This is for again Mr. Wieske.

Mr. WIESKE. They are, yes.

Mr. BILIRAKIS. They are. OK, thank you.

Does it make sense to move a standalone reinsurance bill by itself with no reforms in it, and wouldn't it be better to move legislation to reform the 1332 State innovation waiver to give greater flexibility to States to reform and repair their insurance markets? What do you think of that?

Mr. WIESKE. Yes, I think given the issues surrounding the risk pool that we have all sort of talked about especially in States like Wisconsin, Iowa, and other States, I think it is important not to just look at reinsurance. Reinsurance shifts who pays, as I stated, but we need to find some new ways to sort of improve that risk pool. So I think a broader 1332 will have some value for States.

Mr. BILIRAKIS. OK. This question is regarding State exchanges again.

Mr. Wieske, one of the bills under consideration today would spend $200 million for more State-based exchanges. Wouldn't it make more sense to have private entities running the exchanges rather than government entities? What do you think of that?

Mr. WIESKE. I think Wisconsin and a lot of other States like it could not afford with the 200 million to run its own exchange. So in order to have a first-class experience, I think looking at private entities to be able to offer additional options makes a lot of sense.

Mr. BILIRAKIS. OK. Wouldn't it make more sense again as you said to have the private entity running the exchanges rather than the government entities? Can we have businesses assume the financial risk of running an exchange rather than the Federal Government bankrolling the States? What are the barriers to having private exchanges provide this particular service?

Mr. WIESKE. I think one of the things to understand is that there is still a State regulatory process in place that reviews the plans, reviews the insurers, licenses the agent, licensing the insurers, checks their financial solvency, does everything soup to nuts, currently, in a number of States. And they can serve, continue to serve that role and it changes, functionally, a Web site and an outreach entity to be able to get consumers to sign up for coverage. They existed before the ACA. They exist now, after the ACA.

And I think what our thought is, is that having a first-in-class experience and having an entity, entities offering with State oversight the in-exchange role makes a lot of sense financially. There is a lot less risk.

Mr. BILIRAKIS. Thank you very much.

Unless the ranking member would like the balance of my time, I yield back.

Mr. BURGESS. Well, thank you. In fact, I would like to take just a minute.

Mr. BILIRAKIS. I figured you would.

Mr. BURGESS. It is not really the subject of what this subcommittee is considering today, but, Madam Chair, I just feel like this committee has had such a good relationship with Dr. Scott Gottlieb over the last 2 years and certainly I don't know what was involved in his decision to make his announcement yesterday, but I will just say he will be missed certainly by me personally and I believe by the subcommittee generally. And we certainly want to wish him well in whatever his future endeavors.

I do not know that we have ever had a brighter witness here at the witness table than Dr. Gottlieb and he was never shy about telling us that also, but he will be missed. And I really appreciated the enthusiasm with which he took the job of administrator of the Food and Drug Administration and, really, under his leadership some very positive changes occurred at that agency.

So that is all I wanted to say. I will yield back to the gentleman from Florida.

Mr. BILIRAKIS. And I will yield back, Madam Chair. Thank you.

Ms. ESHOO. Just to thank you, Mr. Bilirakis.

I would like to add my voice to that of the ranking member. I think that our country has been fortunate to have had Dr. Gottlieb as the commissioner of the FDA. It is an agency that the American people, I believe, trust. They always want it to uphold the highest standards because it stands between them and God knows what if the wrong decisions are made.

So I think that we have been more than fortunate to have him as FDA commissioner. I think that he has worked very well with the committee, both sides of the aisle. In his statement he said he was getting tired of commuting from Connecticut. And I thought I wished I had known that ahead of time, because I would have called him and encouraged to keep commuting, because I make a much longer commute across the country every week to California, not to Connecticut.

So I know that on behalf of this subcommittee that we wish him well, and we thank him. We thank him for, I think, exemplary public service.

So with that I will ask unanimous consent to enter into the record the following, and it is kind of a long list: a statement from the American Lung Association in support of H.R.1425; a statement from the American Lung Association in support of H.R. 1386; a letter from the American Medical Association in support of H.R. 1386, 1385, and 1425; a statement for the record from the American Cancer Society Cancer Action in support of H.R. 1386, 1385, and 1425; a letter from the Blue Cross Blue Shield Association in support of 1386, 1385, and 1425; written from the Asian and Pacific Islander American Health Forum in support of H.R. 1386, 1385, and 1425; a letter in support of H.R. 1386 from the Young Invincibles; a report on "Exploring the Impact of State and Federal Actions on Enrollment in the Individual Market: A Comparison of the Federal Marketplace and California, Massachusetts, and Wash-

ington"; a statement from the American Health Insurance Plans; and a letter from the Healthcare Leadership Council.

So we ask that that—I am asking unanimous consent that we enter all of what I just read into the record, including what the ranking member had raised earlier.

Do you have something that you would like to add?

Mr. BURGESS. Yes, if I could be recognized for additional unanimous consent.

Ms. ESHOO. Certainly.

Mr. BURGESS. I would like to ask unanimous consent to insert into the record the text of the bill that I introduced, H.R. 1510, and I would like to introduce into the record a letter from Blue Cross Blue Shield Association in support of that Bill 1510.

Ms. ESHOO. So ordered.

[The information appears at the conclusion of the hearing.]

Ms. ESHOO. I want to thank again—I started out by thanking the witnesses, I want to close by thanking you. You know, it is not very often said around here that we are so dependent upon experts in our country. It never ceases to amaze me the knowledge that resides in experts on so many issues.

And so when you come forward and answer our questions that all becomes part of the record and that stays there for a long time, but it also remains with us because we learn from you. No one can say to any of you, you don't know what you are talking about. You have lived it. You have done it. You have brought your expertise here, and we are, on behalf of all of our constituents and the American people, really very grateful to you for the time and the expertise that you have shared with us.

So with that the subcommittee is adjourned. Thank you, everyone.

Mr. BURGESS. And we have 5 days.

Ms. ESHOO. Oh, we have 5 days for Members—I said that at the beginning of the hearing.

Mr. BURGESS. Oh, OK.

Ms. ESHOO. But I will say it again—time for Members to submit their comments for the record.

[Whereupon, at 12:32 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

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(Original Signature of Member)

116TH CONGRESS
1ST SESSION

H. R. 1385

To amend the Patient Protection and Affordable Care Act to preserve the option of States to implement health care marketplaces, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

February 28, 2019

Mr. KIM introduced the following bill; which was referred to the Committee on Energy and Commerce

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A BILL

To amend the Patient Protection and Affordable Care Act to preserve the option of States to implement health care marketplaces, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "State Allowance for a Variety of Exchanges Act" or the "SAVE Act".

SEC. 2. PRESERVING STATE OPTION TO IMPLEMENT HEALTH CARE MARKETPLACES.

(a) IN GENERAL.—Section 1311 of the Patient Protection and Affordable Care Act (42 U.S.C. 18031) is amended—

(1) in subsection (a)—

(A) in paragraph (4)(B), by striking "under this subsection" and inserting "under this paragraph or paragraph (1)"; and

(B) by adding at the end the following new paragraph:

"(6) ADDITIONAL PLANNING AND ESTABLISHMENT GRANTS.—

"(A) IN GENERAL.—There shall be appropriated to the Secretary, out of any moneys in the Treasury not otherwise appropriated, $200,000,000 to award grants to eligible States for the uses described in paragraph (3).

"(B) DURATION AND RENEWABILITY.—A grant awarded under subparagraph (A) shall be for a period of two years and may not be renewed.

"(C) LIMITATION.—A grant may not be awarded under subparagraph (A) after December 31, 2022.

"(D) ELIGIBLE STATE DEFINED.—For purposes of this paragraph, the term 'eligible State' means a State that, as of the date of the enactment of this paragraph, is not operating an Exchange."; and

(2) in subsection (d)(5)(A)—

(A) by striking "In establishing an Exchange under this section" and inserting "(I) IN GENERAL.—In establishing an Exchange under this section (other than in establishing an Exchange pursuant to subsection (a)(6))"; and

(B) by adding at the end the following:

"(ii) ADDITIONAL PLANNING AND ESTABLISHMENT GRANTS.—In establishing an Exchange pursuant to subsection (a)(6), the State shall ensure that such Exchange is self-sustaining beginning on January 1, 2024, including allowing the Exchange to charge assessments or user fees to participating health insurance issuers, or to otherwise generate funding, to support its operations.".

(b) CLARIFICATION REGARDING FAILURE TO ESTABLISH EXCHANGE OR IMPLEMENT REQUIREMENTS.—Sec-

tion 1321(c) of the Patient Protection and Affordable Care Act (42 U.S.C. 18041(c)) is amended—

(1) in paragraph (1), by striking "If" and inserting "Subject to paragraph (3), if"; and

(2) by adding at the end the following new paragraph:

"(3) CLARIFICATION.—This subsection shall not apply in the case of a State that elects to apply the requirements described in subsection (a) and satisfies the requirement described in subsection (b) on or after January 1, 2014.".

.....

(Original Signature of Member)

116TH CONGRESS
1ST SESSION

H. R. 1386

To amend the Patient Protection and Affordable Care Act to provide for additional requirements with respect to the navigator program, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

Ms. CASTOR of Florida introduced the following bill; which was referred to the Committee on .....

A BILL

To amend the Patient Protection and Affordable Care Act to provide for additional requirements with respect to the navigator program, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Expand Navigators' Resources for Outreach, Learning, and Longevity Act of 2019" or the "ENROLL Act of 2019".

SEC. 2. PROVIDING FOR ADDITIONAL REQUIREMENTS WITH RESPECT TO THE NAVIGATOR PROGRAM.

(a) IN GENERAL.—Section 1311(i) of the Patient Protection and Affordable Care Act (42 U.S.C. 18031(i)) is amended—

(1) in paragraph (2), by adding at the end the following new subparagraph:

"(C) SELECTION OF RECIPIENTS.—In the case of an Exchange established and operated by the Secretary within a State pursuant to section 1321(c), in awarding grants under paragraph (1), the Exchange shall—

"(i) select entities to receive such grants based solely on an entity's demonstrated capacity to carry out each of the duties specified in paragraph (3);

"(ii) not take into account whether or not the entity has demonstrated how the entity will provide information to individuals relating to group health plans offered by a group or association of employers described in section 2510.3–5(b) of title 29, Code of Federal Regulations (or any successor regulation), or short-term limited duration insurance (as defined by the Sec-

retary for purposes of section 2791(b)(5) of the Public Health Service Act); and

"(iii) ensure that, each year, the Exchange awards such a grant to—

"(I) at least one entity described in this paragraph that is a community and consumer-focused nonprofit group; and

"(II) at least one entity described in subparagraph (B), which may include another community and consumer-focused nonprofit group in addition to any such group awarded a grant pursuant to subclause (I).";

(2) in paragraph (3)—

(A) in subparagraph (C), by inserting after "qualified health plans" the following: ", State medicaid plans under title XIX of the Social Security Act, and State children's health insurance programs under title XXI of such Act"; and

(B) by adding at the end the following flush left sentence:

"The duties specified in the preceding sentence may be carried out by such a navigator at any time during a year.";

(3) in paragraph (4)(A)—

(A) in the matter preceding clause (i), by striking "not";

(B) in clause (i)—

(i) by inserting "not" before "be"; and

(ii) by striking "; or" and inserting ";";

(C) in clause (ii)—

(i) by inserting "not" before "receive"; and

(ii) by striking the period and inserting ";"; and

(D) by adding at the end the following new clause:

"(iii) maintain physical presence in the State of the Exchange so as to allow in-person assistance to consumers."; and

(4) in paragraph (6)—

(A) by striking "FUNDING.—Grants under" and inserting "FUNDING.—

"(A) STATE EXCHANGES.—Grants under"; and

(B) by adding at the end the following new subparagraph:

"(B) FEDERAL EXCHANGES.—For purposes of carrying out this subsection, with respect to an Exchange established and operated by the Secretary within a State pursuant to section 1321(c), the Secretary shall obligate $100,000,000 out of amounts collected through the user fees on participating health insurance issuers pursuant to section 156.50 of title 45, Code of Federal Regulations (or any successor regulations) for fiscal year 2020 and each subsequent fiscal year. Such amount for a fiscal year shall remain available until expended.".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply with respect to plan years beginning on or after January 1, 2020.

.....

(Original Signature of Member)

116TH CONGRESS
1ST SESSION

H. R. 1425

To amend the Patient Protection and Affordable Care Act to provide for a Improve Health Insurance Affordability Fund to provide for certain reinsurance payments to lower premiums in the individual health insurance market.

IN THE HOUSE OF REPRESENTATIVES

Mrs. CRAIG introduced the following bill; which was referred to the Committee on _____

A BILL

To amend the Patient Protection and Affordable Care Act to provide for a Improve Health Insurance Affordability Fund to provide for certain reinsurance payments to lower premiums in the individual health insurance market.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "State Health Care Premium Reduction Act".

SEC. 2. IMPROVE HEALTH INSURANCE AFFORDABILITY FUND.

Subtitle D of title I of the Patient Protection and Affordable Care Act is amended by inserting after part 5 (42 U.S.C. 18061 et seq.) the following new part:

"PART 6—IMPROVE HEALTH INSURANCE AFFORDABILITY FUND

"SEC. 1351. ESTABLISHMENT OF PROGRAM.

"There is hereby established the 'Improve Health Insurance Affordability Fund' to be administered by the Secretary of Health and Human Services, acting through the Administrator of the Centers for Medicare & Medicaid Services (in this section referred to as the 'Administrator'), to provide funding, in accordance with this title, to the 50 States and the District of Columbia (each referred to in this section as a 'State') beginning on January 1, 2020, for the purposes described in section 1352.

"SEC. 1352. USE OF FUNDS.

"(a) IN GENERAL.—A State shall use the funds allocated to the State under this part for one of the following purposes:

"(1) To provide reinsurance payments to health insurance issuers with respect to individuals enrolled under individual health insurance coverage (other than through a plan described in subsection (b)) offered by such issuers.

"(2) To provide assistance (other than through payments described in paragraph (1)) to reduce out-of-pocket costs, such as copayments, coinsurance, premiums, and deductibles, of individuals enrolled under qualified health plans offered on the individual market through an Exchange.

"(b) EXCLUSION OF CERTAIN GRANDFATHERED AND TRANSITIONAL PLANS.—For purposes of subsection (a), a plan described in this subsection is the following:

"(1) A grandfathered health plan (as defined in section 1251).

"(2) A plan (commonly referred to as a 'transitional plan') continued under the letter issued by the Centers for Medicare & Medicaid Services on November 14, 2013, to the State Insurance Commissioners outlining a transitional policy for coverage in the individual and small group markets to which section 1251 does not apply, and under the extension of the transitional policy for such coverage set forth in the Insurance Standards Bulletin Series guidance issued by the Centers for Medicare & Medicaid Services on March 5, 2014, February 29, 2016, February 13, 2017, and April 9, 2018, or under any subsequent extensions thereof.

"SEC. 1353. STATE ELIGIBILITY AND APPROVAL; DEFAULT SAFEGUARD.

"(a) ENCOURAGING STATE OPTIONS FOR ALLOCATIONS.—

"(1) IN GENERAL.—To be eligible for an allocation of funds under this part for a year (beginning with 2020), a State shall submit to the Administrator an application at such time (but, in the case of allocations for 2020, not later than 90 days after the date of the enactment of this title and, in the case of allocations for a subsequent year, not later than March 31 of the previous year) and in such form and manner as specified by the Administrator containing—

"(A) a description of how the funds will be used; and

"(B) such other information as the Administrator may require.

"(2) AUTOMATIC APPROVAL.—An application so submitted is approved unless the Administrator notifies the State submitting the application, not later than 60 days after the date of the submission of such application, that the application has been denied for not being in compliance with any requirement of this part and of the reason for such denial.

"(3) 5-YEAR APPLICATION APPROVAL.—If an application of a State is approved for a purpose described in section 1352 for a year, such application shall be treated as approved for such purpose for each of the subsequent 4 years.

"(b) DEFAULT FEDERAL SAFEGUARD.—

"(1) 2020.—For allocations made under this part for 2020, in the case of a State that does not submit an application under subsection (a) by the 90-day submission date applicable to such year under subsection (a)(1) and in the case of a State that does submit such an application by such date that is not approved, the Administrator, in consultation with the State insurance commissioner, shall use, in accordance with paragraph (3), the allocation that would otherwise be provided to the State under this part for such year for such State.

"(2) 2021 AND SUBSEQUENT YEARS.—In the case of a State that does not have in effect an approved application under this section for 2021 or a subsequent year, the Administrator, in consultation with the State insurance commissioner, shall use, in accordance with paragraph (3), the allocation that would otherwise be provided to the State under this part for such year for such State.

"(3) SPECIFIED USE.—An allocation for a State made pursuant to paragraph (1) or (2) for a year shall be used to carry out the purpose described in section 1352(1) in such State by providing reinsurance payments to health insurance issuers with respect to attachment range claims (as defined in section 1354(b)(2), using the dollar amounts specified in subparagraph (B) of such section for such year) in an amount equal to the percentage (specified for such year by the Secretary under such subparagraph) of the amount of such claims.

"SEC. 1354. ALLOCATIONS.

"(a) APPROPRIATION.—For the purpose of providing allocations for States under this part there is appropriated, out of any money in the Treasury not otherwise appropriated $10,000,000,000 for 2020 and each subsequent year.

"(b) ALLOCATIONS.—

"(1) PAYMENT.—

"(A) IN GENERAL.—From amounts appropriated under subsection (a) for a year, the Secretary shall, with respect to a State and not later than the date specified under subparagraph (B) for such year, allocate for such State

the amount determined for such State and year under paragraph (2).

"(B) SPECIFIED DATE.—For purposes of subparagraph (A), the date specified in this subparagraph is—

"(i) for 2020, the date that is 45 days after the date of the enactment of this title; and

"(ii) for 2021 or a subsequent year, January 1 of the respective year.

"(C) NOTIFICATIONS OF ALLOCATION AMOUNTS.—For 2021 and each subsequent year, the Secretary shall notify each State of the amount determined for such State under paragraph (2) for such year by not later than January 1 of the previous year.

"(2) ALLOCATION AMOUNT DETERMINATIONS.—

"(A) IN GENERAL.—For purposes of paragraph (1), the amount determined under this paragraph for a year for a State is the amount that the Secretary estimates would be expended under this part for such year on attachment range claims of individuals residing in such State if all States used such funds only for the

purpose described in paragraph (1) of section 1352 at the dollar amounts and percentage specified under subparagraph (B) for such year. For purposes of the previous sentence and section 1353(b)(3), the term 'attachment range claims' means, with respect to an individual, the claims for such individual that exceed a dollar amount specified by the Secretary for a year, but do not exceed a ceiling dollar amount specified by the Secretary for such year, under subparagraph (B).

"(B) SPECIFICATIONS.—For purposes of subparagraph (A) and section 1353(b)(3), the Secretary shall determine the dollar amounts and the percentage to be specified under subparagraph (A) for a year in a manner to ensure that the total amount of expenditures under this part for such year is estimated to equal the total amount appropriated for such year under subsection (a) if such expenditures were used solely for the purpose described in paragraph (1) of section 1352 for attachment range claims at the dollar amounts and percentage so specified for such year.

"(3) AVAILABILITY.—Funds allocated to a State under this subsection for a year shall remain available through the end of the subsequent year.

"(c) ANNUAL DISTRIBUTION OF PREVIOUS YEAR'S REMAINING FUNDS.—

"(1) IN GENERAL.— In carrying out subsection (b), the Secretary shall, with respect to a year (beginning with 2021), not later than March 31 of such year—

"(A) determine the amount of funds, if any, from the amounts appropriated under subsection (a) for the previous year but not allocated for such previous year; and

"(B) if the Secretary determines that any funds were not so allocated for such previous year, allocate such remaining funds to States for such year, in accordance with paragraph (2).

"(2) ALLOCATION METHODOLOGY.—For purposes of paragraph (1), of the total remaining funds to be allocated for a year pursuant to such paragraph, the Secretary shall allocate to each State an amount that bears the same ratio to such total remaining funds as the amount allocated pursuant to subsection (b) to such State for such year bears to

the total allocations made under such subsection for such year.''.

Congress of the United States
Washington, DC 20515

March 5, 2019

The Honorable Richard Neal
Chairman, House Ways & Means Committee
1102 Longworth House Office Building
Washington, D.C. 20515

The Honorable Frank Pallone
Chairman, House Energy & Commerce Committee
2125 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Bobby Scott
Chairman, House Education & Labor Committee
2176 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairmen Neal, Pallone, and Scott,

Thank you for the work you have done in your committees exploring ways we can lower health care costs, expand coverage and access, and improve quality of care across the country. Our constituents elected a Democratic majority in the House by choosing candidates who stood strongly in support of protecting those with pre-existing conditions and bringing down health care costs for all. Building upon your work and the work of the New Democrat Coalition last Congress, we urge your committees to deliver on the promises made to our constituents by prioritizing strengthening the Affordable Care Act (ACA) and continuing the path toward universal affordable coverage.

First, we believe the House Democratic Caucus should immediately work to stabilize the individual health care marketplace. After years of damage done to the ACA from past Republican Congresses and the Administration, we must start by reversing the sabotage. Junk insurance plans, potentially harmful changes to state innovation waivers, elimination of cost sharing support, and reduced funding for enrollment outreach have only served to make the individual market less stable and uncertain for those with pre-existing conditions.

Second, we can also fortify the ACA by taking proactive steps to bring down costs for consumers. For example, the Congressional Budget Office found that the ACA's temporary transitional reinsurance program reduced premiums by as much as 10 percent. Congress should create a dedicated reinsurance program once more. We also know that expanding health insurance enrollment would strengthen the health care marketplace and lower health care costs for millions of patients. One way to achieve this goal is to create state innovation grants, as was proposed last Congress in H.R. 5155, to help states experiment with new ideas such as auto-enrollment and regional exchanges. Additional actions we could take include providing additional premium assistance, providing more options for Americans near Medicare eligibility age, or reforming bidding areas to encourage competition.

All of these policy solutions would build upon the success of the ACA and deliver on our promises to constituents to work for them and make real progress toward more affordable and universal healthcare. Now that we are in the House Majority, we must follow through on these pledges and take decisive

action to tackle rising health care costs. We know that these issues already have broad bipartisan support, and we urge you to continue your efforts from last Congress. We believe these goals are achievable in the 116th Congress, and the New Democrat Coalition is ready to support you in these efforts.

Sincerely,

Rep. Angie Craig
Co-Chair, Health Care Task Force
New Democrat Coalition

Rep. Kurt Schrader
Co-Chair, Health Care Task Force
New Democrat Coalition

Rep. Kim Schrier
Co-Chair, Health Care Task Force
New Democrat Coalition

Rep. Greg Stanton
Co-Chair, Health Care Task Force
New Democrat Coalition

Rep. Derek Kilmer
Chair
New Democrat Coalition

Rep. Suzan DelBene
Vice Chair
New Democrat Coalition

Rep. Annie Kuster
Vice Chair
New Democrat Coalition

Rep. Scott Peters
Vice Chair
New Democrat Coalition

Rep. Terri Sewell
Vice Chair
New Democrat Coalition

Rep. Pete Aguilar
Whip
New Democrat Coalition

Rep. Kathleen Rice
Leadership Member
New Democrat Coalition

Rep. Ami Bera
Leadership Member
New Democrat Coalition

Rep. Jim Himes
Chair Emeritus
New Democrat Coalition

Rep. Chrissy Houlahan
Freshman Leadership Rep.
New Democrat Coalition

Rep. Mikie Sherrill
Freshman Whip
New Democrat Coalition


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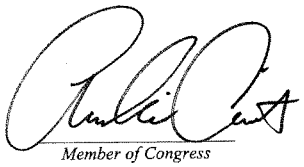

Member of Congress

FRED UPTON, MICHIGAN
CHAIRMAN

HENRY A. WAXMAN, CALIFORNIA
RANKING MEMBER

ONE HUNDRED THIRTEENTH CONGRESS

Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
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Majority (202) 225–2927
Minority (202) 225–3641

April 12, 2013

The Honorable Kathleen Sebelius
Secretary
Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Dear Secretary Sebelius:

Pursuant to Rules X and XI of the United States House of Representatives, the Committee on Energy and Commerce is continuing to investigate the implementation of the Patient Protection and Affordable Care Act (PPACA).

This week, news broke that the Administration would award $54 million to community groups in 33 States to facilitate enrollment in the health insurance marketplaces that open for enrollment in October 2013.[1] These groups will serve as "Navigators" for the federally-facilitated or State partnership exchanges and assist consumers in understanding their health insurance options.

In order to assist the Committee in understanding the role Navigators will play when the PPACA is fully implemented, we ask that you provide written answers to the following requests and questions and the related documents no later than April 30, 2013:

1. Please describe all sources of funding available for Navigators, both currently and in the future, including funding from the Department of Health and Human Serviees (HHS). Does the $54 million represent the total amount HHS or the Center for Consumer Information and Insurance Oversight (CCIIO) expects to invest in Navigators for these 33

[1] Phil Galewitz and Jenny Gold, *Funding to Enroll Uninsured In New Markets Called 'Drop In Bucket'*, KAISER HEALTH NEWS, Apr. 9, 2013 available at http://www.kaiserhealthnews.org/Stories/2013/April/09/54-million-dollar-grants-for-exchange-enrollment-efforts.aspx.

States?[2] For what purposes can award recipients use the $54 million in funding for Navigators?

2. How many Navigators does HHS or CCIIO intend to fund? While some reports indicate that a State like California will need 21,000 "helpers"[3], other reports note that "each state marketplace should have two navigators", one of which must be a nonprofit.[4] If HHS or CCIIO intends to utilize larger organizations who will then delegate responsibilities to their designees, please describe how they will be supervised by either HHS or CCIIO. News reports also indicate that the number of uninsured in each State will determine the Navigator funding available; please describe the apportionment process among the States

3. Describe the role of Navigators in States that are not utilizing federally-facilitated or State partnership exchanges. If they will have no role, describe what requirements exist (either in the PPACA or elsewhere) that require these other States to create or implement a Navigator style program.

4. Describe the process by which Navigators will be chosen. Please provide copies of any applications or forms individuals applying for Navigator positions must complete or submit. In addition, please provide any documents relating to the salary or pay scale for Navigators.

5. Describe the groups, individuals, or entities eligible to become Navigators, including those that are prohibited from doing so and why. For example, news reports indicate that individuals compensated by insurance companies are prohibited from becoming Navigators; please describe the reasons for this and whether underwriters, who have experience in this field, are permitted to become Navigators.

6. The CCIIO website explains that successful applicants will "maintain expertise in eligibility, enrollment, and program specifications." Please describe how this will be determined and monitored, as well as any other ongoing efforts to monitor, review, or otherwise judge the performance of Navigators. Explain how this expertise will be determined considering that the exchanges have yet to be finalized and enrollment does not begin until October 1, 2013.

7. Describe the training, if any, that Navigators will participate in (and whether it will be voluntarily or a requirement). Please provide any documents related to the training of Navigators or guidance provided by HHS relating to the training of Navigators.

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[2] For example, a *Washington Post* article of February 04, 2013, reported that the funding would be drawn from "federal grants, state budgets, or private money" for now, and from the health insurance exchanges over the long term. *See* N.C. Aizenman, *For insurance exchanges, states need 'navigators'—and hiring them is a huge task,* WAPO, Feb. 04, 2013 available at http://articles.washingtonpost.com/2013-02-04/national/ 36743424_1_ insurance-exchanges-navigators-health-insurance. Describe any federal, state, and private money used for this program in your response, along with a description of how the exchanges will fund this in the future.

[3] *Id.*

[4] Sam Baker, *HHS opens applications for ObamaCare 'navigators',* THE HILL, Apr. 9, 2013 available at http://thehill.com/blogs/healthwatch/health-reform-implementation/292731-hhs-opens-applications-for-obamacare-navigators.

We appreciate that representatives from CCIIO have already made an effort to brief relevant Committee staff on the implementation of the Navigators program. Providing written answers to the above questions will further help our understanding of the program. If you have any questions about this request please contact Sean Hayes with Committee staff at (202) 225-2927.

Sincerely,

Fred Upton
Chairman

Tim Murphy
Chairman
Subcommittee on Oversight and Investigations

Joe Barton
Chairman Emeritus

Joseph R. Pitts
Chairman
Subcommittee on Health

Marsha Blackburn
Vice Chairman

Michael C. Burgess
Vice Chairman
Subcommittee on Oversight and Investigations

cc: The Honorable Henry Waxman, Ranking Member

The Honorable Frank Pallone, Ranking Member
Subcommittee on Health

The Honorable Diana DeGette, Ranking Member
Subcommittee on Oversight and Investigations

FRED UPTON, MICHIGAN
CHAIRMAN

HENRY A. WAXMAN, CALIFORNIA
RANKING MEMBER

ONE HUNDRED THIRTEENTH CONGRESS

Congress of the United States

House of Representatives

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June 28, 2013

The Honorable Kathleen Sebelius
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20221

Dear Secretary Sebelius:

Pursuant to Rules X and XI of the U.S. House of Representatives, we write to you regarding the recent update by the Department of Health and Human Services (HHS) of the "Essential Community Provider" (ECP) list.[1]

The Patient Protection and Affordable Care Act (PPACA) requires that insurers offering plans on the Health Insurance Marketplaces, or exchanges, include a "sufficient number and geographic distribution" of providers that serve predominantly "low-income, medically underserved individuals." These providers are referred to as Essential Community Providers. This requirement was described in an April 5, 2013, letter to insurers from the Center for Medicare and Medicaid Services (CMS) Center for Consumer Information and Insurance Oversight (CCIIO).

HHS maintains a "non-exhaustive" database of these providers on the website of CMS.[2] When this database was updated recently, it included over 17,000 organizations. Included in this list of approved Essential Community Providers are private and public organizations, hospitals, state and local health departments, and community health centers as well as 639 Planned Parenthood clinics.

Public reports indicate that Planned Parenthood plans to engage in significant outreach promoting the PPACA. Eric Ferrero, Planned Parenthood vice president for communications, acknowledged that Planned Parenthood's "'goal is to provide localized information so that if you walk into a health center in Florida, you will know about new insurance options and benefits that

[1] https://data.cms.gov/dataset/Non-Exhaustive-List-of-Essential-Community-Provide/ibqy-mswq
[2] http://www.cms.gov/CCIIO/Resources/Regulations-and Guidance/Downloads/2014_letter_to_issuers_04052013.pdf

are available in that area.'"[3] To that end, Planned Parenthood has created refrigerator magnets and online applications to assist in enrollment. In addition, some Planned Parenthood affiliates plan to become official government-funded "Navigators" under the PPACA, so that they may directly advise individuals on enrollment.

In order to help the Committee better understand the PPACA's requirements relating to Essential Community Providers, we ask that you provide the following information by July 12, 2013:

1. The criteria that CMS uses when evaluating whether a health care facility will be listed as an essential community provider;

2. All documents provided to either HHS or the Center for Consumer Information and Insurance Oversight (CCIIO) by Planned Parenthood concerning their identification as an Essential Community Provider. This would include, but is not limited to, communications between administration representatives and Planned Parenthood, including e-mails.

3. All documents submitted to either HHS or CCIIO by insurers or their representatives concerning the approval of Planned Parenthood as an Essential Community Provider. This would include, but is not limited to, communications between administration representatives and the insurance industry (and their representatives), including e-mails.

4. Explain whether the PPACA or its regulations permit an Essential Community Provider to also serve as a Navigator or Assister.

Should you have any questions regarding this request, please contact Committee staff at (202) 225-2927. Thank you for your attention to this matter.

Sincerely,

Tim Murphy
Chairman
Subcommittee on Oversight and Investigations

Joe Pitts
Chairman
Subcommittee on Health

[3] Kathryn Smith, *With ACA outreach role, Planned Parenthood sees potential, pushback*, POLITICO PRO, June 19, 2013 available at https://www.politicopro.com/go/?id=23306.

Marsha Blackburn
Vice Chairman

Joe Barton
Chairman Emeritus

cc: The Honorable Henry A. Waxman, Ranking Member

FRED UPTON, MICHIGAN
CHAIRMAN

HENRY A. WAXMAN, CALIFORNIA
RANKING MEMBER

ONE HUNDRED THIRTEENTH CONGRESS

Congress of the United States
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Minority (202) 225–3641

August 29, 2013

[redacted]

Dear [redacted]:

Pursuant to Rules X and XI of the United States House of Representatives, the Committee on Energy and Commerce is examining the role Navigators will play in efforts to enroll individuals in health insurance exchanges under the Patient Protection and Affordable Care Act (PPACA).

On August 15, 2013, the Centers for Medicare and Medicaid Services (CMS) awarded $67 million in Navigator Cooperative Agreements to entities that will assist consumers in preparing electronic and paper applications to establish eligibility and enroll in coverage through the PPACA marketplaces. Your organization was identified as a recipient of a Navigator grant by the Center for Consumer Information and Insurance Oversight (CCIIO).[1]

In order to better understand the work you will perform as a Navigator and the consumer protections that will be in place before open enrollment begins on October 1, 2013, we ask that you contact Committee staff to schedule a briefing to occur no later than September 13, 2013, to discuss your participation as a Navigator in the health insurance exchanges. We also ask that you provide written answers to the following questions and produce the materials requested no later than September 13, 2013:

1. Provide a written description of the work that will be performed with the funds obtained via your Navigator grant. This would include a description of the number of employees, volunteers, or representatives that will be utilized and the pay and duties for each, as well as a written description of how any other portion of the grant may be spent. If a budget or detailed description of how this funding will be utilized exists or will be created, provide these documents in addition to the written response requested.

[1] http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/Downloads/navigator-list-8-15-2013.pdf

2. Provide a written description of the training or education employees, volunteers, or representatives must complete, including training or education required by the Department of Health and Human Services (HHS), CMS, CCIIO, or any other federal or state entity. Provide a written description of any training or educational efforts employees, volunteers, or representatives must complete that are required by your organization beyond that required by any federal or state entity. Provide copies of these materials.

3. Provide a written description of the processes and procedures in place to monitor, review, or otherwise supervise your employees, volunteers, or representatives. If documentation of these standards exists or will be created, provide these documents in addition to the written response requested.

4. Provide a written description of how your organization will utilize the information obtained during performance of your Navigator grant. This would include, but is not limited to, descriptions of the measures your organization will take to safeguard an individual's personal and medical information. Furthermore, provide a written description of whether your organization may use any of the information obtained during performance of your Navigator grant, including any prohibitions on the use of that information. For example, please provide a written description of whether your organization may contact individuals who have utilized your services as a Navigator for the purposes of fundraising, voter registration efforts, campaign activities, or any other reason.

5. Provide a written description of whether your organization has been contacted by any health insurance company or health care provider to discuss your Navigator grant. This would include, but is not limited to, discussions of supporting your organization in any way or promoting the health insurance company or health care provider to individuals your organization may contact.

6. Provide all documentation and communications related to your Navigator grant. This would include, but is not limited to, materials your organization submitted in order to obtain the grant, materials provided to your organization upon obtaining the grant, and communications between your organization and representatives from HHS, CMS, CCIIO or any other federal or state entity. This request also includes, but is not limited to, any documents provided by (or communications with), representatives from HHS, CMS, CCIIO, Enroll America, or any other entity including federal or state governments discussing individuals to target or solicit for enrollment under the PPACA, including discussions or documents related to geographic area.

Instructions for responding to the Committee's document request are included as an attachment to this letter. Thank you for your prompt attention to this matter. If you have questions or wish to discuss your responses or production, please contact Karen Christian or Sean Hayes with Committee Staff at (202) 225-2927.

Sincerely,

Fred Upton
Chairman

Joe Barton
Chairman Emeritus

Tim Murphy
Chairman
Subcommittee on Oversight and Investigations

Joseph R. Pitts
Chairman
Subcommittee on Health

Marsha Blackburn
Vice Chairman

Michael C. Burgess
Vice Chairman
Subcommittee on Oversight and Investigations

Phil Gingrey
Member

Steve Scalise
Member

Gregg Harper
Member

Pete Olson
Member

Cory Gardner
Member

Morgan Griffith
Member

Bill Johnson
Member

Billy Long
Member

Renee Ellmers
Member

cc: The Honorable Henry Waxman, Ranking Member

The Honorable Diana DeGette, Ranking Member
Subcommittee on Oversight and Investigations

To read a copy of the letter, click here.

To achieve a broad sampling, these letters were sent to all grant recipients in states receiving 61 percent of Navigator dollars. Those groups and states are:

Arizona

- ARIZONA ASSOCIATION OF COMMUNITY HEALTH CENTERS
- ARIZONA BOARD OF REGENTS, U OF ARIZONA
- GREATER PHOENIX URBAN LEAUGE
- CAMPESINOS SIN FRONTERAS

Florida

- UNIVERSITY OF SOUTH FLORIDA
- EPILEPSY FOUNDATION OF FLORIDA
- ADVANCED PATIENT ADVOCACY, LLC
- LEGAL AID SOCIETY OF PALM BEACH COUNTY, INC.
- PINELLAS COUNTY BOARD OF COUNTY COMMISSIONERS
- NATIONAL HISPANIC COUNCIL ON AGING
- CARDON HEALTHCARE NETWORK
- MENTAL HEALTH AMERICA

Georgia

- STRUCTURED EMPLOYMENT ECONOMIC DEVELOPMENT CORPORATION
- UNIVERSITY OF GEORGIA

Indiana

- AFFILIATED SERVICE PROVIDERS OF INDIANA
- PLUS ONE ENTERPRISES
- HEALTH AND HOSPITAL CORPORATION OF MARION COUNTY
- UNITED WAY WORLDWIDE

Louisiana

- SOUTHER UNITED NEIGHBORHOODS
- MARTIN LUTHER KING HEALTH CENTER
- SOUTHWEST LOUISIANA AREA HEALTH EDUCATION CENTER
- CAPITAL AREA AGENCY ON AGING

Missouri

- PRIMARIS HEALTH BUSINESS SOLUTIONS
- MISSOURI ALLIANCE OF AREA AGENCIES ON AGING

New Jersey

- CENTER FOR FAMILY SERVICES
- WENDY SYKES
- URBAN LEAGUE OF HUDSON COUNTY
- PUBLIC HEALTH SOLUTIONS
- FOODBANK OF MONMOUTH AND OCEAN COUNTIES

North Carolina

- RANDOLPH HOSPITAL
- MOUNTAIN PROJECTS
- NORTH CAROLINA COMMUNITY CARE NETWORKS
- ALCOHOL DRUG COUNCIL OF NC

Ohio

- OHIO ASSOCIATION OF FOODBANKS
- CHILDREN'S HOSPITAL MEDICAL CENTER
- CLERMONT RECOVERY CENTER
- HELPING HANDS COMMUNITY OUTREACH CENTER
- NEIGHBORHOOD HEALTH ASSOCIATION

Pennsylvania

- RESOURCES FOR HUMAN DEVELOPMENT
- PENNSYLVANIA ASSOCIATION OF COMMUNITY HEALTH CENTERS
- PENNSYLVANIA MENTAL HEALTH CONSUMERS' ASSOCIATION
- CARDON HEALTH NETWORK
- MENTAL HEALTH AMERICA

Texas

- UNITED WAY OF METROPOLITAN TARRANT COUNTY
- MIGRANT HEALTH PROMOTION, INC.
- NATIONAL HISPANIC COUNCIL ON AGING
- CHANGE HAPPENS
- UNITED WAY OF EL PASO COUNTY
- SOUTHERN UNITED NEIGHBORHOODS
- EAST TEXAS BEHAVIORAL HEALTHCARE NETWORK
- NATIONAL URBAN LEAGUE

FRED UPTON, MICHIGAN
CHAIRMAN

HENRY A. WAXMAN, CALIFORNIA
RANKING MEMBER

ONE HUNDRED THIRTEENTH CONGRESS

Congress of the United States

House of Representatives

COMMITTEE ON ENERGY AND COMMERCE

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September 20, 2013

Mr. Gary Cohen
Deputy Administrator and Director
Center for Consumer Information and Insurance Oversight
Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Mr. Cohen:

Thank you for your testimony yesterday at the hearing before the Subcommittee on Oversight and Investigations, "Two Weeks Until Enrollment: Questions for CCIIO."

During this hearing, members of the Subcommittee asked you several questions about the Navigator program. The Patient Protection and Affordable Care Act (PPACA), and subsequent regulations implementing the law, established that "Navigators" may facilitate enrollment in qualified health plans. Due to concerns about how the health and financial information of exchange applicants will be protected by Navigators, and because the Department of Health and Human Services' (HHS) two-month delay in implementing the program reduced by half the time available to Navigator organizations to train their staff,[1] this Committee recently asked 51 Navigator grant recipients to provide basic information about their enrollment plans. Those questions included how they intended to spend this taxpayer money, how they would protect private consumer information, and what standards would be in place to prevent conflicts of interest. HHS ultimately provided to the Committee copies of the grant applications for nearly all of the organizations the Committee contacted.

We write to you to follow-up on your testimony at yesterday's hearing and to secure responses to Members' questions about implementation of the Navigator program that have arisen in light of our review of the Navigator grant applications provided by HHS. The questions and concerns that emerged in our review appear to be a direct result of the rushed implementation of the Navigator program by HHS and the limited time available for training Navigator grant recipient organizations and their staff. The Committee's review has identified the following issues, many of which were discussed at yesterday's hearing:

[1] United States Government Accountability Office Report, "Status of CMS Efforts to Establish Federally Facilitated Health Insurance Exchanges", June 2013 (GAO-13-601).

- **Some Navigator recipients plan to engage in enrollment activities that increase the likelihood of fraud or abuse, including door-to-door contacts.** The recipient of one of the largest Navigator grants explained in their application that they expected a substantial portion of their program to involve door-to-door contacts. Another described their work plan as involving "door to door outreach to 10,000 households per week." In a report issued by the Oversight and Government Reform Committee, you and Vicki Gottlich, Director of the Consumer Support Group at CCIIO, acknowledged that allowing Navigators to go door-to-door could be problematic.[2] At the hearing yesterday, you stated that you are "confident" that Navigators will follow their instructions not to make door-to-door contact.

- **The plans of some Navigator organizations do not correspond with the enrollment calendar.** Enrollment in the Marketplace will be open from October 1, 2013, until March 31, 2014. This indicates that most enrollment activity should occur during that six-month timeframe, and some Navigators did indeed indicate to Committee staff that they expect the open enrollment period to be the most active period, during which most individuals would enroll in the exchanges. Yet, some Navigator organizations have planned for an equal amount of enrollment activities outside this time period. For example, one Navigator indicated in their application that they expected to enroll the same number of individuals per month during open enrollment as after open enrollment. Likewise, based on their grant applications, many Navigator organizations have budgeted to spend the same amount of funding in each fiscal quarter. It is unclear why a Navigator would plan for significant enrollment activities and spending to take place outside the open enrollment period.

- **The amount of grant funding per expected enrollee varies widely among Navigator grant recipients.** As was discussed yesterday one Navigator received approximately $80,000 to enroll 300 people. Another grant recipient estimated they would be able to enroll 577,500 individuals (75 percent of those reached directly, at a cost of approximately $2.25 per enrollee) across two states. Yet, another Navigator operating in one of those states won a grant for one-third of the funding to enroll 1,500 individuals during open enrollment. This is less than 1 percent of the 577,500 individuals that the other group promises to enroll. In addition, as was discussed yesterday at the hearing, one organization is predicting that each one of their 50 Navigators will be able to enroll over 11,000 individuals.

- **A Navigator that received one of the largest grants plans to engage in extensive enrollee tracking, while other Navigators maintain they will avoid recording or retaining personal information.** One grant recipient's application includes plans to use a "needs based survey to monitor and track healthcare coverage to identify potential new applicants" combined with "survey and tracking of those who attend community meetings." This application also says "contacts" will be entered into a database for

[2] Report of the Committee on Oversight and Government Reform: *Risks of Fraud and Misinformation with Obamacare Outreach Campaign: How Navigator and Assister Program Mismanagement Endangers Consumers*, Sept. 18, 2013.

"follow-up." The applicant did not provide additional detail on this Navigator database, but the fact that HHS awarded this grantee the exact amount of funding they requested to operate in multiple states suggests that HHS has approved this applicant's planned surveys and enrollee tracking. Based on the applications provided to the Committee by HHS, this kind of enrollment activity is not typical. Other applicants informed Committee staff of the great steps they would take *not* to collect consumer data, with one grant recipient informing the Committee they will not retain "any" information.

- **Navigators will receive disparate salaries for similar work tasks.** One organization operating in Florida proposed to hire 50 Navigators to "dedicate 100% of their time to the program at a salary of $15,738." Another organization operating in the same area reported that they will hire four Navigators at salaries of $43,000 per year. This pay disparity is also found in organizations receiving Navigator grants that will be working with a consortium of other agencies to perform the Navigator functions.

- **Navigators are split on the importance of background checks or whether they are cost prohibitive.** While several Navigators reported that they would conduct background checks on their hires, others informed Committee staff that they would not be doing so, with one grant recipient remarking that it would be cost prohibitive. Yet, a recipient of one of the largest Navigator grants informed Committee staff during a briefing that they believe it is "very important" to do background checks regardless of the cost, and would be performing such checks on *every* Navigator.

- **Grant recipients could utilize pay-for-play methods of rewarding Navigators and enrolling consumers.** One Navigator grant recipient's application explicitly stated that it would provide bonuses for enrolling a certain number of people in the PPACA. In addition, another Navigator indicated that they would utilize gift cards so that *consumers* would provide "feedback on assistance provided and consumer knowledge from and satisfaction with events."

- **Third parties are contacting Navigators about enrollment.** Navigators are prohibited from receiving any consideration directly or indirectly from any health insurance issuer in connection with the enrollment of any individuals or employees. Yet, some Navigators informed us that they were being approached by outside groups in response to news that they had obtained a Navigator grant, including unsolicited emails from companies and insurance agents. One Navigator told Committee staff that individuals have attempted to provide brochures on certain health plans.

- **Robo calls.** One Navigator grant recipient's work plan promises to make 240,000 "robo calls" over the course of their contract.

Although you acknowledged that your office is responsible for overseeing the Navigator program, you explained that you had not reviewed the individual grant applications and therefore could not comment on the individual Navigators' planned enrollment activities. You did testify that HHS plans to issue guidance on permissible Navigator activities, and that this guidance will make clear that certain activities, like door-to-door outreach for the purpose of enrollment and

paying Navigators based on the number of individuals enrolled, will not be permitted. With less than two weeks until Navigators are to begin working with consumers, the fact that this guidance has not yet been issued leaves Navigator grant recipients without the clear instruction they would need. In order to better understand the manner in which HHS reviewed Navigator grant applications and plans to implement and monitor the Navigator program, we request a written response to the following questions no later than October 3, 2013:

1. How many Navigator grant recipients list door-to-door contacts as part of their planned enrollment activities? Please describe whether HHS plans to contact those Navigators that plan to engage in door-to-door contacts and whether those Navigators will be permitted to engage in this activity. In addition, please describe whether the grant awards of any Navigators will be adjusted should they not be permitted to engage in this activity.

2. How many Navigator grant recipients indicate in their applications that they plan to pay Navigator staff based on the number of individuals enrolled in the exchanges? Please describe whether HHS plans to contact those Navigators that plan to pay staff based on enrollment and whether those Navigators will be permitted to engage in this activity.

3. The Navigator grant organizations will spend widely varying amounts of funding per expected enrollee. Please describe how HHS evaluated the budget of Navigator grant applicants as compared to the number of expected enrollees. Please identify what other metrics HHS used to evaluate the budgets of Navigator grant applicants. Of the 105 Navigator organizations, please identify any Navigator grant recipients whose planned staff salaries were adjusted or changed by HHS during the grant review process.

4. The enrollment goals of Navigator grant recipients varied broadly. Please describe how HHS evaluated the enrollment goals and plans of Navigator grant recipients. Please identify what steps were taken to ensure reasonable enrollment targets and whether these enrollment targets were adjusted or changed by HHS during the grant review process.

5. Please explain whether Navigator enrollee tracking, the use of gift cards, robo calls, or third party contact, is permitted by HHS and why.

Instructions for responding to the Committee's requests are included as an attachment to this letter. Thank you for your prompt attention to this matter. Please contact Committee staff at (202) 225-2927 if you have any questions about this request.

Sincerely,

Fred Upton
Chairman

Joe Barton
Chairman Emeritus

Tim Murphy
Chairman
Subcommittee on Oversight and Investigations

Joseph R. Pitts
Chairman
Subcommittee on Health

Marsha Blackburn
Vice Chairman

Michael C. Burgess
Vice Chairman
Subcommittee on Oversight and Investigations

Phil Gingrey
Member

Steve Scalise
Member

Gregg Harper
Member

Pete Olson
Member

Cory Gardner
Member

Morgan Griffith
Member

Bill Johnson
Member

Billy Long
Member

Renee Ellmers
Member

cc: The Honorable Henry Waxman, Ranking Member

The Honorable Diana DeGette, Ranking Member
Subcommittee on Oversight and Investigations

AMERICAN LUNG ASSOCIATION.

March 5, 2019

The Honorable Angie Craig
U.S. House of Representatives
Washington, DC 20515

Dear Representative Craig:

I am writing to express the American Lung Association's support for your legislation, HR 1425, "the State Health Care Premium Act." Your legislation will increase funding for reinsurance programs – important tools to reduce health insurance premiums and stabilize health insurance marketplaces for patients with lung disease.

Reinsurance programs help health insurance companies cover the claims of very high cost enrollees, which in turn helps insurers to keep premiums affordable for individuals buying insurance on the individual market. Lower premiums can also encourage younger, healthier individuals to purchase insurance coverage, strengthening the risk pool of the state's marketplace. Additionally, a healthier risk pool can help attract new insurance companies to participate in the state's marketplace, increasing competition and improving choices for consumers. This would help patients with asthma, COPD, lung cancer and other lung diseases obtain affordable, comprehensive coverage.

Reinsurance programs have been successfully used to stabilize premiums in a number of healthcare programs, such as Medicare Part D. A temporary reinsurance fund for the individual market was also established under the Affordable Care Act and reduced premiums by an estimated 10 to 14 percent in its first year.[1] In Minnesota, a state already implementing a reinsurance program through a Section 1332 waiver, premiums for individual insurance plans in 2019 decreased by between 7.4 and 27.7 percent compared to 2018 rates.[2]

We applaud you for your commitment to ensuring that patients are protected and that they can access quality and affordable healthcare coverage. We look forward to working with you to ensure that your legislation becomes law.

Sincerely,

[redacted]

Deborah P. Brown
Chief Mission Officer

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Ph: 202-785-3355 F: 202-452-1805

Corporate Office:
55 West Wacker Drive, Suite 1150 | Chicago, IL 60601
Ph: 312-801-7630 F: 202-452-1805 info@Lung.org

[1] American Academy of Actuaries, Individual and Small Group Markets Committee. *An Evaluation of the Individual Health Insurance Market and Implications of Potential Changes.* January 2017. Retrieved from https://www.actuary.org/files/publications/Acad_eval_indiv_mkt_011817.pdf.

[2] Minnesota Commerce Department. *2019 Health Insurance Rates.* October 2018. Retrieved from https://mn.gov/commerce/consumers/your-insurance/health-insurance/rates/rate-filings/2019/.

AMERICAN LUNG ASSOCIATION.

March 5, 2019

The Honorable Kathy Castor
U.S. House of Representatives
Washington, DC 20515

Dear Representative Castor:

I am writing to express the American Lung Association's support for your legislation, HR 1386, the "Expand Navigators' Resources for Outreach, Learning and Longevity (ENROLL) Act." Your legislation will restore funding for the navigator program– ensuring that consumers will receive the assistance they need to enroll in quality and affordable healthcare coverage.

Navigators play a critical role in helping individuals, including patients with lung disease learn about their healthcare coverage options and enroll in plans that are appropriate for their healthcare needs. In 2017, the Commonwealth Fund found that two-thirds of adults who received personal assistance when they shopped for coverage in the marketplace ultimately enrolled in coverage, compared to less than half of individuals who did not receive personal assistance.[1]

The Lung Association is deeply concerned about the growth of non-ACA compliant health insurance coverage, such as short-term limited-duration insurance plans. These plans are not required to cover the physicians, medications, and services that lung disease patients need. Without robust funding for navigators to inform patients about the comprehensive coverage options available, patients with lung disease could mistakenly enroll in coverage that does not meet their medical needs and be left responsible for massive medical bills.

We applaud you for your commitment to ensuring that patients are protected and that they can access quality and affordable healthcare coverage. We look forward to working with you to ensure that your legislation becomes law.

Sincerely,

[redacted]

Deborah P. Brown
Chief Mission Officer

[1] Sara R. Collins, Munira Z. Gunja, and Michelle M. Doty. Following the ACA Repeal-and-Replace Effort, Where Does the U.S. Stand on Insurance Coverage? Findings from the Commonwealth Fund Affordable Care Act Tracking Survey, March–June 2017. The Commonwealth Fund. Accessed at: https://www.commonwealthfund.org/publications/issue-briefs/2017/sep/following-aca-repeal-and-replace-effort-where-does-us-stand.

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AMA
AMERICAN MEDICAL ASSOCIATION

JAMES L. MADARA, MD
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March 5, 2019

The Honorable Anna Eshoo
Chairwoman
Subcommittee on Health
House Committee on Energy & Commerce
2125 Rayburn House Office Building
Washington, DC 20515

The Honorable Michael Burgess, MD
Ranking Member
Subcommittee on Health
House Committee on Energy & Commerce
2322A Rayburn House Office Building
Washington, DC 20515

Dear Chairwoman Eshoo and Ranking Member Burgess:

On behalf of the physician and medical student members of the American Medical Association (AMA), I am writing to express the AMA's support for H.R. 1425, H.R. 1386, and H.R. 1385, which will be the focus of the Subcommittee on Health's legislative hearing on March 6th entitled, "Strengthening Our Health Care System: Legislation to Lower Consumer Costs and Expand Access." The AMA believes that these bills would help to reduce consumers' health care costs and improve their access to high quality insurance coverage.

H.R. 1425, the "State Health Care Premium Reduction Act," (Craig, D-MN and Peters, D-CA), would provide $10 billion annually to states to help lower costs for consumers purchasing health insurance coverage in the individual market. States would have the option of creating a state reinsurance program or using the funds to help reduce out-of-pocket costs, such as copayments, coinsurance, premiums, and deductibles, of individuals enrolled in exchange qualified health plans offered on the individual market. The legislation would also require the Centers for Medicare & Medicaid Services (CMS) to establish and implement a reinsurance program in states that do not apply for federal funding.

The AMA believes that reinsurance provides an equitable, fair, and cost-effective mechanism to subsidize the costs of high-risk and high-cost patients, and protects patients with pre-existing conditions. State and federal reinsurance programs have been shown to be effective in yielding premium reductions, in comparison to what they otherwise would have been. The temporary reinsurance program in place during the early years of the Affordable Care Act (ACA) implementation (2014-2016) helped to stabilize premiums in the individual health insurance marketplace. Insurers' investments in reinsurance yielded significant premium reductions. For example, in 2014, insurers received reinsurance payments once an enrollee's costs exceeded $45,000 (attachment point), covering 80 percent of enrollee costs up to $250,000 (reinsurance cap). The $10 billion reinsurance fund for 2014 was estimated to reduce premiums by 10 to 14 percent.

H.R. 1386, the "Expand Navigators' Resources for Outreach, Learning, and Longevity (ENROLL) Act" (Castor, D-FL), would require the Seeretary of the U.S. Department of Health and Human Services (HHS) to obligate $100 million per year for the Navigator program. The bill would reinstate the requirement that there be at least two navigator entities in each state and would require HHS to ensure that navigator grants are awarded to entities with demonstrated capacity to carry out the duties specified in the ACA. The bill would also prohibit HHS from considering whether a navigator entity has

demonstrated how it will provide information to individuals relating to association health plans (AHPs) or short-term, limited-duration insurance (STLDI) plans.

The Administration decreased funding for the ACA's 2018 Open Enrollment consumer outreach and enrollment educational activities from $100 million to $10 million, a 90 percent cut from the previous year, and continued to fund such activities at $10 million during the 2019 Open Enrollment period. AMA policy strongly supports providing consumers with assistance in understanding their insurance options and the costs of coverage and in enrolling in the coverage that best meets their individual or family needs. We have watched with concern as the number of individuals enrolling in marketplace coverage has dropped over the past couple of years, and believe that the ENROLL Act could help reverse some of this decline by requiring HHS to adequately fund the Navigator program to conduct consumer outreach and enrollment educational activities for the ACA marketplaces, as well as prohibit HHS from using funding to promote plans such as STLDI and AHPs that do not provide comprehensive consumer protections.

H.R. 1385, the "State Allowance for a Variety of Exchanges (SAVE) Act" (Kim, D-NJ and Fitzpatrick, R-PA), would authorize $200 million in federal funding to states to enable the establishment of state-based marketplaces. The ACA provided states with a choice of establishing their own exchanges or using the federal exchange, and provided grants to states to help support the planning and creation of the state-based exchanges. However, this grant funding was time-limited and could only be awarded up until January 1, 2015. H.R. 1385 would allow states once again to have some assistance in establishing state-based exchanges. According to the Commonwealth Fund, analysts noted that insurance markets in 2018 remained healthier in the states that were running their own insurance marketplaces than in those that relied on the federal marketplace.

The AMA applauds your leadership in holding a hearing on H.R. 1425, H.R. 1386, and H.R. 1385, and looks forward to working with you and your colleagues to advance these bills through the House of Representatives.

Sincerely,

[redacted]

James L. Madara, MD

American Cancer Society
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www.fightcancer.org

Statement for the Record

Committee on Energy and Commerce, Health Subcommittee
Legislative Hearing:
Strengthening Our Health Care System: Legislation to Lower Consumer Costs and Expand Access
March 6, 2019

The American Cancer Society Cancer Action Network (ACS CAN) writes today in strong support of legislation being considered at today's hearing, "Strengthening Our Health Care System: Legislation to Lower Consumer Costs and Expand Access."

ACS CAN is making cancer a top priority for public officials and candidates at the federal, state and local levels. ACS CAN empowers advocates across the country to make their voices heard and influence evidence-based public policy change as well as legislative and regulatory solutions that will reduce the cancer burden. As the American Cancer Society's nonprofit, nonpartisan advocacy affiliate, ACS CAN is critical to the fight for a world without cancer.

In 2019, nearly 1.8 million Americans are expected to be diagnosed with cancer.[1] An additional 15.5 million Americans living today have a history of cancer.[2] For these Americans, access to affordable health insurance is truly a matter of life or death. Research from the American Cancer Society has shown that uninsured Americans are less likely to get screened for cancer and thus are more likely to have their cancer diagnosed at an advanced stage when survival is less likely and the cost of care more expensive.[3]

ACS CAN appreciates the Subcommittee holding today's hearing to examine how policymakers can ensure that cancer patients – and other Americans with serious illnesses – continue to have access to affordable health care. Legislation being considered today will build on critical components of the Affordable Care Act (ACA) and help make health insurance coverage more affordable and available for consumers.

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[1] American Cancer Society, Cancer Facts & Figures 2019, available at https://www.cancer.org/content/dam/cancer-org/research/cancer-facts-and-statistics/annual-cancer-facts-and-figures/2019/cancer-facts-and-figures-2019.pdf.

[2] Ibid.

[3] E Ward et al, "Association of Insurance with Cancer Care Utilization and Outcomes, *CA: A Cancer Journal for Clinicians* 58:1 (Jan./Feb. 2008), http://www.cancer.org/cancer/news/report-links-health-insurance-status-withcancer-care.

H.R. 1425, the State Health Care Premium Reduction Act

In 2014, cancer patients paid nearly $4 billion out-of-pocket for their treatments.[4] Managing the cost of care is critical in the fight against cancer, and one of the most important things policy makers can do to help cancer patients deal with the costs of cancer is to ensure that all Americans have access to comprehensive, affordable health insurance.

H.R. 1425 would provide $10 billion annually to states to establish a state reinsurance program or use the funds to provide financial assistance to reduce out-of-pocket costs for individuals enrolled in qualified health plans. The bill also requires the Centers for Medicare and Medicaid Services (CMS) to establish and implement a reinsurance program in states that do not apply for federal funding under the bill.

ACS CAN endorses this legislation. A well-designed reinsurance program can help to lower premiums and mitigate plan risk associated with high-cost enrollees. A 2017 analysis using RAND's microsimulation model estimated that instating a national reinsurance program could reduce premiums in the marketplaces by 3.9 percent to 19.3 percent in 2020, depending on the generosity of the program.[5]

A reinsurance program may also encourage insurance carriers to continue offering plans through the exchange or begin to offer plans as applicable. This maintenance or increase in plan competition also may help to keep premiums from rising. These premium savings could help cancer patients and survivors afford health insurance coverage and may allow some individuals to enroll who previously could not afford coverage.

A few states have already received federal approval to establish reinsurance programs. Minnesota's reinsurance program covers 80 percent of claims for individuals up to $250,000 once a $50,000 threshold is passed. A recent report from Georgetown University's Center on Health Insurance Reforms found that Minnesota's reinsurance program successfully held rates down for 2018 and 2019, stabilized individual market premiums, and helped contribute to increased enrollment in 2018.[6]

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[4] American Cancer Society Cancer Action Network. *The Costs of Cancer: Addressing Patient Costs*. April 2017. Available at: www.fightcancer.org/costsofcancer.

[5] Eibner, Christine and Jodi Liu, "Options to Expand Health Insurance Enrollment in the Individual Market," Commonwealth Fund, October 19, 2017. Available at https://www.commonwealthfund.org/publications/fund-reports/2017/oct/options-expand-health-insurance-enrollment-individual-market?redirect_source=/publications/reports/2017/oct/options-expand-health-insurance-enrollment-individual-market.

[6] Schwab, Rachel, Emily Curran and Sabrina Corlette, "Assessing the Effectiveness of State-Based Reinsurance: Case Studies of Three States' Efforts to Bolster Their Individual Markets," Georgetown University Health Policy Institute Center on Health Insurance Reforms, November 2018. Available at https://georgetown.app.box.com/s/8gvwo4zjatasrz3ptkpwe2uqi0qnz04x.

H.R. 1386, the Expand Navigators' Resources for Outreach, Learning, and Longevity (ENROLL) Act

Recent action by the administration is jeopardizing enrollment in health insurance marketplaces. In 2017, HHS shortened the enrollment period for marketplace plans from 90 days to 45 days, leaving consumers less time to study options and select the plan that is best for them. In addition, funding for both navigators and marketplace education and enrollment activities has been significantly reduced. Spending on outreach and marketing have shrunk to $10 million – a 90 percent cut since 2016 – and funding for navigator programs has been cut 80 percent.[7] The administration is also requiring navigators to inform consumers about the new Association Health Plans (AHP) and short-term, limited duration (STLD) coverage options – options that provide less comprehensive coverage. For individuals with a serious illness like cancer, choosing the right health insurance plan is important. Navigators help cancer patients and others by providing answers to their questions. Shortened enrollment periods, fewer resources for outreach and education and less funding for consumer navigators not only creates confusion for consumers but directly impacts the number of individuals who enroll in Marketplace coverage.

ACS CAN strongly supports the ENROLL Act, which would provide $100 million annually for the Federally-facilitated Marketplace (FFM) navigator program. The bill would reinstate the requirement that there be at least two navigator entities in each state and would require the Department of Health and Human Services (HHS) to ensure that navigator grants are awarded to entities with demonstrated capacity to carry out the duties specified in the Affordable Care Act. The bill would also prohibit HHS from considering whether a navigator entity has demonstrated how it will provide information to individuals relating to AHPs or STLDI plans, the proliferation of which ACS CAN opposes.

Thank you for your consideration. We look forward to working with members of the subcommittee to ensure that people with cancer, survivors, and people at risk of cancer continue to have access to affordable, adequate health insurance coverage.

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[7] Straw T, Lueck S, Gonzales S, Cloud H, "Strong Demand Expected for Marketplace Open Enrollment, Despite Administration Actions," Center on Budget and Policy Priorities, October 2018. Available at https://www.cbpp.org/research/health/strong-demand-expected-for-marketplace-open-enrollment-despite-administration.

BlueCross BlueShield Association

An Association of Independent Blue Cross and Blue Shield Plans

March 4, 2019

The Honorable Anna Eshoo
Chairwoman
Committee on Energy and Commerce Subcommittee on Health
United States House of Representatives
Washington, DC 20515

The Honorable Michael Burgess
Ranking Member
Committee on Energy and Commerce Subcommittee on Health
United States House of Representatives
Washington, DC 20515

Dear Chairwoman Eshoo and Ranking Member Burgess:

As the House Energy and Commerce Subcommittee on Health prepares for its upcoming hearing, "Strengthening Our Health Care System: Legislation to Lower Consumer Costs and Expand Access," the Blue Cross Blue Shield Association (BCBSA) would like to commend your leadership in considering three important proposals to reduce premiums and improve access to coverage and care for millions of Americans.

BCBSA represents the 36 independent, community-based and locally operated Blue Cross and Blue Shield companies nationwide offering coverage to more than one in three Americans. We have long advocated for policies to strengthen the individual market in order to help individuals and families obtain the medical care they need at an affordable price. We support the legislation being considered during the hearing – "The State Health Care Premium Reduction Act," "The State Allowance for a Variety of Exchanges (SAVE) Act" and "The Expand Navigators' Resources for Outreach, Learning, and Longevity (ENROLL) Act of 2019" – as much-needed steps toward this critical goal.

These proposals – establishing a permanent funding mechanism to help cover the medical costs for those with pre-existing conditions; enabling more state-based exchanges since states are best positioned to regulate insurance; and providing enhanced funding for enrollment education and outreach – align closely with the objectives of BCBSA's policy proposal, "Reducing Individual Market Premiums to Expand Access to Coverage and Care." The provisions in our proposal offer an updated approach to many ideas included in earlier legislation considered by Democratic and Republican lawmakers in previous sessions of Congress. The proposal is attached for your reference.

If the BCBSA proposal was fully implemented, actuarial firm Oliver Wyman estimates that the national average premium in the individual market would drop by about 33 percent, and an additional 4.2 million people would be able to obtain coverage in the ACA market. If only the reinsurance and enrollment education and outreach provisions were adopted, the national average premium would fall by about 20 percent.

Again, we are pleased to offer our support for the Subcommittee's efforts to lower consumer costs and expand access. We look forward to working with you to advance sensible policies to build on our current system in order to continue protecting people with pre-existing medical conditions while reducing premiums and improving access to coverage and care.

Sincerely,

Justine Handelman
Senior Vice President
Office of Policy & Representation

APIAHF
ASIAN & PACIFIC ISLANDER AMERICAN HEALTH FORUM

WRITTEN STATEMENT FOR THE RECORD
http://www.apiahf.org/
FOR THE HEARING ENTITLED "STRENGTHENING OUR HEALTH CARE SYSTEM: LEGISLATION TO LOWER CONSUMER COSTS AND EXPAND ACCESS"

UNITED STATES HOUSE OF REPRESENTATIVES
COMMITTEE ON ENERGY AND COMMERCE, SUBCOMMITTEE ON HEALTH
MARCH 6, 2019

BY THE
ASIAN & PACIFIC ISLANDER AMERICAN HEALTH FORUM
1629 K STREET NW, SUITE 400
WASHINGTON, DC 20006

The Asian & Pacific Islander American Health Forum (APIAHF) submits this written testimony for the record for the March 6, 2019 hearing before the House Committee on Energy and Commerce, Health Subcommittee titled "Strengthening Our Health Care System: Legislation to Lower Consumer Costs and Expand Access."

APIAHF endorses the three pieces of legislation being reviewed in this hearing: H.R. 1425, The "State Health Care Premium Reduction Act," H.R. 1425, the "State Health Care Premium Reduction Act," and H.R.1386, the "Expand Navigators' Resources for Outreach, Learning, And Longevity (ENROLL) Act." All three of these bills will help to improve the health care system, by allowing states to innovate with reinsurance programs, renewing the federal government's commitment to support states in establishing their own health insurance exchanges, and funding and improving the Navigator program under the Affordable Care Act. This testimony focuses on the ENROLL Act, for which we deeply appreciate Representatives Castor, Blunt Rochester, Wilson and Crist for introducing.

With more than 150 community-based organization (CBO) partners in 28 states and territories, APIAHF provides a voice in the nation's capital for Asian American (AA), Native Hawaiian and Pacific Islander (NHPI) communities, who comprise the fastest growing racial and ethnic groups in the country. APIAHF works toward health equity and health justice for all communities, from Arizona to Washington. Since 2012, APIAHF and partners have worked to outreach to, educate and enroll nearly 1 million consumers through Action for Health Justice (AHJ), a national collaborative of more than 70 AA and NHPI national and local community-based organizations and health centers.[1] These efforts have helped to bring down

[1] AHJ was co-founded by the Asian & Pacific Islander American Health Forum, Association of Asian and Pacific Community Health Organizations and Asian Americans Advancing Justice – LA.

the uninsured rates of AAs and NHPIs to their lowest levels ever, reducing disparities for some groups and even eliminating them for others.[2]

Given this experience, we believe that the ENROLL Act takes an important step in addressing the need for consumers to have access to unbiased, in-person assistance in learning about and enrolling in affordable health insurance. Many of our community based organization (CBO) partners have received Navigator and other funding to enroll consumers. Some of our partners have directly felt the impact of the 80% cut to Navigator funding made by the Trump Administration over the past two years and have been force to dramatically reduce or end their outreach and enrollment efforts. These cuts have had a detrimental impact on the communities we serve.

We wish to emphasize the unique role that Navigators and other in-person assistance programs play in ensuring consumers have access to accurate and unbiased information about their health care options. Our partners used their connections to communities, typically immigrant, low-income or limited-English proficient, who are difficult to reach by other means, to help them understand the Affordable Care and how to enroll in it. Over 6 open enrollments, they have built expertise in helping to address complex enrollment situations, like resolving identity verification problems on Exchange applications or helping mixed-status households determine how to input their income. Many of their staff speak multiple languages, ensuring that limited English proficiency is not a barrier to health. This is a professionalized and skilled workforce that deserves more recognition and resources.

Some, including the Trump Administration, have indicated that private actors, such as brokers and agents, can fill the same roles as Navigators. Our experience, and that of our partners, tells a different story. Unlike Navigators, brokers and agents are not required to deliver services in a culturally competent manner, nor are they required to demonstrate that they have or can build connections to the community they serve. While some may do both, our partners tell us their clients come to them because they know for sure that they can be trusted for unbiased advice. A survey from the Kaiser Family Foundation found that, compared to assister programs like Navigators, brokers serve fewer uninsured, fewer people with limited internet, fewer people who qualified for Medicaid and fewer people needing language assistance.[3]

We have expressed our concern to the Department of Health and Human Services (HHS) that the decision to cut Navigator funding was based on flawed data, as verified by the Government Accountability Office.[4] HHS has painted a false picture of Navigators being a poor investment for the money, failing to take into account the myriad of responsibilities they perform, often with very

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[2] According to APAIHF analysis of 1-year American Community Survey Estimates, since the law's passage, the percent of uninsured AAs has dropped from 15.1 percent in 2010 to 6.5 percent in 2016. For NHPIs, that drop was from 14.5 percent in 2010 to 7.7 percent in 2016. However, we are concerned that for the first time since the law's passage, in 2017, the uninsured rate for AAs was stagnant at 6.4 percent, while the rate for NHPIs worryingly increased to 8.3 percent.

[3] Pollitz, Karen, Jennifer Tolbert, and Ashley Semanskee, "2016 Survey of Health Insurance Marketplace Assister Programs and Brokers," Kaiser Family Foundation. (June 8, 2016). Available at: https://www.kff.org/health-reform/report/2016-survey-of-health-insurance-marketplace-assister-programs-and-brokers/.

[4] Letter from advocacy groups to Secretary Alex Azar. (August 31, 2018). Available at: https://www.apiahf.org/wp-content/uploads/2018/09/Concerned-Organizations-Letter-to-Secretary-Azar-GAO-Open-Enrollment-Report.pdf

short staff. HHS's decision to cut funding for Navigators was based on performance targets for enrollment of consumers in QHPs that had previously never been used for funding decisions, and did not include other activities that Navigators perform, such as outreach and education. In addition, our partners tell us that an enrollment appointment takes at a minimum two hours to complete, and often longer or over multiple appointments because so many of their clients require additional documents to verify identity, income, immigration status and other required details. Many of their clients end up being Medicaid or CHIP eligible. Yet those clients are not accounted for in published HHS data for Navigators, nor are clients who may start and not complete enrollments with Navigators.

It is for these reasons that we strongly support the ENROLL Act and urge Congress to pass it. This legislation would undo the funding cuts by this Administration, providing $100 million a year for Navigators, paid for by the user fees that were included in the Affordable Care Act for these purposes. It ensures that Navigator entities are required to have a physical presence in the state they serve, a requirement that used to be in regulation until the Trump Administration removed it. The bill also recognizes that Navigators do play a role in helping consumers access Medicaid and CHIP, by making it part of their statutory responsibilities. And finally, it ensures that Navigators are not required to promote low-quality plans that are not compliant with the Affordable Care Act.

Thank you for organizing this hearing to examine how Congress can act to expand access to health care. We deeply believe it is the responsibility of policy makers to ensure that not only is affordable health insurance available to all people in the United States but that the government puts sufficient resources into making sure all people know how to enroll and use their coverage. We urge the committee to mark up and pass this legislation so that it can be considered by the full House.

For questions, please contact Ben D'Avanzo, Senior Policy Analyst at bdavanzo@apiahf.org or 202-706-6767.

YOUNG YI INVINCIBLES

House Committee on Energy and Commerce
℅ Representative Kathy Castor
2125 Rayburn House Office Building
Washington, DC 20515

Chairman Pallone, Representative Castor, and members of the House Committee on Energy and Commerce:

Young Invincibles is a non-partisan, non-profit organization dedicated to expanding economic opportunity to young people between the ages of 18-34. Our generation, riddled with debt and having come of age in dire economic circumstances, continues to have the highest uninsurance rate of any age group. More than 10 million young Americans are uninsured. This disparity is due to two clear and major factors: **access and affordability concerns and lack of knowledge**. By reinvesting in the Navigator program, the ENROLL Act will begin to rebuild one of the most important tools that we have to fight against that disparity and to get more young people insured.

The Navigator program as it was envisioned in 2009 was a non-political, community-based bridge between the uninsured community and the individual health care marketplace. Navigators were created specifically to serve those with additional barriers to coverage: people with complicated medical needs, and those who have historically had limited and poor quality health care access. The Navigator program is **statutorily required to act in the best interests of consumers**. Key requirements around locality, cultural competency, language competencies, and a deep knowledge of affordability options have, for the past six years, allowed the Navigator program to successfully fulfill this mission and get more people the health coverage they need.

For young people, who often find signing up for health insurance to be as complex as applying for student financial aid or doing their taxes, the Navigator program has been instrumental in providing the necessary guidance they need to not only get covered but to take full advantage of financial assistance available to mitigate costs. Studies have consistently shown that young adults have lower levels of health insurance literacy, and struggle with understanding key health insurance concepts. One study found that less than one-third of young adults in the marketplace population were very or somewhat confident they understand key cost-sharing terms like deductible and coinsurance.[1] Young adult shoppers, who are generally new to the health insurance market, and who enter the marketplace at times of significant change in their lives, want and need impartial guidance through the complicated application process.

[1] Sharon K. Long, Genevieve M. Kenney, Stephen Zuckerman, Dana E. goin, Douglas Wissoker, Fredric Blavin, Linda J. Bumberg, Lisa Clemans-Cope, John Holahan, and Katherine Hempstead. "The Health Reform Monitoring Survey: Addressing Data Gaps To Provide Timely Insights Into The Affordable Care Act." Health Affairs Journal, Vol. 33, No. 1. January 2014. https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2013.0934

The Trump Administration's cuts have been targeted, politically motivated, and based on flawed data meant to minimize the concerted, year-round work Navigators do. While overall enrollment remained steady, since 2016, **new enrollment has decreased 50 percent** in HealthCare.gov states.[2] This alarming contrast between new and returning consumers shows that **those who have the ability to enroll on their own will continue to do so, while those who are either new to health insurance - like young adults - or those who need extra help, will be forgotten.** These cuts are having an impact on the very communities the Navigator program is tasked with serving.

The ENROLL Act would reverse the misguided attacks on this important community-based enrollment assistance program. We commend Representative Castor for leading the call to invest in the Navigator program and, in doing so, prioritizing the long term physical, mental, and financial health of her constituents. We urge every member of this committee to do the same.

Thank you for the opportunity to support this important legislation,
Young Invincibles

[2] Joshua Peck. "Week 7: Demand for quality, comhrehensive health coverage once again overcomes Trump administration." Get America Covered, Medium. December 19, 2018.
https://medium.com/get-america-covered/week-7-demand-for-quality-comprehensive-health-coverage-once-again-overcomes-trump-administration-c85e777fb7f0

Exploring the Impact of State and Federal Actions on Enrollment in the Individual Market: A Comparison of the Federal Marketplace and California, Massachusetts, and Washington

Exploring the Impact of State and Federal Actions on Enrollment in the Individual Market

The sixth open enrollment period under the Affordable Care Act (ACA) for plan year 2019 was recently concluded. This open enrollment period was the first year since the launch of the ACA in which the individual coverage mandate penalty was set to zero by federal action. The 2019 open enrollment period also marked the third year in which the federal government continued a strategy of dramatically reducing support and efforts to encourage enrollment in the states served by the federally-facilitated marketplace (FFM).

The analysis in this report reflects a joint effort on behalf of three state-based marketplaces (SBMs) – California, Massachusetts, and Washington – to better understand how their experiences differ from that of states served by the FFM and seeks to inform policy-makers by conducting early analysis of their enrollment experience.

This analysis focuses on two key dimensions of the performance of the individual markets over the past five years:

- **Change in premium**: Premium increases are critical indicators of individual markets' performance because of the direct relationship between premium increases and cost to the federal government and, more importantly, impacts on unsubsidized individuals who bear the full costs of these increases.
- **Change in new enrollments**: New enrollment (and not renewals or "total" enrollment) is the focus of this analysis because it is a better "leading" indicator of the impact of efforts to keep the individual market healthy and lower cost AND because for 2019 the renewal figures do not reflect paid renewals, which may drop significantly with the removal of the penalty.

The analysis concludes with issues that warrant further investigation. The Appendices includes background information on states' activities and references.

State Solutions to Promote Enrollment in the Individual Market

California, Massachusetts, and Washington are all state-based marketplaces that have used state-specific solutions to build health insurance exchanges that work. These strategies have included:

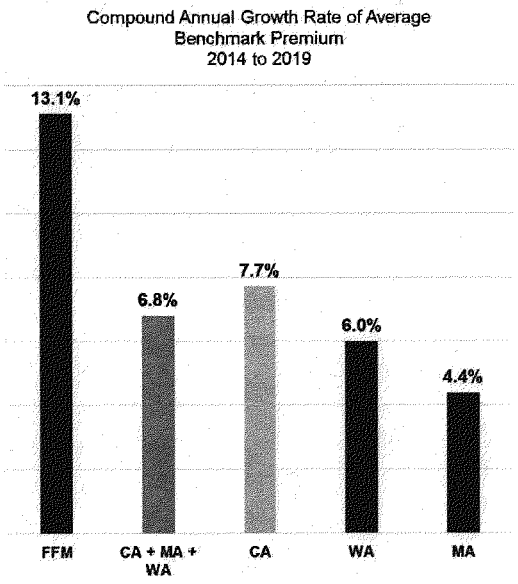
- Active outreach and marketing
- State policies that ensure a stable and competitive individual marketplace
- To varying extents, playing active roles in the certification of Qualified Health Plans (QHPs) to ensure quality and affordable products and having common patient-centered benefit designs and improved choice architecture to simplify the purchase experience and have consumers focus on price and quality
- Expanding their Medicaid programs through the ACA and coordinating with state Medicaid agencies

Examples of these activities and references to research on these states' efforts are included in the appendices.

From 2014 to 2019, Premiums in the FFM Have Grown at a Much Higher Rate than Premiums in California, Massachusetts, and Washington

Together, Massachusetts, Washington, and California have been very successful at restraining growth in the average benchmark premium, holding average annual increases to less than 7 percent since the Marketplaces opened in 2014.

During the same period, FFM average benchmark premiums have grown at an average rate of over 13 percent.



Analysis of enrollment weighted average benchmark premiums reported by Kaiser Family Foundation (2014-2019): https://www.kff.org/health-reform/state-indicator/marketplace-average-benchmark-premiums/. FFM includes SBM-FP states..

The Cumulative Premium Increase in FFM States has been More than Twice as Much as that of California, Massachusetts, and Washington

In 2019, average benchmark premiums in the FFM are now 85 percent higher than they were in 2014. The weighted average increase of the three states was 39 percent.

Had the FFM experienced the lower growth seen in CA, MA, and WA, the estimated savings to the federal government from lower premium payments for those receiving Advanced Premium Tax Credit could have been as much as $14 billion in 2018, or cumulative savings of roughly $35 billion. However, it is likely that some federal costs would have risen with increased enrollment.

More direct savings would have been realized by the millions of Americans who do not receive subsidies – they would have both paid far less in FFM states and have been less likely to have been priced out of coverage.

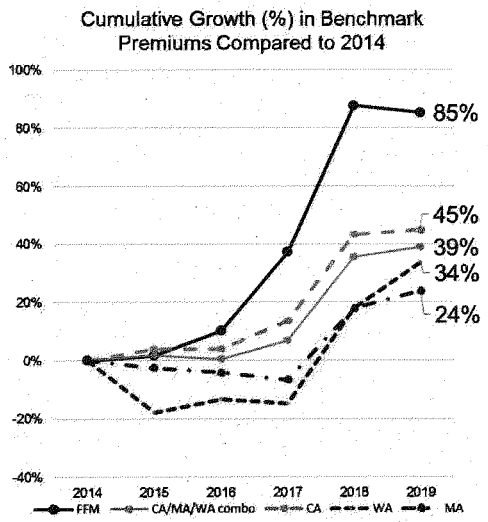
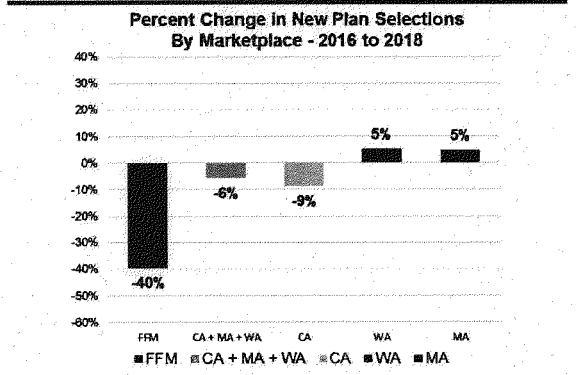


Chart shows analysis of enrollment weighted average benchmark premiums reported by Kaiser Family Foundation (2014-2019): https://www.kff.org/health-reform/state-indicator/marketplace-average-benchmark-premiums/. Estimates of cost savings use benchmark premium data. FFM includes SBM-FP states..

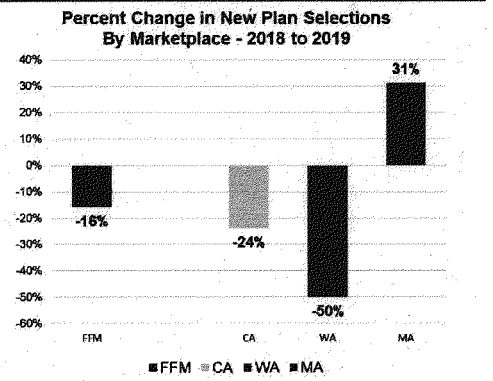
New Sign-Ups During Open Enrollment for 2019: Penalty and State Subsidies Appear to Drive Major Differences

2016 to 2018



- From 2016 to 2018, the FFM saw its level of new enrollments in open enrollment drop considerably – from 4.0 million to 2.5 million – a drop of 40 percent.
- In contrast, California, Washington, and Massachusetts had relatively steady numbers of new sign-ups during open enrollment, from 547k to 516k in 2018, a drop of 6 percent.

FOR 2019



- For 2019, the 16 percent decline in the FFM ***was on top of 40 percent cumulative decline*** from 2016 to 2018.
- California and Washington – both states with very good risk mixes – saw their new sign-ups drop off significantly.
- Washington saw lower enrollment particularly among unsubsidized consumers due to affordability concerns.
- Massachusetts, which still has a state mandate and adds additional state subsidies for enrollees, saw substantial increases in new enrollment.

Analysis of CMS/ASPE reported plan selections in Public Use Files (https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/index.html) and using 2019 releases from CMS (https://www.cms.gov/newsroom/fact-sheets/final-weekly-enrollment-snapshot-2019-enrollment-period), along with state data from CA, MA, and WA. FFM includes SBM-FP states. Kentucky excluded due to shift from SBM to SBM-FP between 2016 and 2017 plan year.

Need for Additional Research: Outstanding Major Questions

These initial observations are not conclusory analysis. Many factors influence the outcomes on premiums and enrollment reviewed here, including changes in regional market conditions for the cost of health care, labor market dynamics, and other state-specific dynamics. As discussed in the Covered California 2019 Open Enrollment Early Observations and Analysis, additional analysis is needed to better understand why enrollment changes over time and between states. Following are some of the areas of investigation that are not within the scope of this analysis (and most are areas for which data is not yet available):

1. ***Off-exchange Impacts:*** What has the enrollment change been in the off-exchange market, where no financial assistance is helping consumers reduce their premiums?

2. ***Effectuated Enrollment:*** How have retention rates among renewing consumers (*after* payment of new year's premium) been affected?

3. ***Risk Mix:*** Does lower level of new enrollments translate into worse risk mix, suggesting large premium increases are on the horizon?

4. ***Public Charge:*** What impact could the proposed shift in the federal application of the "public charge" have had on enrollment in immigrant communities?

5. ***End Date for Open Enrollment Period:*** How does shortening or altering the open enrollment period impact enrollment? (The FFM closes open enrollment on December 15th. For the three states in this analysis their open enrollment closed respectively on December 28th (Washington), January 15th (California), and January 23rd (Massachusetts).)

6. ***Other State-Specific Considerations:*** Expansion of Medicaid, marketing spend, availability and enrollment of alternative plans (short-term and limited duration plans).

APPENDIX

Plan Selections from 2019 in Context

SUMMARY OF ENROLLMENT TRENDS BY MARKETPLACE

HIGHLIGHTING PLAN SELECTION CHANGES BETWEEN 2016->2018 and 2018->2019

Category	Marketplace Type	2016 Count	2017 Count	2018 Count	Cumulative % Change (2016 -> 2018)	2019 Count	% Change (2018->2019)	Cumulative % Change (2016 -> 2019)
New Plan Selections	FFM	4,025,637	2,932,321	2,432,833	-39.6%	2,051,270	-15.7%	-49.0%
	Massachusetts	47,360	65,274	49,620	4.8%	65,119	31.2%	37.5%
	Washington	74,545	91,494	78,475	5.3%	39,237	-50.0%	-47.4%
	California	425,484	368,368	388,344	-8.7%	295,980	-23.8%	-30.4%
Renewals	FFM	5,600,345	6,188,329	6,221,240	11.1%	6,275,724	0.9%	12.1%
	Massachusetts	166,523	201,390	217,640	30.7%	236,760	8.8%	42.2%
	Washington	126,146	134,100	164,752	30.6%	183,399	11.3%	45.4%
	Covered California	1,149,856	1,188,308	1,133,180	-1.5%	1,217,903	7.5%	5.9%
Total	FFM	9,625,982	9,120,650	8,654,073	-10.1%	8,326,994	-3.8%	-13.5%
	Massachusetts	213,883	266,664	267,260	25.0%	301,879	13.0%	41.1%
	Washington	200,691	225,594	243,227	21.2%	222,636	-8.5%	10.9%
	Covered California	1,575,340	1,556,676	1,521,524	-3.4%	1,513,883	-0.5%	-3.9%

Analysis of CMS/ASPE reported plan selections in Public Use Files (https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/index.html) and using 2019 releases from CMS (https://www.cms.gov/newsroom/fact-sheets/final-weekly-enrollment-snapshot-2019-enrollment-period), along with state data from CA, MA, and WA. FFM includes SBM-FP states. Kentucky excluded due to shift from SBM to SBM-FP between 2016 and 2017 plan year.

Massachusetts' Expanded Activities for 2019 Open Enrollment Appears to have Been a Key Driver in Growth in New Enrollment

- Massachusetts Health Connector staff used state-level data to identify uninsured communities and populations. This analysis helped to refresh and tailor OE outreach to the current landscape of uninsurance and real-time needs in the market.
- OE19 outreach included very clear, simple messaging through the OE period (unlike last year when new silver loading dynamics caused disruption).
- There was an overall increase in community engagement activities, paid media, earned media:

Type of Outreach	OE19	OE18	% Change
Pre-OE tour events	9 events	14 events	56%
Total earned media placements and interviews	116 placements	154 placements	33%
Paid radio spots	2,096 radio spots	3,549 radio spots	69%
Paid TV spots	723 TV spots	1,164 TV spots	61%

- This was the Health Connector's third year working with a marketing and communications firm that was charged with "creating a culture of coverage" in under-insured communities through tailored, data-driven outreach. New member gains in OE19 may be the result of that long-term commitment and the resulting consistency in messaging.
- Massachusetts also launched a comprehensive #StayCovered campaign to educate the state population about its continuing individual mandate and about the importance of "shopping smart" for comprehensive health coverage that meets state standards.

Driving Enrollment through Targeted Outreach in Washington State

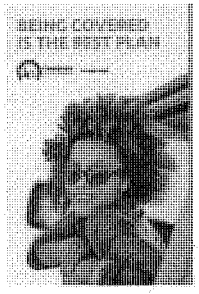
Washington Healthplanfinder has had success in partnering with community organizations to enroll targeted groups.

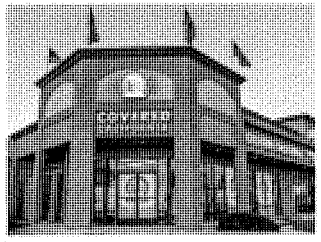
- Community fairs, festivals, and events
- Health fairs and immunization clinics
- Schools (K-12, higher ed, alternative)
- WorkSource adult and youth programs
- Libraries
- Jails and drug courts
- Low-income housing complexes
- Farms and orchards
- Shelters
- Food banks
- Farmers markets
- Faith-based organizations
- WIC and other social services offices
- Project Homeless
- English and foreign language radio, TV spots
- Mobile medical outreach
- Native navigators (Russian, Ethiopian, COFA Islander)
- WorkSource youth programs
- Fiestas Patrias
- Kitsap Public Health Alerts
- Methadone Clinics
- Hockey league
- Stonewall Youth (LGBTQ)
- Back to school events
- Salvation Army
- Small businesses

Outreach in California: Outreach and Marketing Matters in California to Achieve A Healthier Risk Mix and Lower Premium

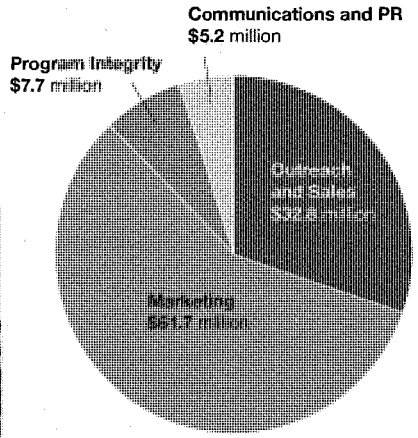
Outreach and marketing efforts reflect a range of evidence-based activities including paid advertising/marketing, funding a community navigator program, supporting certified agents and promotion through earned media.

The $107.4 million spend is about one-third of Covered California's budget and reflects about 1.1 percent of on-exchange premium revenue.





Covered California's 2018-19 Outreach and Marketing Investments $107M (out of total $340M budget)



References

For examples of marketing, enrollment and other state-based strategies pursued by California, Massachusetts, and Washington, and an early analysis of 2019 open enrollment results, see:

- Gasteier, et al. (2018). "Why Massachusetts Stands Out In Marketplace Premium Affordability." *Health Affairs Blog* (September 4, 2018): *https://www.healthaffairs.org/do/10.1377/hblog20180903.191590/full/*
- Washington Health Benefit Exchange (2019). *1 in 4 Washington: Benefits of the ACA in Washington state. https://1in4wa.com.*
- Covered California (2017). "Marketing Matters." *https://hbex.coveredca.com/data-research/library/coveredca_marketing_matters_9-17.pdf.*
- Bingham, et al. (2018). "National vs. California Comparison: Detailed Data Help Explain The Risk Differences Which Drive Covered California's Success." *Health Affairs Blog* (July 11, 2018): *https://www.healthaffairs.org/do/10.1377/hblog20180710.459445/full/*
- Covered California (2019). "Covered California 2019 Open Enrollment Early Observations and Analysis." *https://hbex.coveredca.com/data-research/library/CoveredCA_2019_Open_Enrollment_Early_Analysis.pdf*

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Statement on
"Strengthening Our Health Care System:
Legislation to Lower Consumer Costs and Expand Access"

Submitted to the
House Energy and Commerce Committee
Subcommittee on Health

March 6, 2019

America's Health Insurance Plans (AHIP) is the national association whose members provide coverage for health care and related services to millions of Americans every day. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities, and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access, and well-being for consumers.

Every American deserves affordable, comprehensive coverage—regardless of their income, health status, or pre-existing conditions. This has been a core principle for health insurance providers and a constant commitment by our industry. Our members work every day to promote health, wellness and prevention, address the significant drivers of chronic disease and poor health, give consumers the power to choose the care and coverage that works best for them and their families, and improve patient care and the consumer experience with innovative tools, treatments, and technologies.

We appreciate this opportunity to comment on the three bills the subcommittee will consider in today's hearing and to share our additional recommendations for making premiums more affordable for Americans who buy coverage in the individual market.

Stabilizing Premiums Through Reinsurance Programs

The "State Health Care Premium Reduction Act" (H.R. 1425) would provide $10 billion annually to support state reinsurance programs and other approaches to making health care more affordable for individuals enrolled in qualified health plans. AHIP strongly supports this legislation, consistent with our past support for federal funding of state-based initiatives to stabilize insurance markets.[1]

State-based reinsurance programs are an effective, proven way to stabilize premiums in the individual health insurance market. Building on our experience in the states, a federally-funded reinsurance program would offset some of the costs of patients who have the most complex health conditions and need the most care. In the last three years, several states have adopted reinsurance arrangements through the use of Section 1332 state innovation waivers with notable success in reducing premiums.

Enacting measures like these can help significantly lower premiums for millions of individuals who rely on the individual market to access care, as long as they are adequately funded and designed to ensure that consumers in all states benefit. This approach also can reduce federal spending on premium tax credits.

Promoting Enrollment in Health Coverage Through Navigators

The "Expand Navigators' Resources for Outreach, Learning, and Longevity Act" (H.R. 1386) would provide $100 million annually for the Navigator Program to support outreach and education activities focusing on the annual open enrollment period for the Affordable Care Act (ACA) Exchanges. AHIP supports this legislation, consistent with our past support for these activities.

Our members believe it is important for the federal government to devote adequate resources to marketing, outreach, and education before and during open enrollment to help consumers understand their coverage options and encourage broad market participation. Moreover, even with improved availability and functionality of online tools to help consumers, the process of

[1] Similar proposals AHIP supported in the 115th Congress include the Patient and State Stability Fund that was approved by the House in May 2017 as part of the American Health Care Act, and a bipartisan Senate proposal announced in October 2017 that would have given states more funding flexibility to establish reinsurance, high risk pools, invisible high-risk pools, insurance stability funds, and other programs.

choosing and enrolling in coverage along with understanding eligibility for different programs and federal assistance can still be complicated. Marketing, outreach, and education activities help reduce the number of uninsured Americans by ensuring that consumers are aware of the products available to them and the timing of the annual open enrollment period including the enrollment deadline. In addition, by encouraging continuous coverage and promoting enrollment of a broad mix of both healthy and less healthy individuals, these activities help to stabilize the risk pool and promote more affordable premiums.

Allowing Additional States to Administer Their Own Exchanges

The "State Allowance for a Variety of Exchanges Act" (H.R. 1385) would provide $200 million to support the planning and establishment of state-based Health Insurance Exchanges in states that currently are participating in the federally-facilitated Exchange. AHIP also supports this legislation.

In 2019, 11 states and the District of Columbia are offering ACA coverage options through their own state-based Exchanges. The other 39 states are using the federally-facilitated Exchange. Both approaches are currently working well for millions of Americans. However, to the extent that additional states may wish to transition to state-based Exchanges, we agree that federal funding should be available to support this transition. In states that want to administer their own marketplaces, such funding would help state officials provide a shopping experience that is tailored to meet the specific needs and circumstances of their residents.

Ensuring Affordable, Comprehensive Health Coverage for All Americans

In addition to the bills that are on today's hearing agenda, we believe additional steps are needed to make health care more affordable for people who buy coverage in the individual market. Nearly 15 million Americans purchase their health coverage through the individual market. But without support from an employer contribution or if the individual's income is too high to qualify for premium tax credit assistance, costs can pose a significant challenge to obtaining coverage.

To address this concern, AHIP released a report[2] in November 2018 outlining 12 recommendations that can be implemented, by policymakers at both the state and federal levels,

[2] https://www.ahip.org/12-solutions-to-lower-premiums-for-hardworking-americans-who-buy-their-own-coverage/

to make premiums more affordable in the individual market. The solutions in our report focus on helping hardworking Americans who fall into a gap—earning too much to qualify for financial support, but still struggling to pay their monthly premiums.

Our recommendations are categorized into three areas: (1) addressing rising health care costs and drug prices; (2) offering premium savings to families making over 400 percent of the federal poverty level; and (3) increasing the number of consumers who buy coverage, which will balance the individual market risk pool to bring costs down for everyone.

Our specific recommendations, as explained in our attached report, would accomplish the following:

- Reduce surprise medical bills;
- Increase competition in prescription drugs;
- Expand the use of telehealth;
- Create reinsurance programs;
- Provide savings to consumers who participate in wellness programs;
- Repeal the ACA health insurance tax;
- Provide tax parity for Americans who buy individual market coverage;
- Expand Health Savings Account (HSA) options;
- Curb inappropriate third-party premium payments;
- Increase flexibility for reference pricing;
- Create state premium discount programs; and
- Support marketing and outreach efforts to increase enrollment and strengthen the risk pool.

Conclusion

Affordable, comprehensive coverage for everyone requires effective insurance markets with broad-based participation, clear and consistent rules and regulations, and fair competition. We look forward to continuing to work with the Committee to advance these priorities. By working together, we can ensure that America's health care markets deliver strong patient protections, as well as robust competition and choice that lead to greater affordability.

Improving America's Health Care System

AHIP

12 Solutions to Lower Premiums for Hardworking Americans Who Buy Their Own Coverage

November 2018

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Improving America's Health Care System: 12 Solutions to Lower Premiums for Hardworking Americans Who Buy Their Own Coverage

Introduction

Every American should be able to get affordable, comprehensive coverage - regardless of their income, health status, or pre-existing conditions. But hardworking Americans who buy their coverage on the individual market are increasingly finding their premiums are out of reach if they don't qualify for premium subsidies. This population includes families with an income that is more than 400 percent of the federal poverty level ($47,520 for an individual or $97,200 for a family of four).[1]

Consumers and policymakers at the federal and state levels want solutions. In this paper, we provide several recommendations for actions state and federal policymakers can take to make premiums more affordable. Our recommendations address three issues that drive up premiums for these families:

1. The out-of-control cost of health care services and prescription drugs.
2. Families making over 400 percent of the federal poverty level are the only segment of the American population that don't receive some help with their insurance premiums.
3. Too few healthy people participate in the individual market to balance out the risk.

State and federal policymakers and regulators can take action now to improve premium affordability. Some of these recommendations can be implemented very quickly through regulation, while others require state or federal legislation. While this paper focuses on improving out-of-pocket premium affordability for those who don't qualify for federal support, many of these recommendations will drive down premiums for everyone, reducing the total cost of subsidies and the financial burden they place on taxpayers.

Describing the Challenge

For the 2017 plan year, around 5 million Americans bought comprehensive health coverage without assistance from tax credits, subsidies, or employer contributions that reduce the costs of their premiums.[2] These hardworking Americans include entrepreneurs, those who have retired before qualifying for Medicare, and workers who do not qualify for employer-provided coverage. This includes 2 percent of those insured in the United States. The Centers for Medicare & Medicaid Services (CMS) reports from 2017 to 2018, the average monthly exchange premium for this market increased from $471 to $597.[3] The average premium for the least expensive bronze plan for a single 40-year-old rose from $329 to $394 from 2017 to 2018.[4] Increasing health care costs hit these Americans hardest. It's time we brought them some relief.

Evidence is emerging that individual market premiums are becoming more stable.[5] But in some regions, premiums are too high for many Americans. When families can't afford premiums for comprehensive coverage, some decide to purchase leaner coverage– or even go without coverage at all. That can put their health and financial security at risk.

Premiums aren't affordable for an increasing number of middle-class Americans:

5 million
People bought exchange plans without federal subsidies in 2018.

20%
Fewer people covered without subsidies through the exchange from 2016 to 2017.

$126
Average increase in monthly premium for an exchange plan from 2017-2018.

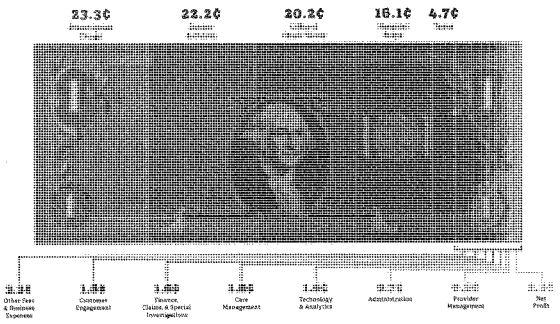
How are Premiums Set?

To overcome the challenges, it's important to know how premiums are set. The vast majority of dollars spent on premiums go to cover the cost of health care – for example, doctor appointments, hospital visits, and prescription drugs. In fact, health insurance providers are mandated by the federal government to spend at least 80 percent of premiums on health services. The remaining 20 percent must cover the cost of important health insurance provider services like customer service, patient care coordination, collaboration with doctors and hospitals, and fraud prevention.

To set premium costs for consumers, health insurance providers calculate the cost of providing care to all their members in a geographic area. This is why the increasing cost of doctors, hospitals, and prescription drugs is so important. These rising costs play the biggest role in consumers' premium costs.

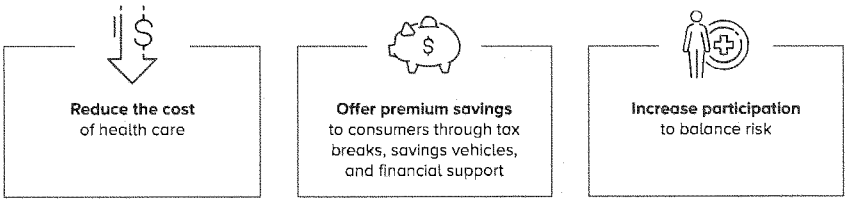
Where Does the Premium Dollar Go?

Example of a Typical Plan[6]



Three Levers to Lower Premiums

There are three tested and proven methods for driving down the costs of premiums for consumers:



Key to Recommendation Categories

FR **FED REG** – Could be achieved through Executive action by proposing new or modifying existing regulation.

FL **FED LEG** – Proposal requires new Federal Legislation.

SR **STATE REG** – Proposal could be enacted at the state level through new regulations in some states.

SL **STATE LEG** – Proposal would require the enactment of state legislation in most states.

LEVER 1: REDUCE THE COST OF HEALTH CARE

Evidence over the last decade indicates by nearly every measure, the United States spends more on health care than any other nation in the developed world. In 2017, the United States spent 17.2 percent of its gross domestic product (GDP) on health care. That is the highest of any nation participating in the Organization for Economic Cooperation and Development (OECD)[7] and almost double the OECD average of 9 percent.[8] In 2017, the nation spent almost $10,000 per person on health care – or 250 percent more than the OECD median of $4,000 per person.[9] For Americans who pay the full cost of their insurance premiums, these inflated costs are reflected directly in their premiums.

Some approaches aim to move the "cost-of-care" lever and bring premium costs down by simply eliminating coverage for things like prescription drugs, preventive care, or care for pre-existing conditions. While this approach will result in reduced premiums for some people in the short-term, it can expose families to finding themselves underinsured when they need their coverage most.

***To provide the kinds of affordable insurance options Americans really want**, options that cover preventive care and protect them from financial devastation if they get sick, it is imperative we tackle the real problem - misaligned incentives and sky-high unit prices.*

Reduce Surprise Billing

Health insurance providers develop networks that offer consumers access to safe, affordable, high-quality care. Most private insurance providers - and many public programs - offer a variety of network options. When providers choose to participate in networks, coverage is more affordable. When providers choose not to participate in networks - or if they do not meet the requirements for inclusion in a network - these providers may charge whatever they like, sometimes billing amounts far above average rates in the same area. Most out-of-network providers bill patients for any amounts not paid by their health insurance provider. From the provider's perspective this is "balance billing." From the consumer's perspective this is "surprise billing."

Health plans that limit out-of-network coverage are more affordable, because in-network doctors agree to provide care at a set price. To help navigate the options, health insurance providers and exchanges have developed tools for consumers to check if their providers are in-network before purchasing a plan. For routine or non-urgent care, consumers should check if a provider is in-network before seeking services. The issue of "surprise billing" most often arises in two scenarios, despite the best efforts of a consumer to use in-network providers: (1) when individual providers practice at an in-network hospital but don't participate in the network; and (2) when people receive emergency care at an out-of-network facility.

If insurance providers are required to reimburse out-of-network providers at whatever rates they bill, this creates a disincentive for providers to join networks. Unreasonable out-of-network reimbursement rates and balance billing of patients undermines affordability and imposes a "blank check" approach to payment. Laws or regulations establishing specific levels or guidelines for out-of-network reimbursement can protect patients from surprise bills and keep premiums down.

Air ambulances generate some of the most egregious surprise bills related to medical emergencies. The Airline Deregulation Act of 1978 prevents states from exercising the same oversight over air ambulances that they exercise for other emergency medical providers. This allows air ambulance providers—who deliver essential emergency medical services to patients who have no choice—to uncompetitively price gouge health care consumers and insurance providers alike. Anticompetitive behavior increases the cost of such life-saving services and premiums for everyone. Far from unleashing the competitive forces that Congress contemplated would result from deregulation, extending the Airline Deregulation Act to the unique market for these highly-specialized emergency medical service providers prevents states from helping to level the playing field, and fosters unfair business practices and consumer harm.

For individual market plans, federal regulation already addresses reimbursement rates for emergency care received out-of-network[10] and notification requirements for out-of-network services provided at in-network hospitals.[11] The current federal requirement specifying reimbursement rates for out-of-network emergency services provides a workable payment benchmark but does not prevent providers from balance billing patients. However, the requirement that health plans notify consumers in advance when they may receive out-of-network services is impractical, because health plans seldom know a member is receiving care until after the care has been provided.

The federal government and states, through legislation and regulation, can take additional steps to: (1) establish regulatory guardrails around health insurance payments to out-of-network providers that provide care at an in-network facility; and (2) protect consumers from surprise bills in emergencies and when care is received at an in-network facility. Any statutory or regulatory approach to the rate of payment to out-of-network providers should be set at a level that does not destabilize provider contracts, but instead continues to encourage health plans and providers to enter into mutually beneficial contracts. We recommend actions below to take patients out of the middle of disputes and provide predictable, fair and reasonable reimbursement rates.

FL SL **Protect patients from surprise bills and prevent unnecessary premium increases related to out-of-network care.** For instances when the consumer did not have the opportunity to select an in-network provider, such as emergencies, and the consumer does not have out-of-network benefits defined in their policy, prohibit providers from balance billing patients and set a payment benchmark that clearly defines what the plan is expected to pay the provider for the services rendered. The benchmark should be designed to ensure a reasonable reimbursement rate for providers, while preventing price gouging and excessive consumer bills. Billed rates should never be used as benchmark for out-of-network reimbursement. Providers should be prohibited from billing patients for amounts that exceed the benchmark-based payment.

FL **Update federal statute to allow states to regulate air ambulance providers to prevent egregious bills.** Many states have attempted to take action to protect consumers from excessive air ambulance bills, which cost $50,199 on average in 2016[12], only to find their efforts stymied in the court due to barriers imposed by federal statute. Congress should update the Airline Deregulation Act of 1978 to allow states to regulate their markets.

FR **In the interim, while policies protecting patients from surprise doctor bills are being implemented, require in-network hospitals and other facilities, rather than health plans, to disclose that a patient may be treated by an out-of-network provider in that facility.** If out-of-network providers may treat the patient while the patient is receiving care at that facility, require the facility to disclose to the patient that out-of-network provider fees may apply. This requirement, which may not be practical for emergency scenarios, should apply to all procedures and services where treatment is scheduled in advance.

Curb Inappropriate Third-Party Premium Payments

Third-party payments for drugs or services typically are made for consumers by outside entities, such as health care providers, pharmaceutical companies, foundations, or other entities. Concerns about third-party payments, specifically related to conflicts of interest between a provider's financial interest and a patient's best interests, have generally resulted in the prohibition of these payments in public programs like Medicare and Medicaid. However, there has been less clarity regarding the use of these payments in the individual market.

Health insurance providers have seen a rise in third-party payments from entities steering Medicare and Medicaid-eligible individuals to the individual market. The third-party organizations steering consumers to the individual market, stand to benefit financially through greater reimbursement rates from private health insurance providers.

Steering older and less healthy consumers to the individual market also skews the risk pool to higher-cost individuals, resulting in higher premiums for everyone. This is especially challenging for hardworking Americans who pay for their coverage without any support. Ensuring consumers are enrolled in appropriate coverage designed to best meet their needs, instead of steering them to coverage that results in financial gain for a third-party providing health care services, will help keep costs lower and contribute to a more stable market.

Another type of third-party payment is the growing use of drug coupons and copay cards. Consumers are given discounts on brand-name drugs, encouraging use of those drugs instead of less expensive generics or therapeutic substitutes. Drug makers pass along the whole cost of the drug to insurers, increasing overall costs and driving up premiums. *Health Affairs* has reported drug coupons lead to unnecessary spending by health insurance providers that is then passed on to consumers through higher premiums and more limited coverage options.[13] Similar to third-party payments, drug coupons are not allowed in Medicare and Medicaid.

Additional Resources:

How Third-Party Premium Payments Can Harm Consumers and Destabilize Markets, May 2018

AHIP Statement on Third Party Payments, December 2016

Recommendations KEY: FED REG FED LEG STATE REG STATE LEG

FR **Reissue rulemaking, under 42 CFR Part 494, to address conditions for coverage for end-stage renal disease third-party payment.** In December 2016, HHS published an interim final rule that outlined a narrow set of circumstances in which third-party payments by dialysis facilities would be allowed. Due to ongoing litigation, the effective date for this rule has been delayed indefinitely. Revised rulemaking should retain requirements for dialysis facilities to meet certain conditions in order to receive reimbursement and clarify health insurance providers would not be required to accept third-party payments if those conditions are not met. Specifically, third-party organizations that make premium and cost-sharing payments on behalf of individual market enrollees should be required to report information on funding sources, governance, relationships with provider and pharmaceutical organizations, etc., and attest they meet the requirements set out in such revised rulemaking.

FR **Prohibit direct and indirect premium payments to entities in which the provider has a financial interest.** Under its conditions of participation requirements, HHS can prohibit direct or indirect payments by providers as a conflict of interest. Similarly, providers could be considered out of compliance with the conditions of coverage if they do not provide consumers with information on their full coverage options.

FR **Clarify existing guidance under 45 CFR § 156.125 related to insurer acceptance of third-party payments.** HHS' long-standing policy is that health insurers may deny any third-party payments that are outside of federal requirements; however, current regulations should be formally amended to include this language.

FR FL SR SL **Do not expand the list of third-party entities from which health insurance providers must accept premium and cost-sharing payments.** HHS has identified a limited roster of entities from which health insurance providers must accept third-party payments, including Ryan White and HIV/AIDS programs, Indian tribes, and state and local programs. Expanding this list to include other entities would result in higher premiums and decreased affordability for consumers.

FR SL **Prohibit the use of copay coupons for brand-name drugs if there is a less expensive, equally effective alternative.** HHS and states should take steps to address the increased use of prescription drug coupons and co-pay assistance cards, by prohibiting their use in the private marketplace just as they are prohibited in federal programs. If coupons are allowed for drugs with no less expensive alternatives, the coupons or copay cards should be available to all patients for the entire length of time they need the medication.

Increase Drug Competition

Prescription drug prices are out-of-control and are contributing to unsustainable health care cost growth across the country. In addition to placing strains on the health care system, rising drug prices also place financial burdens on patients who rely on prescription medicines to treat and manage their chronic conditions.

For employer-sponsored coverage, spending on prescription drugs outpaces spending for inpatient hospital care and drug spending continues at a faster rate than overall health care spending and makes up a greater share of total medical expenses.

Bold steps are needed—at both the legislative and regulatory levels—to ensure people have access to affordable medications.

Recommendations	KEY: FED REG FED LEG STATE REG STATE LEG
FR	**Create a robust biosimilars market.** Biosimilars offer great promise in generating cost savings for consumers. Some of the costliest and most widely used biologics have been on the market for decades without biosimilar competition. To achieve this promise, the FDA should finalize regulations that promote a robust competitive market and ensure patients and providers have unbiased information about the benefits of biosimilars. For example, the FDA should provide clarity for all stakeholders and complete the biosimilar approval pathway by finalizing interchangeability policies.
FR FL	**Reduce federal rules, regulation and red tape to generic entry.** The FDA should provide the necessary resources to clear the backlog of generic drug applications, particularly for classes of drugs with no or limited drug competition. "Pay-for-delay" settlements and "product hopping" should be challenged by the FTC to address patent abuses and anti-competitive tactics. Further, the Inter Partes Review (IPR) process through the U.S. Patent and Trademark Office should be preserved. Additional legislation, via passage of the CREATES Act, is needed to address abuse of patient safety protocols and ensure widespread availability of generic and biosimilar drugs to promote affordability and lower consumers' out-of-pocket costs.
FL	**Revisit and revise orphan drug incentives.** The Orphan Drug Act incentives are being misapplied. The law's incentives should only be used by those developing medicines to treat rare diseases, not as a gateway to premium pricing and blockbuster sales beyond orphan indications. In cases of rare diseases for which no effective therapy exists, policymakers should ensure that newly approved drugs are priced in accordance with their value and efficacy.
FR FL SL	**Publish true R&D costs and explain price setting and price increases.** As part of the FDA approval process, drug manufacturers should be required to disclose information regarding the intended launch price, the use of the drug, and direct and indirect research and development costs. After approval, manufacturers should provide transparency into list price increases. States can also enact state level drug pricing transparency laws. California and Oregon have already done so.
FR FL	**Strictly enforce existing regulations on DTC advertising and evaluate DTC advertising impact to develop additional limits.** Direct-to-Consumer (DTC) drug advertising increases premiums by driving consumers to expensive brand name drugs when more clinically appropriate, higher-value treatments may be available. The FTC should enforce existing regulations to ensure drug ads are not misleading. Further assessment is needed of the impacts of the growth in DTC advertising, particularly broadcast advertising, followed by an evaluation of the best approaches for conveying such information to consumers. As part of this assessment, FTC should examine the impact of DTC advertising and point-of-prescribing drug price disclosures on physician prescribing behavior and/or its effects on generic drug availability and utilization. New requirements for DTC advertising should include provisions to promote transparency and accuracy, including requiring that the drug list price be disclosed in any DTC drug advertising in a meaningful manner, as proposed by the Administration and in bipartisan legislation earlier this year.
FR FL SR SL	**Inform patients and physicians on effectiveness and value.** The first step in promoting high-value drugs is to establish a common definition of value. This requires agreed upon standards that account for quality, outcomes, and price. An independent third-party entity, such as the Institute for Clinical and Economic Review (ICER), should take the lead in establishing this definition. To disseminate information on value, increased funding is needed for private and public efforts to provide information to physicians and their patients on the comparative clinical and cost-effectiveness of different treatments, procedures and drugs. These tools can help facilitate appropriate assessments about the value and effectiveness of different treatment approaches, particularly for those with high costs. Findings from independent entities conducting comparative effectiveness reviews, such as ICER, can and should be used to inform decisions around coverage, payment and reimbursement for therapies and drugs.
FR FL SR SL	**Reduce regulatory barriers to value-based pricing.** Policymakers should address existing statutory and regulatory requirements that may inhibit the development of pay-for-indication and other value-based strategies in public and private health insurance programs.

Expand the Use of Telehealth

More consumers of all ages are using new technologies like smartphones and expect the convenience these technologies offer. Health insurance providers are responding by offering telehealth services for their members. Telehealth is the use of telecommunications, like video chatting, to support health care evaluation, treatment, and education for a variety of patients. Telehealth has the potential to improve engagement between patients and providers; improve health care maintenance, especially for those with chronic conditions; and avoid unnecessary and costly acute care settings. While particularly useful for those in rural areas, seniors, and others with mobility concerns, telehealth services can make it easier for all patients to access care and connect with specialists from a computer or mobile device.

However, challenges to expansion of telehealth services do exist. Numerous states have enacted laws and regulations governing telehealth for plans operating in the commercial market. The disparities among state requirements related to provider licensure, site- and technology-specific use, and reimbursement and/or payment parity, create many barriers to continued use and expansion of telehealth services.

While telehealth alone will not solve the problem of affordability and access to care, estimates show that it can save more than $6 billion annually.[14] This will help meaningfully lower overall costs in the health care system.

Additional Resource:

Telehealth Connects Patients and Doctors in Real Time, November 2017

Recommendations KEY: FED REG FED LEG STATE REG STATE LEG

SR SL **Support establishment of multi-state licensure compacts.** In many cases, providers can only offer services in a state where they are licensed. If a patient can only use an in-state doctor, this closes off doctors that would otherwise be available through national provider networks. Allowing multi-state licensure compacts can promote expedited licensure for physicians and/or reciprocity for certain providers applying in multiple states, will increase the number of accessible services, and expand provider networks available to consumers.

SR SL **Enhance flexibility by not establishing state mandates related to reimbursement and/or payment parity, site-specific use, prior visit requirements, or specific technology use.** Inconsistent state laws and mandates can make providing access to telehealth services difficult for health insurance providers, particularly those that operate in multiple states. State mandates to cover telehealth in specific ways and under specific requirements hinder flexibility to design benefits that meet the needs of consumers.

FR SR SL **Designate telehealth as a means of satisfying network adequacy requirements.** Under 45 CFR 156.230, HHS should establish telemedicine as an option to meet federal requirements for network adequacy standards. In a 2016 revised model law, the National Association of Insurance Commissioners included the use of telemedicine as an option to meet network adequacy standards. And, several states have passed laws or updated regulation to incorporate telehealth in their network adequacy requirements. As part of updating standards to allow greater use of telemedicine, states can identify guardrails to ensure telemedicine use is expanded for scenarios for which it is clinically appropriate.

FL **Permit first-dollar coverage of telehealth services in HSA-eligible health plans.** Existing law restricts what care or services a plan may cover pre-deductible in a high-deductible health plan while retaining HSA-eligibility. Telehealth is not only increasingly popular, it is a means of accessing care that is highly affordable for both the plan and the consumer. Permitting plans to cover telehealth services with first-dollar coverage reduces overall costs to the system and allows greater flexibility and affordability for consumers. The approach to expanding HSAs described in the recommendation "Expand HSA Options" is a more comprehensive approach to HSA modernization that would allow for first-dollar coverage of telehealth. As a fallback, Congress should consider a more limited bill to allow first-dollar coverage of telehealth.

Increase Flexibility for Reference Pricing

Reference pricing entails a health insurance provider setting a specific amount they will pay for a covered service. If a person decides to go to a provider that sets a price higher than the reference price, they are responsible for the difference. High-cost procedures that vary widely for reasons unrelated to quality, like joint replacements, provide opportunities for real savings. Many employer-sponsored plans are using or exploring reference pricing, but Department of Labor (DOL) guidance issued in 2014 and 2016 limits the ability of individual market coverage to use this promising tool to reduce costs.[15]

Significant savings are possible using reference pricing. A 2013 study found that the California Public Employees' Retirement System saved $2.8 million dollars in 2011 due to their reference pricing program for knee and hip replacements.[16]

California Public Employees' Retirement System saved

$2.8 million dollars

in 2011 due to their reference pricing program for knee and hip replacements.

Reference Pricing in Practice, Impact on Savings and Behavior[17]

	Procedure(s)	Reference Price (Percentile)	Savings	% of Consumers Switching from Higher to Lower Cost Providers	Reduction in Prices Charged Among High-Priced Providers
CalPERS	Cataract Surgery	66th	17.9%	8.6%	n.a.
CalPERS	Colonoscopy	66th	21.0%	17.6%	n.a.
CalPERS	Hip and Knee Replacement	66th	20.2%	28.5%	34.3%
CalPERS	Arthroscopy: Knee	66th	17.6%	14.3%	n.a.
CalPERS	Arthroscopy: Shoulder	66th	17.0%	9.9%	n.a.
Safeway	492 CPT Codes, Lab Services	50th	20.8%	12.0%	n.a.
Safeway	Diagnostic Lab Testing	60th	31.9%	25.2%	n.a.
Safeway	Imaging: CT	60th	12.5%	9.0%	n.a.
Safeway	Imaging: MRI	60th	10.5%	16.6%	n.a.

Notes: n.a. Not available—study did not explicitly estimate the reduction in prices charged

Recommendation

KEY: FED REG FED LEG STATE REG STATE LEG

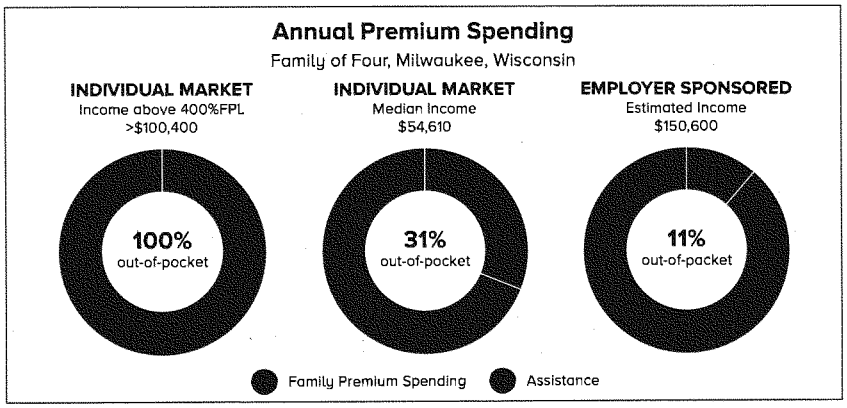
FR

Withdraw "ACA FAQs Part XXI" published October 10, 2014 and "ACA FAQs Part XXXI, Q&A-7" published April 20, 2016. These FAQs can be interpreted to limit reference pricing in individual market plans. Withdrawing the FAQs will provide more flexibility to provide individual market consumers with premium savings similar to those seen in employer-based plans that have implemented reference pricing.

LEVER 2: BRINGING FINANCIAL PARITY TO THE INDIVIDUAL MARKET

Americans who buy their own health coverage with a household income level above 400 percent of the federal poverty level are the only segment of the population that doesn't receive some help with their insurance premiums. Those who are provided coverage at work see thousands of dollars of savings each year in employer contributions to premiums and tax savings. Those who earn under 400 percent of FPL receive premium subsidies that average out to $550 per month per recipient for 2018.[18]

How Much Premium Assistance do Americans Get for Commercial Coverage? *Example: Family Coverage in Wisconsin*		
Coverage Type	**Monthly Premium Spending**	**Typical Monthly Assistance**
Individual Market – Family of 4[19] Income > 400%FPL	Low: $848 High: $1,431	$0
Individual Market - Family of 4 Median Income: $54,610[20]	Low: $848 High: $1,431	APTC[21]: $786
Employer Sponsored	Average: $1,634[22]	Employer Contribution: $1,172[23] Federal Tax Savings: $214[24] State Tax Savings: $97[25]



The most immediate and direct way to help middle-class Americans afford their own coverage is to ensure they have appropriate financial support to do so. Ensuring more equitable treatment of these hardworking Americans can attract healthier people to enroll, improving the risk pool and bringing premiums down for everyone. Below, we recommend approaches to subsidizing premiums.

Provide Tax Parity for Americans who Buy Individual Market Coverage

Section 106 of the Internal Revenue Code excludes health insurance premiums paid through an employer plan from taxable income. This results in substantial tax savings for individuals with employer-provided coverage. In contrast, consumers purchasing individual health insurance coverage must use taxable income to pay their premiums. For consumers earning a household income in excess of 400 percent of the federal poverty level, and who are therefore ineligible for premium tax credits, there are no tax incentives for purchasing health insurance. This is the only segment of the American population that doesn't receive some help with their insurance premiums.

Allowing the cost of health insurance premiums to be deducted from taxable income would create parity between the individual and group markets. If the Code is excluding health insurance coverage from income, that should apply in all markets. Doing so would substantially increase the affordability of coverage for those purchasing insurance on their own.

Recommendation KEY: FED REG FED LEG STATE REG STATE LEG

FL

Amend the Internal Revenue Code to allow individual market health insurance premium costs to be deductible for federal income tax purposes for those who do not qualify for premium tax credits. Individuals and families with gross household incomes over 400 percent of FPL are ineligible for any federal tax assistance. Permitting the cost of health insurance premiums to be deductible from gross income for federal income tax purposes would help millions afford coverage. This would be an "above-the-line" deduction that excludes the premium amount from a taxpayer's gross income but could be subject to the Pease Limitations that existed in the Internal Revenue Code prior to 2018 that phase out deductions based on income.

Expand HSA Options

Millions of Americans currently use Health Savings Accounts (HSA) to save pre-tax dollars for future health care expenses. As deductibles continue to rise, millions of consumers purchasing coverage through the individual market face challenges in paying for expenses before reaching their deductible, as well as meeting cost-sharing requirements throughout the plan year. As HSA funds are not subject to income taxation, using these funds to pay for expenses allows for consumer dollars to go farther, increasing affordability.

Currently, there are strict limits on what health policies can be paired with an HSA, including a minimum deductible amount and a prohibition on plan coverage of services before an enrollee has met their deductible, except for services or visits that are solely preventive. Allowing more individual market plans to be eligible for pairing with an HSA will give more Americans the ability to save for near-term and long-term health expenses without paying taxes on those savings. Additionally, giving health insurance providers the flexibility to offer coverage of certain services, treatments, or medications necessary to treat chronic health conditions before an enrollee has met their deductible will allow millions of Americans in HSA-eligible plans to better afford essential services.

Recommendation KEY: FED REG FED LEG STATE REG STATE LEG

FL

Expand the criteria for health plans to be HSA-eligible, to include all catastrophic and bronze plans. Both catastrophic and bronze plans typically include high deductibles that allow for more affordable premiums but limit overall affordability when it comes to accessing medical care. One way to give consumers a tax-advantaged means of preparing for future medical costs and having funds to access care is to permit those consumers to save in an HSA. Section 223 of the Internal Revenue Code places strict limits on which plans may be HSA-eligible. A federal bill that would accomplish this (HR 6311) recently passed the House.

Create Reinsurance Programs

A reinsurance program provides payments to health insurance providers enrolling higher risk populations. The program can be funded in a myriad of ways. States have paid for reinsurance programs through: state general funds, utilizing savings within other health care programs, pass through savings, and assessments on carriers, hospitals and provider groups. Ultimately, a federally funded reinsurance program would be ideal to provide premium relief for Americans nationwide.

Reinsurance programs have been implemented in Alaska, Minnesota, and Oregon under 1332 waivers. Applications for reinsurance programs have been approved for Maine, Maryland, New Jersey and Wisconsin. Reinsurance programs have proven to protect against premium increases and can be directed solely to the individual market. This year, within the states enforcing or creating reinsurance programs, premium increases have been up lower due to the reinsurance program.

State 1332 Reinsurance Program Premium Savings as Estimated in Waiver Applications Submitted to CMS

State	Reinsurance Year 1	Reinsurance Premium Impact[26]
Alaska	2017	-35%
Minnesota	2018	-20%
Oregon	2018	-7%
Maine	2019	-9%
Maryland	2019	-30%
New Jersey	2019	-15%
Wisconsin	2019	-11%

Additional Resource:

Kaiser Family Foundation 1332 Tracking, August 2018

Recommendations

KEY: FED REG FED LEG STATE REG STATE LEG

SL **Create/reinitiate state reinsurance programs that are not solely funded by carrier assessments.** Reinsurance programs have received bipartisan support in many states. However, funding sources can be controversial. General state funds remain the best option but are scarce. If assessments are necessary, they must be shared by a variety of stakeholders that benefit from reinsurance.

FR **Continue expediting review and approval of state 1332 applications seeking to create a reinsurance program.** In 2017 CMS issued guidance to simplify the application process for states seeking 1332 waivers to establish reinsurance programs and approved three new waivers that include reinsurance. By October of 2018, CMS had approved four additional waivers including reinsurance programs.

FL **Create a permanent federal reinsurance program.** Establishing a permanent federal reinsurance program will offset some of the costs that come with caring for individuals with complex health conditions who have significant health care needs.

Create State Premium Discount Programs

States can also implement discount programs for state residents who don't qualify for federal premium subsidies. For the 2017 plan year, the state of Minnesota created and funded a premium discount program for Minnesotans who did not qualify for APTC. The program was funded by the state and provided a 25 percent premium discount for unsubsidized individual market enrollees.[27]

Recommendation KEY: FED REG FED LEG STATE REG STATE LEG

SL **Create a state premium discount program for individuals and families earning more than 400 percent of FPL.** For the 2017 plan year, the state of Minnesota created and funded a premium discount program for Minnesotans who did not qualify for APTC. The program was funded by the state and provided a 25 percent premium discount for unsubsidized individual market enrollees. States should consider programs if the approach can be funded without imposing fees or assessments that increase the overall cost of coverage.

Repeal the Health Insurance Tax

Allowing the health insurance tax to resume in 2020 will result in higher premiums for consumers. If the tax is not suspended or repealed, individual market health insurance providers will have to factor in the cost of the health insurance tax for 2020 and the tax will contribute $196 per person annually to the cost of coverage in the individual market. Because the tax is calculated as a percent of premium, the consumers paying the highest premiums already bear the biggest burden.

Additional Resource:

Legislation to Suspend the Health Insurance Tax Will Help Make Premiums More Affordable, August 2018

2019 Savings from HIT Suspension	
Individual Coverage	$230
Small Group, Individual	$300
Large Group, Individual	$280
Medicaid	$160
Medicare Advantage	$380
Part D	$17

Source: "Estimated Impact of Suspending the Health Insurance Tax from 2017-2020." Oliver Wyman, December 2015.

2020 Premium Increases due to HIT	
Individual Coverage	$196
Small Group, Individual	$154
Large Group, Individual	$158
Medicaid	$157
Medicare Advantage	$241
Part D	$16

Source: "Analysis of the Impacts of the ACA's Tax on Health Insurance in Year 2020 and Later." Oliver Wyman, August 2018.

Recommendation KEY: FED REG FED LEG STATE REG STATE LEG

FL **Enact legislation to permanently repeal the Health Insurance Tax.** Enactment of this legislation would help deliver more affordable coverage and care as well as lower premiums for millions of Americans—whether they purchase their own coverage on the individual market, obtain coverage through their jobs, or enroll in Medicare Advantage or Medicaid managed care.

LEVER 3: INCREASE ENROLLMENT/IMPROVE THE RISK POOL

The individual health insurance market must operate as a single risk pool under federal law. That means everyone who purchases health insurance in the individual market is grouped together and the cost of their collective health care drives the cost of premiums in each state. A well-balanced risk pool includes both people who do and do not need costly (or complex) health services.

The health of those in the risk pool has a major impact on premium costs. When there are a disproportionate number of unhealthy people covered in a risk pool, health care costs go up because there are fewer healthy people to offset those costs. A well-balanced risk pool keeps premium costs down for everyone and ensures people who need care can get it and people who may need it in the future are protected.

Provide Savings to Consumers who Engage in Wellness Programs

Over the past four decades, wellness programs have become commonplace in many American companies, with most large employers offering some version of a workplace wellness program. For those enrolled, wellness programs help improve overall health and offer opportunities for premium discounts. Thus far, these programs have been limited to the group markets. Increasing the role of wellness programs in the individual market would increase the value of insurance for those who perceive themselves as healthy, attracting more healthy people into the risk pool.

Section 2705 of the Patient Protection and Affordable Care Act (ACA) required the Secretary of Health and Human Services to establish a ten-state demonstration project where health insurance providers would be permitted and funded to develop wellness programs for individual market plans offered on the Marketplace. This was to be established by July 1, 2014, with an option to expand the demonstration to additional states in 2017. No appropriation was made under that section. When wellness programs are included in the individual market as part of the state demonstration project, exchanges in those states may offer health coverage that includes reward/penalty programs that vary people's health insurance costs. The ACA includes a protection that requires these individual market wellness demonstration projects to not result in a decrease of coverage.

Recommendations KEY: FED REG FED LEG STATE REG STATE LEG

FL FR **Implement the 10-state demonstration program for wellness.** Congress should fund an appropriation to enable the program. Federal guidance could be issued to provide general implementation parameters.

FR FL SR SL **Preserve flexibility for plans to promote safe, effective, high-value care.** Allow individual market health insurance providers to use medical management tools and benefit designs that promote safe, effective, and affordable care. Examples of these tools include but aren't limited to: formulary and provider network designs that tier prescription drugs or providers based on quality and value, and prior authorization that ensures evidence-based care.

Marketing and Outreach

A stable individual market requires broad participation of people who are healthy and sick, young and old. It also requires consumers to enroll for a full plan year and continually maintain 12 months of coverage, as opposed to enrolling only when they need care. Open enrollment provides an annual opportunity for new consumers to enroll in marketplace coverage and allows existing enrollees to reenroll in coverage or choose a different plan that best meets their needs.

Unlike other health insurance markets that have more static populations such as employer-provided coverage or Medicare, the individual market is subject to frequent changes as consumers move in and out of coverage for various reasons, for example due to a permanent move or gaining or losing coverage from another source. Thus, marketing, outreach, and education are critical to ensure all consumers are aware of the open enrollment timelines.

Health insurance providers who participate on the federal exchange are required to pay a user fee of 3.5 percent of premiums. While CMS has not provided transparency into allocation of these funds, the user fee is intended to be used to support marketing and outreach activities, amongst other Federal exchange functions. For the 2018 plan year, CMS announced a reduction in the Federal exchange's marketing and outreach budget (from $100 million in 2017, or $11 per enrollee, and $51 million in 2016, or $5 per enrollee).

Recommendations KEY: FED REG FED LEG STATE REG STATE LEG

SR **Support state-based exchange investments in robust advertising and marketing campaigns, so long as these approaches do not increase premiums.** Investments in advertising and marketing should be made without increasing exchange user fees, which would lead to premium increases.

FR **At the option of a state participating in the FFM, transfer a portion of the FFM user fee to the state to conduct outreach, education, and marketing.** As CMS evaluates the user fee as the exchange evolves (e.g., with issuers taking on a wider breadth of activities through enhanced direct enrollment) CMS should identify user fees that can be allocated to support state marketing and outreach activities. States that opt to receive these funds may use them to carry out a defined list of marketing and outreach activities, such as support for navigators or other in-person assistance, collaborating with other outreach groups experienced in helping consumers enroll in coverage through the individual market, TV/radio/print advertising, consumer education and enrollment events, or resources for non-English speaking consumers. States that elect to receive user fee funds would be required to provide a plan for how they anticipate using these funds to support open enrollment activities. A commitment by states to promote robust enrollment during the annual open enrollment period could place downward pressure on premiums, increase uptake, and encourage a more balanced risk pool.

Conclusion

State and federal policymakers and regulators can, and should, act now to improve health care coverage affordability for hardworking Americans. Many of the recommendations above can be implemented through the states or federal regulation and could have impacts on premiums as soon as 2020. We look forward to working with policymakers and other stakeholders to make premiums more affordable.

Additional resources on these recommendations and other AHIP approaches to improve health care for Americans can be found at ***www.ahip.org.***

Endnotes

1 For 2018. From Kaiser Family Foundation.

2 Trends in Subsidized and Unsubsidized Individual Health Insurance Market Enrollment, CMS, July 2 2018

3 Ibid. Note that a significant portion of the change in the average monthly premium from 2017 to 2018 is attributable to silver loading to account for the suspension of federal payments to insurers to cover the cost of cost sharing reductions. In most states consumers that chose metal level plans other than silver would have seen a smaller increase.

4 CCIIO, Health Insurance Exchange Public Use Files found at https://www.cms.gov/CCIIO/Resources/Data-Resources/marketplace-puf.html

5 http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2018/08/16/health-insurance-premiums-are-stabilizing-despite-gop-attacks

6 A full description of methodology and more information on this infographic can be found at https://www.ehip.org/health-care-dollar/

7 OECD was founded by 18 European nations, the United States and Canada and now consists of 36 countries that span the globe. A list of OECD member countries can be found here. http://www.oecd.org/about/membersandpartners/#d.en.194378

8 OECD (2017), *Health at a Glance 2017: OECD Indicators*, OECD Publishing, Paris, https://doi.org/10.1787/health_glance-2017-en.

9 Ibid

10 45 CFR 147.138

11 45 CFR 156.230

12 Up in the Air: Inadequate Regulation for Emergency Air Ambulance Transportation, Consumers Union, March 2017

13 Lara Maggs and Aaron Kesselheim, The Short-Term And Long-Term Outlook Of Drug Coupons, November 12, 2014 http://healthaffairs.org/blog/2014/11/12/the-short-term-and-long-term-outlook-of-drug-coupons/

14 https://www.towerswatson.com/en-US/Press/2014/08/current-telemedicine-technology-could-mean-big-savings

15 ACA FAQs Part XXI (October 10, 2014) and ACA FAQs Part XXXI, Q&A-7 (April 20, 2016)

16 Increases In Consumer Cost Sharing Redirect Patient Volumes And Reduce Hospital Prices For Orthopedic Surgery, James C. Robinson and Timothy T. Brown, Health Affairs, August 3013

17 http://www.actuary.org/files/publications/ReferencePricing_11.2018.pdf

18 Average 2018 APTC nationwide, from Marketplace Average Premiums and Average Advanced Premium Tax Credit, Kaiser Family Foundation

19 2018 premiums found on healthcare.gov for zip code 53207. Based on family members with ages: 40, 35, 13, 8

20 Median household income in 2016 based on census data that can be found at https://www.census.gov/quickfacts/wi

21 APTC is: available for exchange plans only; varies by income level and cost of plans in the area; is not available to those offered affordable employer coverage.

22 For 2018 family coverage, from 2018 Health Benefits Survey, Kaiser Family Foundation

23 Ibid

24 Estimate for a family of four with a combined annual income of $150,600 paying an effective tax rate of 13.1 percent.

25 Estimate for a family of four in Wisconsin with a combined annual income of $150,600 subject to 5.97 percent in state income tax.

26 Reinsurance premium impact represents the difference between expected rate increases or decreases with a reinsurance program versus without. It does not represent the total premium change for the year. For example, if premiums would have increased 10 percent without reinsurance and the reinsurance impact is negative 30 percent, premiums would decrease by 20 percent with the reinsurance program. Reinsurance premiums impacts can be found in the state 1332 waiver applications on CCIIO's 1332 Waiver page. https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers.html

27 Health Insurance Relief FAQ, Minnesota Office of Management and Budget

March 6, 2019

The Honorable Frank Pallone, Jr.
Chairman
Committee on Energy and Commerce
U.S. House of Representatives
2107 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Greg Walden
Ranking Member
Committee on Energy and Commerce
U.S. House of Representatives
2185 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairman Pallone and Ranking Member Walden:

Thank you for holding a hearing on "Strengthening Our Health Care System: Legislation to Lower Consumer Costs and Expand Access." The Healthcare Leadership Council (HLC) appreciates the opportunity to share its thoughts with you on the proposed legislation.

HLC is a coalition of chief executives from all disciplines within American healthcare. It is the exclusive forum for the nation's healthcare leaders to jointly develop policies, plans, and programs to achieve their vision of a 21st century healthcare system that makes affordable high-quality care accessible to all Americans. Members of HLC – hospitals, academic health centers, health plans, pharmaceutical companies, medical device manufacturers, laboratories, biotech firms, health product distributors, post-acute care providers, home care providers, and information technology companies – advocate for measures to increase the quality and efficiency of healthcare through a patient-centered approach.

H.R. 1425, State Healthcare Premium Reduction Act

HLC believes that all Americans should have access to affordable, high-quality healthcare. Congress should establish a reinsurance program as proposed in this bill with predictable, reliable, and broad-based funding. We call on Congress to enact legislation, built around robust funding for reinsurance that is adequate to ensure stability, encourage competition and lower costs for consumers. Reinsurance provisions of this legislation should be structured in a manner to bring relief to

consumers in every state. To assure its sustainability, any legislative solution must be bipartisan.

H.R. 1386, Expand Navigators Resources for Outreach, Learning & Longevity Act
The Affordable Care Act (ACA) created Navigator programs to provide outreach, education, and enrollment assistance to consumers eligible for marketplace and Medicaid coverage and requires that they be funded by the marketplaces. Navigators are tasked with several marketplace enrollment responsibilities, including conducting public education activities to raise awareness of coverage availability on the marketplaces, and providing fair and impartial information on enrollment and financial assistance. This program has been beneficial with increasing the health insurance enrollment rate. HLC supports this legislation to restore funding to the enacted funding level and recommends HHS provide guidance to Navigators on how to effectively set enrollment goals.

H.R. 1385, State Allowance For A Variety of Exchanges (SAVE) Act
HLC supports improved flexibility and healthcare innovation and believes that American ingenuity is critical to achieving a healthcare system that is more efficient, more effective, and of the highest quality. The SAVE Act would restore federal funding to help states move off the federal health exchange and onto their own state-based exchange. This legislation would provide states with the flexibility needed to achieve the most effective healthcare system. States have traditionally been the primary regulators for their local markets, and they understand how best to meet their consumers' needs. HLC urges Congress to consider H.R. 1385 as an avenue to improve and strengthen our healthcare system going forward.

Thank you for the opportunity to comment on the proposed legislation. HLC looks forward to continuing to collaborate with you on this important issue. If you have any questions, please do not hesitate to contact Debbie Witchey at (202) 449-3435 or dwitchey@hlc.org.

Sincerely,

Mary R. Grealy
President

Discussion

kff.org/health-reform/issue-brief/how-affordable-are-2019-aca-premiums-for-middle-income-people

March 4, 2019

The majority of enrollees who purchase health coverage through Affordable Care Act (ACA) exchanges receive premium tax credits to help them afford their monthly premiums. To a large extent, subsidized enrollees are shielded from premium increases because their subsidies rise along with premiums. On the other hand, middle-income people with incomes above 400% of the Federal Poverty Line ("FPL", equal to $48,560 for an individual and $100,400 for a family of four in 2019) are not eligible for subsidies and may struggle to afford ACA-compliant plans.

Marketplace enrollment among subsidized enrollees rose from 8.7 million in 2015 to 9.2 million in 2018. However, premiums increased significantly, and the number of unsubsidized enrollees in ACA-compliant plans has fallen over this same period from 6.4 million to 3.9 million. Unlike subsidized enrollees, those with incomes over 400% of poverty have to bear the full cost of premium increases if they buy an ACA-compliant plan.[1]

While premiums for ACA Marketplace plans are holding steady or falling slightly on average in 2019, whether ACA plan premiums are actually affordable for an individual depends on where they live, how old they are, and how much money they make. We analyzed 2019 premiums data to show how affordable the lowest-cost ACA Marketplace plan is in each county, by age and income, with a focus on middle-class people whose incomes are too high to qualify for subsidies.

This brief finds that affordability challenges are particularly acute for older adults with incomes just above the premium subsidy cutoff (400% of poverty), particularly in rural areas where premiums are highest.

Figure 1

Most unsubsidized enrollees who enroll in ACA-compliant plans do so outside of the Marketplace. This brief only includes premiums for plans that are available on the Marketplace, but bronze premiums for people who are not eligible for subsidies are generally similar whether an enrollee buys through the Marketplace or not. (In all but 14 counties, the lowest-cost plan available is a bronze plan.)

The interactive map shows a substantial decline in affordability between a $45,000 income (which would put an individual at 371% of the poverty level and make them eligible for subsidies) and $50,000 (412% of poverty and therefore not eligible for subsidies). This phenomenon is referred to as the "subsidy cliff" because subsidy eligibility ends sharply at 400% of poverty without a phase-out, even if premiums represent a substantial share of income for those above 400% of poverty.

In 21% of counties, a 40-year-old making $50,000 would have to pay more than 10% of their income for the lowest-cost plan in the Marketplace. However, because premiums are lower in urban areas than in rural areas, just 8% of Marketplace enrollees are in a county where that would be the case. In 25% of non-metropolitan counties (weighted by enrollment), a 40-year-old making $50,000 would spend more than 10% of their income on premiums for the cheapest plan available, compared with only 5% of people in metropolitan counties.[2]

Rhode Island has the lowest average premiums for middle-class people ineligible for subsidies in 2019: a 40-year-old making $50,000 would pay about 5% of their income in premiums for the cheapest plan, on average. Wyoming has the highest average premiums for unsubsidized people: a 40-year-old making $50,000 would pay about 14% of their income in premiums for the cheapest plan, on average, with Nebraska and West Virginia in a close second and third place.

Figure 2 presents an interactive chart showing how much the national average premiums for a low-cost plan vary as a share of income at different income levels for people at various ages. (Figure 3 presents similar results as a static chart.) On average across the U.S., a 40-year-old making $45,000 would pay $227 a month (6% of their income) for a subsidized bronze exchange plan, whereas the same person making $50,000 would pay $340 a month (8% of their income) for the same plan without a subsidy. Because the ACA allows premiums for older adults to be three times those for younger enrollees, middle-class older people with unsubsidized coverage are the most likely to face affordability challenges. For example, a 27-year-old making $50,000 would pay 7% of their income in premiums for the average lowest-cost plan nationally, whereas a 60-year-old making the same income would pay 17% of their income in premiums. Even at an income of $70,000 (577% of the poverty level), a 60-year-old would have to pay 12% of income for a low-cost plan on average.

Figure 2: Average Lowest-Cost Plan Premium (by Income, Age, and Metal Level, 2019)

For older people living in very high-premium counties, the affordability gap is much more stark; in the 28 Nebraska counties with the highest premiums, a 60-year-old making $45,000 would pay nothing in monthly premiums and the same person making $50,000 would pay $1,314 (32% of income) for the lowest-cost plan.

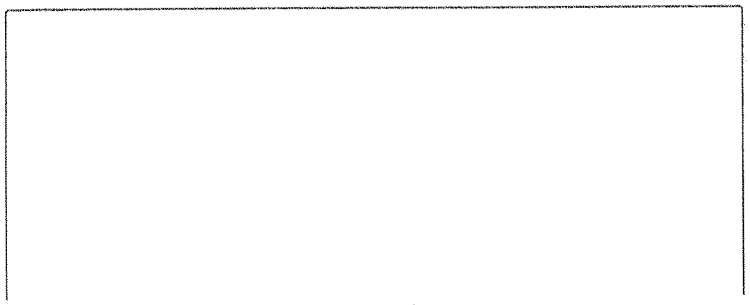
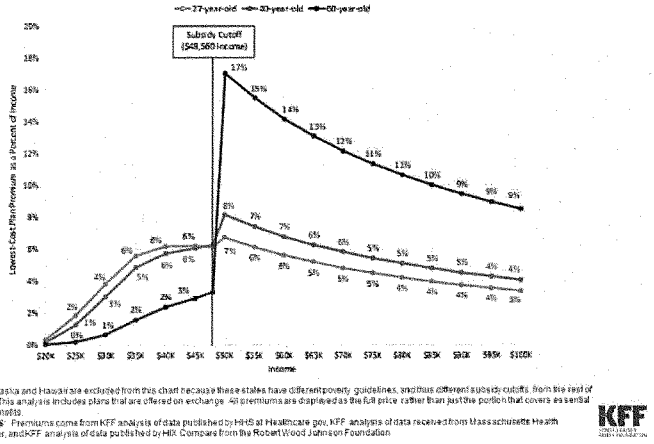


Figure 3

Average Lowest-Cost Bronze Plan Premium as a Percent of Income (by Age and Income, 2019)



NOTE: Alaska and Hawaii are excluded from this chart because these states have different poverty guidelines, and thus different subsidy cutoffs, from the rest of the U.S. This analysis includes plans that are offered on exchange. All premiums are displayed as the full price rather than just the portion that covers essential health benefits.
SOURCES: Premiums come from KFF analysis of data published by HHS at Healthcare.gov, KFF analysis of data received from Massachusetts Health Connector, and KFF analysis of data published by HIX Compare from the Robert Wood Johnson Foundation

Figure 3: Average Lowest-Cost Bronze Plan Premium as a Percent of Income (by Age and Income, 2019)

The premiums in this analysis are for the lowest-cost plan available in each county, but these low-cost bronze plans come with higher deductibles, copayments, or coinsurance than plans at higher metal tiers with higher monthly premiums. The average deductible for bronze plans in 2019 is $6,258, compared to $4,375 for silver plans (for people who do not receive cost-sharing subsidies because their incomes are above 250% FPL). While some services, including preventative care and often a few physician visits, are covered before enrollees reach their deductible, sicker enrollees may be better off choosing a silver or gold plan even if that means they spend a larger proportion of their income on premiums.

After several years of rising ACA plan premiums, premiums are falling in many parts of the country for 2019. Despite this trend, premiums for even the cheapest exchange plans are still out of reach for many middle class people who are not eligible for ACA subsidies, particularly those who are older or live in high-premium areas. Several policy options have been proposed to address affordability for people buying their own coverage without a subsidy, such as expanding more loosely regulated short-term plans, creating state-based reinsurance programs, extending subsidies beyond 400% of poverty, and expanding eligibility for Medicaid or Medicare.

The Trump administration recently made changes to short-term, limited duration plans, with the goal of creating a more affordable option for people who are not eligible for subsidies. Short-term plans generally have significantly lower premiums than ACA-compliant coverage, in large part because these plans can exclude people with pre-existing conditions and may not cover certain services. Thus, while short-term plans come with lower premiums, these plans are generally not an option for people who have pre-existing conditions or expect to

need high-cost services (e.g. for pregnancy, prescription drugs, or mental health care). Additionally, these plans will disproportionately attract healthy individuals away from ACA-compliant coverage, thus having an upward effect on premiums in the ACA-compliant individual market and possibly making unsubsidized coverage less affordable for people with pre-existing conditions.

The ACA established a temporary reinsurance program from 2014 to 2016 with the goal of making premiums more affordable during the early years of new market reforms. Reinsurance covers a portion of the health care expenses for high-cost patients, allowing insurers to reduce premiums.

Seven states (Alaska, Maine, Maryland, Minnesota, New Jersey, Oregon, and Wisconsin) have since created their own reinsurance programs, and initial evidence indicates that these programs have been successful in reducing individual market premiums, although the details of these plans vary widely between states. How much a reinsurance program can reduce premiums depends on the level of funding dedicated to it. Reinsurance reduces premiums somewhat for all enrollees ineligible for premium subsidies. However, this reduction in prices will not be enough to make plans affordable for all unsubsidized middle class people, particularly those facing the highest premiums as a share of income. For example, the cheapest plan in Natrona County, Wyoming costs $1,237 a month for an unsubsidized 60-year-old (25% of income for someone making $60,000). If the implementation of a reinsurance plan reduced all premiums by 10%, the cheapest plan would cost $1,113 (22% of income), which is still too expensive for many people to afford.

Expanding premium tax credits to enrollees over 400% of poverty would provide more significant assistance to those newly eligible for subsidies. For example, California Governor Newsom recently proposed expanding premium tax credits to incomes between 400 and 600% of poverty (incomes up to $72,840 for an individual).

Avoiding a subsidy cliff altogether would cost taxpayers more. One federal bill introduced in the House last year would extend premium subsidies to enrollees in all income brackets, and increase the amount of subsidies across the board. On average nationally, tax credits would need to extend to nearly 800% FPL to bring 2019 bronze premium payments down to 10% of income for a single 64-year-old, or just over 1,100% FPL to accomplish the same for silver premiums. In the 28 Nebraska counties with the most expensive 2019 premiums in the U.S., tax credits would need to extend beyond 1,400% FPL to bring bronze premium payments down to 10% of income for a single 64-year-old, or over 2,000% FPL to accomplish the same for silver premiums. In the case of an older couple living in a high-premium county, subsidies would need to extend beyond 3,000% FPL (a $500,000 income), for 2019 silver premiums to cost less than 10% of their income.

In late 2018, the Trump administration released new guidance and the Centers for Medicare and Medicaid Services (CMS) issued a discussion paper on Section 1332 waivers established by the ACA. This new guidance may prompt states to apply subsidies to ACA non-compliant plans or experiment with different subsidy structures, such as tax credits based on age and not income. One of the CMS waiver concepts describes extending subsidies to higher-income residents to address the "subsidy cliff." Under a budget neutral waiver, however, increasing subsidy resources for one population group would necessitate reducing subsidy dollars

available to other groups. Currently, ACA subsidies are structured so that lower-income enrollees pay a smaller percentage of their income (2% premium cap for those 100-133% of poverty) than higher-income enrollees (10% for those 300-400% of poverty), and they receive the bulk of subsidies. Additionally, as noted above, subsidies would need to extend well beyond 400% FPL to do away with the subsidy cliff altogether.

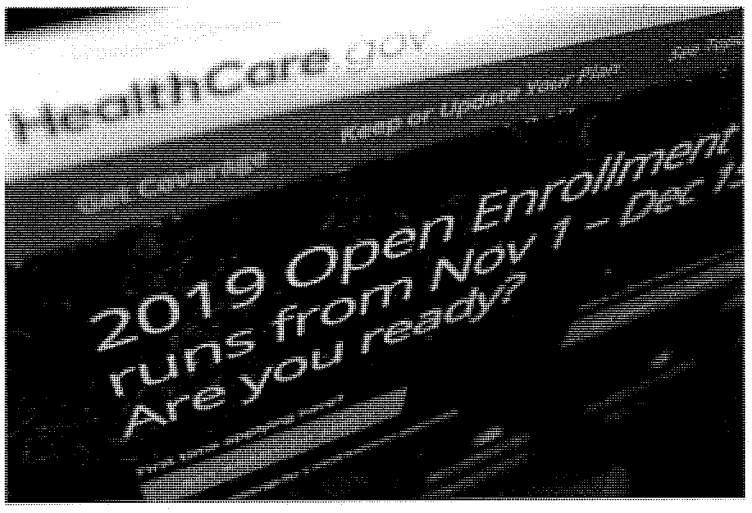
A number of recent congressional proposals would provide lower premium options to middle-class people buying their own coverage by expanding access to public programs like Medicare and Medicaid. For example, one bill would allow people age 50 and over to buy into Medicare, potentially lowering premiums through reduced prices paid to health care providers and curtailing administrative costs and profits. Another bill would allow states to set up programs that allow people to buy into the Medicaid program, capping premiums at 9.5% of income.

So far, while there seems to be a consensus that individual market premiums are out of reach for some middle-class people ineligible for ACA subsidies, there is little consensus around what to do about it.

ACA premiums rising beyond reach of older, middle-class consumers

washingtonpost.com/national/health-science/aca-premiums-rising-beyond-reach-of-older-middle-class-consumers/2019/03/04/bdd07d9e-3e9a-11e9-922c-64d6b7840b82_story.html

Health & Science



A new analysis shows that premiums in Affordable Care Act marketplaces cost a lot for older Americans who earn too much for federal subsidies. (Patrick Sison/AP)

By Amy Goldstein

March 5 at 3:00 AM

The sweeping health-care law created nearly a decade ago to put insurance within reach of more Americans has left significant holes in the ability of older, middle-class people to afford coverage, particularly in rural areas, according to a new analysis.

Sixty-year-olds with a $50,000 income must pay at least one-fifth of what they earn for the least expensive premiums for health plans in Affordable Care Act marketplaces across a broad swath of the Midwest, the analysis shows. In much of the country, those premiums require at least one-sixth of such people's income.

The findings, issued Tuesday by the Kaiser Family Foundation, underscore why the Trump administration and other Republicans are pushinginexpensive insurance that bypasses ACA rules and protections — and why Democrats are pursuing strategies to make ACA plans more affordable.

Both parties focus on the fraction of Americans who need to buy insurance on their own — the group the ACA marketplaces were intended to help — and who earn too much to qualify for federal premium subsidies created under the law. As premiums have escalated, the proportion of consumers buying ACA health plans without a subsidy has dwindled.

More Americans could decide to forgo coverage if it is too expensive now that Congress and President Trump have eliminated a penalty the ACA imposed on consumers who shirked the law's requirement that most people carry health insurance. The penalty ended in January.

The new analysis documents county by county that even as average ACA premiums for the most popular level of coverage dipped slightly for this year — the first time that has happened since the marketplaces opened in 2014 — there is wide geographic variation in how affordable rates are.

Middle-class and older adults are especially vulnerable to high insurance costs for ACA coverage because of two features of the law. One is a "cliff" in which premium subsidies end at 400 percent of the federal poverty line, nearly $49,000 for an individual and just over $100,000 for a family of four. The effect is that most 40-year-olds just under the cliff pay no more than 5 percent of their income for coverage; for those with slightly higher incomes, fewer than 10 U.S. counties have premiums as affordable.

The other feature allows ACA health plans to charge three times as much to older adults — before they turn 65 and become eligible for Medicare — as younger ones.

The combined effects of these rules are especially stark in rural areas, where health plans tend to be more expensive. The analysis shows that in almost all of Nebraska, a 60-year-old with a $50,000 income would pay between 30 percent and 50 percent of that income in premiums for the least expensive ACA health plan.

The Trump administration cites unaffordable premiums as it is trying to increase the sale of short-term health plans with skimpy benefits and consumer protections. Democrats propose different remedies, such as allowing subsidies for consumers with higher incomes, letting people in their 50s buy into Medicare, or creating reinsurance programs that help insurers balance the costs between those with healthy customers and sicker ones.

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Last-minute scramble for ACA plans appears unaffected by court ruling

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Amy Goldstein Amy Goldstein is The Washington Post's national health-care policy writer. During her 30 years at The Post, her stories have taken her from homeless shelters to Air

https://www.congress.gov/bill/116th-congress/house-bill/1510/text

116th CONGRESS
1st Session

H. R. 1510

To amend the Public Health Service Act to provide for a Patient and State Stability Fund.

IN THE HOUSE OF REPRESENTATIVES
March 5, 2019

Mr. Burgess introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To amend the Public Health Service Act to provide for a Patient and State Stability Fund.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. Short title.

This Act may be cited as the "Premium Relief Act of 2019".

SEC. 2. Patient and State Stability.

The Public Health Service Act (42 U.S.C. 201 et seq.) is amended by adding at the end the following new title:

"TITLE XXXIV—Patient and State Stability Fund

"SEC. 3401. Establishment of program.

"There is hereby established the 'Patient and State Stability Fund' to be administered by the Secretary, acting through the Administrator of the Centers for Medicare & Medicaid Services (in this title referred to as the 'Administrator'), to provide health benefits coverage funding, in accordance with this title, to the 50 States and the District of Columbia (each referred to in this section as a 'State') during the period, subject to section 3404(c), beginning on January 1, 2020, and ending on December 31, 2022, for the purposes described in section 3402.

"SEC. 3402. Use of funds.

"A State may use the funds allocated to the State under this title for any of the following purposes:

"(1) Helping, through the provision of financial assistance, high-risk individuals who do not have access to health insurance coverage offered through an employer enroll in health insurance coverage in the individual market in the State, as such market is defined by the State (whether through the establishment of a new mechanism or maintenance of an existing mechanism for such purpose).

"(2) Providing incentives to appropriate entities to enter into arrangements with the State to help stabilize premiums for health insurance coverage in the individual market, as such markets are defined by the State.

"(3) Reducing the cost for providing health insurance coverage in the individual market and small group market, as such markets are defined by the State, to individuals who have, or are projected to have, a high rate of utilization of health services (as measured by cost) and to individuals who have high costs of health insurance coverage due to the low density population of the State in which they reside.

"(4) Promoting participation in the individual market and small group market in the State and increasing health insurance options available through such market.

"(5) Promoting access to preventive services; dental care services (whether preventive or medically necessary); vision care services (whether preventive or medically necessary); or any combination of such services.

"(6) Maternity coverage and newborn care.

"(7) Prevention, treatment, or recovery support services for individuals with mental or substance use disorders, focused on either or both of the following:

"(A) Direct inpatient or outpatient clinical care for treatment of addiction and mental illness.

"(B) Early identification and intervention for children and young adults with serious mental illness.

"(8) Providing payments, directly or indirectly, to health care providers for the provision of such health care services as are specified by the Administrator.

"(9) Providing assistance to reduce out-of-pocket costs, such as copayments, coinsurance, premiums, and deductibles, of individuals enrolled in health insurance coverage in the State.

"SEC. 3403. State eligibility and approval; Default safeguard.

"(a) Encouraging State options for allocations.—

"(1) IN GENERAL.—To be eligible for an allocation of funds under this title for a year during the period described in section 3401 for use for one or more purposes deseribed in section 3402, a State shall submit to the Administrator an application at such time (but not later than March 31 of the previous year) and in such form and manner as specified by the Administrator and containing—

"(A) a description of how the funds will be used for such purposes; and

"(B) such other information as the Administrator may require.

"(2) AUTOMATIC APPROVAL.—An application so submitted is approved unless the Administrator notifies the State submitting the application, not later than 60 days after the date of the submission of such

application, that the application has been denied for not being in compliance with any requirement of this title and of the reason for such denial.

"(3) ONE-TIME APPLICATION.—If an application of a State is approved for a year, with respect to a purpose described in section 3402, such application shall be treated as approved, with respect to such purpose, for each subsequent year through 2022.

"(b) Default Federal safeguard.—

"(1) IN GENERAL.—In the case of a State that does not have in effect an approved application under this section for 2020, 2021, or 2022, the Administrator, in consultation with the State insurance commissioner, shall use the allocation that would otherwise be provided to the State under this title for such year, in accordance with paragraph (2), for such State.

"(2) REQUIRED USE FOR MARKET STABILIZATION PAYMENTS TO ISSUERS.—Subject to section 3404(a), an allocation for a State made pursuant to paragraph (1) for a year shall be used to carry out the purpose described in section 3402(2) in such State by providing payments to appropriate entities described in such section with respect to claims that exceed $50,000 (or, with respect to allocations made under this title for 2021 or a subsequent year during the period specified in section 3401, such dollar amount specified by the Administrator), but do not exceed $350,000 (or, with respect to allocations made under this title for 2021 or a subsequent year during such period, such dollar amount specified by the Administrator), in an amount equal to 75 percent (or, with respect to allocations made under this title for 2021 or a subsequent year during such period, such percentage specified by the Administrator) of the amount of such claims.

"SEC. 3404. Allocations.

"(a) Appropriation.—For the purpose of providing allocations for States (including pursuant to section 3403(b)) under this title there is appropriated, out of any money in the Treasury not otherwise appropriated, $2,500,000,000 for each of years 2020 through 2022.

"(b) Allocations.—

"(1) PAYMENT.—From amounts appropriated under subsection (a) for a year (beginning with 2020 and ending with 2022), the Administrator shall, with respect to a State and not later than January 1 of such year, allocate for such State (including pursuant to section 3403(b)) the amount determined for such State and year under paragraph (2).

"(2) ALLOCATION AMOUNT DETERMINATIONS.—For purposes of paragraph (1), the amount determined under this paragraph for a year for a State is an amount determined in accordance with an allocation methodology specified by the Administrator.

"(c) Annual distribution of previous year's remaining funds.—In carrying out subsection (b), the Administrator shall, with respect to a year (beginning with 2021 and ending with 2023), not later than March 31 of such year—

"(1) determine the amount of funds, if any, from the amounts appropriated under subsection (a) for the previous year but not allocated for such previous year; and

"(2) if the Administrator determines that any funds were not so allocated for such previous year, allocate such remaining funds, in accordance with the allocation methodology specified pursuant to subsection (b)(2)—

"(A) to States that have submitted an application approved under section 3403(a) for such previous year for any purpose for which such an application was approved; and

"(B) for States for which allocations were made pursuant to section 3403(b) for such previous year, to be used by the Administrator for such States, to carry out the purpose described in section 3402(2) in such State by providing payments to appropriate entities described in such section 3402(2) with respect to claims that exceed $1,000,000,

with, respect to a year before 2023, any remaining funds being made available for allocations to States for the subsequent year.

"(d) Availability.—Amounts appropriated under subsection (a) for a year and allocated to States in accordance with this section shall remain available for expenditure through December 31, 2023.

"(e) Limitation.—Amounts appropriated under subsection (a) for a year (beginning with 2020 and ending with 2022) are subject to the requirements and limitations under sections 506 and 507 of division H of Public Law 115–31 in the same manner and to the same extent as if such amounts for such year were appropriated under such division.".

SEC. 3. Aligning qualified health plan grace period requirements with state law grace period requirements.

Section 1412(c)(2) of the Patient Protection and Affordable Care Act (42 U.S.C. 18082(c)(2)) is amended—

(1) in subparagraph (B)(iv)(II), by striking "a 3-month grace period" and inserting "a grace period specified in subparagraph (C)"; and

(2) by adding at the end the following new subparagraph:

> "(C) GRACE PERIOD SPECIFIED.—For purposes of subparagraph (B)(iv)(II), the grace period specified in this subparagraph is—
>
> "(i) for plan years beginning before January 1, 2020, a 3-month grace period; and
>
> "(ii) for plan years beginning during 2020 or a subsequent year, such grace period for non-payment of premiums before discontinuing coverage as is applicable under the State law of the State in which the Exchange operates to health insurance coverage offered in the individual market (or, in the case such a State law is not in place for the State involved, a 1-month grace period).".

BlueCross BlueShield Association

An Association of Independent Blue Cross and Blue Shield Plans

March 6, 2019

The Honorable Michael Burgess, M.D.
Ranking Member
Committee on Energy and Commerce Subcommittee on Health
United States House of Representatives
Washington, DC 20515

Dear Ranking Member Burgess:

The Blue Cross Blue Shield Association (BCBSA) would like to commend the introduction of "The Premium Relief Act of 2019," important legislation which would significantly reduce health insurance premiums for millions of Americans and help ensure they have access to the coverage and care they need.

BCBSA represents the 36 independent, community-based and locally operated Blue Cross and Blue Shield companies nationwide offering coverage to more than one in three Americans. We have long supported policies to make health care more affordable and more accessible. We support "The Premium Relief Act of 2019" as an important step forward in improving affordability in the individual market, which is a critical source of coverage for more than 14 million Americans.

With five percent of people who buy coverage in the individual market representing almost 60 percent of health care claims' costs, the single most impactful thing that Congress can do to lower premiums is to provide sustained federal funding for states to put in place programs to help cover the costs of those with significant medical conditions.

Your legislation aligns closely with the recommended premium affordability program in BCBSA's policy proposal, "Reducing Individual Market Premiums to Expand Access to Coverage and Care." If the BCBSA proposal was fully implemented, actuarial firm Oliver Wyman estimates that the national average premium in the individual market would drop by about 33 percent, and an additional 4.2 million people would be able to obtain coverage in the ACA market. If only the premium affordability program was adopted, the national average premium would fall by about 18 percent.

Again, BCBSA appreciates your leadership in introducing "The Premium Relief Act of 2019." We look forward to working with you to advance this legislation and other sensible approaches to help strengthen the individual market to make coverage more affordable while protecting those with pre-existing conditions.

Sincerely,

Justine Handelman
Senior Vice President
Office of Policy & Representation

COUNCIL FOR AFFORDABLE
HEALTH COVERAGE

Response to Energy and Commerce Questions
J.P. Wieske
Council for Affordable Health Coverage

Committee on Energy and Commerce, Subcommittee on Health
Hearing on "Strengthening Our Health Care System: Legislation to Lower Consumer Costs and Expand Access"

April 25, 2019

The Honorable Michael Burgess, M.D. (R-TX)

1. ***Mr. Weiske, you note in your written testimony that "reinsurance is not a panaceo" and that "it doesn't change the fundamentals of the risk pool nor make the market healthier." The bill that I introduced this week would allow states to use the available funds for reinsurance, but also for services such as maternity coverage and newborn care, promoting participation in the markets, and reducing out-of-pocket costs for patients. What are the benefits of coupling reinsurance with other efforts to reduce costs and improve quality of care for patients?***

This is exactly the point. The individual health insurance market remains a residual market – it is a market for people who do not have access to any other health insurance coverage. This means the market faces more adverse selection issues (i.e. people waiting until they develop a health condition to get coverage and/or dropping coverage when treatment is complete). Pre-ACA, these individuals were typically covered through other arrangements like high risk pools that ensured risks were shared equally.

In the post-ACA world, few of these arrangements exist. Guaranteed issue and community rating have made coverage more accessible, but not more affordable. The result has been rising costs both in the form of higher premiums and increasing consumer cost sharing. Reinsurance has been one tool that helps mitigate the cost for consumers. And while lower premiums can help attract a few more favorable risks to the pool, it doesn't solve the problem.

States like Iowa have realized that the nature of subsidies and the cost of insurance have provided little value for the young and healthy consumers. Iowa's proposed 1332 waiver would have substantially changed subsidies in the state to better attract a healthier risk pool that would drive overall exchange premiums downward.

Unfortunately, the current market functions much like a virtual high risk pool that largely attracts poor risks. In order for the individual market to move back to sustainability, the individual market needs a more balanced risk pool. Consumers who have opted out of the market need to again find value in rising prices and higher cost sharing. In short, Congressmen Michael Burgess, M.D. (R-TX)'s proposal increases the value of health insurance to those currently priced out of the market. It could help lead to a more representative and stable risk pool. This will in turn lead to lower overall costs for the market at large.

2. ***Exchange plans have grown increasingly out-of-reach for many Americans, especially those who are not eligible for any subsidies. Yesterday, Kaiser Family Foundation released an analysis that found "premiums for even the cheapest exchange plans are still out of reach for many middle class people who are not eligible for ACA subsidies." Consumer choice is a critical***

part of the affordability discussion. In what ways Congress or the Administration act to increase the number of lower-cost health insurance options for Americans?

I think it is important to reinforce the fact that the insurance market continues to be regulated by the states where insurers also must be licensed. The states also maintain the critical role of reviewing the rates, forms, and network adequacy of insurance plans in addition to conducting market conduct examinations on insurance companies to ensure compliance, but also respond on behalf of consumers when problems arise. States also have oversight on the sale of plans, and of the agents who conduct those sales. As the former Deputy Commissioner of Wisconsin, I can assure you state insurance commissioners, and their staff take the issue seriously. Similarly, the legislators in Wisconsin and other states who set the rules for insurers to follow and they also take their job seriously. It remains important to allow states the flexibility to respond to the needs of their consumers.

With that preface, President Trump has taken the opportunity to allow states additional flexibility in a number of ways. A variety of states from all sides of the political spectrum have taken advantage of these tools to improve access that suits the needs of their population. :

- State Empowerment or 1332 Waivers – The Trump administration has clarified the interpretation of State Empowerment waivers, and provided clearer guidance to states on the process of applying for and receiving a 1332 Waiver. It is important to note that any state changes can not waive the consumer protections included in the ACA.
- Short Term Health Insurance Plans – The Trump administration has returned the regulation of these plans back to the states. The prior administration's 3 month limit did create consumer issues when consumers missed the open enrollment deadline and needed coverage for most of the year. States, individually, need to see the effect on their market. As a result, state action has been varied. Some states have decided to go much further than federal law requires, and have decided to ban short term health insurance plans altogether. In other cases, states have taken advantage of the flexibility to expand the availability of short term health insurance plans. It is important that the regulation of these plans continues at the state level with states having the best understanding of their markets.
- Association Health Plans – While at this writing, federal courts have struck down the rule, the AHP rule was an attempt to expand access to insurance for small employers. Small employers have the least flexibility under the rules – indeed their health insurance plans largely must follow the same rules as the individual market – but are not required to offer health insurance. The proposed AHP rule arguably contains more stringent rules than the market-at-large including a requirement to provide guaranteed issue and community-rated group coverage to sole proprietors.

Again, it is important to note that all of these decisions were largely left to the states to regulate. And states continue to do what they traditionally do – function as "laboratories of democracy" – and take differing approaches. States may eventually move to a consensus on the best approach, or it might be their markets differ significantly enough that no consensus will emerge. I believe the best course of action is to let states continue to regulate their insurance market in this manner.

3. ***You mentioned in your testimony that most state exchanges lack adequate consumer accessibility and decision-support tools. I personally jumped through hoops when the Affordable Care Act went into effect and I chose my own plan off of healthcare.gov. It is difficult, even when you have a plethora of experience in both delivering health care and as a policymaker, to find a plan that you like and understand. In what ways do the state exchanges fail to meet or adapt to consumers' needs?***

    a. ***Will the state exchanges ever overcome those difficulties or are they structurally ingrained in the marketplace?***

I think it is important to note that when we are talking about exchanges, we are talking about a website in which a consumer purchases health insurance coverage. The point of reference then isn't just whether or not the website delivers necessary information, but whether it provides a world-class customer experience on the website. Consumers can shop for thousands of products on Amazon's website – including products from other retailers serviced by Amazon – and the product integration is seamless. Netflix and Hulu allow consumers to sort through and view thousands of television shows and movies on multiple devices. This is the competition for the exchange, and this seamless experience is the expectation of the consumer..

This is a shifting target that requires a significant financial investment every single year. It requires constant updating of the underlying technology and updating of the consumer experience. There are very few government entities that can afford the long-term price tag of consistently rebuilding an exchange website to continually improve upon the customer experience.

Consumers should expect a one-stop shop from the exchange website when on average the exchange costs each consumer over $140[1] per year. For that amount of money, consumers, agents, and insurers should be demanding more accountability. Unfortunately, in many ways the exchange serves as another regulator of the health insurance market making it difficult for anyone to demand accountability.

The study we conducted bears out these concerns. Since my testimony, we have issued another version of our report. It is located at:

https://www.cahc.net/newsroom/2018/10/29/new-report-highlights-shortcomings-on-healthcaregov-state-based-exchanges-ahead-of-open-enrollment-season

A few highlights from the report:

- More than half the exchanges (7) received a D or F —all of them state-based. There was one A, four Bs and one C. The average exchange website scored 71 out of a possible 100 on our composite index, and had 3 best-in-class shows.

[1] Assuming average monthly premium of $400 month, over 12 months, and a 3 percent exchange fee.

- The DC Health Link's exchange ranked first overall, scoring 92 out of a possible 100. DC Health Link was best-in-class in six of the eight primary features reviewed. Although DC's exchange website offers an out-of-pocket cost calculator, the calculator does not directly factor in consumers' specific prescription drug utilization.

- Healthcare.gov, the federally-facilitated exchange that serves 38 states, ranked fourth in our index, scoring 81 out of a possible 100. The federal exchange had four best-inclass showings. Key minuses included a rudimentary cost calculator—one based on a default order that prioritizes premiums alone rather than more important indicators of consumer value, such as expected annual out-of-pocket costs. These deficiencies can present a misleading view if the expected costs and benefits of plans to consumers.

- Variation in exchange composite scores indicate the consumer experience is uneven across the country, with an F (a 48) at the low end and a high of 92. This may reflect the varying levels of commitment (both political and financial) to public exchanges.

- Five exchanges—DC Health Link, Connect for Health Colorado, Healthcare.gov, Maryland Health Connection, Washington Healthplanfinder—offer both integrated provider and prescription drug directories. These features enable consumers to search and filter for plans based on key areas of suitability, such as the inclusion of preferred providers or the coverage and cost sharing corresponding to their prescribed medications.

- Four exchanges—Access Health CT, Covered California, Healthsource RI, Massachusetts Health Connector—offer integrated provider directories but not prescription drug formularies.

- Ten exchanges—Access Health CT, Connect for Health Colorado, Covered California, DC Health Link, Healthcare. gov, Healthsource RI, MNSure, Vermont Health Connect, Washington Healthplanfinder, Your Health Idaho—offer an out-of-pocket cost calculator, which provide consumers with a cost estimate of total annual out-of-pocket costs (premiums, deductibles, and cost sharing). However, the exchanges vary significantly in the factors considered for their cost estimates and the results provided to consumers. In the cost calculator category, none of the exchanges received an "A" grade for optimal decision-support.

- All insurance exchange websites, with the exception of Massachusetts Health Connector and Vermont Health Connect, now offer complete website translation services into Spanish with one click, including for the window shopping tool.

The technology gap between private exchanges and government-run exchanges will continue to widen. As insurers in all lines find new ways to interact with their customers, government entities face a variety of challenges including laws and regulations that become out dated, technology resource issues, and the general inability of any government to respond to market demands.

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