

ADVANCING PATIENT SOLUTIONS FOR LOWER COSTS AND BETTER CARE

HEARING BEFORE THE SUBCOMMITTEE ON HEALTH OF THE COMMITTEE ON ENERGY AND COMMERCE HOUSE OF REPRESENTATIVES ONE HUNDRED FOURTEENTH CONGRESS SECOND SESSION

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ADVANCING PATIENT SOLUTIONS FOR LOWER COSTS AND BETTER CARE

Friday, June 10, 2016

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

The subcommittee met, pursuant to call, at 9:16 a.m., in room 2322, Rayburn House Office Building, Hon. Joseph R. Pitts (chairman of the subcommittee) presiding.

Present: Representatives Pitts, Guthrie, Murphy, Burgess, Blackburn, Lance, Griffith, Bilirakis, Bucshon, Brooks, Green, Schakowsky, Castor, Sarbanes, Matsui, Schrader, Kennedy, Cardenas, and Pallone (ex officio).

Staff Present: Adam Buckalew, Professional Staff Member; Paul Eddatel, Chief Counsel, Health; Bob Mabry, Fellow, Health; Graham Pittman, Legislative Clerk, Health; Jennifer Sherman, Press Secretary; Heidi Stirrup, Policy Coordinator, Health; Josh Trent, Deputy Chief Health Counsel; Dylan Vorbach, Assistant Press Secretary; Jeff Carroll, Minority Staff Director; Tiffany Guarascio, Minority Deputy Staff Director and Chief Health Advisor; Samantha Satchell, Minority Policy Analyst; Andrew Souvall, Minority Director of Communications, Outreach and Member Services; Arielle Woronoff, Minority Health Counsel; and C.J. Young, Minority Press Secretary.

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

Mr. PITTS. Good morning. The subcommittee will come to order. The chair will recognize himself for an opening statement.

Today's hearing will examine legislation designed to modernize the current health insurance market by empowering states to better regulate markets tailored to their unique conditions. Previously, this committee examined healthcare solutions that centered on promoting patient choice and innovation in the design of health coverage. This hearing is a natural follow-on to that.

Current law is leading to an increase in healthcare premiums. Double-digit premium increases are hurting, not helping patients. It is no surprise that a recent Gallup poll revealed that healthcare costs top American families' financial concerns. Almost daily, headlines across the country offer frightening news on healthcare cost. This undoubtedly is contributing to the fears of the American people.

And here are some of the numbers. In Virginia, nine insurers are looking to raise premiums at high as 37.1 percent. Three of the requests in Oregon are over 29.6 percent. One plan in New York is asking for a shocking 89 percent increase. For Texas, the biggest plan wants to raise its rate 60 percent. In Colorado, Golden Rule is seeking a 40.6 percent hike, Rocky Mountain HMO is seeking a 34.6 percent boost, and Colorado Choice wants a 36.3 percent increase. Connecticut has three plans wanting increases from 12 to 27 percent. In my home State of Pennsylvania, one insurer is seeking a 48 percent increase, while the insurance department says the average request is 23.6 percent for individual plans.

And this is why we are here today—to offer better care at a fair price. Our solutions aim to help patients stabilize the insurance markets, restore flexibility, provide more choices, and keep costs in check.

Health care is the most personal of any political issue. When Congress gets involved in health policy, we are changing people's lives. Decisions we make in Washington can have a tremendous effect on the well-being of families and their budgets. States, on the other hand, are great innovators. When given the flexibility to tailor coverage and conditions, patients are the winners, with greater choices and more affordable options.

The five bills before us today offer a variety of options to begin to reduce cost, including the Flores bill to align grace periods, the Blackburn bill, which requires eligibility verification, the Brooks bill, which adjusts age rating ratio for healthcare pricing, the Griffith-DeGette bill that allows individuals and families to purchase stand-alone dental plans either on or off the exchanges, and the Rick Allen bill, which establishes an audit process for failed state exchanges.

Any unallocated or misspent Federal funds would be returned to the U.S. Treasury. The first thing health reform should accomplish is to stabilize or reduce the cost of health care. The number one complaint people have about health care is the rising cost.

Yet the current law has done little to decrease healthcare spending. In fact, many Americans are paying higher premiums and deductibles for health insurance and care as a result of the law. We can do better. We must make healthcare costs more transparent, give people the freedom to choose the insurance they want, with the benefits they value most, at a price that is fair.

More government bureaucracy, regulations, and spending never successfully reduce the price of health care. Yet, that is exactly the premise of how health insurance is regulated today, with top-down mandates that empower Washington and remove control over healthcare decisions from States, small businesses, families, and individuals. And this has to be changed if we truly want bottom-up solutions that provide better care at lower costs for patients. The bills before our committee today will do just that.

Is there anyone seeking recognition on our side?

[The prepared statement of Mr. Pitts follows:]

PREPARED STATEMENT OF HON. JOSEPH R. PITTS

The Subcommittee will come to order.

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Current law is leading to an increase in health care premiums. Double-digit premiums increases are hurting, not helping, patients. It's no surprise that a recent Gallup poll revealed that health care costs top American families' financial concerns. Almost daily, headlines across the country offer frightening news on health care costs. This undoubtedly is contributing to the fears of the American people.

Here are some of the numbers:

- In Virginia, nine insurers are looking to raise premiums as high as 37.1 percent.
- Three of the requests in Oregon are over 29.6 percent.
- One plan in New York is asking for a shocking 89 percent increase.
- For Texas, the biggest plan wants to raise its rates 60 percent.
- In Colorado, Golden Rule is seeking a 40.6 percent hike, Rocky Mountain HMO is seeking a 34.6 percent boost and Colorado Choice wants a 36.3 percent increase.
- Connecticut has three plans wanting increases from 12 to 27 percent.
- And in my home state of Pennsylvania, one insurer is seeking a 48 percent increase, while the Insurance Department says the average request is 23.6 percent for individual plans.

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The five bills before us today offer a variety of options to begin to reduce costs—including the Flores bill to align grace periods; the Blackburn bill which requires eligibility verification; the Brooks bill which adjusts age-rating ratio for health care pricing; the Griffith/DeGette bill that allows individuals and families to purchase stand-alone dental plans either on or off the exchanges; and the Rick Allen bill which establishes an audit process for failed State exchanges. Any unallocated or misspent Federal funds would be returned to the U.S. Treasury.

The first thing health reform should accomplish is to stabilize or reduce the costs of health care. The number one complaint people have about health care is the rising cost, and yet the current law has done little to decrease health care spending. In fact, many Americans are paying higher premiums and deductibles for health insurance and care as a result of the law.

We can do better. We must make health care costs more transparent and give people the freedom to choose the insurance that they want—with the benefits they value most at a price that is fair.

More government bureaucracy, regulations, and spending never successfully reduce the price of health care. Yet that is exactly the premise of how health insurance is regulated today—with top down mandates that empower Washington and remove control over health care decisions from states, small businesses, families and individuals. This has to be changed if we truly want bottom up solutions that provide better care at lower costs for patients.

The bills before our committee today will do just that. I yield back.

Mr. PITTS. With that, I will yield back and recognize the ranking member, Mr. Green, 5 minutes for an opening statement.

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

Mr. GREEN. Thank you, Mr. Chairman. And I agree that the increases that are requested, although having served as a State legislator in Texas in the 1970s and 1980s and the very early 1990s, I think we saw the same requests. Of course the health insurance market was not regulated in the State of Texas. But as a small-business manager, we saw 25, 30 percent increases over the years.

So increase in health insurance cost is not new to the American public.

Prior to the Affordable Care Act, the individual market on health care was deeply broken. People were sold junk plans at high cost. Individuals with preexisting conditions were essentially locked out of the market altogether. Women would be charged more just because of their gender. And plans could drop you at the moment you got sick, the time when you need the coverage the most.

Three years after the Affordable Care Act, major health expansion went into effect. Approximately 13 million people have coverage through the marketplace and 15 more through coverage of Medicaid. Since the law was enacted in 2010, 20 million more Americans are no longer uninsured and the uninsured rate is at a historic low. Both the newly insured and previously insured are protected from the worst abuses of issuers and what plans must cover is significantly more robust than ever.

Overall, the coverage expansions are improving Americans' access to health care, the marketplaces are competitive and creating value for customers, and premium stabilization programs are working. The evidence is clear that the ACA is a success. The majority of people enrolled in marketplace plans or Medicaid report that they would not have been able to access or afford their care prior to getting their new insurance.

It is important to recognize that marketplaces created under the Affordable Care Act are in their relative infancy. As with almost every new market, particularly in the healthcare space, there will changes and adjustments in early years. Insurers will both enter and exit as they navigate the landscape to the millions of new consumers, protections, and requirements. Medicare, when it was first created, experienced growing pains, as did Medicaid Advantage and part D plans.

The Affordable Care Act is working. But like any law, it is not perfect. As I have been known to say, if you want something done perfectly, don't come to Congress. That is why, after passing major reforms, Congress revisits legislation coming together and improve on it.

Of the five proposals we are considering today, aligning children's dental health coverage stands out as a bipartisan bill that has improved pediatric dental coverage. I am supportive of this legislation and appreciate that the committee is paying attention to this important technical fix for children. However, I am concerned that this bill was included in the legislative hearing evaluating several more controversial and I think irresponsible plans.

The other legislative proposals we are considering today constitute a step backwards for consumers by forcing people out of the exchanges, making it more difficult for consumers to access affordable coverage using premium tax credits. We should be looking for ways to make the law work better on behalf of the American people rather than roll back reforms and protections designed to get more value from hard-earned dollars spent on coverage and put insurance back in charge at the expense of the consumers.

Making it easier and more attractive to get coverage, expanding Medicaid, targeted outreach, these are ways to bring more stability and affordability to the health insurance market. Instead, most of

the bills we are considering today will make it harder for people to get coverage, more expensive for people who need insurance, or only serve to help insurance companies rather than people.

Health insurance is a product that Americans want and need and the Affordable Care Act is creating a system that lends truth to the principle that health care is not a privilege for the few but a right for all Americans. And while I welcome productive conversation on how to improve and make the ACA even better, we must not do anything that would undermine the progress that this important law has already made.

And I look forward to hearing from our witnesses, Mr. Chairman, and I yield back.

Mr. PITTS. The chair thanks the gentleman.

Now filling in for the chairman of the full committee, Dr. Burgess, 5 minutes for an opening statement.

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

Mr. BURGESS. Thank you, Mr. Chairman.

This is a very good hearing for us to be having right now and I am very grateful that you have called it. I am very grateful for the members that have participated and provided us bills for consideration today. We have got an excellent panel of witnesses in front of us this morning, with whom I have either agreed or disagreed over the years, but I know them to all be the best of the very best in healthcare policy, and I am looking forward to their testimony this morning.

Regardless of how you feel about the Affordable Care Act, I don't think there is any question that the fractures are becoming apparent and they are growing. And somewhat ironically, at the very last weeks of the Obama administration, these fractures are likely to become fractures and real people are going to be affected by those fractures.

It is important that we be talking and we be talking now about what we can do to help people when those inevitable failures do occur. The bills in front of us today make significant moves towards fixing some of those problems, but I am also anxious to hear from our witnesses what they see when they look over the horizon, not just for next year, but the year after, the year after. If something does not change, the likelihood is that we will have some very profound and real difficulties within the insurance market, within the provider space, and of course for patients themselves in this country.

So, Mr. Chairman, I think you are to be commended for holding the hearing today. Certainly you have put a great panel of witnesses in front of us. And I will now yield to one of the authors of the bill, Mr. Griffith from Virginia, for his comments.

Mr. GRIFFITH. Thank you, Mr. Chairman.

And thank you, Mr. Burgess. I appreciate that very much.

I just want to let folks know that my little bill along with Diana DeGette, 3463, will in fact level the playing field by applying the same rules to coverage options for dental care offered on the exchange and off the exchange. Currently, unfortunately, the way the language has been interpreted, you can buy a stand-alone dental

plan if you are in the exchange, but if you are out of the exchange it has to be wrapped into your health insurance.

Oftentimes parents want to buy a better pediatric dental care plan for their kids than what is offered in a basic health plan. And so this bill would allow them that option and allow them to go out and buy a stand-alone dental along with a health insurance plan that otherwise qualifies except for the dental portions so that they are not just having their children's dental care taken care of after deductibles are met or taking care of for cleanings but not for filling cavities, et cetera.

I think it is a good bill. And I appreciate Mr. Green saying that they recognize that it is an attempt to fix a little glitch and is a bipartisan bill.

And with that I would be happy to yield to anyone else that wishes time.

Mr. PITTS. Anyone?

Mr. GRIFFITH. I yield back to Dr. Burgess.

Mr. BURGESS. I yield back to the chair.

Mr. PITTS. The chair thanks the gentleman.

I now recognize the ranking member of the full committee, Mr. Pallone, 5 minutes for an opening statement.

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

Mr. PALLONE. Thank you, Mr. Chairman.

Congress passed the Affordable Care Act to ensure that all Americans had access to affordable quality health insurance and the goal was to achieve universal health coverage. Six years later, our uninsured rate is at an all-time low and our uninsured rate among young adults has dropped by 47 percent. Twenty million more people now have health insurance, and a new University of Michigan study shows that the ACA has reduced racial and ethnic disparities in coverage.

And this is all good news. But we have a lot more to do. I believe there are ways we can strengthen and improve the law. However, I am concerned that this hearing is taking a cynical approach to doing so. Rather than have a legislative hearing on bills that would help get more people health coverage, three of the bills being discussed today are designed to make it more difficult for people to get healthcare coverage.

One of the bills we are reviewing today would allow insurance companies to charge premiums that are five times as much for older Americans. Even more troubling, under this bill, a State could establish an age ratio even higher than 5:1. Many older Americans can't afford to pay five times as much as people who are younger than they, and we purposely included in the ACA ways to ensure that younger people have access to health insurance, such as staying on their parents' plan until the age of 26. So I am concerned this will force older Americans to go without coverage at a time when they need it the most.

There are also potential unintended consequences. Studies have shown the 5:1 age rating band charges overcharges older consumers and undercharges younger consumers. Meanwhile, the in-

creased tax credits to accommodate these higher rates for older Americans could cost billions of dollars.

Another bill we are reviewing today would make it more difficult for people to enroll in coverage during a special enrollment period, known as an SEP. SEPs are necessary for people to enroll in coverage when something changes in their lives outside of the open enrollment period.

It is important for SEPs to maintain some flexibility so that individuals can get coverage in a reasonable amount of time as they transition through important life events, such as the birth of a child, a marriage, or a permanent move. We have heard from insurers that SEPs aren't strict enough and are subject to gaming, and that is why the administration has taken major steps to prevent this. They have eliminated seven SEP categories and now require documentation to prove SEP eligibility for the five most common life events.

In addition, starting June 17, CMS will require individuals asking to enroll in coverage through an SEP to provide documentation by a specific deadline. The individual will lose their coverage if the appropriate documentation is not received in time or is incorrect, and these are reasonable guardrails.

Yet, although CMS is implementing stricter verification requirements, this bill goes a step further and requires someone to prove their eligibility for an SEP prior to gaining coverage, and I am concerned that collecting and submitting this documentation may prove difficult and could lead to gaps in health coverage. Cancer patients can't wait a month to get their health treatments.

In addition, the Urban Institute estimates that fewer than 15 percent of people eligible for SEPs use them to enroll in marketplace coverage and the rest are likely to remain uninsured. So I worry that stricter documentation requirements could deter all but the sickest individuals, since they are the most motivated to get coverage, while healthy individuals may choose to remain uninsured, and creating more barriers to access is only going to serve to keep more people out of the insurance market.

I am also concerned by the bill that would shorten the grace period for those lower-income Americans who qualify for tax credits. Grace periods were put in because many of the people who were signing up are doing so for the first time. That population that is eligible for tax credits is also lower income and has more fluctuation in income, which is why we wanted to give them a chance to keep their insurance as part of the ACA. And under the bill before us today, just one missed or partial premium payment would result in someone losing their coverage until the next year, and this isn't good for consumers.

I think I will yield. I have less than a minute left, and I would like to yield that to Ms. Matsui.

Ms. MATSUI. Thank you, Mr. Pallone.

Because of the passage of the ACA, millions of American families have access to affordable quality health care and our country's overall uninsured rate has fallen to a historic low. We have come a long way from the days when patients were denied care because of preexisting conditions and young people were left without coverage as they searched for employment.

There is much we can and should be doing to build on the success of the ACA and keep moving our health system forward and ensuring that patients get the right care at the right time in an efficient way. We can continue looking at models of care that reimburse value over volume. We can infuse technology into medical practice and more.

Some bills we are considering today would, unfortunately, reverse some of the important progress we have made. I oppose any legislation that disrupts the continuity of care for patients. As families seek health insurance, we cannot make the process more burdensome for them by asking them to jump through unnecessary hoops. I hope that instead we can continue to build on the progress of the ACA in a way that benefits American families.

Thank you, Mr. Chairman. I yield back.

Mr. PITTS. The chair thanks the gentlelady.

As usual, all the members' written opening statements will be made a part of the record.

I have a UC request. I would like to submit the following documents for the record: statements from AARP, the Association of Mature American Citizens, a group of seven organizations on H.R. 3463, and the Blue Cross/Blue Shield Association.

Mr. GREEN. No objection.

Mr. PITTS. Without objection, so ordered.

Mr. GREEN. Mr. Chairman, we also have some to submit for the record. Letters from the American Federation of State, County, and Municipal Employees, the AFL-CIO—and I think AARP sent us both the same letter—and the Alliance on Retired Americans, I would like to ask unanimous consent to place in the record.

Mr. PITTS. Without objection, so ordered.

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

Mr. PITTS. At this time, I will introduce our panel of experts. We have three witnesses. I will introduce them in the order of their testimony. And your written statements will be made a part of the report. You will be each given 5 minutes to summarize your testimony.

On our panel today we have, first, Ms. Grace-Marie Turner, founder, president, and trustee of the Galen Institute; secondly, Mr. Douglas Holtz-Eakin, president of the American Action Forum; and finally Ms. Sara Collins, vice president of health coverage and access, Commonwealth Fund.

Thank you very much for coming today.

And at this point, Ms. Turner, you are recognized for 5 minutes for your summary.

STATEMENTS OF GRACE-MARIE TURNER, FOUNDER, PRESIDENT AND TRUSTEE, GALEN INSTITUTE, INC.; DOUG HOLTZEAKIN, PRESIDENT, AMERICAN ACTION FORUM; AND SARA COLLINS, VICE PRESIDENT OF HEALTH COVERAGE AND ACCESS, COMMONWEALTH FUND

STATEMENT OF GRACE-MARIE TURNER

Ms. TURNER. Thank you, Chairman Pitts, thank you, Ranking Member Green and members of the committee, for the opportunity

to testify today on legislation that I believe would advance patient solutions for lower costs and better care.

The ACA was designed to provide people with choices of private insurance, with States in the forefront of organizing a new system of coverage. States had had decades of experience in regulating health insurance, but a battery of ACA rules really overrides these State laws that have been forged by decades of experience and I believe really threaten the future of the ACA and its stability.

For health insurance to attract customers, policies must be affordable, and everyone in the pool must pay their premiums over time so that their insurance coverage is there to pay their bills. If people only purchase health insurance when they need expensive care, the pools break down. It would be like allowing a family to purchase health insurance only when their house is on fire. If too few younger people purchase health insurance, costs will soar and many of the young people will continue to drop out, increasing coverage for everyone, and that is one of the problems, I believe, with the age rating provisions in the ACA.

Under these rules, insurers can charge their oldest policyholders no more than three times their youngest customers. However, the average 64-year-old consumes six times more, in dollar value and health costs, than the average 21-year-old.

One of the top experts on the workings of the ACA is Timothy Jost. He noted early on that age rating compression is going to force younger people to pay more in the individual market as older individuals pay less, making insurance too expensive for younger people. And we need people, not just the 26-year-olds, but people that are up to 35, 40 years old in these pools. They drop out and it means that health insurance actually costs more for older people as we wind up seeing a spiral.

Likewise, the special enrollment verification are designed to help people, as you said, Mr. Green, to obtain health insurance coverage through major life events, but we are finding that more and more people are purchasing health insurance when they need medical care and then dropping it after they receive the medical services they need. This really undermines the concept of insurance.

The claim costs, according to the actuarial firm Oliver Wyman, found that in the first 3 months in 2014, for people enrolling in the special enrollment periods, their claims costs times were 24 percent higher than those who had enrolled during the regular enrollment period. In 2015, the difference increased to 41 percent. And these people are more than twice as likely to drop their policies after a short period of time.

The administration has indeed taken preliminary steps to verify eligibility, but more needs to be done. I commend Congresswoman Marsha Blackburn for taking the lead on legislation to verify eligibility before allowing an individual to enroll in an exchange via the special enrollment period.

Robert Pear has a piece in today's New York Times talking about the expected significant increases in many places in 2017 for premium increases, and talking with experts and actuaries from Geisinger, for example, about why this is happening, and they are finding that people are gaming the system also through these grace

periods. The law allows people to stop paying their premiums and still obtain coverage for another 90 days.

Unfortunately, the incentives are basically designed to undermine the concept of real insurance. McKinsey & Company found that nearly a quarter of consumers stopped payment on their premiums in 2015, yet most repurchased a plan in the exchange the next year, many of them the same plans, without the need to pay their back premiums. Insurers must build the cost of this non-payment of premiums into their costs for the following year, and this raises premium costs for everyone.

Additionally, doctors and hospitals are on the hook to continue to provide coverage even for those patients who are no longer insured. Representative Flores' legislation would end this abuse by aligning the grace period for nonpayment of premiums before coverage ends with grace periods under State law. A 30-day rule would provide greater incentive for people to keep and maintain coverage, basically the standard in State law before the ACA overruled this legislation.

Also, the failed State health exchanges, I think, is really an important issue to address. I know that your committee has issued a report, "Misleading Congress," on this particular issue, focusing on the testimony by Acting CMS Administrator Andy Slavitt. States have decided that they can sue their IT managers who set up their Web sites when their Web sites have failed, and then they want to keep that money. That is really an abuse of taxpayer dollars.

The Federal Government spent \$5.5 billion in helping these States to set up their own exchanges. Oregon received approximately \$305 million to establish an exchange. If it wins this lawsuit, it wants to keep the money. That is really not something that serves taxpayers well.

And then finally, I also commend Representative Griffith and also Representative DeGette for your legislation, bipartisan legislation, to address the issue of really streamlining and unifying the dental plans for pediatric dental care.

Thank you, Mr. Chairman. I will look forward to your questions.
[The prepared statement of Ms. Turner follows:]



A not-for-profit health and tax policy research organization

**Testimony before the
Energy & Commerce Committee
Subcommittee on Health**

United States House of Representatives

**Rep. Joseph R. Pitts, Chairman
Rep. Gene Green, Ranking Member**

Hearing on

Advancing Patient Solutions for Lower Costs and Better Care

June 10, 2016

**Testimony presented by
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*Advancing Patient Solutions for Lower Costs and Better Care***Energy and Commerce Subcommittee on Health****June 10, 2016****Grace-Marie Turner, Galen Institute**

Chairman Pitts, Ranking Member Green, and members of the committee, thank you for the opportunity to testify today on five pieces of legislation designed to Advance Patient Solutions for Lower Costs and Better Care

My name is Grace-Marie Turner, and I am president of the Galen Institute, a non-profit research organization focusing on patient-centered health policy reform. I served as an appointee to the Medicaid Commission from 2005-2006, as a member of the Advisory Board of the Agency for Healthcare Research and Quality from 2005 to 2007, and as a congressional appointee to the Long Term Care Commission in 2013.

The ACA was designed to provide people with choices of private insurance, with states at the forefront of organizing this new system of coverage. States have had decades of experience in regulating health insurance, but a battery of ACA rules overrides state laws that have been forged by experience to keep insurance pools stable.

Today, I will discuss ways in which the Affordable Care Act (ACA) is not working as planned, undermining its original goals of providing universal coverage through stable, affordable health insurance. I will focus on five problems and proposed legislation designed to address them: flawed age rating bands, a lack of verification of qualifications for special enrollment periods, abuse of the grace period for health insurance premium payment, waste of taxpayer dollars on failed state exchanges, and the need for a technical correction involving pediatric dental care.

AGE RATING

Avik S.A. Roy testified before your hearing on May 11, 2016, and explained why the 3:1 age band rating in the Affordable Care Act is backfiring:

Forcing the young to pay more drives costs up for everyone. The average 64-year-old consumes six times as much health care, in dollar value, as the average 21-year-old. Hence, in an underwritten (i.e., actuarially priced) insurance market, insurance premiums for 64-year-olds are roughly six times as costly as those for 21-year-olds.

Under the ACA, policies are age-rated; i.e., insurers cannot charge their oldest policyholders more than three times what they charge their youngest customers. If every customer remains in the insurance market, this has the net effect of increasing premiums for 21-year-olds by 75 percent, and reducing them for 64-year-olds by 13 percent.

However, if half of the 21-year-olds recognize this development as a bad deal for them, and drop out of the market, adverse selection ensues, driving up the average health care consumption per policyholder, thereby driving premiums up for everyone, including the 64-year-olds who were supposed to benefit from 3:1 age rating.

In an attempt to mitigate this problem, the ACA includes an individual mandate...In theory, the individual mandate's fine should force these younger individuals to purchase health coverage, even if that coverage is far more expensive than their actual health care consumption. In reality, however, the ACA's individual mandate is too weak, representing a fraction of the cost of ACA-based coverage. As a result, younger and healthier individuals have disproportionately avoided the exchanges.¹

Before passage of the ACA, 42 states allowed health insurance rates to vary by age by a ratio of 5:1 or more. In a state with a 5:1 age band, the ratio limits the amount an older individual will pay to no more than five times what a younger individual pays in premium dollars. This 5:1 ratio was based upon vast experiential data that shows utilization of health care services is broadly correlated with age. These higher age ratios strike a careful balance: they provide protection to older consumers without making it impractical for younger consumers to purchase insurance. Making health insurance too expensive for the healthier young people we want in the insurance pools drives them away, increasing the cost of insurance for everyone who remains.

The ACA restricts age bands in all states to a ratio no greater than 3:1. The result was predictable. The Congressional Budget Office reported this year that enrollment in ACA exchanges was far below projections.² Healthy young people have been the hardest to attract. Fewer than 40% of enrollees are younger than 35, though 50% of the potential exchange population is in this age bracket, reflecting a missed opportunity to enroll young, healthy consumers.³

One of the top experts on the workings of the ACA is Timothy Jost. He noted early on that age rating compression "is going to force younger people to pay more in the individual market as older individuals pay less."⁴ As younger, healthier individuals are discouraged from buying insurance because of the high cost, an adverse market spiral happens in which costs rise for those who keep coverage, thereby serving to further discourage younger, healthier individuals from keeping or obtaining coverage. The premium increases we are seeing for next year are at least partly attributable to the ACA's restricted age rating bands.

Because affordability is such a high priority in stabilizing the health insurance system in the United States, action must be taken to bring young people back into insurance pools rather than drive them away. Rep. Susan Brooks is the lead sponsor on legislation to address the ACA's age-rating bands. Her bill would defer to the states to decide rating bands, starting in January 1, 2018. If a state does not have a law addressing the issue, the 5:1 ratio would prevail.

This is an important step toward the goal of making health insurance more affordable by attracting the larger number of the healthy young people needed to stabilize health insurance pools.

SPECIAL ENROLLMENT VERIFICATION

In testimony before this committee in May, American Enterprise Institute Scholar Scott Gottlieb said he believes that “some of our current cost challenges show the shortcomings that come from not having defined enrollment periods as a way to also help maintain a stable risk pool.”

He explained that: “One recent analysis, undertaken to evaluate the impact that special enrollment periods have on the non-group market, confirmed that these constructs skew the overall risk pool, ultimately leading to a higher cost and a less stable market.”⁵

Special Enrollment Periods are designed to help people obtain and maintain health insurance coverage through important life events, such as job changes, moving to another state, marriage, birth of a baby, etc. The Obama administration has created more than 30 special enrollment categories and sent emails to millions of Americans last year urging them to see if they might be eligible to sign up after the annual open enrollment deadline. But the administration has done little to verify whether late arrivals were in fact eligible under the special enrollment criteria.

Evidence shows that many Americans have figured out how to game the system by taking advantage of generous special enrollment period rules. A growing number of individuals are purchasing health insurance only when they need medical care and then are dropping it after they receive the medical services they need. This undermines the concept of insurance, drives up costs, increases premiums, and discourages healthy people from purchasing continuous health coverage.

An analysis compiled by the actuarial consulting firm Oliver Wyman found that:⁶

- The average per member per month (PMPM) claim costs for special enrollment period (SEP) enrollees in 2014 was 24% higher on average during the first three months of enrollment than for open enrollment period (OEP) enrollees
- In 2015, the difference in PMPM claims costs increased to 41% for the first three months of enrollment
- SEP enrollees that chose plans with the highest actuarial values showed especially high costs during the first month of enrollment.

At the end of 2014, SEP enrollees represented nearly 20% of total enrollees in the non-group, ACA-compliant market. Data from one plan show that individuals enrolling through a special enrollment period are more than twice as likely to drop their coverage after a short period of time as those who enroll during the annual open enrollment period.⁷

A recent Covered California report also found that “there are credible indications that the risk mix of special enrollment period enrollment is higher cost than those of Open Enrollment and that some of that difference is likely attributed to individuals inappropriately claiming special enrollment period events.”⁸ California found that the cost differential between special

enrollment period enrollees and open enrollment period enrollees ranged from 15% to 50% higher, based upon data from the state's largest four health plans.

The administration has taken preliminary steps to verify eligibility, but much more needs to be done. I commend Rep. Marsha Blackburn for taking the lead on legislation to verify eligibility before allowing an individual to enroll in an exchange via special enrollment period rules.

The goal should be not only for people to get covered, but for people to stay covered. This not only will contribute to stabilizing insurance pools and thereby controlling costs but also to providing incentives for people to maintain continuous coverage so they can benefit from preventive care and coordinated services to help manage their health and medical conditions.

THE GRACE PERIOD

People have learned they can game the system through another ACA rule. The law allows people to stop paying premiums and still obtain medical services for another 90 days. This "grace period" allows someone to stop paying premiums on October 1 and still maintain coverage through the end of the year. The individual can sign up for new coverage during the open-enrollment period for a policy that begins on January 1. That means a person can have a full year of coverage and pay only nine months of premiums.

There is no obligation for people to pay their unpaid premiums from the prior year before re-enrolling in coverage the next year—even if they are enrolling in the same plan. The incentives here are basically *designed* to undermine the concept of real insurance.

The Centers for Medicare & Medicaid Services (CMS) regulations and guidance about the grace period work this way:

- In the first month an enrollee fails to pay premiums, insurers must pay qualifying claims for medical services rendered to the enrollee
- In the second and third months of the grace period, insurers may withhold payment for claims, but the patient is still "insured" and cannot be billed by providers
- If the enrollee fails to pay all of the required premiums by the end of 90 days, the enrollee's coverage can be terminated. Insurers may then reject claims from the second and third months of the grace period, and providers may then try to collect payment from the enrollee for medical services they received during this time.

Independent studies show people have figured out how to use the grace period to their advantage, but to the disadvantage of a stable health insurance system:

- A national consumer survey by McKinsey and Company⁹ found that nearly a quarter of consumers stopped payment on their premiums in 2015, yet most repurchased an

exchange plan in 2016, and many repurchased coverage from the same health plan

- 18% of consumers stopped paying their premium in 2015 and then reenrolled again in 2016. Half of these consumers returned to the same plan they stopped payment for in 2015. Forty-five percent said they had stopped making payments in 2014, too.

Abuse of the grace period is undermining the concept of insurance and driving up the cost of coverage for others. Insurers must build the cost of non-payment of premiums into their premiums for the following year, increasing costs for those enrollees who play by the rules.

Doctors and hospitals are on the hook to continue treatment, even if the patient has stopped paying insurance premiums and the coverage has stopped. Many say they cannot continue to provide care to the growing number of exchange enrollees who are using the grace period to get “free” care.

Rep. Bill Flores is sponsoring legislation to end abuse of this provision of the Affordable Care Act by aligning the grace period for non-payment of premiums before coverage ends with grace periods under state laws. A 30-day rule would provide a greater incentive for people to keep and maintain coverage, and that was basically the standard in state law before passage of the ACA.

FAILED HEALTH EXCHANGES

States that decided to set up their own ACA exchanges were awarded more than \$5.5 billion in federal money to create them. Some states succeeded in creating functional exchanges, but the majority failed—from Massachusetts to Maryland, New Mexico to Nevada, and Oregon to Hawaii.

Oregon, which received approximately \$305 million to establish its exchange, terminated it entirely and opted to use the healthcare.gov federal exchange instead. Massachusetts was given more than \$200 to create an ACA exchange after successfully developing an exchange for its previously-created state health reform program. But the federal exchange failed miserably in the Bay State, with serious problems in determining eligibility and illegally enrolling hundreds of thousands of residents in Medicaid.

Several states, including Oregon, have filed lawsuits against the information technology contractors that helped build their exchange web sites. State officials also have indicated that if they collect any money from the lawsuit, the states want to keep the money instead of sending it back to the federal taxpayers who provided the funds in the first place. This clearly is an abuse and misuse of federal tax dollars.

Your committee released a report, “Misleading Congress: CMS Acting Administrator Offers False Testimony to Congress on State Exchanges,”¹⁰ that documented how CMS Acting Administrator Andy Slavitt gave misleading testimony to Congress on this issue. He testified under oath that state based exchanges returned more than \$200 million in grant funds to the

federal government. However, CMS documents do not support his claim, showing that the federal government has reclaimed only \$21.5 million from 17 exchanges.

Congressman Rick Allen is sponsoring legislation, the “Transparency and Accountability of Failed Exchanges Act,” that would require an audit of a state exchange when it fails and establish a procedure to require states to return any unspent funds to the federal treasury. The federal government also would be able to dispose of real property or repurpose it and deposit the funds in the federal treasury.

It is clear that Congress needs to continue to provide oversight and hold the Obama administration and the states accountable for what is likely to be hundreds of millions of dollars in lost and misspent federal funds on failed state exchanges.

FREE-STANDING DENTAL PLANS

Finally, Reps. Morgan Griffith and Diana DeGette are sponsoring bi-partisan legislation that would expand consumer choice in pediatric dental coverage. This clarifying legislation would allow individuals and families to purchase dental coverage, including pediatric benefits, through a stand-alone dental plan offered outside an ACA exchange. Currently, these stand-alone plans are allowed only for coverage offered inside an exchange. The Griffith-DeGette bill would level the playing field by applying the same rules to exchange plans and off-exchange plans.

“We hear from our members that their clients continue to express confusion regarding dental benefits,” the National Association of Health Underwriters wrote in a letter endorsing the bill. “This legislation would give consumers more choices when shopping for dental coverage and eliminate confusion in the marketplaces outside the public exchanges.”

This clarification is needed to establish that the offer of stand-alone pediatric dental coverage for policies offered outside an exchange is treated the same as coverage inside the exchange.

IN CONCLUSION

For health insurance to attract customers, the policies must be affordable, and everyone in the pool must pay their premiums over time so their insurance coverage is there to pay their bills if they need expensive medical services. If people only purchase health insurance when they need expensive care, the pools break down. It would be like allowing a family to purchase homeowners insurance only when their house is on fire. If the current trajectory with these ACA rules continues, costs will soar, more and more healthy young people will drop out, and the Affordable Care Act will fail in its goal of providing stable, affordable health coverage.

The Galen Institute is not officially endorsing these bills because we are prohibited from doing so by our 501c3 tax status. However, we believe the concepts behind them are sound and that they would begin the process of undoing some of the damage that the ACA has done to the

private health insurance market and that the bills would advance patient solutions for lower costs and better care.

Thank you for the opportunity to offer this testimony today, and I look forward to your questions.

ENDNOTES

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Mr. PITTS. The chair thanks the gentlelady.

And I now recognize Mr. Holtz-Eakin 5 minutes for his summary.

STATEMENT OF DOUG HOLTZ-EAKIN

Mr. HOLTZ-EAKIN. Thank you, Chairman Pitts, Ranking Member Green, and members of the committee for the privilege of being here to discuss these five proposals to make changes to the Affordable Care Act in the interest of having State insurance markets work more efficiently and protecting taxpayer dollars. I think these are important issues.

Let me begin with the issue of restrictions in the age variation of premiums. The ACA does restrict the variation to a ratio of 3:1, of the oldest versus the youngest, and the proposal is to allow this to go to 5:1 or a number that the State would pick. This matches some things that we know about the operation of insurance markets. It matches the ratio of average spending of 64-year-olds to 21-year-olds in a recent CBO study, in February 2016.

We know from work we have done at the American Action Forum that this would lower premiums for younger purchasers of insurance by something like 6 to 8 percent for single individuals, by 7 to 10 percent for families. That would bring millions of additional young and healthy people into these exchange pools.

That is something that the ACA needs. Right now, only about 28 percent of the pool is 18- to 34-year-olds versus 36 percent of the eligible population. The absence of those low-risk purchasers is one of the problems in the ACA. And older purchasers of insurance would benefit over the long term from this change because, without those balanced pools, we are going to see increasingly higher premiums that older and sicker individuals will have to face for their insurance. So this is something that would stabilize those risk pools, bring people in that the ACA exchanges need, and benefit everyone in the long run.

The special enrollment periods. It is a sensible request that we require verification prior to having the insurance. The purpose of a special enrollment period is to allow coverage for those people who are eligible for coverage, and it is a sensible thing to verify eligibility.

It also turns out to be quantitatively important. About a fifth of the people in the exchanges got there through a special enrollment period, through a SEP, and these turn out to be more expensive risks in the pool. They are anywhere from 10 to 55 percent more expensive depending on which source you go to. They appear to be becoming increasingly more expensive over time, and thus their impact as an issue of shifting cost to others and pushing premiums up, is becoming more important, and understanding their eligibility is important.

And they are much more likely to lapse in their premium payments. And so this is a population that is, in its practice of purchasing insurance and letting it lapse, shifting their costs to others, undermining the functioning of an insurance market. And I think it is a good idea for the committee to look closely at this.

Finally, the grace periods and their impact I think are important as well. The proposal to change from 90 days to 30 or 31 to match

State law does provide some basic equity between those who buy their individual market policy on the exchange versus those who buy it off the exchange. And getting the same treatment, I think, is an important matter of fairness.

These generous grace periods do invite abuse. We know that in 2015 about a fifth of individuals stopped paying for their policies, and then half of them turned right around and bought exactly the same policy. This is cost shifting in the most fundamental form. Those costs don't go away. They show up as higher premiums. The higher premiums have proven to be undermining the ability of the ACA to provide broad, well-balanced pools. And that is a concern that I think the committee should address.

And then lastly, on failed exchanges and dental coverage, these strike me as things that the committee should simply just move ahead with. It is always in the interests of the committee to protect taxpayers against the abuse of their dollars. To audit and rescind the unobligated balances is, I think, a very sensible and straightforward thing to do, a matter of program integrity that everyone should endorse. And a technical correction on a bipartisan basis to pediatric dental coverage is something that no one should object to, and I applaud the committee for doing that.

I appreciate the chance to be here, and I look forward to your questions.

[The prepared statement of Mr. Holtz-Eakin follows:]

Common Sense Solutions to Improve the Affordable Care Act:
Simple Changes Can Go a Long Way

United States House of Representatives
Subcommittee on Health,
Energy and Commerce Committee

Douglas Holtz-Eakin, President*
American Action Forum

June 10, 2016

*The views expressed here are my own and not those of the American Action Forum. I thank Christopher Holt and Tara O'Neill for their assistance.

Chairman Pitts, Ranking Member Green, and members of the Subcommittee, I thank you for the opportunity to testify today regarding various proposed changes to the Affordable Care Act (ACA). These changes represent efforts to provide equity, improve transparency, and reduce burdensome requirements that are unnecessarily driving up the cost of health insurance. Further, several of these changes will have the added bonus of assisting in federal deficit reduction.

Making targeted changes to the ACA certainly does not imply that these are the only changes that should be made to the law or that making these changes will suffice to solve all of the issues created by the law. I have testified on many occasions before this Committee and others about the numerous problems with this law, however that is not my purpose today. The changes being discussed today are not groundbreaking ideas that will fundamentally alter the health care system; rather they are common sense improvements that should have broad, bipartisan support. In a less politicized environment, these and other changes would be bipartisan initiatives passing with little fanfare.

Introduction

The ACA was signed into law in 2010 with the goal of providing accessible, affordable health insurance coverage for all. Unfortunately, as I have testified over and over, these goals have yet to be met for many individuals.^{1,2} Today, the Subcommittee is attempting to provide some relief through a handful of proposals that deserve bipartisan consideration.

Grace Periods

Under the ACA, individuals purchasing insurance coverage on the Exchanges were given a 90-day grace period during which insurers were required to continue offering coverage despite an individual not paying their premiums. This is very generous relative to the laws states had implemented for coverage prior to the ACA, and gives individuals buying coverage on the Exchange an advantage over those purchasing off the Exchange – an uneven playing field for consumers. As of 2012, all states but two had a minimum grace period requirement of 30 or 31 days for plans offered in the individual market.³ The generosity of the grace period for plans purchased on the Exchange could easily allow individuals to take financial advantage, at the expense of other paying consumers and taxpayers. With a 90-day grace period, individuals may receive coverage for twelve months while only paying for nine months' worth of coverage.

A study by McKinsey found that 21 percent of 2015 Exchange plan enrollees stopped paying for coverage at some point during the year. In 2016, half of those individuals (49 percent) repurchased the same plan they had stopped paying for the year before; two-thirds of these individuals had also stopped paying for coverage at some point in the 2014 plan year. Insurers and providers both must account for the possibility of not being paid in full and therefore increase their prices, passing the cost onto consumers who do pay their obligations and the taxpayers subsidizing the coverage through the premium tax credit subsidies.

Aligning grace periods for policyholders in the individual market on and off the Exchange within a state will create equity among consumers. Further, reducing the 90-day grace period could significantly reduce the risk of losses for insurers and providers, which in turn will provide greater stability in the market and reduce the additional cost that unfairly burdens other consumers and taxpayers.

Special Enrollment Periods

Between specific statutory language, and subsequent regulatory guidance, the ACA provides for a combined 34 circumstances under which an individual may be eligible to enroll in an Exchange plan under a Special Enrollment Period (SEP). This is extremely generous. Medicare allows just seven of these instances, while the Health Insurance Portability and Accountability Act (HIPAA) requires only three be provided.

I have previously testified about the importance of adequately and efficiently verifying an individual's eligibility for premium assistance under the ACA; verifying an individual's eligibility to enroll during a SEP is equally important.⁴

Many insurers have complained that the plethora of categories rendering people eligible for SEPs—and the seemingly lax verification protocols—allow individuals to take advantage of the system, undermining and destabilizing the market. Insurers found that in 2014 individuals who enrolled during a SEP had much higher medical claims—10 percent, on average, though some as much as 55 percent higher—than those who enrolled during the open enrollment period preceding the coverage period.⁵ Too much flexibility for SEPs may allow individuals to wait until they are sick to enroll in coverage, undermining the insurance market, and ultimately resulting in higher premiums the following year to compensate. In fact, SEP enrollees were found to be 40 percent more likely to have a lapse in coverage than those that enrolled during the open enrollment period.⁶

The Centers for Medicare and Medicaid Services (CMS) evidently agrees with this observation, as evidenced by the recent issuance of an interim final rule tightening restrictions for SEPs. Indeed, the fact that the rule was issued without first seeking public comment implies that the agency believed such changes were either of such import that delay would be especially harmful and/or that such provisions were unlikely to receive significant opposition. However, the rule only affected eligibility for individuals seeking to enroll under the “permanent move” allowance. Given that there are 33 other allowances, more needs to be done. Requiring a formal process for eligibility verification, and requiring proper documentation supporting such claims, will go a long way in reducing the number of individuals unjustly taking advantage of the current system. Further, individuals should not be granted coverage unless and until their eligibility has been verified, with the caveat that coverage be retroactive to the day the application and all necessary documentation was submitted should the individual indeed be determined eligible. Finally, requiring the Secretary to report to Congress on the number of individuals who attempt to enroll during a SEP but are unable to do so, and specifying whether enrollment was not permitted because the individual did not provide the necessary documentation or because the

documentation was invalid, will enable policymakers to make more informed decisions in the future should it be determined that adjustments to such policies are needed.

Age Rating Restrictions

One of several provisions included in the ACA in order to constrain premium variation among individuals was a cap on the permissible variation of premium rates due to age by a ratio of 3:1, such that premiums for the elderly could not be more than three times greater than those for the youngest bracket of individuals in the adult population. Prior to the ACA, this ratio averaged 5:1. This difference was justified by the fact that this was roughly the average difference in spending among 64-year-old patients compared with 21-year-olds, according to the Congressional Budget Office (CBO).⁷ The stricter requirement imposed by the ACA artificially inflates premiums for younger individuals, forcing them to subsidize the coverage of older—and typically sicker—individuals. This result is likely responsible for much of the low enrollment among the younger adult population, despite these individuals having the highest uninsured rate among all age groups.⁸ In 2016, 3.5 million adults aged 18-34 enrolled in Exchange plans, representing only 28 percent of all enrollees, despite representing 36 percent of the potential enrollee population.^{9,10}

As the American Action Forum has previously reported, repealing the age variation limit should allow for premiums to decline and remove at least some of the financial disincentive preventing the younger population from enrolling in Exchange plans.¹¹ Increased enrollment rates among the “young invincibles” would contribute to greater market stability, and help prevent a “death spiral.”¹² The administration has been trying to make progress with this segment of the population, but, despite 2.3 million young adults gaining insurance by enrolling in their parents’ plans, the uninsured rate for these individuals continues to be 2.4 percentage points higher than the average for the total non-elderly population.¹³ Loosening this restriction would greatly assist with that effort.

Accountability for Terminated State Exchange Grants

In order to facilitate the establishment of State Exchanges, states were provided grants under the ACA to assist with the costs of doing so; such grants totaled \$5.5 billion. However, very few states actually succeeded in setting up a state-based Exchange, and many of those that did eventually relinquished control to the Federal government, placing the burden of continued maintenance and upgrades of the system used by 38 states on the Federal government.¹⁴ Of the \$900 million provided to states that failed to accomplish the task for which the money was provided, only \$21.5 million (23.8 percent) has been “returned” to the federal government. More specifically, this money was simply “de-obligated.” Taxpayers deserve to know their dollars are being spent wisely, efficiently, and for the purposes for which they are intended. The federal government should be doing more to ensure that the states that have failed to meet their obligations are held accountable and return those funds in a timely manner. This is a matter of good governance, transparency, and fiscal responsibility. With more than \$19 trillion in national debt, every dollar counts.

Conclusion

The Affordable Care Act, for the time being, is the law under which the country must operate. While we in this room today may differ on pursuing a full repeal of the law, repeal is clearly not achievable at this time. Therefore, we should focus on changes and improvements that provide consumers, providers, and taxpayers the most favorable outcomes possible. The evidence shows that there are clear failures in the law's efforts to regulate the insurance market. Thus, changes that seek to roll back or correct these failed market reforms deserve bipartisan support. Consumers deserve to be freed from provisions that are unnecessarily inflating premium costs and creating inequities among health insurance purchasers. Taxpayers deserve transparency from their government and to have their money returned when improperly spent. And all parties need a clear set of rules, rather than vast amounts of regulation leading to a myriad of loopholes. Eliminating the burdensome and restrictive regulations imposed by the ACA will reduce premium costs, making insurance both more affordable and more accessible.

Notes

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¹² Holtz-Eakin, Doug. "Premium Increases for "Young Invincibles" Under The ACA and The Impending Premium Spiral." American Action Forum, 2 Oct. 2013. Web. 08 June 2016. <<http://www.americanactionforum.org/research/premium-increases-for-young-invincibles-under-the-aca-and-the-impending/>>.

¹³ "HEALTH INSURANCE COVERAGE AND THE AFFORDABLE CARE ACT, 2010–2016." (n.d.): n. pag. Office of the Assistant Secretary for Planning and Evaluation, 3 Mar. 2016. Web. 8 June 2016. <<https://aspe.hhs.gov/sites/default/files/pdf/187551/ACA2010-2016.pdf>>.

¹⁴ "HEALTH INSURANCE MARKETPLACES 2016 OPEN ENROLLMENT PERIOD: FINAL ENROLLMENT REPORT." Office of the Assistant Secretary for Planning and Evaluation, 11 Mar. 2016. Web. 8 June 2016. <<https://aspe.hhs.gov/sites/default/files/pdf/187866/Finalenrollment2016.pdf>>.

Mr. PITTS. The chair thanks the gentleman.
And I now recognize Ms. Collins 5 minutes for your summary.

STATEMENT OF SARA COLLINS

Ms. COLLINS. Thank you, Mr. Chairman and members of the committee, for this invitation to testify today on advancing patient solutions of lower costs and better care.

Three years after the Affordable Care Act's major health insurance expansions went effect, nearly 28 million people are estimated to have coverage either through the marketplaces or Medicaid. There are 20 million fewer people uninsured since the law went into effect in 2010.

There is considerable evidence that marketplace and Medicaid coverage is improving people's access to health care. The Commonwealth Fund's ACA tracking survey of 2016 finds that majorities of enrollees who have used their health plans, either marketplace or Medicaid, report that they would not have been able to access or afford this care prior to getting their new insurance. Majorities of marketplace or Medicaid enrollees are satisfied with their insurance. Federal data are indicating nationwide declines in consumer out-of-pocket spending growth, cost-related problems getting needed health care, and medical bill problems.

Challenges remain. While the uninsured rate has fallen significantly among working-age adults, differences persist between lower- and higher-income adults. This is driven in part by the fact that 19 States have yet to expand their Medicaid programs, as well as dwindling resources for outreach and enrollment. News reports about high premium requests by several insurers and United Health Group's decision to pull out of several State marketplaces next year have raised concerns about the stability of the marketplaces.

There are several reasons why these developments don't portend disaster: Most marketplace enrollees won't pay double-digit increases in 2017, insurers premium requests are subject to State review, and 83 percent of marketplace enrollees receive tax credits to help them pay their premiums. Most of the increases will be absorbed by those credits.

Research is finding that the marketplaces are competitive and creating value for consumers. Most participating insurers remain committed to the marketplaces in 2017. While risk pools remain in flux, the premium stabilization programs are working for the most part. However, the phase-out of the reinsurance program this year will likely lead carriers to adjust their rates upwards to accommodate the loss.

Three bills under discussion today are aimed at addressing concerns about the marketplace. One bill would increase the amount that carriers could charge older adults from three to five times that of younger people. Research by Rand finds that this change would only modestly increase insurance coverage among young adults but would come with the hefty price tag of \$9.3 billion in Federal spending and a loss of coverage for 400,000 older people. Premiums would increase much more for older people than they would decline for younger people.

Another bill would require verification of eligibility for special enrollment periods. The Urban Institute finds that 33.5 million people are actually eligible for the special enrollment periods, the vast majority because of job loss, but only 15 percent actually are using them.

CMS has made adjustment to the special enrollment periods, including a new confirmation process that requires documentation to verify eligibility. People can still enroll while the verification process is underway. The proposed bill goes a step further by not allowing people to enroll until they have submitted this documentation. These tighter standards could lead to even lower enrollment through the special enrollment periods. Only the most motivated people might enroll, those who are most in need of health care, leading to less healthy risk pools.

The third bill would decrease the grace period for nonpayment of premiums from 3 months to 30 days. While some have suggested that people use these periods to game the system, the rules governing them are restrictive and aimed at discouraging this behavior. This policy change could mean a loss of enrollment in the marketplaces among enrollees of very modest means and an increase in the number of people who are uninsured or have gaps in their coverage. The policy change would also seem to favor those who are the most motivated to retain their coverage, those in poorer health.

It is encouraging that the committee is considering ways to improve the marketplaces. In considering these policy adjustments, it is important to remember that the fundamental purpose of the marketplaces is to provide coverage to those who currently lack health insurance and thus cannot get needed care and are currently suffering unnecessarily as a result.

Thank you.

[The prepared statement of Ms. Collins follows:]



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**Consumer Experiences in the ACA Marketplaces, Marketplace
Stability, and Remaining Challenges to Covering the Uninsured**

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Invited Testimony

U.S. House of Representatives Committee on Energy and Commerce, Subcommittee on Health
Hearing “Advancing Patient Solutions of Lower Costs and Better Care”

June 10, 2016

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**Consumer Experiences in the ACA Marketplaces, Marketplace Stability,
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The Commonwealth Fund**

EXECUTIVE SUMMARY

Thank you, Mr. Chairman, members of the Committee, for this invitation to testify today on the Advancing Patient Solutions of Lower Costs and Better Care. Three years after the Affordable Care Act's major health insurance expansions went into effect, 12.7 million people are estimated to have coverage through the marketplaces and 15 million more through Medicaid. There are 20 million fewer people uninsured since the law went into effect in 2010. Yet there remains considerable controversy over how well these reforms are working for consumers and whether the marketplaces are stable and competitive. The bills under discussion in this hearing are aimed at addressing some concerns that have been raised about the marketplaces and how consumers are using their plans. In this testimony, I review current evidence about the experiences of consumers in marketplace plans and Medicaid, the competitiveness and stability of the marketplaces, and ongoing implementation challenges. I also examine three of the proposed bills and their potential implications.

CONSUMER EXPERIENCES IN THE MARKETPLACE PLANS AND MEDICAID

- **The Coverage Expansions are Improving Americans' Access to Health Care**
 - The Commonwealth Fund ACA Tracking Survey February–April 2016 finds that majorities of people enrolled in either marketplace plans or Medicaid who have used their plans report they would not have been able to access or afford this care prior to getting their new insurance.
 - The ability of adults with marketplace plans and Medicaid to find doctors and get appointments is similar to that of U.S. insured adults overall.
 - Majorities of marketplace or Medicaid enrollees are satisfied with their insurance.
 - The early effects of the coverage expansions are also evident in nationwide declines in out-of-pocket spending growth, cost-related problems getting care, and medical bill problems.

- **Implementation Challenges Remain**

- While the uninsured rate has fallen significantly among working-age adults, wide differences persist between lower- and higher-income adults.
- This difference is driven in part by the fact that 19 states did not expand their Medicaid programs, as well as dwindling resources for and legislative barriers to outreach and enrollment in many states
- Affordability remains a key issue for enrollees across the income spectrum.
- Increases in the size and proliferation of deductibles in marketplace and employer plans may create more underinsured people.

PREMIUMS AND MARKETPLACE STABILITY IN 2017

News reports about double-digit 2017 premium requests by several insurers and UnitedHealth Group's decision to pull out of several state marketplaces next year have raised concerns about the ongoing stability of the marketplaces. There are several reasons why these developments don't portend disaster for the marketplaces.

- **Most Marketplace Enrollees Won't Pay Double-Digit Premium Increases in 2017**

- Insurers' premium requests will be reviewed by state regulators and will be adjusted or even rejected in some states.
- 83 percent of marketplace enrollees receive tax credits to help pay their premiums; most of the increases will be absorbed by those credits, so most people won't pay much more next year than they paid this year.
- Marketplace shoppers are highly price-sensitive and will likely not buy the higher-cost plans.
- At the end of the open enrollment period, people who received tax credits experienced average premium increase of only 4 percent.

- **The Marketplaces Are Competitive and Creating Value for Consumers**

- The marketplaces are promoting price competition among insurers.
- Recent research finds that projected premium increases in 2016 were lower for health plans sold inside the marketplaces than for those sold by carriers exclusively outside the marketplaces.
- The concern that UnitedHealth Group's departure from several marketplaces next year is a harbinger of more exits by insurers is overstated.
- Insurer participation in the marketplaces was relatively stable between 2015 and 2016.
- A recent review of first-quarter earnings calls by publicly traded insurers selling plans in the marketplaces suggest that most of these carriers remain committed to the marketplace in 2017.

- Many carriers report opportunities for growth; while the composition of risk pools remains in flux, there is variation across carriers, with some reporting healthier-than-expected pools.
- **Risk Pools Remain in Flux but ACA Premium Stabilization Programs Are Working**
 - Analyses of the risk-adjustment program have concluded that the program is working by transferring funds from insurers with lower-cost enrollees to insurers with enrollees who are sicker and have higher costs.
 - While there is room for improvement, the program appears to be fulfilling its intended objective of encouraging insurers to compete on value rather than risk.
 - The temporary reinsurance program is estimated to have lowered marketplace premiums by 10 percent to 14 percent in 2014, 6 percent to 11 percent in 2015, and by a smaller amount in 2016 as it phases out.
 - The complete phase-out of that program this year will almost certainly lead carriers to adjust their rates upward to accommodate the loss.
- **Ongoing Need for Ensuring Stability of the Marketplaces over Time**
 - The ongoing stability of the marketplaces and reasonable premium growth over time will continue to be dependent on covering the remaining uninsured and encouraging people to enroll in marketplace plans or Medicaid when they experience coverage gaps.
 - States will need resources to provide needed outreach to those who remain unaware of or reluctant to visit the marketplaces.
 - Affordability of health plans and health care for modest-income consumers will also be critical.

DISCUSSION OF PROPOSED BILLS

Three bills under discussion in this hearing are aimed at addressing recent concerns about the marketplaces.

- **Proposed Bill: Changing Permissible Age Variation in Health Insurance Premium Rates**
 - The proposed bill would increase the amount that carriers could charge older adults from three times to five times that of younger people.
 - The proposal also appears to provide an option for states to determine their own limits.
 - RAND researchers previously modeled a change in the ACA age band from 3:1 to 5:1.

- They found that while more—mostly younger—people would become insured under 5:1 rate banding, it would come with a price tag of \$9.3 billion in additional federal spending and a loss of insurance coverage for 400,000 older people.
 - The researchers estimate that the higher limits would increase annual premiums for the average benchmark silver plan for a 64-year-old from about \$8,500 under current limits to \$10,600 under the 5:1 rate bands, while lowering those for a 21-year-old from \$2,800 to \$2,100.
- **Proposed Bill: Requirement of Verification for Eligibility for Enrollment During Special Enrollment Periods**
 - The Urban Institute estimates that 33.5 million people are eligible for SEPs each year—the vast majority because of job loss, but only 15 percent use them.
 - The Centers for Medicare and Medicaid Services (CMS) has made adjustments to the special enrollment periods (SEPs), including a new confirmation process for SEPs that requires documentation to verify eligibility
 - People can still enroll in coverage while the verification process is being conducted, but there are deadlines for submission that trigger loss of eligibility or coverage if missed.
 - CMS is also adding an adjustment factor for partial-year enrollees to the risk-adjustment program for the 2017 plan year.
 - The proposed bill would require the Secretary to institute a verification process for SEPs, but people requesting a SEP would not be allowed to enroll in coverage until they have submitted documentation.
 - Tighter verification standards could lead to even lower enrollment through the SEPs.
 - Only the most motivated people eligible for SEPs—that is, those who are the most in need of health care—might enroll, leading to less healthy risk pools.
 - Given these potential adverse outcomes, it might be prudent to assess the effects of the new CMS verification process before imposing more restrictive requirements on those potentially eligible for them.
 - **Proposed Bill: To Better Align the Grace Period Required for Nonpayment of Premiums**
 - Recognizing that people with modest incomes might struggle in some months to pay their premiums, the law allows a three-month grace period for someone who fails to pay their premium in a given month.
 - While some have suggested that people use the grace periods to game the system and get free coverage, the rules governing them are restrictive and aimed at discouraging such behavior.

- The proposed bill reduces the ACA grace period for marketplace enrollees from three months to one month.
- Such a policy change could mean a loss of enrollment in the marketplaces among enrollees of modest means and an increase in the number of people who are uninsured or have gaps in their coverage.
- The policy change would seem to also favor those who are most motivated to retain their coverage—those in poorer health.

CONCLUSION

- Overall, the insurance provisions of the Affordable Care Act have been successful in achieving a number of goals, including substantial declines in the number of uninsured Americans and improved access to care.
- The marketplaces are competitive and appear to be producing value for consumers.
- But challenges remain:
 - lack of Medicaid expansion in 19 states
 - need for ongoing efforts to reach uninsured people who are eligible for enrollment in Medicaid and marketplace plans
 - ensuring that consumers in marketplace plans and Medicaid have insurance that is affordable and designed with incentives and protections that encourage timely access to high-value health care;
 - ensuring the stability of the marketplaces and reasonable growth in premiums over time.

It is encouraging that the Committee is considering ways to improve the marketplaces. In the end, the fundamental purpose of the marketplaces is to provide coverage to those who lack health insurance and thus cannot get needed care, and are currently suffering unnecessarily as a result.

Thank you.

**Consumer Experiences in the ACA Marketplaces, Marketplace Stability,
and Remaining Challenges to Covering the Uninsured**

**Sara R. Collins, Ph.D.
The Commonwealth Fund**

Thank you, Mr. Chairman and members of the Committee, for this invitation to testify today on the Advancing Patient Solutions of Lower Costs and Better Care. Three years after the Affordable Care Act's major health insurance expansions went into effect, 12.7 million people are estimated to have coverage through the marketplaces and 15 million more through Medicaid.¹ There are 20 million fewer people uninsured since the law went into effect in 2010.² Yet there remains considerable controversy over how well these reforms are working for Americans and whether the marketplaces are stable and competitive. The bills under discussion in this hearing are aimed at addressing some concerns that have been raised about the marketplaces and how consumers are using their plans. In this testimony, I review current evidence about the experiences of consumers in marketplace plans and Medicaid, the competitiveness and stability of the marketplaces, and ongoing implementation challenges. I will also examine three of the proposed bills and their potential implications.

EXPERIENCES OF CONSUMERS IN THE ACA COVERAGE EXPANSIONS

Coverage Expansions Are Improving Americans' Access to Health Care

The most recent Commonwealth Fund Affordable Care Act Tracking Survey, February– April 2016 finds that coverage through the marketplaces or Medicaid is improving people's ability to

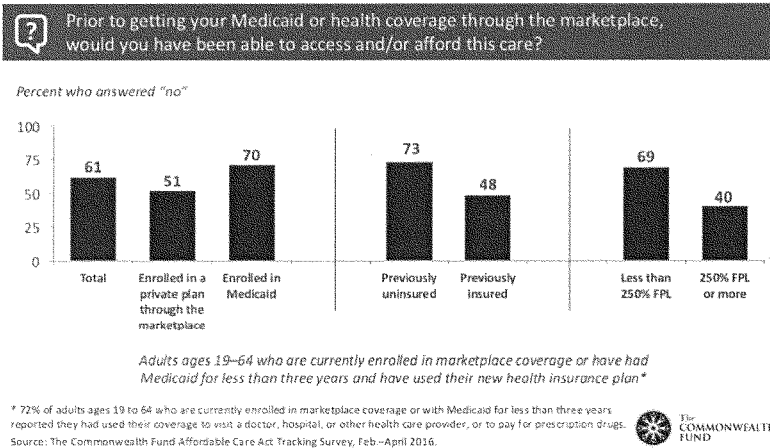
¹ By the end of The Affordable Care Act's third open enrollment period, marketplace plan selections had climbed to 12.7 million people and 15 million more people were enrolled in Medicaid compared to three years earlier. *Health Insurance Marketplaces 2016 Open Enrollment Period: Final Enrollment Period*, ASPE Issue Brief (Washington, D.C.: U.S. Department of Health and Human Services, March 11, 2016), <https://aspe.hhs.gov/sites/default/files/pdf/187866/Finalenrollment2016.pdf>; *Medicaid & CHIP: February 2016 Monthly Applications Eligibility Determinations and Enrollment Report*, CMS Report (Washington, D.C.: U.S. Department of Health and Human Services, April 29, 2016), <https://www.medicaid.gov/medicaid-chip-program-information/program-information/downloads/february-2016-enrollment-report.pdf>.

² R.A. Cohen, M. E. Martinez, and E.P. Zammitti, *Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, 2015* (National Center for Health Statistics, May 2016).

get health care.³ More than 70 percent of enrollees in marketplace plans or Medicaid have used their plans to get care. Of those, 51 percent of those enrolled in marketplace plans and 70 percent of those newly enrolled in Medicaid said they would not have been able to access or afford this care prior to getting their new insurance (Exhibit 1). Enrollees say their ability to get the health care they need has improved or stayed the same since getting their new insurance (Exhibit 2). Those who have looked for new primary care physicians are finding them relatively easily (Exhibit 3). Wait times for doctor appointments are comparable to those reported in other surveys by insured adults (Exhibit 4). Majorities of marketplace or Medicaid enrollees are satisfied with their insurance (Exhibit 5).

Exhibit 1

Three of Five Adults with Marketplace or Medicaid Coverage Who Had Used Their Plan Said They Would Not Have Been Able to Access or Afford This Care Before

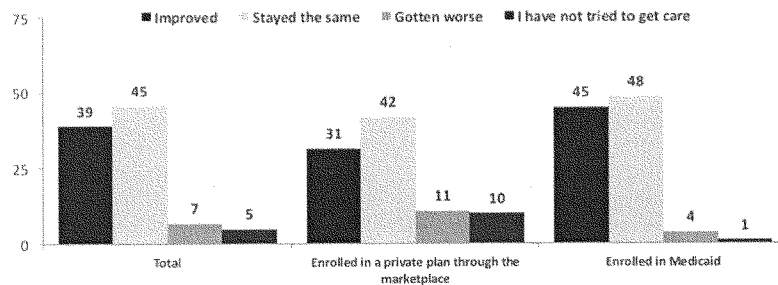


³ S. R. Collins, M. Gunja, M. M. Doty, and S. Beutel, Americans' Experiences with ACA Marketplace and Medicaid Coverage: Access to Care and Satisfaction, The Commonwealth Fund, May 2016, <http://www.commonwealthfund.org/publications/issue-briefs/2016/may/aca-tracking-survey-access-to-care-and-satisfaction>.

Exhibit 2

Eight of Ten Adults with New Coverage Said Their Ability to Get Health Care Has Improved or Stayed the Same

Since obtaining Medicaid or health coverage through the marketplace, would you say your ability to get the health care that you need has improved, stayed the same, or gotten worse?



Percent of adults ages 19-64 who have had a private plan through the marketplace or Medicaid for two months or less

Source: The Commonwealth Fund Affordable Care Act Tracking Survey, Feb.-April 2016.

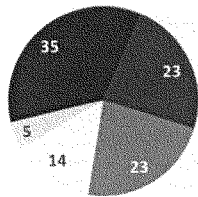


Exhibit 3

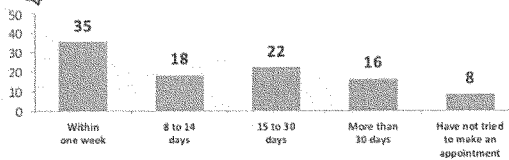
Three of Five Adults with Medicaid or Marketplace Coverage Who Tried to Find a New Primary Care Doctor Found It Very or Somewhat Easy to Do So and More Than Half Waited Two Weeks or Less to See Them

How easy or difficult was it for you to find a new primary care doctor or general doctor?

Very easy
Somewhat easy
Somewhat difficult
Very difficult
Could not find a doctor



How long did you have to wait to get your last appointment to see this doctor?*



Percent of adults ages 19-64 who are currently enrolled in marketplace coverage or have had Medicaid for less than three years and tried to find a primary care doctor or general doctor since getting new coverage*

* 25% of adults ages 19 to 64 who are currently enrolled in marketplace coverage or with Medicaid for less than three years tried to find a primary care or general doctor. * Among those who found a primary care doctor.

Source: The Commonwealth Fund Affordable Care Act Tracking Survey, Feb.-April 2016.



Exhibit 4

Three of Five Adults with Medicaid or Marketplace Coverage Who Needed to See a Specialist Waited Two Weeks or Less

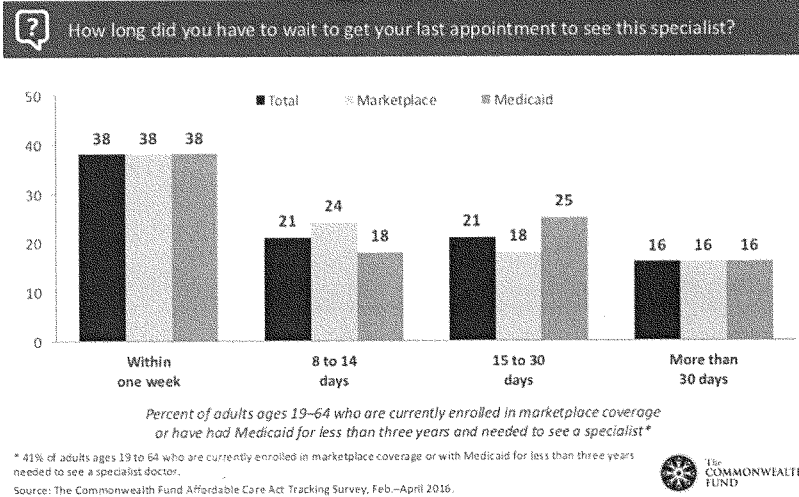
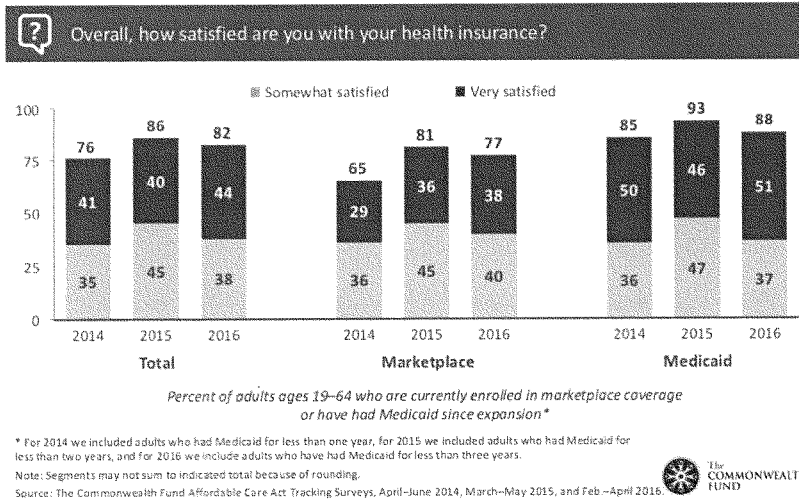


Exhibit 5

Most Adults with Marketplace or Medicaid Coverage Continue to Be Satisfied with It



These reports of improved access to care are evident in national spending account data and populationwide trends in key measures of health care access and medical financial burdens. According to the Centers for Medicare and Medicaid Services (CMS), the annual rate of increase in household out-of-pocket health care spending slowed from 2.1 percent in 2013 to 1.3 percent in 2014.⁴ Out-of-pocket spending on hospital services, a big-ticket item for uninsured families prior to the ACA, fell by more than 4 percent. CMS attributes these changes to increased insurance coverage through the expansions. In addition, federal and private consumer surveys show nationwide declines in reports of medical bill problems and cost-related delays in getting health care.⁵ A recent analysis by the Federal Reserve Bank of New York found a decline in average debt sent to collections agencies among counties in states that expanded eligibility for Medicaid with high rates of uninsured people prior to the ACA.⁶ These gains have occurred because millions more people have full protection against catastrophic health care costs. But they also likely reflect the fact that the ACA requires individual market and marketplace plans, as well as Medicaid plans, to cover a comprehensive set of services and places limits on annual out-of-pocket costs. In addition, more than half of marketplace enrollees have health plans with cost-sharing reductions that have substantially lowered the amount of their deductibles, copays, and out-of-pocket limits.⁷

Ongoing Implementation Challenges

Despite these substantial improvements in coverage and access, there remain obstacles to the goal of providing all Americans with access to high-quality care. Many adults and children who could benefit from the coverage expansions continue to be uninsured. While the Affordable Care Act has significantly reduced the uninsured rate among working-age adults, wide differences

⁴ S. R. Collins and D. Blumenthal, "New U.S. Health Care Spending Estimates Reflect ACA Coverage Expansions and Higher Drug Costs," *The Commonwealth Fund Blog*, Dec. 4, 2015.; A. B. Martin, M. Hartman, J. Benson et al., The National Health Expenditure Accounts Team, National Health Spending in 2014: Faster Growth Driven by Coverage Expansion and Prescription Drug Spending, Health Affairs, December 2015, <http://content.healthaffairs.org/content/early/2015/11/25/hlthaff.2015.1194>

⁵ S. R. Collins and D. Blumenthal, "New Federal Survey Shows Gains in Private Health Coverage and Fewer Cost-Related Problems Getting Care," *The Commonwealth Fund Blog*, Feb. 24, 2016.

⁶ N. Dussault, M. Pinkovskiy, B. Zafar, Is Health Insurance Good for Your Financial Health? Federal Reserve Bank of New York, June 6, 2016, <http://libertystreeteconomics.newyorkfed.org/2016/06/is-health-insurance-good-for-your-financial-health.html#.V1lZNPkrK5s>.

⁷ S. R. Collins, M. Gunja, and S. Beutel, How Will the Affordable Care Act's Cost-Sharing Reductions Affect Consumers' Out-of-Pocket Costs in 2016? The Commonwealth Fund, March 2016, <http://www.commonwealthfund.org/publications/issue-briefs/2016/mar/cost-sharing-reductions>.

persist between lower- and higher-income adults (Exhibit 6). This is driven in part by the fact that 19 states did not expand their Medicaid programs,⁸ as well as dwindling resources for and legislative barriers to outreach and enrollment in many states.⁹ The Medicaid expansion, premium tax credits, and cost-sharing subsidies have made coverage and health care affordable for low- and moderate-income families who were most at risk of lacking insurance.¹⁰ But affordability remains a key issue for enrollees across the income spectrum.¹¹ Concern about affordability is the most oft-cited reason given by uninsured adults who either have not visited the marketplaces or have visited but not signed up for a plan.¹² Increases in both the size and proliferation of deductibles in the marketplace and employer plans can lead to people being “underinsured”—that is, they are insured but have high out-of-pocket cost exposure relative to their incomes.¹³ New policy options are needed to encourage people to enroll in the coverage options for which they are eligible and to ensure all health plans, including those offered by employers, provide the right incentives to enable people to get timely, high-quality health care.

⁸ S. L. Hayes, S. R. Collins, D. C. Radley, D. McCarthy, S. Beutel, and J. Kiszla, *The Changing Landscape of Health Care Coverage and Access: Comparing States' Progress in the ACA's First Year*, The Commonwealth Fund, December 2015, <http://www.commonwealthfund.org/publications/issue-briefs/2015/dec/changing-landscape>.

⁹ B. D. Sommers, B. Maylone, K. H. Nguyen, R. J. Blendon, and A. M. Epstein. “The Impact of State Policies on ACA Applications and Enrollment Among Low-Income Adults in Arkansas, Kentucky, and Texas.” *Health Affairs* 34.6 (2015). <http://content.healthaffairs.org/content/34/6/1010.full>. Web. June 8, 2016; A. G. Mosqueira and B. Sommers, “Better Outreach Critical to ACA Enrollment, Particularly for Latinos,” *The Commonwealth Fund Blog*, January 2016, <http://www.commonwealthfund.org/publications/blog/2016/jan/better-outreach-critical-to-aca-enrollment-particularly-for-latinos>.

¹⁰ S. R. Collins, M. Gunja, and S. Beutel, *How Will the Affordable Care Act's Cost-Sharing Reductions Affect Consumers' Out-of-Pocket Costs in 2016?* The Commonwealth Fund, March 2016, <http://www.commonwealthfund.org/publications/issue-briefs/2016/mar/cost-sharing-reductions>.

¹¹ S. R. Collins, M. Gunja, P. W. Rasmussen, M. M. Doty, and S. Beutel, *Are Marketplace Plans Affordable? Consumer Perspectives from the Commonwealth Fund Affordable Care Act Tracking Survey, March–May 2015*, The Commonwealth Fund, September 2015, <http://www.commonwealthfund.org/publications/issue-briefs/2015/sep/are-marketplace-plans-affordable>.

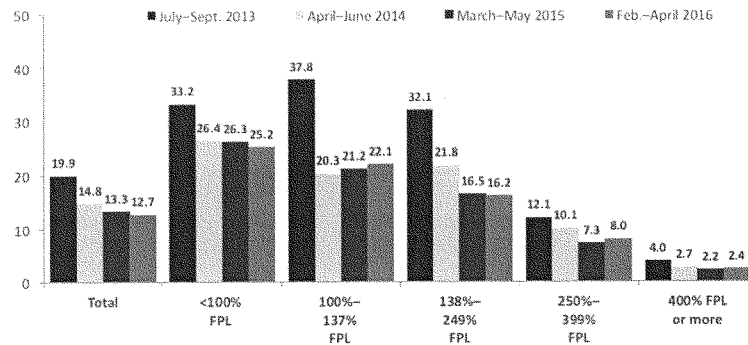
¹² S. R. Collins, M. Gunja, M. M. Doty, and S. Beutel, *To Enroll or Not to Enroll? Why Many Americans Have Gained Insurance Under the Affordable Care Act While Others Have Not*, The Commonwealth Fund, September 2015.

¹³ S. R. Collins, P. W. Rasmussen, S. Beutel, and M. M. Doty, *The Problem of Underinsurance and How Rising Deductibles Will Make It Worse—Findings from the Commonwealth Fund Biennial Health Insurance Survey*, The Commonwealth Fund, May 2015, <http://www.commonwealthfund.org/publications/issue-briefs/2015/may/problem-of-underinsurance>.

Exhibit 6

Uninsured Rates Among Low-Income Adults Have Fallen the Most But Remain Substantially Higher Than Those for Adults with Higher Incomes

Percent of adults ages 19–64 uninsured



Note: FPL refers to federal poverty level.

Source: The Commonwealth Fund Affordable Care Act Tracking Surveys, July–Sept. 2013, April–June 2014, March–May 2015, and Feb.–April 2016.



PREMIUMS AND MARKETPLACE STABILITY

In the last few months, certain news reports have raised concerns about the ongoing stability of the marketplaces. These include stories about double-digit 2017 premium requests by several insurers selling plans in the marketplace and UnitedHealth Group's decision to pull out of several state marketplaces next year. There are several reasons why these developments don't portend disaster for the marketplaces.

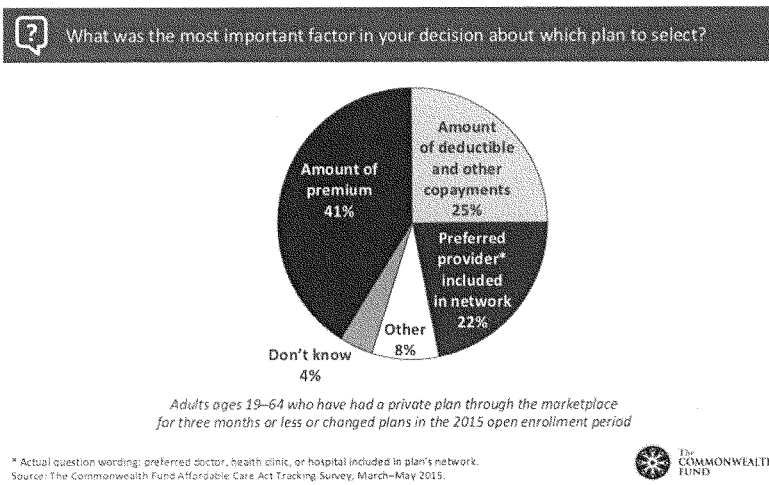
Most Marketplace Enrollees Won't Pay Double-Digit Premium Increases in 2017

It is important to remember that most people who will enroll in marketplace plans in the 2017 open enrollment period will not pay the widely reported double-digit premium increases. There are a number of reasons for this. First, insurers' premium requests will be reviewed by state regulators and will be adjusted or even rejected in some states. Any many insurers in the same state are not requesting large increases. Second, 83 percent of marketplace enrollees receive tax credits to help pay their premiums. Most of the increases will be absorbed by those credits so people won't pay much more next year than they paid this year. Third, marketplace shoppers are

highly price-sensitive and will likely not buy the higher cost plans (Exhibit 7).¹⁴ In the most recent enrollment period, 43 percent of returning marketplace enrollees switched plans. This rate is considerably higher than rates of plan switching in employer plans and among seniors in the Medicare prescription drug program.¹⁵ Indeed, while many carriers last year also requested significant rate increases, and some early analyses predicted double-digit increases on average, at the end of the open enrollment period, people who received tax credits experienced an average premium increase of only 4 percent.¹⁶ Premiums rose by 8 percent across the full group of marketplace enrollees. These increases are also lower than those that characterized the individual market before the reforms of the Affordable Care Act.

Exhibit 7

Premiums and Cost Exposure Were the Most Important Factors in Plan Selection Among Marketplace Enrollees



¹⁴ S. R. Collins, M. Gunja, M. M. Doty, and S. Beutel, *To Enroll or Not to Enroll? Why Many Americans Have Gained Insurance Under the Affordable Care Act While Others Have Not*, The Commonwealth Fund, Sept. 2015.

¹⁵ *Health Insurance Marketplace Premiums After Shopping, Switching, and Premium Tax Credits, 2015-2016*, ASPE Issue Brief, U.S. Department of Health and Human Services, <https://aspe.hhs.gov/sites/default/files/pdf/198636/MarketplaceRate.pdf>; T. DeLeire and C. Marks, *Consumer Decisions Regarding Health Plan Choices in the 2014 and 2015 Marketplaces*, Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, October 28, 2015.

¹⁶ *Health Insurance Marketplace Premiums After Shopping, Switching, and Premium Tax Credits, 2015-2016*, ASPE Issue Brief, U.S. Department of Health and Human Services, <https://aspe.hhs.gov/sites/default/files/pdf/198636/MarketplaceRate.pdf>.

The Marketplaces are Competitive and Creating Value for Consumers

The structure of the marketplaces and the designation of the second-lowest-cost silver plan as the benchmark for tax credits are promoting price competition among insurers. Research by Michael McCue and Mark Hall finds that projected premium increases in 2016 were lower for health plans sold inside the marketplaces than for those sold by carriers exclusively outside the marketplaces.¹⁷ Carriers' profits and administrative costs were also lower inside the marketplaces than outside. Consumers who have plans purchased in the marketplaces are more likely to have plans with closed provider networks like HMOs and EPOs than those outside. These findings show that their premium dollars are providing them with greater overall value than is the case for consumers buying outside the marketplaces. While oversight is needed to ensure that consumers in narrow network plans have timely access to high-quality providers,¹⁸ people in marketplace plans give their plans high ratings¹⁹ and are satisfied with their choice of doctors and hospitals,²⁰ despite the proliferation of these plans in the marketplaces.

The concern that UnitedHealth Group's departure from several marketplaces next year is a harbinger of more exits by insurers is overstated. Insurer participation in the marketplaces was relatively stable between 2015 and 2016.²¹ A recent review by Kevin Lucia and colleagues of first-quarter earnings calls by publicly traded insurers selling plans in the marketplaces suggest that most of these carriers remain committed to the marketplace in 2017.²² Many report

¹⁷ M. J. McCue and M. A. Hall, *Promoting Value for Consumers: Comparing Individual Health Insurance Markets Inside and Outside the ACA's Exchanges*, The Commonwealth Fund, June 2016, <http://www.commonwealthfund.org/publications/issue-briefs/2016/june/insurance-exchanges-promote-value>.

¹⁸ D. Polsky and R. Rosenquist, *Your Narrow Network Will Be 'Basic' But Will It Be Adequate?* University of Pennsylvania, Leonard David Institute of Health Economics, March 9, 2016, <http://ldi.upenn.edu/healthpolicysense/your-narrow-network-will-be-%E2%80%98basic%E2%80%99-will-it-be-adequate>.

¹⁹ S. R. Collins, M. Gunja, M. M. Doty, and S. Beutel, *Americans' Experiences with ACA Marketplace and Medicaid Coverage: Access to Care and Satisfaction*, The Commonwealth Fund, May 2016, <http://www.commonwealthfund.org/publications/issue-briefs/2016/may/aca-tracking-survey-access-to-care-and-satisfaction>.

²⁰ L. Hamel, J. Firth, L. Levitt et al., *Survey of Non-Group Health Insurance Enrollees, Wave 3*, Kaiser Family Foundation, May 2016, <http://kff.org/health-reform/poll-finding/survey-of-non-group-health-insurance-enrollees-wave-3/>.

²¹ E. Curran, J. Giovannelli, and K. Lucia, "Insurer Participation in State-Based Marketplaces in 2016: A Closer Look," Commonwealth Fund Blog, January 2016, <http://www.commonwealthfund.org/publications/blog/2016/jan/insurer-participation-in-state-based-marketplaces-in-2016>.

²² K. Lucia, J. Giovannelli, E. Curran et al., "Beyond UnitedHealthcare: How Are Other Publicly Traded Insurers Faring on the Marketplaces?" To the Point, June 1, 2016.

opportunities for growth, and while the composition of risk pools remains in flux, there is variation across carriers, with some reporting healthier-than-expected pools.

An Urban Institute analysis of marketplace competition in a select number of rating areas in 26 states suggests that carriers other than the large national insurers may be more significant drivers of competition in the marketplaces.²³ While UnitedHealth Group participated in more than half of the regions the researchers analyzed, its premiums were higher relative to their competitors in most markets. In 2016, United was one of the two lowest-cost insurers in 18.5 percent of the regions analyzed. This was true of Aetna in 16 percent of the regions and Humana in 6.2 percent. In contrast, Blue Cross–affiliated insurers, Medicaid insurers selling marketplace plans, provider-sponsored insurers, and regional insurers were far more likely to offer competitively priced plans. Blue Cross plans were one of two lowest-cost plans in 42 percent of regions analyzed. This was true of Medicaid plans in 54 percent of regions, provider-sponsored insurers in 28 percent, and local or regional insurers in 21 percent.

Risk Pools Remain in Flux but ACA Premium Stabilization Programs Are Working

The ACA’s premium stabilization programs, including the temporary reinsurance and risk corridor programs and the permanent risk-adjustment program, were designed to mitigate uncertainty for carriers in the initial years of the marketplaces and encourage competition on value rather than risk. The reinsurance program is estimated to have lowered marketplace premiums by 10 percent to 14 percent in 2014, 6 percent to 11 percent in 2015, and by a smaller amount in 2016 as it phases out.²⁴ The complete phase-out of that program this year will almost certainly lead carriers to adjust their rates upward to accommodate the loss. Because the risk-corridor program was ultimately implemented without federal funding, payments to carriers are being prorated in each year based on the balance of funds collected from insurers.²⁵ Consequently, for plan year 2014, plans that expected to receive risk corridor payments only received 12.6 percent of what they were owed under the program.

²³ J. Holahan, L.J. Blumberg, E. Wengle, What Does the Failure of Some CO-Ops and the Possible Pullout of United Healthcare Mean for the Affordable Care Act? The Urban Institute, January 2016, <http://www.urban.org/research/publication/what-does-failure-some-co-ops-and-possible-pullout-united-healthcare-mean-affordable-care-act>.

²⁴ American Academy of Actuaries, Drivers of 2016 Health Insurance Premium Changes, August 2015.

²⁵ American Academy of Actuaries, Insights on the ACA Risk Adjustment Program, April 2016.

Recent analyses of the permanent risk-adjustment program have concluded that the program is working as it was intended to by transferring funds from insurers with lower-cost enrollees to those with sicker and higher-cost enrollees.²⁶ While analysts caution there is room for improvement, the program appears to be fulfilling its intended objective of encouraging insurers to compete on value rather than risk.²⁷ However, unlike the temporary reinsurance and risk-corridor programs, the risk-adjustment program is not intended to insure premium stability over time. The temporary programs were designed to address the likelihood that the initial marketplace enrollment would be sicker than average, given that many people were uninsured prior to gaining coverage and would have higher demand for care services. Over time as enrollment grew, the risk pools were expected to become more balanced with a mix of healthier and sicker enrollees. To the extent this has not yet happened, the phase-out of the reinsurance program in particular will lead carriers to set higher rates in 2017.

Ongoing Need for Ensuring Stability of the Marketplaces over Time

The ongoing stability of the marketplaces and reasonable premium growth over time will continue to be dependent on strong enrollment of a diverse group of people. To achieve this, given the large number of remaining uninsured Americans, states will need the resources to provide the necessary outreach and education to reach people unaware of or reluctant to visit the marketplaces. But more fundamentally, consumers will need to continue to view their plans as both affordable and providing high-value care through reasonable coverage of out-of-pocket costs and adequate access to high-quality providers.

ANALYSIS OF PROPOSED BILLS

Three bills under discussion in this hearing are aimed at addressing recent concerns about the marketplaces. This section provides some analysis of the proposals in the context of their ability to address key challenges: helping uninsured people who are eligible for marketplace and Medicaid coverage enroll, achieving balanced risk pools, and ensuring affordability of health plans and access to high-value health care for consumers.

²⁶ American Academy of Actuaries, Insights on the ACA Risk Adjustment Program, April 2016.

²⁷ Oliver Wyman, A Story in 4 Charts: Risk Adjustment in the Non-Group Market in 2014.

Proposed Bill: Changing Permissible Age Variation in Health Insurance Premium Rates

Prior to the Affordable Care Act, insurers in the individual market generally charged older people higher premiums than they did younger people because their expected medical expenses are higher. Similarly, insurance carriers charged higher premiums to small companies with older workforces. Premiums varied by age by as much as 25-to-1 in the individual and small-group markets, pricing many older adults and small businesses out of the market.²⁸

While the ACA completely banned insurers from setting premiums based on health or gender, it allows carriers to adjust premiums based on age, tobacco use, family size, and geographic region, within defined limits. With respect to age, insurers are allowed to charge older people up to three times what they charge a younger person. This rule has had the effect of lowering premiums for older people who were at risk of exorbitant premiums in the individual market before the ACA, and increasing premiums for younger people who were viewed as far better health risks. In this way, the law has allowed risk to be shared in a reasonable fashion across the age spectrum, as intended by the principles of insurance generally. But also, by allowing rating on age, the law limits the extent to which younger people subsidize the costs of older people.²⁹

There has been considerable focus on young adults in the marketplaces. On average they have fewer health problems than older adults and encouraging their enrollment may lead to more balanced risk pools. Despite early concerns that young adults might not sign up for coverage, enrollment of those under age 34 in both the marketplaces and Medicaid has been relatively strong. Recent data from the Commonwealth Fund ACA Tracking Survey indicates that among 19–64-year-old adults, about 32 percent of marketplace enrollees in 2016 are ages 19-to-34 which is comparable to their overall representation in the population.³⁰ Young adults are disproportionately represented among adults newly enrolled in Medicaid, comprising 46 percent

²⁸ National Association of Insurance Commissioners and Center for Insurance Policy Research, Health Insurance Rate Regulation, http://www.insurance.naic.org/documents/topics_health_insurance_rate_regulation_brief.pdf.

²⁹ Eibner C and Saltzman E, Assessing Alternative Modifications to the Affordable Care Act: Impact on Individual Market Premiums, Santa Monica, Calif.: RAND Corporation, RR-708-DHHS, 2014, www.rand.org/t/RR708.

³⁰ S. R. Collins, M. Gunja, M. M. Doty, and S. Beutel, *Americans' Experiences with ACA Marketplace and Medicaid Coverage: Access to Care and Satisfaction*, The Commonwealth Fund, May 2016, <http://www.commonwealthfund.org/publications/issue-briefs/2016/may/aca-tracking-survey-access-to-care-and-satisfaction>.

of enrollment among adults. The most recent HHS estimates of 2016 marketplace enrollment show that young adults comprised 28 percent of those who selected health plans in the last open enrollment period.³¹

The proposed bill would increase the amount that carriers could charge older adults from three times to five times that of younger people. The proposal also appears to provide an option for states to determine their own limits. The intent is presumably to increase enrollment of young adults in the marketplaces.

Christine Eibner and Evan Saltzman at RAND previously modeled a change in the ACA age band from 3:1 to 5:1, which is the change called for in the bill.³² The researchers found that while more—mostly younger—people would become insured under a 5-to-1 rate banding, it would come with a price tag of \$9.3 billion in additional federal spending and a loss of insurance coverage for 400,000 older people. Premiums would increase for adults over age 47 and decrease for those under age 47. The researchers estimate that the higher limits would increase annual premiums for the average benchmark silver plan for a 64 year -old from about \$8,500 under current limits to \$10,600 under the 5:1 rate bands, while lowering those for a 21 year old from \$2,800 to \$2,100. The higher premiums for older adults over age 47 would result in an increase in tax credits at a cost of \$9.3 billion in federal spending. The lower premiums for younger people would increase enrollment in the marketplaces by 4.4 million, but 40 percent of those new enrollees would shift out of employer plans, mostly from parents' policies. The vast majority of new enrollees would have higher incomes and thus not be eligible for subsidies. The policy would lead to decline in employer coverage of 1.4 million, an increase in individual market and marketplace coverage of 3.3 million, with a net gain in coverage of 1.8 million.

While the proposed policy change might marginally increase enrollment of young adults in the marketplaces, it significantly increases federal costs while leading to a loss of coverage

³¹ *Health Insurance Marketplaces 2016 Open Enrollment Period: Final Enrollment Period, ASPE Issue Brief* (Washington, D.C.: U.S. Department of Health and Human Services, March 11, 2016), <https://aspe.hhs.gov/sites/default/files/pdf/187866/Finalenrollment2016.pdf>.

³² C. Eibner and E. Saltzman, "Charging Older Adults Higher Premiums Could Cost Taxpayers," *The Commonwealth Fund Blog*, Sept. 15, 2015, <http://www.commonwealthfund.org/publications/blog/2015/sept/charging-older-adults-higher-premiums-could-cost-taxpayers>.

among older adults. In addition, there is also no guarantee that these new enrollees will in fact be healthier than average. Since carriers are allowed to rate on age, but barred from rating on health, swapping out older adults for younger adults may in some cases leave them more exposed to risk. Prior research by Eibner and Saltzman finds that young adults are only slightly more likely than older adults to have a positive effect on risk pools.³³

Proposed Bill: Requirement of Verification for Eligibility for Enrollment During Special Enrollment Periods

The Affordable Care Act's insurance market reforms have vastly improved the ability of older people or those with health problems to gain health insurance coverage. In 2010, the Commonwealth Fund Biennial Health Insurance Survey found that an estimated 9 million adults who had either purchased a plan or tried to buy a plan in the individual insurance market were turned down, charged a higher price, or had a service excluded from their policy because of a preexisting condition.³⁴ To prevent people from enrolling in coverage only when they most need it, the law also included an individual mandate and defined open enrollment periods. People who miss the chance to enroll during open enrollment have to wait until the following year.

But because most people continue to have coverage through an employer and millions lose it throughout the year because of job loss or change, loss of a spouse/partner or parent, and other life changes, the ACA included special enrollment periods (SEPs) outside the open enrollment period to provide a means for people to gain health insurance when they lose other forms of coverage or experience other life changes such as moving to a new state or a birth.

But a recent analysis by the Urban Institute suggests that only a fraction of people who are likely eligible for a SEP actually request them. The analysis estimates that 12.9 million people will experience a SEP-qualifying event in 2016, lose their coverage, and remain uninsured for the remainder of the year. Of those, 9.7 million would qualify for a SEP because of

³³ Eibner C and Saltzman E, Assessing Alternative Modifications to the Affordable Care Act: Impact on Individual Market Premiums, Santa Monica, Calif.: RAND Corporation, RR-708-DHHS, 2014, www.rand.org/t/RR708.

³⁴ S. R. Collins, M. M. Doty, R. Robertson, and T. Garber, Help on the Horizon: How the Recession Has Left Millions of Workers Without Health Insurance, and How Health Reform Will Bring Relief—Findings from The Commonwealth Fund Biennial Health Insurance Survey of 2010, The Commonwealth Fund, March 2011, <http://www.commonwealthfund.org/publications/fund-reports/2011/mar/help-on-the-horizon>.

a job loss. An additional 20.6 million people this year are estimated to be able to use SEPs to prevent temporary coverage gaps. Of this group, the vast majority (18.2 million) qualify because of a job change and would otherwise be uninsured in the period between the end of one job and the beginning of another in same year. But based on 2015 CMS data, the Urban Institute estimates that fewer than 15 percent of uninsured people who are eligible for a SEP are enrolling through one.

The Department of Health and Human Services provided guidance for SEPs in regulations in 2012 and has amended them in each year since.³⁵ This year, CMS has made several adjustments to the SEPs in response to insurer complaints that people who enrolled through the SEPs had greater health care needs than average and that some stayed in plans only long enough to get the care they needed. CMS eliminated seven SEPs, narrowing the number to the current six. The six SEPs are for : losing other qualifying coverage; changes in household size like marriage or birth; changes in residence, with significant limitations; changes in eligibility for financial help, with significant limitations; defined types of errors made by marketplaces or plans; and other specific cases like cycling between Medicaid and the marketplace or leaving Americorps coverage. CMS also tightened some rules for SEPs including requiring that individuals who request a SEP because of a permanent move must have minimum essential coverage for one or more days in the 60 days preceding the move, unless they were living outside of the United States or in a United State territory prior to the permanent move. CMS notes that this ensures that individuals are not moving for the sole purpose of obtaining health coverage outside the open enrollment period. But such requirements would not apply to those who moved and were previously incarcerated or were in the coverage gap in a Medicaid nonexpansion state.

CMS this year has also introduced a new confirmation process for SEPs requiring all consumers applying through the most common special enrollment periods to submit documentation to verify their eligibility to use a SEP. This becomes effective June 17, and CMS has posted examples of the SEP eligibility notices that people will receive when they request one of five SEPs. These notices include the list of documents people need to prove they are eligible

³⁵ Timothy Jost, *After Insurer Complaints, Small Steps to Toughen Special Enrollment Period Eligibility* (Update), Health Affairs Blog, January 20, 2016.

for a SEP, such as letters from employers in the case of loss of coverage, leases or rental agreements in the case of a move, medical records in the case of a birth, adoption letters, and marriage certificates, among a long list of other documents. People can still enroll in coverage while the verification process is being conducted but there are firm deadlines for submission of the required documents that trigger loss of eligibility or coverage if missed.

In another adjustment that recognizes carrier reports of higher-than-average claims costs of those enrolling through SEPs, CMS is making a change to its risk adjustment program for the 2017 plan year that includes an adjustment factor for partial-year enrollees. As Tim Jost has pointed out, at least one of the SEP qualifying events—that is, birth—triggers higher than average costs by definition.

The proposed bill under discussion would also require the Secretary of HHS to institute a verification process for SEPs. The proposal goes a step further than the new CMS confirmation process: people requesting a SEP would not be allowed to enroll in coverage until they have submitted the required documentation.

CMS's tightened rules and new confirmation process should help allay insurers' concerns about abuse. The new 2017 adjustment factor in the risk-adjustment program for partial year enrollees should also help protect insurers for greater cost exposure associated with the SEPs. But it seems that the provision under the proposed bill that prevents people from enrolling prior to the provision of documents could unnecessarily discourage those qualified for a SEP from enrolling. This could have the effect of lowering potential enrollment in the marketplaces. Even the new CMS process could have this effect for many people. Ironically, by setting a higher bar for verification, both processes could discourage those who are the least motivated to gain coverage—the healthiest—from completing or even starting the enrollment process.³⁶ Both processes could also disproportionately affect people with low incomes and possibly multiple jobs. For such people, the process of producing the necessary documentation might be the most difficult.

³⁶ Sarah Lueck, *To Make Marketplaces Work Best, Enroll More People – Not Fewer*, Center on Budget and Policy Priorities, January 2016.

Tighter verification standards thus could lead to even lower enrollment through the SEPs and therefore lower enrollment overall in the marketplaces. Only the most motivated people eligible for SEPS—those who are the most in need of health care—might enroll, leading to less healthy risk pools. Given these potential adverse outcomes, it might be prudent to assess the effects of the new CMS verification process and narrower definitions of SEPs before imposing more restrictive requirements on those potentially eligible for them.

Proposed Bill: To Better Align the Grace Period Required for Nonpayment of Premiums

Prior to the ACA, the vast majority of uninsured Americans had low or moderate incomes. This is why the law’s major coverage expansions with subsidized marketplace plans and broadened eligibility for Medicaid were aimed at making insurance and health care affordable for people with incomes under 400 percent of poverty. Accordingly, people with the lowest incomes have made the greatest gains in coverage, but, for reasons explained previously, the gap in coverage between low- and higher-income adults persists.

People enrolled in marketplace plans who are eligible for tax credits must pay monthly premiums to insurance companies that are defined as a share of their income. The federal government pays the balance of the premium to the insurance company in the form of an advance premium tax credit. Recognizing that people with modest incomes might struggle in some months to pay their premiums, the law allows a three-month grace period for someone who fails to pay their premium in a given month. While some have suggested that people use the grace periods to game the system and get free coverage, the actual rules governing the grace period are highly restrictive and are aimed at discouraging such behavior.

When someone with subsidized marketplace plan fails to pay their premium, it triggers a three-month grace period.³⁷ The insurer still receives the tax credit for the enrollee from the federal government and is responsible for any claims incurred in that month. But if the enrollee still fails to pay his premium in the second and third months, the carrier is not obligated to cover any claims costs. If the enrollee still hasn’t paid premiums for months one through three, the carrier can retroactively terminate his coverage as of the last day of month one. When coverage

³⁷ Edwin Park, Key Facts You Need to Know About: Premium Payments and Grace Periods, Center on Budget and Policy Priorities, December 3, 2015.

is terminated at the end of the third month, the tax credits for months two and three are returned to the Treasury. The insurer keeps the premium tax credit for the first month when claims were paid, but the enrollee has to pay back the tax credit amount through the premium reconciliation process on his tax returns. He also still owes his share of the premium to the insurer for the first month.

The complexity of the grace period and the burden of the potential penalty for failure to pay (i.e., pay back of the tax credit while still owing his share of the premium) seems to provide a considerable disincentive for people to game the system. There is no publicly available evidence showing that people are using the grace periods to get free coverage. In fact, given the complexity of the grace-period rules, it is very likely that consumers with tax credits may not be aware of the three-month period and may assume that failure to pay in one month effectively terminates their coverage.³⁸ Data on grace periods also indicate that people often enter them unwittingly, such as through the failure to cancel a marketplace policy when one becomes eligible for Medicaid.

The proposed bill reduces the ACA grace period for marketplace enrollees from three months to one month. Such a policy change could mean a loss of enrollment in the marketplaces among enrollees of modest means and an increase in the number of people who are uninsured or have gaps in their coverage. Given the lack of evidence of abuse of the three-month grace period, the loss of enrollment might not be offset by any clear gains for insurers. And like the more onerous requirements in the bill proposed for new verification requirements, the policy change also would seem to also favor those who are most motivated to retain their coverage—those in poorer health.

CONCLUSION

Overall, the insurance provisions of the Affordable Care Act have been successful in achieving a number of goals including substantial declines in the number of uninsured Americans, and nationwide declines in out-of-pocket spending growth, cost-related problems getting care, and medical bill problems. The majority of enrollees in both marketplace plans and Medicaid are

³⁸ Edwin Park and Tara Straw, Center on Budget and Policy Priorities, personal communication.

satisfied with their health plans and their doctors. The marketplaces are competitive and appear to be producing value for consumers. The law's premium stabilization programs have mostly worked as intended with the exception of the risk-corridor program, which was barred from using federal dollars last year.

But challenges remain. They include:

- lack of Medicaid expansion in 19 states
- need for ongoing efforts to reach uninsured people who are eligible for enrollment in both Medicaid and marketplace plans
- ensuring that consumers in marketplace plans and Medicaid have insurance that is affordable and designed with incentives and protections that encourage timely access to high value health care
- ensuring the stability of the marketplaces and reasonable growth in premiums over time.

It is encouraging that the Committee is considering ways to improve the marketplaces and help consumers get affordable insurance and health care. In the end, the fundamental purpose of the marketplaces and the Medicaid expansion is to provide coverage to those who lack health insurance and thus cannot get needed care, and are currently suffering unnecessarily as a result.

Thank you.

Mr. PITTS. The chair thanks the gentlelady.

That concludes the opening statements of the witnesses. We will now begin questioning, and I will recognize myself 5 minutes for that purpose.

Ms. Turner, in my opening statement I spoke about the tremendous premium increases that are dominating headlines across the country, and we are looking for some solutions to this. In your testimony, you said that the President's healthcare law was designed to provide people with choice. Would you expound on that, explain that? Under current law, do you think patients have choice? Please elaborate.

Ms. TURNER. Increasingly, unfortunately, Mr. Chairman, they don't, because many of the plans are dropping out in areas where they find that they are losing too much money to stay in the exchange market even though they made a commitment earlier on to try to participate in this marketplace. And one of the reasons is particularly because of the gaming of the system that that these bills are designed to address.

I think it is very important, if we want to have a stable market of more affordable coverage, that these bills help stabilize the market. I know that there was a consumer advocate quoted in that New York Times article today from Pennsylvania who said that over time these markets will stabilize, that this is just a spike, because people are getting care that previously did not have health insurance. But it is not going to stabilize if people only pay their premiums when they need coverage and if they have paid their premiums for only 9 months and try to get 12 months of coverage.

So I am concerned this is going to actually exacerbate problems going forward if these bills aren't allowed to address the problems.

Mr. PITTS. And in addition to the premium increases, what about the deductibles? Can you speak to that?

Ms. TURNER. The deductibles are much higher. Many people are faced with a \$6,000 deductible. They are paying \$500 a month in premiums. And \$12,000 out of pocket is often more than their mortgage payments. And so increasingly we have got to address this to give people more choices rather than the cookie-cutter kinds of plans that the ACA requires.

Mr. PITTS. Thank you.

Mr. Holtz-Eakin, you remarked that the President's law was signed with the goal of providing accessible, affordable health insurance. And I mentioned my home state, the percent increase in premiums for individual plans. And the numbers provide factual evidence that plans have little room to innovate and adapt in today's government-controlled exchange market. Might the bills in front of this committee today lead to lower patient cost as a result of giving states flexibility and plans the fairness to innovate? Would you elaborate on that?

Mr. HOLTZ-EAKIN. I think that is right. Our estimate, for example, of the benefits of allowing wider age rating bands is that something like three million younger Americans might be able to move into the exchanges. That would be an incredibly valuable addition of low-cost purchasers into these exchange pools.

One of the deep concerns that I have is that we are seeing these exchange pools become progressively more expensive, that we are

not in a dramatic death spiral yet, but we are moving in that direction. That serves no one well. Those who remain in the pools pay higher premiums. Others are excluded from health insurance coverage that was the basic goal of the law.

Finding ways to innovate and allow low-cost insurance options instead of four colors that are getting increasingly expensive I think would be a very valuable thing, and the approaches that the committee has in front of it are a start on that course.

Mr. PITTS. Ms. Turner, you mentioned that everyone must play by the rules. Can you talk a little bit about how people are gaming the system that hurts working families who are playing by the rules?

Ms. TURNER. I think that is really the important point, is that those people who figured out that they can get 90 days of coverage after they stop paying premiums, that really hurts the people who are playing by the rules and paying a full year's of premiums to get their coverage.

So increasingly people will figure out: Oh, well, I can stop paying my premiums on October 1 and I can still get coverage until the end of the year and I can then go back and enroll in the same plan without having to pay the back premiums. That means that the insurance company has to build that nonpayment of premiums into the premium costs for next year, which gets to the problem that you asked Dr. Holtz-Eakin about, is that fewer and fewer people buy the coverage, making it more expensive for everyone.

Mr. PITTS. And real quickly, so it is your view that giving states flexibility on grace periods and age bands, while tightening the special enrollment periods, could lead to lower costs for families?

Ms. TURNER. Absolutely. And states have much more experience, decades of experience, in learning that those kinds of regulations really do help to stabilize the market so it can become more affordable.

Mr. PITTS. My time has expired.

The chair now recognizes the ranking member, Mr. Green, 5 minutes for questions.

Mr. GREEN. Thank you, Mr. Chairman.

And thank our panel for being here.

Prior to the ACA, the individual market was deeply broken. And, again, having worked in health insurance, which wasn't regulated in Texas, we did regulate some policies, but the ACA has made great strides and to make coverage more meaningful and affordable and expand access and stabilize the individual insurance market. Many of the challenges in the individual market are intrinsic to the market and have been around long before the ACA. One example is this churn. It is a term describing people moving in and out of coverage every year.

Dr. Collins, can you talk about the churn and how the individual market was previously broken and why changes like churn are not unique and will continue to happen?

Ms. COLLINS. That is absolutely correct. The individual market has long been characterized by high rates of turnover. But prior to the Affordable Care Act it was extremely difficult for people to get policies when they tried to buy them. They were very expensive. People were priced out of coverage if they had a preexisting condi-

tion, or even turned down. We estimate, the Commonwealth Fund Biennial Health Insurance estimates that about nine million people who tried to buy a plan in 2010 were turned down or charged a higher price or had a preexisting excluded because of their health and didn't end up buying a plan.

So the market was broken prior to the Affordable Care Act. The provisions that have been put in place under the law have made it vastly more accessible for people with health problems and people who have low incomes and couldn't afford to pay a premium.

Mr. GREEN. OK. Of the legislative type proposals we are considering, I am particularly concerned about the bill that would change the current 90-day grace period to 30 days. It is worth mentioning that Medicaid Advantage has 60-days grace period, Medicaid has a 60-day grace period. After reading the bill, I am worried my colleagues have become focused on that fraction of the people who try to game the system that historically have always tried to game the system, and that they have forgotten the realities of everyday life.

Under this bill, a person who is eligible for an advanced premium tax credit misses a single premium payment, they would lose their insurance after 30 days and not be able to get coverage until the next enrollment period. I understand the need for oversight, but especially for this population we should be looking for ways to keep people insured and not the opposite.

Dr. Collins, can you talk a bit about the population that is eligible for this advanced premium tax credit?

Ms. COLLINS. Right. So people who are eligible for the tax credits have incomes under 400 percent of poverty, low and moderate incomes. The vast of people who are currently receiving tax credits have incomes even lower than that, more in the 250 percent of poverty and below.

I would also like to correct some statements that have been made about how the grace period works. Carriers are only on the hook for the first month of nonpaid premiums and they get a tax credit to cover those expenses, this claims cost in the first month. They are not on the hook for the second and third months of that grace period. They receive a tax credit, but they do not have to pay claims costs. Those tax credits have to go back at the end of the year.

Also, individuals who don't pay their premiums for the full time of the grace period have to pay their tax credits back for that first month and also continue to owe the premium paid in that first month. So it is not true that carriers are on the hook for those claims costs in the second and third months when they are not receiving reimbursement.

Mr. GREEN. OK. What impact do you think this policy would have on consumers in the risk pool?

Ms. COLLINS. One of the biggest issues with enrollment right now is that we need to encourage people to come in rather than discourage them to come in. What a more restrictive grace period would do would make it more likely that healthy people would drop out because of failure to pay a premium in the first month. People who are highly motivated to stay in, the less healthy people, would likely try to make that premium payment in that first month and

stay in. So it would skew the risk pool away from healthy people and more towards sicker people.

Mr. GREEN. Well, one of the concerns I have on this legislation, some of it may be adjusted, but the biggest concern I have is in our district in Houston, Texas, I have 50,000 people who would be covered if the State of Texas expanded Medicaid. I think that is something we ought to be concerned about instead of that.

But also what happened because of the Supreme Court decision, we have people who are not poor enough to get Medicaid, but they also don't earn enough money to get the subsidies. So they are caught in the middle, and that is something maybe we ought to look at and see how we can fix that for these people who are not the poorest of the poor but very close to it, because in Texas you have to be pretty destitutely poor to get Medicaid.

Mr. Chairman, thank you for the time.

Mr. PITTS. The chair thanks the gentlemen.

And I now recognize the gentleman from Pennsylvania, Dr. Murphy, 5 minutes for questions.

Mr. MURPHY. Thank you, Mr. Chairman.

I thank the panel too for being here to give us some important insights.

One of the subcommittees of this overall committee, the Oversight and Investigations Subcommittee, which I chair, has been conducting some pretty robust oversight over the state exchanges for more than a year. And specifically the subcommittee has been and continues to examine the expenditure of Federal funds on state-based exchanges' activities and long-term sustainability challenges that these State exchanges face. And another significant component of this work is examining CMS' oversight over these.

Ms. Turner, in its oversight of the state exchanges, the subcommittee has held hearings and requested CMS on the state-based exchanges produce documents and information to our subcommittee and to the full committee. But most recently the subcommittee released a report detailing Acting Administrator Slavitt's misleading testimony before the O&I Subcommittee on December 8, 2015, about \$200 million supposedly being returned from state-based exchanges.

Based on its ongoing oversight, our committee remains very concerned about the long-term sustainability challenges the state-based exchanges face and CMS' lack of oversight over them. So given all this, I want to ask you, do you believe that CMS is performing adequate oversight over these state-based exchanges.

Ms. TURNER. I don't believe that there is significant evidence that they are. I believe that they have their hands full with many of the other provisions of trying to run this law and I think oversight of the states has really been lax. In particular with the failed state exchanges, they should have probably been more alert in the beginning to begin to see that States like Oregon and Maryland and Massachusetts were failing.

And I commend you for the report, because when Acting Administrator Slavitt said that about \$200 million had been returned and your committee found that his own data showed that only a little bit more than \$21 million had been returned, I do think that they need to square what one CMS agency is saying with what the Ad-

ministrator is telling Congress and really get to the bottom of that. The taxpayers require that.

Mr. MURPHY. Yes. And it is very important to us. Look, we want to make sure people have adequate health care, but between that unaccountability and other errors and fraud, we have heard from CMS that billions of dollars are unaccounted for. It is a problem for us. So what steps would you recommend that Congress take to make sure we have adequate oversight of these?

Ms. TURNER. Well, I think what you are doing with the hearings and with the oversight, and if it requires subpoenas to get the information about why there is this disconnect between what he is telling you in your hearings and what the reports are showing, I think that the taxpayers need to have that information. Continued oversight, I think, is tremendously important. Thank you for that.

Mr. MURPHY. So given that, are there any indications that CMS is actively trying to recoup taxpayer dollars that were provided to states for the purpose of providing these state exchanges? Do you see any evidence? We would like to know if there is anything positive.

Ms. TURNER. Well, I understand that they have provided some very limited and highly redacted memos to your committee. It does not appear that they are being as responsive as they need to be in order, once again, to make sure that taxpayers are being well served and their money is being spent on the intent of this law, as you point out, to provide affordable coverage to millions of people.

Mr. MURPHY. Thank you.

Mr. Holtz-Eakin, good to see you again. I have a question for you on this issue about the most expensive plan can only cost three times more than the least expensive plan when it comes to the patients' ages, and this 3:1 band has led to some problems.

I received a letter from an association last evening that said modifying age variation in premiums would help balance risk pools and stabilize markets, and that is one of the bills this committee is reviewing. Is it fair to say that working families and sick patients would benefit from other balanced risk pools and stabilize the marketplace overall? Do you think so?

Mr. HOLTZ-EAKIN. I believe so. I am concerned that we will see these exchange pools become increasingly unbalanced and thus expensive for those who remain in them and crowding some people out—

Mr. MURPHY. Particularly the younger?

Mr. HOLTZ-EAKIN [continuing]. And working families unable to purchase insurance. That is at odds with the intent of the law. And I think stabilizing the pools is a priority.

Mr. MURPHY. So one of the things we keep coming up with in reality, as was described among the panel here too, is that people may sign up for something and then drop it. It is sort of like people will buy car insurance when they need to get their car, and then they drop it immediately afterwards. I experienced that once being hit by a driver who dropped their car insurance. Didn't help me at all.

But the issues here, do you think that lowering that price and balancing those risk pools will be an enticement to have people stay in with insurance?

Mr. HOLTZ-EAKIN. I do. I know there is an immediate concern about the older consumer under this proposal, and I understand that. But those consumers of exchange insurance are going to be increasingly harmed by unbalanced risk pools. It is in their long-term interest to get the young and healthier into the pools. This is one way to do that.

And in the end, if you look at all of the things that are being considered in this front, costs don't go away. If they are not paid by an insurance company, they are going to be put into providers' rates and they are going to show up in insurance premiums regardless. And so having people pay for the medical costs they incur through the insurance that they have bought is the primary objective and anything that aligns those incentives you should pursue.

Mr. MURPHY. Thank you.

I yield back. Thank you.

Mr. PITTS. The chair thanks the gentleman.

Now I recognize the ranking member of the full committee, Mr. Pallone, 5 minutes for questions.

Mr. PALLONE. Thank you.

The Affordable Care Act has made great strides in expanding health coverage to an additional 20 million Americans, but there are still Americans who we have not reached. Unfortunately, 2.9 million Americans lack coverage because their states have not expanded Medicaid. But in the private insurance market there are still more than 10 million Americans who are uninsured and eligible for marketplace coverage, and 7 million of them are eligible for tax credits to help them pay their premiums.

Before we consider revising or even backtracking on the progress we have made, one important thing we can do to stabilize the individual insurance market is to grow it, and we need to reach these people so that they know they are eligible. And the more people enrolled, the greater the risk pool, and the more stability we will see.

So my questions are of Dr. Collins. What can we do to reach the uninsured? Can you describe the importance of outreach efforts and navigators and the role that you might see navigators occupying as we move forward?

Ms. COLLINS. A lot of research has shown that outreach is critical to both letting people know about what their options are and helping them enroll. We see greater enrollment among people who get assistance in the enrollment process.

I also think on the issue of young adults, this is particularly important. Most young adults who are eligible for coverage under the law have incomes that make them eligible for the tax credits, incomes that make them eligible for Medicaid. But disproportionate numbers of people enrolled in Medicaid are actually young people.

So the change in the rate banding really won't have much of an effect on enrollment of young people. It is really getting young people to enroll in the marketplaces and find out that they are eligible for subsidies, find out that they are eligible for Medicaid. States expanding their Medicaid programs would also significantly increase enrollment of young adults in the pools.

The other important point about young adults is that they actually are a relatively large percentage of people enrolled in the marketplace. It is about 30 percent of people currently enrolled in mar-

ketplace plans are between the ages of 19 and 34. Forty-six percent of those enrolled in Medicaid among the adult population are young people.

So it is not really true that we don't have any young adults in the marketplace. This is actually a pretty sizeable number of people who are enrolled who are in that age group.

Mr. PALLONE. Now, what about navigators, do you want to talk about that and what role they could play as we move forward?

Ms. COLLINS. So navigators continue to be very important. We do see that people are much more likely to understand the options they have available to them when they are choosing marketplace plans if they have some assistance. People are much more likely to complete the enrollment process if they have navigation.

Mr. PALLONE. Now, I use that term "navigators." How would you define "navigators," basically?

Ms. COLLINS. Basically someone who helps people through the enrollment process. Brokers can also help people through the enrollment process and they have also been critical to getting people enrolled.

Mr. PALLONE. Just talk about insurance brokers. I think a lot of people don't even realize they can still use an insurance broker. Is that an area where maybe we need to do more, to have actual insurance brokers play a bigger role?

Ms. COLLINS. So brokers can absolutely help people enroll in plans. They have been critical. They have also been very important for small businesses getting coverage under the——

Mr. PALLONE. But even for an individual, can use a broker, right?

Ms. COLLINS. Even individuals can use a broker.

Mr. PALLONE. But not that many do, it seems. I am just doing anecdotally. I don't have any statistics. But it seems to me that people in the individual market rarely go to brokers.

Ms. COLLINS. Right. So part of the outreach efforts could be to inform people that they can get help if they aren't able to do it on their own.

Mr. PALLONE. All right. Then the last question, would the bills before us today help to enroll the uninsured in any way?

Ms. COLLINS. The bills today would likely have a depressing effect on enrollment, particularly the change in the special enrollment periods, making people provide documentation. We know that very few people are actually using special enrollment periods. They were designed expressly for people who lose coverage between open enrollment periods and most of those are as a result of a job loss. And so we should be trying to make this process easier, make people aware of it.

The reduction in the amount of time for the grace period would also likely lead to a loss of enrollment in the marketplaces and probably among less healthy people. The rate banding change would mostly affect older adults. Many of them would see their costs go up exponentially. They actually will pay much more in premiums than their average expenses.

And there would be only a marginal effect on enrollment of young adults. And most of the change in the enrollment of young

adults that Rand is showing comes from a shift out of employer coverage and into the marketplaces.

Mr. PALLONE. Thank you very much.

Thank you, Mr. Chairman.

Mr. PITTS. The chair thanks the gentleman and now recognizes Dr. Burgess, 5 minutes for questions.

Mr. BURGESS. Thank you, Mr. Chairman.

And, first off, let me just address the special enrollment period. I can remember some hearings we had in the past and maybe even some forums we did in the Health Caucus where we talked about community rating and guaranteed issue and the experiments that were tried in some states in the 1990s and the predictable effect of escalating premiums and then, subsequent, people dropping out of coverage.

It did come up in my district. We had a constituent case earlier this year. Right after the closure of the open enrollment period, a fellow who actually has a medical background in my district—he is a pharmacist, and he called, and he said, “One of my employees is really, really sick. I am afraid she might have cancer. She has no insurance. Do you have any advice for me?” And I said, well, the open enrollment period had just closed. Why didn’t you encourage her to buy insurance then? He said, “Well, she wasn’t sick then.”

And, that just kind of underscores—here is, again, someone with some medical knowledge. It just underscores the difficulty of what the special enrollment period can engender. Now, this individual, it turns out, our office helped, and she did have a legitimate claim to a special enrollment period and did receive the retroactive coverage.

I have an e-mail that I received from healthcare.gov, and I don’t know if you can read that well enough, but I actually had an unsubsidized individual market policy in the Federal fallback exchange in Texas. And I had that for a couple of years until it got too expensive and I had to find something else. But it was hard to get into ObamaCare, and then it was hard to get out of. And I do want to stipulate, this was unsubsidized. These were my own dollars that I was paying for this coverage.

Three months, 4 months after I have left ObamaCare, I am getting these e-mails. “The open enrollment period is closed, you missed your chance, but, doggone it, you can still get in.” And there is a big, yellow button there that you can click on, and we can perhaps help you find a backdoor back into ObamaCare if you would like.

Now, the good news for people who are worried about us spending too much money, the yellow button didn’t work, and so there wasn’t really a way back in.

But it just underscores the problem that we have with the special enrollment period. It really does lead to, again, what was found to be a very difficult time in an experiment with guaranteed issue/community rating in some States that tried that back in the 1990s.

I just wondered, Ms. Turner or Dr. Holtz-Eakin, if you had any thoughts on that.

Ms. TURNER. This really gets to what you said earlier, Dr. Burgess, about where is this going. And I think that you have to look at the incentives that these provisions allow. They allow people to

wait until they are sick to get coverage. They allow people to really game the system in a number of different ways.

And if people figure out they can do that, then you are going to wind up with unstable pools, you are going to wind up with higher and higher costs, and someone has to pay those costs. Maybe most of the people in the exchanges are subsidized, but the taxpayers are paying those costs. So, one way or the other, we are going to be paying for laws that encourage people basically to do the wrong thing.

The individual mandate was designed to try to keep people—have insurance and can keep it, but these provisions really undermine that goal and, I think, undermine, therefore, the goal of the law.

Mr. BURGESS. Well, and I of course opposed the individual mandate and continue to oppose it, but I guess it begs the question, is the individual mandate just not harsh enough? Are we not penalizing people enough to force them into these insurance policies?

Ms. TURNER. Doug Holtz-Eakin mentions that in his testimony.

Mr. HOLTZ-EAKIN. We testified last year on alternatives to the individual mandate, because it is clear it is not doing what it was intended to do in principle. And so some other approaches might be necessary.

I mean, I think the history of those states that had guaranteed issue/community rating speaks for itself. I lived in New York State, and that was an insurance market that had self-destructed, and there is not a happy history on that.

I think it is ironic that we are having this discussion today about shifting costs and there are some who would defend the cost shift, because the entire Affordable Care Act was premised on the notion that it was inappropriate to have these cost shifts and we had to get everybody in the pool. That same principle should apply in the discussion today.

And it is also important to recognize, as a matter of arithmetic, you can't count on the tax credits to cover all ills. ACA spending is projected to grow at a rate of 7.7 percent per year over the next decade—much faster than our economy, much faster than revenue, which is going to be 4 percent, and the most rapidly growing Federal health program. There are not infinite dollars to solve all problems.

Mr. BURGESS. Thanks, Mr. Chairman. I hope we will have time for a second round. I will yield back.

Mr. PITTS. The chair thanks the gentleman and now recognizes the gentlelady from Florida, Ms. Castor, 5 minutes for questions.

Ms. CASTOR. Thank you very much.

Thank the witnesses for being here.

And I want to yield just a few seconds to Gene Green, because he wanted to follow up on a point.

Mr. GREEN. After this exchange, I have been around a while. It seems like in the 1990s the Heritage Institute is the one who recommended the individual mandate because people ought to be self-reliant. Is that correct? Do you all remember that statement?

Ms. TURNER. The Heritage Foundation did. And they——

Mr. GREEN. Seems like in 1993 and 1994——

Ms. TURNER [continuing]. Have since rescinded that.

Mr. GREEN [continuing]. When we had the Clinton plan that that was one of the recommendations for that, so—but anyway.

Thank you, and thank my colleague for yielding.

Ms. CASTOR. Thank you.

Well, thanks again.

It is very important for us to continue to focus on improving the Affordable Care Act, but you can't deny the success on behalf of the families we represent back home. I mean, we are at the lowest uninsured rate in the history of the country, at about 9 percent. That is pretty remarkable, and that has been a godsend to so many families. The ability to end discrimination in health insurance so that our neighbors and family members with a cancer diagnosis or some serious preexisting condition, they now can access affordable health insurance.

The policy that you buy is so much more meaningful than what it used to be in kind of this scattershot pre-ACA market. Plus, the policies usually promote better health because we focus on wellness and there are certain incentives for preventative care, like no co-pays for certain things.

And then all of my neighbors that rely on Medicare, Medicare is stronger now after the Affordable Care Act. And one of the stats that I love for the State of Florida is how much money the ACA has helped put back into the pockets of my older neighbors—it is about \$980 million—just because of the closing of the doughnut hole and their savings on prescription drugs.

Also, in Florida, we were the leader in the Federal exchange. We had a very high uninsured rate, a completely unbalanced market. So 1.7 million Floridians now have been able to access affordable coverage. And it is important to focus on the cost. In Florida, 72 percent of the Florida marketplace enrollees obtained coverage for \$100 or less. That is after the tax credits.

And the competition is key. And in some states that don't have these robust marketplaces, one of the things we need to focus on is how we incentivize greater competition. In Florida, consumers could choose from an average of 42 health plans for 2015, and we think this coming year it will be about that, if not a larger number of issuers and plans.

And Ms. Collins is right that, prior to the ACA or as we were working through the early years, people were very concerned that younger folks would not enroll, but it is not true now. We have been pleasantly surprised that it is pretty balanced, and in Florida about 525 consumers under the age of 35 are signed up for marketplace coverage. That is 33 percent. So that is pretty good.

So, as a reminder, open enrollment begins November 1. Go to healthcare.gov to check out your options.

Americans are doing what they do best: they are going shopping. It is another surprise that they are actually looking at these plans and switching. We thought that many people would just stick with that one issuer, but they are pretty discerning if they have the information they need. So that is another area where we could work together to improve, to ensure people know the providers and the doctors that are being offered.

But I would like to focus on premiums, because I think we all agree it is incredibly important that premium prices on the ex-

changes remain affordable. But I worry that the bills that are under discussion today will actually increase costs and also harm access to insurance.

And I am afraid that some of the headlines in the press sensationalize the premium rates and confuse consumers. For example, despite headline predictions in 2015 that, based on preliminary rate filings, there would be double-digit rate hikes in the marketplaces in 2016, the average cost of marketplace coverage for people getting tax credits went from \$102 last year to \$106, a 4-percent change, just \$4 per month. And, in Florida, the premiums rose only 2 percent, the average monthly cost of \$84 in Florida with the tax credits.

So, Dr. Collins, why did the preliminary rate filings differ from the actual rates? Maybe you can help clear this up a little bit.

Ms. COLLINS. So there are a few different reasons for that. The high prices that were seen by some requests—requests by some insurers are preliminary. They are subject to rate review. And in many states—

Ms. CASTOR. At the state level. I mean—

Ms. COLLINS. At the state level. At the state level. Many states will just adjust those down.

The other major factor is that people will shop around. So just because carriers are charging high prices in some markets doesn't mean people are actually going to buy those plans. As you mentioned, 43 percent of people that shopped for plans changed plans last year. And we see the effect in the increases in premiums that people actually paid as opposed to those that we are hearing about now.

So it is the rate review, it is people shopping, choosing the highest value plan for them, and it is the tax credits that protect them from these—

Ms. CASTOR. And active state regulators that will push back on some of the insurers' requested rate increases.

Ms. COLLINS. That is right.

Ms. CASTOR. Great. Thank you very much.

I yield back.

Mr. PITTS. The chair thanks the gentlelady and now recognizes the gentleman from New Jersey, Mr. Lance, 5 minutes for questions.

Mr. LANCE. Thank you, Mr. Chairman.

And good morning to the panel.

I would like to concentrate on cost-shifting.

Dr. Holtz-Eakin, you say that the ACA is likely to increase 7.7 percent—was that the figure you gave?—over the next several years, regarding the costs?

Mr. HOLTZ-EAKIN. In the most recent CBO baseline, the average annual increase in ACA spending is 7.7 percent per year over the next 10 years.

Mr. LANCE. And this is clearly higher than anticipated growth in the economy. Is that accurate?

Mr. HOLTZ-EAKIN. Yes. The economy will grow at 4.1 percent, nominal, over the 10 years in their projection.

Mr. LANCE. And, therefore, in your professional judgment, how will the difference be made up?

Mr. HOLTZ-EAKIN. It will come arithmetically by either cutting spending in other programs, raising taxes, or borrowing even more.

Mr. LANCE. And I would certainly like the expert view of the other members of the panel—Dr. Collins—regarding that issue. And do you agree with the figures that have just been presented?

Ms. COLLINS. Well, 7.7 percent is actually—what we are seeing in the marketplaces, in terms of rate increases, are very similar to what we are seeing in employer-based plans.

Mr. HOLTZ-EAKIN. It is not a premium. It is a Federal spending number.

Ms. COLLINS. Right.

But, also, the other important thing to keep in mind is that costs have been much lower than were originally projected by the Congressional Budget Office.

Mr. LANCE. I am speaking about where we are now, not where we may have been in the past. Are you in agreement that this is likely to be 7.7 percent each year, compounded I assume, over the next decade?

Ms. COLLINS. I think that we can expect some growth in costs over the next year. We have seen a reduction in the rate of growth in healthcare costs—

Mr. LANCE. A reduction in the rate of growth. That is different from an increase.

Do you agree or disagree—that is why we have experts on this panel who are not necessarily in agreement. Do you agree that it is likely over the next decade, a 7.7-percent increase in each of the next 10 years? And perhaps Dr. Holtz-Eakin is wrong. I am asking your professional opinion.

Ms. COLLINS. That is a relatively moderate rate of growth in healthcare costs, relative to the past, over the next few years.

Mr. LANCE. I am sorry. I didn't understand that response. Is it likely to be 7 percent? Is it likely to be 2 percent? Or perhaps Commonwealth Fund doesn't know.

Ms. COLLINS. I think that you have to look at estimates in the context of where we have been in the past, what was projected. And these are likely in line, maybe slightly higher. But they will vary over time. Estimates are estimates, and we will have to see how that plays out.

Mr. LANCE. Ms. Turner, your comments on what I am suggesting? I am persuaded that it is likely to be roughly 7 or 8 percent, and, of course, only time will tell. And, from my perspective, the economy is not going to grow at that rate. I wish it were, but I don't think it is. And, therefore, I am asking where the difference has to be made up. And perhaps you disagree with me, but I would like your comments.

Ms. TURNER. Well, certainly, if it is 7.7 percent, as CBO says—and Dr. Holtz-Eakin, as former Director of the CBO, I think is our most expert witness on this panel—

Mr. LANCE. Yes.

Ms. TURNER [continuing]. Would suggest that it is growing much faster than economic growth.

Mr. LANCE. Yes.

Ms. TURNER. And if, in fact, these provisions, which could help stabilize pools and, therefore, premium rates, do not go into effect—

Mr. LANCE. Yes.

Ms. TURNER [continuing]. Then you are going to wind up with higher and higher costs of premiums. And even if the individual policyholder isn't paying that, the taxpayer is. And that is really what this number is about, is overall taxpayer spending, the rate of growth of spending on health care.

Mr. LANCE. Right. From my perspective, taxes could be increased. Those who were formerly insured and remain insured will have their premiums increase. Or, alternatively, as is always an option, there will be further deficit-spending in this country. I have seen estimates that the deficit annually is likely to increase at the end of this decade. We have done a better job since Republican control of the House of Representatives: \$1.4 trillion, \$1.3 trillion in the first 2 years of the Obama presidency, now roughly \$450 million. In my judgment, it is going to go up again unless we get a handle on this. And these are the issues that concern me greatly.

Thank you. I yield back 18 seconds.

Mr. PITTS. The chair thanks the gentleman, now recognizes Mr. Schrader, Dr. Schrader, 5 minutes for questions.

Mr. SCHRADER. Well, thank you, Mr. Chairman. And I appreciate the hearing. It is fun to actually be talking about ways to improve the delivery of health care, so I appreciate the opportunity to embark on that.

I notice that the title of the hearing is "Patient Solutions for Lower Costs and Better Care" and point out for my colleagues here that myself and Congressman Bilirakis have introduced a bill that talks about lowering drug costs through competition. I would like to maybe get a hearing on that at some point in time. As you know, some of these folks come in with their hedge-fund money and buy up these drug companies and then charge exorbitant prices that no one can afford. And so this is a nice market-based solution for that.

Just a little perspective—and maybe I am wrong. We have experts that can correct me. But the individual market that we are worried about really constitutes only about 5 or 6 percent of the total insurance market out there. We have Medicare, we have employer plans and everything else. So while we are working very hard to fix the individual market in particular, keep it in perspective. It is a small portion of our healthcare market.

That doesn't mean we shouldn't work on it. It doesn't mean that some of what happens there will influence certain healthcare costs in other arenas also. So I think this is worthwhile.

I would also point out that the instability in the market is I don't think unexpected. I did not expect, with the advent of the ACA, everything was going to be great. No one had any idea of what the uninsured population out there would really bring. The rate at which young people would sign up was always in question. And maybe some of these ideas will hopefully address that.

Some competing information that I am going to be looking at from Commonwealth versus some of the other studies, the McKinley study for instance, it would be very interesting to get to some

of these things. And I, for one, would be interested in working on it.

Let's talk about the age bands a little bit. My biggest concern isn't to the consumer; it is to the government. If we go to that 5:1 age band—I think, Ms. Collins, Dr. Collins, you alluded to it—the costs to the government could be significant. My understanding is the subsidies will go up to match the increased premiums for a lot of these people.

So the out-of-pocket expense to the senior, who is going to be paying a higher rate, may not be that much more, but the cost to the government could be in the billions of dollars.

Could you comment on that, Doctor?

Ms. COLLINS. That is right. So this is from research that RAND has done. And what happens is that people—the higher rate bands means that premiums go up for older adults significantly, and because many of them are eligible for tax credits, it means the costs of those plans will go up—

Mr. SCHRADER. Yes.

Ms. COLLINS [continuing]. On the order of \$9.3 billion. So that is the big source of—

Mr. SCHRADER. So I think, as we discuss this, we want to make sure we know how we are going to pay for that. Is the taxpayer on the hook?

Mr. Eakin, do you have a—

Mr. HOLTZ-EAKIN. If I could, that is one piece of the story, but, remember, there would be a reduction in premiums for younger Americans, and many of them will be having subsidized insurance coverage as well.

As the Congresswoman from Florida pointed out, preventive care is an important part of the design of the ACA. Presumably, getting those young people in and undertaking preventive care will make them less expensive risks when they age, so they simply won't show up and be expensive, which is a cost the government would ultimately have to pick up. And an unbalanced pool is the greatest threat to the budget and to the premium costs.

Mr. SCHRADER. Agreed.

Mr. HOLTZ-EAKIN. I think you have to look at all those factors, not just the rifle shot to older purchasers, in the moment when you make the change.

Mr. SCHRADER. Well, we have to because CBO will score this, and we have to find a way under the current rubric to find a way to pay for it.

And I agree with you that, over the long term, the ACA will be a huge plus because of the preventative care. And we are in the worst possible situation right now. We have to pay for the expensive population that hasn't had good health care and, at the same time, spend money to do the preventable healthcare work so that it won't cost us too much later.

On the grace period, I think, clearly, 3 months is too long. It is interesting to hear about the gaming of the system. I think 1 month is way too short. And I think there is, listening to some of the testimony, maybe we keep it consistent with Medicare and some of the other insurance plans we have. Two months—pick a

number—I think that would be something that could be a little more reasonable opportunity for folks.

And I guess I will stop there, Mr. Chairman. I will stop there. And I yield back.

Ms. COLLINS. May I just make one quick point on the tax credits?

There actually aren't any savings for young adults that enroll, on the tax subsidies, on the tax subsidy side, because they are already receiving subsidies. So when the premium goes down for them, the premiums only go down very marginally, and there is really no offsetting savings for the young. There is very little offsetting savings from the lower premiums for young adults.

Mr. PITTS. Did you want to continue, Mr. Holtz-Eakin?

Mr. HOLTZ-EAKIN. I will just agree to disagree and would be happy to provide our analysis.

Mr. PITTS. All right. Thank you.

The chair thanks the gentleman and now recognizes Mr. Griffith, 5 minutes for questions.

Mr. GRIFFITH. As I hear the various folks talking today and I hear both sides talking about costs increasing and costs not increasing as much, I am reminded that when the American public was sold this plan that the President said repeatedly it was going to save the average or typical family \$2,500 in their insurance premium a year.

Nobody is arguing that we are anywhere close to that. The question is are the costs going up more than they would have otherwise? This is a failed promise that was made by this administration, and there is no way around that.

Now, where are we at? We have some bills in front of us. I have heard a lot of discussion about some of the bills, and I am glad that folks realize that I am just trying to fix something with my little bill that ought to be fixed.

But I also know that my colleague Mr. Allen has a bill that basically says that if a state exchange fails and says, "We are done," that there ought to be an audit to make sure that any moneys that the Federal Government has given those state exchanges—we can see what happened to it. We can figure out later if there is money left over and try to get it back, but if there is no money left over, we may not have an opportunity.

And I am just wondering if the three of you all would comment on that, because I haven't heard anybody comment on that today.

Mr. HOLTZ-EAKIN. I will repeat what I said at the outset, which is I believe this is absolutely what the committee should do. These are taxpayer dollars. They should be spent wisely, and there should be the oversight to make sure that is taking place. And if there are moneys left over, they should come back.

Mr. GRIFFITH. Do any of our panelists disagree with that?

Ms. TURNER. Absolutely not.

And I think that Congressman Allen's bill is very responsible. If a state exchange fails, then the Federal Government will go in to conduct an audit to require states to return any unspent funds to the Treasury. It is really hard to argue with being responsible for Federal taxpayer dollars, as this bill does.

Mr. GRIFFITH. Ms. Collins, any comment?

Ms. COLLINS. I completely agree. Unspent funds should be returned. Spent funds is another issue.

If anything, the marketplaces right now are struggling and in need of more dollars for outreach. So the issue before in much of the discussion has involved enrollment. States are facing dwindling resources for outreach and enrollment, so, if anything, more resources are needed to increase enrollment in the marketplaces.

Mr. GRIFFITH. Another part of the original plan included various levels. And we have heard some discussion today about how many different plans are available in various parts. I represent probably the most rural part of Virginia that you can get as a district in toto. And in many of my areas, there is only one provider, so we are having some difficulties with choice in some of the areas. Some of the areas have two or three, but there are areas in my district—I represent 29 different geopolitical subdivisions, so it is a mix, but some of them only have one provider.

And then I saw a headline recently that caused me concern, and that was that Group Hospitalization and Medical Services, a unit of CareFirst Blue Cross Blue Shield, will not offer the bronze-level plans through Virginia's health insurance exchange in 2017. And, of course, the bronze level was the lowest. You have to buy a plan, but you can buy the cheaper version if that is what you want. If you were relatively healthy and you didn't want to go to the expensive plans, you could buy this one.

And some people think this might be an omen for the future that a lot of other companies will drop the bronze plan. But, in 2016, 23 percent of the purchasers in the exchange were bronze-level purchasers.

I am just wondering if any of you all have any comments on what—is that an omen, that this group has decided not to carry the bronze plan or offer the bronze plan? And what does this mean for rates for those folks who are trying to buy the insurance but are on the end where they either don't want to spend more money or can't spend more money to get the silver or better plan?

Ms. TURNER. It is certainly not a good omen for participation in the marketplace by people who are just trying to afford the coverage they are required to buy. And if those policies aren't offered, I think we will see fewer people in the pools, leading to the kind of spirals we have been discussing today that really wind up harming everybody that is in the pools and discouraging others from purchasing insurance.

Mr. GRIFFITH. Is this just another sign of failure of the plan overall, the ObamaCare plan overall?

Ms. TURNER. I think it is a sign of the failure to be able to have the flexibility to provide the kinds of policies that people want. If they don't purchase the policies that are offered—and they are very cookie-cutter plans—then more and more people won't buy them, and I think we will see a destabilized market, really undermining the goal that I believe we all share of what health reform should do, and that is provide more affordable coverage to more people.

Mr. GRIFFITH. I don't have any problem, Mr. Chairman. Mr. Holtz-Eakin wants to say something, but I am out of time.

Mr. PITTS. He may proceed.

Mr. HOLTZ-EAKIN. I just want to emphasize that, on top of the issues that Grace-Marie has raised, the issue of high-quality competition, making sure there are many providers, many plans in every piece of geography, is a concern for me.

And we have seen, if you do apples-to-apples comparison of the same plan that existed last year and then this year, in the most recent year the weighted average increase is 10 percent. That is sort of apples to apples. That is what is going on. With diminished competition, you can expect even worse performance, and I think that is a concern for the future.

Ms. COLLINS. Most people are actually enrolling in silver-level plans, so the majority of the marketplace is at the silver plan level. That is where the tax credits are. That is where the cost-sharing reductions are. So most people are enrolling in those plans.

That is where the price competition really is, and we are seeing very strong competition in many markets. Some markets, some rural markets, maybe less so. But, on average, competition is really high. It is delivering value to consumers.

Ms. TURNER. But many of the people purchasing the bronze plans aren't eligible for those subsidies. And we want them in the plans—we want them to participate in insurance, as well. And that is a real concern.

Ms. COLLINS. I agree that there should be a range of choices.

Mr. GRIFFITH. I yield back.

Mr. PITTS. The chair thanks the gentleman and now recognizes the gentlelady from Illinois, Ms. Schakowsky, 5 minutes for questions.

Ms. SCHAKOWSKY. Thank you, Mr. Chairman.

You know, I am the co-chair of the Senior Task Force of the Democratic Caucus, so I am particularly concerned about the impact a 5:1 age rating policy could have on older Americans and on the marketplaces in general.

Dr. Collins, the Commonwealth Fund conducted a study on this very issue last September, and one of the most striking and almost, I would say, counterintuitive findings from this report was that implementing a 5:1 band, age differential, would increase total Federal spending by \$9.3 billion.

Can you elaborate on that?

Ms. COLLINS. That is right. So RAND found in its analysis that, first, about 400,000 older people would lose their coverage because of the rate band change, but people who remained, older people who remained in the marketplaces would see their premiums go up, and that triggers an increase in their tax credit amount.

The amount of that tax credit RAND estimates to be \$9.3 billion a year, so a big, big increase in cost from the rate band being changed.

Ms. SCHAKOWSKY. Well, thank you.

And, Mr. Chairman, I would like to put at least a summary of the Commonwealth Fund report into the record.

Mr. PITTS. Without objection, so ordered.

Ms. SCHAKOWSKY. Thank you.

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

Ms. SCHAKOWSKY. And I have another one from the Urban Institute, "Why the ACA's Limit on Age Rating Will Not Cause Rate Shock." If I could put that in the record, as well.

Mr. PITTS. And, without objection, so ordered.

Ms. SCHAKOWSKY. Thank you.

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

Ms. SCHAKOWSKY. I wanted to discuss the results of a different study about the Urban Institute study. This study concluded that a 5:1 age band would actually undercharge young adults relative to their actual expenses and overcharge older adults relative to their actual expenses.

I wonder, Dr. Collins, if you could discuss this finding and any other relevant findings from these two reports.

Ms. COLLINS. That is right. So the Urban Institute looked at people's average costs over their lifetime, and the 3:1 rate banding actually tracks those expenses pretty well. So people who are young pay close to what their average costs are, maybe somewhat higher. People who are older pay a little bit lower than their average costs are, or around the same, in a 3:1 banding.

When you change this to 5:1, you get premiums that are much higher for older adults relative to their actual spend, premiums that are lower for younger adults relative to their actual spend. So it actually is less efficient in terms of what people's actual spend is over their lifetime.

Ms. SCHAKOWSKY. Thank you.

I also wanted to go back to an issue that has been discussed before, and that is changing to a 1-month grace period. We have been getting a number of calls from people about that, and let me just tell you and give you a couple examples.

A family of four from my district was told that their subsidy was included in their premium payments. When there was an error processing her subsidy, the insurance chose to terminate the coverage. Now this family is facing thousands of dollars in bills for the care they received during the months when their coverage was terminated, and it was really no fault of their own.

Another constituent, who used auto-pay to make their premiums, received a letter stating that their insurance had been terminated because of some kind of glitch in the auto-pay that was from the insurance company. And despite making those payments, the insurer continues to refuse to reinstate their coverage, claiming they violated the 3-month grace period. And now they will be without insurance until the open enrollment period.

And what this means for people, if they got kicked off in February and the next enrollment period isn't until January, they could be without insurance for a long time.

So, this idea of gaming the system, we are talking about the most vulnerable people. Because they are getting subsidies, that means they make no more than 400 percent of the poverty level. And it just seems to me that 90 days would make—or is it 60? No, no, it goes to 30, but from 90, right?

Yes, that changing from the 90 to the 30, I think, is really unreasonable, and that 90 is not unreasonable.

I guess I am out of time. That must have to qualify as a statement then. Thank you.

Mr. PITTS. The chair thanks the gentlelady and now recognizes the gentleman from Indiana, Dr. Bucshon, 5 minutes for questions.

Mr. BUCSHON. Thank you, Mr. Chairman.

First of all, Ms. Collins, you said that there is a decline in out-of-pocket costs. Which group of patients are their out-of-pocket costs declining specifically? And be short. Because I just don't believe that.

Ms. COLLINS. So that estimate comes from CMS, from the national spending account data. And what they showed between 2013 and 2014 was a slowdown in the rate of growth and out-of-pocket expenses.

Mr. BUCSHON. OK. Let me repeat what you just said. It is a slowdown in the rate of growth. That is different than a decline in out-of-pocket costs. OK. There is no—

Ms. COLLINS. But they also found a decline in—

Mr. BUCSHON. You are on my time.

Ms. COLLINS. Sorry.

Mr. BUCSHON. OK. Thank you.

Ms. COLLINS. Sorry.

Mr. BUCSHON. So it is a slowdown in the increase.

And the reason I say that is because that is very important, because if a deductible goes from \$1,000 to \$6,000, if you have a medical problem, your out-of-pocket costs are going to be six times as much. And what I am hearing, from all of my constituents—I hear this every day, every business, every individual—deductibles are way up.

So, a decrease in the rate of growth of out-of-pocket costs is totally different than saying there is a decline in out-of-pocket costs. That is just factually not true. And so you can respond to that.

Ms. COLLINS. Well, right, there is a decline in the rate of growth. This is across the population. But they also found an actual decline in out-of-pocket spending on hospital care. And that is really—

Mr. BUCSHON. For which group of patients?

Ms. COLLINS. That is the entire—

Mr. BUCSHON. Now, in fact, that could be Medicaid, because—

Ms. COLLINS. Right.

Mr. BUCSHON [continuing]. It is true that if somebody had no Medicaid before and now they have Medicaid, of course their out-of-pocket costs are down, because now they have coverage. Because there is no deductibles or anything for the Medicaid population, right?

So I am going to—

Ms. COLLINS. Right. But this is across the—

Mr. BUCSHON. I am going to need to move on.

Ms. COLLINS. Uh-huh.

Mr. BUCSHON. Thank you for that.

And the other thing you said is they need more money to tell people that coverage is available to them. I can tell you, since ObamaCare was put into law, if you don't know that there are possible options out there to get healthcare coverage in this country, you haven't turned on the TV or listened to any—I mean, the constant thing that "more people will sign up if we just convince them, if we just get the message to them that they can do this" is just not factually true. The reason people aren't signing up is because

it is too expensive and because they are making a personal choice not to acquire health care.

And, by the way, 9 percent of the American people is 28 million or 30 million people. And the number of uninsured before was about 47 million or 48 million people. So, I just want to make sure that we get all that stuff correct.

So, normally, Dr. Holtz-Eakin, how do insurance companies determine their pricing? I mean, is it just a general—I mean, if you are an insurance company and you are going to determine prices for auto insurance, how do they do that normally?

Mr. HOLTZ-EAKIN. You look at the—based on history, the projected frequency of accidents, you look at the cost per accident, what kind of vehicles people are driving, and repairs are increasingly expensive, and you look at the structure of the policy and whether people would be paying deductibles, and look at what is left. And what is left, the premiums have to cover.

Mr. BUCSHON. Right. And you look at the type of risk you are assuming, right?

Mr. HOLTZ-EAKIN. Yes, who is driving.

Mr. BUCSHON. A 16-year-old who just got his license is much more risky. And, you can't necessarily extrapolate that to health care, but they are generally higher-cost people, right?

Mr. HOLTZ-EAKIN. Right.

Mr. BUCSHON. And the rate is set by professional actuaries—

Mr. HOLTZ-EAKIN. Yes.

Mr. BUCSHON [continuing]. That determine this. So, what we are doing in the ACA is we are creating a not-actuarially-sound system, so we are getting the result that we would expect. Would you agree or disagree with that?

Mr. HOLTZ-EAKIN. I would agree. I think the actuaries are struggling to price, and we are seeing these large premium increases as a reflection of their past failures, given the instabilities.

Mr. BUCSHON. Yes.

So, you know, the average, it has been said, was one-five before, approximately? Just the average marketplace, the pricing difference, on average, was about that before, somewhere in that range?

Mr. HOLTZ-EAKIN. Yes. I think this is an important issue. I mean, the CBO in February put out a report that said that the spending for 64-year-olds versus 21-year-olds, the ratio is 4.8:1. So that is the data on what is going on. The pricing should reflect that. And so 5:1 doesn't seem unreasonable.

And I just want to emphasize, nobody in this individual market, on average, is paying the costs. It is a heavily subsidized market.

Mr. BUCSHON. Right.

Mr. HOLTZ-EAKIN. And so, on average, no one is paying their insurance costs.

Mr. BUCSHON. Yes.

And, I was a practicing physician before, I was a cardiac surgeon. And so a lot of people ask me—because they know that—when I am in my district, they ask me about this subject. And when you create—and this will be a statement, and I will end, Mr. Chairman.

When you create a non-actuarially-sound system, you get the expected result. We are just trying to make some modest changes

here to get us back on track so that we can accomplish the goals that we all believe in and get everybody health coverage.

I yield back.

Mr. PITTS. The chair thanks the gentleman and now recognizes Mr. Cardenas, 5 minutes for questions.

Mr. CARDENAS. Thank you very much.

I appreciate the opportunity to hear from you and your perspective on this important issue.

And thank you for holding this hearing, Mr. Chairman.

I was happy to see that the administration announced a series of actions which included a proposed regulation to help consumers who turn 65 make the transition to Medicare so the older consumers are served by the program designed for them to meet their healthcare needs.

So, Ms. Collins, can you talk a little bit about how the administration's actions will help seniors strengthen themselves and help the marketplace pools, as well?

Ms. COLLINS. So that is right. So helping people move into the coverage that they are eligible for is very important. There are multiple different paths to coverage across the age spectrum and also dependent on income, Medicaid, marketplace plans. And now the transition to Medicaid is very important.

So helping people move into the coverage that they are eligible for is extremely important, getting the appropriate subsidies for them and making sure that they are getting the coverage and the care that they need.

Mr. CARDENAS. So one of the fundamental things of anything—private sector, public sector, et cetera—is if something is designed with actuarials in mind and formulas, et cetera, that are truthful and honest about how that should work if it plays out appropriately, part of that is that, in this case, that people are actually in the particular pools or in the particular categories, that helps it play out more to the reality of how it would work better than if it falls apart loosely.

In this case, if people are not aware of their eligibility and they stay in one category versus another, that is part of what hurts any system. Right?

Ms. COLLINS. That is right. So it is very helpful that people, as they age into Medicare, enroll in the Medicare program. And it is also better for them. If they continue on in marketplace plans, they are obviously losing subsidies. So it is very important from a financial perspective, from a coverage perspective that they are able to make that transition and are aware of it.

Mr. CARDENAS. OK. Thank you.

One of the things that frustrates me as a legislator when I was at the state level and the city council level and now in Congress is that when we start arguing about what is wrong with the current system or policy and yet at the same time we are not being honest with the public by juxtaposing that against what the system was like before the change.

Like, right now, one of my colleagues extracted from some of the panelists some of the truths. A lot of complaints from our American citizens here that, their deductibles go up a little faster, what have

you, it is uncomfortable, they don't want to spend that money, et cetera.

But isn't it true that, under the ACA, that the overall cap per individual, single person in a plan is \$6,850 and it caps? And then, therefore, there is no more out of pocket. The plan takes care of the rest. And if you are a family, it can go no higher than \$13,700. Isn't that part of the ACA currently, that fact?

Ms. COLLINS. That is correct.

Mr. CARDENAS. OK.

Secondly is, under the ACA, a person, whether they are on a public plan or private plan, et cetera, marketplace plan, they are not allowed to be kicked off for a precondition. Isn't that current, the law in the United States, when it comes to healthcare coverage? Fact?

Ms. COLLINS. That is correct.

Mr. CARDENAS. OK.

But, see, the thing is, what I think it is important for me to do in the last minute and a half of my time here is to point out that, before the ACA came into law, what was the deductible cap in America for healthcare coverage?

Let me help because of the limited time. Did it cap at \$100,000? Maybe in a particular plan. Did it cap at \$200,000? Maybe in a particular plan. Wasn't it legal for someone to sign up for a plan, an insurance company to give them that plan and have an unlimited deductible?

For example, if a family member or several family members under one plan actually got cancer, you could have deductibles of eventually 20 percent of whatever the expenditure was. So if that cancer treatment in that family was a million dollars—which is not unlikely, correct, panelists? That is possible, right, in America?

OK. That being the case, then the family could be on the hook for \$200,000 in 1 year's worth of coverage. But, today, the worst-case scenario for a family if you have cancer is \$13,700.

And my last point that I want to make is that it is inappropriate for us as legislators to remind America about the things that we don't like about the Affordable Care Act without reminding them that if that family got cancer and then next year, for example, the father lost his job or what have you and then had to go to a different plan, before the ACA, they might not be able to find a plan because they had the right to be denied because of a precondition.

And under today, one last question to the panel is, under the ACA, isn't it illegal for someone to be not allowed to have coverage if they have a precondition? Aren't they required to be able to be provided coverage by the private sector or the public sector?

Ms. COLLINS. Yes.

Mr. CARDENAS. Yes.

Yes?

Yes?

Thank you very much.

I yield back.

Mr. PITTS. The chair thanks the gentleman and now recognizes the vice chairman of the subcommittee, Mr. Guthrie, 5 minutes for questions.

Mr. GUTHRIE. Thank you. Thank you so much.

And the cap would actually lessen the impact of a rating band change, because if people are at the cap and it went from 3:1 to 5:1, then they actually wouldn't see an effect if they were at the cap, so the cap would fix that.

But one thing that we are talking about and, trying to reach out to encourage more people to get into the exchanges without spending Federal dollars, if the marketplace worked like it should, then the insurance companies would be doing that. They would be marketing themselves and trying to attract people to come into their insurance companies, because that was kind of the concept. And so it puts into perspective what the problem is: The insurance companies are exiting the exchanges.

And a month ago, we talked about plans, including the Nation's largest insurer in the exchange. United has pulled out of over 25 states because they project \$650 million in losses this year.

And this hurts patients. Plans exiting exchanges has the potential to severely limit competition in some states where patients may have only one option. And Alaska is an example. This week, their state legislature acted out of desperation to save their last remaining plan from running away from ObamaCare. They set up a \$55 million bailout fund, paid for by insurance companies, to subsidize enrollees that can't afford ObamaCare's premium hikes.

In the next decade, the Federal taxpayer will spend \$568 billion on premium subsidies, \$130 billion on cost-sharing programs, and, still, exchanges are collapsing. So all those people are getting benefits, but they are also coming at costs to the taxpayer that we have to balance.

So, Ms. Turner, is the answer to a failed Federal program more Federal intervention?

Ms. TURNER. No. At some point, I think you realize that the rules and regulations of the ACA are becoming counterproductive because people are figuring out how to game the system. And I think that is really what we have to look at. Where is this going?

And could I just correct the record earlier about Dr. Collins saying that the 3:1 age band really reflects more the consumption of individuals? It is really closer to 6:1.

And the 5:1 rating band that would be allowed under this legislation really still gives the states the authority to override this. So it basically says, states, we understand you have been regulating health insurance for a long time. If you know best, then you do that, but let's not use wrong data.

Mr. GUTHRIE. Well, Mr. Holtz-Eakin, would the age rating band change? How would that affect what is happening in Alaska today? Would that have a benefit to try to keep people into the marketplace?

Ms. TURNER. Absolutely. Absolutely. If you want to get more young people in and if you—

Mr. HOLTZ-EAKIN. I agree with her.

Mr. GUTHRIE. You agree with that?

Ms. TURNER. Oh, I am sorry. Was he asking you?

Mr. GUTHRIE. OK. Yes, you agree.

Well, I asked for that, but that is fine.

And in the time I have left—I was going to yield some time to Dr. Burgess, but he just stepped out, I guess. In the time I have

left, I would like to call attention to another number. There are 23,000, that is the number of Alaskans that state lawmakers are hoping to save with a \$55 million cash infusion.

This is real life in the current law. It is not working.

And, with that, I don't see him here. I will yield back.

Mr. PITTS. All right. The chair thanks the gentleman and recognizes the gentlelady from Indiana, Mrs. Brooks, 5 minutes for questions.

Mrs. BROOKS. Thank you, Mr. Chairman.

I am really pleased that our committee is focusing on market reforms for our healthcare system, particularly those that might give states greater flexibility to operate their individual markets in ways that reflect their respective needs.

Before 2010, 42 different states allowed an age band rating of 5:1. In 2010, of course, it was restricted to 3:1. As we have heard, this change has resulted in higher premiums for younger Americans, who have stayed out of the marketplace. And with fewer young Americans in the marketplace balancing out the premium costs for older Americans, this is leading to that more older and more costly insurance pool, which is providing no cost relief to seniors' rates. So it seems to me to be a no-win situation, but it should have a solution.

The State Age Rating Flexibility Act would give states the right to establish age rating bands that best fit their insurance market to be more reflective of the needs of their population. And it seems that our goal should be to attract younger, healthier patients to the healthcare plans. This would benefit everyone, the young and the elderly.

And so I would like to continue to focus on that, and I will start with you, Ms. Turner. You indicated in your testimony making health insurance too expensive for healthier young people that we want in these insurance pools drives them away, increasing the cost of the insurance for everyone else who remains.

Can we go deeper on this issue? And studies you have seen, analyses you have seen, moving that ratio back to 5:1, would it have an immediate impact on the cost?

Ms. TURNER. Actually, I think Dr. Holtz-Eakin may have some data here that would inform that.

Mrs. BROOKS. So, Dr. Holtz-Eakin, please.

Mr. HOLTZ-EAKIN. These are not average premiums for singles and for families—this includes both the older and the younger ones which would fall in these markets. That is a benefit. That is going to lower the out of pocket, the sort of premium costs for individuals. It is going to lower the taxpayer costs for subsidies. This is a beneficial move. It matches the data on spending by those groups, and it leads to better long-run stability.

So I would be happy to provide this analysis for the record.

Mrs. BROOKS. We would certainly like that analysis provided for the record.

And, I guess, Ms. Collins, how do you refute those studies?

Ms. COLLINS. The RAND analysis shows an increase in premiums for someone who is 64 years old—this is the silver benchmark plan—of \$2,000, relative to a decline, only a marginal de-

cline, in someone who is 21 years old of about \$700. So, much bigger increases in premiums for older adults.

Mrs. BROOKS. And so, Dr. Holtz-Eakin, how would you compare what that RAND—because I am sure you have seen that RAND study that differs from the studies that you have. So how do you explain this discrepancy?

Mr. HOLTZ-EAKIN. To be honest, I can't at the table. But I would be happy to provide, along with ours, our analysis of the RAND study and why they have come to a different conclusion. That seems perfectly reasonable.

Mrs. BROOKS. OK. I think that would be important to clarify this.

Ms. Turner, would you like to comment?

Ms. TURNER. I think one of the things that—there is a new study out, actually, this week by the Council for Affordable Health Coverage that shows that fewer than 40 percent of enrollees in the exchanges are younger than 35 years old, although they are 50 percent of the potential exchange market.

So I think that really shows that the premiums, even now—and the first year, 2 years really did not reflect as much experience in premium setting as I think subsequent years were—already we see a smaller percentage of young people signing up for the exchange than are eligible for them. And I see that if we continue this same trend, allowing the gaming of the system and other provisions in this law, that is going to get even worse and we are going to see even more young people dropping out. And the costs are going to go up for older people in the exchanges, no matter what, if young people are not participating.

Mrs. BROOKS. That is the point that I think is so important here.

Would you agree, Ms. Collins, that if fewer young people don't get into the exchange, prices will go up for seniors?

Ms. COLLINS. That is exactly right. And—

Mrs. BROOKS. And our goal—

Ms. COLLINS. Right.

Mrs. BROOKS [continuing]. Is to try to bring as many young people into the pool because that would lower the cost for seniors.

Ms. COLLINS. Right. But most young adults who are outside the pool, outside the marketplace right now actually have incomes that make them eligible for the subsidies. So they wouldn't actually be affected by the change in the rate.

Mrs. BROOKS. Could you all respond to that?

Ms. TURNER. We want more people in the exchanges who are not eligible for subsidies. And the only way to attract them is to make the policies more affordable.

Mrs. BROOKS. OK.

Dr. Holtz-Eakin?

Mr. HOLTZ-EAKIN. And it is not a bad thing to have premiums be lower and have the subsidies be less of a drain on the taxpayer.

Mrs. BROOKS. Thank you.

I yield back. Thank you very much.

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

Mrs. BLACKBURN. Thank you all. And I know we are going to be running up against votes, so I am going to move on through this.

I have legislation that would deal with this open enrollment period. And I am so appreciative of you all being here. And this is a particular concern of mine because of what we lived through in Tennessee with TennCare, which was the test case for HillaryCare.

And, Ms. Turner and Mr. Holtz-Eakin, I know that you both are familiar with the failures of that program and some of the strain that was put on that program because of extremely generous open enrollment and not doing the verification on eligibility.

And, Mr. Holtz-Eakin, I appreciated that you had called the ObamaCare special enrollment period extremely generous. That was how we defined what was happening in Tennessee.

Back in December, Chairman Upton asked CMS for details about the special enrollment, and we were trying to get numbers. We are told the insurance companies have those numbers, that CMS does not have those. But what we did get was a list of the special enrollment exceptions, which is loss of minimum essential coverage, a permanent move, a birth, adoption, placement for adoption, placement for foster care, child support or other court order, or marriage.

So my question would be—and, Ms. Turner, I will come to you because you had made the comment—and we saw this in Tennessee too—that a growing number of people are using ObamaCare as just-in-time insurance. They only get it if they think they are going to need it.

So, in your view, would going into a pre-enrollment verification process and applying that to special enrollment avoid part of this problem that we are seeing with the special enrollment programs and the just-in-time insurance?

Ms. TURNER. Yes. And you can't, Congresswoman Blackburn, have a system in which people aren't following the rules of insurance. If you are going to have private health insurance system, it has to work like private health insurance. And if people can only buy the coverage when they are sick and then drop out afterwards and buy coverage again if they get sick again later, that is not going to work at stabilizing these pools over time.

And people are figuring it out. A study with consulting firm Oliver Wyman said that people who enrolled during the special enrollment period were 24 percent more likely to have high costs in the first 3 months than regular enrollees and 41 percent more likely in the next year. So, over and over, we are seeing that this is a trend, and it is not a trend that is going to be sustainable over the long term.

Mrs. BLACKBURN. Well, based on that, wouldn't you say that doing pre-enrollment verification is really a fairness mechanism to be fair to everybody?

Ms. TURNER. Absolutely. And there should be exceptions. If somebody has problems with the electronics of the system, which some people do, then certainly there will be exceptions to protect people who are trying to play by the rules, but to make sure people who are not are not incentivized to misuse this insurance.

Mrs. BLACKBURN. Yes.

Ms. COLLINS, would you agree with that, that the pre-enrollment verification would be fair to everybody involved in the process?

Ms. COLLINS. I really think it would actually discourage people from enrolling. And we really do need to make sure we have a lot of people in the risk pools, have young adults in the risk pools.

Mrs. BLACKBURN. Wait a minute. You think that having to prove worthiness would be unfair?

Ms. COLLINS. The new guidance by the administration, by CMS, is requiring people to submit documentation proving that they lost their job, proving that they got married, proving that they had a baby, which is probably the big source of costs that insurers are seeing. Babies are, by definition, more expensive when they are born.

And the other thing the administration is doing, they have made an adjustment in their risk adjustment program to allow for——

Mrs. BLACKBURN. OK. Let me get back to the——

Ms. COLLINS [continuing]. Partial enrollment.

Mrs. BLACKBURN [continuing]. Topic, though. But you would say that to submit to pre-enrollment verification would be an unfairness?

Ms. COLLINS. I think that people should be able to enroll before they provide documentation. So we don't want to——

Mrs. BLACKBURN. Oh, so you think——

Ms. COLLINS [continuing]. Discourage people from enrolling.

Mrs. BLACKBURN [continuing]. They ought to be able to get the benefits before they prove who they are. I am going to disagree with you on that one.

And, Mr. Holtz-Eakin, I am going to come to you on this. Because we are hearing that stability and balance in the programs, that is the goal—stability. And we know that verification leads to that.

So wouldn't it behoove these programs to do their verification on the front end before they let somebody in, rather than letting them in, letting them get what they want, paying the bills, and then kicking them out, or them just not paying the bill?

Mr. HOLTZ-EAKIN. I think we have to look closely at this. The reality is that the term "special enrollment period" suggests the exception to the rule, a tiny thing. One in five of the enrollees comes through these SEPs. They are disproportionately expensive, so more than one-fifth of the costs are coming through this. They are disproportionately likely to stop paying their premiums, so cost-shifting comes from this.

It seems to me a simple matter to make sure that if those phenomena are going to happen they should happen only with people who are genuinely eligible for the coverage.

Mrs. BLACKBURN. Thank you.

I yield back.

Mr. PITTS. The chair thanks the gentlelady.

And, without objection, we will go to Mr. Flores, who is a member of the full committee, for questions, 5 minutes.

Mr. FLORES. Thank you, Chairman Pitts. I want to thank you and Ranking Member Green for allowing me to be part of this important hearing today.

This hearing is about finding solutions that will better the healthcare outcomes for our constituents. And one of the issues be-

fore us today is grace periods, which we are trying to address in my legislation as set forth in H.R. 5410.

As I understand it, under current law, patients with subsidized exchange plans have up to a 3-month grace period to maintain coverage when they don't pay their health insurance premiums for a given period of time. During that 3-month grace period, the plan they subscribe to cannot discontinue the service for the non-payment of premiums.

Given this payment structure, this means that patients receiving the advanced premium tax credits can pay for only 9 months of health coverage but receive a full year of coverage.

Ms. Turner, is this correct?

Ms. TURNER. Yes, that is absolutely correct. And a growing number of people are doing that, as studies are showing, and it—

Mr. FLORES. We will dig into that in a minute, so thank you.

Mr. Holtz-Eakin?

Mr. HOLTZ-EAKIN. Yes.

Mr. FLORES. Ms. Collins?

Ms. COLLINS. No, that is actually not correct. So if they don't pay their premium in the first month, their claims cannot be paid and—

Mr. FLORES. No, no, no, no. Are they receiving coverage? They can go to the doctor, right, during months two and three and get treatment, correct?

Ms. COLLINS. But their claims are not covered.

Mr. FLORES. Go read the—

Ms. COLLINS. Their claims are not covered.

Mr. FLORES. Go read the law. It does say that.

And my second question is, in the first month, the plan must cover claims. And here is where you are correct, Ms. Collins, is that in months two and three, the plan may hold the claim, but the patient is still insured. And that is where you are incorrect. And after 3 months, the plan may finally discontinue the coverage and reject the claims from the second and third months, and then the provider, the doctor, is on the hook to recoup the outstanding payments from the patient.

So three questions for you.

The first one is, what effect does this have on the economics of health care? The second one is, what effect does this have on premiums? And the third one is, what effect does this have on the providers, our doctors, to their cost and how do they have to recoup that?

So, Ms. Turner, again, on the economics of health care.

Ms. TURNER. I think, in particular, that we have to look at doctors because doctors and hospitals are on the hook for this. And one of the things that that does is discourage them from wanting to take exchange patients.

Mr. FLORES. Right.

Ms. TURNER. And so that is going to wind up having access problems, if people have a history of not paying their claims, because people are often repeat offenders in misusing this.

Mr. FLORES. Now also, what happens—let's say, if a doctor has to provide 12 months' worth of procedures to a patient, let's say you have got a chronically ill patient, but 2 of those months the

doctor doesn't get paid for that. What does the doctor do with that 2 months that they have to charge off?

Ms. TURNER. Yes, they eat the cost.

Mr. FLORES. And what happens then?

Ms. TURNER. Their practices are increasingly threatened by non-payment of premiums—or of bills and——

Mr. FLORES. How do they recoup it? They are not——

Ms. TURNER. They have to go after the patient.

Mr. FLORES. OK. But if the patient doesn't pay, then what happens? They have to raise the cost for everybody else. Right?

Ms. TURNER. That is right.

Mr. FLORES. OK. Mr. Holtz-Eakin—and what effect does it have on premiums, Ms. Turner? I am sorry. I didn't mean to—on premiums.

Ms. TURNER. Well, of course, it increases premiums because that has to be built in.

Mr. FLORES. OK. Mr. Holtz-Eakin, on the economics of health care.

Mr. HOLTZ-EAKIN. Costs are incurred.

Mr. FLORES. Right.

Mr. HOLTZ-EAKIN. And they will be paid in one form or another somewhere in the system.

Mr. FLORES. Right.

Mr. HOLTZ-EAKIN. They simply don't disappear.

Mr. FLORES. And so, theoretically, premiums would go up to offset the loss, the high claims but low premium receipts. Right?

Mr. HOLTZ-EAKIN. The insurers piece, they will try to raise premiums to cover theirs. The providers' piece, they will try to raise price to cover theirs. And if they can't do that, they will stop seeing those patients or leave practices entirely. You will have fewer providers, costs will go up anyway.

Mr. FLORES. OK. So this law is supposed to be about fairness, yet doesn't this 3-month gap work as a penalty to patients who follow the law and follow their plans and pay for 12 months' worth of coverage as compared to those who get 12 months of coverage but only pay for 9 months? Mr. Holtz-Eakin, does that sound fair to you?

Mr. HOLTZ-EAKIN. No. Deliberate gaming of the system is inappropriate.

Mr. FLORES. OK. Ms. Turner, does that sound fair to you?

Ms. TURNER. Absolutely not. And it is going to discourage the people who want to play by the rules from doing so.

Mr. FLORES. Ms. Collins, does that sound fair to you?

Ms. COLLINS. There is very little evidence that people are gaming the system. If anything——

Mr. FLORES. Well, I disagree with you on that because I have got—I am not running out of time here. As Mr. Holtz-Eakin—this is in response to you, Ms. Collins. As Mr. Holtz-Eakin points out, this same report goes on to say that 57 percent of the patients who stopped paying for coverage are medium or high risk, and roughly have the patients admitted that they stopped paying for their plan in 2014 as well.

So, Mr. Holtz-Eakin, as you note, and the current process could easily allow individuals to take financial advantage at the expense

of other paying consumers and taxpayers. What defense is there in not closing this gap?

There is not any. OK.

And I will just end by reading a quote from Ms. Turner's testimony that I found to be particularly alarming, and that is, "Abuse of the grace period is undermining the concept of insurance and driving up the cost of coverage for others." If we all bought 12 months' worth of car insurance and only paid for 9 months, then we would all wind up paying for 12 months of car insurance somehow somewhere.

So thank you, Mr. Chairman. I yield back.

Mr. PITTS. The chair thanks the gentleman. That concludes the first round of questioning.

I have a UC request. The statement by America's Health Insurance Plans submitted for the record. Without objection, so ordered. [The information appears at the conclusion of the hearing.]

Mr. PITTS. We are going to go to one follow-up per side.

The chair recognizes the ranking member, Mr. Green, 5 minutes for a followup.

Mr. GREEN. Thank you, Mr. Chairman. I appreciate the chance to do a followup. Again, I want to be sure we are trying to get more—the whole point of the Affordable Care Act was trying to expand coverage. The three bills limiting grace periods, special enrollment periods, prior authorization, and age rating would make it much harder to get and even to keep coverage. And I understand the churn because that happens every day. People buy auto insurance and then they get their card, in Texas, because you have to have mandatory liability, and then they cancel. And that is part of the system, whether it is Affordable Care Act or the private sector.

So my concern is, Ms. Collins, would these three bills limit that opportunity to get more coverage instead of less coverage? Again recognizing it is a checkerboard. Because if the states didn't expand their Medicaid, even though for the first 3 years it would be 100 percent reimbursement—which, by the way, I introduced a bill that would require Congress to do it instead of just—because all my legislators said: Well, how do we know you are going to do it? Well, let's put it in the law and make sure that happens.

But will these three bills limit the ability to expand coverage under the Affordable Care Act?

Ms. COLLINS. It will definitely limit enrollment. Requiring people to provide documentation before they enroll in a special enrollment period will definitely moderate or modulate people's ability to do that. There is an under use, if anything, of special enrollment periods among people who are eligible for them, particularly people who lose their jobs. So they are experiencing gaps in coverage. We know there is much more likely to have a cost-related access problem or not get care when you have a gap in coverage.

So that would definitely—and the reduction in the grace period would also make it likely that people wouldn't—and I think most people probably think when they don't pay a premium in one month that their coverage is over. So allowing people, making sure people are aware that they have a 3-month period to make up that premium would ensure that they are able to continue that coverage

throughout the year rather than just drop it and be uninsured for the rest of the year.

Mr. GREEN. Well, I have to admit when I first saw the posting on these bills, I thought: Well, good. We are getting to some level that we can work on the problems with the ACA and expand coverage at the same time. And I think my colleague from Oregon mentioned, we might be able to work on the grace period, to match it with some other Federal—like some other Federal—but that is not going to happen.

And again, I think the bottom line when we do some day get into saying, OK, let's fix what is wrong with the ACA, the goal still ought to be to make sure we have more coverage. Because that is what the intent was and—of the bill or the law now. And I would hope that is the intent, to provide opportunity for people to have health care in our country instead of making it harder. And, again, the free market will do it.

If I owned an insurance company, believe me, I would want to make sure everybody was healthy. We used to have examples—for seniors, for even Medicare Advantage I heard: If you can walk up these two flights of stairs, we will say you are Medicare Advantage. That is not something we need to do. People need health care no matter what their illness is.

Now, again, ratings is ratings. And age is age. But the whole goal is to expand the coverage for people who don't have it. Because right now we are paying for it. The private sector is paying for it. If someone shows up in our emergency rooms in Houston and maybe—and uncompensated care fund, I think they may get 10 percent of whatever they—but believe me, those for-profit, even nonprofit, are somehow going to get reimbursed from someone, whether it be through the regular insurance market, the folks who have it. But to get those folks to have something, even if it is just Medicaid.

Thank you, Mr. Chairman. I will yield back.

Mr. PITTS. The chair thanks the gentlemen and now goes to Dr. Burgess, 5 minutes for a followup.

Mr. BURGESS. Thank you, Mr. Chairman.

Ms. Collins, earlier this year the news reports were that UnitedHealth Group was withdrawing from covering in the exchanges. Do I understand that correctly?

Ms. COLLINS. That is right.

Mr. BURGESS. Do you know why they made that decision?

Ms. COLLINS. Well, if you look at the data on UnitedHealth Group, they were very uncompetitive in most of the markets that they were operated in. So they were rarely the second lowest cost silver plan in most of the markets they were operating in. So they actually were probably not the choice of many consumers just because they weren't pricing very competitively.

Mr. BURGESS. Or perhaps they were pricing more sanely because—clearly, if a big group like that thinks they can make money in the system, they are likely to stay. And if they think they are going to lose money, they are likely to withdraw. Do you think they saw something that the other companies didn't see earlier on?

Ms. COLLINS. Well, they had very little experience in the individual market prior to entering the marketplaces. So they knew

less about their risk pool than some of the other carriers that had more experience in the individual market, so which might have been reflected in their higher premium rating.

Mr. BURGESS. Might have been, but they also may have had the ability to peer over the horizon a little bit. Now, a company that does have extensive experience in the individual market in my state, in Texas, Blue Cross Blue Shield, and they have asked for a 60-percent increase for next year. Does that seem reasonable that they would come in with that sort of request?

Ms. COLLINS. It seems very high. Again, these are preliminary rates, so they will be adjusted by regulators through the rate review process. And it is very unlikely that consumers would end up paying that size of increase, both because they may choose to enroll in different plans that are lower priced in Texas or that the tax credits will actually protect them from that kind of increase.

Mr. BURGESS. Yes. But someone like myself who is in the individual market in an unsubsidized plan, there is no protection from a subsidy. You either pay the price or you don't buy the product. Right?

Ms. COLLINS. Right. But if you have other choices that are lower priced, then we have evidence that about 43 percent of people switched plans last year.

Mr. BURGESS. I don't mean to interrupt you, because time is short. What evidence do we have that the number of choices in a marketplace like Texas are going up?

Ms. COLLINS. The plan offerings between 2015 and 2016 were relatively stable. We do know that most carriers—UnitedHealth Group is an exception, really, to the rule. Most carriers are committed to the marketplaces in 2017.

Mr. BURGESS. I guess we will find out if that is correct.

Let me just ask a couple of questions on the 90-day issue, because you made some comments earlier in the testimony that on the nonpayment part, after we have gone the 30 days, the carrier is on the hook for the first 30 days, I believe you said, then beyond that the insurance carrier is no longer on the hook for that. But the recipient, the insured, perhaps they would be required to pay the part that now was in arrears. Is that correct?

Ms. COLLINS. Right. So if they didn't pay their premium in the first month, and they don't pay in the second month or the third month, they are responsible for continuing to pay the premium in the first month, but they also have to pay their tax credit back in that first month. The claims that they incur in the second and third months would not be covered by their insurance coverage. So by restricting—and by the design of that, of the grace period allows people who have fluctuating incomes, low income, who can't come up with the premium payment in that first month, it gives them time to make up that—to pay that premium. It makes providers happier because their second month they will get coverage for their care. Third month, be able to get coverage for their care. Cutting it off at one month, they will continue to get care but have no health insurance for that care. Providers would be on the hook too.

Mr. BURGESS. But let's talk about that 60 days after the first 30 days. That insured is no longer receiving the tax credit in those months. Is that correct?

Ms. COLLINS. The carrier receives it, but the insured is not covered.

Mr. BURGESS. Is the carrier then required to pay that tax credit back?

Ms. COLLINS. The insurer has to pay the tax credit back, if the premium is not paid in the second or third month.

Mr. BURGESS. Does any portion of that recovered tax credit go to offset the cost of the care that was delivered to the insured that was being carried during those 30 days? 60 days?

Ms. COLLINS. In the first month.

Mr. BURGESS. No, I am taking about specifically the second or the third month, the second—the 60-day outlier part of that.

Ms. COLLINS. Right. The carrier is not responsible for covering the claims in the second and third month the premium is paid.

Mr. BURGESS. So is any portion of that recovered tax credit from the insurance company, does that go to somehow offset the cost of the care that was delivered?

Ms. COLLINS. I do not think so.

Mr. BURGESS. Yes. And that is inherently the problem here. And as much as—with all the affection that I have for Dr. Holtz-Eakin, doctors generally cannot increase their prices. We generally work under contracts. I know it is supposed to be a free market, but generally we sign contracts with insurance companies to provide at a set fee. So it is very difficult—particularly for the individual provider to raise fees to cover that which was not covered by the time the patient was in arrears.

I thought you turned me off because my time was up. You let me go on. I do want to again thank the panelists for being here. It was an important hearing. I am glad we have had this opportunity today.

Thank you, Mr. Chairman, and I yield back.

Mr. PITTS. The chair thanks the gentleman. That concludes the questions from the members present. We will have follow-up questions in writing that we will provide to you. We ask that you please respond.

I remind members that they have 10 business days to submit questions for the record. That means they should submit their questions by the close of business on Friday, June 24.

Very interesting hearing, interesting back and forth. We thank you very much for your presentation today.

And I understand, Ms. Turner, we should wish you happy birthday today. Thank you for spending your birthday with us.

Without objection, this hearing is adjourned.

[Whereupon, at 11:28 a.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]



Lee Saunders
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Laura Reyes
Secretary-Treasurer

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Jeanette Di Wynn
Tallahassee, FL

800-451-1515
1115

June 9, 2016

Dear Representative:

On behalf of the 1.6 million members of the American Federation of State, County and Municipal Employees (AFSCME), I am writing with respect to tomorrow's hearing on "Advancing Patient Solutions for Lower Costs and Better Care." Specifically, we want to express our opposition to the proposals under discussion that would increase age rating for older Americans, restrict the ability of consumers to enroll in coverage during special enrollment periods and reduce the grace period available to marketplace enrollees. These proposals would not reduce costs or ensure better care. Instead, they would drive up costs and cause more consumers to experience delays and termination of coverage.

The Affordable Care Act (ACA) addressed one of the most pressing problems in our health care system, the inability of older Americans to afford or even obtain health coverage due to their age and health status. Under the ACA, insurers may not charge older adults more than three times the amount young people are charged for similar health care coverage. This key feature of the ACA has helped to cut the number of uninsured Americans, age 50-64, by half. Rep. Susan Brooks' proposal would allow insurers to charge older individuals five times the amount younger adults are charged. This proposal would not only drive up costs substantially for older individuals, it would increase the number of uninsured by an estimated 400,000 according to research by the Commonwealth Fund. Moreover, the Commonwealth Fund found that the proposal would also increase federal spending.

Our economy is large and dynamic, with large numbers of people relocating, moving in and out of jobs and in and out of Medicaid eligibility. We urge the Committee to be cautious about pursuing changes to the ACA's special enrollment periods (SEPs) that would force individuals experiencing changes in their lives to wait to access health coverage and tax credits for which they are eligible. It is not surprising that those who make greater use of SEPs tend to be less healthy. They are more motivated to seek coverage while some healthier individuals may be willing to wait until the next regular enrollment period. But Rep. Marsha Blackburn's proposal may actually create adverse selection problems by imposing obstacles that further reduce the number of healthier individuals who pursue coverage during SEPs.

We also oppose the proposal to reduce the ACA's three-month grace period for nonpayment of premium, to the 30-day period established by most states prior to the ACA. Grace periods established by states were designed for very different circumstances. The state grace periods apply to coverage that is wholly paid for by the insured. In contrast, the ACA grace period applies to coverage that is paid in large part

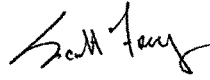
American Federation of State, County and Municipal Employees, AFL-CIO

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by federal tax credits that cover 73% of the premium on average. As a result, insurers are paid a significant share of the premium for marketplace enrollees who are late or who fail to pay their share of the premium. In addition, state grace periods were established when there was no requirement that individuals and families have health coverage. It would be punitive to impose such a short grace period on those who would then be penalized for going without insurance. This is especially true when so many eligible for tax credits struggle to meet other basic needs.

We appreciate the opportunity to convey our concern about these proposals.

Sincerely,

A handwritten signature in black ink, appearing to read "Scott Frey". The signature is fluid and cursive, with the first name "Scott" and last name "Frey" clearly distinguishable.

Scott Frey
Director of Federal Government Affairs

SF:BC:rf

AFL-CIO

LEGISLATIVE ALERT

June 9, 2016

Dear Representative:

On behalf of the AFL-CIO, I am writing in regard to tomorrow's hearing in the Energy and Commerce Subcommittee on Health titled, "Advancing Patient Solutions for Lower Cost and Better Care." We believe that three of the bills to be examined tomorrow represent harmful policy proposals that should be opposed.

One of these bills would change the allowed age variation in health insurance premium rates from the current ratio of 3:1 to 5:1 in the Affordable Care Act (ACA) marketplaces and the individual and small group markets. Charging older adults up to five times more than the premium costs faced by the average consumer would have several negative effects. The Commonwealth Fund found that higher premium costs under this policy would cause 400,000 seniors to lose their insurance coverage and the federal government would face \$9.3 billion in extra costs. The net effect of this policy is to provide a financial boost to insurance companies while imposing substantial costs on seniors and taxpayers. We urge you to oppose this policy that picks the wrong winners and losers.

A second bill would restrict the grace period that currently protects ACA marketplace insurance enrollees when they are unable to cover their monthly premium on time. Currently, when enrollees fail to pay their full premium on time, they have a three-month period in which to catch up with their payments before their coverage is terminated. This protection is particularly important for low-income households that may see their income fluctuate from month to month. This legislation, however, would limit the grace period to 31 days or the length required under a state's statute. Presumably, this bill is intended to ensure that insurance companies will not face losses from the nonpayment of premiums, but their liability is already limited under current law to one month's worth of claims. Like the previous bill, this legislation puts the interests of insurance companies over that of working people.

Another of the bills would require the Centers for Medicare and Medicaid Services to establish procedures to verify eligibility for enrollment in a marketplace plan when a person has experienced a major life change (such as the loss of a job or the birth of a child) that provides for a special enrollment period (SEP). The bill does not, however, provide for additional funding to ensure that the collection of new information will be efficient and user-friendly. In addition, the insurance industry has not produced data showing that these SEPs have been abused, and the Urban Institute has estimated that only 15 percent of the people eligible for SEPs actually use them. Since this bill does not target a significant problem and has the potential to creating barriers to coverage, we ask that you oppose it.

We hope you will have an opportunity to explore the shortcomings of these bills at tomorrow's hearing and will work against their enactment going forward.

Sincerely,

A handwritten signature in black ink, appearing to read 'William Samuel', with a stylized, cursive script.

William Samuel, Director
GOVERNMENT AFFAIRS DEPARTMENT

American Federation of Labor and Congress of Industrial Organizations

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June 9, 2016

The Honorable Joe Pitts
 Chairman
 House Energy & Commerce
 Subcommittee on Health
 2125 Rayburn House Office Building
 Washington, DC 20515

The Honorable Gene Greene
 Ranking Member
 House Energy & Commerce
 Subcommittee on Health
 2322A Rayburn House Office Building
 Washington, DC 20515

Dear Chairman Pitts and Ranking Member Greene:

Thank you for holding this week's hearing entitled, "Advancing Patient Solutions for Lower Cost and Better Care." AARP shares the subcommittee's desire to examine ways in which costs can be lowered and better care provided to all Americans. However, charging older Americans more for coverage purchased through the Affordable Care Act's (ACA) federal and state insurance marketplaces via relaxed age-rating will achieve neither of these goals. In fact, not only will seniors' costs rise dramatically, ample evidence suggests that relaxing restrictions on age rating bands could increase – rather than reduce – federal outlays on health care.

AARP, with its nearly 38 million members in all 50 States and the District of Columbia, Puerto Rico, and U.S. Virgin Islands, is a nonpartisan, nonprofit, nationwide organization that helps people turn their goals and dreams into real possibilities, strengthens communities and fights for the issues that matter most to families such as healthcare, employment and income security, retirement planning, affordable utilities and protection from financial abuse.

The Affordable Care Act's (ACA) Impact on Older Adults

The ACA addressed key obstacles in availability of health coverage for Americans ages 50-64. The result has been stark and historic – implementation of the ACA has reduced by half the number of Americans 50-64 years old who are uninsured.

Prior to the ACA, health insurance coverage was out-of-reach for many older Americans not yet eligible for Medicare. Many paid more for less coverage than they do today and a great number of state laws permitted insurers to charge older

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Americans five times or more than younger people for insurance coverage. In many instances, due to a pre-existing condition, coverage was not only unaffordable but also unavailable. In fact, for older adults without access to employer-based coverage, the average out-of-pocket costs for premiums and health care purchased on the individual market were typically two-and-a-half times higher than those similar in age with employer coverage. The ACA's limit on age-rating of 3:1, combined with the law's coverage subsidies, are critical to ensuring that pre-Medicare eligible Americans can afford coverage.

Proposed Changes to Age Bands Would Increase Federal Spending

In September 2015, the Commonwealth Fund published an analysis entitled, "Charging Older Adults Higher Premiums Could Cost Taxpayers."

Commonwealth found that increasing rate bands to 5:1 would cost the federal government more tax dollars than the current 3:1. This is because older adults with low to moderate incomes (below 400 percent of poverty) would face cost increases that rise above premium contribution caps, making them eligible for increased subsidies.

Commonwealth concludes that "...the increase in premiums caused by 5-to-1 rate banding would be financed primarily by the federal government." In other words, if the coverage is more expensive, the federal government would pay for a large part of the difference. In addition, they also found that such a change would result in 400,000 older people losing health coverage altogether.

In short, changing the age rating bands in current law to 5:1 would make coverage for older Americans more expensive, come at an increased cost to the federal government and result in many older Americans losing coverage.

A 3:1 Age Band is More Price Efficient for the Market

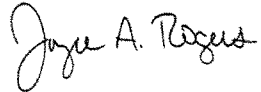
According to a 2013 Urban Institute study, the 3:1 band, "results in age-based premiums that more accurately match age-related costs among likely purchasers than would a looser rate band." The Urban study goes on to say that higher rate bands "would significantly increase out-of-pocket rates" paid by older Americans and that a 5:1 band – as called for in one of the bills the subcommittee is examining today – tends to overcharge older adults relative to their actual health expenses.¹

Relaxing age-related rate bands is therefore a bad deal for Americans aged 50-64 and leads to higher costs and reduced coverage. For these reasons, AARP strongly opposes efforts to expand age rating bands and shift more costs onto older Americans.

¹ Blumberg, Linda J. and Matthew Buettgens. *Why the ACA's Limits on Age-Rating Will Not Cause "Rate Shock": Distributional Implications of Limited Age Bands in Nongroup Health Insurance*. Washington DC: Urban Institute, 2013

Thank you for the opportunity to submit written testimony. If you have further questions, please feel free to contact me or have your staff reach out to Andrew Schwab of our Government Affairs staff at aschwab@aar.org or 202-434-3770.

Sincerely,

A handwritten signature in black ink that reads "Joyce A. Rogers". The signature is written in a cursive, flowing style.

Joyce A. Rogers
Senior Vice President
Government Affairs



June 9, 2016

The Honorable Susan Brooks
1505 Longworth House Office Building
Washington, DC 20515

Dear Congresswoman Brooks,

On behalf of the 1.3 million members of AMAC, the Association of Mature American Citizens, I am writing in support of the *State Age-Rating Flexibility Act*. This timely and crucial piece of legislation, aimed at raising the current age-based premium ratios from 3:1 to 5:1, has the potential to save all Americans significant money when choosing their healthcare plan. AMAC has been opposed to several mandates of the *Patient Protection and Affordable Care Act* (PPACA), including its one-size-fits-all approach to age-based premium ratios. This legislation will remedy nationwide uniformity and allow the states more freedom when determining premium rates.

Prior to *PPACA* implementation, 42 states had adopted 5:1 or higher age-based premium ratios—spurring innovative thinking and free-market approaches to control healthcare costs within their states. As mandated under *PPACA* regulation, an age-based premium rate of 3:1 was imposed on states unequipped and unprepared for such drastic changes to their healthcare premium calculating systems. In turn, these steep and rigid changes are forcing younger Americans to pay more for insurance than they have before. Relying on younger Americans to offset the costs of older Americans by paying higher premium rates is unacceptable.

Although capping the age-based premium ratio at 3:1 as opposed to 5:1 sounds good to many seniors, the economic repercussions of such caps on the American healthcare system are staggering. As premiums continue to rise for younger Americans, individuals are more likely to pay the end-of-year penalty for failing to be covered by insurance than to purchase costly, less-than-ideal insurance plans. Additionally, younger people are more likely to visit the emergency room and enroll in insurance only after a traumatic health event has occurred—once again causing increases in prices to the entire healthcare system. Lifting the age-based ratio from 3:1 to 5:1 has the potential to save all Americans money by allowing the respective states the necessary flexibility they need to adequately insure their residents.

As an organization committed to representing the interests of mature Americans and seniors, AMAC is dedicated to ensuring senior citizens' interests are protected. Simply put, AMAC members—and millions more seniors nationwide—do not wish to see their children and grandchildren paying higher prices for the rest of their lives so seniors can save a few bucks. Though there are many more things to be done to fix healthcare in this country, the *State Age-Rating Flexibility Act* is an important step forward in the right direction to reduce costs for all Americans.

Sincerely,

Dan Weber
President and Founder of AMAC



Statement for the Record to:

**COMMITTEE ON ENERGY AND COMMERCE
SUBCOMMITTEE ON HEALTH
U.S. HOUSE OF REPRESENTATIVES**

Hearing on Advancing Patient Solutions for Lower Costs and Better Care

Submitted by:

Blue Cross and Blue Shield Association

June 9, 2016

The Blue Cross and Blue Shield Association (BCBSA) appreciates the opportunity to comment on legislative proposals under consideration by the House Energy and Commerce Subcommittee on Health.

BCBSA is a national federation of 36 independent, community-based and locally operated Blue Cross and Blue Shield companies ("Plans") that collectively provide healthcare coverage for more than 107 million members – one-in-three Americans. BCBS Plans offer individual coverage across the United States and provide coverage in the vast majority of the Exchange Marketplaces today. BCBS Plans have an 85-year history providing coverage across all markets in their local communities.

BCBSA commends the Health Subcommittee for considering proposals that will help to ensure that the individual market is stable, affordable and encourages people to get the ongoing health care they need to stay healthy and manage their chronic illnesses.

Three bills address existing policies that allow some people to buy health insurance only when they need care, making coverage more expensive. We believe these bills would help balance the overall risk pool and stabilize the market by:

- Ensuring individuals are eligible for a Special Enrollment Period before enrolling;
- Aligning grace periods for non-payment of premium with state requirements; and
- Modifying age variation in premium rates to 5:1 or a rate set by a state

A system where people can get health insurance regardless of preexisting conditions can only be viable if people maintain continuous coverage and there are appropriate incentives for all Americans to participate. Experience from the past two and a half years shows that the newly enrolled individuals are older than originally projected; have higher rates of certain conditions (e.g., hypertension, diabetes, depression, coronary artery disease, HIV and Hepatitis C); use more medical services; and have much higher costs.¹ In addition, medical costs continue to increase with significant growth in prescription drug costs.

BCBSA offers the following comments on the bills:

1. Eligibility for Special Enrollment Periods (SEPs) should be determined up front before coverage is effective.

Special enrollment periods (SEPs) play a key role in promoting continuity of coverage during important life transitions, such as job changes, relocations, marriage, and births. However, CMS allows SEPs for more events than either Medicare Advantage or employer coverage. The bill will ensure SEPs are used appropriately by requiring CMS to verify that consumers are eligible for SEPs before they are enrolled.

Individuals who gain coverage through SEPs are a substantial and growing percentage of the Exchange population and they incur significantly higher medical claims than others. In the first two years of the Exchange marketplaces, up to one-third of those enrolled in coverage through SEPs. Moreover, these enrollees typically incur higher costs than those individuals who sign up during the open enrollment period. In fact, the actuarial firm Oliver Wyman found those individuals enrolling in

¹ BCBSA Health of America Report, "Newly Enrolled Members in the Individual Health Insurance Market after Health Care Reform: The Experience from 2014 and 2015".

coverage through SEPs incurred 24% more in health care costs over their first three months of coverage in 2014 than those coming in during the open enrollment period. Oliver Wyman found strong evidence that the relative cost of the enrollees signing up for coverage during SEPs was even higher in 2015.²

2. Grace periods for non-payment of premiums should be shortened to 30 days as required by almost all states.

The ACA required a three-month grace period for certain individuals to continue receiving coverage without paying their health insurance premiums. The ACA requirement far exceeds state grace periods which are typically 30 days, allowing some individuals to stop paying premiums in October but continue to receive medical services through December and then re-enroll the following January without paying any outstanding premiums, causing premiums to rise for everyone. The bill before the Committee would address this issue.

A recent national consumer survey shows that more individuals are using the grace period than before. It found that 18% of consumers stopped paying their premium in 2015 and then reenrolled again in 2016. Further, half of these consumers returned to the same plan they stopped payment for in 2015. Of the consumers that stopped paying premiums last year, 45% said they had stopped payments in 2014.³

3. Allow states to determine the age rating factors to ensure appropriate incentives to enroll younger, healthier people.

The ACA limited the amount premiums for adults can vary based on age to a 3 to 1 band. This has made premiums for younger people much more expensive than the actual medical costs they claim and resulted in fewer people age 25-44 obtaining health insurance. In fact, the uninsured rate is much higher than was originally projected for those ages 25-44. The bill before the Committee would help bring younger, healthier people into the system, making it more affordable for everyone.

CONCLUSION

Keeping premiums affordable for everyone is crucial to increasing participation among healthier individuals who help balance the overall risk pool and stabilize the market. The current risk pool is out of balance – with a disproportionate number of people who need significant healthcare services – making health insurance more expensive for everyone.

The legislation under consideration by the Subcommittee provides a needed course correction to ensure greater affordability.

² Oliver Wyman, “Special Enrollment Periods and the Non-Group, ACA-Compliant Market”.

³ http://healthcare.mckinsey.com/sites/default/files/McK%202016%20OEP%20Consumer%20Survey%20Infographic_vF.pdf

The Honorable H. Morgan Griffith
United States House of Representatives
1108 Longworth House Office Building
Washington, DC 20515

The Honorable Diana DeGette
United State House of Representatives
2368 Rayburn House Office Building
Washington, DC 20515

Dear Representatives DeGette and Griffith,

Our organizations strongly support your legislation, *H.R. 3463, the Aligning Children's Dental Coverage Act of 2015*. This legislation would provide greater clarity and consistency for employers offering health and dental coverage and would eliminate the current confusion in the small group and individual marketplaces outside the public Exchanges.

H.R. 3463 would ensure small businesses can continue to offer families in off-Exchange markets access to the same variety of dental coverage choices currently enjoyed inside the public Exchanges. Without this clarification, small businesses must contend with the confusion of two differing standards for how dental coverage is offered—one inside and one outside the Marketplaces. In addition, consumers may find their choices limited in the future.

We appreciate your leadership on this important bill and look forward to working with you to ensure that children and families have clarity in understanding their coverage options as well as expanded choices when shopping for dental coverage in the off-Exchange market. Families and small businesses should be able to choose dental coverage that best suits their needs.

Sincerely,

American Supply Association
Council for Affordable Health Coverage
Council of Insurance Agents and Brokers
National Association of Dental Plans
National Association of Health Underwriters
National Retail Federation
Small Business & Entrepreneurship Council



Charging Older Adults Higher Premiums Could Cost Taxpayers



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[\(/about-us/experts/saltzman-evan/\)](/about-us/experts/saltzman-evan/)

Tuesday, September 15, 2015

By Christine Eibner (</about-us/experts/eibner-christine/>) and Evan Saltzman (</about-us/experts/saltzman-evan/>)

[us/experts/saltzman-evan/](/about-us/experts/saltzman-evan/))

This post is the second in a series analyzing proposals that seek to change provisions in the Affordable Care Act.

First post: [The Ramifications of Repealing the Individual Mandate \(/publications/blog/2015/aug/the-ramifications-of-repealing-the-individual-mandate/\)](/publications/blog/2015/aug/the-ramifications-of-repealing-the-individual-mandate/)

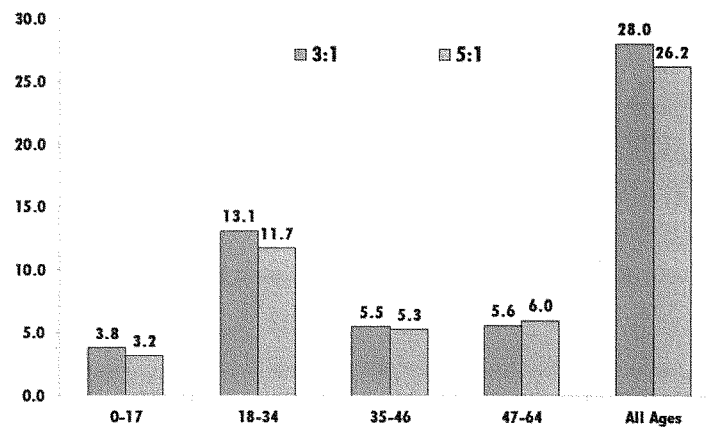
The Affordable Care Act (ACA) requires that health insurers make coverage accessible and affordable to all individuals, regardless of age, gender, or health status. Under the ACA, people age 64 and older cannot be charged more than three times as much as 21- to 24-year-olds for the same plan (this is known as 3-to-1 “rate banding”). In general, this rule reduces premiums for older enrollees, while raising costs for younger enrollees. While the goal of the regulation is to make insurance affordable for all age groups, critics argue that it discourages young, healthy people from enrolling.

Several recent proposals, including one offered by Senators Richard Burr (R-N.C.), Orrin Hatch (R-Utah), and Rep. Fred Upton (R-Mich.), would allow insurers to charge older adults up to five times as much as younger adults (5-to-1 rate banding) while simultaneously making other changes to the ACA. We analyzed the effects of relaxing the ACA’s rate bands from 3-to-1 to 5-to-1 while leaving other ACA provisions in place. We focused on marketplace plans and other ACA-compliant health plans in the individual market, and excluded plans offered by employers (which are regulated differently). We found that while more—mostly younger—people would become insured under 5-to-1 rate banding, federal health spending would increase and 400,000 older people, who tend to have more health problems, would lose coverage.

We conducted our analysis using the RAND COMPARE microsimulation model, a tool that uses economic theory and data to predict how individuals and employers will respond to the ACA. Our [technical appendix \(/media/files/publications/blog/2015/eibner_rate_banding_tech_append_090215_clean_pf.pdf?la=en\)](/media/files/publications/blog/2015/eibner_rate_banding_tech_append_090215_clean_pf.pdf?la=en) describes the model approach and methods in detail.

Simulations using the COMPARE model suggest that, with 5-to-1 rate banding, people age 47 and older would face higher premiums than they would under 3-to-1 rate banding, while people under age 47 would benefit from lower premiums. For example, a benchmark annual premium for a 64-year-old would rise from about \$8,500 under the ACA to \$11,000 under 5-to-1 rate banding. In contrast, the annual premium for a 21-year-old would fall by about \$700, from \$2,800 to \$2,100. As a result, our modeling finds that a net 1.8 million additional people would be insured with 5-to-1 rate banding relative to 3-to-1 rate banding (Exhibit 1). However, this change—a 6 percent decrease in the number of uninsured—comes with a hefty price tag, because many of the older adults facing higher premiums would surpass the ACA's premium contribution cap. Because the young people who would newly enroll would be mostly ineligible for subsidies, the increase in federal spending on older adults would more than offset any federal savings stemming from new enrollment among young people. We estimate that total federal spending would increase by \$9.3 billion as a result of the rate-banding change.

Exhibit 1. Estimated Number of People Without Health Insurance, by Age, 2017



Source: Estimates based on the COMPARE microsimulation model

To fully understand the shifts in spending and the number of insured, it is helpful to consider how changes in coverage vary across age and income groups. Relaxing the rate bands results in 4.4 million people under the age of 47 newly enrolling in the individual market. The vast majority of these people (88 percent) have incomes too high to enable them to qualify for subsidies. In addition, more than 40 percent of these new enrollees shift from employer coverage into the individual market, rather than becoming newly insured. About 75 percent of those who are estimated to shift from employer to individual market are under age 20 and enrolled on their parents' plans. (Families would save money by moving a child or children to the individual market.) Meanwhile, a net 400,000 people over age 47 lose coverage when the rate bands are relaxed from 3-to-1 to 5-to-1, because these older individuals face higher marketplace premiums and have no alternative source of coverage. Most of those losing coverage are unsubsidized as well. Overall, younger, unsubsidized people benefit from the change, while older people face higher premiums.

While few new enrollees receive subsidies, federal spending increases under 5-to-1 rate banding because subsidy spending increases for existing enrollees. This increase in spending occurs because the ACA caps premium contributions for low- and moderate-income marketplace enrollees as a percent of income. If the premium exceeds the cap, the federal government pays the difference, as long as the enrollee chooses a benchmark plan or cheaper coverage. Older adults are more likely to hit the contribution cap than younger adults because, although premiums increase with age, the cap remains fixed. Because many older enrollees already hit the cap under 3-to-1 rate banding, the increase in premiums caused by 5-to-1 rate banding would be financed primarily by the federal government.

Simultaneously, revenue from the ACA's individual mandate penalty declines with 5-to-1 rate banding, because more people become insured. Overall, annual federal costs associated with the ACA would increase by \$9.3 billion dollars if rate bands were relaxed from 3-to-1 to 5-to-1 (Exhibit 2).

Exhibit 2. Annual Federal Budgetary Effects of Relaxing ACA's Rate Bands from 3-to-1 to 5-to-1, 2017

Budget Outcome	Net Effect on Cost of ACA (in \$ billions)
Spending on subsidies	\$8.3
Loss of individual mandate revenue	\$1.0
Total change in spending	\$9.3

Source: Estimates based on the RAND COMPARE microsimulation model.

Should policymakers wish to encourage enrollment among the young and healthy, 5-to-1 rate banding may not be a cost-effective solution, given that federal spending for existing older enrollees would likely increase and the need for charity care among vulnerable older adults would rise. Other approaches, such as expanding outreach to younger enrollees, educating consumers about the benefits of insurance, and improving the functionality of marketplace websites to make it easier to enroll, could yield higher enrollment at a lower cost to taxpayers.

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Why the ACA's Limits on Age-Rating Will Not Cause "Rate Shock": Distributional Implications of Limited Age Bands in Nongroup Health Insurance

Timely Analysis of Immediate Health Policy Issues

March 2013

Linda J. Blumberg and Matthew Buettgens

Summary

As the 2014 start date for the ACA's full implementation approaches, insurers are calling attention to a potential "rate shock" – or substantial increase in health insurance premiums – that will push young adults out of the nongroup insurance market, leaving them uninsured and raising premiums for older adults. Accordingly, the industry advocates pulling back on the ACA's requirement that premiums for adults age 64 be no more than three times higher than the premium for adults age 21 for the same coverage (a constraint relative to the fivefold-or-more difference that applies in today's market). This paper compares the likely impact of the ACA's 3:1 rate band to a "looser" 5:1 alternative—using the Urban Institute's Health Insurance Policy Simulation Model (HIPSM) to examine behavior of likely purchasers. The analysis considers not only the ACA's rating requirements but also the impact of subsidies and Medicaid, CHIP or other coverage that will

limit the out-of-pocket health costs individuals and families actually pay.

Overall, we find that loosening the rate bands from 3:1 to 5:1 would have very little impact on out-of-pocket rates paid by the youngest nongroup purchasers, once subsidies are taken into account. This is not only the case for all likely purchasers, but also for two populations of particular concern: the 10 million 21-27 year olds who are currently uninsured and the 3 million who currently have nongroup coverage.

The vast majority of these young adults will be protected by Medicaid/CHIP, subsidies provided through the exchanges, or by their parents' employer-based coverage. By contrast, looser rate bands would significantly increase out-of-pocket rates paid by the oldest purchasers, who lack a parental option and are substantially less likely to be eligible for subsidies.

Introduction

Considerable attention has been given to the possible "rate shock" in nongroup insurance markets once the full reforms associated with the Affordable Care Act (ACA) are implemented in 2014. The insurance industry warns, in particular, that the 3-to-1 age bands included in the law will substantially increase premiums faced by young adults, pushing them out of the insurance market and leaving them uninsured.¹ These age bands constrain carriers from charging a 64-year-old more than three times the premium of a 21-year-old for the same coverage. The industry believes these bands should more closely align with the premium variation by age seen in today's nongroup insurance markets (typically at least 5 to 1).

This paper explores the full distributional implications of the 3:1 bands relative to the "looser"

policy alternative of 5:1 bands, and specifically examines what the young adults currently covered through the nongroup insurance market and those uninsured will face once the reforms are fully in place. A complete analysis, such as the one presented here, requires an assessment of how other changes forthcoming in the ACA could also affect this population, including eligibility for tax credits to offset some of the costs of premiums and cost-sharing responsibilities, as well as Medicaid eligibility. We use the Urban Institute's Health Insurance Policy Simulation Model (HIPSM) to examine these issues comprehensively.

Tighter age-rating bands will increase premiums charged for the youngest adults older than 20 and lower them for the oldest adults compared to looser age bands. However, most young adults currently covered by

nongroup insurance will be shielded from the full effects of the narrower age-rating bands by the ACA's increased eligibility for Medicaid, the tax credits offered through the health insurance exchanges, or through access to employer-sponsored insurance.

Methods

We use the Urban Institute's Health Insurance Policy Simulation Model to estimate the effects of health reform among the nonelderly population.² Individuals eligible for Medicare are excluded from the analysis.

HIPSM simulates the decisions of businesses and individuals in response to policy changes, such as Medicaid expansions, new health insurance options, subsidies for the purchase of health insurance, and insurance market reforms. The model estimates changes



Table 1: CMS Proposed Standard Age Curve

Age	Premium ratio	Age	Premium ratio	Age	Premium ratio
0-20	0.635	35	1.222	50	1.786
21	1.000	36	1.230	51	1.885
22	1.000	37	1.238	52	1.952
23	1.000	38	1.246	53	2.040
24	1.000	39	1.262	54	2.135
25	1.004	40	1.278	55	2.230
26	1.024	41	1.302	56	2.333
27	1.048	42	1.325	57	2.437
28	1.087	43	1.357	58	2.548
29	1.119	44	1.397	59	2.603
30	1.135	45	1.444	60	2.714
31	1.159	46	1.500	61	2.810
32	1.183	47	1.563	62	2.873
33	1.198	48	1.635	63	2.952
34	1.214	49	1.706	64+	3.000

Source: Federal Register, vol. 77, no. 227, Monday, November 26, Proposed Rules

in government and private spending, premiums, rates of employer offers of coverage, and health insurance coverage resulting from specific reforms. We simulate the main coverage provisions of the ACA as if they were fully implemented in 2017. We expect that behavioral changes by individuals and employers to the 2014 reforms will have reached equilibrium at most three years after implementation.

Age rating is simulated consistent with the November 2012 notice of proposed rulemaking's "CMS Proposed Standard Age Curve" reproduced in table 1,³ which is referenced in the final rules as well.⁴ Under this approach, all those age 20 and younger are grouped together for premium rating purposes, 21- to 24-year-olds are rated the same, and then premium rates increase each year through age 64. Since the intention for the published 3:1 curve was to follow the natural distribution of costs by age for a standardized population as much as possible, the compressed rating was achieved by flattening the curve for the very youngest (from 21 to about 27) and very oldest (about 57 and older). With the 5:1 rating, we followed the same

approach, except with modified age curves, loosening this flattening enough to achieve the higher ratios. Once the ratios were established, the level of the entire curve was raised or lowered to ensure that the aggregate insured costs of those enrolled were covered. Premium administrative loads are then added to these adjusted averages. Nongroup premiums are constructed by summing the appropriate premium costs for each member of the health insurance unit, consistent with the notice of proposed rulemaking.⁵ As a result, premiums will vary not only with age, but also by the number of individuals in the family.⁶ All individuals are simulated to enroll in ACA-compliant insurance plans.

We simulate age-rating bands of 3:1 (as written in the ACA) and compare those findings to looser age rating bands of 5:1, leaving all other provisions of the ACA constant. We also assume a similar age gradient approach outlined by CMS, but scaled upward to allow greater variation between the top and the bottom of the relevant age distribution. Additional methodological details are provided in the appendix.

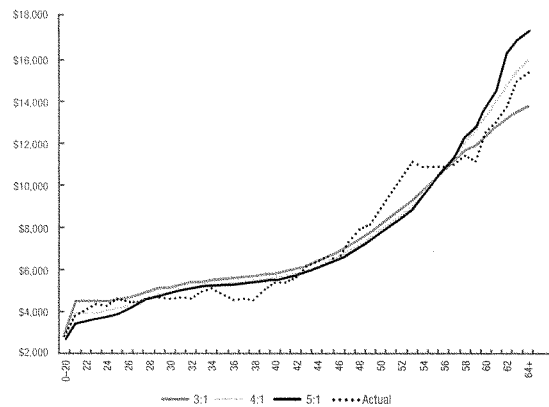
Results

Exchange-Based Nongroup Health Insurance Premiums.

Figure 1 illustrates the average premium by age for a silver-tier policy under the ACA as simulated in HIPSM using the CMS proposed standard age curve. Silver is the tier to which premium and cost-sharing subsidies in the nongroup health insurance exchange will be calculated. Using a bronze-tier plan would shift all the curves in the figure down; using gold or platinum plans would shift them up. While CMS only delineates the age curve for 3:1 rating since that is the approach required under the ACA, we adapt their gradient for 4:1 and 5:1 age-rating bands by changing the relative differences between age groups proportionately. While the remainder of the analysis focuses exclusively on comparisons of 3:1 and 5:1 ratings, we show 4:1 rating in figure 1 as well in order to clarify its implications relative to the other two, particularly for phasing down from looser to tighter bands as some in the industry have proposed.

The orange line represents the 3:1 premium gradient, the light blue the

Figure 1: Premiums at Different Age Compression Ratios, New HHS Method



4:1 gradient, and the dark blue line the 5:1 gradient. Since family premiums will be constructed in the post-reform nongroup market by summing the age-rated individual premiums of each family member, these curves reflect the age-rated premiums facing all nongroup enrollees expected to purchase coverage in the exchange, whether they would enroll in a single or family policy. By design, there is very little difference between the premium curves under the different age bands except for the youngest and oldest adults. Premiums are noticeably higher for those age 21 to 27 under 3:1 rating and are noticeably lower for those age 57 and older. The difference between premiums charged on behalf of those age 28 to 56 are considerably smaller across the different rating approaches, with the premiums under 3:1 slightly higher than under 4:1 and 5:1.

The red dotted line represents the variation in premiums that would be expected if age rating varied by the average covered expenses of those

individuals actually expected to enroll in nongroup coverage under the ACA. The 3:1 age gradient developed by CMS is reasonably consistent with expected enrollee expenses, particularly for those up to age 27 and for those age 42 and older. Using the 5:1 age gradient would tend to undercharge young adults relative to their actual expenses and overcharge older adults relative to their actual expenses.

Table 2 shows the full average premiums for exchange-based nongroup coverage, by policy type (single versus family), and age of those covered for each of the two rating scenarios. The overall averages differ very little (less than 4 percent), due to slight differences in the age and health care risk of the nonelderly population enrolled in nongroup coverage and in the mix of policies purchased across the actuarial value tiers (bronze, silver, gold, and platinum).⁷ For family policies, premium differences also reflect family size and age composition variation in those insured across the scenarios.

The largest differences in average single premiums between the age-rating scenarios, as would be expected, occur for adults age 21 to 27 and age 57 and up. Premiums for 21- to 27-year-olds are \$850 lower under 5:1 than under 3:1 rating, while premiums for the 57- to 64-year-olds are \$1,770 higher under 5:1 bands, on average. Average premiums for 18- to 20-year-olds are \$150 lower under 5:1 rating than under 3:1 rating, about a 5 percent difference. Those age 28 to 56 would also see considerably smaller differences in average premiums under the two rating scenarios, in the range of 4 to 5 percent.

Similarly, average family premiums for those with older family members (57 and above) but without members 21 to 27 years old are significantly lower under 3:1 than under 5:1 rating. Conversely, those families with at least one member age 21 to 27 but without members from the older age group would save under 5:1 rating compared to 3:1. However, the savings for the younger units of moving to 5:1 rating would be about half the size of the increased cost that would be imposed on the older families. Differences in premiums across the rating regimes are much smaller for other mixed-age families.

Net Cost to Families, Taking Account of Premiums, Out-of-Pocket Costs, and Subsidies. As noted, premiums alone do not accurately portray the implications of different age-rating bands within the context of the ACA. Health care costs under reform also include out-of-pocket spending (e.g., deductibles, co-insurance), and federal subsidies reduce these costs for those with modest incomes. Table 3 shows the average 2017 health care costs faced by those insured through the nongroup insurance exchanges, by age, policy type, and income group, under the two age-rating band scenarios. For all insureds with incomes between 133 percent and 300 percent of the federal poverty level (FPL), within each age group, there is almost no difference in net costs between scenarios. This

Table 2: Average Premium for Exchange Based Nongroup Health Insurance Under Comprehensive Health Care Reform by Premium Age Rating Option and Age of Covered Individuals, 2017

Age Group of Policyholder	Premium Rating Option		
	3:1	5:1	Difference
Single Adults			
18–20	3,050	2,900	-150
21–27	4,850	4,000	-850
28–44	5,840	5,540	-300
45–56	8,930	8,560	-370
57+	13,160	14,930	1,770
Overall	6,930	6,660	-270
Family Units			
At least one age 21–27, none age 57+	11,580	10,340	-1,240
Other mixed-age families	16,200	15,440	-760
At least one age 57+, none age 21–27	23,450	25,930	2,480
Overall	16,970	16,570	-400

Source: The Urban Institute's Health Insurance Policy Simulation Model, 2013.

Notes: Affordable Care Act simulated in 2017. Medicare recipients are excluded from the 57+ age group. Estimates include portions of premiums paid privately and via federal subsidies.

Table 3: Net Cost to Families for Nongroup Policyholders by Premium Age Rating Option, Age of Covered Individuals, and Income Relative to Poverty, 2017

Age Group Single Units	Age-rating restriction	Covered lives (thousands)	Out-of-Pocket by Income		
			133–300% of FPL	300–400% of FPL	400%+ of FPL
18–20	3:1	290	\$1,390	\$4,640	\$3,910
	5:1	286	\$1,370	\$4,560	\$3,780
	Difference		-\$20	-\$80	-\$150
21–27	3:1	1,544	\$1,530	\$4,850	\$5,820
	5:1	1,568	\$1,530	\$4,580	\$5,350
	Difference		\$0	-\$270	-\$470
28–44	3:1	1,718	\$1,660	\$5,030	\$6,530
	5:1	1,735	\$1,660	\$4,920	\$6,200
	Difference		\$0	-\$110	-\$330
45–56	3:1	1,329	\$1,830	\$5,610	\$11,360
	5:1	1,347	\$1,840	\$5,620	\$10,860
	Difference		\$10	\$10	-\$500
57+	3:1	718	\$2,270	\$6,250	\$15,620
	5:1	672	\$2,260	\$6,260	\$17,020
	Difference		-\$10	\$0	\$1,400
Age Group Family Units	Age-rating Restriction	Policies (thousands)	Out-of-Pocket Costs by Income		
			133–300% of FPL	300–400% of FPL	400%+ of FPL
At least one age 21–27, none age 57+	3:1	353	\$3,590	\$7,770	\$12,900
	5:1	369	\$3,590	\$7,220	\$11,670
	Difference		\$0	-\$550	-\$1,230
Other mixed-age families	3:1	2,315	\$4,440	\$10,030	\$21,500
	5:1	2,388	\$4,410	\$10,000	\$20,740
	Difference		-\$30	-\$30	-\$760
At least one age 57+, none age 21–27	3:1	642	\$4,730	\$9,970	\$28,410
	5:1	615	\$4,710	\$9,970	\$30,730
	Difference		-\$20	\$0	\$2,320

Source: The Urban Institute's Health Insurance Policy Simulation Model, 2013.

Notes: Affordable Care Act simulated in 2017. Medicare recipients are excluded from the 57+ age group. Net cost is premiums plus out-of-pocket costs less subsidies.
FPL = federal poverty level.

consistency results from the structure of the federal premium subsidies, which limit the amount of premium owed to a share of family income. The same is largely true for those with incomes

between 300 percent and 400 percent of FPL, as this income group is also eligible for federal subsidies.

We do, however, see net costs somewhat lower for the younger adult

age groups purchasing policies under the looser rating scenarios. With 3:1 age rating, single premiums for a young adult in this income group are generally greater than the amount they would

Table 4: Number of Policies and Median Health Care Spending Relative to Income for Nongroup Insurance Purchasers by Premium Age-Rating Option, Age of Covered Individuals, and Income Relative to Poverty

Age Group Single Units	Age rating restriction	Income Relative to Poverty and Percentile of Financial Burden Distribution					
		133–300% of FPL		300–400% of FPL		400%+ of FPL	
		Median Burden	Policies (000s)	Median Burden	Policies (000s)	Median Burden	Policies (000s)
18–20	3:1	7.2%	233	12.9%	19	5.5%	14
	5:1	7.2%	228	13.0%	20	5.3%	14
	Difference	0.0%		0.1%		-0.2%	
21–27	3:1	7.2%	1,317	11.2%	48	9.6%	64
	5:1	7.2%	1,314	11.1%	42	8.1%	79
	Difference	0.0%		-0.1%		-1.5%	
28–44	3:1	7.2%	1,206	11.3%	49	8.4%	156
	5:1	7.2%	1,207	11.3%	47	8.0%	164
	Difference	0.0%		0.0%		-0.4%	
45–56	3:1	7.8%	875	13.9%	87	12.6%	143
	5:1	7.8%	874	14.2%	86	12.0%	148
	Difference	0.0%		0.3%		-0.6%	
57+	3:1	9.3%	483	18.7%	67	13.9%	86
	5:1	9.3%	485	18.7%	67	16.0%	72
	Difference	0.0%		0.0%		2.1%	
All	3:1	7.5%	4,115	13.2%	270	10.0%	464
	5:1	7.5%	4,108	12.8%	261	9.5%	477
	Difference	0.0%		-0.4%		-0.5%	
Age Group Family Units	Age rating Restriction	Income Relative to Poverty and Percentile of Financial Burden Distribution					
		133–300% of FPL		300–400% of FPL		400%+ of FPL	
		Median Burden	Policies (000s)	Median Burden	Policies (000s)	Median Burden	Policies (000s)
At least one age 21–27, none age 57+	3:1	8.4%	299	12.0%	26	14.5%	46
	5:1	8.6%	307	11.9%	28	13.2%	46
	Difference	0.2%		-0.1%		-1.3%	
Other mixed families	3:1	9.6%	1,465	14.2%	257	16.4%	601
	5:1	9.6%	1,461	14.4%	268	16.1%	621
	Difference	0.0%		0.2%		-0.3%	
At least one age 57+, none age 21–27	3:1	14.0%	332	18.4%	78	17.6%	174
	5:1	13.9%	331	18.4%	78	18.8%	153
	Difference	-0.1%		0.0%		1.2%	
All families	3:1	10.0%	2,096	14.7%	361	16.5%	821
	5:1	10.0%	2,099	14.7%	374	16.0%	820
	Difference	0.0%		0.0%		-0.5%	

Source: The Urban Institute's Health Insurance Policy Simulation Model, 2013.

Notes: Analyses based on the ACA in 2014. Medians (percentiles) are calculated from the 57+ age group. Significant numbers of adult non-group policyholders age 27 or younger report losing students. As a result, some in this age group will be eligible for student insurance through their colleges and universities. It is unclear how many will opt for school-based coverage over exchange-based coverage, so they are all included here. Numbers of single policies equal number of covered lives. More than one person is covered under each family policy. Median health care spending is premiums plus out-of-pocket costs, minus subsidies.

FPL = federal poverty level

be required to contribute toward their coverage; the federal subsidy pays the excess of their premium over 9.5 percent of their income. If age rating is 5:1 instead, premiums for this age group would sometimes be lower than the 9.5 percent of income contribution requirement, in which case the federal subsidy would be \$0. These young adults would thus pay modestly less, on average, for single coverage under 5:1 age rating even though they are eligible for subsidies by virtue of their income.

Ninety-two percent of adults age 21 to 27 enrolling in single plans⁸ in exchange-based coverage have incomes below 300 percent of FPL—in other words, the vast majority of young adults enrolled in these plans would not face different health care costs regardless of the rating bands chosen because of the protection afforded them by the ACA's subsidies (calculated from number of policies provided in table 4).⁹ The same is true for 88 percent of 18- to 20-year-olds, 85 percent of 28- to 44-year-olds, 79 percent of 45- to 56-year-olds and 76 percent of those age 57 and older. Only about 4 percent of the youngest age group purchasing single plans have incomes high enough to make them ineligible for subsidies,¹⁰ compared with about 14 percent of the oldest age group. Over 80 percent of the youngest families buying coverage are eligible for financial assistance for exchange-purchased family coverage.

The largest differences in costs across the age rating scenario are apparent for those with incomes over 400 percent of FPL, those who are ineligible for subsidized coverage. Average net costs for higher-income young adults age 18 to 20 buying single coverage are \$150 lower under 5:1 rating than under 3:1, and the cost difference for 21- to 27-year-olds is \$470. In contrast, those age 57 and older purchasing single policies would face \$1,400 higher average costs under 5:1 age rating than under 3:1 rating. Similar patterns are seen for families with different age compositions. Again, the gains to the young adult families from moving to a 5:1 age rating approach would be half

the increased costs imposed on the older families.

Net costs for older adults are considerably higher than for the younger adults, not only because of age rating and its consequent higher premiums, but also because older adults' use of medical care tends to be significantly higher, meaning their out-of-pocket spending is considerably higher as well. Thus, average spending under 3:1 rating by single 21- to 27-year-olds with incomes above 400 percent of FPL is \$5,820, while it is \$15,620 for singles age 57 and older of the same income. Likewise, average direct costs for older families under 3:1 rating are \$28,410 compared with \$12,900 for younger families.

Health Care Financial Burdens for Those Purchasing Exchange-Based Nongroup Coverage. Table 4 provides median direct health care expenses relative to income for those buying health insurance coverage through the nongroup exchanges. As indicated by the average expenses shown in table 3, the choice of age bands has almost no effect on the financial burdens of those with incomes at or below 400 percent of FPL, which account for about 85 percent of policies sold through the nongroup exchanges. While higher-income 21- to 27-year-olds buying single coverage would see a 1.5 percentage point higher health care financial burden under 3:1 than under 5:1 rating (9.6 percent of income compared with 8.1 percent), their 57- to 64-year-old counterparts would see their financial burdens lessen by over 2 percentage points (13.9 percent of income compared with 16.0 percent). The impact on the other age groups would be substantially smaller. Median financial burdens for 21- to 27-year-old single-policy purchasers outside the subsidy eligibility range would be about half that for those age 57 or older; the differential would shrink under 3:1 rating, but the burdens would remain significantly higher for the older adults. Similar patterns are seen for family policies where the members have different age compositions.

Status of Current Nongroup

Enrollees Under the ACA. Current (pre-ACA) young nongroup enrollees constitute a central concern related to the implications of new insurance market rules. This population is most at risk for experiencing disruptions to their current coverage. While tables presented above include all those purchasing coverage in the nongroup markets post reform (both those newly purchasing and those continuing on from prior nongroup coverage), we now change our focus to those with current nongroup coverage.

Table 5, section A shows the number (in thousands) of covered lives in today's nongroup market by age and status under the ACA.¹¹ As we saw previously, the one group for whom 3:1 age-rating bands potentially have the largest negative implications is young adults age 21 to 27. Of the 2.9 million adults in this age group with pre-ACA nongroup coverage, 67 percent would be eligible for either Medicaid or CHIP under the ACA or for exchange-based subsidies for the purchase of private nongroup insurance, thus being protected from the potential negative effects of age rating on their premiums. Of the remaining 33 percent, two-thirds are up to age 26 and in families with an offer of coverage from an employer (data not shown), and thus could obtain coverage that way instead of through the nongroup market via the ACA's provisions regarding expansion of dependent coverage in private plans. More than three-quarters of the 1 million younger adults (age 18 to 20) with nongroup coverage would also be eligible for financial protection under the law. Older adults with current nongroup insurance coverage, those most assisted by the ACA's 3:1 age-rating bands, are significantly less likely to be eligible for financial assistance under the law than their younger counterparts.

Status of Currently Uninsured

Under the ACA. Table 5, section B shows the post-reform eligibility status of those currently uninsured, by age. Young adults without insurance far outnumber those young adults with

Table 5:

A. Post-Reform Eligibility Status of Those with Current Nongroup Coverage, by Age Group
(numbers in thousands)

Age group	Eligible for Medicaid, CHIP, or Subsidies		Not Eligible for Subsidies		Total with Current Nongroup in Age Group
	Number Currently Covered	Share of Those Currently Covered	Number Currently Covered	Share of Those Currently Covered	
18–20	785	78.0%	221	22.0%	1,006
21–27	1,927	66.9%	951	33.1%	2,878
28–44	1,434	41.0%	2,067	59.0%	3,501
45–56	1,342	41.4%	1,903	58.6%	3,244
57–64	1,105	50.3%	1,094	49.7%	2,199
Total	6,593	51.4%	6,235	48.6%	12,828

B. Post-Reform Eligibility Status of Those Currently Uninsured, by Age Group
(numbers in thousands)

Age group	Eligible for Medicaid, CHIP, or Subsidies		Not Eligible for Subsidies		Total Currently Uninsured in Age Group
	Number Currently Uninsured	Share of Those Currently Covered	Number Currently Uninsured	Share of Those Currently Covered	
18–20	1,918	82.7%	400	17.3%	2,318
21–27	6,954	70.5%	2,913	29.5%	9,867
28–44	10,700	62.9%	6,307	37.1%	17,007
45–56	7,065	66.2%	3,615	33.8%	10,680
57–64	3,167	74.3%	1,098	25.7%	4,265
Total	29,804	67.5%	14,333	32.5%	44,137

Source: The Urban Institute's Health Insurance Policy Simulation Model, 2013.

Notes: Analysis based on the ACA in 2017.

nongroup coverage today. For example, almost 10 million 21- to 27-year-olds today are uninsured, compared with just under 3 million with nongroup coverage. Over 70 percent of uninsured young adults will be eligible for financial assistance—either through Medicaid or the exchanges—once the ACA is implemented. Over 80 percent of uninsured young adults age 18 to 20 will also be eligible for Medicaid or tax credits in the nongroup exchanges. Consequently, the vast majority of these young adults, a central target population for enrollment in the nongroup market beginning in 2014, will also be shielded from significant financial effects of the change to narrower age-rating bands.

Aggregate Costs and Rates of Insurance Coverage. Consistent with our previous analyses on the distributional effects of age-rating options,¹² the current analysis shows virtually no difference in overall

insurance coverage of the nonelderly across age-rating scenarios (appendix table 1). In addition, there is extremely little difference in the distribution of insurance coverage within age categories. Also consistent with our earlier work, aggregate government, employer and household costs under the ACA are not significantly affected by the choice of age-rating bands, with aggregate costs differing by less than 1 percent between 3:1 and 5:1 rating (appendix table 2). While larger percentages of young adults are eligible for exchange-based subsidies due to being lower income, lowering their premiums does not decrease total federal subsidies significantly since the average premiums for the older adults increase so substantially under 5:1 rating.

Conclusions

The modified community rating rules that will be implemented under the

ACA in January 2014 will change how individually purchased insurance premiums will be determined in the vast majority of states. The law will significantly reduce the current market's variation in premiums between older and younger adults purchasing the same coverage. However, the claims by some in the insurance industry that this change will have dramatic implications for the out-of-pocket costs of young adults are unfounded. Those most affected by the changed rating rules will be those age 21 to 27, for whom average premiums will tend to be higher under 3:1 rating than under looser rating rules, and those age 57 and above, for whom average premiums will tend to be lower under 3:1 rating. However, the 3:1 age gradient developed by CMS is a reasonable proxy for the health expenses of those expected to enroll in the new nongroup marketplace, particularly for those up to age 27 and for those age 42 and older.

Appendix Table 1: Distribution of Health Insurance Coverage Under Comprehensive Health Care Reform by Premium Age Rating Option and Age of Covered Individuals 2017

Age Group	Age Rating Restriction	Private Health Insurance	Public Coverage	Uninsured	Total
Children, < 18	3:1	53.4%	41.4%	5.2%	100.0%
	5:1	53.4%	41.4%	5.2%	100.0%
18–20	3:1	34.5%	48.3%	17.2%	100.0%
	5:1	34.5%	48.3%	17.2%	100.0%
21–27	3:1	55.5%	28.5%	16.1%	100.0%
	5:1	55.5%	28.8%	15.7%	100.0%
28–44	3:1	71.5%	16.0%	12.4%	100.0%
	5:1	71.6%	16.1%	12.3%	100.0%
45–56	3:1	73.5%	17.7%	8.8%	100.0%
	5:1	73.5%	17.7%	8.8%	100.0%
57–64	3:1	65.4%	26.4%	8.2%	100.0%
	5:1	65.4%	26.4%	8.2%	100.0%
All nonelderly	3:1	63.3%	27.2%	9.4%	100.0%
	5:1	63.4%	27.3%	9.4%	100.0%

Source: The Urban Institute's Health Insurance Policy Simulation Model, 2013.

Notes: Affordable Care Act simulated in 2017.

Appendix Table 2: Aggregate Government, Employer, and Household Costs for the Nonelderly Under Comprehensive Health Care Reform by Premium Age Rating Option 2017 (in billions)

	Reform	
	3:1	5:1
Government Spending		
Medicaid/CHIP and household subsidies	597	597
Employer subsidies	6	5
Less assessments and penalties	8	8
Net government spending	595	594
Uncompensated Care	48	47
Employer Spending, incl. assessments	844	838
Household Spending, incl. penalties	482	480
Total Public and Private Spending	1,969	1,959

Source: The Urban Institute's Health Insurance Policy Simulation Model, 2013.

Notes: Affordable Care Act simulated in 2017. Household spending includes health insurance premium payments by workers and others as well as direct out-of-pocket spending on medical care.

In addition, large majorities of the young adults purchasing nongroup insurance today, those uninsured today, and those expected to purchase nongroup coverage under the fully implemented ACA, would be shielded from the negative effects of tighter age-rating rules. This financial protection will come from the availability of federal subsidies for the purchases of private nongroup insurance and, for some current nongroup purchasers and the currently uninsured, the expanded Medicaid program.

Appendix: Methodology

We use the Urban Institute's Health Insurance Policy Simulation Model to estimate the effects of health reform among the nonelderly population.¹⁵ The core of the national model is two years of the Current Population Survey's Annual Social and Economic Supplement, matched to several other national datasets, including the Medical Expenditure Panel Survey–Household Component.¹⁶ Individuals eligible for Medicare are excluded from the analysis.

HIPSM simulates the decisions of businesses and individuals in response to policy changes, such as Medicaid

expansions, new health insurance options, subsidies for the purchase of health insurance, and insurance market reforms. The model provides estimates of changes in government and private spending, premiums, rates of employer offers of coverage, and health insurance coverage resulting from specific reforms. We simulate the main coverage provisions of the ACA as if they were fully implemented in 2017. We choose 2017 because we expect that behavioral changes by individuals and employers to the reforms being implemented in 2014 will have reached equilibrium at most three years after implementation.

This approach differs from that of the Congressional Budget Office (CBO) or the Centers for Medicare and Medicaid Services (CMS) actuaries who by necessity provide 10-year estimates. Our approach permits more direct comparisons of various reform scenarios with each other. The key coverage provisions of the ACA and their implications for coverage and costs were summarized in an earlier policy brief and are not repeated here.¹⁵

For purposes of this analysis, we assume that the nongroup and small group markets are not pooled together in computing premiums. However, states choosing to do so could decrease the magnitude of any nongroup premium increases associated with the ACA.¹⁶ Small firms are defined as those of 100 (full-time-equivalent) or fewer workers as all states must use this definition beginning in 2016. We simulate the affordability exemption to the individual mandate that observers expect to be in the forthcoming regulations; this differs from the interpretation of the Joint Committee on Taxation and CBO that we used in earlier modeling. We assume that dependents will not incur mandate penalties if they do not obtain coverage and the lowest available family premium is above 8 percent of family income. A family would still be barred from subsidized exchange coverage if the lowest single premium offered to one member was less than 9.5 percent of family income. The Basic Health Plan option was not modeled.

The Supreme Court's ruling on the ACA means that states may decide whether or not to expand Medicaid coverage to nonelderly adults. Our analysis assumes that all states take advantage of the opportunity to increase eligibility to those with incomes below 133 percent of FPL. Beginning in 2014, states do not have to maintain Medicaid eligibility for adults above 133 percent of FPL. We assume that states would discontinue eligibility for adults eligible under Section 1115 waivers or Section 1931 who are above that income threshold. Other categories of adults could be

affected, notably the medically needy and pregnant women, but we do not model any change in their eligibility due to the difficulty in identifying them in our underlying survey data.

We assume that college student plans are required to be Essential Health Benefit compliant plans starting in 2014. The structure of the CPS is intended to include students temporarily residing away at college in their parents' permanent residence if they are tax dependents of their parents. Consequently, full-time students reporting on the CPS that they reside independently are treated as independent tax units. However, we recognize that the survey may not correctly identify all full-time students living at school as to whether they are tax dependents of their parent or not, particularly those living outside university housing.

Age rating is simulated consistent with the November 2012 notice of proposed rulemaking's "CMS Proposed Standard Age Curve" reproduced in table 1,¹⁷ which is referenced in the final rules as well.¹⁸ Under this approach, all those age 20 and younger are grouped together for premium rating purposes, 21- to 24-year-olds are rated the same, and then premium rates increase each year through age 64. Since the intention for the published 3:1 curve was to follow the natural distribution of costs by age for a standardized population as much as possible, the compressed rating was achieved by flattening the curve for the very youngest (from 21 to about 27) and very oldest (about 57 and older). With 4:1 and 5:1 rating, we followed the same approach, except with modified age curves, loosening this flattening enough to achieve the higher ratios. Once the ratios were established, the level of the entire curve was raised or lowered to ensure that the aggregate insured costs of those enrolled were covered. Premium administrative loads are then added to these adjusted averages. Nongroup premiums are constructed by summing the appropriate premium costs for each member of the health insurance unit, consistent with the

notice of proposed rulemaking.¹⁹ As a result, premiums will vary not only with the age, but also by the number of individuals in the family.²⁰

A number of factors that could impact premium differences by age are not taken into account here. We do not model the option for catastrophic coverage for adults under age 30 as provided under the ACA. This coverage option makes lower-cost coverage with higher cost-sharing requirements than the bronze level available to young adults, creating a lower premium option than those modeled here. As a consequence, average premiums for the young adults presented will overstate the actual averages under full implementation of the law. In addition, we do not model specific tobacco use-related premium adjustments (permitted in the small group and nongroup markets under the ACA) or premium adjustments due to wellness programs (permitted in the group market under the ACA). Tobacco adjustments are more likely to increase premiums of younger adults than older adults as they are somewhat more likely to use tobacco products.²¹ Wellness adjustments are more likely to increase premiums of older adults, as the health problems they most frequently target (e.g., high blood pressure, high cholesterol, abnormal blood sugar) are more likely to occur among the older population. Depending upon how widespread these premium rating approaches are used, they could significantly affect decisions of adults of different ages and their decisions to enroll in insurance coverage in the small group and nongroup markets, and thus could also affect premiums in those markets.

We simulate age rating bands of 3:1 (as written in the ACA) and compare those findings to looser age rating bands of 5:1, leaving all other provisions of the ACA constant and assuming a similar age gradient approach outlined by CMS, but scaled upward to allow greater variation between the top and the bottom of the relevant age distribution.

Endnotes

- ¹ For example, Karen Ignagni says, "Unless the restrictions on age rating are loosened, younger people will face significant cost increases at the same time the broader coverage expansion begins to take effect in 2014" ("Now is the time to focus on affordability," <http://blogs.reuters.com/great-debate/2012/07/10/now-is-the-time-to-focus-on-healthcare-affordability/>).
- ² For more about HIPSM's capabilities and a list of recent research using it, see "The Urban Institute's Health Microsimulation Capabilities," <http://www.urban.org/publications/412154.html>. A more technical description of the construction of the model can be found at <http://www.urban.org/publications/412471.html>.
- ³ <http://www.gpo.gov/fdsys/pkg/FR-2012-11-26/pdf/2012-28428.pdf>.
- ⁴ http://www.ofr.gov/OFRUpload/OFRData/2013-04335_P1.pdf.
- ⁵ A health insurance unit consists of the group of family members that can typically enroll in private health insurance together. This includes married adults, their dependent children up to age 18, and full-time students age up to age 23.
- ⁶ For the remainder of this paper, "family" is used to refer to the health insurance unit.
- ⁷ For example, in a small number of cases, older adults purchase plans from a higher tier under 3:1 rating than they would under 5:1 rating because the more comprehensive coverage is more affordable under the narrower rating bands.
- ⁸ Single policies each cover one individual (i.e., number of policies is equal to the number of people covered by those policies). Each family policy covers more than one person.
- ⁹ 92 percent is calculated from table 4 as follows: In 2017, we estimate that the total number of single policies for adults age 21 to 27 held through nongroup exchange plans will be 1,429,000. We also estimate that 1,317,000 of those policies will be held by individuals with income at or below 300 percent of FPL. $1,317,000/1,429,000 = 92$ percent.
- ¹⁰ Another 4 percent of this age group has income between 300 and 400 percent of FPL. They are eligible for subsidies by virtue of their income, but as we saw earlier, under 5:1 rating some will not actually receive a subsidy because the premium cost they would face is less than the 9.5 percent of income premium cap they receive from the federal government.
- ¹¹ Here, we include full-time adult students reporting nongroup coverage under the current system. Although much of this coverage is student insurance through colleges and universities, we are unable to identify specifically the source of any particular nongroup plan.
- ¹² Blumberg IJ, Buettgens M and Garrett B. "Update: Age Rating under Comprehensive Health Care Reform." Insight on the Issues brief. Washington: AARP; 2010. Available at <http://assets.aarp.org/rgcenter/ppi/health-care/1000-age-rating.pdf>; and Blumberg IJ, Buettgens M and Garrett B. "Age Rating Under Comprehensive Health Care Reform: Implications for Coverage, Costs, and Household Financial Burdens." Timely Analysis of Immediate Health Policy Issues. Washington: The Urban Institute; 2009. Available at <http://www.urban.org/publications/411970.html>.
- ¹³ For more about HIPSM's capabilities and a list of recent research using it, see "The Urban Institute's Health Microsimulation Capabilities," <http://www.urban.org/publications/412154.html>. A more technical description of the construction of the model can be found at <http://www.urban.org/publications/412471.html>.
- ¹⁴ HIPSM uses data from several national datasets: the March Current Population Survey (CPS) Annual Social and Economic Supplement, the February CPS Contingent Work and Alternative Employment Supplement, the Medical Expenditure Panel Survey (MEPS), the Statistics of Income (SOI) Public Use Tax File and the Statistics of U.S. Business. Distributions of coverage are based on March CPS data with adjustments for the Medicaid undercount.
- ¹⁵ Buettgens M, Garrett B, and Holahan J. "America under the Affordable Care Act." Washington: The Urban Institute; 2010. <http://www.urban.org/publications/412267.html>.
- ¹⁶ See Blavin F, Blumberg IJ, Buettgens M, Holahan J and McMorro S. "How Choices in Exchange Design for States Could Affect Insurance Premiums and Levels of Coverage." Health Affairs 31 (2012): 2290–2298. Relatedly, The November Notice of Proposed Rulemaking on market rules (<http://www.gpo.gov/fdsys/pkg/FR-2012-11-26/pdf/2012-28428.pdf>) specifically allows small groups and small group issuers to "deconstruct" group premiums, assigning the underlying age-adjusted (and tobacco-adjusted) cost of coverage to each member of the group. Depending upon the frequency with which small employers and carriers use this option, and depending upon how those employers structure their premium contributions and how that affects workers of different ages, some workers could change their insurance enrollment decisions, which could in turn affect small group and nongroup risk pools and premiums. We do not take this possibility into account in the estimates presented here.
- ¹⁷ <http://www.gpo.gov/fdsys/pkg/FR-2012-11-26/pdf/2012-28428.pdf>.
- ¹⁸ http://www.ofr.gov/OFRUpload/OFRData/2013-04335_P1.pdf.
- ¹⁹ A health insurance unit consists of the group of family members that can typically enroll in private health insurance together. This includes married adults, their dependent children up to age 18, and full-time students up to age 23.
- ²⁰ "Family" is used to refer to the health insurance unit.
- ²¹ Trends in Tobacco Use. Washington: American Lung Association; 2011. Available at <http://www.lung.org/finding-cures/our-research/trend-reports/tobacco-trend-report.pdf>.

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